GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

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

Professor Clair Chilvers
Chair

22 July 2016

AGENDA

				Approximate Timings
1.	Welcome and Apologies			09:00
2.	Declarations of Interest			
	WELL LED			
	Minutes of the Board and its Sub-Committees	(subject to ratification by the Board and its relevant sub-committees)		
3.	Minutes of the meeting held on 24 June 2016	**PAPER**	**To approve**	09:02
4.	Matters Arising	**PAPER**	**To note**	09:03
5.	Summary of the meeting of the Finance and Performance Committee to be held on 27 July 2016	**PAPER (To follow)** (Tony Foster)	**To note**	09:07
6.	Minutes of the meeting of the Finance and Performance Committee held on 22 June 2016	**PAPER** (Tony Foster)	**To note**	09:11
7.	Minutes of the meeting of the Health and Wellbeing Committee held on 5 July 2016	**PAPER** (Tony Foster)	**To note**	09:15
8.	Minutes of the meeting of the Quality Committee held on 15 July 2016	**PAPER** (Gordon Mitchell)	**To note**	09:20
9.	Summary of the meeting of the Workforce Committee to be held on 27 July 2016	**PAPER (To follow)** (Keith Norton)	**To note**	09:25
	Chief Executive's Report and Environmental Scan			
10.	July 2016	**PAPER** (Deborah Lee)	**To note**	09:30
	EFFECTIVE			
11.	Integrated Performance Framework Report	**PAPER** Helen Simpson)	**To endorse**	09:40
12.	Financial Performance Report	**PAPER** (Helen Simpson)	**To endorse**	09:55
13.	Emergency Pathway Monthly Report	**PAPER** (Deborah Lee)	**To endorse**	10:10
14.	Nurse and Midwifery Staffing	**PAPER** (Maggie Arnold)	**To approve**	10:25
15.	Board Statements	**PAPER** (Helen Simpson)	**To approve**	10:30
16.	Board Assurance Framework and Trust Risk Register	**PAPER** (Andrew Seaton)	**To approve**	10:35
17.	Staff Survey Action Plans	**PAPER** (Dave Smith)	**To note**	10:50
18.	Proposed Revisions to the Constitution	**PAPER** (Martin Wood)	**To approve**	11:00
	SAFE			
19.	Seven Day Services Update	**PAPER** (Sean Elyan)	**To note**	11:10

	FOR INFORMATION			
20.	Minutes of the meeting of the Council of Governors held on 6 July 2016	**PAPER** (Clair Chilvers)	**To note**	11:20
	Next Meeting			
21.	Items for the next meeting and Any Other Business	**DISCUSSION (All)**	**To Discuss**	11:25
	Staff Questions			
22.	A period of 10 minutes will be provided to respond to questions submitted by members of staff		**To Discuss**	11:30
	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**	11:40 11:50
	Break			

Date of the next meeting: The next meeting of the Main Board will take place at on **Friday 26 August 2016** in the **Board Room, Alexandra House, Cheltenham General Hospital** at 9.00 am. **(PLEASE NOTE VENUE FOR THIS MEETING)**

Public Bodies (Admissions to Meetings) Act 1960

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST BOARD HELD IN THE SUBSCRIPTION ROOMS, GEORGE STREET, STROUD ON FRIDAY 24 JUNE 2016 AT 9.30 AM

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

PRESENT	Prof Clair Chilvers	Chair
	Deborah Lee	Chief Executive
	Dr Sally Pearson	Director of Clinical Strategy
	Dr Sean Elyan	Medical Director
	Maggie Arnold	Director of Nursing
	Eric Gatling	Director of Service Delivery
	Helen Simpson	Executive Director of Finance
	Dave Smith	Director of Human Resources and Organisational Development
	Gordon Mitchell	Senior Independent Director/ Vice Chair
	Tony Foster	Non-Executive Director
	Clive Lewis	Non-Executive Director
	Anne Marie Millar	Non-Executive Director
	Helen Munro	Non-Executive Director
	Keith Norton	Non-Executive Director
APOLOGIES	None	
IN ATTENDANCE	Martin Wood	Trust Secretary
	Dr Mark Silva	Chief of Service - Medicine
	Sue Barnett	Improvement Director
PUBLIC/PRESS	Mandy King	Staff
	Elizabeth Hemlock	Staff
	Craig Macfarlane	Head of Communications
	Prof Chris Dunn	Public Governor, Stroud

The Chair welcomed all to the meeting. In particular, she welcomed Deborah Lee who was attending her first meeting following her appointment as Chief Executive.

ACTION

180/16 DECLARATIONS OF INTEREST

There were none.

181/16 MINUTES OF THE MEETING HELD ON 20 MAY 2016

RESOLVED: That the minutes of the meeting held on 20 May 2016 were agreed as a correct record and signed by the Chair.

182/16 MATTERS ARISING

044/16 Nurse 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. The Chair undertook to invite the Interim Assistant Nursing Director / Revalidation Lead to progress the Freedom of Information request. *The request has been progressed and a response is awaited. Ongoing*

082/16 Financial Performance Report: In response to a question from the Chair, the Finance Director said that the revised report format will be introduced in May 2016. The Acting Chief Executive said that this will be presented to the June Finance and Performance Committee and subsequently to the June 2016 Board meeting. *The revised format report was presented to the June 2016 meeting of the Finance and Performance Committee and appears later in the Agenda. Completed as a Matter Arising.*

083/16 Emergency Pathway Report: 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. *This item appears later in the Agenda. Completed as a Matter Arising.*

150/16 Recruitment of New Chair: The dates for the revised recruitment timetable will be circulated to the Board when determined. *The revised timetable has been circulated to the Board. Completed.*

151/16 Acting Chief Executive's Report and Environmental Scan – Trust Risk Register: IT – 2246 – aging and out of support network hardware, single internet circuit causing increased likelihood of hardware failures, decreasing likelihood and increase 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 through foot (using manual processes) backlog of data entry – The Director of Clinical Strategy said that work is underway to replace the equipment and it is anticipated that the risk will be mitigated by the end of July 2016. She undertook to pick up with the Director of Safety a clearer articulation of the risk and the mitigating actions. *Ongoing.*

155/16 Integrated Performance Framework Report: Mrs Munro referred to the length of stay standard which had not been met and asked for the reasons why which the Director of Service Delivery undertook to provide in the next report. *Ongoing*

The Chair invited the Executive Team to consider what performance aspirations could be achieved and to include them in the report. *Ongoing*

157/16 Nurse and Midwifery Staffing: The Chair undertook to write to the County Members of Parliament expressing concern over the £1,000 per annum charge to be introduced for each candidate employed from a non-EU country. *Ongoing*

158/16 Final Accounts: The updated final accounts together with the analytical review would be circulated to the Board. *These documents were circulated to the Board as part of seeking approval to the Final Accounts. Completed.* [0936]

183/16 SUMMARY OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 22 JUNE 2016

The Chair of the Committee, Tony Foster, presented the summary of the meeting of the Finance and Performance Committee held on 22 June 2016. The Committee had received presentations from each of the five Divisions on their year to date financial performance, financial controls, Cost Improvement Programme delivery and performance issues. Gaps in meeting the Cost Improvement Programme had been identified in four of the five Divisions. Committee members have received a presentation from the Improvement Director and the Director of Service Delivery providing greater detail on the Emergency Pathway for the Committee to be able to undertake a robust challenge.

In response to a question from Mrs Munro, the Chair of the Committee said that further information on our Trust's cash position is to be presented to the next Committee meeting.

The Board considered the benefit of the weekly telephone calls for Non-Executive Directors and concluded that the telephone calls be replaced by a weekly e-mail and that this be reviewed by the Committee in three months' time.

The Chair thanked Mr Foster for his report.

RESOLVED: That the report be noted. [0951]

184/16 MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 18 MAY 2016

RESOLVED: That the minutes of the meeting of the Finance and Performance Committee held on 18 May 2016 be noted. [0951]

185/16 SUMMARY OF THE MEETING OF THE AUDIT COMMITTEE HELD ON 17 MAY 2016

RESOLVED: That the minutes of the meeting of the Audit Committee held on 17 May 2016 be noted. [0951]

186/16 MINUTES OF THE MEETING OF THE QUALITY COMMITTEE HELD ON 10 JUNE 2016

The Chair of the Committee, Gordon Mitchell, presented the minutes of the meeting of the Quality Committee held on 10 June 2016. The

Committee had reflected on the need for the Board to take assurance on quality issues based on how the Committee seeks to take assurance. Firstly, the quarterly Directors' Statement by the Director of Clinical Strategy, the Nursing and Medical Directors, Divisional attendances and other reports presented to the Committee provides a summary of the issues. Secondly, a discussion on assurance from quality metrics, Key Lines of Enquiry (KLOEs), summaries of reports, CQC alerts and mortality data. The attendance by Women and Children's Division provided data and a statement by the Chief of Service on risks in five areas upon which action had been taken in four. The major risk being the staffing on ward 2a and workload issues. The Medical Director said that work is progressing to improve the position commenting that patient flow is not related solely to the Emergency Department.

(Ms Anne-Marie Millar left the meeting).

The Committee had considered how assurance is presented to the Board and the Director of Clinical Strategy, the Nursing and Medical Directors have been invited to consider reporting in relation to the CQC standards.

The Chair commented that it was now opportune to look at the roles of both the Quality and Finance and Performance Committees as to the information they received based more on business intelligence rather than information.

The Chair thanked Mr Mitchell for his report.

RESOLVED: That the report be noted. [1008]

187/16 CHIEF EXECUTIVE'S REPORT AND ENVIRONMENTAL SCAN

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

- **Introduction:** She expressed her appreciation for the warm welcome she had received from the Board and the wider organisation.
- **National:** The results of the referendum on the Junior Doctors' contract will be published on 6 July 2016.
- **Our Trust:** The annual Staff Awards took place on 16 June 2016 at Hatherley Manor Hotel which was a huge success.

The Chief Executive gave her first impressions of the organisation following her second week in post. At a high level from walkabouts at Gloucestershire Royal Hospital, the operating model was not serving patients and impacting on the Best Care For Everyone. Staff are not able to practice in their skilled area. She had received positive comments from partners to re-set the operating model. There are opportunities for the model to be changed. GPs are triaging patients going home and the decision making process needs to be explained if this is different to the Emergency Department doctor. She had invited the Improvement Director to support the Nursing Director and the Director of Service Delivery to deliver those changes. She had operated the "Involve" session on 23 June 2016 as a question and answer session, where sensible questions had been asked.

The Chair thanked the Chief Executive for her report.

RESOLVED: that the report be noted. [10:15]

188/16 INTEGRATED PERFORMANCE FRAMEWORK REPORT

The Finance Director presented the Integrated Performance Framework report and drew attention to the key highlights on performance, emphasising that in May 2016 the number of patients waiting over six weeks for a key diagnostic test continues to not achieve the 1% month end target at 1.3%. This is due to capacity issues in MRI and action plans have been agreed with clinicians. The cancer two week wait standard was not met in April 2016 and our Trust did not meet the recovery trajectory for the 62 day cancer standard in the same month and is not expected, in the action plan, to do so until September 2016. It did, however, meet the Sustainability and Transformation Plan trajectory of 77.1%. The 95% four hour target for Emergency Department performance was not successfully met in May 2016 with Trust wide performance reported as 87.4%. This was considered in great detail in minute number 190/16 below.

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

- The Chair commented with disappointment at the volume of planned/surveillance endoscopy patients waiting at month end which continues to rise and our Trust did not achieve the 1% waiting at month end. The Director of Service Delivery explained that the issue is regarding surveillance patients who require a follow-up appointment which has risen historically due to the backlog being cleared and then further patients requiring treatment. Extra capacity is being provided to clear the backlog. The Director of Service Delivery said that he would prepare further details to the next meeting of the Finance and Performance Committee in July 2016 based on a what a right size service should look like taking into account demand and the backlog. **EG (MW to note for Agenda)**
- The Medical Director said that the mortality data is within the acceptable range but does not provide a sense of what the Board needs to know in terms of Best Care For Everyone. The indicators may be out of date due to the Dr Foster reporting arrangements and the issue is how to report contemporary data. A more considered view will be presented in the report to the July Board.
- Mr Lewis asked for information as to the background for the improved performance in length of stay. In response, the Director of Service Delivery said that the work streams have given a focus to all parts of the pathway and part of the overall plan is for this improvement to be sustained.
- The Chief Executive asked for information on the clinical assurance for the backlog of patients. The Medical Director in response said that the backlog is not always in the same clinical speciality, commenting that in some specialities the issue has been resolved and then not sustained. The backlog should not appear in the first place. The Chair invited the Medical Director and the Director of Service Delivery to prepare a report for the Quality Committee on the assurance for clinical oversight over the backlog of patients. **SE/EG (MW to note for agenda)**

- Mr Foster commented that the current report contains a great deal of data and the Finance and Performance Committee are looking for the report to be more forward looking.

The Chair thanked the Finance Director for the report.

RESOLVED: That the Integrated Performance Framework Report be noted and that the actions being taken to improve performance be endorsed. [1028]

189/16 FINANCIAL PERFORMANCE REPORT

The Finance Director presented the report providing a high level view of the financial position for the end of May 2016. The financial position of our Trust at the end of May 2016 is an operating deficit of £1.2m representing an adverse variance of £3.5m from the planned position of a £2.3m surplus for May 2016, largely due to the phasing of the Financial Plan. The financial sustainability risk rating based on the performance in May 2016 is 2. Providing that the overall plan position is delivered, this will rise to 3 for the 2016/17 financial year. Our Trust has submitted a revised plan trajectory to NHS Improvement for approval to reflect the additional costs currently relating to operational pressures and the non-recurrent costs in quarters 1 and 2 relating to our Emergency Department recovery work streams. This maintains the agreed control total of £5.3m but alters the phasing allowing for a deficit in the earlier months of the financial year. Expenditure on temporary staff in May 2016 was £3.0m which was £0.5m higher than the average for 2015/16. The facility at Cirencester Hospital is only operating at 50% capacity and this needs to increase to ensure a return on the investment. The Trust has taken a number of measures to improve cash flow and support the reduction of aged payables around contracting arrangements, internal process and governance, and use of the working capital facility although there remains a backlog. The cash balance at the end of May 2016 stands at £5.1m which is not as good as it should be. Gloucestershire Care Services have refused to pay £1m towards the county-wide IT arrangements with which they are contracted to do so. The system of payments backed by orders is working well. The plans for the delivery of the Cost Improvement Programme have now been reviewed and deep dive reviews have been undertaken with all divisions to ensure that plans are robust and deliverable.

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

- Mr Norton asked when the financial sustainability risk rating would return to 3. In response, the Finance Director said that the position will not recover until at least quarter 3 depending on a reduction in the run rate on variable pay and the need for the Cost Improvement Programme to be in place with increasing pace.
- Mr Lewis observed that the receivables from English Clinical Commissioning Groups amounted to £45.5m and asked whether the year end figure from arbitration had been received. In response, the Finance Director said that the monies had been received as a charge outside the contract. Gloucestershire Care Services had not paid quickly resulting in a £6m debtor and £5m creditor position. Adjustments to the

accounts had not been made until the monies had been received.

- Mr Lewis asked for details of the changes in place to improve cash collection. In response, the Finance Director said that additional resources were provided for shared services last year and the new Director of Operational Finance has experience in this area. Interviews for the appointment of a commercial credit controller are taking place on the afternoon of the Board meeting with one senior and one junior appointment being planned rather than the current three middle grade staff. The senior appointment will report directly to the Director of Operational Finance. Mr Lewis sought further information on payables. The Chief Executive said that this information had been requested by the Finance and Performance Committee and will be presented to them.

(Ms Anne-Marie Millar returned to the meeting).

- Mr Lewis understood that there were concerns if the cash balances fell below £5.8m observing that currently they stand at £5.1m. In response, the Finance Director said that it is a lower figure of approximately £4m. Mr Foster added that with the availability of the working capital facility, the cash balance is not so critical. The Finance Director said that this is dipped into and then replenished. The Finance Director would consider for inclusion in future reports details of the working capital facility used. **HS**
- The Director of Human Resources and Organisational Development asked whether details on pay expenditure included the cost of living increase. The Finance Director responded by stating that this is provided separately.
- The Director of Human Resources and Organisational Development said that NHS Improvement was looking at reducing back office expenditure and consideration will be given to how this could be achieved, not only for back office staff but for all staff groups.
- Mr Foster said that the las time the financial sustainability risk rating was presented to the Board was in February 2016 which he considered to be wrong and will be addressed as part of the learning. The Finance Director apologised for not including this information in the report.

The Chair thanked the Finance Director for the report.

RESOLVED: That:-

1. The financial position of the Trust at the end of month 2 of the 2016/17 financial year is an operational deficit of £1.2m be noted. This is an adverse variance to plan of £3.5m, although a favourable variance of £0.05m against the proposed revised plan.
2. The Trust needs to improve its controls on the use of agency staff as this has already impacted the early part of 2016/17 be noted; although there is a small reduction in month 2, it is not material in impact.
3. Actions to address the issued identified in the report will continue and progress will continue to be reported monthly to the Finance and Performance Committee and the Foundation

Trust Board. [1048]

190/16 EMERGENCY PATHWAY REPORT INCLUDING EMERGENCY CARE RECOVERY PLAN

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

- The format of the report is being revised to be more succinct.
- The 95% four hour target for Emergency Department performance was not successfully met in May 2016 with Trustwide performance being reported as 87.4%. Cheltenham General Hospital achieved the 95% standard in May 2016 but Gloucestershire Royal Hospital did not. There has been an upward trend of improvement compared to the previous four months and particularly compared to March 2016 when performance was 77.7%. For the first 23 days of June 2016, performance is meeting the improvement trajectory of 85%.
- The drivers impacting on performance are the attendances and admissions where work is underway with partners to manage demand. The number of patients on the medically fit list for one day and over has been at an average of 62 throughout May 2016 against a system-wide plan of no more than 40 patients.
- Action plans are in place to improve performance. The next three work streams are being developed and a visit is planned to Oxford to look at their health system to see what lessons can be learned. He stressed that the action plans are clear and capacity and capability issues are being addressed to deliver those plans and this work is linking with that being undertaken by the Cultural Change team.

The Improvement Director commented that the action plans will not solve every issue but will address the key issues and key risks to provide assurance to NHS Improvement that the submitted plans are being delivered and there is an aspiration to achieve beyond those plans. The Board needs to compare the critical elements of those plans to see progress.

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

- Ms Millar sought an assurance on the quality of the data in the report particularly with regard to admission/transfers. In response, the Director of Service Delivery said that staff are clear on entering data but he acknowledged that more work needs to be undertaken. The particular issue is validation where staff are treating patients and entering real time information. The Medical Director added that staff are taking ownership of the data entered.
- The Chief of Service for Medicine Division congratulated staff on reducing length of stay, commenting that the Emergency Department would be more challenging without that reduction.
- Mr Mitchell asked how progress against the action plans will be recorded. In response, the Improvement Director said that the plan is a “live” document and since publication of the Board papers, there may be some changes by a few days. The plans are aligned to existing resources and relate to each other. The Chief Executive added that the proposal is to develop an

exception reporting format in the Emergency Care Programme Board. At this stage, she could not give confidence about the capacity and actions owned and completed by the date, and this will become clearer following the first meeting of the revised Emergency Care Programme Board arrangements when an assurance report will be prepared. The first of the revised format will be presented to the Board in July 2016. The emphasis from NHS Improvement is on delivery and that confidence to do so is yet to be fully available.

- The Improvement Director said that there are internal issues for the Board to address.
- The Chief Executive said that the building works for the Emergency Department at Gloucestershire Royal Hospital have been agreed in principle to increase the resuscitation capacity by one with four cubicles in the main department to deal with "minors". The cost and programming of the work is yet to be determined and this is being undertaken by the Nursing Director in the Emergency Department work stream. The proposal is to provide maximum benefit by undertaking minimum works. The Nursing Director added that the costs for those works are to be known in the next two weeks.
- Mr Norton asked for information on patient flow both before and after the Emergency Department. In response, the Director of Service Delivery said that in the before situation, the Clinical Commissioning Group and Community Working Group met weekly. The Emergency Department is a key component in the Sustainability and Transformation Plan. A GP from the community is working in the Emergency Department and, following the undertaking of an audit, is now treating patients. The after position is that a new work stream 6 will be looking at other models of care with the Clinical Commission Group and Gloucestershire Care Services who need to buy in to the new models with action developing. It is anticipated that this will be undertaken in the next couple of months. The Nursing Director added that she is working with the Nursing Director of the Clinical Commissioning Group on new models of care and if a new model can be agreed for the County, will have most effect. A gap analysis is being undertaken between the service provided in our County and Oxfordshire is to be completed within the next two weeks and will be shared with commissioners. It is hoped that the new care model will be operational before 1 October 2016. This will be considered at the first meeting of the reformed Emergency Care Programme Board. The Director of Clinical Strategy commented that a national review of emergency care will feed into the local Urgent Care Strategy meetings leading to changes in urgent care in the community.

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

RESOLVED: That:-

1. The report be noted and the actions being taken to improve performance be endorsed.
2. The Emergency Care recovery Plan be approved. [1112]

191/16 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 May 2016. In line with the set parameters for the safer staffing guidance, there were no exceptions for May 2016; however, divisional nursing directors have been asked to review and report in divisions on their data sets.

The key first benchmark exercise has been undertaken and updated to reflect the acuity of patients in acute hospitals resulting in some investment being required. The Finance Director has confirmed that the money required has been identified. Our Trust need to reflect on the impact of this on both the agency spent and recruitment; for example, allocating the money but not recruiting substantively will result in higher costs as more agency nurses will be required to fill the "new" gaps. The current numbers will therefore be reported on as and when the posts are substantively recruited to. On this basis, the numbers can be reported accurately. The Nursing Director assured the Board that she will maintain a very close scrutiny of this and will continue to review and allocate agency staff with the Divisional Nursing Director as appropriate to maintain patient experience and safety while still pursuing all recruitment avenues.

The three areas for quality improvement identified in Medicine Division from the care contact audit related to nursing handover, nursing documentation and medication rounds. On several wards concerns have been raised as to the standard and quality of these three areas. An action plan for improvement has been produced which will look at the implementation of the productive handover and ward round. This will take time to implement due to the current recruitment position. In the interim, however, bedside handovers have been produced across many of the wards where concerns have been raised. This approach is considered best practice to enhancing patient communication and engaging the patient in their ongoing care delivery. There has been an over-recruitment of HCAs to assist nurses. The University of Gloucester is being approached to fill nursing vacancies and our Trust is to look at appointment nurses from Oxford Brookes. The freedom of information request regarding the IELTS examination is proceeding.

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

- The Chair expressed considerable concern over the news that there are insufficient numbers of nurses emanating from the University of the West of England and that no provision appears to be made to make up the difference. She also expressed concern that potential nurses would not be able to pay the qualification fees and suggested that our Trust develop a scheme to support mature nurses undertaking the qualification with a condition that they work for our Trust for a period of time when qualified. In response, the Director of Human Resources and Organisation Development said that our Trust is being as creative as it can in looking at ways to recruit and retain nurses. Our Trust needs to retain staff in great numbers and this is a corporate issue rather than for individual Divisions. The Chief Executive added that the Vice Chancellor of the University of Gloucester has expressed the desire to work with our Trust on

nurse training.

- Mr Foster observed that the vacancy forecast is increasing indicating the current plans are not working with the situation deteriorating and our Trust needs to be more creative to resolve. The Director of Service Delivery commented that the estimated vacancy forecast was lower than anticipated due to the opening of escalation beds which were funded as substantive staff. Offers of employment have been made to Advanced Nurse Practitioners following a recent recruitment event to work alongside nurses particularly in Diagnostics and Specialties Division.
- The Chief Executive invited the Nursing Director to include a percentage as well as the actual numbers in the nursing vacancies. The forecast should be for the whole year.

The Chair thanked the Nursing Director for the report.

RESOLVED: That the report for assurance that our Trust is delivering safe staffing levels and has plans to maintain and improve upon this position be noted. [1125]

192/16 TRUST RISK REGISTER

The Chief Executive said that the Trust Risk Register is presented for information as the document articulated a commentary and not the identification of the actual risk. She will work with the Director of Safety to better express the risks and a revised format will be presented to the Board in July 2016. She assured the Board that following a meeting of the Health and Safety Committee earlier in the week, that there were no risk management issues identified.

The Chair thanked the Chief Executive for the report.

RESOLVED: That the Trust Risk Register be noted. [1129]

193/16 EDUCATION, LEARNING AND DEVELOPMENT ANNUAL PLAN 2016/17

The Director of Human Resources and Organisational Development presented the report providing a summary of the progress made against the annual Education, Learning and Development (ELD) work plan for 2015/16 and proposes the work plan for 2016/17. He drew particular attention to the progress made against the 2015/16 Strategic Aims Work Plan and the priorities for 2016/17.

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

- In response to a question from Ms Millar, the Director of Human Resources and Organisational Development said that plans for areas for apprentices are being developed and will be shared with Board members.
- Mr Lewis asked how training is to be delivered stating that it could be face to face, e-learning or on the job and this needs to be factored in. In response, the Director of Human Resources and Organisational Development said or there is a need to recognise who has received training.
- The Chair said the newly-established Workforce Committee will

be holding its inaugural meeting in July 2016 and will, in due course, receive updates on the Plan.

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

RESOLVED: That progress against the 2015/16 work plan for Education, Learning and Development and the annual priorities for 2016/17 in support of the Workforce Strategy 2015/20 be noted. [1143]

194/16 ANNUAL REVALIDATION OF SENIOR MEDICAL STAFF

The Medical Director presented the report provided an up to date review of the appraisal and revalidation process for our Board. Revalidation began in December 2012 and the three year cycle has been completed with 394 doctors having been revalidated by the end of March 2016. NHS England request an end of year report which was attached to the report in addition to the quarterly reports. The process has expanded the 360 review with a focus on communication. Personal development plans are also scored. There are currently 37 appraisers undertaking the requisite number of appraisals and our Trust has to ensure that numbers do not fall below the critical level of appraisers. It is difficult to provide information on the time spent on training by consultants but, in many instances, it is considered an opportunity. The Medical Director acknowledged the work of Dr Janet Ropner, Associate Medical Director, in the annual appraisal/revalidation process.

During the course of the discussion, the Chair asked if it was difficult to maintain the requisite number of doctors to undertake appraisals. In response, the Medical Director said that this is not an issue as involvement gives a good reputation.

The Chair thanked the Medical Director for the report.

RESOVLED: That the report for assurance that the Trust has a robust medical appraisal and revalidation system which is compliant with national requirements be noted. [1149]

195/16 ANNUAL COMLAINTS REPORT 2015/16

The Nursing Director presented the report providing information on the complaints and concerns reported to our Trust during 2015/16. The annual benchmarking report for written complaints received by NHS organisations is not published until the end of August 2016 so the information in the report represented our Trust's internal performance. She highlighted that during 2015/16, our Trust was notified of 28 cases which had been referred by complainants to the Parliamentary and Health Service Ombudsman (PHSO) for second stage resolution and which the PHSO has decided to investigate. This equated to approximately 3% of the total number of complaints received. The PHSO do not inform our Trust of the referrals not investigated as they do not meet their threshold. Letters to complainants are to be in a softer style saying "sorry" as we are the professional providing the service. Learning from what our patients and carers tell us works well and what may need improving is a key component of enabling us to deliver our Trust strategic objective "to improve the experience of our patient's year on year". During 2015, our Trust participated in the national pilot Patient Association: NHS Benchmarking Complainant

Survey. The response rate was 36% with our Trust scoring positively in four areas and three areas identified for improvement. One of those areas was an explanation of how we will manage individuals including any human resources processes when the complaint involves specific Trust members of staff as we we are not allowed to disclose what has happened to individual members of staff.

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

- Mr Lewis observed that there were approximately ten times more compliments than complaints and enquired whether there are personal complaints and others which may not be captured. In response, the Nursing Director stressed that she always advices potential complainants to log their complaints with the complaints department and she expressed confidence that all complaints are recorded. There is always learning from complaints.
- Mr Lewis suggested that the graph containing complaints per 1000 episodes of care by Division should also include numbers and the respective percentage. He also said that the relationship between the breakdown of clinical treatment and the learning needed to correlate with each other. He suggested that offering an apology in the process was often beneficial. In response, the Nursing Director said that training is provided for people who chair complaint meetings.
- Mr Foster observed that there were nearly twice as many concerns as complaints and following his observation of PALS, he was impressed with the speed at which issues were addressed. The Nursing Director said that the supervisory ward sisters are able to address concerns immediately.
- The Chief Executive said in response to a question from the Chair that she had previously introduced a diary placed at the end of each patient's bed, indicating the care received and she invited the Nursing Director to consider whether this could be introduced. The Medical Director added that this is already undertaken for outpatients. The Director of Service Delivery undertook to pick up as part of the outpatient project, the recording of patient care. **MA** **EG**

The Chair thanked the Nursing Director for the report.

RESOLVED: that the 2015/16 Annual Report on Complaints be noted. [1203]

196/16 INFECTION CONTROL ANNUAL REPORT

The Nursing Director presented the annual report in her capacity as Director of Infection and Prevention Control, providing information on the progress and achievements of the infection control objectives set for 2015/16 and outlined the objectives for 2016/17. During the last year, our Trust has seen further progress with regard to infection prevention and control building on the increasing recognition, within all levels of the organisation, that infection prevention and control is everyone's business. Maintaining low numbers of clostridium difficile cases has remained a challenge and the final number of hospital-acquired cases was 41 against a trajectory of 37. Six of these cases were deemed unavoidable due to their comorbidities and the need for

anti-antibiotic therapy and have been successfully appealed with the Commissioners. Therefore, the total number of avoidable clostridium difficile cases was 35. Outbreaks of norovirus have been much less despite high numbers circulating in the Gloucestershire community with our Trust reporting twelve bay or ward closures. During 2015/16, the high standard of anti-microbial prescribing, set by the previous year's Commissioning for Quality and Innovation (CQUINN), has continued with the average HAPPI score remaining above the target of 90% throughout. The HAPPI score consists of an assessment of the documentation on the patient drug chart of anti-microbial allergy, review/stop date and clinical indication for use together with the appropriate choice and route of administration of antibiotic. The County are working together to reduce cases of infection. Challenges for 2016/17 are to achieve zero healthcare acquired MRSA bacteraemias and the clostridium difficile target of 37 cases.

During the course of the discussion, the Chair commented on the good news emanating from the report observing that there is little information on MRSA which she considered disappointing. In response, the Nursing Director said that NHS England publish guidance on the reporting and monitoring arrangements but there is no benchmarking information available.

The Chair thanked the Nursing Director for the report.

RESOLVED: that the 2015/16 Annual Infection Prevention and Control report be endorsed. [1207]

197/16 MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON 18 MAY 2016

The Chair presented the minutes of the meeting of the Council of Governors held on 18 May 2016.

RESOLVED: That the minutes be noted. [1208]

198/16 ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

Items for the next meeting:

No additional items were identified for the next meeting.

Any other business:

There were no further items of business. [1211]

199/16 STAFF QUESTIONS

There were none. [1211]

200/16 PUBLIC QUESTIONS

Prof Christopher Dunn, Public Governor, Stroud, submitted two questions regarding increased investments in GP surgeries and the reluctance of the Clinical Commissioning Group to fund development this year on work towards seven day services and whether there were any common denominators between periodic closures of at least some

of the County's minor injuries units and the challenges encountered by our Trust's ED departments.

The Chair read the response to these questions as follows:-

Critical to the success of 7 day working is a whole system approach to service provision. For example, there will be limited benefit from developing services to promote Sunday discharge from hospital if the community services to support discharge are not also in place. The Clinical Commissioning Group has recently re-iterated its commitment to investing in 7-day services, including services provided by Gloucestershire Hospitals and work is now underway to develop a system wide investment and delivery plan (under the auspice of the Sustainability and Transformation Programme) to develop the detail. Resources have been set aside to support this development but investment will be contingent on the system reducing current levels of high demand so these funds are not required to fund other pressures.

In respect of Primary Care Investment, this targeted investment is aimed at reducing the burden on other services at weekends by widening access for patients who might otherwise attend services such as Accident & Emergency and Minor Injury services, and as such is very welcome.

Supplementary Question

Prof Dunn asked a supplementary question linking Emergency Departments and the minor injury units and whether information on the waiting times at minor injuries units could be publicised. It was acknowledged that minor injury units are the responsibility of Gloucestershire Care Services.

In response, the Chair invited the Director of Service Delivery to revisit the publicising on the Trust's website waiting times at minor injury units. **EG**

The Chief Executive explained that South West Ambulance Service has withdrawn from the out of hours service which is the responsibility of the Clinical Commissioning Group. This will provide an opportunity to look at the Emergency Department pathway. [1212]

201/16 DATE OF NEXT MEETING

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

202/16 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 12.13pm.

Chair
29 July 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JULY 2016

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
July 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. The Chair undertook to invite the Interim Assistant Nursing Director / Revalidation Lead to progress the Freedom of Information request. *The request has been progressed and a response is awaited. Ongoing*
June 2016	May 2016 Minute 151/16 Acting Chief Executive's report and Environmental	**SP**	IT – 2246 – aging and out of support network hardware, single internet circuit causing increased likelihood of hardware failures, decreasing likelihood and increase costs of finding

	Scan - Trust Risk Register		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 through foot (using manual processes) backlog of data entry – The Director of Clinical Strategy said that work is underway to replace the equipment and it is anticipated that the risk will be mitigated by the end of July 2016. She undertook to pick up with the Director of Safety a clearer articulation of the risk and the mitigating actions. *Ongoing*.
June 2016	May 2016 Minute 155/16 Integrated Performance Framework Report	**EG** **Exec Team**	Mrs Munro referred to the length of stay standard which had not been met and asked for the reasons why which the Director of Service Delivery undertook to provide in the next report. *Ongoing* The Chair invited the Executive Team to consider what performance aspirations could be achieved and to include them in the report. *Ongoing*
June 2016	May 2016 Minute 157/16 Nurse and Midwifery Staffing	**CC**	The Chair undertook to write to the County Members of Parliament expressing concern over the £1,000 per annum charge to be introduced for each candidate employed from a non-EU country. *Ongoing*
July 2016	May 2016 Minute 159/16 Cultural Change Programme Update	**RW**	The Chair invited the Associate Director of Transformation to present a further update to the Board in July 2016. *This item was considered at the Board seminar on 20 July 2016. Completed as a Matter Arising.*
July 2016	June 2016 Minute 188/16 Integrated Performance Framework Report	**EG**	The Director of Service Delivery said that he would prepare further details at the volume of planned/surveillance endoscopy patients waiting at month end to the next meeting of the Finance and Performance Committee in July 2016 based on a what a right size service should look like taking into account demand and the backlog. *This item was considered by the Committee on 27 July 2016. Completed.*
July 2016	June 2016 Minute 188/16 Integrated Performance Framework Report	**SE/EG**	The Chair invited the Medical Director and the Director of Service Delivery to prepare a report for the Quality Committee on the assurance for clinical oversight over the backlog of patients. *This report is to be presented to the Quality Committee in September 2016. Completed as a Matter Arising.*

July 2016	June 2016 Minute 189/16 Financial Performance Report	**HS**	The Finance Director would consider for inclusion in future reports details of the working capital facility used. *Ongoing.*
July 2016	June 2016 Minute 195/16 Annual Complaints Report 2015/16	**MA** **EG**	The Chief Executive said in response to a question from the Chair that she had previously introduced a diary placed at the end of each patient's bed, indicating the care received and she invited the Nursing Director to con *Ongoing.*sider whether this could be introduced. The Director of Service Delivery undertook to pick up as part of the outpatient project, the recording of patient care. *Ongoing.*

FUTURE TARGETS

There are none.

COMPLETED TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
June 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. The Acting Chief Executive said that this will be presented to the June Finance and Performance Committee and subsequently to the June 2016 Board meeting. *The revised format report was presented to the June 2016 meeting of the Finance and Performance Committee and appears later in the Agenda. Completed as a Matter Arising.*
June 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. *This item appears later in the Agenda. Completed as a Matter Arising.*
June 2016	May 2016 Minute 150/16 Recruitment of New Chair	**DS/MW**	The dates for the revised recruitment timetable will be circulated to the Board when determined. *The revised timetable has been circulated to the Board. Completed.*

June 2016	May 2016 Minute 158/16 Final Accounts	**HS**	The updated final accounts together with the analytical review would be circulated to the Board. *These documents were circulated to the Board as part of seeking approval to the Final Accounts. Completed.*

ITEM 5

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

PAPER (To follow)

Tony Foster
Chair

ITEM 9

SUMMARY OF THE MEETING OF THE WORKFORCE COMMITTEE TO BE HELD ON 27 JULY 2016

PAPER (To follow)

Keith Norton
Chair

MAIN BOARD – JULY 2016

REPORT OF THE CHIEF EXECUTIVE

1. Introduction

As I embark upon my second month as Chief Executive, the positive welcome from staff across the Trust has continued. The priorities for the organisation are becoming clearer and not surprisingly there are numerous challenges ahead however, staff across the Trust appear committed to working together, to ensure we not only survive some of the difficult times ahead but that we thrive.

2. National

2.1 The junior doctor ballot resulted in junior doctors rejecting the contract negotiated on their behalf by the British Medical Association by 58% to 42%; disappointingly this will now result in the national imposition of the revised contract with effect from October 2016 which we all hoped would be avoided.

2.2 The implications for health services following the EU Referendum result remain unclear however, the Trust has sent a message of support to all of its overseas staff re-affirming their value to the Trust and thanking them for the contribution they make.

2.3 The long awaited guidance setting out how the national Sustainability and Transformation Fund (STF) will be allocated to those providers who accepted the funding offer as part of their agreed control total, was received this week. In broad terms, the funds will be allocated to providers, on a quarterly basis, based upon the financial and service performance they have achieved. 70% of the funding is linked to financial performance and 30% to performance against three national access standards – 4 Hour A&E Standard, Cancer 62 Day Standard and the 18 Week Referral To Treatment (RTT) Standard. The Trust is currently assessing the implications of the guidance on our plan.

2.4 Following the review into the circumstances surrounding the unexpectedly high number of deaths at Southern Healthcare NHS Foundation Trust, the Care Quality Commission (CQC) has commenced a review into how NHS Trusts investigate and learn from deaths. The Trust is required to participate in the review and action is underway to provide the CQC with the required information, by the end of this month.

2.5 The Trust has been invited by the Cabinet Office & Department of Health to participate in a “deep dive” looking at Trusts progress with implementing *7 day services*. The review will take place over two days towards the end of July and is expected to inform the national direction, whilst giving the Trust an opportunity to showcase some of the good work it has done in this area.

3. Regional

3.1 NHS England South has set out its plans for responding to national guidance regarding the establishment of Cancer Alliances. The purpose of these Alliances is to establish a means of bringing clinicians from across sectors – primary, secondary, tertiary – together with the aim of driving improvements in cancer outcomes and specifically in those areas where the UK is lagging behind other developed countries.

3.2 As a Trust with links to cancer services in two clinical networks, we will need to consider how best to respond to this developing agenda. On a positive note, this development is a response to widely expressed views that the changes to previous cancer network arrangements had not brought about the expected benefits and

cancer support to providers and cross provider working was weaker as a result of the changes.

4. Our System

4.1 Chief Executives from the five Sustainability and Transformation Plan (STP) lead organisations attended a STP "check pint" meeting on Friday 15th July. The purpose of the meeting was to provide assurance to NHS England and NHS Improvement that the plan is on track, ahead of the final submission required in September. If not, the team was asked to present their three biggest challenges and articulate the support they will need to deliver their plan in the coming months and years. For this Trust, we took the opportunity to present our vision for service reconfiguration and a request for additional capital funding to enable the site development work to take place; positively, further information on both these issues has been requested as part of the September submission.

4.2 Operational pressures continue and attendances and admissions remain above plan presenting both operational and financial pressures. System partners have agreed that "business as usual" approaches to this problem are not bringing about the scale or pace of change required and extraordinary measures are required. This will include developing plans that enable the Trust to close all escalation capacity by the end of August. A workshop is planned for mid-July to agree what measures will be taken.

5. Our Trust

5.1 NHS Improvement will be meeting on the 25th July 2016 to consider whether the Trust is in breach of its license following a prolonged period throughout which it failed to meet the national 4 Hour A&E Standard. Whilst a very disappointing outcome for the Board and wider organisation, it will provide the Trust with access to further support to ensure we resolve this long standing issue once and for all, which will benefit all of our patients and staff, not just those attending and working in our A&E departments. On a positive note, despite some very high attendance levels throughout Quarter 1 and July, we are ahead of our recovery trajectory.

5.2 July saw the 100 Leaders community come together to do work on the Trust's emerging approach to *Transforming Care For Everyone.* The event was extremely well attended with more than 100 staff working together on how we turn the Trust's vision into a reality and what culture we expect to emerge as a result of these efforts. Next steps will include Board endorsement of the revised programme, followed by a Trust-wide launch and roll out of the renewed approach.

5.3 Following in the footsteps of my predecessor, I review and sign all formal complaints responses from the Trust. One of the issues presented through recent complaints was the issue of disabled parking and in particular complaints from patients and carers who have been subjected to parking penalties as a result of parking in non-disabled parking places, when disabled parking bays have been full. As a result of these concerns, the parking policy has been revised and with immediate effect parking penalty notices will no longer be issued to those displaying a *Blue Badge* when forced to park in regular parking spaces. Negotiations are also now underway with Indigo Parking to revise the policy and amend public information accordingly.

5.4 There was one consultant interview panel during the period, in the spinal surgery service but regrettably no appointment was made.

6. Signing and Sealing

262 Renewal lease – Barnwood Trust and GHNHSFT – Wheatstone House, Barnwood, Glos.

263 Deed of Covenant – GHNHSFT, Halliwell Properties Ltd and Markey Student Properties Ltd – Whitfield House, Whitfield St, Gloucester

Deborah Lee
Chief Executive Officer

July 2016

INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK

EXECUTIVE SUMMARY

TRUST BOARD – JULY 2016

1.0 INTRODUCTION

This report summarises the key highlights and exceptions in Trust performance up until the end of June 2016 for the financial year 2016/17.

2.0 PERFORMANCE

In overall terms in June, GP referrals were 7.9% higher than 2015/16, thus exceeding the 2.5% variance target, this trend built on the increasing trend experienced during last financial year. Additionally attendances to ED departments continues to significantly exceed planned levels.

2.1 ARE WE SAFE?

KEY HIGHLIGHTS

- There have been no MRSA cases during May and June, with the exception of 1 case in April 2016. Although the performance has improved, this compares to an annual target of 0 cases for the year.
- Performance against the Dementia target has consistently been met throughout Q1 with 90% in June compared to the Q1 target of 86%. This is an improvement when compared with 86.3% in Q4 2015/16.

AREAS FOR IMPROVEMENT

- There were 2 cases of C-Difficile and although this is an improvement in the month, the total number of cases in Q1 is 10 which has exceeded the quarterly target of 9.
- The percentage of women seen by a midwife within 12 weeks remains slightly below target throughout Q1.
- Acute Kidney Injury (AKI) performance was 25% in June and has fallen each month. in Q1; from 56% in April to 25% in June; averaging out at 37% for the quarter. The clinical leads is reviewing this position and identifying the areas requiring urgent attention and improvement.

2.2 ARE WE RESPONSIVE?

KEY HIGHLIGHTS

- There has been a continuing improvement to ambulance handover delays over 60 minutes in Q1 with 3 cases reported in April and none since.
- During May, 6 out of the 9 cancer measures have met their target's, with the following measures achieving 100%:
  - maximum wait 31 days to decision to treat to subsequent treatment: surgery
  - maximum wait 31 days decision to treat to subsequent treatment: drugs
  - maximum wait 31 days decision to treat to subsequent treatment: radiotherapy
  - maximum wait 62 days from consultant upgrade to 1st treatment

AREAS FOR IMPROVEMENT

- The Trust met the agreed improvement trajectory of 85% for June 2016, with Trustwide performance reported as 87.06%. However, this performance does not meet the 95% 4 hour target for Emergency Department and was a slight decrease compared to May 2016 (87.42%). There has been overall improvement since February 2016.
- Planned/surveillance endoscopy patients waiting at the month end continue to rise, to 441 up to 30th June. Actions are being taken to address the performance and a

separate briefing paper has been produced for the Finance and Performance Committee.

- Max 2 week wait for cancer patients urgently referred by GP performance has improved by 8.8% during May however this still does not achieve the target . An exception report has been produced for the Finance and Performance Committee to provide further details on the Recovery Plan.
- Maximum wait 62 days from urgent GP referral to first cancer treatment (excluding rare cancers) performance is below the target in May of 85%, actual performance is at 77.4%.
- The percentage of patients with a maximum wait 62 days from national screening programme to first treatment has not achieved the 90% standard during May, with actual performance at 84.6%.

2.3 ARE WE EFFECTIVE?

KEY HIGHLIGHTS

- The percentage of patients spending 90% of time on stroke ward continues to increase each month, to 89.0% in May, compared with a target of 80%.
- The percentage of patient discharges summaries continues to achieve the target of 85% in May, with actual performance at 85.7%.

AREAS FOR IMPROVEMENT

- The number of patients on the medically fit list for one day and over has been at an average of 75 throughout June 2016. This remains above the system-wide plan of no more than 40 patients.
- The percentage of eligible patients with VTE risk assessment is below the 95% target throughout Q1, ending at 93.4% for June and Q1 overall.
- The percentage of elective patients cancelled on day of surgery for a non-medical reason has not achieved the 0.8% target, ending at 1.6% in June and Q1. There were 8 patients who had operations cancelled and not rebooked within 28 days in June, leading to a total of 35 patients in Q1, compared with the target of 0 patients.
- Emergency spells were 9.6% above plan in June, thus exceeding the 2.5% variance target.

2.4 ARE WE WELL LED?

KEY HIGHLIGHTS

- Staff who have completed mandatory training in June continues to achieve the >90% standard in June at 92%.

AREAS FOR IMPROVEMENT

- The Trust Financial Risk Rating is now at level 2. Recovery actions have been identified to return the Trust risk rating to a level 3 and a separate briefing has been given to the Finance and Performance Committee.

3.0 RECOMMENDATIONS

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

Author: **Eric Gatling, Director of Service Delivery**
Helen Simpson, Deputy Chief Executive & Executive Director of Finance

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

Date: **July 2016**

Gloucestershire Hospitals NHS
NHS Foundation Trust

PERFORMANCE MANAGEMENT FRAMEWORK

2016/17

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TRUST OVERVIEW

June 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
Financial 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

ASSESSMENT AGAINST THE NHS IMPROVEMENT RISK ASSESSMENT FRAMEWORK

	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	2016/17 Q1	2016/17 Apr	2016/17 May	2016/17 Jun	NHSI Weighting	Estimated Current Position for Q1
18 WEEKS															
Incomplete pathways - % waited under 18 weeks	92%	92.2%	92.0%	92.3%	92.1%	92.3%	92.1%	92.2%	92.0%	92.0%	92.1%	92.0%	92.0%	1.0	
ED															
% patients spending 4 hours or less in ED	95%	93.3%	94.3%	89.5%	82.7%	93.4%	89.7%	85.6%	78.5%	86.7%	85.4%	87.4%	87.1%	1.0	1.0
CANCER															
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%		78.2%	77.4%		1.0	1.0
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%		91.7%	84.6%			
Max wait 31 days decision to treat to subsequent treatment : surgery %	94%	99.0%	100%	100%	98.8%	100%	100%	99.5%	99.5%		98.1%	100%		1.0	
Max wait 31 days decision to treat to subsequent treatment : drugs %	98%	100%	100%	100%	100%	100%	100%	100%	100%		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 31 days decision to treat to treatment %	96%	99.6%	99.8%	99.5%	100%	99.5%	99.7%	100%	99.8%		98.6%	99.6%		1.0	
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%		77.7%	86.5%		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%		94.6%	94.3%			
INFECTION CONTROL															
Number of Clostridium Difficile (C-Diff) infections - post 48 hours	37/yr	9	6	8	13	8	10	10	13	10	5	3	2	1.0	1.0

PERFORMANCE MONITORING AGAINST THE SUSTAINABILITY AND TRANSFORMATION PLAN

2016/17

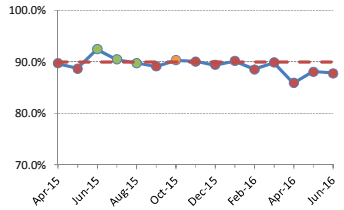
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
ED													
% patients spending 4 hours or less in ED	Trajectory	80.00%	85.00%	85.00%	87.00%	87.00%	91.90%	89.10%	91.20%	85.70%	85.10%	80.10%	89.60%
	Actual	85.38%	87.41%	87.05%									
% patients spending 4 hours or less in ED (incl. Primary Care ED cases)	Trajectory	80.00%	85.00%	85.00%	87.00%	87.00%	91.90%	89.10%	91.20%	85.70%	85.10%	80.10%	89.60%
	Actual	85.70%	87.73%	87.36%									
18 WEEKS													
Incomplete pathways - % waited under 18 weeks	Trajectory	92.02%	92.00%	92.01%	92.04%	92.04%	92.00%	92.00%	92.04%	92.01%	92.00%	92.00%	92.00%
	Actual	92.10%	92.01%	92.00%									
DIAGNOSTICS													
15 key Diagnostic tests : % waiting over 6 weeks at month end	Trajectory	2.71%	2.16%	1.46%	0.99%	0.99%	0.99%	0.99%	0.94%	0.99%	0.98%	0.99%	0.99%
	Actual	5.06%	1.34%	1.40%									
CANCER													
Cancer: Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) %	Trajectory	77.17%	80.37%	82.64%	82.91%	93.70%	85.31%	85.03%	85.19%	85.03%	85.00%	85.07%	85.62%
	Actual	78.2%	77.4%										

TRUST PERFORMANCE & EXCEPTIONS (as at end June 2016)

ARE WE SAFE?

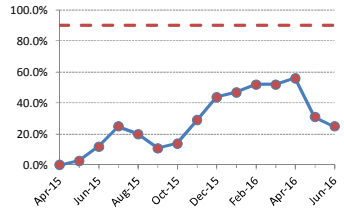
MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q1	Q2	Q3	Q4	2016/17 Q1	Apr	May	Jun	FORECAST Jul	Aug	Sep	Oct	Nov	Dec	FoT	Standard	Target Set By	How often	Data Month
INFECTION																				
Number of Clostridium Difficile (C-Diff) infections - post 48 hours		8	10	10	13	10	5	3	2	0	2	3	3	3	5		37 cases/year	NHSI	M	Jun
Number of Methicillin-Resistant Staphylococcus Aureus (MRSA) infections - post 48 hours		0	0	2	1	1	1	0	0	0	0	0	0	0	0		0	GCCG	M	Jun
MORTALITY																				
Crude Mortality rates %		1.2%	1.0%	1.2%	1.4%	1.2%	1.3%	1.2%	1.1%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%		<2%	Trust	M	Jun
Summary Hospital-Level Mortality Indicator		109.9	109.7	110.7						1.1%			1.1%				≤1.1%	Trust	Q	Dec-15
HSMR (Analysis-relative risk-basket HSMR basket of 56-mortality in hospital) (rolling 12 months)		112.7	110.8	107.5	106.8												Confidence interval	Dr Foster	M	Mar
SMR (rolling 12 months)		111.6	110.3	108.0	110.2												Confidence interval	Dr Foster	M	Mar
SAFETY																				
Number of Never Events		0	1	1	0		0	0		0	0	0	0	0	0		0	GCCG	M	May
% women seen by midwife by 12 weeks		90.3%	90.0%	90.0%	89.6%	87.2%	85.9%	88.1%	87.8%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%		>90%	GCCG	M	Jun
CQUINS																				
Acute Kidney Infection (AKI)		5%	19%	29%	50%	37%	56%	31%	25%	55.0%	55.0%	55.0%	55.0%	55.0%	55.0%		>90% by Q4	National	M	Jun
Sepsis Screening 2a		69%	83%	96%	92%					90.0%	90.0%	90.0%	90.0%	90.0%	90.0%		>90% of eligibles	National	M	Mar
Sepsis Antibiotic Administration 2b			32%	43%	49%					90.0%	90.0%	90.0%	90.0%	90.0%	90.0%		>90% of eligibles	National	M	Mar
Dementia - Seek/Assess		88.7%	87.5%	88.8%	86.3%	88.1%	87.0%	87.5%	90.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%		Q1>86%; Q2>87%; Q3>88%; Q4>90%	National	M	Jun
Dementia - Investigate		100%	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	Jun
Dementia - Refer		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Q1>86%; Q2>87%; Q3>88%; Q4>90%	National	M	Jun
ED																				
% patients triaged in ED in 15 minutes		65.1%	61.4%	57.9%	53.7%	75.3%	68.5%	78.9%	78.1%								≥ 99%	Trust	M	Jun
% patients assessed by doctor in ED in 60 minutes		53.7%	45.4%	44.7%	43.3%	47.1%	48.1%	47.2%	46.0%								≥ 90%	Trust	M	Jun

ARE WE SAFE?

MEASURE		QUARTERLY PROGRESS Q2	Q3	Q4	Q1	NOW	FOT	OWNER
% women seen by midwife by 12 weeks Standard is >90%								Director of Nursing and Midwifery

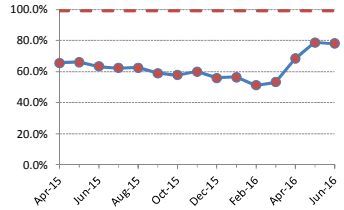
Commentary on what is driving the performance & what actions are being taken

Dependent upon on 3 main issues
1. Each woman contacting maternity services - work with primary care to raise awareness and importance of early booking in pregnancy.
2. Community Midwives caseloads capacity to book women in a timely fashion and capacity in GP practices to see women under 12 weeks - funding for additional midwifery staffing recently allocated to community to improve caseloads and looking at a range of alternative facilities in the community where women might be seen, e.g. Children's Centres.
3. Accurate, timely recording of bookings – education of Midwives to ensure correct data entry, where women are transferred into county within pregnancy and have already pre-booked elsewhere - Review post implementation of Smartcare which should also capture data in a more timely and accurate manner.
Further audit to monitor issues affecting performance.

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

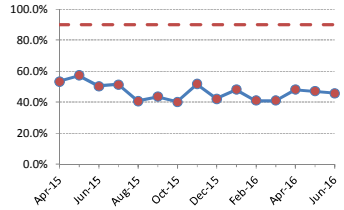
Commentary on what is driving the performance & what actions are being taken

Q1 CQuIN requirements focus on case review of poorly completed discharge summaries and sharing of lessons learned, this has been undertaken. Red status reflects the unexpected drop in compliance with requirements in May and June which may impact on results achieved in Q2. Actions implemented by the F2 improvement group over the last financial year continue to be in use. Additional analysis has been undertaken to assess compliance achieved in different areas. This did not highlight any areas that were particularly poor, therefore teaching and awareness of AKI requirements and the correct use of Infoflex continues to be undertaken, including the new F1 intake at induction.

% patients triaged in ED in 15 minutes Standard is ≥ 99%								Director of Safety

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

The actions to address this standard are being picked up by the Emergency Care Programme. Please refer to the Emergency Care Pathway Report for further information.

% patients assessed by doctor in ED in 60 minutes Standard is ≥ 90%								Director of Safety

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

The actions to address this standard are being picked up by the Emergency Care Programme. Please refer to the Emergency Care Pathway Report for further information.

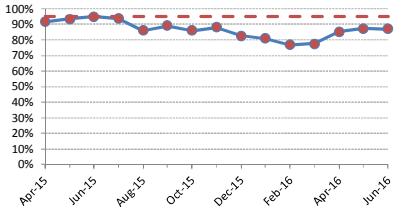
TRUST PERFORMANCE & EXCEPTIONS (as at end June 2016)

ARE WE RESPONSIVE?

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q1	Q2	Q3	Q4	2016/17 Q1	Apr	May	Jun	FORECAST Jul	Aug	Sep	Oct	Nov	Dec	FoT	Standard	Target Set By	How often	Data Month
ED																				
% patients spending 4 hours or less in ED		93.4%	89.7%	85.6%	78.5%	86.7%	85.4%	87.4%	87.1%	87.0%	87.0%	87.0%	90.0%	90.0%	90.0%		≥ 95%	NHSI	M	Jun
Number of ambulance handovers delayed over 30 minutes		205	212	241	428	517	168	194	155	100	100	70	70	80	90		< previous year	GCCG	M	Jun
Number of ambulance handovers delayed over 60 minutes		13	21	28	33	3	3	0	0	7	7	10	10	10	11		< previous year	GCCG	M	Jun
18 WEEKS																				
Incomplete pathways - % waited under 18 weeks		92.3%	92.1%	92.2%	92.0%	92.0%	92.1%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%		≥ 92%	NHSI	M	Jun
15 key Diagnostic tests : % waiting over 6 weeks at month end		5.4%	5.9%	1.5%	4.0%	2.6%	5.1%	1.3%	1.4%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%		<1% waiting at month end	GCCG	M	Jun
Planned/surveillance endoscopy patients - nos. waiting at month end with and without dates		400	341	142	225	363	308	340	441	200	250	200	200	150	100		< 1% waiting at month end	GCCG	M	Jun
CANCER																				
Max 2 week wait for patients urgently referred by GP %		91.5%	90.3%	92.4%	88.7%		77.7%	86.5%		93.0%	93.0%	93.0%	93.0%	93.0%	93.0%		≥ 93%	NHSI	M	May
Max 2 week wait for patients referred with non cancer breast symptoms %		95.2%	91.8%	93.4%	95.3%		94.6%	94.3%		92.0%	92.0%	93.0%	93.0%	94.0%	94.0%		≥ 93%	NHSI	M	May
Max wait 31 days decision to treat to treatment %		99.5%	99.7%	100%	99.8%		98.6%	99.6%		100%	100%	100%	100%	100%	100%		≥ 96%	NHSI	M	May
Max wait 31 days decision to treat to subsequent treatment : surgery %		100%	100%	99.5%	99.5%		98.1%	100.0%		100%	100%	100%	100%	100%	100%		≥ 94%	NHSI	M	May
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	May
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	May
Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) %		73.9%	75.6%	79.5%	76.7%		78.2%	77.4%		83.0%	84.0%	85.0%	85.0%	85.0%	85.0%		≥ 85%	NHSI	M	May
Max wait 62 days from national screening programme to 1st treatment %		97.3%	94.0%	95.6%	94.9%		91.7%	84.6%		92.0%	92.0%	92.0%	92.0%	92.0%	92.0%		≥ 90%	NHSI	M	May
Max wait 62 days from consultant upgrade to 1st treatment %		60.0%	92.9%	100%	100%		- *	100.0%		100%	100%	100%	100%	100%	100%		≥ 90%	NHSI	M	May

* Zero patients this month

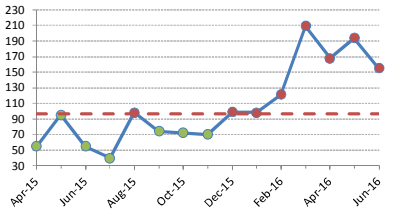
ARE WE RESPONSIVE?

MEASURE		QUARTERLY PROGRESS Q2	Q3	Q4	Q1	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.

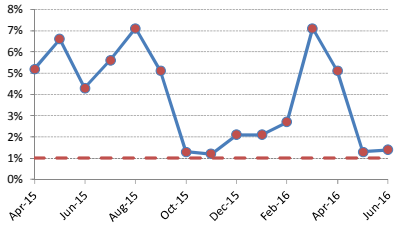
The trajectory for ED has been reviewed in conjunction with the NHSI sustainability and transformation requirements. The trajectory for 2016/17 is: Q1 (85%); Q2 (87%); Q3 (90%); Q4 (90%).

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 the Emergency Pathway Report.

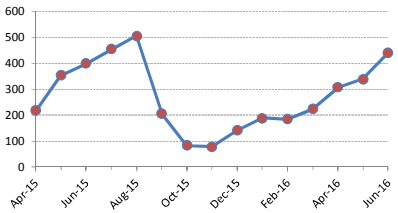
Also to note; South West Ambulance Service implemented a new computer aided dispatch system in April 2016. Joint work is ongoing between the Emergency Department and SWAST.

15 key Diagnostic tests : % waiting over 6 weeks at month end Standard is < 1% waiting at month end								Director of Service Delivery

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

108 patients of which: Flexi sigmoidoscopy 32; Colonoscopy 24; Urodynamics 19; Gastroscopy 16; Cardiology - echocardiography 11; Cystoscopy 5, Audiology - Audiology Assessments 1.

Recovery plans in place with Divisions to deliver the agreed trajectory.

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

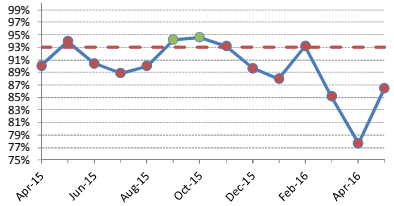
Commentary on what is driving the performance & what actions are being taken

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 Q2	Q3	Q4	Q1	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

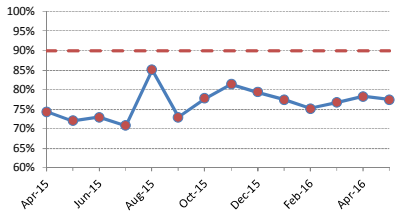
Under-performance in the standard is in the main across most of the tumour sites. Specific issues have been raised in dermatology and gynaecology with regard to capacity, which are being addressed. Demand for TWW demand continues to be a pressure in services with a 19.5% (819) increase in referrals in QTR1 2016/17 compared to the same period in 2015/16. Services have been reviewing their clinic templates to align TWW demand with clinic structures. June's performance is showing some improvement with anticipated performance to be >90%.

	April 16 (current)			May 16 (current)			Average treatments / month (rolling 12 months)
Target	Latest Position	Breaches	Treatments	Latest Position	Breaches	Treatments	
93%	**77.7%**	**365**	1636	**86.6%**	**230**	1715	1597
Brain / CNS	**89.5%**	2	19	**82.6%**	4	23	20
Breast	**96.6%**	9	261	**99.6%**	1	251	256
Gynaecological	**84.1%**	17	107	**83.8%**	19	117	108
Haematological*	**16.7%**	5	6	**28.6%**	10	14	8
Head & Neck	**88.4%**	22	190	**88.9%**	16	144	162
Lower GI	**84.2%**	44	279	**82.5%**	63	361	314
Lung	**73.6%**	14	53	**86.4%**	8	59	49
Skin	**90.3%**	28	290	**93.4%**	22	334	284
Testicular	**20.0%**	12	15	**61.1%**	7	18	15
Upper GI	**83.6%**	33	201	**95.3%**	8	170	184
Urological	**16.7%**	179	215	**67.9%**	72	224	197

* Excludes acute leukaemia

ARE WE RESPONSIVE?

MEASURE	QUARTERLY PROGRESS Q2	Q3	Q4	Q1	NOW	FOT	OWNER
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

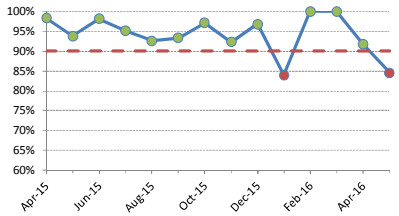
The Trust had 4.5 more breaches than projected in May – mainly due to a poorer than anticipated performance in lung, skin and upper GI. One skin breach was due to Max Fax surgical capacity. There were also 2ww capacity issues in March – they had a particularly busy month and sickness absence in the CNS team leading to 29 2ww breaches. Overall, this translated into 1.5 62 day breaches – when they usually have 100% performance. In Upper GI, the service anticipated one breach (based on historical performance) but had 3 breaches – one due to patient fitness, one due to patient choice and one due to a complex diagnostic pathway. Lung had 4.5 breaches (anticipated 2.5 – again based on historical performance). 3 were shared breaches with the BRI. Two patients had complex diagnostic pathways, one patient was unfit for treatment within the target date, one patient wanted thinking time, one patient breached due to a delay with treatment by one day for chemo and one had a diagnostic delay (had to wait for EBUS – endobronchial US).

Latest figures suggest the Trust is close to being back on track in June (81.4% against a projected performance of 82.6%) but we are anticipating a dip in July as the Trust has taken a more proactive approach to PTL management and focus on the longer waits, which has taken 400 patients off the 62 day PTL in the last week.

	April 16 (current)			May 16 (current)			Average treatments / month
Target 85%	Latest Position	Breaches	Treatments	Latest Position	Breaches	Treatments	
	79.7%	33.5	165.0	78.0%	34.5	156.5	152
Brain / CNS	100.0%	0.0	0.5				0
Breast	100.0%	0.0	25.5	100.0%	0.0	26.0	26
Gynaecological	94.1%	0.5	8.5	92.9%	1.0	14.0	10
Haematological*	50.0%	2.0	4.0	90.9%	1.0	11.0	7
Head & Neck	52.9%	4.0	8.5	72.7%	1.5	5.5	7
Lower GI	87.1%	2.0	15.5	73.3%	2.0	7.5	17
Lung	73.3%	4.0	15.0	59.1%	4.5	11.0	12
Other	55.6%	2.0	4.5	50.0%	1.5	3.0	2
Sarcomas	100.0%	0.0	0.5	100.0%	0.0	0.5	1
Skin	100.0%	0.0	30.0	96.6%	1.0	29.0	29
Upper GI	90.6%	1.5	16.0	72.7%	3.0	11	12
Urological	52.1%	17.5	36.5	50.0%	19.0	38	29

* Excludes acute leukaemia

Max wait 62 days from national screening programme to 1st treatment % Standard is ≥90%						Director of Service Delivery



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

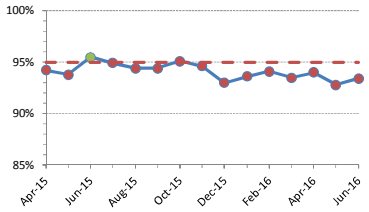
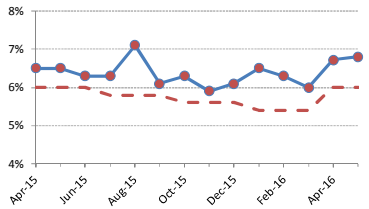
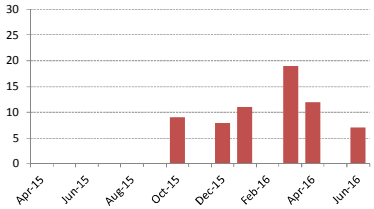
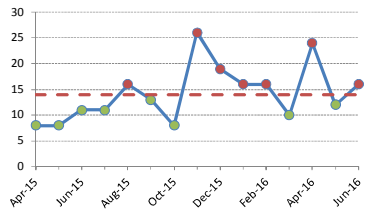
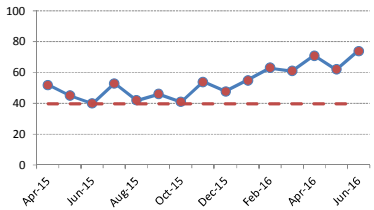
These include referrals from the breast screening programme, cervical screening programme and bowel screening programme and this is a target which we routinely hit. There were particular issues in colorectal in May which impacted on their ability to meet the 62 day target across the board – including screening referrals. These included the overall increase in 2ww referrals (and difficulties in meeting the increased demand in March – performance has improved month-on-month since then) and issues with Radiology capacity and attendance at MDT (now resolved). The current June position is 95.2%.

TRUST PERFORMANCE & EXCEPTIONS (as at end June 2016)

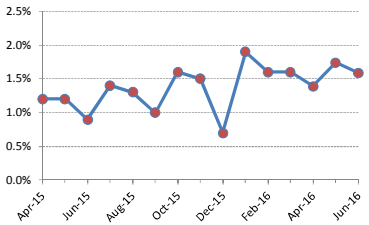
ARE WE EFFECTIVE?

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q1	Q2	Q3	Q4	2016/17 Q1	Apr	May	June	FORECAST Jul	Aug	Sep	Oct	Nov	Dec	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%		84.6%	89.0%		82.0%	82.0%	82.0%	82.0%	82.0%	82.0%		> 80%	GCCG	M	May
% of eligible patients with VTE risk assessment		94.5%	94.6%	94.2%	93.7%	93.4%	94.0%	92.8%	93.4%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%		> 95%	GCCG	M	Jun
Emergency re-admissions within 30 days - elective & emergency		6.4%	6.4%	6.1%	6.4%		6.7%	6.8%		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	May
Number of Breaches of Mixed sex accommodation		0	0	17	30	19	12	0	7	0	0	0	2	0	5		0	GCCG	M	Jun
Number of delayed discharges at month end (DTOCs)		11	13	19	10	16	24	12	16	12	12	12	14	14	16		<14	Trust	M	Jun
No. of medically fit patients - over/day		46	47	48	60	69	71	62	74	40	40	40	40	40	40		≤ 40	Trust	M	Jun
Bed days occupied by medically fit patients		1,189	1,334	1,486	1,504		2,115	1,914	2,230	1,450	1,450	1,450	1,450	1,450	1,450		None	Trust	M	Jun
Patient Discharge Summaries sent to GP within 24 hours		87.7%	89.1%	88.6%	85.6%		86.4%	85.7%		88.5%	88.5%	88.5%	88.5%	88.5%	88.5%		≥85%	GCCG	M	May
BUSINESS OPERATION																				
Elective Patients cancelled on day of surgery for a non medical reason		1.1%	1.2%	1.3%	2.0%	1.6%	1.4%	1.7%	1.6%								≤ 0.8%	Trust	M	Jun
Patients cancelled and not rebooked in 28 days		17	18	15	27	35	20	7	8								0	GCCG	M	Jun
GP referrals year to date - within 2.5% of previous year		4.9%	4.4%	2.9%	3.7%	7.9%	12.9%	10.3%	7.9%								range +2.5% to -2.5%	Trust	M	Jun
Elective spells year to date - within 2.5% of plan		-1.3%	5.1%	5.0%	7.3%	4.9%	4.7%	9.9%	0.4%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%		range ≥-1% to plan	Trust	M	Jun
Emergency Spells year to date - within 2.5% of plan		2.4%	4.0%	6.9%	7.1%	7.7%	10.5%	3.2%	9.6%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%		range ≤2.5% over plan	Trust	M	Jun
LOS for general and acute non elective spells		5.8	5.6	5.7	6.0	5.9	6.3	5.4	6.0	5.4	5.4	5.4	5.4	5.4	5.4		Q1 /Q2 <5.4days, Q3 /Q4 <5.8days	Trust	M	Jun
LOS for general and acute elective IP spells		3.6	3.6	3.6	3.6	3.3	3.0	3.4	3.6	3.4	3.4	3.4	3.5	3.6	3.5		≤ 3.4 days	Trust	M	Jun
OP attendance & procedures year to date - within 2.5% of plan		-0.5%	0.6%	0.6%		0.5%	1.1%	1.8%	-1.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%		range +2.5% to -2.5%	Trust	M	Jun
Records submitted nationally with valid GP code (%)		100%	100%	100%	99.9%		100%			100%	100%	100%	100%	100%	100%		≥ 99%	Trust	M	Apr
Records submitted nationally with valid NHS number (%)		99.8%	99.7%	99.7%	99.8%		99.9%			99.6%	99.6%	99.6%	99.6%	99.6%	99.6%		≥ 99%	Trust	M	Apr

ARE WE EFFECTIVE?

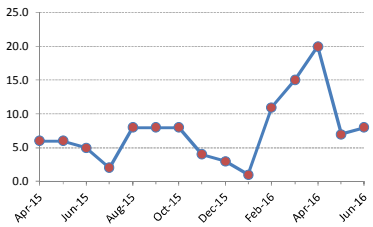
MEASURE		QUARTERLY PROGRESS Q2	Q3	Q4	Q1	NOW	FOT	OWNER
% of eligible patients with VTE risk assessment Standard is >95%		🔴	🔴	🔴	🔴	🔴	🔴	Trust Medical Director
		Commentary on what is driving the performance & what actions are being taken						
		Further improvements to embed the system changes in the process 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						
		Readmissions are an important indicator as a balancing measure in our PMF. We will continue to monitor this closely and review readmissions to ensure any learning from these cases is used to improve patient care.						
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 7 breaches affecting 29 patients with all breaches occurring in the Acute care Units.						
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.						

ARE WE EFFECTIVE?

MEASURE		QUARTERLY PROGRESS Q2	Q3	Q4	Q1	NOW	FOT	OWNER
Elective Patients cancelled on day of surgery for a non medical reason Standard is <0.8%		🔴	🔴	🔴	🔴	🔴	🔴	Director of Service Delivery

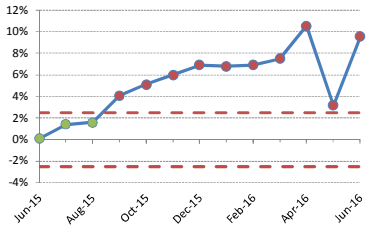
Commentary on what is driving the performance & what actions are being taken

The increase in the number of medically fit patients and level of emergency admissions impacted 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

This is an improving position and performance managed daily, although some patients choose to wait longer than 28 days.

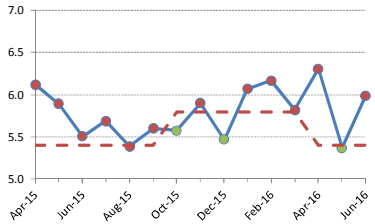
Emergency Spells year-to-date Standard is ±2.5% of plan		🟡	🔴	🔴		🔴	🔴	Director of Service Delivery

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.

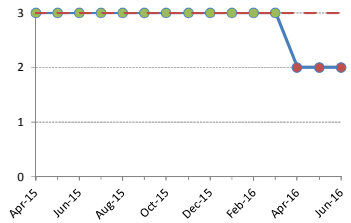
A specific project is in place to review patients with a length of stay over 14 days as part of Workstream 3 of the ED Improvement plan.

TRUST PERFORMANCE & EXCEPTIONS (as at end June 2016)

ARE WE WELL LED?

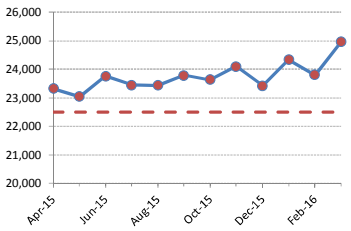
MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q1	Q2	Q3	Q4	2016/17 Q1	Apr	May	Jun	FORECAST Jul	Aug	Sep	Oct	Nov	Dec	FoT	Standard	Target Set By	How often	Data Month
FINANCIAL HEALTH																				
NHSI Financial Risk Rating		3	3	3	3	2	2	2	2	2	2	2	3	3	3		Level 3	NHSI	M	Jun
Achieve planned Income & Expenditure position at year end		-£1.4m	-£1.6m	-£1.6m	-£1.6m	£18.2m	£18.2m	£18.2m	£18.2m	£18.2m	£18.2m	£18.2m	£18.2m	£18.2m	£18.2m		Achieved or better at year end	NHSI	M	Jun
Total PayBill spend £M		£23.8m	£23.8m	£23.4m	£24.3m					£25m	£25m	£25m	£25m	£25m	£25m		Target + 0.5%	Trust	M	Mar
Total worked WTE		6,576	6,628	6,623	6,670		6,606			6,687	6,687	6,687	6,688	6,688	6,689		Target + 0.5%	Trust	M	Apr
WORKFORCE HEALTH																				
Annual sickness absence rate (%)		3.8%	3.8%	3.8%	3.8%		3.5%			3.7%	3.7%	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%			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%	84%	83%	83%	87%	87%	87%	87%	87%	87%		> 90%	Trust	M	Jun
Staff having well structured appraisals in last 12 months (staff survey, on a 5 point scale)		38%	38%	38%	38%		3.0	3.0		3.1	3.1	3.1	3.1	3.1	3.1		> 3.8	Trust	A	May
Staff who completed mandatory training (%)		92%	92%	91%	91%	92%	91%	92%	92%	90%	90%	90%	90%	90%	90%		> 90%	Trust	M	Jun
Staff Engagement indicator (measured by the annual staff survey on a 5 point scale)		3.66	3.66	3.66	3.69		3.71	3.71		3.8	3.8	3.8	3.8	3.8	3.8		> 3.8	Trust	A	May
Improve communication between senior managers & staff (staff survey) (%)		35%	35%	35%	34%		34%	34%									> 38%	Trust	A	May

ARE WE WELL LED?

MEASURE		QUARTERLY PROGRESS Q2	Q3	Q4	Q1	NOW	FOT	OWNER
NHSI Financial Risk Rating Standard is Level 3								Director of Finance

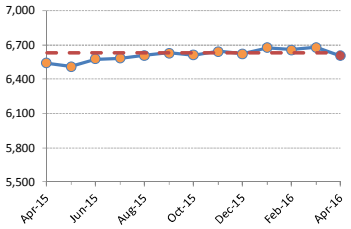
Commentary on what is driving the performance & what actions are being taken

The Trust has achieved the planned financial position for Q1 of the financial year and is forecasting to achieve the control total outturn for 2016/17. The planned income and expediture relected above of £18.2m is inclusive of STP funding. The operational surplus is planned and forecast to eb £5.3m for 2016/17.

Total PayBill spend £M Standard is Target + 0.5%								Director of Finance

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

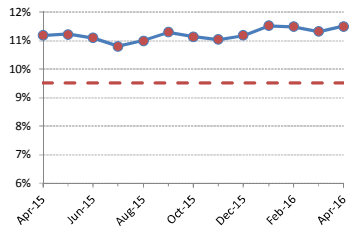
Agency spend reducing albeit still above target trajectories. Short life 'agency task force' established under supervision of CIP Director. Numerous actions however main focus will be on controls/authorisation process, alternative job roles and escalation beds.

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 NHSI 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 NHSI plan, which is constant, needs to reconciled.

The challenge is not so much on the numbers worked but their make up in terms of the split between substantive and agency staff.

Turnover rate (FTE) Standard is Target 7.5% - 9.5%								Director of Human Resources

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

Still unacceptably high figures in Nursing and focus is being placed on specific areas where local issues are driving turnover as opposed to corporate issues. There has also been a surprising increase in turnover amongst Healthcare Scientists and the reasons for this will be established.

TRUST PERFORMANCE & EXCEPTIONS (as at end June 2016)

CQUINs

MEASURE	ACTUAL 2015/16 Q1	Q2	Q3	Q4	2016/17 Q1	Apr	May	Jun	FORECAST Jul	Aug	Sep	Oct	Nov	Dec	FoT	Standard	Target Set By	How often	Data Month
NATIONAL CQUINS																			
Antimicrobial Resistance Part a) 1. Reduction in antibiotic consumption per 1000 admissions								Report Aug								1% reduction against baseline	National	Q	
Antimicrobial Resistance Part a) 2. Total consumption Carbapenem per 1000 admissions								Report Aug								1% reduction against baseline	National	Q	
Antimicrobial Resistance Part a) 3. Total consumption Piperacillin-Tazobactam per 1000 admissions								Report Aug								1% reduction against baseline	National	Q	
Antimicrobial Resistance Part b) Empiric review of antibiotic prescriptions								Report Aug								Review 90% cases	National	Q	
LOCAL CQUINS																			
Transition Year 2: Planned processes for the transition from child to adult services								Report Aug								Further rollout	Local	Q	Mar
Medicines Safety Thermometer																Service improvements	Local	Q	Jun
Diabetic Foot - Year 2: Reduction in the number/rate of lower limb amputations through the deployment of a Multi-Disciplinary Team Approach																Further rollout foot checks	Local	Q	Jun
Cancer survivorship	Report	Report	Report					Report Aug								Q4 Target	Local	Q	Mar
Safer Flow Bundle Year 2: 1.1 Senior review -Board rounds utilising SORT methodology			Report		Report Aug			Report Aug								Reduce LOS by 10% from baseline on defined wards	Local	Q	Mar
Safer Flow Bundle Year 2: 1.2 All patients to have an EDD that is evidence based			Report	Report May	Report Aug			Report Aug								30% pts discharged on original EDD	Local	Q	Mar
Safer Flow Bundle Year 2: 1.3 - Flow from ACU measured against internal proff std (IPS)			Report	Report May	Report Aug			Report Aug								IPS 50% time	Local	Q	Mar
Safer Flow Bundle Year 2: 1.4 - Early discharge -reduce on day transport bookings			Report	Report May	Report Aug			Report Aug								<50% transport booked on day	Local	Q	Mar
Safer Flow Bundle Year 2: 1.5 - Review - Reduction LOS			Report	Report May	Report Aug			Report Aug								improvement and quarterly targets	Local	Q	Mar
SPECIALISED CQUINS																			
Clinical Utilisation Review *(2016/17 detail under review)*								Report Aug								*Under review*		Q	Mar
Ti - Adult Critical Care timely discharge *(2016/17 detail under review)*	100%; 8%	100%; 2%	100%	100%; 11%				Report Aug								improvement >=4hr discharges & >=24hr discharges *(under review)*		Q	Mar
Spinal Surgey Networks, data, MDTs *(2016/17 detail under review)*								Report Aug								Network setup and audit MDT supported cases		Q	
Nationally standardised dose banding (SACT) *(2016/17 detail under review)*								Report Aug								0.5% annual chemo spend to be dose banded		Q	
ARMED FORCES CQUINS - NHSE																			
Armed Forces heath																*Under review*		Q	

CQUINs

ALL MEASURES

OWNER

Director of Clinical Strategy

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

Final schedules for Specialised CQUINS are still under review - no Q1 reports available.

Antimicrobial Resistance - Reduction in antibiotic consumption per 1,000 admissions. The data has to be submitted to Public Health England, but they have had a problem with their data tool, there was an error in it; date of submission to Public Health England has subsequently been put back to end of month 31-Jul16. Q1 reports are mostly not due for submission until 31-Jul-16 and reports will be available in August.

REPORT OF THE FINANCE DIRECTOR

FINANCIAL PERFORMANCE FOR THE PERIOD TO 30TH JUNE 2016

1. Executive Summary

The position presented in this paper is a high level view of the position for Month 3.

The table below summarises the performance for the year to 30th June 2016 against the financial plan as agreed by NHS Improvement.

	Month 3 YTD actual	Month 3 YTD plan	Variance	Full Year Plan
Delivering planned surplus	(£1.88m)	(£1.90m)	£0.02m	£5.3m

The above plan figures reflect the revised plan trajectory submitted to NHS Improvement, which we understand has now been accepted and reflects the additional costs currently relating to operational pressures and the non-recurrent costs in Q 1 and Q2, relating to our A&E recovery workstreams. This maintains the agreed control total of £5.3m but alters the phasing, allowing for a deficit in the earlier months of the financial year.

The financial position of the Trust at the end of M3 of the 2016/17 financial year is an operating deficit of £1.88m, which represents a small favourable variance of £0.02m against the planned position.

Latest guidance on the Sustainability and Transformation Funding (STF) means that the Trust should receive the full amount for Q1 of 2016/17.The criteria for accessing the fund for Q1 was compliance with the planned financial control total and having an agreed trajectory for key performance and financial targets. Performance including the STF is shown below:

	Month 3 YTD actual	Month 3 YTD plan	Variance	Full Year Plan
Delivering planned surplus	(£1.88m)	(£1.90m)	£0.02m	£5.3m
STF Funding	£3.225	£3.225	£0.00m	£12.9m
Delivering planned surplus – restated to include STF	£1.345m	£1.325m	£0.02m	£18.2m

The position presented in this paper is prior to STF funding to aid simplicity.

Key Issues:

- The Month 3 position includes expenditure on temporary staff of £2.9m in the month which is also £0.5m per month higher than the average for 2015/16. This includes expenditure on bank staff. Agency expenditure (as related to the Monitor cap) is £1.6m against a trajectory of £1.15m. The figure has reduced slightly in the month with a small reduction in nursing agency being compensated for with an increase in other clinical agency. This expenditure is one of the key drivers of the year-to-date deficit position.

- As a result of operational pressures which have continued throughout Quarter 1upward pressure on pay expenditure continues to be a challenge, with the total pay bill increasing by £0.1m in June.

- The CIP target at £18.2m for the Trust is lower than 2015/16, but remains a challenge. YTD performance shows £1.568m has been delivered against a target of £4.643m, noting this is profiled on an equal months' basis. The interim CIP Director has produced a recovery plan but the key issues remains one of delivery rather than planning.

- The Financial Sustainability Risk Rating based on M3 performance is 2, largely driven by the YTD deficit position. If the overall planned position is delivered this will rise to 3 for the 2016/17 financial year.

2. Income & Expenditure

As shown in the table below the Trust is currently showing over-performance of £2.7m against clinical income.

2016/17 Healthcare contracts position as at Month 3	Month 3 Plan £000	Month 3 Actuals £000	Variance £000
NHS Gloucestershire CCG	76,026	78,346	2,320
Worcestershire Health Community	2,722	2,712	(11)
NHS Hereford CCG	1,078	1,057	(21)
Wiltshire Health Community	656	729	73
NHS South Warwickshire CCG	52	62	10
Oxfordshire CCG	127	118	(9)
Specialist Commissioning Group	19,923	20,316	392
Welsh Commissioners	1,035	1,111	76
Other Commissioner Income	4,559	4,509	(49)
Non Contractual Agreements (NCAs)	1,063	977	(86)
NHS CLINICAL REVENUE	**107,242**	**109,937**	**2,695**

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 though a significant proportion at marginal rate of 30%.

As in previous financial years there are significant levels of over-performance being recorded against the Gloucestershire CCG contract. We have made an assessment of risk within the figure presented. The CCG have raised a number of challenges against the over-performance with a view to minimising their level of overspend.

The table below show the divisional expenditure performance against budget for Month 3.

	2016/17 Month 3 YTD Expenditure Budget £'000 £'000	2016/17 Month 3 YTD Expenditure Actual £'000 £'000	2016/17 Month 3 YTD Expenditure Actual £'000 £'000
PAY			
Corporate Services	4,939	5,256	(317)
Estates and Facilities Division (EFD)	3,325	3,532	(208)
Diagnostics & Specialist	15,529	15,446	83
Medicine	16,051	19,008	(2,956)
Surgery	20,703	21,673	(970)
Women and Children	8,204	8,726	(522)
Total Pay	**68,751**	**73,641**	**(4,890)**
NON-PAY			
Corporate Services	8,951	8,879	72
Estates and Facilities Division (EFD)	5,043	4,806	236
Diagnostics & Specialist	8,951	10,385	(1,434)
Medicine	7,707	9,271	(1,565)
Surgery	6,877	8,217	(1,340)
Women and Children	678	996	(318)
Total Non Pay	**38,206**	**42,554**	**(4,349)**
Total Divisional Expenditure	**106,957**	**116,196**	**(9,238)**

There are significant overspends in clinical Divisions, a summary of the key drivers are laid out below, hence the importance of delivery of the cost improvement programme:

Emergency Department (ED) Investments
The Trust has made a number of investments in the ED and Urgent Care workstreams that were not planned at the start of the financial year. These formed the basis for re-phasing our financial plan.

Cirencester
The opening of Cirencester has been slower than planned and is currently causing a cost pressure within the division. Utilisation needs to improve as per the initial plan and the loss to be recouped.

Agency Expenditure
Based on expenditure up to Month 3 the current position suggests agency expenditure of around £22m for the 2016/17 year, £2m higher than last financial year. This is one of the most significant drivers of the deficit position.

The Trust will undertake a forensic pay analysis led by the CIP Director, supported by finance and HR, to understand further the drivers of the pay expenditure trends and develop actions to address them.

Non-Pay is over-committed in all clinical divisions, largely as a result of non-pay costs associated with contract over-performance.

A review of the divisional expenditure for Month 3 shows that the total expenditure run-rate is running at £2.0m higher than the monthly average for 2015/16.

CIP Performance

As at Month 3 the Trust has recorded actual delivery of £1.568m against a plan of £4.643m.

The CIP plan has focusses on real expenditure reduction; with service change required by the Trust and is made up of both divisional and corporate schemes. These schemes are 90% recurrent and exceed the CIP target of 4.8%, with further schemes being identified to provide mitigation for slippage. The risk is that some of these schemes will not be realised until month 6.

A review of divisional plans for CIP has indicated that further assurance is required to ensure delivery of the programme for 2016/17. The decision has been taken to continue engagement of the interim CIP Director until the end of the year to provide greater focus and assurance given the current under-delivery.

The RAG rating of schemes for 2016/17 is shown in the table below:

Divisions	2016/17 In Year Targets	2016/17 Recurrent CIP Schemes	2016/17 Non Recurrent CIP Schemes	Total 2015/16 CIP Schemes	Low risk	Medium Risk	High Risk
	£000	£000	£000	£000	£000	£000	£000
Surgery	5,124	4,746	29	4,775	828	3,193	754
Medicine	4,474	3,710	384	4,094	1,770	1,600	724
W&C	1,514	1,084	86	1,170	145	799	226
D&S	4,406	3,480	391	3,871	1,520	2,277	74
EFD	1,616	1,154	0	1,154	650	504	0
Corporate	1,045	435	0	435	435	0	0
Trustwide	0	6,009	1,000	7,009	2,709	2,800	1,500
Total	**18,179**	**20,617**	**1,890**	**22,508**	**8,056**	**11,173**	**3,278**

The current plan totals £22.5m against a target of £18.2m, to allow for slippage in delivery.

3. Balance Sheet

The Trust balance sheet as at 30th June 2016 is shown below:

Trust Financial Position as at 30 June 2016	Opening Balance £000	Closing Balance £000
Non-Current Assests		
Intangible Assets	3,584	3,585
Property, Plant and Equipment	308,065	307,907
Trade and Other Receivables	4,512	4,516
Total Non-Current Assets	316,161	316,008
Current Assets		
Inventories	8,221	6,339
Trade and Other Receivables	33,454	37,820
Cash and Cash Equivalents	5,066	5,675
Total Current Assets	46,741	49,834
Current Liabilities		
Trade and Other Payables	(58,450)	(62,509)
Other Liabilities	(147)	(147)
Borrowings	(9,283)	(9,283)
Provisions	(186)	(182)
Total Current Liabilities	(68,066)	(72,121)
Net Current Assets	(21,325)	(22,287)
Non-Current Liabilities		
Other Liabilities	(7,924)	(7,924)
Borrowings	(54,093)	(53,694)
Provisions	(1,440)	(1,440)
Total Non-Current Liabilities	(63,457)	(63,058)
Total Assets Employed	231,379	230,663
Financed by Taxpayers Equity		
Public Dividend Capital	166,519	166,519
Reserves	67,543	67,543
Retained Earnings	(2,683)	(3,399)
Total Taxpayers' Equity	231,379	230,663

Cash Balances

The Trust cash balance at the end of June 2016 stands at £5.7m. The position is shown in the table below.

Trust Cashflow Statement Jun-15	June £'000
Opening Bank Balance	5,066
Receipts	
Main CCG SLAs	34,409
All other NHS Organisations	5,072
Other Receipts	1,600
Total Receipts	41,082
Payments	
Payroll	(25,491)
Creditor(including capital)payments	(14,982)
Other Payments	0
Total Payments	(40,473)
Closing Bank Balance	**5,675**

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. The expected STF funding for Q1 will also improve the cash position.

Mindful of the cash challenges across the NHS as a whole, the finance team has recently changed the structure of credit control and appointed to a senior support post in this area in order to focus on debt recovery and resolution.

4. Recommendation

The Board are asked to note:

- The financial position of the Trust at the end of Month 3 of the 2016/17 financial year is an operational deficit of £1.88m. This is a small favourable variance to plan of £0.02m.
- Commissioners contract challenges are significant and a risk assessment has currently been made against these.
- 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.
- The Director of Finance, Director of Service Delivery and CIP Director have recommended a Financial Recovery Programme to provide greater assurance that the Trust can improve its current financial performance.

Author: **Sarah Stansfield, Director of Operational Finance**

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

Date: **July 2016**

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

EMERGENCY PATHWAY REPORT
MONTHLY PERFORMANCE REPORT: JUNE 2016
FOR MAIN BOARD IN JULY 2016

1. Executive Summary

1.1 Report Purpose

To provide the Board with assurance regarding the safety and quality of emergency care services within the Trust and to demonstrate that adequate progress is being made to deliver the recovery actions and plans within the Emergency Care Programme to achieve the recovery trajectory agreed with our regulator. Where assurance cannot be provided, key risks are described and plans to mitigate these risks are set out alongside actions to recover delayed plans. The report reflects data up to 30th June 2016.

1.2 Key Messages

- The Trust met the agreed improvement trajectory of 85% for June 2016, with Trustwide performance (includes GP in ED activity) reported as 87.37%. The position for Quarter 1 was 86.97%.

- However, this performance does not meet the 95% 4 hour target for the Emergency Department and was a slight decrease compared the Trustwide performance in May 2016 (87.73%).

- The daily average number of Emergency Department attendances in June 2016 was 378 patients (11,343 for the month), compared to June 2015 (363 per day) and May 2016 (382 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 currently included in the 2016/17 attendances.

- The daily average number of admissions from the Emergency Department in June 2016 was 119 patients (3,577 for the month), which is comparable with June 2015 (117 per day) and is a slight decrease on May 2016 (124 per day).

- General and Acute average length of stay for non-elective admissions has increased from 5.37 days in May 2016 to 5.99 days in June 2016. The average length of stay for June 2015 was 5.51 days. The average length of stay for emergency and elective patients in June 2016 was 5.0 days, compared to 4.8 days in June 2015.

- The number of patients on the medically fit list for one day and over has been at an average of 74 throughout June 2016. This remains above the system-wide plan of no more than 40 patients.

- Programme arrangements both within the Trust and across the system have been strengthened within period and further plans are in hand to address outstanding risks.

1.3 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, further increases in demand need to be addressed with alternative staffing models and strategies.

- Enhanced performance is co-dependent on a number of countywide projects to streamline the urgent care system, as detailed in the system wide plan. This involves close working with health and social care partners. Details of these projects are contained within this report.

1.4 Key Changes in Period

Key elements of work completed within the last period, along with key performance indicators (grouped into programme workstreams) are:

Workstream 1 – Emergency Department

- Completion of a demand and capacity and staffing model for the Emergency Departments at Cheltenham and Gloucester.
- A trial of a GP working as part of the Emergency Department team, to provide additional capacity was undertaken by Jeremy Welch w/c 20th June 2016.
- The total duration of ambulance diverts from Gloucester to Cheltenham in June is the lowest for more than three years.
- Performance is above the NHSI trajectory for April, May and June.
- Ambulance handover delays over 30 minutes decreased from 194 in May to 155 in June. There were no delays over 1 hour in June.
- The admission rate from the Emergency Department dropped in June by 1% from 32.47% to 31.53%.
- The proportion of patients who met the 15 Minute Time to Initial Assessment standard was 78.10% in June 2016, an increase of 14.7% compared to June 2015.
- The proportion of patients who met the Time to Treatment standard was 46.6% in June 2016. However, the number of patients waiting over four hours continues to reduce month-on-month.

Workstream 2 – Site Management

- The completion of the consultation for the Silver on-call rota, the outcome of which has been communicated.
- The completion of a draft Patient Flow and Escalation Policy, which has been circulated within the organisation and NHS Improvement.
- Training commenced for all staff on the Bronze, Silver and Gold rotas in line with trialling the aforementioned policy.

Workstream 3 – SAFER Patient Flow Bundle

- Discharge Planning Communication folder has been distributed to all adult inpatient wards for immediate use to support improved discharge processes.
- A series of engagement sessions have been held across specialties, departments and within Divisional and Specialty Tris, utilising a Patient Flow presentation which highlights the importance of timely board rounds (using SORT criteria), review of long-stay patients and updating the Patient system screens to ensure the Site Office is informed of the wards' status.
- The completion of a training video on SAFER to be used at training sessions and on line.
- Bed Occupancy rates have reduced from 97.6% at the start of June to 95.2% w/e 3rd July. 2016.

1.5 Emergency Pathway Metrics – Constraints at a glance

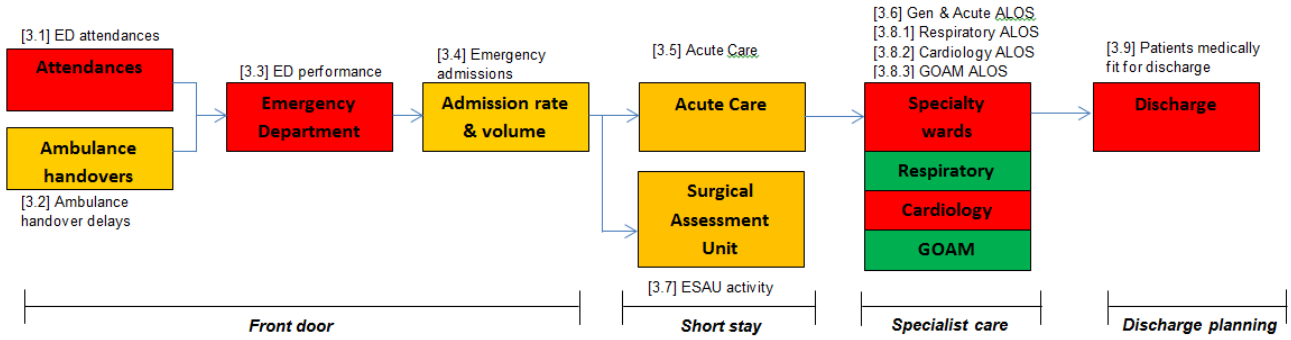
The diagram below shows the key processes within the emergency pathway.

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:



2.0 Emergency Pathway Metrics

2.1 Emergency Department Attendances

Aim: To ensure Emergency Department attendances remain in line with 2016/17 plan.

How: Work with:-

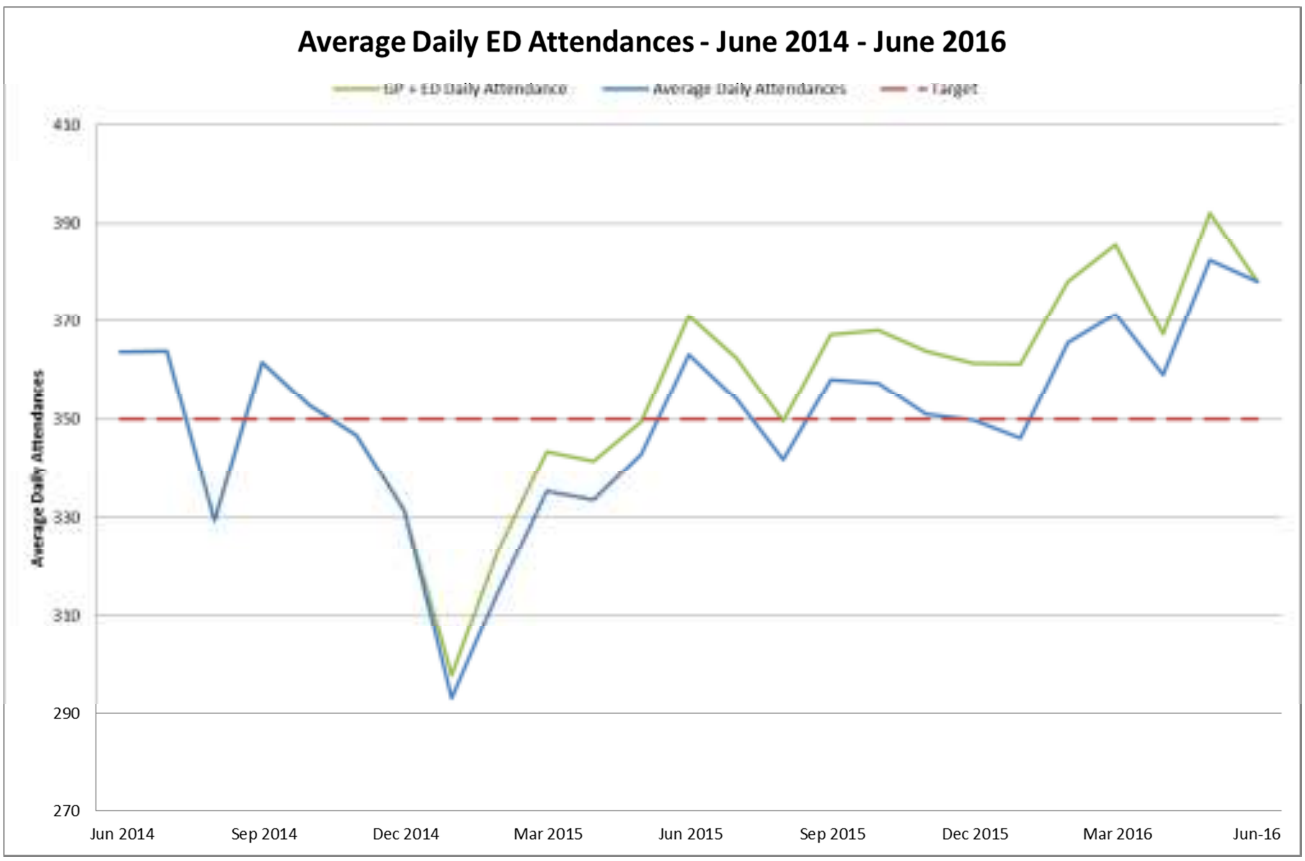
- South Western Ambulance Service NHS Foundation Trust (SWAST) to 'Smooth' emergency demand in the system;
- Integrated Discharge Team (IDT) within Emergency Department to increase direct admissions to community hospitals from Emergency Department;
- Develop the Older Person's Assessment and Liaison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

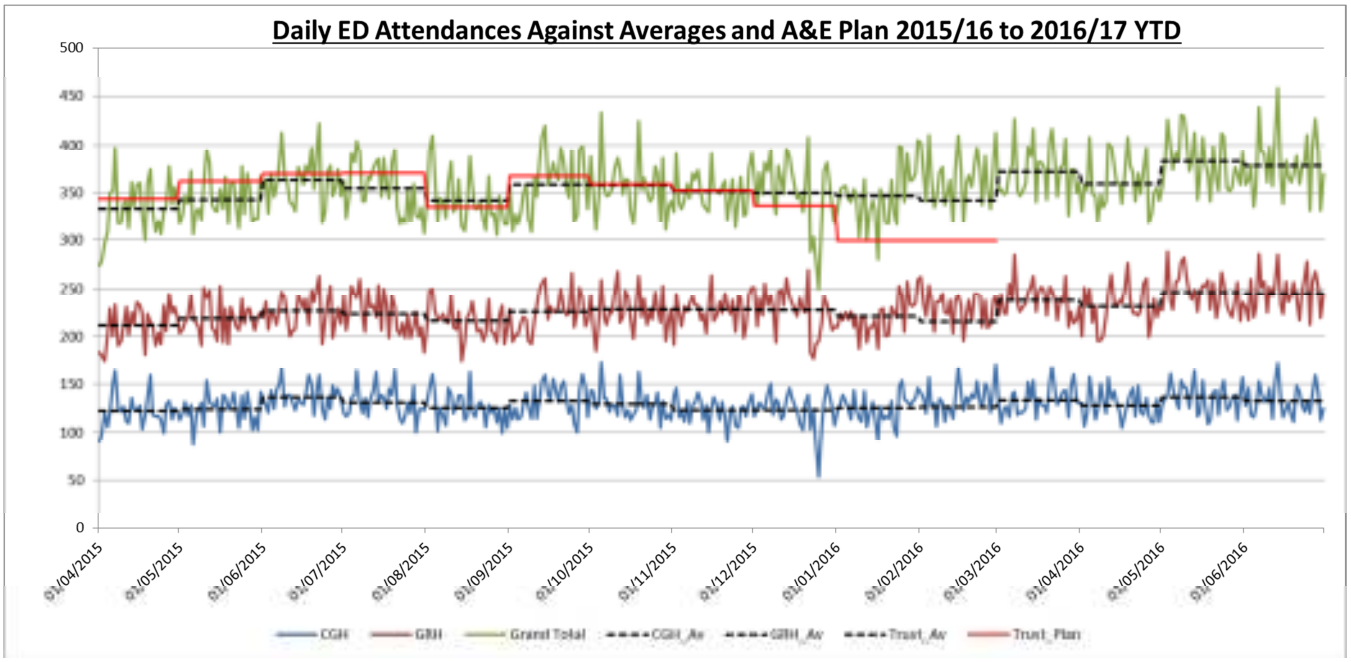
2.1.1 There were 11,343 attendances in June 2016 (average of 378 per day) which is 4 less per day than May 2016 and a 4% increase on June 2015's average. This is higher than the 2016/17 plan of 358 per day pre-QIPP. Taking into account the level of planned attendances for 2016/17 this should be 330 a 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



Department Daily Attendances against Plan



2.1.2 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.

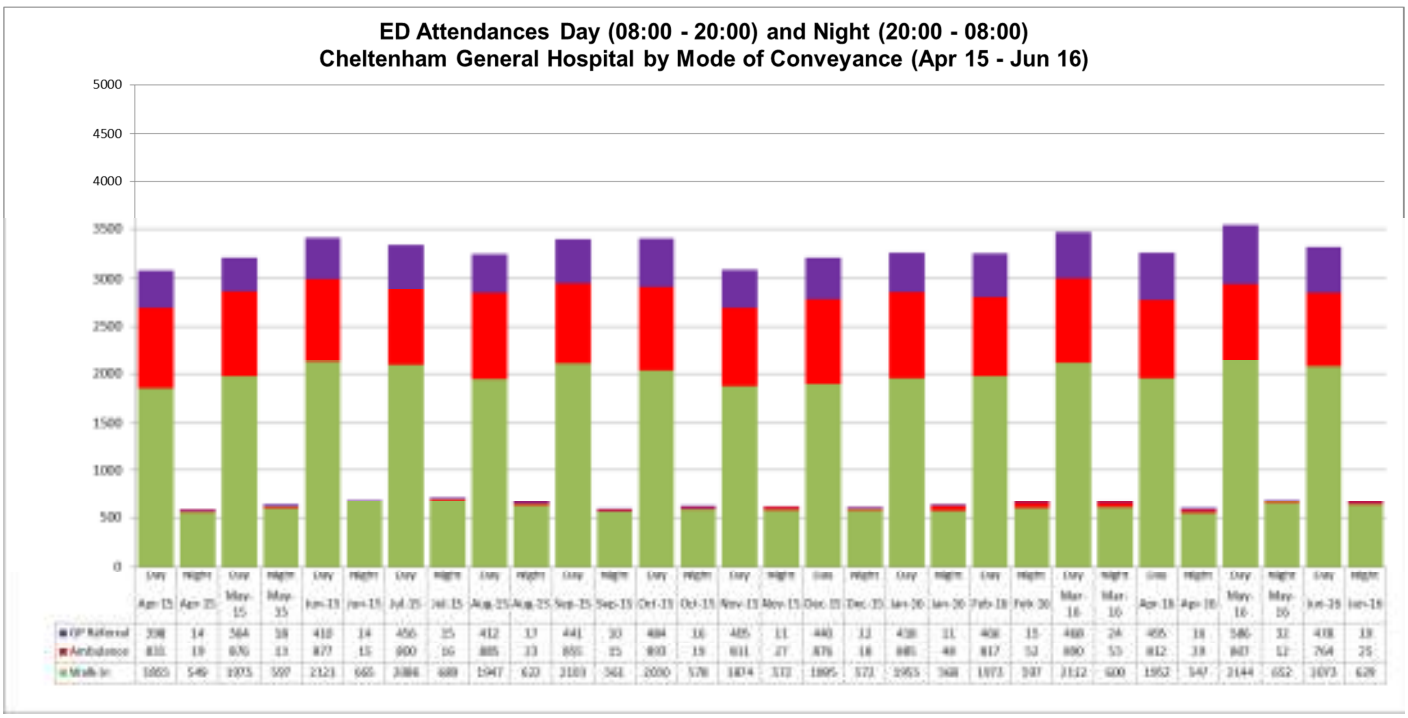
More recently, a GP has spent a week in the department working as part of the Emergency Department team to provide additional capacity. The intention is for this to be piloted for a period of three months starting in August 2016. The objective will be for the whole department to reduce admissions by 25 per day.

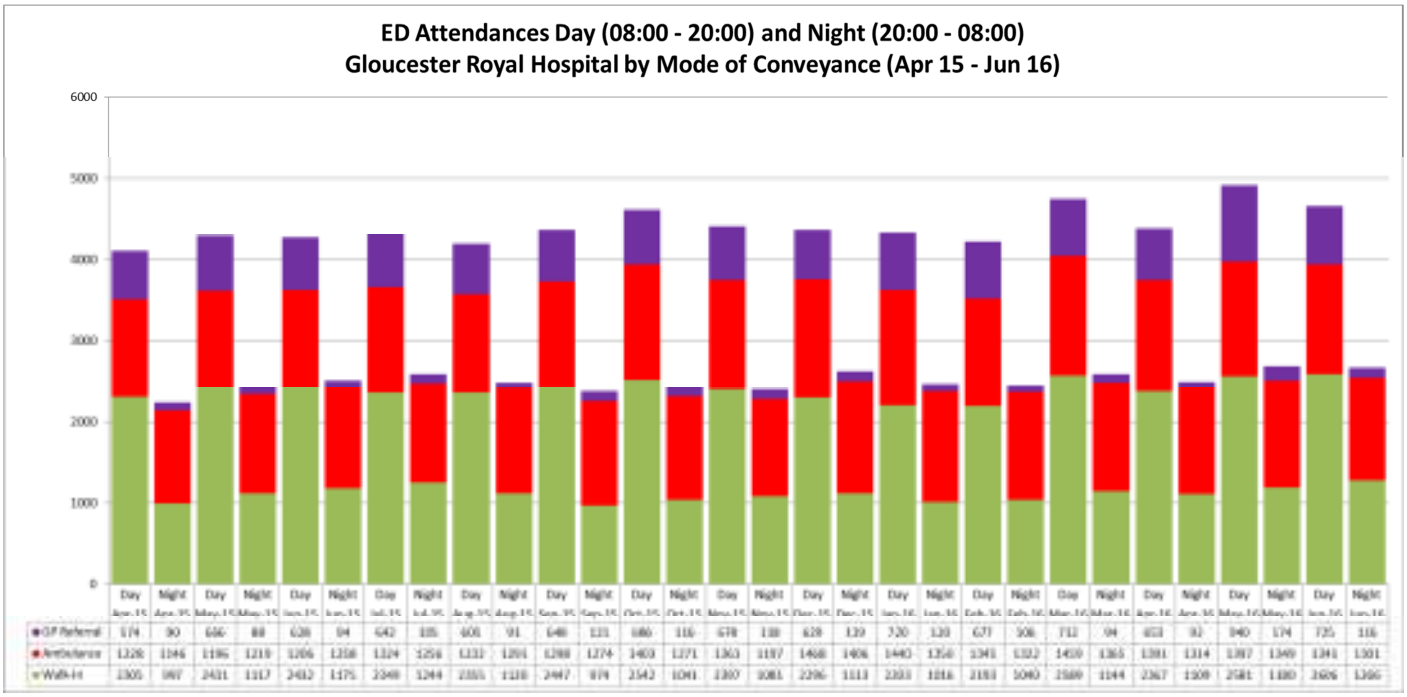
The table below shows a monthly breakdown of the impact of adding the number of Primary Care in Emergency Department cases (provided by Gloucestershire Clinical Commissioning Group), into the denominator of our Emergency Department performance calculation.

Arrival Month	ED Attendances	4 Hour Breaches	Performance	GP in ED cases	Trustwide Performance
Sep-15	10747	1187	88.96%	268	89.22%
Oct-15	11079	1538	86.12%	332	86.52%
Nov-15	10532	1252	88.11%	386	88.53%
Dec-15	10844	1882	82.64%	363	83.21%
Jan-16	10734	2130	80.16%	468	80.99%
Feb-16	10603	2499	76.43%	361	77.21%
Mar-16	11510	2559	77.77%	443	78.59%
Apr-16	10777	1575	85.39%	244	85.71%
May-16	11854	1491	87.42%	301	87.73%
Jun-16	11343	1467	87.07%	271	87.37%

2.1.3 Emergency Department Attendances by Mode of Conveyance Charts

In June 2016 there were 3,431 ambulance arrivals across both sites (average 114 per day). This is an increase of 2.2% on the same period last year, when there were 3,356 ambulance arrivals (average 112 per day).




ED Attendances Day (08:00 - 20:00) and Night (20:00 - 08:00)
Gloucester Royal Hospital by Mode of Conveyance (Apr 15 - Jun 16)
6000
5000
4000
3000
2000
1000
0

2.1.4 Diverts Between Gloucestershire Royal Hospital & Cheltenham General Hospital

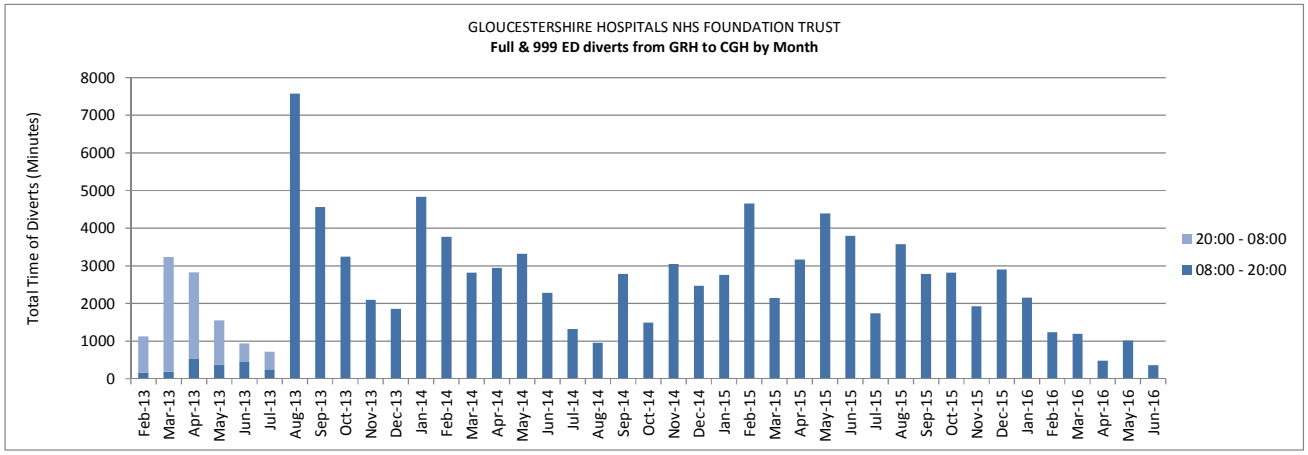
Aim: To reduce the number of across site diverts.

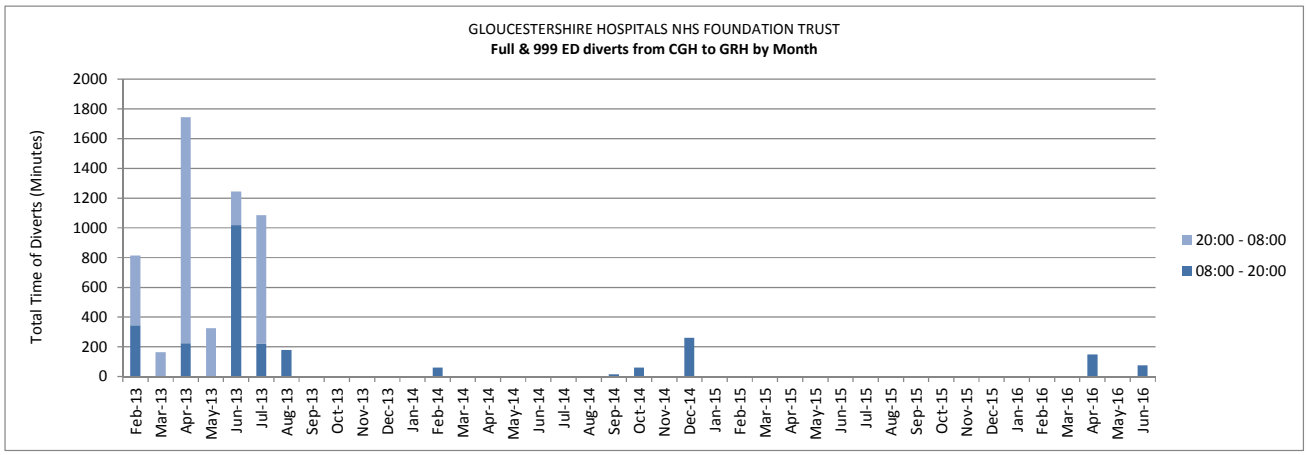
How: Enable flow within each site to ensure consistently available bed space for patients requiring admission.

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 4 occasions when a Full/999 divert took place in June 2016 compared to 5 in May; one of which was from Cheltenham General to Gloucester Royal on the 12th June due to a leak in the Acute Care Unit caused by torrential rain.

The total duration of diverts decreased from 17 hours in May 2016 to 7 hours 20 minutes in June 2016. The average number of hours per divert in June was 2 (from Gloucester to Cheltenham (compared to 3.4 hours last month)).





2.2 Ambulance Handover Delays

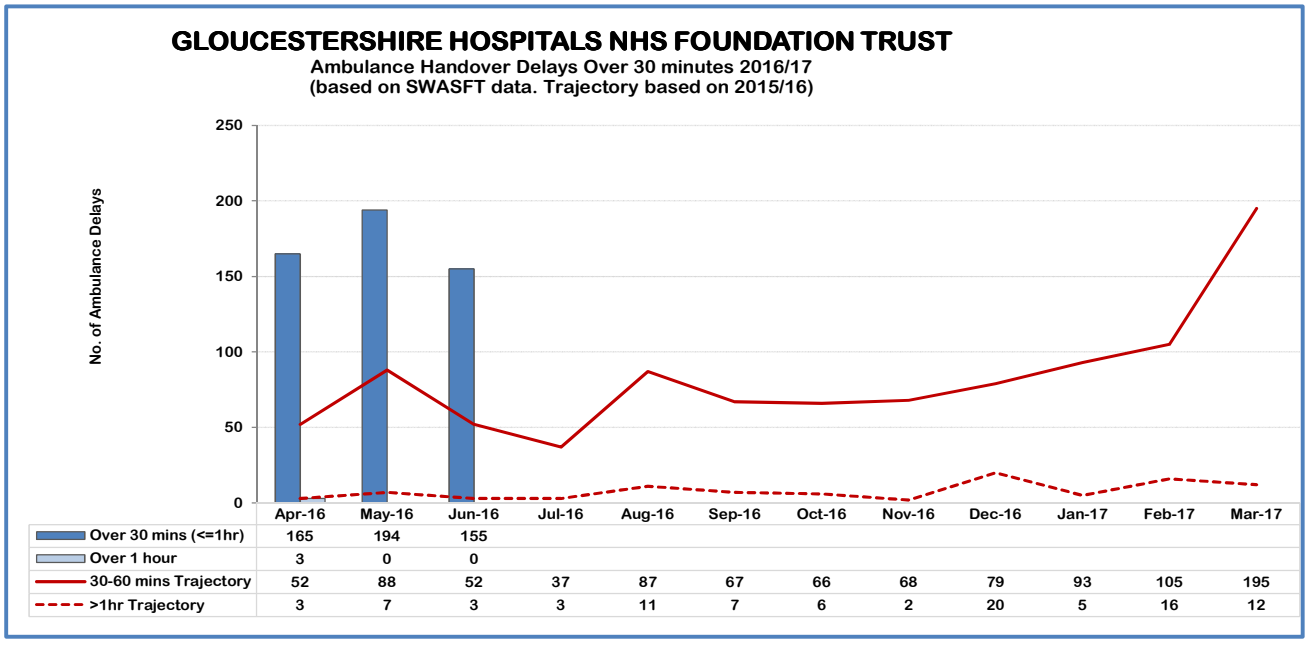
Aim: To reduce the number and time associated with ambulance handover delays.

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.

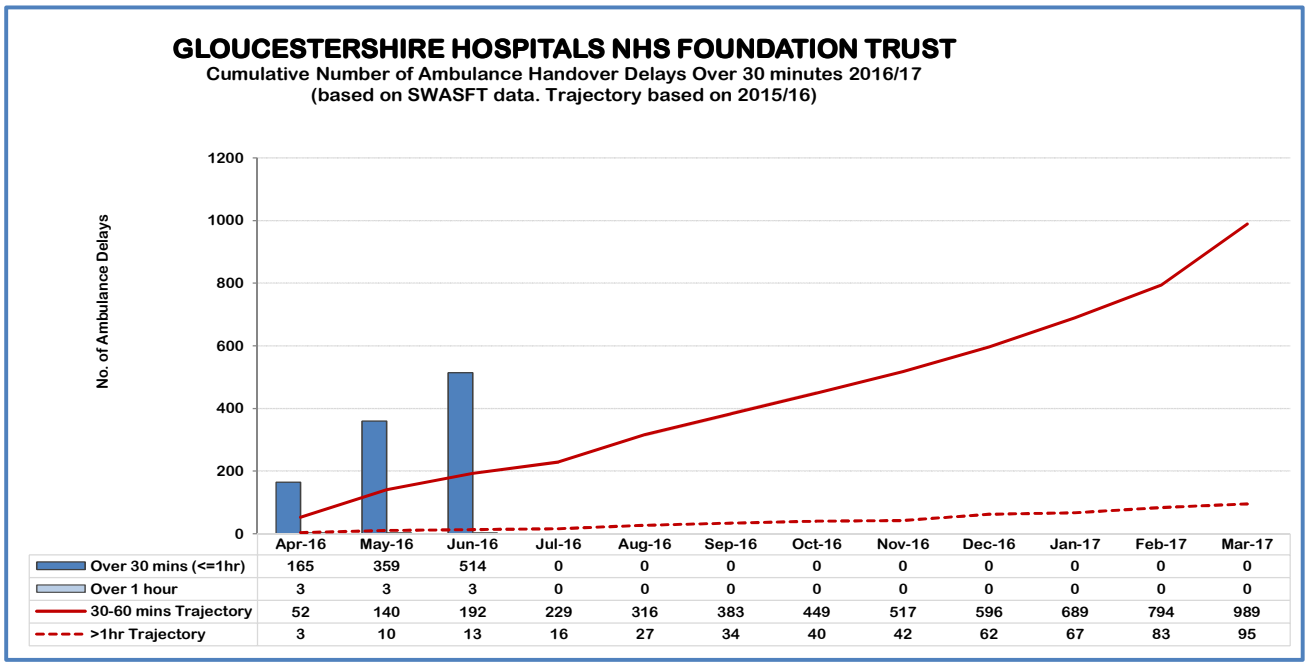
There were 155 ambulance handover delays in June 2016; with no delays over an hour. This is a reduction of -20% compared to May 2016. However, this is a significant increase compared to June 2015, when there were 52 delays between 30 – 60 minutes

The level of ambulance handover delays remains higher than the trajectory, which is based on 2015/16 actuals.

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.



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Over 30 mins (<=1hr)	165	194	155									
Over 1 hour	3	0	0									
30-60 mins Trajectory	52	88	52	37	87	67	66	68	79	93	105	195
>1hr Trajectory	3	7	3	3	11	7	6	2	20	5	16	12



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Over 30 mins (<=1hr)	165	359	514	0	0	0	0	0	0	0	0	0
Over 1 hour	3	3	3	0	0	0	0	0	0	0	0	0
30-60 mins Trajectory	52	140	192	229	316	383	449	517	596	689	794	989
>1hr Trajectory	3	10	13	16	27	34	40	42	62	67	83	95

2.3 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.

The table below shows Emergency Department performance against the national standard.

Note: these performance figures currently exclude patients seen by the GP in the Emergency Department. For the Trustwide performance, please refer to the table in section 2.1.2.

June 2016 data shows that neither site achieved the 95% standard in comparison to the same period last year when Cheltenham achieved 97.25% bringing the Trust performance to 95.03%. The overall Trust performance in June 2016 was 87.07%. This is a slight decrease on May 2016, although there has been general improvement since February 2016.

2.3.1 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%	95.94%	92.93%									
GRH actual	83.93%	82.68%	83.87%									
National std	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Trust actual	85.39%	87.42%	87.07%									

Source: April 2016 onwards – Monthly SITREP return

NHS England (Type 1) Emergency Department performance for Quarter 1 2016/17 has not yet been published. The Trustwide position (includes GP in ED activity) for Quarter 1 was 86.97%.

Four Hour Standard – Major / Minor split

	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 Minors	98.52%	98.54%	98.52%	98.75%	97.01%	97.93%	97.19%	98.24%	96.19%	96.71%	97.32%	96.76%
CGH Majors	89.57%	91.24%	95.17%	91.12%	84.53%	89.50%	80.40%	81.93%	77.92%	72.98%	73.68%	72.00%
GRH Minors	96.41%	98.26%	97.76%	97.62%	93.44%	95.61%	93.76%	95.82%	92.48%	92.11%	88.81%	91.88%
GRH Majors	82.44%	85.90%	89.41%	87.01%	71.21%	75.94%	72.91%	75.72%	67.02%	63.01%	50.98%	52.28%
Trust Minors	97.30%	98.37%	98.09%	98.11%	94.94%	96.62%	95.21%	96.81%	94.02%	94.09%	92.53%	93.92%
Trust Majors	84.60%	87.53%	91.18%	88.18%	75.29%	79.90%	75.09%	77.46%	70.08%	65.84%	57.46%	57.97%

	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 Minors	96.37%	98.98%	97.56%									
CGH Majors	73.03%	89.79%	83.57%									
GRH Minors	94.07%	94.83%	93.73%									
GRH Majors	74.27%	69.61%	73.21%									
Trust Minors	95.04%	96.57%	95.30%									
Trust Majors	73.93%	75.15%	76.04%									

Source: InSight – EDS003 – ED Monthly Performance Summary

The Trustwide performance for 2016/17 to date against the trajectory agreed with NHS Improvement is shown below:

Metric	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
NHSI Trajectory	80.00%	85.00%	85.00%	87.00%	87.00%	91.90%	89.10%	91.20%	85.70%	85.10%	80.10%	89.60%
GHFT Performance Against NHSI Trajectory	85.39%	87.42%	87.07%									
Trustwide Performance (incl. GP in ED)	85.71%	87.73%	87.37%									

2.3.2 Breach Analysis

A summary of the main contributing factors to Emergency Department 4 hour breaches in June 2016 is outlined in the following table:

June 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	282	25	128	46	12	71
GRH	1187	323	359	120	186	198
Total	1467	348	487	166	198	269
%		23.72%	33.20%	11.32%	13.50%	18.34%

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

Source: Insight, Unscheduled Care, Breaches, EDB003. Breach Reasons by Month

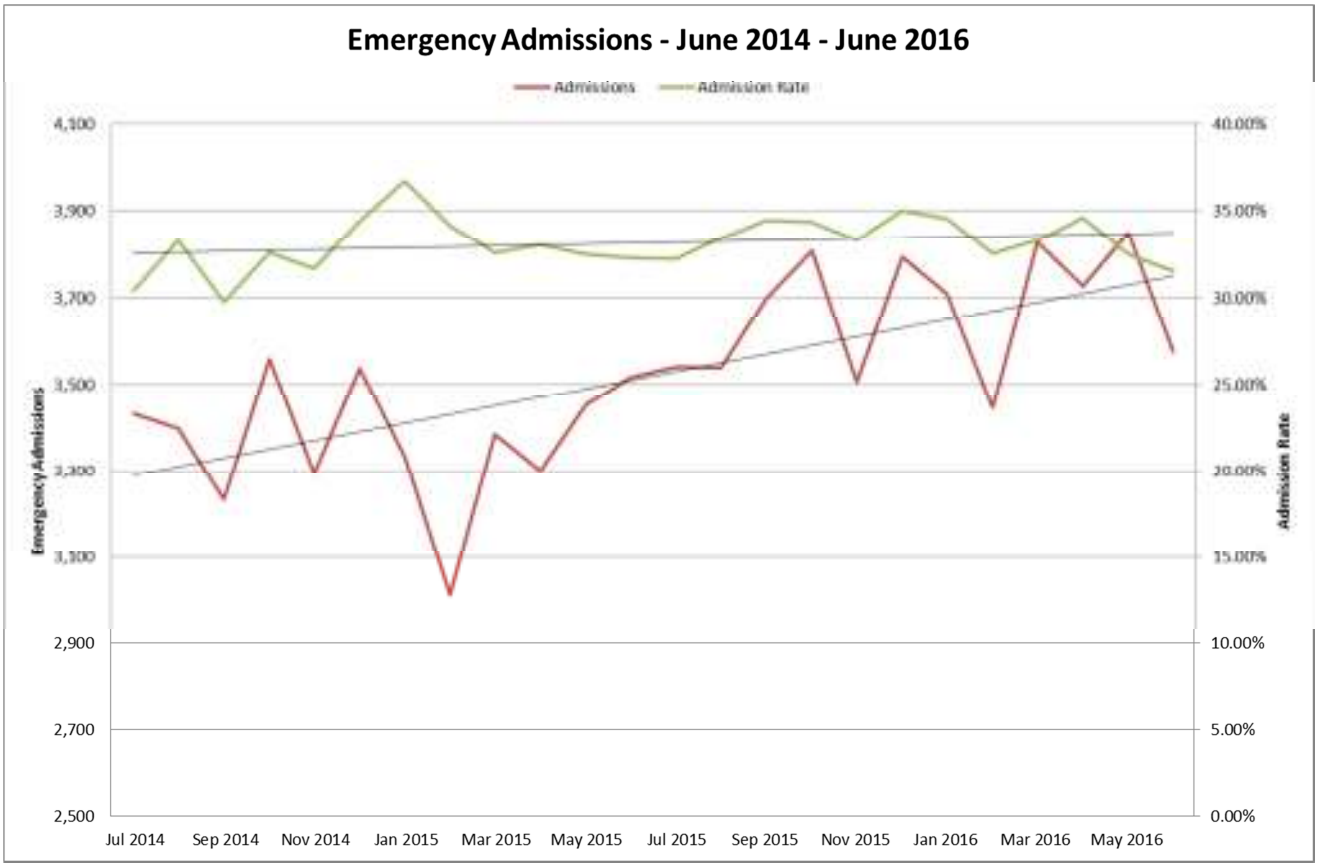
2.4 Emergency Admissions

2.4.1 Emergency Admission Rate

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

How: By avoiding admissions through alternatives as appropriate.

The Emergency admission rate in June 2016 was 31.53% compared to May 2016, when the admission rate was 32.39% and June 2015 which was 32.28%. In June 2016 there were 11,343 Emergency Department attendances and 3,577 patients were admitted (average 119 per day), compared to June 2015 when there were 10,895 attendances but 3,517 patients were admitted (average 117 per day).



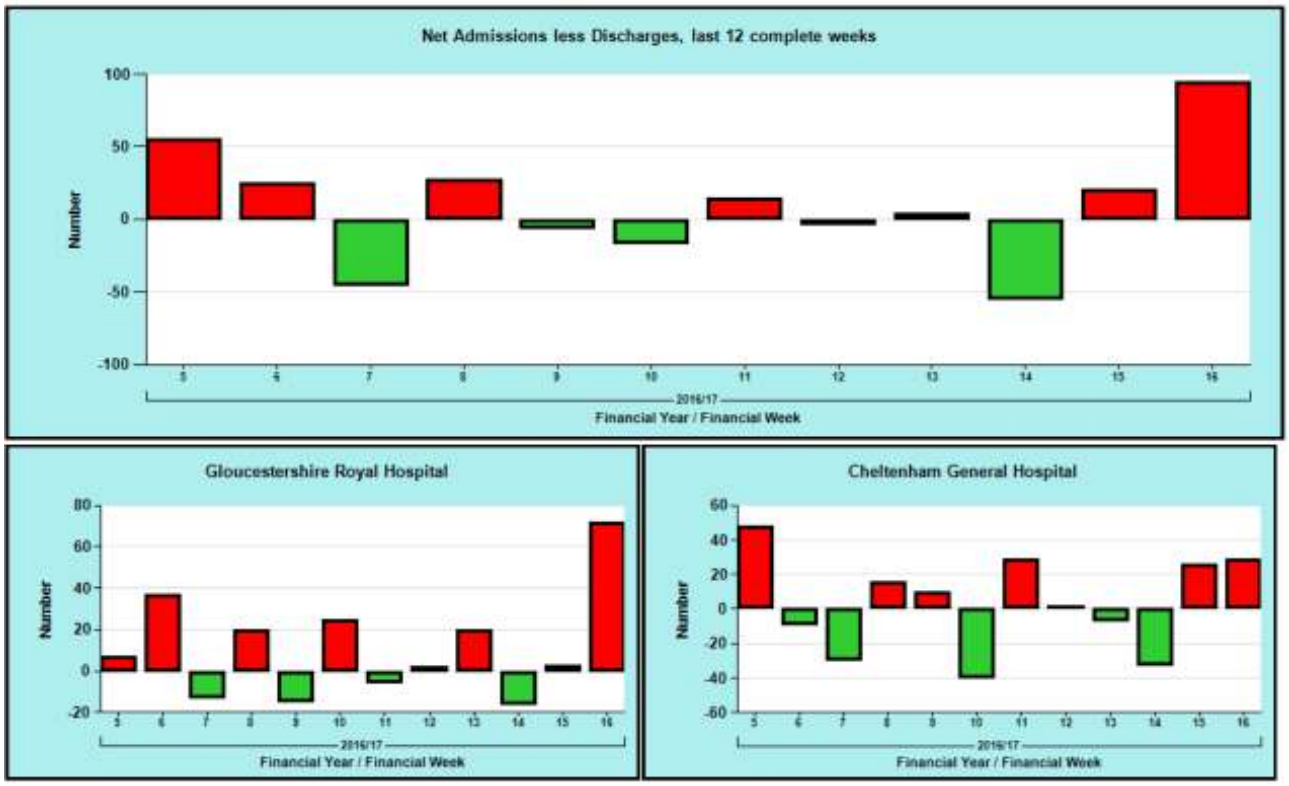
2.4.2 Admissions vs Discharges

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.

The following graphs show the level of discharges on each site subtracted from the number of admissions. Red signifies where there have been fewer discharges than admissions.

This data includes both emergencies and electives.



2.5 Ambulatory Emergency Care Attendances

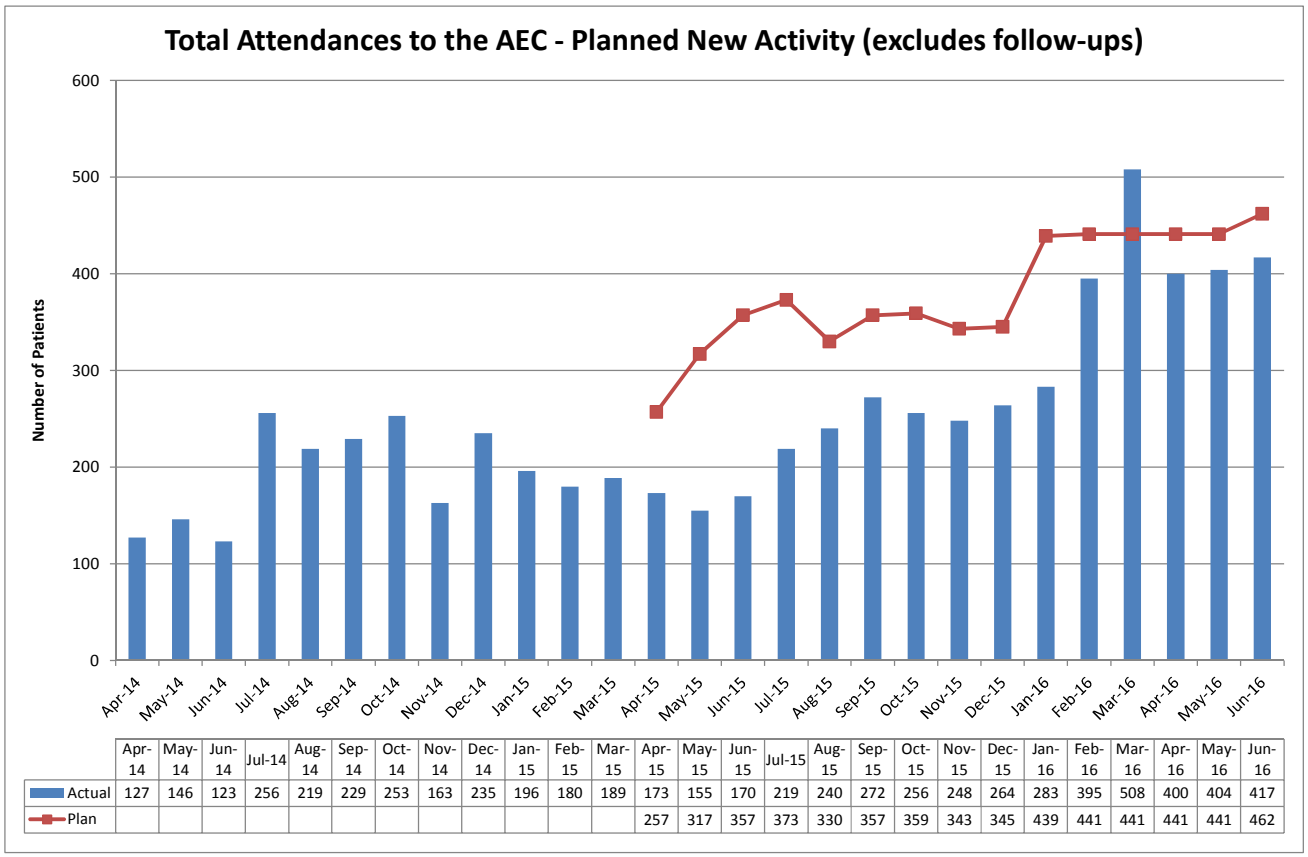
Aim: To increase the number of emergency patients managed on an ambulatory pathway.

How: Expand pathways and remodel ambulatory services.

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.

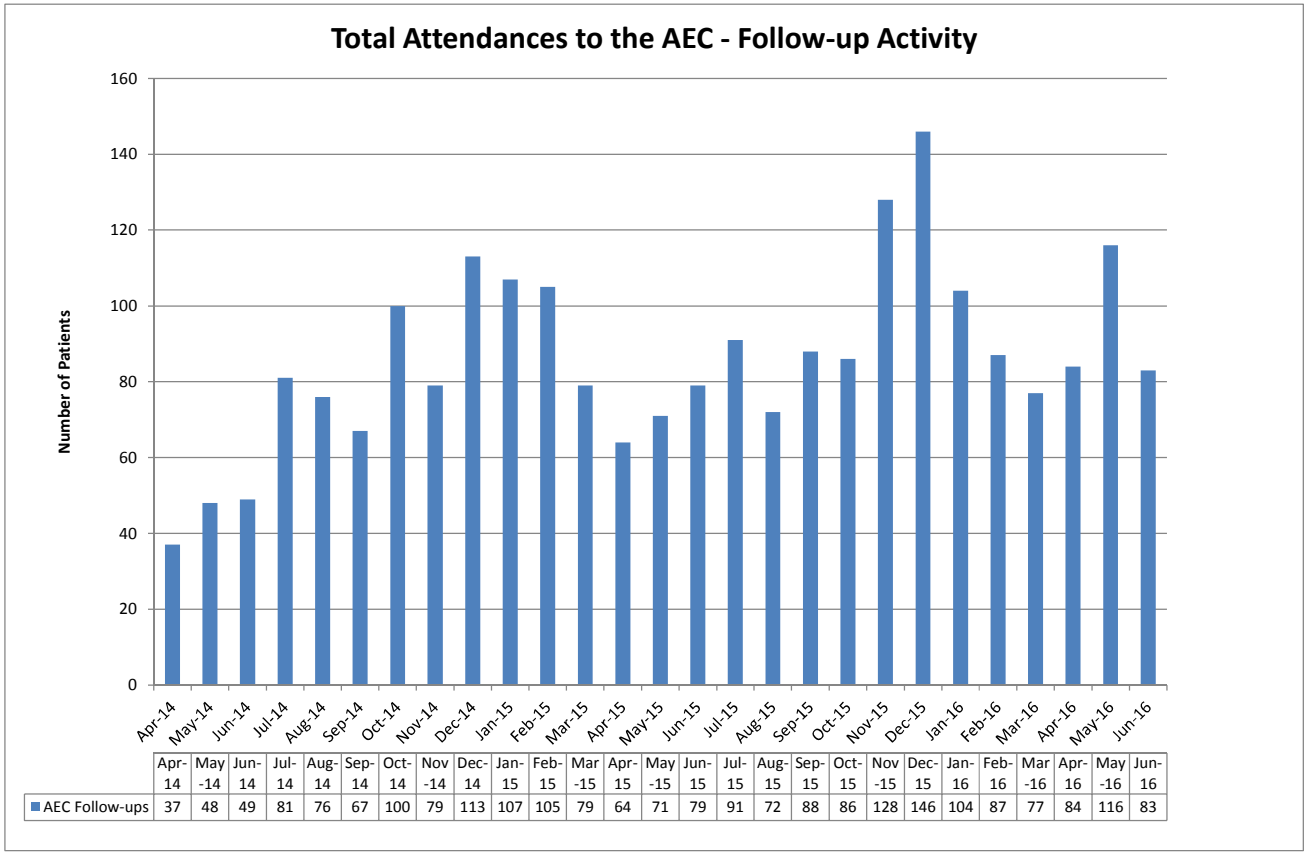
The chart below shows the actual number of new Ambulatory Emergency Care patients (excluding Follow ups) from April 2014. The daily average of new patients seen in June 2016 was 19.0 compared to 20.2 last month. It should be noted that there were 22 working days in June and only 20 in May.

Although the activity in 2016/17 to date has not reached the trajectory (with the exception of March), there has been a significant increase in the number of new attendances. June 2016 saw an increase of 145% compared to the same period last year.



	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	May-16	Jun-16
Actual	127	146	123	256	219	229	253	163	235	196	180	189	173	155	170	219	240	272	256	248	264	283	395	508	400	404	417
Plan													257	317	357	373	330	357	359	343	345	439	441	441	441	441	462

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.



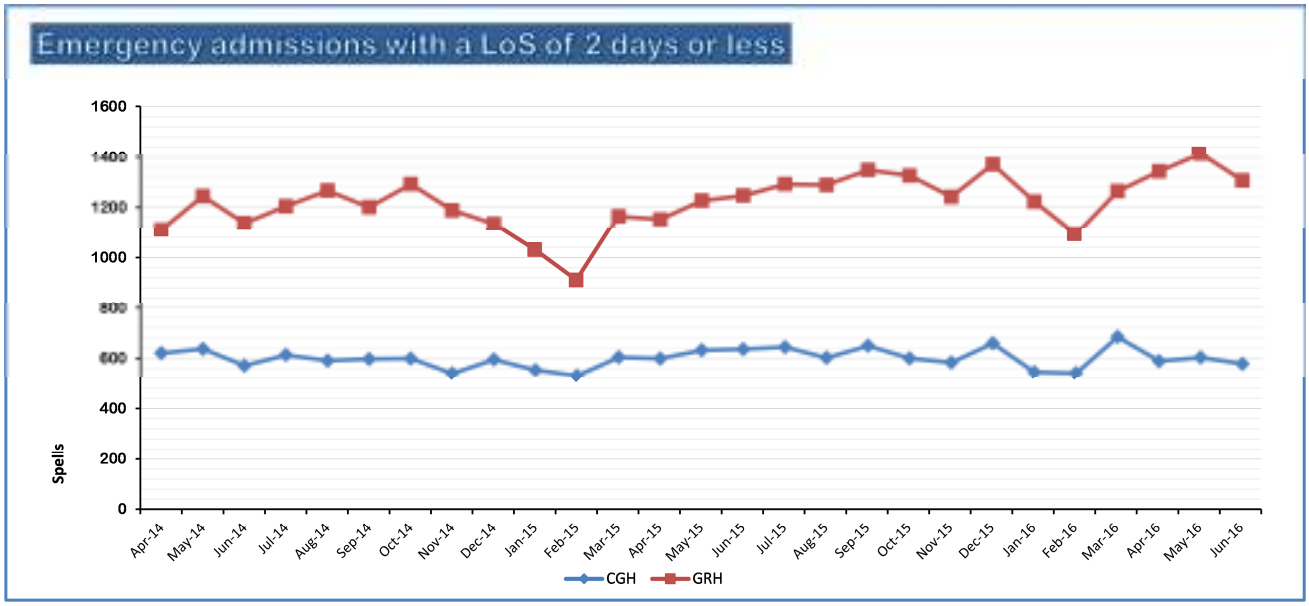
	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
AEC Follow-ups	37	48	49	81	76	67	100	79	113	107	105	79	64	71	79	91	72	88	86	128	146	104	87	77	84	116	83

2.5.1 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).

June 2016 showed 1,886 patients with a length of stay of 2 days or less Trustwide (average 62.9 discharges per day); compared to May which showed 2,017 patients (average 65.1 discharges per day). The average per day for June 2015 was 62.8.



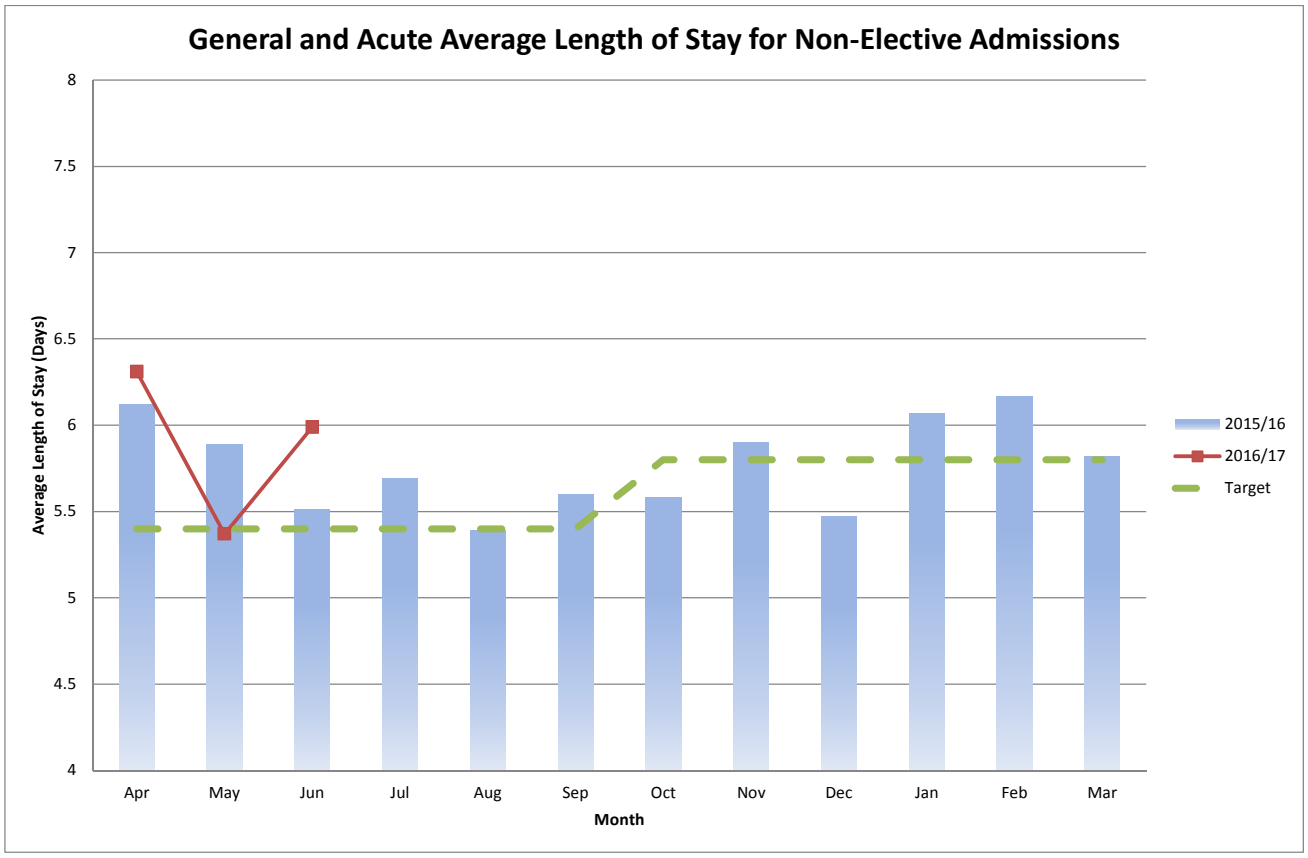
2.6 General & Acute Emergency Admissions Average Length of Stay

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.

June 2016 shows an increase in the Average Length of Stay at 5.99 days compared to 5.37 days last month.

The Trustwide quarterly targets will be reviewed by the Emergency Care Programme Workstream 5 – Bed Distribution and there is continued focus to ensure all patients who have been in hospital 14 days or more, have a clear treatment and discharge plan (as part of Workstream 3 – SAFER Patient Flow Bundle).



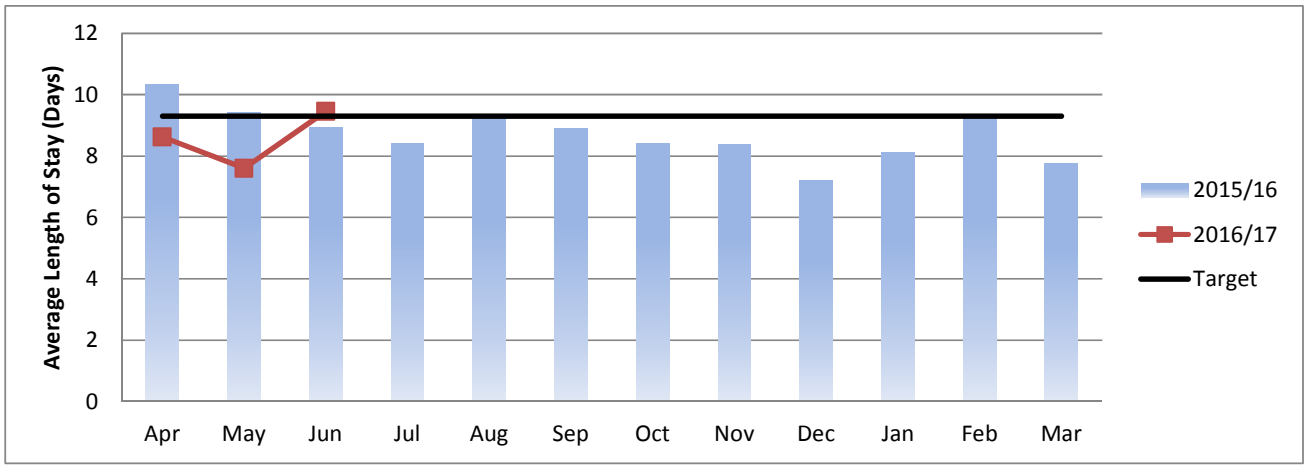
2.7 Average Length of Stay of Targeted Specialties

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 by the Emergency Care Programme Workstream 5 – Bed Distribution. 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.

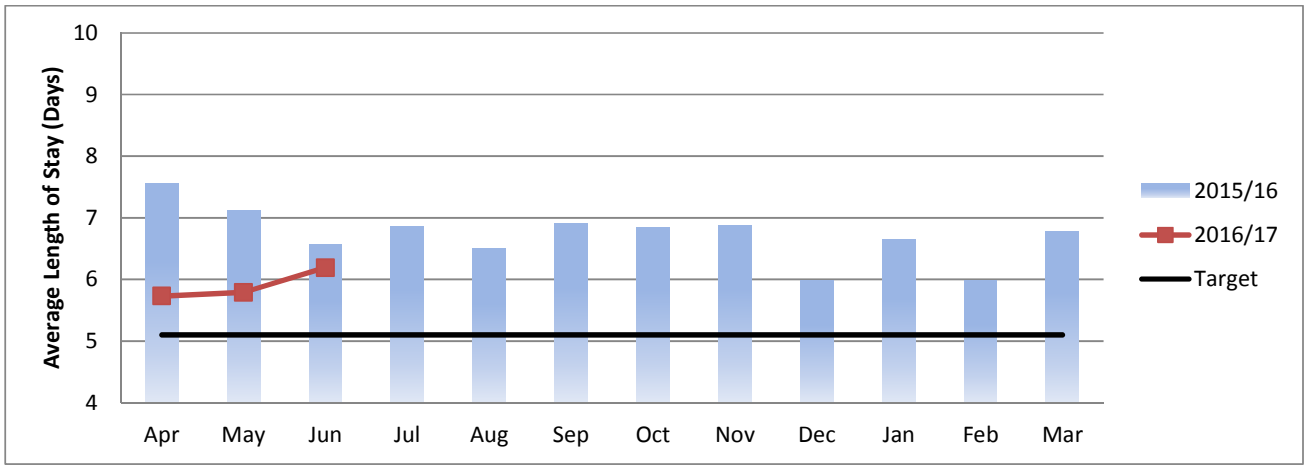
2.7.1 Respiratory Medicine - Average Length of Stay

The internal target is currently set at 9.3 days for 2016/17. The Average Length of Stay increased from last month to 9.46 days in June 2016 and is slightly above target.



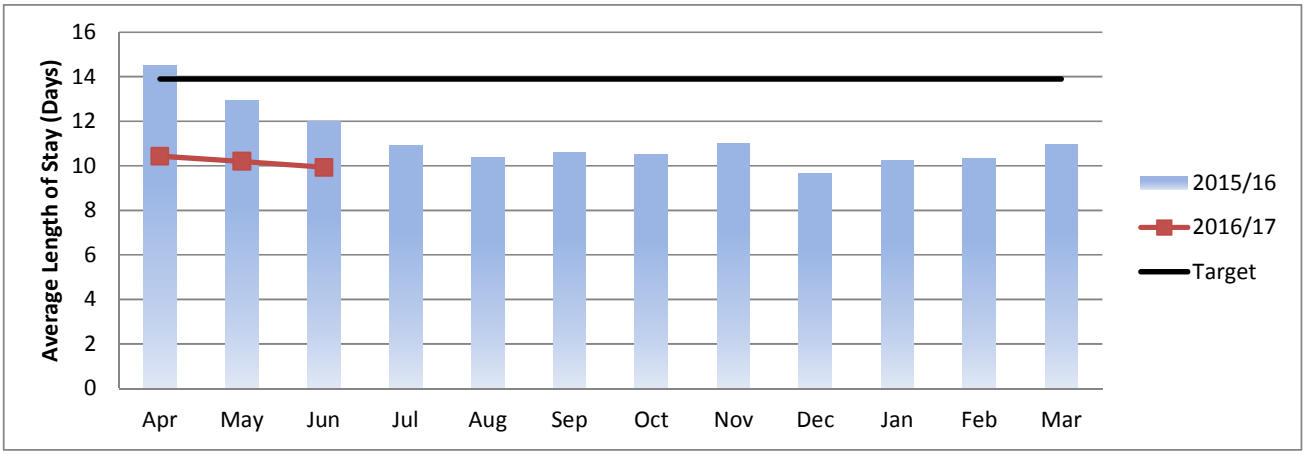
2.7.2 Cardiology - Average Length of Stay

The internal target is currently set at 5.1 days for 2016/17. The Average Length of Stay for non-elective Cardiology discharges was 6.19 days in June 2016.



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

The internal target is currently set at 13.9 days for 2016/17. The General Old Age Medicine Average Length of Stay remains static around 10 days and is well below target.



2.8 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.

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 June 2016:

The number of patients on the medically fit list for one day and over has been at an average of 74 throughout June 2016. This remains above the system-wide plan of no more than 40 patients. The method of reporting weekly Medically Fit numbers is aligned with CCG reporting so each financial week starts on a Friday. The table below shows the weekly averages, demonstrating lots of variation within June:

Week Commencing (Friday)	Fin. Week 2016	Average Per Day	Bed Days Lost
03/06/2016	Week 10	84	586
10/06/2016	Week 11	66	465
17/06/2016	Week 12	78	549
24/06/2016	Week 13	71	499

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:

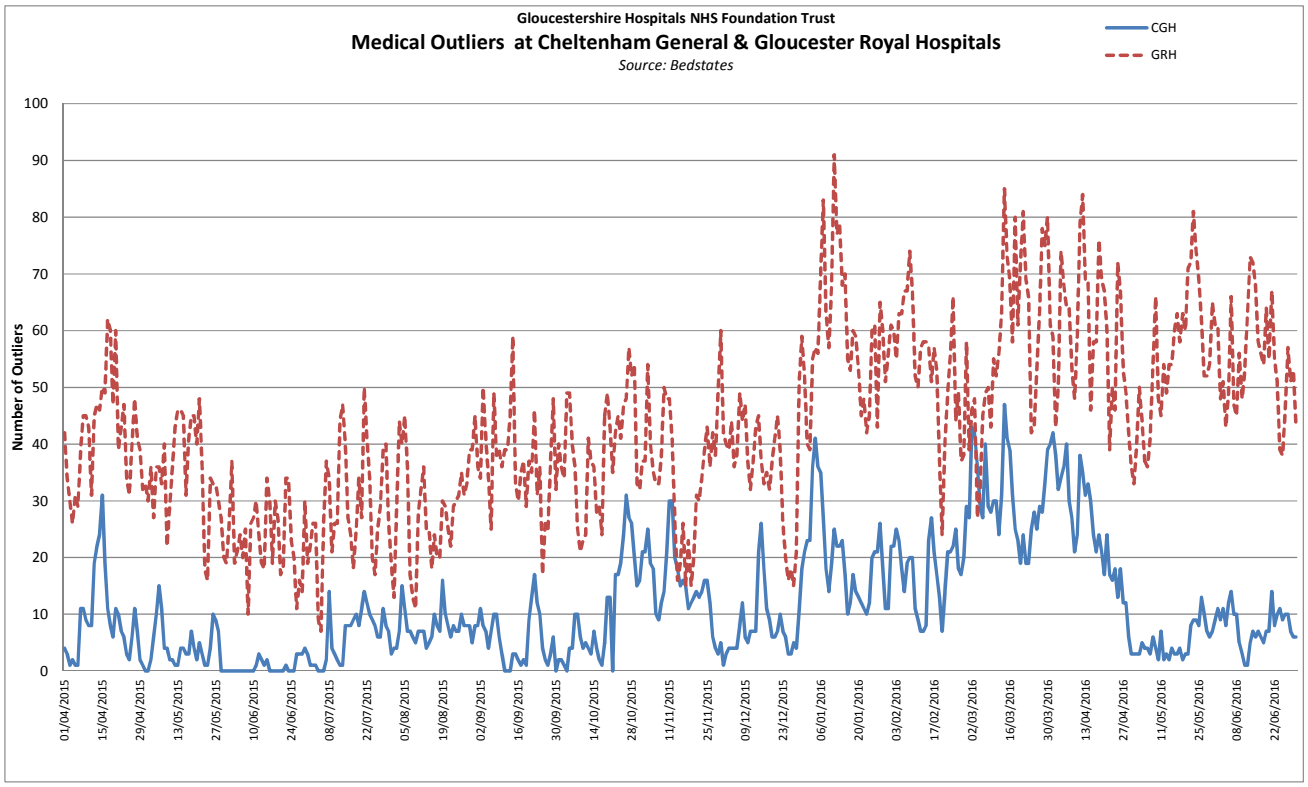
- With Single Point of Clinical Access, waiting for community services;
- With Ward and Integrated Discharge Team to activate existing support;
- In Assessment with Adult Social Care.

2.9 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.

The daily average number of medical outliers was 54 at Gloucestershire Royal and 8 at Cheltenham General in June 2016; compared to 56 and 5 respectively last month.

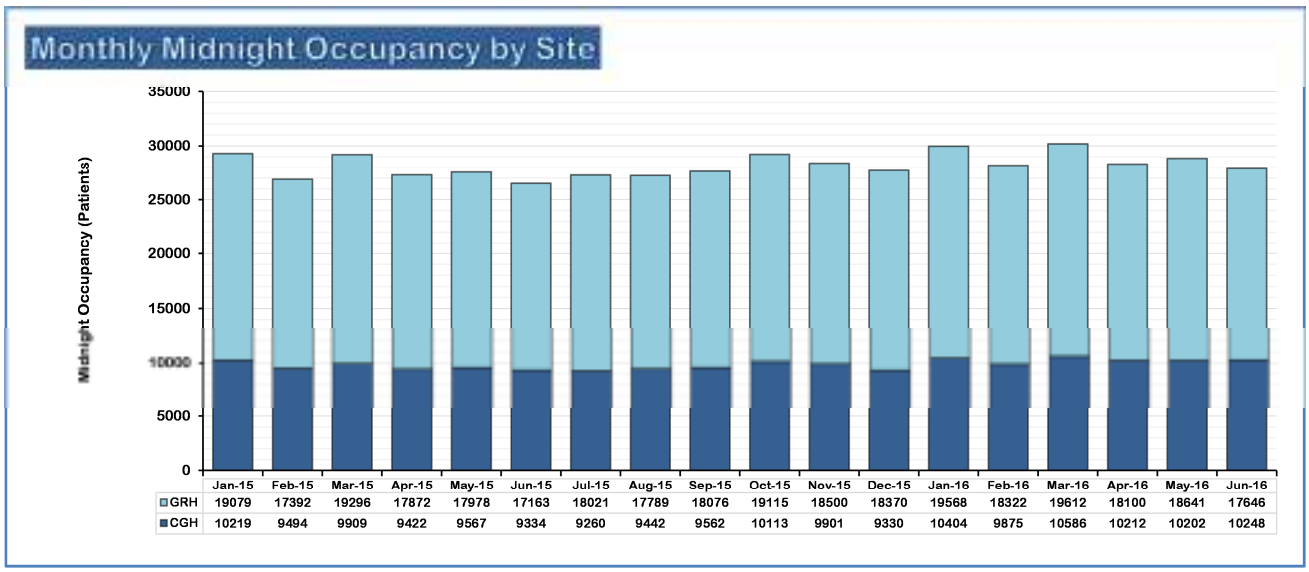


2.10 Midnight Bed Occupancy

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

How: All workstreams within the Emergency Care Programme are working towards reducing this statistic.

The daily average number of beds occupied in June 2016 was 929.8, compared to June 2015 (883.2 per day) and May 2016 (930.4 per day). The overall occupancy rate, although reducing, remains a significant issue in addressing patient flow. Reducing this is fundamental to improving the emergency pathway, reducing outliers and ensuring elective patients have the treatment they require.



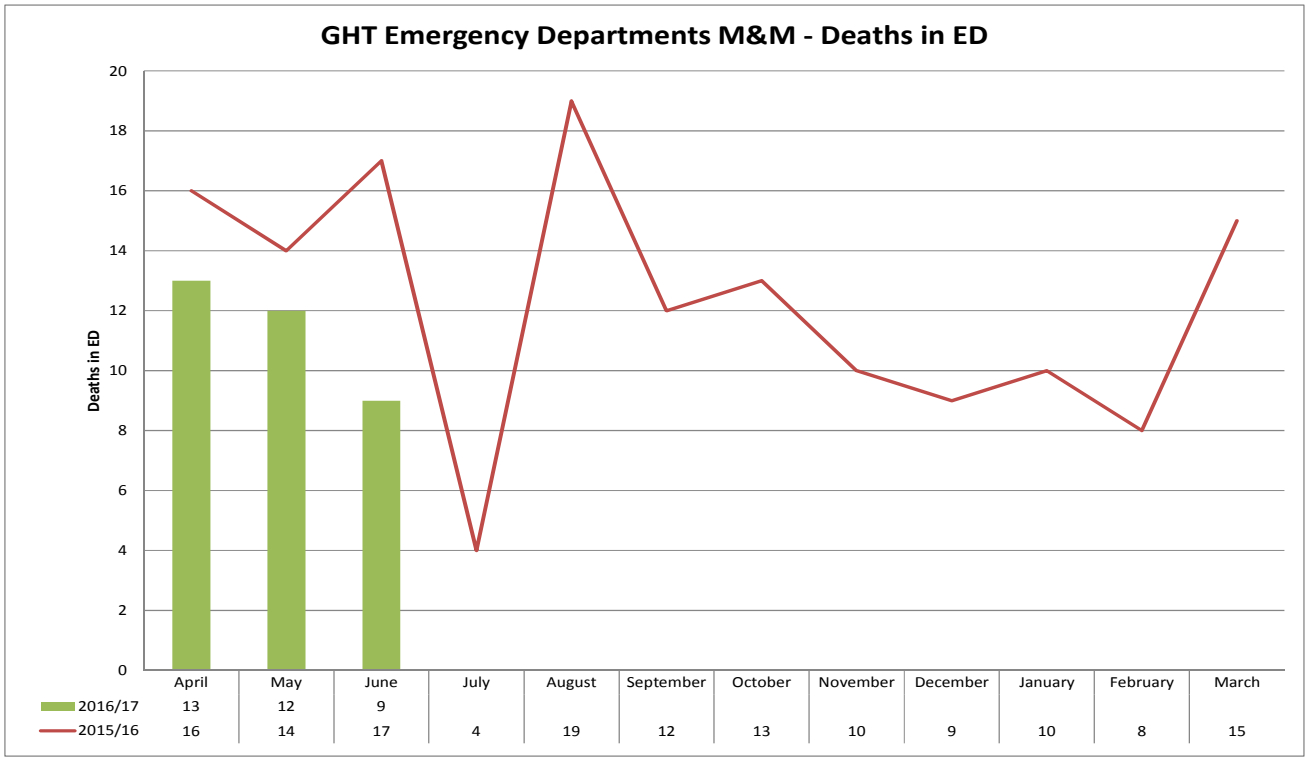
% Bed Occupancy (as at Thursday snapshot)

Week ending:	CGH	GRH	Total
05/06/2016	94.4%	99.8%	**97.6%**
12/06/2016	95.6%	99.4%	**97.9%**
19/06/2016	96.4%	98.9%	**97.9%**
26/06/2016	97.3%	96.8%	**97.0%**
03/07/2016	95.0%	95.3%	**95.2%**

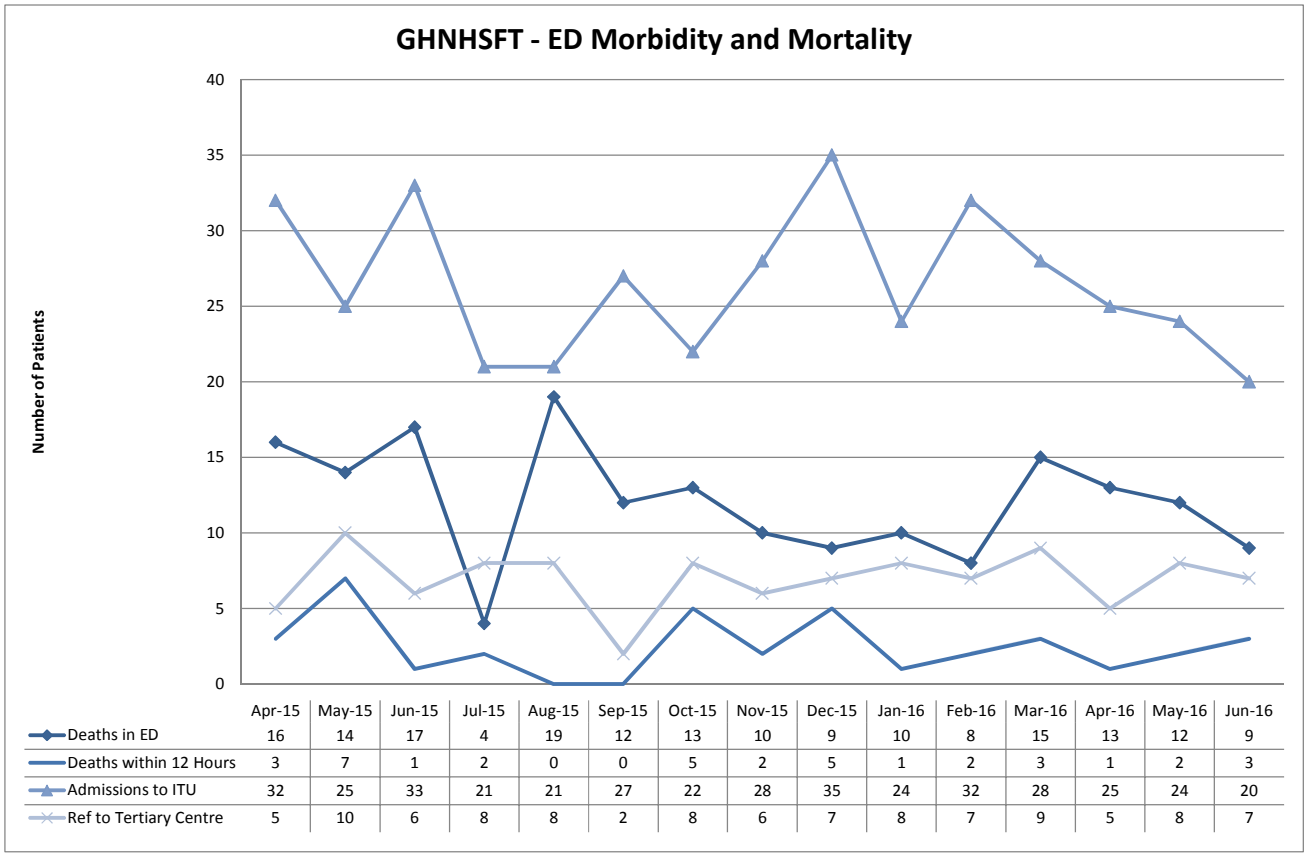
2.11 ED Morbidity and Mortality

Aim: To review the Morbidity and Mortality trend.

During June 2016 there were 9 deaths in the Emergency Department, which is lower than June last year (-8). There were 20 admissions to ITU and 7 referrals to tertiary centres. All of the deaths are reviewed in detail at the Service Line Morbidity and Mortality Reviews.



	April	May	June	July	August	September	October	November	December	January	February	March
2016/17	13	12	9									
2015/16	16	14	17	4	19	12	13	10	9	10	8	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	May-16	Jun-16
Deaths in ED	16	14	17	4	19	12	13	10	9	10	8	15	13	12	9
Deaths within 12 Hours	3	7	1	2	0	0	5	2	5	1	2	3	1	2	3
Admissions to ITU	32	25	33	21	21	27	22	28	35	24	32	28	25	24	20
Ref to Tertiary Centre	5	10	6	8	8	2	8	6	7	8	7	9	5	8	7

2.12 Medical Staffing

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

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 June (wte)	Variance In Post vs. Establishment	Variance vs. in Post in May
Emergency Department	Consultants	17.70	19.31	+1.61	-0.20
	Trainee Doctors	44.13	30.30	-13.83	-2.0
Acute Medicine	Consultants	11.03	8.53	-2.50	-0.20
	Trainee Doctors	83.29	67.40	-15.59	-0.20

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 Medical Director and is underpinned by the Demand & Capacity work undertaken within Workstream 1.

Despite recruiting additional consultants, further increases in demand need to be addressed with alternative staffing models and strategies. The capacity and demand work to address increasing attendances is now complete with suggested solutions.

3.0 Emergency Care Programme

As part of addressing the fundamental diagnosis of the issues in emergency care, the following work programme has commenced. These are a subset of those contained in the economy-wide plan, monitored by the System Resilience Group. This will be aligned to the work of the system-wide Urgent Care Strategy Group and the Sustainability and Transformation Plan Delivery Board for governance and oversight.

3.1 Six Main Workstreams of the Emergency Care Programme – The objectives of each workstream, which are the primary areas of focus for the Trust in this programme, are detailed below.

Workstream 1 – Emergency Department

- Staffing & Skill Mix
  - Demand & Capacity (Consultant & Nursing)
  - Identify gaps and change rotas if required
  - Operational Policies & Training
- Review >4hr wait breaches
  - Provide regular details for hospital-wide weekly review
  - Root Cause Analysis for any patient >10 hours
  - Implement solutions
- ED Capacity (GRH)
  - Increase Resus Capacity for this winter
  - Increase Majors Capacity for this winter
  - Increase Minors Capacity for this winter

Workstream 2 – Site Management

- Escalation Policies Implemented
  - Rewrite ED policy to ensure it is robust, delivers tangible results and is embedded
  - Rewrite Trustwide policy to ensure it is robust, delivers tangible results and is embedded
- Bronze, Silver & Gold Roles & Responsibilities
  - Competency Framework and role descriptions
  - Operational Policy
  - Systematic training programme
- Site Meetings
  - Structured, timely, action-focussed & fit-for-purpose
  - Repatriation policies systematically applied
  - Extend opening hours of temporary staffing office

Workstream 3 – SAFER Patient Flow Bundle

- Robust discharge planning, based on SAFER principles
  - Daily visibility of patients with a LoS of >14 days
  - Weekly review meeting for all >14 day patients, by Divisions
  - Systematically conduct MADE events
- Implement SAFER Patient Flow Bundle
  - Structured and consistent board rounds before midday
  - Estimated Dates of Discharge provided by Consultants
  - Increase discharges before 10:00 and increase weekend discharges
  - TTOs written in advance or real time

Workstream 4 – Clinical Patient Flow Model

Stream GP & ED referrals direct to assessment areas for Medicine, Surgery, Paediatrics, Trauma & Frail Elderly

- Identify and map clinical model for four emergency pathway presentations [within each of the above areas]
- Increase low risk chest pain and COPD pathways into Ambulatory Emergency Care units
- Identify workflows / volumes and capacity requirements (physical and human) and location
- Ensure workforce model, operational policies, rotas and training are aligned to requriements

Workstream 5 – Bed Distribution

Ensure bed capacity meets contractual and actual patient demand, across elective & emergency care

- Provide baseline scenario of bed requirement, based on contract predicted activity
- Model emergency bed requirement, based on current practice / demand (not contract)
- Provide correct bed allocation between sites / divisions / specialties
- Benchmark against national best practice and develop alternative scenarios

Workstream 6 – Remove Delays to Discharge

External Delays (Assessment & Provision)

- Safe, prompt and timely discharge, utilising intermediate care beds in nursing homes
- Scope the model for Gloucestershire to determine what aspects of the 'Oxford Model' would work for us and which elements need to be developed to make it relevant to our approach.

The following gives a short synopsis of each of the workstreams, the achievements to date, further actions identified and the lead indicators used to track delivery.

3.1.1 Emergency Department:

What have we done:

- Doctors & Nurses conduct hourly board rounds to identify and address issues causing delays and to resolve and / or escalate as required.
- Finalised the Demand & Capacity work, and developed business case for any staffing gaps.
- Undertaken flow co-ordinator training, using the expertise of NHS Improvement (NHSI).
- Introduced weekly cross-divisional breach analysis meetings.
- Revised the Emergency Department Escalation Policy, including action cards and triggers and aligned it with the revised Trust Escalation Policy.

Next Steps:

- Train staff in operational policies, ED Safety Checklist and Emergency Department Escalation Policy.
- Implement outcome of flow co-ordinator training.
- Recruit to the Emergency Care Practioner posts.
- Agree staffing with Executive for capacity and commence recruitment.

Measures (against February 2016 baseline):

For All Patients	CGH					GRH					TRUST				
	Feb	Mar	Apr	May	Jun	Feb	Mar	Apr	May	Jun	Feb	Mar	Apr	May	Jun
Avg. Time to Initial Assessment (mins)	17	16	13	10	11	26	21	16	13	14	22	19	15	12	13
% Assessed within 15 mins	57.7%	61.7%	74.7%	83.8%	84.5%	47.6%	48.4%	65.0%	76.2%	74.6%	51.3%	53.2%	68.5%	78.9%	78.1%
Avg. Time to Treatment (mins)	66	65	61	53	60	106	103	89	90	90	91	89	79	77	79
% Treated within 60 mins	53.9%	55.8%	59.8%	64.8%	59.6%	33.3%	32.8%	41.6%	37.5%	39.5%	40.9%	41.1%	48.1%	47.2%	46.6%
Number >6hrs (avg. per day)	4	7	7	2	2	34	34	15	14	11	38	41	22	16	14
% waiting >6hrs	3.0%	5.2%	5.7%	1.3%	1.8%	14.6%	14.3%	6.4%	5.8%	4.6%	10.3%	11.0%	6.1%	4.2%	3.6%
Patients in Corridor (avg. per day) *CGH figures collected since June 2016. June-16 will be taken as baseline for July onwards.	0*	0*	0*	0*	2	77	80	63	51	41	77	80	63	51	43

3.1.2 Site Management:

What have we done:

- Revised the Patient Flow and Escalation Policy, including action cards and Key Performance Indicators. The draft has been shared with NHS Improvement.
- Full consultation for proposed changes to the On-Call arrangements for silver undertaken, in line with HR policies. This closed on 1st July 2016 and in response, a revised rota is being proposed for implementation in September.
- Commenced training staff to enable Bronze, Silver and Gold participants to perform their duties.
- Created consistent structure to the Capacity & Flow meetings.

Next Steps:

- Finalise the Trust Patient Flow and Escalation Policy and roll out across the Trust

Measures (against February 2016 baseline):

For All Patients	CGH					GRH					TRUST				
	Feb	Mar	Apr	May	Jun	Feb	Mar	Apr	May	Jun	Feb	Mar	Apr	May	Jun
Number of Surgical Outliers Bed Days *methodology has changed	103	19	49	49	23	5	0	7	17	10	108	19	56	66	33
Number of Medical Outliers Bed Days *methodology has changed	514	528	267	161	45	1358	724	992	771	550	1872	1252	1259	932	595
Number of Medical Outliers (avg. per day) *methodology has changed	21	35	11	7	3	54	48	38	29	23	37	42	25	18	14
Number of days in Black Escalation	0	0	2	0	0	15	12	5	9	10	15	12	7	9	10
Number of days in Red Escalation	7	8	8	6	8	5	16	13	12	18	12	16	12	12	19

3.1.3 SAFER Patient Flow Bundle:

What have we done:

- Daily review of patients with a Length of Stay >14 days, as part of board rounds.
- Introduced weekly dashboards, so each ward can monitor their metrics against the patient flow bundle.
- Rolled-out discharge planning folders to all wards, including a revised Single Point of Clinical Access form, discharge planning and communication form and discharge menu.
- Presentation delivered to engage all staff on the importance of patient flow and how we can achieve it.
- The completion of a training video on SAFER to be used at training sessions and on line.

Next Steps:

- Systematically conduct Multi Accelerated Discharge Events (MADE) – the next one is 23rd and 24th August 2016.
- Deliver structured and consistent board rounds across the Trust, ensuring Senior Review before midday.
- Increase weekend discharges, including provision of 7-Day ward rounds for Gastroenterology and Cardiology.

Measures (against February 2016 baseline):

For All Patients	CGH					GRH					TRUST				
	Feb	Mar	Apr	May	Jun	Feb	Mar	Apr	May	Jun	Feb	Mar	Apr	May	Jun
Number of >=14 days on list	69	64	65	59	75	153	147	133	116	131	222	211	198	176	206
Number of Bed Days Occupied by >=14 day patients (Average)	1821	1560	1596	1535	2021	3949	4584	4184	3284	3648	5770	6144	5779	4820	5668
Total Bed Days Occupied (Average)	3089	2860	2882	2752	3273	5867	6466	5985	5257	5486	8956	9326	8867	8009	8758
% of Bed Days Occupied by >=14 Los Patients	59.0%	54.5%	55.4%	55.8%	61.7%	67.3%	70.9%	69.9%	62.5%	66.5%	64.4%	65.9%	65.2%	60.1%	64.8%
EDD Accuracy	29.9%	27.8%	29.2%	31.3%	31.1%	19.4%	20.8%	25.6%	25.6%	25.7%	23.5%	23.6%	26.9%	27.7%	27.7%
Bed Allocation (from ACU to ward) within 30 minutes	12.5%	10.0%	10.5%	13.9%	12.5%	8.7%	3.9%	5.7%	4.5%	7.1%	11.2%	8.0%	9.1%	10.7%	10.5%
Number of Discharges before 12pm (avg. per day)	30	29	32	29	30	44	41	47	41	42	74	70	78	70	72
% of Discharges before 12pm	18.1%	18.2%	19.4%	19.0%	18.2%	21.6%	20.8%	23.3%	21.4%	21.4%	20.1%	19.6%	21.5%	20.3%	19.9%
Number of Weekend Discharges	355	420	439	436	333	884	844	1015	970	701	1239	1264	1454	1406	1034
Number of Inpatients on DSU overnight	115	125	207	90	156	503	514	425	445	439	618	639	632	535	595
Number of Inpatients on DSU overnight (avg. per day)	4	4	7	3	5	17	17	14	14	15	21	21	21	17	20

3.1.4 Clinical Patient Flow Model:

What have we done:

- Conducted a workshop with relevant stakeholders regarding the Shortness of Breath pathway. This is the first of many to determine the desired clinical model.

Next Steps:

- Identify three further medical pathways and four pathways for surgery and trauma, along with frail elderly and paediatrics.
- This work will lead to the establishment of the desired clinical model, with the intention to implement a soft-launch in October 2016 for medical, paediatric and frail elderly pathways.
- Increase referrals for Low Risk Chest Pain and COPD into Ambulatory Care.
- Implement the Abdominal Pain Pathway in Ambulatory Care.

Measures are in development for this workstream.

3.1.5 Bed Distribution:

What have we done:

- Reviewed previous bed models to determine workstream requirements.
- Establishing brief, initial models and agreement of scenarios.
- Created a first cut iteration of a model with draft assumptions.

Next Steps:

- Ensure bed capacity meets the contractual and actual patient demand, across elective and emergency care.
- Provide the correct bed allocation between sites / divisions / specialties to accommodate utilisation, demand and escalation on the recommended scenario

Measures are in development for this workstream.

3.1.6 Remove Delays to Discharge:

What have we done:

- Visited Oxford to understand alternate options to enable safe, prompt and timely discharge, by utilising intermediate care beds in nursing homes.
- Engaged with community partners to develop an integrated approach.

Next Steps:

- Scope the model for Gloucestershire to determine what aspects of the 'Oxford model' would work for us, and which elements we need to develop to make it relevant to our approach.

Measures are in development for this workstream.

4.0 Quality & Safety:

4.1 National Quality Indicators

The key objective for the whole programme is to ensure we consistently deliver best care for everyone. The key to this is not only delivering the quality indicators in the Emergency Departments, but also looking at the wider issues of quality and the soft intelligence from the department.

Aim: To consistently deliver national Emergency Department quality standards.

How: Emergency Department and length of stay initiatives as defined in the Emergency Care Programme Plan.

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

Measure	Target	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Unplanned reattendance rate	<5%	1.40%	1.30%	1.30%	1.50%	1.40%	1.60%	1.40%	1.30%	1.40%	1.70%	1.50%	1.30%	1.30%	1.60%
Total time in department	95th % < 4hrs	04:36	04:00	04:26	06:01	05:35	06:05	05:38	06:25	06:53	07:37	07:37	06:25	05:45	05:33
Patients left without being seen	<5%	1.50%	1.60%	1.50%	2.40%	2.00%	2.20%	1.20%	1.70%	1.40%	1.80%	1.90%	1.70%	1.80%	2.00%
Time to Treatment	Median = 60 mins	00:50	00:59	00:57	01:13	01:08	01:14	00:57	01:10	01:02	01:13	01:12	01:02	01:03	01:05

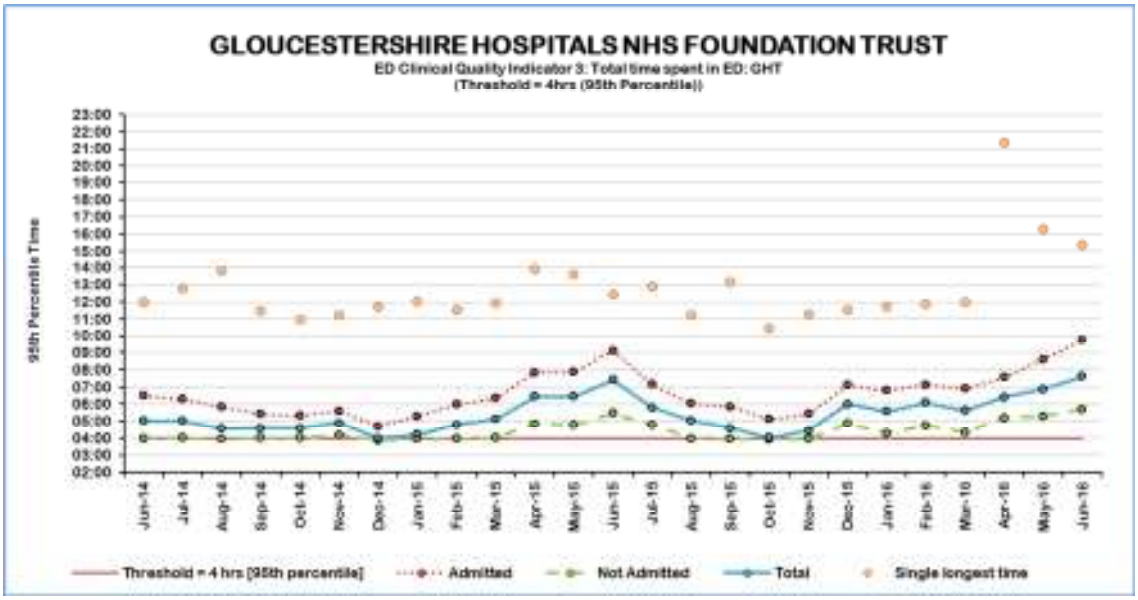
Time to Initial Assessment Compliance *(Standard: within 15 minutes of arrival)*:

	Number of....	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Trust Total	Total Patients	10632	10895	10982	10600	10747	11079	10532	10844	10734	10603	11510	10777	11854	11343
	Patients seen within 15 minutes	7043	6912	6864	6646	6350	6406	6328	6072	6076	5441	6127	7381	9353	8857
	Patients not seen within 15 minutes	3589	3983	4118	3954	4397	4673	4204	4772	4658	5162	5383	3396	2501	2486
	% Compliant	66.20%	63.40%	62.50%	62.70%	59.10%	57.80%	60.10%	56.00%	56.60%	51.30%	53.20%	68.50%	78.90%	78.10%

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 on the next page shows patients' time spent in the department reducing after the winter pressures (post February 2015) and with the actions being taken.

The 95th percentile of total time in department (for all patients) in June 2016 was 5 hours 33 minutes, compared to 4 hours exactly in June 2015, which was the last time that the target was achieved. The single longest wait in June 2016 was 16 hours 39 minutes, this patient did not require an admission and was under the care of the Mental Health team.


GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
ED Clinical Quality Indicator 3: Total time spent in ED: GHT
(Threshold = 4hrs (95th Percentile))
95th Percentile Time
23:00
22:00
21:00
20:00
19:00
18:00
17:00
16:00
15:00
14:00
13:00
12:00
11:00
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Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Threshold = 4 hrs (95th percentile)
Admitted
Not Admitted
Total
Single longest time

4.2 Safety

During the month of June 2016, there were no Never Events or Serious Incidents reported.

Following implementation of the ED Safety checklist in Cheltenham, our documentation and monitoring and recording of vital signs has improved, in particular, use of the checklist has gone up to almost 60% of eligible patients in May 2016 (compared to 30% in March and April). June data is not currently available.

The Care Quality Commission "must do" action regarding management of pain in the Emergency Department has also shown an improvement as a consequence of the Safety checklist.

Measure	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	June 16	Comments/themes and actions
SAFETY METRICS									
Number of Never Events	0	0	0	0	0	0	0	0	
Number of confirmed serious incidents	0	1	0	1	1	0	1	0	

Top ten categories for incident reporting by staff in Emergency Department
Admission transfer – the peaks between Jan – June 2016 relates to a staff member entering all occasions where there were capacity issues e.g. corridor patients on the reporting system.
Abuse and violence – incidents include verbal, physical aggression involving patients/ 3rd parties or for disruptive patients/ 3rd parties ED staff have received conflict resolution /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 and implementation of the hourly board rounds
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

	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	Jun 2016	Total
Admission/ transfer	18	6	5	30	9	47	23	37	98	94	47	19	11	75	**519**
Abuse and Violence	12	22	15	19	11	19	17	18	8	6	20	4	22	9	**202**
Care, Monitoring, Review	4	2	6	7	7	15	29	4	2	6	11	3	5	12	**113**
Diagnosis & Assessment	6	7	6	5	7	4	7	10	4	9	8	5	5	4	**87**
Communication	4	5	5	9	3	5	5	6	6	3	6	8	6	5	**76**
Medication Incident	6	5	8	5	5	4	3	3	1	4	4	5	3	6	**62**
Staffing / Beds / Systems (no individual patient involvement)	1	0	1	3	5	4	9	4	2	4	4	2	2	7	**48**
Treatment/ Procedure	2	4	4	2	2	3	3	2	4	3	6	2	2	2	**41**
Discharge & Transfer	0	0	3	0	2	2	2	5	1	2	6	1	2	0	**26**
Pathology sampling issues	2	2	1	3	2	1	1	3	0	2	4	3	0	0	**24**
Total	**55**	**53**	**54**	**83**	**53**	**104**	**99**	**92**	**126**	**133**	**116**	**52**	**58**	**120**	**1198**

Current Improvement and Audit projects

- **Patient Safety Checklist – part of the** 2016 and GRH June 2016**WEAHSN (Academy supported) –** implemented in CGH March

Actions planned include

- Link earlier sepsis screening to checklist
- Improve refreshment and clinical pathway recording

- **Improve Pain Management (CQC recommendation) (Academy supported)**

– 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

The Patient Safety Checklist and Pain Management Project are linked through the data collection for the checklist

– May data for Cheltenham following implementation of the checklist has led to an improvement in our documentation and monitoring and recording of vital signs. In particular, use of the checklist has gone up to almost 60% of eligible patients (compared to 30% in March and April)
– Pain scoring at triage and on an hourly basis has improved.

(Full report available)

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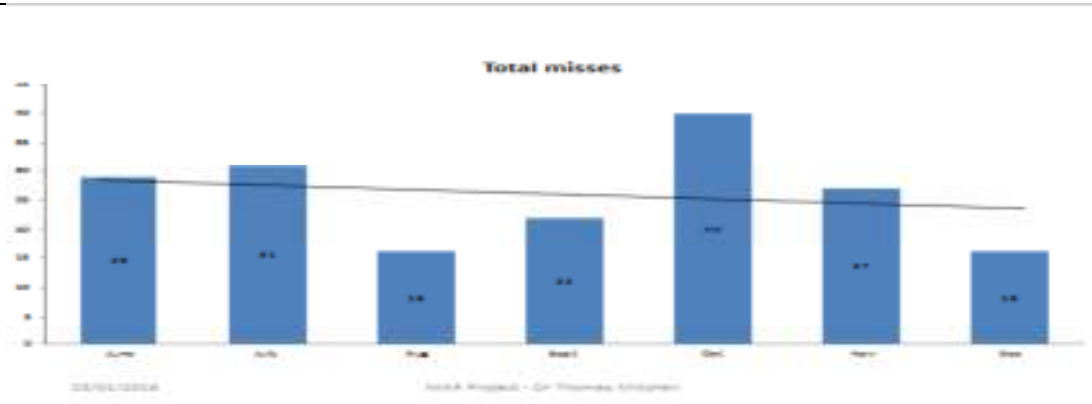
• **Missed Abnormal Radiology (NHSLA funded)** **Actions have included** – Teaching and education sessions contributing to a decrease in missed fractures – Identification of new pathways involving T&O and radiology – Production of newsletter raising awareness of project and actions	
Hourly board rounds 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	The project continues to inform the weekly quality report and Stream 1 actions
Morbidity and Mortality considerations	None reported

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									
	Nov-15	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**	**Apr-16**	**May-16**	**Jun-16**	
Family and Friends positive response rate	2.4	1.9	0.7	2.5	4.5	2.3	4.9	8.3	2 Health care assistants are championing F&FT. Receptionist in Majors handing out cards on late shift. Raising the profile, increased patient experience team presence. Transfer from card to digital methodology will start in July.
Rate of Complaints	10	9	10	12	12	11	14	8	Clinical Care
Number of Concerns	3	1	6	8	2	1	3	8	Facilities and Lost Property
Number of compliments	4	23	11	8	6	10	11	35	

5.0 Next Steps

In line with the review of Governance Arrangements, this report will continue to change and develop over the coming months in order to ensure alignment and visibility from 'ward to board', including the key issues and performance metrics.

Report Authors:

Sue Barnett – Improvement Director

Kim Hemming – Divisional Information Manager, Medicine

Jackie Miller – Senior Information Analyst

Lou Porter – Programme Manager

Andrew Seaton – Director of Safety

Presenting Executive:

Eric Gatling – Director of Service Delivery

NURSE AND MIDWIFERY STAFFING
JULY 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 July 2016.

2 Background

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 and now includes data regarding contact time per nurse as explained in last month's Board paper.

3 Findings

The divisional nursing directors have analysed their department's data and have individually responded for the purpose of this report.

3.2 Surgical Division

3.2.1 From a nursing metrics performance all areas scored GREEN. Safer Staffing - all areas GREEN. DCC due to staff flexing can trigger, that staffing is below their usual staffing level. This month say the additional collection of the Care Hours Per Nursed Day. We are currently awaiting further guidelines on how to interpret and benchmark this data internally and externally with other organisations.

3.2.2 Harm free Care – Department of Critical Care (DCC) at CGH and GRH triggered 90.1% and 87.5% due to pressure ulcer development within the units. The Units are proactively reviewing patient management systems to lessen impact of often equipment related pressure ulcers (i.e. Endotracheal tunes). Pressure ulcers also contributed to Prescott ward scoring 96.1%, and 5b 97.1%. Dixton ward (92.3%) due to patient falls, as was Guiting (96.4%), and 3a (95%). All areas use the Swarm form (rapid intervention following an incident like a fall - based on how bees swarm) to greater understanding of reasons being the fall to then support remedial actions.

3.2.3 Funding has been agreed for additional beds on Guiting, 2b, and Snowshill. Day Surgery Unit (DSU) as escalation area on both sites, remain unfunded whilst work continues to enhance discharges effectively which would result in not using this area. Recruitment is ongoing. A rapid improvement initiative has been agreed with the aim of closing these areas in September.

3.2.4 High use of bank and Agency continues within unfunded bed area. 40% of agency spend is to offset the vacancy position. However the Division has a set trajectory for reduction in nursing, medical and administrative and clerical temporary staffing.

3.2.5 Sickness levels for RGN's are higher than normal for the period; therefore, this will be discussed and reviewed with the Modern Matrons.

3.2.6 Whilst the number of vacancies on the bottom line staffing report show vacancies just being 33.09 fte (full time equivalent), this includes an over-establishment on the Band 2 line which is over by 19.71 fte, as overseas nurses awaiting registration are placed in this budget line. In addition, there are some over establishments due to agreed decisions on other band lines. Once these matters are taken into account, the actual Band 5 vacancies are currently, 51.02 fte. We are awaiting 19 full time band 5 newly

qualifying staff to commence in early August 2016, and 3 part time registered staff. Specific recruitment exercises continue to target specialised areas such as Theatre and Critical care. Looking at reasons why staff are leaving continues and does not show any trend within any particular area. Recruitment continued in line with the Trust recruitment strategies

3.3 **Medical Division**

3.3.1 In the month of June 10 areas used more hours than planned. The increased hours relate to additional shifts to 1:1 specialing and increased patient acuity and dependency. Cardiology used additional shifts to support the new mobile catheter laboratory at GRH. 1 area fell below planned levels of HCA's due to high sickness rates and staff vacancies and inability of agencies to help us fill the gaps.

3.3.2 The Division recognises that the retention of staff is paramount to ensuring safe staffing levels and a contented workforce. The Division is reviewing the options around adopting a more integrated workforce approach by exploring other staff groups to appoint on a fixed term basis. Weekly review meetings are ongoing to monitor recruitment and retention information. All registered nurses leaving the Division have their exit interview undertaken with the DND to identify themes and put actions in place to slow turnover.

3.4 **Women & Children's Division**

3.4.1 Within the Women and Children's Division to date safer staffing data has only been collected for in patient areas namely the Maternity Ward, Children's in Patients, SCBU and Stroud Maternity. Following the publication of new guidance consideration is now being given to the collection of data in areas providing intrapartum care; the Delivery Suite and Birth Units at Gloucester and Cheltenham. It is difficult to provide meaningful data as staffing levels in intrapartum areas need to fluctuate according to activity.

3.4.2 Currently based on the June data all areas of the Division are currently showing 100% compliance with safer staffing and harm free care with the exception of 2a which is showing 95.83% harm free care and total safer staffing levels of 98% and 99% on day and night duty respectively.

3.4.3 Continued use of the Gynaecology Day Surgery Unit as an inpatient bed base during escalation has resulted in the use of additional temporary staff to support the additional bed capacity. Shortfalls in the nursing rotas cannot always be filled despite the use of bank, and at times, agency. Patient experience can be affected by the use of temporary staff that are unfamiliar with the area and in turn the use of gynaecology nurses to care for patients from unfamiliar specialities. These problems have had a negative impact on moral and the difficulties have had a detrimental effect on retention of staff this has been reviewed with some of the executive directors and divisional directors and plans to improve both patient and staff experience are being further explored.

3.4.4 The 3 month pilot to incentivise staff to work for the Trust bank within paediatrics has now been completed and is currently being evaluated from both the quality and financial perspective. The planned reduction in the bed base over the summer within children's in patients is continuing over the coming months. However activity and acuity of the patients in the area can be unpredictable and subject to rapid change therefore closure of the 5 beds with the associated reduction in nurse staffing is being closely monitored. Recruitment is positive and we anticipate seeing a significant fall in the use of agency staff in the coming months

3.5 **Diagnostic & Specialist Division**

3.5.1 From a nursing metrics performance all areas scored GREEN.

3.5.2 Both Lilleybrook and Rendcomb wards within the Oncology centre were green in relation to fill rates for both registered and unregistered staff. Harm free care was also measured at 100%. Operationally there are a small number of vacancies but this has not affected care delivery. Bank staff are utilised always in the first instance with minimal agency used and no non-framework agency nursing this month. There is a wider strategic plan around retention of specialist nurses in cancer care which is being developed by the centre.

4 Care Hours Per Patient Day (CHPPD)

4.1 The recent publication "safe sustainable and productive staffing improvement resource" was received on 06.07.16 by NHS Provider Trusts. The Divisional Nursing Directors will over the next few weeks analyse both this resource and our own CHPPD data and take actions as appropriate.

5 Revalidation at Gloucestershire NHS Trust

5.1 Our Board was informed of the new regulation regarding Revalidation earlier in the year; the process became live in April 2016.

Those revalidating in April and may have reported that the process has been a much easier process than first thought.

Our Revalidation Officer works alongside Human resource team accessing information from ESR (electronic staff record) contact staff 120 days before they are due to Revalidate. Likewise the NMC contact members of staff as well to inform them when their revalidation area is live on the NMC website and open to Revalidate online. This is 60 days before deadline. Managers are sent a list of staff with the date they are due to Revalidate; in the future this can be done alongside an appraisal making the process slicker and preventing duplication

Revalidation workshops are running which help staff understand the process and gives them the opportunity to ask any questions they may have. These are held at both sites and on different days and times to cater for all staff. Posters have also been put up at both sites and a webpage with all the information and workshop dates.

The Revalidation workshops thus far been very well attended and have received very positive feedback.

We have been advised by NMC that if a member of staff is going to be verified i.e. further reviewed by NMC staff; they will be contacted within 24 hours of Revalidating online and their validator will also be contacted by email. So far, no staff in our trust have been contacted.

MONTH	DUE FOR REVALIDATION	REVALIDATED	CODE	VERIFIED by NMC
APRIL 2016	40	39	1	0
MAY 2016	26	26		0
JUNE 2016	21	19	1 (x2 staff)	0
JULY 2016	114	Report to be run 18/7/16		
AUGUST 2016				
SEPTEMBER 2016				
OCTOBER 2016				
NOVEMBER 2016				
DECEMBER 2016				
JANUARY 2017				
FEBRUARY 2017				

MARCH 2017				
APRIL 2017				

CODE- 1-Retired 2-long term sick 3-Pregnancy related 4-Non compliant 5-Left Trust

6 Recruitment Update

6.1 UK Pipeline

- There are 61 newly-qualified adult nurses due to join the Trust between 11 July and 05 September, which equates to 59 WTE. These newly-qualified nurses are predominantly (36.8 WTE) being allocated to Medicine, with the majority of the remaining candidates (20.6 WTE) being allocated to Surgery. There are 1.6 WTE being allocated for Oncology. Paediatrics and NICU have run separate recruitment campaigns and are not included in these figures.
- There are currently only eight experienced UK-based Band 5 nurses in the recruitment pipeline due to commence employment in summer 2016.
- There are currently 10 live Band 5 Registered Nurse advertisements open, but interest continues to be low. There is a separate advertisement open for Bank Nurses.

6.2 Overseas-Qualified Nurses

- The majority of the candidates interviewed in March have commenced employment during June and July. There are eight overseas-qualified nurses with confirmed start dates in July/August, plus a further 12 with start dates still to be confirmed (four delayed due to the requirement of a new work permit for the position).
- There are currently 23 candidates awaiting interview for the programme, and interviews are scheduled for 8th, 14th, 15th, and 25th July. Interviews will be conducted by staff from the Medicine Division, with the view that all remaining candidates are appointed to Medicine.

6.3 EU Recruitment

- The Trust is currently in discussions with the British Council in Greece to attend the October 2016 Healthcare Careers Fair in Athens and Thessaloniki. It is hoped that a discounted rate can be agreed, with the addition of a free seminar session to 'sell' Gloucestershire Hospitals as the employer of choice for EU healthcare workers.
- The Trust continues to interview and appoint nurses from across Europe, with regular Skype interview days being booked. There are delays in these nurses joining the Trust now that IELTS is a mandatory requirement for European nurses.

6.4 Philippines Recruitment

- The NMC has relaxed rules on English language proficiency for candidates applying for registration from outside the UK. The previous rule stipulated a score of 7.0 in speaking, reading, writing, and listening in a single sitting of the Academic IELTS Examination. The new rules still require the 7.0 score, but candidates who narrowly miss out on the first attempt can take a second attempt within six months and will be deemed successful if they have a 7.0 in each of the four disciplines across both attempts, and score at least 6.5 in the failed sections. We are currently awaiting confirmation from the NMC about whether previous examination results can be taken into consideration under the new rules.
- The first eight candidates to undertake the new NMC Test of Competence (OSCE) did so in June, with three passing on their first attempt. These three nurses now have their PIN. The other five candidates are booked for re-sits in either July or early August. If candidates fail the OSCE examination twice, their visa will be curtailed by UK Visas & Immigration.

6.4.1 November 2015 Campaign

- The first three nurses from the November 2015 campaign arrived commenced employment on 16 May 2016, and a further two nurses joined the Trust in mid-June. A sixth nurse will join in mid-July.

Status	**Numbers**
Commenced employment	5
Awaiting deployment	1
Passed IELTS and CBT exams, accepted by the NMC, waiting for visa application	2
Passed IELTS and CBT exams, waiting for NMC decision letter	9
Passed IELTS examination, waiting for CBT examination	3
Not passed the IELTS examination (Note: 71 nurses have taken the exam at least once)	97
Candidate withdrawn	19
Total (minus withdrawn candidates)	**118**

6.4.2 May 2016 Campaign

- The Trust conducted interviews across one week in May 2016 and made a further 65 offers of employment to successful candidates for positions within our medical and surgical wards, and within unscheduled care. Further interviews have been conducted via Skype during June for Paediatrics, ICU and NICU, and there are also still candidates awaiting interview with no confirmed interview date for Theatres and Recovery.
- Of the candidates to not yet pass the IELTS examination, four have taken the test and failed, and 54 are booked to take their first attempt before the end of September.

Status	**Numbers**
Passed IELTS examination, waiting for CBT examination	3
Not passed the IELTS examination	73
Candidate withdrawn	1
Total (minus withdrawn candidates)	**77**

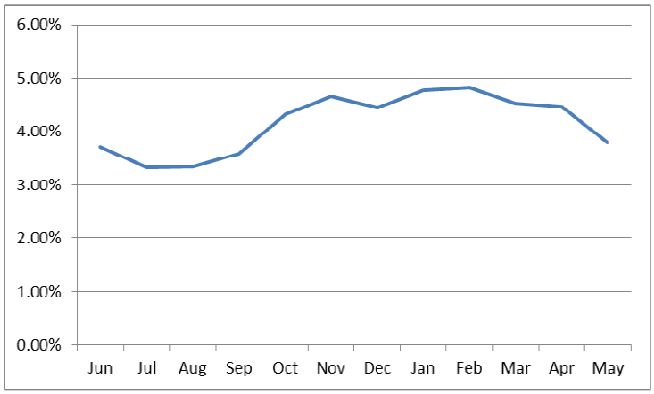
6.5 **Nursing Workforce Metrics**

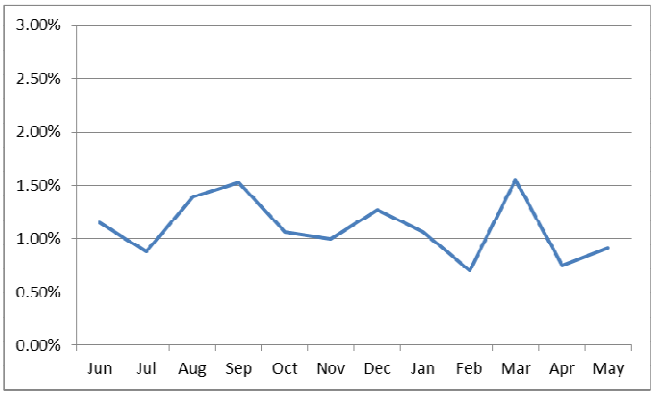
Division	**Band 2 Vacancies**		**Band 5 Vacancies**		**Band 6 Vacancies**	
Diagnostic & Specialties	-1.04	overestablished	-4.05	overestablished	3.07	7.54%
Medicine	-25.88	overestablished	103.00	22.04%	5.96	4.30%
Surgery	-19.71	overestablished	51.02	9.28%	-6.40	overestablished
Women & Children	-2.49	overestablished	-2.62	overestablished	10.73	4.64%

Data Note: Data for this table is from 31 May 2016

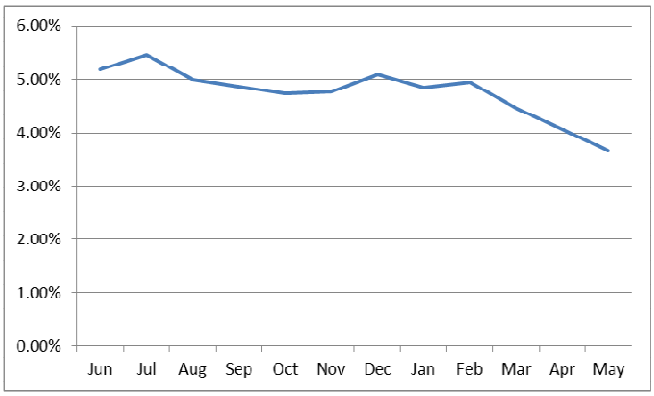
Division	Sickness		Turnover		Maternity	
	RGNs	HCAs	RGNs	HCAs	RGNs	HCAs
Diagnostic & Specialties	4.16%	5.07%	13.04%	14.86%	3.49%	1.52%
Medicine	3.76%	5.55%	18.15%	19.43%	3.39%	3.80%
Surgery	4.43%	4.22%	11.07%	19.08%	4.14%	2.14%
Women & Children	4.03%	3.44%	13.33%	9.73%	3.52%	4.53%

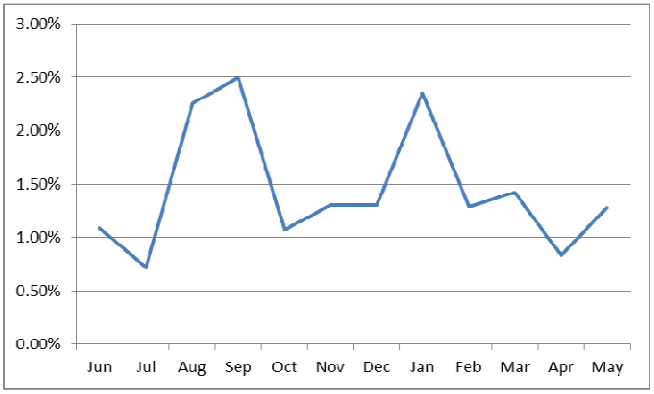
Data Note: 12 month rolling data





RGN: Sickness Absence by Month (Jun 15 – May 16) **RGN:** Turnover by Month (Jun 15 – May 16)





HCA: Sickness Absence by Month (Jun 15 – May 16) **HCA:** Turnover by Month (Jun 15 – May 16)

6.6 Vacancy Forecast

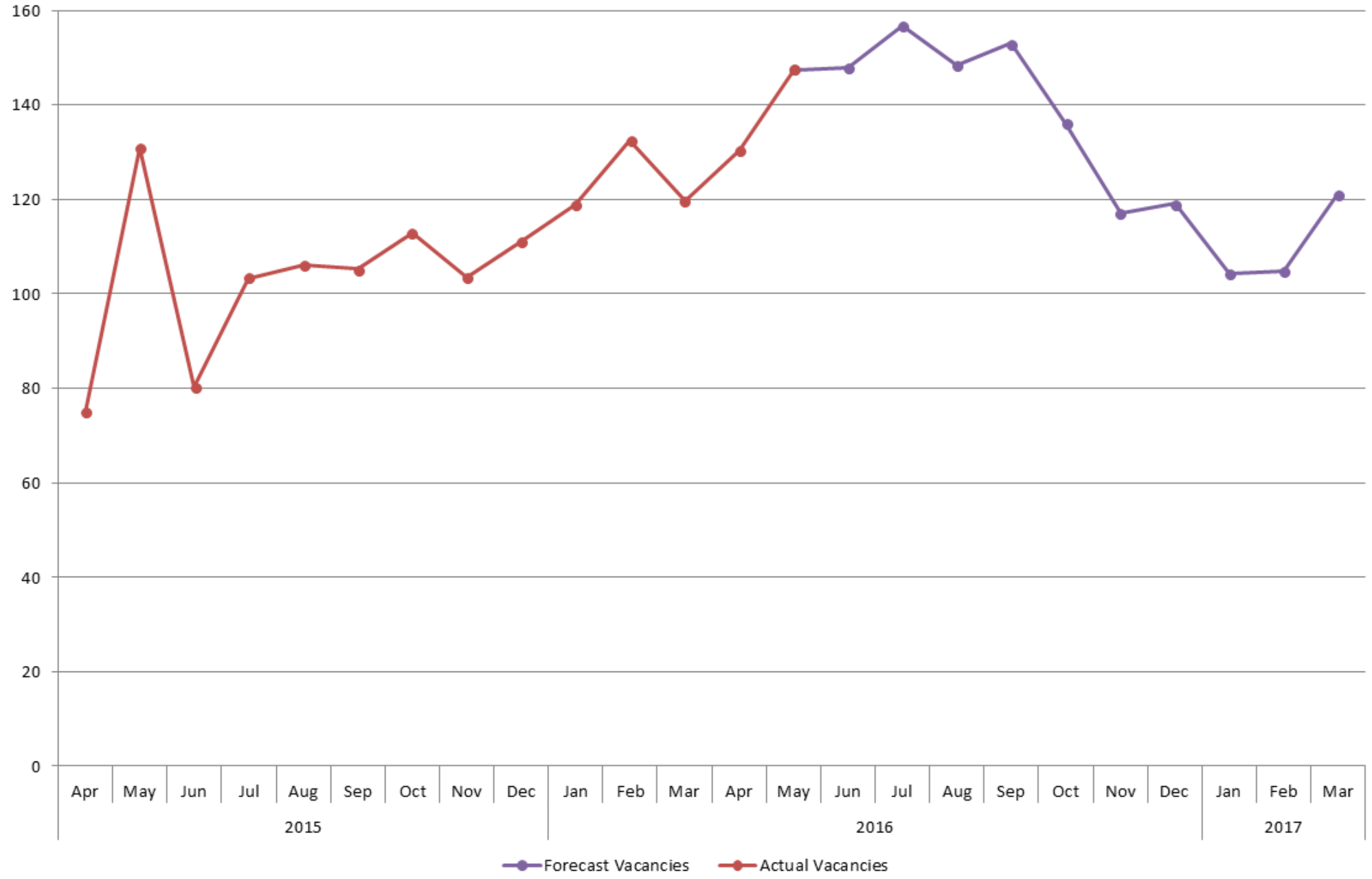
There are currently 147.35 WTE vacancies for Band 5 nurses across the Trust (exc. Corporate Services). This is the highest vacancy rate experienced by the Trust, despite best efforts to recruit and retain staff. The vacancy forecast continues to show an increasingly negative outlook, due to three separate elements that independently impact the number of nurses required, these are:

- Continually increasing establishment: The Band 5 nurse establishment has increased by 50.52 WTE posts since May 2015, and the current establishment of 1216.81 WTE nurses (exc. Corporate Services) is the highest that it has ever been. The greatest increases to establishment have been since March 2016 when an additional 24.64 WTE posts have been added to the establishment.

- Increasing numbers of leavers: The number of staff leaving the organisation has been greater than the number of new staff joining for seven of the last 12 months. In the

last six months, 91.31 WTE have left the organisation. This is compared to just 64.09 WTE joining over the same period: a net decrease of 27.22 WTE.

- Reduced numbers of new staff: In each of the last four months, the numbers of new Band 5 nurses joining the organisation have been less than 10 WTE. In May 2016, only 5.00 WTE new Band 5 nurses joined the organisation. Other than the imminent arrival of newly-qualified nurses in August/September, all other pipelines have been significantly reduced in the last 12 months. The only currently viable pipeline is to recruit from The Philippines, however this has the longest time to hire, and registration once in the UK can take up to eight months.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2015
2016
2017
Forecast Vacancies
Actual Vacancies

7 Next Steps and Communication

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

8 Recommendations

The Board is invited to note this report for assurance that our Trust is delivering safe staffing levels and has plans to maintain and improve upon this position.

Authors:

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JULY 2016

BOARD STATEMENTS

1. Introduction

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

For Finance that:

The Board anticipates that the Trust will deliver Financial Sustainability Risk Rating (FSRR) of 3 by the end of the financial year 2016/17. A financial recovery programme is underway to ensure that improvements are made to return FSRR to level 3 in the latter part of this financial year.

For Governance that:

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

Otherwise:

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

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

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

2. Finance

The Trust has delivered its continuity of service rating in previous years however the Trust continues to experience ongoing demand pressures and has also incurred additional expenditure relating to the improvement plans for emergency care which has had a consequential impact on the Q1 risk rating which has moved to a level 2. Plans are being implemented to return the Trust to a FSRR 3 in the latter part of this financial year.

3. Governance

In addition to the financial challenge in section 2 of this report, there are two additional performance challenges which mean that the Trust is not able to sign the Governance Statement.

The financial positions and the t performance challenges below both of which have been presented to the Finance and Performance Committee and are as follows:

ED - Although the ED performance for Q1 is above the improvement trajectories agreed with NHS Improvement this does not comply with the 95'% standard. The ED 4 hour wait standard has not been achieved to date, and levels of demand to continue to be higher than planned against a 95% target. Additionally the number of medically fit patients awaiting discharge continues to be significantly higher than the target agreed with Gloucestershire CCG.

The Trust is working closely with NHS Improvement on our plans to improve performance in addition to the wider system issues.

Cancer - The Trust did not meet the 62-day target for Q1, however, a recovery plan is being implemented and will be reviewed by the Finance and Performance Committee. Particular issues relating to capacity within the Urology Service and we have plans in place to address the capacity issues.

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

4. Any other Areas

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

5. Conclusion

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

6. Recommendation

The Board is asked to consider that:-

1. An exception report is made to NHS Improvement on the ED 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 the targets agreed with Commissioners and NHS Improvement.

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

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

July 2016

Table A1: Indicators and their thresholds

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

Appendix 2

Table 3: Examples of where an exception report is required

	Examples

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

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

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

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

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

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

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

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

MAIN BOARD JULY 2016

COMBINED ASSURANCE FRAMEWORK & TRUST RISK REGISTER

1 Purpose of Report

1.1 To receive the 2016/17 Board Assurance Framework (BAF) and Trust Risk Register (TRR).

1.2 Of note, the BAF has been updated to reflect the 2016/17 annual objectives, as set out in the Annual Plan. Further work is still required to complete this refresh and will be presented to the next Board.

2 Background

2.1 The Board Assurance Framework (Appendix 1) is the means through which the Board tracks delivery of its stated annual objectives through the tracking of risks which have the potential to undermine delivery of the objectives.

2.2 The BAF sets out the controls to mitigate the potential risks and provides assurance that the controls are effective or describes further actions to strengthen the controls.

2.3 Where the risk exposure becomes significant through failure of the controls or unexpected events in the year, these risks will appear on the Trust Risk Register to ensure there is clear visibility and oversight of the risk and the controls and actions to mitigate or eliminate the risk.

2.4 So that the Board can understand the level of assurance carried by the evidence a simple rating scheme has been included as follows:

Level 1	Internal Management reviewed assurance
Level 2	Board reviewed assurance (Usually Board reports e.g PSF)
Level 3	External provided assurance (e.g. External assessments\sign off)

3 Recommendation

To receive the updated Assurance Framework and endorse the revised approach; in doing so note the potential risks to the 2016/17 objectives and the controls in place to mitigate these risks.

Author: **Andrew Seaton, Director of Safety**

Presenting Director: **Deborah Lee, Chief Executive Officer**
Date: **25th July 2016**

February 2016 - Full Assurance Framework - Key - for reference

Strategic Objective……

Principal Risks to the plan	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Risk Rating** (Likelihood x Impact)
What could prevent the above principal objective being achieved? You may have more than 1 risk Start with Risk of…….	Which Director is responsible and which assurance committee is responsible for monitoring?	What management controls/systems we have in place to assist in securing delivery of our objective The controls and assurance are rated by level of assurance **Management Reviewed Assurance = 1** **Board Reviewed Assurance = 2** **External Reviewed Assurance = 3**	Where we can gain independent evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks, and objectives are being delivered	Assessment of the quality of the controls to manage the risk (not assessment of the risk itself)
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			Where do we still need to put controls/ systems in place? Where do we still need to make them effective?	Where do we still need to gain evidence that our controls/ systems, on which we place reliance, are effective	Are the controls and assurances improving? ↑ ↓ ↔

Actions Agreed for any gaps in controls or assurance		**By Whom**	**By When**	**Update**
1				
2				

Strategic Objective - To continue to improve the quality of care we deliver to our patients and reduce variation

Principal Risks to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of failing to achieve key clinical objectives through the lack of clinical engagement e.g Emergency Care plan, failure to establish clinical management pathways in smartcare	**Medical Director** **ECB\Smartcare Board**	1. Development of internal professional standards for clinicians. (1) 2. Clinical leadership in the SAFER ward based project (1) 3. Maintaining involvement through the Clinical design authority who are responsible for the clinical design of Trakcare (1)	1. Emergency pathway report (Stream 11) 2. Emergency pathway report (Stream 3) 3. Progress monitored in the Smartcare Board(2)	1. Emergency pathway report to Board	3x4=12
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			1. Required funding to support clinical back fill to facilitate time to engage	None	↔
Principal Risk to the plan	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Risk Rating (Likelihood x Impact)**
Risk of delay to the development and implementation of standardised pathways to reduce variation in practice as a consequence of the delay of implementing Trakcare	**Medical Director** **Smartcare Board**	1. Maintaining involvement through the Clinical design authority who are responsible for the clinical design of Trakcare (1) 2. Engagement session with all clinical teams to describe and design the clinical pathways (1)	1. Progress monitored in the Smartcare Board	1.monthly reports to board on progress	3x4=12
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			None	None	↔

Actions Agreed for any gaps	By Whom	By When	Update
Investment plan to be considered by the Board	Medical Director	October 2016 Trust Board	Blank

Strategic Objective - To continue to align our services between our sites

Principal Risks to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of insufficient suitable physical locations to support the alignment of services	**Director of Clinical Strategy** **Trust Board**	1. Outline Site Development plans agreed by Board (2) 2. Site Development plans reflected in the emerging Sustainability and Transformation Plan the STP submission (2)	1. Progress reports on site development plans (2)	Board endorsement of outline business cases.	3X5=15
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			1. Availability of capital		
Principal Risk to the plan	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Risk Rating (Likelihood x Impact)**
Risk of key stakeholders not supporting any significant service changes required	**Director of Clinical Strategy** **Trust Board**	1. Participation in system wide engagement activities (1) 2. Stakeholder engagement plan (2)	1. Board report on progress of changes (2). 2. Sustainability & Transformation programme reports (2)	None	3x4=12
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			None	None	↔

	Actions Agreed for any gaps	By Whom	By When	Update
1	To scope the Modernising Our Hospitals Workstream of the Transformation Programme	Director of Clinical Strategy	September 2016	None
2	Maintain “no surprises” commitment to key stakeholders, through regular engagement	Director of Clinical Strategy	On going	None

Strategic Objective To future proof our services through clinical collaboration

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of organisations serving neighbouring populations seeking clinical collaborations with other providers	**Director of Clinical Strategy** **Trust Management Team**	1. Regular executive level meetings with neighbouring trusts (2)	1.Review of clinical services by clinical senates and Strategic Clinical Networks (1)	None	2X4=8
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			1.Links with neighbouring STPs	None	↔
Principal Risk to the plan	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Risk Rating** (Likelihood x Impact)
Risk of key stakeholders not supporting any significant service changes required	**Director of Clinical Strategy** **Trust Management Team**	1. Participation in system wide engagement activities (1) 2. Stakeholder engagement plan (2)	1. Board report on progress of changes.(2) 2. Transformation programme reports (2)	None	2X4=8
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			None	None	↔
Actions Agreed for any gaps			**By Whom**	**By When**	**Update**
Maintain “no surprises” commitment to key stakeholders, through regular engagement			Director of Clinical Strategy	On going	None

Strategic Objective To improve the health and wellbeing of our staff, patients and the wider community

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of inability to demonstrate the impact of health & wellbeing initiatives to support continued allocation of resources.	**Director of Clinical Strategy** **Health & Wellbeing Committee**	1. Staff survey (3) 2. Monitoring of impact of healthy living services (1) 3. Participation in Healthiest Workplace Initiative (2) 4. Representation on Gloucestershire Health and Wellbeing Board (2)	1. Staff survey results (3) 2. Health & Well Being Committee (2)	None	2X3=6
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			1. Baseline information on Health and lifestyle status of staff	None	None

	Actions Agreed for any gaps	By Whom	By When	Update
1	To review specification and outcome of tender for healthy living services	Director of Clinical Strategy	February 2017	None

Strategic Objective To continue to treat our patients with care and compassion

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of providing a poor patient experience as a consequence of pressures on the emergency pathway creating temporary bed and staffing solutions	**Director of Nursing** **Quality Committee**	1. Recruitment Standards(1) 2. Trust Education programmes (1) 3. Nursing & Midwifery Strategy (2) 4. Patient Experience Strategy (2) 5. Management of the 4Cs (1) 6. Senior Nurse and Midwifery Committee (1) 7. Safer Staffing Report including recruitment & Retention(2) 8. ECB workstream action plans particularly 3&6 (2)	1. Directors statement (2) 2. Divisional Quality Report (1) 3. Family & Friends Test (3) 4. Patient Surveys (3) 5. Formal comments – Health watch, Governors (3) 6. Local Supervisors of Practice Annual report(3) 7. ECB report (2)	None	4x4=16
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			None	None	↑
Principal Risk to the plan	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Risk Rating** (Likelihood x Impact)
Risk of a poor patient experience as a consequence of patients being placed in outlying beds different to their required specialty to manage flow and bed	**Director of Nursing** **Quality Committee**	1. Recruitment Standards(1) 2. Trust Education programmes (1) 3. Nursing & Midwifery Strategy (2) 4. Patient Experience	1. Directors statement (2) 2. Divisional Quality Report (1) 3. Family & Friends Test (3) 4. Patient Surveys (3) 5. Formal comments –	None	4x4=16

pressures		Strategy (2) 5. Management of the 4Cs (1) 6. Senior Nurse and Midwifery Committee 7. Safer Staffing Report including recruitment & Retention(2) 8. ECB workstream action plans particularly 3&6 (2)	Health watch, Governors (3) 6. Local Supervisors of Practice Annual report(3) 7. ECB report (2)		
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			None	None	↑
Actions Agreed for any gaps			**By Whom**	**By When**	**Update**
1 None					

Strategic Objective To provide care closer to home where safe and appropriate

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of delays to discharging patients in a timely manner causing an increase above agreed system wide targets for medically fit patients, high occupancy, delays in patient flow and poor patient experience.	**Director of Service Delivery** **Financial & Performance Committee** **Emergency Care Board**	1. System Resilience Group (3) 2. Emergency Care Board (1) 3. Emergency Care plan(2) 4. Integrated Discharge Team Implementation Plan & Steering Board(1)	1. PMF (2) 2. Emergency Care Report (2) 3. Weekly system wide call of all Nursing Directors to review medically fit list	Blank	3x4=12
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			None	Blank	↔
Principal Risk to the plan	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Risk Rating** (Likelihood x Impact)
Risk of the failure of local health & social care system to manage demand within the current agreed contracted capacity leading to insufficient internal capacity, displacement of elective activity, loss of income and potential compromised care.	**Director of Service Delivery** **Financial & Performance Committee**	1. Emergency Care Plan(2) 2. Planned Care Plan(2) 3. Winter plan (2) 4. Improvement Director post.(1) 5. CCG Contract(3) 6. CCG Contract Review Board(3) 7. Financial & Performance Committee(2) 8. System Resilience Group Gloucester (3) 9. Sustainability & Transformation Plan	1. Emergency care Board & Report (2) 2. Planned Care Board (1) 3. Finance & Performance Committee 4. Quality Committee	Blank	5x4=20
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			1. Insufficient plan to manage the difference between contracted post QIPP activity	None	↔

		10. 2016-17 QIPP plans	and actual activity.		
Principal Risk to the plan	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurance**	**Risk Rating** (Likelihood x Impact)
Risk of inability to reduce demand for outpatients follow up activity in line with commission plan	**Director of Service Delivery** **Finance & Performance**	1. Planned Care Plan(2) 2. Individual specialty recovery plans (1) 3. CCG contract (3) 4. CCG performance review (3)	1. Performance Management Report (2)	None	**4x3=12**
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			1. Reporting line to F&P	None	↔

Actions Agreed for any gaps		**By Whom**	**By When**	**Update**
1	Revised Emergency Pathway Report	Director of Service Delivery	June 2016	Completed
2	Plan to address difference between contracted gap and actual expected activity	Director of Service Delivery	August 2016	Blank
3	Response to NHSI investigation	Director of Service Delivery	End of July 2016	Blank
4	Revise reporting arrangements to F&P	Director of Service Delivery	August 2016	Blank

Strategic Objective - To improve our internal efficiency

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of Inability to deliver financial targets caused by a failure to reduce expenditure as per plan particular agency costs, reducing the ability to invest in our estate, affecting our Monitor Risk Rating and STP.	**Director of Finance** **Finance & Performance Committee**	1. Operational Plan (3) 2. Divisional & Corporate Budgets (1) 3. Cost Improvement Plans (1) 4. Quarterly Review by Monitor (3) 5. Executive Divisional Reviews (1) 6. CIP Delivery Board (1) Efficiency & Service Improvement Board	1. Board F&P (2) 2. Finance Report(2) 3. E& SI Board (1) 4. Audit Committee (2) 5. Audit reports (3) 6. Carter Review outputs (1)	Last year – Unqualified opinion on the accounts	**5x4=20**
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			1. Workforce recruitment & Agency spend	Blank	↑

	Actions Agreed for any gaps	By Whom	By When	Update
1	Appoint Lead Director to revise and monitor CIP plans & Agency costs	DoF	April 2016	Completed
2	Appoint Operation Finance Director to provide operations oversite	DoF team	May 2016	Completed

Strategic Objective - Exploiting the opportunities for new markets

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of competition in the private patient marketplace slowing development – Other than for paediatrics all private services the Trust is delivering or expanding are already delivered by other providers locally	**Director of Finance** **Private Patient Committee**	1. Short-term: Differentiation of GH NHS FT private patient offer on price point (1) 2. Medium term: Differentiation of GH NHS FT on environment and service provision (1)	1. Regulator Reports from PP (1) 2. Periodic reports to Board (2)	None	3x3=9
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			1. None	1. No regular formal reporting to a Board level	

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of delivery of an expanded private patient unit – The management and commercial infrastructure is currently under-developed	**Director of Finance** **Private Patient Committee**	1. Recruitment to key posts as expansion progresses (1)	1. Regulator Reports from PP (1) 2. Periodic reports to Board (2)	None	2x3=6
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
				1. No regular formal reporting to a Board level	

Actions Agreed for any gaps	By Whom	By When	Update
1 Review the reporting arrangements to ensure sub Board \Board level monitoring	Director of Finance	August 2014	None

Strategic Objective To improve our clinical estate

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of the condition and responsiveness of the estate affecting and limiting the planning and development of the site and the ability to improve overall patient experience.	**Director of Finance** **Capital Control Group**	1. Backlog maintenance programme (1) 2. Estates strategy (2) 3. Management of Space process (1) 4. Oversite of the service reconfiguration programme (Infrastructure workstream) (2)	1.Risk identification from programmes. (1) 2. Annual update on estates strategy (2) 3, E&F Risk Register (1)	1.Quality of space management information 2.Back log maintenance programme	**2x4=8**
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			Blank	Blank	Blank

	Actions Agreed for any gaps	By Whom	By When	Update
1	Commission further six facet survey of site	Director of E&F	March 2017	Blank
2	Prioritise key back log maintenance and address in capital programme	Director of E&F	April 2016	Completed

Strategic Objective - Harnessing the benefits of information technology

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of unsuccessful implementation of Trakcare	**Director Of Clinical Strategy** **Smartcare Programme Board**	1. Implementation Plan reviewed by HSCIC and Internal Audit (3) 2. Authority to Proceed processes reviewed by Internal Audit (3) 3. Learning from successful implementations in other Trusts (1)	1. HSCIC/DH Gateway Review (3) 2. Internal Audit (3) 3. Programme report to Board (2) 4. Non executive lead	Monthly Programme Board Reports to Board	2x5=10
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			None	None	↔
Principal Risk to the plan	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Risk Rating** (Likelihood x Impact)
Risk of technical infrastructure not being able to support developing technology	**Director of Clinical Strategy** **Trust IM&T Board**	1. IT Blueprint strategy (1) 2. Network Business Case (1) 3. Local Digital Roadmap submission to NHSE (3)	1. NHSE assessment of LDR	None	2x5=10
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			None	None	↔

Actions Agreed for any gaps	By Whom	By When	Update
None			

Strategic Objective - To develop leadership both within our organisation and across the health and social care system

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of that current Leadership Development Programme does not deliver the internal leadership capability required.	**Director of HR and OD** **Workforce Committee** **Education, Learning and Development Committee**	1. Objectives and workplan for Leadership reviewed by Workforce Committee (1) 2. Coaching Faculty established internally (1) 3. Access to national programmes via Leadership Academy(2) 4. Periodic reviews of talent/succession by senior team (1) 5. Leadership capabilities scored on annual appraisals (1)	Programmes (accredited and non-accredited) established for entry level managers upwards and including clinical staff (3)	Workplan established and coaching faculty fully operational.	2x4 = 8
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			Succession planning and talent management insufficiently linked to access to national courses and/or allocation of investment	Partial compliance with leadership behaviour scores on appraisal. No real assessment of health of current trust leadership.	↓
Principal Risk to the plan	**Risk Owner (Executive Director & Committee)**	**Key Controls**	**Assurance on Controls**	**Current Assurances**	**Risk Rating** (Likelihood x Impact)
Risk that partners do not engage with senior leadership of the Trust, for the benefit of the system	**Chief Executive** **Trust Board**	1. CEO and leadership team actively engage in partnership working and notably STP work programme (1)	1.External assurance on progress of STP (3) 2. Internal Audit review(s) of partnership working and other third party feedback (3)	NHS E and NHS I review of STP plan and progress. (3)	2 x 4 = 8
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**

			None	None	↔

	Actions Agreed for any gaps	By Whom	By When	Update
1	Complete succession planning exercise for all key posts and assess gaps/actions to follow	DS	Sept 16	Divisions asked to submit plans by end July.
2	Triangulate appraisal scores with Talent pool nominations	DS	Sept 16	Scores currently being analysed

Strategic Objective - To redesign our workforce

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of not being able to recruit and retain a workforce with the right profile to deliver the changing clinical/service needs of the organisation, resulting in shortages in specific occupations.	**Director of HR & OD** **Workforce Committee Fed by;** **Sustainable Clinical Services Group** **Education, Learning and Development Committee** **Seven day services Project Board** **Recruitment Strategy Group**	1. Workforce plans produced by each division/specialty in alignment with operational plans. (1) 2. Individuals (and HRBP's) trained within divisions on workforce planning(1) 3. 6 monthly review of safer staffing metrics (2) 4. Annual job planning process in place (1) 5. Workforce Strategy (2) 6. Annual programme of work for sub-groups of Workforce Committee (1) 7. Countywide workforce planning group and development of consistent workforce planning tools (3)	1. Workforce Committee establishing and reviewing programme of work for each sub-group (1)	1. Nurse Recruitment strategy in place and active local, national and international recruitment (2)	4x5=20
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			1. Workforce Committee has not developed traction and has not set/agreed programmes of work for sub-groups.	1. Limited plans beyond Nursing (specifically for Junior Doctors/Middle Grades) 2. Impact of removal of Nursing Bursaries not clear.	. ↑

Principal Risk to the plan	Risk Owner (Executive Director & Committee)	Key Controls	Assurance on Controls	Current Assurances	Risk Rating (Likelihood x Impact)
Risk of poor engagement with staff which negatively impacts on our vision and movement towards Best Care for Everyone	**Director of HR & OD** **Workforce Committee** **Divisional Engagement Group**	1. Staff Survey Action Plan (2) 2. Divisional/Department Action Plans (1) 3. Joint working programme with Staff Side/LNC (1) 4. Executive Walkabouts (1) 5. Involve (1)	1. Staff Survey results (3) 2. Divisional Engagement Group feedback (2)	1. Current Staff survey results showing moderate improvement	2x4=8
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			1. Survey does not capture sufficient 'real time' feedback 2. Plans too 'corporate' in nature.	1. Further work required with specific staff groups (eg Medics and EFD)	↔

	Actions Agreed for any gaps	By Whom	By When	Update
1	Establish Workforce Committee with clear programme of work for sub-groups below.	Dir HR&OD	September 16	None
2	Establish focused strategy for reduction of agency costs focusing on Controls, Alternative Roles and Plan to close Escalation Areas	Dir HR&OD	August 16	
3	Share plans with NHSI for assessment/additions	Dir HR&OD	August 16	
4	Establish campaign headed up by CEO to resolve 'top 3' issues relating to staff engagement (Parking/Repairs/Bureaucracy)	Dir HR&OD	August 16	

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MAIN BOARD – JULY 2016

STAFF SURVEY ACTION PLANS

1. Aim

1.1 To update the Trust Board on the key action plans at Trust and Divisional level arising from the 2015 staff survey findings.

2. Background

2.1 The national staff survey results from 2015 strongly reflected the progressive trend in results which had begun in 2012. Whilst it was clear that steady progress had been made, particularly in terms of engagement levels and improvements in critical areas (such as how staff perceive our trust as both a place to work and receive treatment), it was disappointing that there had not been a step change in engagement, particularly in a year when there had been considerable consultation and engagement on a new trust vision. This in itself had resulted in a tangible change to the wording and subsequent feedback suggested that the simplicity and directness of 'Best Care for Everyone' strongly resonated with staff at all levels. Notwithstanding this, it has been recognised that our trust 'transformation programme' has not captured the imagination of staff and in particular, the link between the new vision and how that will be translated into the day to day experience of both patients and members of staff.

2.2 Our approach to building traction up to this point has been akin to a flywheel. It had been recognised that making significant changes depended upon consistency of approach and in particular, a recognition that some issues could not be 'fixed' in a single year. The concept of rolling action plans was therefore developed which would enable new corporate work streams to be added and old ones to be discarded, as appropriate. A further recognition that issues of engagement were as much influenced by local actions has resulted in the creation of Divisional Action plans which complement the broader trust-wide plans and seek to give greater control to managers and staff locally. The third element of our approach has been the development of Divisional Engagement Groups which require sponsorship by local senior managers and these groups are now in their 4th year of existence. Their role is to act as a conduit for staff at all levels not only to their divisional senior managers but also to the trust Board.

2.3 Whilst all of this reflects good practice in engagement terms, the reality is that whilst vital to maintain, it doesn't capture the imagination of many staff as it doesn't speak sufficiently to their day to day experience. Neither in the busy world of many of our staff can they be expected to carry knowledge about the multitude of different plans. It is important that staff can see and feel a difference and like the Board, they want to see and hear about progress on real issues that matter to them. As a result of this a different approach has been selected for this year and that is to define the 'top 3' issues that matter to staff, whilst allowing other work to continue as before. Recognising the top 3 issues and making a Board commitment to tackling them and communicating progress is a vital step in moving from 'steady' to 'step change' and has informed the development of action plans below.

3. 2015 Staff Survey Action Plans

3.1 Upon receipt of the results, these were cascaded to the following stakeholders with a view to obtaining feedback to inform both the corporate and divisional plans;

- Divisional Boards
- Divisional Engagement Groups
- Trust Board

- 100 Leaders
- Employee Representatives
- Senior Staff Groups (e.g. Senior Nurse Committee)
- Council of Governors
- Health and Safety Committee and Health and Wellbeing Committee.
- Executive Safety Walkabouts

In addition to a template presentation providing an overview of results, divisions, departments and major staff groups were encouraged to access a suite of reports containing more localised data, to help inform their actions.

3.2 The process adopted was to mix a presentation of the results with facilitated discussions with the brief of identifying three priority issues. What became clear was that each group was likely to see the issues through the lens of that particular group. As an example, the '100 Leaders' would see the importance of maximising on the potential issued by Smartcare and were quizzical on the 'real' progress made with Service Line Management. Whilst these may appear to have a significant senior management focus, for other groups similar issues would be expressed in a different way and in particular there were a number of comments about not having the freedom to act or not receiving explanations about changes that impacted. The feedback was crystallised in a Board seminar in June of this year which also afforded the opportunity to hear from Divisional Engagement representatives in a more informal fashion. This allowed for greater dialogue with the group, unlike previous years when they seemed to feel under pressure to deliver a presentation with a perceived emphasis on 'performance' as opposed to 'content'. Both the feedback from the wider groups and the feedback from the Divisional Engagement Representatives provided rich feedback on what really matters to staff and the Director of Human Resources and Organisational Development and the Head of Leadership and Organisational Development agreed to draw up a plan designed to recognise and address the key issues.

4. Top 3 Priorities

4.1 Parking – There is absolutely no doubt that parking for our staff remains hugely challenging. There are a number of staff, particularly afternoon shift workers who arrive on site up to an hour before their shift begins with a view to securing a space. This not only interferes with their off-duty time but can impact ward/department arrivals. Each Winter, space reduces as more and more staff use their cars and this is compounded by a significant increase in the number of permits authorised over the last few years, far in excess of the additional staff employed. The solutions however are not purely parking related and need to be considered as a 'safe transport' issue with consideration given to additional options such as additional cross site buses, more 'park and ride' options and the ability during the peak of winter to flex parking capacity with access to additional space. In the absence (specifically in Cheltenham) of planning permission to build an additional car park it would not be correct to set the expectation that the experience of staff in this regard will be immeasurably improved in the short term, however recognising the issue and setting out a series of key actions and a trajectory for improvement is feasible. Executive ownership for this should rest with the Directors of HR & OD and the Director of Finance.

4.2 Maintenance – A common refrain from staff has been around the inability to get things fixed, including very simple issues such as handles and shelves to the point where many no longer place requests. This is an important issue as demonstrating to staff that we care about their environment should not be underestimated in terms of developing engagement and sits at the heart of 'Best Care for Everyone'. The employment of a couple of 'handymen', as suggested by the Chief Executive, who are specifically allocated to wards and departments each week to take care of the 'niggles' demonstrates that we have listened. This is in hand and is being led at Executive level by Nursing Director Maggie Arnold.

4.3 **Bureaucracy –** During her engagement visit to many staff groups our new Chief Executive has picked up a sense that we make things too difficult to just get on and implement, or fail to explain why processes that are in place are necessary for good governance. There is a disconnect between our oft-stated stance of 'ask for forgiveness and not permission' and the experience, perceived or real, of staff on the ground. This is not a suggestion that all rules can be discarded but that we start a campaign of simplification, where corporately and individually we see where we can reduce complexity and permission seeking and encourage initiative taking. This should be led by the Chief Executive who can set the tone (and balance) and publicise those examples of where it is working successfully.

5. Trustwide 'Rolling' Plans

5.1 Included within the rolling plans were the following key issues;

- *To improve the perception of staff in terms of learning and development opportunities beyond mandatory training.*
- *To understand the reason behind the high numbers of staff reporting violent incidents from patients/members of the public, as well as staff.*
- *To understand the reasons why disabled staff report a worse employment experience*
- *To continue to reduce incidence of stress felt by staff*
- *To improve the focus on staff health and well being*
- *To increase the confidence of staff in Raising Concerns*

5.2 Whilst progress has been made in a number of key areas it is important that these established work streams continue. Progress against each of these was described in the Board paper in February 2016 and need not be repeated here although a proposal will come to the Trust Board regarding the appointment of a 'Freedom to Speak Up Guardian', revisions to the 'Raising Concerns' policy and a re-tendering exercise for our anonymised e-mail raising concerns system.

6. Divisional Action Plans

6.1 Divisional action plans are locally refreshed each year on the basis that for many staff, their engagement is very locally driven. These plans are reviewed at the monthly Divisional Executive Review meetings. As with engagement generally, this is an idea that has taken time to develop traction, however it is clear that all divisions have now recognised the importance of engagement and crucially, their role in developing it. The detailed plans are listed in Appendix 1, however the main highlight from each division is summarised below;

6.2 Medicine.
Bi-monthly rebranded '*staff involvement forum'* with a 'bottom up approach' focusing on actions/solutions and staff involvement in problem solving and decision making.

6.3 Surgery
Increase the frequency of Divisional tri Walkabouts, and have an improved follow up of issues process. Speciality Triumvirates to develop local engagement plans, based on the breakdown of the 2015 Surgery results applicable to their areas.

6.4 Women and Children
The division are focusing primarily on those actions that make engagement part of the 'core business' and are using an engagement approach to develop and address local issues raised in the staff survey. This includes clinical visits to listen to staff and understand concerns by providing a vehicle for two way communication.

6.5 Diagnostics and Specialties

The division are putting strong emphasis on team meetings and have identified that these are not simply an opportunity to disseminate information (which has hitherto been their primary function), but to use them as a forum for genuine staff engagement. They are also increasing the value of meetings and how they are perceived by ensuring actions are acted upon (and not carried over) and are only cancelled as a last resort.

6.6 Estates and Facilities

The team are focusing very heavily on engagement activities with specific emphasis on communicating with divisional staff the importance of the work that they do and their contribution to the trust. In addition they are focusing very heavily on generating a customer service culture amongst team members.

6.7 Corporate

Corporate Division comprises a mix of different directorates without a unifying Board structure and so the highlights below from Clinical Strategy and HR represent a sample of activity within the division;

6.7.1 Clinical Strategy

The Clinical Strategy team are looking to develop a service user feedback tool to facilitate feedback from outside of the team. They are also looking to hold a team event every 6 months as well as creating a 'LinkedIn' team page, where team discussions can take place and good ideas presented and reviewed.

6.7.2 HR

A whole department meeting to be held every 6 months where team members will 'creatively' showcase their work to each other to promote greater understanding. In addition, senior team meetings to be extended to receive feedback from departmental representatives and an internal awards scheme to be set up.

7. Conclusions

7.1 With the appointment of a new Chief Executive Officer who has stated very clearly the importance she places on engagement and her clear expectation that traction on this will gather pace, there is a significant window of opportunity which needs to be taken. As a currency for engagement, the staff survey has had a chequered history, however remains the most obvious and accurate barometer of how people are feeling about our Trust. Whilst the proximity of the next survey mitigates against an immediate significant uplift in scores, the positioning of the Chief Executive as both recognising the 'top 3' and committing to resolving the issues raised, is also designed to move staff away from the previous default thought that 'nothing ever happens' as a result of surveys. A number of years ago our Trust adopted the approach of 'You Said……..We Did', finding and publicising sporadic examples of this happening. This year we need to move from sporadic to consistent and this approach is likely to be the issue that moves improving engagement from 'management speak' to something genuinely experienced and this opportunity must be captured.

8. Recommendations

- The Board is asked to **note** the Trust-wide rolling action plans arising from the 2015 (and previous) staff survey(s).
- The Board is asked to **note** the individual divisional engagement plans.
- The Board is asked to **agree** the 'top 3' issues raised by staff and to commit to resolving them and publicising progress.

Author: David Smith
Presenting Director; David Smith, HR and OD Director,
July 2016

MEDICINE DIVISION 2015 STAFF SURVEY ACTION PLAN LINKED WITH DIVISIONAL STAFF ENGAGEMENT AGENDA

July 2016

Priority Area	Actions Identified	Owners	Timescales
Re-branding and re-launch of the staff engagement Strategy within medicine. Actions to address Key Findings: KF7: Staff contribution at work. KF8: Satisfaction with responsibility and involvement. KF9: Effective team working. KF14: Satisfaction with resourcing and support. KF17: Stress in the workplace. KF19: Organisation interest in health and wellbeing.	• Bi-monthly rebranded '*staff involvement forum'* with a 'bottom up approach' focusing on actions/solutions and staff involvement in problem solving and decision making. • Immediate 'Quick Wins' for the division to be identified to improve staff and patient experience and optimise best use of resources. • Opportunity to debrief and share confidentially at the close of Staff Involvement Forum gaining advice and support from a multi-professional perspective.	Eve Olivant (EO)/Sara Lees (SL). Div Tri/ Speciality Tri's/ Matrons/Dept leads EO/SL, Matrons/dept leads	Dates to be arranged from Sept 2016 End of August 2016 Dates to be arranged from Sept 2016
Communication Strategy Actions to address Key findings: KF5: Recognition and value of staff by managers and organisation. KF6: Reporting good communication between senior management and staff. KF10: Support from immediate mangers.	• Feedback from Speciality Tri at 'Staff Involvement Forums' incorporating dissemination of key information and priorities from Trust/divisional meetings. • Re-Launch of 'Walkabouts' at speciality and divisional Tri level-feedback and monitoring through Divisional Board H&S etc. • Increased networking; exploring uses of blogs apps/social media to gain feedback from staff and extend the 'reach' from bottom up to top down. • Dynamic multi- faceted approach to comms throughout the division to ensure all staff groups are	Div Tri Div Tri's/Speciality Tri's EO/SL/Communications Team, All staff Division, Matrons Ward/Dept managers	Dates to be arranged from Sept 2016 Dates to be arranged from Sept 2016 Ongoing Ongoing.

	captured. ➢ Face to Face. ➢ Multi-media ➢ 'Quick Wins Posters-'*You said We did'* ➢ Forums ➢ Social engagements	all staff.	
Quality of Staff Recognition and Feedback. Actions to address Key Findings: KF2: Staff satisfaction with the quality of work and patient care they are able to deliver. KF3 Agreeing role makes a difference to service users. KF4: Staff motivation at work. KF5: Recognition and Value of staff by managers and the organisation.	• Medical Division Strategy Day to be held yearly to include a range of speakers/activities and sharing of success and best practice. • Medical Division Awards ceremony to recognise outstanding staff contribution in all staff groups. • Proud to care awards for nomination of staff by patients for excellence in care delivery.	Div Tri, Matrons/Dept leads. EO/SL to lead Div Tri, Matrons/Dept Leads. EO/SL to lead. Div Tri, Matrons, Dept Leads	March 2017 April 2017. Monthly from Sept 2017.

Surgery Division 2016 - 17

Priority Area	Actions Identified	Owners	Timescales
Staff Engagement/Communication	• Increase the frequency of Divisional tri Walkabouts, and have an improved follow up of issues process • Ensure 'Cutting Edge' Surgical Divisional newsletter is issued quarterly, and to include a rolling section from all Service Lines • To encourage a similar walkabout by Speciality Tri's • Speciality Tri's to develop local engagement plans, based on the breakdown of the 2015 Surgery results applicable to their areas.	Surgical Tri Surgical Tri SD's/GM's/Modern Matrons " "	Ongoing Ongoing Ongoing By end July 2016
Projects	• Implement a Divisional "Ask Anything" email address to allow open and honest question asking by any Divisional Staff • Ensure wide notification of the new email address through divisional emailing, and use within the Divisional News letter	Surgical Tri	In place by July 2016
Divisional focus areas from Staff Satisfaction Survey 2015	• Staff satisfaction with the quality of work and patient care they are able to deliver (3.96 - 2) • % feeling pressure in the last 3 months to attend work when feeling unwell (4.01 – 1) • Quality of non-mandatory training, learning or development (4.01 – 1) • Effective use of patient/service user feedback (3.56 – 3)	Surgical Tri/Speciality Tri " " " "	Ongoing work to define actions around these components.

Division of Diagnostics and Specialties 2016 Staff Survey Action Plan

Priority Area	Actions Identified	Owners	Timescales
Staff Engagement Key Findings: Engagement Score 3.66 KF6: Reporting good communication between senior management and staff. KF7: Staff contribution towards improvement at work. KF8: Satisfaction with levels of responsibility and involvement. KF9: Effective team working.	• Relaunch a quarterly Divisional Staff Engagement Forum with involvement from all departments in the Division • Divisional Quartet to attend Department meetings for an open Q&A forum – ensuring there is a process put in place to feedback on any actions that are taken from the meeting. • Ensure key messages are cascaded top-down, i.e. from 100 leaders, via Divisional Newsletter and management meetings in the Division • Managers to create opportunities for staff to be more involved in decision making at local level • Implement a 'spotlight on' interview with a staff member for the staff magazine.	AW/JB Quartet Quartet/Senior Department Leads Department Leads Quartet	Dates to be arranged from August 2016 Dates already in Department up until December 2016 Ongoing Ongoing Ongoing
Staff Motivation (reward and recognition) Key findings: KF4 – Staff Motivation at Work KF5: Recognition and value of staff by managers and organisation. KF10: Support from immediate managers.	• Division to set up mechanism for recognising good work within the Division on a monthly basis (possibly some sort of 'Employee/Team of the month), which could then feed into nominations for the annual staff survey. • Division to develop a reward strategy to look at non financial ways of incentivising staff, i.e. different job titles within bands, recognising experience and capability • Develop a programme of 'shadow buddy 'visits where staff can get to understand other departments job roles.	Quartet Quartets/HR Quartet	To be up and running by October 2016 September 2016 Ongoing
Staff Health and Well-Being Key Findings: KF14: Staff satisfaction with resourcing and support. KF18 Feeling pressure in the last 3 months to attend work when feeling unwell KF19: Organisation & Management interest in action on health and wellbeing	• Departments to undertake the stress risk assessment, and develop a local action plan, and feedback to the quartet. • Ensure effective management of absence is maintained, and that staff are supported and have access to staff support services	Department leads. Department Leads/HR	All assessments to be completed by Nov 2016. Ongoing

DIRECTORATE OF CLINICAL STRATEGY STAFF ENGAGMENT ACTION PLAN 2016

This action plan was developed during a Clinical Strategy Team session at the end of May, attended by a cross section of 40 staff from across the varied teams within the directorate. People worked in their "home" teams to review the findings of the 2015 staff survey and identify for them the things they wanted to Stop, Start or Keep and the support they required from their managers

	STOP	**START**	**KEEP**	**NEED MANAGER SUPPORT**
Clinical Strategy	- Apportioning blame - "Half empty, half full!" - Coming in with a horrible bud - home working - Go more paperless	- Capturing of processes – service offer - "Enjoying ourselves" - Lunch club - CC to meet with others - Sort coffee - Conference phone for meeting room	- Being helpful – outside brief - Saying hello etc - Hearing hello - Meeting times – buses	- Permission to/ valuing team building
Research & Development	- Moaning	- Thinking positively - Working more closely with clinical teams - Be brave – make decisions to improve performance. Don't wait to be asked. - Solution focused - Improving visibility of research - More staff engagement	- Putting trial patients first - Talking/ listening - Being supportive	- Doing things we don't need to do – "stick to your knitting" - Resolve/ facilitate issues with other departments that take up so much time - Explore responses around decision making questions
Communications	- Saying yes to every meeting and task (where appropriate)	- Assign higher priority to efficient team meetings with assigned actions - Take time to review and evaluate team projects – to	- Idea sharing - Effective team working - Promoting our service offer - High quality outputs/	- More briefings re high-level priorities - Clear shared goals and targets (appraisals) - Promoting the team and

		effect change – evidence and analytics - More quality/ focus on appraisals	creativity - Looking at ways to improve	trust in our work at high level - Support in managing high level requests
Contracts	- Lunch at 11am! - Non-productive meetings	- More out and about contract road shows (clarified offer, improves communication, increases awareness, more ownership, better understanding, in touch with services)	- Prioritising 'us' - Chasing others - Choir - Arts	- Chasing others – more escalation
PM&SI	- Working through lunch - Printing so much - Moaning	- S Manager briefing - Personal well-being around returning to work - Asking for help - Induction – structured, softer	- Retaining strong relationships - Team meetings - Nominations/ celebrate success - Socials - Safe and supportive environment - Continual alignment to trust objectives - Cascade information from Execs - Coaching/ mentoring - It's ok to make mistakes – lessons learnt	- Supporting absent individuals off sick - Critical feedback to/ from manager - Availability/ accessibility of manager - Championing the funding for CPD

Patient Experience
Percentage of staff agreeing that feedback from patients/service users is used to make informed decisions in their directorate/department (KF 29).
Actions undertaken: • Involvement of patient feedback techniques within Quality Improvement Academy – established • Participation on training days for varying staff groups – a number attended varying from ward clerks to Medical Physics - ongoing throughout year • Revision of way that patient feedback information is captured on trust website – due completion September 2016 • Increased visibility of feedback and actions within trust communications such as Involve and Outline - initial actions completed • Participation of different staff groups within discrete patient experience feedback projects for example National Age UK project with GOAM wards (completed June 16) , Oxford University Usefulness of Patient Experience data project with the GRH Gastroenterology ward (commenced June 16), paediatric patient experience capture and actions (commenced March 2016) • Refresh of Friends and Family Test methodology and staff awareness – commenced June 16. Due for completion September 16 • Clearer requirement within Divisional reporting quality framework

Human Resources

Create greater connection with our colleagues and patients by testing views on our services	Set up a user survey for each area which asks our customers to list; • The top 3 things they value about our service • The top 3 things they would like us to improve	DS and Senior Team	September
Senior Manager Accessibility and general communications	Continue with 'Ask Dave' sessions, supported by other senior team members as appropriate. Senior managers to 'drop in' to meetings on regular basis to take questions and share updates GC and AC to attend HR Senior Leads to ensure Service Centre and Professional Education fully included in comms loop. Key messages from HR Leads to be centrally cascaded with 'quote of the month' and any high level messages for sharing with all	DS and senior team DS and senior team MP DS and MP	Already in motion Ongoing Immediately Immediately
Freedom to Act	Most improvements to ways of working are put in place by teams 'on the ground', not by senior managers. If you've got one thing to shout about, one thing to make better, what would it be? If you have something in mind, don't seek permission, 'just do it'. The best ideas will be recognised through an 'Improving Processes' award (see Celebrating Success below) and these ideas do not have to be 'grand schemes' as long as they make some sort of difference	All	With immediate effect
Make work more fun	More social events such as breakfasts, picnics, sporting events, quizzes etc Rather than prescribe the same thing for everyone, again use your 'freedom to act' to recognise what you could/could not do as not every work environment is the same, with some areas being more public than others.	All	With immediate effect

Women & Children's Division				
Priority Area	**Actions identified**	**Owners**	**Timescales**	**Need Managers Support**
Improving communication with staff	Incentivised quiz to improve communication from managers and encourage staff to access this.	• Jo Harvey	Completed	
	Team Talk	• Michelle Poole	In Place	
Improving engagement with staff	Local survey & focus groups	• Eirwen Rees (Maternity) • Yonne Laishley (2a)	September 2016	Kate Harrison to review outcome of survey with Ward Manager Eirwen Rees
	Patient & Staff Engagement project NICU • Feeding • Parental engagement • Visiting	• Mel Randles • Karen Thomas • Jennifer Holman	December 2016	
Reducing Abuse, harassment & bullying from staff.	Obstetrics are offering all staff one day's human factors training. Plans for the future will integrate this within obstetrics skills based mandatory training which emphasises effective team work.	• Vivien Mortimore • Mark James	In progress Completion by December 2017 January 2017	

Women & Children's Division				
Priority Area	**Actions identified**	**Owners**	**Timescales**	**Need Managers Support**
	Staff survey within Maternity to better understand culture and specifically the issues around bullying and harassment.	• Dawn Morrall	September 2016	
	Stress Audit NICU Initial findings revealed the needs to improve communication and information giving. Further work being done to understand and address issues.	• Karen Tomasino	December 2016	
Reducing Abuse, harassment & bullying from patients friends or relatives.	Consider a contract of behavioural standards for those patients/relatives who consistently abuse staff.	• Vivien Mortimore	December 2016	Need support from Dave Smith

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JULY 2016

PROPOSED REVISIONS TO THE CONSTITUTION

1 Introduction

1.1 The purpose of this report is to invite the Board to consider the recommendation from the Governance and Nominations Committee that the following proposed revisions to the Trust's Constitution be approved.

2 Background

2.1 The Council of Governors in May 2016 approved a programme of development following consideration by the task group of the Governor Effectiveness Sections of the RSM Board Governance Review. One element of the programme is to undertake a review of the Trust's Constitution and in furtherance of this an initial review of the constitution has been undertaken by the Lead Governor, the Trust Secretary and the Vice Chair of the Board. The Council of Governors agreed that the constitution be updated in 2 phases as follows:-

1. An initial set of amendments, which relate to updating terminology and clarification, can be considered by the Governance and Nominations Committee with a view to seeking agreement of both the Board of Directors and the Council of Governors. This would be a refresh on the documentation put in place in anticipation of the Trust achieving foundation status in 2004.
2. A second set of issues require wider discussion and may reflect the outcome of other aspects of this workplan, eg, relating to governor constituencies, number, etc. it is anticipated this could be brought forward later in the year.
3. Consideration of further development of the code of conduct to include disciplinary processes for governors (as recommended by RSM) should be considered in phase 2.

2.2 Apart from updating terminology and clarification the main changes relate to the appointment of Stakeholder Governors. Currently, the Constitution provides for four Appointed Governors; two from Gloucestershire Clinical Commissioning Group, one from Healthwatch Gloucestershire and one from Gloucestershire County Council. The Governance and Nominations Committee recommend that there should be up to four stakeholder appointed Governors. One of these should come from the Gloucestershire Clinical Commissioning Group, one from Gloucestershire County Council and one from Healthwatch Gloucestershire (or their successor organisations). The fourth position could be an appointment from any other stakeholder or partnership organisation, as agreed at the time by the Board and the Council of Governors. In the light of this, all references to Partnership Governors in the Constitution to be amended accordingly. The appointment of a Lead Governor has also been recognised in the Constitution.

2.3 The proposed changes to the Constitution are shown by track changes in the attached document.

2.4 The Council of Governors in July 2016 approved the Board's recommendation of the appointment of an Additional Non-Executive Director and consequent changes to the Constitution. These relate to increasing the number of Non-Executive Directors to seven (from six) and increasing the quorum for meetings of the Board of Directors. These changes have been incorporated into the Constitution in paragraphs 12.1.1.2 and 12.18 respectively together with the new Trust Headquarters in Alexandra House, Cheltenham General Hospital (Paragraph 25).

3 Changes to the Constitution

3.1 Revisions to the Constitution require the approval of both the Board of Directors and the Council of Governors when more than half of the members of the Board and half the members of the Council of Governors voting approve the amendments. Changes take effect from the date of final approval. The proposed revisions are being presented to the Council of Governors on 3 August 2016.

4 Recommendation

4.1 The Governance and Nominations Committee recommend that the proposed revisions to the Trust's Constitution as set out in the attached document be approved.

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Author and Presenter: Martin Wood, Trust Secretary

Date: July 2016

CONSTITUTION OF

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

May 2013

(August 2016)

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GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST CONSTITUTION

1. Definitions

1.1 Unless the contrary intention appears or the context otherwise requires, words or expressions contained in this constitution bear the same meaning as in the Health and Social Care (Community Health and Standards) Act 2003.

1.2 References in this constitution to legislation include all amendments, replacements, or re-enactments made.

1.3 Headings are for ease of reference only and are not to affect interpretation.

1.4 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall include the plural and vice-versa.

1.5 References to clauses and paragraphs are to clauses and paragraphs in this Constitution.

1.6 All annexes referred to in this Constitution shall form part of it.

1.7 In this constitution:

"the 2012 Act"	means the Health and Social Care Act 2012
"the 2006 Act"	means the National Health Service Act 2006
"the 2003 Act"	means the Health and Social Care (Community Health and Standards) Act 2003;
"the 1977 Act"	means the National Health Service Act 1977;
"Annual Members' Meeting"	means the meeting held annually at which the Members of the Trust are presented with certain statutory reports as provided for in Clause 10
"appointed Governors"	means those Governors appointed by the appointing organisations
"appointing organisations"	means those organisations named in this constitution who are entitled to appoint Governors
"areas of the Trust"	means the areas specified in Annex 1 which are (1) Cheltenham (2) Tewkesbury (3) Stroud (4) Cotswolds (5) Gloucester, and (6) Forest of Dean;
"authorisation"	means an authorisation given by the Independent Regulator
"Board of Directors"	means the Board of Directors as constituted in accordance with this constitution;

"carer"	means a person who has within the period of three years immediately prior to applying to become a member provided care to any patient, provided that such person is not providing care in pursuance of a contract (including a contract of employment), or as a volunteer for a voluntary organisation;
CQC	means the Care Quality Commission;
"Clinical Commissioning Group (CCG)"	means ~~two members of the Council of Governors appointed by the Clinical Commissioning Groups for which the Trust provides goods or services; one of whom shall be appointed by the~~ Gloucestershire Clinical Commissioning Group or its successor organisation;
"Council of Governors"	means the Council of Governors as constituted in this constitution, which is called a council ~~board~~ of governors in the 2003 Act as amended;
"Director"	means a member of the Board of Directors;
"elected Governors"	means those Governors elected by the public constituencies, the patients' constituency and the classes of the staff constituency
"Financial Year"	means~~:~~ a ~~(a) a period beginning with the date on which the Trust is authorised and ending with the next 31 March; and~~ ~~(b) each~~ successive period of twelve months beginning with 1 April.
"General Meeting"	means a meeting of the Council of Governors of which notice has been given to all Governors and at which all Governors are entitled to attend;
"Independent Regulator"	means NHS Improvement~~Monitor~~, the body corporate known as NHS Improvement ~~Monitor~~ as provided by Section 61 of the 2012 Act as amended ;
"Initial Elected Governor"	~~means those Governors elected by the public constituencies, patient constituency and the staff classes of the staff constituency to be the initial Governors of the Trust and whose names and periods of office are as set out in Annex 2;~~
"Local Authority Governor"	means a member of the Council of Governors appointed by one or more local authorities whose area includes the whole or part of the area of the Trust;

"member"	means a member of the Trust;
"the NHS Trust"	means the NHS Trust which made the application to become the Trust
"	
"patient"	means a person who has attended any of the Trust's hospitals as a patient in the period of three years immediately prior to them applying to become a member;
"Patient Governor"	means a member of the Council of Governors elected by the patients' constituency;
"Stakeholder Governor"	means up to four stakeholder appointed Governors. One of these should come from the Gloucestershire Clinical Commissioning Group, one from Gloucestershire County Council and one from Healthwatch Gloucestershire (or their successor organisations). The fourth position could be an appointment from any other stakeholder or partnership organisation, as agreed at the time by the Board and the Council of Governors.
"public constituency"	means a public constituency of the Trust as defined in Annex 1;
"Public Governor"	means a member of the Council of Governors elected by the members of a public constituency;
"Secretary"	means the Secretary of the Trust or any other person appointed to perform the duties of the Secretary;
"Sex Offender Order"	means an order made pursuant to Section 20 of the Crime and Disorder Act 1998;
"Specialist Commissioning Services"	means the Area Team of Specialist Commissioning services for which the Trust provides goods or services;
"Staff Governor"	means a member of the Council of Governors elected by the members of one of the classes of the staff constituency
"the Trust"	means Gloucestershire Hospitals NHS Foundation Trust.

2. Name and status

2.1 The name of the Trust is to be Gloucestershire Hospitals NHS Foundation Trust.

2.2 The Trust is a public benefit corporation incorporated under the 2003 Act.

3. Purpose

3.1 The Trust's principal purpose is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purpose related to:-

3.31 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.32 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4. Functions

4.1 The function of the Trust is to provide goods and services, including education and training, research, accommodation and other facilities, for purposes related to the provision of health care.

4.2 The Trust may also carry on other activities for the purpose of making additional income available in order to carry on the Trust's principal purpose better.

5. Powers

5.1 The Trust may do anything which appears to it to be necessary or desirable for the purposes of or in connection with its functions.

5.2 In particular it may:

5.2.1 acquire and dispose of property,

5.2.2 enter into contracts,

5.2.3 accept gifts of property (including property to be held on Trust for the purposes of the Trust or for any purposes relating to the health service),

5.2.4 employ staff. Any power of the Trust to pay remuneration and allowances to any person includes the power to make arrangements for providing, or securing the provision of pensions or gratuities (including those payable by way of compensation for loss of employment or loss or reduction of pay).

5.3 The Trust may borrow money for the purposes of or in connection with its functions, subject to the limit published by the Independent Regulator from time to time.

5.4 The Trust may invest money (other than money held by it as Trustee) for the purposes of or in connection with its functions. The investment may include investment by:

5.4.1 forming, or participating in forming bodies corporate.

5.4.2 otherwise acquiring membership of bodies corporate.

5.5 The Trust may give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its functions.

6. Commitments

6.1 The Trust shall exercise its functions effectively, efficiently and economically.

Representative membership

6.2 The Trust shall at all times strive to ensure that taken as a whole actual membership of its public constituencies, its patients' constituency and the classes of its staff constituency is representative of those eligible for membership. To this end, the Trust shall at all times have in place and pursue a membership strategy which shall be approved by the Council of Governors and shall be reviewed by them from time to time and at least every three years,

Co-operation with Health bodies

6.3 In exercising its functions the Trust shall co-operate with those organisations in the health and social care system both commissioning and providing services.~~Strategic Commissioning Services , Special Health Authorities, Clinical Commissioning Groups , Community Care Services NHS Trusts and NHS Foundation Trusts..~~

Openness

6.4 In conducting its affairs, the Trust shall have regard to the need to provide information to members and conduct its affairs in an open and accessible way.

Prohibiting distribution

6.5 The profits or surpluses of the Trust are not to be distributed either directly or indirectly in any way at all among members of the Trust.

7. Framework

7.1 The affairs of the Trust are to be conducted by the Board of Directors, the Council of Governors and the members in accordance with this constitution. The members, the Council of Governors and the Board of Directors are to have the roles and responsibilities set out in this constitution.

Members

7.2 Members may vote in elections to, and stand for election for the Council of Governors, attend and take part in annual members meetings, and take such other part in the affairs of the Trust as is provided for in this constitution and the 2003 Act.

Council of Governors

7.3 The roles and responsibilities of the Council of Governors and its members are to hold, attend at and participate in the General Meetings of the Council of Governors and at or through such meetings:

7.3.1 to hold the non-executive Directors individually and collectively to account for the performance of the Board of Directors;

7.3.2 to represent the interests of the members of the Trust as a whole and the interests of the public;

7.3.3 the Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such;

7.3.4 to appoint or remove the Chair of the Trust (who shall also be Chair of the Board of Directors) and the other non-executive Directors;

7.3.5 to approve an appointment (by the non-executive Directors) of the chief executive;

7.3.6 to decide the remuneration and allowances, and the other terms and conditions of office, of the non-executive Directors;

7.3.7 to appoint or remove the Trust's financial auditor;

7.3.8 to appoint or remove any auditor appointed to review and to publish a report on any other aspect of the Trust's affairs;

7.3.9 to be presented with the annual accounts, any report of the financial auditor on them and the annual report;

7.3.10 to provide their views to the Board of Directors when the Board of Directors is preparing the document containing information about the Trust's forward planning.

7.3.11 to respond as appropriate when consulted by the Board of Directors in accordance with this constitution.

7.3.12 to undertake such functions as the Board of Directors shall from time to time request.

7.3.13 to prepare and from time to time to review the Trust's membership strategy, its policy for the composition of the Council of Governors and of the non-executive Directors.

7.4 There is a general duty of the Council of Governors and of each Governor individually to act with a view of promoting the success of the Foundation Trust so as to maximise the benefits for members as a whole and for the public. Governors will also have an explicit duty to avoid conflicts of interests and to declare if any should arise. Governors also have an explicit duty not to accept benefits from a third party by reason of being a governor.

Board of Directors

7.5 The business of the Trust is to be managed by the Board of Directors, who (subject to this constitution) shall exercise all the powers of the Trust.

8. Members

8.1 The members of the Trust are those individuals whose names are entered in the register of members and an individual shall become a member upon the date upon which their name is entered in the said register of members and they shall cease to be a member upon the date upon which their name ceases to be entered in the said register of members. Every member is either a member of one of the public constituencies, or a member of the patients' constituency or a member of one of the classes of the staff constituency.

8.2 Subject to this constitution, membership is open to any individual who:

8.2.1 is 15 years of age or older,

8.2.2 is entitled under this constitution to be a member of one of the public constituencies, or of the patient constituency or of one of the classes of the staff constituency, and

8.2.3 completes a membership application form in whatever form the Council of Governors specifies.

8.3 An individual who is entitled to be a member of one of the public constituencies and is also entitled to be a member of the patient constituency shall be entitled to choose whether he is to be entered on the register of members as a member of the public constituency or of the patient constituency.

Public constituencies

8.4 There are six public constituencies corresponding to the six areas of the Trust specified in Annex 1. Membership of a public constituency is open to individuals who

8.4.1 live in the relevant area of the Trust;

8.4.2 are not a member of another public constituency; and

8.4.3 are not eligible to be members of any of the classes of the staff constituency.

8.5 The minimum number of members of each of the public constituencies is to be four.

Patients' constituency

8.6 Membership of the patients' constituency is open to individuals who:

8.6.1 are a patient when they apply for membership; or

8.6.2 are a carer when they apply for membership; and

8.6.3 who are not eligible to be members of any of the classes of the staff constituency.

8.7 Not more than one carer may be registered as a member in relation to each patient.

8.8 The minimum number of members of the patients' constituency is to be four.

Staff constituency

8.9 The staff constituency is divided into four classes as follows;

8.9.1 the Medical and Dental Staff staff class;

8.9.2 the Nursing and Midwifery Staff staff class;

8.9.3 the Allied Health Professionals and Other Clinical, Scientific and Technical Staff staff class;

8.9.4 the Other Staff staff class.

as each such staff class is more particularly defined in Annex 2.

8.10 Membership of one of the classes of the staff constituency is open to individuals:

8.10.1 who are employed under a contract of employment by the Trust and who either

8.10.1.1 are employed by the Trust under a contract of employment which has no fixed term or a fixed term of at least 12 months, or

8.10.1.2 who have been continuously employed by the Trust for at least 12 months; or

8.10.2 who are not so employed but who nevertheless exercise functions for the purposes of the Trust and who have exercised the functions for the purposes of the Trust continuously for at least 12 months. For the avoidance of doubt,

this does not include those who assist or provide services to the Trust on a voluntary basis.

8.11 The Secretary shall make a final decision about the class of which an individual is eligible to be a member.

8.12 The minimum number of members of each of classes of the staff constituency is to be four.

9. Termination of membership

9.1 A member shall cease to be a member if:

9.1.1 they resign by notice to the Secretary;

9.1.2 they die;

9.1.3 they cease to be entitled under this constitution to be a member of any of the public constituencies, or of the patients' constituency, or of one of the classes of the staff constituency;

9.1.4 they are expelled under this constitution.

9.1.5 if it appears to the Secretary that they no longer wish to be involved in the affairs of the Trust as a member, and after enquiries made in accordance with a process approved by the Council of Governors, they fail to establish that they have a continuing wish to be involved in the affairs of the Trust as a member.

9.2 A member may be expelled by a resolution approved by a majority of the Council of Governors present and voting at a General Meeting. The following procedure is to be adopted.

9.2.1 Any member may complain to the Secretary that another member has acted in a way detrimental to the interests of the Trust.

9.2.2 If a complaint is made, the Council of Governors may itself consider the complaint having taken such steps as it considers appropriate to ensure that each member's point of view is heard and may either:

9.2.2.1 dismiss the complaint and take no further action; or

9.2.2.2 arrange for a resolution to expel the member complained of to be considered at the next General Meeting of the Council of Governors.

9.2.3 If a resolution to expel a member is to be considered at a General Meeting of the Council of Governors, details of the complaint must be sent to the member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

9.2.4 At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.

9.2.5 If the member complained of fails to attend the meeting without due cause the meeting may proceed in their absence.

9.3 A person expelled from membership will cease to be a member upon the declaration by the Chair of the meeting that the resolution to expel them is carried.

9.4 No person who has been expelled from membership is to be re-admitted except by a resolution carried by a majority of the Council of Governors present and voting at a General Meeting.

10. Annual Members Meeting

10.1 The Trust is to hold a members meeting (called the Annual Members Meeting) within eight months of the end of each Financial Year. The Annual Meeting shall be open to members of the public.

10.2 The Annual Members Meeting is to be convened by the Secretary by order of the Council of Governors.

10.3 The Council of Governors may decide where a members meeting is to be held and may also for the benefit of members arrange for the Annual Members Meeting to be held in different venues each year.

10.4 At the Annual Members Meeting:

10.4.1 At least one member of the Board of Directors shall present to the members:

10.4.1.1 the annual report and accounts

10.4.1.2 any report of the financial auditor

10.4.1.3 any report of any other auditor of the Trust's affairs

10.4.1.4 forward planning information for the next financial year

10.4.2 the Council of Governors shall present to the members:

10.4.2.1 a report on steps taken to secure that (taken as a whole) the actual membership of the public constituencies, the patients' constituency and of the classes of the staff constituency is representative of those eligible for such membership;

10.4.2.2 the progress of the membership strategy

10.4.2.3 any proposed changes to the policy for the composition of the Council of Governors and of the non-executive Directors

10.4.3 the results of any election and appointment of Governors will be announced.

10.5 Notice of the Annual Members Meeting is to be given:

10.5.1 by notice sent to all members;by notice prominently displayed at the Trust's Head Office; and

10.5.2 by notice on the Trust's website

at least 14 clear days before the date of the meeting.

10.6 The notice must:

10.6.1 be given to the Council of Governors and the Board of Directors, and to the Trust's financial auditors;

10.6.2 give the time, date and place of the meeting; and

10.6.3 indicate the business to be dealt with at the meeting.

10.7 Before a members meeting can do business there must be a quorum present. Except where this constitution provides otherwise a quorum is twenty members entitled to vote at the meeting.

10.8 The Chair of the Council of Governors or in their absence the Vice-Chair of the Council of Governors, and in their absence another Governor nominated by the Council of Governors shall preside at an Annual Members Meeting.

10.9 If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Council of Governors determine and the Secretary shall in either case give notice to each Governor that the meeting has been adjourned and shall give details of the day, time and place upon and/or at which the adjourned meeting will take place. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of members present during the meeting is to be a quorum.

11. Council of Governors

11.1 The Trust is to have a Council of Governors. It is to consist of Public Governors; a Patient~~s~~' Governor~~s~~; Staff Governors; and up to four stakeholder appointed Governors. One of these should come from the Gloucestershire Clinical Commissioning Group, one from Gloucestershire County Council and one from Healthwatch Gloucestershire (or their successor organisations). The fourth position could be an appointment from any other stakeholder or partnership organisation, as agreed at the time by the Board and the Council of Governors. ~~two Clinical Commissioning Group Governors; one of whom shall be appointed by the Gloucestershire Clinical Commissioning Group, a Local Authority Governor and a Partnership Governor.~~

11.2 Subject always to the provisions of the 2003 Act, the composition of the Council of Governors shall seek to ensure that:

11.2.1 the interests of the community served by the Trust are appropriately represented; and

11.2.2 the level of representation of the public constituencies, the patients' constituency and the classes of the staff constituency and the appointing organisations strikes an appropriate balance having regard to their legitimate interest in the Trust's affairs

and to these ends, the Council of Governors

11.2.3 shall at all times maintain a policy for the composition of the Council of Governors which takes account of the membership strategy and is representative of the membership of their constituencies as set out in paragraph 6.2, and

11.2.4 shall from time to time and not less than every three years review the policy for the composition of the Council of Governors, and

11.2.5 when appropriate shall propose amendments to this constitution

11.3 The Council of Governors of the Trust is to comprise:

11.3.1 twelve Public Governors, from the following public constituencies:

11.3.1.1 Cheltenham – two Public Governors

11.3.1.2 Tewkesbury – two Public Governors

11.3.1.3 Stroud – two Public Governors

11.3.1.4 Cotswolds – two Public Governors

11.3.1.5 Gloucester – two Public Governors

11.3.1.6 Forest of Dean – two Public Governors

11.3.2 one Patient Governor

11.3.3 ~~from the date of the Trust's authorisation to the date of the Annual Members Meeting convened pursuant to Clause 10 of this Constitution for the Financial Year ending 31 March 2007 seven Staff Governors and thereafter six~~ Staff Governors from the following staff classes:

11.3.3.1 the Medical and Dental Staff staff class – one Staff Governor;

11.3.3.2 the Nursing and Midwifery Staff staff class – ~~from the date of the Trust's authorisation to the date of the Annual Members Meeting convened pursuant to Clause 10 of this Constitution for the Financial Year ending 31 March 2007 three Staff Governors and thereafter~~ two Staff Governors;

11.3.3.3 the Allied Health Professionals and Other Clinical, Scientific and Technical Staff staff class – one Staff Governor;

11.3.3.4 the Other Staff staff class – two Staff Governors.

~~11.3.4~~ up to four stakeholder appointed Governors. One of these should come from the Gloucestershire Clinical Commissioning Group, one from Gloucestershire County Council and one from Healthwatch Gloucestershire (or their successor organisations). The fourth position could be an appointment from any other stakeholder or partnership organisation, as agreed at the time by the Board and the Council of Governors." ~~two Clinical Commissioning Group (CCG) Governors, one to be nominated and appointed by the Gloucestershire CCG. In each case the appointment to be made in accordance with the process of appointment agreed pursuant to Clause 11.10 of this Constitution One Specialist Commissioning Services Group Governor nominated and appointed by the Area Team of the Specialist Commissioning Services for which the Trust provides goods or services in accordance with the process of appointment agreed pursuant to Clause 11.10 of this Constitution;~~

~~11.3.5~~11.3.4 ~~from the date of the Trust's authorisation to the date of the Annual Members Meeting convened pursuant to Clause 10 of this Constitution for the Financial Year ending 31 March 2007 two Local Authority Governors and thereafter~~ The ~~one~~ Local Authority Governor to be nominated and appointed by Gloucestershire County Council to represent Gloucestershire County Council, Gloucester City Council, Cheltenham Borough Council, Forest of Dean District Council, Stroud District Council, Cotswold District Council, Tewkesbury Borough Council or in the event of any subsequent boundary changes affecting the electoral areas of the above local authorities such local authorities as shall then include the whole or part of any area specified in Annex 1 as an area of the Trust's public constituencies; and

~~11.3.6 one Partnership Governor to be appointed by Healthwatch serving the Gloucestershire health community in the capacity of a partnership organisation.~~

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Elected Governors

11.4 Public Governors are to be elected by members of the public constituencies, Patients' Governors are to elected by members of the patients' constituency, and Staff Governors are to be elected by members of their class of the staff constituency.

11.5 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Rules for Elections, as may be varied from time to time.

11.6 The Model Rules for Elections, as may be varied from time to time, form part of this Constitution and are attached at Annex 3.

11.7 A variation of the Model Rules by the Department of Health shall not constitute a variation of the terms of this Constitution. For the avoidance of doubt, the Trust cannot amend the Model Rules.

11.8 If contested, the elections must be by secret ballot.

11.9 A member of a public constituency or the patients' constituency may not vote at an election unless within 28 days before they vote they have made a declaration in the form specified by the Council of Governors that they are qualified to vote as a member of the relevant constituency. It is an offence to knowingly or recklessly make such a declaration which is false in a material particular.

Stakeholder ~~CCG~~ Governors

11.10 There shall be up to four stakeholder appointed Governors. One of these should come from the Gloucestershire Clinical Commissioning Group, one from Gloucestershire County Council and one from Healthwatch Gloucestershire (or their successor organisations). The fourth position could be an appointment from any other stakeholder or partnership organisation, as agreed at the time by the Board and the Council of Governors." Partnership Governors are to be appointed by the partnership organisation in accordance with a process to be agreed with the Trust Secretary ~~two nominated and appointed CCG Governors, one by the Gloucestershire CCG.~~

11.11 **Local Authority Governor**

11.12 Gloucestershire County Council having consulted with Gloucester City Council, Cheltenham Borough Council, Forest of Dean District Council, Stroud District Council, Cotswold District Council and Tewkesbury Borough Council (and in the event of any subsequent boundary changes affecting the electoral areas of the above local authorities such local authorities as shall then include the whole or part of any area specified in Annex 1 as an area of the Trust's public constituencies) is to agree the appointment of a Local Authority Governor with those local authorities.

~~**Partnership Governor**~~

~~11.13 The Partnership Governor is to be appointed by the partnership organisation in accordance with a process to be agreed with the Secretary.~~

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Appointment of Lead Governor~~Deputy Chair of the Council of Governors~~

~~11.14~~11.13 The Council of Governors shall appoint a Lead Governor in accordance with a procedure agreed by the Council of Governors.~~one of the Governors from the patient and public constituencies to be Deputy Chair of the Council of Governors.~~

Terms of office for Governors

~~11.15~~11.14 Elected Governors:

~~11.15.1~~11.14.1 shall hold office for a period of three years commencing immediately after the Annual Members Meeting at which their election is announced save as otherwise provided for in Clause 11.1920 ~~and the Initial Elected Governors shall hold office for the periods set out in Annex 4~~;

~~11.15.2~~11.14.2 are eligible for re-election at the end of that period;

~~11.15.3~~11.14.3 may not hold office for more than nine consecutive years and shall not be eligible for re-election without a break from office of three years.

~~11.16~~11.15 Appointed Governors:

~~11.16.1~~11.15.1 shall hold office for a period of three years commencing immediately after the Annual Members Meeting at which their appointment is announced;

~~11.16.2~~11.15.2 are eligible for re-appointment at the end of that period;

~~11.16.3~~11.15.3 may not hold office for longer than nine consecutive years.

~~11.17~~11.16 For the purposes of these provisions concerning terms of office for Governors, "year" means a period commencing immediately after the conclusion of the Annual Members Meeting, and ending at the conclusion of the next Annual Members Meeting.

Eligibility to be a Governor

~~11.18~~11.17 A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so if:

~~11.18.1~~11.17.1 they are a Director of the Trust;

~~11.18.2~~11.17.2 they are under 15 years of age;

~~11.18.3~~11.17.3 being a member of one of the public constituencies or of the patients' constituency they refuse to sign a declaration in the form specified by the Council of Governors that they are a member of the relevant constituency and are not prevented from being a member of the Council of Governors

~~11.18.4~~11.17.4 they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

~~11.18.5~~11.17.5 they have made a composition or arrangement with, or granted a Trust deed for, their creditors and have not been discharged in respect of it;

~~11.18.6~~11.17.6 they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed;

~~11.18.7~~11.17.7 they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

~~11.18.8~~11.17.8 they are a person whose tenure of office as the Chair or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

~~11.18.9~~11.17.9 they have had their name removed, by a direction under section 46 of the 1977 Act from any list prepared under Part II of that Act, and have not subsequently had their name included in such a list;

~~11.18.10~~11.17.10 they are the subject of a Sex Offender Order;

~~11.18.11~~11.17.11 if within the last 5 years they have been involved in a serious incident of violence at any of the Trust's hospitals or facilities or against any of the Trust's employees or registered volunteers.

Termination of office and removal of Governors

~~11.19~~11.18 A person holding office as a Governor shall immediately cease to do so if

~~11.19.1~~11.18.1 they resign by notice in writing to the Secretary;

~~11.19.2~~11.18.2 they are appointed a non-executive Director of the Trust;

~~11.19.3~~11.18.3 in the case of an elected Governor, they cease to be a member of the Trust;

~~11.19.4~~11.18.4 in the case of an appointed Governor, the appointing organisation terminates the appointment;

~~11.19.5~~11.18.5 if they refuse to undertake any training which the Council of Governors requires all Governors to undertake;

~~11.19.6~~11.18.6 they have failed to sign and deliver to the Secretary a statement in the form required by the Council of Governors confirming acceptance of the code of conduct for Governors;

~~11.19.7~~11.18.7 they are removed from the Council of Governors under the following provisions.

~~11.20~~11.19 Governors are expected to attend as a minimum 4 of the ~~-~~6 Council of Governor meetings per year. Where a Governor is absent from 4 Council of Governor meetings, the Chair shall write to the Governor concerned seeking reasons for absence. Illness usually to be the only approved reason for absence. The Governance and Nominations Committee to consider what action, if any, should be taken in respect of a Governor absent from 4 Council of Governor meetings per year.

~~11.21~~11.20 A Governor may be removed from the Council of Governors by a resolution approved by not less than three-quarters of the remaining Governors on the grounds that

~~11.21.1~~11.20.1 they have committed a serious breach of the code of conduct, or

~~11.21.2~~11.20.2 they have acted in a manner detrimental to the interests of the Trust, and

~~11.21.3~~11.20.3 the Council of Governors consider that it is not in the best interests of the Trust for them to continue as a Governor.

Vacancies amongst Governors

~~11.22~~11.21 Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

~~11.23~~11.22 Where the vacancy arises amongst the appointed Governors, the Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office.

~~11.24~~11.23 Where the vacancy arises amongst the elected Governors, the Council of Governors shall be at liberty:

~~11.24.1~~11.23.1 to call an election to fill the seat for the remainder of that term of office; or

~~11.24.2~~11.23.2 having regard to the number of Governors remaining in post to represent that constituency, to defer the election until the next round of routine elections; or

~~11.24.3~~11.23.3 invite the next highest polling candidate for that constituency at the most recent election to take office to fill the post for any unexpired period of the term of office and if that candidate is not willing to do so to invite the candidate who secured the next highest number of votes until the vacancy is filled.

Notwithstanding the provisions of Clause 11.2~~1~~2, an election shall be called by the Trust as soon as reasonably practicable if by reason of the vacancy the number of Public Governors and Patient Governors thereby ceases to be more than half of the total number of Governors in office at that time.

~~11.25~~11.24 No defect in the appointment or election (as the case may be) of a Governor nor any vacancy on the Council of Governors shall invalidate any act of or decision taken by the Council of Governors.

Expenses and remuneration of Governors

~~11.26~~11.25 The Trust may reimburse Governors for travelling and other costs and expenses at such rates as the executive remuneration committee of non-executive Directors decides.

~~11.27~~11.26 Governors are not to receive remuneration for holding office as Governors of the Trust.

Meetings of the Council of Governors

~~11.28~~11.27 The Council of Governors is to meet at least three times in each Financial Year. Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Council of Governors to all Governors. Notice will also be published in the Members' Newsletter, on the Trust's website and at the Trust Head Office a clear three days before the meeting.

~~11.29~~11.28 Meetings of the Council of Governors may be called by the Secretary, or by the Chair, or by eight Governors including at least one appointed Governor who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Governors as soon as possible after receipt of such a request. The Secretary shall call a meeting on at least fourteen but not more than twenty-eight days' notice to discuss the specified business. If the Secretary fails to call such a meeting then the Chair or eight Governors including at least one appointed Governor, whichever is the case, shall call such a meeting.

~~11.30~~11.29 All meetings of the Council of Governors are to be General Meetings open to members of the public unless the Council of Governors decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds. Any member of the public attending a General Meeting of the Council of Governors is entitled to speak at the meeting. The Chair may exclude any member of the public from a meeting of the Council of Governors if they are interfering with or preventing the proper conduct of the meeting.

~~11.31~~11.30 Eight Governors shall form a quorum.

~~11.32~~11.31 The Chair of the Trust or, in their absence, the Vice Chair of the Council of Governors who is also the Vice Chair of the Trust, ~~one of the non-executive Directors~~ shall preside at meetings of the Council of Governors. If both the Chair and the Vice Chair are absent one of the Non-Executive Directors shall preside at meetings of the Council of Governors

~~11.33~~11.32 The Council of Governors may invite a representative of the Trust's auditors or other advisors to attend a meeting of the Council of Governors. For the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance) the Council of Governors may require one or more of the Directors to attend a meeting.

~~11.34~~11.33 The Council of Governors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

~~11.35~~11.34 Subject to this constitution, including the following provisions of this paragraph, issues arising at a meeting of the Council of Governors shall be decided by a majority of votes.

~~11.36~~11.35 In case of an equality of votes the ~~Deputy~~ Chair shall have a casting vote.

~~11.37~~11.36 No resolution of the Council of Governors shall be passed if it is unanimously opposed by all of the Public and Patients' Governors present.

~~11.38~~11.37 The Council of Governors may appoint committees consisting of its members, Directors, and other persons to assist the Council in carrying out its functions.

~~11.39~~11.38 The Council of Governors may, through the Secretary, request that advisors with the support of the Trust assist them or any committee they appoint in carrying out their functions.

~~11.40~~11.39 All decisions taken in good faith at a meeting of the Council of Governors or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Governors attending the meeting.

~~11.41~~11.40 The Board of Directors shall send either by post or electronically to the Council of Governors:

~~11.41.1.1~~11.40.1.1 the annual report and accounts

~~11.41.1.2~~11.40.1.2 any report of the financial auditor

~~11.41.1.3~~11.40.1.3 any report of any other auditor of the Trust's affairs

~~11.41.1.4~~11.40.1.4 forward planning information for the next financial yea

Referral to the Panel

~~11.42~~11.41 In this paragraph, the Panel means a panel of persons appointed by NHS Improvement ~~Monitor~~ to which a Governor of an NHS Foundation Trust may refer a question as to whether the Trust has failed or is failing:-

~~11.42.1.1~~11.41.1.1 To act in accordance with its Constitution, or

~~11.42.1.2~~11.41.1.2 To act in accordance with the provision made under Chapter 5 of the 2006 Act

~~11.43~~11.42 A Governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

Disclosure of interests

~~11.44~~11.43 Any Governor who has a material interest in a matter as defined below shall declare such interest to the Council of Governors and:

~~11.44.1~~11.43.1 shall not be present except with the permission of the Council of Governors in any discussion of the matter, and

~~11.44.2~~11.43.2 shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

~~11.45~~11.44 Any Governor who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Governors.

~~11.46~~11.45 A material interest in a matter in any interest (save for the exceptions referred to below) held by a Governor or their spouse or partner in any firm or company or business which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust. The exceptions which shall not be treated as material interests are as follows:

~~11.46.1~~11.45.1 shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;

~~11.46.2~~11.45.2 an employment contract held by Staff Governors;

~~11.46.3~~11.45.3 a contract with their CCG held by a CCG Governor;

~~11.46.4~~11.45.4 an employment contract with a local authority held by a Local Authority Governor.

~~11.47~~11.46 The Council of Governors is to adopt its own standing orders for its practice and procedure, in particular for its procedure at meetings.

~~11.48~~11.47 An elected Governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the form specified by the Council of Governors that they are qualified to vote as a member of a particular public constituency or of the patients' constituency or of a particular class of the staff constituency as the case may be and are not prevented from being a member of the Council of Governors by any of the provisions contained in paragraphs 11.17.~~4~~ to 11.17.~~116~~. An elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors, and every agenda for meetings of the Council of Governors will draw this to the attention of elected Governors.

12. Board of Directors

12.1 The Trust is to have a Board of Directors. It is to consist of executive and non-executive Directors. The Board is to include:

12.1.1 the following non-executive Directors:

12.1.1.1 a Chair, who is to be appointed (and removed) by the Council of Governors in a General Meeting;

12.1.1.2 six non-executive Directors who are to be appointed (and removed) by the Council of Governors in a General Meeting;

in each case subject to the approval of a majority of the Council of Governors (in the case of an appointment) present and voting at the meeting, and a three-quarters majority of all of the members of the Council of Governors (in the case of a removal) voting at the meeting;

12.1.2 the following executive Directors:

12.1.2.1 a Chief Executive (who is the accounting officer), who is to be appointed (and removed) by the non-executive Directors, and whose appointment is subject to the approval of a majority of the members of the Council of Governors present and voting at a General Meeting;

12.1.2.2 a Finance Director;

12.1.2.3 a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984);

12.1.2.4 a registered nurse or registered midwife;

12.1.2.5 three other executive Directors; and

12.1.2.6 not less than one and not more than three other executive Directors,

all of whom save for the Chief Executive are to be appointed (and removed) by a committee consisting of the Chair, the Chief Executive and the other non-executive Directors.

12.2 Only those directors specified in Clause 12.1.2.1 – 12.1.2.5 above shall be entitled to vote on any resolution of the Board of Directors.

12.3 The Board of Directors shall elect one of the non-executive Directors to be Vice-Chair of the Board. If the Chair is unable to discharge their office as Chair of the Trust, the Vice-Chair of the Board of Directors shall be acting Chair of the Trust.

12.4 Only a member of a public constituency or the patients' constituency is eligible for appointment as a non-executive Director.

12.5 Non-executive Directors are to be appointed by the Council of Governors. The Council of Governors will maintain a policy for the composition of the non-executive Directors which takes account of the membership strategy, and which they shall review from time to time and not less than every three years.

12.6 The general duty of the Board of Directors and each Director individually is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Terms of Office

12.7 The Chair and the non-executive Directors are to be appointed for a period of office in accordance with the terms and conditions of office decided by the Council of Governors at a General Meeting.

12.8 Any re-appointment of a non-executive Director shall be subject to a satisfactory appraisal carried out in accordance with procedures which the Board of Directors have approved.

12.9 The executive remuneration committee of non-executive Directors shall decide the terms and conditions of office including remuneration and allowances of the executive Directors including the Chief Executive and the Finance Director.

Disqualification

12.10 A person may not become or continue as a Director of the Trust if:

12.10.1 they are a member of the Council of Governors;

12.10.2 they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

12.10.3 they have made a composition or arrangement with, or granted a Trust deed for, their creditors and have not been discharged in respect of it;

12.10.4 they have within the preceding five years been convicted in the British Islands of any offence, and a sentenced of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed;

12.10.5 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

12.10.6 in the case of a non-executive Director, they are no longer a member of one of the public constituencies or of the patients' constituency;

12.10.7 they are a person whose tenure of office as a Chair or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non attendance at meetings, or for non-disclosure of a pecuniary interest;

12.10.8 they have had their name removed, by a direction under section 46 of the 1977 Act from any list prepared under Part II of that Act, and have not subsequently had their name included on such a list;

12.10.9 they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

12.10.10 in the case of non-executive Directors, they have refused to undertake any training which the Board of Directors requires all non-executive directors to undertake;

12.10.11 they have failed to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for Directors.

Committees and delegation

12.11 The Board of Directors may delegate any of its powers to a committee of Directors or to an Eexecutive Director.

12.12 The Board of Directors shall appoint a committee of non-executive Directors to act as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

12.13 The Board of Directors shall appoint an executive remuneration committee of non-executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the executive Directors.

Meeting of Directors

12.14 Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Board of Directors to all Directors.

12.15 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as is practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

12.16 Meetings of the Board of Directors shall be open to members of the public unless the Board of Directors decides otherwise in relation to all or part of a meeting for special reasons.. The Chair may exclude any member of the public from a meeting of the Board of Directors if they are interfering with or preventing the proper conduct of the meeting.

12.17 Meetings of the Board of Directors are called by the Secretary, or by the Chair, or by four Directors who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Directors as soon as possible after receipt of such a request. The Secretary shall call a meeting on at least fourteen but not more than twenty-eight days' notice to discuss the specified business. If the Secretary fails to call such a meeting then the Chair or four Directors, whichever is the case, shall call such a meeting.

12.18 Four Directors including not less than two executive, and not less than two non-executive Director's shall form a quorum.

12.19 The Board of Directors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

12.20 The Chair of the Trust or, in their absence, the Vice-Chair of the Board of Directors, and in their absence one of the other non-executive Directors in attendance is to chair meetings of the Board of Directors.

12.21 Questions arising at a meeting of the Board of Directors shall be decided by a majority of votes. In case of an equality of votes the Chair shall have a second and casting vote.

12.22 The Board of Directors is to adopt Standing Orders covering the proceedings and business of its meetings. The proceedings shall not however be invalidated by any vacancy of its membership, or defect in a Director's appointment.

Conflicts of Interest of Directors

12.23 The duties that a Director of the Trust has by virtue of being a Director include in particular:-

12.23.1 A duty to avoid a situation in which the Director has (or can have) a direct of indirect interest that conflicts (or possibly may conflict) with the interests of the Trust

A duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

12.24 The duty referred to in sub paragraph 12.23.1 above is not infringed if:-

12.24.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

12.24.2 The matter has been authorised in accordance with the Constitution.

12.25 The duty referred to in sub paragraph 12.24.1 above is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

12.26 In sub paragraph 12.23.2 "third party" means a person other than:-

12.26.1 The Trust, or

12.26.2 A person acting on its behalf

12.27 If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors.

12.28 If a declaration under this paragraph proves to be, or becomes, inaccurate, a further declaration must be made.

12.29 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

12.30 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

12.31 A Director need not declare an interest:-

12.31.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest

12.31.2 If, or to the extent that, the Directors are already aware of it

12.31.3 If, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered

12.31.4 By a meeting of the Board of Directors or

12.31.5 By a Committee of the Directors appointed for the purpose under the Constitution.

12.32 Any Director who has a material interest in a matter as defined below shall declare such interest to the Board of Directors and:

12.32.1 shall not be present except with the permission of the Board of Directors in any discussion of the matter, and

12.32.2 shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

12.33 Any Director who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Directors.

12.34 A material interest in a matter is any interest (save for the exceptions referred to below) held by a Director or their spouse or partner in any firm or company or business which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust.

12.35 a holding of shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange shall not be treated as material interests:

Expenses

12.36 The Trust may pay travelling and other expenses to Directors at such rates as the executive remuneration committee of the non-executive directors decides.

12.37 The remuneration and taxable allowances for Directors are to be disclosed in the annual report.

13. Secretary

13.1 The Trust shall have a Secretary who may be an employee. The Secretary may not be a Governor, or the Chief Executive or the Finance Director. The Secretary shall be responsible for:

13.1.1 acting as Secretary to the Council of Governors, the Board of Directors and any committees;

13.1.2 summoning and attending all meetings of the Council of Governors, and keeping the minutes of those meetings;

13.1.3 keeping the register of members and other registers and books required by this constitution to be kept;

13.1.4 publishing to members in an appropriate form information which they should have about the Trust's affairs;

13.1.5 preparing and sending to the Independent Regulator and any other statutory body all returns which are required by Part 1 of the 2003 Act to be made.

13.2 Minutes of every members meeting, of every meeting of the Council of Governors and of every meeting of the Board of Directors are to be kept. Minutes of meetings will be read at the next meeting and signed by the Chairman of that meeting. The signed minutes will be conclusive evidence of the events of the meeting.

13.3 The Secretary is to be appointed and removed by the Board of Directors, in consultation with the Council of Governors.

14. Registers

14.1 The Trust shall have:

14.1.1 a register of Members showing, in respect of each Member:

14.1.2 the constituency and where relevant the class of the constituency to which they belong;

14.1.3 any address which they have authorised the Trust to use for the purposes of any communications.

14.1.4 a register of members of the Council of Governors;

14.1.5 a register of Directors;

14.1.6 a register of interests of Governors;

14.1.7 a register of interests of Directors.

14.2 The Secretary shall remove from the register of members the name of any member who ceases to be entitled to be a member under the provisions of this constitution.

15. Public Documents

15.1 The following documents of the Trust are to be available for inspection by members of the public free of charge at all reasonable times, and shall be available on the Trust's website:

15.1.1 a copy of the current constitution;

15.1.2 a copy of the current licence

15.1.3 a copy of the latest annual accounts and of any report of the financial auditor on them;

15.1.4 a copy of the latest annual report;

15.1.5 a copy of the latest information as to its forward planning;

15.1.6 a copy of the Trust's membership ~~development~~ strategy;

15.1.7 a copy of the Trust's policy for the composition of the Council of Governors and the non-executive Directors;

15.1.8 a copy of any notice given under section 23 of the 2003 Act (regulator's notice to failing NHS foundation Trust).

15.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times, and shall be available on the Trust's website:

15.2.1 a copy of any order made under Section 65D (appointment of Trust Special Administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (Trusts coming out of administration), or 65LA (Trusts to be dissolved) of the 2006 Act

15.2.2 a copy of any report laid under Section 65D (appointment of Trust Special Administrator) of the 2006 Act

15.2.3 a copy of any information published under Section 65D (appointment of Trust Special Administrator) of the 2006 Act

15.2.4 a copy of any draft report published under Section 65F (administrator's draft report) of the 2006 Act

15.2.5 a copy of any statement provided under Section 65F (administrator's draft report) of the 2006 Act

15.2.6 a copy of any notice published under Section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act

15.2.7 a copy of any statement published or provided under Section 65G (consultation plan) of the 2006 Act

15.2.8 a copy of any final report published under Section 65I (administrator's final report)).

15.2.9 a copy of any statement published under Section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act

15.2.10 a copy of any information published under Section 65M (replacement of Trust Special Administrator) of the 2006 Act

15.3 The registers (but not the addresses of members of the Trust) shall be made available for inspection by members of the public, except in circumstances prescribed by regulations; and so far as they are required to be available they are to be available free of charge at all reasonable times.

15.4 Any person who requests it is to be provided with a copy or extract from any of the above documents or registers. The Trust may impose a reasonable charge for providing the copy or extract, but a member is entitled to a copy or extract from the registers free of charge.

16. Auditors

16.1 The Trust is to have a financial auditor and is to provide the financial auditor with every facility and all information which he may reasonably require for the purposes of his functions under Part 1 of the 2003 Act.

16.2 A person may only be appointed as the financial auditor if he (or in the case of a firm of each of its members) is a member of one or more of the bodies referred to in paragraph 19 (3) of Schedule 1 to the 2003 Act. An officer of the Audit Commission may be appointed with the agreement of the Commission.

16.3 The Council of Governors at a General Meeting shall appoint or remove the Trust's auditors.

16.4 The financial auditor is to carry out his duties in accordance with Schedule 5 to the 2003 Act and in accordance with any directions given by the Independent Regulator on standards, procedures and techniques to be adopted.

16.5 The Board of Directors may resolve that auditors be appointed to review and publish a report on any other aspect of the Trust's performance. Any such auditors are to be appointed by the Council of Governors.

17. Accounts

17.1 The Trust must keep proper accounts and proper records in relation to the accounts.

17.2 The Independent Regulator may with the approval of the Secretary of State give directions to the Trust as to the content and form of accounts.

17.3 The accounts are to be audited by the Trust's auditor.

17.4 The following documents will be made available to the Comptroller and Auditor General for examination at his request:

17.4.1 the accounts;

17.4.2 any records relating to them; and

17.4.3 any report of the financial auditor on them.

17.5 The Trust is to prepare in respect of each financial year annual accounts in such form as the Independent Regulator may with the approval of the Secretary of State direct.

17.5 In preparing its annual accounts, the Trust is to comply with any directions given by the Independent Regulator with the approval of the Secretary of State as to:

17.5.1 the methods and principles according to which the accounts are to be prepared;

17.5.2 content and form of the accounts;

17.6 The annual accounts, any report of the financial auditor on them, and the annual report are to be presented to the Council of Governors at a General Meeting.

17.7 The Trust shall:

17.7.1 lay a copy of the annual accounts, and any report of the financial auditor on them, before Parliament; and

17.7.2 once it has done so, send copies of those documents to the Independent Regulator within such a period as the Independent Regulator may direct..

18. Annual reports, forward plans and non-NHS work

18.1 The Trust is to prepare annual reports and send them to the Independent Regulator.

18.2 The reports are to give:

18.2.1 information on any steps taken by the Trust to secure that (taken as a whole) the actual Membership of the public constituencies and of the

patients' constituency and of the classes of the staff constituency is representative of those eligible for such membership; and

18.2.2 any other information the Independent Regulator requires.

18.3 The Trust is to comply with any decision the Independent Regulator makes as to:

18.3.1 the form of the reports;

18.3.2 when the reports are to be sent to him;

18.3.3 the periods to which the reports are to relate.

18.4 Each forward plan must include information about:-

18.4.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

18.4.2 the income it expects to receive from doing so.

18.5 Where a forward plan contains proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 18.4.1 the Council of Governors must:-

18.5.1 determine whether it is satisified that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions.

18.5.2 notify the Directors of the Trust of its determination.

18.6 If the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purpose of the health service in England it may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

18.7 The Trust is to give information as to its forward planning in respect of each financial year to the Independent Regulator. The document containing this information is to be prepared by the Directors, and in preparing the document, the Board of Directors must have regard to the views of the Council of Governors.

19. Indemnity

19.1 Members of the Council of Governors and the Board of Directors and the Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust. The Trust may purchase and maintain insurance against any such liability for its own benefit and the benefit of members of the Council of Governors and the Board of Director

20. Execution of documents

20.1 A document purporting to be duly executed under the Trust's seal or to be signed on its behalf is to be received in evidence and, unless the contrary is proved, taken to be so executed or signed.

20.2 The Trust is to have a seal, but this is not to be affixed except under the authority of the Board of Directors.

21. Dispute Resolution Procedures

21.1 Every unresolved dispute which arises out of this constitution between the Trust and:

21.1.1 a member; or

21.1.2 any person aggrieved who has ceased to be a member within the six months prior to the date of the dispute; or

21.1.3 any person bringing a claim under this constitution

is to be submitted to an arbitrator agreed by the parties or in the absence of agreement to be nominated by the Strategic Commissioning Services. The arbitrator's decision will be binding and conclusive on all parties.

21.2 Any person bringing a dispute must, if required to do so, deposit with the Trust a reasonable sum (not exceeding £500) to be determined by the Council of Governors and ratified by the ~~Company~~ Secretary. The arbitrator will decide how the costs of the arbitration will be paid and what should be done with the deposit.

22. Amendment of the Constitution

22.1 The Trust may make amendments of its Constitution only if:-

22.1.1 More than half of the members of the Council of Governors of the Trust voting approve the amendments, and

22.1.2 More than half of the members of the Board of Directors of the Trust voting approve the amendments.

22.2 Amendments made under paragraph 22.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act.

22.3 Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust;-

22.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

22.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment

22.4 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

22.5 Amendments by the Trust of its constitution are to be notified to NHS Improvement~~Monitor~~. For the avoidance of doubt, NHS Improvement's~~Monitor's~~ functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendment, accords with Schedule 7 of the 2006 Act

23. Mergers

23.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

23.2 The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

2.2.2 "Significant transaction" means an investment or divestment worth more 25% of the Trust as an investment or divestment valued at more than 25% of the Trust, as measured by any of Income; Gross Assets; or Gross Capital.

24. Dissolution of the Trust

24.1 The Trust may not be dissolved except by order of the Secretary of State for Health, in accordance with the 2003 Act.

25. Head Office and Website

25.1 The Trust's head office is at Trust Headquarters, Alexandra House, ~~1 College Lawn,~~ Cheltenham General Hospital, Sandford Road, Cheltenham~~,~~ Gloucestershire. GL53 7ANN

25.2 The Trust will maintain a website, the address of which shall be www.gloshospitals.org.uk or such other website address as it may determine from time to time.

25.3 The Trust will display its name and website on its business letters, notices, advertisements, other publications.

26. Notices

26.1 Any notice required by this constitution to be given shall be given in writing or shall be given using electronic communications to an address for the time being notified for that purpose. "Address" in relation to electronic communications includes any number or address used for the purposes of such communications.

26.2 Proof that an envelope containing a notice was properly addressed, prepaid and posted shall be conclusive evidence that the notice was given. A notice shall be treated as delivered 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.

Annex 1: List of public constituencies

Constituencies as defined by Local Authority boundaries	Area	Minimum number of Members
Gloucester City Council Area ("Gloucester")	Gloucestershire	4
Stroud District Council Area ("Stroud")		4
Tewkesbury Borough Council Area ("Tewkesbury")		4
Cheltenham Borough Council Area ("Cheltenham")		4
Cotswolds District Council Area ("Cotswolds")		4
Forest of Dean District Council Area ("Forest of Dean")		4
Total		24

Annex 2: Definitions of the Trust's staff classes

1. The Medical and Dental Staff staff class

The members of the Medical and Dental Staff staff class are those individuals who are members of the staff constituency who:

1.1 are fully registered persons within the meaning of the Medicines Act 1956 or the Dentist Act 1984 (as the case may be) and who are otherwise fully authorised and licensed to practice in England and Wales; or

1.2 are otherwise designated by the Trust from time to time as eligible to be members of this staff class having regard to the usual definitions applicable at that time for persons carrying on the professions of a medical practitioner or a dentist; and

1.3 are employed by the Trust in that capacity at the date of their application or invitation (as the case may be) to become a member in accordance with the provisions of this constitution and at all times thereafter remain employed by the Trust in that capacity.

2. The Nursing and Midwifery Staff staff class

The members of the Nursing and Midwifery Staff staff class are individuals who are members of the staff constituency who:

2.1 are registered under the Nurses, Midwives and Health Visitors Act 1997 and who are otherwise fully authorised and licensed to practice in England and Wales; or

2.2 are otherwise designated by the Trust from time to time as eligible to be members of this staff class having regard to the usual definitions applicable at that time for persons carrying on the profession of registered nurse or registered midwife; and

2.3 are employed by the Trust in that capacity at the date of their application or invitation (as the case may be) to become a member in accordance with the provisions of this constitution and who at all times thereafter remain employed by the Trust in that capacity.

3. The Allied Health Professionals and Other Clinical, Scientific and Technical Staff staff class

The members of the Allied Health Professionals and Other Clinical, Scientific and Technical Staff staff class are those individuals who are members of the staff constituency:

3.1 whose regulatory body falls within the remit of the Council for the Regulation of Healthcare Professions established by Section 25 of the NHS Reform and Healthcare Professions Act 2002; or

3.2 are otherwise designated by the Trust from time to time as eligible to be members of this staff class having regard to the usual definitions applicable at that time for persons carrying on such professions; and

3.3 are employed by the Trust in that capacity at the date of their application or invitation (as the case may be) to become a member in accordance with the provisions of this Constitution and who at all times thereafter remain employed by the Trust in that capacity.

4. The Other Staff staff class

The members of the Other Staff staff class are those individuals who are members of the staff constituency who:

4.1 do not come within those definitions set out in paragraphs 1–3 above and who are

4.2 designated by the Trust from time to time as eligible to be members of this staff class; and

4.3 are not otherwise eligible to be members of another staff class having regard to the relevant definitions applicable at that time; and

4.4 are employed by the Trust in that capacity at the date of their application or invitation (as the case may be) to become a member in accordance with the provisions of this constitution and who at all times thereafter remain employed by the Trust in that capacity.

Annex 3: Model Election Rules

Part I - Interpretation

1. Interpretation

Part 2— Timetable for election

2. Timetable
3. Computation of time

Part 3— Returning officer

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

Part 4 - Stages Common to Contested and Uncontested Elections

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Part I - Interpretation

1. Interpretation —(1) In these rules, unless the context otherwise requires -

“corporation” means Gloucestershire Hospitals NHS Foundation Trust subject to this constitution;

“election” means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the Council of Governors;

“the regulator” means the Independent Regulator for NHS foundation trusts; and

“the 2003 Act” means the Health and Social Care (Community Health and Standards) Act 2003.

(2) Other expressions used in these rules and in Schedule 1 to the Health and Social Care (Community Health and Standards) Act 2003 have the same meaning in these rules as in that Schedule.

Part 2— Timetable for election

2. Timetable - The proceedings at an election shall be conducted in accordance **with the** following timetable.

Proceeding	**Time**
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination papers to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll
Close of the poll	By 5.OOpm on the final day of the election.

3. Computation of time - (1) In computing any period of time for the purposes of the timetable -

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

(2) In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

Part 3— Returning officer

4. Returning officer — (1) Subject to rule 64, the returning officer for an election is to be appointed by the corporation.

(2) Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff — Subject to rule 64, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure - The corporation is to pay the returning officer —

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation — The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

Part 4 - Stages Common to Contested and Uncontested Elections

8. Notice of election The returning officer is to publish a notice of the election stating —

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the board of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination papers may be obtained;

(e) the address for return of nomination papers and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer, and

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates — (1) Each candidate must nominate themselves on a

single nomination paper.

(2) The returning officer-

(a) is to supply any member of the corporation with a nomination paper, and

(b) is to prepare a nomination paper for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer.

10. Candidate's particulars — (1) The nomination paper must state the candidate's

(a) full name,

(b) contact address in full, and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests — The nomination paper must state —

(a) any financial interest that the candidate has in the corporation, and
(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility — The nomination paper must include a declaration made by the candidate—

(a) that he or she is not prevented from being a member of the board of governors by paragraph 8 of Schedule I of the 2003 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate — The nomination paper must be signed and dated by the candidate, indicating that —

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

14. Decisions as to the validity of nomination — (1) Where a nomination paper is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer-

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination paper is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

(2) The returning officer is entitled to decide that a nomination paper is invalid only on one of the following grounds -

(a) that the paper is not received on or before the final time and date for return of nomination papers, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, as required by rule 13.

(3) The returning officer is to examine each nomination paper as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

(4) Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination paper, stating the reasons for their decision.

(5) The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination paper.

15. Publication of statement of candidates — (1) The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

(2) The statement must show —

(a) the name, contact address, and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination paper.

(3) The statement must list the candidates standing for election in alphabetical order by surname.

(4) The returning officer must send a copy of the statement of candidates and copies of the nomination papers to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination papers —
(1) The corporation is to make the statements of the candidates and the nomination papers supplied by the returning officer under rule 15(4) available for inspection by members of the public free of charge at all reasonable times.

(2) If a person requests a copy or extract of the statements of candidates or their nomination papers, the corporation is to provide that person with the copy or extract free of charge.

17. Withdrawal of candidates - A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election — (1) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the board of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

(2) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the board of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

(3) If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be board of governors, then —

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

Part 5— Contested elections

19. Poll to be taken by ballot — (1) The votes at the poll must be given by secret ballot.

(2) The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

20. The ballot paper — (1) The ballot of each voter is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

(2) Every ballot paper must specify —

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the board of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

(3) Each ballot paper must have a unique identifier.

(4) Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies) — (I) In respect of an election for a public or patient constituency a declaration of identity must be issued with each ballot paper.

(2) The declaration of identity is to include a declaration —

(a) that the voter is the person to whom the ballot paper was addressed,

(b) that the voter has not marked or returned any other voting paper in the election, and

(c) for a member of the public or patient constituency, of the particulars of that member's qualification to vote as a member of the constituency or class within a constituency for which the election is being held.

(3) The declaration of identity is to include space for —

(a) the name of the voter,

(b) the address of the voter,

(c) the voter's signature, and

(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that, if it is not returned with the ballot paper, or if it is returned without being correctly completed, the voter's ballot paper may be declared invalid.

Action to be taken before the poll

22. List of eligible voters — (1) The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 26 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

(2) The list is to include, for each member, a mailing address where his or her ballot paper is to be sent.

23. Notice of poll - The returning officer is to publish a notice of the poll stating—

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the board of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the address for return of the ballot papers, and the date and time of the close of the poll,

(g) the address and final dates for applications for replacement ballot papers, and

(h) the contact details of the returning officer.

24. Issue of voting documents by returning officer — (1) As soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following documents to each member of the corporation named in the list of eligible voters—

(a) a ballot paper and ballot paper envelope,

(b) a declaration of identity (if required),

(c) information about each candidate standing for election, pursuant to rule 59 of these rules, and

(d) a covering envelope.

(2) The documents are to be sent to the mailing address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope — (1) The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

(2) The covering envelope is to have —

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

(3) There should be clear instructions, either printed on the covering envelope or elsewhere,

instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer —

(a) the completed declaration of identity if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

The poll

26. Eligibility to vote — An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

27. Voting by persons who require assistance — (I) The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

(2) Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

28. Spoilt ballot papers (1) — If a voter has dealt with his or her ballot paper in **such a manner that** it cannot be accepted as a ballot paper (referred to a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

(2) On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

(3) The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she —

(a) is satisfied as to the voter's identity, and

(b) has ensured that the declaration of identity, if required, has not been returned.

(4) After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers") —

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29. Lost ballot papers — (I) Where a voter has not received his or her ballot paper by the fourth day before the close of the poll, that voter may apply to the returning officer for a replacement ballot paper.

(2) The returning officer may not issue a replacement ballot paper for a lost ballot paper unless he or she —

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original ballot paper, and

(c) has ensured that the declaration of identity if required has not been returned.

(3) After issuing a replacement ballot paper for a lost ballot paper, the returning officer shall enter in a list ("the list of lost ballot papers") —

(a) the name of the voter, and

(b) the details of the unique identifier of the replacement ballot paper.

30. Issue of replacement ballot paper - (1) If a person applies for a replacement ballot paper under rule 28 or 29 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue a replacement ballot paper unless, in addition to the requirements imposed rule 28(3) or 29(2), he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

(2) After issuing a replacement ballot paper under this rule, the returning officer shall enter in a list ("the list of tendered ballot papers") —

(a) the name of the voter, and

(b) the details of the unique identifier of the replacement ballot paper issued under this rule.

31. Declaration of identity for replacement ballot papers (public and patient constituencies) — (1) In respect of an election for a public or patient constituency a declaration of identity must be issued with each replacement ballot paper.

(2) The declaration of identity is to include a declaration —

(a) that the voter has not voted in the election with any ballot paper other than the ballot paper being returned with the declaration, and

(b) of the particulars of that member's qualification to vote as a member of the public or patient constituency, or class within a constituency, for which the election is being held.

(3) The declaration of identity is to include space for —

(a) the name of the voter,

(b) the address of the voter,

(c) the voter's signature, and

(d) the date that the declaration was made by the voter.

(4) The voter must be required to return the declaration of identity together with the ballot paper.

(5) The declaration of identity must caution the voter that if it is not returned with the ballot paper, or if it is returned without being correctly completed, the replacement ballot paper may be declared invalid.

Procedure for receipt of envelopes

32. Receipt of voting documents — (1) Where the returning officer receives a —

(a) covering envelope, or

(b) any other envelope containing a declaration of identity if required, **a** ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 33 and 34 are to apply.

(2) The returning officer may open any ballot paper envelope for the purposes of rules 33 and 34, but must make arrangements to ensure that no person obtains or communicates information as to —

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

(3) The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

33. Validity of ballot paper — (I) A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly completed, signed, and dated.

(2) Where the returning officer is satisfied that paragraph (1) has been fulfilled, he or she is to—

(a) put the declaration of identity if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

(3) Where the returning officer is not satisfied that paragraph (1) has been fulfilled, he or she is to —

(a) mark the ballot paper “disqualified”,

(b) if there is a declaration of identity accompanying the ballot paper, mark it as “disqualified” and attach it the ballot paper,

(c) record the unique identifier on the ballot paper in a list (the “list of disqualified documents”); and

(d) place the document or documents in a separate packet.

34. Declaration of identity but no ballot paper (public and patient constituency) — Where the returning officer receives a declaration of identity if required but no ballot paper, the returning officer is to —

(a) mark the declaration of identity “disqualified”,

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper; and

(c) place the declaration of identity in a separate packet.

35. Sealing of packets — As soon as is possible after the close of the poll and after the completion of the procedure under rules 33 and 34, the returning officer is to seal the packets containing—

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the declarations of identity if required,

(c) the list of spoilt ballot papers,

(d) the list of lost ballot papers,

(e) the list of eligible voters, and

(f) the list of tendered ballot papers.

Part 6 - Counting the votes

36. Interpretation of Part 6 — In Part 6 of these rules — "continuing candidate" means any candidate not deemed to be elected, and not excluded,

"count" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"deemed to be elected" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"mark" means a figure, an identifiable written word, or a mark such as "X", "non-transferable vote" means a ballot paper —

(a) on which no second or subsequent preference is recorded for a continuing candidate, or

(b) which is excluded by the returning officer under rule 44(4) below,

"preference" as used in the following contexts has the meaning assigned below—

(a) "first preference" means the figure "I" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"quota" means the number calculated in accordance with rule 4l below,

"surplus" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable papers from the candidate who has the surplus,

"stage of the count" means —

(a) the determination of the first preference vote of each candidate,

(b) the transfer of a surplus of a candidate deemed to be elected, or

(c) the exclusion of one or more candidates at any given time,

"transferable paper" means a ballot paper on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"transferred vote" means a vote derived from a ballot paper on which a second or subsequent preference is recorded for the candidate to whom that paper has been transferred, and

"transfer value" means the value of a transferred vote calculated in accordance with paragraph (4) or (7) of rule 42 below.

37. Arrangements for counting of the votes — The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

38. The count — (1) The returning officer is to —

(a) count and record the number of ballot papers that have been returned, and

(b) count the votes according to the provisions in this Part of the rules.

(2) The returning officer, while counting and recording the number of ballot papers and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper.

(3) The returning officer is to proceed continuously with counting the votes as far as is practicable.

39. Rejected ballot papers — (1) Any ballot paper —

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

(2) The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

(3) The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of paragraph (1).

40. First stage — (I) The returning officer is to sort the ballot papers into parcels according to the candidates for whom the first preference votes are given.

(2) The returning officer is to then count the number of first preference votes given on ballot papers for each candidate, and is to record those numbers.

(3) The returning officer is to also ascertain and record the number of valid ballot papers.

4l. The quota — (1) The returning officer is to divide the number of valid ballot papers by a number exceeding by one the number of members to be elected.

(2) The result, increased by one, of the division under paragraph (1) above (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

(3) At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in paragraphs (1) to (3) of rule 44 has been complied with.

42. Transfer of votes — (1) Where the number of first preference votes for any candidate exceeds

the quota, the returning officer is to sort all the ballot papers on which first preference votes are given for that candidate into sub-parcels so that they are grouped —

(a) according to next available preference given on those papers for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

(2) The returning officer is to count the number of ballot papers in each parcel referred to in paragraph (I) above.

(3) The returning officer is, in accordance with this rule and rule 43 below, to transfer each sub-parcel of ballot papers referred to in paragraph (1)(a) to the candidate for whom the next available preference is given on those papers.

(4) The vote on each ballot paper transferred under paragraph (3) above shall be at a value ("the transfer value") which —

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot papers on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

(5) Where at the end of any stage of the count involving the transfer of ballot papers, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot papers in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped —

(a) according to the next available preference given on those papers for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

(6) The returning officer is, in accordance with this rule and rule 43 below, to transfer each sub-parcel of ballot papers referred to in paragraph (5)(a) to the candidate for whom the next available preference is given on those papers.

(7) The vote on each ballot paper transferred under paragraph (6) shall be at —

(a) a transfer value calculated as set out in paragraph (4)(b) above, or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

(8) Each transfer of a surplus constitutes a stage in the count.

(9) Subject to paragraph (10), the returning officer shall proceed to transfer transferable papers until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

(10) Transferable papers shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are —

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

(11) This rule does not apply at an election where there is only one vacancy.

43. Supplementary provisions on transfer — (1) If, at any stage of the count, two or more candidates have surpluses, the transferable papers of the candidate with the highest surplus shall be transferred first, and if—

(a) The surpluses determined in respect of two or more candidates are equal, the transferable papers of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable papers of the candidate on whom the lot falls shall be transferred first.

(2) The returning officer shall, on each transfer of transferable papers under rule 42 above —

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare—

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

(3) All ballot papers transferred under rule 42 or 44 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that paper or, as the case may be, all the papers in that sub-parcel.

(4) Where a ballot paper is so marked that it is unclear to the returning officer at any stage of the count under rule 42 or 44 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot paper as a non-transferable vote; and votes on a ballot paper shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

44. Exclusion of candidates — (1) If—

(a) all transferable papers which under the provisions of rule 42 above (including that rule as applied by paragraph (11) below) and this rule are required to be transferred, have been transferred, and

(b) subject to rule 45 below, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where paragraph (12) below applies, the candidates with the then lowest votes).

(2) The returning officer shall sort all the ballot papers on which first preference votes are given for the candidate or candidates excluded under paragraph (1) above into two sub-parcels so that they are

grouped as—

(a) ballot papers on which a next available preference is given, and

(b) ballot papers on which no such preference is given (thereby including ballot papers on which preferences are given only for candidates who are deemed to be elected or are excluded).

(3) The returning officer shall, in accordance with this rule and rule 43 above, transfer each sub-parcel of ballot papers referred to in paragraph (2)(a) above to the candidate for whom the next available preference is given on those papers.

(4) The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

(5) If, subject to rule 45 below, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable papers, if any, which had been transferred to any candidate excluded under paragraph (1) above into sub-parcels according to their transfer value.

(6) The returning officer shall transfer those papers in the sub-parcel of transferable papers with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those papers (thereby passing over candidates who are deemed to be elected or are excluded).

(7) The vote on each transferable paper transferred under paragraph (6) above shall be at the value at which that vote was received by the candidate excluded under paragraph (1) above.

(8) Any papers on which no next available preferences have been expressed shall be set aside as non-transferable votes.

(9) After the returning officer has completed the transfer of the ballot papers in the sub-parcel of ballot papers with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot papers with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under paragraph (1) above.

(10) The returning officer shall after each stage of the count completed under this rule—

(a) record—

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d)compare—

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

(11) If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with paragraphs (5) to (10) of rule 42 and rule 43.

(12) Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning

officer shall in one operation exclude such two or more candidates.

(13) If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest—

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

45. Filling of last vacancies — (1) Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

(2) Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

(3) Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

46. Order of election of candidates — (1) The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule 42(10) above.

(2) A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

(3) Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

(4) Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

47. Declaration of result for contested elections — (1) In a contested election, when the result of the poll has been ascertained, the returning officer is to—

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected —

(i) where the election is held under a proposed constitution pursuant to powers conferred on the Gloucestershire Hospitals NHS Trust by section 4(4) of the 2003 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

(2) The returning officer is to make —

(a) the number of first preference votes for each candidate whether elected or not,
(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule 39(I), available on request.

48. Declaration of result for uncontested elections — In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election —

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

Part 8— Disposal of documents

49. Sealing up of documents relating to the poll — (1) On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets —

(a) the counted ballot papers,

(b) the ballot papers endorsed with “rejected in part”,

(c) the rejected ballot papers, and

(d) the statement of rejected ballot papers.

(2) The returning officer must not open the sealed packets of —

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the declarations of identity,

(c) the list of spoilt ballot papers,

(d) the list of lost ballot papers,

(e) the list of eligible voters, and

(f) the list of tendered ballot papers.

(3) The returning officer must endorse on each packet a description of —

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

50. Delivery of documents — Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 49, the returning officer is to forward them to the chair of the corporation.

51. Forwarding of documents received after close of the poll — Where —

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement ballot papers are made too late to enable new ballot papers to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

52. Retention and public inspection of documents — (1) The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the regulator, cause them to be destroyed.

(2) With the exception of the documents listed in rule 53(1), the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

(3) A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

53. Application for inspection of certain documents relating to an election —
(1) The corporation may not allow the inspection of, or the opening of any sealed packet containing —

(a) any rejected ballot papers, including ballot papers rejected in part,

(b) any disqualified documents, or the list of disqualified documents,

(c) any counted ballot papers,

(d) any declarations of identity, or

(e) the list of eligible voters,

by any person without the consent of the Regulator.

(2) A person may apply to the Regulator to inspect any of the documents listed in (1), and the Regulator may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part II.

(3) The Regulator's consent may be on any terms or conditions that it thinks necessary, including conditions as to —

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

(4) On an application to inspect any of the documents listed in paragraph (1), —

(a) in giving its consent, the regulator, and

(b) and making the documents available for inspection, the corporation,

must ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established —

(i) that his or her vote was given, and

(ii) that the regulator has declared that the vote was invalid.

Part 9— Death of a candidate during a contested election

54. Countermand or abandonment of poll on death of candidate — (1) If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to —

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that —

(i) ballot papers which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot papers which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

(2) The ballot papers which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot papers pursuant to rule 49(1)(a).

Part 10— Election expenses and publicity

Election expenses

55. Election expenses — Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application to the regulator under Part II of these rules.

56 Expenses and payments by candidates - A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to —

(a) personal expenses,

(b) traveling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

57. Election expenses incurred by other persons — (1) No person may -

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift,

donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

(2) Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 58 and 59.

Publicity

58. Publicity about election by the corporation — (1) The corporation may —

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

(2) Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 59, must be —

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

(3) Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

59. Information about candidates for inclusion with voting documents - (1) The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

(2) The information must consist of— a statement submitted by the candidate of no more than 250 words.

60. Meaning of "for the purposes of an election" - (I) In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

(2) The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

Part II — Questioning elections and the consequence of irregularities

61. Application to question an election — (1) An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to the regulator.

(2) An application may only be made once the outcome of the election has been declared by the returning officer.

(3) An application may only be made to the Regulator by -

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

(4) The application must —

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the Regulator may require.

(5) The application must be presented in writing within 21 days of the declaration of the result of the election.

(6) If the Regulator requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

(a) The Regulator shall delegate the determination of an application to a person or persons to be nominated for the purpose of the Regulator.

(b) The determination by the person or persons nominated in accordance with Rule 61(7) shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

(c) The Regulator may prescribe rules of procedure for the determination of an application including costs.

Part 12— Miscellaneous

62. Secrecy — (I) The following persons —

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to —

(i) the name of any member of the corporation who has or has not been given a ballot paper or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the candidate(s) for whom any member has voted.

(2) No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter.

(3) The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

63. Prohibition of disclosure of vote — No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

64. Disqualification — A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is —

(a) a member of the corporation,
(b) an employee of the corporation,
(c) a director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.

65. Delay in postal service through industrial action or unforeseen event — If industrial action, or some other unforeseen event, results in a delay in —

(a) the delivery of the documents in rule 24, or
(b) the return of the ballot papers and declarations of identity,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll, with the agreement of the Regulator.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JULY 2016

7 DAY SERVICES UPDATE

1 Background

1.1 The Main Board was last updated on the 7 Day Services project in April 2016 and is updated quarterly. This report will comment on the embedded components of the work so far on 7 Day Services, the review of the work in line with the Trust Emergence Care Programme and the Sustainability and Transformation planning across the County.

1.2 This note will also provide an update on the Countywide activity.

1.3 The Board is requested to note this update.

2 Embedded Components

2.1 A substantive Consultant post in Respiratory medicine has been appointed. This enables the practice tested within the respiratory pilot conducted last year to become business as usual.

2.2 The investment in extended evening and weekend ward clerk cover has been completed and appointments made ensuring enhanced cover with this pivotal role across the Trust.

3 National Picture

3.1 The board will recognise the move to progress towards compliance with 4 of the 10 standards by 2018 in line with the national requirements. The 4 standards concerned are Standard 2 - Time to first consultant review, Standard 5 - Diagnostics, Standard 6 - Intervention / key services, Standard 8 - Ongoing review.

3.2 As a Trust we have taken part in the national audit of performance on 7 day Working in March this year and this will be repeated in September. Results of the March 2016 Survey show that the Trust is performing well against the Priority Standards during the week but at weekends and for some specialties there is some development required. Details against the four standards from the survey:

- **Consultant Job Planning**. Of 23 Specialties reviewed in the survey, the Trust is compliant in 12 and has no inpatient service in 5, leaving 6 non-compliant, including Gastroenterology and Cardiology which are to be developed in 2016.
- **Standard 2**. For Standard 2, Time to First Consultant the Trust is below the National Mean for weekdays at 48% against a mean of 68 % (with confidence intervals of 55 – 81%) and for Saturday 35% against a mean of 59% (confidence intervals of 45 – 78%).
- **Standard 5**. Diagnostics includes CT, Echocardiography, Histopathology, Microbiology, MRI, Ultrasound and Upper GI Endoscopy. The Trust has been performing well in this area and continues to show performance above the National Mean in most areas although CT is at 50% against a National mean of 68% (confidence intervals of 75 – 100%). For completed reporting our performance is below the national mean across all diagnostics except Echocardiography (reports within 12 hours for urgent care).
- **Standard 6**. For Standard 6, Consultant Directed Interventions we provide a service across the 7 day week in all areas; Cardiac Pacing, Critical Care Emergency General

Surgery, Interventional Endoscopy, Interventional Radiology, PCI, Renal, Replacement Thrombolysis and Urgent Radiotherapy.

- **Standard 8**. For standard 8, Ongoing Review, the Trust performs well, just short of the National Mean (37% against 38%) for weekdays but falls short at weekends with Saturday at 19% against a National mean of 34% (confidence interval 13-62%).

3.3 Nationally Trusts that indicated full compliance with these 4 standards are now identified as Phase 1 implementers. NHS England are undertaking a deep dive of progress with some Trusts and a higher level review with others (GHNHSFT are included in this cohort) which involves a series of interviews with clinical and managerial staff on the 27th July.

4 Whole Trust Plan and Linkages

4.1 The summary of high level divisional priorities presented in the last Board update generally align well with the national focus on the 4 National Priority Standards listed above. These were developed following an extensive gap analysis. A business case for full implementation of all 10 standards over the period to 2020 has been shared with the Clinical Commissioning Group and discussions are progressing to align the immediate priorities with the Emergency Care programme and the Sustainability and Transformation plan.

- **Emergency Care Programme**

  - **Standard 2 – Time to first Consultant Review.** This standard is central to the work within work streams 1 and 4. The progress towards good performance in the Emergency Department and the revision of the patient pathway to ensure patients are seen by a senior decision maker capable of appropriate assessment and initiating an initial management plan are in line with Standard 2 achievement.

  - **Standard 5. - Appropriate time to diagnostics.** Whilst our performance against this standard was good within the national survey the need for improvement in line with achieving optimum patient flow is acknowledged. Work stream 3 is particularly looking at delays in inpatient pathways and ensuring we align services including diagnostics to need. This needs to be consistent for all patients not just those in hospital for 14+ days (the current focus of work steam 3).

  - **Standard 6 - Access to interventions**. This includes critical care, interventional radiology, interventional endoscopy, emergency general surgery. Work streams 3 and 4 will review and progress some components of these services but others will require additional review and potential investment.

  - **Standard 8 – Ongoing Consultant review.** Work stream 3 is establishing a robust and consistent process for ongoing review which will be extended to all patients as the process is embedded. This will ensure ongoing clinical review and will need to link with work streams 2 and 4 to ensure appropriate escalation and sustainable services to deliver 7 day cover.

- **Sustainability and Transformation plan**

  - Cross County work with the Clinical Commissioning Group and other partners to develop sustainable services are pivotal to the long term delivery of robust Seven Day Services.

- The plans developed with partners include delivery of 7 day working as a key driver and achieving the standards will be key performance indicators relating to this plan.

- The final programme will be important to inform the additional internal and Countywide work necessary to progress towards full compliance with the current high priority standards and future standards as they are implemented.

5 County-wide Activity

5.1 The County-wide Steering Group met in early July and is currently focused on improving weekend discharges from the Acute and Community Hospitals. The group is linking with work we have planned to run a Multidisciplinary Accelerated Discharge Event (MADE) in August. The themes identified at the MADE event will be used as a focus for all providers to improve the weekend services.

5.2 NHS England Project update. Our performance against the national survey is mentioned above. A repeat audit of current performance is planned for September 2016 and this data will enable us to measure progress against the national requirements. We will have participated on the 27 July in the Department of Health/NHSI/NHS England Visit on 7 Day Services deep dive interviews.

6 The Future

Achieving the recommended standards defined in the National 7 Day Services programme is integral to achieving effective flow of emergency patients through our system. Components of the current 4 priority standards are included in the current work internally and with partner organisations. Residual issues will be identified reviewed with partners and progressed.

7 Recommendation

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

Author: **Dr Sean Elyan**

Presenting Director: **Dr Sean Elyan**

Date: July 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD IN THE LECTURE HALL, SANDFORD EDUCATION CENTRE, KEYNSHAM ROAD, CHELTENHAM ON WEDNESDAY 6 JULY 2016 AT 5.30 PM

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

PRESENT

Governors/ Constituency	Mrs S Attwood	Staff, Nursing and Midwifery
	Dr D Beard	Public, Tewkesbury
	Prof C Dunn	Public, Stroud
	Dr C Feehily	Appointed, Health Watch
	Mrs J Harley	Patient, Governor
	Mrs J Hinks	Public, Cotswold
	Mrs C Johnson	Public, Forest of Dean
	Dr P Jackson	Public, Forest of Dean
	Mrs A Lewis	Public, Tewkesbury
	Dr T Llewellyn	Medical and Dental
	Ms C McIndoe	Staff, Other/ Non Clinical
	Mr J Marstrand	Public, Cheltenham
	Cllr B Oosthuysen	Appointed, Gloucestershire County Council
	Mr M Pittaway	Staff, Other/ Non Clinical
	Mrs D Powell	Public, Gloucester
	Ms F Storr	Public, Gloucester
	Mr A Thomas	Public, Cheltenham (Lead Governor)
Directors	Prof C Chilvers	Chair
	Ms D Lee	Chief Executive
	Dr S Pearson	Director of Clinical Strategy
	Mr Tony Foster	Non-Executive Director
Public/ Press/ Observers	None	
IN ATTENDANCE	Mr M Wood	Trust Secretary
APOLOGIES	Mrs P Adams	Staff, AHPs
	Mr R Randles	Staff, Nursing and Midwifery
	Dr A Seymour	Appointed, Clinical Commissioning Group

The Chair welcomed members of the Council and thanked Governors for attending. She referred to the untimely death of Mr Alek Ciecuira, public governor representing the Stroud Constituency. She wished to place on record on behalf of the Governors their thanks for his work and input to the Council. His funeral was held on 27 June 2016 and attended by representatives of the Council. This had been greatly appreciated by his son.

The Chair welcomed Deborah Lee to her fist meeting of the Council of Governors following her appointment as Chief Executive.

ACTION

059/16 DECLARATIONS OF INTEREST

There were none.

060/16 MINUTES OF THE MEETING HELD ON 18 MAY 2016

RESOLVED: That the minutes of the meeting held on 18 May 2016 were agreed as a correct record and signed by the Chair.

061/16 MATTERS ARISING

Update From Governors On Member Engagement: Prof Dunn said that the section of the Salisbury Hospital's website is out of date and the Trust Secretary undertook to pursue this with the Secretary of the South West Governor Exchange Network. *The Trust Secretary reported that this has been escalated with their Trust Secretary and the website is now up-to-date. Completed.*

036/16 Quality Report 2015/16: During the course of the discussion, Mr Marstrand referred to the differing emergency department performance figures in the audited Quality Report and those in the Q4 performance report. The Acting Chief Executive and Finance Director undertook to look into this matter and to respond to Mr Marstrand. *The Finance Team have reviewed the reports on A&E performance that Mr Marstrand highlighted and can confirm that there was a typographical error in the quarter four Governor's summary. The correct data were reported in the Board Performance Management Framework and Quality Account viz 85.6% and 78.5% for the third and fourth quarters of 2015/16 respectively. Completed.*

039/16 Governor Focus Conference: The Lead Governor commended the Governor courses organized by NHS Providers and the Trust Secretary was invited to recirculate the programme and Governors were encouraged to attend relevant courses. *The Trust Secretary reported that the web link to the Govern Well Training Programme has been circulated to Governors with an invitation to let him know if they wish to attend any relevant courses. Completed as a matter arising.*

044/16 Governor Elections: During the course of the discussion in response to a question from Dr Beard, the Trust Secretary undertook to inform existing governors of the date by which they had to submit their nomination papers should they wish to seek re-election and to include that date in the election timetable. *The Trust Secretary reported that this date (4 August 2016) has been included in the election timetable and circulated to Governors. Completed.*

047/16 Governor Sub Committee Reports: The Chair as Chair of the Committee reported on the main items discussed at the meeting of the Patient Experience Strategic Group held on 23 March 2016. Mr Marstrand referred to the patient information leaflets produced by the Trust and the Trust Secretary was invited to provide Governors with the web-link containing that information. *The Trust Secretary reported that the web-link containing this information has been sent to Governors. Completed.*

062/16 MINUTES OF THE MEETING OF THE GOVERNANCE AND NOMINATIONS COMMITTEE HELD ON 22 JUNE 2016

RESOLVED: That the minutes be noted.

063/16 QUALITY REPORT

(Geraldine Daly, Engagement Lead, Grant Thornton, was due to attend the meeting for the presentation of this item but submitted her apologies for not being able to make the meeting due to traffic delays en route from Bristol.)

The Director of Clinical Strategy presented the report prepared by Grant Thornton to Governors on the Quality Report 2015/16. She said that the report had been prepared on three requirements.

1. Compliance with regulations and the conclusion of Grant Thornton was that the quality report was compliant with the regulations.
2. Consistency with other sources of information. Grant Thornton's conclusion, based on the results of their procedures, is that the Quality Report is consistent with the process for identifying and engaging stakeholders in the preparation of the Quality Report
3. The quality of data used in the preparation of the quality report for the incomplete pathways: Grant Thornton's conclusion, based on the results of their procedures, is that the indicator has not been reasonably stated in that a number of errors were identified including four relating to clock start dates. For the A&E four hour wait indicator Grant Thornton, based on the results of their procedures, had concluded that the indicator has been reasonably stated.
4. With regard to the indicator relating to dementia - seek, investigate and refer - chosen by the Governors, Grant Thornton, based on their procedures, had concluded that the indicator has not been reasonably stated as they had identified two of the seven cases tested where performance was understated although this is unlikely to lead to a material error.

The issues identified in the Grant Thornton report will be resolved before the preparation of the next Quality Report.

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

- The Lead Governor said that the report had been presented to the Audit Committee which he attends as a Governor, and expressed concern that errors were identified in the dementia indicator but accepted that this was not a major issue. The Director of Clinical Strategy said that this is a challenge for Grant Thornton as they are not used to undertaking audits on a dementia assessment which is incorporated into discharge summaries. Information is recorded in the notes and may not be translated to the discharge summary and therefore is not counted. An electronic template has been developed and it is not possible to pass that section unless it is undertaken. This will be included in the clinical record in TrackCare.
- The Trust Secretary advised that, in the absence of Grant Thornton but with the Director of Clinical Strategy's explanation, the report be received.

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

RESOLVED: That the report be received.

(Dr Sally Pearson, Director of Clinical Strategy, left the meeting).

064/16 APPOINTMENT OF NON-EXECUTIVE DIRECTOR

The Trust Secretary presented the report providing the Council of Governors with a further opportunity to consider increasing the membership of the Board of Directors by the appointment of one additional Non- Executive Director who will be from the University of Gloucestershire. This will require an amendment to the Trust's Constitution. This recommendation was bought to the Council of Governors for approval by the Board of Directors and had been considered by the Governance and Nominations Committee.

The Trust has established links with the University of Gloucestershire and it now seemed appropriate that the link is established on a more formal basis at Board level in having a Non- Executive Director from the University on the Board of Directors. The appointment of an additional Non-Executive Director will make a total of seven Non-Executive Directors giving a clear majority on the Board rather than the Chair exercising any casting vote. This will fully fulfil the NHS Improvement Code of Governance requirement in that the Board of Directors should comprise a majority of Non-Executive Directors. The process for the appointment of the addition Non-Executive Director will follow that for all other Non- Executive Director appointments.

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

- The Lead Governor said that there were no issues with the process for this appointment but some Governors had concerns about restricting this additional appointment to the University of Gloucestershire. Prof Dunn and Mrs Powell expressed their concerns about limiting the appointment to the University of Gloucestershire. Our Trust has training links with both the University of the West of England in Bristol and the University of Worcester and by limiting those links it might appear that the links were being severed completely.
- In response to a question from Prof Dunn, the Chair said that Dr Harsent's appointment to the University of Gloucestershire was a personal appointment.
- The Chief Executive explained the rationale for the appointment of an additional Non-Executive Director. Firstly, such an appointment will better reflect an understanding of teaching to equip our workforce. Secondly, the Board considered that it is important to develop a strategic alliance within the Gloucestershire community and this could be best achieved by one geographical representative who is best placed to develop the nursing workforce. There is no intention to sever the links with the University of the West of England or the University of Worcester.
- Mrs Powell asked whether an appointment from the University of Gloucestershire could represent other Universities. In response, the Chief Executive said that it would be expected that an appointment from the University of Gloucestershire would have a wide reference group upon which to draw to bring that experience to the Board and this would be included in the job description.
- Prof Dunn commented that the University of the West of England has premises in Gloucester docks and therefore at least has a presence already in the County.
- It was acknowledged that the best person for the post should be appointed and that they must fulfil the criteria of developing a

strategic alliance with our Board on educational priorities. The Chair said that the advantages of a strategic alliance are that people often stay and work in the location where they were trained and this was evidence by people from Bristol who had trained in the County and then returned to Bristol. Research and development links are already being developed with the University of Gloucestershire and it is pleasing that links are being found which were not previously imagined. The proposal to develop the University Technology College in the County will be of benefit.

- The Trust Secretary said that the changes required to the constitution related to increasing the number of Non- Executive Directors to seven (from six) and increasing the quorum of the Board of Directors to five (from four) together with authorising the Trust Secretary to amend the Trust Headquarters upon the move to Alexandra House.

The Chair thanked the Trust Secretary for the report.

In the light of the discussion, the recommendation that the membership of the Board of Directors be increased by the appointment of one additional Non-Executive Director who will be from the University of Gloucestershire was put to the meeting. There were nine votes in favour of the recommendation, five votes against and two abstentions.

RESOLVED: That the membership of the Board of Directors be increased by one additional Non- Executive Director who will be from the University of Gloucestershire and that the changes to the constitution as set out in the report be approved.

065/16 GOVERNOR QUESTIONS

None received.

066/16 066/16 ANY OTHER BUSINESS

Annual General Meeting:

The Chair reminded Governors that the Annual General Meeting is to take place on Saturday 1 October 2016 in the Atrium at the Gloucestershire Royal Hospital. The formal meeting will start at 3:15PM and is scheduled to finish at 4:30PM. At 2:30PM there will be exhibitions remaining from the Extraordinary Everyday event that morning which members are invited to attend. She said that this will be an opportunity for members and governors to meet and she said that a brightly coloured sash will be available for Governors to wear so that they are readily identifiable. Professor Dunn suggested that brightly coloured lanyards with the word 'Governor' could also be used.

067/16 DATE OF NEXT MEETING:

The next meeting of the Council of Governors will be held in The Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital on Wednesday 3 August 2016 commencing at 5:30PM.

068/16 PUBLIC BODIES (ADMISSION TO MEETINGS) ACT 1960

RESOLVED: That under the provisions 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 6:06PM.

Chair
3 August 2016

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