GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on Friday 20 May 2016 in the **Gallery Room, Gloucestershire Royal Hospital** commencing at 9.00 a.m. with tea and coffee. **(PLEASE NOTE VENUE FOR THIS MEETING)**

Professor Clair Chilvers
Chair

13 May 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 29 April 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 18 May 2016	**PAPER (To follow)** (Mr Gordon Mitchell)	**To note**	09:06
6.	Minutes of the meeting of the Finance and Performance Committee held on 27 April 2016	**PAPER** (Mr Gordon Mitchell)	**To note**	09:09
7.	Summary of the meeting of the Audit Committee to be held on 17 May 2016	**PAPER (To follow)** (Ms Anne Marie Millar)	**To note**	09:10
8.	Minutes of the meeting of the Sustainability Committee held on 22 April 2016	**PAPER**	**To note**	09:13
	Appointment of Chair			
9.	Retirement of the Chair in December 2016	**VERBAL** (Prof Clair Chilvers)	**To note**	09:14
10.	Recruitment of New Chair	**PAPER** (Mr Dave Smith)	**To approve**	09:17
	Acting Chief Executive's Report and Environmental Scan			
11	May 2016	**PAPER** (Mrs Helen Simpson)	**To note**	09:22
	Quality Report			
12.	Draft Quality Report 2015/16	**PAPER** (Dr Sally Pearson)	**To approve**	09:30
	EFFECTIVE			
13.	Integrated Performance Framework Report	**PAPER** (Mrs Helen Simpson)	**To endorse**	09:35
14.	Improving the Target for Percentage of Stroke Patients Spending 90% of Time on a Stroke Ward	**PAPER** (Mr Eric Gatling)	**To note**	09:45
15.	Financial Performance Report	**PAPER** (Mrs Helen Simpson)	**To endorse**	09:50
16.	Emergency Pathway Report	**PAPER** (Mr Eric Gatling)	**To endorse**	10:05
17.	Nurse and Midwifery Staffing	**PAPER** (Mrs Maggie Arnold)	**To approve**	10:15
18.	Final Accounts	**PAPER** (Mrs Helen Simpson)	**To approve**	10:20

	RESPONSIVE			
19.	Cultural Change Programme Update	**PAPER** (Ms Rebecca Wassell)		10:25
	CARING			
20.	Health and Wellbeing of our Patients	**PAPER** (Dr Sally Pearson)	**To approve**	10:40
	Next Meeting			
21.	Items for the next meeting and Any Other Business	**DISCUSSION (All)**	**To Discuss**	10:50
	Staff Questions			
22.	A period of 10 minutes will be provided to respond to questions submitted by members of staff		**To Discuss**	10:55
	Public Questions			
23.	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 24 June 2016** in the **Subscription Rooms, George Street, Stroud** at **9.30 am. (PLEASE NOTE TIME AND 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 BOARDROOM, 1 COLLEGE LAWN, CHELTENHAM ON FRIDAY 29 APRIL 2016 AT 9 AM

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

PRESENT	Prof Clair Chilvers	Chair
	Dr Frank Harsent	Chief Executive
	Dr Sally Pearson	Director of Clinical Strategy
	Dr Sean Elyan	Medical Director
	Mrs Maggie Arnold	Director of Nursing
	Mr Eric Gatling	Director of Service Delivery
	Mr Dave Smith	Director of Human Resources and Organisational Development
	Mrs Helen Simpson	Finance Director and Deputy Chief Executive
	Mr Gordon Mitchell	Senior Independent Director/ Vice Chair
	Mrs Maria Bond	Non-Executive Director
	Mr Tony Foster	Non-Executive Director
	Mr Clive Lewis	Non-Executive Director
	Ms Anne Marie Millar	Non-Executive Director
	Mrs Helen Munro	Non-Executive Director
APOLOGIES	None	
IN ATTENDANCE	Mr Martin Wood	Trust Secretary
	Dr Mark Silva	Chief of Service – Medicine
PUBLIC/PRESS	Ms Heather Paine	GHNHSFT
	Mrs Sandra Attwood	Staff Governor
	Mrs Jennifer Harley	Patient Governor
	Mr David Chalk	Windrush Care
	Mr Alan Thomas	Lead Governor
	Mr Julius Marstrand	Public Governor
	Ms Rebecca Wassell	Associate Director of Transformation
	Mr Craig Macfarlane	Head of Communications
	Mr Matt Discombe	Echo/ Citizen

The Chair welcomed all to the meeting.

ACTION

106/16 DECLARATIONS OF INTEREST

There were none.

107/16 MINUTES OF THE MEETING HELD ON 24 MARCH 2016

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

108/16 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 this continues to be work in progress. He confirmed that the correct numbers are now included in the Integrated Performance Framework Report and work is continuing with teams to ensure that the VTE Assessments are carried out. Further updates will be included in the Integrated Performance Framework Report. Completed for the purposes of the minutes.*

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 issue is being raised at every opportunity and will be raised again at the Gloucestershire Strategic Form on 29 March 2016. Completed for the purposes of the 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 and that a timeframe for completion will be presented to the next meeting of the Board in May 2016. Ongoing.*

EG
(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. *The Chair reported that she had spoken to the Director of Human Resources and Organisational Development and the Nursing Director and a response is awaited to a freedom of information request regarding the pass rate from those from different countries. Ongoing.*

075/16 Minutes of the meeting of the Quality Committee held on 11 March 2016: 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. *Mrs Munro has spoken to the Associate Director*

of Transformation and this is completed for the purposes of the minutes.

078/16 Operational Plan 2016/17: 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. *The Director of Clinical Strategy reported that the final plan was submitted to Monitor by 11 April 2016. Completed.*

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. *The Director of Clinical Strategy reported that the Finance Director is working with the Clinical Commissioning Group and is close to sign off of the QIPP plans to reflect the Operational Plan. Completed.*

088/16 Items for the next meeting and any other business: The Workforce Race Equality Standard was identified as an item for the next Board meeting. *This item appears later in the Agenda. Completed.*

083/16 Emergency Pathway Report: The Chair said that it is important that safety and quality aspects of Emergency Department performance are reviewed by the Quality Committee. *The Chair reported that discussions are proceeding to ensure that a proportionate and appropriate report is presented to the Quality Committee. Completed.*

109/16 SUMMARY OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 27 APRIL 2016

The Chair of the Committee, Mr Gordon Mitchell, presented the summary of the meeting of the Finance and Performance Committee held on 27 April 2016. The Committee considered a report from the Medical Director on temporary medical staffing and the actions which are under development for this piece of work. The Committee welcomed the new focus of the work by the Divisional Nursing Director for Medicine to better understand in the Division the reasons for the challenges in recruiting and retaining nursing staff. This piece of work is in its early stages and there is a level of optimism that it will make a difference. The Committee received a presentation on the overview of the Lord Carter Review setting out costs and benchmarking to enable an understanding of the differences and opportunities to change. The review needs to be connected to the Trust's Cost Improvement Programme. The Committee's main focus at the meeting was on the Emergency Pathway Report and seeking confidence that the right schemes are being followed. A discussion will take place as part of the substantive item on the Board agenda for confirmation when there will be a return to meeting the trajectory. Following the submission of the final accounts a settlement was reached with the Clinical Commissioning Group which will form part of the 2016/17 financial year resulting in a surplus in line with expectations for 2015/16. There were four issues considered in the Integrated Performance Management Framework Report. These were the areas of exception in the number of patients waiting over six weeks for a key diagnostic test, the 62 day cancer standard and emergency department performance. Additionally, the Committee wish to draw the Board's attention to ambulance handover delays which is now more challenging. The overall message is that there is good work being performed in the Trust and there needs

to be a focus on the areas where there is slippage.

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

- The Chair sought information on the opportunities for the Trust to improve following the publication of the Lord Carter Review. In response, Mr Mitchell said that the headlines from the Review are an aggregate of Trusts efficiency by organisation and compared to the national average our Trust is in the top 10 for efficiency. There are areas which the Review indicates that further work is required within our Trust. However, the Review does not cover all of our Trust's Cost Improvement Programme work in particular, Theatre Utilisation. The Finance Director added that the Trust has fed back comments that the Review does not recognise that our Trust is a cancer centre. However, it did signpost areas of further work for our Trust.

The Chair thanked Mr Mitchell for his report.

RESOLVED: That the report be noted. [0915]

110/16 MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 23 MARCH 2016

RESOLVED: That the minutes of the meeting of the Finance and Performance Committee held on 23 March 2016 be noted. [0915]

111/16 MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING COMMITTEE HELD ON 5 APRIL 2016

The Chair of the Committee, Mr Tony Foster, presented the minutes of the meeting of the Health and Wellbeing Committee held on 5 April 2016. He highlighted that the smokefree signage has now been funded and the signs have been erected. Our Trust's Patient Health and Wellbeing Strategy is to be presented to the Board in May 2016. Smoking Cessation and reducing obesity in our Trust are areas of focus for the Committee and the eLearning module on obesity has been taken by approximately 3500 staff which is considered to be a high proportion. Further work is required in raising the profile to reduce obesity. The Committee has undertaken its first year review based on its terms of reference and a wider range of issues.

SP
(MW to note for agenda)

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

- In response to a question from the Chair, the Trust Secretary reported that the Chair of the Health and Wellbeing Committee is due to report to the Council of Governors on 3 August 2016 on the work of the Committee.
- The Director of Human Resources and Organisational Development reported that he and the Director of Clinical Strategy have enrolled our Trust in the 'Healthiest Work Place in Britain' survey. All staff are being encouraged to complete an on-line questionnaire which will immediately produce a high level printed report for them which has helpful tips on developing and maintaining a healthy lifestyle. Board members were urged to take the lead and participate.

The Chair thanked Mr Foster for his report.

RESOLVED: That the minutes be noted. [0919]

112/16 SUMMARY OF THE MEETING OF THE SUSTAINABILITY COMMITTEE HELD ON 22 APRIL 2016

The Chair of the Committee, Mrs Maria Bond, reported on the final meeting of the Sustainability Committee held on 22 April 2016 as it is to become an Executive function. The catering team gave a presentation about local food purchasing and the identification of opportunities expanding the farm shop stall, developing more seasonal local products, for example, summer salads and exploring the options around home baked cakes. The Committee congratulated Kate Jeal, Communications Specialist, on her work in raising the profile of sustainability issues particularly the articles in 'Outline'. The arrangements for video conferencing of meetings had worked efficiently but clearer instructions are required on the use of the equipment. The Chair commented that the Committee had made good progress on sustainability issues particularly with regard to travel and the hospital estates and that now it was opportune to become an executive function of which Ms Millar had agreed to be the Non-Executive Director Lead.

The Chair thanked Mrs Bond for her report.

RESOLVED: That the summary minutes be noted. [0921]

113/16 MINUTES OF THE MEETING OF THE QUALITY COMMITTEE HELD ON 15 APRIL 2016

The Chair of the Committee, Mrs Helen Munro, presented the minutes of the meeting of the Quality Committee held on 15 April 2016. She expressed her appreciation to the Director of Clinical Strategy for the preparation of the draft Quality Report. Surgery Division had presented to the Committee and the dashboard showed that medication errors continue to represent the third highest trend within the Division which is piloting a national medication safety thermometer to capture missed doses. The overall Divisional complaint response rate is currently red risk-rated and the Committee has asked the Division to provide an earlier response which is better for the patient. All the CQC must do actions have been completed. For consent in Urology proforma has been piloted and agreed pending final approval and printing. In December 2015 there was a serious untoward missed never event regarding wrong side implant presented to joint. The Committee received an update on the current position and future work relating to the high reported mortality for patients treated in our Trust with fractured neck of femur. Almost all of the patients are brought into our 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. 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. An update was provided on the Duty of Candour which from the outset of the introduction of the legislation was going to place a big burden on our Trust with between 20 and 30 incidents reported. The Committee has reviewed its performance

based on a similar approach to that used in the Health and Wellbeing Committee.

The Chair thanked Mrs Munro for her report.

RESOLVED: That the minutes be noted. [0925]

114/15 MINUTES OF THE MEETING OF THE EQUALITY COMMITTEE HELD ON 14 MARCH 2016

RESOLVED: That the minutes of the meeting of the Equality Committee held on 14 March 2016 be noted.

The Chair reported that she had taken the opportunity with the appointment of new Non-Executive Directors to review the Non-Executive Director membership on Committees and the changes will take effect on 1 May 2016.

115/16 CHIEF EXECUTIVE'S REPORT AND ENVIRONMENTAL SCAN

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

- **National:** NHS England has published the Clinical Commissioning Group improvement and assessment framework for 2016/17 and the set of indicators that will be used was attached as annex A to the report.

  NHS England and NHS Improvement have published a national whistleblowing policy (attached as Annex B to the report) and the Trust will need to examine our raising concerns approach to see if it needs amendment. The Director of Human Resources and Organisational Development added that any changes required would be made to our policy which had been written jointly with Staff Side.

  Additionally, the Chief Executive reported that on 28 April 2016 the National Guardian for raising concerns has resigned after 6 weeks in post. An advertisement for a successor is due to be published during the forthcoming week and a national office is to be established to work with Trusts on training and development for raising concerns. The Director of Human Resources and Organisational Development added that there is a requirement for the Trust to appoint a freedom to speak guardian to be effective from 1 April 2017 and a report will be presented to the Board in September 2016.

  DS (MW to note for agenda)

- **Our Trust:** A visit was undertaken to the University Technical College at West Bromwich which has a healthcare focus. This has given impetus to the bid being created for submission in October 2016 led by the University of Gloucestershire upon which our Trust is well represented. A decision on the bid is anticipated in early 2017 and, if approved, the academic intake will commence in September 2019.

  Health and Social Care partners have agreed a process by which Gloucestershire will submit as a separate area its Sustainability and Transformation Plan in June 2016. The first stage is to submit its early high level view of a draft plan which

is required in a set format and was attached as Annex D to the report. The Director of Clinical Strategy will lead on this piece of work for our Trust.

Two separate episodes of industrial action by junior doctors took place in April 2016 where arrangements were put in place to maintain safe services. The Chief Executive expressed his thanks to staff for coping with this situation and for the junior doctors who behaved in a professional manner. Our Trust will need to consider contingency arrangements if there is future industrial action.

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

- Mrs Munro asked for information on the impact of the junior doctors industrial action on the Emergency Department. In response, the Chief Executive said that there was a drop in attendance of between 50 and 60 people equating to between 15 and 20%. On the days of the industrial action our Trust performance was above 95%. A conclusion could be that if it is possible to reduce attendances by this number regularly and with the support of partners our Trust should be in a position to meet the 95% target. However, on the day after the second industrial action admissions were up to 136 (from an average of 110) resulting in an extra ward of admissions. Our Trust is working with partners to ensure they take appropriate patients. Mr Foster asked for details of the operations cancelled on the days of the Junior Doctors Industrial Action. In response, the Director of Service Delivery said that approximately 400 outpatient and 50 elective procedures were cancelled which is a relatively small number and arrangements are in place to catch up. Bookings were stopped when the dates of the industrial action were known and the impact is likely to add a day to waiting times. The Medical Director added that Emergency Department performance could be affected during the Industrial Action as Senior Clinicians – Consultants and Nurses were working on the wards where other areas of activity had been cancelled. Patients had been seen quickly but this situation is unsustainable on a normal basis.
- Mr Lewis asked for the key themes emerging from the visit from Dame Gill Morgan, Chair of NHS Providers, in March 2016. The Chief Executive explained in response that this is a series of monthly visits to Trusts to keep in touch with member organisations. The opportunity was taken to lobby regarding the International English Language Testing System (ILETS) test which is impeding the appointment of foreign nurses to the UK.

The Chair invited the Board to consider the items in the Trust Risk Register and no amendments were made.

The Chair thanked the Chief Executive for his report.

RESOLVED: That the report be noted. [0939]

116/16 INTEGRATED PERFORMANCE FRAMEWORK REPORT

The Finance Director presented the report summarising the key highlights and exceptions in Trust performance up to the end of March 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 Nursing Director added that Our Trust is awaiting the outcome of appeal on 3 Clostridium Difficile decisions. The Trust is on course to meet the target.
- The Director of Service Delivery explained the reasons why our Trust did not meet the recovery trajectory for the 62 day cancer standard in February 2016. He said that approximately 50% of the breaches were in Urology. Additional Consultants have been appointed but the benefit has not been seen due to sickness amongst other consultant staff. Other actions to improve performance are the appointment of a Cancer Services Manager and meetings are taking place with each Division to review cases on a line by line basis with a root cause analysis being undertaken of each breach to understand the delay and to address performance. There are no consistent reasons for the breaches. There are three pathways to improve performance. Those specialities meeting the 85% standard with an emphasis to improve; those specialities close to 85% and a focus to achieve that target and Urology which is being treated separately. There is a County strategy to address demand as a result of national campaigns with one stop clinicians for early diagnosis being established with additional clinics over forthcoming weekends.
- Mrs Munro referred to the Acute Kidney Infection (AKI) performance which has been red risk-rated since December 2015. In response, the Medical Director said that considerable effort has been put in to improving performance which has proved challenging as the standard has increased. The Chief Executive added that our Trust needs to ensure that AKI is included in the discharge summary to obtain credit for performance. SmartCare will help as a reminder as it can be included from a drop down box.
- Ms Millar referred to the numbers waiting over six weeks at month end for 15 key diagnostic tests which had risen to 7.1% red risk-rated in March 2016. In response, the Director of Service Delivery said that issues in Endoscopy and Echocardiograms had been addressed; however, there were issues with MRI and ultrasound scans. Additional capacity has been introduced with a trajectory of two months to return to target and the national requirement to return to target by September 2016.
- Mr Mitchell drew attention to the number of ambulance handover delays which were red risk-rated for March 2016 and was an area of concern raised by the Finance and Performance Committee.

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. [0948]

117/16 FINANCIAL PERFORMANCE REPORT

The Finance Director presented the Financial Performance Report

stating that the position presented is consistent with the draft accounts which are subject to audit. 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. Negotiations with the Clinical Commissioning Group were completed after the production of the annual accounts for additional income based on performance by results leading to an improved position for 2016/17. Effective management of the finances have led to the surplus. Temporary staffing expenditure in March 2016 was £0.2m higher than in February 2016. Considerable effort is taking place to recruit and retain staff to reduce reliance on temporary staffing which is a national issue. The desktop revaluation of our Trust asset base as at 31 March 2016 has resulted in a net impairment reversal of £3.8m which has the effect of moving the reported operational surplus from £0.9m to £4.7m. This represents a technical adjustment in the accounts that NHS Improvement disregards when assessing a Foundation Trust's performance. Emergency spells were 7.5% above plan in activity terms and income was above plan by 6.3%. The impact on income of the emergency cap at March 2016 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. At a 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 overspend was the impact of operational pressures within the health system and agency costs.

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

- The Chair expressed her appreciation to the Finance Director and her team for the work done to finalise the accounts to a tight deadline. This was echoed by the Chief Executive who said that nationally there is only a handful of Trusts reporting a financial surplus.
- The Chief Executive said that the emergency spells had increased by an extra 3400 patients to around 49500 patients per year of which the bulk were through the Medicine Division explaining the pressure in the system. This equated to approximately 10 additional patients per day.
- Mr Lewis said that during the last financial year there were approximately 20% of Trusts reporting a financial surplus and he asked for the percentage this year. In response, the Chief Executive said that it is between 5 and 10 acute trusts reporting a financial surplus this year.

(Ms Sue Barnett, Improvement Director, joined the meeting)

- Mr Foster referred to the analysis by staff group of temporary staffing expenditure and enquired what constitutes a reasonable level of such expenditure. Ms Millar suggested that the Finance and Performance Committee should monitor the position to understand the target in the Sustainability and Transformation Plan. In response, the Finance Director said that the Finance and Performance Committee support the new forward looking targets of which the agency cap forms a part. She stressed that safety is the priority above the agency cap.
- Mr Mitchell said that overall the financial surplus had been met. There is a risk that other Trusts reporting a deficit will not be

penalised and that it is important that our Trust promotes the benefits of achieving a surplus to enable investment in a capital programme and reducing the Cost Improvement Programme target. The Chief Executive, in response, said that the amount of overspend in other Trusts will be regarded as debt.

The Chair thanked the Finance Director for the report.

RESOLVED: That:-

1) The financial position of the Trust at the end of the financial year 2015/16 is an operational surplus of £0.5m on income and expenditure which is £0.2m higher than the position reported in February 2016.
2) The Trust needs to improve its controls on the use of agency staff and discretionary expenditure during the new financial year.
3) Actions to address the issues identified in the report will continue and progress will continue to be reported monthly to the Finance and Performance Committee and the Board. [1002]

118/16 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 March 2016 with Trustwide performance reported as 77.77%.
- He acknowledged that it was a retrospective report detailing the increase in both attendances and admissions. The number of patients on the medically fit list for one day and over was at an average of 61 for March 2016 (2 patients less than February 2016) but remains above the system-wide plan of no more than 40 patients. The target of 5.8 days for General and Acute average length of stay for non-elective admissions was met in March 2016.
- The Workplan is in place with three workstreams – time in the Emergency Department, site management and reducing the number of patients with a length of stay greater than 14 days. Early indications are that there is a slight improvement in Emergency Department performance but there are days when performance dips and need to be rebuilt. This is work in progress.
- There has been an increase in the number of ambulance handovers of 30 minutes and a decrease in delays over 60 minutes. Performance is better than the corresponding period in 2015. The number of ambulance diverts is low. The South West Ambulance Service Trust prefers not to divert. That Trust has changed the log in system and data base when they enter the Emergency Department and an analysis of these data needs to be undertaken.
- The Director of Service Delivery said that he will be reporting to the Finance and Performance Committee within the next couple of months with details of trajectories for the Trust to return to compliance with the 4 hour standard. **EG (MW to note for Agenda)**
- There are actions for the Trust to take to improve performance and actions for the health system to take. The Clinical Commissioning Group will ensure that all in the health system

sign up to the recovery plan which is to be based on firm assumptions and schemes which will deliver. The Chair emphasised that our Trust needs to be clear that what is suggested can be delivered.

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

- Mr Foster noted that ambulance staff could leave patients after 15 minutes of arrival in the Emergency Department and asked for information on patient safety should this arise. In response, the Director of Service Delivery said that the introduction in the Emergency Department of the safety checklist sets out how patients are to be cared for in that situation. Extra staff are on duty at peak times. The target is for patients to be triaged within 15 minutes and seen by a doctor within 60 minutes. This will reduce the length of time patients are in the Department and waiting time with ambulance staff.
- Mrs Bond referred to the % bed occupancy snapshot ranging from 95.6% to 99.7% commenting that this should be highlighted as a reduction will lead to a requirement for less nurses and provide better performance. The Director of Service Delivery said that the national standard is 85% bed occupancy. During the last two days bed occupancy had reduced to 90%.
- The Chief Executive observed that our Trust needs to see a reduction in the planned emergency metrics. The Medical Director added that the reported figures are based at midnight and are higher during the daytime. Our Trust needs one empty bed on each of the 40 wards to reduce total bed occupancy.
- Mr Mitchell said that Emergency Department performance has improved last year and had then dipped. The Finance and Performance Committee focus on the right things to ensure that they are manageable taking the view that fewer plans are a realistic approach. The three workstreams provide assurance and the weekly Touchpoint telephone calls for Non-Executive Directors with the Director of Service Delivery and the Improvement Director are helpful. The health system needs to work better, but acknowledged that there are things within our Trust's control to do.
- The Chief of Service for Medicine Division said the input from the Improvement Director has been helpful in providing challenge. With regard to bed occupancy, speciality teams are overstretched with outliers and a new team will deal with this from the next week. There is a national shortage of emergency care and elderly care consultants necessitating the use of other staff.
- The Improvement Director said that the focus on the three workstreams will release pressure to allow more to be done. It is a challenge for staff and she applauded the successes, albeit limited, where there is improvement in the 14 day occupancy and a reduction of 40% in medical outliers in the last month. The performance in the time to treat patients has also improved. There is more to do but she recognised that this is a national issue with a local focus on our patients.
- The Medical Director, as Executive Lead for the 14 day Workstream, said that these patients currently occupy 65% of total bed days across our Trust. There has been a reduction to 5,200 (from 6,000) bed occupancy days. There are patient

management issues and a more radical approach is required for these patients to leave earlier. The Improvement Director said that the Director of Clinical Strategy is looking at the whole issue of bed occupancy for both emergency and elective patients. The Chief of Service said that sight of outpatient activity should not be lost.

- Mr Mitchell observed that there are indications of fresh discussions with partners. The Director of Service Delivery said that our Trust is working hard with the Clinical Commissioning Group and other partners to ensure a consistent approach. He acknowledged that tensions will remain. The Sustainability and Transformation Plan will provide an opportunity to act as a lever with discussions with partners. He concurred with Mr Mitchell's assessment of the beginning of an improvement in discussions with partners. The Improvement Director added that the System Resilience Group will provide more challenge to partners. Individual organisational sovereignty should not take precedence and behaviours should be challenged.
- The Chair said that there are opportunities across the health system and if the right approach is agreed could lead to system-wide savings. A realistic trajectory needs to be agreed with partners by June 2016. She appreciated the hard work undertaken observing that a change in culture is necessary.

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. [1025]

(Ms Sue Barnett, Improvement Director, left the meeting)

119/16 NURSE AND MIDWIFERY STAFFING

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

In April 2016 the CQC requested information regarding staffing in specific areas in Gloucestershire Royal Hospital. Although due to no agency or bank staff being available to fill late requests it is clear that there is no evidence of harm to patients. The response to the CQC was attached as annex A to the report.

The Nursing Director commented on the challenges faced by junior nurses to manage patients with complex needs which might impact on our Trust's ability to recruit nurses to certain wards. To alleviate this situation the intention is to recruit more HCAs to support junior nurses. There is now a charge of £1,000 for every overseas nurse recruited to our Trust. The Trust received notification on 22 April 2016 of a requirement to report from 1 May 2016 a safer staffing rota based on a number of patients to a ratio. This may have consequences for our Trust. She assured that Board that everything possible is being done to

recruit nurses on a permanent basis. She stressed that patient safety and the right number of nurses is always the priority irrespective of cost.

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

- The Chair referred to the response sent to the CQC regarding staffing in specific areas in Gloucestershire Royal Hospital noting that it demonstrated the number of staff who do not attend at short notice and wondered if a message for staff to give greater notice when they know that they are unwell is appropriate. The Nursing Director said that this is always an issue. The Medical Director added that there are instances of agency staff not attending due to sickness or receiving a more financially attractive offer of work. Their service is stopped if it occurs frequently. The Director of Human Resources and Organisational Development said that there are also instances of agency staff attending but not wishing to work on specific wards. Sickness data during weekends is being collated. The financial incentives to nurses is beginning to help recruitment. Bank hours work has increased by 60% with a reduction in agency hours of 20% which is an indication that the message is having an impact in the organisation.
- Mr Foster referred to the 105 Philippine nurses who had not passed the International English Language Testing System (ILETs) examination and asked if the opportunity to join our Trust had been lost. In response, the Nursing Director said that they have another opportunity to undertake the test.
- Mr Mitchell said that the Finance and Performance Committee have considered staff retention as part of the work started in Medicine Division and that work should be recognised.
- The Director of Service Delivery said that the Emergency Department Workstream 2 – Site Management is to increase on call and on site management presence at weekends to address staffing issues at source.

The Chair thanked the Nursing Director for the report.

RESOLVED: That the report be endorsed. [1035]

120/16 BOARD STATEMENTS

The Finance Director presented the report advising that the Trust is 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; 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 which have not already been reported.

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

these declarations.

The Chair thanked the Finance Director for the report.

RESOLVED: 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 targets 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. [1037]

121/16 WORKFORCE RACE EQUALITY STANDARD

The Director of Human Resources and Organisational Development presented the report providing an update on progress made in the first year of reporting following the introduction of the Workforce Race Equality Standard (WRES) in 2015. He outlined the research which had led to the establishment of the standard which consists of nine measures; the first four relate to workforce data, four taken from the staff survey and one linked to the diversity of the Board. The detail of our performance was presented in the appendix to the report and included data for comparison from our submission from April 2015. There is one issue with the data collation in relation to indicator 8 regarding discrimination from managers or colleagues and further information has been requested from the survey provider. There have been very few movements in the scores relating to each indicator. In support of the WRES our Trust is joining a countywide group to consider equality and diversity issues.

During the course of the discussion, Mr Lewis commented that the results were as expected. He expressed a willingness to talk on the subject. The Chair invited Board members to contact the Director of Human Resources and Organisational Development with any reflections. **ALL**

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

RESOLVED: That the WRES report be published in line with our obligations and that future progress is relayed to the Board via the minutes of the Equality and Diversity Steering Group. [1037]

122/16 7 DAY SERVICES UPDATE

The Medical Director presented the report providing an update on the 7 Day Services pilot in Respiratory and the roll out plan for the remainder of the Trust. The pilot has continued to demonstrate positive outcomes, particularly with regard to the reduced length of stay. 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. The Gloucestershire Respiratory Team is exploring integrated working and will support the Sustainability and Transformation planning across the County. The Project Team is working with Divisions to refine our Trust plan and confirm the priorities for 2016/17. NHS England has published that our Trust 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. The County-wide Steering Group meeting scheduled for the end of April 2016 has been cancelled but the intention is to hold the next meeting in June 2016. All acute Trusts have again been asked by NHS England to conduct another review of 7 Day Services with this survey taking account feedback from the first and with a refined process. The results will be available at the end of April 2016 and will provide a comparison with other Trusts. The risks to the whole Trust plan are being reviewed concentrating on the delivery against the priority areas rather than just a focus on the respiratory pilot.

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

- The Medical Director said the introduction of 7 day services is the right approach and has to be delivered. 7 day services cannot be taken forwarded without additional resources and the concern is the reluctance of the Clinical Commissioning Group (CCG) to fund future work during this financial year. The Chief Executive added that a gap analysis has been undertaken on each of the 10 standards which is the right way to plan. The £7.5m cost (which is in line with NHS England's expectation of between 1 and 2% of total expenditure for the introduction of 7 day services) will require negotiation with the CCG in the latter two years on the requirement for the introduction of 7 day services. Mr Mitchell said that he could not understand the rationale for the CCG's decision in that 7 day services will have to be introduced in a much shorter timeframe leading to risks and unrealistic expectations. There need to be a link between 7 day services and the Emergency Pathway to help reduce pressure in the health system. The Chief of Service for Medicine Division said that discussions are taking place with specialities to deliver 7 day services and more could be done if additional resources were available.
- The Chair undertook to write to the Chair of the CCG to place on record the Board's concern and to seek an explanation of the decision not to fund 7 day services in the current financial year. **CC**

The Chair thanked the Medical Director for the update.

RESOLVED: That progress towards the introduction of 7 Day Services into the Trust be noted. [1048]

123/16 INSTITUTE FOR HEALTHCARE IMPROVEMENT – LESSONS LEARNT

The Nursing Director gave a presentation providing an update at April 2016 on our Trust programme of actions following the visit to the Institute for Health Care Improvement. The presentation covered the following aspects:-

- Patient experience quality improvement methodologies – patient and family centred care, experience based co-design and embedding policies that work in practice and use scenarios to embed learning
- Champions supporting - positive patient outcomes and improving the health of our patients who have dementia.
- Engaging front line staff
- Caesarean section audit summary and action plan from the audit findings
- Lessons learnt and change concepts – SAFER flow and use of PDSA (Plan Do Study Act)
- Reduce "waste" from the pathway – Oncology and Pathology as models.
- Impact of the Digital Age
- Creating a movement – the quality improvement pathway
- Do our staff know how well we are doing?

During the course of the discussion the Chair commented that visits to the Institute for Healthcare Improvement provide an opportunity for our Trust to learn new ideas and new ways of working in an authoritative setting.

The Chair thanked the Nursing Director for the presentation.

RESOLVED: That the presentation be noted.

At the conclusion of the presentation, the Nursing Director read a poem entitled "Farewell to Dr Harsent" which was applauded by the Board. [1108]

124/16 ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

Items for the next meeting: The Trust Secretary reported that the usual Annual Reports are to be presented to the meeting in May 2016.

Any other business:

Cheltenham Borough Council Overview and Scrutiny Committee: The Chair reported that she together with the Director of Clinical Strategy had met the Overview and Scrutiny Committee for a productive discussion on the "One Hospital with a Long Corridor" leading to an opportunity for the Director of Clinical Strategy to meet the Council's Planning Department.

New Chair of the Clinical Commissioning Group

The Chief Executive reported that Dr Andrew Seymour, current Vice Chair, has been appointed Chair of the Clinical Commissioning Group. [1109]

125/16 STAFF QUESTIONS

The following question was submitted by Jonathan Ord, Consultant Urologist:-

"Why has the business case for Consultant Anaesthetist led pre-assessment 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 pre-assessed 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?"

Response provided by the Director of Service Delivery

The Trust has invested over £1.4m in urology services in response to business cases. This funding is this year's budget. This has included investment for additional Consultants and supporting staff to enable patients to be treated quicker. Part of this funding is for pre assessment services and staff are currently being recruited.

Eric Gatling, Director of Service Delivery is happy to meet with Mr Ord to discuss any specific details. [1111]

126/16 PUBLIC QUESTIONS

There were none. [1111]

127/16 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at **9am** on **Friday 20 May 2016** in the **Gallery Room, Gloucestershire Royal Hospital**.

128/16 MRS MARIA BOND – NON-EXECUTIVE DIRECTOR

The Chair reported that this will be the last meeting which Maria Bond will be attending following her period as a Non-Executive Director for the last seven years. She paid tribute to the work which Maria had undertaken in taking forward the work of the Sustainability Committee and in her role as supporting the Nursing Director in Safeguarding and in health and safety. She had provided challenge to the Board. Here experience in property matters will be much missed. The Chair made a presentation to Maria on behalf of the Board.

Maria thanked the Board for their good wishes and wished Board Members well for the future.

The Board applauded the work undertaken by Maria Bond.

129/16 DR FRANK HARSENT – CHIEF EXECUTIVE

The Chair reported that this will be the last meeting which Dr Frank Harsent will be attending before his retirement from the post of Chief Executive. A presentation will be held later that day at which the Chair would say more. She paid tribute to Frank for his leadership over the past 8 years, for his resilience and for the achievements that he had

led, particularly in patient safety and patient care She thanked him for all is service to the NHS and our Trust and, on behalf of the Board, wished him well for the future.
Frank said that over his 20 years as a Chief Executive he had worked with 7 Chairs, approximately 70 Executive and Non-Executive Directors and this was the best Board with which he had worked. He wished the Board every success in dealing with the future challenges.

The Board applauded Dr Harsent's achievements.

130/16 EXCLUSION OF THE PUBLIC

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

The meeting ended at 11.17am.

Chair
20 May 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – MAY 2016

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
May 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 and that a timeframe for completion will be presented to the next meeting of the Board in May 2016. *This item appears later in the Agenda.*
May 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. *The Chair reported that she had spoken to the Director of Human Resources and Organisational Development and the Nursing Director and a response is awaited to a freedom of information request regarding the pass rate from those from different countries. 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. *This item appears later in the Agenda. Completed.*
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.*

FUTURE TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
June 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 June 2016 Board Seminar. *Ongoing.*

COMPLETED 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 this continues to be work in progress. He confirmed that the correct numbers are now included in the Integrated Performance Framework Report and work is continuing with teams to ensure that the VTE Assessments are carried out. Further updates will be included in the Integrated Performance Framework Report. Completed for the purposes of the minutes.*
		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 issue is being raised at every opportunity and will be raised again at the Gloucestershire Strategic Form on 29 March 2016. Completed for the purposes of the minutes.*
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. *Mrs Munro has spoken to the Associate Director of Transformation and this is completed for the purposes of the minutes.*
April 2016	March 2016 Minute 078/16 Operational Plan 2016/17	**ALL**	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. *The Director of Clinical Strategy reported that the final plan was*

			submitted to Monitor by 11 April 2016. Completed.
		SP	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. *The Director of Clinical Strategy reported that the Finance Director is working with the Clinical Commissioning Group and is close to sign off of the QIPP plans to reflect the Operational Plan. Completed.*
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. *The Chair reported that discussions are proceeding to ensure that a proportionate and appropriate report is presented to the Quality Committee. Completed.*

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

SUMMARY OF THE MINUTES OF THE MEETING OF THE TRUST FINANCE AND PERFORMANCE COMMITTEE HELD ON WEDNESDAY 18 MAY 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

070/16 FINANCIAL PERFORMANCE REPORT

The financial position of the Trust at the end of April of the 2015/16 financial year is an operating deficit of £0.5m representing an adverse variance of £1.5m from the planned position of a £1.0m variance at the end of April 2016 partly due to the phasing of the financial plan, the junior doctors' industrial action and increases in pay and agency costs. Actions to address this concern are being discussed with Chiefs of Service. The Committee focused on agency spend recognising that the Trust will need to look at innovative ways to reduce significantly this area of spend.

071/15 INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK

The Committee has considered the Performance Management Framework and focused on the areas of exception on performance in the Emergency Department including the medically fit list, key diagnostic tests and cancer two week waits. The report was in the new format and the Committee considered improvements including headlines explaining the detail and the safety issues surrounding the Emergency Department

072/15 EMERGENCY PATHWAY REPORT

The Director of Service Delivery reported on the performance to date, the work being undertaken in the three workstreams, the weekly telephone calls with the Non-Executive Directors, the plans to develop the three further longer term workstreams and the trajectories to improve performance over the coming months. The format of the report is to be changed to ensure that all aspects are captured.

073/15 CASH POSITION UPDATE

Due to final account activity, this report is to be circulated by the end of the week.

074/16 PREPARATION FOR THE JUNE MEETING

The Committee has invited the Chiefs of Service, Director of Estates and Facilities. Divisional Nursing and Divisional Operations Directors to attend the June 2016 meeting to present on the respective Divisional financial position, performance (by exception), and doctor and nurse staffing. This year Divisions have been invited to prepare a short paper covering these topics.

075/15 PROGRESS UPDATE ON CONTRACTING PROCESS

The Committee noted that contract negotiations with the Clinical Commissioning Group have been concluded. Commissioner QIPP schemes are outside of the contract. Specialised Commissioner contracts have been concluded on a full pbr basis. Although agreement appeared to have been reached with Gloucestershire Care Services; however, differences remain unresolved and arbitration is underway. The Committee has invited the Finance Director to report to the July 2016 meeting to enable an understanding of the issues involved.

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 27 APRIL 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
	Mr E Gatling	Director of Service Delivery
	Mrs H Simpson	Finance Director and Deputy Chief Executive
APOLOGIES	None	
IN ATTENDANCE	Mr M Wood	Trust Secretary

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

ACTION

049/16 DECLARATIONS OF INTEREST

There were none.

050/16 MINUTES OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 23 MARCH 2016

RESOLVED: That the minutes of the meeting of the Finance and Performance Committee held on 23 March 2016 were agreed as a correct record and signed by the Chair.

051/16 MATTERS ARISING

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. *The Finance Director reported that this information will be included in the month 1 financial report presented to the Committee. Complete.*

036/16 Integrated Performance Management Framework: The Finance Director undertook in response to a question from Mrs Bond to check the impact of performance on coding. *The Finance Director reported that the Clinical Commissioning Group has noted the improved quality of coding and the Trust is discussing the coding at source which is being challenged by the Clinical Commissioning Group. Ongoing.*

008/16 Update on Pay Expenditure: The Chair said that the Committee should consider in April 2016 the work currently being undertaken by the Divisional Nursing Director for Medicine to determine what can be done differently to recruit and retain staff. The Trust should learn from the work undertaken in Bath. *This item appeared later in the agenda as Staff Recruitment and Retention. Completed.*

025/16 Cost Improvement Programme Update: The Chief Executive said that the Committee should receive a briefing on the Carter Review and it was agreed that this be presented to the Committee in April 2016. *This item appeared later in the agenda. Completed.*

052/16 FINANCIAL PERFORMANCE REPORT

The Finance Director presented the Financial Performance Report stating that the position presented is consistent with the draft accounts which are subject to audit. 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. Negotiations with the Clinical Commissioning Group were completed after the production of the annual accounts for additional income based on performance by results leading to an improved position for 2016/17. Effective management of the finances have led to the surplus. Temporary staffing expenditure in March 2016 was £0.2m higher than in February 2016. Considerable effort is taking place to recruit and retain staff to reduce reliance on temporary staffing which is a national issue. The desktop revaluation of our Trust asset base as at 31 March 2016 has resulted in a net impairment reversal of £3.8m which has the effect of moving the reported operational surplus from £0.9m to £4.7m. This represents a technical adjustment in the accounts that NHS Improvement disregards when assessing a Foundation Trust's performance. Emergency spells were 7.5% above plan in activity terms and income was above plan by 6.3%. The impact on income of the emergency cap at March 2016 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. At a 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 overspend was the impact of operational pressures within the health system and agency costs.

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

- Mrs Bond said that in the light of the outcome of the negotiations with the Clinical Commissioning Group a message needs to be cascaded throughout the organisation that Divisions will not receive a financial bailout.
- The Finance Director said that the year-end position has not been resolved with Gloucestershire Care Services although there is no contract upon which to reach a conclusion.

The Chair thanked the Finance Director for the report.

RESOLVED: That:-

1) The financial position of the Trust at the end of the financial year 2015/16 is an operational surplus of £0.5m on income and expenditure which is £0.2m higher than the position reported in February 2016.
2) The Trust needs to improve its controls on the use of agency staff and discretionary expenditure during the new financial year.
3) Actions to address the issues identified in the report will continue and progress will continue to be reported monthly to the Finance and Performance Committee and the Board.

053/16 INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK

The Finance Director presented the report summarising the key highlights and exceptions in Trust performance up to the end of March 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 Director of Service Delivery reported with regard to the key diagnostic test performance additional capacity is being introduced to improve performance. With the agreement of the Clinical Commissioning Group GP referrals are being turned away. Performance is expected to be back on track during the summer 2016.
- The Finance Director reported with regard to the 62 day cancer standard that additional capacity is being introduced and a change in Team Leader should make a difference. The Director of Service Delivery added that the main challenge is in Urology. Discussions are taking place with consultants to introduce three session days and planned activity on Saturdays to improve performance.
- The Director of Service Delivery explained that a detail review is being undertaken of the cancer plan as there were 1,750 two week wait referrals in March 2016 with a monthly increase of 100 patients. National campaigns and the Government desire for GPs to refer patients is impacting on demand and performance. The incident rate of detected cancer has not changed. There is a concern that GPs may not be referring cases soon enough given the number of cases identified in the Emergency department.
- Mrs Bond referred to endoscopy performance which had deteriorated. The Director of Service Delivery explained that performance is affected by waiting times and surges in the annual follow up tests particularly in April and May. Six endoscopy rooms are operating at capacity.
- The Chair referred to the ambulance handover delays which were red risk-rated for March 2016 and sought an explanation. In response, the Director of Service Delivery said the Ambulance service has introduced system changes in the Emergency department which are taking longer to validate which is a reflection of the pressures in the Department. There were two incidents during the month where ambulance crews did not remain longer than the required 15 minutes. Additional nurses were working in the Department to provide support. Diverts had not happened as frequently as previously. Performance was better than the corresponding period in 2015.
- Mrs Bond observed that the pay bill was the highest since 2014 which the Financer Director said was as a result of increased agency spend.
- In summary the Chair said that the Board's attention should be drawn to performance in endoscopy, 62 day cancer standard and ambulance handovers.

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.

054/16 EMERGENCY PATHWAY REPORT

(Ms Sue Barnett, Improvement Director attended the meeting for the discussion of this item)

The Director of Service Delivery presented the report stating that 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 Chair referred to the weekly telephone calls with the Non-Executive Directors, the Director of Service Delivery and the Improvement Director where there is a high level of NED involvement. The overarching issue is the focus of intervention in the programme and sought comments on the level of confidence in that the right things are being undertaken and they will make progress. The Director of Service Delivery said that there performance challenges and risks remain unchanged. The telephone calls with NEDS have been helpful to shape the dialogue and provide up-to-date information. The three workstreams are in the very early stages. There has been a slight improvement in the performance indicators. The plans to provide support to the Emergency Department are making a difference. Site management is al longer term issue. The Improvement Director added that three thigs are pivotal to improved performance. The building blocks are been laid during the 8 weeks of the programme to begin the process to make changes to our Trust's working arrangements and to make those changes a business as usual. These are sensible steps as there are others things to be done. There are capacity and capability issues to address. The building blocks need to be tested with front line staff.

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

- Mr Foster referred to the shortage of doctors, the discharge arrangements and internal actions observing that our Trust should concentrate on the latter as the other two could not be changed. The Improvement Director said that the latter two are within the Trust's gift whereas the shortage of doctors is a national issue.
- The Chief Executive added that the increased weekend discharges have eased the pressure on Mondays with more beds available. The Trust neds to build on this. He expressed the view that to achieve the 95% performance target will require assistance from partner organisations. The Improvement Director said that from her perspective the local health system is not working as such and the challenge to the wider system will be when the Trust has undertaken its actions and what will they do.
- The Chief Executive said that April is currently at about 83% performance based on some of the improvements and the challenge is to get to the high 80% and early 90% but it will take much longer for performance to be sustained.
- Mrs Bond referred to the positive experience felt when there was spare bed capacity and she enquired whether undertaking less elective work will produce financial savings. The Director of Service Delivery said that the number of patients in hospital greater than 14 days has reduced by 20 allowing more elective work to be undertaken.
- The Chief Executive said that the Trust needs to raise with the System resilience Group to raise with the ambulance service the absence of a GP over the weekends, which has to be resolved.

The Clinical Commissioning Group reviewed the medical fit list on 26 April 2016 and most of the resultant actions are with system partners.

- The Chair asked how the cultural issues can be overcome, the timings to get to the trajectory and then the timings to meet the target, for example patients seen within 15 minutes, 60 minutes an four hours. The Improvement Director said that this is an issue for discussion at the Board meeting on 29 April 2016. A system-wide target needs to be agrees by which partners can be held to account.

The Chair thanked the Director of Service Delivery for the report and for the Improvement Director for her comments.

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

055/16 BOARD STATEMENTS

The Finance Director presented the report inviting the Committee to recommend confirmation of 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.

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

The Chair thanked the Finance Director for the report.

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

(Mr Dave Smith, Director of Human Resources and Mrs Sue Milloy, Divisional Nursing Director – Medicine Division, attended the meeting for the presentation of this item)

The Divisional; Nursing Director gave a presentation on the work undertaken in Medicine Division on recruitment and retention. The presentation covered the challenges faced, the negative effects of the inability to recruit and retain staff and a summary of the actions taken so far. Details of the Medicine Division workforce data were also provided together with key themes emerging from the exit interviews and the next steps.

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

- The Chief Executive explained that the introduction of Associate Nurses will provide a career path and will enable their appointment to support nurses.
- Mrs Bond said that we should promote that the Trust is in an attractive area in which to work and she thought that incentives should be offered to attract staff to work on certain wards and what could be done to prevent nurses leaving. The Director of Human Resources and Organisational Development explained that staff do not like being moved due to operational pressures as it disrupts the teamwork on their normal ward. The Divisional Nursing Director said that the appointment of Band 8a and 7 nurses on each ward has improved retention and improved sickness levels. The pilot in Woodmancote and Ryeworth Wards has improved attendances and reduced ward pressures.
- The Director of Human Resources and Organisational Development said that our Trust is doing all that it can to make substantive appointments.
- The Chief Executive cautioned about paying incentives as if made to one group then all groups will expect it.

The Chair thanked the Director of Human Resources and Organisational development and the Divisional Nursing Director for their presentation.

RESOLVED: That the presentation be noted.

057/16 TEMPORARY MEDICAL STAFFING

(Dr Sean Elyan, Medical Director, and Mr Sean Ceres, Interim Director of Operational Finance, attended the meeting for the presentation of this item)

The Medical Director presented the report on the financial consequences relating to temporary medical staffing. In March 2016 medical agency spend and locum expenditure accounted for 33% (£9,439k) of all temporary staffing spend for 2015/16. The Trust's overall temporary staffing in March 2016 was £28,989k). Details of the medical locum and agency expenditure by Division and grade was presented noting that Corporate services are GP hosted trainees which are recharged to the host Trust. Temporary medical staffing is a key area of operational and financial pressure and is subject to detailed review at Delivery and Efficiency and Improvement Boards. Action plans to address this issue are already underway or are under consideration. The priority for our Trust is the safety of our patients and therefore we will not be able to dramatically or significantly reduce reliance on temporary medical staffing in the very near future. There are steps that can be taken to make measurable reductions in our use of temporary medical staff and it is clearly important that wherever possible patients are treated by a substantive member of staff.

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

- The Medical Director said that consultant job plans will not deliver the required level of savings. There needs to be a focus on medical spend around medical staff with more permanent staff and less reliance on temporary staff.
- The Interim Director of Operational Finance commented that our Trust needs to ensure that temporary expenditure is for the right reasons and the Finance team will work with the HR team to ensure that situation is managed.
- The Medical Director commented that three General Old Age Medicine (GOAM) consultants have been appointed which has an expense but there is value for money if they are delivering more. The spend where there is value for money needs to be more clearly identified. The national employment position in respect of some specialities is a risk to recruiting permanent staff.
- The Director of Service Delivery said that permanent staff know Trust processes and work is at an early stage to understand the extent of the problem.
- In response to a question from Mr Foster, the Medical Director said that the
- The Chair asked for an indication of the timeframe for taking forward this piece of work. In response, the Medical Director said that assistance is required to take this forward, but by the end of July there should be a clearer idea of the areas upon which to focus. The Committee invited the Medical Director to present an update to the Committee in July 2016.

SE
(MW to note for Agenda)

The Chair thanked the Medical Director and the Interim Director of Operational Finance for the report.

RESOLVED: That the report be noted.

058/16 OVERVIEW OF LORD CARTER REVIEW

(Mrs Paula Perks, Cost Improvement Manager and Mrs Alex Gent, Head of Shared Services attended the meeting for the presentation of this item)

The Cost Improvement Programme Manager gave a presentation to the Lord carter Review and the Interim Report published in June 2015 outlining that potentially £5bn of operational efficiency savings could be delivered by 20120 by decreasing variation and improving workforce costs, hospital pharmacy medicines optimisation, estates management and procurement. Each Trust received details of high level savings opportunities with an invitation to feedback on the validity of the analysis and inform if the indicative value for savings identified were realistic. The final report issued in February 2016 set out how the £5bn potential savings can be achieved whilst improving overall performance of acute trusts and quality of care they provide to the public. The report contained 15 recommendations with NHS Improvement responsible for delivery working closely with all organisations with Trust Boards held to account.

From the detailed analysis provided by Lord Carter our |Trust benchmarks approximately 10p less expensive per £1 of national cost weighted output and is one of the top 10 Trusts in England. £21.2m of saving opportunities were identified equating to 6% of total clinical expenditure. For each of the 15 recommendation key items for the Trust to lead had been identified. The recommendations and actions

should be integral to the Trust's Cost Improvement Programme and service improvement programme for all Divisions. Progress will be followed up at Cost Improvement Programme meetings, Delivery Board and the Efficiency and Service Improvement Board .

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

- The Chief Executive commented that the Carter review had not picked up the Trust's two site operation and comparisons were based on a single site operation leading to diseconomies of scale issues.
- In response to a question from the Chair the CIP Manager said that the priorities for the Trust were cardiology and Trauma and orthopaedics. However, the not all of the 15 recommendations would realise financial savings. The Director of Service Delivery added that service reconfigurations which not been indented specifically within the recommendations will provide opportunities for financial savings.
- The Chair asked if targets had been set. In response, the CIP Manager said that targets have been set nationally and the Trust is working out the gaps behind the data which was based on the two pilots.
- The Director of Service Delivery said that the 15 recommendations are cross cutting themes for our Trust where the current position is to be established, opportunities and how to achieve. The focus will be on the areas where the greatest financial savings can be made as our Trust cannot sustain working on all 15 recommendations when some will not realise any financial savings.

The Chair thanked the Cost Improvement Manager and the Head of Share service for the presentation.

RESOLVED: That the presentation be noted.

059/16 PROGRESS UPDATE ON CONTRACTING PROCESS

The Finance Director presented the report providing an update on the key points associated with the 2015/16 and 2016/17 contracting process. The bulk of the discussion took place in minute number 052/16 above as part of the Financial performance Report. The only main issue related the decision by the Clinical Commissioning group not to fund seven day services. The Chief Executive added that the CCG are being pressed to fund this and investment is needed to introduce seven day services. The Trust does not have the financial resources to introduce seven day services alone.

The Finance Director said that the year-end settlement for 2015/16 has been resolved with Specialised Commissioners and negotiations continue on the 2016/17 contract resolution. The basis is full payment by results as specialised commissioners are asking the Trust to undertake more activity.

The Chair thanked the Finance Director for the report.

RESOLVED: That the progress made in managing 2015/16 contracts and progress to date on the 2016/17 negotiations be noted.

060/16 NOTES OF THE EFFICIENCY AND SERVICE IMPROVEMENT BOARD MEETING HELD ON 13 APRIL 2016

The Finance Director presented the notes of the meeting of the Efficiency and Service Improvement Board held on 13 April 2016.

The Chair thanked the Finance Director for the notes.

RESOLVED: That the notes be noted.

061/16 FINANCE AND PERFORMANCE COMMITTEE WORK PLAN

The Committee invited the Trust secretary to update the workplan as follows:- **MW**

July 2016 – Add Update on Temporary Medical Staffing.

The Director of Service Delivery added that by the time all Divisions present in June 29016 there will be a substantive Director of Operations in post.

062/16 ANNUAL APPRAISAL 2015/16

The Committee invited Mr Foster and the Trust Secretary to consider the format for the annual appraisal 2015/16. **TF/MW**

063/16 WASH UP SESSION TO ENHANCE THE TRANSPARENT FLOW OF ASSURANCE AND RISKS

No comments were made.

064/16 COMMITTEE REFLECTION

No comments were made.

065/16 ANY OTHER BUSINESS

Mr Gordon Mitchell, Mrs Maria Bond, Dr Frank Harsent: Members noted that this would be the last meeting which Gordon Mitchell would be Chair, Maria Bond's last meeting as a Non- Executive Director and Frank Harsent's last meeting as Chief Executive before his retirement.

066/16 DATE OF NEXT MEETING

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Finance and Performance Committee will be held on **Wednesday 18 May 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 9 May 2016**.

The meeting ended at 12.12pm.

Chair
18 May 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

SUMMARY OF THE MINUTES OF THE TRUST AUDIT COMMITTEE HELD ON 17 MAY 2016

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

040/16 ANNUAL ACCOUNTS FOR YEAR ENDED 31 MARCH 2016

The Finance Director advised that the draft accounts had been prepared in line with standards and were submitted on time. Attendees noted that there had been subsequent agreements on other contracts and changes made by other organisations which were made in April and not shared or agreed with the Trust. Mr Ceres explained that this has some benefits which the Trust has been able to utilise. Attendees noted the accounts report an operating surplus of £0.8m

The Finance Director also update on robust negotiations with Commissioners which has resulted in a good settlement for the Trust.

Analytical Review
Attendees discussed the review which looks at the movements between the 2014/15 and the 2015/2016 draft financial accounts.

- Property Plant and Equipment (PPE) The Chair commented on the depreciation and Mr Ceres explained that this was of a result of the revaluation work agreed last year and this was a pre-planned expectation.
- analysis of the operating income - a reduced income in catering was noted , the Finance Director advised that this was due to the closure of the Glass House Café for a planned refurbishment.

Annual Governance Statement
Attendees discussed the paper and the Trust Secretary is to consider the inclusion of a report of Committee work for future statements.

Letter of Representation
The Committee approved the letter of representation.

041/16 REPORTS OF THE FINANCE DIRECTOR

Losses and Compensations
Attendees noted the ex gratia payments made and approved the write off of 517 invoices totalling £ 28,390.93. Attendees noted that invoices were at least two year old before considered for write off and Mr Ceres agreed to provide further financial analysis for future reports.

Single Tender Action
Attendees noted the single tender actions which had been signed since the Audit Committee held on 8 March 2016.

042/16 EXTERNAL AUDIT

Audit Findings Report
Grant Thornton reported that to date they had noted identified any adjustments affecting the Trust retained surplus position. Attendees agreed timescales for outstanding audit work the most significant being resolution of an imbalance with Gloucestershire Care Services.

Report of the Quality Committee
Grant Thornton confirmed that the Quality Report had been prepared in all material

respects in line with requirements. Work on the Quality report is still ongoing, subject to completion of testing Grant Thornton are proposing to issue a qualified conclusion on the Quality Report

043/16 INTERNAL AUDIT

Draft Annual Report and Head of Internal Audit Opinion 2015/2016
Price Waterhouse Coopers gave a opinion as follows 'Generally satisfactory with some improvements required 'this is the second highest opinion of four and is consistent with previous years.

Internal Audit Plan 2016/2017
Attendees noted the report including the use of contingency days which had been used for additional work, additional days would be required for any further work. The proposed plan was noted by attendees.

Internal Audit Charter 2016/2017
Attendees noted the report which is produced annually to provide the framework for the conduct of the Internal Audit function in Gloucestershire Hospitals NHS FT.

Core Financial Systems Phase 3
The report summarised the continuous auditing and monitoring of core financial systems, there were a number of transactions and testing undertaken, attendees noted that there were very few recommendations which attendees were reassured by.

SmartCare
Price Waterhouse Coopers reported one high risk, two medium risk findings and three low risk findings overall the report was noted as high risk.

Draft Estates and Procurement Review
The backward looking report has been prepared to assist in identifying areas of concern and suggested remediation actions. The report highlighted two high, one medium and one low risk, overall the report was noted as high risk.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE SUSTAINABILITY COMMITTEE
VIDEO CONFERENCE FROM REDWOOD EDUCATION CENTRE (ROOM F6) IN GLOUCESTER TO SANDFORD EDUCATION CENTRE (ROOM 6) IN CHELTENHAM
ON 22 APRIL 2016

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:-

Maria Bond	MB	Non Executive Director - Chair
Neil Jackson	NJ	Director, Estates & Facilities Division
Kate Jeal	KJ	Communications Dept
Cllr Brian Oosthuysen	BO	Public Governor Representative
Jen Cleary	JC	Sustainability Manager
Dee Gibson-Wain	DGW	Associate Director of Education and Development
Alex Gent	AG	Interim Head of Shared Services

APOLOGIES

Helen Simpson	HS	Executive Director of Finance & Deputy CEO
John Wells	JW	Clinical Divisions Representative
Georgina Smith	GS	Sustainability Advisor, CCG
Sandra Attwood	SA	Lead Nurse/Modern Matron, Staff Governor Rep
Andy Heaysman	AH	Energy & Utilities Manager

IN ATTENDANCE

Jane Evans	JE	Associate Director, Facilities
Simon Aquilina	SA	Catering Department
Mark Lane	ML	Catering Department
Bridget Hooper	BH	Catering Department
Elaine Davies	ED	Secretary EFD

ITEM	DETAILS	ACTION

013/16 The Chair informed the group that this is the final meeting of the Committee in its current format, it is to become an executive function. Anne Marie Millar will be the Non Executive Director Sustainability lead and in future the committee will not have a purely Estates focus, it will be led by Procurement and ELD and Estates on a rotating chair basis.

014/16 There were no declarations of interest.

015/16 MINUTES OF MEETING HELD ON 18 JANUARY 2016
These were **AGREED** as a correct record.

016/16 MATTERS ARISING (see separate enclosure)

017/16 PRESENTATION:-
CATERING AND FOOD MILES
The Chair welcomed Jane Evans, Bridget Hooper, Simon Aquilina and Mark Lane of the Catering Department who were presenting on 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 they conform to the Government Buying Standards and rules around food safety. If the Trust is to use local suppliers who are not on the Framework then there would need to be more local policies, arrangements for food hygiene audits, processes agreed with Procurement and potentially, more funding. However, local suppliers could prove to be more competitive than the NHS Framework.

The team also identified opportunities including expanding the Farm Shop stall, developing more seasonal local products, for example summer salad bowls, and exploring the options around home baked cakes.

The team were thanked for an extremely interesting presentation and for the hard work put into the programme.

018/16 MONITORING REPORTS

i Procurement

AG reported on progress against the P4CR Flexible Framework confirming that level 1 of the Framework has now been achieved. Achievement of Level 2 is predicted for September 16 and Level 3 by March 2017.

The NHS Supply Chain catalogue now has flags which indicate whether products meet GBS standards or have a recognised EU Eco label, or are ethically sourced.

Contract review of sustainable measures in place indicates the B.Braun contract for Haemodialysis has resulted in water consumption and waste savings.

ACTION: AG to liaise with Estates to see if savings can be evidenced. Key improvements: reduction of 2734 cubic metres of water usage per annum and a change in disposal route with the diversion of approximately 11,000kg per annum of clinical waste into black bag waste (disposal via landfill or waste-to-energy).The Chair requested the tables showing P4CR progress indicate red, amber, green status against programme to hit target at the end of the year. **ACTION AG** **AG** **AG**

ii

Carbon & Energy Report including CHP

NJ reported on the current position.

Electricity consumption at GRH & CGH

The reduction in electrical demand for CGH continues, although still disappointing at 2.3%, demonstrating a need to target staff behaviour and encourage change. GRH reduction is 3.16% but the TRIADs for November, January and February resulted in £130K additional network charges.

Gas CGH/GRH Energy

CGH Increased gas consumption continues as expected in line with running the CHP plant. Reduced consumption continues at GRH.

Water

CGH metering results do not show the expected reduction in consumption, showing 206m3 per day; we are working to establish independent measurements. GRH consumption has reduced to 600m3 per day.

Trust CO_2 Emissions

Carbon emissions continue to reflect the running of the CHP plant. The forecast for 2015-16 is that we will miss 10% target to reduce emission from the 2007 baseline) by 0.1%.

Vital Energi Energy Performance Contract

The first anniversary validation report is still awaited from Vital Energi, this will effectively compare performance to approved business case. A liaison meeting was held 14 March. AH to bring 12 month savings figures to June meeting. **ACTION: AH.** **AH**

The Chair requested confirmation that it will be possible to recharge other users for cost of CRC charges to value of £23K which would bring us under budget. NJ confirmed this point.

A placement for a third year engineering graduate student from Cardiff University has been agreed, and he will be working with the Energy Manager for two months helping to develop strategies for improving the energy performance of plant equipment around the Trust.

iii

Waste & Recycling

The Chair requested consistency with colours to match Energy report key. **ACTION:JC.** **JC**

The Volume of clinical waste has increased by 41 tonnes on last years figures, and bed occupancy has increased accordingly. Recycling figures have increased as more cardboard is now removed from domestic waste stream. General recycling from wards

has increased by 37% on last year, attributable to greater staff awareness, introduction of more recycling bins etc. DGW reiterated the need to make recycling as easy as possible for staff around the trust. The Chair recommended publicising the figure of waste saved to encourage more staff efforts. **ACTION:JC.** **JC**

iv

Sustainability Team

DGW confirmed that there are now 51 members with a core group of 20 who are active and enthusiastic with many ideas to make colleagues think more sustainably, and supporting each other to move initiatives on. NJ suggested the Sustainability Team should be kept informed of bigger projects which affect the Trust – multifunctional devices will have a significant impact on paper, cartridges etc. Two members of the team will attend the October Committee to share some of their ideas.

v

Communications

The Chair congratulated KJ 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. These articles will continue and a reminder issued to staff to turn off equipment ahead of the Bank Holiday weekends.

ACTION: KJ **KJ**

019/16

TERMS OF REFERENCE REVIEW 2016

Agreement on Chair and Vice Chair.

After some discussion it was agreed there would be a rotating Chair and rotating Vice Chair, with Alex Gent, Dee Gibson Wain and Neil Jackson sharing the roles. The Non-Executive Director will be Anne Marie Millar who will be in attendance but will not Chair the meetings. Governor membership will not be required going forward. HS to be available for all future meetings. **ACTION:JC** to confirm HS availability. **JC**

020/16 UPDATE ON TRAVEL AND CARBON EMISSION LIMITS FOR LEASE CARS

Ownership of the lease car policy was established as being with HR and this policy is currently being updated. It will need to be shared with Director of Finance and then to the Sustainability Committee and Workforce groups. DGW, NJ and Dave Smith to discuss development of policy changes. The Committee agreed a maximum limit of 120g/km C02 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.

021/16 FORWARD WORK PROGRAMME

The programme going forward needs to be agreed. The Chair suggested a focus on Procurement, Carbon emissions and Travel. Meeting to be arranged with NJ, DGW, AG and the new NED Anne Marie Millar. **ACTION:ED**. **ED**

022/16 SHARING GOOD PRACTICE

Future meetings of this committee for 2016 will be held as video conferencing calls and attendees should arrive at the meeting 15 minutes early to set up equipment for videos conferencing.

DGW to contact Zack Pandor (IT) to see if there are other video conferencing facilities within the Trust that we could access. **ACTION: DGW** **DGW**

DGW to contact the Education Centre technician and ask if instructions can be written on how to turn on the video conference equipment, instructions could then be left in the room box. **ACTION: DGW** **DGW**

023/16 ANY OTHER BUSINESS

This Sustainability Committee meeting is Maria Bond's last meeting as Non Executive Director. On behalf of Helen Simpson, Alex Gent offered thanks to Maria for her work in Chairing the Sustainability Committee.

024/16 PLANNED DATE AND TIME OF NEXT MEETING –

Monday 6 June 2016 to be conducted by video conferencing

Venue

Room 6 SANDFORD EDUCATION CENTRE, CGH
Room F6 REDWOOD EDUCATION CENTRE, GRH

Signed

Date

ITEM 9

RETIREMENT OF THE CHAIR IN DECEMBER 2016

VERBAL

Prof Clair Chilvers
Chair

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – MAY 2016

APPOINTMENT OF CHAIR OF THE TRUST

1 Aim

To update the Board on the process to be followed to appoint a new Chair of the Trust.

2 Background

As Board members will be aware, Professor Clair Chilvers term of office as Chair of the Trust will come to an end on the 31st December 2016. As the Chair of the Trust is a Council of Governors appointment, the attached paper (Appendix 1) to the Council of Governors, sets out in greater detail the process and timetable to be followed to enable a successful appointment to be made and is summarised below.

3. Process

Executive Search agency Gatenby Sanderson have been appointed to lead the search and the team will be headed up by Robin Staveley who has worked with us on a number of key appointments, including the current Chair, Chief Executive Officer Designate, Non-Executive and Executive Directors.

It is expected that the post will be advertised in early July 2016 and will feature in one of the national Sunday newspapers. The selection process will be expected to be completed by the end of the first week of October 2016 and is likely to involve Board members in engaging with prospective candidates as they gain further information on the role and our Trust. The Council of Governors will be asked to delegate authority to an appointments panel (appointed by the Governance and Nominations Committee) who will recommend an appointment for consideration by the full Council of Governors.

4. Recommendations

The Board is asked to **note** the process for appointing a new Chair of the Trust.

Author and Presenting Director: Dave Smith Executive Director HR & OD

Date: May 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS – MAY 2016

APPOINTMENT OF CHAIR

1 Aim

To invite the Council of Governors to approve the arrangements for the appointment of a new Chair of the Trust.

2 Background

2.1 As Governors will be aware, Prof Clair Chilvers term of office as Chair of the Trust will come to an end on 31 December 2016. It is therefore necessary to make the necessary arrangements to recruit a successor from 1 January 2017. Following discussions between the Chair and Lead Governor, the following recruitment process is proposed:-

Date(s)	Activity
1 July	Search starts. 3 July post advertised
TDB	Open evening
2 August	Closing date
w/c 8 August	Sifted applications passed to Trust
w/c 15 August	Long list meeting
w/c 29 August, 5 and 12 September	Preliminary interviews with Gatenby Sanderson
20 September (12.30pm)	Short list meeting
	Shortlised candidates given opportunity to meet with Chair and Chief Executive
3 and 4 October	Final selection process Interview Panel to comprise a Non-Executive Director nominated by the chair, Lead Governor, two further Governors, and an external assessor selected by the Chair. The Chief Executive will be present at the interviews but is not part of the panel.

3 Discussion

It is proposed that the recruitment process will be overseen by the Governance and Nominations Committee. The appointment of Chair of the Trust is a Council of Governors appointment. To enable an appointment to be made at interview it is recommend that authority be delegated to the interview panel to make an offer to the candidate as determined by the panel. This will be formally circulated by e-mail immediately afterwards inviting all Governors to approve the appointment.

4 Recommendation

The Council of Governors are invited to approve the arrangements for the appointment of a new Chair of the Trust as set out in paragraphs 2 and 3 above.

Author and Presenters:

Prof Clair Chilvers, Chair and Alan Thomas, Lead Governor

May 2016

MAIN BOARD – MAY 2016
REPORT OF THE ACTING CHIEF EXECUTIVE

1. National

1.1 At the time of writing this report the BMA and the government are in talks over the Junior Doctor's contract.

2. Regulators

2.1 NHS Improvement have written to all Trusts setting out their expectation that the caps in levels of agency spend and rates of pay. The targets are stretching and access to the transformation funds available to local health economies could be dependent on achieving them in addition to other targets.

3. Our Trust

3.1 Attendance continues to remain high. In April there were 10,777 attendances. This compares to 10,007 attendances for the same period the previous year (April 2015). This is a continuing trend.

3.2 Congratulations to colleagues who have been short-listed for this year's staff awards. This year's ceremony has been brought forward to Thursday 16th June to make the most of the summer weather and the gardens at Hatherley Manor Hotel. All Board members, Non-Executive Directors and Governors are welcome to attend.

3.3 Congratulations to Radiographer Sam Bostock, Tissue Viability Nurse Julie Bryan and our Tissue Viability Team at CGH, our Radiographers and the team from Aspen Medical who came second in the BJN Awards for Oncology Nurse of the Year for a booklet they helped develop. The BJN Awards acknowledge the enormous contribution individual nurses make towards the development of the profession as a whole.

3.4 Following a donation from FOCUS, our Radiotherapy team, which is based in Oncology at Cheltenham General, are now treating patients in their new, dedicated High Dose Rate (HDR) Brachytherapy Suite. Brachytherapy is when cancer is treated by inserting radioactive material directly into the affected area. A high dose of radiation is given to the tumour, but healthy tissue only gets a small amount of radiation. Brachytherapy is usually used to treat prostate cancer, cervical and womb cancer. It's also used to treat other cancers such as head and neck cancers.

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

You Said	We Did
Relatives not called in when patient's condition deteriorated.	Nursing staff have reflected on the complaint and will be more vigilant in future.
Doctor did not perform a thorough check of details when entering information on computer.	Doctor now following a strict process of rechecking and reconfirming patient details before requesting tests.
Patient felt that there was a lack of privacy when staff were pre-assessing patients on the telephone in an area where other patients were sitting.	Pre-assessment calls to be made from a separate more private area in future.

3.6 The following consultants have been appointed:

Radiology	-	Raymond Ramnarine
	-	Christopher Pawley

3.7 The Risk Register is at Annex A.

Mrs Helen Simpson
Acting Chief Executive

May 2016

TRUST RISK REGISTER –May 2016

ANNEX A

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 **NB this risk is being re-evaluated by the lead Director in the next month**	• 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. **NB Risk rating reduced, risk to be moved to the lead directors risk register**	• 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	2 (4)	4	8 (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	• **Business case agreed and implementation has started.** • 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 • Agreed Business case is being delivered for: o IDT cover for Oncology o Increased staffing for palliative care	Medical Director CoS D&S	TMT	Monthly	4	4	16

Gloucestershire Hospitals NHS

NHS Foundation Trust

Quality Report 2015/16

What is a quality report?

A Quality Report is an annual report about the quality of services provided by an NHS healthcare organisation.

Quality Reports aim to increase public accountability and drive quality improvements in the NHS. Our Quality Report looks back on how well we have done in the past year at achieving our goals.

It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

Glossary Symbol
This symbol ⓘ indicates a term's inclusion in the glossary on p79.

Contents

1

Statement from the Chief Executive

Welcome to the Quality Report for 2015/16.

I am delighted to introduce our Quality Report for Gloucestershire Hospitals NHS Foundation Trust, which provides us with an opportunity to reflect on our successes over the past 12 months and to identify areas for further improvement in the coming year.

Each section of the report will explore how well we have achieved our quality priorities for 2015/16 and what we intend to do in the year ahead. Our priorities for 2016/17 have been structured slightly differently to reflect the dimensions of quality that we are measured against by the Care Quality Commission; safe, effective, responsive, caring and well led. Our hospitals were inspected in 2015 and we were pleased that the majority of our services were rated as 'Good', with our Department of Critical Care at both Cheltenham General and Gloucestershire Royal Hospitals rated 'Outstanding'. Overall we received a rating of 'requires improvement' and we have already implemented all of the compulsory recommended actions to address these concerns. You can read more about this and see our action plan on p60.

We are relentless in our pursuit of quality and each year we set ourselves demanding plans and targets to achieve our goals. This is supported by the development and training of our staff, the application of systematic and rigorous processes and the continued drive for research and innovation, all of which help deliver high quality care for our patients.

In line with national trends, our Trust has seen unprecedented demand for our services again this year with another year-on-year increase in admissions to our wards. Combined with the high level of medically fit patients in our wards, often patients with complex needs, this has inevitably placed significant pressure on our services. This is reflected in our current performance against the national four-hour A&E waiting time standard as you will see on p17.

During the year, this increased demand on services also affected the speed of access to diagnostic imaging and cancer waiting times, which are monitored by our Board. You can view our performance against the cancer waiting times targets on p68.

In 2015/16 we have taken further steps to strengthen our culture of safety. As well as continuing to promote our online anonymous Speak in Confidence service, we have ensured that our findings from serious incidents are always shared with staff and those families affected to ensure lessons are learnt. We are fully committed to the Sign Up To Safety campaign and you can read more about this on p57. Patients should also be reassured that our rates of infection for C-difficile and MRSA bacteraemia are at an all-time low and that we continue to provide 'harm-free care' as measured by the National Safety Thermometer for almost all our patients.

This year we launched a new vision for our Trust; to provide the 'Best Care for Everyone.' Our vision is about being the best that we can be as individuals, teams and as an organisation to deliver high quality care for our patients. We established the Gloucestershire Safety & Quality Improvement Academy (GSQIA) in June 2015, which provides our staff with the knowledge, skills , opportunity and support to contribute to patient safety by making practical improvements in the way we provide care in our hospitals. Our aim is that our structured programmes will contribute to the development of a culture of continuous improvement in our Trust, where staff at all levels have the confidence to highlight areas for improvement and have the skills, knowledge and support to implement them.

Our SmartCare project to introduce a new Electronic Health Record (EHR) , giving our clinical staff access to health information about a patient when they need it, wherever they are, is progressing. This is the biggest single investment we have ever made, directly impacting on the quality of care we provide, and with the support of

our staff, will make our hospitals safer, our information more secure and transform the way we communicate both within the organisation and with colleagues and agencies externally. The security of patient data remains a central focus of this programme and it is important to note that a patient's record will only be accessible to those who need access for clinical reasons. The timetable will see some modules implemented throughout the summer and autumn of 2016 with the complete system in place by Spring 2017. The EHR will be fundamental to the quality and safety of our services for years to come.

As we enter 2016/17 the health and social care organisations in the county are discussing how to pilot integrated care for patients in the community. This will see teams created for populations of around 30,000 people with the aim of supporting more patients to remain in their own home. In addition, teams will be created from hospital and community staff to provide care for specific areas such as lung disease and diabetes.

Together we are working to develop a Sustainability and Transformation Plan which will set out our ambitious blueprint across the health and social care system for addressing the three pressing gaps identified in the Five Year Forward View, published by NHS England in October 2014. These are the health and wellbeing gap, the care and quality gap, and the funding and efficiency gap.

I would like to take this opportunity, my last as Chief Executive at Gloucestershire Hospitals NHS Foundation Trust, to thank all our staff who make our hospitals what they are today. They have worked so hard to deliver the best care they can for our patients and I am proud of what they have achieved. There will always be more to do and I know our Board remain committed to delivering the Best Care for Everyone.

I can confirm that to the best of my knowledge the information included in this document has been subject to all the appropriate scrutiny and validation checks to ensure the data is accurate.

Dr Frank Harsent
Chief Executive

Next part:
Our priorities and statements of assurance

2

Our priorities and statements of assurance

Helping us improve the quality of care

Each year our Quality Committee agrees a set of priorities which help us improve the quality of care we provide for our patients.

These priorities are identified because they are important to our regulators and/or commissioners or are decided following discussions with our Council of Governors, the Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC) and Healthwatch Gloucestershire. We also meet at regular intervals throughout the year with Healthwatch Gloucestershire to maintain a continuing dialogue and ensure any issues raised can be addressed in our improvement plans.

The following section is divided into four parts:

- How well have we done in 2015/16: looks at what our priorities were during 2015/16 and whether we achieved the goals we set ourselves. Where performance was below what was expected we explain what went wrong and what we are doing to improve
- What are our priorities for 2016/17: explains why these priorities have been identified and how we intend to meet our targets in the year ahead
- Statements of assurance from the Board
- Reporting against core indicators

The later sections of the report provide an overview of the range of services we offer and give some context to the data we share in section three.

The Quality Committee is responsible for monitoring the progress of the organisation against our quality improvement priorities. The Committee meets eight times a year and reviews a series of measures which give us a picture of how well we are doing.

The Quality Committee is a sub-committee of the Board and has clinical and managerial representation from across our Trust. It includes non-executive directors, executive directors, governors, representation from Gloucestershire Clinical Commissioning Group and during 2015/16 was chaired by Helen Munro, Non-Executive Director.

2.1.1

How well have we done in 2015/16?

The table opposite provides an overview of our priorities for 2015/16. The table gives you an at-a-glance view of the work undertaken in the past year and which our stakeholder groups identified as priorities for improvement. In 2015/16 our priorities were aligned with the three dimensions of quality, as supported by the Care Quality Commission.

Priorities for improving quality in 2015/16

Priorities	Incomplete from last year	National priority for 2014/15	Issue for commissioners / CQUIN	Issue for HCCOSC	Issue for Healthwatch	Issue identified internally inc. governors
1. Safety						
Pressure ulcers	✔		✔	✔		
Reduce the risk of VTE				✔		
Improving patient flow	✔	✔	✔	✔	✔	
Improving handover			✔	✔	✔	✔
Reducing missed fractures				✔		✔
2. Clinical Effectiveness						
Dementia and delirium	✔	✔	✔	✔		
Acute Kidney Injury	✔	✔	✔	✔		
Improving diabetic footcare			✔	✔		✔
Improving care of patients requiring emergency abdominal surgery			✔	✔		✔
Improving care for fragility fractures				✔		✔
Improving management of sepsis	✔	✔	✔	✔		
3. Patient Experience						
Improving transition from child to adult care			✔	✔		✔
Learning from users	✔			✔	✔	✔
Improving patient information				✔	✔	✔
Living with and beyond cancer			✔	✔		✔

2.1.1

How well have we done in 2015/16?
Safety

Reducing pressure ulcers

Pressure ulcers are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure and develop over a short period of time. Pressure ulcers tend to affect people with health conditions that make it difficult to move, especially those confined to a bed or sitting for long periods of time.

For some patients, pressure ulcers require basic nursing care. For others they can be serious and lead to life-threatening complications, such as blood poisoning or gangrene.

Even with the highest standards of care it is not always possible to prevent pressure ulcers in particularly vulnerable patients. However, 95% of pressure ulcers are completely avoidable, if the right steps are taken by our nursing teams. Our staff are taught that by turning and moving patients regularly, making sure any incontinence is well managed and that patients are well fed and hydrated, they are unlikely to develop an ulcer.

We have five Tissue Viability Nurses in our hospitals who lead on the training and education of our nursing staff and work with Tissue Viability Link Nurses on each ward to improve the prevention, identification and treatment of pressure ulcers.

This year we have noticed a significant increase in the number of Grade 2 ulcers identified on our wards, particularly in General Old Age Medicine (GOAM) and Respiratory wards. It is not unusual to see higher numbers of pressure ulcers in these groups of patients as they are often particularly frail, elderly patients with multiple, chronic illnesses, making them vulnerable to pressure ulcers. We wanted to find out why these lower graded ulcers were being increasingly reported in these ward areas. Following an audit we discovered that many moisture lesions (superficial damage to the skin, generally caused as a result of incontinence) were being incorrectly reported as ulcers. Training nursing staff to help them recognise the difference between these two conditions will now be a priority for our Tissue Viability Nurses and their Link Nurse colleagues on the wards.

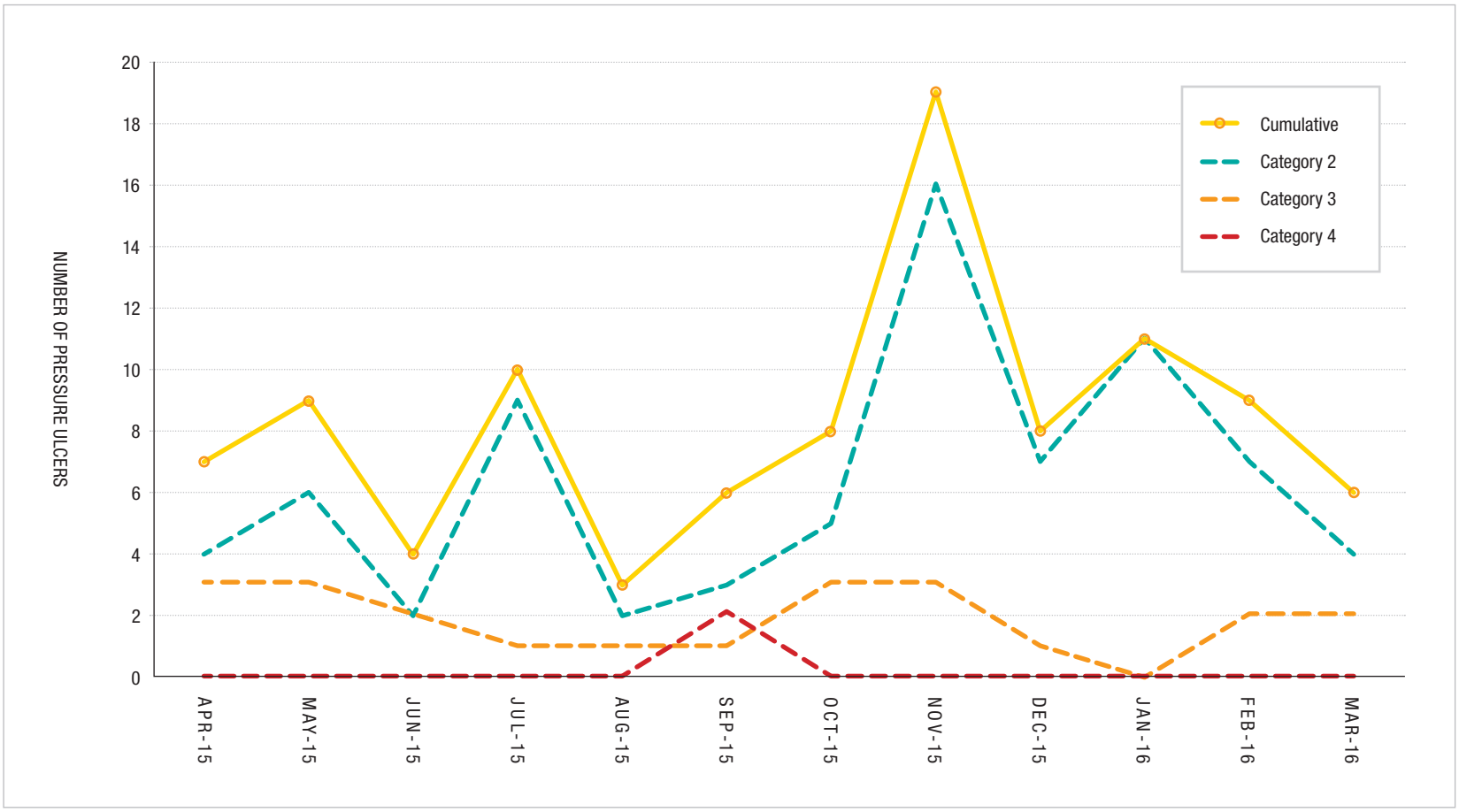
We did not have a CQUIN[i] target for the reduction of pressure ulcers this year, but despite our efforts we are disappointed to note an overall small increase in their incidence in our hospitals, particularly in the GOAM wards, for the reasons outlined above. We continue to be committed to achieving a reduction and in addition to investing £200k in pressure relieving equipment for patients, our pressure ulcer reduction action plan during 2015/16 has included:

- Updates to e-learning and mandatory training programmes
- Use of patient stories to help staff training
- Focus on reducing ulcers caused by incorrect fitting of plaster casts and fracture ‘boots’
- Ensuring tissue viability is included in Band 5 and Health Care Assistant Development Days
- Rolling out a new SSKIN bundle, a nationally agreed five-step model for pressure ulcer prevention, incorporating best practice care plans.

In the year ahead we will be ensuring that assessing a patient for pressure ulcers, or whether they are at risk of developing a pressure ulcer, is added to a new SAFE checklist to be used by staff when a patient arrives on their ward. The checklist, which is currently being piloted in a medical ward, must be completed within one hour – known as the ‘Golden Hour’ – of a patient arriving on a ward, therefore providing early identification of key safety concerns.

We are also piloting the use of handheld ultrasound scanners in our GOAM and vascular wards, allowing nurses to identify early skin damage before it is visible to the naked eye. Patients in these wards will be routinely scanned and treated to avoid the development of ulcers.

Fig. 1: Pressure ulcers, month on month, by grade



Improving flow through emergency care, outpatients and discharge

The term 'patient flow' refers to the way our patients move through the hospital, from admission through to discharge. We want to design efficient services which allow our patients to move quickly through the Emergency Department (A&E) to a ward where the staff are specially trained to deal with their particular condition or illness, before discharging them – either to their own home or to another appropriate care provider.

Good patient flow allows us to provide safe, effective care and gives patients the best possible experience of our services. Conversely, research has linked poor patient flow with increased mortality, an increased risk of adverse incidents and poor financial performance. In October 2015 Healthwatch Gloucestershire[1] published a Hospital Discharge Task Group report which concluded that while many people do not experience problems during the process of being discharged from hospital, a minority had very poor experiences and improvements could be made. Their recommendations are being collectively addressed by our Trust and our colleagues at Gloucestershire Clinical Commissioning Group, Gloucestershire Care Services NHS Trust and social services and we have taken into account the findings of the report in the development of our action plans.

We measure our success at improving patient flow and their discharge by looking at a range of different indicators, including Length of Stay (how long patients stay in the hospital), compliance with the Estimated Date of Discharge (whether patients stayed for as long as, less than, or longer than we thought they would), the 4-hour wait target (how many patients waited less than four hours in the Emergency Department from arrival to discharge or admission).

Improving the flow of patients through our hospitals has continued to be a significant challenge for us this year. This is partly due to the increasing demand on our services, as experienced by hospitals across the country, with attendances at the Emergency Department increasing year on year. We continue to have a significant number of patients on our 'medically fit list'. While the majority of our patients can be simply discharged from our care once they are medically fit to leave hospital, on average around 10% of patients need a package of care to be in place either in their own home, or by another care provider such as a nursing home, before they can leave hospital. Sometimes these placements can be difficult or take time to arrange, particularly for patients with complex care needs. This then leads to patients who no longer need the care of an acute hospital – known as 'medically fit' – waiting in a hospital bed when they don't need to be. If the number of medically fit patients is high (high is generally considered to be over 40 patients, the equivalent of 5% of our beds) then this can cause a shortage of beds available for new admissions.

However, despite the challenges faced, during 2015/16 we have successfully delivered a range of initiatives aimed at improving flow, as part of an action plan shared with our regulator, Monitor. These include the following (PTO):

CASE STUDY

Introducing the SAFER flow bundle

This is a set of actions which when combined, should improve the flow of patients through our hospitals and prevent unnecessary waits. If we routinely carry out these actions we will improve the experience of patients when they are admitted to hospital and meet our targets. Since October 2015 we have been holding a 'SAFER week' each month, helping to introduce simple adjustments to key processes throughout the patient journey.

CASE STUDY

Expansion of the Discharge Lounge (GRH) and the Discharge Waiting Area (CGH).

The discharge lounge, or waiting area, is a dedicated area for patients who are ready to go home but are perhaps waiting for medication or transport home or to another care provider. They are run by nursing staff who can arrange delivery of, or offer advice on taking medication or using specialist equipment, can arrange transport services, ensuring that the patient's discharge runs smoothly. The lounge is open until 7pm at night.

Sister Jane Miller, from the Discharge Lounge at GRH, said: "A&E is the front door and we are the back door. We are open until 7pm at night with a fully trained nurse here.

"We are the discharge facility, and not just a waiting room as some people may think. They get a lot of care and some patients need feeding and changing and the care continues right up until they go out of the door and beyond. We work closely with district nurses and we provide more of a link with onward care in the community. "We also help to provide a better patient experience for patients and their families. We really do care about our patients."

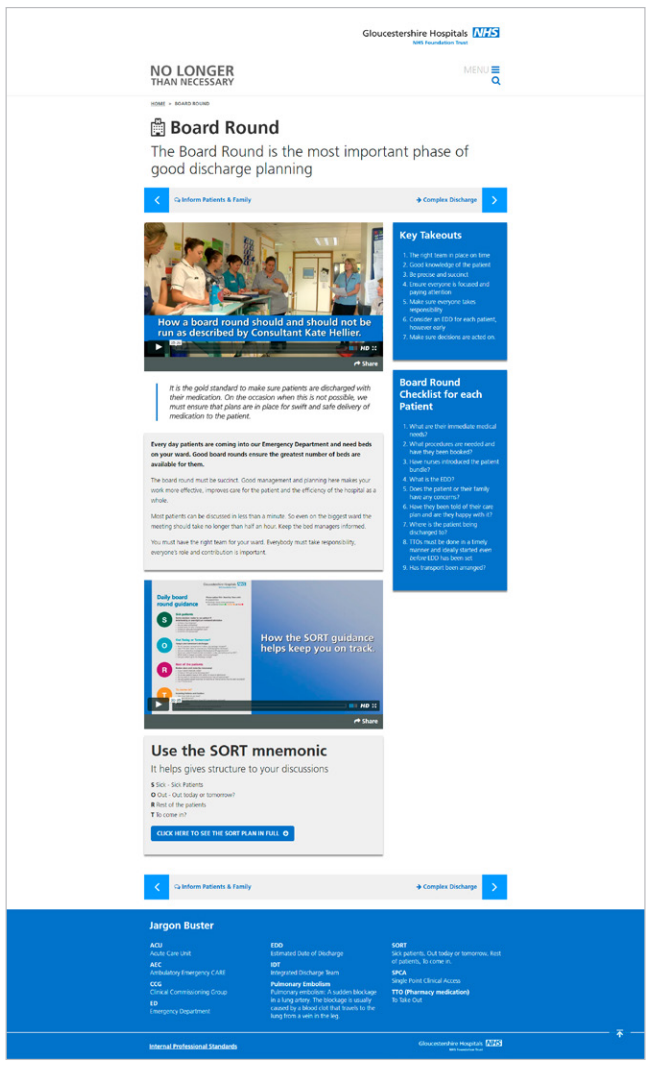
CASE STUDY

safergloshospitals website

During 2015/16 our Trust was awarded funding from the Health Education South West Membership Council Innovation Fund to build a web-based training resource with the ultimate aim of improving the discharge process in our hospitals.

The website was developed during 2015 and is structured to help staff quickly and easily navigate the different stages of the discharge process. Each stage – from the Emergency Department (A&E) to Acute Care, the importance of communicating well with patients and their families through an example of a complex discharge to organising medication To Take Out (known as TTOs) and eventual discharge home or to another care provider.

Targeting nurses, junior doctors and Allied Health Professionals (eg physiotherapists or occupational therapists), each step of the journey is supported by videos and key 'take home' messages to help explain best practice. The website launched in Spring 2016 and as a mobile friendly, externally-hosted website, it is hoped will be used across our hospitals to support discharge training.



We measure our success in improving patient flow by monitoring a range of key indicators, while acknowledging that the experience of patients themselves may not always be captured via these methods. Patient experiences in relation to the patient flow, handovers between departments or staff and the discharge process have been explored this year through the Learning from Users projects. You can see how we have performed in the more quantitative patient flow measurements in the following Figures:

Fig. 2: Number of admissions to our hospitals by month

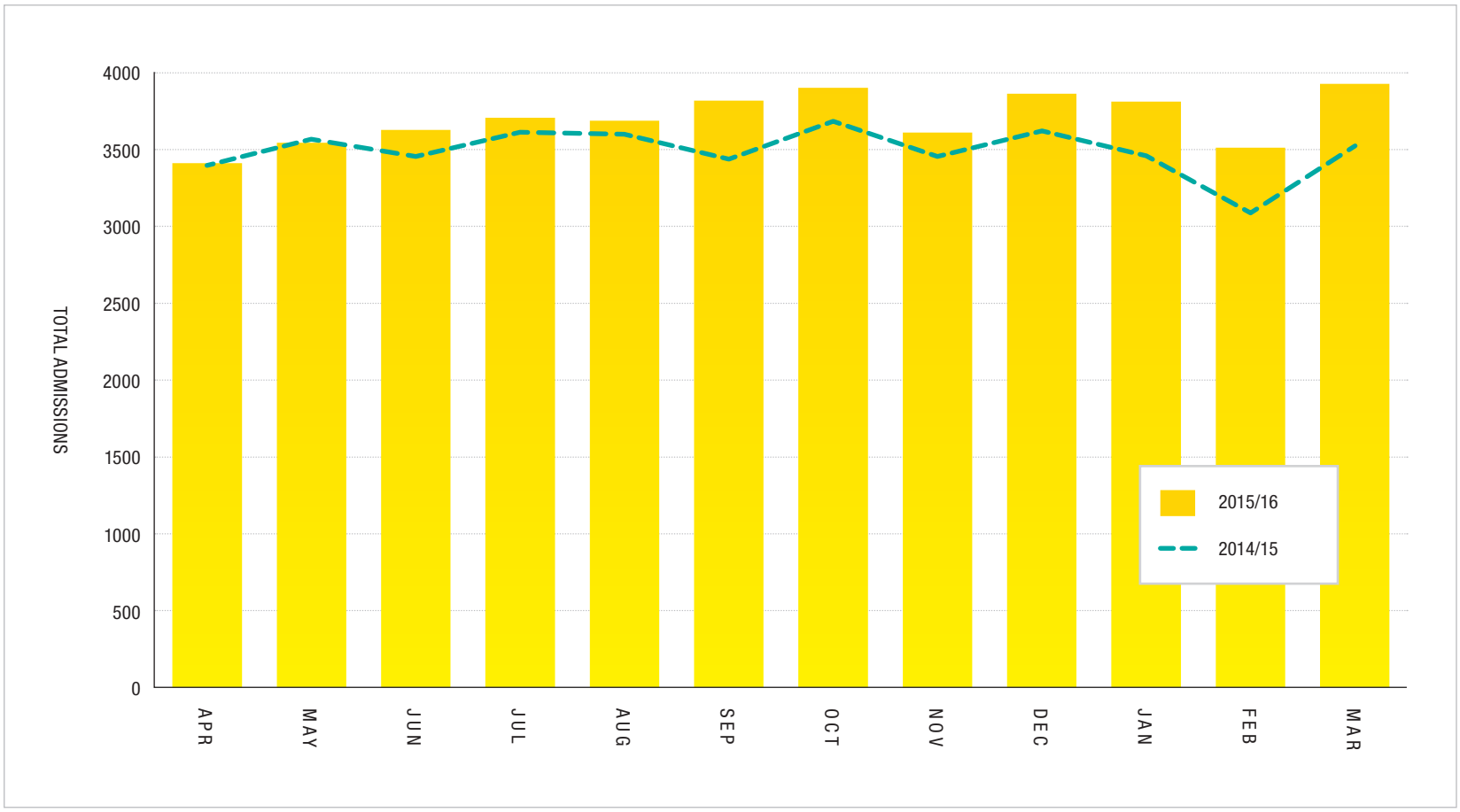


Fig. 3: Total number of patients considered 'medically fit' and ready for discharge

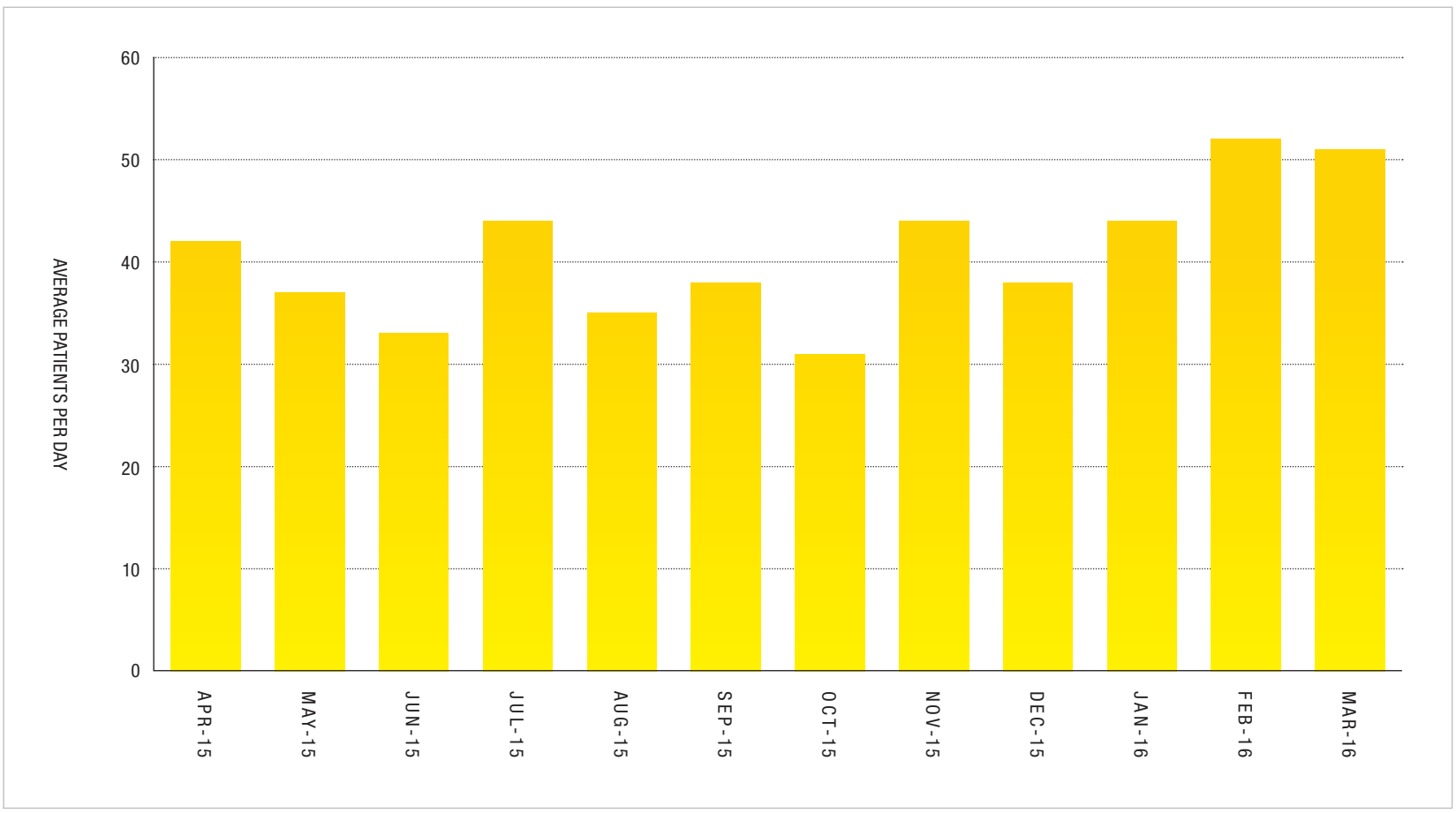


Fig. 4: Number and accuracy of patients given an Estimated Discharge Date

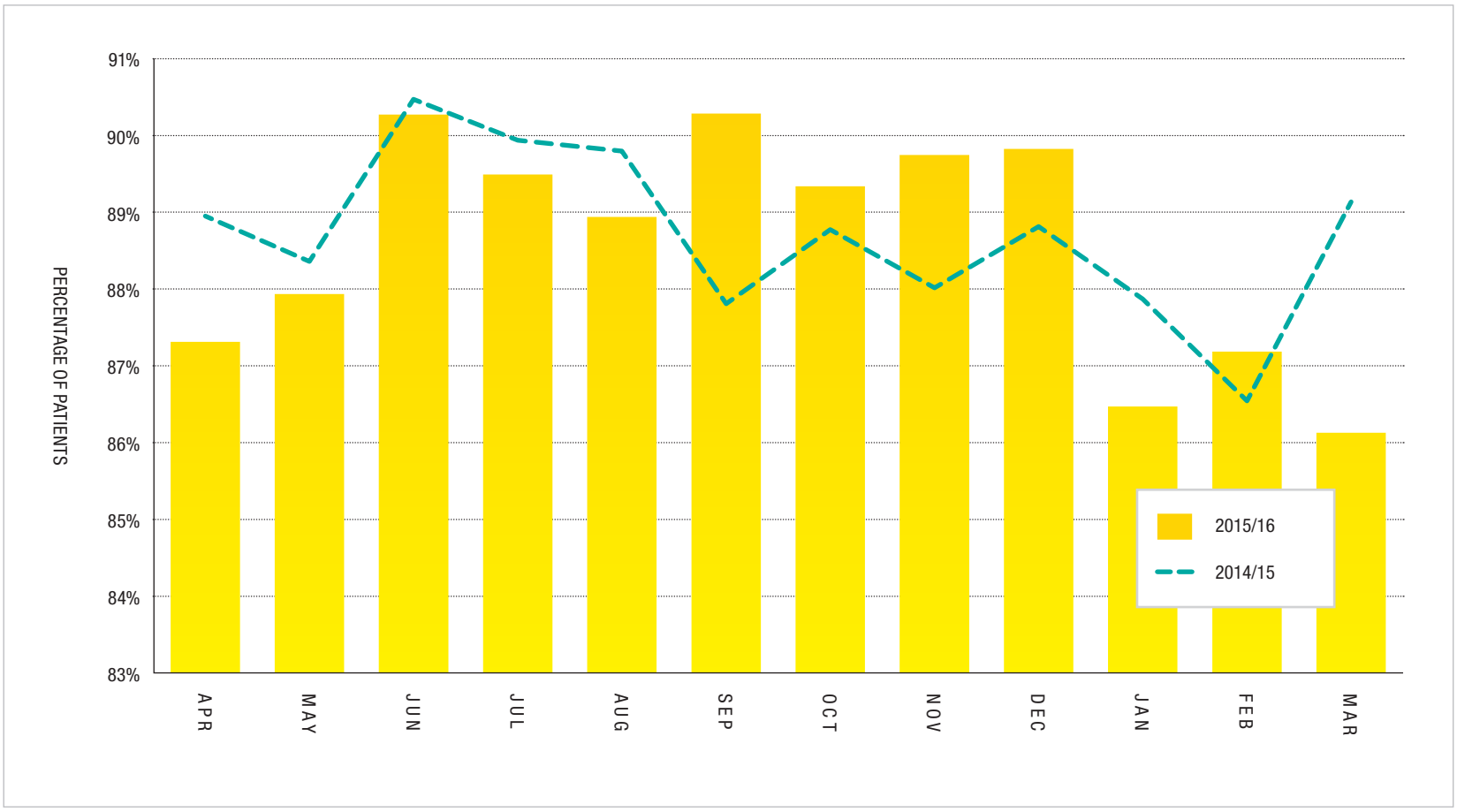


Fig. 5: Number of discharges by hour of the day

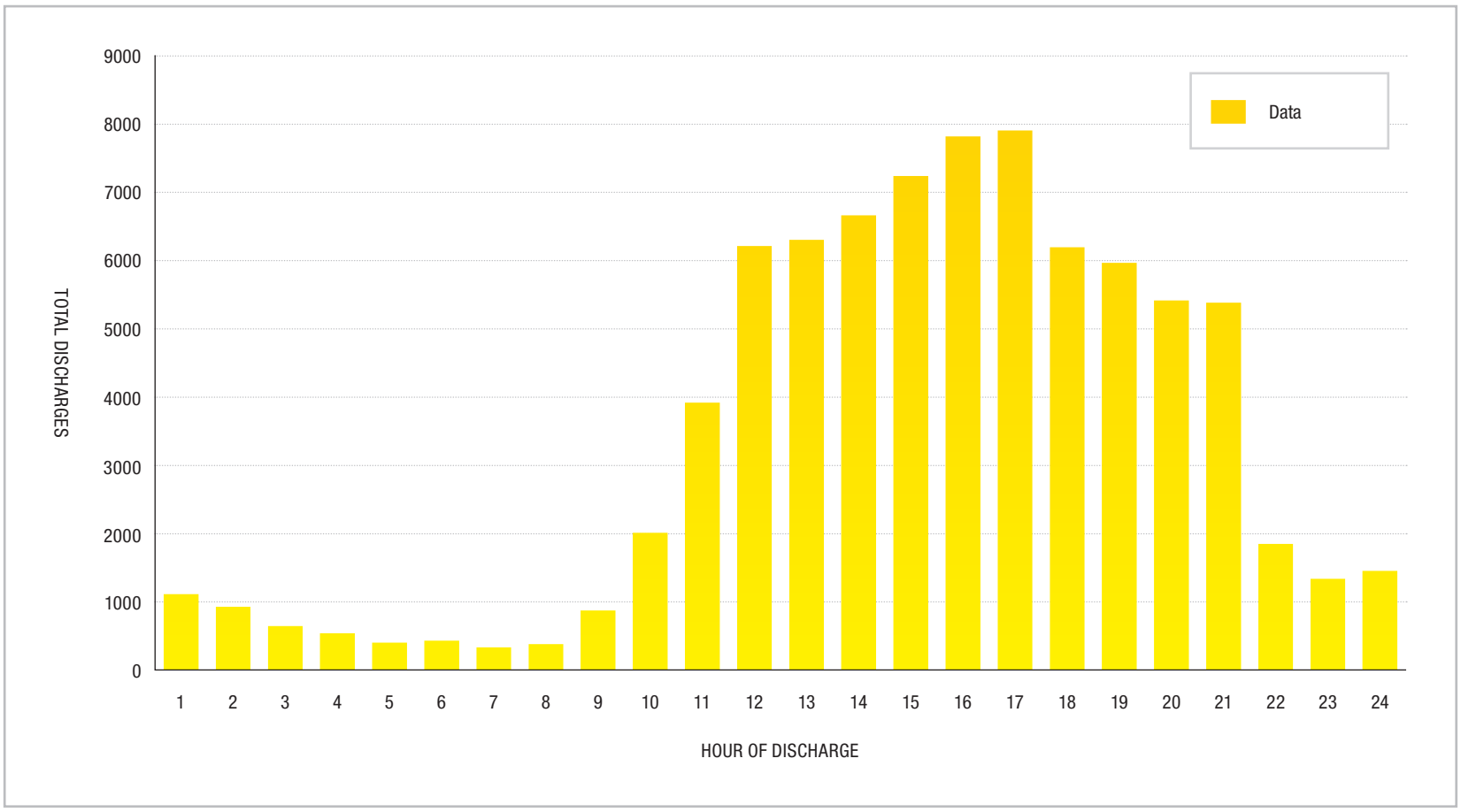
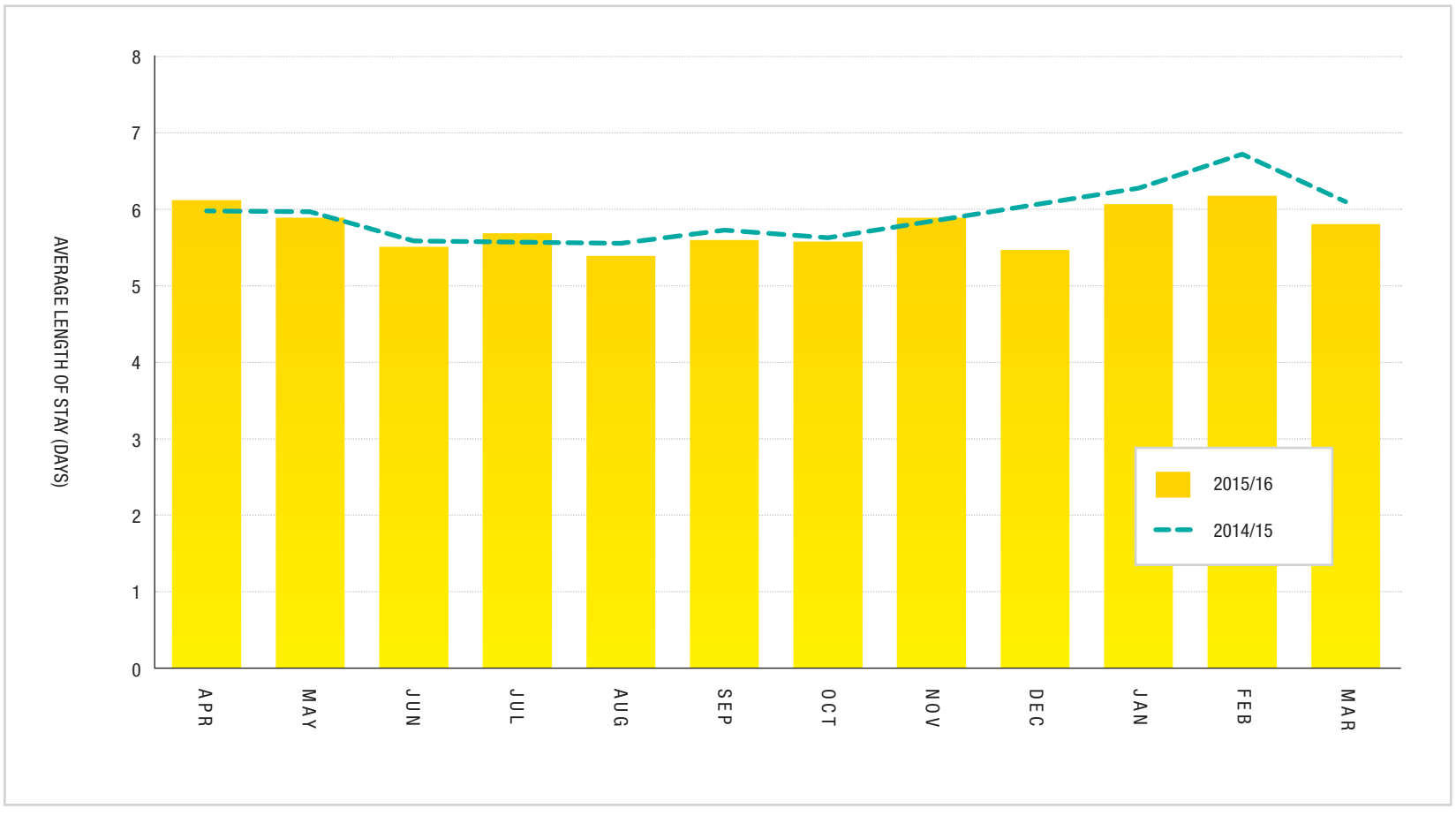


Fig. 6: Emergency Department 4-hour wait performance

	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016
CGH	95.20%	95.79%	97.32%	96.21%	92.32%	94.91%	91.12%	92.43%	89.25%	88.01%	89.18%	87.85%
GRH	89.51%	92.27%	93.70%	92.43%	82.40%	85.61%	83.28%	85.86%	79.06%	76.84%	69.70%	72.09%
Total	91.60%	93.54%	95.06%	93.83%	86.06%	89.06%	86.13%	88.17%	82.64%	80.88%	76.90%	77.77%

Fig. 7: Average Length of Stay: Non-elective (unplanned admissions)



Reducing the risk of Venous Thromboembolism

Venous thromboembolism (VTE) is the collective term for Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE). DVT is a blood clot in one of the deep veins in the body. It can cause pain and swelling and may lead to complications, such as PE. This is when a piece of blood clot breaks off into the bloodstream and blocks one of the blood vessels in the lungs.

Each year more than 25,000 people in England die from VTE contracted in hospitals. This is more than the combined total deaths from breast cancer, AIDS and traffic accidents and more than 25 times the number who die nationally from MRSA.

Around half of all cases of VTE are associated with hospitalisation, with many VTE 'events' occurring up to 90 days after admission. While global estimates of the true burden of disease vary, it is clear that the economic burden of VTE is considerable – with the total cost to the UK of managing VTE estimated at £640 million (ref. Health Select Committee report, 2005). Our over-arching objective is to reduce avoidable harm and death from hospital-associated thrombosis by ensuring that VTE prevention is embedded in our processes and procedures. This year our action plan included:

- Adding a VTE risk assessment to the patient prescription chart in the Acute Care Unit
- Creation of a new Multi-Disciplinary Team with the specific remit to improve VTE assessment
- Appointment of new VTE Champions to work during weekends
- Engagement with the Pharmacy team. They can also carry out risk assessments themselves.

The national target is to risk assess 95% of all patients for VTE, every patient, every time. In previous years we have reached and even exceeded this target, but during 2015/16 a change to the way patients are coded (a process which adds a code to a medical diagnosis for monitoring and billing purposes) meant that additional patients were listed as needing a risk assessment.

For the above reason, and because we have struggled to improve the number of risk assessments carried out in Day Surgery and the Acute Care Unit, we have failed to meet our target for much of the year (see Fig. 8), performing at between 93% and 95%. In the year ahead, we hope to resolve the anomaly outlined above and ensuring that the actions above start to deliver the planned improvements.

Improving handover

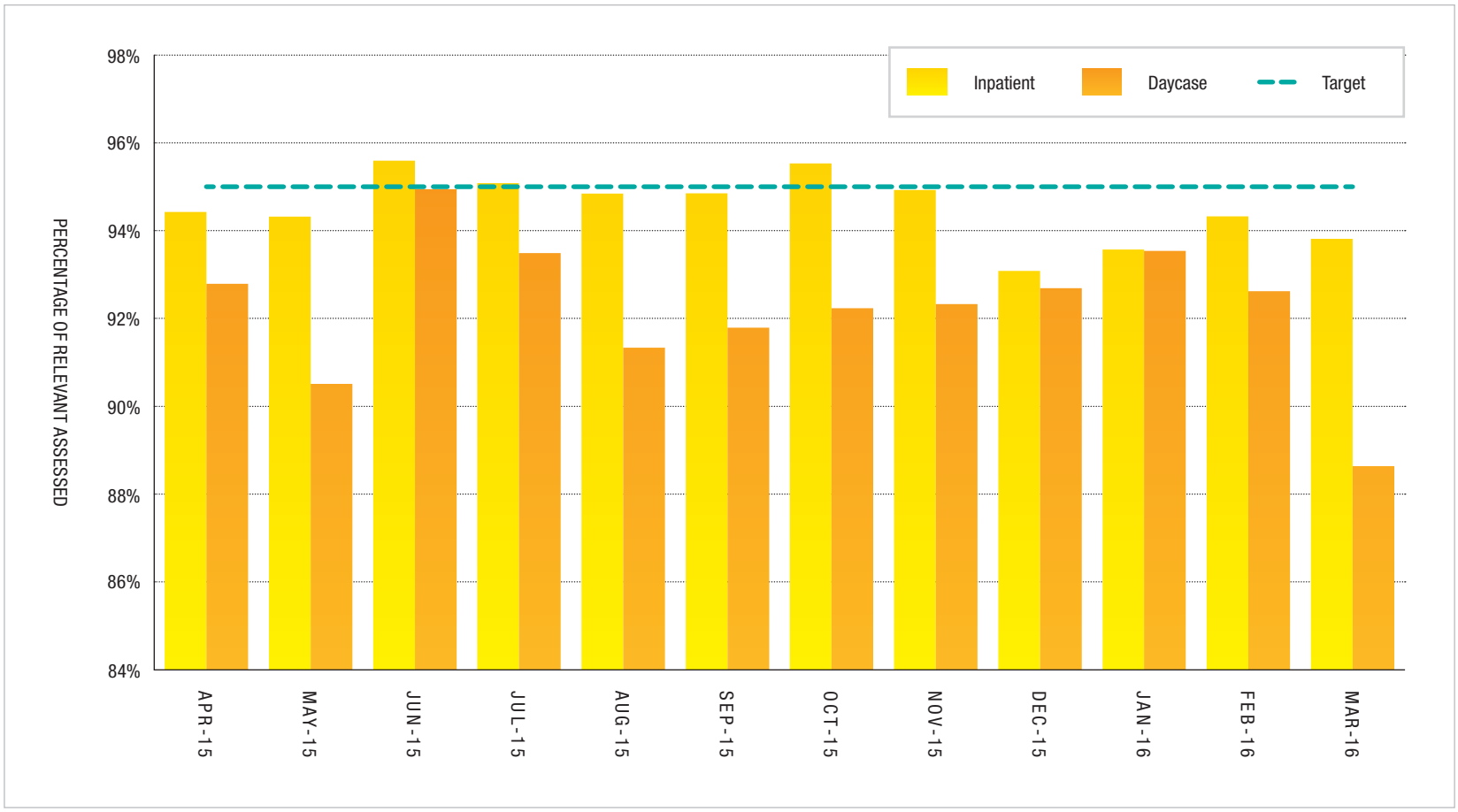
We want to provide a safe, effective handover of care between our clinical teams, as well as between other care providers such as GPs or social care. By improving the way we communicate between teams we can make sure that all relevant information about medical and nursing care is passed on to other professionals, providing a seamless service.

Improving the way our clinical staff refer patients between teams in our hospitals was identified as both a quality priority and a corporate objective for our Trust during 2015/16. We know that a poor handover can lead to a poor experience for patients, can affect the continuity of care and increase length of time a patient stays in hospital.

The No Longer Than Necessary website (see Case Study on p14) that we developed this year includes training videos which demonstrate how not to do a Board Round, followed by an example of a perfect Board Round. To help with this we introduced a new SORT mnemonic to give structure to discussions between clinicians about patients:

We know that there is still much to be done to improve the handover process and it will continue to be a priority in 2016/17.

Fig 8. Percentage of relevant patients assessed for VTE



Gloucestershire Hospitals NHS
NHS Foundation Trust

Daily board round guidance

Please update PAS+ Board by 10am with:
- Updated EDDs
- Discharge status where appropriate (see guidance) **Green**, **Amber**, **or Red**

S

Sick patients

Senior decision-maker to see patient if deteriorating or overnight/un-reviewed admission

- Is there a clear diagnosis?
- Are any tests outstanding?
- Is there clarity on who is doing what next?
- Is there an adequate management plan?
- Is the EDD still appropriate?

O

Out Today or Tomorrow?

Today's and tomorrow's discharges

- Are all necessary arrangements in place: care package, transport?
- Have TTOs been taken to pharmacy by 14:00 day before discharge?
- Can any outstanding investigations be booked as OP appointments?
- Could your patient's treatment be concluded in a day case setting such as AEC?
- What needs to happen to enable morning discharges?
- Can your patient go to the Discharge Lounge?

R

Rest of the patients

Review plans and revise (as neccessary)

- Is your patient medically stable?
- Is there an EDD and active discharge plan?
- Do all new patients have an EDD within 24 hours of admittance?
- Are any tests or interventions outstanding (are they still appropriate)?
- Has your patient waited more than 24 hours for an internal service (has this been escalated)?
- Can TTOs be done?

T

To come in?

Incoming Patients and Outliers

- How many beds do you have?
- Expected admissions?
- Outliers in other specialties? Have ACU requests been actioned?

Weekend plans

- Does every patient have a plan of care and management?
- Is the patient suitable for nurse-led discharge?

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BETTER FOR YOU

Reducing missed fractures

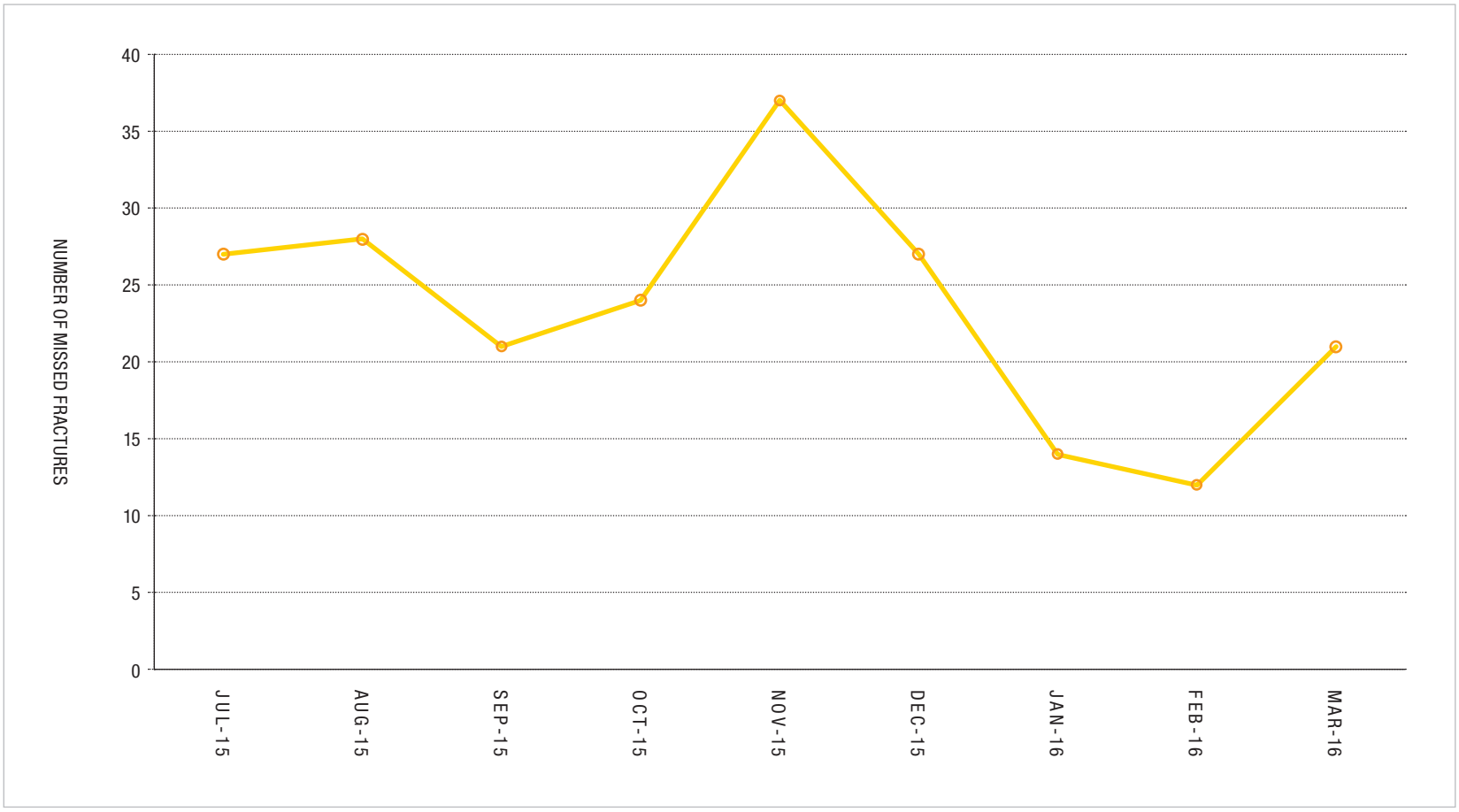
Studies show that a failure to detect a fracture on an x-ray is the most common diagnostic error made in Emergency Departments (A&E). Ordering the correct x-ray or ultrasound scan, then detecting an abnormality on the image takes skill and experience. This is why all diagnostic images (or scans) are reviewed by a specialist (either a radiologist or radiographer) so that a fracture that has been missed by staff in A&E can be identified on review. An undiagnosed fracture can cause significant pain and distress to the patient and could have potentially serious consequences.

In 2015 we submitted a bid for funding to the NHS Litigation Authority to help us reduce the number of missed abnormal results. We received £67,809.12 which has enabled us to address this issue in the following ways:

- Appointment of another radiographer to help reduce the amount of time it takes to review a scan or x-ray
- Backfill of a Band 7 Emergency Department nurse's time (the ED Champion), meaning that this senior nurse can be released from normal duties for two days a week, to focus on training and support of more junior staff members in interpreting scans.

Our targets in 2015/16 were to reduce the delay in the radiology team reviews of imaging (scan or x-ray) results, to reduce the incidence of missed fractures which may have been detectable on ultrasound and lead to litigation by 25% and to establish a data record to look a performance in the future. You can see our current performance against our goal to review all imaging within three days in Fig. 9.

Fig 9. Performance against three day target for diagnostic image reviews



Next section:
How well have we done in 2015/16?
Clinical Effectiveness

2.1.1

How well have we done in 2015/16?
Clinical Effectiveness

Improving care for patients with dementia and delirium

It is estimated there are around 850,000 people living with dementia in the UK, with numbers set to rise to over one million by 2025. Around 225,000 people will develop dementia this year alone – that's one every three minutes. In our hospitals, one in four patients may experience cognitive impairment (problems with memory and processing thoughts) and around 180 patients a month with a diagnosis of dementia are discharged every month.

During 2015/16 we have continued to assess patients admitted via our Emergency Departments (A&E) who are aged 75 years and above, in line with national best practice. This helps to identify patients who may be experiencing memory loss and enables assessment and specialist referral. Information is shared with the patient's GP and enables the patient to connect with services which help them live well with dementia.

Delirium is a state of new confusion, typically caused by a physical illness. It may develop over hours or days or it can be sudden, or a sudden worsening of a pre-existing condition. No one knows why some people get delirium when others with the same illness don't. It is more common in older people, people with sensory impairment and people with dementia. A medical illness, accident, operation or drug can also act as a trigger for delirium.

Delirium is not the same as dementia, although people living with dementia are more at risk of developing an episode of delirium when they are physically unwell or when they are admitted to hospital. Unlike dementia, delirium is curable, but left undetected it can become a life-threatening condition. We know that improving the environment, our understanding and the way we care for a patient with delirium will help reduce their distress. During 2015/16, our CQUIN goal was to introduce a delirium best practice assessment and management tool in all six of our General and Old Age Medicine (GOAM) wards, where patients with delirium are most likely to be cared for. This tool is used by the medical team and is a checklist of actions to take once a patient is diagnosed with delirium. To support the implementation of the tool, we have also provided a training programme for junior doctors working on GOAM wards, which was delivered by our Dementia Care Clinical Lead, and a ward-based training programme for the GOAM nursing team, delivered by our Senior Nurse for Safeguarding Adults and the Professional Education Team.

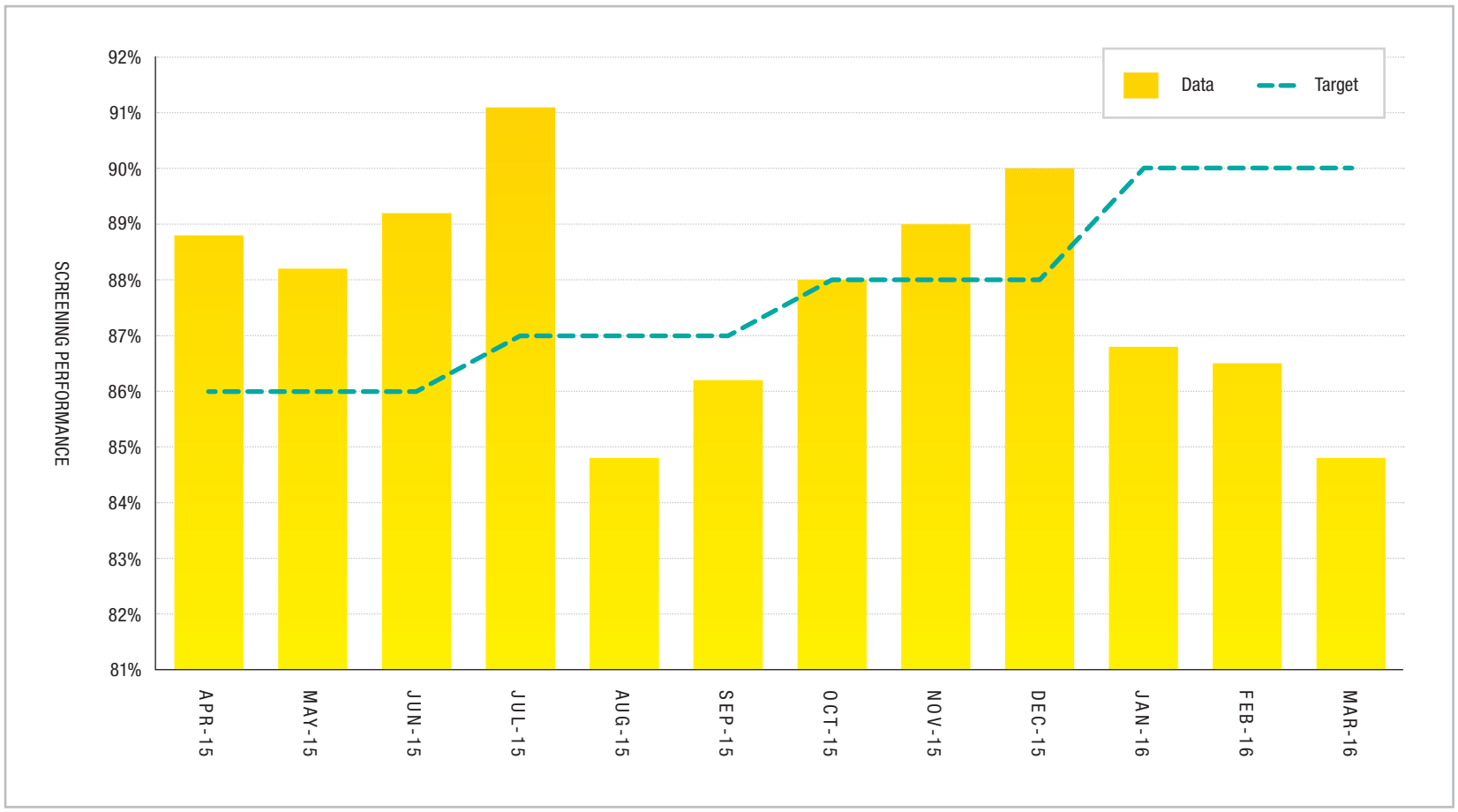
The second part of the CQUIN was to audit the wards where the tool was introduced to evaluate whether it was being used. We have further improved this best practice checklist and will be rolling it out to other wards and have started working with theatres, cardiology and critical care – areas which also care for patients who experience delirium and are hoping to improve the experience and care of these patients.

Other actions we have taken to improve the care of patients with delirium include:

- The introduction of delirium resource folders for staff on all six GOAM wards
- The introduction of a delirium intranet page
- The introduction of delirium pocket prompt cards to all teams on the GOAM wards. These display best practice tips to reduce the risk of delirium
- Delirium now forms part of the development programme for all our Dementia Champions.

In order to help support our patients with dementia, during 2015/16 we have been holding weekly Cognitive Stimulation Therapy (CST) sessions, led by the Clinical Psychology Team in our GOAM wards. CST is a group activity or exercise therapy recommended for patients with mild to moderate dementia as it can help with memory and communication, particularly

Fig. 10: Dementia monthly case finding performance



CASE STUDY

Making our hospitals Dementia Friendly

As part of our drive to make the ward environment more dementia friendly, we will be submitting a further bid for funding to introduce more clocks and calendars to our wards. During 2014/15 we introduced 70 dementia-friendly clocks which help orientate patients with dementia and/or delirium, reducing anxiety and distress. Quick visual access to the date and time is considered to be best practice by the Royal College of Psychiatrists. A traditional-style analogue clock face (with hands) is considered to be the most suitable for patients with dementia as it is a familiar format for older people.

During 2015/16 we also began to install dementia-friendly signage in our wards at Gloucestershire Royal Hospital. Again, helping to orientate patients wherever they are on our wards, the signs include colours and pictures known to be useful to improve the experience of patients and are consistent across the hospital. Phase one of this project is already been complete and the second phase is due to be implemented in 2016/17.

among hospital patients who may be at risk of becoming isolated, agitated and distressed. It can also be helpful to patients experiencing other forms of cognitive impairment, not just those with dementia.

Our Trust's Dementia Working Group have this year been working with the Estates and Facilities team to update our 'Environmental Toolkit' , a guide used to determine the internal decoration used in patient areas eg lighting, paint colours, flooring or curtains. The toolkit now reflects best practice for a Dementia Friendly Environment, helping to make sure that the needs of our dementia patients will be at the forefront of any improvements to ward areas.

Improving the care for fragility fractures

Fragility fractures are fractures (broken bones) that result from a fall from standing height or less. They often affect frail, elderly patients and are an increasing cause of admissions to hospitals nationally. Each year the UK spends around £2 billion treating and caring for patients with hip fractures. Hip fractures are debilitating, restrict the patient's independence and the mortality associated with them is high.

In our hospitals, our own mortality rate indicators and the National Hip Fracture Database have alerted us to a higher than expected mortality rate in patients with hip fractures. In addition, these patients with fragility fractures are not receiving their operations as quickly as they should.

To help us identify how we can improve, we asked the Royal College of Surgeons to conduct a review of our hip fracture service. This took place in June 2015. The recommendations of this report along with the findings of two initial audits were consolidated into one action plan which is being progressed. To date there has been little impact on the mortality indicators so this will remain a priority for us in 2016/17.

The areas identified for improvement are:

- theatre capacity at CGH
- environment and equipment
- staffing of the service
- availability of phlebotomy service
- patient feedback
- care documentation
- clinician/manager relationships
- trauma list.

Improving diabetic footcare

Diabetes can lead to a number of complications including heart disease, kidney disease, retinopathy (eye problems), problems with peripheral circulation (peripheral vascular disease) and neuropathy (a nerve disorder). Peripheral vascular disease and neuropathy can lead to the development of ulcers in the feet which, because of reduced blood flow, heal poorly and can lead to surgical amputations.

In Gloucestershire the number of amputations we perform on patients with diabetes is above the national average. There is no one single reason that can explain this, but it is thought that we can reduce the need for amputation by improving the recognition of potential footcare issues in diabetic patients, by working more closely with GPs and other healthcare providers in 'the community.'

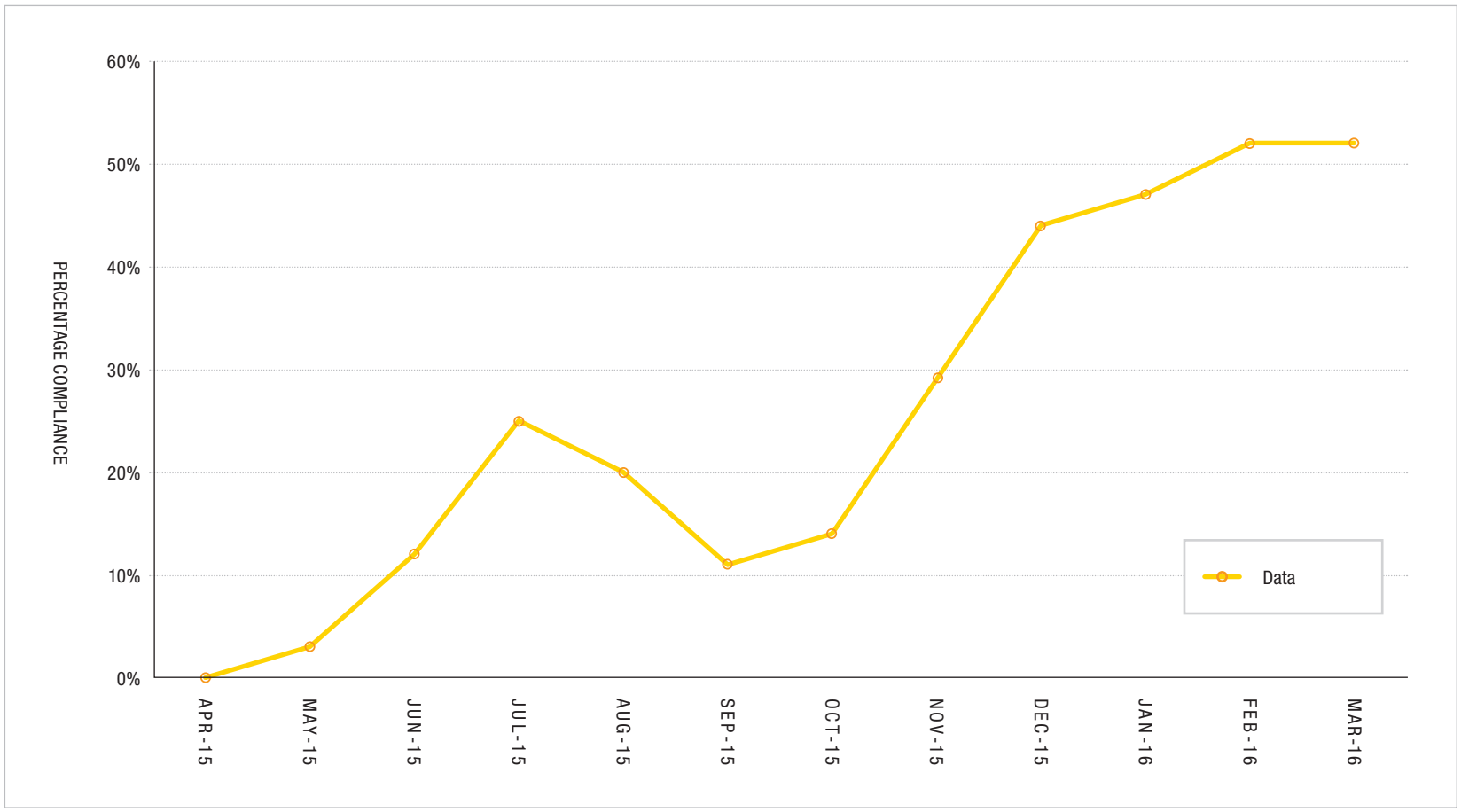
A National Diabetes Audit carried out in 2012/13 showed that in Gloucestershire we carried out 172 minor amputations on diabetic patients. In order to address this, we have been working with our partners in the Gloucestershire Clinical Commissioning Group to identify ways we can improve the care for patients with diabetes.

We have taken the following steps:

- We have created a new referral form for the community for patients with diabetic foot disease so that referrals can be triaged to the right service first time. This is now part of the G-Care website, a site used by GPs for reference about how to access healthcare services
- For in-patients a sticker in the notes will soon to be piloted to highlight the need for a sensory foot check assessment of patients with diabetes to identify those at risk of ulceration during their admission and to identify patients with active diabetic foot disease that clinical staff were unaware of. All patients with diabetes on the ward will be assessed as 'green' (no footcare issues), 'amber' (at risk) and 'red' (active disease). The patients classified as 'red' will need referral to the footcare team via our internal e-referral system.
- We are working with the Gloucestershire Clinical Commissioning Group on a footcare CQUIN that ensure we are compliant with NICE guidelines for in-patient foot care – assessment within 24 hours of admission to hospital

The first part of our CQUIN target during 2015/16 was to create a project plan to address the issues outlined above and to develop a pathway and this has been met.

Fig. 11: The percentage of discharge summaries for AKI patients compliant with CQUIN goals



Improving the management of patients with Acute Kidney Injury

Acute Kidney Injury (AKI) is a sudden loss of kidney function and is strongly linked to high mortality rates and an increased length of stay. In a hospital there are a number of reasons why a patient may develop an AKI, for example through infection or as a result of dehydration.

Improving the management of patients with AKI is a national CQUIN target. For any patient who has had an AKI during their stay in our hospital, we must ensure that their discharge letter should inform the GP:

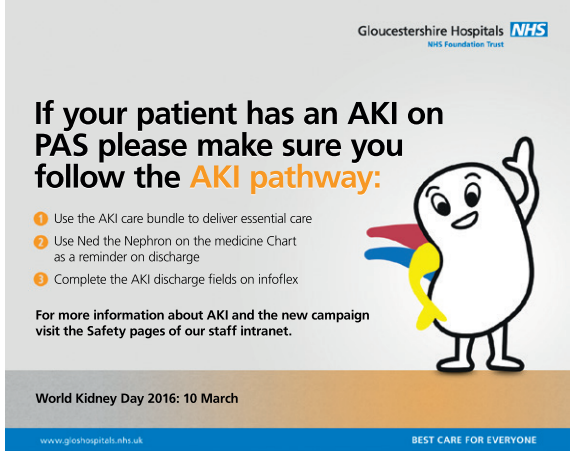
- What stage AKI has been diagnosed
- Whether their medication has been reviewed and if so, what the outcome was
- What blood tests will be required once they have been discharged
- How frequently they will require these blood test.

Previous CQUINs have focussed on the treatment of patients identified as being at risk of an AKI, but while hospital care is undoubtedly important in the prevention of AKI, it has been acknowledged that there is also much we can do in the community to prevent AKI and hospital readmissions. In the early part of 2015/16 our performance against these CQUIN goals was poor, as we did not have a system which would capture the required information in the discharge summary sent to GPs when a patient leaves hospital (see Fig. 11).

However, we have now introduced two key changes which we expect to deliver significant improvements:

- Using the model of quality improvement taught by our Gloucestershire Quality & Safety Improvement Academy (you can read more about this on p44), three junior doctors developed a highly visible sticker which will be fixed to a patients' medication chart to indicate that their medication review must be included in the discharge summary. Known as 'Ned the Nephron' this character is now being used in our hospitals.
- We made a change to the system being used to generate discharge summaries so that the section relating to AKI is more visible.

The implementation of TrakCare, our new Electronic Health Record, will ensure that this process is further automated and that information relating to AKI is a core component of the shared health record.



Improving the management of patients requiring emergency laparotomy

Emergency laparotomy is a name used to describe a number of different surgical procedures performed on emergency patients with severe problems affecting their abdomen.

There are approximately 80,000 emergency laparotomy procedures every year in the UK, but the procedure is risky, with 14% of patients dying within 30 days. For those over the age of 80, this can increase to 25%. The main risk to these patients is sepsis and it is critical that those patients at risk are identified as soon as possible after they arrive in our hospitals.

In 2015/16 our CQUIN goals were:

- To establish a baseline measurement of our performance against national standards for laparotomy procedures, as measured by the National Emergency Laparotomy Audit
- To develop a new pathway and begin to test the process for a new surgical pathway for this group of patients. This took the form of a checklist used ahead of any laparotomy procedure to ensure the correct actions had been taken
- To review all cases where emergency laparotomy procedures resulted in the patient's death and to identify lessons learned from these.

You can see how we performed against the national standards in Fig. 12.

Fig. 12: National emergency laparotomy audit results

		Site	April 2015	May 2015	June 2015	July 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016
	Total patients receiving surgery and 'locked' onto NELA database	CGH	7	12	11	7	11	9	5	15	10	8	4	
		GRH	11	14	12	14	6	2	17	13	11	13	5	
1	**% of patients seen by a consultant surgeon <12 hours**	CGH	2/6 33%	2/8 25%	2/8 25%	0/5 0%	3/8 38%	7/8 88%	1/5 20%	9/13 69%	5/9 56%	3/6 50%	1/4 25%	
		GRH	4/9 44%	3/14 21%	6/9 67%	7/13 54%	1/5 20%	1/2 50%	4/15 27%	2/9 22%	2/9 22%	3/13 23%	2/3 67%	
2	**% of patients CT performed pre-op**	CGH	6/7 86%	10/12 83%	10/11 91%	6/7 86%	10/11 91%	9/9 100%	12/14 26%	12/14 86%	9/10 90%	8/8 100%	3/4 75%	
		GRH	10/11 91%	11/14 79%	10/12 83%	11/14 79%	5/6 83%	2/2 100%	13/13 100%	13/13 100%	10/11 91%	11/13 85%	5/5 100%	
	% of patients who had CT report available pre-op	CGH	5/6 83%	10/10 100%	9/10 90%	6/6 100%	9/10 90%	7/9 78%	2/2 100%	10/10 100%	8/8 100%	5/5 100%	3/3 100%	
		GRH	10/10 100%	10/11 91%	9/10 90%	9/11 82%	4/5 20%	2/2 100%	16/16 100%	13/13 100%	10/10 100%	11/11 100%	3/4 75%	
3	**% of patients with risk of mortality documented**	CGH	5/7 71%	8/12 67%	5/11 45%	5/7 71%	7/11 64%	7/9 78%	4/5 80%	9/15 60%	7/10 70%	8/8 100%	3/4 75%	
		GRH	6/11 55%	10/14 71%	7/12 58%	10/14 71%	4/6 67%	1/2 50%	8/13 62%	8/13 62%	6/11 55%	7/13 54%	4/5 80%	
4	**% of patients arriving in theatre within a timescale appropriate to their operative urgency***	CGH	7/7 100%	12/12 100%	11/11 100%	4/7 57%	10/11 91%	8/9 89%	5/5 100%	14/15 93%	10/10 100%	8/8 100%	4/4 100%	
		GRH	10/11 91%	12/13 92%	11/12 92%	11/14 79%	5/6 83%	0/2 0%	15/17 88%	10/13 77%	11/11 100%	13/13 100%	4/5 80%	
5	**% of patients who presented to ED with red flag/severe sepsis who had antibiotics administered within 1 hour****	CGH	NA	1/4 25%	1/3 33%	0/1 0%	0/2 0%	1/2 50%	NA	NA	NA	NA	NA	
		GRH	NA	0/3 0%	0/3 0%	2/4 50%	0/3 0%	NA	NA	NA	NA	NA	NA	
6	**% of patients admitted to DCC post op if predicted risk of death >5% (post op p-possum score >5%)**	CGH	3/5 60%	6/8 75%	4/6 67%	1/4 25%	6/8 75%	6/7 86%	3/3 100%	7/10 70%	6/9 71%	5/7 71%	1/3 33%	
		GRH	5/9 56%	9/9 100%	5/6 83%	6/6 100%	5/6 83%	1/1 100%	7/12 58%	8/10 80%	3/3 100%	6/9 67%	2/3 67%	

*NCEPOD operative urgency **Reporting stopped after Q2 as it is incorporated in the Sepsis CQUIN results

Improving the management of sepsis

Every year in the UK there are 150,000 cases of sepsis, resulting in 44,000 deaths, more than bowel, breast and colon cancer combined. Sepsis is a life-threatening condition that arises when the body's own response to an infection injures its own tissues and organs. Sepsis can lead to shock, multiple organ failure and death, especially if not recognised early and treated quickly. Each month our hospitals' Emergency Department treats between 40 and 50 patients with severe sepsis.

This year our CQUIN target was in two parts:

- **Part A**: All patients who attend our hospitals via any emergency route (eg as a walk-in patient in A&E, brought in by ambulance or by GP referral) must be screened for sepsis.
- **Part B:** Patients with severe sepsis must receive antibiotics within an hour of admission.

Our performance against both of these CQUIN goals can be seen in Figures 13 and 14. We have done well against Part A, achieving close to 100% compliance in the second half of the year. However Part B has been more challenging. There are areas within our hospitals which are very good at ensuring the antibiotics are administered within one hour of admission, for example in Oncology (cancer services) where a dedicated helpline can advise patients at risk of sepsis to attend a clinic immediately where they can receive their antibiotics.

Our focus on achieving Part B is now on the Emergency Department (A&E) and anyone who develops sepsis on a ward during an inpatient stay, ensuring that once a diagnosis of severe sepsis is made, antibiotics are administered quickly. The challenge in this department is that the clock starts as soon as the patient walks through the door. A new Emergency Department checklist will support this drive, helping our clinicians quickly and reliably assess patients for sepsis wherever they are in the department, even at the triage stage.

Fig. 13: Percentage of patients screened for Sepsis

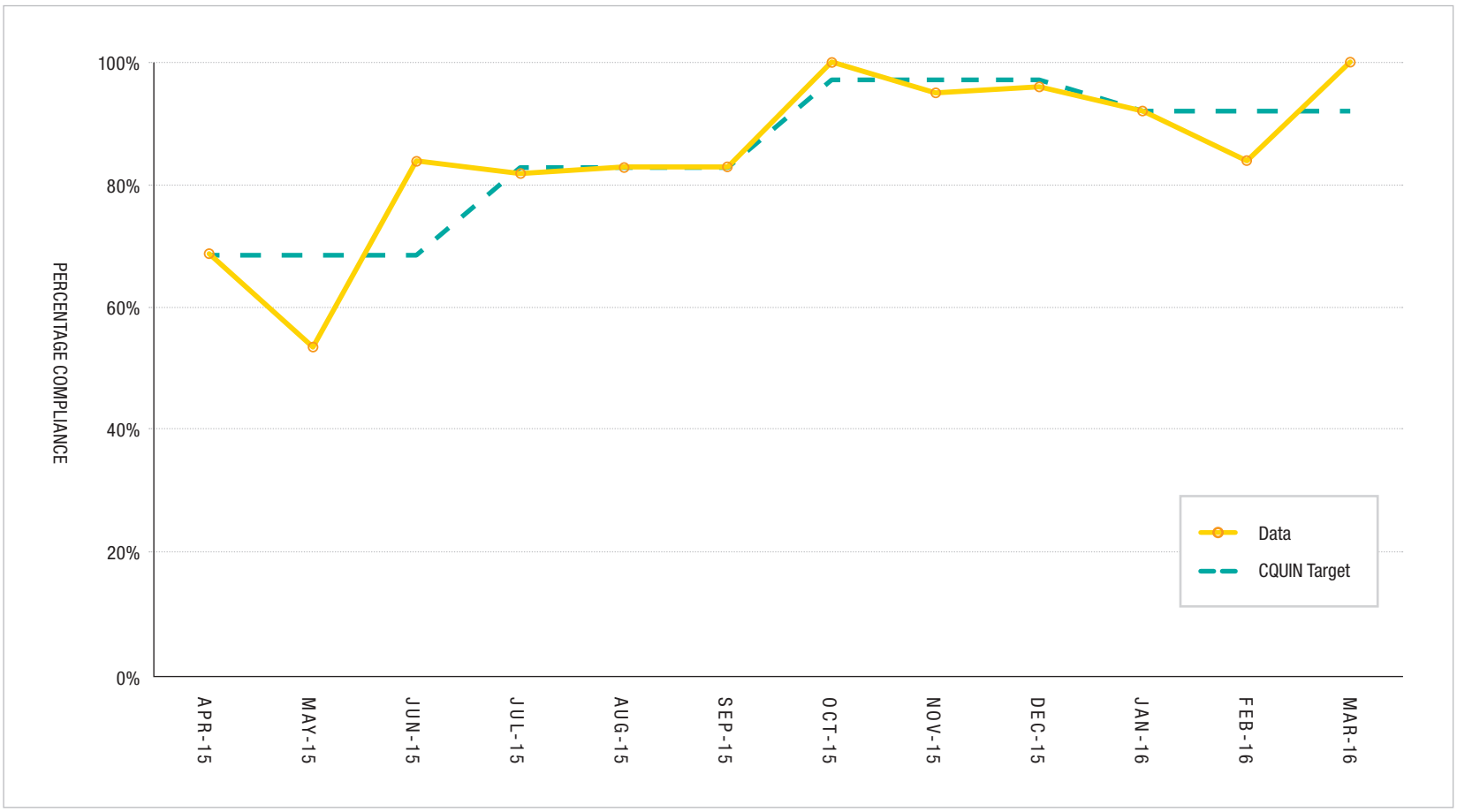
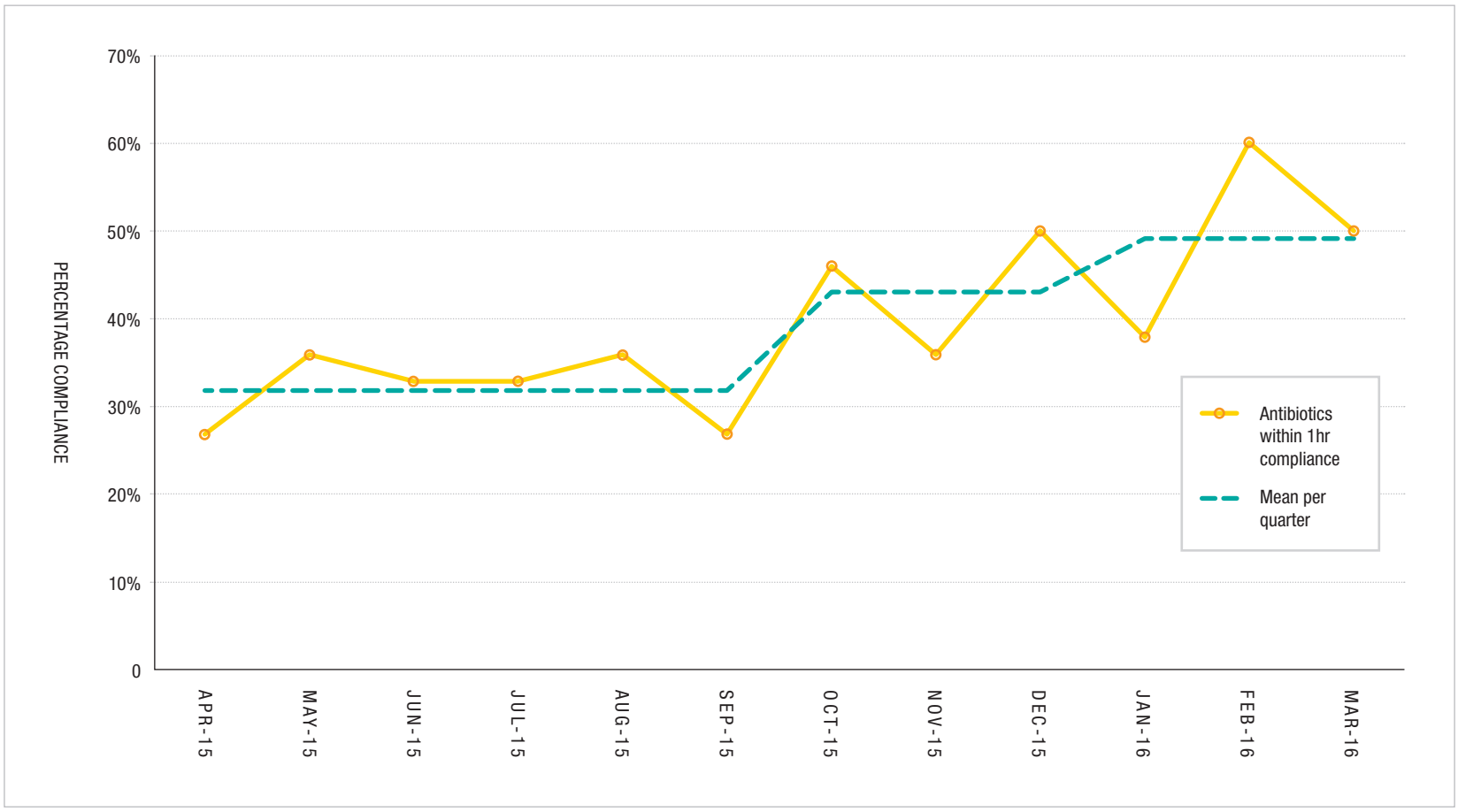


Fig. 14: Percentage of sepsis patients receiving antibiotics within an hour



2.1.1

How well have we done in 2015/16?
Patient Experience

Improving care transition from children's to adult services

We use the word 'transition' to describe the process of preparing, planning and moving from children's to adult services. This can be a difficult time for younger patients who will be leaving a team of doctors and nurses that they may have been involved with for many years. The University Hospital Southampton NHS Foundation Trust's Children's Hospital developed a 'Ready, Steady, Go' method to help these patients through their transition to adult services. The aim of this transition programme is to focus on what is positive and possible for the young person (from age 11 onwards) and to identify support available to develop a plan of structured, individualised care. This is done in partnership with the young person's family or carer.

In accordance with NICE guidance (NG43, 2016) the approach to the transition pathway of our young adults with long term conditions is to ensure better communication between all parties involved with the young person. This is achieved by successful implementation of transition protocols which enable better outcomes for young people in our hospitals.

During 2015/16 we adopted this model to support our own patients. We have achieved this by introducing a Transition Policy and Transition Pathway supported with documentation. A Trust Transition Steering Group led by the Director Of Nursing, Maggie Arnold, along with a Transition Working Group have also been established enabling a multi–professional approach to improving transition care for our young people, promoting safe and best practice.

In support of this, a bespoke Trust e-learning package has been designed to inform and educate our staff on the transition pathway from children's to adult's services. Patient experience and feedback on transition has also been sought to identify any areas needed to improve the overall patient transition experience as well as what has worked well.

The aim of this transition programme is to focus on what is positive and possible for the young person and to identify the support available to formulate a plan of individualised structured care from the age of 11 years, working in partnership with the young person and their families/carers. Enabling transition through the different phases of Ready, Steady, Go and Hello, whilst promoting engagement, empowerment, management and responsibility of the young person's long term condition (NICE NG43, 2016).

Working in conjunction with the NHS England Lead for Transition and with the South West Children and Maternity Strategic Clinical Network, we have implemented the structured transition pathway "Ready, Steady, Go and Hello." The transition pathway is currently being piloted within the Epilepsy Services and will be rolled out to other speciality services across our Trust over 2016/2017.

We also held a Transition Awareness Week in March 2016, which ended with an event to celebrate our achievements so far and to promote the further developments including the roll out to other specialities; the use of the Easy Read version of the Ready, Steady, Go and Hello (awaiting release from University Hospital Southampton) for the young people with a long term health condition and Learning Disability and the development of a transition webpage.

In accordance with NICE guidance (NG43) the approach to the transition pathway of our young adults with long term conditions is to ensure better communication between all parties involved with the young person with successful implementation of transition protocols which will impact on enabling better outcomes for young people within our Trust.

Learning from users

We believe that patients are well placed to give useful feedback on the way services work and on how they can be improved in the future.

Our patients experience our services first hand; they have a unique, highly relevant perspective on what works and what doesn't. Their input into designing services can therefore be invaluable. Sometimes, seeing services from the patients point of view opens up real opportunities for improvement that may not have been considered before.

During 2015/16 we used three evidence-based methodologies to involve 'users' of our services in their improvement. This work was undertaken using the quality improvement methodology supported by the Gloucestershire Safety and Quality Academy (see p44 to read more about the academy). The three projects were as follows:

CASE STUDY

Listening and Learning

In 2015/16 we worked with Age UK on a national research project which involved actively listening and learning from older, frail, elderly patients on our wards.

We know that understanding how a person has lived their life before they became a patient will help our staff see beyond their immediate needs and incorporate the patient's goals and aspirations into healthcare decisions we make. We used trained volunteers on Wards 4a, 4b, 6a (at Gloucestershire Royal Hospital) and Ryeworth (Cheltenham General Hospital), to spend time with patients, listening to their feedback on their experiences in our hospitals. These stories were then shared with the nursing staff who in turn can then turn these experiences into actions. The idea was not to identify short comings in care, but to identify changes to practice as the project evolved. The listening took the form of informal 'chit chats' and 'time for tea' sessions, giving patients the opportunity to discuss their care and interact with other patients. There have been many positive outcomes to this project to date, from the useful feedback received, to the unintended consequence on Ryeworth Ward of increasing the intake of food consumed by patients attending the 'time for tea' session.

All wards involved in the project have agreed they will continue with the methodologies after the project ends. The final report will be shared with Gloucestershire Clinical Commissioning Group, and will be published nationally, once complete.

CASE STUDY

Experience based co-design

The term 'experience-based approach' refers to a way in which patients and staff work together to improve the way a service works through interviewing patients, group discussions and observations.

In 2015/16 we used this approach to improve stroke services. The stroke team are always looking for new ways to improve their service, and following a reorganisation of the services onto one site, it was considered a good time to review the experience of their patients. On October 29, 2015, we held an event, attended by staff and patients, where the group watched films of patients discussing their experiences of stroke services and discussions were held with actions identified to help improve future services. These were to increase the variety of activities available for patients while in hospital, to review the role of a volunteer within stroke services, improve the availability of hydrotherapy and other activities for patients and carers after discharge and designating domestic staff for the stroke ward.

We have now created an Experience Based Co-Design toolkit as part of the Gloucestershire Safety & Quality Improvement Academy to help embed it as a quality improvement method for use elsewhere in our hospitals. A participant in the project came to speak to our Trust Board in January 2016 to share this experience as a stroke patient, as well as being part of the project.

CASE STUDY

Shadowing

Shadowing is an observation technique where a third person records what happens during a patient's journey through our hospital.

The person shadowing the patient witnesses everything the patient experiences, observing and recording each step of the process and then seeking feedback from the patient at each point. Shadowing gives staff the opportunity to see the care experience through the eyes of a patient, offering a unique opportunity to see what works well and where improvements could be made.

In 2015/16 we have been shadowing patients in the elective hip pathway; including pre-assessment clinic, hip classes, surgical admission suite, theatres/ recovering and on Ward 3a at Gloucestershire Royal Hospital. Initial findings have included:

- *The pre-assessment clinic was hard to find, but the friendliness of staff was noted by all patients*
- *The staff in the Surgical Admissions Suite are friendly and welcoming. It is a busy area during the morning before surgery begins and space is a challenge. A significant issue affecting patient experience is that all patients are asked to attend at 7.15am, even if a patient is not scheduled for surgery until the end of the day*
- *Emerging themes from the inpatient stay so far include communication and food, though not enough patients have been shadowed to date to draw conclusions.*

A full report will now be considered by the Surgical Divisional Board, including the following actions:

- *consider where patient belongings are placed when they arrive on the ward from Recovery as they are often out of reach or not visible*
- *ensure each patient is welcomed to the ward*
- *address the issue of cold toast on the ward*
- *review information given after discharge re key contacts for patients.*

Another tool we use to measure our performance in this area is the Friends & Family Test. In 2015/16 the emphasis on reporting the Friends & Family Test moved from measuring the response rate itself to the positive recommendations that we receive. We do, however, still aim to achieve a minimum response rate of 20% in inpatient areas.

During 2015/16 we received 15,288 responses from inpatients in both hospitals. On average, 95% of patients who responded said they were extremely likely or likely to recommend our Trust to their friends and family if they needed similar care or treatment. We have found it harder to achieve a good response rate in our Emergency Departments after moving from a token-based system to paper responses. We have an action plan in place to help us increase our response rate to 15% by June 2016. In total we received 1322 responses, with 76% of patients saying they were extremely likely or likely to recommend the department to their friends and family if they needed similar treatment.

Outpatients were included in the Friends & Family Test for the first time this year. During 2015/16, 10,905 outpatients completed a Friends & Family Test survey – an average of 93% said they would be extremely likely or likely to recommend us to friends or family.

All comments made via the Friends & Family Test are sent to the relevant ward and department managers to be shared with all staff. From this, staff can draw up their own learning logs, highlighting what they are most proud of and any areas where improvements can be made. The results are updated each month and posted on notice boards on our wards.

Improving patient information

Good patient information is important because it can:

- Help to ensure that patients arrive on time and are prepared for their treatment, procedure or appointment
- Give patients confidence, improving their overall experience
- Remind patients of what they have been told (in case they have forgotten)
- Provide patients with accurate information
- Involve patients and carers in their care.

For these reasons, it is important that the information we provide patients and their families with is accurate, up to date, well presented and easy to understand. Our patient leaflets were considerably out of date and there was a recognition that the process for managing the updating of leaflets needed to be reviewed.

In 2015/16 we conducted an initial stock take of all 1,000 patient information leaflets and implemented a new process for managing new and existing leaflet content. There are now only 480 leaflets, half of which are available in a printable A4 format on our website. Work is now in progress to ensure all 480 leaflets are available in this format.

Working with both patients and staff, we have also produced new Easy Read leaflets, and all ward areas have now been supplied with a stock of core leaflets. The new Patient Information Steering Group now meets quarterly, with 'users' and representatives from our Divisions attending. A new policy outlines the much simplified process for approving and updating the content of leaflets.

Members of the public help us review the content, ensuring that the information written is clear and easy to understand.

In 2016/17 we will be reviewing our learning disability literature using a newly formed user group, as well as ensuring we meet the Accessible Information Standards.

Living with and beyond cancer

Around 1.8 million people in England are currently living with a diagnosis of cancer. This number is increasing by more than three percent a year with the total figure of over 3 million by 2030. As the population ages and the incidence of cancer rises there is a greater need to transform cancer services for our population in Gloucestershire. Every year 3,400 more people in Gloucestershire receive a cancer diagnosis and there are an estimated 18,000 cancer survivors in the county.

As a result of this pattern shift the National Cancer Survivorship Initiative (NCSI) promoted a strategic shift towards promoting recovery, care planning, supported self-management, managing the consequences of treatment and improving patient experience.

In October 2014 NHS England's Five Year Forward View[i] included a range of specific plans for the development of cancer services which included support for initiatives to bring cancer care closer to home and endorsing the wider use of the Cancer Recovery Package. The national cancer strategy Achieving World Class Cancer Outcomes: a Strategy for England 2015-2020 includes a number of key recommendations on improving the quality of life after treatment including:

- Ensuring people are supporting and have their needs met including managing the late effects of disease or treatment
- Commissioning of services to incorporate using the Cancer Recovery Package across all sites, and to implement risk-stratified follow-up for breast cancer and for two other sites by 2020.
- Improving integration across primary, secondary and social care.

As a result of this Gloucestershire Clinical Commissioning Group [i] along with Macmillan, our Trust and Gloucestershire Care Services launched the county-wide Living With & Beyond Cancer Programme. This programme consists of a two-year CQUIN of which our Trust is responsible for implementing the following in breast, prostate and colorectal cancer services:

- Holistic Needs Assessments (HNA) – to enable patient and clinician to address wider health and wellbeing issues to promote recovery
- Treatment Summaries – to enable patients to self-manage their own condition and to communicate relevant clinical information to the patient's GP
- Risk Stratified Pathways – to identify appropriate patients for a new supported self-management pathway opposed to a 'one size fits all' model

In 2015/16 we aimed to implement all three projects by the end of the year. However, it was recognised by us and our commissioners, that the project required further design and planning for a large system change that the Living With and Beyond Cancer programme requires. Holistic Needs Assessments have been piloted in all three cancer sites which informed a workforce plan to ensure we have the necessary resources to implement HNAs on a consistent and systematic basis. Agreement has been made about the particular Treatment Summary to be used and relevant information to be included. An implementation plan has been drawn up ready for 2016. Due to the complex nature of the change that the risk stratification pathways project requires, we needed to spend significant time on designing the new follow up pathways to ensure the best clinical outcome whilst improving the patient experience. We have now produced detailed service delivery plans that will inform implementation in 2016/17.

2.1.2

What are our priorities for 2016/17?

The table opposite provides an overview of our priorities for 2016/17. The table gives you an at-a-glance view of the work to be undertaken in the year ahead and which our stakeholder groups identified as priorities for improvement. In 2016/17 our priorities will be aligned with the dimensions of quality we are measured against by the Care Quality Commission: Safe, Effective, Caring, Responsive and Well-led.

Progress against the priorities identified will be measured by agreed metrics and monitored by the Quality Committee throughout the year.

Priorities for improving quality in 2016/17

Priorities	Incomplete from last year	National priority for 2016/17	Issue for commissioners / CQUIN	Issue for HCCOSC	Issue for Healthwatch	Issue identified internally inc. governors
1. Safe						
Reducing the likelihood of fractures being missed in our emergency departments	✔					
To implement the National Safety Standards for Invasive Procedures		✔				
To ensure patients with overwhelming infection receive antibiotics within an hour	✔	✔				
Improving the management of patients with Acute Kidney Injury (AKI)	✔	✔	✔			
2. Effective						
Reducing the number of lower limb amputations in people with diabetes	✔		✔			
Improving the management of patients requiring emergency abdominal surgery	✔	✔	✔			✔
To ensure people are prescribed antibiotics in accordance with local formularies		✔	✔			
To improve the management of patients with fractured neck of femur	✔		✔			✔
3. Caring						
Living with and beyond cancer	✔	✔	✔			
Improving End of Life care				✔		✔
4. Responsive						
To improve the care of emergency patients through the implementation of the SAFER programme	✔	✔	✔	✔	✔	✔
Improving discharge	✔		✔	✔	✔	✔
Improving care for people who use our services and have dementia and delirium		✔		✔		✔
Learning from users	✔			✔	✔	✔
Improving the experience for children and their families as they move from paediatric to adult services	✔		✔	✔		✔
5. Well-led						
To ensure all staff in leadership roles are trained in service improvement methodology				✔		✔

2.1.2

What are our priorities for 2016/17?
Safe

Reducing the likelihood of fractures being missed in our Emergency Departments (A&E)

As outlined on p20, we are working to reduce the number of fractures which are missed or misdiagnosed in our Emergency Departments. An undiagnosed fracture can cause significant pain and distress to the patient and could have potentially serious consequences.

Some x-rays will always be difficult to interpret by staff in the Emergency Department (A&E), so a second review by a radiologist is always carried out. Building on the work done In 2015/16, our targets for the coming year will be to reduce the amount time between this specialist second review of an x-ray and the recall of a patient.

Currently the average (mean) time taken to review and then recall a patient is 8.8 days. By the end of Quarter 2 we aim to have reduced this to five days and by the end of Quarter 4, to three days.

To implement the national safety standards for invasive procedures

In September 2015 a new set of national safety standards were published by NHS England to help hospitals provide safer surgical care for patients. The National Safety Standards for Invasive Procedures (NatSSIPs) aim to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events (errors that should never happen) could occur.

These new standards set out broad principles of safe practice and advise healthcare professionals on how they can implement best practice, such as through a series of standardised safety checks and education and training. The standards also support NHS providers to work with staff and develop and maintain their own, more detailed, local standards and encourage the sharing of best practice between organisations. The actions prescribed in this 'Patient Safety Alert' must be completed by September 2016. The actions are:

- Agree director (or equivalent) with lead responsibility for ensuring all relevant staff are aware of the NatSSIPs and are supported in developing local checklist
- Identify all procedures undertaken across clinical settings in our organisation that the NatSSIPs are applicable to
- For these identified clinical procedures, develop and test our processes based on the relevant NatSSIPs using local insight, including from patients and the public, together with the resources, networks and collaborative opportunities highlighted in the Alert
- Commence implementation of procedures and practice compliant with local processes within cycles of continuous improvement including consideration of teamwork and training, human factors and cultural aspects of compliance
- Share best practice with NHS England.

In 2016/17 we will be making sure we meet the above, using established improvement methodology, working through our own Gloucestershire Quality & Safety Improvement Academy. We will be holding 'human factors' training, helping our clinicians to design a checklist that works in almost every circumstance, taking human error into account.

To ensure that patients with overwhelming infection receive antibiotics within an hour

Sepsis is a life-threatening condition that arises when the body's own response to an infection injures its own tissues and organs. As outlined on p28, sepsis can lead to shock, multiple organ failure and death, especially if not recognised early and treated quickly. This priority is a national CQUIN for us in 2016/17, which builds on targets for previous years. The CQUIN has two main objectives:

- patients who meet the clinical criteria for sepsis, should be screened for sepsis using the local tool
- those who present with red flag sepsis, severe sepsis or septic shock must receive antibiotics within an hour. These patients should also receive a review after three days of antibiotics.

These two objectives apply to both child and adult patients arriving at the hospital via the Emergency Departments or other direct emergency admission routes (such as via maternity or oncology).

This also applies to the treatment of patients in acute inpatient settings (patients who have already been admitted to a ward and then develop sepsis).

National targets will be set for the above as part of the CQUIN.

To improve the management of patients with Acute Kidney Injury

Acute Kidney Injury (AKI) is a sudden loss of kidney function and is strongly linked to high mortality rates and an increased length of stay. In a hospital there are a number of reasons why a patient may develop an AKI, for example through infection or as a result of dehydration.

Improving the management of patients with AKI will continue to be a local CQUIN during 2016/17. For any patient who has had an AKI during their stay in our hospital, we must ensure that their discharge letter should inform the GP:

- What stage AKI has been diagnosed
- Whether their medication has been reviewed and if so, what the outcome was
- What blood tests will be required once they have been discharged
- How frequently they will require these blood test.

Next section:
**What are our priorities for 2016/17?
Effective**

2.1.2

What are our priorities for 2016/17?
Effective

Reducing the number of lower limb amputations in people with diabetes

Subject to the agreement of the CQUIN goals, in 2016/17 our diabetes team will be undertaking quarterly root cause analysis investigations of three major and three minor amputations to identify what could have been done differently to improve the footcare for patients with diabetes.

A business case is being developed to create an in-patient diabetic footcare team.

Improving the management of patients requiring emergency abdominal surgery

In 2016/17 we will be participating in the Emergency Laparotomy Collaborative (ELC), a two-year quality improvement project which involves Trusts from across the country, aimed at improving standards of care and outcomes for patients undergoing emergency laparotomy (surgical procedures on the abdomen).

The collaborative aims to deliver five key themes using a 'care bundle' approach (a series of simple actions which collectively improve care), involving Consultant Surgeons Mr Mark Vipond and Mr Mark Peacock, Consultant Anaesthetists Dr Michael Copp and Dr Belinda Pryle and other doctors specialising in critical care, from the time a patient presents to hospital to their time in the operating theatre and beyond.

Our internal targets, for patients undergoing emergency laparotomy, are:

- for 90% of patients to be operated on by a consultant surgeon
- for 90% of patients to be anaesthetised by a consultant anaesthetist
- for 90% of patients to have a pre-operative lactate blood test to help the diagnosis of sepsis
- to carry out multi-disciplinary mortality and morbidity reviews four times a year
- for 90% of patients to have access to critical care after surgery.

The target is to have achieved the above by the end of Quarter 4.

To ensure people are prescribed antibiotics in accordance with local formularies

Antibiotics have a vital role in the treatment and prevention of infection and increasing bacterial resistance to antibiotics is a major concern. Antibiotic resistance is linked to antibiotic usage. Unfortunately the development and introduction of new classes of antibiotics is currently proving problematic. It is therefore essential that we use antibiotics appropriately to try and maintain their effectiveness. This is known as "antimicrobial stewardship".

The importance of antimicrobial stewardship was highlighted in 2015 with the publication of a national patient safety alert as well as guidance from the National Institute for Health and Care Excellence (NICE).

An antimicrobial stewardship toolkit for English hospitals, "Start Smart – then Focus", has been produced to help promote best practice in this area. This toolkit highlights the importance of prescriber compliance with local antimicrobial prescribing guidelines. These local antibiotic guidelines are produced and reviewed by the Antimicrobial Stewardship Team working with other health professionals.

A number of measures are in place to ensure that people are prescribed antibiotics in accordance with our local guidelines. In 2015 our educational and promotional activities included highlighting the "Start Smart – then Focus" approach as part of World Antibiotic Awareness Week as well as the introduction of a new Trust e-learning resource on antimicrobial prescribing. Audit activity is ongoing and includes HAPPI (Hospital Antibiotic Prudent Prescribing Indicators) data which is regularly communicated to prescribers. This data includes measures of appropriate documentation and use of antibiotics compared to our local guidelines.

In 2016/17 the Antimicrobial Stewardship Team will be working with others to further review and develop our local antibiotic guidelines and to promote and monitor compliance with these through education, training and audit activities. 2016 should also see the first publication of validated antibiotic prescribing data for NHS acute trusts in England and it is hoped that this data will be of use in informing local antibiotic policy, it should be noted that regional data suggests that our Trust is above average in terms of the percentage of in-patients receiving antibiotic therapy. The ongoing development and implementation of e-Prescribing as part of our SmartCare project will be important in allowing improved monitoring and feedback of antibiotic prescribing data in the future.

To improve the management of patients with fractured neck of femur

As outlined on p24 improving the care of patients with fragility fractures was a priority for us in 2015/16. Recognising that we still have work to do to make the required improvements for these patients, work will continue in 2016/17, specifically targeting the care of patients with a fractured neck of femur.

Patients who suffer a fractured neck of femur (a broken hip) have a high mortality and morbidity rate with up to 20% needing long term care and a further 30% not returning to their pre-fracture health.

Our action plan for 2016/17 includes initiatives in the following areas:

- theatre capacity
- the treatment pathway
- staffing
- environment and equipment.

Next section:
**What are our priorities for 2016/17?
Caring**

2.1.2

What are our priorities for 2016/17?
Caring

Living with and beyond cancer

In 16/17, we look forward to working closely with Macmillan, Gloucestershire Clinical Commissioning Group and Gloucestershire Care Service colleagues as the project moves from the design and planning stages to implementation.

Next year, we expect that 90% of all cancer patients treated in the three cancer services to have been offered an Holistic Needs Assessment (HNA) with a further 25% offered two HNA's along their pathway. 25% of all patients will be offered a Treatment Summary following completion of treatment and 95% of all patients are risk stratified and placed on a suitable pathway. Our CQUIN targets will focus on the delivery of these targets for colorectal, prostate and breast cancers.

To improve end of life care

As a Trust we are committed to achieving the best possible standards of care for patients approaching the end of their life.

There are a number of areas of work that we are undertaking to achieve this. In conjunction with our colleagues in the Gloucestershire Clinical Commissioning Group (CCG) we are contributing very actively to the County-wide End of Life Strategy group. This work, which is led by the CCG, includes a needs assessment and the development of an integrated training programme for all those providing end of life care. It will allow us to develop ward-based champions in our hospitals. These ambassadors for improving care will be pivotal in helping other staff to provide consistently high quality end of life care.

We have developed a bid on End of Life care with our partners at Gloucestershire Care Services (who provide community hospital services) to participate in a programme of work led by NHS England and a national group called the Point of Care Foundation, called Living Well Until the Very End. This bid has been successful and will ensure our team receive dedicated support in improving in this area. We will use a proven improvement methodology to develop the skills of our staff and ensure support for families and carers through these difficult times. Receiving feedback from local and national surveys will assist in measuring our progress.

All of this work is intentionally being undertaken in partnership with commissioners and other providers in recognition of the vital importance of ensuring high quality care is maintained during any transfers of care between organisations.

Next section:
**What are our priorities for 2016/17?
Responsive**

2.1.2

What are our priorities for 2016/17?
Responsive

To improve the care of emergency patients through the implementation of the SAFER programme

Improving the way that patients move through our hospital, from admission to discharge, will continue to be a key priority for us in the year ahead.

Crucially, we will need to improve our ability to discharge patients at the weekend, so that the system works seamlessly, seven days a week. For the past two years we have been trialling seven day services, as defined by Sir Bruce Keogh's National Seven Days a Week Forum, in our Respiratory Department. This pilot, which has met all ten clinical standards outlined by the Seven Days a Week Forum, has resulted in a shorter length of stay for respiratory patients, as well as several other improvements.

The Emergency Care Programme for 2016/17 has initially identified three priority workstreams for immediate improvement, one of which is a focus on reducing the number of patients with a Length of Stay of 14 Days or more within our hospitals. These patients currently occupy 65% of total bed days across the Trust and reducing the number of them will help improve flow and reduce outliers.

The primary focus of this workstream is to remove any unnecessary delays to a patient's stay; this includes both internal and external delays within the discharge process, including internal and external factors.

This forms part of the 'SAFER' CQUIN which is a localised initiative to ensure that the right patients are in the right place, first time – the CQUIN is directly linked with this workstream.

The 2016/17 CQUIN requirements, and subsequent workstream activity, will focus on delivering improvements in the following areas:

- Senior Review: effectiveness of board round processes (utilising SORT criteria)
- All patient s to have an EDD: improve accuracy for Expected Dates of Discharge (evidence based, with an individualised approach)
- Flow: timely flow from assessment units to inpatient wards through the use of internal professional standards
- Early Discharge: pre-planning and booking of transport to support early discharges
- Review: Reduction in length of stay supported by positive risk taking strategies.

Of course, improving the discharge process, and our ability to deliver it seven days a week, cannot be done by our hospitals alone. In 2015 we formed a county-wide steering group to ensure that the provision of seven day services were being considered across the whole 'patient pathway' rather than in individual organisations. This work will continue in the 12 months ahead.

To improve the discharge process

As outlined above, the Emergency Care Programme for this year has initially identified three priority workstreams for immediate improvement, one of which is a focus on reducing the number of patients with a Length of Stay of 14 Days or more within our hospitals.

The primary focus of this workstream is to remove any unnecessary delays to a patient's stay; this includes both internal and external delays within the discharge process, including internal and external factors. For example:

- Streamlining the planning and communication process for discharges by documenting the progress of patients' discharge plans
- Weekly review meetings for all long length of stay patients in order to expedite the discharge where appropriate and safe to do so
- Improve system-wide links with community partners to support discharge processes.

Longer-term this workstream will incorporate the SAFER CQUIN initiatives as outlined above.

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

Our Trust key objectives, pending national and locally-agreed indicators, are to implement both our Trust-wide delirium best practice flow chart and the national best practice delirium assessment tool.

Our Trust Dementia Working Group will also continue to work in partnership with other initiatives across our hospitals, such as the Falls Prevention and Management programme and the Reduction of Clinically-Induced Violence and Aggression programme. We are also exploring best practice delirium prevention and management as part of the patient pathway within theatres and recovery.

Learning from users

In the year ahead we will be continuing with the successful work we carried out in 2015/16 with shadowing and co-design projects, embedding the quality improvement techniques we have piloted throughout our hospitals. The national Age UK project, which involved listening to, and learning from inpatients on our wards, will also continue in 2016/17.

We will also be taking part in a project entitled 'Living Well to the Very End,' led by the Point of Care Foundation. We are one of nine pilot sites across the country who will, in partnership with our colleagues at Gloucestershire Care Services NHS Trust, be looking at how we can improve End of Life care for a particular group of patients who are moved from acute hospital to community care.

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

The plan for 2016/2017 is the continuation of the transition CQUIN, whereby there will be the implementation of the Ready, Steady, Go and Hello pathway to other specialities, the use of the Easy Read version of the Ready, Steady, Go and Hello (awaiting release from University Hospital Southampton) for young people with a long term health condition and learning disability and the development of a transition presence on our website for use by both our staff and for the public.

Our Patient Experience Team will continue to work with us in collecting feedback from young people and their families/carers, to enable us to further improve transition care and experience

Next section:
**What are our priorities for 2016/17?
Well-led**

21.2

What are our priorities for 2016/17?
Well-led

To ensure all staff in leadership roles are trained in service improvement methodology

The Gloucestershire Safety & Quality Improvement Academy (GSQIA) was established in our Trust in June 2015. Through our courses, our students are provided with the knowledge, the skills, the opportunity and the support to contribute to patient safety and to make practical improvements to the way we provide care in our hospitals.

Our aim is that our structured programmes will contribute to the development of a culture of continuous improvement within our Trust, where staff at all levels have the confidence to highlight areas for improvement and then have the skills, knowledge and support to be able to introduce those changes. Our Quality Improvement Programme is about being the best we can be. It's about taking the things that we know can be better and making a lasting improvement.

In 2016/17 we will be training every new Consultant or senior doctor or leader on induction at Bronze level, introducing them to quality improvement and encouraging them to think of ways they can use the methodologies to introduce improvements in their own specialties. We will also be training all new Band 5 nurses in their transition training.

The GSQIA was introduced to support our new Vision – to provide the Best Care for Everyone – as it supports our ambitions to improve leadership and continuous improvement.

Next section:
Statements of assurance

2.2

Statements of assurance

The following section includes responses to a nationally defined set of statements which will be common across all Quality Reports. These statements serve to offer assurance that our organisation is:

- performing to essential standards, such as securing Care Quality Commission registration
- measuring our clinical processes and performance, for example through participation in national audits
- involved in national projects and initiatives aimed at improving quality such as recruitment to clinical trials.

Information on the review of services

The purpose of this statement is to ensure we have considered quality of care across all our services. The information reviewed by our Quality Committee is from all clinical areas. Information at individual service level is considered within our divisional structure and any issues escalated to the Quality Committee.

During 2015/16 Gloucestershire Hospitals NHS Foundation Trust provided and/or subcontracted 41 NHS services.

The Trust has reviewed the data available to us on the quality of care in all of these NHS services. The income generated by the NHS services reviewed in 2015/16 represents 100% of the total income generated from the provision of NHS services by Gloucestershire Hospitals NHS Foundation Trust for 2015/16.

Information on participation in clinical audit

The purpose of this statement is to demonstrate that we monitor quality in an ongoing, systematic manner.

From 1 April 2015 to 31 March 2016, 36 national clinical audits and 3 national confidential enquiry covered NHS services that Gloucestershire Hospitals NHS Foundation Trust provides.

During that period Gloucestershire Hospitals NHS Foundation Trust participated, or is currently participating in 35 (97%) of national clinical audits and 4 (100%) national confidential enquiry of the national clinical audits and national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquires in which Gloucestershire Hospitals NHS Foundation Trust participated, and for which data collection was completed during 1st April 2015 – 31st March 2016 are listed in Table 1, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry or a straight percentage of cases submitted

The reports of 23 national clinical audits/confidential enquiries participated in were reviewed by the provider in 2015/2016, 12 reports are still awaited. The actions Gloucestershire Hospitals NHS Foundation Trust intends to take to improve the quality of healthcare provided are summarised in Table 1.

The reports of over 200 local clinical audits were reviewed in 2015/2016 and Gloucestershire Hospitals NHS Foundation Trust either has or intends to take the following actions to improve the quality of healthcare provided:

- Development of a local quality improvement project to improve discharge information given to GP's in relation to Acute Kidney Injury – changes to electronic system, increased education and development of posters/stickers is showing improvement in the information given on discharge
- Further education and development of stamps for ECG machines in ED, to allow ease of documentation of name, signature, time of review, findings and plan for patients admitted with possible ACS to ED.
- Following an audit of intravenous fluid prescribing, a quality improvement project to improve patient hydration standards through the development of a new fluid balance chart and the review of teaching around this topic

Clinical Audit has been an integral part in the Trust's CQUIN programme for the years 2015/2016 providing evidence information for example VTE, Sepsis, Acute Kidney Injury, Safety Thermometer. Additionally clinical audit has also provided information for other national projects e.g. Saving Lives campaign.

This high level of participation demonstrates that quality is taken seriously by our organisation and that participation is a requirement for clinical teams and individual clinicians as a means of monitoring and improving their practice.

Participation in clinical research

The inclusion of this statement demonstrates the link between our participation in research and our drive to continuously improve the quality of services.

The number of patients receiving NHS services provided or subcontracted by Gloucestershire Hospitals NHS Foundation Trust in 2015/16, which were recruited during that period to participate in research approved by an NHS Research Ethics Committee, and included on the National Institute for Health Research (NIHR) Portfolio is currently 1053. This figure includes recruitment recorded on the NIHR Internet Portal up to 19th April 2016.

The figure will increase over the coming months as participants recruited to research studies in the final weeks of the financial year continue to be reported. If recruitment continues at a similar rate, we can expect a final total for 2015/16 of around 1,100 participants – although it is always difficult to plan for seasonal variations in recruitment and closure of high recruiting studies.

This is lower than recruitment in 2014/15 and is a reflection of national pressures on recruitment relating to a dynamic portfolio and a reduction in the number of higher recruiting studies available to sites. For example, three, high-recruiting studies closed late 14/15 and early 15/16 meaning recruitment to those studies dropped dramatically in the current recruitment period. In 2014/15, these three studies recruited 30% of the total recruitment for that year.

Targets for 2016/17 are being set and Gloucestershire Hospitals NHS Foundation Trust is currently forecasting a target of 1,004 patients. However, this is based on the current portfolio and studies pending approval so is likely to change as the local portfolio changes over the recruitment period. The CRN West of England also applies "stretches" to these targets and these are currently in negotiation with the Network.

To 31st March 2016, Gloucestershire Hospitals NHS Foundation Trust approved 101 new studies approved since 1st April 2015. Of these studies:

- 52 were Non-Commercial Portfolio studies
- 14 were Commercial Portfolio studies
- 22 were Academic/Student projects
- 10 were Non-Commercial, Non-Portfolio studies; and
- 3 were Commercial Non-Portfolio studies

In total the Trust was recruiting to 106 Portfolio Studies over the 12 month period, a slight increase on 2014/15.

There was a wide range of clinical staff participating in research approved by an NHS Research Ethics Committee during 2015/16. These staff participated in research covering the majority of medical specialties across all four divisions in Gloucestershire Hospitals NHS Foundation Trust.

Duty of Candour

For many years our Trust has delivered the 'being open' standards recommended for patients who have suffered avoidable serious harm or death. These standards require us to inform the patient or family of the event and provide an explanation and apology for what went wrong. Depending on the family's wishes, this can take the form of meetings, letters and/or sharing the serious incident report. The Duty of Candour is new legislation that came into force at the end of October 2015 that extends the definition from 'serious harm and death' to include 'moderate harm.'

Arrangements within our divisions for investigating incidents which have (or have the potential to have) caused moderate harm varied. The Women's & Children's Division had established and effective processes in place to review moderate incidents, escalating to the corporate team where appropriate and disseminating learning throughout their division. In the Diagnostics & Specialties Division, ward staff are effectively encouraged and supported by their Divisional Risk Manager so that root cause analysis investigations are undertaken and documented in a timely manner. Work was required, however, in our Medical and Surgical Divisions to standardise the investigation of moderate incidents. In order to streamline the way we investigate moderate incidents, making it consistent across the organisation, we have established a new process that is being applied in line with divisional arrangements, these processes will continue to be developed in the coming year.

Figure 15: Participation in National Audits

Audit title	Did the Trust Participate?	Number of case submitted / number required	Was the report reviewed?	Actions taken as a result of audit / use of the database
Peri and Neonatal				
Neonatal Intensive and Special Care Audit Programme (NNAP)	Yes	The NNAP uses the mandatory database, 'Badger' to access all records needed per question.	Yes: at Paediatric Governance meetings	An action plan has been developed regarding central line sepsis and temperature: actions ongoing. In addition an agreement has been made that all Badger applicable cases will be signed off by Consultants to improve accuracy.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRACE-UK)	Yes	Data entered for all maternal deaths and still births	All maternal deaths and stillbirths reviewed at Governance meetings	Development of a new 'fetal movements' leaflet to be put into booking packs
Children				
Diabetes (Paediatric) (NPDA)	Yes	283	Report was reviewed at the paediatric diabetes MDT meeting and the South West Network Meeting.	Ongoing work to improve patient outcomes.
Paediatric Asthma	Yes	82 cases submitted	Data entry period closed end of Feb '16	Awaiting report
Child health clinical outcome review programme – adolescent mental health – chronic neurodisability	Yes	Retrospective data collection for adolescent mental health: 77 cases submitted. Chronic neurodisability: ongoing	Data submission March 2016: continuation of study into 2017. Chronic neurodisability 2016/17	Awaiting study results
Acute Care				
Procedural Sedation in Adults (care in emergency departments)	Yes	72 GRH, 29 CGH	Awaiting report release, but local data presented at ED M&M meeting 27/11/15	Review and redesign of sedation proforma
Vital signs in Children (care in emergency departments)	Yes	100 GRH, N/A CGH	Awaiting report release but local data presented at ED M&M meeting 27/11/15	Awaiting national report to allow benchmarking, but local review action to promote use of PEWs charts to better highlight abnormal observations.
VTE risk in lower limb immobilisation (care in emergency departments)	Yes	100 GRH, 130 CGH	Awaiting report release	Data retained for use in local QI project via GSQIA to improve documentation and related assessment/treatment
National Cardiac Arrest Audit (NCAA)	Yes	101 GRH. 60 CGH (Ongoing)	Resuscitation Team, continual reviewing throughout the year. Resuscitation Committee meeting every quarter. Quarterly information reviewed and end of year results.	Gaining statistical analyses of National Data allows us to compare our Trust data against a National representation thus providing a benchmark by which to attain. By means of constant evaluation by the Resuscitation Team, highlighted areas of significance and themes for consideration are taken to the Resuscitation Committee for discussion. From there points of interest are then disseminated to staff via various routes of training. Current actions include the ongoing monitoring of resuscitation attempts and DNACPR decisions, increasing our understanding and training into escalation of care of the deteriorating patient and a continued effort to continue a reduction of 'futile' events occurring, as a marker of quality. The Trust will be undertaking root cause analysis on all cardiac arrests in 2015/16 and identifying training needs of differing areas within the Trust.
Emergency Use of Oxygen	No			Audit planned, but due to unforeseen circumstances unable to be undertaken by lead clinician.
Case Mix Programme	Yes	100% of patients admitted to critical care areas 651 CGH & 975 GRH cases submitted 1/4/15 – 31/12/15	Yes at individual unit M&M meetings and lessons shared between units at cross county quarterly meetings.	The reports provide information on mortality rates, length of stay etc and provide the Trust with an indication of our performance in relation to other ICUs. Where trends are identified then these allow us to make recommendations about changes to practice. Standards are reviewed against those proposed as quality indicators by the Intensive Care Society.

Audit title	Did the Trust Participate?	Number of case submitted / number required	Was the report reviewed?	Actions taken as a result of audit / use of the database
Long term conditions				
Renal replacement therapy (Renal Registry)	Yes	All renal dialysis and transplant patients registered – current numbers: Haemodialysis 256, Peritoneal dialysis 42, Transplant 183	Will be reviewed at Renal Team Audit meetings. Latest report is 18th annual report not yet released	Awaiting audit results.
National Diabetes Inpatient Audit (NaDIA)	Yes	70 patients audited at GRH and 48 at CGH (all patients with diabetes as inpatients and over 24 hours were audited)	The report is reviewed by NaDIA HSCIC and all audit data is reported and released at Diabetes UK in March and then published approx. May	Awaiting audit results.
National Pregnancy in Diabetes Audit	Yes	31 cases submitted	Data collection closed in February 2016, report will be reviewed and disseminated once available	Report published later this year
National Diabetes – Adult	Yes	2384 OP clinic attendances. 81 of which had an insulin pump. Submission via the hospital PAS system, with data being connected to care processes and lab results recorded by GPs		National Diabetes Audit: 2013–2014 and 2014–2015: Report 1, Care Processes and Treatment Targets. Publication date: January 28, 2016. Minimal info submitted: report relates more to primary care
Inflammatory bowel disease (IBD)	Yes	17 (no target given)	Results disseminated electronically and will be discussed at IBD service planning meeting on 23/4/16	New nurse recruited. Pathways in place. Team attended IBD Audit regional workshop in Taunton in March 2015 + follow up meeting in January 2016. Dr Shaw, is also co-lead for the National IBD Audit.
Bowel Cancer (NBOCAP)	Yes	430	Results reviewed by individual MDTs (GRH and CGH)	Continued review of outcomes. Review of nationally published data and comparisons with other Trusts
Lung cancer (NLCA)	Yes	302 (data from 2014, published Dec 2015)	Results discussed at GRH MDT business meeting Nov 2015 and will be reviewed at AGM June 2016	Figures for process, imaging and nursing measures were all within or above National average range. Surgical resection rates at 18.6% are above national average. Chemo rates were low for NSCLC PS 0-1 and SCLC. This has been looked at through an internal audit, which found that these figures were incorrect and the true rates for NSCLC PS 0-1 are around 60%. Data presented to GRH Lung MDT business meeting Feb 16.
Oesophago-gastric cancer (NAOGC)	Yes	2015 report groups data over previous 2 years (2012-2014) 255 tumour records submitted (expected cases based on HES 301–350)	2015 Annual report published Dec 2015. Reports discussed at the annual business meeting for the MDT & at the Cancer Management Board	Grouped as 81–90% cases ascertainment (RAG rating: Green)
Rheumatoid and Early Inflammatory Arthritis	Yes	17 patients entered to date	Will be discussed at speciality meetings	1st year report due to published spring/summer 2015
National Prostate Cancer Audit	Yes	394 patients submitted to Feb 2016	Will be discussed at unit audit and research group	
UK Parkinson's Audit	Yes	50 cases submitted, plus 20 patient reported outcome returns	Report due end of March for individual Trusts and Nationally in May 2016	Awaiting report publication

Audit title	Did the Trust Participate?	Number of case submitted / number required	Was the report reviewed?	Actions taken as a result of audit / use of the database
Cardiovascular Disease				
Coronary angioplasty	Yes	CGH: cases of PCI performed. Returns to this body are mandated by DoH and the British Cardiovascular Intervention Society	Yes at departmental meetings and monthly mortality and morbidity meetings	Returns are used to indicate unit performance against defined limits with regard to in-hospital and 30 day (via OPCS) mortality as well as major complication rates. Where performance of a unit/operator falls outside these limits, there is a nationally agreed process for further investigation/assessment.
Acute coronary syndrome or Myocardial Infarction National Audit Project (MINAP)	Yes	100% for patients with ST elevation	Yes: Shared with regional, network and local colleagues	Aiming to improve total number of patients with ACS entered to achieve the minimum data standard of 70%
National Heart Failure Audit	Yes	235 cases submitted	Reports reviewed at speciality meetings	Local QI project underway to improve information given to patients post ACS in relation to NICE Guidance on smoking, dietary advice. The Trust is working to increase the number of cases entered to meet the minimum data standard of 70%.
National Vascular Registry	Yes	AAA repair 70 (83 HES estimate) Carotid endarterectomy 72 (75 HES estimate)	Yes at specialty and divisional meetings	Noted that for carotid endarterectomy the median delay from symptom to surgery had increased to 17 days (from 10 in 2014). Work is ongoing to review timings.
Surgery				
Major Trauma: The Trauma Audit and Research Network (TARN)	Yes	519 cases submitted	Report reviewed jointly at ED and T&O morbidity and mortality meeting	Data coordinator recruited: July 2015 Implement TARN SQL script to facilitate monthly completeness check Improve data completeness from 26% in 2014 to 45.9% in 2015 so far with TARN coordinator in place for only 9 months out of 12.
Elective surgery (National PROMs Programme)	Yes	Patient Reported Outcome Measures (PROMs) measure quality of a procedure from the patient perspective. PROMs calculate the health gain after surgical treatment using pre and post operative surveys. Patients are invited to participate, it is not mandatory. Currently there are four procedures being measured groin hernias, varicose veins, total knee and total hip. Participation Rate (pre-op): → Knee replacements 75.9% → Hip replacements 66% → Varicose veins 53.1% → Groin hernias 45.9% Issue and return rate (post op) → Knee replacements 99.8% (issue rate) 82.8% (return rate) → Hip replacements 100% (issue rate) 84% (return rate) → Varicose veins 100% (issue rate) 66.2% (return rate) → Groin hernias 100% (issue rate) 70.4% (return rate)		Actions taken with the division: → Monthly monitoring of patient participation and forms returns from wards. → Weekly volunteer who visits wards to collect forms. → Regular reports by Consultant lead to surgical division
Falls and Fragility Audit Programme (FFAP) – National Hip Fracture Database	Yes	About 700 cases per year, ongoing every year for past 7 years	Reports reviewed at Hip Fracture departmental meetings, orthopaedic and GOAM speciality meetings	
Sentinel Stroke National Audit Programme (SSNAP)	Yes	All patients admitted with stroke or TIA entered: Approximately 900 every year	There are quarterly reports and an overall organisational report that are reviewed at the monthly departmental meetings of the stroke service as and when the reports are available.	→ 1. Reorganisation of the stroke service to a Hyperacute Stroke Unit (6B) and rehab (parts of 6B, 6A and parts of 8A) → 2. Change in working pattern for all stroke consultants → 3. Business case for enhanced therapy staffing → 4. Training of all stroke unit nurses to do ward swallow screens Other ongoing actions.

Audit title	Did the Trust Participate?	Number of case submitted / number required	Was the report reviewed?	Actions taken as a result of audit / use of the database
National Emergency Laparotomy Audit (NELA)	Yes	170 GRH, 128 CGH	Data being presented quarterly at Joint Surgical/ Anaesthetic Audit/M&M as a Trust CQUIN project Data being submitted to Emergency Laparotomy Collaborative group	Development of local quarterly MDT meetings to discuss all deaths post emergency laparotomy. The Trust is now part of the Emergency Laparotomy Collaborative and will be developing local QI projects to improve performance Pilot version of new surgical emergency pathway currently in progress
National Joint Registry	Yes	All patients in GHNHSFT have their details recorded on NJR 1526 (1 April 2014 – 31 March 2015)	Annual report is reviewed at Governance meetings	Potential outliers noted and casemix investigated identifying difficult cases
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Mental Health Number of cases included: 2	Study currently open. Will be reviewed when reports available at speciality and divisional meetings: publication due winter 2016.	
		Acute pancreatitis Number of cases included: 10	Will be reviewed when reports available at speciality and divisional meetings Publication date: July 2016	
		Sepsis Number of cases included: 9		Sepsis: National CQuIN for the timely identification of sepsis in emergency departments and in acute inpatient settings
		Gastrointestinal haemorrhage Number of cases included: 5	Discussed at divisional/ specialty level	
National Complicated Diverticulitis Audit (CAD)	Yes	15 required 17 submitted	Analysis of the data is currently taking place (national audit) and the results not yet disseminated	Awaiting results
National Comparative Audit of Blood Transfusion programme				
→ 2015 National Comparative Audit of Patient Blood Management in Scheduled Surgery	Yes	55	Report has been circulated to key members of the HTC but is due to be tabled at the next Hospital Transfusion Committee (HTC) meeting in March 2016	Await HTC decisions
→ 2016 National Comparative Audit of Red Cell & Platelet Transfusion in Haematology	Yes	29	Data collection has only just been completed (4/2/16)	Results will not be published until later this year and then will need to be reviewed by the HTC
National Ophthalmology Audit	Yes	Prospective collection of cataract surgery dataset	Review at specialty meetings	

Information on the use of Commissioning for Quality & Innovation (CQUIN)[4] framework

The agreed national, local and specialised CQUIN schemes, the rationale behind them and the associated payments for 2015/16 can be seen in Figure 16 on p53.

The level of the Trust's income in 2015/16 which was conditional upon the quality and innovation goals was £7,883,560 out of a total planned eligible income of £291,637,168. In line with national rules this represented about 2.5% of income (with 0.1% removed from Specialised Income to support a ODN national development fund).

Current indications show that £6,825,070 has been secured. The main area of loss was the missed improvement score for AKI (£400,690) for the AKI CQUIN, antibiotic administration target for Sepsis CQUIN (£66,780) and missed targets for the Home Renal Dialysis CQUIN (£150,650), some elements of SAFER and frailty (value as yet unknown). Cancer Survivorship is a local two year and Specialised commissioned one year CQUIN; locally it was redeveloped part way through the year to allow for some local implementation considerations, however this was not part of the one year Specialised contract and the milestones will not be achieved in just one year, therefore, a proportion of the £200,840 will not be realised.

The final reports are awaited on all our CQUINS, most are expected to deliver but until the final audits are completed it is not guaranteed.

The CQUIN schemes agreed for 2016/17 can be seen in Figure 17 on p54. These (provided last week) include three nationally mandated, five local schemes, four from specialised commissioning and one from the Armed Forces branch of NHSE.

It should be noted that for 16/17 there is a significant shift in the national approach specialised CQUINs. Up to 1.2% of the 2.4% value of CQUINs are available to provide outcome related payments for local QIPP schemes and transformation plans. (Quality assured through regional processes).

There is a high level of overlap between these goals and the priorities in our Quality Account for 2016/17. This demonstrates the high level of active engagement with our commissioners in quality improvement. It has been confirmed from national guidance that the value of CQUIN schemes in 2016/17 has again been set at 2.5% of total patient care income value.

Figure 16: 2015/16 CQUIN goals

Goal No.	Measure	Description	Weighting as % of contract value	Actual value of goal £	Quality domain
National CQUIN goals (including specialised element)					
1	Acute Kidney Injury (AKI)	Diagnosis of AKI, treatment in hospital and the plan of care to monitor kidney function after discharge. The focus on recovery and follow up elements of the pathway are important elements given that over 50% of AKI is currently occurring in primary care. Improving information to GPs at the time of discharge will start to develop the knowledge base of GPs of AKI and will also positively impact on readmission rates for patients with AKI.	0.25	667,830	Safety
2	Sepsis Screening	To screen all appropriate patients and to rapidly initiate intravenous antibiotics within 1 hour of presentation for those in septic shock, Red Flag sepsis or suspected severe sepsis.	0.25	667,830	Safety
3	SAFER Patient Flow Bundle	A combined set of actions to improve patient flow and prevent patients waiting unnecessarily. Patient journey from hospital admission to discharge is improved by adopting the 5 principals of SAFER: → **S**: Senior review, **A**: All patients to have an EDD, **E**: Early discharge, **F**: Flow from assessment units, **R**: Review daily of long stay patients (>14 days)	0.5	1,335,660	Clinical Effectiveness
4	Dementia and Delirium	To support the identification and assessment of patients with dementia and delirium using the pathway elements of: Seek, Assess, Refer and implementation of Delirium Trigger Tool as appropriate.	0.25	667,830	Safety
Local CQUIN goals (including specialised element)					
5	Transition from young peoples services to adult services	To improve the outcomes for young people (16-25) transitioning from young peoples services to adult services, improving experience and longer term outcomes. Provides an individualised transition plan, using a structured approach for all young adults.	0.188	502,210	Patient Experience
6	Configuring Emergency Surgical Services: National Emergency Laparotomy Audit (NELA)	Improving the care of patients requiring emergency laparotomy to improve clinical outcomes. To develop and test a suitable pathway which involves collaboration between surgical, anaesthetic and radiological teams and establish reliable measures of key performance	0.187	499,540	Safety
7	Diabetic Foot: improving care of acute diabetic foot	To improve the quality and timeliness of care in the management of the acute diabetic foot and reducing the burden of care and the numbers of unnecessary complications.	0.187	499,540	Clinical Effectiveness
8	Cancer Survivorship	Supporting people Living with and Beyond Cancer,a National Cancer Survivourship initiative. Involves the development, implementation and sustainable embedding of new pathways for Colorectal, Breast and Prostate cancer	0.5 0.4	1335.66 200.87	Patient Experience
Specialised CQUIN goals					
9	Increasing Home Renal Dialysis	To achieve an increase in the % of dialysis patients who receive their dialysis at home, either by peritoneal dialysis or home haemodialysis. Providing a formalised integrated and planned pathway of educational initiatives focused on the learning needs of patients approaching ESRD treatment. The emphasis will be on improving home therapies along with offering in centre dialysis or transplantation if suitable and appropriate.	0.4	200,870	Patient Experience
10	Reducing delayed discharges from ICU to ward level	Improving bed management, which supports the national standard that all discharges should be made within 4 hours of decision being made to discharge. Data collection is required to identify delays from ICU to ward based care and a plan produced to reduce such delays to less than zero.	0.4	200,870	
11	2 Year Outcomes for Infants <30 weeks gestation.	The monitoring of 2 year outcomes of infants <30 weeks gestation, to avoid late detection of neuro-development and/or learning disability and to inform future service development and improvement.	0.4	200,870	Clinical Effectiveness
12	Clinical utilisation review (CUR)	CUR technology is used to provide evidence-based decision support for clinicians to ensure patients are cared for in the optomal setting and to reduce admission rates, improve flow and discharge as well as, with commissioners, right size capacity in step down and community services to match clinical need. Year 1 of this 2 year project consists of installation and implementation with a planned wider rollout in year 2.	0.4	200,870	
13	C6 Oncotype DX	Oncotype DX Testing and data collection to help patients with early breast cancer, who cannot be catagorised as low or high risk by existing clinical practice, make more informed choices about whether to undergo chemotherapy through greater insight into the likely benefit.	0.4	200,870	Clinical Effectiveness
TOTAL			2.5	8,195,830	

Figure 17: 2016/17 CQUIN goals – AS OF 15/4/16

Goal No.	Measure	Description	Weighting as % of contract value	Potential value of goal £	Quality domain
National CQUIN goals (including specialised element)					
1	Sepsis/Paediatric Sepsis	To screen all appropriate patients and to rapidly initiate intravenous antibiotics within 1 hour or presentation for those in septic shock, Red Flag sepsis or suspected severe sepsis.	TBC	TBC	Safe
2	Antimicrobial resistance	Reduce antibiotic consumption and encouraging focus on antimicrobial stewardship and ensuring antibiotic review within 72 hours	TBC	TBC	Safe
Local CQUIN goals					
5	Transition: Planned processes for the transition from child to adult services	To improve the planned process of young people 16-25 transitioning from young peoples services to adult services. Provide an individualised transition plan, using a structured approach for all young adults.	TBC	TBC	Responsive
6	Medicines Safety Thermometer	Medicines safety	TBC	TBC	Safe
7	Diabetic Foot: Reduction in the number/rate of lower limb amputations through the deployment of a Multi-Disciplinary Team Approach	Year 2 of this CQUIN is to improve diabetic foot care with the aim of detecting foot ulcers earlier and then onward referral to a formalised diabetic foot team for treatment and to prevent unnecessary complications.	TBC	TBC	Responsive
8	Cancer Survivorship	Year 2 of this CQUIN supporting people Living with and Beyond cancer – a National Cancer Survivourship initiative. Involves the development, implementation and sustainable embedding of new pathways for Colorectal, Breast and Prostate cancer.	TBC	TBC	Responsive
9	SAFER flow bundle	A combined set of actions to improve patient flow and prevent patients waiting unnecessarily. Patient journey from hospital admission to discharge is improved by adopting the 5 principals of SAFER: S-Senior review, A-All patients to have a EDD, F-Flow from assessment units, E – Early discharge, R-Review daily longstay patients (>14 days)	TBC	TBC	Responsive
Specialised CQUIN goals					
10	Gi: Clinical Utilisation Review	Installation and implementation of CUR technology – a proven software and approach, supported by robust medical intelligence in the form of a developed clinical evidence base. Supports the prevention of unnecessary hospital admissions and reduce length of stay for patients by determining the most suitable level of care according to clinical need.	TBC	TBC	Responsive
11	Cii: Dose Banding of Adult Intravenous Systemic Anticancer Therapy (SACT)	Standardisation chemotherapy doses of SACT through nationally consistent approach to dose banding in order to increase safety, efficiency and to support the parity of care across all NHS providers of SACT in England	TBC	TBC	Effective
12	Ti: Adult Critical Care timely discharge	To reduce delayed discharges from ACC to ward level care by improving bed management, thus removing delays and improving flow. This supports the National standard that all discharges should be made within 4 hours of decision being taken to discharge within daytime hours.	TBC	TBC	Responsive
13	Spinal Surgery Networks, data, MDT's	Establish regional spinal surgery networks, data flows and MDT for surgery patients with aim to promote better management of spinal surgery by creating and supporting a regional network of a hub centre and partner providers that will ensure data is collected to enable evaluation of practice effectiveness and that elective surgery only takes place following MDT review.	TBC	TBC	Effective
14	Armed Forces Health	Review and revision of Provider Waiting List/Access Policy to ensure the principals of the Armed Forces Covenant as set out in the in the NHS Constitution and NHS contract are appropriately reflected ensuring no disadvantage to the Defence Medical Service population.	TBC	TBC	Responsive

Information Governance

The Trust's Information Governance Toolkit score for 2015/16 has been published as 75%, and is graded green.

The Information Governance Toolkit is available on the Health and Social Care Information Centre (HSCIC) website (igt.hscic.gov.uk).

The information quality and records management attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation.

The effectiveness and capacity of these systems is routinely monitored by our Trust's Information Governance and Health Records Committee. A performance summary is presented to our Trust Board annually in March.

Information governance incidents including any data breaches classified using HSCIC guidance at level 1 or level 2 in severity are reviewed and investigated throughout the year and reported internally through the Trust's Information Governance and Health Records Committee. In addition any level 2 severity incidents are reported to the Information Commissioner's Office in accordance with HSCIC reporting guidelines.

Summary of Serious Incident Requiring Investigations involving personal data as reported to the Information Commissioner's office in 2015–16 (Level 2)

Date of incident (month)	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
February 2016	Uploaded to website in error (internal intranet)	Staff names, professional registration numbers, payroll assignment numbers, and fixed term contract details.	7,000	Included in internal all staff email communication
Further action on information risk	GHNHSFT will continue to monitor and assess its information risks, in light of the incident above, the processes and controls within the three teams involved have been reviewed in order to identify and address any weakness and ensure improvement of systems. In this instance the information was available for a brief period only and not obviously accessible hidden in separate filtered worksheet. Additional controls have been or are in process of being implemented.			

Summary of other personal data related incidents internally reported 2015–16 (Level 1) As per HSCIC guidance

Category	Breach Type	Total
B	Disclosed in Error	6
E	Lost or stolen paperwork	1
J	Unauthorised access/disclosure	5

Quality of data

Good quality data underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made. The patient NHS number is the key identifier for patient records. Accurate recording of the patient's General Medical Practice Code is essential to enable the transfer of clinical information about a patient from a trust to the patient's GP.

During 2015/16, Gloucestershire Hospitals NHS Foundation Trust has taken the following actions to improve data quality (DQ):

- all existing reports have been reviewed and revised
- routine DQ reports have now been automated and are routinely available to all staff on the Trust intranet via the Business Intelligence portal 'inSight'
- we asked our internal auditors to audit the data contributing to our performance indicators.

The Trust continues to work with an external partner to advise the Trust on optimising the recording of clinical information and the capture of clinical coding data.

Gloucestershire Hospitals NHS Foundation Trust has submitted records during 2015/16 to the Secondary Users Service (SUS) for inclusion in the Hospital Episode Statistics.

In data published for the period April 2015 to February 2016 (the most recent available as of April 2016), the percentage of records which included a valid patient NHS number was:

- 99.8% for admitted patient care (national average: 99.2%)
- 100% for outpatient care (national average: 99.4%)
- 98.8% for accident and emergency care (national average: 95.6%)

The percentage of published data which included the patient's valid GP practice code was:

- 99.9% for admitted patient care (national average: 99.9%)
- 99.9% for outpatient care (national average: 99.8%)
- 99.9% for accident and emergency care (national average: 99.9%)

A comprehensive suite of data quality reports covering the Trust's main operational system (PAS) is available and acted upon. These are run on a daily, weekly and monthly basis and are now available through the Trust's Business Intelligence system, Insight. These include areas such as:-

- outpatients including attendances, outcomes, invalid procedures
- inpatients including missing data such as NHS numbers, theatre episodes
- critical care including missing data, invalid Healthcare Resource Groups
- A&E including missing NHS numbers, invalid GP practice codes
- waiting list including duplicate entries, same day admission.

On a weekly basis any missing/incorrect figures are highlighted to staff and added or rectified. Our Trust Data Quality Policy is published on the intranet setting out responsibilities for data quality. All Trust systems have an identified system manager with data quality as a specified duty for this role. System managers are required under the Clinical and Non-Clinical Systems Management Policy to identify data quality issues, produce data quality reports, escalate data quality issues and monitor that data quality reports are acted upon.

Clinical coding error rate

GHNHSFT was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary diagnosis 81%
- Secondary diagnosis 78.3%
- Primary procedure 91.1%
- Secondary procedure 73%

The results should not be extrapolated further than the actual sample audited as these results reflect only a small sample of patients coded during this quarter.

A sample of 200 Finished Consultant Episodes (FECs) were audited: 100 were selected for the National area for audit to inform the costing audit (HRG Sub-chapter FZ Digestive system procedures and disorders); and the other 100 selected for the local area for audit which was highlighted through benchmarking of data quality indicators (HRG Sub-chapter DZ Thoracic procedures and disorders).

All data was from quarter 2 in financial year 2014/15. It was evident that due to the number of FCE's within a spell, where an error happened in the first FCE, this 48 2.3 error occurred in all the subsequent FCE's which in turn had a negative impact on the error rate.

GHNHSFT will be taking the following actions to improve data quality:

- All errors uncovered during the course of the audit fed back to the coding team and any areas of training covered.
- Audit plan has been formulated ensuring that a follow up audit of the areas examined during the course of the PbR audit which is scheduled for December 2015.
- A new training plan has been put together to ensure the coders have the skills to perform their role, with specialty focussed training courses having already been booked throughout the course of this financial year.

These courses are to be delivered in part by the Trust's Clinical Coding Manager, who is also a CCS (Clinical Classifications Service) Approved Experienced Trainer and Auditor.

- Individual coder audits will be carried out on a monthly basis, with five spells each coder each month being examined. This will serve to highlight potential training issues/areas of concern and will inform whether individual coders need to be audited more frequently.
- The department is striving to increase awareness around the importance of accurate coded data throughout the organisation. This is being achieved through meetings with clinicians, divisional leads, General Managers and Assistant General Managers.
- The Coding Manager is working with Patient Records, Ward Clerks and clinical staff to ensure patient case notes reach the coding department in a timely manner and that appropriate information and documentation is incorporated.
- The Coding Manager with some members of the team is working with the Staff Development Team at the Trust on an eLearning programme for Clinical staff to improve their knowledge on Clinical Coding.
- The recruitment of a Clinical Coding Auditor to assist with the audit process and ensure the 'live audit' option is achieved. This will ensure that any training errors and areas of concern are addressed at the time of coding, or within 4 working days of the coding being entered onto the Trust PAS by the coder.
- Protected time to be given to coders at 30 minutes per day to update the classifications with new standards. This will also be covered to some extent during the monthly team meetings, which everyone attends, when any changes come in.

Staff Survey key indicators

In the 2015 Staff Survey, we reported the following results:

- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (KF26): 25%
- Percentage of staff believing that our trust provides equal opportunities for career progression or promotion (KF21): 86%

Sign up to safety

Our Trust has signed up to the principles of the Sign Up To Safety campaign ambitions of halving avoidable harm over the next three years and as a consequence, saving lives.

Each year we review and consult on our current safety priorities and develop key targets. These objectives, developed in consultation with our partners at the Clinical Commissioning Group and Healthwatch, are incorporated in the Trust Performance Management Framework and the Quality Dashboard for continuous monitoring.

We are committed to delivering year on year improvements in safety. We do this by working with patients and our dedicated front line teams to report and learn from incidents, by reviewing and learning from national audits and guidance (such as NICE) and by learning from staff and patients experiences. Members of our Trust Board visit more than 100 departments and wards every year to emphasise the importance of safety and patient experience and carry out both day and night visits to listen to talk about good quality patient care, allowing time for staff to raise their concerns.

Our safety improvement plans for the year ahead to help us reduce avoidable harm can be seen below in Figure 18.

Figure 18: Safety improvement plan for 2016/17

Priority Area	Rationale
To develop the Gloucestershire Safety and Quality Improvement Academy	The Academy was launched in June with the aim of developing a culture of continuous improvement within the Trust. This year we want to extend the structured programme of courses and support improvement projects.
Reducing the likelihood of fractures being missed in our emergency departments	This project funded by the NHSLA as part of their Sign Up to Safety Initiative, was delayed and will continue into 2016/17.
To implement the National Safety Standards for Invasive Procedures	This new set of standards builds on the existing WHO Surgical Checklist, ensuring safety checks are consistently performed across the NHS for all invasive procedures.
Improving the management of patients requiring emergency abdominal surgery	This was identified as a priority by the Royal College of Surgeons and the South West Clinical Senate. We are part-way through a 2 year programme to change our care pathways.
Learning from users	This programme, which includes co-design and shadowing, will continue next year. The priority will be to embed the training and learning in our Quality Academy.
To implement the Emergency Department checklist	This is part of a spread programme supported by the West of England Academic Health Science Network
Continue to develop and refine the Duty of Candour process	The Trust has delivered the Duty of Candour for serious incidents for many years, spreading this to include moderate harm is challenging but essential.

The Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. From April 2010, all NHS trusts have been legally obligated to register with the CQC. Registration is the licence to operate and to be registered, providers must, by law, demonstrate compliance with the regulatory requirements of the CQC (Registration) Regulations 2009.

From April 2015 all providers had to meet the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) is registered with the CQC without conditions. This means that our Trust has continued to demonstrate compliance with the regulations.

The Care Quality Commission visited us during March 2015 as part of their new inspection regime. The new inspections ask five key questions:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

This results take the form of a rating for each hospital – inadequate, requires improvement, good or outstanding. The outcome of this visit is set out in the tables opposite and in our action plan overleaf. In addition to identifying 'must do' areas for improvement the CQC also identified a number of 'should do's' which are also being addressed by the relevant services.

From April 1 2015, all trusts are expected to publish the results of their CQC inspection as part of the new regulations on their website and display their rating prominently on hospitals sites.

The CQC has not taken enforcement action against Gloucestershire Hospitals NHS Foundation Trust during 2015/16. Gloucestershire Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

CQC ratings for Gloucestershire Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

CQC ratings for Cheltenham General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Medical care	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

CQC ratings for Stroud Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

CQC ratings for our overall trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement

Figure 19: Areas for improvement from CQC inspection

CQC area	"Must do" area for improvement	Status
Safe	Develop clear protocols with regard to the care of patients queuing in the corridors in the emergency departments. This should include risk assessment and the identification of safe levels of staffing and competence of staff deployed to undertake this care.	Complete: September 2015
	Ensure the premises for the medical day unit are suitable to protect patients' privacy, dignity and safety.	Complete: September 2015
	Take immediate steps to address infection control risks in the ambulatory emergency care unit.	Complete: September 2015
	Continue to take steps to ensure there are sufficient numbers of suitably qualified, skilled and experienced consultants and middle grade doctors to provide senior medical presence in the emergency departments 24 hours a day, seven days a week, and to reduce reliance on locum medical staff.	Complete: monitored via the Trust risk register and Board reporting process. September 2015
	Ensure that systems to safeguard children from abuse are strengthened and children's safeguarding assessments are consistently carried out. There must be a process to ensure all appropriate child safeguarding referrals are made.	Complete: September 2015
	→ 1. Ensure patients' mental capacity is clearly documented in relation to 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) and 'unwell/ potentially deteriorating patient plan' (UP) forms.	Action recommended for closure with an agreed implementation plan for all actions.
	→ 2. Improvements in record keeping must include documented explanations of the reasoning for decisions to withhold resuscitation,	Results of audits to be presented to the Quality Committee in May.
	→ 3. Documented discussions with patients and their next of kin, or reasons why decisions to withhold resuscitation were not discussed.	NB Delayed because of agreement of wording with CQC
	Ensure that where emergency equipment in the form of resuscitation trolleys is not available, the decision to not supply it is based on a thorough risk assessment.	Complete: September 2015
	Ensure that where emergency equipment is available, this should be ready to use at all times.	Complete: September 2015
	Ensure that systems are in place to ensure that all medication available is in date and therefore safe to use.	Complete September 2015
	Review communication methods within maternity services to ensure that sensitive and confidential information is appropriately stored and handled, whilst being available to all appropriate staff providing care for the patient concerned.	Complete: Notice board function changed, September 2015
	Ensure an effective system is in place on the medical wards to detect and control the spread of healthcare-associated infection	Complete: September 2015
	Ensure that patients' records across the hospitals are stored securely to prevent unauthorised access.	Recommended for closure with future regular communication about safe storage.
Effective	Ensure that senior medical staff in the emergency department are trained in level 3 safeguarding.	Recommended for closure training completed or planned.
	Ensure that in the surgical division, when medicines are issued from wards or departments, the issued medicines comply with the relevant legislation and best practice.	Complete: September 2015
	Ensure the administration of eye drops complies with the relevant legislation	Recommended for closure. New policy and practice agreed. Future Divisional Quality report monitoring
	Take steps to strengthen the audit process in the emergency department to provide assurance that best (evidence-based) practice is consistently followed and actions continually improve patient outcomes.	Complete: monitor future audits through the Divisional Quality Committee. September 2015
	Ensure minutes are kept of mortality and morbidity meetings in medicine so that care is assessed and monitored appropriately, lessons learnt and actions taken and recorded.	Recommended for closure. New framework developed and agreed, future monitoring through Divisional Quality report.

CQC area	"Must do" area for improvement	Status
Responsive	Improve its performance in relation to the time that patients spend in the emergency department to ensure that patients are assessed and treated within appropriate timescales.	Complete: monitored via the Trust risk register and Board reporting process. September 2015
	Continue to reduce ambulance handover delays and take steps to ensure that patients arriving at the emergency departments by ambulance do not have to queue in the corridor because there is no capacity to accommodate them in clinical areas.	Complete: monitored via the Trust risk register and Board reporting process. September 2015
	Work with healthcare partners to ensure that patients with mental health needs who attend the emergency departments out of hours receive prompt and effective support from appropriately trained mental health practitioners.	Complete: September 2015
	Ensure that patients in the emergency departments have an assessment of their pain and prompt pain relief administered when necessary.	Complete: action monitor progress through Divisional Quality Report. September 2015
	Ensure that appropriate written consent is obtained prior to procedures being carried out in the outpatient department.	Recommended for closure audit shows 82% compliance, further monitoring through Divisional Quality report
	Ensure that all patients (men and women) are able to access the full range of tests in the urology outpatient department.	Complete: September 2015

2.3

Reporting against core indicators
A review of our quality performance

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the trust by the Health and Social Care Information Centre (HSCIC).

Monitor, the Foundation Trust regulator, produces guidance each year for the Quality Account, outlining which performance indicators should be published in the annual document. This year, as last year, we have been required to publish data from the HSCIC only for at least two reporting periods.

You can see our performance against these mandated indicators in Figure 20 on p63.

Figure 20: Reporting against core indicators

Indicator (required by NHS England)	Year	GHNHSFT	National average	Highest trust figure	Lowest trust figure	Explanation of why GHNHSFT considers that the data from the HSCIC are as described	Actions GHNHSFT intends to take to improve the indicator and quality of services
(a) SHMI for the trust for the reporting period; and	**2013/14**	1.06	1.00	1.19	0.54	For 2015/16 the data is only available for the period April – September 2015	Figures are as expected range compared with other trusts. We have established a Trust Mortality Review Group, chaired by the Medical Director, which reviews this indicator and other more granular parameters in relation to mortality. We also use the Dr Foster Intelligence System to monitor mortality indicators.
	2014/15	1.09	1.00	1.21	0.67		
	2015/16	1.10	1.00	1.17	0.65		
(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	**2013/14**	21.0%	23.6%	48.5%	0.0%	This indicator cannot be calculated locally as it uses the same national dataset as SHMI which includes ONS data on post-hospital deaths. A proxy using in-hospital data only can be calculated but this is not currently routinely reported	This places us close to the national average and we do not regard ourselves to be significantly different from it.
	2014/15	21.3%	25.7%	50.9%	0.0%		
	2015/16	22.8%	26.6%	53.5%	0.2%		
Number of patient safety incidents / number which resulted in severe harm or death	**2013/14**	8,411 / 125	8,890 / 54	15,367 / 183	2,754 / 10	The way the data has been recorded is now different hence the large increase in numbers nationally since last year. Previously we were in the 'Large Acute' sector and we used the 'Large Acute' total as the national average. In 2015/16 the Trusts are divided into new categories, we are in Acute (Non-Specialist) which houses more Trusts than last year's 'Large Acute' category. *Data for April 2015 – September 2015	Results are within the expected range compared with other trusts. The Trust will continue to encourage reporting of patient safety incidents and carry out root cause analysis investigations for significant patient safety incidents.
	2014/15	9,758 / 64	8,809 / 43	24,804 / 193	2,116 / 4		
	2015/16	5,540 / 23*	4,647 / 20	12,080 / 26	1,559 / 13		
Rate per 100 admissions of patient safety incidents resulting / rate per 100 admissions resulting in severe harm or death	**2013/14**	5.64 / 0.08	7.14 / 0.04	11.76 / 0.11	3.01 / 0.01	For years up to and including 2013/14, England, Highest and Lowest are drawn from Large Acute Trusts group only and standardised as 'per 100 admissions.' For 2014/15 England, Highest and Lowest are drawn from all non-specialist acute trusts and standardised as 'per 1,000 bed days' *Data for April 2015 – September 2015	Figures are within the expected range compared with other trusts. The Trust will continue to encourage reporting of patient safety incidents and carry out root cause analysis investigations for significant patient safety incidents
	2014/15	5.94 / 0.04	7.03 / 0.03	14.53 / 0.23	3.63 / 0.00		
	2015/16	3.47 / 0.01*	3.81 / 0.02	7.47 / 0.05	1.81 / 0.03		
Rate of C diff (per 100,000 bed days) among patients aged over two	**2013/14**	18.6	14.7	37.1	0.0		
	2014/15	11.5	15.1	62.2	0.0		
	2015/16	N/A	N/A	N/A	N/A		
Percentage of patients risk assessed for VTE	**2013/14**	94.5%	95.7%	100.0%	82.0%	Source: NHS England VTE Risk Assessment Statistical Work Area. National dataset compiled from monthly local data submissions. National indicator values may differ slightly from locally calculated values due to small variations in assumptions for denominator. *April 2015 to December 2015	GHNHSFT intends to take the following actions to improve this percentage and so the quality of its services, by targeting individual areas where performance isn't meeting the required standard. See pxx for more information
	2014/15	94.4%	96.0%	99.6%	90.5%		
	2015/16	93.50%*	95.80%	100.0%	80.60%		

Continued overleaf

Indicator (required by NHS England)	**Year**	**GHNHSFT**	**National average**	**Highest trust figure**	**Lowest trust figure**	**Explanation of why GHNHSFT considers that the data from the HSCIC are as described**	**Actions GHNHSFT intends to take to improve the indicator and quality of services**
The percentage of patients aged 0–15 readmitted to hospital within 28 days of being discharged	**2011/12**	9.88%	10.26%	14.94%	6.40%	The data on the HSCIC has not been updated beyond 2011/12. This indicator is no longer reported locally. The preferred national and local indicator is now readmissions within 30 days which is broadly consistent with this indicator. Next release is expected August 2016	
	2012/13	N/A	N/A	N/A	N/A		
	2013/14	N/A	N/A	N/A	N/A		
	2014/15	N/A	N/A	N/A	N/A		
	2015/16	N/A	N/A	N/A	N/A		
Readmissions within 28 days: age 16 or over	**2011/12**	10.52%	11.45%	13.80%	9.34%	No national data has been published since 2011/12. This indicator is no longer reported locally. The preferred national and local indicator is now readmissions within 30 days which is broadly consistent with this indicator. Next release of data is expected in August 2016.	
	2012/13	N/A	N/A	N/A	N/A		
	2013/14	N/A	N/A	N/A	N/A		
	2014/15	N/A	N/A	N/A	N/A		
	2015/16	N/A	N/A	N/A	N/A		
Responsiveness to inpatients' personal needs	**2013/14**	67.3%	68.7%	84.2%	54.4%	Data is taken from the Health & Social Care Information Centre NHS Outcomes Framework website under the section 'Ensuring Patients Have a Positive Experience of Care.' This indicator is based on five questions from the national inpatient survey. The next release of data is expected in May 2016	
	2014/15	66.5%	68.9%	86.1%	59.1%		
	2015/16	N/A	N/A	N/A	N/A		
Friends & Family Test Q12d (If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation)	**2013**	55.8%	66.2%	93.9%	39.6%	Data is taken from the National Staff Surveys 2013, 2014 & 2015 which is administered and analysed by a third party. We have use the cluster of acute trusts for benchmarking the England average, high and low values. This is calculated by calendar year, instead of financial.	
	2014	61.9%	65.2%	92.8%	38.2%		
	2015	69.4%	69.2%	85.4%	46.0%		

Patient Reported Outcome Measures (PROMS)

Patient Reported Outcome Measures (PROMs) collect information on the effectiveness as perceived by the patients themselves of the NHS care they have received. Since April 2009, patients undergoing four different types of elective surgery – hip replacement, knee replacement, groin hernia repair, varicose vein surgery – have been invited to complete lifestyle questionnaires before and after their operations. Their responses are converted into scores and when taken with other clinical information, they allow the effectiveness of treatments to be assessed and hospital providers to be compared.

Two well-established general health and lifestyle surveys are used – EQ-5D & EQ-VAS (EuroQol five-dimensional descriptive health questionnaire and visual analogue scale) – alongside condition-specific questionnaires – Aberdeen Varicose Vein Questionnaire, Oxford Hip Scores and Oxford Knee Scores – each of which pose questions relating to the individual experience of the patient with the condition. Patients complete these surveys and questionnaires before and after their operations and the difference in their scores are used as a measure of the improvement resulting from their operation being carried out.

The figures we have reported in Figure 21 are the percentage of patients reporting an improvement in their health and wellbeing after their procedure as measured by each of the questionnaires. The figure for the Trust is shown against the England average improvement rate for comparison.

Fig. 21:

April 2014 – March 2015

	EQ-5D		EQ VAS		Condition-specific Measure	
Procedure	**Trust %**	**England %**	**Trust %**	**England %**	**Trust %**	**England %**
Groin	52.0	50.7	42.3	38.1		
Hip	87.3	89.6	63.9	66.0	96.9	97.3
Knee	81.1	81.1	50.8	55.6	95.3	93.8
Varicose Veins	68.9	52.1	48.9	39.3	91.7	82.6

April 2015 – September 2015 (latest available as of April 2016)

	EQ-5D		EQ VAS		Condition-specific Measure	
Procedure	Trust %	England %	Trust %	England %	Trust %	England %
Groin	70.5	51.1	44.4	36.8		
Hip	86.5	89.7	59.5	66.9	98.1	97.5
Knee	78.8	82.8	41.9	55.6	100.0	94.8
Varicose Veins	57.1	54.1	35.7	39.6	80.0	83.6

No condition-specific measure for groin surgery. Where numbers of cases are small, data is not published at Trust level to preserve patient confidentiality. There are shown as 'too few'.
Source: HSCIC website – Patient Reported Outcome Measures (PROMS) section. National data collated from locally-generated survey data

3

Other information

Other information on the quality of our services

The following section presents more information relating to the quality of the services we provide.

In Figure 22 on p68 there are a number of performance indicators which we have chosen to publish which are all reported to our Quality Committee.

The majority of these have been reported in previous Quality Account documents. These measures have been chosen because we believe the data from which they are sourced is reliable and they represent the key indicators of safety, clinical effectiveness and patient experience within our organisation.

Figure 22: Other indicators we've chosen to report

Indicators	2014/15	2015/16	National target for 15/16
Safety			
Clostridium difficile year on year reduction: post 48 hours	36	41*	36 (local target)
MRSA bacteraemia at less than half the 2003/4 level: post 48 hours	2	2*	0
MSSA*	30	25*	N/A
Rate of Inpatient Falls per 1000 bed days	6.2	7.1*	N/A
Rate of Medication Incidents per 1000 bed days	4.7	3.2*	N/A
Never events	3	2*	0
Number of RIDDOR	4	37*	N/A
Rate of Staff Falls per 1000 head count	1.3	1.7*	N/A
Rate of Incidents arising from Clinical sharps per 1000 staff	2.6	2.5*	N/A
Rate of physically violent and aggressive incidents occurring per 1000 staff	3	3*	N/A
Global Trigger Tool per 1000 bed days	N/A	39.7**	N/A
NHS Safety Thermometer – percentage receiving harm free care	94%	93.13%*	N/A
Risk assessment for patients with Venous Thromboembolism (VTE)	93.9%	94.2%	95%
Crude mortality rate	1.36%	1.19%*	N/A
Effectiveness			
Dementia 1a: Case Finding – 90% of eligible patients aged 75 years and over, as emergency admissions, asked the case finding question	86.7%	88%*	90%
Dementia 1b: Clinical Assessment – 90% of eligible patients aged 75 years and over, as emergency admissions will receive clinical assessment of their reported memory loss	100%	100%*	90%
Dementia 1c: Referral for Management – 90% of eligible patients aged 75 years and over, as emergency admissions, who score positively on the Abbreviated Mental Test (a test used to assess dementia), and where concerns over memory function remain will be referred onwards	100%	100%*	90%
% patients spending 4 hours or less in ED	90.2%	86.74%*	95%
Number of ambulance handovers delayed over 30 minutes	1038	983*	N/A
Number of ambulance handovers delayed over 60 minutes	142	95*	N/A
Emergency readmissions within 30 days – elective & emergency	6.2%	6.35%	N/A
Research Accruals	1813	1053	N/A
Comparison of median time (months) to complete local governance checks	97%	98%	N/A
% stroke patients spending 90% of time on stroke ward	76.6%	84.3%&	80%
% women seen by midwife by 12 weeks	91.2%	90.10%***	90% (local target)

Indicators	2014/15	2015/16	National target for 15/16
Patient Experience			
Number of written complaints	904	961	N/A
Rate of written complaints per 1000 inpatient spells	6.2	6.3*	N/A
Number of comments on NHS Choices: Positive / Negative	87 / 31	106 / 39*	N/A
Number of comments Patient Opinion: Positive / Negative	60 / 22	112 / 29*	N/A
Max 2 week wait for patients urgently referred by GP	92%	90.9%*	93%
Max 2 week wait for patients referred with non cancer breast symptoms	87.5%	93.6%*	93%
Max wait 31 days decision to treat to treatment	99.7%	99.8%*	96%
Max wait 31 days decision to treat to subsequent treatment : surgery	99.4%	99.3%*	94%
Max wait 31 days decision to treat to subsequent treatment: drugs	100%	100%*	98%
Max wait 31 days decision to treat to subsequent treatment: Radiotherapy	99.7%	99.9%*	94%
Max wait 62 days from urgent GP referral to 1st treatment (exl. rare cancers)	82.4%	76.7%*	85%
Max wait 62 days from national screening programme to 1st treatment	93.1%	95.3%*	90%
18 week maximum wait from point of referral to treatment (admitted patients adjusted)	90.7%	86.5%*	90%
18 week maximum wait from point of referral to treatment (non-admitted patients unadjusted)	95.1%	92.8%*	95%
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways ◊	92.1%	92.1%*	92%

* 01 April 2015– 31 March 2016

** 01 April 2015 – 31 October 2015

*** 01 April 2015 – 31 January 2016 & April 2015 – February 2016

Next part:
Annex 1: Statements from stakeholder organisations

A1

Annex 1:
Statements from stakeholder organisations

Statement from NHS Gloucestershire Clinical Commissioning Group

NHS Gloucestershire Clinical Commissioning Group welcomes the opportunity to provide comments on the Quality Account prepared by Gloucestershire Hospitals NHS Foundation Trust (Gloucestershire NHSFT) for 2015/16.

The past year has presented major challenges across both Health and Social care in Gloucestershire. The CCG would like to acknowledge where Gloucestershire NHSFT have worked with the CCG and other providers to deliver a system wide approach as we all work together for the benefit of the people of Gloucestershire.

Gloucestershire NHSFT has been inspected by the CQC and the final report received this year indicated an overall rating of 'requires improvement' and Gloucestershire NHSFT has already implemented all of the compulsory recommended actions to address these concerns.

The CCG were pleased that the majority of the services were rated as 'Good', with the Department of Critical Care at both Cheltenham General and Gloucestershire Royal Hospitals rated 'Outstanding'.

What was particularly pleasing was the clear message from the CQC that the staff were found to be caring.

The 2015/16 Quality Account is easy to read and understandable given that it has to be read by a variety of stakeholders. The account clearly identifies how the Trust performed against last year's quality priorities and outlines the following year's ambitions for improving quality.

The CCG endorses the quality priorities indicated in the report and welcomes the focus on all areas. One of these priority areas in 2015/16 was improving the care of patients with fragility fractures. Gloucestershire NHSFT recognises that they still have work to do to make the required improvements for these patients, specifically targeting the care of patients with a fractured neck of femur. Patients who suffer a fractured neck of femur (a broken hip) have a high mortality and morbidity rate with up to 20% needing long term care and a further 30% not returning to their pre-fracture health. Gloucestershire NHSFT is a national mortality outlier in the care of this group of patients and the CCG fully support the increased focus on improving the outcomes for this patient group.

Last year the CCG along with Macmillan, Gloucestershire Care Services and Gloucestershire NHSFT launched the countywide Living with & beyond Cancer Programme. This remains a priority across Gloucestershire this year as well as ensuring Gloucestershire NHSFT achieve all the national targets including 62 day target which has not been met over the past year.

The CCG also welcome the commitment to improve the handover of care between clinical teams to ensure it is safe and effective, as well as supporting improved joint working between other care providers such as GPs and social care. An inadequate handover can lead to a poor experience for patients and their carers and can affect the continuity of care and increase length of time a patient stays in hospital. The CCG therefore supports the inclusion of improving discharge as a quality priority for the coming year.

The CCG are keen to see a specific focus on patient and staff experience in 2016/17 and are committed to working with Gloucestershire NHSFT to assist them to deliver the quality priorities for the coming year.

Gloucestershire CCG can confirm to the best of our knowledge that we consider that the quality account contains accurate information in relation to the quality of services provided by Gloucestershire NHSFT. During 2016/17 the CCG would like to work with all stakeholders and the population of Gloucestershire to further develop ways of receiving the most comprehensive assurance we can regarding the quality of services provided to the residents of Gloucestershire and beyond.

Marion Andrews Evans
Executive Nurse and Quality Lead
May 2016

Statement from Healthwatch Gloucestershire (HWG)

This is the third year in which HWG has had the opportunity to be involved with the Trust's Quality Account process. The Quality Account describes a very large range of activities in a complex organisation, therefore we have chosen to focus on a relatively small number of points.

General Comments

This is one of several ways in which HWG and the Trust are able to work together and in which the Trust seeks feedback from our organisation so that what we learn from the public influences the Trust's efforts to continually improve the quality of services and patient care.

This year we have continued our series of regular meetings with members of the Trust's leadership team where we address the comments, concerns, problems and compliments that the public have raised with us.

We have continued to be involved in the Trust's Patient Experience Strategy Group where ideas for the sustained improvement of engagement and experience are developed. We were pleased to support a Healthwatch member in making a training film for the Trust in which she identified aspects of her late husband's care and treatment for cancer that were unsatisfactory. We use our involvement in other Trust groups to bring a lay perspective to the Trust's work. We feel there are further ways in which we could support the Trust and will continue to look for opportunities to do so.

The Quality Account for the most part is a highly accessible and readable document. We welcome the opening material that clearly explains the purpose of the Account and the work of the Quality Committee. At some points, however, eg in the Statement of Assurance, the language becomes very complex. We encourage the Trust, wherever it can, to use as accessible a form of language as possible. Case studies are a compelling form of evidence and their use could be extended to show how quality improvements are changing patients' actual experience of care and treatment.

The use of tables is helpful in clarifying some complex information. In some cases, however, the use of local and national data can distract from local performance. Wherever possible in future could the Trust maintain an explicit focus on the local situation so that the experience in Gloucestershire is not lost in the more general national picture? In one or two other places it is not immediately clear (to the lay reader) whether local performance was good or not. Eg laparotomy audit results. Where necessary, could statistical data be supplemented with written commentary?

The Account makes several welcome references to working collaboratively, eg with the University Hospital of Southampton and with Macmillan.

The section on Improving Patient Information, in contrast, suggested a less outward-facing approach. HWG is working with other provider organisations in Gloucestershire to allow a wider range of independent lay voices to influence and co-develop patient information.

The work of our Readers' Panel has been well received elsewhere with its independent audit of NHS and County Council public information. We hope the Trust will consider using these resources in 2016/17 so that all opportunities for external input are taken.

Performance in 2015/16

Treatment of pressure ulcers

We were concerned that, notwithstanding increased focus and investment, the incidence of pressure ulcers is rising.

Patient Flow

HWG reported in October 2015 to support the Trust to focus on areas of poor patient experience of discharge. We recommended that the Trust improves: the way in which it learns from patients about their experience of leaving hospital; the timeliness and content of discharge paperwork; coordination with others in the discharge.

We have real concerns that the Trust reached the national 4-hour wait target in only one month in 2015/16 and that the evidence between November 2015 and January 2016 suggests a further reduction in performance. HWG will continue to work with the Trust, commissioners and NHSI (formerly Monitor) to ensure that patients' experiences of these delays form part of the continuing scrutiny of the Trust's performance.

Reducing the risk of Venous Thromboembolism

We were unclear as to why the coding issue might account for the reported change in performance. It was unclear from the statistical data as to why there is reported confidence that the improvement target will be met.

Hip fractures

We were concerned to learn of the mortality data and National statistics concerning higher than expected mortality among patients win such fractures.

Can the findings and action plans referred to in the Quality Account be made publicly available in the interests of maintaining public confidence in these services?

Some clear expectations as to when and how this position will improve in 2016/17 should be an urgent priority.

Priorities for 2016/17

We were given early opportunities to identify those specific subjects that we felt, based on our public engagement, the Trust should adopt as priorities for 2016/17.

In addition the Trust receives all of the material that we collect from members of the public about their care - both compliments and concerns - which have also been used to shape the Trust's priorities for the year ahead.

Particular themes have emerged during the course of our conversations with the general public about their hospital care as follows:

- The quality of communication
- Arrangements for discharge from hospital where people have described feeling they were discharged too soon and / or before appropriate are agreements had been made for their care after leaving hospital
- Delays in having appointments made in specific departments eg cardiology and urology
- Waiting times in the Emergency Department

HWG has worked effectively with the Trust this year and early involvement in the production of this Quality Account has been appreciated. We were pleased to be asked by the Trust Chair to participate in the selection of its new CEO. We look forward to welcoming Deborah and to the further opportunities for collaboration and influencing that the new appointment will bring.

Claire Feehily
Chair, Healthwatch Gloucestershire

healthwatch Gloucestershire

Statement from Gloucestershire Health and Care Overview and Scrutiny Committee

On behalf of the Health and Care Overview and Scrutiny Committee I welcome the opportunity to comment on the Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) Quality Account 2015/16.

One of the difficulties of commenting on quality accounts is that due to their prescriptive nature in that they are obliged to focus on the individual Trust they do not easily demonstrate/communicate the integrated working across health and social care. This is challenging for the committee as it is of the view that the NHS and social care commissioners and providers in Gloucestershire must all work together for the benefit of the patient. By working effectively together duplication of effort can be reduced and limited resources used effectively in line with the aims of the Gloucestershire Strategic Transformation Plan (STP).

The committee would have preferred that the section on discharge/patient flow better reflected the joint working across health and social care in Gloucestershire. The committee also remains concerned with the Trusts' performance against the cancer and stroke targets and will continue to monitor this situation.

Listening to and hearing what patients have to say about their experience and learning from this is important. The committee recognises that the Trust has a programme of work around patient experience and wants to understand where things can be improved, and as importantly celebrate the good work of staff. However it is of concern that in the section relating to improving the care transition from children's to adults services there does not seem to be mention of talking to the young person about what they want, what outcomes they would like to achieve. Talking to parents/carers is a positive action but it is important not to overlook the patient no matter what their age.

Caring well for people at the End of Life is so important and members welcome the work on Living Well to the Very End.

Safeguarding is everyone's responsibility. The Care Quality Commission inspection of the Trust raised specific concern with regard to children's safeguarding and whilst it is good to note that the Trust has responded quickly to this action it would have been good to see Safeguarding matters reflected within the body of this Quality Account.

The committee recognises that workforce challenges are a significant issue for this Trust, and indeed across the whole health and social care landscape. The committee will be debating these workforce challenges in Gloucestershire at its meeting in May 2016.

This is a period of transition for the Trust with the handover from the retiring Chief Executive to the incoming Chief Executive. The committee wishes Dr Harsent well in his retirement, and looks forward to working with the new Chief Executive.

Cllr Iain Dobie
Chairman, Health and Care Overview and Scrutiny Committee

Independent Auditor's Limited Assurance Report to the Council of Governors of Gloucestershire Hospitals NHS Foundation Trust on the Quality Report

TO FOLLOW

TO FOLLOW

Next part:
Annex 2:
Statements of directors' responsibilities

A2

Annex 2:
Statements of directors' responsibilities

Statement of directors' responsibilities for the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
- board minutes and papers for the period April 2015 to March 2016
- papers relating to quality reported to the board over the period April 2015 to March 2016
- feedback from commissioners dated 05/05/2016
- feedback from governors dated 24/02/2016
- feedback from local Healthwatch organisations dated XX/XX/20XX
- feedback from Overview and Scrutiny Committee dated 03/05/2016
- the trust's draft complaints report to be published, under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, in June 2016
- the [latest] national patient survey April 2015
- the [latest] national staff survey March 2016
- the Head of Internal Audit's annual opinion over the trust's control environment dated XX/XX/20XX
- CQC Intelligent Monitoring Report – May 2015
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board,

Dr Frank Harsent
Chief Executive
Gloucestershire Hospitals NHS Foundation Trust
May 2015

Clair Chilvers
Chair
Gloucestershire Hospitals NHS Foundation Trust
May 2015

G

Glossary of abbreviations and terms

Academic Health Science Networks: are new partnerships responsible for driving improvements in patient care by sharing innovations across the NHS. Their creation was announced in December 2011 in the Government's 'Innovation, Health and Wealth' report as a way to align education, clinical research, informatics, innovation, training, education and healthcare delivery at a local level.

C. Difficile: Clostridium difficile, also known as CDF/cdf, or C. diff, is a species of Gram-positive spore-forming bacteria that is best known for causing antibiotic-associated diarrhea

Care bundle: A care bundle is a set of clinical interventions that, when used together, significantly improve patient care.

Care Quality Commission (CQC): the independent regulator of health and social care in England

CGH: Cheltenham General Hospital

Clinical Commissioning Group: In 2013, our commissioners became the Gloucestershire Clinical Commissioning Group. Commissioning is the process of assessing the needs of a local population and putting in place services to meet those needs. Commissioners are those who do this and who agree service level agreements with service providers for a range of services.

Cognitive Stimulation Therapy: this is a recommended therapy based on stimulating activities and exercises in a group to help memory and communication.

CQUIN: This stands for the Commissioning for Quality and Innovation payment framework. The motivation behind CQUINs is to reward excellent performance by linking a proportion of providers' income to the achievement of local quality improvement goals.

DVT: Deep Vein Thrombosis. This is the formation of a blood clot (thrombus) in a deep vein, predominantly in the legs

Electronic Health Record (EHR): this is a digital version of a patient's health record. A health record in our hospital will contain all clinical information about a patient's care, including x-rays, treatments received or ongoing, allergies, medications, long-term conditions, test results, personal data such as name and date of birth and admission and discharge notes.

Emergency Department: Otherwise known as A&E

Five Year Forward View: published by NHS England in October 2014, this document set out the vision for the NHS, based around new models of care.

Friends & Family Test (FFT): this is a simple, but important feedback tool which asks if patients, carers and visitors to our hospitals would recommend us to their friends or family.

GHNHSFT: Gloucestershire Hospitals NHS Foundation Trust

Governors: Members can become more involved by standing for election as a governor and representing their fellow members' views on the Council of Governors. Governors play an important role in the governance of the Trust. They represent the views of patients, carers and patients.

GRH: Gloucestershire Royal Hospital

Healthwatch Gloucestershire: Healthwatch was established in April 2013 and is the consumer champion of health and social care in England, giving children, young people and adults a powerful voice

HCOSC: Gloucestershire Health and Care Overview and Scrutiny Committee. This is a body which scrutinises the decisions of local health organisations

Members: As an NHS Foundation Trust we are accountable to our local community. This means we give greater say in how we're run to local people, staff and all those who use our services including patients, their families and carers. Each foundation trust must recruit 'members' to reflect these groups and help us ensure that we are providing the best service we can.

MDTs: Stands for Multidisciplinary Team, which is a team composed of members from different healthcare professions with specialised skills and expertise.

MRSA: Methicillin-Resistant Staphylococcus Aureus. This is a type of bacterial infection that is resistant to a number of widely used antibiotics. This means it can be more difficult to treat than other bacterial infections.

MSSA: Methicillin-Sensitive Staphylococcus Aureus. Staphylococcus aureus is a very common bacterium (germ) that around 30% of the population carry on their skin or on the lining of their nose and throat without knowing. Usually this germ is harmless. Sometimes it can cause local infections such as abscesses or boils and it can infect any wound that has caused a break in the skin eg. grazes or surgical wounds.

NHS Safety Thermometer: a quick and simple method for surveying patient harms and analysing results so that you can measure and monitor local improvement and harm free care (external) (Opens in a new window) over time.

Regulators: The Care Quality Commission (CQC) regulates all health and adult social care services in England, including those provided by the NHS, local authorities, private companies or voluntary organisations. It also represents the interests of people detained under the Mental Health Act. Monitor is also another regulatory body, responsible for safeguarding choice, protecting and promoting the interests of patients.

Triage: this is an initial assement of a patient to determine the severity of their condition and help prioritise treatment

Venous thromboembolism (VTE): This is a disease that includes Deep Vein Thrombosis (DVT) and pulmonary embolism (PE)

Waterlow Scoring System: The Waterlow score (or Waterlow scale) gives an estimated risk for the development of a pressure sore in a given patient. The tool was developed in 1985 by clinical nurse teacher Judy Waterlow.

INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK

EXECUTIVE SUMMARY

MAIN BOARD – MAY 2016

1.0 INTRODUCTION

This report summarises the key highlights and exceptions in Trust performance up until the end of April 2016 for the financial year 2016/17. It should be noted that given the earlier timing of the May Board meeting, not all the performance information is available by the submission deadline for papers.

2.0 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 overall at Trust level for incomplete pathways as it has done each month in 2015/16. Data has not yet been validated for April 2016.

- The Trust continues to meet its targets for crude mortality as well as the summary hospital-level mortality indicator (SHMI).

- At 84.6%, the percentage of stroke patients spending time on a stroke ward has exceeded the target of 80%.

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

- The percentage of staff who have completed their mandatory training has exceeded the Trust's target each month this financial year.

3.0 AREAS OF EXCEPTION ON PERFORMANCE

- Emergency admissions continued to run at levels over the plan for the year 2015/16, ending as 7.5% over plan at the end of March, a significant increase over the 6.9% reported in February. The plan for emergency admissions has not yet been confirmed for 2016/17. The percentage of patients spending less than 4 hours in the Emergency Department was 85.4% compared to the target of 95%, this is an improvement on the 77.7% reported in March. A recovery plan is in place with Monitor support.

- The percentage of women seen by a midwife by 12 weeks has not been met in April; 87.4% compared to the standard of 90%. This is likely due to the high level of new midwives resulting in an increased amount of errors being made when recording dates.

- The number of patients waiting over six weeks for a key diagnostic test continues and is predicted to not meet target due to capacity issues in MRI and neurophysiology. Action plans have been agreed with our Clinical Divisions.

- The Cancer two week wait standard has not been met. Actions plans are in place.

- The Trust did not meet the recovery trajectory for the 62 day cancer standard in March and is not expected in the action plan to do so until September. The trajectory is under constant review due to ongoing capacity issues in Urology.

- The number of delayed discharges (24) at month end and the number of medically fit patients (57) remaining in a hospital bed continue to run at high levels and above agreed system wide standards. This inability to discharge has impacted on our performance.

- The length of stay for general and acute elective spells has not met the 5.4 day standard rising to 6.3 days.

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: **May 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 April 2016.

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

MONITOR INDICATORS AND TARGETS		Target	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	2015/16 Q1	2015/16 Q2	2015/16 Q3	2015/16 Q4	Feb	Mar	Apr	Monitor Weighting	Current Position for 4
Number of Clostridium Difficile (C-Diff) infections - post 48 hours		37/yr	9	6	8	13	8	10	10	13	6	1		1.0	1.0
Incomplete pathways - % waited under 18 weeks		92%	92.2%	92.0%	92.3%	92.1%	93.2%	92.0%	92.0%	92.1%	92.2%	92.0%		1.0	
% patients spending 4 hours or less in ED		95%	93.3%	94.3%	89.5%	82.7%	93.4%	88.7%	85.6%	78.5%	76.9%	77.7%	85.4%	1.0	1.0
Cancer	Max wait 31 days decision to treat to subsequent treatment : drugs %	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		1.0	
	Max wait 31 days decision to treat to subsequent treatment : surgery %	94%	99.0%	100%	100%	98.8%	100%	100%	99.5%	99.5%	100%	100%			
	Max wait 31 days decision to treat to subsequent treatment : Radiotherapy %	94%	100%	98.6%	99.8%	100%	100%	100%	100%	100%	100%	100%			
	Max wait 62 days from national screening programme to 1st treatment %	90%	91.4%	97.1%	92.4%	91.3%	97.3%	94.0%	95.6%	94.9%	100%	100%		1.0	1.0
	Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) %	85%	88.1%	86.1%	78.4%	77.1%	73.9%	75.6%	79.5%	76.7%	75.2%	76.7%			
	Max 2 week wait for patients urgently referred by GP %	93%	90.5%	94.1%	94.3%	88.8%	91.5%	90.3%	92.4%	88.7%	93.2%	85.2%		1.0	1.0
	Max 2 week wait for patients referred with non cancer breast symptoms %	93%	66.1%	93.6%	96.6%	94.9%	95.2%	91.8%	93.4%	95.3%	95.2%	96.6%			
	Max wait 31 days decision to treat to treatment %	96%	99.6%	99.8%	99.5%	100%	99.5%	99.7%	100%	99.8%	100%	99.3%		1.0	
			2.0	1.0	2.0	3.0	3.0	3.0	4.0	4.0					4.0

Gloucestershire Hospitals NHS
NHS Foundation Trust

PERFORMANCE MANAGEMENT FRAMEWORK

2016/17

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TRUST OVERVIEW

April 2016

ARE WE SAFE?

	Last 3 mths	Now	Next 3 mths	Management Priority	Forecast status
Infection	🔴	🟢	🟢	Minor	Stable
Mortality	🟢	🟢	🟢	Excellent	Stable
Safety	🟢	🟢	🟢	Moderate	Stable

ARE WE RESPONSIVE?

	Last 3 mths	Now	Next 3 mths	Management Priority	Forecast status
Emergency Department	🔴	🔴	🔴	Significant	At Risk
18 weeks	🟢	🟢	🟢	Minor	Stable
Cancer	🔴	🟡	🟡	Significant	At Risk

ARE WE EFFECTIVE?

	Last 3 mths	Now	Next 3 mths	Management Priority	Forecast status
Clinical Operation	🔴	🔴	🔴	Moderate	At Risk
Business Operation	🔴	🔴	🟡	Moderate	Improving

ARE WE WELL LED?

	Last 3 mths	Now	Next 3 mths	Management Priority	Forecast status
Finanical Health	🟢	🟢	🟢	On Track	Stable
Workforce Health	🟡	🟡	🟡	Moderate	At Risk

Management Priority Definition

Significant	Significant interventions are planned or in progress due to one or more factors: an externally-reported metric is off-track; multiple internal metrics are off-track; qualitative experiences are raising significant concerns
Moderate	Moderate interventions are planned or in progress due to one or more factors: an important internal metric is off-track; qualitative experiences are raising concerns; future projections are
Minor	Some interventions are planned or in progress: stretch targets are off-track; trends are adverse; qualitative experiences suggest performance may be at risk
On Track	All areas within this theme on track
Excellent	Amongst top performers nationally, with internal stretch targets consistently met

Forecast Status Definition

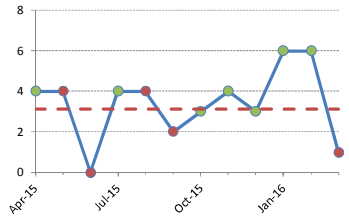
At Risk	Expected to worsen by next reporting period
Stable	Not expected to change significantly by next reporting period
Improving	Expected to improve by next reporting period

TRUST PERFORMANCE & EXCEPTIONS (as at end April 2016)

ARE WE SAFE?

MEASURE	LAST 12 MTHS	ACTUAL Q1	Q2	Q3	Q4	Feb	Mar	Apr	FORECAST May	Jun	Jul	Aug	Sep	Oct	FoT	Standard	Target Set By	How often	Data Month
INFECTION																			
Number of Clostridium Difficile (C-Diff) infections - post 48 hours		8	10	10	13	6	1		3	2	0	2	3	3		37 cases/year	NHSI	M	Mar
Number of Methicillin-Resistant Staphylococcus Aureus (MRSA) infections - post 48 hours		0	0	2	1	1	0		0	0	0	0	0	0		0	GCCG	M	Mar
MORTALITY																			
Crude Mortality rates %		1.3%	1.0%	1.2%	1.4%	1.5%	1.4%	1.3%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%		<2%	Trust	M	Apr
Summary Hospital-Level Mortality Indicator		1.1%	1.1%	1.1%	1.1%			1.1%			1.1%					≤1.1%	Trust	Q	Apr
SAFETY																			
Number of Never Events		0	1	1	0	0	0	0	0	0	0	0	0	0		0	GCCG	M	Apr
% women seen by midwife by 12 weeks		90.3%	90.0%	90.0%	89.6%	88.6%	89.9%	87.4%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%		>90%	GCCG	M	Apr
CQUINS																			
Acute Kidney Infection (AKI)		5%	19%	29%	50%	52%	52%	56%	55.0%	55.0%	55.0%	55.0%	55.0%	55.0%		>90% by Q4	National	M	Apr
Sepsis Screening 2a		69%	83%	96%	90%	91%	90%		90.0%	90.0%	90.0%	90.0%	90.0%	90.0%		>90% of eligibles	National	M	Mar
Sepsis Antibiotic Administration 2b		0%	32%	43%	90%		90%		90.0%	90.0%	90.0%	90.0%	90.0%	90.0%		>90% of eligibles	National	M	Mar
Dementia - Seek/Assess		88.7%	89.3%	89.0%	86.9%	86.8%	84.8%	86.5%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%		Q1>86%; Q2>87%; Q3>88%; Q4>90%	National	M	Apr
Dementia - Investigate		100%	100%	100%	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		Q1>86%; Q2>87%; Q3>88%; Q4>90%	National	M	Apr
Dementia - Refer		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Q1>86%; Q2>87%; Q3>88%; Q4>90%	National	M	Apr

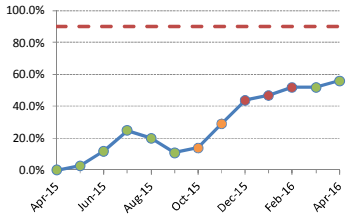
ARE WE SAFE?

MEASURE		QUARTERLY PROGRESS Q1	Q2	Q3	Q4	NOW	FOT	OWNER
Number of Clostridium Difficile cases - post 48 hours admissions Standard is ≤37 per year								Director of Nursing

Commentary on what is driving the performance & what actions are being taken

The monthly trajectory was 4 cases of post 48 hour cases and the actual number was 1 giving a 2015/16 total of 41. Six of the cases have been successfully appealed with the commissioners. If all are agreed then the actual number deemed avoidable across the year will be 35 thereby meeting target.

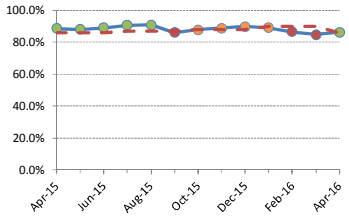
All cases have been revewed by root cause analysis to establish if cases are avoidable or unavoidable. All periods of increased incidence are investigated and ribotyped and action plans put in place. A summary of avoidable and unavoidable cases is discused monthly at the Infection Control Committee.

Acute Kidney Infection (AKI) Standard is >90% of 4 key items in discharge summaries Q4								Director of Safety

Commentary on what is driving the performance & what actions are being taken

Project required creation of a new electronic recording process associated with the electronic discharge summary. Launched on July 1st with supporting briefings and education, through testing several changes have been made through the 2nd quarter. Forecast that results would steadily improve but in Sep/Oct there was a significant and unexpected fall. Further changes the results improved level to 44% in December. Negotiations are ongoing with the CCG to mediate any loss of income.

F2 Improvement Group supported by the academy and the clincal leads continue to evaluate & modify the systems in place. Actions include Peer teaching and demonstation of the system by the F2s of the infoflex system. Redesign of the infoflex system through user evaluation. Other actions include sharing results with Divisions and directly with consulants, SAS doctors and junior doctors. General awareness raising and screensavers. Target for the 4th quarter will be very difficult to achieve.

Dementia - Seek/Assess Standard is Q1>86%; Q2>87%; Q3>88%; Q4>90%								Director of Nursing

Commentary on what is driving the performance & what actions are being taken

The target for Q4 was an average of 90%, this wasn't achived due to continued pressure on Juniors to report information on Rosterpro.

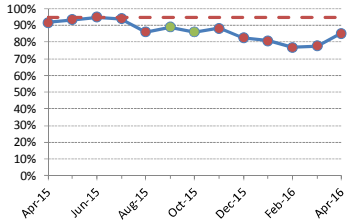
To improve the performance education activities are continuing as well as prompting of the Juniors.

TRUST PERFORMANCE & EXCEPTIONS (as at end April 2016)

ARE WE RESPONSIVE?

MEASURE	LAST 12 MTHS	ACTUAL Q1	Q2	Q3	Q4	Feb	Mar	Apr	FORECAST May	Jun	Jul	Aug	Sep	Oct	FoT	Standard	Target Set By	How often	Data Month
ED																			
% patients spending 4 hours or less in ED		93.4%	88.7%	85.6%	78.5%	76.9%	77.7%	85.4%	85.0%	85.0%	87.0%	87.0%	87.0%	90.0%		≥ 95%	NHSI	M	Apr
Number of ambulance handovers delayed over 30 minutes		192	191	213	393	105	195	165	130	100	100	100	70	70		< previous year	GCCG	M	Apr
Number of ambulance handovers delayed over 60 minutes		13	21	28	33	16	12	3	7	7	7	7	10	10		< previous year	GCCG	M	Apr
18 WEEKS																			
Incomplete pathways - % waited under 18 weeks		93.2%	92.0%	92.0%	92.1%	92.2%	92.0%		92.0%	92.0%	92.0%	92.0%	92.0%	92.0%		≥ 92%	NHSI	M	Mar
15 key Diagnostic tests : % waiting over 6 weeks at month end		4.3%	5.1%	2.1%	4.0%	2.7%	7.2%		2.2%	1.5%	1.0%	1.0%	1.0%	1.0%		<1% waiting at month end	GCCG	M	Mar
Planned/surveillance endoscopy patients - nos. waiting at month end with and without dates		400	341	142	225	184	225	308	200	200	200	250	200	200		< 1% waiting at month end	GCCG	M	Apr
CANCER																			
Max 2 week wait for patients urgently referred by GP %		91.5%	90.3%	92.4%	88.7%	93.2%	85.2%		93.0%	93.0%	93.0%	93.0%	93.0%	93.0%		≥ 93%	NHSI	M	Mar
Max 2 week wait for patients referred with non cancer breast symptoms %		95.2%	91.8%	93.4%	95.3%	95.2%	96.6%		95.0%	95.0%	92.0%	92.0%	93.0%	93.0%		≥ 93%	NHSI	M	Mar
Max wait 31 days decision to treat to treatment %		99.5%	99.7%	100%	99.8%	100.0%	99.3%		100%	100%	100%	100%	100%	100%		≥ 96%	NHSI	M	Mar
Max wait 31 days decision to treat to subsequent treatment : surgery %		100%	100%	99.5%	99.5%	100.0%	100.0%		100%	100%	100%	100%	100%	100%		≥ 94%	NHSI	M	Mar
Max wait 31 days decision to treat to subsequent treatment : drugs %		100%	100%	100%	100%	100.0%	100.0%		100%	100%	100%	100%	100%	100%		≥ 98%	NHSI	M	Mar
Max wait 31 days decision to treat to subsequent treatment : Radiotherapy %		100%	100%	100%	100%	100.0%	100.0%		100%	100%	100%	100%	100%	100%		≥ 94%	NHSI	M	Mar
Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) %		73.9%	75.6%	79.5%	76.7%	75.2%	76.7%		80.4%	82.6%	83.0%	84.0%	85.0%	85.0%		≥ 85%	NHSI	M	Mar
Max wait 62 days from national screening programme to 1st treatment %		97.3%	94.0%	95.6%	94.9%	100.0%	100.0%		92.0%	92.0%	92.0%	92.0%	92.0%	92.0%		≥ 90%	NHSI	M	Mar
Max wait 62 days from consultant upgrade to 1st treatment %		60.0%	92.9%	100%	100%	100.0%	100.0%		100%	100%	100%	100%	100%	100%		≥ 90%	NHSI	M	Mar

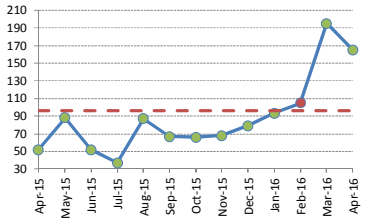
ARE WE RESPONSIVE?

MEASURE		QUARTERLY PROGRESS Q1	Q2	Q3	Q4	NOW	FOT	OWNER
% patients spending 4 hours or less in ED Standard is ≥95%		🔴	🔴	🔴	🔴	🔴	🟡	Director of Service Delivery

Commentary on what is driving the performance & what actions are being taken

Please refer to Emergency Pathway Report. Recovery plan in place.

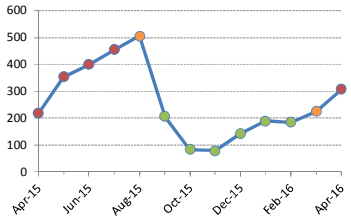
The trajectory for ED has been reviewed in conjunction with the NHSI sustainablity and transformation requirements. The trajectory for 2016/17 is: Q1 (85%); Q2 (87%), Q3 (90%) &; Q4 (90%)

Number of ambulance handovers delayed over 30 minutes Standard is < last year		🟢	🔴	🟢	🔴	🔴	🟢	Director of Service Delivery

Commentary on what is driving the performance & what actions are being taken

Please refer to Emergency Pathway Report.

Also to note, South West Ambulance Service implemented a new computer aided dispatch system in April 2016. Joint work is ongoing between the Emergency Department and SWAST.

Planned/surveillance endoscopy patients - nos. waiting at month end with and without dates Standard is < 1% waiting at month end		🔴	🔴	🔴	🔴	🔴	🟢	Director of Service Delivery

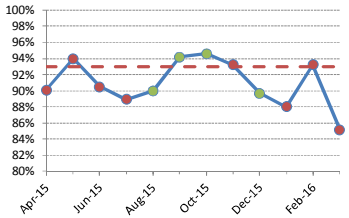
Commentary on what is driving the performance & what actions are being taken

Demand continues to increase, particularly for 2ww Endoscopy, which has impacted on capacity available.

Additional activity is being undertaken and discussions are underway with the surgeons to agree follow up protocols.

ARE WE RESPONSIVE?

MEASURE	QUARTERLY PROGRESS Q1	Q2	Q3	Q4	NOW	FOT	OWNER
Max 2 week wait for patients urgently referred by GP Standard is ≥93%	🔴	🔴	🔴	🔴	🔴	🟢	Director of Service Delivery



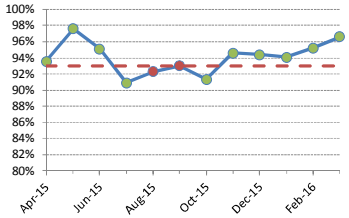
Commentary on what is driving the performance & what actions are being taken

Referrals remain high in January and are currently 13% higher than the same time last year.. Action plans are in place to recover by the end of May 2016.

Target	March 16 (current) Latest Position	Breaches	Treatments	Average treatment s / month (rolling 12 months)
93%	85.58%	294	1725	1549

Acute Leukaemia				0
Brain / CNS	100.00%	0	94	94
Breast	96.30%	10	267	249
Gynaecological	79.58%	25	122	103
Haematological*	80.00%	2	10	7
Head & Neck	85.10%	29	195	157
Lower GI	83.20%	61	324	305
Lung	95.36%	2	43	47
Skin	90.60%	29	303	276
Testicular	53.38%	7	15	15
Upper GI	89.08%	20	199	183
Urological	88.29%	89	217	187

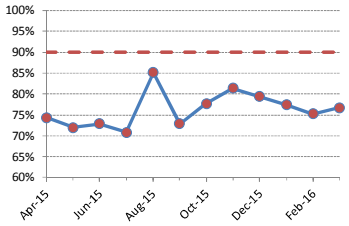
Max 2 week wait for patients referred with non cancer breast symptoms % Standard is ≥93%	🟢	🔴	🟢	🟢	🔴	🔴	Director of Service Delivery



Commentary on what is driving the performance & what actions are being taken

Referrals remain high in January and are currently 13% higher than the same time last year.. Action plans are in place to recover by the end of May 2016.

Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) Standard is ≥85%	🔴	🔴	🔴	🔴	🔴	🟡	Director of Service Delivery



Commentary on what is driving the performance & what actions are being taken

The position is in line with the Recovery Trajectory documented in the detailed cancer action plan prepared with help of Intensive Support Team. Progress to delivery of plan reviewed monthly at Cancer Services Managerment Group and the position is in line with the Recovery Trajectory formeeting standard by May 2016.

Target	March 16 (current) Latest Position	Breaches	Treatments	Average treatment s / month
85%	76.20%	33.5	140.5	147

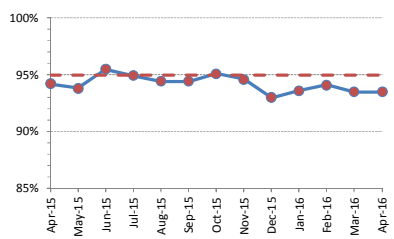
Brain / CNS		0	0	0
Breast	95.70%	1	23	28
Gynaecological	72.70%	1.5	5.5	9
Haematological*	86.70%	1	7.5	7
Head & Neck	100.00%	0	2	7
Lower GI	73.30%	4	15	17
Lung	62.50%	3	8	12
Other	100.00%	0	0.5	2
Sarcomas	50.00%	0.5	1	1
Skin	96.80%	1	32	28
Upper GI	86.20%	2	14.5	11
Urological	38.50%	19.5	31.5	28

TRUST PERFORMANCE & EXCEPTIONS (as at end April 2016)

ARE WE EFFECTIVE?

MEASURE	LAST 12 MTHS	ACTUAL Q1	Q2	Q3	Q4	Feb	Mar	Apr	FORECAST May	Jun	Jul	Aug	Sep	Oct	FoT	Standard	Target Set By	How often	Data Month
CLINICAL OPERATION																			
% stroke patients spending 90% of time on stroke ward		80.4%	78.7%	91.4%	86.0%	91.0%	84.0%	84.6%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%		> 80%	GCCG	M	Apr
% of eligible patients with VTE risk assessment		94.5%	93.7%	93.3%	93.5%	94.1%	93.5%	93.5%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%		> 95%	GCCG	M	Apr
Emergency re-admissions within 30 days - elective & emergency		6.4%	6.4%	6.1%	6.4%	6.3%	6.0%		6.4%	6.4%	6.4%	6.4%	6.4%	6.4%		Q1<6%; Q2<5.8%; Q3<5.6%; Q4<5.4%	Trust	M	YTD
Number of Breaches of Mixed sex accommodation		0	0	17	30	0	19	12	0	0	0	0	0	2		0	GCCG	M	Apr
Number of delayed discharges at month end (DTOCs)		11	13	19	16	16	10	24	12	12	12	12	12	14		<14	Trust	M	Apr
No. of medically fit patients - over/day		40	56	51	56	63	51	57	55	55	55	55	55	55		≤ 40	Trust	M	Apr
Bed days occupied by medically fit patients		1,189	1,334	1,486	1,504	1,584	1,575	1,716	1,450	1,450	1,450	1,450	1,450	1,450		None	Trust	M	Apr
Patient Discharge Summaries sent to GP within 24 hours		87.7%	89.1%	88.6%		88.1%	88.0%		88.5%	88.5%	88.5%	88.5%	88.5%	88.5%		≥85%	GCCG	M	YTD
BUSINESS OPERATION																			
Elective Patients cancelled on day of surgery for a non medical reason		1.1%	1.2%	1.3%		1.6%	1.6%									≤ 0.8%	Trust	M	Mar
Patients cancelled and not rebooked in 28 days		17	18	15	27	11	15									0%	GCCG	M	Mar
GP referrals year to date - within 2.5% of previous year		4.9%	4.4%	2.9%	3.7%	4.0%	4.3%									range +2.5% to -2.5%	Trust	M	Mar
Elective spells year to date - within 2.5% of plan		-1.3%	5.1%	5.0%	7.3%	7.4%	6.7%		1.0%	1.0%	1.0%	1.0%	1.0%	1.0%		range ≥-1% to plan	Trust	M	Mar
Emergency Spells year to date - within 2.5% of plan		2.4%	4.0%	6.9%	7.1%	6.9%	7.5%		1.0%	1.0%	1.0%	1.0%	1.0%	1.0%		range ≤2.5% over plan	Trust	M	Mar
LOS for general and acute non elective spells		5.8	5.6	5.7	6.0	6.2	5.8	6.3	5.4	5.4	5.4	5.4	5.4	5.4		Q1 /Q2 <5.4days, Q3 /Q4 <5.8days	Trust	M	Apr
LOS for general and acute elective IP spells		3.6	3.6	3.6	3.6	3.7	3.7	3.0	3.5	3.4	3.4	3.4	3.4	3.5		≤ 3.4 days	Trust	M	Apr
OP attendance & procedures year to date - within 2.5% of plan		-0.5%	0.6%	0.6%		0.3%	0.2%		0.2%	0.2%	0.2%	0.2%	0.2%	0.2%		range +2.5% to -2.5%	Trust	M	Mar
Records submitted nationally with valid GP code (%)		100%	100%	100%		100.0%			100%	100%	100%	100%	100%	100%		≥ 99%	Trust	M	Feb
Records submitted nationally with valid NHS number (%)		99.8%	99.7%	99.7%		99.0%			99.6%	99.6%	99.6%	99.6%	99.6%	99.6%		≥ 99%	Trust	M	Feb

ARE WE EFFECTIVE?

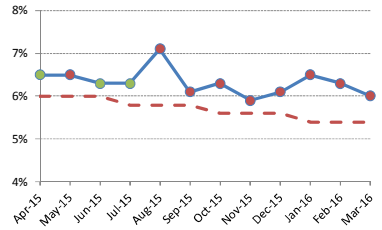
MEASURE		QUARTERLY PROGRESS Q1	Q2	Q3	Q4	NOW	FOT	OWNER
% of eligible patients with VTE risk assessment Standard is >95%								Trust Medical Director

Commentary on what is driving the performance & what actions are being taken

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

This has been through regular multidisciplinary team, doctors, nurses, pharmacists and ward clerks, improving the rate of prescription charts arriving with the patient from ED and optimising specific roles, pharmacists, ward clerk, doctors, nurses.

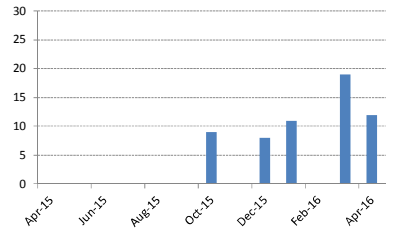
In addition the VTE committee will initiate a ward by ward review of performance and visit areas to identify improvement.

Emergency re-admissions within 30 days - elective & emergency Standard is Q1<6%; Q2<5.8%; Q3<5.6%; Q4<5.4%								Trust Medical Director

Commentary on what is driving the performance & what actions are being taken

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

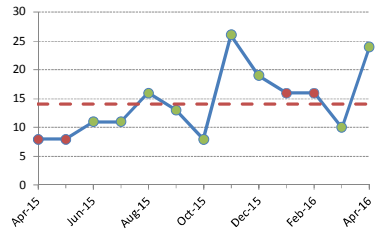
This is being scrutinised by the Emergency Care Board. Specific actions have been agreed with Divisions as part of an overall improvement plan for delivery by April 2016.

Number of breaches of mixed sex accommodation Standard is 0								Director of Nursing

Commentary on what is driving the performance & what actions are being taken

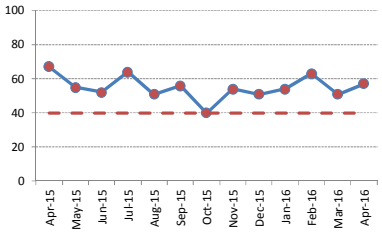
Please refer to Emergency Care Report. There were 12 breaches affecting 69 patients with all breaches occuring in the Acute care Units.

ARE WE EFFECTIVE?

MEASURE		QUARTERLY PROGRESS Q1	Q2	Q3	Q4	NOW	FOT	OWNER
Number of delayed discharges at month end (DTOCs) Standard is <14								Director of Service Delivery

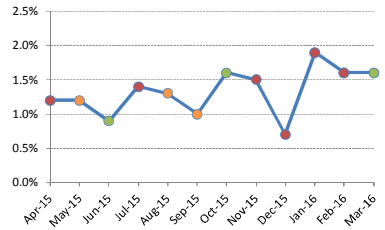
Commentary on what is driving the performance & what actions are being taken

Please refer to Emergency Care Report.

No. of medically fit patients - over/day Standard is <40								Director of Service Delivery

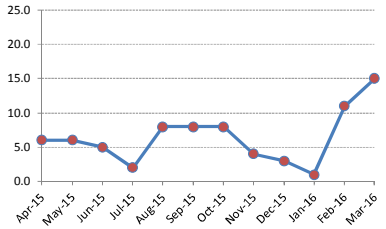
Commentary on what is driving the performance & what actions are being taken

Please refer to Emergency Care Report.

Elective Patients cancelled on day of surgery for a non medical reason Standard is <0.8%								Director of Service Delivery

Commentary on what is driving the performance & what actions are being taken

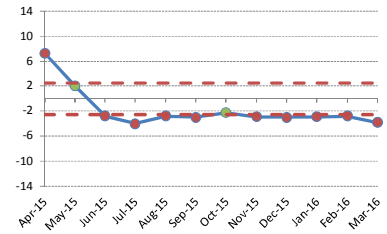
The increase in the number of medically fit patients and level of emergency admissions inpacted on this measure. The Surgical Division focus has been adjusted to reduce the number of cancellations on the day with a process established to review all elective activity daily.

Patients cancelled and not rebooked in 28 days Standard is 0%								Director of Service Delivery

Commentary on what is driving the performance & what actions are being taken

The increase in the number of medically fit patients and level of emergency admissions inpacted on our ability to rebook patients in 28 days. This is currently the focus of Surgical Division for remedy.

ARE WE EFFECTIVE?

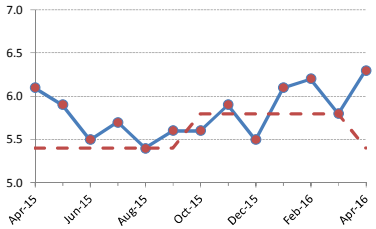
MEASURE		QUARTERLY PROGRESS Q1	Q2	Q3	Q4	NOW	FOT	OWNER
Emergency Spells year-to-date Standard is ±2.5% of plan								Director of Service Delivery

Commentary on what is driving the performance & what actions are being taken

Emergency spells have increased in the winter months. The average per day is as follows:

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
128	127	129	130	124	139	138	139	145	139	141

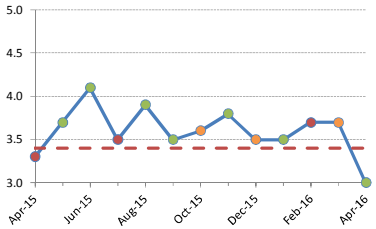
Actions are captured in the Emergency Pathway Report for delivery.

LOS for general and acute non elective spells Standard is Q1/Q2 ≤5.4days, Q3 Q4 ≤5.8days								Director of Service Delivery

Commentary on what is driving the performance & what actions are being taken

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

A specific project is in place to review patients with a length of stay over 14 days as part of the Safer workstream of the ED Improvement plan.

LOS for general and acute elective IP spells Standard is ≤3.4 days								Director of Service Delivery

Commentary on what is driving the performance & what actions are being taken

Elective length of stay has fluctuated close to the Trust's target in 2015-16. A specific project is in place to review patients with a length of stay over 14 days

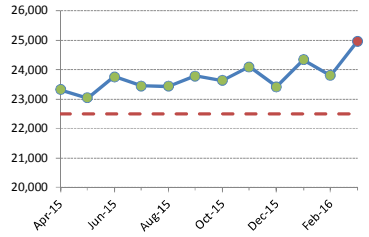
TRUST PERFORMANCE & EXCEPTIONS (as at end April 2016)

ARE WE WELL LED?

MEASURE	LAST 12 MTHS	Q1	Q2	Q3	Q4	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	FoT	Standard	Target Set By	How often	Data Month
FINANCIAL HEALTH																			
Monitor Financial Risk Rating		3	3	3	3	3	3		3	3	3	3	3	3		Level 3	NHSI	M	Mar
Achieve planned Income & Expenditure position at year end		-£1.4m	-£1.6m	-£1.6m	-£1.6m	£0.2m	-£1.6m		£18.2m	£18.2m	£18.2m	£18.2m	£18.2m	£18.2m		Achieved or better at year end	NHSI	M	YTD
Total PayBill spend £M		£23.8m	£23.8m	£23.4m	£24.3m	£23.8m	£24.9m		£25m	£25m	£25m	£25m	£25m	£25m		Target + 0.5%	Trust	M	Mar
Total worked WTE		6,576	6,628	6,623	6,670	6,657	6,677		6,687	6,687	6,687	6,687	6,687	6,688		Target + 0.5%	Trust	M	Mar
WORKFORCE HEALTH																			
Annual sickness absence rate (%)		3.8%	3.8%	3.8%	3.8%	3.5%	3.5%	3.5%	3.8%	3.8%	3.7%	3.7%	3.7%	3.7%		< 3.5	Trust	M	Apr
Turnover rate (FTE)		11.2%	11.3%	11.1%	11.7%	11.6%	11.6%	11.6%	10.5%	10.5%	10.5%	10.5%	10.5%	10.5%		7.5-9.5%	Trust	M	Apr
Staff who have annual appraisal (%)		85%	83%	83%	83%	83%	83%	84%	85%	86%	87%	87%	87%	87%		> 90%	Trust	M	Apr
Staff having well structured appraisals in last 12 months (%)		38%	38%	38%	38%	38.0%										> 31%	Trust	A	Feb
Staff who completed mandatory training (%)		92%	92%	91%	91%	91%	91%	91%	90%	90%	90%	90%	90%	90%		> 90%	Trust	M	Apr
Staff Engagement indicator *(staff survey)* (%)		3.66	3.66	3.66	3.69	3.71	3.71	3.71								> 3.8	Trust	A	Apr
Improve communication between senior managers & staff *(staff survey)* (%)		35%	35%	35%	34%	34%	34%	34%								> 38%	Trust	A	Apr

ARE WE WELL LED?

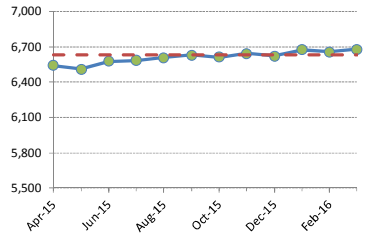
MEASURE	QUARTERLY PROGRESS Q1	Q2	Q3	Q4	NOW	FOT	OWNER
Total PayBill spend £M Standard is Target + 0.5%							Director of Service Delivery



Commentary on what is driving the performance & what actions are being taken

Overall increase of £1,151K from last month. Agency increased by £201K; Shared Services accounts for 45.6% & W&C Division for 31% of this increase. Of £957K spent on agency staff last month, 46% is for Medicine Division. Temporary spending overall was £2,482K (10.2% of the overall pay-bill. Permanent expenditure also increased by £483K. Nearly 49% was on Medical Staff & 41% was on the Registered Nursing staff bill. A meeting has taken place with senior nursing staff to plan an exit from the more expensive 'off framework' agencies by April 1st, supported by additional recruitment in HCA's.

Total worked WTE Standard is Target + 0.5%							Director of Service Delivery



Commentary on what is driving the performance & what actions are being taken

The worked FTE is lower than funded by 99 but higher than the Monitor Plan by 107 (1.6%). Contracted fte was 79.34 higher than in March 15. There are an additional 44.96 substantive Additional Clinical Staff & 20.47 Admin staff since March 15, these increases are offset by a reduction of 20.76 Estates & Ancillary & 18.92 Nursing staff. Temporary staff usage is 23.57 fte higher than in March last year. Additional operational pressures in January saw the greater use of unfunded areas. The difference between the funded posts which have increased due business cases and the Monitor plan, which is constant, needs to reconciled.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

IMPROVING THE TARGET FOR PERCENTAGE OF STROKE PATIENTS SPENDING 90% OF TIME ON A STROKE WARD

MAIN BOARD – MAY 2016

1. Introduction

The national target is that at least 80% of patients with a stroke should spend 90% of their time in hospital on a designated stroke ward.

Over 2015/16 the Trust has met and exceeded this standard on 10 out the 12 months, and the performance is reported in the monthly Integrated Performance Management Framework report to the Trust Board and the Finance and Performance Committee. The standard was also achieved in April 2016.

At the March 2016 Trust Board a question was asked about what could be done to achieve 100%. This paper responds to that question.

2. Current position

Within the Trust the intention is for every patient with a stroke or a suspected stroke to spend all of their time on a stroke ward.

At the Trust there are 3 wards at Gloucestershire Royal Hospital that are stroke wards. However any stroke patient who is not on one of these wards still is under the care of a Consultant Stroke physician.

In February 2016 there were 70 patients admitted with a stroke or suspected stroke and in March 2016 there were 73. So on average just over 2 patients a day, however range can be as high as up to 7 patients in a day.

The clinical pathway is that any patient arriving at the emergency department with a suspected stroke is transferred to a stroke ward as soon as possible and they should not go via the Acute Care Unit. There has been considerable education with the emergency departments and the site management teams to ensure that this pathway is followed.

A protected stroke bed is held every day to accommodate an emergency admission and when this has been used and there are no discharges planned then a patient is identified to step down and receive their remaining care on a general ward.

All breaches of the standard are validated on an ongoing basis by the clinical team and reviewed at the monthly stroke management meeting.

The three main reasons why patients spend less than 90% of their time on a stroke ward are:

- Lack of immediate capacity – at times there may be insufficient beds to meet the demand. In these cases priority is given to the sickest patients.

- Delays in the capacity for step down care – this could be for a nursing home or the early stroke discharge team. In these cases these are most likely the patients to be cared for on a general ward.

- Late diagnosis of a stroke – in some cases the diagnosis of a stroke is not always possible at the time of admission.

3. Recommendations

The overall aim is for every patient with a stroke or a suspected stroke to spend all of their time on a stroke ward. To achieve this aim the following would be required.

- Additional beds on the stroke wards - In 2015 additional capacity was created through ward moves. This is sufficient capacity to meet the national standard. To move beyond this standard will require investment in additional bed capacity and an acceptance that at least a lower occupancy rate would be required. Currently there is no spare capacity and no identified funds to deliver this.

- Zero delays for step down care – these patients currently are part of the medically fit list, and the Board is already aware that the medically fit list remains in excess of the agreed system wide target.

- Earlier diagnosis – for some patients this is not possible due to their clinical presentation and co-morbidities.

Author and Presenting Director: **Eric Gatling**
Director of Service Delivery
May 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REPORT OF THE FINANCE DIRECTOR

FINANCIAL PERFORMANCE FOR THE PERIOD TO 30TH APRIL 2016

1. Executive Summary

Due to the timing of the audit of the Trust Annual Accounts and annual planning and contracting processes for 2016/17 the financial performance report for Month 1 is shorter than the usual report. The position presented in this paper is a high level view of the actual position for Month 1.

The table below summarises the performance for the year to 30 April 2016 against key elements of the Trust's plan and financial duties.

	Month 1 YTD actual	Month 1 YTD plan	Variance	Full Year Plan
Delivering planned surplus	(£0.5m)	£1.0m	(£1.5m)	£5.3m

Key Issues:

- The financial position of the Trust at the end of M1 of the 2016/17 financial year is an operating deficit of £0.5m.
- This represents an adverse variance of £1.5m from the planned position of a £1.0m for Month 1, partly due to the phasing of the financial plan. If the planned surplus had been phased in equal twelfths then the variance would have been reduced from £1.5m to £1.0m
- As a result of operational pressures which have continued throughout April continued upward pressure on pay expenditure continues to be a challenge. A comparison of Month 1 to the previous financial year shows the in-month expenditure to be £1.5m higher than the 2015/16 average.
- The above includes expenditure on temporary staff of £3.1m in the month which is also £0.7m higher than the average for 2015/16. This includes expenditure on bank staff.
- The position has been impacted due to the rescheduling of elective work resulting as part of the Trust plans in advance of the industrial action by junior doctors.
- The Cirencester development is now underway and we anticipate that activity will increase as the year progresses
- The CIP target for the Trust is lower than 2015/16, but remains a challenge. This will be managed with strong governance and focus to ensure delivery

2. Financial Position to 30th April 2016

The position at the end of Month 1 of the 2016/17 financial year is an operating deficit of £0.5m, which represents an adverse variance of £1.5m against plan. The actual position is summarised in the table below.

	YTD Actual £000's
SLA & Commissioning Income	36,815
PP, Overseas and RTA Income	544
Operating Income	5,077
Total Income	**42,435**
Pay	27,384
Non-Pay	13,767
Total Expenditure	**41,152**
EBITDA	**1,284**
EBITDA %age	**3.0%**
Depreciation	882
Public Dividend Capital Payable	621
Interest Receivable	-3
Interest Payable	321
Funds Available for Investment	**(538)**

A comparison of the overall expenditure run-rate in Month 1 to the average for 2015/16 shows a total increase of £1.8m (+4.6%).

Agency staffing expenditure continues to be a significant pressure on the overall pay expenditure position. 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 risk needs to be robustly managed over the course of the 2016/17 financial year whilst remaining mindful of our priority to provide safe services.

3. Income

The total Trust income for M1 is £42.4m, of which £36.8m is from commissioning contracts.

The majority of contractual income for 2016/17 has now been agreed and associated contracts signed. The table below shows the current contract values for 2016/17 by main Commissioner.

The plan for 2016/17 is, in the main, a PbR contact. If activity continues to increase, as was the case last financial year, this will be reflected in additional income. We are still awaiting the HRG level detail of the contracts from major commissioners and will further update the Board at Month 2.

CCG / Area Team Name	16/17 Contract Value £'000
NHS Gloucestershire CCG	305,000
NHSE Specialised Commissioning	78,867
NHS South Worcestershire CCG	10,436
NHS Herefordshire CCG	4,305
Bath, Gloucestershire, Swindon and Wiltshire Area Team	4,315
Bath, Gloucestershire, Swindon and Wiltshire Area Team Dental	6,244
Other Commissioner	19,938
Trust Total	**429,106**

It is noted that a lower than expected volume of activity at Cirencester Hospital was delivered in Month 1. It is anticipated that this will pick up as the year continues and support additional income.

4. Expenditure

Breakdown of plans by division are being updated in accordance with contractual agreements now in place with Commissioners. This is to ensure that income and expenditure plans correlate with the activity and associated operational targets stipulated in contracts. This also includes the CIP requirements for each division.

A review of the divisional expenditure for Month 1 shows that the total expenditure run-rate is £1.7m higher than the monthly average for 2015/16 and breaks down as shown below.

	2015/16 Monthly Average £'000	2016/17 Month 1 £'000	Run-Rate Movement £'000
PAY			
Corporate Services	1,591	1,540	51
Estates and Facilities Division (EFD)	1,166	1,166	(0)
Diagnostics & Specialist	4,915	5,135	(220)
Medicine	5,848	6,445	(597)
Surgery	6,999	7,359	(360)
Women and Children	2,695	2,936	(240)
Total Pay	**23,214**	**24,581**	**(1,366)**
NON-PAY			
Corporate Services	2,313	2,590	(277)
Estates and Facilities Division (EFD)	1,571	1,699	(128)
Diagnostics & Specialist	3,268	3,670	(402)
Medicine	3,069	3,019	51
Surgery	2,952	2,475	477
Women and Children	337	345	(8)
Total Non Pay	**13,510**	**13,798**	**(288)**
Total Divisional Expenditure	**36,725**	**38,379**	**(1,654)**

The table below shows a sub set of the pay expenditure above and shows the temporary staffing expenditure by staff group and expenditure type. Comparison of trends to previous year shows April expenditure at £0.7m higher than the 2015/16 average. This is most pronounced for agency nursing, where the Month 1 expenditure is more than double the average for 2015/16.

Temporary Staffing Expenditure – Analysis by Staff Group	**Expenditure 2015/16 Average £000's**	**Expenditure Month 1 £000's**	**Fav/(Adv) Movement £000's**
Medical Agency & Locum	787	631	156
Nursing Agency	598	1,294	(696)
Nursing Bank	552	722	(170)
Other Clinical staff	107	172	(64)
Non Clinical staff	372	307	65
Total	**2,416**	**3,125**	**(710)**

The Board are closely scrutinising expenditure on agency staffing and the Executive Team have agreed actions to further control this spend.

Revised arrangements are being implemented in relation to those services provided by the Trust by Gloucestershire Care Services. This is to ensure that increased value for money is delivered within these contracts for the 2016/17 financial year.

5. Savings Plans

The CIP target for the Trust is £18.2m for 2016/17, which is £5.8m lower than the target for 2015/16. The target equates to 4.8% of expenditure. The split of this target by division is shown in the table below:

CIP PROGRAMME SUMMARY 2016/17	
Divisions	**2016/17 In Year Targets £'000**
Surgery	5,124
Medicine	4,474
W&C	1,514
D&S	4,406
EFD	1,616
Corporate	1,045
Total (£'000)	**18,179**

The £18.2m target for the 2016/17 financial year has a robust programme of schemes already identified to support delivery. These plans are currently being progressed by the Executive Team, Chiefs of Service and with the support of the Interim CIP Director.

6. Statement of Financial Position 2015/16

Cash Balances

The Trust cash balance at the end of April 2016 stands at £6.9m. The position is shown in the table below.

Trust Cashflow Statement Apr-15	April £'000
Opening Bank Balance	4,223
Receipts	
Main CCG SLAs	33,267
All other NHS Organisations	7,192
Other Receipts	1,850
Total Receipts	42,309
Payments	
Payroll	(24,502)
Creditor(including capital)payments	(15,101)
Other Payments	0
Total Payments	(39,603)
Closing Bank Balance	6,929

Revised contractual measures have been put in place as part of the 2016/17 contracting round to help improve the cash position moving forward this financial year.

7. Recommendation

The Board are asked to note:

- The financial position of the Trust at the end of Month 1 of the 2016/17 financial year is an operational deficit of £0.5m. This is an adverse variance to plan of £1.5m.
- The Trust needs to improve its controls on the use of agency staff as this has already impacted the first month of 2016/17.
- The position has been impacted due to the rescheduling of elective work resulting as part of the Trust plans in advance of the industrial action by junior doctors.
- 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: **Sarah Stansfield, Director of Operational Finance**

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

Date: **May 2016**

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

1. Executive Summary

Key Messages

- The 95% 4 hour target for Emergency Department performance was not successfully met in April 2016, with Trustwide performance reported as 85.38%. Neither site achieved the 95% standard in April. However, there has been an upward trend of improvement compared to the previous four months and particularly compared to March 2016 when the performance was 77.7%.

- The daily average number of Emergency Department attendances in April 2016 was 359 patients (10,777 for the month), compared to April 2015 (334 per day) and March 2016 (371 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 2016/17 attendances.

- The daily average number of admissions from the Emergency Department in April 2016 was 124 patients (3,728 for the month), which is an increase compared to April 2015 (110 per day), but in line with March 2016 (123 per day).

- General and Acute average length of stay for non-elective admissions has increased from 5.82 days in March 2016 to 6.31 days in April 2016. The internal target for Q1 is 5.4 days.

- The number of patients on the medically fit list for one day and over has been at an average of 57 throughout April 2016. This remains above the system-wide plan of no more than 40 patients.

- During April 2016 there were three days of industrial action by Junior Doctors.

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 30th April 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

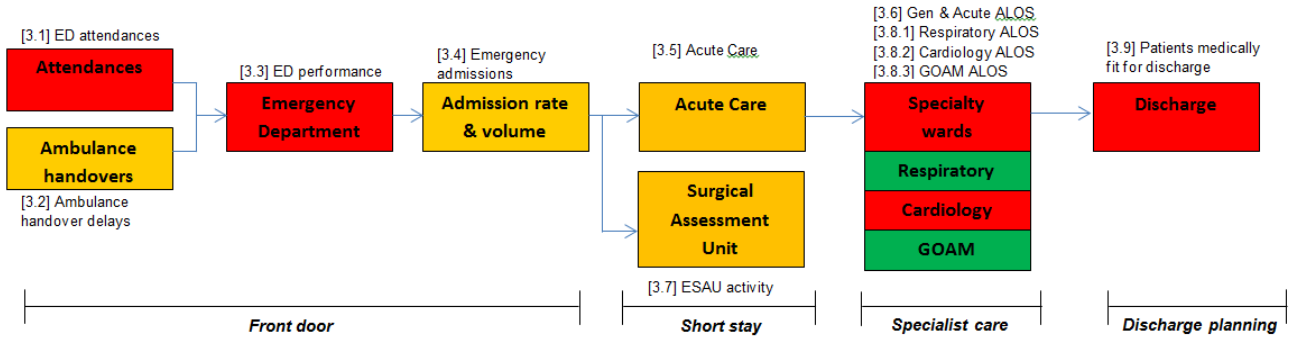
The diagram below shows the key processes within the emergency pathway.

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.

2.1 Safety & Quality

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. The first draft of the Safety & Quality report is included below, for consideration by the Board:

Measure	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	Comments/themes and actions
SAFETY METRICS								
Number of Never Events	0	0	0	0	0	0	0	
Number of confirmed serious incidents	0	0	1	0	1	1	0	• **December** - Delay to act of confirmed severe sepsis – actions informs Sepsis /FAB60 project • **February** - Transfusion of blood intended for another patient – Reorganisation of blood fridge so emergency O neg blood separate from patient specific blood. Staff involved received further training • **March –** assessment and management of ventilated patient - actions include reinforcing pathways for patients with existing invasive ventilation requirements

Top ten categories for incident reporting by staff in Emergency Department

Admission transfer – the increase in Jan – Feb 2016 relates to a staff member entering all occasions where there were capacity issues e.g. corridor patients on the reporting system. Alternative methods for monitoring of this have ow been identified

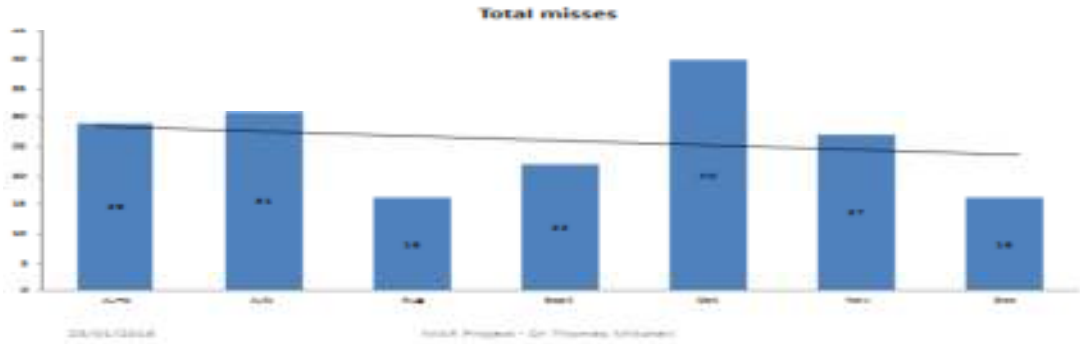
Abuse and violence – most incidents relate to disruptive patients/ members of public. 12% involve physical violence to staff members, but ED staff have received safe holding training and have access to the 2222 escalation security process

Care monitoring and review – monitoring of patients NEWS score supporting earlier intervention and informing the SAFER proforma project below

Diagnosis and assessment – includes occasions for missed fractures and other diagnoses helping to inform the missed abnormal radiology project see below

Communication – issues identified during handovers between staff in the department and with other specialties are being addressed through the projects listed below

	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Total
Admission/ transfer	8	15	8	6	25	9	45	22	36	98	88	36	9	0	**405**
Abuse and Violence	20	11	21	15	18	9	19	12	17	7	6	20	3	6	**178**
Care, Monitoring, Review	8	3	4	6	5	6	11	28	4	1	6	8	3	1	**93**
Diagnosis & Assessment	5	6	5	3	3	4	3	7	7	3	6	8	6	1	**66**
Communication	4	4	5	4	7	2	4	5	6	3	5	6	5	2	**60**
Medication Incident	7	7	5	8	4	3	5	4	3	1	2	3	2	1	**54**
Staffing / Beds / Systems (no individual patient involvement)	9	1	0	0	3	5	4	8	4	2	4	4	6	1	**50**
Treatment/ Procedure	5	3	4	2	2	1	2	3	1	2	2	4	5	1	**36**
Falls	2	2	2	2	2	4	2	3	1	3	0	3	0	0	**26**
Discharge & Transfer	1	0	1	3	0	2	2	2	4	1	2	5	1	0	**24**
Total	**69**	**52**	**55**	**49**	**69**	**45**	**97**	**94**	**83**	**121**	**121**	**97**	**40**	**13**	**992**

Current Improvement and Audit projects	
Patient Safety Checklist – part of the WEAHSN (Academy supported)	This has been piloted in CGH since March 2016, early review of completion has led to refinements to the proforma with the aim to implement in GRH in June.
• **Missed Abnormal Radiology (NHSLA funded)** **Actions have included** – Teaching and education sessions contributing to a decrease in missed fractures – Identification of new pathways involving T&O and radiology – Production of newsletter raising awareness of project and actions	
• **Improve Pain Management (CQC recommendation) (Academy supported)** **Actions planned include** – Increased staff training, – Increased usage of Patient Group Directives initiative for nursing staff to prescribe and administer a dose of analgesic prior to medical review – 'Safer' checklist' introduced to improve monitoring of pain management	Data to follow
• **Removal of foreign body from eyes (Academy supported)** Actions include Development of evidence based proforma for ED and Ophthalmology staff for patients presenting with foreign bodies in eyes to include removal and assessment of damage PDSA methodology	Data to follow
Hourly board rounds in Emergency Departments in both hospitals Actions include - Consultants are completing hourly rounds in both departments to ensure awareness of senior clinicians of the sickest patients supporting escalation and prompt treatment / transfer	Data to follow

Morbidity and Mortality considerations	• **OOH referral to ED of a young patient who collapsed on premises. Diagnosed as a stroke** Learning: good observations and history taking established a list of problems to investigate further. Overnight CT - difficulties organising out of hours CT angio. Raising awareness that younger persons do have strokes • **Elderly patient admitted post fall. CT head and CXR performed. Admitted overnight and discharged the next day. Returned to ED next day. Lt sided effusion seen on Xray. Chest drain inserted.** Learning: Thorough exam showed chest injury, chest drain inserted. Age not seen as a barrier to care. All patients presenting with injury should be seen by ED team and images reviewed before handing care to a specialty team. Always use chest drain check list when inserting chest drains

Trust Risk Register

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

M1a - The clinical risk of delay in treating patients arriving at Accident and Emergency during periods of high demand or staff shortage

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.

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

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

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

PATIENT EXPERIENCE

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	
Family and Friends response rate	2	2.4	1.9	0.7	2.5	4.5	2.3	2 Health care assistants are championing F&FT. receptionist in Majors handing out cards on late shift. Raising the profile
Rate of Complaints	13	10	9	10	12	12	11	Care/treatment
Number of Concerns	10	3	1	6	8	2	1	Admissions
Number of compliments	5	4	23	11	8	6	0	
"You said we did" lessons learnt	Patients have requested drinking water and a television., Both of these requests are being actioned							

National Quality Indicators

Aim: To consistently deliver national Emergency Department quality standards.

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

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

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	Apr-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%	1.30%
Total time in department	95th % < 4hrs	06:26	07:25	05:49	05:03	04:36	04:00	04:26	06:01	05:35	06:05	05:38	06:25	06:53	07:37	07:37	07:25
Patients left without being seen	<5%	1.20%	2.00%	1.90%	1.20%	1.50%	1.60%	1.50%	2.40%	2.00%	2.20%	1.20%	1.70%	1.40%	1.80%	1.90%	1.70%
Time to Treatment	Median = 60 mins	00:48	01:05	01:01	00:55	00:50	00:59	00:57	01:13	01:08	01:14	00:57	01:10	01:02	01:13	01:12	01:02

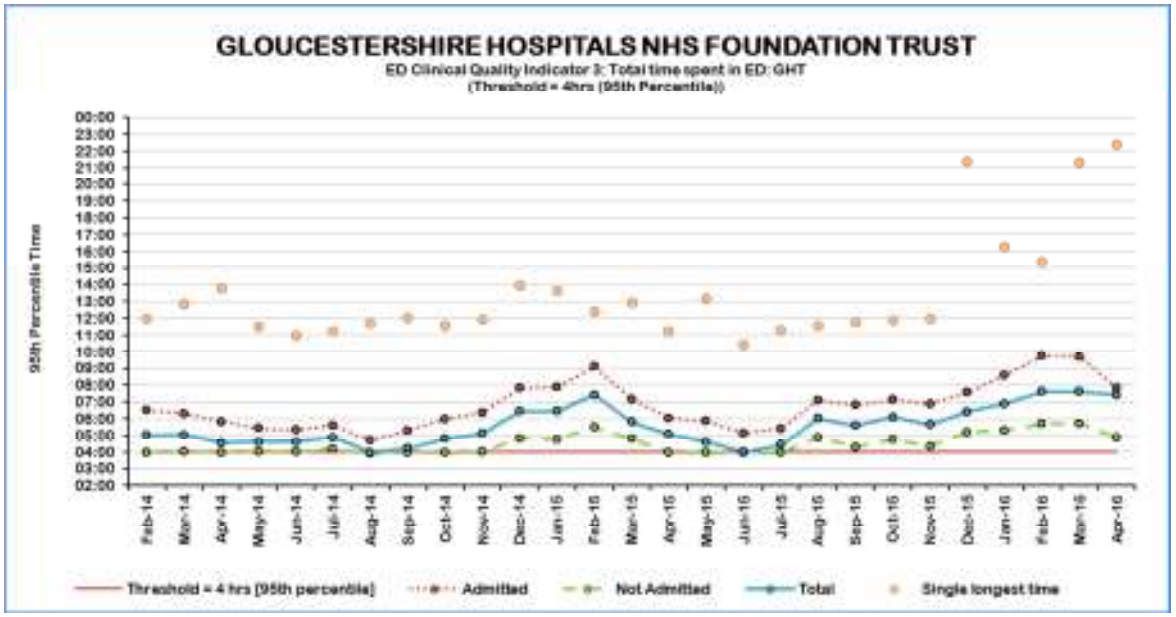
Time to Initial Assessment Compliance *(Standard: within 15 minutes of arrival)*:

	Number of….	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Trust Total	Total Patients	10007	10632	10895	10982	10600	10747	11079	10532	10844	10734	10603	11510	10777
	Patients seen within 15 minutes	6572	7043	6912	6864	6646	6350	6406	6328	6072	6076	5441	6127	7381
	Patients not seen within 15 minutes	3435	3589	3983	4118	3954	4397	4673	4204	4772	4658	5162	5383	3396
	% Compliant	**65.7%**	**66.2%**	**63.4%**	**62.5%**	**62.7%**	**59.1%**	**57.8%**	**60.1%**	**56.0%**	**56.6%**	**51.3%**	**53.2%**	**68.5%**

Source: Insight – Immediate Priority Dashboard (Monthly – 15 Minute Assessment)

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 April was 7 hours 25 minutes, compared to 5 hours 3 minutes the previous year. The single longest wait was identified as circa 22 hours however, this has been validated by the service and confirmed as a data quality error. The long-wait in March was an out-of-county Mental Health patient requiring review by the Crisis team.



2.2 Immediate Priority Workstreams

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.

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.

Measures:

For all Patients	**CGH**			**GRH**			**TRUST**		
	Feb	**Mar**	**Apr**	**Feb**	**Mar**	**Apr**	**Feb**	**Mar**	**Apr**
Avg. Time to Initial Assessment (mins)	17	16	13	26	21	16	22	19	15
% Assessed within 15 mins	57.7%	61.7%	74.7%	47.6%	48.4%	65.0%	51.3%	53.2%	68.5%
Avg. Time to Treatment (mins)	66	65	61	106	103	89	91	89	79
% Treated within 60 mins	53.9%	55.8%	59.8%	33.3%	32.8%	41.6%	40.9%	41.1%	48.1%
Number >6hrs (avg. per day)	4	7	7	34	34	15	38	41	22
% waiting >6hrs	3%	5.2%	5.8%	14.6%	14.3%	6.4%	10.3%	11.0%	6.2%
Patients in Corridor (avg. per day)	0*	0*	0*	77	80	63	77	80	63

Note: Data for patients waiting in the corridor not currently captured. Request for the Clinical System to be changed to accommodate this measure has been made.

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.

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.

Measures:

For all Patients	CGH			GRH			TRUST		
	Feb	Mar	Apr	Feb	Mar	Apr	Feb	Mar	Apr
Number of Surgical Outliers	526	317	226	122	71	31	648	388	257
Number of Medical Outliers	514	921	565	1476	1685	1170	1990	2606	1735
Number of Medical Outliers (avg. per day)	18	30	19	51	54	39	69	84	58
Number of days in Black Escalation	0	0	2	15	12	5	15	12	7
Number of days in Red Escalation	7	8	8	5	16	13	12	16	12

Note: The data relating to Outliers is currently under validation.

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.

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.

Measures:

For all Patients	CGH			GRH			TRUST		
	Feb	Mar	Apr	Feb	Mar	Apr	Feb	Mar	Apr
Number of >=14 days on list	69	64	65	153	147	132	222	211	197
Number of Bed Days Occupied by >=14 day patients (Average)	1821	1560	1596	3949	4584	4148	5770	6144	5744
Total Bed Days Occupied (Average)	3089	2860	2884	5867	6466	5949	8956	9326	8833
% of Bed Days Occupied by >=14 Los Patients	59.0%	54.5%	55.3%	67.3%	70.9%	69.7%	64.4%	65.9%	65%
EDD Accuracy	29.9%	27.8%	28.9%	19.4%	20.8%	25.5%	23.5%	23.6%	26.8%
Bed Allocation (from ACU to ward) within 30 minutes	30.4%	27.0%	28.9%	57.2%	55.9%	58.0%	46.7%	45.3%	47.1%
Number of Discharges before 12pm (avg. per day)	30	29	31	44	41	47	74	70	78
% of Discharges before 12pm	18.1%	18.2%	19.3%	21.6%	20.8%	23.3%	20.1%	19.6%	21.5%
Number of Weekend Discharges	355	420	440	884	844	1015	1239	1264	1455
Number of Inpatients on DSU overnight	115	125	207	503	514	425	618	639	632
Number of Inpatients on DSU overnight (avg. per day)	4	4	7	17	17	14	21	21	21

Note: The data relating to Bed Allocation (ACU to ward) is currently under validation.

3.1 Emergency Department Attendances

Aim: To ensure Emergency Department attendances remain in line with 2016/17 plan.

How: Work with:-

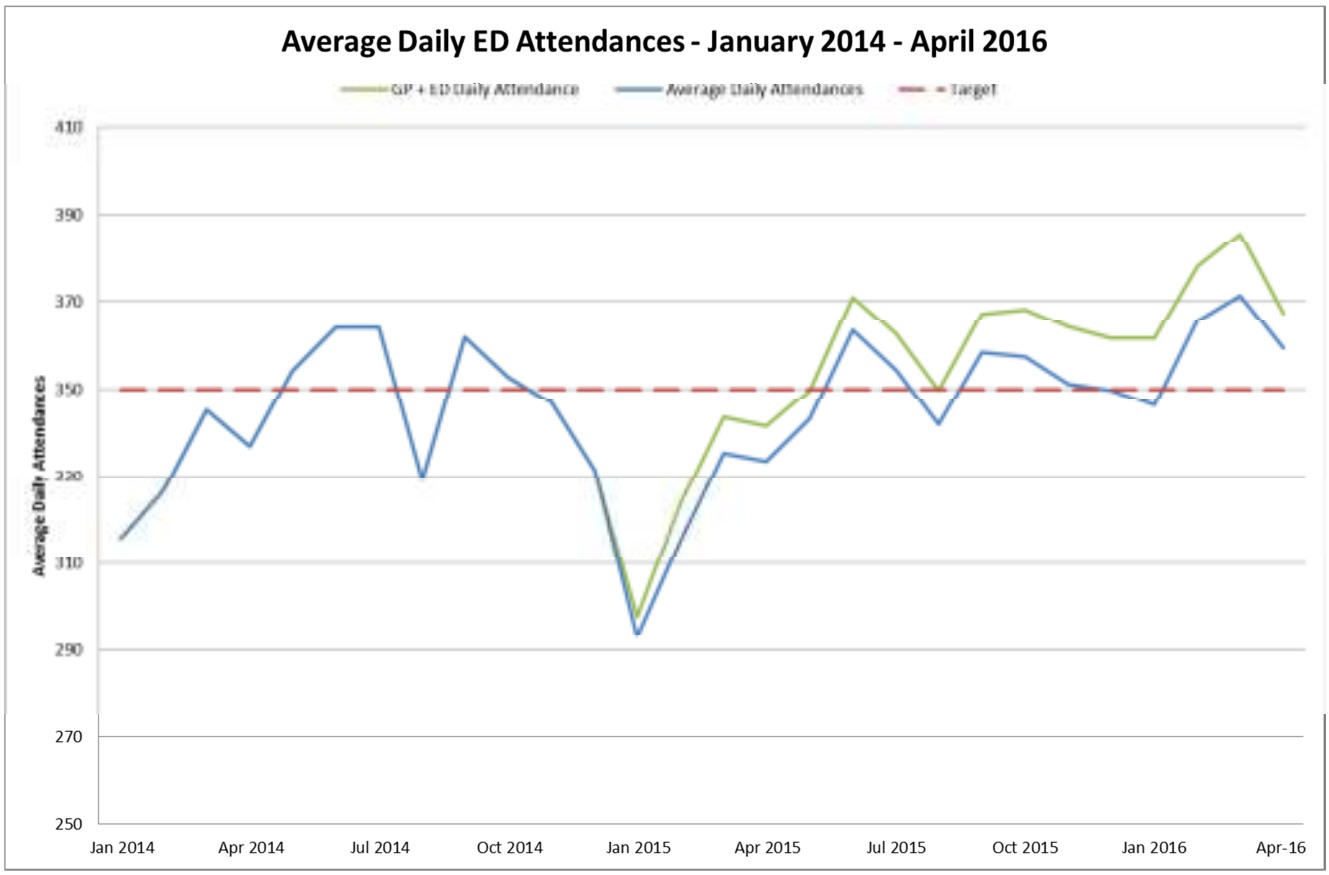
- South Western Ambulance Service NHS Foundation Trust (SWAST) to 'Smooth' emergency demand in the system;
- Integrated Discharge Team (IDT) within Emergency Department to increase direct admissions to community hospitals from Emergency Department;
- Develop the Older Person's Assessment and Liaison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

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

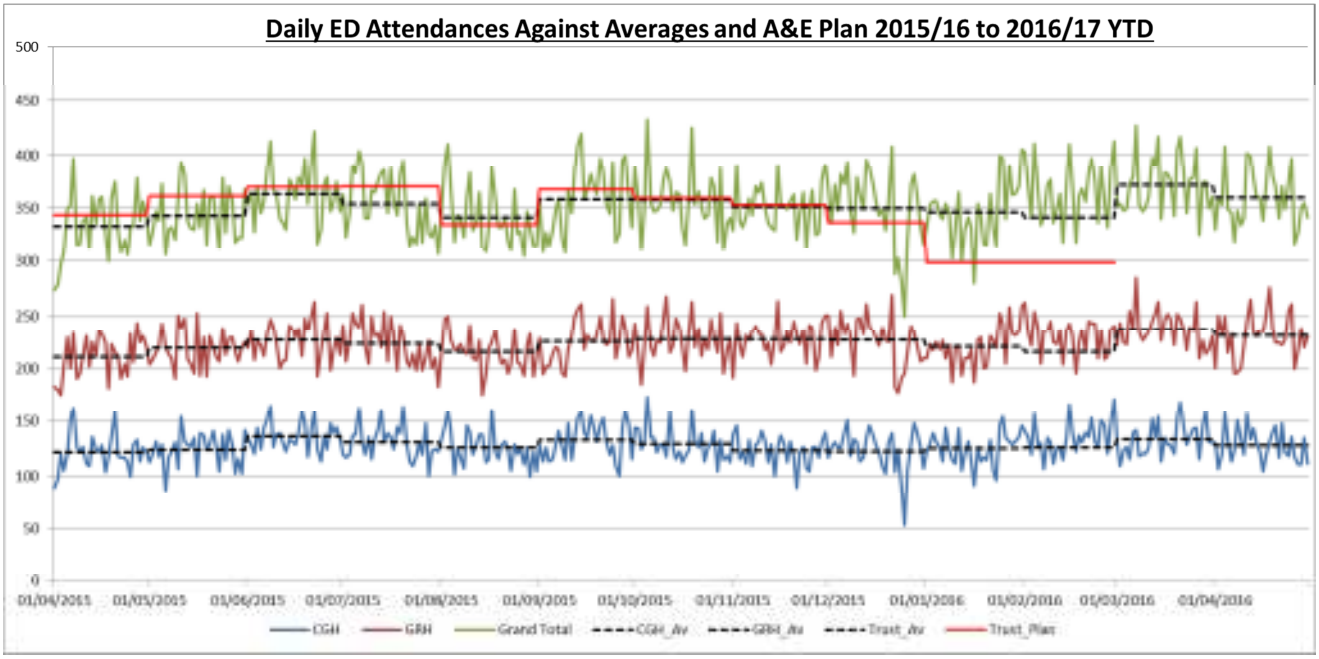
Narrative: There were 10,777 attendances in April 2016 (average of 359 per day) which is 12 lower than March 2016 and in line with 2016/17 plan of 358 per day pre-QIPP. Taking into account the level of planned attendances for 2016/17 this should be 330 a day.

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
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%
April 2016	10777	1576	85.38%	244	85.70%

Actions to be taken

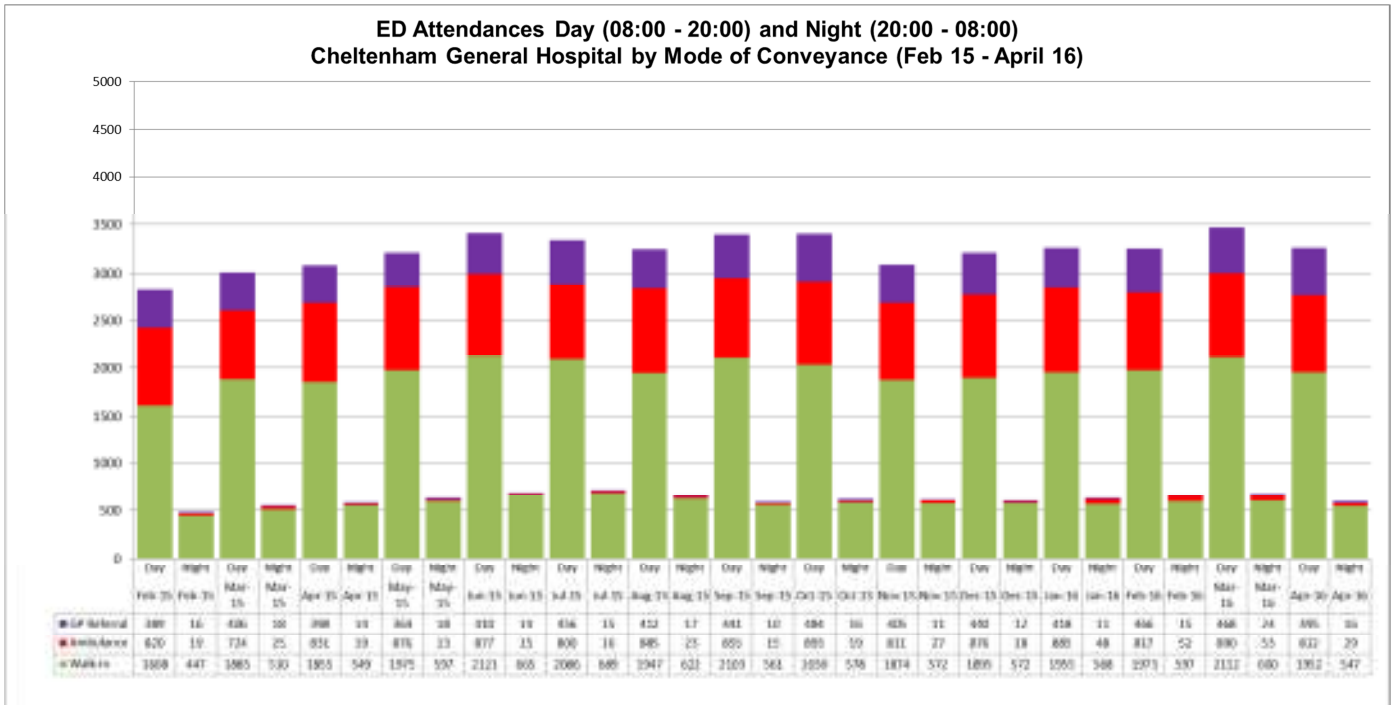
- Continue with Primary Care in Emergency Department pilot (now extended to July 2016) and managed by South West Ambulance Trust. The service is provided from a dedicated room near to Gloucestershire Royal Emergency Department reception.

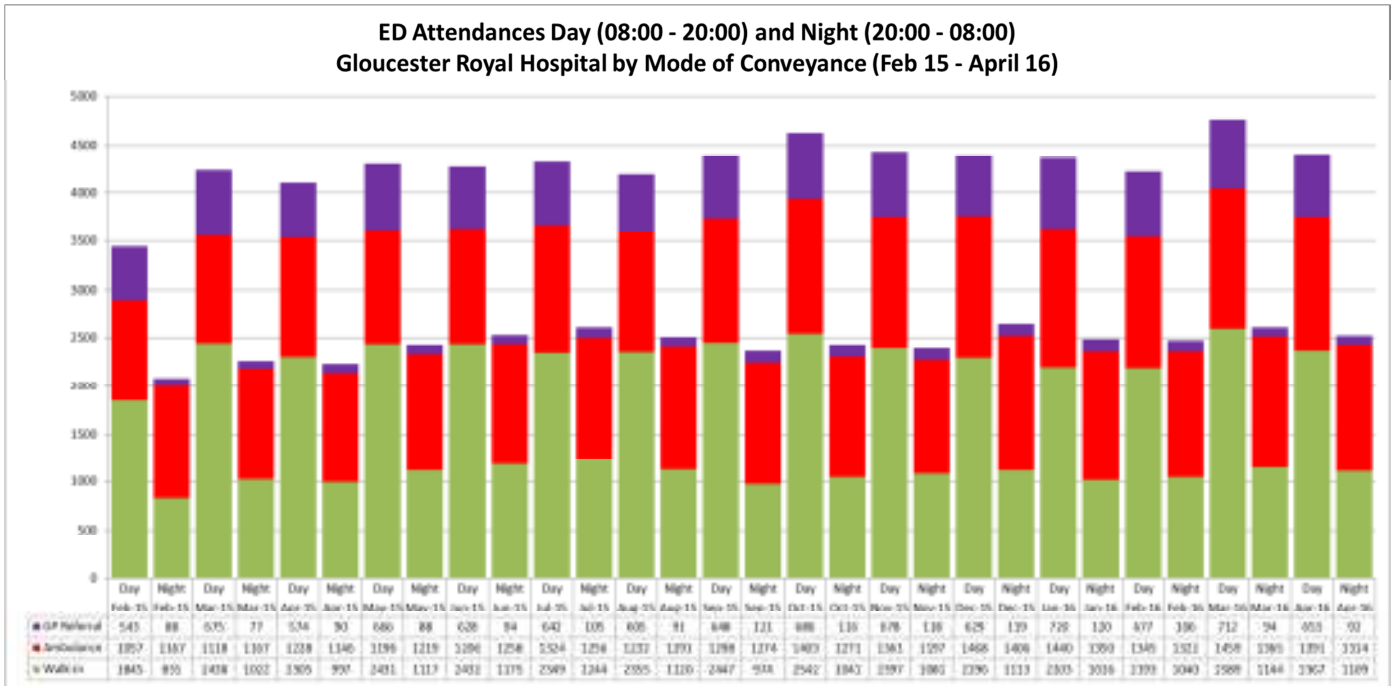
- Streamlining Urgent Care Programme: the 'Streaming' function and pathways have been revised, and a pilot that tested the role of a Clinical Navigator took place over two days w/c 12th October. This proved successful and Gloucestershire Clinical Commissioning Group has agreed to fund the post until 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 April 2016 there were 3,546 ambulance arrivals across both sites (average 118 per day). This is an increase of 10% on the same period last year, when there were 3,224 ambulance arrivals (average 107 per day).

Diverts Between Gloucestershire Royal Hospital & Cheltenham General Hospital

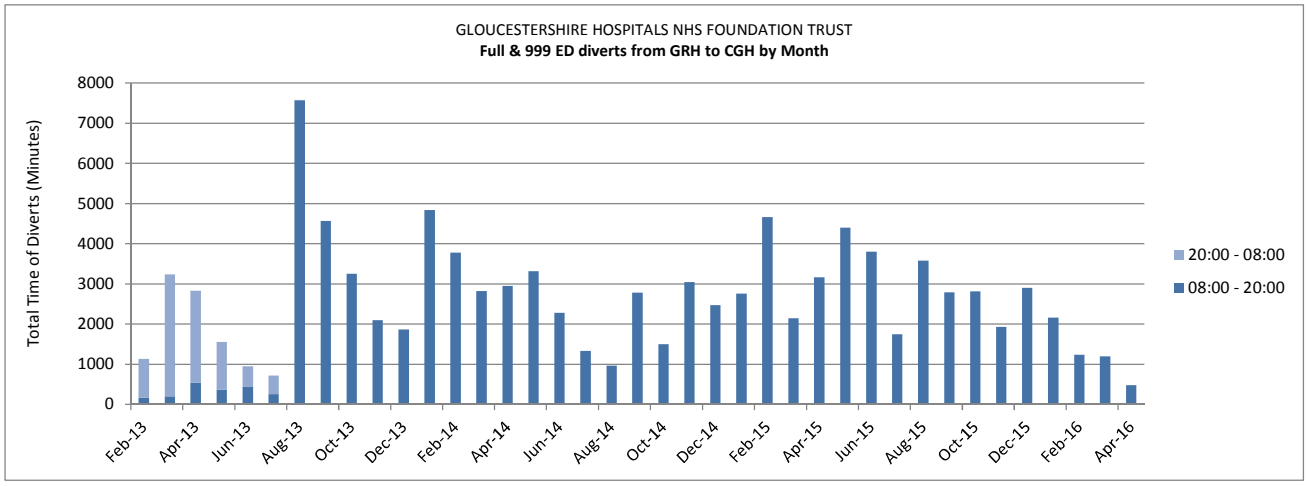
Aim: To reduce the number of across site diverts.

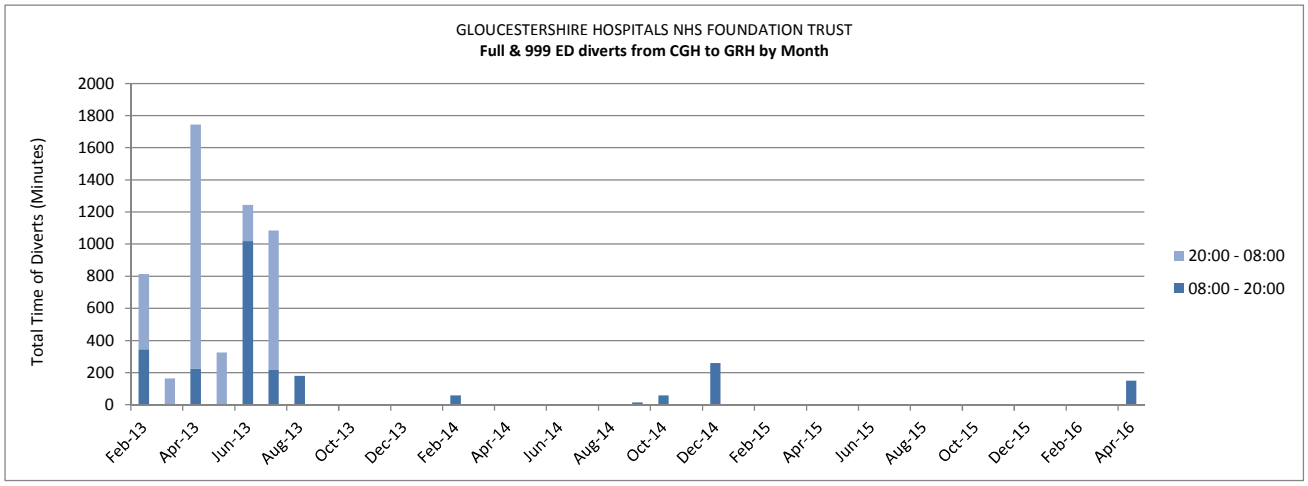
How: Enable flow within each site to ensure consistently available bed space for patients requiring admission.

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 six occasions when a Full/999 divert took place in April 2016 compared to five last month; three of which were from Cheltenham General to Gloucestershire Royal.

The total duration of diverts reduced significantly from 20 hours in March to 10 ½ hours in April. The average number of hours per divert in April was 2.7 from Gloucester to Cheltenham (compared to 4 hours last month) and 50 minutes from Cheltenham to Gloucester.





3.2 Ambulance Handover Delays

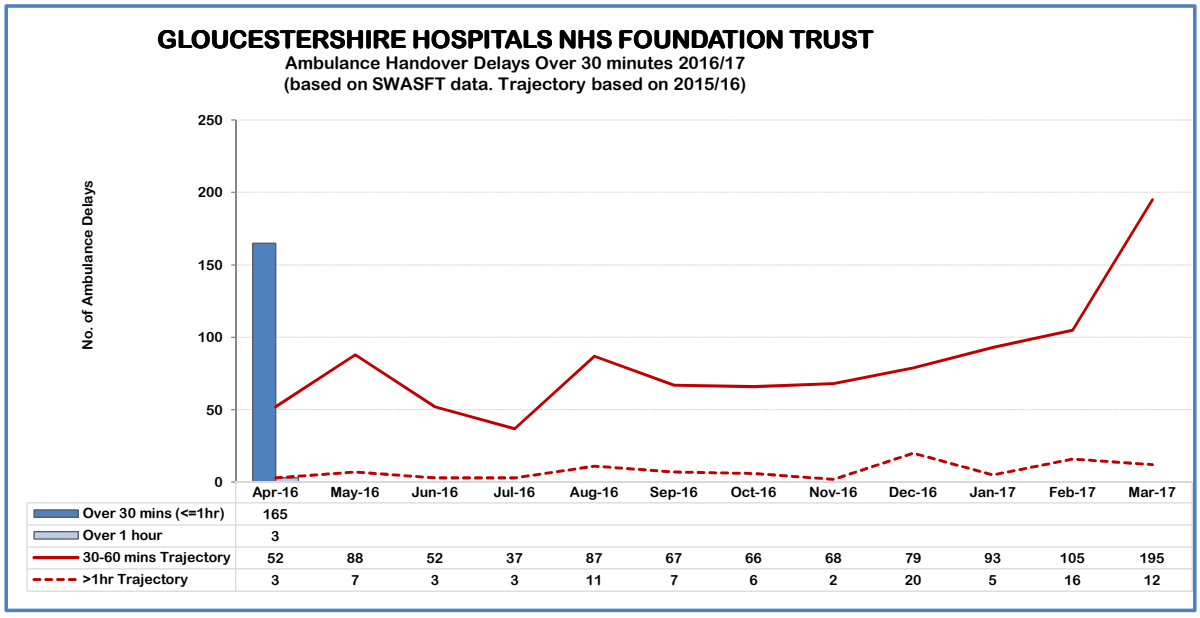
Aim: To reduce the number and time associated with ambulance handover delays.

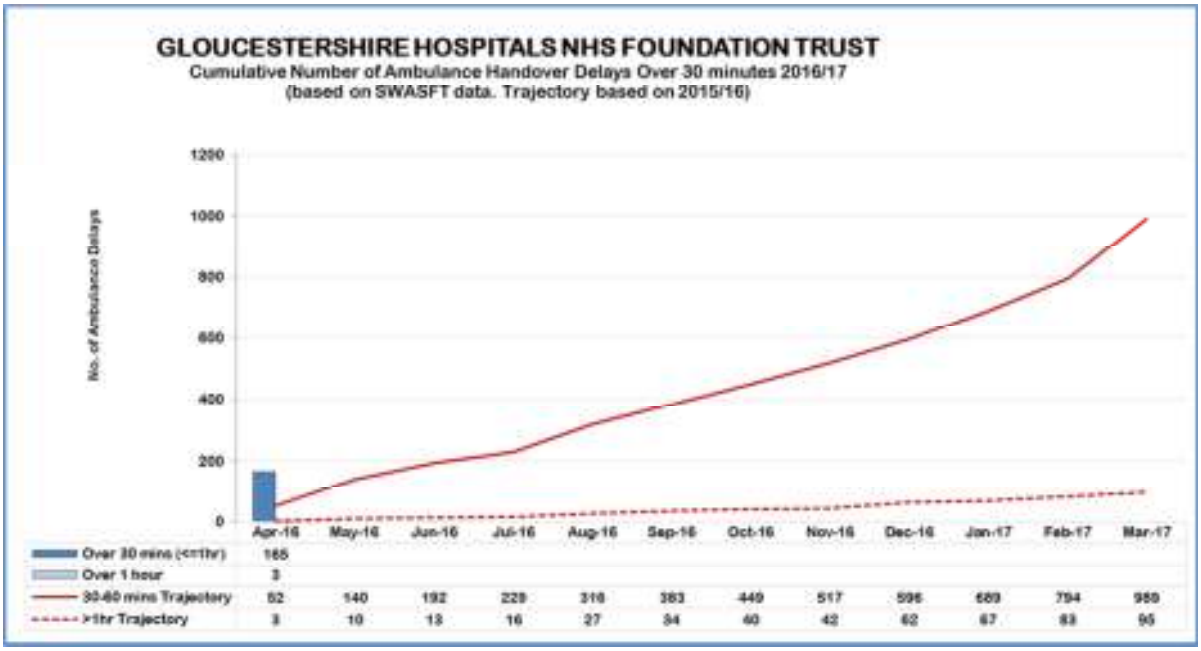
How: Doctor and nurse rotas better aligned to demand, revised handover process, improved reporting, trialling new 'flow coordinator' post, implementing capacity and escalation action cards and use of Rapid Assessment and Treatment (RAT) model.

Narrative: There were 168 ambulance handover delays in April 2016; of which three were over one hour. This is an improvement from last month when there were 207 delays (of which 12 were over one hour), but almost triple the number recorded in April 2015.

There was an overall improvement in 2015/16 compared to 2014/15. However, in April 2016 the number of delays over 30 and 60 minutes was above the trajectory (which is based on 2015/16 levels).

Note – The South West Ambulance Trust have recently introduced changes to their Computer Aided Dispatch (CAD) system that has resulted in a number of data validation issues in March. These are currently being worked through and will be resolved for future reports.





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. April 2016 data shows that neither site successfully met the 95% standard. The overall Trust performance in April was 85.38%.

3.3.1 Four Hour Standard

	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%

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
CGH actual	87.98%											
GRH actual	83.93%											
National std	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Trust actual	85.38%											

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 as a whole.

Factors affecting performance included:

- 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 April 2016 is outlined in the following table:

April 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	463	43	276	31	46	67
GRH	1113	336	311	120	159	187
Total	1576	379	587	151	205	254
%		24.05%	37.25%	9.58%	13.01%	16.12%

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

3.4 Emergency Admissions

3.4.1 Emergency Admission Rate

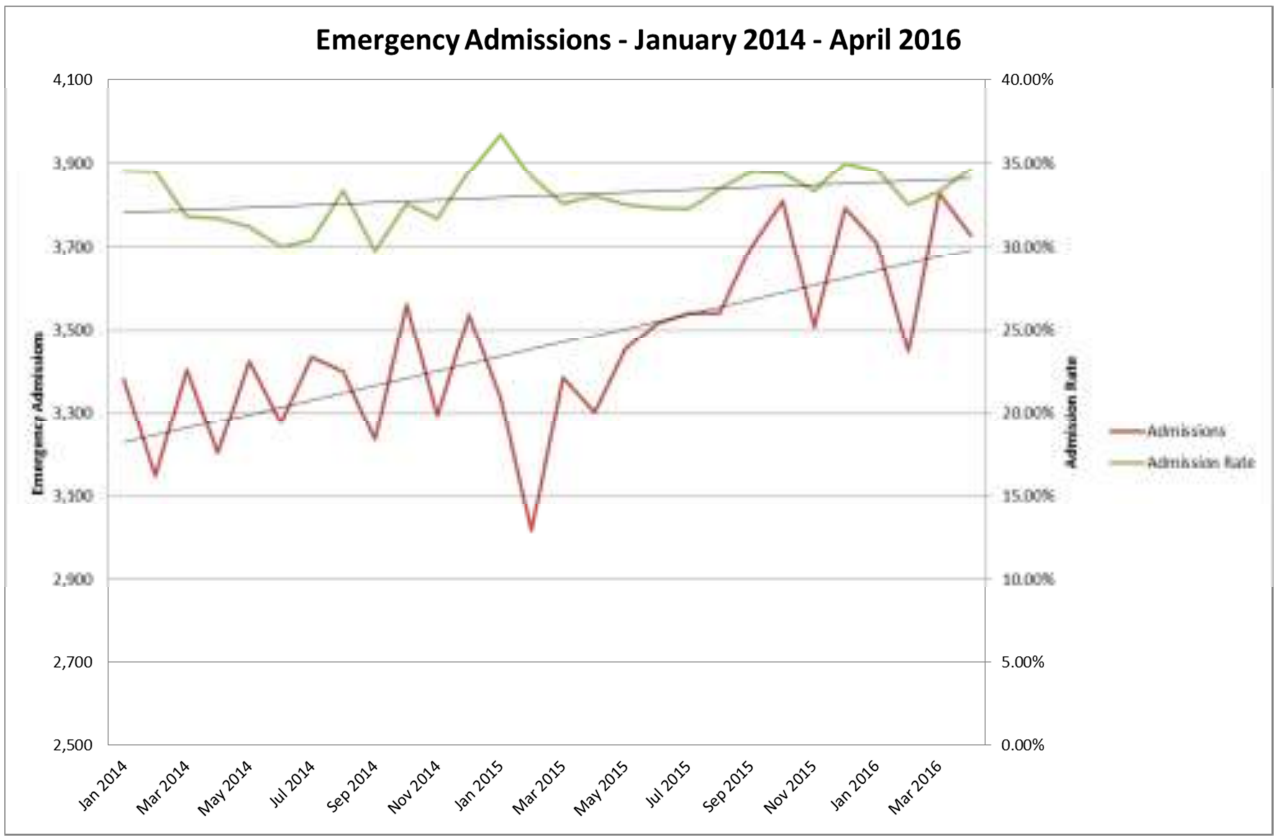
Aim: To ensure the admission rate from the Emergency Department remains in control.

How: By avoiding admissions through alternatives as appropriate.

Narrative: The Emergency admission rate in April 2016 was 34.59% compared to March 2016, when the admission rate was 33.24%. In April 2016 there were 10,777 Emergency Department attendances and 3,728 patients were admitted (average 124 per day), compared to April 2015 when there were 10,007 attendances but 3,302 patients were admitted (average 110 per day).

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

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

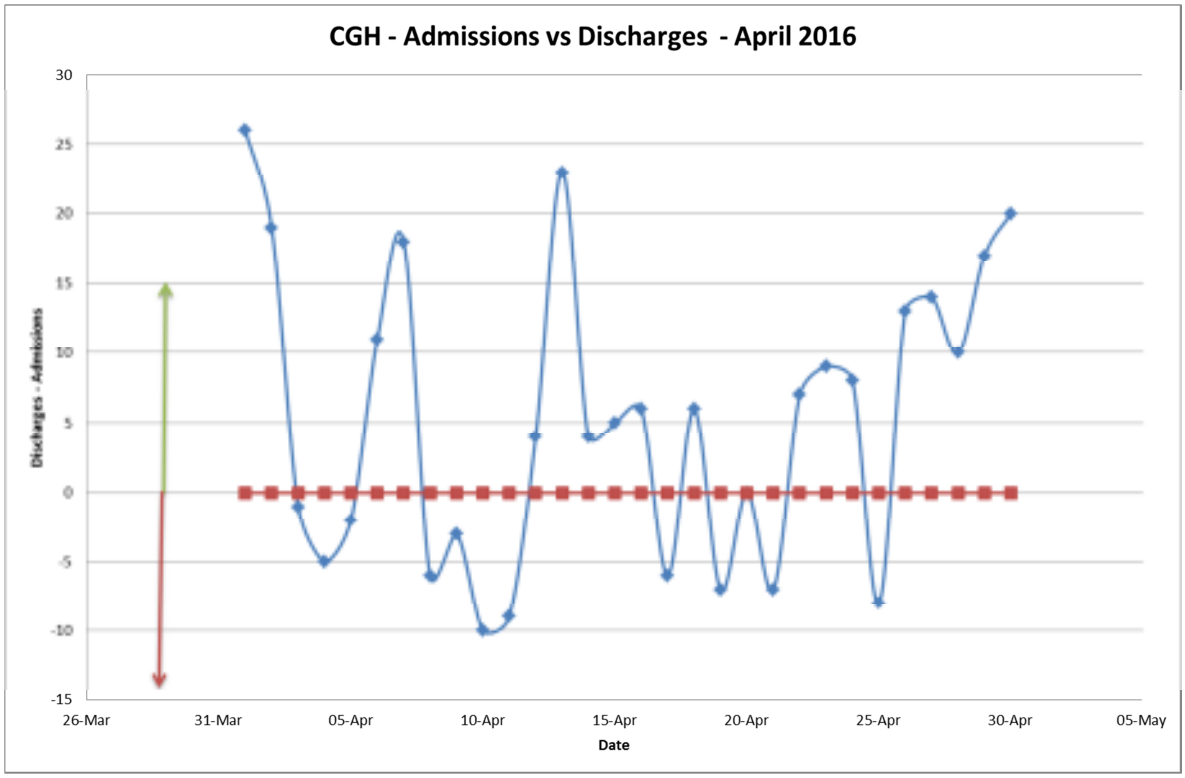


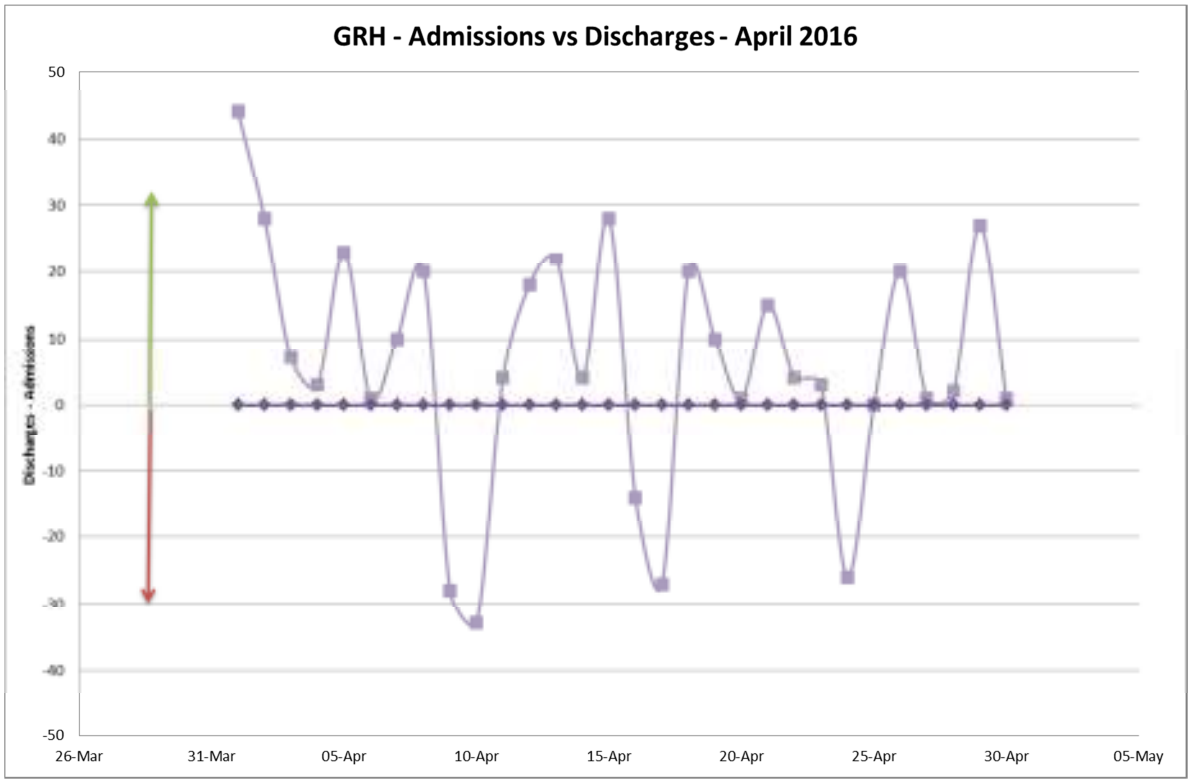
3.4.2 Admissions vs Discharges

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

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

Narrative: The following two graphs show the level of discharges on each site subtracted from the number of admissions.





3.5 Ambulatory Emergency Care Attendances

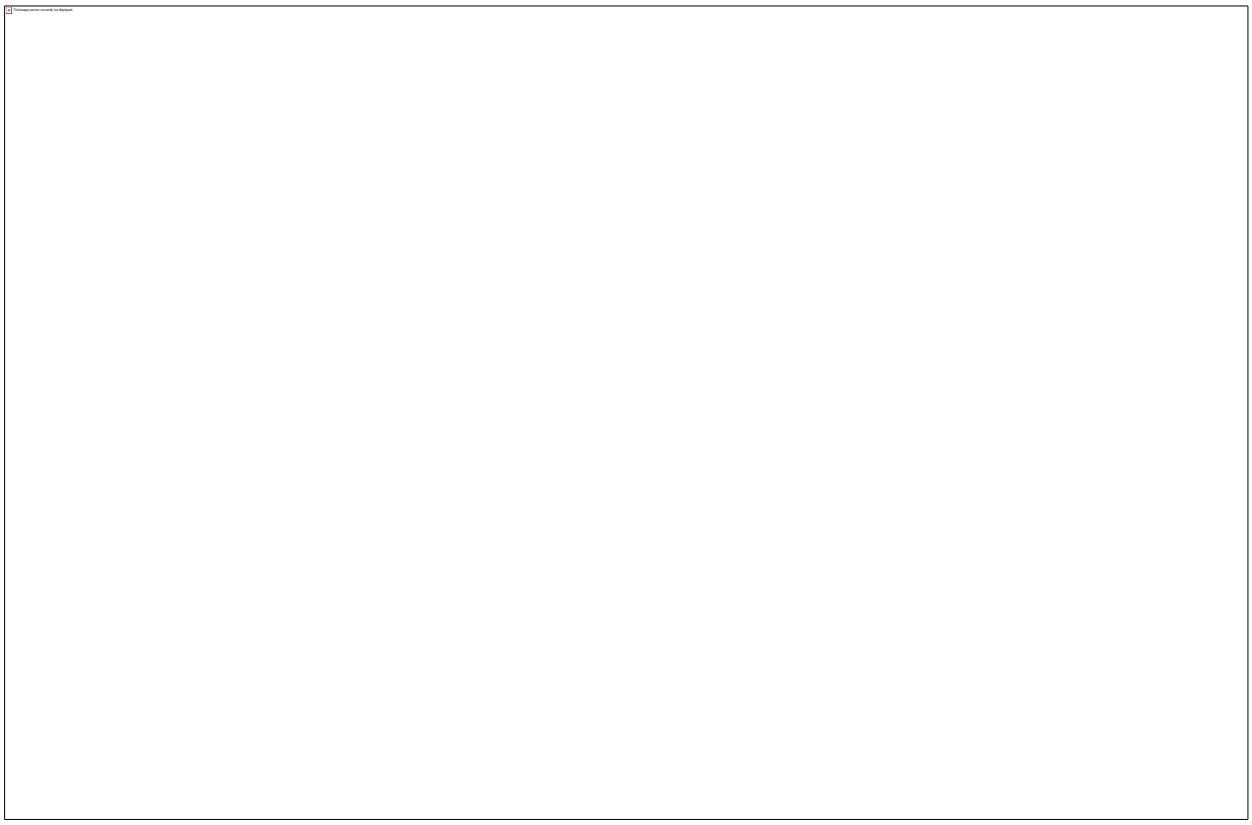
Aim: To increase the number of emergency patients managed on an ambulatory pathway.

How: Expand pathways and remodel ambulatory services.

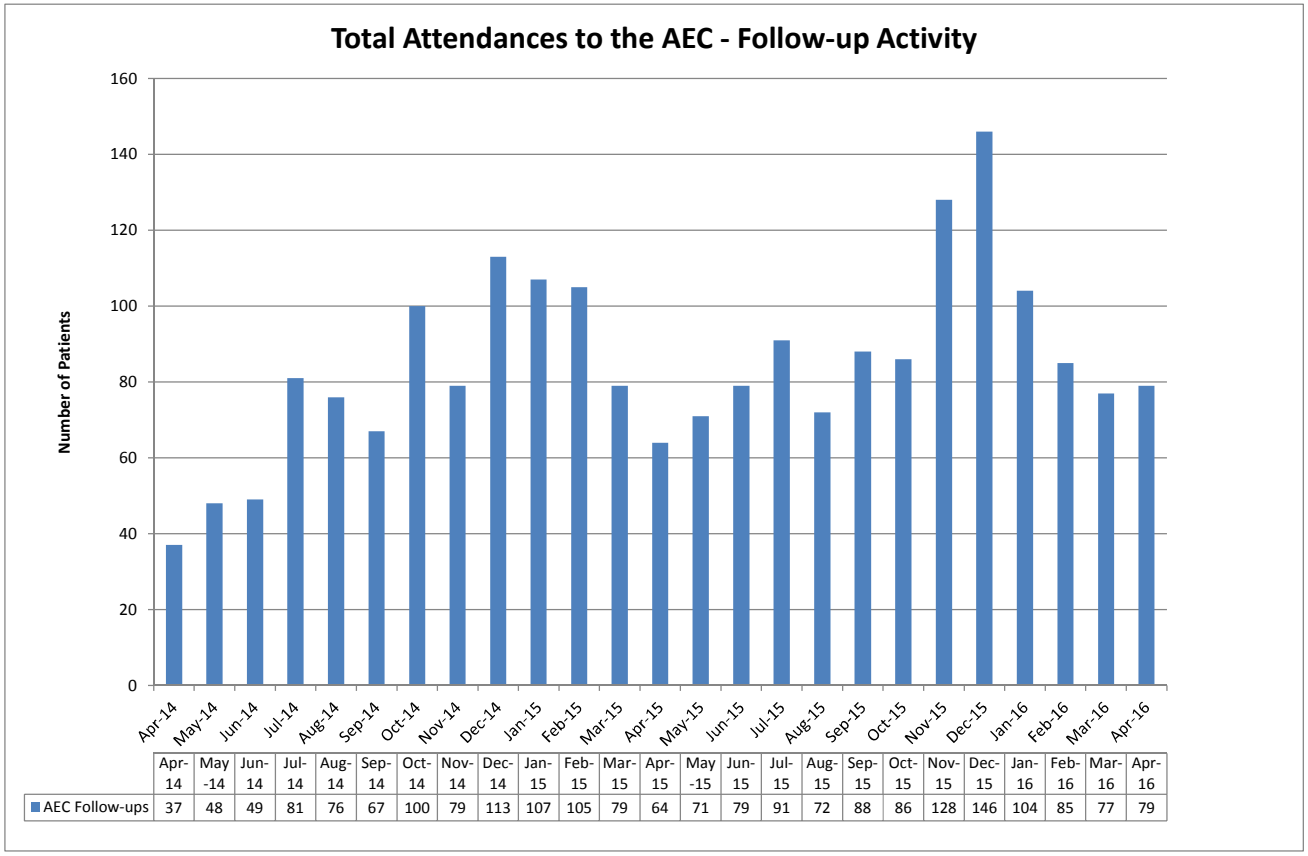
Narrative: The Ambulatory Emergency Care service accepts patients either direct from the Emergency Department or via the Single Point of Clinical Access from GPs and South West Ambulance Trust.

The chart below shows the actual number of new Ambulatory Emergency Care patients (excluding Follow ups) from April 2014. The plan for 2015/16 was based on actuals from 2014/15 plus the impact of the planned pathway developments. The plan for 2016/17 is in development and indicative figures have been provided from February 2016, whilst awaiting agreement with the Commissioners. The average for April 2016 was 19 compared to an average of 24 last month.

A service review was undertaken in November 2015, 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.



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 2014 are shown in the graph on the next page.



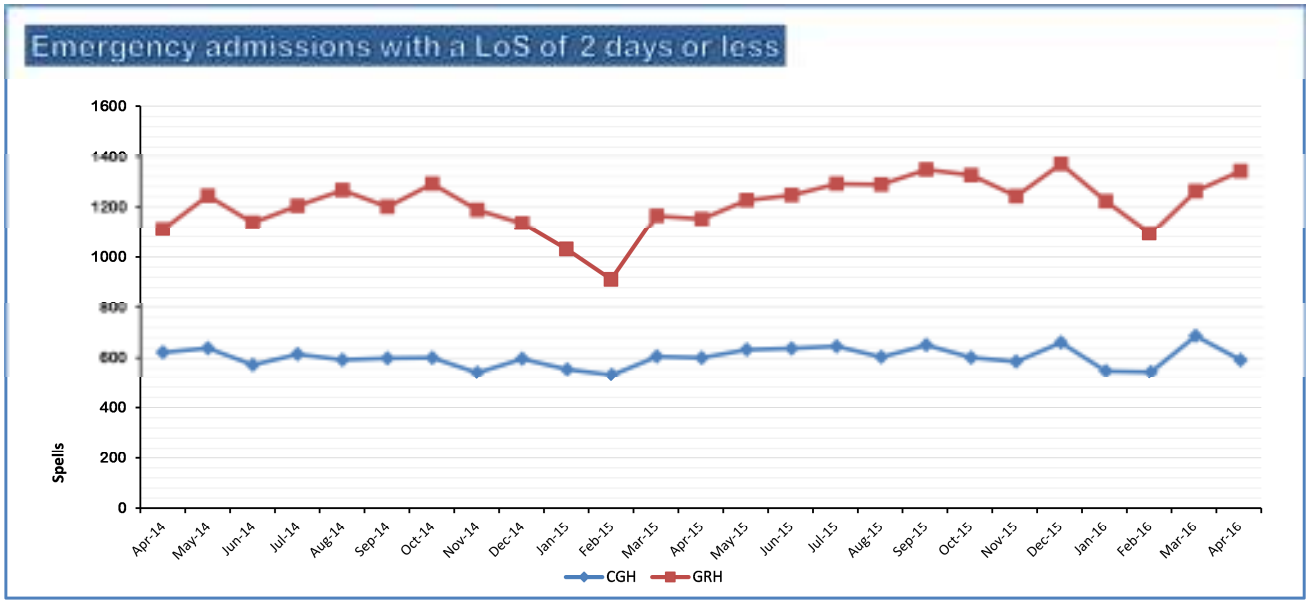
	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
AEC Follow-ups	37	48	49	81	76	67	100	79	113	107	105	79	64	71	79	91	72	88	86	128	146	104	85	77	79

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 April 2016 showed 1,933 patients with a length of stay of 2 days or less Trustwide (average 64.4 discharges per day); compared to March which showed 1,949 patients (average 62.9 discharges per day). The average per day for April 2015 was 58.4.



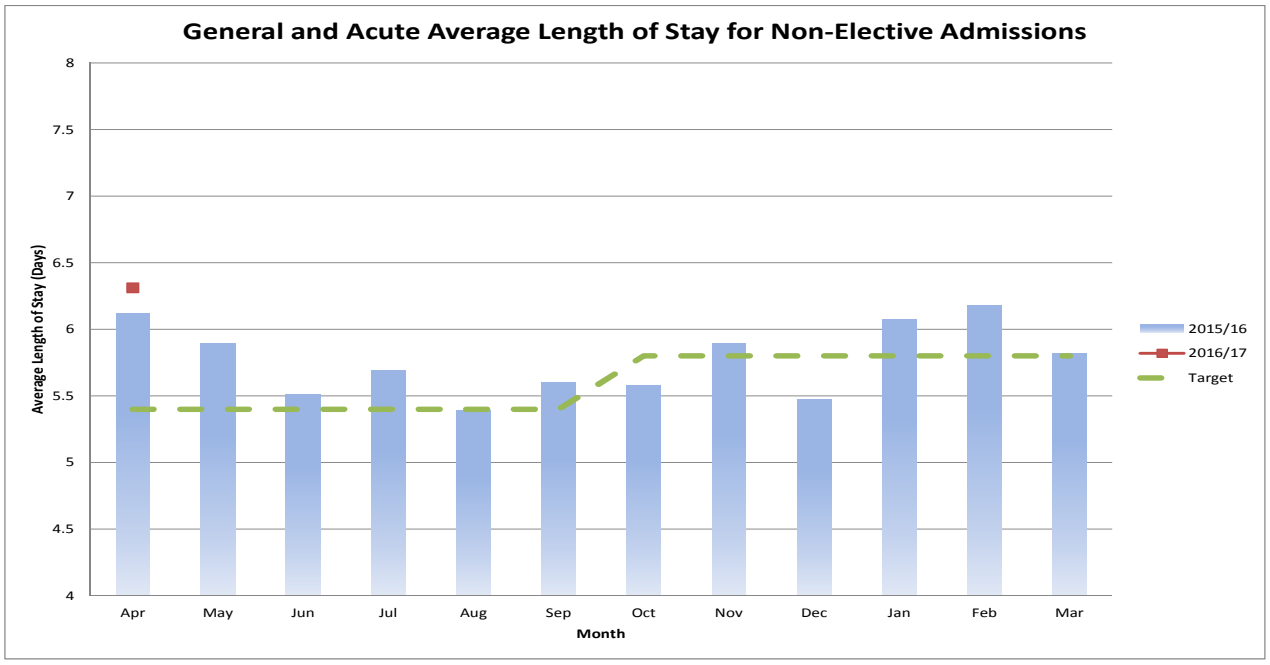
3.6 General & Acute Emergency Admissions Average Length of Stay

Aim: To reduce Trustwide general and acute emergency length of stay to less than 5.4 days in Quarter 1 of 2016/17.

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: The Trustwide quarterly targets will be reviewed throughout Quarter 1 2016/17. Divisions and Service Lines have been asked to develop internal action plans to bring down the Length of Stay in their area. April 2016 shows an Average Length of Stay of 6.31 days which is an increase from March (5.82 days).

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.

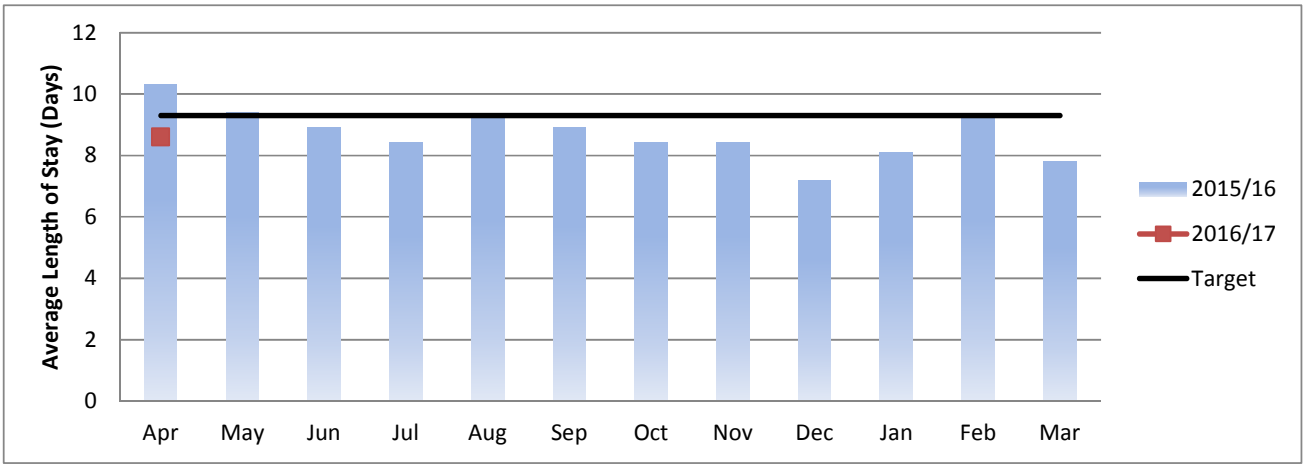
3.7 Average Length of Stay of Targeted Specialties

On continuation from last year Respiratory, Cardiology and General Old Age Medicine will be highlighted in this report. For Quarter 1 of 2016/17, the individual targets remain as per last year. The Specialty length of stay targets for this year will be reviewed throughout Quarter 1 2016/17. 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.

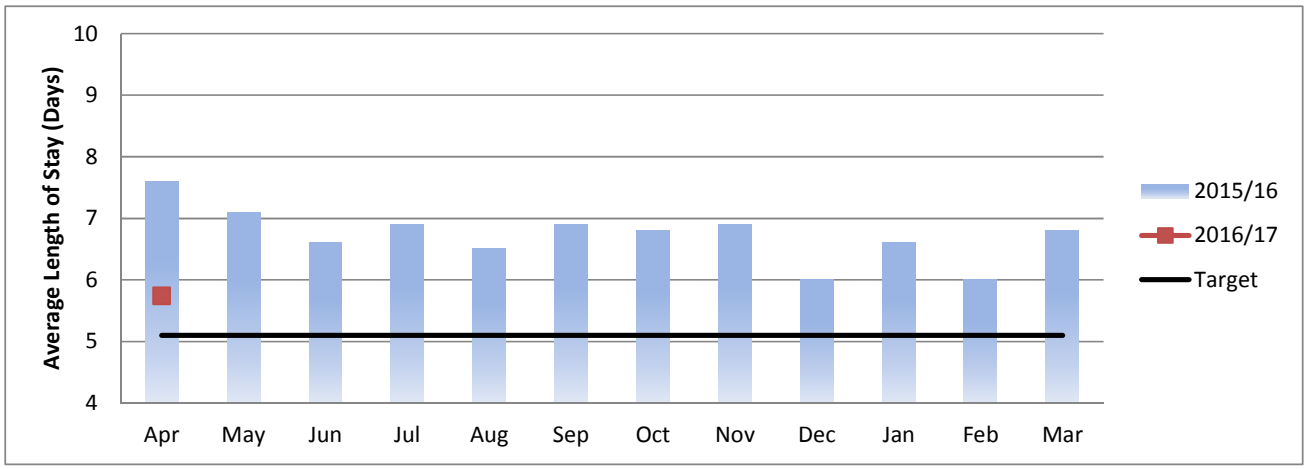
3.8.1 Respiratory Medicine - Average Length of Stay

Narrative: The internal target is currently set at 9.3 days for 2016/17**.** The Average Length of Stay increased from last month to 8.6 days in April 2016; although remains within the target.



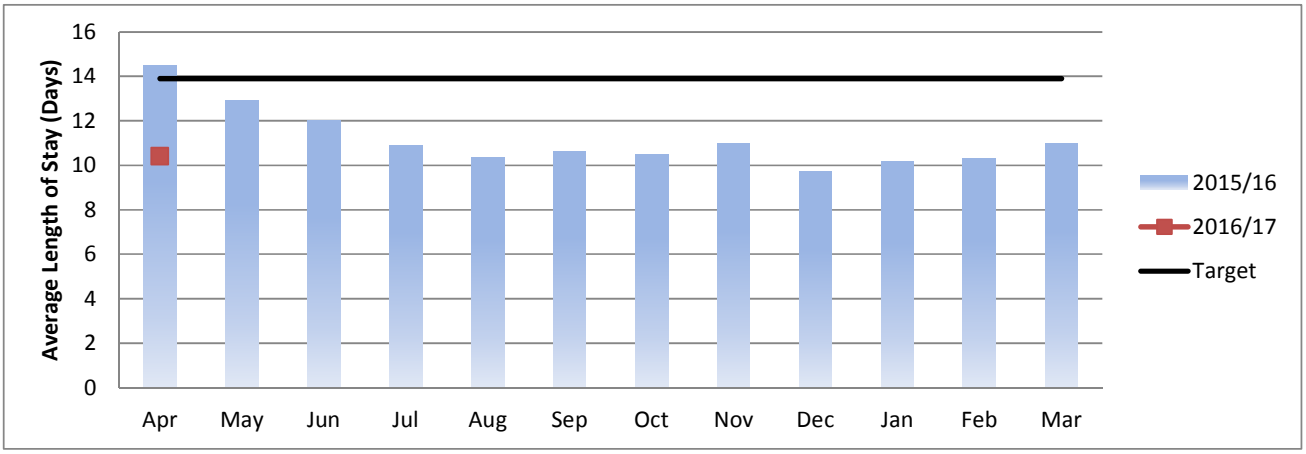
3.8.2 Cardiology - Average Length of Stay

Narrative: The internal target is currently set at 5.1 days for 2016/17. The Average Length of Stay for non-elective Cardiology discharges was 5.74 days in April 2016, which is an improvement on the same period last year.



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

Narrative: The internal target is currently set at 13.9 days for 2016/17. The General Old Age Medicine Average Length of Stay has remained static for several months and is well within target.



3.9 Average Number of Patients Medically Fit for Discharge

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

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

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

Medically Fit: Average Number of Patients on the Medically Fit List for April 2016:

The number of patients on the medically fit list for one day and over has been at an average of 57 throughout April 2016. This remains above the system-wide plan of no more than 40 patients. The table below shows the weekly averages, demonstrating improvement in the last week:

Week	Date Range (April 2016)	Patients (Average)
Week 1 *(note only three days)*	Friday 1st – Sunday 3rd	73
Week 2	Monday 4th – Sunday 10th	51
Week 3	Monday 11th – Sunday 17th	59
Week 4	Monday 18th – Sunday 24th	64
Week 5 *(note only six days)*	Monday 25th – Saturday 30th	46

Source: InfoFlex and PAS (Integrated Discharge Team data)

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.

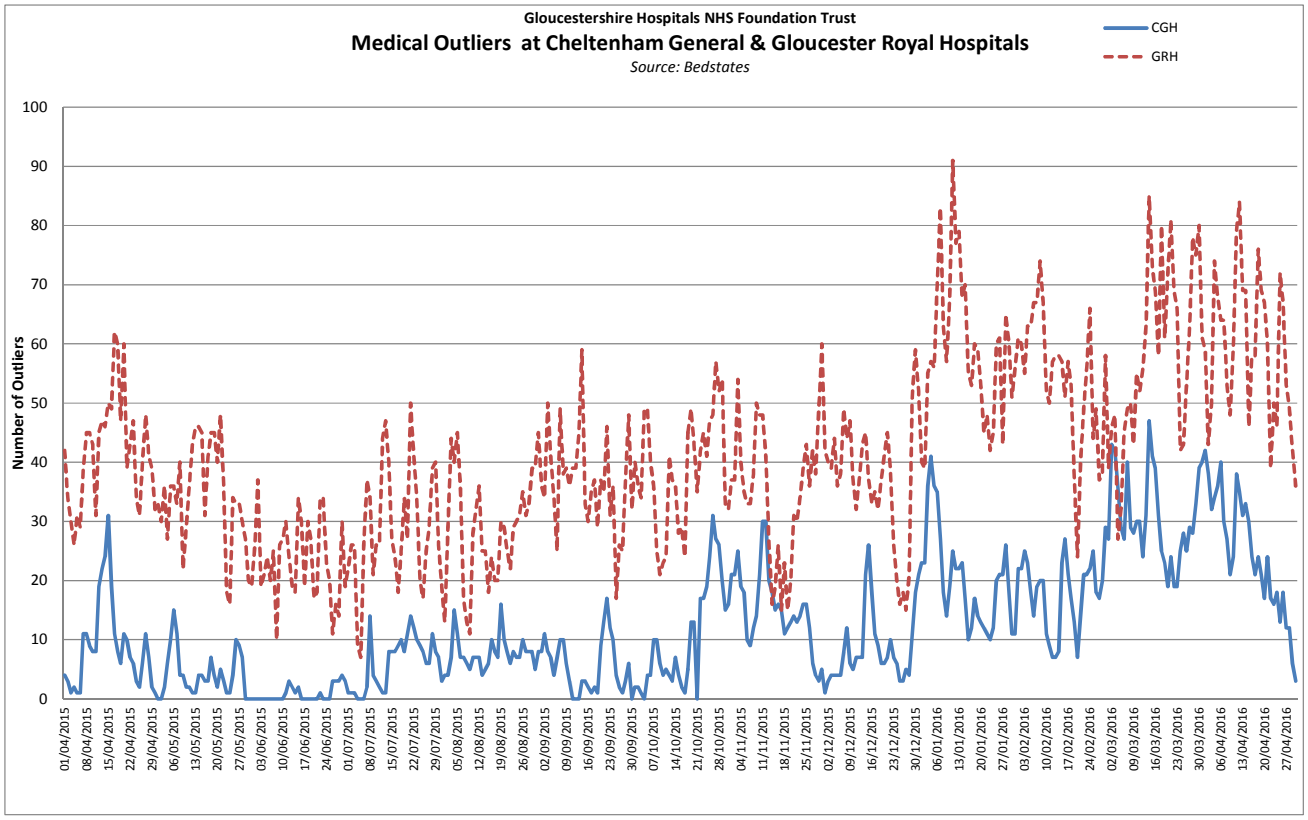
Currently, the Integrated Discharge Team manager is working to a 10 point plan of the most frequent reasons for delays across all systems both internal and external and to manage Medically Fit patients better in the future.
From September 2015, a weekly Senior Executive review of all Medically Fit patients 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 59 at Gloucestershire Royal and 25 at Cheltenham General in April; a reduction from 66 and 33 last month.

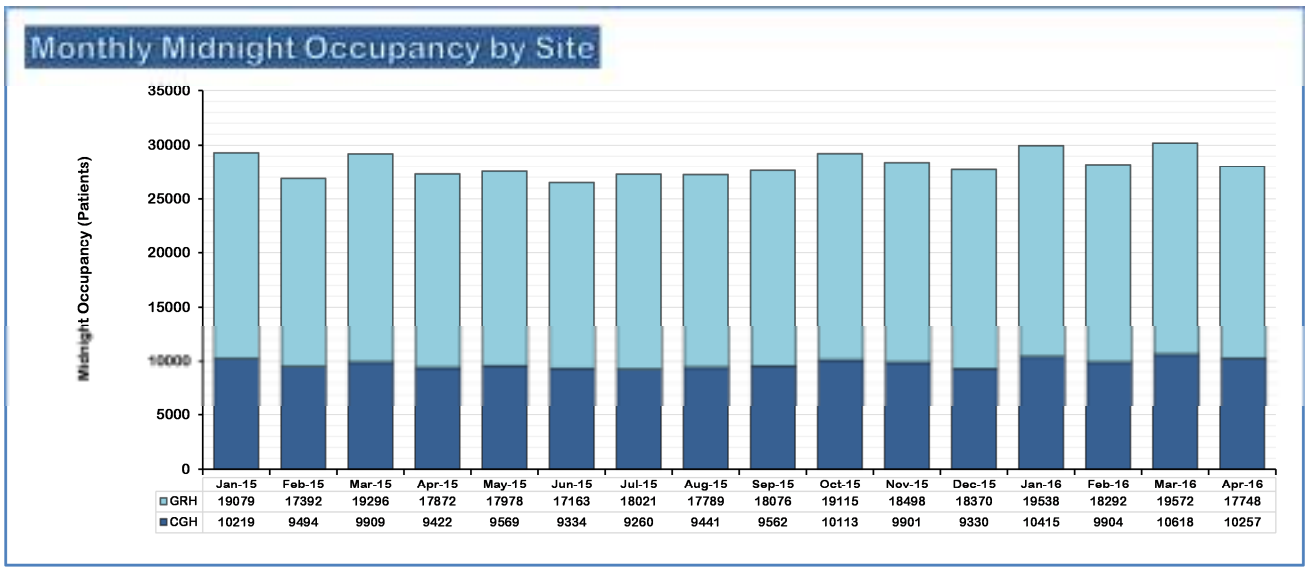


3.9.3 Midnight Bed Occupancy

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: The daily average number of beds occupied in April 2016 was 933.5, compared to April 2015 (909.8 per day) and March 2016 (973.9 per day).



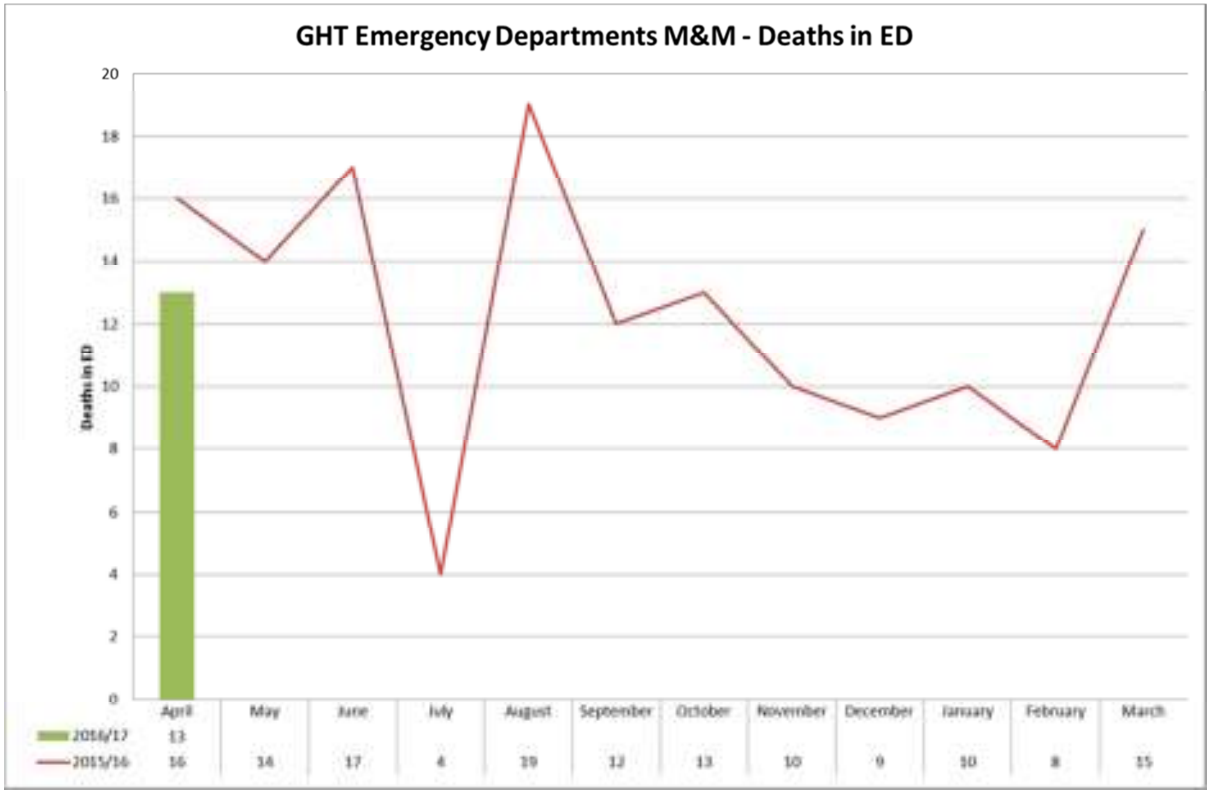
% Bed Occupancy (as at Thursday snapshot)

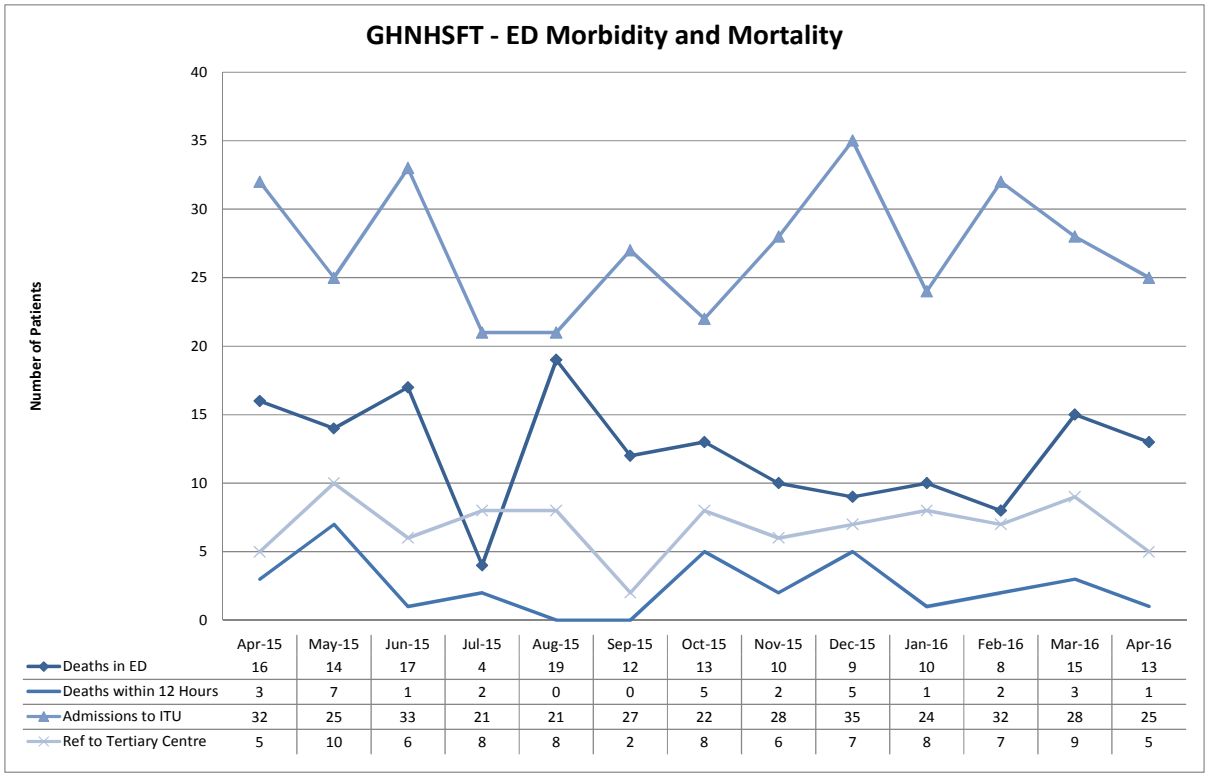
Week ending:	CGH	GRH	Total
03/04/2016	96.1%	98.7%	**97.6%**
10/04/2016	93.4%	95.5%	**94.6%**
17/04/2016	96.6%	97.8%	**97.3%**
24/04/2016	98.4%	98.2%	**98.3%**
01/05/2016	91.6%	90.7%	**91.1%**

3.10 ED Morbidity and Mortality

Aim: To review the Morbidity and Mortality trend.

Narrative: During April 2016 there were 13 deaths in the Emergency Department, which is lower than April last year (-3). There were 25 admissions to ITU and 5 referrals to tertiary centres. All of the deaths are reviewed in detail at the Service Line Morbidity and Mortality Reviews.





	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Deaths in ED	16	14	17	4	19	12	13	10	9	10	8	15	13
Deaths within 12 Hours	3	7	1	2	0	0	5	2	5	1	2	3	1
Admissions to ITU	32	25	33	21	21	27	22	28	35	24	32	28	25
Ref to Tertiary Centre	5	10	6	8	8	2	8	6	7	8	7	9	5

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 April (wte)	Variance In Post vs. Establishment	Variance vs. in Post in March
Emergency Department	Consultants	17.70	19.51	+1.8	-0.9
	Trainee Doctors	34.49	32.30	-2.2	+0.20
Acute Medicine	Consultants	11.03	8.33	-2.70	0
	Trainee Doctors	83.29	67.60	-15.70	+1.2

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

- To continue with the three immediate priority workstreams:

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.

- 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.

Report Authors:

Andrew Seaton – Director of Safety

Heather Beer – Head of Patient Experience

Kim Hemming – Divisional Information Manager, Medicine

Jackie Miller – Senior Information Analyst

Lou Porter – Programme Manager

Presenting Executive:

Eric Gatling – Director of Service Delivery

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

NURSE AND MIDWIFERY STAFFING
MAY 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 April 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 reported verbally due to the timing of the Board and the collection and verification of the data which is not normally ratified until the second week of the month. The data will then be uploaded to NHS Choices and the UNIFY system on 14th May.

3 Findings

3.1 Annex A attached to this report is the communication received from NHS Improvement on 22nd April. Within the communication to all acute trust boards there is notification of new information that is to be submitted within the safer board papers regarding Care Hours per patient day (CHPPD). The divisional nursing directors are currently reviewing this document and liaising with the information teams as to how best to report findings etc. The first report in response to CHPPD will be in the next Safer Staffing Board paper as time will be needed to test data calculations.

3.2 The Board is reminded that twice each year we are required to undertake the Keith Hurst bench mark exercise and report any changes to our Board. This exercise is currently underway however it should be noted that the Keith Hurst database has been updated recently to reflect the acuity of patients in acute trusts and therefore early indication is that further investment will be required to keep nursing numbers in line with the national benchmark. Results will be reported to Main Board in June.

3.3 Our Trust has received notification that from 01 April 2017, there will be a £1,000 per annum charge for each candidate employed from a non-EU country. This will affect recruitment of both senior Medical staff and nurses recruited from overseas and unfortunately the government has announced that nurses and teachers will not be exempt from the charge, or permitted to pay the reduced charge of £364 per annum soon to be levied for small and charitable businesses.

The visas currently being used for Filipino nurses are for three years, and would therefore incur a total charge of £3,000 per candidate. It is not clear if staff employed before 01 April 2017 will be subject to the charge in their second or third years of employment etc.

Full details are available here;
https://www.gov.uk/government/news/governments-new-immigration-skills-charge-to-incentivise-training-of-british-workers

3.4 The issue regarding those recruited from overseas and their ablitiy to pass the IELTs examination continues to frustrate our recruitment and subsequent plan to reduce our agency spend.

3.5 Surgical Division

The Department of Critical Care appears an anomaly from the latest safer staffing report, but only due to the local practice of 'flexing' staff off, when the units are quiet, and bringing in more staff when the units are busier.

Within the Division, 'pure' vacancies have fallen to 8.70 wte, as a bottom line, but this hides an over-establishment on the band 2 line (27.38 fte) which are overseas nurses awaiting registration. We are continuing to support these nurses in moving quickly to registration. True band 5 vacancies are 25.79, a slight decrease on last month, and is also disproportionate in some wards (I.e., Prescott 6 fte) which have a higher vacancy factor.

Sickness levels for both RGNs and HCAs are higher than normal for the period; therefore, this will be discussed with the Modern Matrons.

High use of bank and agency continues within unfunded bed area, such as the Guiting four beds, and Kemerton/Chedworth for winter pressures, and Day surgery at Gloucestershire Royal.

Care Hours Per Patient Day (CHPDD)

NHS Improve has agreed to add a further criteria to the existing Safer Staffing report. From June, the total hours per day of Registered and Healthcare Assistance staff will be divided by the number of patient in the care area at 23.59 each night. This is to give a score of average care hours per patient, per day. There will be future guidance on how with will help in benchmarking nursing/midwifery staffing, subsequently.

Nursing Metrics

The existing set of Nursing Metrics has been in place for over five years. Since then the development of the Safety Thermometer, and the new Medicines Safety Thermometer datasets, coupled with the Safer Staffing report, has led to a duplication of effort on the part of ward staff. It is therefore proposed that our Trust moves away from the separate Nursing Metrics and, instead use the information now being generated for the national reports (Thermometers, staffing) and report, and analysis that data instead. This, as said, will prevent duplication. A working group will consider how to amalgamate the data into a comparative table, similarly to how the current Nursing Metrics are reported. A further report on this will be presented in future Safer Staffing and Quality reports.

3.6 Medicine Division

The Medical Division will report next month as this was not possible due to the early Main Board date and annual leave of some of the senior nurses.

3.7 Women & Children's Division

3.7.1 Maternity

Safer staffing is reported for inpatient wards only within maternity not intra partum care settings. Across maternity concern with regard to the age profile of the workforce and the speciality are doing further work to analyse the issue. The concerns relate to the loss of experienced midwives in the clinical areas, difficulties recruiting midwives with the necessary experience to work in the free standing Midwifery Led Units and difficulties in appointing to Senior posts. Actions include offering flexible retirement contracts to midwives retiring so that they return on part time hours whilst retaining their experience. This is a national problem but unlike the national picture the services does not have a general recruitment problem and uses no agency, only Trust bank midwives cover short term absence.

Further to the Trusts funding of additional midwifery staff, there has been an increase of staff on the co-located birth unit at Gloucester from 2 midwives to 3 midwives per shift which better enables 1:1 care in labour and an additional midwife is now on each shift in Triage to enable more timely and effective assessment of women in this high risk area.

3.7.2 Gynaecology

The opening of the day surgery unit on 2a and its subsequent use as an inpatient ward for outliers has led to the continued use of unfunded nursing posts to ensure safe staffing levels for the ward. This increased staffing is a cost pressure and also brings with it additional risk as the specialist gynaecology nurses are required to care for medical patients and may be less familiar with treatments and medication for this group of patients and the agency staff used to supplement the staffing may be unfamiliar with the ward . The Band 7 ward manager is working clinically to support the ward but in doing so has lost her supernumerary time. Despite ward staff working extra hours to cover the short falls, the use of both bank and agency the ward is not always able to staff the additional beds to the required level . Therefore a risk assessment has been undertaken and added to the specialty risk register.

A specific area of concern is the negative impact on staff morale and retention. The ward has lost three members of trained staff, two who have chosen to take retirement earlier than they originally planned.

The Advanced Nurse Practitioner team / Clinical Nurse Specialists are depleted by 4 WTE at present which is unsustainable. An extra Junior Dr and Nurse Secondment to the team are planned to mitigate this deficit commencing in August and June respectively. The Matron is also working extra hours to support the team at this challenging time.

3.7.3 Paediatrics and Neonatal

There have been significant nurse vacancies within paediatrics over the past year and the paediatric ward is currently not funded to comply with RCN guidance 2013, which recommends that 1 nurse should be looking after 4 inpatients (3 if under 2).

The paediatric services have formulated an action plan which includes overseas recruitment; participation in the Trust annual rolling recruitment programme; developing roles of housekeepers to assist senior staff in non-clinical aspects of their roles. Development programme to recruit and extend the role of the HCA is working well and 5 staff have been recruited to develop these new roles.

Proactive recruitment has improved the vacancy level to 4 registered wte staff by April 2016, with further nurses coming into post over the next 4 months. In addition a pilot is being undertaken within paediatrics to pay trained staff who work an extra 30 hours an addition to contract over a six week period an £500 bonus. The aim being to minimise the requirement to employ nursing staff for the speciality from Agencies. Under this scheme £2,000 pounds was spent by the Paediatric service line in April

It is proposed that the inpatient ward will reduce its bed base by 5 (29 – 24 general inpatient beds) from the 1st of June. This will enable the staffing for the inpatient ward to be reduced by 1 nurse per shift, which the service aims to maintain until 30th September. It is anticipated that the proposal will create a £52.7k reduction in expenditure.

Contact time was undertaken by all paediatric speciality nurses. The finding of most significance was the time spent undertaking hand over and this is an area that the speciality is trying to understand further as it does not seem in keeping with the practice.

In the neonatal unit has positive recruitment picture with staff from the Philippines who are currently working through the adaptation course to enable them to register with the NMC as well as from students and both adult and child trained nurses. There has also been an increase in the number of nursery nurses, housekeepers and ward clerks appointed to add

support to the registered workforce 75% of trained staff now have the QIS which is above the recommended 70%, a significant achievement .

3.8 Diagnostic & Specialist Division

Contact Time data for specialist nurse workforce in D&S revealed several issues. Top 3 that were identified were, clinical and non-clinical admin, time spent on telephone patient contact time and role descriptor issues leading to AFC banding anomalies. The divisional nurse director is working with the lead cancer nurse to ensure there is a robust workforce plan and review of posts including the appropriate skill mix reviews where appropriate. There is a plan to pilot a band 3 HCA role with a specialist nurse to help with efficiency and patient treatment pathway issues. In relation to workforce retention, there are no specific issues and nurse vacancies when they occur generate interest. The role development pathways in D&S are very well managed by the practice development team. Late calls for sickness absence are managed at ward and matron level. Amongst substantive staff this is not a major problem. It is however often a problem with temporary workforce clinical staff.

4 Recruitment Update

4.1 UK Pipeline

- There are currently 12 experienced UK-based nurses in the recruitment pipeline due to commence employment in May/June 2016.
- There are currently 10 live Band 5 Registered Nurse advertisements open, but interest continues to be low.
- A rotational post across Gastroenterology and Endoscopy has generated a small number of applications from candidates wishing to develop their skills across a specialty area. It is hoped that a second rotational post will be advertised shortly to ensure the Trust remains competitive with other organisations.
- Following a number of newly-qualified nurse candidates withdrawing due to receiving offers from Gloucestershire Care Services or neighbouring acute hospitals, there are now 74 newly-qualified nurses due to start at the Trust in summer 2016.
- The Recruitment Team attended the Birmingham City University nursing careers fair on 27 April 2016, and generated a lot of interest in positions in Gloucestershire. A mailing list of interested candidates has been created, and a follow-up email will be sent in August in advance of the students applying for their first job for a January 2017 start date.

4.2 Overseas-Qualified Nurses

- The first cohort of candidates interviewed in March are due to commence employment on 06 June 2016. Some candidates have requested a later start date to fit around family/work commitments, and this is being honoured where appropriate.
- Two further testing days have been scheduled for 01 June and 03 June, and 125 candidates have been invited to the two days. To date, 71 candidates have confirmed their intentions to attend the testing day. Following these two testing dates, the candidates will be invited to one of four interview dates throughout June.
- A separate advertisement specifically targeting candidates with the requisite IELTS examination result continues to be popular, and there are currently nine successful fast-track candidates, plus more scheduled for interview in May 2016.

4.3 EU Recruitment

- One EU nurse joined the Trust in May 2016, and a further five candidates are being processed to start shortly.
- Two EU nurses are scheduled for interview during May, and nine further candidates are being scheduled for interviews on 26 May and 08 June 2016.

- The Trust will attend a recruitment event hosted by the British Council in Thessaloniki and Athens on 04 and 05 June 2016. There is the possibility of attending a second event hosted by the British Council in October if this campaign is successful.

4.4 Philippines Recruitment

- The Home Office has announced plans to introduce an Immigration Skills Charge to employers that recruit from outside of the European Union from April 2017.
  - This will be a £1,000 per annum levy payable in advance of a visa being issued.
  - For our current Filipino nurses on a three year visa, this would be a £3,000 charge.
  - This charge is in addition to the existing Certificate of Sponsorship cost, visa charge, and the new Immigration Health Surcharge.
  - Therefore, from April 2017, the cost of employing a non-EU worker on a three year visa will increase by £3,000 to £4,374.
  - These charges can be avoided by arranging visas for overseas candidates to start before April 2017.

- 2015 Campaign: The first three nurses from the November 2015 campaign arrive in the UK on 11 May 2016, and will commence employment on 16 May 2016. A further nine candidates are either waiting for paperwork from the NMC before they can obtain their visas, and one candidate has all of the paperwork and is awaiting issuance of the visa to arrange a travel date. A further seven have passed the IELTS examination and are waiting to take the NMC Test of Competence Part 1 (the Computer Based Test (CBT)).

Status	**Numbers**
Commencing employment on 16 May 2016	3
Passed IELTS and CBT exams, accepted by the NMC, waiting for visa application	1
Passed IELTS and CBT exams, waiting for NMC decision letter	9
Passed IELTS examination, waiting for CBT examination	7
Not passed the IELTS examination	101
Not yet accepted the offer	7
Withdrawn	9
Total (minus withdrawn candidates)	**128**

- 2016 Campaign: To ensure a robust pipeline of overseas nursing candidates, the Trust is returning to The Philippines during May 2016 to recruit additional candidates. A two-pronged approach will take place, with face-to-face interviews during w/c 16 May for medical and surgical wards (inc. ED and Oncology), and a second-wave of Skype interviews for specialist areas, including Critical Care, Paediatrics, NICU, Theatres and Recovery. Separate interviews will be arranged on Skype during June for these areas.

5 Next Steps and Communication

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

6 Recommendations

The Board is invited to endorse this report.

Authors:

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

ANNEX A

NHS Improvement

22 April 2016

Wellington House
113-155 Waterloo Road
London
SE1 8UG
W: improvement.nhs.uk

To Directors of Nursing of Acute Providers

Dear colleague,

Care Hours Per Patient Day (CHPPD) Guidance

As set out In Lord Carter's final report, *Operational productivity and performance in English acute hospitals: Unwarranted variations*, better planning of staff resources is crucial to improving quality of care, staff productivity and financial control. Working closely with trusts, the Carter Team found there is not a consistent way to record and report staff deployment, meaning that trusts could not measure and then improve on staff productivity.

The report recommended that all trusts start recording Care Hours Per Patient Day (CHPPD) – a single, consistent metric of nursing and healthcare support workers deployment on inpatient wards and units. This metric will enable trusts to have the right staff mix in the right place at the right time, delivering the right care for patients.

From 1 May, all trusts should report back monthly CHPPD data to NHS Improvement so that we can start to build a national picture of how nursing staff are deployed. This will allow trusts to see how their CHPPD relates to other trusts within a speciality and by ward in order to identify how they can improve their staff deployment and productivity.

We have made this data collection as easy as possible by including one new field into the UNIFY template which you already fill in every day. The new field – **Patient count at midnight** – is the total number of patients on the ward at 23.59. CHPPD will automatically be calculated by taking the actual hours worked (split into registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight. This new field will be included from the May collection.

We tested CHPPD data collection with 27 trusts through April and we found that collecting patient count at midnight is the least burdensome on trusts and preliminary analysis shows this data is robust. The trusts also worked with us to develop the technical guidance, which also includes a UNIFY CHPPD factsheet and FAQ to make this collection and reporting as easy as possible.

By collecting CHPPD each month, we will soon begin to see where unwarranted variation is happening and identify what good looks like. We will be able to learn best practice from these trusts and adopt their principles to ensure all trusts are deploying their staff in the most productive and efficient way. This will ultimately lead to better quality of care for patients and better financial controls for trusts.

We will continue to work with trusts over the coming months to ensure we get this

data collection right. If you have any additional questions which are not covered off in the FAQ please email Lyn McIntyre (Lyn.McIntyre@dh.gsi.gov.uk) or Marcus Albano: (marcus.albano@nhs.net).

Yours sincerely

Ruth May
Executive Director of Nursing

Elizabeth O'Mahony
Director of Finance

Copy to:
Directors of Finance of NHS Acute Providers

Enclosure
Care Hours Per Patient Day (CHPPD) Implementation Guide for May 2016

NHS Improvement

Care Hours Per Patient Day (CHPPD) Implementation Guide for May 2016

April 2016

1. Background

The Lord Carter Review 1highlights the importance of ensuring that workforce and financial plans are consistent in order to optimise deliver of clinical quality and use of resources. The review recommended that Care hours per patient day (CHPPD) is collected monthly (beginning in April 2016) and for this to be collected daily from April 2017. Senior nursing leaders in the NHS support the Carter review that CHPPD is developed to become the principal measure of nursing and healthcare support worker deployment; with similar approaches in place for medical staff and Allied Health Professionals to be introduced by April 2017 (excluding those in non-acute areas). The CHPPD approach to recording and reporting builds upon the Nursing Hour per Patient Day (NHPPD) practice we have seen in Western Australia, New Zealand, and the US, where local senior leaders have greater control and flexibility in deploying staff, with greater effectiveness. This has also demonstrated improvements in quality and patient outcomes2. NHPPD is reviewed daily to check variation at ward level to ensure the right staff are deployed at the right place at the right time.

We adapted that measure to be CHPPD so we could include other staff in future including Allied Health Professionals (AHPS). AHPs will be measured from April 2017 (excluding those in non-acute areas) to ensure the right teams are in the right place at the right time, providing high quality, safe effective care.

In April 2016 the Department of Health (DH) ran a voluntary data collection with 27 trusts to help us formulate this guidance and to begin the process of data capture for CHPPD. This work will continue as we embed CHPPD in organisations and develop in the NHS.

2. Introduction to CHPPD

One of the obstacles to eliminating unwarranted variation in nursing and care staff deployment across the NHS provider sector has been the absence of a single means of recording and reporting deployment. Conventional units of measurement that have been developed previously , have informed the evidence base for staffing models ,– such as reporting staff complements using WTEs, skill-mix or patient to staff ratios at a point in time, but it is recognised by Nurse leaders may not reflect varying staff allocation across the day or include the wider multidisciplinary team. Also, because of the different ways of recording this data, no consistent way of interpreting productivity and efficiency is straightforward nor comparable between organisations.

To provide a single consistent way of recording and reporting deployment of staff working on inpatient wards/units we developed, tested and adopted Care Hours per Patient Day (CHPPD).

- CHPPD is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by every 24 hours of in-patient admissions (or approximating 24 patient hours by counts of patients at midnight**)**

- CHPPD reports split out registered nurses and healthcare support workers to ensure skill mix and care needs are met.

3. CHPPD and the Model Hospital

Another recommendation from the Carter Review was to develop a model hospital so trusts can see what good looks like from other trusts and learn and adopt their best practice. We are currently developing the Model Hospital prototype portal - a user-friendly and intelligible online portal with a series of themed compartments which break down key performance metrics for that area – for example Clinical Staff. These metrics show how an individual trust is performing in comparison to their peers, and where relevant, how they compare to international performance.

By giving hospitals information on what good looks like in and using this portal for trusts to share best practice, each hospital can take action to improve and reduce the unwarranted variation. Through the Model Hospital work stream we are developing tools including a live dashboard which includes staffing information collected and presented in a standardised way. This means trusts will be able to compare staffing metrics including CHPPD, sickness rates, agency costs and local

quality data including pressure ulcers, falls and patient experience information to other trusts and identify areas where they need to improve.

The Model Hospital using the CHPPD methodology allows a localised, efficiency-oriented approach to productivity: it situates the measurement of staffing contact with patients and clinical outputs in the broader context of cost efficiency and the quality of care, and it does so using measures that are meaningful to decision-makers at ward and board levels.

4. Implementation Guide to CHPPD

From May 2016, CHPPD will become the principle measure of nursing and care support deployment, with the expectation that it will form part of an integrated ward/unit level quality framework and dashboard encompassing patient outcomes, people productivity and financial sustainability.

To make this collection as easy as possible, we have included one new field into the UNIFY safe staffing return which you already fill in every day. The new field – Patient count at midnight – is the total number of patients on the ward at 23.59.

CHPPD will automatically be calculated by taking the actual hours worked (split into registered nurses/midwives and healthcare support workers) divided by the number of patients at midnight. This new field will be included from the May collection (Posted on unify on the 1st of June2016) and data must be returned by 12 noon on 15th June 2016.

We have included a step by step guide to the updated UNIFY template which now includes the new - Patient count at midnight field. We have also developed a FAQ sheet based on questions asked by the trusts we tested the collection with.

UNIFY CHPPD FACTSHEET

Nursing, Midwifery and Care (CHPPD) Care Hours Per Patient Day Indicator UNIFY Return

This factsheet will be updated weekly for the next four weeks to take account of additional queries

Timeframes

• The first data collection period is 1 to 31 May 2016. This data must be returned by 12 noon on 15th June 2016.

UNIFY

- The template for inputting the data should be downloaded from the UNIFY system, and will be made available on 1st June. Check the 'News' section on UNIFY for updates.
- Data should be entered into the white cells. The values in green cells will be calculated automatically from the data entered.
- When completed the spreadsheet should be uploaded to the UNIFY system.
- **The current safe staffing unify return will need to continue to be used, until the new collection is made available on the 1 June 2016.**

Contact Details

Can all questions or queries in regards to this guidance paper, or the current or future collection be directed to central.returns@nhs.net . We will endeavour to respond to any questions or queries within 24 hours.

The Template Explained

Reporting Period	The calendar month
Hospital Site Code	Select your hospital site code from the drop down box. All hospital sites can be added to one overall return for each Trust.
Ward Name	Enter the ward number or number. All wards with inpatient beds need to be included, with the exception of; • Day care wards • CDU/other clinical assessment units • Additional capacity wards Where appropriate please ensure the ward name is in line with the names of wards used on the FFT submission to allow alignment on the NHS Choices website. Please make sure you do not use abbreviations.
First Speciality	Select the first speciality for the ward from the drop down box.
Second Speciality	If there is more than one, select the second speciality for the ward from the drop down box. Data should be entered for the whole ward. If the ward covers more than two specialities please select the two for which there are most patients.
Night	Night is defined as the shift period within which midnight falls.
Day	Day shifts are all the periods not included in the night shift.
Registered Nurse/Midwife	A member of registered nursing or midwifery staff on the duty rota dedicated to the inpatient area.
Care Staff	A member of staff on the duty rota dedicated to the impatient area with delegated responsibility from a registered nurse/midwife. Examples include: • Nursing Assistants • Midwifery Assistants • Healthcare Assistants • Support Workers • Auxiliary Nurses

	• Assistant Practitioners Students should not be included.
Patient count	The number of patients that were in the ward at Midnight on the date of the shift
Total monthly planned staff hours	Enter the total monthly planned hours for: • Registered Nurses/Midwives on day shifts • Registered Nurses/Midwives on night shifts • Care Staff on day shifts • Care Staff on night shifts
Total monthly actual staff hours	Enter the total monthly actual hours worked for: • Registered Nurses/Midwives on day shifts • Registered Nurses/Midwives on night shifts • Care Staff on day shifts • Care Staff on night shifts
Patients count at midnight	Enter the number of patients on the ward at 23.59 on the date of the shift. (This is a new field)
CHPPD – Care Hour Per Patient Day	This information will be automatically calculated from the data entered on the template. The CHPPD is calculated by taking the actual hours worked divided by the number of patients at midnight split by registered nurses/midwives and care staff.
Staff to be included	The following staff should be included: All members of registered nursing/midwifery and care staff on the duty rota dedicated to the inpatient area – this includes: • ward co-ordinators • staff specifically booked to provide 'enhanced care' (special) to a patient • staff doing additional hours on top of their booked shift should have their extra hours included • bank and agency staff.
Staff to be excluded	The following staff should be excluded: Staff not included on the staff duty rota. This would usually include: • specialist nurses covering a number of wards/units • registered nurses undertaking a period of preceptorship (if not planned to be in the planned staffing and therefore supernumerary) • physiotherapists • occupational therapists • hospitality staff such as hostesses • student nurses

FAQ's – Frequently Asked Questions

General queries raised by the CHPPD volunteer Trusts

Questions		Answers
1	What happens if we cannot or do not do this?	There is an expectation from the Lord Carter Review and NHS Improvement that all acute Trusts will be reporting CHPPD monthly from May 2016.
2	How will communication with the media take place?	NHS Improvement press office will work closely with other press offices.
3	How will CHPPD be reported as total or will it be separated?	CHPPD will be reported as RN CHPPD and Healthcare Support Worker (Care Staff) CHPPD separately
4	Do we only need to record patient numbers once a day at midnight?	Yes. Number of patients in bed at 23.59 each day for each ward totalled for the month.
5	Why have you put midnight as 23.59?	Our early reporting identified some confusion on whether midnight was before or after 24.00. To make it clearer we have made it 23.59.
6	Will we have warning pre-publication of our Trust position so we can prepare media and internal messaging?	How CHPPD will be reported has not been set yet. A number of options are being reviewed but as soon as an option has been selected Trusts will be informed. This will be prior to publication and we will provide a series of briefings that can customised.
7	Is A & E included?	No
8	In the event that a day surgery ward was open past midnight do we need to report for that ward? Would it just be reported for that day?	No
9	On the UNIFY Safe Staffing return we submit data on wards/units that are not open at night. What would like us to do with these areas because there will be no Patients at night?	Please include "zero (closed at night)" in the field for patient count.
10	On our maternity ward do you record Mothers and Babies separately as individual patients?	Only record the mother as the patient.
11	Do we include Day case Units that may be open 2 or 3 nights a week?	If these units are planned to open on a regular basis then the staffing required for that unit should be planned for. So these should be included.
12	If the ward is a mixed inpatient and day patient/outpatient unit do I count all staff or just those staff who are delivering the inpatient care?	Only those staff delivering inpatient care should be included.
13	Are labour and midwifery led units included – including delivery suites?	Yes. Whilst it is acknowledged that delivery suites are not classed as inpatient areas they should have planned staffing levels and often can be supported by staff moved from other areas of the maternity department. Therefore staff in delivery suites should be included.
14	What do I report when a ward has a temporary planned closure part way	The planned and actual staffing days when the ward is open should be reported as

	through the month?	normal. The actual and planned for the days when the planned closure occurs should be recorded as zero. The variance in the staffing and patient count and the rationale should be reflected in the monthly submission.
15	What do I report when a ward is permanently closed?	This ward should no longer be reported on. You should remove this ward from NHS Choices. This needs to be done by the person in your organisation who has editor's permissions to the NHS Choices system.
16	Is this change to CHPPD for all providers or just acute services?	The change to adding the patient count at midnight into the UNIFY data collection is currently only for acute services. Plans will be developed to move to other services going forward.
17	Can we get a copy of the UNIFY data template for May's return before we need to upload on June 15th?	The template will be made available on 1st June. Check the 'News' section on UNIFY for updates.
18	If we are a multi-site Trust do we have to do a UNIFY return for each site?	The UNIFY template has been created so that you can submit one template per Trust. The return asks for the hospital site in order to obtain the data for NHS Choices.
19	Who should validate the data prior to upload to UNIFY?	The data should be validated by the Trust prior to uplift. You will wish to introduce a mechanism to validate your data and achieve sign off prior to submission.
20	Are bank and agency staff still included in the numbers?	Yes
21	What about AHPs who are included in our ward establishment numbers – do we include them too?	No – this return is for nursing staff. A separate programme of work to review AHP CHPPD is underway.
22	Do we include supernumerary staff such as new starters who are not in the numbers?	If these staff are not included in the planned numbers then they should be excluded from the actual numbers.
23	Why is the reporting a calendar month and not 28 days?	This is consistent with the reporting of other metrics and information on NHS Choices.
24	By including patients on enhanced care (specials) does this not distort the staffing levels?	Yes but that is legitimate and is an accurate reflection of your staffing need to manage acuity and dependency.
25	Should we count the number of worked hours (paid) or the number of full shift hours including break times?	The number of worked hours (paid).
26	If external staff to a ward assists with direct care needs of patients for longer than 2 hours should they be recorded as actual hours?	Yes

Gloucestershire Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2016

Foreword to the accounts

Gloucestershire Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2016, have been prepared by Gloucestershire Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed ……

Name **Helen Simpson**
Job title **Chief Executive and Accounting Officer**
Date **27 May 2016**

Consolidated Statement of Comprehensive Income

		2015/16		2014/15	
		Trust	Group	Trust	Group
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	428,747	428,747	416,041	416,041
Other operating income	4	71,490	72,400	64,323	65,346
Total operating income from continuing operations		**500,237**	**501,147**	**480,364**	**481,387**
Operating expenses	5, 7	(483,956)	(485,522)	(482,476)	(483,864)
Operating surplus/(deficit) from continuing operations		**16,281**	**15,625**	**(2,111)**	**(2,476)**
Finance income	10	32	211	30	90
Finance expenses	11	(4,195)	(4,195)	(4,536)	(4,536)
PDC dividends payable		(7,447)	(7,447)	(7,528)	(7,528)
Net finance costs		**(11,610)**	**(11,431)**	**(12,034)**	**(11,974)**
Movement in the fair value of investment property and other investments	17	-	(112)	-	74
Surplus/(deficit) for the year from continuing operations		**4,671**	**4,082**	**(14,145)**	**(14,376)**
Surplus/(deficit) for the year		**4,671**	**4,082**	**(14,145)**	**(14,376)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	6	(7,031)	(7,031)	(8,363)	(8,363)
Revaluations	14.1	7,748	7,748	12,081	12,081
Other reserve movements		-	-	(11)	(11)
Total comprehensive income/(expense) for the period		**5,388**	**4,799**	**(10,439)**	**(10,670)**
Surplus / (deficit) for the period attributable to:					
non-controlling interests; and		-	-	-	-
the Foundation Trust		4,671	4,082	(14,376)	(14,376)
Total comprehensive income / (expense) for the period attributable to:					
non-controlling interests; and		-	-	-	-
the Foundation Trust		5,388	4,799	(10,670)	(10,670)

Statements of Financial Position

	Note	31 March 2016 Trust £000	31 March 2016 Group £000	31 March 2015 Trust £000	31 March 2015 Group £000
Non-current assets					
Intangible assets	13, 14	3,584	3,584	594	594
Property, plant and equipment	14, 15	308,601	308,601	298,598	298,598
Other investments	17	-	1,974	-	2,423
Trade and other receivables	20	4,505	4,505	7,829	7,829
Total non-current assets		**316,690**	**318,664**	**307,021**	**309,444**
Current assets					
Inventories	19	8,036	8,036	8,039	8,039
Trade and other receivables	20	31,625	31,663	21,222	21,482
Cash and cash equivalents	21	3,950	4,148	10,662	10,695
Total current assets		**43,611**	**43,847**	**39,922**	**40,215**
Current liabilities					
Trade and other payables	22	(57,057)	(57,157)	(44,737)	(44,753)
Other liabilities	23	(497)	(497)	(1,084)	(1,084)
Borrowings	24	(5,283)	(5,283)	(5,843)	(5,843)
Provisions	27	(186)	(186)	(264)	(264)
Total current liabilities		**(63,023)**	**(63,123)**	**(51,928)**	**(51,944)**
Total assets less current liabilities		**297,278**	**299,388**	**295,016**	**297,716**
Non-current liabilities					
Other liabilities	23	(7,987)	(7,987)	(8,363)	(8,363)
Borrowings	24	(54,537)	(54,537)	(59,083)	(59,083)
Provisions	27	(1,396)	(1,396)	(601)	(601)
Total non-current liabilities		**(63,920)**	**(63,920)**	**(68,047)**	**(68,047)**
Total assets employed		**233,358**	**235,468**	**226,969**	**229,669**
Financed by					
Public dividend capital		166,519	166,519	165,519	165,519
Revaluation reserve		67,334	67,334	66,617	66,617
Other reserves		209	209	209	209
Income and expenditure reserve		(704)	(615)	(5,376)	(5,325)
Charitable fund reserves	18	-	2,021	-	2,649
Total taxpayers' and others' equity		**233,358**	**235,468**	**226,969**	**229,669**

The notes on pages 6 to 41 form part of these accounts.

Name **Helen Simpson**
Position **Chief Executive and Accounting Officer**
Date **27 May 2016**

Statement of Changes in Equity for the year ended 31 March 2016

Trust & Group	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	NHS charitable funds reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2015 - brought forward	**165,519**	**66,617**	**209**	**(5,325)**	**2,649**	**229,669**
Surplus/(deficit) for the year	-	-	-	4,671	(589)	**4,082**
Impairments	-	(7,031)	-	-	-	**(7,031)**
Revaluations	-	7,748	-	-	-	**7,748**
Public dividend capital received	1,000	-	-	-	-	**1,000**
Other reserve movements	-	-	-	39	(39)	**-**
Taxpayers' and others' equity at 31 March 2016	**166,519**	**67,334**	**209**	**(615)**	**2,021**	**235,468**

Statement of Changes in Equity for the year ended 31 March 2015

Trust & Group	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	NHS charitable funds reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2014 - brought forward	**165,476**	**62,900**	**209**	**8,811**	**2,900**	**240,296**
Prior period adjustment	-	-	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2014 - restated	**165,476**	**62,900**	**209**	**8,811**	**2,900**	**240,296**
Surplus/(deficit) for the year	-	-	-	(14,144)	(232)	**(14,376)**
Impairments	-	(8,363)	-	-	-	**(8,363)**
Revaluations	-	12,081	-	-	-	**12,081**
Public dividend capital received	43	-	-	-	-	**43**
Other reserve movements	-	-	-	8	(19)	**(11)**
Taxpayers' and others' equity at 31 March 2015	**165,519**	**66,617**	**209**	**(5,325)**	**2,649**	**229,669**

Information on reserves

NHS charitable funds reserves
This balance represents the ring-fenced funds held by the NHS charitable funds consolidated within these accounts. These reserves are classified as restricted or unrestricted.

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. Additional PDC may also be issued to NHS Foundation Trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Available-for-sale investment reserve
This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

Other reserves
On the original setting up of the Trust in 2003 there was an error made in in the granting of the initial PDC to cover the total value of the net assets of the new organisation. The adjustment was credited to other reserves. This reserve will remain with the Trust until the Trust is dissolved.

Merger reserve
This reserve reflects balances formed on merger of NHS bodies.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS Foundation Trust.

Statement of Cash Flows

	Note	2015/16 Trust £000	2015/16 Group £000	2014/15 Trust £000	2014/15 Group £000
Cash flows from operating activities					
Operating surplus/(deficit)		16,281	15,625	(2,110)	(2,476)
Non-cash income and expense:					
Depreciation and amortisation	5.1	9,847	9,847	16,671	16,671
Impairments and reversals of impairments	6	(3,795)	(3,795)	15,544	15,544
(Gain)/loss on disposal of non-current assets	5.1	-	-	(42)	(42)
Income recognised in respect of capital donations	4	(659)	(659)	(955)	(955)
(Increase)/decrease in receivables and other assets		(10,299)	(10,506)	8,924	8,841
(Increase)/decrease in inventories		3	3	(1,589)	(1,589)
Increase/(decrease) in payables and other liabilities		9,039	9,039	2,005	2,005
Increase/(decrease) in provisions		709	709	(97)	(97)
NHS charitable funds - net movements in working capital, non-cash transactions and non-operating cash flows		-	512	-	(46)
Net cash generated from/(used in) operating activities		**21,126**	**20,775**	**38,351**	**37,856**
Cash flows from investing activities					
Interest received		32	32	30	30
Purchase of intangible assets		(2,990)	(2,990)	(594)	(594)
Purchase of property, plant, equipment and investment property		(8,745)	(8,745)	(20,942)	(20,942)
Sales of property, plant, equipment and investment property		-	-	42	42
Investing cash flows of NHS charitable funds		-	516	-	59
Net cash generated from/(used in) investing activities		**(11,703)**	**(11,187)**	**(21,464)**	**(21,405)**
Cash flows from financing activities					
Public dividend capital received		1,000	1,000	43	43
Movement on loans from the Department of Health		(2,635)	(2,635)	(2,635)	(2,635)
Movement on other loans		-	-	(21)	(21)
Capital element of finance lease rental payments		(2,803)	(2,803)	(3,147)	(3,147)
Capital element of PFI, LIFT and other service concession payments		(371)	(371)	(232)	(232)
Interest paid on finance lease liabilities		(345)	(345)	(412)	(412)
Interest paid on PFI, LIFT and other service concession obligations		(2,273)	(2,273)	(2,334)	(2,334)
Other interest paid		(1,561)	(1,561)	(1,661)	(1,661)
PDC dividend paid		(7,148)	(7,148)	(7,765)	(7,765)
Net cash generated from/(used in) financing activities		**(16,136)**	**(16,136)**	**(18,163)**	**(18,163)**
Increase/(decrease) in cash and cash equivalents		**(6,713)**	**(6,548)**	**(1,276)**	**(1,712)**
Cash and cash equivalents at 1 April		**10,662**	**10,695**	**11,939**	**12,408**
Cash and cash equivalents at 31 March	21	**3,950**	**4,148**	**10,662**	**10,695**

Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation

Monitor is responsible for issuing an accounts direction to NHS Foundation Trusts under the NHS Act 2006. Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the FT ARM which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2015/16 issued by Monitor. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Going concern

The Board has been regularly updated on the ongoing financial plans of the Trust and agreed the overall budget for 2016/17 at its meeting in March 2016. This was also presented to Monitor as part of the Operational Plan submission. The Operational plan outlines the priorities for the year, taking account of the expected financial, operational and environmental conditions and associated risks. The Finance and Performance Committee also considered upside and downside scenarios associated with the risks of changing levels of demand and the impact of savings schemes.

The current economic environment for all NHS Trusts and NHS Foundation Trusts is challenging with on-going internal efficiency gains necessary due to annual tariff (price) reductions; cost pressures in respect of national pay structures; non-pay and drug cost inflation; as well as nationally set contract penalties for contract performance deviations combined with local commissioner (CCG) QIPP targets such as reducing activity through local area networks.

The Directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Note 1.1 Consolidation

The NHS Foundation Trust is the corporate Trustee to Gloucestershire Hospitals charitable fund. The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Foundation Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Generally Accepted Accounting Principles (UK GAAP). On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

• recognise and measure them in accordance with the Foundation Trust's accounting policies; and
• eliminate intra-group transactions, balances, gains and losses.

Joint operations
The Trust participates in a pooled Budget arrangement under S31 of the Health act 1999 for the provision of equipment loaned to the community e.g. walking frames. This arrangement constitutes a jointly controlled operation in accordance with IAS 31. Where the balances are material the Trust has recognised its share of assets, liabilities, income and expenditure in its accounts.

Note 1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services.
Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.3 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Accounting valuation
A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Note 1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.5 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes;
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
• it is expected to be used for more than one financial year; and
• the cost of the item can be measured reliably.
• individually have a cost of at least £5,000: or form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependendent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or form part of the initial setting-up costs of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing to the location and condition necessary for it to be capable of operating in the manner intended by management.

Non Current assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs, such as installation, directly attributable to bringing them into working condition. The carrying values of non current assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. The costs arising from financing the construction of the fixed asset are not capitalised but are charged to the income and expenditure account in the year to which they relate.

During the year the Trust conducted a tender exercise and subsequently awarded the valuation contract to Debenham Tie Zeung Ltd (DTZ) as the preferred bidder, taking over from the Valuation Office .
Valuations were carried out as mandated by a qualified Debenham Tie Zeung Ltd (DTZ) valuer in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. A formal revaluation is required every 5 years, with an interim formal valuation in the third year of each cycle. Accordingly a formal valuation was undertaken in 2015/16 with the effective date being 31 March 2016.

The valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value. Depreciated replacement cost has been measured on a Modern Equivalent Asset (MEA) basis from 2010. The Market value is on the assumption that the property is sold following the cessation of the existing operations consistent with the Department of Health guidelines.

Assets in the course of construction are valued at cost and are valued by professional valuers as part of the Trust's valuation exercise when they are brought into use.

Operational equipment is valued at fair value except where these are considered to be of short useful life or low value. If this is the case a depreciated replacement cost basis is used as a proxy. Equipment surplus to requirements is valued at net recoverable amount.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Impairments
In accordance with the *FT ARM* , impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

Assets under construction
Assets under construction are measured at cost of construction as at 31 March. Assets are reclassified to the appropriate category when they are brought into use.

De-recognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, government grant and other grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions
PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment at their fair value, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Finance Lease Assets
Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the FT expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Useful Economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life (Years)	**Max life (Years)**
Land	1	100
Buildings, excluding dwellings	37	60
Dwellings	37	60
Plant & machinery	5	15
Transport equipment	7	7
Information technology	3	5
Furniture & fittings	10	10

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the FT expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.6 Intangible assets

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the Trust intends to complete the asset and sell or use it
• the Trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
• the Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful economic life of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life (Years)	Max life (Years)
Intangible assets - internally generated		
Development expenditure	1	8

TrakCare Asset implementation
During 2014/15 the Trust has procured a clinical information system "TrakCare" which is been implementing from 2014-15 and will be completed 2016-17. The system will be run through a managed service agreement and accounted for through the Statement of Comprehensive Income.
During the implementation phase a significant number of staff will be utilised to ensure there is appropriate knowledge within the organisation to effectively operate the system. These will be defined roles with defined benefits arising from them. The Trust proposes to capitalise the costs arising from the implementation due to the future economic benefits that will be derived from the knowledge base gained by individuals. The basis for this treatment is under IAS 38 Intangible Assets (Research and Development).
In recognising that some of the knowledge will be lost post implementation through staff leaving the organisation the Trust proposes to amortise the asset on the basis of the 8 years of the contract. This is the maximum number of years over which the costs will be amortised. However, an annual review will be undertaken to ensure that the rate of amortisation is appropriate by reference to the number of relevant staff who have left the Trust's employment.

Note 1.7 Revenue government and other grants

Government grants are grants from government bodies other than income from commissioners or NHS Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Note 1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The Trust inventories comprise mainly of drugs held in the Pharmacy and medical and surgical equipment (MSE) principally held in operating theatres and surgical departments. The pharmacy stock is subject to an integrated stock system which accounts for the stock held at average cost basis. MSE is held in a variety of locations and is accounted for on a first in first out basis.

Note 1.9 Trade Receivables

Trade receivables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method, which usually equates to invoice total, less provision for impairment. A provision for impairment of trade receivables is estimated when there is objective evidence the Trust will not be able to collect the debt.

Note 1.10 Trade Payables

Trade payables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest rate which usually equates to invoice value.

Note 1.11 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Classification and measurement
Financial assets are categorised as "fair value through income and expenditure", as loans and receivables, and financial liabilities are classified as other financial liabilities.
Financial liabilities are classified as "fair value through income and expenditure" or as "other financial liabilities".

Financial assets and financial liabilities at "fair value through income and expenditure"
Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not "closely-related" to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise of: current investments, cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Financial liabilities
All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced.

Note 1.12 Leases

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.13 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 27.2 but is not recognised in the NHS Foundation Trust's accounts.

Non-clinical risk pooling
The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 28 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 28, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Corporation tax

Gloucestershire Hospitals NHS Foundation Trust is a Health Service Body under the definition of section 519A Income and Corporation Taxes Act (ICTA) 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this Act. There is a power for HM Treasury to dis-apply the exemption in relation to specified activities of a Foundation Trust (section 519A (93) to (8) ICTA 1988). The Trust is not within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, as the profits derived from these activities do not exceed £50,000 per annum

Note 1.18 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.
Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:
• monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.
Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.
Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.19 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).
However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Transfers of functions [to / from] [other NHS bodies / local government bodies]

The Trust had no transfer of functions in or out 2015-16

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2015/16.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 10 - Consolidated Financial Statements
IFRS 11 - Joint Arrangements
IFRS 12 - Disclosure of Interests in Other Entities

Note 1.24 Critical accounting estimates and judgements

The following are the critical judgements apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

a) Plant and equipment is valued at depreciated replacement cost, the valuation being assessed by DTZ (professional adviser) who values those assets with a written down value of greater than £100k. This process also includes those equipment items currently leased.

b) the Trust leases a number of equipment assets and the Trust has assessed the risks and rewards of ownership in categorising these leases as either operating or finance leases.

c) The Trust is required to review property, plant and equipment for impairment in between formal valuations by a suitably qualified valuer. Management make judgements about the condition of assets and review their estimated lives taking account of the professional advice of DTZ.

Note 1.25 Key sources of estimation uncertainty

The following are the key assumptions concerning the future and any key sources of estimation uncertainty at the end of the reporting period that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

a) the cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements as an accrual. As the calculation involves a large number of staff, sampling techniques are used to collate the results for the entire Trust.

b) for partially completed spells an estimate is made of the income accruing to the Trust from patients in hospital on 31 March 16 awaiting discharge or part way through their treatment (partially completed spells or PCS). This technique uses an average figure based on accrued monthly income received over the first three quarters of the year.

c) The useful economic life of each category of fixed asset is assessed when acquired by the Trust. A degree of estimation is occasionally used in assessing the useful economic lives of assets.

Note 2 Operating segments

The financial information presented to the Trust Main Board (Chief Operating Decision Maker - CODM) by the Director of Finance/Deputy Chief Executive regarding the performance of the Trust is based on the whole Trust as one entity (i.e. it is not split over operating segments). The Trust's internal management structure is based on operating divisions i.e. Surgery, Medicine, Diagnostics and Specialties, Women and Children, Estates and Facilities and Corporate Services. The Divisional boards are provided with financial information specific to their operational areas.

Accordingly, for segmental reporting the Trust considers the presentation to inform the CODM representative of the business of healthcare as its sole segment. As the Trust works towards Service Level Reporting the position of its operating segments as reported to the CODM will be re-assessed.

April 2016 Main Board financial performance to final out turn .

Operating Division	**2015/16**			**2014/15**		
	Trust	**Hosted Services**	**Total**	**Trust**	**Hosted Services**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Diagnostics & Specialities	98,201		98,201	94,999	0	94,999
Medicine	107,003		107,003	74,212	0	74,212
Surgery	119,413		119,413	117,261	0	117,261
Women & Children	36,392		36,392	35,430	0	35,430
Estates & Facilities	32,841		32,841	34,114	0	34,114
Corporate Services	46,844	27,039	73,883	63,084	24,787	87,871
Trustwide	4,238		4,238	4,928	0	4,928
Capital financing	21,491		21,491	28,305	0	28,305
Total Expenditure	466,423	27,039	493,462	452,333	24,787	477,120
Total Income	467,299	27,039	494,338	454,135	24,787	478,922
Surplus	**876**	**0**	**876**	**1,802**	**0**	**1,802**

2014/15 & 2015/16 Hosted Services relate to GP and Public Health Trainee Schemes.

Reconciliation between Statement of Comprehensive Income (SOCI) and April 2016 Board report on financial performance:

	2015/16	**2014/15**
	£000	**£000**
Statement of Comprehensive Income	4,671	(14,145)
Net impairments	(3,795)	15,989
Charitable fund contra		
Profit on disposal of Property, Plant and Equipment	-	(42)
Annual Surplus	**876**	**1,802**

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2015/16		2014/15	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Income from Activities				
Elective income	77,657	77,657	75,970	75,970
Non elective income	93,210	93,210	90,507	90,507
Outpatient income	69,645	69,645	68,069	68,069
A & E income	15,478	15,478	13,341	13,341
Other NHS clinical income	167,153	167,153	163,137	163,137
Private patient income	3,340	3,340	3,013	3,013
Other clinical income	2,264	2,264	2,004	2,004
Total income from activities	**428,747**	**428,747**	**416,041**	**416,041**
Other Operating Income				
Research and development	2,661	2,661	3,195	3,195
Education and training	12,713	12,713	13,343	13,343
Receipt of capital grants and donations	659	659	955	955
Non-patient care services to other bodies	11,738	11,738	13,616	13,616
Profit on disposal of non-current assets	-	-	42	42
Reversal of impairments	5,928	5,928	424	424
Income in respect of staff costs where accounted on gross basis	2,612	2,612	2,249	2,249
Income in respect of staff costs relating to GP Trainee Hosted Service	26,962	26,962	24,635	24,635
Incoming resources received by NHS charitable fund	-	910	-	1,023
Other income ****	8,217	8,217	5,864	5,864
Total other operating income	**71,490**	**72,400**	**64,323**	**65,346**
	500,237	**501,147**	**480,364**	**481,387**

****** Analysis of Other Operating Income: Other**	**2015/16 Total**	**2014/15 Total**
	£000	**£000**
Car parking **	946	693
Crèche services	851	754
Catering	914	929
Other	5,506	3,488
Total	**8,217**	**5,864**

Note 3.2 Income from patient care activities (by source)

	2015/16		2014/15	
Income from patient care activities received from:	Trust	Group	Trust	Group
	£000	£000	£000	£000
CCGs and NHS England	418,601	418,601	406,868	406,868
Other NHS foundation trusts	247	247	245	245
NHS other	4,295	4,295	3,725	3,725
Non-NHS: private patients	3,340	3,340	3,013	3,013
Non-NHS: overseas patients (chargeable to patient)	408	408	211	211
NHS injury scheme (was RTA)	790	790	899	899
Non NHS: other	1,066	1,066	1,080	1,080
Total income from activities	**428,747**	**428,747**	**416,041**	**416,041**
Of which:				
Related to continuing operations	428,747	428,747	416,041	416,041

** with effect from 1 April 2010 the operation of the Trusts car parks was taken over by an external car parking provider. All revenues and expenses (see note 3.1) formerly derived by the Trust are now accounted for by the external operator. The income for car parks relates to commission paid by the provider to the Trust when certain income levels are met.

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	2015/16		2014/15	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Income recognised this year	408	408	211	211
Cash payments received in-year	202	202	97	97
Amounts written off in-year	122	122	30	30

Note 4 Income from activities arising from commissioner requested services

Under the terms of its provider license, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Group	
	2015/16	2014/15
	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	418,601	406,868
Income from services not designated as commissioner requested services		
Total	**418,601**	**406,868**

Note 4.1 Profits and losses on disposal of property, plant and equipment

The Trust did not have any disposal of property, plant and equipment in 2015-16

Note 5.1 Operating expenses

	2015/16		2014/15	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Services from NHS Foundation Trusts	1,489	1,491	1,568	1,568
Services from NHS Trusts	7,955	7,955	8,246	8,246
Services from CCGs and NHS England	-	-	508	508
Services from other NHS bodies	39	39	62	62
Purchase of healthcare from non NHS bodies	330	330	416	416
Employee expenses - executive directors	1,244	1,244	1,126	1,126
Remuneration of non-executive directors	140	140	140	140
Employee expenses - staff	309,092	309,134	295,645	295,717
Supplies and services - clinical	46,306	46,306	45,441	45,441
Supplies and services - general	9,818	9,818	8,812	8,812
Establishment	4,249	4,249	4,766	4,766
Transport	1,028	1,028	906	906
Premises	18,357	18,357	20,029	20,029
Increase/(decrease) in provision for impairment of receivables	38	38	23	23
Change in provisions discount rate(s)	1	1	33	33
Drug costs	2,266	2,266	2,293	2,293
Inventories consumed	51,645	51,645	45,674	45,674
Rentals under operating leases	511	511	598	598
Depreciation on property, plant and equipment	9,847	9,847	16,671	16,671
Impairments	2,133	2,133	15,968	15,968
Audit fees payable to the external auditor				
audit services- statutory audit	66	70	83	87
other auditor remuneration (external auditor only)	17	17	-	-
Clinical negligence	12,949	12,949	8,354	8,354
Loss on disposal of non-current assets	-	-	-	-
Legal fees	126	126	102	102
Consultancy costs	1,476	1,476	1,455	1,455
Internal audit costs	-	-	-	-
Training, courses and conferences	1,382	1,382	1,635	1,635
Patient travel	7	7	13	13
Car parking & security	276	276	415	415
Redundancy	30	30	74	74
Hospitality	14	14	7	7
Insurance	377	377	446	446
Losses, ex gratia & special payments	15	15	59	59
Other resources expended by NHS charitable funds	-	1,518	-	1,313
Other	732	732	907	907
Total	**483,956**	**485,522**	**482,475**	**483,864**
Of which:				
Related to continuing operations	485,522	485,522	482,475	483,864
Related to discontinued operations	-	-	-	-

In prior years "inventories consumed excluding drugs" and "supplies and services clinical" were disclosed seperately these are both now disclosed under supplies and services clinical.

Note 5.2 Other auditor remuneration

	Group	
	2015/16	**2014/15**
	£000	**£000**
Other auditor remuneration paid to the external auditor:		
2. Audit-related assurance services	17	-
Total	**17**	**-**

Note 5.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2015/16 or 2014/15.

Note 6 Impairment of assets

	Group	
	2015/16	**2014/15**
	£000	**£000**
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(3,795)	15,544
Total net impairments charged to operating surplus / deficit	**(3,795)**	**15,544**
Impairments charged to the revaluation reserve	7,031	8,363
Total net impairments	**3,236**	**23,908**

Note 7 Employee benefits

	Group			
			2015/16	2014/15
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	250,588	348	**250,936**	243,489
Social security costs	17,701	-	**17,701**	17,572
Employer's contributions to NHS pensions	30,243	-	**30,243**	28,819
Termination benefits	-	-	**-**	74
Agency/contract staff	-	11,484	**11,484**	6,891
NHS charitable funds staff	44	-	**44**	72
Total gross staff costs	**298,576**	**11,832**	**310,408**	**296,917**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**298,576**	**11,832**	**310,408**	**296,917**
Of which				
Costs capitalised as part of assets	-	-	**-**	-

Note 7.1 Retirements due to ill-health

During 2015/16 there were 4 early retirements from the Trust agreed on the grounds of ill-health (8 in the year ended 31 March 2015). The estimated additional pension liabilities of these ill-health retirements is £215k (£557k in 2014/15).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.2 Directors' remuneration

The aggregate amounts payable to directors were:

	Group	
	2015/16	2014/15
	£000	£000
Salary	994	996
Taxable benefits	5	7
Employer's pension contributions	102	100
Total	**1,101**	**1,103**

Further details of directors' remuneration can be found in the remuneration report.

Note 8 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation for the NHS Pension scheme was completed for the year ended 31 March 2012 .

The scheme regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Note 9 Operating leases

Note 9.1 Gloucestershire Hospitals NHS Foundation Trust as a lessor

The Trust does not receive any operating lease income.

The Trust has a number of short term (tenable with 1 years notice by either side) "leases" whereby other NHS organisations within Gloucestershire use rooms or facilities. The charge incorporates facilities management together with other recharges to facilitate the use of the accommodation. Accordingly there is no rent as such to be able to split out of the total cost. The income such is therefore recorded above within other operational income.

Note 9.2 Gloucestershire Hospitals NHS Foundation Trust as a lessee

The Trust provides staff (subject to meeting certain criteria) with a lease vehicle, which is available for both personal and business duties. This is based on the NHS lease scheme. Vehicles are initially leased on a fully maintained basis for 3 years with an option to extend to a fourth year.

The Trust occupies a former Victorian Warehouse converted to office accommodation which houses the County's Finance and Procurement Shared Services. This lease has 1 yrs and 6 months remaining.

	Group	
	2015/16	**2014/15**
	£000	**£000**
Operating lease expense		
Minimum lease payments	511	598
Contingent rents	-	-
Less sublease payments received	-	-
Total	**511**	**598**

	31 March 2016	**31 March 2015**
	£000	**£000**
Future minimum lease payments due:		
- not later than one year;	470	77
- later than one year and not later than five years;	164	522
- later than five years.	-	-
Total	**634**	**598**
Future minimum sublease payments to be received	-	-

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	Group	
	2015/16	2014/15
	£000	£000
Interest on bank accounts	32	30
Investment income on NHS charitable funds financial assets	179	60
Total	**211**	**90**

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	Group	
	2015/16	2014/15
	£000	£000
Interest expense:		
Loans from the Department of Health	1,570	1,661
Finance leases	345	411
Main finance costs on PFI and LIFT schemes obligations	1,421	1,496
Contingent finance costs on PFI and LIFT scheme obligations	851	838
Total interest expense	**4,187**	**4,406**
Other finance costs	-	-
Total	**4,187**	**4,406**

Note 11.2 The late payment of commercial debts (interest) Act 1998

The Trust did not incur any expenditure relating to the late payment of commercial debt.

Note 12 Foundation Trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The Trust's surplus for the period was £4.7 million and deficit (2014/15: £14.1 million). The Trust's total comprehensive income/(expense) for the period was £500.3million (2014/15: £480.4 million).

Note 13.1 Intangible assets - 2015/16

Trust & Group	Development expenditure	Total
	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	**594**	**594**
Valuation/gross cost at start of period for new FTs	**-**	**-**
Additions	2,990	**2,990**
Gross cost at 31 March 2016	**3,584**	**3,584**
Amortisation at 1 April 2015 - brought forward	**-**	**-**
Amortisation at start of period for new FTs	**-**	**-**
Provided during the year	-	**-**
Amortisation at 31 March 2016	**-**	**-**
Net book value at 31 March 2016	**3,584**	**3,584**
Net book value at 1 April 2015	**594**	**594**

Note 13.2 Intangible assets - 2014/15

Trust & Group	Development expenditure	Total
	£000	£000
Valuation/gross cost at 1 April 2014 - as previously stated	**-**	**-**
Prior period adjustments	-	**-**
Gross cost at 1 April 2014 - restated	**-**	**-**
Gross cost at start of period for new FTs	**-**	**-**
Additions	594	**594**
Valuation/gross cost at 31 March 2015	**594**	**594**
Amortisation at 1 April 2014 - as previously stated	**-**	**-**
Prior period adjustments	-	**-**
Amortisation at 1 April 2014 - restated	**-**	**-**
Amortisation at start of period for new FTs	**-**	**-**
Provided during the year	-	**-**
Amortisation at 31 March 2015	**-**	**-**
Net book value at 31 March 2015	**594**	**594**
Net book value at 1 April 2014	**-**	**-**

Note 14.1 Property, plant and equipment - 2015/16

Trust & Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	**33,654**	**238,249**	**10,695**	**2,666**	**65,327**	**576**	**25,950**	**336**	**377,452**
Valuation/gross cost at start of period for new FTs	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Additions	-	4,477	-	1,541	5,731	-	3,589	-	**15,338**
Impairments	-	(5,247)	(1,784)	-	-	-	-	-	**(7,031)**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	2,258	-	(2,258)	-	-	-	-	**-**
Revaluations	1,077	6,671	-	-	-	-	-	-	**7,748**
Valuation/gross cost at 31 March 2016	**34,731**	**246,408**	**8,911**	**1,949**	**71,058**	**576**	**29,539**	**336**	**393,507**
Accumulated depreciation at 1 April 2015 - brought forward	**(45)**	**10,172**	**720**	**-**	**45,424**	**536**	**21,721**	**326**	**78,854**
Depreciation at start of period for new FTs	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	-	3,637	219	-	4,545	35	1,404	7	**9,847**
Impairments	-	2,133	-	-	-	-	-	-	**2,133**
Reversals of impairments	-	(5,928)	-	-	-	-	-	-	**(5,928)**
Revaluations	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2016	**(45)**	**10,014**	**939**	**-**	**49,969**	**571**	**23,125**	**333**	**84,906**
Net book value at 31 March 2016	**34,776**	**236,394**	**7,972**	**1,949**	**21,089**	**5**	**6,414**	**3**	**308,601**
Net book value at 1 April 2015	**33,699**	**228,077**	**9,975**	**2,666**	**19,903**	**40**	**4,229**	**10**	**298,598**

Note 14.2 Property, plant and equipment - 2014/15

Trust & Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2014 - as previously stated	**33,210**	**240,538**	**7,732**	**9,079**	**59,800**	**660**	**24,203**	**320**	**375,542**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation/gross cost at 1 April 2014 - restated	**33,210**	**240,538**	**7,732**	**9,079**	**59,800**	**660**	**24,203**	**320**	**375,542**
Valuation/gross cost at start of period for new FTs	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Additions - purchased/ leased/ grants/ donations	-	12,944	-	887	5,876	-	1,747	16	**21,470**
Impairments	(1,213)	(23,118)	-	-	-	-	-	-	**(24,331)**
Reversals of impairments	-	424	-	-	-	-	-	-	**424**
Revaluations	1,657	7,461	2,963	-	-	-	-	-	**12,081**
Disposals / derecognition	-	-	-	(7,300)	(349)	(84)	-	-	**(7,733)**
Valuation/gross cost at 31 March 2015	**33,654**	**238,249**	**10,695**	**2,666**	**65,327**	**576**	**25,950**	**336**	**377,452**
Accumulated depreciation at 1 April 2014 - as previously stated	**(45)**	**(419)**	**562**	**-**	**41,110**	**585**	**20,314**	**320**	**62,427**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2014 - restated	**(45)**	**(419)**	**562**	**-**	**41,110**	**585**	**20,314**	**320**	**62,427**
Depreciation at start of period for new FTs	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	-	10,591	158	-	4,474	35	1,407	6	**16,671**
Disposals / derecognition	-	-	-	-	(160)	(84)	-	-	**(244)**
Accumulated depreciation at 31 March 2015	**(45)**	**10,172**	**720**	**-**	**45,424**	**536**	**21,721**	**326**	**78,854**
Net book value at 31 March 2015	**33,699**	**228,077**	**9,975**	**2,666**	**19,903**	**40**	**4,229**	**10**	**298,598**
Net book value at 1 April 2014	**33,255**	**240,957**	**7,170**	**9,079**	**18,690**	**75**	**3,889**	**-**	**313,115**

Note 14.3 Property, plant and equipment financing - 2015/16

Trust & Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2016									
Owned	32,161	194,605	(0)	1,949	11,267	5	6,414	3	**246,403**
Finance leased	2,615	8,929	7,972	-	7,260	-	-	-	**26,776**
On-SoFP PFI contracts and other service concession arrangements	-	30,503	-	-	-	-	-	-	**30,503**
Donated	-	2,357	-	-	2,562	-	-	-	**4,919**
NBV total at 31 March 2016	**34,776**	**236,394**	**7,972**	**1,949**	**21,089**	**5**	**6,414**	**3**	**308,601**

Note 14.4 Property, plant and equipment financing - 2014/15

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2015									
Owned	32,157	182,221	-	2,666	8,474	40	4,229	10	**229,797**
Finance leased	1,542	9,692	9,975	-	8,842	-	-	-	**30,050**
On-SoFP PFI contracts and other service concession arrangements	-	33,956	-	-	-	-	-	-	**33,956**
Donated	-	2,208	-	-	2,587	-	-	-	**4,795**
NBV total at 31 March 2015	**33,699**	**228,077**	**9,975**	**2,666**	**19,903**	**40**	**4,229**	**10**	**298,598**

Disclosure

Included within the land (£2,615k) and dwelling (£7,972k) above at 31 March 2015 relate to a number of properties formerly in the ownership of Gloucestershire Royal NHS Trust and the East Gloucestershire NHS Trust (which now form the Gloucestershire Hospitals NHS Foundation Trust) sold to a registered Housing Association in April 2000 and June 2004 respectively. These units were for residential accommodation mainly to NHS staff and families. The registered Housing Association is now responsible for this provision with the Trust having nomination rights. Both separate agreements contain a 99 year lease with a Trust only option to break at 30 years and every 5 years, which if exercised will enable the Trust to take back the freehold of the land and buildings with vacant possession at no cost. They have been valued by the independent professional advisor on a fair value basis.

Plant and machinery includes a number of "finance leases" included as part of the IFRS requirements which relate to high cost medical equipment which the Trust will use for the whole primary lease period which is consistent with its perceived asset life. At the balance sheet date the value of these leases equates to £8,842k. This equipment is for Radiology equipment, linear accelerators and ultrasound machines . At the Statement of Financial Position date the Trust has entered into 6 new finance leases agreements, the equipment was made available during the year. The minimum payments under the lease total £500k payable over 7 or 5 years.

Included within building is the PFI scheme consisting of a Diagnostic & Treatment centre, therapy services, a new accident and emergency department and 75 inpatient bed spaces. The scheme was handed over in April 2002 and runs for 31 years and 10 months from that date. The initial scheme cost including all fees was £38m. The value at the Statement of Financial Position date is £30.5m.

With the exception of plant and machinery the above values have been determined by the DTZ revaluation of the Trust estate to DRC values consistent with Department of Health guidance. A formal review of the values was undertaken by the District Valuer in 2012/13 with the effective date being 31 March 2013.

The residential accommodation properties above have been valued at market value, which have been valued under fair value as above.

In April 2011 a new Multi Storey Car Park became operational. This facility has been constructed by a third party on land owned by the Trust and leased to the Third party for a period of 30 years.

During that period the car park will be used for car parking by staff and visitors at Gloucestershire Royal Hospital. The third party operator will receive all income and be responsible for all out goings with the Trust receiving income when a certain level of receipts are achieved. The value of its construction was £8.7m, which was brought onto the balance sheet at 31 March 2012 as a leased asset offset by deferred income.

In August 2014 the new Hereford Radiotherapy Centre became operational. This facility has been constructed on land owned by a third party This has previously been classified as a asset under construction and in 2014-15 was reclassified as a long term debtor to be amortised over a period of 25 years.

Note 15 Donations of property, plant and equipment

Additions - donated relate to assets either purchased wholly or items partially funded by the Trust's own charitable funds. The Charitable Funds are administered by the Trust's Main Board as corporate Trustees. Funds are registered with the Charity Commissioners registration charity number 1051606. Additionally from time to time an external charity working closely with the Trust may provide funding directly for a capital project.

Note 16 Revaluations of property, plant and equipment

The value and remaining useful asset lives of land and building assets are estimated by Debenham Tie Zeung Ltd (DTZ). The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property.

The difference between the methodologies adopted by the Valuation Office and DTZ is that in assessing the value of individual components within a building, DTZ recognise the need to replace elements of a building such as the electrics and lifts during a buildings lifecycle rather than giving an asset life for just the building as a whole. If not accounted for individually the life span of a building artificially reduces and gives an unrealistic residual life for the asset.

A desk top valuation exercise was undertaken during 2015/16 in line with national guidance on revaluation cycles. At the valuation date of 31 March 2016 by DTZ, land and buildings have suffered an overall impairment loss, i.e. a reduction in value totalling £9.1m. In addition some land and buildings have increased value totalling £13.7m. The net effect of these changes in value amounts to an overall increase in land and buildings of £4.5m.

The appropriate assets have been written down to their recoverable amount within the Statement of Financial Position, with the loss charged to the revaluation reserve to the extent there was a balance remaining and thereafter to expenditure as an impairment of property, plant and equipment.

Note 17.1 Investments - 2015/16

Trust & Group	Other investments
	£000
Carrying value at 1 April 2015	**2,423**
Movement in fair value	(112)
Disposals	(337)
Carrying value at 31 March 2016	**1,974**

Note 17.2 Investments - 2014/15

Trust & Group	Other investments
	£000
Carrying value at 1 April 2014	**2,349**
Prior period adjustment	-
Carrying value at 1 April 2014 - restated	**2,349**
Movement in fair value	74
Carrying value at 31 March 2015	**2,423**

Note 18 Analysis of charitable fund reserves

	31 March 2016 £000	31 March 2015 £000
Unrestricted funds:		
Unrestricted income funds	1,688	2,167
Other reserves	331	442
Restricted funds:		
Restricted income funds	2	40
	2,021	**2,649**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested,or retained for use rather than expended.

Note 19 Inventories

	31 March 2016		31 March 2015	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Drugs	3,403	3,403	3,511	3,511
Consumables	4,186	4,186	4,431	4,431
Energy	446	446	96	96
Total inventories	**8,036**	**8,036**	**8,039**	**8,039**

Inventories recognised in expenses for the year were -£68,406k (2014/15: -£62,450k). Write-down of inventories recognised as expenses for the year were £0k (2014/15: £0k).

Note 20.1 Trade receivables and other receivables

	31 March 2016		31 March 2015	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Current				
Trade receivables due from NHS bodies	27,484	27,484	13,236	13,236
Other receivables due from related parties	-	-	1,611	1,611
Provision for impaired receivables	(1,124)	(1,124)	(1,199)	(1,199)
Prepayments (non-PFI)	1,208	1,208	1,344	1,344
Accrued income	249	249	2,795	2,795
PDC dividend receivable	-	-	237	237
VAT receivable	703	703	939	939
Other receivables	3,105	3,105	2,260	2,260
Trade and other receivables held by NHS charitable funds	-	38	-	260
Total current trade and other receivables	**31,625**	**31,663**	**21,222**	**21,482**
Non-current				
Other receivables	4,505	4,505	7,829	7,829
Total non-current trade and other receivables	**4,505**	**4,505**	**7,829**	**7,829**

Note 20.2 Provision for impairment of receivables

	2015/16		2014/15	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
At 1 April as previously stated	**1,199**	**1,199**	**1,240**	**1,240**
Prior period adjustments	-	-	-	-
At 1 April - restated	**1,199**	**1,199**	**1,240**	**1,240**
At start of period for new FTs	**-**	**-**	**-**	**-**
Increase in provision	38	38	138	138
Amounts utilised	(113)	(113)	(64)	(64)
Unused amounts reversed	-	-	(115)	(115)
At 31 March	**1,124**	**1,124**	**1,199**	**1,199**

Note 20.3 Analysis of impaired receivables

Trust & Group	**31 March 2016**		**31 March 2015**	
	Trade receivables	**Other receivables**	**Trade receivables**	**Other receivables**
Ageing of impaired receivables	**£000**	**£000**	**£000**	**£000**
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	-	-	-	-
Over 180 days	1,124	-	1,314	-
Total	**1,124**	**-**	**1,314**	**-**
Ageing of non-impaired receivables past their due date				
0 - 30 days	1,467	-	1,130	-
30-60 Days	973	-	221	-
60-90 days	117	-	108	-
90- 180 days	107	-	77	-
Over 180 days	1,308	-	912	-
Total	**3,972**	**-**	**2,447**	**-**

Note 21 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2015/16		2014/15	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
At 1 April	**10,695**	**10,695**	**11,939**	**12,408**
Prior period adjustments	-	-	-	-
At 1 April (restated)	**10,695**	**10,695**	**11,939**	**12,408**
At start of period for new FTs	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-
Net change in year	(6,547)	(6,547)	(1,713)	(1,713)
At 31 March	**4,148**	**4,148**	**10,226**	**10,695**
Broken down into:				
Cash at commercial banks and in hand	-	-	13	13
Cash with the Government Banking Service	3,950	4,148	10,649	10,682
Deposits with the National Loan Fund	-	-	-	-
Other current investments	-	-	-	-
Total cash and cash equivalents as in SoFP	**3,950**	**4,148**	**10,662**	**10,695**
Bank overdrafts (GBS and commercial banks)	-	-	-	-
Drawdown in committed facility	-	-	-	-
Total cash and cash equivalents as in SoCF	**3,950**	**4,148**	**10,662**	**10,695**

Note 21.1 Third party assets held by the NHS foundation trust

The Trust held £2k cash and cash equivalents at 31 March 2016 (£5k at 31 March 2015) which relates to monies held by the Trust on behalf of patients

Note 22.1 Trade and other payables

	31 March 2016		31 March 2015	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Current				
Receipts in advance	-	-	-	-
NHS trade payables	3,748	3,748	5,186	5,186
Amounts due to other related parties	-	-	4,177	4,177
Other trade payables	2,206	2,206	-	-
Capital payables	3,696	3,696	1,705	1,705
Social security costs	5,818	5,818	5,779	5,779
VAT payable	-	-	-	-
Other taxes payable	-	-	-	-
Other payables	23,058	23,058	27,891	27,891
Accruals	18,262	18,262	-	-
PDC dividend payable	62	62	-	-
Trade and other payables held by NHS charitable funds	-	307	-	16
Total current trade and other payables	**56,850**	**57,157**	**44,737**	**44,753**
Non-current				
Total non-current trade and other payables	**-**	**-**	**-**	**-**

Note 23 Other liabilities

	31 March 2016		31 March 2015	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Current				
Deferred grants income	497	497	1,084	1,084
Total other current liabilities	**497**	**497**	**1,084**	**1,084**
Non-current				
Other deferred income	7,987	7,987	8,363	8,363
Total other non-current liabilities	**7,987**	**7,987**	**8,363**	**8,363**

Note 24 Borrowings

	31 March 2016		31 March 2015	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Current				
Loans from the Department of Health	2,635	2,635	2,635	2,635
Obligations under finance leases	2,129	2,129	2,232	2,232
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	519	519	976	976
Total current borrowings	**5,283**	**5,283**	**5,843**	**5,843**
Non-current				
Loans from the Department of Health	29,179	29,179	31,814	31,814
Obligations under finance leases	6,049	6,049	7,430	7,430
Obligations under PFI, LIFT or other service concession contracts	19,309	19,309	19,839	19,839
Total non-current borrowings	**54,537**	**54,537**	**59,083**	**59,083**

Note 25 Other financial liabilities

The Trust does not have any other financial liabilities

Note 26 Finance leases

Trust as a lessor

Future lease receipts due under finance lease agreements where Gloucestershire Hospitals NHS Foundation Trust is the lessor:

The Trust did not have any finance lease agreement as a lessor.

Trust as a lessee

Obligations under finance leases where Gloucestershire Hospitals NHS Foundation Trust is the lessee.

	31 March 2016		31 March 2015	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Gross lease liabilities	**9,034**	**9,034**	**10,893**	**10,893**
of which liabilities are due:				
- not later than one year;	2,400	2,400	2,236	2,236
- later than one year and not later than five years;	5,618	5,618	6,360	6,360
- later than five years.	1,016	1,016	2,297	2,297
Finance charges allocated to future periods	(857)	(857)	(1,231)	(1,231)
Net lease liabilities	**8,177**	**8,177**	**9,662**	**9,662**
of which payable:				
- not later than one year;	2,129	2,129	2,232	2,232
- later than one year and not later than five years;	5,158	5,158	5,409	5,409
- later than five years.	891	891	2,021	2,021
	8,177	**8,177**	**9,662**	**9,662**

Note 27.1 Provisions for liabilities and charges analysis

Trust & Group	Pensions - other staff	Other legal claims	Total
	£000	£000	£000
At 1 April 2015	**688**	**177**	**865**
Change in the discount rate	1	-	**1**
Arising during the year	943	40	**983**
Utilised during the year	(88)	(55)	**(143)**
Reversed unused	(69)	(63)	**(132)**
Unwinding of discount	8	-	**8**
At 31 March 2016	**1,483**	**99**	**1,582**
Expected timing of cash flows:			
- not later than one year;	87	99	**186**
- later than one year and not later than five years;	348	-	**348**
- later than five years.	1,048	-	**1,048**
Total	**1,483**	**99**	**1,582**

Trust & Group	Pensions - other staff	Other legal claims	Total
	£000	£000	£000
At 1 April 2015	**612**	**220**	**832**
Change in the discount rate	33	-	**33**
Utilised during the year	(86)	(3)	**(89)**
Reversed unused	-	(40)	**(40)**
Unwinding of discount	130	-	**130**
At 31 March 2016	**688**	**177**	**865**
Expected timing of cash flows:			
- not later than one year;	87	177	**264**
- later than one year and not later than five years;	300	-	**300**
- later than five years.	301	-	**301**
Total	**688**	**177**	**865**

Note 27.2 Clinical negligence liabilities

At 31 March 2016, £155,041k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Gloucestershire Hospitals NHS Foundation Trust (31 March 2015: £95,848k).

Note 28 Contingent assets and liabilities

	31 March 2016		31 March 2015	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Value of contingent liabilities				
NHS Litigation Authority legal claims	-	-	-	-
Employment tribunal and other employee related litigation	-	-	-	-
Redundancy	-	-	-	-
Other	(790)	(790)	(500)	(500)
Gross value of contingent liabilities	**(790)**	**(790)**	**(500)**	**(500)**
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	**(790)**	**(790)**	**(500)**	**(500)**
Net value of contingent assets	**-**	**-**	**-**	**-**

Note 29 Contractual capital commitments

	31 March 2016		31 March 2015	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Property, plant and equipment	1,800	1,800	381	381
Intangible assets	2,700	2,700	-	-
Total	**4,500**	**4,500**	**381**	**381**

Note 30 Defined benefit pension schemes

The Trust's past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Note 31 On-SoFP PFI, LIFT or other service concession arrangements

Note 31.1 Imputed finance lease obligations

The trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2016		31 March 2015	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Gross PFI, LIFT or other service concession liabilities	**35,759**	**35,759**	**38,157**	**38,157**
Of which liabilities are due				
- not later than one year;	1,882	1,882	2,398	2,398
- later than one year and not later than five years;	6,981	6,981	7,111	7,111
- later than five years.	26,896	26,896	28,648	28,648
Finance charges allocated to future periods	(15,931)	(15,931)	(17,342)	(17,342)
Net PFI, LIFT or other service concession arrangement obligation	**19,828**	**19,828**	**20,815**	**20,815**
- not later than one year;	519	519	976	976
- later than one year and not later than five years;	1,866	1,866	1,866	1,866
- later than five years.	17,443	17,443	17,973	17,973
	19,828	**19,828**	**20,815**	**20,815**

Note 31.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

The trust's total future obligations under these on-SoFP schemes are as follows:

	31 March 2016		31 March 2015	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	107,816	107,816	112,532	112,532
Of which liabilities are due				
- not later than one year;	4,834	4,834	4,716	4,716
- later than one year and not later than five years;	20,575	20,575	20,073	20,073
- later than five years.	82,407	82,407	87,743	87,743
	107,816	**107,816**	**112,532**	**112,532**

Note 31.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's expenditure in 2015/16:

	31 March 2016		31 March 2015	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Unitary payment payable to service concession operator	**4,716**	**4,716**	**5,086**	**5,086**
Consisting of:				
- Interest charge	**1,421**	**1,421**	**1,496**	**1,496**
- Repayment of finance lease liability	**976**	**976**	**1,108**	**1,108**
- Service element	**1,092**	**1,092**	**927**	**927**
- Capital lifecycle maintenance	**-**	**-**	**-**	**-**
- Revenue lifecycle maintenance	**376**	**376**	**717**	**717**
- Contingent rent	**851**	**851**	**838**	**838**
Total amount paid to service concession operator	**4,716**	**4,716**	**5,086**	**5,086**

Note 32 Off-SoFP PFI, LIFT and other service concession arrangements

The Trust has no Off-SoFP PFI scheme.

Note 33 Financial instruments

Note 33.1 Financial risk management

A financial instrument is a contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

IFRS 7, Financial Instruments Disclosure and Presentation, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities.

Credit Risk

Because of the continuing service provider relationship that the NHS Foundation Trust has with local Clinical Commissioning Groups and NHS England and the way those bodies are financed, the NHS Foundation Trust is not exposed to the degree of credit risk faced by many other business entities. The Trust has invoices for services and facilities provided to NHS organisations which are currently being queried by the other parties, notably NHS bodies, within Gloucestershire and Welsh NHS bodies .These are subject to a bad debt provision as set out in note 19.2. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies.

Market Risk

This is the risk that the fair value or cash flows of a financial instrument will fluctuate because of changes in market prices. This includes currency risk (foreign exchange rates) and interest rate risk.

The NHS Foundation Trust has limited powers to borrow or invest surplus funds. Cash is held on deposit with a number of safe harbour institutions which are deemed to have significantly low risk and high liquidity.

100% of the Foundation Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Gloucestershire Hospitals NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk. The Trusts PFI scheme unitary payments are linked to RPI.

Liquidity risk

This is the risk that the NHS Foundation Trust will encounter difficulties meeting obligations associated with financial liabilities.

The NHS Foundation Trust's net operating costs are incurred under annual service agreements with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Foundation Trust also largely finances its capital expenditure from funds made available from Government under an agreed limit. Gloucestershire Hospitals NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

Note 33.2 Financial assets

Trust & Group	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2016					
Trade and other receivables excluding non financial assets	31,671	-	-	-	**31,671**
Cash and cash equivalents at bank and in hand	3,950	-	-	-	**3,950**
Financial assets held in NHS charitable funds	198	1,974	-	-	**2,172**
Total at 31 March 2016	**35,819**	**1,974**	**-**	**-**	**37,793**

Trust & Group	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2015					
Trade and other receivables excluding non financial assets	20,193	-	-	-	**20,193**
Cash and cash equivalents at bank and in hand	10,662	-	-	-	**10,662**
Financial assets held in NHS charitable funds	293	2,423	-	-	**2,716**
Total at 31 March 2015	**31,148**	**2,423**	**-**	**-**	**33,571**

Note 33.3 Financial liabilities

Trust & Group	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2016			
Borrowings excluding finance lease and PFI liabilities	31,814	-	**31,814**
Obligations under finance leases	8,177	-	**8,177**
Obligations under PFI, LIFT and other service concession contracts	19,828	-	**19,828**
Trade and other payables excluding non financial liabilities	57,100	-	**57,100**
Total at 31 March 2016	**116,919**	**-**	**116,919**

Trust & Group	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2015			
Borrowings excluding finance lease and PFI liabilities	34,448	-	**34,448**
Obligations under finance leases	9,662	-	**9,662**
Obligations under PFI, LIFT and other service concession contracts	20,815	-	**20,815**
Trade and other payables excluding non financial liabilities	34,782	-	**34,782**
Provisions under contract	865	-	**865**
Financial liabilities held in NHS charitable funds	16	-	**16**
Total at 31 March 2015	**100,589**	**-**	**100,589**

Note 33.4 Maturity of financial liabilities

	31 March 2016		31 March 2015	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
In one year or less	62,382	62,382	41,515	41,515
In more than one year but not more than two years	5,283	5,283	5,204	5,204
In more than two years but not more than five years	12,281	12,281	13,562	13,562
In more than five years	36,973	36,973	40,308	40,308
Total	**116,919**	**116,919**	**100,589**	**100,589**

Note 33.5 Fair values of financial assets at 31 March 2016
Financial Assets are carried at cost which is not considered to be significantly different to fair value.

Note 33.6 Fair values of financial liabilities at 31 March 2016
Financial Liabilities are carried at cost which is not considered to be significantly different to fair value.

Note 34 Losses and special payments

Group and Trust	2015/16 Total number of cases Number	2015/16 Total value of cases £000	2014/15 Total number of cases Number	2014/15 Total value of cases £000
Losses				
Bad debts and claims abandoned	1,258	157	1,066	64
Total losses	**1,258**	**157**	**1,066**	**64**
Special payments				
Ex-gratia payments	30	7	44	36
Total special payments	**30**	**7**	**44**	**36**
Total losses and special payments	**1,288**	**164**	**1,110**	**100**
Compensation payments received		-		-

Note 35 Transfers by absorption

The Trust had no transfer by absorption.

[Note 36 Prior period adjustments

The Trust had no prior period adjustments.

Note 37 Events after the reporting date

The Trust has no events after the reporting date.

Note 38 Related parties

Gloucestershire Hospitals NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the period, none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Gloucestershire Hospitals NHS Foundation Trust.

The Department of Health is regarded as a related party. During the period, Gloucestershire Hospitals NHS Foundation Trust, including in carrying out its role of host to the Gloucestershire Finance, Procurement and Estates Shared Services, has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

NHS Gloucestershire CCG
NHS Wyre Forest CCG
NHS Redditch & Bromsgrove CCG
NHS South Worcestershire CCG
NHS Herefordshire CCG
NHS Wiltshire CCG
NHS Swindon CCG
NHS South Warwickshire CCG
NHS Oxfordshire CCG
NHS England
Wye Valley NHS Trust
Gloucester City Council
Cheltenham Borough Council
NHS Litigation Authority
NHS Logistics Authority
National Blood Authority
NHS Pensions Agency

The Foundation Trust has also received revenue and capital payments from its charitable fund. The Trustees of this fund are also members of the NHS Foundation Trust Board.

	Receivables		Payables	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Value of balances with related parties				
- Department of Health	63	295	62	-
- Other NHS bodies	25,815	13,444	2,916	4,652
Total	**25,878**	**13,739**	**2,978**	**4,652**

	Income		Expenditure	
	2015/16 £000	2014/15 £000	2015/16 £000	2014/15 £000
Value of balances with related parties				
- Department of Health	202	-	-	4
- Other NHS bodies	482,235	462,072	26,035	22,976
Total	**482,437**	**462,072**	**26,035**	**22,980**

Average number of employees (WTE basis)

	Group			
	Permanent Number	Other Number	2015/16 Total Number	2014/15 Total Number
Medical and dental	1,240	2	**1,242**	1,188
Administration and estates	1,406	16	**1,422**	1,387
Healthcare assistants and other support staff	374	6	**380**	373
Nursing, midwifery and health visiting staff	2,744	64	**2,808**	2,715
Scientific, therapeutic and technical staff	1,206	7	**1,213**	1,203
Other	-	5	**5**	3
Total average numbers	**6,970**	**100**	**7,070**	**6,869**
Of which:				
Number of employees (WTE) engaged on capital projects	21	19	**40**	6

Reporting of compensation schemes - exit packages 2015/16

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
£25,001 - 50,000	1	-	**1**
Total number of exit packages by type	**1**	**-**	**1**
Total resource cost (£)	£30,000	£0	**£30,000**

Reporting of compensation schemes - exit packages 2014/15

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
£10,001 - £25,000	-	1	**1**
£50,001 - £100,000	-	1	**1**
Total number of exit packages by type	**-**	**2**	**2**
Total resource cost (£)	£0	£74,300	**£74,300**

Exit packages: other (non-compulsory) departure payments

	2015/16		2014/15	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	2	74
Total	**-**	**-**	**2**	**74**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

For all off-payroll engagements as of 31 Mar 2016, for more than £220 per day and that last for longer than six months

	2015/16 Number of engagements
Number of existing engagements as of 31 Mar 2016	15
Of which:	
Number that have existed for less than one year at the time of reporting	7
Number that have existed for between one and two years at the time of reporting	5
Number that have existed for between two and three years at the time of reporting	2
Number that have existed for between three and four years at the time of reporting	1
Number that have existed for four or more years at the time of reporting	-

For all new off-payroll engagements, or those that reached six months in duration, between 01 Apr 2015 and 31 Mar 2016, for more than £220 per day and that last for longer than six months

	2015/16 Number of engagements
Number of new engagements, or those that reached six months in duration between 01 Apr 2015 and 31 Mar 2016	9
Number of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and national insurance obligations	9
Number for whom assurance has been requested	9
Of which:	
Number for whom assurance has been received	9
Number for whom assurance has not been received	-
Number that have been terminated as a result of assurance not being received	-

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 Apr 2015 and 31 Mar 2016

	2015/16 Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	-
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	14

Work Stream Progress Report

CULTURE CHANGE PROGRAMME

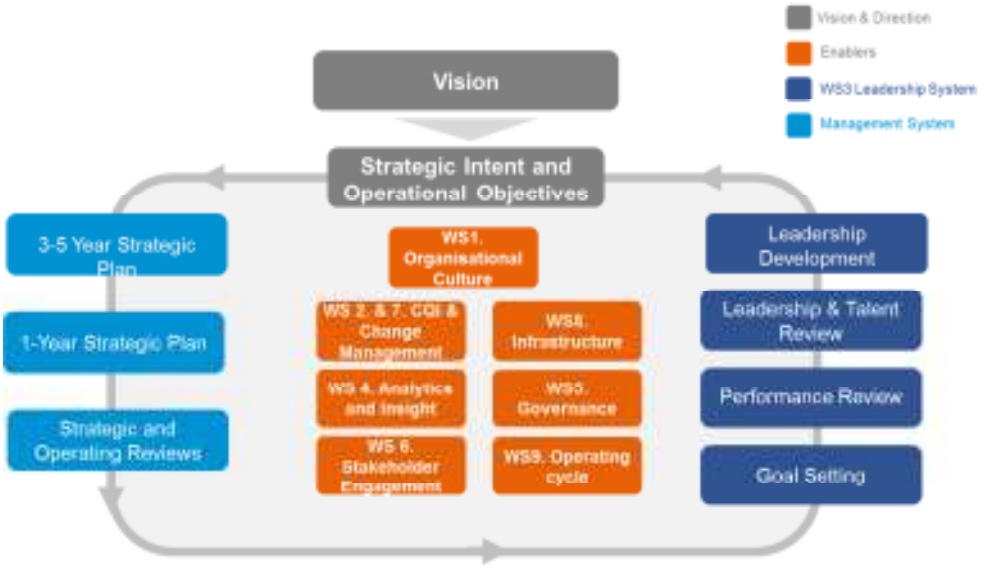
TRUST BOARD, 20 May, 2016

1 Executive Summary

1.1 The programme is expected to define and implement new and revised organisational systems and enabler processes (work streams) to provide the Trust with the framework and tools required to deliver the vision and transform the Trust from an 'OK' organisation to a 'fantastic' organisation.

1.2 The main aims of this proposed shift in culture and performance are to:

- Empower leaders and managers
- Build on, and improving our reputation
- Develop consistent pathways, outcomes, experience
- Address the issues that prevent our current system from delivering
- Respond to social and moral pressure (e.g. on 7-day services)
- Retain & develop our workforce and making them feel valued
- Encourage creativity so we can determine our own destiny
- Maximise the use of technology
- Move to a stable and sustainable financial model.



1.3 Each work stream is managed by a work stream lead drawn from our current teams, and is sponsored by an executive director. There are however, gaps within the structure (work streams 1 and 9) and some anticipated changes within the work stream lead team, most notably work stream 3 (from end July) and work stream 4 (from end May).

Work Stream Progress Report

Work Stream	Board Sponsor	Work Stream Lead
1. Culture Change	CEO	
2. Continuous Quality Improvement and 7. Change Management	CEO Dr S Pearson	Mr A Seaton Mr I Quinnell
3. Leadership	Mr D Smith	Ms B Wheeler
4. Analytics & Insight	Ms H Simpson	Mr P Hopwood
5. Governance	Prof. C Chilvers	Mr M Wood
6. Stakeholder Engagement	Dr S Pearson, Mr D Smith	Mr C MacFarlane
8. Infrastructure	Ms H Simpson	Mr N Jackson
9. Operating cycle	Dr S Elyan, Mr E Gatling	

1.4 In brief, the purpose of each work stream is outlined below:

- Organisational Culture: To develop an engaged and involved workforce who work in an increasingly devolved and effective organisation.
- Continuous Quality Improvement: To embed Continuous Quality Improvement (CQI) in our normal, everyday working.
- Change Management: To strengthen our organisational capability to plan, test, implement, monitor, evaluate and embed service change.
- Leadership: To equip the organisation with the excellent leadership and followership required to consistently deliver our vision and objectives.
- Analytics & Insight: To move from a descriptive reporting of the past to a predictive forward looking approach providing scenarios, benchmarks and advice on appropriate actions to take.
- Governance: To provide excellent governance to underpin our vision and objectives.
- Stakeholder Engagement: To achieve exemplary engagement levels with all internal and external stakeholders.
- Infrastructure: To provide the best environment we can for patients and staff by optimising our available capital spend to invest or adapt our building and service infrastructure.
- Operating Cycle: To define and establish an operational drumbeat that plans prospectively to avoid reactive management and crisis intervention.

2 Programme benefits

2.1 At the outset, the desired visible benefits of the programme were defined by the Board (see table overleaf).

Work Stream Progress Report

Domain	Outcome	How we will measure it
Our Staff (workforce)	We have staff that are good enough to leave, but happy enough to stay	• Talent management process established • Turnover rate for talent pool is ≤5% • We are in the top 10% of Trusts in the country for staff engagement scores • We have a healthy staff turnover rate – between 7 and 9.5% • Our appraisal ratings for senior managers aligns to trust performance scores and average ≥2.5 out of 3 • 100% staff receive an annual appraisal and we are in the top 10% of Trusts in the country for staff participating in a quality appraisal
	We are known and renowned for the quality of our education and development	• Feedback from students and the deanery • We are in the top 10% of Trusts in the county for staff survey education and development scores
	GHFT is an employer of choice	• There is a waiting list for jobs • We have a staff attraction strategy underpinned by an employee proposition measured through new starter questionnaires
	We have effective leadership across all levels of the organisation	• Our leaders are visible on the shop floor • We can evidence aspirational and inspiration leadership across the Trust
Our Patients	Patients trust us and have confidence in the safety of the care we deliver	• We are in the top 10% for patient survey results • We are in the top 10% in the country for staff recommending the trust as a place to receive treatment • At the next CQC inspection the Trust is rated good overall, with outstanding features and is rated outstanding overall at the subsequent inspection

Work Stream Progress Report

Domain	Outcome	How we will measure it
Our Business (reputation)	Our internal and external stakeholder engagement plan and methods are exemplary	• External 'pulse checks' provide evidence that our system partners are informed, engaged and rate us as 'fantastic' • Internal 'pulse checks' provide evidence that staff are informed, communication is open and honest and staff are encouraged and supported to raise concerns and ideas knowing they will be heard and acted upon • There is consistency in the way we promote and present ourselves externally e.g. all external messages are linked to overarching themes linked to our long term strategy
	We are recognised nationally and internationally for our culture, experience, improvement methodology and outcomes	• Our project closure process includes an action to promote success and lessons learned • We publicise our successful projects internally and externally • We know the timetable for submitting applications to national and international quality and safety awards and have a process that ensures we regularly provide high quality submissions • Individuals, teams and services are recognised in national awards • We receive invitations to present at national events • Our executive & clinical leaders are invited to join national and international review panels • Our executive & clinical leaders are at the heart of the strategy design for Gloucestershire - our partners want us there • We can demonstrate our rapid adoption of good research and innovation
Our Services (performance)	We are a high performing organisation	• The performance standards in our Performance Management Framework (PMF) define 'outstanding' and are above the required national standard • Our Gloucestershire Academy provides staff with a gateway to accessing Continuous Quality Improvement (CQI), change and project management training, tools, qualifications, coaching and support. • Staff access the Academy and apply the skills and tools to identify, define and implement continuous service improvement
Our Services (infrastructure)	Our environment is patient centred	• We are delivering on our long term estates plan • Staff have pride in their working environment • The working environment supports staff to deliver efficient care pathways

3 Next steps

3.1 Following a slow start to the delivery of the programme, some good progress has now been made across many of the work streams. This is detailed in the quarterly programme summary report (pages 8 - 9 of this report) and the quarterly individual work stream progress reports (pages 10 - 25). With the continued support from executive Sponsors and the Board, this progress is expected to continue, given appropriate resourcing.

3.2 With c.6-months of the programme completed, now is the ideal time to review and the Boards comments are invited on the following:

3.2.1 Programme structure

3.2.1.1 The structure of the current programme is not readily interpreted across the wider organisation in terms of how it will improve the day-to-day working of the Trust. Whilst this can, in part, be enhanced by appropriate and regular communications, for staff and patients to see, and feel, improvement within the services, the programme also needs to be 'brought to life'. In this way staff can see how they are contributing to the success of the Trusts development and how we progress towards meeting our goal of Best Care for Everyone.. Programme content

3.2.1.2 The content of the individual work streams vary greatly in terms of depth and impact. Whilst this in itself is not a problem per se, much of the activity is transactional in nature rather than real transformation.

3.2.1.3 There is no clear alignment with Trust objectives and strategies – it has to be sought.

3.2.1.4 There is no clear connection between activities within some of the work streams and the desired benefits

3.2.2 Programme positioning

3.2.2.1 The programme is the 'culture change programme' yet the content of the programme points more towards whole Trust transformation, of which culture is a part – a culmination of the outputs of the various work streams. This may add to the disconnect between the understanding of those engaged within the programme and those outside of the work stream activities.

3.2.2.2 There are a number of Trust wide initiatives/brands e.g. Extraordinary Everyday and SAFER that are both well known amongst staff, but the connections between these, and the vision are not well defined.

4 Recommendations

4.1 That consideration is given to revising the scope of the programme from culture change to transformation, of which culture will be both a part, and a key output, rather than a fixed work stream.

4.2 That the programme structure is revised to provide greater clarity on what the transformation and culture change will mean to everyone within the Trust. This should include narrative on what Best Care for Everyone will look like.

4.3 That the programme content is revised to become aligned with the Trust goals and strategic objectives:

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

4.4 That the programme is linked formally to other transformation activities within the Trust, both current and future, rather than continue as a separate, standalone activity, which further confuses the organisations understanding of the purpose and priorities of the various initiatives, innovations and changes the Board wishes to implement, i.e. to connect the vision with other activities such as ED flows, Extraordinary Everyday and

SAFER to bring to life 'how' staff are engaged in, and contributing to, performance improvement activities.

4.5 That the expected benefits are revised and prioritised, with appropriate measures, linked to the change programme activities.

4.6 That a proposal covering recommendations 4.1 – 4.5 is prepared for Board consideration at a date to be agreed, but expected to be no earlier than July, 2016.

5 Quarterly Programme Summary Progress Report

See page 8

6 Quarterly Individual Work Stream Progress Reports

See pages 10 - 26

Rebecca Wassell
Associate Director of Transformation
Gloucestershire Hospitals NHS Foundation Trust

May 2016

Work Stream Progress Report

Gloucestershire Hospitals NHS
NHS Foundation Trust

Culture Change Programme

Quarterly Summary Progress Report

Status	Last	Current	Next
	A	A	A

Key Achievements this Period

• NEDS have been invited to join the PALS team to gain insight into patient perceptions of our services and where the pressure points for staff are and to date, Prof Chilvers and Mr Foster have taken up the challenge. These observations have proven to be valuable in highlighting issues relating to organisational culture.
• Culture change work stream documents and reports have been made available to NEDS via SharePoint.
• The on-going communication of programme activity will play a key part in employee and stakeholder engagement. Each work stream is updating on progress via Outline, relating how outputs impact on day to day working. Since January, WS 3 has twice highlighted successes, and WS 4 and WS 8 will be highlighted in May.
• Work with the Finance Directorate senior team re transformation has continued
• A proposed implementation plan for the revision and re-implementation of SLM has been submitted

Key Activity Next Period

• To review and prioritise expected programme benefits and the connections between achieving the vision via the transformation programme and other initiatives and brands within the Trust.
• To review the programme structure, content and positioning within the Trust, aligning activities to Trust strategies and goals that can be measured
• To drive a campaign of inclusivity to identify what Best Care for Everyone will look like, to enable staff to see how they contribute to achieving the vision and to provide an understanding of what the transformation will mean to them in their every day work.
• To lead a work shop with newly appointed senior managers to ensure an understanding of the vision, the transformation programme and what it means for them at the local level (decision at April TMT - **ACTION: D SMITH)**

Key Milestones (see WS progress reports for detail)

WS	*Milestone*	*Status*
2/7	Staff awards recognise QI achievements	G
2/7	Mgrs./leads improvement skills	A
2/7	PM & PI toolkits	G
3	Leadership welcome, consultant induction, new appraisal papers	G
4	Future BI portal identified	Met
4	Proof of concept access with HR	G
4	ED proof of concept	G
4	Verification system	A
5	Informal programme to maintain good personal relationships amongst Board	G
6	Patient flow, emergencies & programme: newsletters & supporting	G
8	Phase 1 lead improvement programme	G

Key Issues (see WS progress reports for detail)

• Alignment of some activities with Trust objectives is not clear
• Leadership for some work streams, in particular WS 9, and (shortly) WS 3 and WS4
• Slippage on some work streams due to late decisions /resource availability.
• Progress understanding and links to day-to-day Trust activity to be taken up.
• Attendance at some meetings remains sporadic for some work streams.
• Focus and pace on achieving deliverables

Decisions Required

• To undertake a programme review as outlined within this paper
• Identify and appoint work stream leads for the outstanding items in work stream 1 and, most especially, for work stream 9.
• To determine on-going leadership capability for WS 3 and 4 •
CoS to determine level of divisional involvement/communication

Date of last Board report: 26-Feb-16

Next Board report: 26-Aug-16

Work Stream Progress Report

Key Risks

Risk Description (see individual WS progress reports for detail)	*Risk Rating*	*Mitigation (Y/N)*
WS2/7: Inability to identify a suitable knowledge base to share lessons learnt & areas of expertise across Trust	A	Y
WS 3: Insufficient resource identified within the L&OD team to explore senior leader key competency framework	A	Y
WS4: Pace of capability & product development	R	Y
WS4: Lack of leadership to drive workstream forward.	R	Y
WS5: Limited capacity to deliver programme content	R	Y
WS5: Changes to NED composition on Board	A	Y
WS6: Poor staff engagement	R	Y
WS6: Website & intranet: Costs	A	Y
WS8: Resource supporting policy development & 'Workstyles' programme engagement	A	Y
WS8: Uncertainty of clinical strategy in some areas esp. for longer term	A	Y

Key Briefings & Communications planned over next period

When?	*What?*	*Objective / Message*	*Medium / How?*
May-16	Outline	Work Streams 4 & 8 - Analytics & Insight, Infrastructure	Written articles
Jun-16	Outline	Work Stream 5 & 7 - Governance, Change Management	Written articles
Jun-16	Workshop with new key snr	Engagement with the programme and linking BAU with the vision	TBD
Jul-16	100 Leaders	Further links between the vision and local activities	TBD
Aug-16	Board report	Progress report	CEO report

Key Assumptions / Interdependencies

Description	*Impact*
WS4: Interdependency on the SmartCare programme	Delivery of Trak, its infrastructure and associated workflow metrics
WS4: Internal prioritisation of Information Unit activity allowing staff release to work on development	Failure to resource WS 4 will lead to slippage
WS 7 Leadership & Development	Design and development of programmes across a number of WS
WS8: Interdependency re Clinical strategies	Establish set of planning assumptions to inform

Changes in Scope

Description	*Impact*
WS2 and WS 7 to be fully amalgamated, to bring together the continuous improvement and change management piece under one	To remove ambiguity and to align methodologies

Work Stream Progress Report

WORK STREAMS 2 & 7 – CONTINUOUS IMPROVEMENT & CHANGE MANAGEMENT						
Date completed	02/05/16			**Version**	0.1	
Work Stream Sponsor	Dr Sally Pearson		**Work Stream Manager**	Andrew Seaton & Ian Quinnell		
Overall	**Milestones**	**Benefits**	**Budget**	**Risks & Issues**	**Scope**	**Resources**

	Approved Budget	Expected spend to-date	Actual spend to date
Capital	£0	£0	£0
Revenue	£0	£0	£0

Progress in period covering February 2016 to May 2016

Projects progressing to schedule

Continuous Improvement

- Links with Leadership team to coordinate QI & change management training has been completed.
- Co-design & shadowing tools available are being linked through Academy website and form part of the Silver training
- Discussions with Information team regarding "data over time" to be shown in Run Chart and SPC charts initiated to demonstrate variation in systems
- The role of 'Gold' is being scoped and will form part of the strategy discussions in May, this will then initiate the revision and re-design of the current infrastructure systems that support quality improvement and clinical governance.
- Bronze training for Trust Board has been completed and the First Bronze session has been delivered on Consultant Induction.
- Academy training and supervision linked with new Improvement Medical Chief Registrar posts, with the possibility of creating a medical trainee chapter.
- Advise on Emergency pathway improvement projects linking the Vision work and goals through the projects with members of ECB to be taken through the improvement training.
- The first graduation event is on the 12 May 2-5pm at Redwood with 4 prizes, the best improvement programme will go forward to the main staff awards.
- Several QI projects have been accepted as posters at the Bristol Safety Conference in May

Change Management

Current 'Leading change' training provision is being reviewed and to be aligned to the Quality Improvement Academy bronze award. The revised managing change training course has now been developed and is being delivered as part of the Management Essentials offering and signposted within the new Leadership Welcome day.

The Project Management tool kit along with –

- A project 'lite' approach has also been developed for smaller level changes. A 'Project in a file' has been developed and is now available online. This will be incorporated into the Managing Change training materials along with an overview of Project Management as a tool to deliver successful change
- Process Mapping and how to run rapid improvement event (RIE) guidance has been developed and available online. This material is aligned to the content delivered within the QIA Silver training provision

Other progress to note

- Project Plans and work stream briefs to be combined to reflect the close alignment of WS2 & WS7 going forward

Work Stream Progress Report

- A vision workshop is scheduled for 4th May to develop the QIA strategy

Planned activities in next period May 2016 to August 2016

- Provide Project Management content into revised course content to support the 'how to' aspect of the learning
- Launch new Project Management website incorporating -
  - Project in a file
  - Process Mapping and RIE guidance
  - Sign posting to training and QIA

WS 2 Milestones				
Milestone	**Date started**	**Target date for completion**	**Actual date completed**	**Comments**
Developing the QI Strategy			Sept 2016	May meeting
Recognition of individuals, teams / services for quality improvement recognised through staff awards			Sept 2016	Process agreed and planned for 2017
In-house leadership and management development programmes link to CQI			January 2016	Complete
Create improvement skills framework for managers/leads			January 2016	Final framework still being developed
GHFT improvement projects presented at national conferences			March 2017	Bristol Conference May 2016
WS 7 Milestones				
Review existing CM training provision and requirements		28/02/16	28/02/16	Complete
Develop revised training programme		31/05/16	31/05/16	Complete
Refine PM toolkit		30/01/16	30/01/16	Complete
Process Improvement toolkit		30/04/16	30/04/16	Complete
Develop solution & processes for knowledge base		31/12/16		

Risks (Where score on Risk Log requires escalation)			
ID	**Risk description**	**RAG**	**Mitigation**
	Inability to identify a suitable knowledge base in order to share lessons learnt and areas of expertise across the organisation	**A**	Define requirements and identify a solution (internal/external)
	Option to deliver the Project Management aspects of the CM course without PMSI team involvement	**G**	Fully define requirements and explore options for a solution (internal / external)

Work Stream Progress Report

Issues (Where score on Issues Log requires escalation)			
ID	**Issue description**	**RAG**	**Mitigation**
		R	
		A	

Benefits Realisation Tracking				
Ref	**Benefit**	**Definition**	**Owner**	**RAG Status**
01	Change Managers	Develop cohorts of managers to successfully deliver change across the Organisation	Ian Quinnell / OD	G
02	Change Management Training provision	To provide a comprehensive training package to enable leaders to understand the theory, the process and the 'how to' of managing change	Ian Quinnell / OD	G
03	Project & Process Management toolkit	To provide the organisation with flexible toolkits to help support the delivery of change	Ian Quinnell	G
04	Improvement Strategy	To develop a clear vision and direction that meets the future requirements of the Trust	Andrew Seaton	G
05	Accreditation of courses	Added internal and external value of the improvement programme to provide achievement and recognition rewards and motivation	Andrew Seaton	G
06	Working with partners to explore opportunities	To build reputation externally to attract interest in future courses and Gloucestershire wide improvement.	Andrew Seaton	G
07	Bronze level improvement skills for managers.	Effective management of projects using the standardised approach and tool set	Andrew Seaton	G
08	Support of a Trust critical problem – Emergency Pathway	Demonstrating in practice the usefulness of the techniques and building the QI movement and Vision	Andrew Seaton	G

Work Stream Progress Report

WORK STREAM 3 - LEADERSHIP						
Date completed	29 April 2016			**Version**	1	
Work Stream Sponsor	Dave Smith		**Work Stream Manager**	Becky Wheeler		
Overall	**Milestones**	**Benefits**	**Budget**	**Risks & Issues**	**Scope**	**Resources**

Approved Budget		Expected spend to-date	Actual spend to date
Capital	£0	£0	£0
Revenue	£0	£0	£0

Progress in period covering March 2016 to May 2016

- The Leadership Behaviours have now been finalised and are available on the intranet. An article was written for the March/April Outline highlighting the behaviours and linking to the new appraisal paperwork. The behaviours are also explored as part of all the internal management/leadership development programmes and Welcome Days.
- The appraisal paperwork has been simplified. It was launched at the 100 Leaders event in March and is now available on the intranet. All senior managers' appraisal dates have been moved to the period April – June 2016. Drop in sessions were arranged during April to further understanding where needed. The paperwork is to be trialled during this period with a session at the July 100 Leaders to gather feedback. Amendments can then be made before a full organisational launch.
- The Leadership Welcome Day was launched on 7 March. The feedback in the main was very positive and some amendments have been made as a result of listening to our staff.
- The Consultant Induction Day was launched on 25 April 2016. We will be evaluating its effectiveness directly with those Consultants who attended and a de-brief session is being arranged for Sean Elyan, Becky Wheeler and Paul Wain in order to make any necessary changes.
- Work has begun on a Knowledge, Skills and Experience Competency Framework for our clinical leadership model to align with our Leadership Behaviours Framework.
- Changes have been made to the Management Essentials Leading Change Workshop to ensure that there is synergy between the L&OD offering, the Programme Team and the QI work.
- Work has started on a Recruitment Assessment Toolkit which will incorporate our Leadership Behaviours.

Planned activities in next period May 2016 to August 2016

- De-brief session to be arranged for Consultant Induction event. Consultant Induction slide (similar to the Service Line Director Induction slide) to be finalised and disseminated to all new Consultants.
- The Knowledge, Skills and Experience Competency Framework draft to be completed for circulation initially to the Executive Team for comment and ratification.
- Appraisal paperwork to be evaluated at the July 100 Leaders event.
- Divisional teams to be contacted to revisit succession planning.
- Recruitment Assessment Toolkit to be finalised and launched.

Milestones

Milestone	Date started	Date completed	Comments
Leadership Behaviours aligned to our Trust Values	1.9.15	31.10.15	

Consultation re Leadership Behaviours	17.11.15	27.1.16	
Leadership Welcome Day programme established and publicised	1.8.15	31.1.16	
Leadership Welcome Day launched		7.3.16	
Consultant Induction Day launched		25.4.16	
Appraisal paperwork simplified and launched to senior manager cohort	1.10.15	31.3.16	

Risks (Where score on Risk Log requires escalation)			
ID	**Risk description**	**RAG**	**Mitigation**
BW	Insufficient resource identified within the L&OD team to explore senior leader key competency framework project.	**A**	Review to be undertaken to establish current priorities and resource implications. Discussion to be held with respect to further investment or slipping of other priorities.

Issues (Where score on Issues Log requires escalation)			
ID	**Issue description**	**RAG**	**Mitigation**
		R	
		A	

Benefits Realisation Tracking				
Ref	**Benefit**	**Definition**	**Owner**	**RAG Status**
	To define leadership in GHNHSFT and refresh the leadership portfolio using a range of internal and external programmes to deliver the required skills and competencies.	Setting standards and expectations for our leaders	BW	**G**
	To embed 'what it means to be a leader at GHFT' in all relevant people processes e.g. recruitment, induction, training, appraisals, re-validation, performance management, reward and recognition.	Alignment of key processes with Trust requirements	BW	**G**
	To design and implement a leadership induction day (for new recruits and promotions), ensuring interview assessment results and gaps flow through.	Assessment of skills gap and initial identification of development plans	BW	**G**
	To design and implement robust succession planning processes at Service/Support line, Division and Trust wide level.	Appropriate processes in place to safeguard future Trust activities	DS	**G**
	To design and implement a talent retention and development programme to support the identification and development of talent at team, service/support line, division and Trust wide level. To establish a talent pool consisting of CVs, aspirations, knowledge and skills.	Ensuring that cohorts of skills are available to meet future Trust requirements and service demands, improving retention of hi-potential individuals and creating career pathways	DS	**G**

Work Stream Progress Report

WORK STREAM 4 - ANALYTICS & INSIGHT						
Date completed	4 May 2016			**Version**	1.0	
Work Stream Sponsor	Helen Simpson		**Work Stream Manager**	Phil Hopwood		
Overall	**Milestones**	**Benefits**	**Budget**	**Risks & Issues**	**Scope**	**Resources**

	Approved Budget	Expected spend to-date	Actual spend to date
Capital	£0	£0	£0
Revenue	£0	£0	£0

Progress in period covering November 2015 to February 2016

Management

- During this period the outline project plan of the key areas of development was agreed at the inaugural Project Board on 9 February together with the requirement for additional resources to form a development team. A business case was developed and approved by the Sponsor.
- Following the arrival of the Improvement Director, the urgency associated with operational analytics to support the Emergency Care area was significantly uplifted resulting in a re-planning exercise to prioritise the development of Emergency Care analytics. It also resulted in the need to further augment the already agreed development team and immediately staff up this team. The business case for additional staffing was revised, with presentation at Director's Group for approval scheduled for 11 May 2016. In the meantime contract developers have been engaged starting from 6 May 2016.
- More broadly the Analytics plan has been rapidly adjusted to be coherent with the rapidly developing Informatics workstream of the Emergency Care Improvement programme and thereby avoid duplication of effort and delivery.

Delivery

People.

- The restructure of the Divisional Information team within the Information Unit, required in order to shape the team to be ready to support a consultancy based operating model going forwards as well as developing the analytics capability, has been completed. Originally scheduled for delivery by November 2015, the slip has presented a brake on development.
- Also as part of developing the right capability within the Information team, a skills audit was rolled out in February and the results analysed. Specific gaps were identified in some forecast statistical techniques as well as in the applications used within the BI warehouse and future dashboard design applications. A training plan has been developed together with a budget line proposal to cover the required external training.

Offer.

- It was expected that the future Information Unit offer would be agreed and roll-out commenced during the period. This has not occurred due to the urgent priority associated supporting the Emergency Care Improvement programme.

Product.

- A series of Emergency Care operational dashboards have been prototyped and then operationally rolled out responding to the requirements of the three work streams of the Emergency Care Improvement programme, specifically improvements to: the Emergency Department; Site Management and; Length of Stay.
- An identified information gap was the ability to draw together clinical activity information with resourcing and

patient caring information. Prototype links to staffing and friends & family data have been established in the design and population of an organisational dashboard covering Trust operations which will be piloted in the coming weeks

- Linked to this the development and initial production of a forecast Board performance report has been completed with first operation scheduled for the May Board. Design has also commenced to the Quality and Finance reports.
- An identified system gap was the ability to nimbly present analytical information to users in a summary fashion with a response time of the order of seconds with the capability to filter and drill-down. Activity has commenced to review the current market suppliers with the aim of inviting tenders during the next period.

Planned activities in next period March 2016 to May 2016

Management

- Recruitment of an Analytics development team.

Delivery

People.

- Training plan completed and implementation underway.

Offer.

- The future Information Unit offer will be defined and the re-brand to a Business Intelligence function commenced.

Product.

A number of developments will begin in the next period with the most influential being:

- Continued Emergency Care analytics development in response to the further emerging requirements of the Emergency Care Improvement programme.
- Prototypes of Quality and Finance Board reports.
- Tender let for the provision of a visualisation front end to the Trust's existing data warehouse and other information systems such as ESR (HR).
- Aligned to this an ability to verify all forecasting products will also be implemented so that the on-going accuracy of the techniques employed can be assessed and used not only in decision making but also in future development.
- In addition, the ability to access automatically HR and Finance data from their respective systems will be assessed and tested.

Milestones

Milestone	Date started	Target date for completion	Actual date completed	Comments
Agreed outline plan	Sep 2015	Nov 2015	Jan 2016	Slippage from Nov 2015
Information Unit restructure	Sep 2015	Nov 2015	Mar 2016	Slippage from Nov 2015
Skills audit completed	Nov 2015	Nov 2016	Mar 2016	
Information Unit offer	Mar 2016	May 2016		Slippage from Nov 2015
Stakeholder engagement	Feb 2016	Feb 2016	Feb 2016	Routine activity over next 10 mths
Information architecture, dashboard design & interface agreed	Feb 2016	May 2016		Underway
ED proof of concept	Feb 2016	Feb 2016	Mar 2016	In response to Emergency Care improvement plan
Verification system	Jan 2016	Jun 2016		Delayed

Work Stream Progress Report

Streamlining & "speeding up" of reporting	Jan 2016	May 2016		Underway
Identify future BI portal	Apr 2016	May 2016		On schedule
Boundaries with Trak analytics identified	Feb 2016	TBC		Link to Trak deliverables, slipped with Trak schedule
Assess access to HR & Finance information	Feb 2016	Jan 2017		Proof of concept access with HR achieved in Apr 2016

Risks (Where score on Risk Log requires escalation)			
ID	**Risk description**	**RAG**	**Mitigation**
1	**Risk**: Operational - The pace of capability & product development is not fast enough **Cause 1**: Resource required from the Information Unit cannot be released due to operational commitments &/or SmartCare delivery **Cause 2**: Resource required from the Information Unit cannot be released due to vacancies & the need to deliver BAU **Cause 3**: Funds are not available to support project augmented specialist resource. **Impact**: Delay in product delivery & benefit realisation **Impact:** Increasing levels of stress and anxiety within the Information Unit with the associated welfare risk and potential increased attrition	**R**	a) Prioritisation of tasking in the Information Unit b) Reduce tasking on the information Unit c) Provision of additional trained resource d) Utilise SmartCare resource e) Lengthen delivery timescales to match Information Unit resource load f) Ensuring Information Unit is at complement
2	**Risk:** Operational – Lack of leadership to drive the workstream forward. **Cause 1:** Gap in the workstream lead role **Cause 2:** Gap in the Head of Business Intelligence role	**R**	a) Identify new workstream lead with capability & capacity to drive the workstream forward. b) Initiate & deliver recruitment process for Head of Business Intelligence & Deputy Head of Business Intelligence (Analytics)

Issues (Where score on Issues Log requires escalation)			
ID	**Issue description**	**RAG**	**Mitigation**
		R	
		A	

Benefits Realisation Tracking				
Ref	**Benefit**	**Definition**	**Owner**	**RAG Status**
1	Information Unit analysts become business consultants to the Divisions and Corporate centre with move from information provision to scenario analysis performed by data subject matter experts	Reduction in the number of requests for ad hoc data & increase in the number of deep dive requests	Head of Business Intelligence / Divisional Ops Directors / Exec Team	**A**

Work Stream Progress Report

2	Enhanced capability of Information Unit analyst staff covering statistical analysis & forward prediction with more assured & evidence based decision making and greater insight into root causes of Trust performance & likelihood of success of actions	Reporting contains references to benchmarks, historic trends and impact analysis	Head of Business Intelligence	**G**
3	End users understand what information they need that is essential to their operational roles and key information informs operational decisions	Total number of required BI reports falls & number of reports with less than 10 views per year falls	Head of Business Intelligence / Divisional Ops Directors	**G**
4	End users of information are sufficiently capable to interpret basic data & perform basic analysis giving reduction in Information requests for basic data & analysis allowing resource to be deployed onto deep-dive analysis	Number of requests for basic data & analysis	Head of Business Intelligence / Divisional Ops Directors	**G**
5	Make operational information easier & quicker to interpret to increase use of operational information in decision making	Usage of reporting and analysis	Head of Business Intelligence	
6	The Trust understands the key drivers to operational performance and can forecast from them	Action plans prioritised on most important drivers and operational decisions based of forecast performance metrics	Head of Business Intelligence / Divisional Ops Directors / Exec Team	**G**
7	Development of a simulation capability to understand the impact of changes such as re-configurations on Trust & Divisional performance	Simulation is used as key evidence in re-configuration plan	Head of Business Intelligence / Divisional Ops Directors / Exec Team	**A**

Work Stream Progress Report

WORK STREAM 5 - GOVERNANCE						
Date completed	6 May 2016			**Version**	1	
Work Stream Sponsor	Prof Clair Chilvers		**Work Stream Manager**	Martin Wood		
Overall	**Milestones**	**Benefits**	**Budget**	**Risks & Issues**	**Scope**	**Resources**

	Approved Budget	Expected spend to-date	Actual spend to date
Capital	£0	£0	£0
Revenue	£0	£0	£0

Progress in period covering February to May 2016

- The Council of Governors has established a Task Group comprising five Governors, Tony Foster, and led by Gordon Mitchell and supported by the Trust Secretary to consider those aspects of the Board Governance review relating to Governor Effectiveness. The Group has met on three occasions and the second session provided an opportunity for all Governors and Non-Executive Directors to input into the work. The Group are to report to the Council of Governors on 18 May 2016 with recommended next steps to take forward this work.
- A revised standard for servicing Board Committees has been prepared setting out timeframes for the publication of agenda and reports and minutes. Templates have been prepared for agenda, reports, minutes and notes to ensure a consistent approach throughout the organisation. This will be discussed at a meeting which the Director of Service Delivery has with Chiefs of Service as an opportunity to cascade the approach throughout the organisation.
- In April 2016 the Trust Secretary presented those actions which had been implemented to increase the visibility and accessibility of the Board and to engage with the wider workforce in developing interest and understand of Trust Governance arrangement. Further suggestions were outlined and the discussion opened for brainstorming ideas which are being considered for implementation

Planned activities in next period May to August 2016

- Following the Council of Governors meeting on 18 May 2016 to take forward the recommendations agreed in respect of the Governor Effectiveness elements of the Board Governance Review.
- To implement the standards for Committee servicing.
- To consider and take forward the suggestions made to increase the visibility of Board members. To open an e-mail account for staff to contact a Board member.
- To refine the Committee structures taking into account the views of the new Chief Executive.

Milestones

Milestone	Date started	Target date for completion	Actual date completed	Comments
Refine “fit for the Future” Committee Structure	Aug 2015	Q3 2016		
Recommendations from the 2015 Board Governance Review	Aug 2015	80% completed by December 2016		Good progress being made and on track
Revised Board agendas to be 60% forward-looking	Oct 2015	September 2016		

Reflection and development time built into Board away days and seminars (to include Chiefs of Service)	Aug 2015	August 2016		
Trust Standards implemented for committee servicing	Feb 2016	August 2016		Will depend on take up by Divisions
Informal event programme in place to maintain good personal relationships among Board members	Feb 2016	July 2016	Feb 2016	Considered at each Board development session
Council of Governors	Feb 2016	December 2016		Plan will be in place but not completed
Communication – increased visibility of Board Members	From Dec 2015			

Risks (Where score on Risk Log requires escalation)			
ID	**Risk description**	**RAG**	**Mitigation**
	Limited capacity to deliver programme content	R	Improvement forward planning to meet timescales
	Changes to NED composition on Board	A	Essential we develop robust programmes to allow in coming NEDs to contribute quickly

Issues (Where score on Issues Log requires escalation)			
ID	**Issue description**	**RAG**	**Mitigation**
		R	
		A	

Benefits Realisation Tracking				
Ref	**Benefit**	**Definition**	**Owner**	**RAG Status**
1	Governance	To ensure that our Trust has good Governance arrangements in place	M Wood	G

Work Stream Progress Report

WORK STREAM 6 – STAKEHOLDER ENGAGEMENT							
Date completed	6 May 2016				Version		
Work Stream Sponsor	Sally Pearson & Dave Smith		Work Stream Manager		Craig MacFarlane		
Overall	Milestones	Benefits	Budget	Risks & Issues	Scope	Resources	

Approved Budget		Expected spend to-date	Actual spend to date
Capital	£0	£0	£0
Revenue	£0	£0	£0

Progress in period covering February – May 2016

Re-scoping the project

Focus throughout this period has been on supporting a new programme of work established to address performance across emergency care and patient flow. To enable a shift in cultural behaviours which are necessary to achieve better performance, a communications and engagement strategy has been developed. The overarching narrative of this work is our vision: *Best Care for Everyone.* This is the vehicle for stimulating challenging conversations and perceived ways of working (both clinical and non-clinical). A key strand of the communications and engagement work has been to embed the principles of continuous quality improvement through the application of the PDSA cycle. This is on-going. Work undertaken by clinical colleagues to improve patient flow, known as SAFER, has been developed and significantly enhanced as a visual identity. Key deliverables include:

- Dedicated website (www.safergloshospitals.co.uk) established as an educational resource tool.
- Dedicated newsletter
- Outline feature
- Membership Involve feature
- Dedicated intranet section
- Global email communications
- Posters (remain in development)
- Staff consultation pack and supporting Q&As

Cultural change programme: Keeping up the momentum

Running in parallel to the emergency care and patient flow work is the wider programme of cultural change and our cultural journey. A key deliverable for communications throughout the programme is to embed and develop momentum in the project throughout the organisation. This stretches back to the programme launch in June 2015. A programme of stakeholder engagement supported by communications was implemented over the summer period and into the autumn. This programme has continued into the winter/spring period. Key deliverables are identified below:

Outline:

- March & April edition: Leadership feature article.

Service improvements

Website & intranet: Funding identified

The IM&T Board identified and has allocated a significant capital sum (in the region of £200,000) over the next two years to develop a new website and intranet platform. This is a major investment in our Trust's digital

communications channels and presents an opportunity to dramatically improve customer/patient experience as well as better support higher levels of staff engagement. A full business case is now being developed before a procurement exercise is undertaken.

Working without silos

Synergies across all work streams continue to be developed resulting in closer more joined up ways of working, as demonstrated by the examples below:

- Governance: Repeated promotion of Board meetings and staff questions to the Board.
- Planning service change: Closer working arrangements across communications, clinicians and project managers to embed a more holistic approach to service enhancement.

Planned activities in next period May to August 2016

Patient flow & emergency care

Continue to implement the communications & engagement strategy to enable better engagement.

Programme momentum

Outline & Involve:

Continue to work with workstream leads to plan feature articles into the forthcoming coming editions of Outline i.e. May, June, July & August.

Service improvements

Qualitative/quantitative research:

A piece of work (survey, focus group etc.) to explore with staff what communication and engagement methods they prefer. This will help inform our Trust's future approach and methodology.

Website and intranet:

Develop a full business case in support of a new website and intranet platform.

Milestones

Milestone	Date started	Date completed	Comments
Patient flow & emergency care: Continue to deliver monthly newsletters and supporting materials i.e. posters etc.	March 2016		Ongoing
Programme momentum: Keeping momentum in the project through corporate communications e.g. Outline	July 2015		Ongoing - Developing interesting messages from work stream leads

Risks (Where score on Risk Log requires escalation)

ID	Risk description	RAG	Mitigation
	Staff engagement: Poor staff engagement	R	• Implement the principles of continuous quality improvement and make the PDSA cycle meaningful to staff
	Website & intranet: Costs	A	• Stage costs over two years • Explore external revenue sources

Work Stream Progress Report

Benefits Realisation Tracking				
Ref	**Benefit**	**Definition**	**Owner**	**RAG Status**
1	Refreshed vision breathes new life into the cultural change programme and refocuses efforts on quality, patient care and staff's role to contribute positively.	Refreshed visual identity.	Head of Communications	A
3	A new website and intranet to reflect the radically changing landscape of digital communications.	Reach the full potential of stakeholder communication and engagement through modern and responsive digital communications.	Head of Communications & Head of CITS.	A
4	Better management of and increased understanding of communication and engagement processes linked to public perception around service change.	Communications planning embedded in service change processes i.e. The Future's Group.	Head of Communications/Associate Director of Service Improvement/Divisional Ops Directors	G
5	Improved staff engagement through enhanced mechanisms and supported by the ability to communicate back to staff effectively.	Scheduled meetings that enable staff to engage effectively and a commitment to inform colleagues rapidly on specific outcomes.	Head of Organisational Development/Head of Communications.	R

Work Stream Progress Report

WORK STREAM 8 - INFRASTRUCTURE							
Date completed	29/04/2016				**Version**	1	
Work Stream Sponsor	Helen Simpson		**Work Stream Manager**		Neil Jackson		
Overall	**Milestones**	**Benefits**	**Budget**	**Risks & Issues**	**Scope**	**Resources**	

	Approved Budget	Expected spend to-date	Actual spend to date
Capital	£250k TBC #	£100k	£
Revenue	£0	£0	£0

note, approved budget will change as business cases develop.

Progress in period covering February to May 2016

- College Lawn moves underway. Aim to move boardroom to Alexander House before the end of June and move executive team across early June ahead of new CEO starting with the Trust. This releases £250k PA in revenue and potentially £2.0m in capital released value
- Phase 2 rationalisation planning underway, Move to more agile working presented to CIP group and a number of service leads. Rationalising the 'back office' estate forms the next phase of estate rationalisation to reduce off site revenue costs and annual revenue costs by approximately £500k and further capital assets released for sale or investment leverage.
- Long term site option appraisal draft developed, for comment. This is a short report outlining costs and benefits of site options.
- Implications of telephony re-tender have been reviewed and revised procurement approach taken to encourage innovation.
- GRH Site initial review of space use has highlighted opportunities to free up high value space for high value uses and better use buildings with limited life.
- The draft 2020 Strategic service improvement model for Estates and facilities has also been developed is currently being review by EFD senior management team ahead of wider discussion with the team and stakeholders.
- We have also undertaken a review of the Lord Carter findings and assessment of the Trust which sets out specific improvement targets and timelines. The main areas for significant improvement for the Trust are, reduction in nonclinical space as a proportion of clinical space, reduced energy consumption and improved commercial activity. Board approved plan to be in place June 2017 for delivery of improvement by 2020
- Estates and Facilities LEAN efficiency work streams first wave part completed. Remaining to conclude shortly once workstream outcomes are brought back together.

Planned activities in next period May to August 2016

- Hold full programme board to undertake detailed planning of approach to move to Agile working particularly focussing on alignment with Workforce an Organisational Development work stream, next step to define staff types and defining the workplace needs for each group.
- Prepare agile working implementation plan.
- Professional team appointment for the admin/business hub accommodation.
- Estates strategy approach and planning assumptions to be developed.
- Conclude first round of LEAN work streams and commence next round of lean improvement projects within Estates and Facilities.

Work Stream Progress Report

Milestones				
Milestone	**Date started**	**Target date for completion**	**Actual date completed**	**Comments**
Phase 1 LEAN Improvement Programme first round complete	22/01/2016	30/05/2016		Key programme started to embed continuous improvement within Estates and Facilities
Phase 1 CL moves programme	01/11/2015	31/06/2016		Phase 1 moves to complete June
Phase 2 CL moves programme		Qtr. 3 2016/17		Phase 2 scope increased to accommodate revised
Strategic site option agreed		30/05/2016		To include strategic planning assumptions
Agile programme phase 1		Qt1 2017/18		Enables exit from Victoria Warehouse at lease termination date

Risks (Where score on Risk Log requires escalation)			
ID	**Risk description**	**RAG**	**Mitigation**
1	Resource to support policy development and engagement with 'Workstyles' programme	**A**	Planning impacts on key resources in collaboration with all work streams
2	Uncertainty of clinical strategy in some areas, particularly for longer term	**A**	Establish set of planning assumptions to inform estates strategy development

Issues (Where score on Issues Log requires escalation)			
ID	**Issue description**	**RAG**	**Mitigation**
		R	
		A	

Benefits Realisation Tracking				
Ref	**Benefit**	**Definition**	**Owner**	**RAG Status**
	Estates operational cost reductions	Reduction in overall floor area and associated operational costs.	NJ	**G**
	Capital asset value released to invest of priorities or leveraging investment or income.	Minimise leased or rented floor area, reduction in poor estate floor area, release of space for higher value use, release of surplus estate for disposal or investment/income leverage.	NJ	**G**
	Charitable Funds income	Increased income generation from charitable contributions	KG	**G**
	Work environments and infrastructure enable clinical and non-clinical efficiency and effectiveness	Environment supports and encourages agile, efficient and effective operational services.	NJ	**G**

	Customer experience improves	The environment and engagement with the E and F service feedback improves	NJ	**G**

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – MAY 2016

PATIENT HEALTH AND WELLBEING STRATEGY

1 Purpose

1.1 The purpose of this report is to ask members of the Board, to consider and approve the Trust's draft "Patient Health and Wellbeing Strategy".

2 Background

2.1 Our Trust is one of the largest in the country, with well in excess of a million contacts with patients each year and over 7,250 staff. Whilst our core role as an acute provider is the diagnosis, treatment and care of our patients, we recognise that we can also contribute to the county's broader health and wellbeing (H&WB) agenda.

2.2 At the beginning of last year, the Board approved the Trust's "Health and Wellbeing Strategy". This was designed to be an overarching document setting out, in broad terms, our ambitions for the three key groups, whose wider H&WB we can also help to support. These three groups are our staff, our patients and the wider community. We agreed the main Strategy should be supported by three more detailed documents, one for each of these three groups. In 2015, we published the "Staff Health and Wellbeing Strategy" which was developed collaboratively with staff representatives.

2.3 Our "Patient Health and Wellbeing Strategy" is the second of these supporting documents. The current document has been developed in conjunction with members of the Trust's H&WB Committee, which oversees the Trust's H&WB agenda, and with leads for relevant priority areas. With their help we have been able to introduce a number of patient stories to demonstrate more clearly how our actions can impact on our patients' health and wellbeing.

3 The wider context for our Patient Health and Wellbeing Strategy

3.1 At the same time as we were developing our main Strategy the "Five Year Forward View for the NHS" was published. This visionary document identified the need for a radical upgrade in prevention and public health to ensure the sustainability of the NHS and the country. It also stressed the need to reframe the current relationship between patients, communities and healthcare providers – empowering and supporting people to take greater responsibility for their health, for self-care and management of their conditions.

3.2 The "Five Year Forward View" also highlighted the need for hard-hitting national action on obesity, smoking, alcohol and other major health risks, together with action to incentivise and support healthier behaviours and reduce inequalities.

3.3 Gloucestershire's countywide H&WB Strategy "Fit for the Future", and its supporting action cards, provide the more local context for our strategy. This identifies five key priorities for the county:

- achieving a healthy weight
- reducing harm caused by alcohol
- improving mental health
- improving health and wellbeing into old age
- tackling inequalities

3.4 These priorities are reflected in our Strategy together with a small number of additional elements.

4 Our Patient Health and Wellbeing Strategy

4.1 The broad ambition for this Strategy is *"every contact will count for promoting health and wellbeing"*. Making Every Contact Count (MECC) is an approach which is now widely recognised across the country and within Gloucestershire. Groups of our staff have been involved in the countywide training initiative which is designed to provide

them with the skills and confidence to raise health and wellbeing issues with patients. It is known that patients may be more receptive to messages about promoting health and wellbeing from health care professionals and evidence suggests that patients think it is appropriate for us to raise these issues with them.

4.2 Over the period ahead, our objective is to extend these skills across a wider selection of staff groups and identify how, increasingly, we can build "prompts" to raise H&WB related factors or opportunities for prevention and self-management within the Trust's and the countywide patient pathways.

5 Oversight and monitoring of the Strategy

5.1 To improve the H&WB of our staff, patients and the wider community is a key theme in the Trust's "Framework for the Future". To implement the staff and the patient H&WB Strategies and to contribute to the countywide obesity strategy are two of the Trust's more specific corporate objectives for the period ahead. Members of the Trust are already involved with Public Health, Clinical Commissioning Group colleagues and others in early work on a countywide obesity strategy. The current lack of a specialist weight management service for children has been identified as a particular priority.

5.2 Once approved, the "Patient H&WB Strategy" will be underpinned by a more detailed work programme, recognising that some elements of this will be led by other groups or individuals in the Trust. The work programme will be monitored on a quarterly basis by the Trust's H&WB Committee. As well as wide ranging membership from across the Trust, colleagues from Public Health, the Clinical Commissioning Group and Gloucestershire NHS Stop Smoking Services are also co-opted to the Committee to support and facilitate a collaborative and more joined up approach.

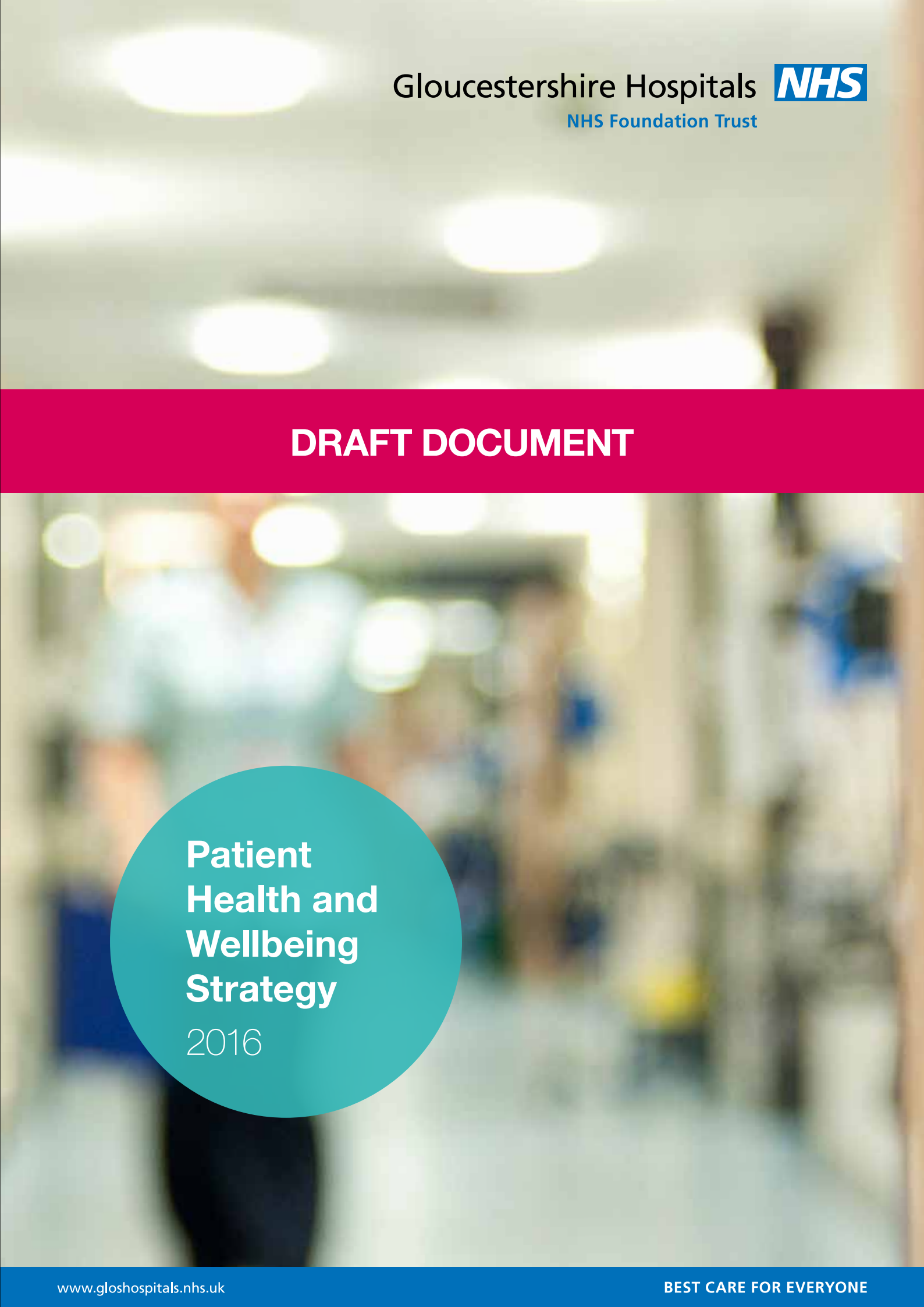
6 Recommendation

6.1 Members of the Board are asked to approve the Trust's "Patient Health and Wellbeing Strategy".

Authors: **Catherine Boyce: Clinical Strategy Manager**
Kate Jeal: Communications Specialist

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

Date: May 2016



Gloucestershire Hospitals NHS
NHS Foundation Trust

DRAFT DOCUMENT

Patient Health and Wellbeing Strategy

2016


VARIAN

Foreword

We recognise that beyond fulfilling the core role of an Acute Hospitals Trust, of diagnosing, treating and caring for our patients, we also have the opportunity to contribute to the wider health and wellbeing (H&WB) of the people of Gloucestershire and to the Countywide H&WB Strategy, 'Fit for the Future'.

At the end of 2014, we produced our own over-arching Trust Health and Wellbeing Strategy to describe how we could make this broader contribution.

We realised that there are three key groups with which we come into contact: our staff, our patients and the wider community. Since we also realised that our contribution to the H&WB of each of these groups is different, we committed to focus on each of these groups in turn.

In 2015, in conjunction with our Staff Side, we developed a more detailed Staff H&WB Strategy and accompanying action plan.

In 2016, the focus is on our patients. This strategy, 'The Health and Wellbeing of our Patients' has been developed by the members of our H&WB Committee, which has oversight of H&WB activities in the Trust.

Building on what we already do, this strategy considers more closely the further opportunities we have to improve the H&WB or our patients – in partnership with a wide range of countywide health, social care and other stakeholders.

This Strategy will be underpinned by a detailed work programme for the year ahead and beyond. It will be overseen and monitored, on behalf of the Trust Board, by the Trust's H&WB Committee.

Sally Pearson
Director Clinical Strategy

Tony Foster
Non-executive Director

Introduction

Our health and wellbeing vision

To be recognised as a health-promoting Trust, one that makes an active contribution to promoting and improving the wider health and wellbeing of those with whom we come into contact.

Our ambitions

Our overarching Trust H&WB strategy sets out the three broad ambitions, reflecting the three groups of people with which we come into contact – our staff, our patients and the wider community. These ambitions will underpin our vision and be reflected in our annual work programmes.

- **Our staff:** every employee will be supported to maintain and improve their health and wellbeing and every employee will be expected to take reasonable steps to improve their health and wellbeing
- **Our patients:** every patient contact will count for promoting health and wellbeing
- **The wider community:** the wider community will also benefit through our involvement in the broader countywide health and wellbeing agenda

What is a health promoting hospital?

"A health promoting hospital does not only provide high quality comprehensive medical and nursing services, but also develops a corporate identity that embraces the aims of health promotion, develops a health promoting organisational structure and culture, including active, participatory roles for patients and all members of staff, develops itself into a health promoting physical environment, and actively cooperates with its community."

World Health Organisation (WHO)

The wider context

Links with our values and corporate objectives

Our Trust's mission is to improve health by putting patients at the centre of excellent specialist patient care.

By using the contact which we have with patients to promote healthier lifestyles and prevent ill health, we can make an additional contribution to our patients' more general health and wellbeing.

Two of our current Trust objectives particularly reflect the H&WB agenda:

- To implement the patient H&WB strategy
- To contribute to the countywide obesity strategy.

This Strategy will also bring benefits to us as a provider of NHS specialist services, and contribute to our wider organisational objectives to make more effective use of resources – for example by reducing length of stay and unnecessary admissions.

Health promotion in action:

- Smoking cessation can reduce complications at birth and improve the outcomes for pregnant mothers and their babies
- Provision and signposting of support for mental health or alcohol addiction in our emergency department can assist in reducing admissions
- A holistic and proactive approach to assessing our elderly care patients can speed a safer return home or reduce unnecessary admissions
- Providing advice about diet and wellbeing can have a huge impact on many areas of our patients' lives.

Five Year Forward View

The Five Year Forward View, launched by NHS England in 2014, gives a powerful message:

"If the nation fails to get serious about prevention then the recent progress in healthy life expectancies will stall, health inequalities will widen and our ability to fund beneficial treatments will be crowded out by the need to spend billions of pounds on wholly preventable illness."

Our Trust Strategy is consistent with a responsibility to support the wider prevention agenda.

Working together in Gloucestershire to improve health and wellbeing

Within the county, the wider H&WB agenda is led by the Gloucestershire H&WB Board.

Its ambitions and plans are informed by the local Joint Strategic Needs Assessment (JSNA) and are set out in the Countywide H&WB Strategy and its associated action cards.

We recognise the importance of a shared sense of direction and take the countywide Strategy as the context for our own activities.

Key priorities for the county are:

- Achieving a healthy weight
- Reducing harm caused by alcohol
- Improving mental health
- Improving health and wellbeing into old age
- Tackling health inequalities

Our county:

In Gloucestershire:

- Overall, in Gloucestershire we enjoy better health than average for the country, but this is not so for some groups and areas in our county
- 82 out of every 100 people over 65 are in good health – higher than the national average
- Cancer, cardiovascular disease and respiratory disease are the three leading causes of death in the county
- 1 in 4 adults are obese
- At Year 6, 31% of pupils have excess weight levels
- Gloucestershire has an ageing population, By 2035, people aged over 65 will increase from 19% to 28% of the population
- 18,300 children are living in poverty according to official figures
- There are still 900 deaths from smoking-related diseases each year
- Over a quarter of people are estimated to have harmful or hazardous drinking levels

Our patients: Every contact will count for promoting health and wellbeing

Every year we come into contact with a significant proportion of the local population.

Making Every Contact Count is an approach which is now widely recognised across the country and within the county of Gloucestershire. This is also overarching ambition for this Strategy.

We already take the opportunity 'to make our contacts count' in many areas of our hospitals – but we want to build on this and extend this approach more widely.

Groups of our staff have been involved in the countywide training initiative which enables them to gain the skills and confidence to raise health and lifestyle issues with patients and we also want to build this capacity more generally across our staff.

The Five Year Forward Plan for the NHS talks of the opportunity for NHS staff to serve as ambassadors for health and in their communities – for the NHS and its staff to lead by example and act as models for promoting health more widely.

We are well placed to influence our patients. We often have access to groups which are more likely to be suffering from preventable illnesses. Even where people have an established illness, there are still steps that they can take to improve or delay progression through adopting healthier lifestyles. There may be other preventive services which may help and which we can signpost or refer our patients to.

People in hospital may be more receptive to messages about promoting health and to information from healthcare professionals. There is evidence that the majority of hospital patients think that it is appropriate for hospitals to take a role in promoting health.

Health promoting and prevention initiatives can lead to quicker healing and recovery, fewer complications, fewer admissions or lower lengths of stay, risk reduction and increased independence. As well as improving the health and wellbeing of our patients, this also contributes to the improved use of increasingly pressurised NHS and social care resources.

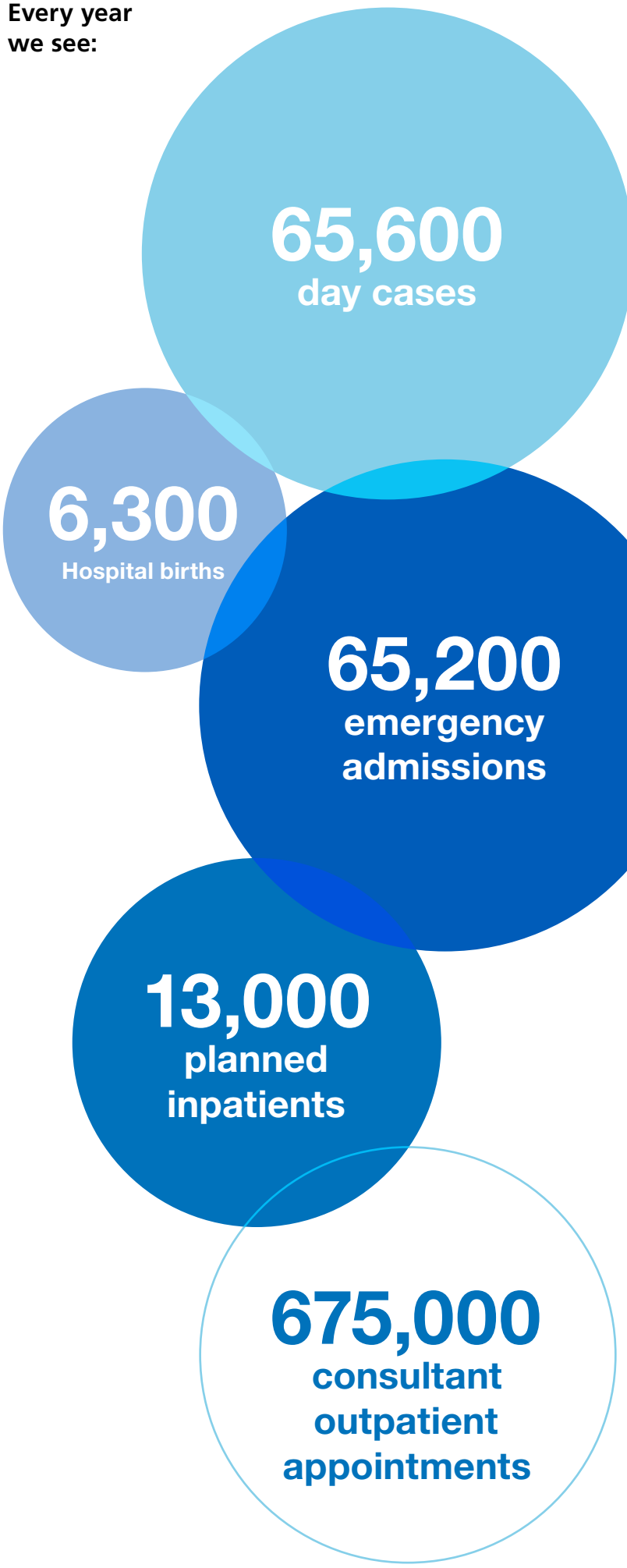
Our organisation:

Gloucestershire Hospitals NHS Foundation Trust is one of the largest hospital trusts in the country and provides high quality acute, elective and specialist health care for a population of more than 850,000 people.

Some services are run on both our sites while other specialist services are focused at just one to optimise the use of specialist staff, skills and equipment.

- We are the second largest employer in Gloucestershire, with more than 7,400 employees. Our success depends on the commitment and dedication of our staff. Many of our staff are world leaders in the fields of healthcare, teaching and research and we aim to recruit and retain the best staff possible.
- Our patients are cared for by more than 2,100 registered nurses & midwives and 800 doctors. In addition, we employ more than 600 estates staff, 190 healthcare scientists and 425 health professionals, such as physiotherapists and speech therapists.

Every year we see:



Achieving a healthy weight

Background

Currently 64% of the county's adults are overweight or obese. Adult obesity is a major cause of early death and avoidable ill health and is linked to diseases including cardiovascular disease, type 2 diabetes, cancer and poor mental health. In the county's schools, at Reception, just under a quarter of children have excess weight levels. By Year 6 this has increased to around 32%.

The causes of obesity are often complex, requiring action across the wider community. It is not as simple as eat less and exercise more. Psychological and environmental issues are very important and help with them is often needed.

What we do now: some examples

- Our Specialist Weight Management Service supports adults with complex weight management issues. Our ambition is to be able to offer an equivalent service for children.
- We have developed a Food and Drink Strategy and action plan. We run training and awareness raising activities during Nutrition and Hydration Week.
- LEAP, a programme for people with hip or knee joint osteoarthritis, offers supervised exercise advice on weight management, pain relief and self-management strategies.
- Our dietetic team receives referrals from primary care and the hospital. The team works closely with clinical teams and their patients, including those with long term conditions.
- We support a range of local and national campaigns, including Diabetes Awareness Week, raising awareness and highlighting the link between overweight and diabetes
- We have a weekly stall in the canteen selling fresh, locally sourced, vegetables.

Areas for action:

- Contribute to the development of the countywide Obesity Strategy, by engaging in countywide initiatives to:
  - develop options for supporting children and young people who are overweight or obese and establish specialist weight management services for children
  - implement recommendations of the adult care pathway review and strengthen links between tiers of care
  - undertake a three-year programme of work, supported by Leeds Beckett University, to co-develop a whole systems approach to addressing obesity in the county
- Make healthy choices easier by working with catering teams, commercial outlets and suppliers to offer and promote healthy options and improve nutritional labelling.

Patient case study: Specialist Weight Management

The Specialist Weight Management Service (SWMS) is a small team of psychologists and dietitians. The bulk of their work is supporting patients to manage their weight more effectively but they also provide the pre-surgery preparation for patients eligible for bariatric surgery, and post-surgery follow up.

Patient story:

"I am a 55 year old woman and was in control of all aspects of my life except my weight. That was until I was referred to the Specialist Weight Management Service. Today I am in a much happier place and am more than five stones lighter.

"I have had an ongoing battle with my weight all my adult life; losing weight (and sometimes in great quantities) but eventually always putting it all back on, and more to boot. Every time I started a new diet, I was convinced this was the one that I was going to succeed with and each time I failed. I went to various slimming clubs in the hope that as we were all suffering the same deprivations, we could console each other in mutual misery. But it wasn't enough to overcome the complex issues of overeating I had or understood. I became convinced that I would never gain control of my weight and it would always control me.

"My weight continued to increase and in desperation when I felt I wouldn't be able to continue with my job for much longer, I turned to my GP who referred me to the Specialist Weight Management Service. I knew it wasn't going to be a quick fix solution but I was prepared for the long haul.

"The first session was a very tearful occasion as my counsellor gently coaxed me to reveal details about my situation. I found myself able to open up and say things that I had never been able to admit even to myself. As the sessions continued I felt as though I had a big knotted ball of string in the pit of my stomach that my counsellor was managing to tease apart and unravel. I filled in various questionnaires and seeing how I felt on paper was a terrible shock and made me feel incredibly sad for me. But my counsellor made me feel valued and positive about my future.

"Through my sessions she gave me 'tools' to use in various situations and I found myself using them in situations where I was likely to overeat. I realised that diets set us up to fail and I was always going to fail because the route cause is never addressed, just the outcome. My attitude began to change with my counsellor's support and I stopped dieting altogether. Instead I became conscious about what I was eating, picking healthier options and stopping to ask myself if I really wanted what was in front of me.

"I learned to like myself again. I started to lose weight, but more importantly than losing weight, my relationship with food began to change and it became far less significant in my life. My life took on new meaning as I started to be able to do things that my weight had prevented me from doing in the past. I have come a very long way."

Smoking cessation:

What do we do now

Although local smoking rates are lower than in many other areas of the country, smoking remains a major risk for many diseases, including lung cancer, chronic obstructive pulmonary disease and heart disease.

Smoking is associated with a significant number of hospital admissions and it is estimated that up to a half of all smokers will die from a smoking related condition.

Smoking in pregnancy has detrimental effects on both the health of the mother and the growth of the baby. It can bring higher rates of miscarriage and still birth. Illnesses among children caused by exposure to second hand smoke are responsible for higher levels of admission to hospital than for other children.

Supporting the service

Our Smoking Cessation Group provides the focus for smoking cessation in the Trust.

- We work closely with advisers from GSSS, the Gloucestershire specialist NHS Stop Smoking Service. This collaboration has brought a range of initiatives – including the establishment a network of trained Smoking Cessation Champions with representation on every ward and department.
- GSSS has worked especially closely with our midwifery team to provide tailored training and to implement an opt out referral scheme for pregnant women who smoke.
- As part of the countywide StopB4op initiative, patients undergoing pre-admission assessment are encouraged to give up smoking before they come into hospital – this is known to speed the rate of healing and recovery and reduce length of stay. We also provide NRT to inpatients who are finding it challenging to be in hospital without cigarettes. Stop smoking advisors are able to see patients on our wards and can continue to support them after discharge.
- E-learning modules have been developed and undertaken by many of our staff, encouraging them to raise smoking cessation with their patients.
- We support national and local stop smoking campaigns.

Areas for action:

- Intensify our efforts to reduce smoking amongst pregnant women – a high priority for the county in the year ahead.
- Reinforce our smoke free site status by replacing the external smoke free notices and messages across our sites.
- Continue to work with NHS specialist stop smoking services and our specialty teams to introduce smoking cessation effectively in a wider range of care pathways.
- Continue to promote events such as National No-smoking Day.

Case studies: referring patients from hospital

Our teams are ideally placed to refer patients on our wards and in surgical pre-assessment to specialist stop smoking advisors from Gloucestershire Stop Smoking Service.

Patient stories:

Patient Graham*, who has COPD (Chronic Obstructive Pulmonary Disease) reflected on his experience:

"I had been approached before about being referred, but it was when I went on holiday to visit relatives that I was inspired to take up the offer. They had arranged a very busy itinerary and I realised quite quickly that I was unable to keep up due to COPD.

"The service I received from the Gloucestershire Stop Smoking Service was great – my advisor was upbeat and positive and my questions were always answered cheerfully and quickly.

"I know that the damage to my lungs is permanent, but there are so many positives to having quit. I no longer have coughing fits, my house and clothes no longer smell and my friends and family find visiting me a more pleasant experience. I found E-cigarettes very useful in managing my cravings as a big part of the challenge is what to do with your hands.

Brian* and Terry* were both referred following repair of aortic aneurysm (AAA).

Brian says: "I didn't want to quit, but I was in hospital and they asked if I needed any help with not smoking while I was an inpatient.

"I was prescribed nicotine replacement therapy while I was on the ward, which helped to manage my cravings. I certainly wasn't fit enough to go outside to smoke, so it really helped.

"The nurse also asked if I would like to be referred to the stop smoking service, and I agreed to see an advisor.

"When I smoked I coughed all the time, and it's been remarkable to me that this has stopped entirely since I quit.

"I would say to anyone who is in my position, do give it a go, they are very helpful and you will feel better.

"Don't be deluded into thinking that you can have just one ciggy as it's easy to slip back. You will get cravings, but they will get better and the products they offer you really can support you."

Terry says: "Following a near-critical aortic aneurysm, I have been advised to give up smoking, lose weight and take statins. I am taking all of this advice!

"I was able to begin my stop smoking journey in hospital. The specialist advisor prescribed me medication, which I would say has made my attempt much easier as it has really reduced my cravings.

"Now, my breathing is better, food tastes better and I have fewer headaches. Like many other former smokers, I wish I had done this years ago! I would encourage anyone to contact the service and get some help to quit and not to wait until they are hospital to do so."

** names have been changed*

Reducing harm caused by alcohol

Background

Alcohol misuse is a major cause of early death and dysfunction for individuals. It is the biggest risk for cancer after smoking, the most frequent cause of liver disease and the cause of a range of other diseases, mental ill health and antisocial behaviour. Alcohol is estimated to cost the NHS £3.5 billion each year.

Within our Trust, we have contact with both alcohol-specific admissions (where alcohol is the sole cause of the health condition) and also alcohol-related admissions which combine to give the broader picture that alcohol makes to ill health locally.

It is estimated that in Gloucestershire about 28% of the population have harmful or hazardous drinking levels.

What we do now: some examples

Our Trust provides comprehensive services including a dedicated alcohol team with specialist nurses trained in mental health, addiction and liver disease.

- As well as supporting Public Health England's Dry January campaign each year, mainly through social media, 2015 also saw a focus on this area during Alcohol Awareness Week which occurs in November. This proved a great success within the hospitals, giving the team a chance to highlight their work.
- Around Christmas and the New Year period we regularly see higher levels of alcohol-related attendances at our Emergency Department. We use the local media to draw attention to the impact on the hospital and encourage people to drink sensibly.

Areas for action:

- We are investigating what investment in a local fibroscanner could add to care for groups of patients such as those with fatty liver and hazardous drinking levels. This type of ultrasound would help our doctors to understand how much scarring is in a patient's liver, increasing awareness in the patient and allowing staff to plan treatment and follow-up.
- The Alcohol Liaison Team would like to increase out-patient referrals from ED and hopes that new training provided by one of the Lecturer Practitioners will help raise awareness of their service and encourage staff to signpost more patients to the service.
- We are exploring the possibility of being able to refer a greater number of patients to the correct services through access to the alcohol liaison service outside office hours. It is felt that currently, opportunities may be missed to provide some patients with adequate support and follow-up.
- We will continue to support implementation of the County's Alcohol Harm Reduction Plan

Patient case study: liver transplant

Ken's story:

Ken, 68 has been a patient at our hospitals for more than 16 years. Two years ago, Ken had a liver transplant from which he has made a remarkable recovery.

Previously a heavy social drinker, he had experienced health issues caused by drinking alcohol. When advised by a consultant to quit drinking is he wanted to see his grandchildren grow up, Ken complied immediately and his condition stabilised.

He says: "I didn't drink every day and never drank at home, it was always in a social situation. I didn't feel any ill effects from drinking, but one day I noticed that my skin and eyes had become quite yellow. The doctors at the hospital advised me that I should stop drinking and I did. That was 15 and a half years ago."

More than ten years after he had stopped drinking, Ken's liver began to fail and he developed regular accumulation of fluid in the abdominal cavity, called ascites. Ascites is common in people with cirrhosis and it usually develops when the liver is starting to fail. In general, the development of ascites indicates advanced liver disease and patients may be considered for referral to liver transplantation.

"This is the message that I'd like people to know, that I never did" said Ken. "The damage that drinking can do to you will probably not be obvious at the time, but it can all catch up with you so many years later."

Ken was seeing Liver Nurse Debbie Durrant for weekly drainage of his ascites – paracentesis. This was becoming a regular appointment where up to a gallon of liquid was being drained.

Ken commented: "Debbie was wonderful and I got to know her so well during this time. Because I was coming in so often, I was grateful to be able to benefit from the fact Debbie had introduced the drainage as a day procedure rather than having to be admitted for a night every time."

As his health issues became insurmountable, he was referred by our hepatology team for a liver transplant at University Hospitals Birmingham.

There is a strict assessment process that decides who can have a liver transplant, as donated livers are scarce, both in the UK and worldwide. Ken was able to meet the criteria – to have ceased drinking and also to be ill enough to warrant inclusion on the transplant list but also to be well enough to survive this major surgery.

Liver transplants take about 8 hours and require the patient to be well enough to withstand the operation and the recovery period afterwards. As well as extensive physical assessments, there is a lot of psychological help and support.

Ken was put on the transplant list in January 2014 and received his transplant later that year. Six months after the transplant, Ken felt that he had recovered from the trauma of the operation.

In his words:
"It was like being born again."

Improving mental health:

Background

Mental health problems are common. Each year one in four people may experience a mental health problem. Risk factors include deprivation, substance misuse, poverty, relationships, isolation and discrimination.

There are also strong links between physical and mental health problems. Many people with a long term-physical health problem also have a mental health problem. Within the hospitals, joint working with mental health colleagues is central to identifying and managing these problems.

For many it is difficult to talk about mental ill health. One in ten people who experience mental health problems say they face stigma and discrimination.

Examples of what we do now

- Collaborative working is central to improving the mental health of our patients. The mental health liaison team (MHLT) and other mental health support at our hospitals is provided by colleagues from 2gether Trust.
- For young people who self harm, we now have rooms which provide a safe environment during their stay in the our Children's Unit. We have developed a leaflet which explains about their admission to hospital and what may happen next.
- The alcohol liaison team or ALT provide specialist assessment and intervention to those patients undergoing treatment for alcohol withdrawal, or for whom high risk alcohol consumption has been identified as a factor during their admission.
- Older age liaison specialise in the assessment and treatment of patients over the age of 65 years with conditions including dementia, delirium, depression and anxiety.
- All of the services benefit from having direct access to the supervision and expertise of a senior Consultant Psychiatrist.

Areas for action:

- We will to work towards increasing staff awareness of mental health in our patients by including this more widely in training and development.
- We will also develop a mental health section on the intranet to brings together resources and pathways for any member of staff who may wish to refer a patient
- A specialist young persons' assessment room will be created in our Children's Emergency Area to allow young people to be assessed by specialist mental health experts

Case studies: Mental health care plans

The mental health team undertake specialist assessments of the mental health needs of patients who are in receipt of care from GHNHSFT. They work in conjunction with medical and nursing staff, patients and carers to develop individualised discharge plans which engage patients with community mental health services if required.

Patient A:

Patient A was brought to hospital by ambulance following an overdose of paracetamol and admitted to ACUA for IVI Parvolex (a medicine used in paracetamol overdoses), monitoring and observation. An assessment of risk on admission identified that the patient posed a high risk to themselves in the immediate future. ACUA staff followed the mental health risk assessment policy and 1:1 care was implemented overnight. This ensured that Patient A received appropriate supervision and a high quality of individualised care during a period of acute distress and anxiety.

The mental health team undertook a comprehensive face to face biopsychosocial assessment with patient A the following morning. This identified a long standing depressive disorder which had been exacerbated by acute stress (marital separation and moving out of the family home) and excessive alcohol use.

A comprehensive package of care was developed with Patient A, his GP and the Crisis Team with onward referrals for Alcohol Outpatient work in A&E and Turning Point in the community. Patient A went on to make a full recovery.

Repeated attendances at ED

In 2015, a frequent attender manager was appointed to the MHLT. This post was created and manages circa 50 patients who were attending our Emergency Departments on a very regular basis. Anecdotally, many regular attenders have combinations of mental health, substance misuse and social care issues.

Key to the role is looking at each patient individually, and putting together packages of care designed to reduce dependence on hospital services.

Patient Z:

Patient Z attended the ED on a weekly basis, specifically 49 attendances in 2014 (29 admissions) and 51 attendances in 2015 (18 admissions).

Looking at the case, it was identified that a multi agency approach including A&E, GP, mental health and the ambulance trust (SWAST) would provide a forum to develop a care plan.

A plan was developed for Patient Z which provided better support for the patient and also encompassed alternative advice for pain relief provided by the Pain Management Team. This plan better supported the patient in meeting their complex needs in a more proactive way, reducing A&E/SWAST attendances.

The effect of this has been to reduce the prescribing of regular opiates given by ED, ward and the ambulance service. This strategy has been very successful – since June 2015 when it was put in place, Patient Z has only been admitted to hospital on a single occasion.

Improving health and wellbeing into old age

The number of older people aged 65+ in Gloucestershire has grown steadily. This rise is projected to rise more steeply in the decades ahead and at a higher rate than for the country as a whole. Older people often have multiple health conditions, resulting in a range of health-related and social care needs. Many of our older patients are also frail.

Over 9,000 people aged over 65 are estimated to be living with dementia in Gloucestershire. This is forecast to rise by two thirds to almost 15,000 by 2030.

What we do now

- OPAL is our older person's assessment team. With early specialist assessment and planning, our aim is to prevent or minimise hospital stays, wherever possible, to maximise independence and enable patients to return to their usual place of residence.
- A number of our older patients experience a degree of memory loss or are living with dementia. Early assessment, diagnosis and individualised treatment and support can improve quality of life.
- We have developed a Trust dementia care strategy 'What Does Good Dementia Care Look Like in our Hospitals' and we work in partnership with others to deliver the Countywide Dementia Strategy.
- We have developed and trained a network of Dementia Champions across the Trust to promote and support best dementia care.
- We have enhanced our care environment with new signage to help our older patients find their way more easily – we have introduced visual prompts and pictograms, clocks and calendars, and coloured crockery. In addition, a programme of weekly cognitive stimulation sessions are held on our general and old age medicine wards.
- Over a third of people over 80 fall each year. The Falls service offers a detailed assessment of risk factors and personalised treatment plans to minimise risks.
- Our Food & Drink Strategy highlights the importance of managing malnutrition and dehydration in older patients to minimise reduced cognitive function, falls or poor diabetes control.
- Our lecturer practitioners have been involved in the development of a course for the Care of Frail Older People with the University of Gloucestershire.

Areas for action:

- Continue to progress elements of the Frailty Programme, including working with Glos CCG to establish two community-based consultant posts to reduce or prevent admission of older people and support their earlier discharge
- Continue to support implementation of the Countywide and the Trust's Dementia Strategies and also lead a countywide group to improve communication with patients and the public to assist people to live well with dementia.
- Over time, as more staff across the Trust undergo Making Every Contact Count (MECC) training, we will work to encourage younger people to adopt healthier lifestyles which may delay the onset of ill health in older age.

Case study: older people

OPAL – older persons' assessment and liaison team

For older people, hospital is not the best place to be for a long term stay. The unfamiliarity of a hospital environment can often trigger or worsen existing confusion and patients are at risk of falls and injury. It can also make them more vulnerable to hospital acquired infections such as pneumonia, C. difficile and MRSA. Longer stays in hospital can lead to loss of muscle mass, where patients may struggle to regain their previous level of mobility and independence.

Our older persons assessment and liaison team, or OPAL, aims to provide the best expertise to enable patients to avoid long stays in hospital. The objective of this specialist team is to provide a comprehensive assessment when an older person comes to hospital via the emergency department. They will consider what other support the person may require to continue living independently at home.

Their comprehensive assessment looks at all aspects of physical and social wellbeing, giving an indication of the individual's frailty to allow us to plan and involve the appropriate services at an early stage. The team comprises an elderly care consultant, registrar, GP trainee and Nurse practitioners, working alongside an Integrated Discharge Team.

June's story: June* was admitted following a fall at home. She had been found by carers on the floor, having fallen on the way to the bathroom.

When June was admitted to our Emergency Department, the OPAL team were called to assess her. The reasons for June's fall were assessed, through speaking to her but also to relatives and care staff. Carers are often able to give the team a more comprehensive and detailed account of the patient's previous levels of function and mobility.

June's injuries were assessed and the team looked at possible medical reasons for her fall via blood tests, ECG and X-rays. As she had a head injury and seemed confused, a CT scan was ordered. June was also found to have an infection for which IV antibiotics were required, necessitating an admission to hospital.

During June's admission, more detailed assessments of her functioning and cognition were undertaken. Her confusion improved substantially following treatment for the infection.

A medication review was a crucial aspect of her assessment as many medications can contribute to falls. June's carers were able to gain a better understanding of the medication she was taking and the possible side effects.

After 48 hours, June was discharged home with additional support in place. Her carers and relatives were also involved and were given the following advice to help safeguard June against future falls:

- Wearing suitable footwear and keeping active and mobile as much as possible
- Regularly discussing and rationalising medications with the GP
- Regular eye checks and using her mobility aids as advised by professionals
- Wearing her lifeline at all times

** name has been changed*

Tackling health inequalities:

Background

Health inequalities are preventable and unjust differences in health experienced by certain groups in the population. They may be linked to wider factors influencing health such as housing, environment, social background, income, employment and education.

Other factors which contribute to health inequalities are differences in individual lifestyle behaviours, isolation and poor access or use of healthcare. Those with poorer health and wellbeing may come from deprived areas, from black or ethnic communities, have a physical or learning disability, mental health problems or be homeless.

Examples of what we do now

- Our midwives work closely with health visitors and Children's Centres as part of the Midwifery Partnership Teams initiative providing support to families and their children.
- Concerned about the fate of homeless people leaving hospital, one of our Consultants joined with a number of local groups and secured government funds to set up the Time to Heal project. This aims to ensure that homeless people are not discharged from Gloucestershire Royal Hospital without planned housing or support.
- We have set up a network of trained Learning Disability (LD) Champions in the Trust. The Champions work closely with specialist LD liaison nurses from 2gether and have developed a 'traffic light assessment' tool for our patients with LD.
- A range of initiatives have been undertaken to Increase sensory awareness and good practice in the Trust, to improve and support patients with hearing and sight loss – through listening devices, training, special signage and use of pictograms, supporting Deaf Awareness Week and other campaigns.

Areas for action:

Although many actions to tackle health inequalities lie with other agencies and the wider community, we will work with them in a range of areas for action highlighted in the Countywide 'Tackling inequalities Action Plan', including:

- contributing to the development of multi-agency plans to improve breastfeeding rates in those least likely to breast feed
- increasing referrals of pregnant women who smoke to specialist smoking cessation support
- supporting initiatives to increase coverage of cervical and breast screening
- improving outcomes for patient groups who have trouble in accessing the health service in a traditional way
- increasing the number of professionals undertaking Making Every Contact Count (MECC) training.

Case study: supporting families

Midwifery Partnership teams

Though the image of Gloucestershire is of a rural and a relatively affluent county, there are areas of significant deprivation. In these areas, families may be classed as 'hard to reach' for a number of social reasons.

Midwifery Partnership Teams are an initiative in Gloucestershire that provides practical and emotional support to families through pregnancy and their children's early years.

By working together, midwives, health visitors and Children's Centres share information and training, meaning that they can offer a more flexible service and intensive support to families. This can include joint home visits, enhanced antenatal education to support women to have a healthy pregnancy and a normal birth and access to midwifery appointments within Children's Centres in these areas.

The midwives are trained in Motivational Behaviour Change techniques to support healthy lifestyles and smoking cessation.

This service provides midwifery support in a more intensive way and for an extended period in the postnatal period for vulnerable women and babies, supporting parenting and prolonged breastfeeding as well as supporting attendance and take up of Children Centre support.

Outcomes:

- Maintenance of higher than normal breastfeeding rates for this cohort of women through to 6 weeks
- High levels of smoking cessation in pregnancy compared to Gloucester comparator group and Gloucestershire as a whole
- Higher numbers of home births compared to Gloucester comparator and Gloucestershire as a whole.
- Providing contraception services to vulnerable women including long acting options.
- Early labour home assessments to avoid unnecessary antenatal admissions

Families who used this service benefitted from more support with emotional wellbeing, increased levels of breastfeeding, decreased levels of smoking and support to feel more confident as parents.

Having begun in Hester's Way, Cheltenham, the service has now been extended to Children's Centres in Matson, Bartongate, Linden and Cinderford.

Feedback includes:

"It was great to know that there is always someone there to help. I can rely on them. If my Mum can't help I know they can."

"Much more confident knowing that there is support available if I need it."

"It was reassuring having a familiar face with a good understanding of my circumstances. It helped not having to repeat my story to lots of different midwives. My partner was much happier too – he felt reassured."

"I liked being able to text midwife or go to the drop-ins."

Screening programmes

Background

Screening is the process of identifying healthy people who may be at increased risk of disease or a condition. A series of national screening programmes have been introduced over the years. A number of our Trust's clinicians were involved in the early stages of establishing some of these national schemes. A range of the programmes are provided by staff linked to the Trust, for local people living in Gloucestershire or nearby.

Abdominal aortic aneurysm screening programme

Available for all men aged 65+, a simple ultrasound to identify an expansion or weakening of the main blood vessel in the body. Some men will be referred for surgery.

Bowel cancer screening programme

Men and women aged 60-74 are sent a home test kit every 2 years to check for the presence of blood in a stool sample, a possible early sign of bowel cancer. People with abnormal tests are referred for further assessment and if necessary, further investigation with a colonoscopy.

Breast screening programme

Eligible women 50–70 are invited for x-ray screening every 3 years. Women with abnormal changes in breast tissue are referred for further assessment and treatment if required.

Cervical screening programme

Women aged 24-64 are invited for screening every 3 or 5 years. Abnormal tests may be referred to colonoscopy for further investigation or treatment.

Diabetic eye screening programme

Early identification and treatment of diabetic eye disease can reduce sight loss. This is for people with type 1 and type 2 diabetes aged 12+. Some people will be referred for further assessment or laser surgery.

Antenatal and new born screening programmes

Offered to women in pregnancy, or after a child is born, these are designed to help detect a range of abnormalities and conditions, infectious diseases, physical and hearing problems.

Areas for action:

- Support wider initiatives associated with the Reducing Inequalities Action Plan, to increase coverage of cervical and breast screening.
- Continue the roll-out of the Bowel Scope screening programme in the county – an additional programme offered to men and women at the age of 55
- Explore the potential for some screening staff to undertake MECC training to enable them to raise healthy lifestyles factors with those attending for screening.

Case study: AAA screening

The Gloucestershire & Swindon Abdominal Aortic Aneurysm (AAA) Screening Programme has been screening men aged 65 and over for a potentially fatal expansion and weakening of the main blood vessel in the body in Gloucestershire since 1990. In July 2012, the Programme expanded to include men in Swindon.

Abdominal aortic aneurysms are formed when the main blood vessel in the body weakens and expands. Nationally, around 5,000 people, most of them older men, die every year after large aneurysms burst.

Bob's story: Bob lives in Highworth in Swindon and was diagnosed and treated at Gloucestershire Hospitals. This is his story:

"In October of 2012 I got a telephone call out of the blue from my local surgery asking would I like to come along for an AAA scan as I met the criteria and that people of my age were more at risk of having one.

"Well, along come November 20th 2012 which I remember as a bright sunny day. I remember vividly walking out of our front door and saying to my wife: "Why did I agree to this? There is nothing wrong with me, I feel just fine, my diabetes and angina are all under control and I have better things to be doing", so off I went smugly confident that they would tell me what I already knew: "All OK, no problems."

"At the surgery I was called into the scanning room where they took some details and asked me lay down on the couch where they explained what would happen. One of the team came in and explained to me that I did have an aneurysm and that they would be referring me for further tests. They even told me at this early stage that surgery would be needed.

"In under two weeks I had a CT scan and was referred to Mr Poskitt, the Consultant Surgeon at Cheltenham General Hospital. I had my first consultation with Mr Poskitt where he spent time explaining to me exactly what I had and what the possible options were. Whilst I will admit to being a bit frightened by the diagnosis, I came away from the consultation confident that I had someone professional, caring and would listen on my side.

"I agreed with Mr Poskitt to proceed with the full open operation as, yes there was a risk involved it would be silly not to realise it however the 'Do Nothing' option would leave me forever wondering if today was the day it would burst.

"I was admitted to Avening Ward at Cheltenham General Hospital on 25th March and was met by Mr Poskitt and his team who talked me through the procedure and checked that I was still ok to go ahead. Although apprehensive I had made my decision and the operation was carried out the next morning. Mr Poskitt's team and the nursing staff on the ward as well as the multitude of other departments involved in my care were excellent and I was finally discharged home.

"I would urge anyone who has the opportunity to have the AAA scan to do so. For me it was the right and most sensible thing to do and I owe the service a debt of gratitude along with all the other professionals and staff treatment and care shown during the time I spent both pre-op and post care."

Delivering the strategy: enablers

Training for staff – MECC

The ambition behind this strategy is that "every contact will count for promoting the health and wellbeing of our patients". We want our staff to feel confident in raising health and wellbeing issues with patients and will increase the number of staff undertaking the "Making Every Contract Count" (MECC) training, provided within the county.

Working together with others

We will continue to work in close collaboration with other stakeholders in the county in areas where we can contribute to the Gloucestershire H&WB Strategy. This will involve joint working on a day to day basis, and playing an active part in countywide strategy and planning forums, in the Healthy individuals Programme Group and other CCG Programme Groups, and in and new projects and initiatives.

Electronic health records

A major project is underway in the Trust to introduce, over the next two years, an electronic health record system. Over time this will provide opportunities to capture more health and lifestyle data, to prompt staff to raise health and lifestyle issues, and to introduce swift electronic means of referring or signposting patients to appropriate support and advice.

NICE guidance

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care NICE. The H&WB Committee will continue to review relevant guidance relating to health and lifestyle to identify gaps and areas for potential action.

Staff H&WB

We recognise that the NHS and its staff have a responsibility to lead by example. Our Staff H&WB Strategy was launched last year and has an on-going work programme, designed to improve the health and wellbeing of our staff and encourage and support them in this. In line with the 5 Year Forward View, we will explore how we can model healthy behaviours more clearly and become effective health champions in the wider community.

Media and communications

Wherever possible we promote healthy lifestyle issues in a range of ways – on our website, through the local press, by supporting national and local awareness campaigns, and, through the use of social media.

We recognise that in an increasingly digital world there is the potential for extending our use of social media. This is a key area on which we shall be working.

Delivering the strategy - monitoring

Work programme

The strategy will be underpinned by a work programme, which will be updated at least annually and monitored quarterly.

Where relevant, it will reflect elements of the Countywide H&WB Strategy's Priority Action cards or other emerging H&WB related plans. We will work to develop better metrics for monitoring progress in implementing this Strategy.

Oversight and monitoring

Responsibility for overseeing and monitoring the Strategy rests with the Trust's H&WB Committee, which reports directly to the Trust Board.

The Committee is chaired by one of our non-executive Directors. Its core membership is drawn from across the clinical and corporate Divisions and includes Occupational Health and Staff side colleagues and Trust Governors.

Representatives from the local CCG, the county's Public Health Team and specialist NHS stop smoking services are co-opted members of the Committee – reflecting our shared commitment to collaborative working.

Strategy review

The Strategy will be reviewed at least every two years, and more frequently if required.

Risks to implementation

Many benefits associated with H&WB and public health activities are only seen in the longer term – health promoting activities may be perceived as a lower priority in the context of short-term service delivery pressures.

Insufficient financial resources and staff time and capacity.

An uncoordinated approach to H&WB across the county will diminish our ability to maximise the progress which we can make together.

Equality Impact Assessment

An equality impact assessment has been undertaken.

Glossary of terms

Term	Definition
CCG	Clinical Commissioning Group
Commissioning/ Commissioners	Our commissioners are the Gloucestershire Clinical Commissioning Group. Commissioning is the process of assessing the needs of a local population and putting in place services to meet those needs. Commissioners are those who do this and who agree service level agreements with service providers for a range of services
Disadvantaged groups	Sometimes called 'marginalised', 'hard-to-reach' or 'seldom-heard' groups, these are people who experience inequalities in health, healthcare and employment, but who are not specifically protected by the Equality Act. They can include homeless people, sex workers, people who misuse substances, people with low socioeconomic status, and people living in rural isolation
Equality Impact Assessments	Process used to ensure the impact upon all protected characteristics has been considered prior to any service changes being introduced.
Foundation Trust	NHS providers who achieve foundation trust status have greater freedoms and are subject to less central control. Foundation Trusts are part of the NHS and have to meet the same national targets and standards
Foundation Trust Governors	The Board of Governors are elected by Foundation Trust members. Over half our members are local people or service users, other membership includes staff members and local partner organisations. Governors advise a Foundation Trust on how it carries out its work so that this is consistent with the needs of members and the wider community
GCC	Gloucestershire County Council
Gloucestershire Health & Wellbeing Board and Strategy	The Board is a partnership between local council representatives, the NHS and the wider community to improve the health of everyone in the county. Its plans and ambitions are set out in the county's HWB Strategy
Health	A complete state of physical and mental health and wellbeing and not merely the absence of disease and infirmity
Health promotion	The process of enabling people to increase control over, and to improve, their health
Healthwatch	Healthwatch was established in April 2013 and is the new consumer champion of the health and social care in England, giving children, young people and adults a powerful voice
JSNA	Joint Strategic Needs Assessment, a high level overview of need in the county
Long term conditions (LTC)	Chronic health conditions which cannot at present be cured, but which can be controlled by medication, and other therapies and action. Among the most common LTC's are: diabetes, coronary heart disease, stroke, heart failure, respiratory diseases and asthma, severe mental health conditions and epilepsy
MECC	Make Every Contact Count - an initiative and associated training which encourages staff to raise issues about healthy lifestyle behaviours with their patients
NICE	The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care
Public Health	The science and art of promoting and protecting health and wellbeing, preventing ill-health and prolonging life through the organised efforts of society
Screening	The process of identifying healthy people who may be at increased risk of disease or a condition
Service users	Those who use services or those who may use them. Service user involvement can be directly or through representatives
Stakeholder engagement	A process by which an organisation or Local Health Community learns about the perceptions, issues and expectations of its stakeholders and uses these views to assist in managing, supporting and influencing any planned changes/improvements in service delivery
Stakeholders	Any person or group of people who have a significant interest in services provided, or will be affected by, any planned changes in an organisation or Local Health Community
Wellbeing	Wellbeing is a subjective concept, often associated with people feeling comfortable, secure and fulfilled in their lives, or with improving economic, social and environmental factors.

ITEM 21

ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

DISCUSSION

ITEM 22

STAFF QUESTIONS

Prof Clair Chilvers
Chair

ITEM 23

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