GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on Friday 30 September 2016 in the **Gallery Room, Gloucestershire Hospital** commencing at 9.00 a.m. with tea and coffee. **(PLEASE NOTE VENUE FOR THIS MEETING)**

Professor Clair Chilvers
Chair

23 September 2016

AGENDA

				Approximate Timings
1.	Welcome and Apologies			09:00
2.	Declarations of Interest			
	WELL LED			
	Minutes of the Board and its Sub-Committees	(subject to ratification by the Board and its relevant sub-committees)		
3.	Minutes of the meeting held on 29 July 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 28 September 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 Finance and Performance Committee held on 27 July 2016	**PAPER** (Tony Foster)	**To note**	09:12
8.	Minutes of the meeting of the Finance and Performance Committee held on 24 August 2016	**PAPER** (Tony Foster)	**To note**	09:13
9.	Minutes of the meeting of the Health and Wellbeing Committee held on 5 July 2016	**PAPER** (Tony Foster)	**To note**	09:14
10.	Minutes of the meeting of the Quality Committee held on 15 July 2016	**PAPER** (Clair Chilvers)	**To note**	09:15
11.	Minutes of the meeting of the Quality Committee held on 2 September 2016	**PAPER** (Clair Chilvers)	**To note**	09:16
12.	Minutes of the meeting of the Audit Committee held on 6 September 2016	**PAPER** (Anne Marie Millar)	**To note**	09:20
13.	Minutes of the meeting of the Workforce Committee held on 27 July 2016	**PAPER** (Keith Norton)	**To note**	09:25
	Chief Executive's Report and Environmental Scan			
14.	September 2016	**PAPER** (Deborah Lee)	**To note**	09:30
	EFFECTIVE			
15.	Integrated Performance Framework Report	**PAPER** (Stuart Diggles)	**To endorse**	09:40
16.	Financial Performance Report	**PAPER** (Stuart Diggles)	**To endorse**	09:55
17.	Emergency Pathway Report	**PAPER** (Deborah Lee)	**To endorse**	10:25
18.	Nurse and Midwifery Staffing	**PAPER** (Maggie Arnold)	**To approve**	10:40

19.	Board Assurance Framework and Trust Risk Register	**PAPER** (Deborah Lee)	**To approve**	10:45
20.	Staff Survey Action Plans - Update	**PAPER** (Dave Smith)	**To note**	11:00
	RESPONSIVE			
21.	Complaints and Concerns Q1 April – June 2016	**PAPER** (Maggie Arnold)	**To note**	11:10
22.	Financial Governance Review – Terms of Reference	**PAPER** (Deborah Lee)	**To approve**	11:20
	FOR INFORMATION			
23.	Minutes of the meeting of the Council of Governors held on 3 August 2016	**PAPER** (Clair Chilvers)	**To note**	11:35
	Next Meeting			
24.	Items for the next meeting and Any Other Business	**DISCUSSION (All)**	**To Discuss**	11:40
	Staff Questions			
25.	A period of 10 minutes will be provided to respond to questions submitted by members of staff		**To Discuss**	11:45
	Public Questions			
26.	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**	11:55 12:05
	Break			

Date of the next meeting: The next meeting of the Main Board will take place at on **Friday 28 October 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 GALLERY ROOM, GLOUCESTSHIRE ROYAL HOSPITAL, ON FRIDAY 29 JULY 2016 AT 9AM

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
	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
	Helen Munro	Non-Executive Director
	Keith Norton	Non-Executive Director
APOLOGIES	Helen Simpson	Executive Director of Finance/Deputy Chief Executive
	Anne Marie Millar	Non-Executive Director
IN ATTENDANCE	Martin Wood	Trust Secretary
	Sarah Stansfield	Director of Operational Finance
	Mr Vinay Takwale	Chief of Service-Surgery
PUBLIC/PRESS	Lucy Blandford	GHNHSFT - Staff
	Alan Thomas	Public Governor, Cheltenham
	Rebecca Wassell	Associate Director of Transformation
	R Wachecki	
	Bren McInerney	Public
	Carol McIndoe	Staff Governor (Non-Clinical)
	Kelly Baya	GHNHSFT - Staff
	Xanthe Whittaker	UH Bristol

The Chair welcomed all to the meeting. In particular, she welcomed Sarah Stansfield who was attending in place of Helen Simpson.

ACTION

217/16 DECLARATIONS OF INTEREST

There were none.

218/16 MINUTES OF THE MEETING HELD ON 24 JUNE 2016

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

219/16 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 Chair reported that some progress has been made in relaxing the examination requirements. She undertook to circulate the response received and to raise this issue with NHS Providers requesting that representations be made on behalf of all Trusts. 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 increasing costs of finding replacement parts, reduction in resilience leading to loss of IT services in physical locations and systems, operational disruption, reducing efficiency of clinical delivery and patient throughput (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. *The Director of Clinical Strategy reported that that further work is taking place which is planned to be completed by the end of August 2016. 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. *This have been addressed in the report which appears later in the Agenda as part of Workstream 3. Completed.*

The Chair invited the Executive Team to consider what performance aspirations could be achieved and to include them in the report. *This work is ongoing as part of the wider discussions. Completed.*

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. *The Chair reported she has written to all County MPs and the only response received was from Mr Geoffrey Clifton-Brown. Completed.*

159/16 Cultural Change Programme Update:
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.*

188/16 Integrated Performance Framework Report: The Director of Service Delivery said that he would prepare further details of 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 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.*

188/16 Integrated Performance Framework Report:
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.*

189/16 Financial Performance Report:
The Finance Director would consider for inclusion in future reports details of the working capital facility used. *This item appeared later in the Agenda. Completed.*

195/16 Annual Complaints Report 2015/16:
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 Nursing Director reported that this continues to be addressed by the Quality Committee. Completed.* The medical division are currently piloting ' My hospital' diaries' for patients with dementia on Ryeworth at CGH. The aim of theses diaries is to provide an essential means of sharing information between our patients, their families and care professionals. This is considered as 'best practice' in dementia care. The relationship between our patients, their family and professionals is often referred to as the 'triangle of care.

Information gathered within the diaries not only provides comfort to the patient if read later, but also provides reassurance and promotes patient's well-being. The diary will also support the therapeutic relationship for patients with dementia in hospital. It is the intention of the division to roll this programme to the other GOAM wards and progress will be reported in the divisional quality report.

The Director of Service Delivery undertook to pick up as part of the outpatient project, the recording of patient care. *The Director of*

Service Delivery reported that this is being worked through. Ongoing.

200/16 Minor Injuries Units:
The Chair sought progress on revisiting the publication on our Trust website of waiting times in Minor Injuries Units. In response the Director of Service Delivery reported that there are two different IT systems involved and he is looking to see if a solution can be found to provide basic information with a view to putting more substantive information later. *Completed.* [09:04]

220/16 SUMMARY OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 27 JULY 2016

The Chair of the committee, Mr Tony Foster, presented a summary of the meeting held on 27 July 2016. He drew attention to the change in the reporting arrangements where data are provided to give a level of assurance. On the particular issues, the Committee considered cancer 62 day performance and the issues in urology where assurance had not been provided, theatre efficiency, debtors and creditors, and NHS Improvement criteria to access Sustainability and Transformation funding. A meeting of the Committee is to be held in August 2016 when the cancer recovery plan will be re-presented. No detail on the calculation of the Financial Risk Rating has been provided and had been provided for all future reports.

The Chair thanked Mr Foster for his report.

RESOLVED: That the summary be noted. [09:09]

221/16 MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE HELD 22 JUNE 2016

These minutes were deferred to the meeting in August 2016. [09:09]

222/16 MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING COMMITTEE HELD ON 5 JULY 2016

The Chair of the Committee, Mr Tony Foster, presented a summary of the meeting of the Health and Wellbeing Committee held on 5 July 2016. He highlighted the presentation from the Associate Director of Estates and Facilities on catering.

The Chair thanked Mr Foster for his report.

RESOLVED: That the summary be noted. [09:10]

223/16 MINUTES OF THE MEETING OF THE QUALITY COMMITTEE HELD ON 15 JULY 2016

(Mr Gordon Mitchell joined the meeting).

The Chair of the Committee, Mr Gordon Mitchell, presented a summary of the meeting of the committee held on 15 July 2016. The Committee considered three themes around assurance. Firstly, the Estates and Facilities Division provided positive assurance of improvement with issues highlighted for attention being smoking at

entry points to the hospitals, environmental improvements and re-assurance that ways will be found to recover deep cleaning which is behind schedule due to operational pressures. Secondly, annual reports on serious untoward incidents, safeguarding and medical optimisation had been received. Thirdly, a presentation was received on the clinical risk management of SmartCare. The Director of Clinical Strategy added with regard to SmartCare that the ISO standards are non-mandatory but have been agreed with InterSystems that they will be adopted which will be helpful for delivery of the project.

The Chair thanked Mr Mitchell for his report.

RESOLVED: That the summary be noted. [09:14]

224/16 SUMMARY OF THE MEETING OF THE WORKFORCE COMMITTEE HELD ON 27 JULY 2016

The Chair of the Committee, Mr Keith Norton, presented a summary of the meeting of the Workforce Committee held on 27 July 2016. He highlighted that this was the inaugural meeting of the Committee where terms of reference had been determined. The Chief Executive presented her top workforce priorities. A draft Workforce Strategy was presented which will be considered further at the next meeting of the Committee in September 2016. Governors have been invited to serve on the Committee. The Director of Human Resources and Organisational Development added that the draft Workforce Strategy will be circulated to stakeholders for comment.

The Chair thanked Mr Norton for his report.

RESOLVED: That the summary be noted. [09:16]

225/16 CHIEF EXECUTIVE'S REPORT AND ENVIRONMENTAL SCAN

The Chief Executive presented her report stating that the positive welcome from staff across our Trust has continued. The priorities for our organisation are becoming clearer and unsurprisingly there are several key challenges ahead.

She highlighted the report under each of four main headings and added the following. With regard to the junior doctors' contract, meetings have been held with junior doctors locally and a positive response has been received for contract implementation from October 2016. Our Guardian of Safe Working has been appointed. Following attendance at the Sustainability and Transformation Plan (STP) "check point" meeting on 15 July 2016, our Plan has been placed in category 1 which has a light touch from regulators. The Chief Executive had sought support for our capital scheme changes of £70M and the "must do" schemes of £19M. Positive feedback had been received to develop the "must do" scheme for submission to NHS England in September 2016. Bids exceed the capital available but she remains hopeful of a contribution to our Trust. Operational pressures continue with particular challenges on 25 July 2016 which were more like a peak in winter months. This is a national issue. There is positive engagement with partners and it is hoped that

escalation capacity will cease by the end of August 2016. An announcement by NHS Improvement on our failure to meet the national four hour A&E standard is expected later on the day of the board meeting. She said that our Trust is well underway on its journey to improve and she expressed her appreciation to the Board for acknowledging the pressures that staff, throughout the organisation, are currently working under.

The Chief Executive additionally reported that on 19 July 2016 an open day was held with the University of West of England to promote nurse training. 103 people who attended the event have expressed an interest in registering with most of the places now taken up. She expressed her thanks to the Nursing Director and the Director of Human Resources and Organisational Development and their teams for the success of the event.

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

- Mrs Munro referred to the number of medically fit patients of 75 at the end of June 2016 and asked if discussions with our partners are sufficiently robust to make an improvement. In both response, the Chief Executive said that there is ambition and commitment to make a difference. Partners recognise that the actions which they have all committed to now need to be managed and delivered. A pilot scheme has been introduced in the Forest of Dean where community nurses will attend our wards to assess medically fit patients from that area to see if they can return home. The pilot is of three weeks' duration and if it makes a difference it will be rolled out further. From August 2016 eight GPs will be working at the front door of the Emergency Departments with the aim of reducing the number that go into be admitted.
- The Nursing Director reported that the Senior Nursing Committee has expressed appreciation of the improvement in the language in communications sent to complainants.
- The Medical Director emphasised the pressure in the system in that on the current run rate it is likely that attendances in the Emergency Departments during July 2016 will exceed 12,000.
- Mr Lewis asked if there is a risk in nurse recruitment by the removal of bursaries. In response, the Chief Executive said that this will be significant if our Trust does nothing. The University of Gloucestershire is committed to providing nurse training which will be of considerable benefit to our Trust.
- The Chair reminded Board members to prepare their pledge to delivering Best Care for Everyone.

The Chair thanked the Chief Executive for her report.

RESOLVED: That the report be noted. [09:39]

226/16 INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK REPORT

The Director of Service Delivery presented the report summarising the key highlights and exceptions in Trust performance up until the

end of June 2016 for the financial year 2016/17. A number of measures reflect an unvalidated position for June 2016 and, as such, may change when reported in July 2016 though typically not materially. Of the areas for improvement he highlighted Emergency Department performance, planned/surveillance endoscopy patients waiting at month end and the 18 week Referral to Treatment Target. Assurance could not be provided that our Trust will achieve all of the cancer measures and a clearer action plan will be provided for the next meeting. This is a risk to our Trust. The Finance and Performance Committee noted that Acute Kidney Injury (AKI) performance has fallen each month in quarter 1 and have referred the matter to the Quality Committee for detailed review. The Director of Service Delivery is working with the Nursing Director to improve the performance of women seen by a midwife within 12 weeks which remained slightly below target throughout quarter 1.

The Director of Service Delivery drew attention to the increase in GP referrals of 7.9% and Emergency Department attendances have increased 9.6%, both in excess of plan. 50% of cancer issues are in urology due to the increased referrals. The number of planned/surveillance endoscopy patients waiting at month end is now approximately 500 and a clinical review is to be presented to the Quality Committee in September 2016. Our follow up appointments are in excess of national standards and a review is being undertaken to agree less frequent follow ups. Two locum appointments have been made into substantive posts to improve performance. The Chief Executive added that demand and supply in urology are not balanced and this is being addressed. Locums typically are able to provide the same level of quality and there is an increased cost in their use. Action needs to be taken earlier when it becomes known that demand cannot be met. She has raised this with NHS Improvement and is confident that performance can get back on track but we are very unlikely to meet our original trajectory. Our Trust needs to be more proactive in addressing potential issues such as the 18 week Referral to Treatment performance.

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

- Mrs Munro drew attention to the positive elements of the key highlights including dementia performance. She observed that the total number of C-Difficile cases in quarter 1 of 10 has exceeded the quarterly target of 9 and should be monitored. The Nursing Director added that three cases of C-Difficile have been agreed with commissioners as unavoidable.

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

RESOLVED: That the Integrated Performance Framework Report be noted and the actions being taken to improve performance be endorsed. [09:50]

227/16 FINANCIAL PERFORMANCE REPORT

The Director of Operational Finance presented the report providing a high level review of the financial position for June 2016. The financial position of our Trust at the end of June 2016 is an operating deficit of

£1.88M which represents a small favourable variance of 0.02M against the plan position. NHS Improvement has accepted the revised trajectory plan which reflects the additional costs currently relating to operational pressures and the non-recurrent costs in quarter 1 and 2 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. Latest guidance on Sustainability and Transformation Funding (STF) means that our Trust should receive the full amount for quarter 1 of the 2016/17 financial year which will support our cash position. There has been slippage in the Cost Improvement Programme and the Cost Improvement Programme Director's engagement has been extended to December 2016 to develop an annual plan to mitigate that slippage. Our Trust's cash balance at the end of June 2016 was £5.7M.

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

- The Chair referred to the Cost Improvement Programme Strategy noting that it is a considerable challenge now that the readily identifiable savings have been made. In response, the Chief Executive said that the Strategy links to our transformation work to reduce our cost base and to give sight of quality impacts on the programme. Our Trust spends £20M per annum on agency staff which is typically detrimental to quality and is an area to be addressed quickly. There is a link between the correct staffing numbers and capacity. However, there are hard to fill posts; for example, middle and junior doctor rotas and there is no quick solution to this given the national position. However, roles and duties can be examined locally. The immediate challenge is to reduce agency expenditure and in the future to be more creative in the way roles are performed.
- The Medical Director commented that there has been an over-focus on nursing expenditure and there needs to be a solution to get to the right number of substantive medical posts which will improve quality and reduce expenditure. The Director of Human Resources and Organisational Development added that this is an area being looked at by the Sustainable Workforce Group which will report to the Workforce Committee.
- The Director of Service Delivery reported that a revised action plan has now been agreed at Cirencester Hospital which will increase utilisation from September 2016. Clear promotional material has been provided.
- Mr Foster said that the Cost Improvement Programme Director is working to increase the proportion of savings which are recurrent , which was to be welcomed.

The Chair thanked the Director of Operational Finance for the report.

RESOLVED: That:-

- 1) The financial position of the Trust at the end of month 3 of the 2016/17 financial year is an operational deficit £1.88M be noted. This is a small favourable variance to plan of £0.02M.
- 2) Commissioners contract challenges are significant and a

risk assessment has currently been made against these.

- 3) Actions to address the issues identified in the report will continue and progress will continue to be reported monthly to the Finance and Performance Committee and the Board.
- 4) The Director of Finance, Director of Service Delivery and the Cost Improvement Programme Director have recommended a financial recovery programme to provide greater assurance that our Trust can improve its current financial performance. [09:59]

228/16 EMERGENCY PATHWAY MONTHLY REPORT

(Sue Barnett, Improvement Director, joined the Meeting).

The Chief Executive presented the report providing the Board with assurance regarding the safety and quality of emergency care services within our 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 30 June 2016. The Emergency Care Programme Board has now been established and the reporting mechanism needs to evolve further.

Of the key messages the Chief Executive highlighted that our Trust met the agreed improvement trajectory of 85% for June 2016 with Trust-wide performance (including GP in the emergency department activity) reported as 87.37%. The position for quarter 1 was 86.97%. However, this performance did not meet the 95% four hour target for the Emergency Department and was a slight decrease compared to our performance in May 2016 of 87.73%. On safety and quality issues there were no serious untoward incidents reported since the meeting of the Board in June 2016. There has been an improvement in the 15 minute to assessment performance leading to improved safety but further work in this area needs to be undertaken. The SHINE checklist is operating in both Emergency Departments to give greater visibility on safety aspects and provides assurance. A plan is being prepared for a response to provide safe services in high peaks of demand. The first meeting of the Emergency Care Programme Board provided good oversight and good progress being made w. A significant number of breaches occurred from minors which she considered to be unusual as plans to address this are in hand. A review of the workforce is underway and is expected to be completed by the end of July. The Emergency Department at Gloucestershire Royal Hospital is not correctly sized and original plans to expand with a larger suite will lead to operational disruption and not improve performance. It is now proposed that a minor scheme proceed to accommodate additional resuscitation capacity with minimal operational impact. The Utopia model is being reviewed as part of Workstream 4 and good progress is being made.

The Director of Service Delivery said that the workstreams have a comprehensive plan for improvement where there is a greater focus on the front end of the pathway. Actions are in line with other Trusts

and the main issue is patient flow and discharges. The new approach has been operating for approximately six weeks and front line staff are commenting that the working experience is better.

The Improvement Director said that the last two weeks have been particularly challenging for staff and she wished to place on record her appreciation their considerable efforts during this difficult period. On 28 July 2016 NHS Improvement published its National Improvement Plan and some of the actions in that plan are already in place internally and the publication will assist in discussions with partner organisations. The Chief Executive added that the improvement plan's underlying focus is on the Emergency Department and lighter on system-wide plans.

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

- Mr Mitchell asked what safety measures are in place during periods of high demand noting that the 15 minute to assessment performance is currently 80%. In response, the Medical Director said that there is not one safety measure. The 15 minute to assessment target is an internal measure with a one hour safety meeting taking place. He acknowledged that performance in the 15 minute to assessment measure should be 90%+ and work to achieve this would continue. The Improvement Director added that the position is improving.
- The Chief Executive said that she will work with the Board to develop a safety assurance report which was supported by the Chair. The Director of Service Delivery said that such a report is likely to be available for the September 2016 Board meeting.

The Chair thanked the Chief Executive for the report.

RESOLVED: That the report be noted and the actions being taken to improve performance be endorsed. [10:18]

229/16 NURSE AND MIDWIFERY STAFFING

The Nursing Director presented the report updating the Board on the exception report made regarding compliance with the "Hard Truths" – safe staffing commitments for June 2016. The report now includes data regarding contact time per nurse and the Divisional Nursing Directors have analysed their Departments' data and their responses were set out in the report. The recent publication "Safe Sustainable and Productive Staffing Improvement Resource" is being analysed together with our own Care Hours Per Patient Day (CAPPD) data and actions will be taken as appropriate. The new regulation regarding revalidation became effective in 2016. Revalidation workshops are running which help staff understand the process and give them an opportunity to ask questions. These workshops have so far been very well attended and positive feedback has been received. The recruitment process continues but the current financial situation will not allow our Trust to continue as before and support needs to be given to undertake tasks differently, This will require assurance that patient care is not affected and the Nursing Director is seeking

guidance from NHS England if this approach is being undertaken elsewhere from which our Trust can learn. The recommendations in the Carter Report regarding rostering are being examined; however, the Nursing Director stressed that if a patient needs nursing care it will be provided. That will incur a cost but if undertaken by substantive staff will be at a lower cost than agency staff. The work undertaken by Surgery Division in this regard is being considered further.

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

- Mrs Munro referred to the increased sickness levels with RGNs and said that she would feed this into the Health and Wellbeing Committee to help support for staff. **HM**
- Mr Foster supported the approach of finding different ways of working. He also said that there should be a focus on exit interviews to understand better the reasons why staff leave our Trust. The Director of Human Resources and Organisational Development said that a focus group will be starting work in September 2016 on this aspect and a report will be presented to the Board in autumn 2016.
- The Director of Service Delivery said that arrangements are in place to track outlier patients to get them into the right area. This may lead to an extra move but in overall terms is a better experience for both patients and staff.

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. [10:27]

230/16 BOARD STATEMENTS

The Director of Operational Finance presented the report advising that the Trust is required to confirm the following Board statements:-

- *For finance that:* the Board anticipates that the Trust will deliver a 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; and the commitment to comply with all known targets going forwards.
- *Otherwise:* The Board confirms that there are no matters arising in the quarter requiring an exception report to NHS Improvement which have not already been reported.

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

The Chair of the Finance and Performance Committee reported that the following recommendations are made to the Board:-

- Finance to be amended so that the Board remains committed

that the Trust will deliver a Financial Sustainability Risk Rating (FSRR) of 3 by the end of the financial year 2016/17.
- The exception report be amended to state that our Trust did not meet the 62 day or the two week wait cancer target for Q1. However, we continue to have demand and capacity action plans in place and these improvement plans have shown benefit in addressing both standards.
- The Chair said that in future reports an analysis be provided of the Trust's performance in each area.

The Chair thanked the Director of Operational Finance for the report.

RESOLVED: That:-
- 1) The Board remains committed that the Trust will deliver a 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.
- 2) An exception report is made to NHS Improvement on the ED four hour standard, cancer 62 day standard and two week wait 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 the commissioners and NHS improvement.
- 3) The Board is satisfied that the plans in place are sufficient to ensure ongoing compliance with all other existing targets as set out in the compliance framework and the commitment to comply with all known targets going forward. [10:34]

231/16 BOARD ASSURANCE FRAMEWORK AND TRUST RISK REGISTER

The Chief Executive presented the report inviting the Board to note the 2016/17 Board Assurance Framework (BAF) and Trust Risk Register (TRR). 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 board in August 2016. The BAF sets out the controls to mitigate the potential risks to the delivery of the annual objectives and provides assurance that the controls are effective or describes further actions to strengthen those controls. Where the risk exposure becomes significant then those risks will appear on the TRR to ensure there is clear visibility. The BAF and TRR will be developed in the Trust Management Team. **DL**

The Chair invited the board to consider the risk rating in each element of the BAF and the following amendments were made:-
- Page 9- 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 – risk rating to be increased from 3x4=12 to 4x4=16
- Page 10- Risk of inability to reduce demand for outpatients follow up activity in line with commission plan- risk ownership to also include the Medical Director.

- Page 13- 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 – risk rating of 2x4=8 considered to be too low.
- Page 18- Risk of poor engagement with staff which negatively impacts on our vision and movement towards Best Care For Everyone – amend risk rating to 3x4=12 (from 2x4=8).

The Chair thanked the Chief Executive for the report.

RESOLVED: That the updated Board Assurance Framework be noted and the revised approach be endorsed and in doing so the potential risks to the 21016/17 objectives and the controls in place to mitigate these risks. [10:40]

232/16 STAFF SURVEY ACTION PLANS

The Director of Human Resources and Organisational Development presented the report providing an update on the key action plans at Trust and Divisional level arising from the 2015 staff survey findings. The results of the 2015 staff survey were cascaded to a wide range of stake holders with a view to obtaining feedback to inform both the Corporate and Divisional Plans. Following that feedback the Director of Human Resources and Organisational Development and the Head of Leadership and Organisational Development drew up a plan designed to recognise and address the key issues with the top three priorities being parking, maintenance of the estate and bureaucracy. It is important that the workstreams established as part of Trust-wide "rolling" plans continue. All Divisions have now recognised the importance of engagement and their role in developing it with Divisional Action Plans refreshed locally each year. The Chief Executive has stated very clearly the importance she places on engagement and her clear expectation that traction on this will gather pace.

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

- Mr Norton said that communication from the Board should be open, honest and effective as reliance on cascading communication was not effective. In response, the Chief Executive said that a fourth priority should be promoted relating to openness, candour and transparency. The Director of Human Resources and Organisational Development undertook to liaise with the Head of Communications on the best methods for communication. **DS/CM**
- The Chair invited the Director of Human Resources and Organisational Development to present a further update to the board in September 2016. **DS (MW to note for agenda)**
- Mr Norton suggested that as part of transformation the Board should be explicit in its communication.

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

RESOLVED: That :-

1) The Trust-wide rolling action plans arising from the 2015 (and

previous) staff survey(s) be noted.
2) The individual Divisional Engagement Plans be noted.
3) The top four issues raised by staff and the commitment to resolving them and publicising progress be endorsed. [10:51]

233/16 PROPOSED REVISIONS TO THE CONSITUTION

The Trust Secretary presented the report inviting the Board to consider the recommendation from the Governance and Nominations Committee that proposed revisions to our Trust's constitution be approved. One element of the Governor Effectiveness sections of the Board Governance Review is to undertake a review of our Trust's constitution. The Council of Governors agreed that the constitution be updated in two phases; firstly, an initial set of amendments relating to updating terminology and clarification which would refresh the documentation in place in anticipation of our Trust achieving Foundation Trust status in 2004 and, secondly, a set of issues requiring wider discussion. Apart from updating terminology and clarification the main change relates to the appointment of Stakeholder Governors where the recommendation is that there should be up to four Stakeholder Appointed Governors, one from the Gloucestershire Clinical Commissioning Group, one from Gloucestershire County Council, and one from Health Watch Gloucestershire (or their successor organisations). The fourth position could be an appointment from any other Stakeholder or partner organisation as agreed at the time by the Board and the Council of Governors. The proposed changes to the constitution were shown in track changes in the document attached to the report. Revisions to the constitutions require the approval of both the Board of Directors and the Council of Governors.

The Trust Secretary then presented the supplemental report providing the Board with an opportunity to amend the definition in the constitution of the out of county patient constituency to give greater clarity of eligibility for membership of our Trust which in turn will allow those members, if they so wish, to seek election/appointment to other positions in our Trust. It was proposed that the current patient constituency be replaced by a public constituency; membership of the public constituency is open to individuals who are resident in an out of county geographical area where services are provided to the population living in that area. The required amendments to the constitution to give effect to this proposal were set out in the report.

The Chair thanked the Trust Secretary for the reports.

RESOLVED: That the proposed revisions to the trust's constitution as set out in the report and the supplemental report be approved. [10:54]

234/16 SEVEN DAY SERVIDES UPDATED

The Medical Director presented the report providing an update commenting on the embedded components of the work so far on seven day services, the review of the work in line with our Trust emergency care programme and the sustainability and transformation planning across the county. A substantive consultant

post in respiratory medicine has been appointed enabling the practice tested within the respiratory pilot to become business as usual. The investment in extended evening and weekend ward clerk cover has been completed ensuring enhanced cover with this pivotal role across our Trust. In line with national standards our Trust is required to move to progress towards compliance with four of the ten standards by 2018. Our Trust has taken part in the national audit performance on seven day working in March 2016 which will be repeated in September 2016. Results of the March 2016 survey show that our Trust is performing well against the priority standards during the week but at weekends and for some specialities there is some development required. Plans are in place to improve performance. NHS England undertook a deep dive of progress with some Trusts and a higher level review with others (including our Trust) in July 2016. The gaps identified were understood and plans are in place to move forward. A business case for full implementation of all ten 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. Meeting the recommended standard is integral to achieving effective flow of emergency patients through our system. Components of the current four priority standards are included in the current work internally and with partner organisations.

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

- Mr Norton asked when our Trust will fully implement seven day services. In response, the Medical Director said that there is a very high likelihood that the full standards will be achieved by 2018 with the aim to implement sooner.
- The Chief Executive said that insufficient detail was provided to the Clinical Commissioning Group for our Trust to receive financial investment in the first round. Our Trust is clear on the gaps and an application for financial assistance on a smaller scale will be submitted for the next round.
- The Chair said that update report should continue to be presented to the Board quarterly. **SE (MW to note for agenda).**

The Chair thanked the Medical Director for the report.

RESOLVED: That the update on progress towards the introduction of seven day services into our trust be noted. [11.01]

235/16 MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON 6 JULY 2016

The Chair presented the minutes of the meeting of the Council of Governors held on 6 July 2016.

RESOLVED: That the minutes be noted. [11:01]

236/16 ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

Items for the next meeting:
No additional items were identified for the next meeting which will

focus on financial, performance and Emergency Department issues.

Any other business:
There were no further items of business.
[11:01]

237/16 STAFF QUESTIONS

There were none.

238/16 PUBLIC QUESTIONS

Mr Bren McInerney submitted the following question "After being elected, how do the Foundation Trust Governors actively connect with their constituency members?"

The Chair read the response to this question as follows: -

Communication between Governors and members is an area highlighted for further development in the Governor Effectiveness Section of the recent Board Governance Review. The Council of Governors is taking this forward with the aim by October 2016 to have set up a working group to review arrangements and propose an action plan. This will include a review of the resources needed. Arrangements in place at other NHS organisations will be explored including the possibility of collaboration with local NHS partner organisations on public engagement activities.

239/16 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at **9am** on **Friday 26 August 2016** in the **Board Room, Alexandra House, Cheltenham General Hospital.**

240/16 EXCLUSION OF THE PUBLIC

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

The meeting ended at 11: 03 am.

Chair
26 August 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – SEPTEMBER 2016

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
September 2016	May 2016 Minute 151/16 Acting Chief Executive's report and Environmental Scan - Trust Risk Register	**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 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. *The Director of Clinical Strategy reports that* the *outcome based tender was awarded on high-level design with assumptions. Low-level design activities have exposed a higher degree of technical complexity and integration with existing design and technology than originally believed. Additional workshops are being held between GHC and our technology partner, Updata, to validate the correct solution and any dependencies which has brought about the delay to implementation against original plan. Completed.*
September 2016	June 2016 Minute 195/16 Annual Complaints Report 2015/16	**EG**	The Director of Service Delivery undertook to pick up as part of the outpatient project, the recording of patient care. *The Director of Service Delivery reports that this is now a standing item on the Outpatient Delivery Team meeting from the meeting on 22 September 2016. Completed.*
September 2016	July 2016 Minute 229/16 Nurse and Midwifery Staffing	**HM**	Mrs Munro referred to the increased sickness levels with RGNs and said that she would feed this into the Health and Wellbeing Committee to help support for staff. *This has been undertaken. Completed.*

September 2016	July 2016 Minute 232/16 Staff Survey Action Plans	**DS** **DS**	Mr Norton said that communication from the Board should be open, honest and effective as reliance on cascading communication was not effective. In response, the Chief Executive said that a fourth priority should be promoted relating to openness, candour and transparency. The Director of Human Resources and Organisational Development undertook to liaise with the Head of Communications on the best methods for communication. *This has been undertaken. Completed.* The Chair invited the Director of Human Resources and Organisational Development to present a further update to the board in September 2016. *Ongoing.*

FUTURE TARGETS

October 2016	May 2016 Minute 234/16 Seven Day Services Update	**SE**	The Chair said that update report should continue to be presented to the Board quarterly. *Ongoing.*

COMPLETED 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 Chair reported that good progress has been made in relaxing the examination requirements. She undertook to circulate the response received and to raise this issue with NHS Providers requesting that representations be made on behalf of all Trusts. Completed.*
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. *This have been addressed in the report which appears later in the Agenda as part of Workstream 3. Completed.* The Chair invited the Executive Team to consider what performance aspirations could be achieved and to include them in the report. *This work is ongoing as part of the wider discussions. Completed.*
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. *The Chair reported she has written to all County MPs and the only response received was from Mr Geoffrey Clifton-Brown. Completed.*
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. *This item appeared later in the Agenda. Completed.*
July 2016	June 2016 Minute 195/16 Annual Complaints Report 2015/16	**MA**	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 Nursing Director reported that this continues to be addressed by the Quality Committee. Completed.*
July 2016	June 2016 Minute 200/16 Minor Injuries Units	**CC**	The Chair sought progress on revisiting the publication on our Trust website waiting times in Minor Injuries Units. In response the Director of Service Delivery reported that there are two different IT systems involved and he is looking to see if a solution can be found to provide basic information with a view to putting more substantive information later. *Completed.*

ITEM 5

SUMMARY OF THE MEETING OF THE FINANCE COMMITTEE TO BE HELD ON 28 SEPTEMBER 2016

PAPER (To follow)

Tony Foster
Chair

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST FINANCE AND PERFORMANCE COMMITTEE HELD IN THE BOARDROOM, 1 COLLEGE LAWN, CHELTENHAM ON WEDNESDAY 22 JUNE 2016 AT 10AM

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

PRESENT	Tony Foster	Non-Executive Director (Chair)
	Deborah Lee	Chief Executive
	Gordon Mitchell	Non-Executive Director
	Keith Norton	Non-Executive Director
	Helen Simpson	Executive Director of Finance
	Eric Gatling	Director of Service Delivery
APOLOGIES	None	
IN ATTENDANCE	Martin Wood	Trust Secretary
	Sarah Stansfield	Director of Operational Finance

The Chair welcomed the members of the Committee to the meeting and in particular, he welcomed Deborah Lee to her first meeting of the Committee following her appointment as Chief Executive. He also welcomed Sarah Stansfield to her first meeting as Director of Operational Finance.

ACTION

082/16 DECLARATIONS OF INTEREST

There were none.

083/16 MINUTES OF THE MEETING HELD ON 18 MAY 2016

RESOLVED: That the minutes of the meeting of the Finance and Performance Committee held on 18 May 2016 were agreed as a correct record and signed by the Chair subject to the following amendments:-
-035/16 Financial Performance Report: The second sentence to be amended to read 'Mr Foster observed that if the creditor position improved the existing working capital facility, if needed, could be used to pay suppliers.'
-067/16 Declarations of Interest: Mr Norton's Declaration of Interest to relate to the Roses Theatre, Tewkesbury (and not Cheltenham).

084/16 MATTERS ARISING

073/16 Cash Position Update: The Finance Director said that a Report on the Cash Position including creditor/ debtor details will be presented to the next meeting of the Committee in July 2016. **HS (MW to note for agenda)**

In response to a question from the Chair about the Working Capital Facility, the Finance Director said that it is used when needed and replenished at month end. She expressed confidence that the Treasury Management arrangements including the management of cash will be better in the future. A credit controller is to be appointed reporting directly to the Director of Operational Finance. The Finance Director undertook to share the draft report with the Chair. The Chief Executive said that information should be provided on the debtors greater than 120 days with an indication as to their age. The Finance Director said, in response, that some relate to Gloucestershire Care

Services. The Director of Operational Finance added that the result of the arbitration with Gloucestershire Care Services (GCS) in our favour is still being worked through to understand the GCS components which is approximately £1m attributable to the last financial year. GCS have declined to pay for the County IT Service which is being pursued.

The Director of Operational Finance said that the revised report format is in draft form which she will share with the Finance Director and circulate to the Committee Members for comment with a view to it being in effect in month four.

085/16 DIVISIONAL ATTENDANCES

The Finance Director provided a presentation setting put the background to the financial position, a summary of the Cost Improvement Plan for 2016/17, the risks to delivery and the next steps. Each of the five Divisions had supplied a presentation setting out the year to date performance, financial controls and Cost Improvement Programme delivery and performance issues. Each Division highlighted the main points from their respective presentations and were questioned by the Committee.

Medicine

(Bob Pearce, Divisional Operations Director, attended the meeting for the presentation of this item. Apologies were received for Dr Mark Silva and Mrs Sue Milloy)

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

- In response to a question from Mr Norton, the Director of service delivery said that Cost Improvement Pans should be included as part of the personal objectives for staff.
- In response to a question from the Chief Executive, the Director of Operational Finance said that all Divisional schemes are validated by the Cosy Improvement programme Director to ensure that there is no double counting.
- The Divisional Operations Director explained that the Division is more focused with each Service Line drawing up plans both for the current and the next financial year. Acknowledging the demand and capacity issues, he expressed a reasonable level of confidence that the plans can be delivered. The main risks related to the efficient flow of patients, changing working practices in cardiology, changes in stroke patients with movement out of hospital.
- Mr Mitchell asked whether there is capacity to deliver the Programme. In response, the Divisional Operations Director said that said that are staffing issues with vacancies and sickness in respiratory, cardiology, stoke and General Old Age Medicine (GOAM) which are being addressed. Work is in place to strengthen Assistant General Managers. There are similar challenges in nursing.
- In response to a question from the Chair, the Divisional Operations Director said that the financial challenges are to reduce agency and non-pay overspend.
- The Divisional Operations Director said in response to a question from Mr Norton that Business Cases for the more

straightforward schemes are to be prepared within the next month with the more complex cases falling into next year.
- In response to a question from the Chief Executive, the Director of Service Delivery said that there are no coding changes as part of the contract with the Clinical Commissioning Group.

The Chair thanked the Divisional Operations Director for his presentation.

Surgery

(Beryl Woodall, Divisional Operations Director and Paul Garrett, Divisional Nursing Director attended the meeting for the presentation of this item. Apologies were received for Mr Vinay Takwale)

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

- The Divisional Operations Director said in response to a question from the Chair that the Cost Improvement Plans are close to target. The focus is on the quality of clinical pathways, greater efficiency with patient flow and to finding ways to increase capacity for cancer Referral To treatment targets. Staff have been asked for their ideas both to save money and generate additional income. The focus is on outpatients, theatres, non-pay and developing clinical leads. Weekly deep dives are held in all specialities. The Divisional Operations Director expressed confidence in delivering the Cost Improvement Programme target.
- In response to a question from the Chair, the Divisional Operations Director said that a reduction of 20 theatre sessions will provide a full year saving of approximately £1.95m. Proposals are being sense checked with Clinicians including community theatres. The Finance Director added that in line with the Carter proposals, our Trust should do what is in its gift regarding theatre utilisation. The Director of Service Delivery stressed the link with both Medicine and Surgery Divisions over theatre utilisation and the ring fencing of surgery beds. The Divisional Nursing Director said that the Division will liaise with Surgery Division looking at the wider organisational picture. The theatres in Cirencester are now operational and need to be fully utilised. A deep dive is being undertaken into consultant job plans.
- The Director of Service Delivery said that saving could be achieved by ceasing day surgery overnight. The Division needs to focus on agency and non-pay spend.

The Chair thanked the Divisional Operations Director and the Divisional Nursing Director for their presentation.

Women & Children

(Hillary Lucas, Divisional Operations Director and Vivien Mortimore, Divisional Nursing Director attended the meeting for the presentation of this item. Apologies were received for Mr Dhushy Mahendran)

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

- The Divisional Operations Director expressed confidence that

the cost Improvement Programme can be delivered. A scheme to provide a better patient experience in gynaecology at Gloucestershire Royal Hospital is underway which will also increase income. The Divisional Nursing Director added that this will improve staff retention. The Director of Service Delivery said that the capital costs for the scheme need to be resolved. The planned start date of 1 August 2016 may be too soon but it was acknowledged that a date needed to de determined soon for the right staff to be in place.

- In response to a question from the Chair, the Divisional Operations Director said that the agreed Cost Improvement Programme schemes will have completed Project Initiation Documents prepared within the next ten days. Schemes will be delivered throughout the year. Income could be increased with a protected bed base for private patients.
- In response to a question from the Chair, the Divisional Operations Director said that some schemes need to be finalised to provide over performance in month 1 of the 2017/18 financial year.
- The Divisional Operations Director in response to a question from the Chair expressed in the light of the challenges confidence in delivering the Cost Improvement Programme.

The Chair thanked the Divisional Operations Director and the Divisional Nursing Director for their presentation.

Diagnostics & Specialties

(Tracy Iles, Divisional Operations Director, Jon Burford, Divisional Nursing Director and Nicola Turner, Divisional Director AHP and Scientific Staff attended the meeting for the presentation of this item. Apologies were received for Dr Frank Jewell)

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

- The Divisional Operations Director stressed that the Division needs to engage with other Divisions to work on Cost Improvement Programme schemes. The Division should receive the proportion of the savings. There is currently a Cost Improvement Programme gap of approximately £1m. Plans to reduce expenditure in Outpatients and the operating plan will close this gap. The Finance Director commented that the Carter Review has identified areas in Outpatients where considerable savings can be achieved.
- The Divisional Director AHP and Scientific Staff added that following a meeting on 21 June 2016 the Division is to invest in the booking system to provide a more efficient service.
- The Divisional Operations Director said that there needs to be a specific focus on achieving the cancer 62 day target which will significantly help the Division's Cost Improvement Programme. The Divisions has plans to find additional capacity.
- The Divisional Director AHP and Scientific Staff said that there is a backlog of approximately 30,100 x rays equating to approximately 6 months of work. Work is being undertaken by a reporting house to reduce the backlog.
- The Finance Director commented that there is greater scope within the Division to improve the Cost Improvement Programme performance.

The Chair thanked the Divisional Operations Director, the Divisional Nursing Director and the Divisional Director AHP and Scientific Staff for their presentation.

Estates & Facilities

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

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

- The Director of Estates and Facilities said that the Division is well placed in meeting the Cost Improvement targets compared to last year. The particular challenge for the Division is that it has limited control over expenditure. Approximately 75% of the Division's workload is reactive with planned work only being undertaken intermittently.
- Mr Norton commented that the outstanding Cost Improvement Programme target id £200k and asked whether this was good planning or a lack of ambition. In response, the Director of Estates and Facilities said that the Division has other schemes to deliver which could result in over achievement of the target.
- In response to a question from the Chair, the Director of Estates and facilities said that the Division is concentrating on high risk areas which means that decorating is not undertaken which impacts on patient experience. Two staff have been appointed to undertake minor works identified by Matrons.
- Mr Michell asked how the Division addresses patient experience, the building fabric and cleanliness given the reductions in capital expenditure. The Director of Service Delivery added that there are currently two cleaning contracts in operation, one for each site with different standards. This will be picked up as part of the Estates and Facilities review in conjunction with the Infection Control Committee to deliver savings. The Medical and Nursing Directors consider impact assessments as part of the PID process.

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

At the conclusion of the presentations, the Committee wished to consider further the Cost Improvement programme and agreed that the Cost Improvement Programme Director be invited to the July 2016 Committee meeting to provide an update on plans.

HS
(MW to note for Agenda)

RESOLVED: That the presentations and the level of assurance provided on the delivery of the Cost Improvement Programme be noted.

086/16 FINANCIAL PERFORMANCE REPORT

The Finance Director presented the revised Financial Performance report providing a high level view of the position for May 2016. There was an adverse variance of £3.52m against key elements of our Trust's plan and financial duties. 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 quarter one and quarter two relating to our A

and E 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. Whilst the trajectory has not yet been approved by NHS Improvement current performance against the stated plan shows a positive variance of £0.05m. The financial sustainability risk rating based on the performance for May 2016 is 2. Providing that the overall plan position is delivered this will rise to 3 for the 2016/17 financial year. Expenditure on temporary staff was £3m which was £0.5m higher than the average for 2015/16 due to operational pressures.

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

- In response to a question from Mr. Norton, the Finance Director confirmed that expenditure on agency staff was based on that used.
- The Chief Executive asked for details of the phasing on agency expenditure to achieve the cost improvement programme target of a 5.2% reduction. In response, the Finance Director said that a reduction in agency expenditure is assumed to achieve the target but in the first two months of the 2016/17 financial year expenditure has increased. Approval for agency staff now rests with the Medical/ Nursing Directors. The Committee agreed that the Nursing Director and the Director of Human Resources and Organisational Development be invited to join the Cost Improvement Programme Director for the presentation of the Cost Improvement Programme in July 2016.
- The Director of Service Delivery explained that a reduction in capacity and beds will reduce the reliance on agency nurses. Some agencies are not reducing their prices to the cap level and there has been an increase in patients requiring one to one care.
- In response to a question from the Chair, the Chief Executive explained that it is NHS Improvement's responsibility to control the cap.
- The Chair said that there was no breakdown of the financial sustainability risk rating being reduced to 2 from 3 and that information should be available for the plans in place to return to 3. In response, the Finance Director explained that the financial sustainability risk rating would always be a 3 due to our financial surplus. However, with a deficit the financial sustainability risk rating reduced to 2 due to the adverse cash position. The Finance Director apologised for not including this information which the Chair said that progress on the Cost Improvement Programme and the Financial Sustainability Risk Rating should be included in every report.
- The Chief Executive said that she, the Finance Director and the Director of Operational Finance are to meet to consider further the revised format for the report.

The Chair thanked the Finance Director for the report.

RESOLVED: That:-

1. The financial position of the Trust at the end of May 2016 of the 2016/17 financial year is an operational deficit of £1.2m be noted. This is an adverse variant to plan on £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, although there is a small reduction in May 2016, it is not material in impact.
3. Actions to address the issues identified in the report will continue and progress will continue to be reported monthly to the Finance and Performance Committee and the Board.

087/16 INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK

The Finance Director presented the report summarising the key highlights and exceptions in Trust performance up to the end of May 2016 for the financial year 2016/17. For May 2016, our Trust has met the four trajectories which it is required to meet in order to demonstrate improvement and to access the Strategic Transformation Fund. The format of the report was now based on the CQC Key Lines Of Enquiry (KOLEs) of 'are we safe?', 'are we responsive?', 'are we effective?' and 'are we well led?'.

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

- The Director of Service Delivery referred to the 62 day cancer standard which was not met in April 2016 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 77.17%. He said that he will provide a more detailed focus on performance to the July 2016 meeting of the Finance and Performance Committee. **EG (MW to note for agenda)**
- Mr Norton asked whether our Trust's performance met the four KLOEs. In response, the Direct of Service Delivery said that the information presented provides a range of indicators with well led being rated as green. In the light of that information, Mr Norton said that our Trust needed to be in a position to indicate compliance. Mr Mitchell added that in his capacity as Chair of the Quality Committee he had asked a similar question at the last meeting of that Committee. Mr Norton commented that our Trust should start from an agreed position of truth. The Director of Service Delivery said that the CQC assesses performance on a whole range of indicators forming a spectrum. The 'are we caring' indicator is a matter for the Quality Committee.
- The Director of Service Delivery said that the cancer performance monitoring against the Sustainability and Transformation Plan should be 80.3% (and not 78.2%) as reported.
- The Chief Executive said that a forecast should be included in the report where the figures are not known based on a target. The Finance Director added that the forecast status definition of 'at risk' and 'stable' needed refining.

The Chair thanked the Finance Director for the report.

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

088/16 EMERGENCY PATHWAY REPORT

The Director of Service Delivery presented the Emergency Pathway Report stating that the 95% four hour target for Emergency Department Performance was not successfully met in May 2016 with Trust wide performance reported at 87.4%. There had been an upward trend of improvement compared to the previous four months and particularly compared to March 2016 when performance was 77.7%. He also presented the Emergency Care Improvement Plan which was appended to that report which formed the focus of the Committee's deliberations. As a consequence of our Trust not achieving the Emergency Department Performance Standard for the last five years at an annual level the Executive and Divisions have sought to reflect and identify the fundamental root causes of the issues in Emergency Care and provide solutions for the short and medium term, whilst simultaneously the System Resilience Group (SRG) is undergoing a similar process for the system. The three main issues our Trust will be addressing are ensuring patients in ED are assessed and treated in a timely way, improving the capacity and flow of beds across our Trust and externally and improving the physical capacity of the ED Departments. Our Trust has sought to narrow its focus and concentrate on what shall make the most significant difference to patient experience and outcome in the short and medium term with the key premise of this programme to make into reality 'Best Care For Everyone' underpinning any and every improvement. The essence of the programme of work is to ensure the department models the demand and capacity for ED using best practice guidance from NHS Improvement, and to ultimately have the right staff, with the right skills at the right time to provide best care. Revised governance arrangements will include a Non- Executive Director lead (Keith Norton) as a member of the newly- constituted Emergency Care Programme Board (with a monthly meeting chaired by the Chief Executive) that will ensure the programme stays on track and delivers the objectives. The reporting from frontline to board will be aligned to the timescales as detailed in the programme. The detailed scrutiny of the plan and holding the Executive to account will sit with the Committee.

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

- In response to a question from the Chair about the new Safety and Quality Report, the Director of Service Delivery said that there has been no feedback from NHS Improvement as to whether this will satisfy their requirement commenting that they are more focused on what our Trust is doing during particularly challenging periods.
- The Chief Executive explained that the newly-constituted Emergency Care Programme Board will meet on a weekly basis with three of those meetings considering operational issues and one meeting which she will Chair holding the programme to account.. Work streams four, five and six had now been established with action plans and details of the further work streams were also set out.
- Given the establishment of the newly-constituted Emergency Care Programme Board the Committee considered that with immediate effect the weekly telephone calls for Non- Executive Directors on ED performance should cease.

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

RESOLVED: That the Emergency Pathway Report be noted and the actions being taken to improve performance be endorsed.

RESOLVED TO RECOMMEND: That the Emergency Care Improve

089/16 REFERENCE COSTS

The Finance Director presented the report inviting the Committee to confirm in advance of the reference cost submission and the integrated collection submission that it is satisfied with our Trust's costing processes and systems, and that our Trust will submit its reference cost returns in accordance with NHS Improvement's approved costing guidance which includes the reference cost and education and training guidance. Trust's that are unable to provide this confirmation should provide details of non-compliance. The requirements which the Committee were required to confirm were set out in the report. Those confirmations will be achieved by the Finance Director signing off the Statement of Directors' responsibilities for the reference costs. In November 2015 the Committee approved the 2015/16 reference cost plan providing assurance to the process being followed to produce the reference costs and further assurance was provided by completion of the self-assessment quality check list at the time of reference cost submission. At that time the Committee received confirmation that all action points from Capita's audit of the 2013/14 reference cost return were implemented in the 2014/15 reference cost submission. The Audit Committee in November 2015 received an internal audit report from PWC on the 2014/15 reference cost submission which confirmed all actions had been completed. These outcomes support the review of internal controls in place in the collection and reporting of information included in reference costs to provide assurance that they are working effectively in practice.

The Chair thank the Finance Director for the report.

RESOLVED: That the reference costs submission be approved and that the Finance Director be authorised to sign the necessary forms

090/16 PROGRESS UPDATE ON CONTRACTING PROCESS

The Finance Director presented the report updating the Committee on the key points associated with the 2016/17 contracting process. Despite concluding negotiations and signing the contract in May 2016 our Trust has yet to receive, despite numerous requests, the detailed breakdown of the contract by HRD. Our concern on this significant delay have been formally communicated to the Clinical Commissioning Group. By not providing detail to support the contract, cancelling the Contract Board and not implementing effective demand management schemes is exacerbating the pressures in the local health system and in our view frustrating efforts by the Trust to improve the position. Our Trust is planning to give notice and market test a number of services provided by Gloucestershire Care Services which do not represent value for money. Our Trust has signed a Heads of Terms Agreement with NHS England as Specialised Commissioner and is working towards final contract signature by the end of June 2016.

The Director of Service Delivery added that roadshows are being held with Divisions including frontline staff to explain the Clinical Commissioning Group Contract as it applies to them individually and the delivery requirement.

The Chair thanked the Finance Director for the Report.

RESOLVED: That the current position on our main contracts and frustrations on the ongoing response to the system wide issues, not helped by the cancellation by the Clinical Commissioning Group of the May 2016 Contract Board for the Gloucestershire CCG contract be noted.

091/16 NOTES OF THE EFFICIENCY AND SERVICE IMPROVEMENT BOARD MEETINGS HELD ON 11 MAY AND 8 JUNE 2016

The Executive Director of Finance presented the notes of the meetings of the Efficiency and Service Improvement Board held on 11 May and 8 June 2016.

The Committee agreed to review the reporting arrangements for The Efficiency and Service Improvement Board in the Autumn 2016.

The Chair thanked the Executive Director of Finance for the notes.

RESOLVED: That the notes be noted

092/16 FINANCE AND PERFORMANCE COMMITTEE WORK PLAN

The Trust Secretary was invited to update the work plan as follows:-
July 2016- Cost Improvement Programme update including theatre efficiencies with attendance additionally by the Nursing Director and the Director of Human Resources and Organisational Development; cash position update, revised financial report template and cancer update on delivering trajectories. **MW**

093/16 COMMITTEE REFLECTION

As part of the reflection, it was noted that there was no discussion on performance issues in the Divisional presentations and the presentations focused on progress rather than actions. The Chair welcomed the Chief Executive's questions. The Chief Executive undertook to personally invite divisions to attend in October 2016. **DL**

094/16 ANY OTHER BUSINESS

There were no further items of business.

095/16 DATE OF NEXT MEETING

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Finance and Performance Committee will be held on **Wednesday 27 July 2016** in the **Boardroom, Alexandra House, Cheltenham General Hospital** commencing at **10am**.

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

The meeting ended at. 1:23pm.

Chair
27 July 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST FINANCE AND PERFORMANCE COMMITTEE HELD IN THE BOARDROOM, ALEXANDRA HOUSE, CHELTENHAM GENERAL HOSPITAL ON WEDNESDAY 27 JULY 2016 AT 10AM

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

PRESENT	Tony Foster	Non-Executive Director (Chair)
	Deborah Lee	Chief Executive
	Gordon Mitchell	Non-Executive Director
	Keith Norton	Non-Executive Director
	Helen Simpson	Executive Director of Finance
	Eric Gatling	Director of Service Delivery
APOLOGIES	None	
IN ATTENDANCE	Martin Wood	Trust Secretary
	Sarah Stansfield	Director of Operational Finance

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

096/16	**DECLARATIONS OF INTEREST** There were none.	**ACTION**
097/16	**MINUTES OF THE MEETING HELD 22 JUNE 2016** **RESOLVED:** That the minutes of the meeting of the Finance and Performance Committee held on 22 June 2016 were agreed as a correct record and signed by the Chair.	
098/16	**MATTERS ARISING** **073/16 Cash Position Update:** Details of the cash position would be provided to the Committee by the end of the week of the meeting. The Finance Director said that a report on the cash position including creditor/debtor details will be presented to the next meeting of the Committee in July 2016.*This item appeared later in the Agenda as part of the Financial Performance report. Completed.* **025/16 Cost Improvement Programme Update:** The Chair invited the Finance Director to include in the finance report in July 2016 an indication of progress in meeting the Cost Improvement Programme. *This item appeared later in the Agenda. Completed.* **075/16 Progress Update on Contracting Process:** The Finance Director was invited to present to the July 2016 meeting of the Committee details of the outcome of the contract negotiations.	

	This item appeared later in the Agenda. Completed. **087/16 Integrated Performance Management Framework:** The Director of Service Delivery referred to the 62 day cancer standard which was not met in April 2016 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 77.17%. He said that he will provide a more detailed focus on performance to the July 2016 meeting of the Finance and Performance Committee. *This item appeared later in the Agenda. Completed.*	
099/16	**INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK AND ENDOSCOPY RECOVERY PLAN** The Finance Director presented the report summarising the key highlights and exceptions in Trust performance up until the end of June 2016 for the financial year 2016/17. A number of measures reflect an unvalidated position for June 2016 and, as such, may change when reported in July 2016 though typically not materially. Of the areas for improvement he highlighted Emergency Department performance, planned/surveillance endoscopy patients waiting at month end and the 18 week Referral to Treatment Target. Assurance could not be provided that our Trust will achieve all of the cancer measures and a clearer action plan will be provided for the next meeting. This is a risk to our Trust. The Finance and Performance Committee noted that Acute Kidney Injury (AKI) performance has fallen each month in quarter 1 and have referred the matter to the Quality Committee for detailed review. The Director of Service Delivery is working with the Nursing Director to improve the performance of women seen by a midwife within 12 weeks which remained slightly below target throughout quarter 1. During the course of the discussion, the following were the points raised:- - Chair observed that Acute Kidney Injury (AKI) performance had deteriorated and it was agreed that the Director of Safety be invited to present to the Quality Committee. - The Chief Executive Referred to Referral to Treatment performance noting that GP referrals continue to increase with a risk that this performance standard will not be achieved. The Director of Service Delivery would look at the percentage of patients by time band to indicate whether there is an issue. - The Chief Executive said that work is underway to provide the Committee with performance predictions. - The Chief Executive said that with the focus on Emergency Department performance our Trust should not lose sight of other performance targets. The Chair Finance Director for the report. **RESOLVED:** That the Integrated Performance Framework Report be noted and the actions being taken to improve performance be endorsed.	**AS** **(MW to note for Agenda)** **EG**

100/16	**CANCER 62 DAY PERFORMANCE** The Director of Service Delivery presented the report stating that our Trust has not met the 62 day standard for patients urgently referred with a suspicion of cancer since the first two quarters of 2014/15 which reflects the national position. The target is 85%. In late 2015 performance improved with assistance from NHS Interim Management and Support Intensive Support Team and performance improved although the national standard was not achieved. Performance has improved since February 2016 and currently is 81.4%. There remain significant challenges in some tumour sites, particularly Urology, Colorectal and Lung cancers. Recent performance has been compromised by difficulties in meeting the 2 week wait target for referrals with suspected cancer. However, additional2 week wait clinic capacity has been found to ensure that the 2 week wait target is met. Demand continues to increase. Other contributing factors are the loss of one Urology consultant due to long term sickness, lack of Radiologist cover to Multi-disciplinary Team meetings and lack of Trans-rectal Ultrasound and template biopsy capacity for prostate cancer patients. An action plan is in place for the three most challenged tumour sites. It is anticipated that these actions will result in recovery of the 62 day position to meet the national standard for September 2016 which can then be sustained. The greatest risk is the continuing rise in referrals. During the course of the discussion, the Chief Executive expressed concern that there did not appear to be a thorough plan to meet the national standard and she would pursue this with the Director of Service Delivery. The Chair thanked the Director of service Delivery for the report. **RESOLVED:** That the report be noted.	
101/16	**THEATRE UTILISATION UPDATE** *(Mr Vinay Takwale, Chief of Service, Surgery Division, Beryl Woodall, Divisional Operations Director and Paul Garret, Divisional Nursing Director, attended the meeting for the presentation of this item)* The Chief of Service presented the report stating that the Theatre QPV Programme has been endorsed to deliver a Cost Improvement Programme value of approximately £1.05m in 2016/17. Two clinically led Theatre Project Groups have been convened to manage theatre productivity plans with estate reconfiguration and theatre utilisation. Plans in progress include the Cirencester six week improvement plan, mobile decommissioning plan and speciality rapid improvement plans based on key performance indicators and benchmarking. A benefits realisation profiling is to take place from August 2016 to year end following endorsement of improvement plans by Surgery Divisional Board. During the course of the discussion, the following were the points raised:- - In response to a question from the Chair, the Chief of Service	

	said that the savings are planned to be achieved on the basis of £300k from the mobile unit, £500k from productivity, £200k from the community and £800k by the use of Cirencester. £350k of savings were achieved during the last financial year by the closure of Orchard House. - The Chief of Service explained in response to a question from the Chair, that there were staffing issues resulting in a delay in utilising the facility at Cirencester. The cultural issues are being address and a leaflet promoting the facility has now been prepared. The challenge is to divert cases to Cirencester. - The Finance Director referred to the three orange rated and the one red rated risks for Cirencester and asked when they could be green rated. In response, the Divisional Director of Operations said that they can now be green rated as the operation plan has now been agreed. - The Director of Service Delivery explained that the Clinical Commissioning Group and Gloucestershire Care services have accepted the development of Cirencester which sets the model for other areas. - The Committee invited the Chief of Service to provide an update on the utilisation of Cirencester in six months' time. The Chair thanked the Chief of service, Divisional Operations Director and Divisional Nursing Director for the report. **RESOLVED:** That the report be endorsed.	**VT** **(MW to note for Agenda)**
102/16	**PROGRESS UPDATE ON CONTRACTING PROCESS** The Finance Director presented the report updating the Committee on the key points associated with the 2016/17 contracting process. Our Trust continues to await the full and detailed breakdown of the contract by HRG. With regard to Specialised Commissioners, our Trust has signed the Heads of Terms Agreement with NHS England and continues to work towards final contract signature. Arbitration with Gloucestershire Care Services has concluded although there remains a dispute between organisations. During the course of the discussion the Chief Executive stressed that progress needs to be made in the contract negotiations to avoid this situation arising in future. The Chair thanked the Finance Director for the report. **RESOLVED:** That the current position and challenges on our main contracts be noted.	
103/16	**EMERGENCY CARE PROGRAMME BOARD REPORT** The Chief Executive presented the report providing the Committee with assurance regarding the safety and quality of emergency care services within our 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 30 June 2016. The Emergency Care Programme Board has now been established and the reporting mechanism needs to evolve further. The Chief Executive said that our Trust is ahead of trajectory in meeting the improvement plan, but there is not yet confidence in improvement to meet and sustain the national performance standard. The report is being developed to provide assurance and a revised report will be presented to the Board in August 2016. During the course of the discussion, the following were the points raised:- - The Director of Service Delivery said that the diagnostic will be concluded and presented to the Emergency Care Programme Board on 11 August 2016. Once presented this will be circulated to the Committee. - The Chief Executive said that workforce capacity to meet demand has not yet been resolved. Workstream I is looking at a more minor capital scheme to provide increased resuscitation facilities at Gloucestershire Royal Hospital which will involve less disruption. Workstream 4 lead by the Director of Clinical Strategy is undertaking a substantial piece of work on the model and this will also be presented to the Programme Board on 11 August 2016. The Chair thanked the Chief Executive for the report. **RESOLVED:** That the report be noted and the actions being taken to improve performance be endorsed.	**EG**
104/16	**FINANCIAL PERFORMANCE REPORT** The Director of Operational Finance presented the report providing a high level review of the financial position for June 2016. The financial position of our Trust at the end of June 2016 is an operating deficit of £1.88M which represents a small favourable variance of 0.02M against the plan position. NHS Improvement has accepted the revised trajectory plan which reflects the additional costs currently relating to operational pressures and the non-recurrent costs in quarter 1 and 2 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. Latest guidance on Sustainability and Transformation Funding (STF) means that our Trust should receive the full amount for quarter 1 of the 2016/17 financial year which will support our cash position. There has been slippage in the Cost Improvement Programme and the Cost Improvement Programme Director's engagement has been extended to December 2016 to develop an annual plan to mitigate that slippage. Our Trust's cash balance at the end of June 2016 was £5.7M. The Finance Director then presented the report providing an	

	assessment of the current forecast outturn financial position for the 2016/17 financial year and the associated financial recovery plan required to support delivery of our Trust's internal control total of £5.3M. The Clinical Commissioning Group are challenging our data provided on our over performance. A deficit of £2.8M has been identified leaving a gap of £8.1M to our control total. This is over and above the amount identified in the Cost Improvement Programme. A financial recovery plan has been identified with savings of £5.8M and work is progressing towards the remaining gaps. The three key issues are delivering a robust Cost Improvement Programme, undertaking the additional actions in the financial recovery plan and reducing agency spend. The Director of Service Delivery added that the aim is to remove expenditure over the next six months and has already begun. The Committee then focused on our Trust's cash position. During the course of the discussion the following were the points raised:- - An assurance had previously been provided by the Finance Director that the taking out of the Working Capital Facility would ensure that payments would be made on time and in accordance with contract terms. This was clearly not the case as our Trust did not have sufficient cash to service its regular requirements. This is impacting adversely on our Trust's Capital Programme. - Sustainability and Transformation Plan funding for Q 2, 3 and 4 is at risk. A cash management strategy needs to be developed quickly to determine requirements now and until the end of the financial year and managing the risk to the capital programme. - In response to a question from Mr Norton, the Finance Director assured the Committee that our Trust was solvent and that the cash position would improve towards the end of the financial year when our Trust was planned not to be in deficit. The Chair thanked the Finance Director for the report. **RESOLVED:** That:- - 1) The financial position of the Trust at the end of month 3 of the 2016/17 financial year is an operational deficit £1.88M be noted. This is a small favourable variance to plan of £0.02M. - 2) Commissioners contract challenges are significant and a risk assessment has currently been made against these. - 3) Actions to address the issues identified in the report will continue and progress will continue to be reported monthly to the Finance and Performance Committee and the Board. - 4) The Director of Finance, Director of Service Delivery and the Cost Improvement Programme Director have recommended a financial recovery programme to provide greater assurance that our Trust can improve its current financial performance	
105/16	**COST IMPROVEMENT PROGRAMME UPDATE** *(Mr Dave, Smith, Director of Human Resources, Mrs Maggie Arnold, Nursing Director and Val Doyle, Cost Improvement Programme Directors attended the meeting for the presentation of this item)*	

	The Cost Improvement Programme Director gave a presentation setting out the current position in relation to the agency and locum cap in place form 1 April 2016 and the subsequent ceilings and phased approach as determined by NHS Improvement. Our Trust ceiling is £12.168 against the previous year's spend of £22m. In June 2016 NHS Improvement set out the requirement for out Trust to submit monthly returns in line with the ceilings set out in that letter. A taskforce has been established to produce a plan to deliver our Trust ceilings and provide sustainable solutions to the problem of continued reliance and increasing spend on temporary staffing. Despite a slight reduction in expenditure in Q1 we are already in breach of the phased ceilings in the previous financial submissions. These have been re-profiled to recover the current position and bring the expenditure back in line with NHS Improvement ceilings. To deliver our Trust control total an agency spend of not more than £16m is required. During the course of the discussion, the following were the points raised:- - The Cost Improvement Programme Director said that the taskforce has concluded that the agency spend reduction to £12 is not deliverable. A target of £16m which is a very stretched target is the aim which can be recognised in Divisions. - The Director of Operational Finance said that the cap affects all staffing and that hitherto the focus has been on nursing agency spend, but it applies equally to medical staff. - The Nursing Director said that budgets are to be devolved to Ward Managers for them to understand how expenditure is to be managed. Our Trust is looking at different ways of working to release more time for nurses to undertake nursing duties. She is looking for other Trusts who are introducing different ways of working to see what can be learned for our Trust. - The Chief Executive emphasised that our Trust needs to be more creative to meet the recruitment challenges. - The Director of Human Resources and Organisational Development suggested that NHS Improvement be involved in looking at how different ways of working can be achieved. The Chair thanked the Director of Human Resources and Organisational Development, Nursing Director and Cost Improvement Programme Director for their report and presentation. **RESOLVED;** That the report, presentation and the actions to address the agency and locum spending gap be endorsed.	
106/16	**TEMPORARY MEDICAL STAFFING** In the light of the discussion in minute no 105/16 above, this item will be considered at the meeting in August 2016.	
107/16	**SUSTAINABILITY AND TRANSFORMATION PROGRAM** The Finance Director presented the report informing the Committee of	

	the recent guidance issued by NHS Improvement relating to the Sustainability and Transformation Fund (STF) for 2016/17. She also updated the Committee as to the position for quarter 1 for 2016/17. The guidance set out a number of criteria in order to be able to access the funding made available and in essence 70% of funding will be made available based on performance against agreed financial trajectories and 30% of funding will be made available on performance against agreed trajectories. Our Trust has had £12.9M of STP funding made available, phased equally in four quarters of £3.225M. Our Trust has reported a financial performance of a £1.8M deficit against a planned deficit value of £1.9M meaning that we will secure the 70% allocated for financial performance. Performance trajectories for all performance areas have been agreed with our main Commissioners which means that we will secure the 30% funding for non-financial performance. In quarter 1 we will secure 100% of the £3.225M available although it is unclear at this stage how that money will be paid. In order to secure this funding in future quarters the separate report on the financial recovery programme provides greater assurance that the additional expenditure incurred and year to date Cost Improvement Programme slippage can be recovered. The Chair thanked the Finance Director for the report. **RESOLVED:** That the current position in relation to the Sustainable Transformation Fund funding for the 2016/17 financial year be noted	
108/16	**BOARD STATEMENTS** The Finance Director presented the report advising that the Trust is required to confirm the following Board statements:- - *For finance that:* the Board anticipates that the Trust will deliver a 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; and the commitment to comply with all known targets going forwards. - *Otherwise:* The Board confirms that there are no matters arising in the quarter requiring an exception report to NHS Improvement which have not already been reported. The paper set out the issues that the Board must consider in making these declarations. During the course of the discussion, it was agreed that the following recommendations are made to the Board:- - Finance to be amended so that the Board remains committed that the Trust will deliver a Financial Sustainability Risk Rating (FSRR) of 3 by the end of the financial year 2016/17. - The exception report be amended to state that our Trust did not meet the 62 day or the two week wait cancer target for Q1. However, we continue to have demand and capacity action	

	plans in place and these improvement plans have shown benefit in addressing both standards. The Chair said that in future reports a greater analysis be provided of the Trust's performance in each area including the calculation for the Financial Sustainability Risk Rating. The Chair thanked the Finance Director for the report. **RESOLVED TO RECOMMEND:** That:- - 1) The Board remains committed that the Trust will deliver a 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. - 2) An exception report is made to NHS Improvement on the ED four hour standard, cancer 62 day standard and two week wait 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 the commissioners and NHS improvement. - 3) The Board is satisfied that the plans in place are sufficient to ensure ongoing compliance with all other existing targets as set out in the compliance framework and the commitment to comply with all known targets going forward. *(Mr Mitchell left the meeting)*	
109/16	**NOTES OF THE EFFICIENCY AND SERVICE IMPROVEMENT BOARD MEETING HELD ON 13 JULY 2016** The Executive Director of Finance presented the notes of the meeting of the Efficiency and Service Improvement Board held on 13 July 2016. The Chair thanked the Executive Director of Finance for the notes. **RESOLVED:** That the notes be noted.	
110/16	**FINANCE AND PERFORMANCE COMMITTEE WORK PLAN** The Chair will liaise with the Trust Secretary to formulate an agenda for the meeting in August 2016.	**AF/MW**
111/16	**COMMITTEE REFLECTION** On this occasion there was not an opportunity for Committee reflection.	
112/16	**ANY OTHER BUSINESS** There were no further items of business.	

113/16	**DATE OF NEXT MEETING** The next meeting of the Gloucestershire Hospital's NHS Foundation Trust Finance and Performance Committee will be held on **Wednesday 24 August 2016** in the **Board Room, Alexandra House, Cheltenham General Hospital** commencing at **10am.** **Papers for the next meeting:** Completed papers for the next meeting are to be logged with the Trust Secretary no later than 3pm on **Monday 15 August 2016**. The meeting ended at 12.43pm. **Chair** **24 August 2016**	

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST FINANCE AND PERFORMANCE COMMITTEE HELD IN THE BOARDROOM, ALEXANDRA HOUSE, CHELTENHAM GENERAL HOSPITAL ON WEDNESDAY 24 AUGUST 2016 AT 10AM

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

PRESENT	Tony Foster	Non-Executive Director (Chair)
	Deborah Lee	Chief Executive
	Gordon Mitchell	Non-Executive Director
	Keith Norton	Non-Executive Director
	Eric Gatling	Director of Service Delivery
APOLOGIES	Helen Simpson	Executive Director of Finance
IN ATTENDANCE	Martin Wood	Trust Secretary
	Sarah Stansfield	Interim Director of Finance
	Dr Sean Elyan	Medical Director

The Chair welcomed the members of the Committee to the meeting which was focusing on performance issues.

ACTION

114/16 DECLARATIONS OF INTEREST

There were none.

115/16 MINUTES OF THE MEETING HELD ON 27 JULY 2016

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

116/16 MATTERS ARISING

099/16 Integrated Performance Framework and Endoscopy Recovery Plan: The Chief Executive referred to Referral to Treatment (RTT) performance noting that GP referrals continue to increase with a risk that this performance standard will not be achieved. The Director of Service Delivery would look at the percentage of patients by time band to indicate whether there is an issue. *This item appeared later in the agenda. Completed.*

103/16 Emergency Care Programme Board Report: The Director of Service Delivery said that the diagnostic would be concluded and presented to the Emergency Care Programme Board on 11 August 2016 and once presented will be circulated to the Committee. *This item appeared later in the agenda. Completed.*

117/16 INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK

The Director of Service Delivery presented the report summarising the key highlights and exceptions in Trust performance up until the end of July 2016 for the financial year 2016/17. Some of the performance issues referred to the report were set out as separate reports later in the agenda. He drew attention to the following from the report:-

- A never event occurred in July 2016 which is being investigated with the outcome being reported to the Quality Committee in due course.
- Further work continues with the ambulance service to improve the validation process and there are no over 60 minute delays.
- The percentage of patients spending 90% of time on a stroke ward continues to exceed the 80% target each month with the July 2016 position at 88%. Outpatient attendances and procedures are -0.8% below plan in June 2016 achieving the +/-2.5% variance target. This is in line with the QUIPP target as agreed with the Clinical Commissioning Group.

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

- The Chair commented that for certain performance indicators the in month position is stated and therefore the figures are unvalidated. He enquired when those figures identified as "lozenge" would change to orange. In response, the Director of Service Delivery said that this would occur in the following month but any issues identified from the current data would be brought to the Committee's attention.
- The Chair referred to the planned/surveillance endoscopy patients waiting at the month end which continued to rise to 441 patients in June 2016 and averaging out at 363 for quarter 1. There were no patients waiting more than 6 weeks for diagnostic endoscopy. He asked how the information in the covering report and the Performance Management Framework report linked. In response, the Chief Executive said that the Trust received the monies for the financial performance for quarter 1 and the Director of Service Delivery undertook to include the quarterly position in the report for greater clarity. **EG**
- Mr Norton said that it is important for the written reports to contain a conclusion rather than the present arrangements of a written report with oral assurance provided at meetings. This should become a standard feature of all reports to the Board and Committees. In response, the Chief Executive said that this will be undertaken. This will more readily enable Non-Executive Directors to hold the Executive to account.
- Mr Mitchell asked when the improved performance monitoring arrangements will become effective. The Chief Executive said in response that a performance function will be established with the Executives and will be a step change with the appointment of the Head of Performance role with which Mr Norton will be involved.
- The Director of Service Delivery said that additional capacity is being put in place to meet the rise in planned/surveillance endoscopy patients and the Quality Committee will be informed of the patient outcomes. Mr Foster referred to the forecast when the performance target is likely to be achieved.The Chief Executive said in response that the term "forecast" should be described as "trajectories" to demonstrate the plans to achieve the targets.

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

RESOLVED: That the Integrated Performance Framework report be noted and the actions being taken to improve performance be

endorsed.

118/16 EMERGENCY PATHWAY REPORT

The Director of Service Delivery presented the Emergency Pathway report stating that the report format has been revisited and is now based on 4 sections namely, quality and safety, performance and recovery trajectory, the Emergency Care Programme and a system-side update. He sought views from Committee members on this revised format.

With regard to quality and safety the Director of Service Delivery stressed that there is nothing in the report to indicate deterioration and in some instances there have been improvements.

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

- Mr Norton said that the information on quality and safety provides a good example of a summary and he offered to assist in the preparation of the revised report format discussed in minute 117/16 above.
- The Chair commented on the absence on the detail of safety to address NHS Improvement concerns. In response, the Chief Executive said that NHS Improvement are closing the actions from the risk summit as our systems and processes regarding overcrowding in the Emergency Departments are now safer than when the investigation was opened.
- Mr Norton referred to his recent Executive walkabout in the hospitals and said that there is more to do to inform the community when our Trust is experiencing high levels of demand. The Chief Executive said that the challenge rather than repeating the message that Cheltenham General Hospital Emergency Department is open 24 hours a day (with no night ambulances) but to look for a different method of community engagement to draw attention to alternatives to ED. which is a task for Workstream 6. Details of the availability of pharmacies and the minor injuries units need to be made available to assist in changing the behaviour of attendances at the Emergency Department. Mr Norton suggested that the communication should be on one Emergency Department in two locations rather than two Emergency Departments.
- The Chair referred to the increase in attendances and admissions and sought information on the actions being undertaken to address this. In response, the Director of Service Delivery said that there was a particular increase in attendances and admissions in July 2016 which has reduced in August 2016. Arrangements are underway to free up more community beds to assist with discharges. The benefit of a second GP in the back end of the Emergency Department is being evaluated. The level of attendances and admissions is being regarded as the new “norm”. The increasing number of admissions is a particular cause for concern for our Trust. On meeting the 95% performance target, there is a belief amongst staff that it can be achieved as for two consecutive days during the week before the Committee meeting performance was at 95%. For the first 23 days of August 2016 performance is at 93.5%. This is in excess of the trajectory target and is an

improvement on the July 2016 performance. Our Trust's position nationally has improved to 77 from 125 and recently rose to 32. The Chief Executive added that there is no system which can be put in place to predict the considerable peaks in demand.

- The Director of Service Delivery drew attention to the actions completed or embedded and the key actions for the next reporting period for the site management, SAFER patient flow bundle and the patient clinical flow model workstreams.
- The Chair asked how the proposed medical staffing appointments are to be made. In response, the Director of Service Delivery said that the proposals are outside the Deanery and it is worth pursuing this opportunity as it is believed that there are people wishing to undertake the roles. He expressed confidence in being able to appoint 2 additional Emergency Department Consultants. Two Acute Physicians are being interviewed and it is believed that the four Band 7 nurses can be appointed. The Chief Executive added that if these appointments can be made within a budget there will be a financial saving on the Agency costs.
- The Director of Service Delivery said that our Trust is working with the Clinical Commissioning Group on the winter plan which will be presented to the Board in October 2016.
- In response to a question from the Chair, the Director of Service Delivery explained that System Resilience Groups are to be transformed into Local A&E Delivery Boards with the sole focus on urgent and emergency care and are to be attended at Executive level of member organisations. The system-wide 2016/17 A&E improvement plan outlines five mandated improvement initiatives; namely, streamlining at the front door, NHS 111, ambulances, improved flow and discharge. The workstream content has been cross-checked against the currently known requirement for these mandatory improvement initiatives and our Trust is satisfied that the requirement is accounted for within the programme. This will, however, be kept under regular review as further information is released and through discussions with partners on the local A&E Delivery Board.
- Mr Mitchell referred to last year's winter plan containing flexibility on assumptions to cope in all reasonable circumstances and the assurance that our Trust would be able to do so if others did. In response, the Director of Service Delivery said that last year's assumptions did not materialise.
- The Director of Service Delivery said that representatives of Healthwatch had been attending Emergency Departments in the evenings and speaking to patients. The information is to be collated and our Trust has been asked to be supplied with a copy of the report. Healthwatch believe that they can direct partners to improve performance.
- The Chair said that the revised report format was more forward looking and authors are to be congratulated.

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

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

119/16 DIAGNOSTIC AND PROGRAMME INITIATION DOCUMENT – EMERGENCY CARE

The Director of Service Delivery presented the report providing an overview of the Emergency Care Programme and specifically setting out our Trust's "diagnosis" of the underlying causes of the continued failure to achieve the 4 hour A&E standard, the actions our Trust is taking (with its partners) to address the underlying causes through the established workstreams and the governance arrangements established to ensure delivery of the programme and expected performance improvement. The content of this programme, and supporting documentation, will provide key elements of the assurance required to fulfil the Enforcement Undertakings recently accepted by our Trust.

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

- Mr Mitchell asked why things should be different following this work and what will happen in leadership to translate the actions throughout the organisation. In response, the Chief Executive said that the yet to established Transformation Board will take forward this work.

(Dr Sean Elyan, Medical Director, joined the meeting)

- The Chair welcomed views from Committee members on staff aspirations to take forward this piece of work. In response, the Chief Executive said that the physical aspects are being addressed which leaves culture to further develop with staff. The Medical Director added that it is not so much about meeting the 4 hour performance target but more about individual staff perceptions of what is in the culture piece for them. The Multi-Accelerated Discharge Events (MADE) are providing better patient care on wards and better care in the Emergency Department will help wards. Staff are more engaged. The SAFER workstream is reducing patients over 14 days and there is improvement in this area. Getting patient flow right will help the cultural transformation. During the week before the Committee meeting there were good days for staff with the message that it could be like that all of the time. These days should be emphasised as the black escalation days are considered the norm. Mr Mitchell said that the report should focus more on leadership. In response, the Medical Director said that there are both Clinical and Executive leads and communication and engagement is being addressed in Workstream 9. The Chief Executive added that she will invite the Emergency Care Programme Board to devote time to understanding and delivering this within that Workstream. **DL**

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

RESOLVED: That the report be noted and the approach identified be endorsed.

120/16 REFERRAL TO TREATMENT TIME (RTT) – PERFORMANCE UPDATE

The Director of Service Delivery presented the report stating that our

Trust has consistently achieved the 18 week Referral to Treatment (RTT) standard over a number of years. However, in July 2016 our Trust did not achieve the 92% standard. From October 2015 the rules for the calculation of 18 weeks RTT were modified and the admitted and non-admitted performance was no longer a national return. In agreement with the Clinical Commissioning Group a local decision was made to stop validating these treatments. This decision has reduced visibility and ability to track in month performance. To reinstate the validation locally will require additional investment of £60k in clerical staff as this was given up as a cost improvement saving. He drew attention to the incomplete pathways for all patients by speciality and tabled incomplete pathways per speciality by wait band and RTT completes – totals and admitted/non-admitted split for July and August 2016. He drew attention to the immediate actions being taken to address performance in September 2016.

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

- The Chief Executive said that there needs to be a robust system in place which identifies those patients who have been waiting almost 18 weeks to provide transparent data.
- The Director of Service Delivery said that the level of confidence in improving performance in August 2016 was not as low as July 2016. Improving performance depends on a number of factors.
- The Chief Executive said that the current data recording system is not designed to capture RTT data. Cleansing of the current database has already begun. This could be added to TrakCare and staff trained as the current training plan is behind schedule. She added that it is important to capture data if there is a risk of harm to patients waiting beyond 18 weeks.

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

RESOLVED: That the report be noted and that a recovery plan be produced to provide assurance for the September 2016 meeting of the Committee.

EG
(MW to note for Agenda)

121/16 CANCER PERFORMANCE RECOVERY PLAN

The Director of Service Delivery presented the report on the current cancer waiting times performance and presenting action plans to address the issues which are preventing our Trust from consistently meeting the cancer waiting times targets, particularly the 62 day target (between urgent referral and first definitive treatment) and the 2 week wait target (2ww) (between urgent referral and first appointment), thereby providing assurance to the Board via the Committee. All tumour sites are increasing 2ww capacity to meet the additional demand although this is at the expense of routine referrals in some tumour sites. It is anticipated that the 2ww position will be recovered by October 2016 by flexing capacity in this way. This performance can be sustained in the short term; however, long term sustainability will only be achieved by working with the Clinical Commissioning Group and Primary Care to manage demand. 31 day performance continues to be delivered and sustained. However, there have been some internal concerns raised recently about the accuracy of reporting

in respect of start and stop clocks and the internal auditors will be undertaking an audit in September 2016 to ensure compliance with the national rules. 62 day performance has recovered since February 2016. However, it is anticipated that performance will deteriorate in July and August 2016 as our Trust focusses on treating as many patients as possible and recording as many breaches as possible to facilitate sustainable improvement from September 2016 onwards. The action plan has been signed off by each of the 4 Divisional Directors of Operations and the Director of Service Delivery. Progress against the delivery of the plan is reviewed monthly at the Cancer Services Management Group.

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

- The Chair referred to performance in Urology which is currently red risk-rated and asked for information on the actions being undertaken to improve performance. In response, the Director of Service Delivery said that additional staff and additional capacity is being provided. It is necessary for all the marginal gains to come together at the same time for performance to improve. The business case for nurse cover has been approved. A decision is awaited on the bid to the National Diagnostic Fund for cancer equipment.
- The Chief Executive said that a target is needed for every tumour site group setting out the previous month and year position. A further update should be presented to the Committee in January 2017.
- The Chief Executive said that the Quality Committee should be informed of any potential patient risks.

EG
(MW to note for agenda)

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

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

122/16 CANCER DATA QUALITY

The Chief Executive presented the report stating that an initial review of the application of cancer waiting time rules, on clock start decisions, has been undertaken and confirms the likelihood of data quality issues affecting reporting performance. A review of clock stop decisions has not yet been undertaken but the same concerns exist and this has the potential to also distort 62 day cancer standard performance, which our Trust is currently not achieving and is the subject of regulatory scrutiny. In the light of this, it is proposed that the internal auditors, Price Waterhouse Coopers, undertake an audit along the lines set out in annexe 1 of the report.

The Chair thanked the Chief Executive for the report.

RESOLVED: That the proposal to proceed with a data quality audit as set out in the report be endorsed.

123/16 AGENCY COST CONTROL

The Interim Director of Finance presented the report stating that our Trust is required to implement an improvement plan to reduce

expenditure on temporary agency staffing in accordance with the ceiling agreed with NHS Improvement. The original ceiling would be £12.168m against the previous year's spend of £23.7m. However, the Committee in July 2016 agreed that the profile for agency expenditure be adjusted to a maximum expenditure of £16m whilst still delivering our Trust controlled total of £5.3m. This was on the basis that every possible action is taken to ensure that our Trust endeavours to continue to get as close as possible to the original NHS Improvement ceiling of £12.1m. New trajectories have been agreed with each Division and this focuses on medical, nursing and all other spend associated with agency staffing. As at month 5 of the 2016/17 financial year there has been a reduction in agency expenditure which is required to be sustained for the remainder of the financial year. There is a risk to the delivery of the revised target of £16m.

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

- Mr Norton asked when our Trust will fully commit to this revised ceiling. In response, the Interim Director of Finance said that the detailed work will be completed in September 2016.
- In response to a question from the Chair, the Interim Director of Finance said that there are occasions when our Trust is paying for agency staff which are not needed and this needs to cease. Mr Mitchell said that the Nursing Director and the Director of Human Resources and Organisational Development need to establish firm control on agency costs. The Chief Executive added that some plans were unclear as to how the reductions in agency expenditure could be delivered. The Director of Service Delivery commented that there is a practice of getting agency staff in just in case and sometimes it is based on activity.

(Deborah Lee, Chief Executive, left the meeting)

- Mr Norton asked how well the requirement to reduce agency costs is understood by staff as there is no reference to communication in the report. In response, the Interim Director of Finance said that she thought the requirement is understood by Nursing Directors and Matrons. Mr Norton asked that the next report to the Committee identify actions on communications. **SS**
- Mr Foster asked if the use of Thornbury nurses has ceased. In response, the Director of Service Delivery said that there are no Thornbury HCA's. However, there are nursing exceptions when there is a requirement for specialist nursing, for example, paediatrics. He undertook to pick this up with the Cost Improvement Programme Director. The Interim Finance Director added that Thornbury nurses have to be used on occasions as the master vendor under the procurement arrangements cannot always meet the requests. **EG**

The Chair thanked the Interim Director of Finance for the report.

RESOLVED: That the report be noted and the actions taken to reduce agency expenditure be endorsed.

124/16 TEMPORARY MEDICAL STAFFING

The Medical Director presented the report further updating the Committee with respect to medical staff and agency locum spend. Following support from the Committee, the top 10 medical staffing agency principles have now been finalised. There is confidence that if each Division implemented these principles it is possible to meet the reduction in temporary medical staffing expenditure and possibly beyond for doctors. The focus is on making substantive appointments within budget. Unfunded beds need to be reduced as it is necessary for junior doctors to be appointed for these areas. The next stage is to work with the Chiefs of Service to develop the targets to reduce agency expenditure.

During the course of the discussion and in response to a question from the Chair, the Medical Director said that if required for capacity reasons consultants can be paid at a temporary rate which is not an issue but our Trust needs to articulate that staff can be financially better off in substantive posts.

The Chair thanked the Medical Director for the report.

RESOLVED: that the report be noted.

125/16 FINANCE AND PERFORMANCE COMMITTEE WORKPLAN

The Committee's future work programme will depend on the decision of the Board on 26 August 2016 regarding future Board Committee arrangements. However, the Committee considered that it is important for all 5 Divisions to attend a meeting in October 2016.

126/16 COMMITTEE REFLECTION

None considered.

127/16 ANY OTHER BUSINESS

There were no further items of business.

128/16 DATE OF NEXT MEETING

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Finance and Performance Committee will be held on **Wednesday 28 September 2016** in the **Boardroom, Alexandra House, Cheltenham General Hospital** commencing at **10am**.

Papers for the next meeting: Completed papers for the next meeting are to be logged with the Trust Secretary no later than 3pm on **Monday 19 September 2016**.

The meeting ended at 12.15pm

Chair
28 September 2016

GLOUCESTERSHIRE HOSPITALS NHS TRUST

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

PRESENT:

Tony Foster	TF	Non-Executive Director (Chair)
Sally Pearson	SP	Director of Clinical Strategy
Kate Jeal	KJ	Communications Specialist
Catherine Boyce	CB	Clinical Strategy Manager
Carol MacIndoe	CM	Trust Governor (Staff)
Jane Evans	JE	Associate Director of Facilities
Julie Shepherd	JS	Physiotherapy Manager CGH
Kay Davis	KD	Senior Midwifery Manager
Den Powell	DP	Trust Governor (Public)
Jane Hadlington	JH	Staff side, Chair Staff H&WB Group
Coral Hollywood	CH	Heptology Consultant
Tanya Richardson	TR	Public Health Consultant and SEND provision
Claire Knights	CK	Staff side representative
Philip Lort	PL	Practice Development Nurse, Surgery (for P Garrett)

APOLOGIES:

Helen Munro	HM	Non-Executive Director
Sue Maxwell	SM	Infant Feeding Specialist Midwife
Sarah Scott	SS	Director of Public Health (GCC)
Lisa Riddington	LR	Library Services Manager
Jenny Bowker	JW	Associate Director of Strategic Planning (GCCG)
Elaine Watson	EW	Interim Manager Countywide Services/Head of Health Improvemt.(GCS)
Fiona Brown	FB	Senior Dietician
Dave Smith	DS	Director of HR and Organisational Development
Karen Tomasino	KT	Lead Nurse, Paediatrics
Paul Garrett	PG	Deputy Nursing Director
Heather Beer	HB	Head of Patient Experience
Joanna Glasscock	JG	Service Manager/Specialist Advisor Smoking Cessation (GSSS)

IN ATTENDANCE

Dr Vellore Abitha Kujambal	VK	Consultant Paediatrician
Alice James	AJ	Medical Student
Simon Aquilina	SA	Trust Food and Beverage Manager
Bridget Hooper	BH	Site Catering Manager – CGH
Mark Lane	ML	Site Catering Manager – GRH

ACTION

34/16 **APOLOGIES –** noted as above.

35/16 **MINUTES OF PREVIOUS MEETING HELD ON 5 APRIL 2016**
Agreed without to amendment

36/16 **MATTERS ARISING** (where not covered elsewhere on the agenda)

- ***Board Committee self-assessment*** – TF thanked colleagues for their comments on this assessment, which had now been forwarded to the Trust Chair.

FOCUS ON FOOD - PRESENTATIONS

3716 ***The Real Food Lifestyle***

JE and catering colleagues Simon Aquilina, Bridget Hooper and Mark Lane presented a wide-ranging overview of their work to encourage healthier eating choices.

Areas covered in the presentation, included:

- Context – regulations, guidance/standards, national policy.
- Health burden of unhealthy lifestyles and issues of personal choice *v* "nanny state"?
- Working with non-Trust retailers on the site to make healthier choices easier
- In-house" provision and the challenge of achieving a substantial income target
- Patient menus – greater focus on patient experience in general, patient involvement in menu group, working to meet the needs of particular groups e.g. children, people with dementia, nursing mothers and the multicultural society.
- Kitchen production – e.g. reduced salt, healthier fats and cooking processes, staff training, in-house fresh soups, quality produce, food specifications and product evaluation; more sustainable sourcing and procurement where feasible.

- Restaurants. *Recent initiatives* - e.g. fresh salads, more fresh/prepared fruit options; freshly made smoothies, pricing to promote some healthier options; freshly made in-house sandwiches, healthier breakfast menus, staff survey, GRH Farm Shop. *Planned* e.g. product placement, review chocolate/snacks/drinks selection, healthy eating theme days/promotions, deli bar, review of vending options.
  (slides to be circulated to Committee members with the notes of the meeting) **CB**

In the course of discussion a number of points were raised, including:

- the importance of publicising initiatives more widely to staff and patients
- the potential for a branding theme for in-house products
- greater access to food out of hours, for staff and visitors – this was being explored.

TF thanked the Catering Team and congratulated them on their proactive approach to the challenge and on the range of initiatives which were in place and under discussion.

38/16 MEDICAL STUDENT ATTACHMENT AND PROJECT ON CHILDHOOD OBESITY

TF welcomed Alice James, a 5th year Medical Student, undertaking an attachment with the Trust during July. AJ made a brief presentation on her project, which would focus on a number of areas relating to child obesity, including:

- The *Sugar Tax* and its likely impact on childhood obesity;
- Elements of the *NICE Quality Standards on Obesity in Children and Young People,* on which she would be undertaking an audit in the Trust, on the extent to which:
  - vending machines in venues used by children and young people offered healthy food and drink options
  - nutritional information was available at the point of choosing food or drink options
  - healthy food and drink choices were displayed in prominent positions

AJ would also be undertaking a range of clinical placements with Trust teams and a number of other teams in the county involved in the childhood obesity agenda.

SP indicated that the project would be very helpful in informing the wider work being undertaken in the county. The Committee looked forward to learning the outcome of the project at a future meeting.

THE WIDER COMMUNITY

39/16 COUNTYWIDE H&WB BOARD

TR provided a brief update on a number of activities:

- *Tendering process for the provision of Healthy Lifestyle Support Services* - This was underway with responses due in July and a new service would start in January 2017.
- *Countywide Obesity Strategy* – a number of initial sessions had taken place to discuss issues relating to adult and child obesity. Consideration was being given on how to take forward the more detailed work in this complex area.
- It was hoped that the audit which AJ had started in the Trust could be extended into a wider range organisations and settings in the county.

The minutes of the May meeting of the H&WB Board were noted.

40/16 SUSTAINABILITY & TRANSFORMATION PLAN (STP) AND ASSOCIATED AREAS

MW reported briefly on a number of areas:

- The county's STP was currently a draft outline plan, which had been submitted for review by NHSE. Priority areas included: Enabling Active Communities; "One Place, One Budget, One System"; the Clinical Programme Approach: Clinical Variation. Following national review, more detailed proposals based on the STP priority areas would be developed for discussion with the public over the course of the next year.
- Prevention and self care were a key theme within the STP. In the light of this, and the establishment of a high level Prevention and Self Care Board, it had been agreed that the Healthy Individuals Programme Group should now be disbanded.

(Post meeting note – further detail in the Community Partner E-bulletin, which would be circulated with the minutes).

SP highlighted the importance of the Trust being actively engaged in relevant elements of the Prevention and Self-care agenda and the work of the Prevention and Self-care Board. It was noted that the Chairs of the key service providers had now been invited to join the main Countywide H&WB Board. This was greatly welcomed by the Trust Board.

ACTION

PATIENTS' HEALTH AND WELLBEING

41/16 THE HEALTH AND WELLBEING OF OUR PATIENTS STRATEGY

TF reported that the final version had been very well received and endorsed by the Board at its recent meeting. TF thanked those who had contributed to the document. The final version was available on the publications section of the Trust website.

CB reminded colleagues that following the Board's endorsement of the Strategy, the next step would be to develop a work programme to underpin the Strategy and support its implementation in the year ahead and beyond. The Committee considered an early outline work programme. In the course of discussion a number of points were made:

- broad agreement to the approach and proposed elements
- "physical activity" should be included as an additional element
- leads should be identified for each of the priority areas
- further work needed with leads to identify more detailed actions and milestones.

CB + leads

It was noted that PG had identified a number of further staff to undertake the current countywide *Make Every Contact Count* (MECC) training. The delivery of this type of training had been included in the countywide healthy lifestyle tendering exercise.

42/16 BREASTFEEDING

The Committee noted the most recent quarterly report. KD indicated that for the period April-June 78.6% of new mothers initiated breastfeeding or the use of breast milk. The percentage of women continuing to breastfeed at discharge had increased since the previous quarter as a result of a range of actions which had been taken. A more detailed report would be made to a future meeting.

43/16 SMOKING CESSATION MONITORING REPORT

Activity for the year 2015/16 was noted and a number of points were highlighted:

- **General acute referrals to GSSS** - 7.5% increase in 2015/16 in comparison with 2014/15 despite a decrease in CGH referrals in the first half of the year.
- Specialty or opt out approaches, where GSSS colleagues worked particularly closely with individual departments tended to bring increased levels of referral (respiratory, pre-assessment/stopB4op, vascular, cardiology, and IVF services).
- 40 out-patient staff had undertaken Very Brief Advice/MECC-type training.
- **Maternity** - 7.4% decrease overall in maternity referrals to GSSS during 2015/16. During Q3 and Q4 the proportion of women recorded as smoking at booking, and who were then referred, had fallen significantly. KD and GSSS colleagues had been working to understand this decline. Action was being taken, including an audit of CO testing which identified midwives whose levels of CO testing were low, who were then followed up. It was suggested that greater use e-cigarettes or changes in the maternity booking form might also have had an effect on referrals, and recognised that behavioural factors might also influence the level or uptake of referrals. This would also be explored further.

KD/ GSSS

- **Smokefree signage** – KJ shared examples of potential designs for replacement internal and external smokefree signage, for which resources had now been agreed. The use of large scale and photos of members of a young family was one of the proposed approaches designed to make a more personal appeal to encourage people not to smoke on site.

STAFF AND HEALTH AND WELLBEING

44/16 STAFF HEALTH AND WELLBEING GROUP(SH&WBG) UPDATE

JH reported on a number of areas associated with the group's key work streams: -

Mental well-being

- The Committee noted the Annual Report of the GHT Staff Support and Psychological Profiling Service, which offered individual staff support and a variety of training activities including *Resilience Training; Supporting Mental Health in the Workplace; Management of Conflict.* Support and training activities were well received by staff who reported a range of positive benefits. The length of time for first appointments for staff support remained a concern. Where staff were experiencing stress, this support often enabled them to keep working.
- Mindful meditation sessions run by a Buddhist nun had been well received.

Physical Health

- Presentation at the recent SH&WB meeting, reviewing current initiatives, resources and support for healthy eating, weight management and physical activity. Nottingham

University Hospitals NHSFT was identified as an example of good practice, employing a dedicated H&WB Coordinator and assistant to oversee activities, which included a wide range of classes and wider initiatives.

- A number of "quick win" initiatives had been identified, including the potential to establish a network of Wellbeing Champions. Further proposals which the group had identified included development of a Physical Activity Plan and the creation of a dedicated H&WB Coordinator for the Trust. Funding would be required for this.
- The Pilates classes which had been run in the Trust had been well-received.

Ageing Workforce

- NHS Employers' *Ageing Workforce Checklist* was being used as the basis for this work – areas included: age-profiling, workforce planning, flexible workforce, job design & review, retirement planning etc.

Clubs and societies

- Work on-going.

In the course of discussion, the possibility of establishing a slimming group on the hospital sites was raised. However, colleagues indicated that guaranteeing sufficient interest for sessions (minimum 30 people) and identifying suitable times for classes had been problematic. Staff often preferred to access classes near their home.

45/16 BRITAIN'S HEALTHIEST WORKPLACE INITIATIVE

It was noted the approximately 300 staff had completed a voluntary confidential H&WB questionnaire as part of this initiative. An organisational self-assessment and aggregated results of the individual surveys would be available in the autumn.

46/16 WORKPLACE WELLBEING CHARTER

It was noted that in common with other organisations in the county, the Trust had undertaken to sign up to this initiative. This encouraged organisations to audit and benchmark against an established and independent set of standards and to develop plans to address any gaps with a view to applying for the Charter award.

47/16 COMMUNICATIONS UPDATE

KJ shared examples of recent initiatives currently publicised in Outline, Involve, through the internet and website, and increasingly, through social media. Opportunities for special features in local media were fewer than in the past. In response to a question on the reach of different communication methods, it was noted that data was generally readily available on social media activity, but limited for other methods of communication.

48/16 NICE PUBLIC HEALTH RELATED GUIDANCE

The report was noted. Recommendations on recent guidance on Sunlight Exposure risks and benefits and Community Engagement for improving H&WB and Reducing Inequalities rested largely with other organisations, although the Trust would continue to support and contribute to relevant elements of this guidance.

49/16 TERMS OF REFERENCE

Minor changes to the terms of reference were agreed.

50/16 ITEMS FOR NEXT MEETING

It was recognised that a range of H&WB initiatives were taking place within Divisions and Departments. It was proposed that at each meeting one Division should make a brief presentation on their current H&WB activities, challenges and opportunities. It was agreed that the Surgical Division should present first. *(Post meeting note – a programme would be drawn up to start in 2017.)* **PG/PL**

It was agreed that the Committee should devote some time in October to the subject of alcohol and reducing harm caused by alcohol – introduced by a number of short presentations – e.g.countywide context and the hospital perspective etc. CB to liaise with TR and CH. **CB→ CH/TR**

The results of the audit on the availability of healthy food and beverage options should also be available for reporting to the next meeting.

51/16 DATE AND TIME OF NEXT MEETING

Tuesday 4 October – please note later start time of 9.30. Venue TBC.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST QUALITY COMMITTEE HELD IN THE BOARDROOM, 1 COLLEGE LAWN, CHELTENHAM ON FRIDAY 15 JULY 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	Mr G Mitchell	Non-Executive Director (Chair)
	Prof C Chilvers	Chair of the Trust
	Mr Clive Lewis	Non-Executive Director
	Mrs D Lee	Chief Executive
	Dr S Pearson	Director of Clinical Strategy
	Dr S Elyan	Medical Director
	Mrs M Arnold	Nursing Director
	Mr A Seaton	Director of Safety
	Mrs H Beer	Head of Patient Experience
	Mrs K Haughton	CCG Deputy Director of Nursing
	Mrs P Adams	Governor – Staff, AHPs
	Dr P Jackson	Governor – Forest of Dean District Council Area
	Mrs C Johnson	Governor – Forest of Dean District Council Area
	Mrs A Lewis	Governor – Tewkesbury District Council Area
	Ms F Storr	Governor – Gloucester City Council Area
IN ATTENDANCE	Mr M Wood	Trust Secretary
	Mrs V Collins	Safety Improvement Practice Educator
	Ms B Williams	Trust Risk Manager
APOLOGIES	None	

The Chair welcomed all to the meeting.

		ACTION
085/16	**DECLARATIONS OF INTEREST**	
	There were none.	
086/16	**MINUTES OF THE QUALITY COMMITTEE MEETING HELD ON 10 JUNE 2016**	
	RESOLVED: That the minutes of the meeting of the Quality Committee held on 10 June 2016 were agreed as a correct record and signed by the Chair.	
087/16	**MATTERS ARISING**	
	050/16 Divisional Attendance – Surgery: The Chair observed that the presentation referred to a number of external reports where only a summary is presented to the Committee and not the actual report. In response, the Director of Clinical Strategy said that an annex can be provided to the Directors' Statement providing details of all reports, the key findings and actions taken. This will then provide assurance	

	and an audit trail. *The format of the Divisional reports is to be revised to reflect the Directors' Report and will be presented to the Committee in September 2016. Ongoing.* **060/16 Annual Appraisal 2015/16 and Frequency of Committee Meetings:** The Chair invited the Medical Director, Nursing Director and the Director of Clinical Strategy to consider a mechanism to sign off standards for example triangulation of royal college and patient experience standards. The Chair invited the Medical Director, Nursing Director and Director of Clinical Strategy to give further consideration to this matter and report to the next Committee meeting. *The Director of Clinical Strategy and Medical Director reported that this is a particular challenge to determine the key standards at speciality and sub-speciality level. Key performance indicators are part of doctors' annual performance review. Completed as a Matter Arising.* The Chair thanked Committee members for their appraisal suggestions and any further suggestions should be submitted to the Trust Secretary. *This would be considered further. Completed as a Matter Arising* **007/16 Divisional Attendance – Estates and Facilities:** The Chair invited the Director of Estates and Facilities to reinstate in future reports the performance data for ward and department cleaning which was incorporated into previous reports to the Committee. *This item appears later in the Agenda. Completed.* **009/16 Medicine Optimisation Bi-Annual Report 2015/16:** The Chair invited the Pharmacy Director to ensure that future reports to the Committee contained up-to-date information. *This item appears later in the Agenda. Completed.* **065/16 Minutes of the Quality Committee – Divisional Attendances:** The Chair of the Trust invited the Trust Secretary to review in consultation with the Director of Safety the Divisional attendances so that there is only one such presentation at a meeting. *The Trust Secretary reports that the programme of Divisional Attendances has been revisited and Surgery Division will in future attend with Estates and Facilities Division and all other meeting will have one Divisional Attendance. Completed.* **070/16 Serious Untoward Incidents:** The Chair invited the Director of Safety to provide details for the remit for a Non-Executive Director to be involved in falls. *The Director of Safety reported that the national frailty audit and guidance has been passed to Mr Tony Foster. Completed.* The Director of Safety undertook to provide further details to Dr Jackson of the delays to the availability of blood products in obstetric haemorrhage emergency relating to the incident in May 2016 in Women & Children's Division. *The Director of Safety said this information is now available and will be provided. Completed.* **073/16 CQC Action Plan**: The Medical Director undertook to circulate	

	the Resuscitation Committee's action plan to the Committee which is not Division based. The Committee invited the Medical Director to liaise with the Trust Secretary regarding the presentation to the Committee of the Resuscitation Committee's annual report. *The Medical Director reported that this will be presented to the Committee in September 2016. Ongoing.* **076/16 Research Delivery – Maintaining the Infrastructure and delivering Trials To Time and Target:** The Chair of the Trust commented that at Consultant interview panels a number of applicants express an interest in being involved in research and asked how this could be captured upon appointment. In response, the Medical Director undertook to consider this so that this is addressed on induction and appointment with an opportunity to meet the Associate Director of Research and Development as part of a personalised induction programme. *The Medical Director reports that this has been undertaken. Completed.*	**SE** **(MW to note for Agenda)**
088/16	**NEW CHIEF EXECUTIVE**	
	The Chair welcomed Deborah Lee to her first meeting of the Committee following her appointment as Chief Executive. He invited her to give her thoughts on the quality Agenda. The Chief Executive said that from a first impression she had observed a positive approach to quality and safety. The appointment of a Director of Safety and Head of Patient Experience were in her view insightful. The establishment of the Quality Academy was at the forefront of quality. There is, however, further work to be undertaken to provide quality and safety assurance with the provision of clear information. There needs to be a stronger focus on quality. The current operating model does not always place patients in the right environment for their care. The escalation beds need to be closed which requires all partners in the health system to address. There is a high number of falls on wards in a number of specialities which also needs to be addressed. The views of our workforce need to be obtained through greater engagement so that they are well supported which in turn provides better patient care. The Chief Executive has observed that staff are tired and more freedoms and autonomy within guidelines should be devolved to staff. Quality is a performance measure and not confined solely to finance and performance. The Chair then invited Committee members to ask questions of the Chief Executive and the following points were raised:- - Mrs Lewis asked how staff will become more engaged. In response, the Chief Executive said that she will be out and about to meet staff and is keen for them to share their experiences. Her first impressions are that staff are positive and loyal but is a sense that they can become more involved. - Ms Storr asked if it is still worth the effort for staff to raise issues so that their concerns can be addressed. The Chief Executive said that the culture needs to be re-set to one of "can do". - Dr Jackson applauded the Chief Executive's approach to	

	getting patients in the right place in hospital. - Mrs Lewis asked if there is confidence to work with our partners to move forward. The Chief Executive said in response that she has been encouraged by her initial contact. All partners are engaged in the Sustainability and Transformation Programme. The elderly and frail need to be in hospital for short periods for their treatment. Gloucestershire Care Services recognise this and work needs to be developed to achieve this. The Chair thanked the Chief Executive for her thoughts and for members questions.	
089/16	**DIVISIONAL ATTENDANCE – ESTATES AND FACILITIES**	
	(Mr Terry Hull, Head of Estates and Mrs Jane Evans, Associate Director of Estates and Facilities attended the meeting for the presentation of this item) The Head of Estates presented the report highlighting that the process regarding internal quality improvements commenced in January 2016. The first stage of this process is complete with improvements to contract specification guidance implemented. The review of the existing internal administration of financial management arrangements is also complete and, subject to the publication of the audit report, the development of new processes will commence in late July 2016 with the aim to complete during August 2016. The implementation of a revised financial governance structure across the service is ongoing with close ties being established between the Division and Shared Services Procurement Team supplemented by Leaseguard. Two painters/handypersons are being recruited to liaise directly with matrons and undertake local improvements. The Head of Estates drew attention to the quality data and narrative providing information on the Division's performance across a number of quality measures which have been the basis of previous reports to the Committee. He highlighted the Division's effectiveness. 2016/17 is a significantly challenging year financially and greater challenge is anticipated in addressing historic and current cost pressures, savings targets and retaining largely compliant and acceptable services. The Division aims to build on its good record of delivery and meet these stretching targets again this year. During the course of the discussion, the following were the points raised:- • The Chair referred to responding issues surrounding cleanliness and the possible negative impact on patient experience. In response, the Nursing Director said that the Infection Control Committee look at complaints and the issues raised on Datix. Environmental control audits are undertaken with the outcomes presented to the Committee. The Associate Director of Estates and Facilities added that the PLACE provide information on cleanliness and the area for action. She acknowledged that there is more work which can be done in this area. The Chief Executive commented that the entrance to the Tower Block at Gloucestershire Royal Hospital does not	

	give a good first impression with smokers outside. No smoking notices are displayed but she thought that this is something which the Health and Wellbeing Committee might look into. • The Chair of the Trust added that it is not good for staff morale when they are not able to leave wards for lunch breaks. She supported the appointment of two handy persons to respond to minor environmental improvements in a timely manner. • The Associate Director of Estates and Facilities drew attention to communicating with ward staff when they do not have access to a PC unless that access is at the start of their shifts. • The Director of Safety referred to the summary of compliance noting that the areas requiring additional attention to increase the level of assurance around decontamination and ventilation. In response, the Head of Estates said that there were staffing issues which have now been resolved and performance is beginning to improve. • The Director of Safety referred to the cleaning programme at Gloucestershire Royal Hospital which is behind schedule. The Nursing Director said in response that the deep cleaning is challenging to undertake to due operational pressures and the absence of areas to move patients to enable that level of cleaning to be undertaken. Different cleaning methods are being investigated. The enhanced cleaning undertaken last year had been effective as there were no ward closures as a result of infection. • Dr Jackson sought an assurance that the Business Case for additional porters will provide sufficient numbers to deliver the required level of service commenting that they play an essential part in the patient process. In response, the Associate Director of Estates and Facilities said that the Business Case is based on an assessment of the number of porters considered necessary to undertaken the level of work. The Chair of the Trust added that the introduction of SmartCare will avoid the necessity for Porters to transport patient notes around the sites. • Mrs Johnson asked whether the level of security will improve with the proposal to bring that service back “in house”? In response, the Head of Estates said that the security and violence and aggression undertaken by Porters will be brought together to be more effective. Mrs Adams referred to the recent “lock down” incident at Cheltenham General Hospital which in her view had not worked well with a debriefing session. The Nursing Director said that the correct procedures had been followed. The Director of Clinical Strategy said that she will check the positon with the Emergency Planning Manager. • The Chair, in summary, said that the focus for the Division is on addressing environmental concerns and getting the deep cleaning schedule back on track. He acknowledged the positive aspects in the report. The Chair thanked the Head of Estates and the Associate Director of Estates and Facilities for the report. **RESOLVED:** That the report providing information on the quality of	**SP** **SP**

	services provided by the Division and the plans to improve performance be noted. *(The meeting adjourned from 10.41 to 10.48 am)*	
090/16	**ANNUAL REVIEW OF SERIOUS UNTOWARD INCIDENTS 2015/16 AND SERIOUS UNTOWARD INCIDENTS**	
	The Director of Safety circulated a paper from the CQC that sets out the standards for investigation which was released very recently. The Director of Safety presented the annual report providing an analysis of compliance with our Trust Serious Incident process, confirmation of key contributing factors and corporate learning identified during the investigation process. The report also included the normal serious untoward incidents report. The report set out the process for escalation of incidents to serious incident status, compliance with our Trust quality contract and themes of incidents reported as serious incidents. Most learning requires a change in behaviour of staff such as the issues identified in the misplaced naso–orgo-gastric tubes Never Events. This work was led by the Divisional Nursing Director, as part of the work he looked at the data as evidence that procedures have been followed. Near miss never events follow the same investigation process as serious incidents. Feedback for on serious incidents is provided to patients and families as part of being open and in line with the Duty of Candour requirements During the course of the discussion, the following were the points raised:- • The Chief Executive congratulated the Director of Safety on a comprehensive report. • In response to a question from the Chief Executive, the Trust Risk Manager said that the CQC are notified of investigations but are not part of the investigation process. The Chief Executive asked the Director of Safety to look at involving lay people in the investigation process. • In response to a question from the Chair of the Trust about the wrong implant prosthesis in Trauma and Orthopaedics, the Director of Safety said that the guidelines were not followed for a new piece of equipment • The Chair of the Trust referred to the two hospital acquired infections which have been escalated to serious incident status noting that improvement plans are not working and asked if the flu vaccination can be made compulsory for staff. In response, the Nursing Director said that the vaccination cannot be enforced; however, staff may be informed that there is a risk to patients to work on wards if they have not received the vaccination. The Medical Director added that this process happens in Oncology. Mrs Lewis asked if Occupational health staff could attend Departments for the vaccination which the Nursing Director said that there were insufficient staff to do this . • The Chair of the Trust referred to the two missed/delayed diagnosis which have been escalated to serious incident	**AS**

	status noting that one was as a delay of 12 months in purchasing equipment which the Medical Director said was now in place. Dr Jackson observed that the Business Plan was presented in April 2015 but not implemented. The Chief Executive said in response that there is further work to do on procurement processes. • Mr Lewis asked if senior clinicians were involved in the investigations. In response, the Director of Safety said that they were involved providing information and support. The Medical Director added that a similar system is in place for nurses. *(The Chief Executive left the meeting)* • In response to a question from Mr Lewis, the Director of Safety said that he will consider addressing the balance of time on investigations and learning so that it is more equal. • The Chair invited the Director of Safety to provide an update in six months' time including checks to ensure that learning has been effective and there are no repeated incidents. • Mrs Haughton said that the Clinical Commissioning Group is pleased to be part of the investigation process to put investigations into a national context of the level of reporting. The Chair thanked the Director of Safety for the report **RESOLVED:** That the report be noted.	**AS** **AS** **(MW to note for Agenda)**
091/16	**INTRODUCTION OF GLOUCESTERSHIRE SAFETY AND QUALITY IMPROVEMENT ACADAMY**	
	The Director of Safety presented the report providing information on the progress of the Gloucestershire Safety and Quality Improvement Academy within our Trust. He highlighted that the number of staff trained to Bronze level has exceeded initial projections as collaboration with the Leadership Development and Education Teams has enabled the Academy to deliver the Bronze training as part of Band 5 nurse transition programme, the Foundation Year 1 Doctors' training programme, the Leadership Welcome Day and the Consultant Induction Day. This has greatly increased the ability of staff to access the Quality Improvement training that is available. During the course of the discussion, the following were the points raised:- - In response to a question from the Chair, the Diretor of Safety said that Bronze level training is open to all staff and is being rolled out across out Trust. Gold improvement training will have a coaching emphasis and is being developed for individual Specialities. - The Chair of the Trust asked if Quality Improvement is included in the Sustainability and Transformation Plan. In response, the Director of Clinical Strategy said that ownership of this aspect is being discussed by our Chief Executive and the Chief Executive of the 2gether Trust.	

	The Chair thanked the Director of Safety for the report. **RESOLVED:** That the progress of the Gloucestershire Safety and Quality Improvement Academy be noted. *(Mrs V Collins Safety Improvement Practice Educator and Ms B Williams Trust Risk Manager left the meeting)*	
092/16	**SAFEGUARDING CHILDREN ANNUAL REPORT 2015/16**	
	The Nursing Director presented the Safeguarding Children Annual Report 2015/16 providing assurance to the Committee that local arrangements are in place to safeguard children, that mandatory training is being delivered and that staff are supported in the challenging role of safeguarding children within our Trust. She highlighted the work being undertaken to meet CQC recommendations. With the exception of one member of staff all Registrars and Consultants in the Emergency Department have completed level 3 safeguarding training. The remaining member of staff will have completed the training by November 2016. During the course of the discussion, the following were the points raised:- • Ms Storr asked if there is sufficient staff with safeguarding skills. In response, the Nursing Director said that in 2017 a training hub for the County will be established with a link to Specialise Commissioners. Children will only be placed in a Paediatric Unity or the Acute Assessment Unit. • The Chair drew attention that Mr Keith Norton had Non-Executive oversight for safeguarding. • In response to a question from the Chair of the Trust, the Nursing Director said that the Agency Return Action Plan is updated at every Safeguarding Board meeting. The Chair thanked the Nursing Director for the report. **RESOLVED:** That the Safeguarding Children Annual Report 2015/16 be noted.	
093/16	**PREVENTION OF PRESSURE ULCERS ANNUAL PLAN AND LESSONS LEARNT FROM INVESTIGATION**	
	The Committee agreed that this report be considered at the meeting in September 2016.	**MA** **(MW to note for Agenda)**
094/16	**MEDICINES OPTIMISATION BI-ANNUAL REPORT**	
	(Mr Martin Pratt, Pharmacy Director, attended the meeting for the presentation of this item). The Pharmacy Director presented the report providing an updater regarding progress made in relation to the medicines optimisation agenda. Attached to the report were the annual Antimicrobial Stewardship report and the Medicines Related Patient Safety Incidents for October to December 2015. Assurance is provided	

	through the QUIP which were met in full and there is learning from incidents. E-learning modules provide education to promote understanding and knowledge of local policies. There is a rolling review of existing controls in place against Never Events and related alerts. The Department of Health antimicrobial self-assessment toolkit for acute hospitals provides the framework for achieving excellence in antibiotic management and the Clinical Commissioning Group set the targets to achieve. The Medications of Safety Thermometer focuses on medication reconciliation, allergy status, medication omission and identifying harm from high risk medicines. During the course of the discussion, the following were the points raised:- - The Chair referred to the national statistic that 6.7% of patients will have a serious or potentially serious medication error whilst in hospital and asked how our trust compared with this statistic. In response, the Pharmacy Director said that this is on the workplan to address as part of reporting as investigations are not always closed. The Medical Director added that assurance needs to be provided. - In response to a question from Mrs Lewis, the Pharmacy Director said that sepsis performance is included in QUIP and CQUINS. - Dr Jackson asked how the introduction of TrackCare will reduce medication errors. In response, the Pharmacy Director said that prescribing is not included in Phase 1, but will be introduced next year. Over time performance will improve. The Chair thanked the Pharmacy Director for the report. **RESOLVED:** That the report be noted.	
095/16	**CLINICAL RISK MANAGEMENT FOR SMARTCARE**	
	(Dr Paul Downie from the SmartCare Team, attended the meeting for the presentation of this item). The Director of Clinical Strategy introduced the report containing evidence and argument for the clinical safety for the implementation of TrackCare in our Trust. This is a new process for the introduction of TrackCare. Dr Downie noted that the report is to provide the Committee with assurance that the SmartCare Programme has evaluated InterSystems TrackCare product and implemented the highest clinical safety standards. The report provided evidence of compliance with the standards described in ISB 0160.The residual severity risk rating in the Clinical Risk Control and Validation were all amber rated (from an initial red risk rating) with the exception of missing information which remained red risk rated. This was due to discharge summaries and remains a risk throughout the organisation. During the course of the discussion, the following were the points raised:-	

	- The Chair asked if there were any further risks associated with the introduction of TrackCare, the Director of Clinical Strategy said that the difficulty is that there is nothing to compare with the risks on the current Patient Administration System. The future will become clearer about assurance levels. - Mr Lewis asked how much training had been provided given the pressures on staff. In response, Dr Downie said that training had commenced on 11 July 2016 and that the training provision is adequate. When the system goes live there will be "floor walkers" and "super users" to provide assistance where necessary. - Mrs Johnson asked when patients will be alerted to the new system. In response, the Director of Clinical Strategy said that patients will be engaged when the system goes live. - Mrs Haughton asked if a paper duplicate system will be available for a period from go live. Dr Downie said in response that said that such a system will operate and the intention is to cease the paper duplicate as soon as possible after go live. - Dr Jackson asked if there are any issues impacting on pour Trust from the experiences of the other Trusts when they went live. Dr Downie emphasised that this is new to all and he was not aware of any issues which might have an adverse impact on our Trust. The Chair thanked the Director of Clinical Strategy and Dr Downie for the report. **RESOLVED:** That the report providing assurance for the introduction of TrackCare be endorsed.	
096/16	**ESTABLISHMENT OF TRUST END OF LIFE CARE GROUP**	
	The Medical Director presented the report recommending the establishment of a Trust End of Life Care Group. Our Trust is committed to ensuring that the quality of End of Life Care continues to improve across our services. The CQC inspection in March 2015 identified areas for improvement. A County Group established at that time and led by the Clinical Commissioning Group has recently published a comprehensive End of Life Care Strategy which defines core principles for ensuring consistent end of life care in hospitals and other settings. To provide leadership, guidance and support to our Trust staff involved in end of life care, it is proposed that and End of Life Care Group is established reporting to the Committee. During the course of the discussion, the following were the points raised:- - In response to a question from the Chair regarding the justification for the establishment of the Group, the Medical Director said that the Group is necessary to ensure that actions for our Trust are undertaken. The Group will undertake a gap analysis of our position against national standards to establish a base line and align with the County-wide strategy. The Group will report periodically to the Committee. - Ms Storr asked if Healthwatch Gloucestershire were included	

	in the reporting lines. In response, the Head of Patient Experience said that Healthwatch is represented on the County Group and has contributed to the work. - The Chair said that a Non-Executive Director should be identified to oversee the Group and assist with reporting. The Chair thanked the Medical Director for the report. **RESOLVED:** That the establishment of an End of Life Care Group with the terms of reference attached to the report be approved.	**GM/CC**
097/16	**MINUTES OF THE PATIENT SAFETY FORUM MEETING HELD ON 25 MAY 2016**	
	The Director of Safety presented the minutes of the meeting of the Patient Safety Forum held on 25 May 2016. He highlighted the proposal using a rapid review of events/casenotes to inform whether care provided had impacted on the outcome. This would confirm the level of investigation required. The Chair thanked the Director of Safety for the minutes. **RESOLVED:** That the minutes be noted.	
098/16	**MINUTES OF THE HEALTH AND SAFETY COMMITTEE MEETING HELD ON 23 JUNE 2016**	
	The Director of Safety presented the minutes of the meeting of the Health and Safety Committee held on 23 June 2016. He highlighted that the Committee is concerned about the absence of weekend security cover under the Kingdom Security contract (currently out to tender) which is being undertaken by security trained porters. The Chair thanked the Director of Safety for the minutes. **RESOLVED:** That the minutes be noted.	
099/16	**MINUTES OF THE RESEARCH AND INNOVATION FORUM MEETING HELD ON 7 JUNE 2016**	
	The Director of Clinical Strategy presented the notes of the meeting of the Research and Innovation Forum meeting held on 7 June 2016. She highlighted that the finance reports are not allocated until the infrastructure to support is identified. The Chair thanked the Director of Clinical Strategy for the notes. **RESOLVED:** That the notes be noted.	
0100/16	**NOTES OF THE HOSPITAL MORTALITY INDICATORS GROUP MEETING HELD ON 6 JUNE 2016**	
	The Medical Director presented the notes of the meeting of the Hospital Indicators Group held on 6 June 2016. He highlighted that	

	the data when analysed is often not current and everything is being done to ensure that data is current. The Chair thanked the Medical Director for the notes. **RESOLVED:** That the notes be noted.	
101/16	**ANY OTHER BUSINESS**	
	There were no further items of business.	
102/16	**QUALITY COMMITTEE WORK PLAN**	
	The Committee invited the Trust Secretary to update the Work Plan as follows:- • September 2016 – Delete West of England Genomics Centre Clinical Pathway and CQC Evidence Assurance which will now appear in the Divisional reports. Add Prevention of Pressure Ulcers Annual Plan and Lessons Learnt from Investigation • October 2016 – add update on Gloucestershire Safety and Quality Improvement Academy	**MW**
103/16	**COMMITTEE REFLECTION**	
	This Chair invited Committee members to offer their reflections on the meeting and the following points were raised:- - The lead given by the Chief Executive - The learning form incidents - The balance of data and description in the reports - Value of clinical medical alerts - The ability to ask questions - The benefit of Divisional attendances - The end of life strategy - The measurement of the quality metrics - Summary of annual reports to ensure that messages are not lost - The report on the clinical safety of SmartCare - The development of quality priorities for the Committee	
104/16	**DATE OF NEXT MEETING**	
	The next meeting of the **Quality Committee** will be held on **Friday 2 September 2016** in the **Boardroom, Alexandra House, Cheltenham General Hospital** commencing at **9.30am**. The meeting ended at 12.52pm. **Chair** **2 September 2016**	

MINUTES OF THE MEETING OF THE TRUST QUALITY COMMITTEE HELD IN THE BOARD ROOM, ALEXANDRA HOUSE, CHELTENHAM GENERAL HOSPITAL ON FRIDAY 2 SEPTEMBER 2016 AT 09:30AM

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	Gordon Mitchell	Non-Executive Director (Chair)
	Clair Chilvers	Chair of the Trust
	Dr Sally Pearson	Director of Clinical Strategy
	Dr Sean Elyan	Medical Director
	Maggie Arnold	Nursing Director
	Andrew Seaton	Director of Safety
	Pam Adams	Governor – Staff, AHPs
	Ann Lewis	Governor – Tewksbury District Council Area
	Fannie Storr	Governor – Gloucester City Council Area
IN ATTENDANCE	Martin Wood	Trust Secretary
	Debra Clark	Senior Patient Experience Manager (For Heather Beer)
	Dr Zoe Jones	Chief Registrar – shadowing Dr Elyan
APOLOGIES	Deborah Lee	Chief Executive
	Tracey Barber	Non-Executive Director
	Heather Beer	Head of Patient Experience
	Kay Haughton	CCG Quality Lead
	Dr Peter Jackson	Governor – Forest of Dean District Council Area
	Chrissie Johnson	Governor – Forest of Dean District Council Area

The Chair welcomed the all to the meeting.

105/16 DECLARATIONS OF INTEREST — ACTION

There were none.

106/16 MINUTES OF THE QUALITY COMMITTEE MEETING HELD ON 15 JULY 2016

RESOLVED: That the minutes of the meeting of the Quality Committee held on 15 July 2016 were agreed as a correct record and signed by the Chair subject to the correct spelling of the word "Divisional" in the first line of minute 007/16.

107/16 MATTERS ARISING

050/16 Divisional Attendance - Surgery: The Chair observed that the presentation referred to a number of external reports where only a summary is presented to the Committee and not the actual report. In response, the Director of Clinical Strategy said that an annex can be provided to the Directors' Statement providing details of all reports, the

key findings and actions taken. This will then provide assurance and an audit trail. The format of the Divisional reports is to be revised to reflect the Directors' Report and will be presented to the Committee in September 2016. *This item appeared later in the Agenda. Completed.*

073/16 CQC Action Plan: The Medical Director undertook to circulate the Resuscitation Committee's action plan to the Committee which is not Division based. The Committee invited the Medical Director to liaise with the Trust Secretary regarding the presentation to the Committee of the Resuscitation Committee's annual report. The Medical Director reported that this will be presented to the Committee in September 2016. *This item appeared later in the Agenda. Completed.*

067/16 Directors' Statement to the Quality Committee: The Chair said that our evidence needs to demonstrate assurance in line with the CQC framework. The Director of Clinical Strategy said that a process needs to be found to provide that assurance. The Chair invited the Director of Clinical Strategy to consider this matter and provide a report to the Committee in September 2016. *This item appeared later in the Agenda. Completed.*

089/16 Divisional Attendance – Estates and facilities Division: The Chief Executive commented that the entrance to the Tower Block at Gloucestershire Royal Hospital does not give a good first impression with smokers outside. No smoking notices are displayed but she thought that this is something which the Health and Wellbeing Committee might look into. *The Director of Clinical Strategy said that this matter has been raised by the Chief Executive. On the recommendation of the Smoking Cessation Group the Health and Wellbeing Committee is being asked to approve the provision of smoking shelters. Completed as a Matter Arising.*

Mrs Adams referred to the recent "lock down" incident at Cheltenham General Hospital which in her view had not worked well with a debriefing session. The Nursing Director said that the correct procedures had been followed. The Director of Clinical Strategy said that she will check the positon with the Emergency Planning Manager. *The Director of Clinical Strategy said that report following the incident had concluded that our trust's procedures had worked. Completed.*

090/16 Annual Review of Serious Untoward Incidents 2015/16: In response to a question from the Chief Executive, the Trust Risk Manager said that the CQC are notified of investigations but are not part of the investigation process. The Chief Executive asked the Director of Safety to look at involving lay people in the investigation process. *The Director of Safety reported that this will appear in the Annual Report. Completed.*

In response to a question from Mr Lewis, the Director of Safety said that he will consider addressing the balance of time on investigations and learning so that it is more equal. *The Director of Safety reported that this will appear in the Annual Report. Completed.*

093/16 Prevention of Pressure Ulcers Annual Plan and Lessons Learned from Investigation: In response to a question from the Chief

Executive, the Trust Risk Manager said that the CQC are notified of investigations but are not part of the investigation process. The Chief Executive asked the Director of Safety to look at involving lay people in the investigation process. *The Director of Safety reported that this will appear in the Annual Report. Completed.*

In response to a question from Mr Lewis, the Director of Safety said that he will consider addressing the balance of time on investigations and learning so that it is more equal. *The Director of Safety reported that this will appear in the Annual Report. Completed.*

096/16 Establishment of Trust End of Life Care Group: The Chair said that a Non-Executive Director should be identified to oversee the Group and assist with reporting. *The Chair reported that Tracey Barber has Non-Executive Director oversight of this Group. Completed.*

108/16 DIRECTORS' STATEMENT TO THE QUALITY COMMITTEE

The Director of Clinical Strategy presented the key issues relating to the quality of care delivered in our trust from the perspective of the Nursing and Medical Directors and the Director of Clinical Strategy. She said that the format of the report has changed providing the quality data which can be readily related to the Committee's specific activities. It has been more aligned with the CQC's Key Lines Of Enquiry (KLOEs). The report answers the questions in the domains of Are we safe? Are we responsive? Are we effective? and Are we well lead? It provides an indication of where there may be concerns. She acknowledged that the analysis is limited to the measures from the data. It does, however, enable reflection. With regard to the review of nursing metrics and the emergence of the national safety thermometer data set, the safer staffing requirements and the medicine safety thermometer now provides a similar set of outcome data that our nursing and midwifery metrics did. To avoid over-burdening ward and departmental staff in duplication of data collection, the plan is to move to the national information and develop an internal dashboard, in particular, for individual wards. The recent move within the CQC assessment standards to KLOEs and away from the previous CQC outcome standards has meant that self-assessment is more difficult for some broader areas because the CQC regulations do not now fit within the KLOE frameworks. The Quality Standards Group has reviewed the process of assurance and is proposing a hybrid of assurance against both KLOE and CQC regulations which will be presented to the meeting of the Committee in October 2016. There have been no reports from regulatory, accreditation or professional bodies in the last quarter. NHS Improvement has confirmed that it has reasonable grounds to suspect that our Trust is in breach of its license, in respect of Board governance arrangements specific to the A&E four hour performance and consequently has taken regulatory action. As a result, the Board has been invited to accept a set of enforcement undertakings to prevent further regulatory action being taken. Two mortality alerts have been received; one relating to cancer 30 days which is a data issue rather than a quality issue; and one regarding fractured neck of femur which our Trust was aware and where the mortality indicator had reduced to 9% (from 13%).

SP
(MW TO NOTE FOR AGENDA)

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

- The Chair welcomed the gradual change in the revised report format. He drew attention to safety performance, acute kidney infection, of which there was a separate report later in the agenda, and Emergency Department triage assessment and sought information to improve performance. In response, the Medical Director said that these are part of the broader work being undertaken to improve ED performance a review of safety has been undertaken and the safety huddle has been introduced and actions taken to provide assurance on safety. He expressed confidence in the focus on emergency department performance. The Director of Safety explained the four components of the safety work undertaken in the Emergency Department and the work undertaken at speciality level should take that approach to other areas.
- The Chair of the Trust referred to the forecast for acute kidney injury which was green rated and she questioned whether this was the case. In response, the Director of Clinical Strategy acknowledged that the forecasting is not always reliable.
- In response to a question from Miss Storr, the Director of Clinical Strategy said that details of the number of patients seen in ED within 15 minutes of arrival is set out in the report presented to the Board. No service can plan for the sudden fluctuations in demand and the issuing of press releases regarding alternatives to ED may not always be taken up and published by the press.

The Chair then invited the committee to consider the four key questions and the following points were raised:-

Are we responsive?

- The Chair referred to the planned/surveillance endoscopy performance which was red risk-rated and asked for information on the actions to improve performance. In response, the Medical Director said that a risk assessment is being undertaken of each patient to assess the risk to them and ensure that patients who need to be seen are seen.

Are we effective?

- The Chair referred to the mortality rates which are red risk-rated and asked if the issues are discussed in the Committee. In response, the Director of Clinical Strategy said that issues are discussed in the Mortality Indicators Group and processes are shared with the Committee to review regularly. The Group also consider the Doctor Foster mortality report. The Group is best placed to pick up trends but acknowledges that there is further work to do. There is an action plan for fractured neck of femur to improve performance. Mrs Lewis asked if a forensic investigation had been undertaken in each case. In response, the Medical Director said that there is an individual case review but the data especially for fractured neck of femur is six months in arrears. The crude mortality indicator for Gloucestershire Royal Hospital is now 9% (from 12.5%) suggesting that changes to the pathways are beginning to have a beneficial impact. The indicator for the two sites is now almost equal.

- Mrs Lewis asked if the recruitment issues for nurses and junior doctors remain as this impacts on the level of care provided. In response, the Nursing Director said that there are a number of vacancies which are back-filled with agency staff which has a negative effect on permanent staff. Our Trust is going to the Philippines later in the month to recruit nurses. 55 newly qualified nurses have now started in our trust. 8 nurses from the Philippines have passed the ILETS test and the County is now looking at the provision of associate nurses. The Chair added that a Workforce Committee has been established to give a focus on recruitment and discussions are taking place in that committee. The Director of Safety added that the challenges being faced in the recruitment of nurses and medical staff is on the Trust Risk Register.
- The Chair of the Trust sought clarity of the business operations section in the trust overview relating to are we effective? In response, the Director of Clinical Strategy said this is taken from the Performance Management Framework report and is not relevant to this Committee. Its inclusion will be addressed.

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

RESOLVED: That the report be noted.

109/16 DIVISIONAL ATTENDANCE – DIAGNOSTICS AND SPECIALTIES

(Nicola Turner, Divisional Director, AHP and Scientific staff, attended the meeting for the presentation of this item.)

The Divisional Director AHP and Scientific Staff attended the meeting in the absence of the Chief of Service and the Divisional Nursing Director to present the Diagnostic and Specialties Divisional Quality Report.

In considering the report the following points were raised:-

- The Chair referred to the CQC self-assessment gap analysis considered by the Divisional Board in August 2016 noting that once completed it will be presented to the Committee. He also referred to the inability to recruit radiology consultants which remains an issue together with the increasing work load indicating that this is a long term issue. In response, the Divisional Director AHP and Scientific Staff said that the work load continues to increase. However, the Division is coping well but the staffing levels are now becoming a challenge to keep pace with the work load. This is a national issue regarding the availability of radiologists. Two radiographers retired during the summer with replacements difficult to recruit. The Division is looking how to manage the work load with radiologists to provide a short term solution. The Chief of Service has presented a business case to the Directors' Group which has been approved seeking arrangements for radiologists to help in covering this work. Miss Storr asked if there was support for radiologists to which the Divisional Director AHP and Scientific Staff said that the Trust recruits and trains staff and fourteen graduates have been recruited this year. The issue is that high level skills are lost due to experienced staff retiring from our Trust. The requirement for staff to pay for university courses may not have

an impact on the individuals but the issue is will universities invest in courses because they are expensive to run in terms of equipment. The Division is looking at introducing apprenticeship roles both for radiographers and other Allied Health Professionals.

- The Chair of the Trust referred to the failure of the MRI scanner at Cheltenham General Hospital impacting adversely on capacity noting that it has been repaired but questioned whether this was value for money and this would be replaced. In response, the Divisional Director of AHP and Scientific Staff said that the issue is how long the repair will last and it will be replaced in due course. The equipment is used beyond its expected lifespan and the scanner in Gloucestershire Royal Hospital is older. The scanner is on the replacement equipment programme where there are competing priorities.
- The Director of Clinical Strategy said that the link to the University Technical College might help in the local training of radiologists.
- The Chair asked whether there is any benchmarking data available for the incidents reported by year in the Radiotherapy Department. In response, the Medical Director said that the work performed in the Department is impressive and it may be more useful to benchmark internally to analyse common themes rather than benchmark more widely as our Trust may become an outlier. The Director of Safety added that there should not be a reliance on the number of incidents but what can be learnt from them.
- Mrs Lewis referred to the changes in process that the Division no longer write in treatment sheets so that is no visible reminder for checking a previous image as this is now stored electronically. This has probably meant that many images not reviewed She asked what action is being taken to remedy this. In response, the Director of Clinical Strategy explained that this is a broader issue with the introduction of TrakCare where a paper system will operate alongside the electronic system for a period of time. There are inherent risks in this process. The increase in the use of mobile devices will also help. The Divisional Director AHP and Scientific Staff added that the information will be in one place with TrakCare but the issue is to get staff to use the system. The visit to Yeovil to see TrakCare in operation has provided assurance.
- The Chair referred to the positive aspects from the reports on the lessons learned, staff awards, the complimentary report following the HSE inspection into medical physics and radiology and the self-assessment on governance arrangements. The Divisional Director AHP and Scientific Staff said that the challenges are capacity with the right staff and equipment with looking at different ways of working with different staff groups. The Division relishes changes and is embracing SmartCare.
- The Director of Safety referred to the reporting turn around (CQC) within five days in MRI and asked when it became critical in terms of quality and safety due to the current red risk rating. He said that there is a risk that something significant may be missed and the Chair invited the Division to provide greater depth in this area in the next report to the Committee. **NJ**

The Chair thanked the Divisional Director AHP and Scientific Staff for the report.

RESOLVED: That the report be noted.

(The committee adjourned from 10:40 to 10:47am).

110/16 SERIOUS UNTOWARD INCIDENTS

The Director of Safety presented the report updating the Committee on current Serious Untoward Incidents (SUIs), never events, high level reviews and RIDDOR reportable incidents. He highlighted that with the RIDDOR reported incidents the outcome for staff and patients is now reported. Named members of staff are now identified to undertake investigations reporting to the Safety Experience Review Group with learning undertaken. This process provides greater ownership and transparency of investigations. All positions in his team dealing with the duty of candour have now been filled and cases of moderate harm identified will be provided in future reports.

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

- The Director of Clinical Strategy referred to the Board discussion on the status of the action plan and the description of represented as incomplete. In response, the Director of Safety said that the review is based on evidence in the action plan and the represented as incomplete is when it is due back to the Safety Experience Review Group for consideration. He acknowledged that a better description would be “to be revised in…”. The Nursing Director added that all action plans were considered at the Safety Experience Review Group on 1 September 2016.

The Chair thanked the Director of Safety for the report.

RESOLVED: That the progress on current Serious Untoward Incidents be noted.

111/16 REPORT FROM THE DETERIORATING PATIENT AND RESUSCITATION COMMITTEE

(Mr Ben King, Lead for Acute Care Response, Resuscitation and Clinical Skills; and Dr David Gabbott, Consultant Anaesthetist, Clinical Lead for Resuscitation; attended the meeting for the presentation of this item).

Mr Ben King and Dr David Gabbott presented the report from the Deteriorating Patient and Resuscitation Committee. They gave a presentation on cardiac arrest prevention and management which focused on the impact of their work. The presentation covered:-

- Strategy for patient safety setting out the five aspects of identification and management of vulnerable/at-risk patients; identifying deteriorating patients – early escalation/decision making; acute care response team call for emergency review; Resuscitation Team called to prevent; and cardiac arrest.
- The Team before the Resuscitation Team with the three

important factors of communication, handover and human factors.
- The technical skills for the Resuscitation Team and the team before them.
- Non-technical skills.
- The National Cardiac Arrest Audit report in respect of Gloucestershire Royal and Cheltenham General Hospitals.
- The reason why resuscitation was stopped on each site.
- The ReSPECT – Recommended Summary Plan for Emergency Care and Treatment.
- National Cardiac Arrest Audit outcome flows.

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

- Mr King and Dr Gabbott stressed the following points:-
  - It is essential to recognise patients at the front door. 75% of calls to the Resuscitation Team are to live patients with a small proportion for cardiac arrests.
  - Dr Gabbott assisted the National Cardiac Arrest Audit in setting up their database which reports at 3 monthly intervals with a substantial volume of data.
  -The Resuscitation Team receive a number of calls which are inappropriate particularly when a Do Not Resuscitate Order is in place.
  - The forms used in our Trust are being used nationally and Dr Gabbott is a member of the respective committee.

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

- Miss Storr asked about the systems in place in wards where staff know which patients are unwell and those patients can ring the call bell for assistance. Dr Gabbott commented that each patient should have an early warning score as few patients ring the bell when they are unwell. They may be unwell but not necessarily unwell on the resuscitation scoring mechanism. Scores above 7 require staff to phone 2222 for the Resuscitation Team if they are unwell. The Nursing Director added that there is a plan of action when the Resuscitation Team is called to a patient.
- Mrs Adams asked whether there should be a wider identification of critical patients on the beds or with a similar arrangement to the butterfly. In response, Dr King said that this would be a breach of confidentiality. However, a red bandana is worn in other Trusts and the issue is does the confidentiality nature outweigh the benefit. The Director of Safety said that a similar approach might be suitable which is used in the United States for paediatric patients which identifies to parents that children are ill. Dr King undertook to explore this.
- The Chair of the Trust referred to the two sites and said that more work needed to be done to understand the implications caused by the different treatment pathways on each site, for example, the fact that Gloucestershire Royal Hospital where there is no catheter laboratory whilst Cheltenham General Hospital has a catheter laboratory.

The Chair thanked Mr King and Dr Gabbott for their informative presentation and the inspiring work undertaken by the Team.

RESOLVED: That the report and presentation be noted.

112/16 ACUTE KIDNEY INFECTION (AKI) PERFORMANCE

(Dr Preetham Boddana attended the meeting for the presentation of this item).

The Director of Safety introduced the report stating that the acute kidney injury (AKI) improvement programme has over the past years successfully implemented an early identification and clinical intervention process for patients within the hospitals, the rational for the programme was to prevent worsening AKI which has high mortality in a potentially large group of patients. In the past year the national emphasis has been to hand over the information to the community on discharge for awareness and continued management by GPs. The report set out the current position, future action and the action plan.

Dr Boddana gave a presentation on acute kidney infection covering the following aspects:-

- The study undertaken in the United States identifying the number of people per year who get AKI during a hospital stay and the number of people who die annually in the USA which is greater than prostate cancer, breast cancer, heart failure and diabetes. People are living longer and there are patients with multiple conditions. This leads to a cost burden and increases length of stay. This position is replicated in this Country and in our Trust.
- Targets for 2016/17. It is acknowledged that our Trust is not meeting the targets which is recognised within the team and monthly audits are undertaken to improve performance. There is a well-run patient safety team lead by the Director of Safety which is a credit to our Trust. This Team works in partnership with clinicians. There are human factors explaining why performance targets are not achieved in that junior doctors have to remember to look back over the entire admission for previous AKI and it is considered a lower priority. The current Patient Administration System and Infoflex are two different systems and with the introduction of TrakCare it is hoped that this will overcome the human factors by automatically feeding the discharge summary. It is currently unclear about what details of the AKI discharge summary will be available in TrackCare and the delay in implementation will adversely affect results in Q4. To overcome this problem it is necessary to think differently to achieve the desired state.
- The action plan for quarter 2 was set out with the issues being the knowledge of new cohort of doctors in August of the current systems for AKI; introduction of TrakCare and generate new ideas to improve performance. Some of these actions were completed in August 2016.
- In summary, AKI is common and largely avoidable. It is a burden of morbidity and mortality and the management is straightforward with “good clinical care” and “team work”. Our Trust needs to improve further with 95% reliability.

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

- The Chair of the Trust expressed concern about AKI performance observing that the introduction of TrakCare will be helpful to doctors in preparing discharge summaries. The Director of Safety commented that he is working with the AKI team to improve performance which is not necessarily seen as a priority as doctors are unsure of the end product. Our Trust is unlikely to achieve the performance target of 90% in quarter four due to human factors. It is hoped to improve performance at marginal gains which will lead to the required 95% performance.
- The Medical Director stressed that there is no harm to patients where our trust fails to tell GPs in the discharge summary. GPs themselves have been informed of the work they need to do to avoid AKI. GPs think about the appropriate medication to prescribe. The Director of Safety said that Dr Boddana has the trained community GPs by providing an education programme to them as part of the NHS England sponsored audit.
- Mrs Adams said that there is a big change with pharmacies being located in GP practises with a change in medication reviews. The Chair observed that our Trust has achieved the AKI performance target in quarter 1 and has received the CQUIN monies. He commented that it appears that the 90% target will not be achieved unless there is an electronic recording system and the CCG is aware of our Trust's decision to postpone the introduction of TrakCare with the consequences on improving AKI performance. The Director of Safety observed that the safety aspect is a matter for the community and not our hospitals.

The Chair thanked Dr Boddana for his informative presentation.

113/16 **RESOLVED:** That the report containing the current position, future action and action plan together with the presentation be noted.

FALLS HIGH LEVEL REVIEW

Unfortunately, due to sickness, the report author, Mr Jon Burford, Divisional Nursing Director for Diagnostics and Specialties Division, was not able to attend the meeting.

The Chair in commenting on the report said that in September 2015 the Medicine Division reported to the Safety Patient Experience Review Group that they were seeing an increase in the number of patients experiencing harm from falls. Subsequently, the National Falls And Fragility Audit results were released and it was clear that there remained room for improvement in relation to falls. A high level review was agreed and an action plan for the review has been developed.

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

- The Chair expressed surprise that there was no data in the action plan which appeared to have been prepared from a table-top exercise.

- The Director of Safety said that this is the first time that data from the national falls and fragility audit has been collected for acute hospitals. There was a delay in setting up meetings for the high level review with a consequent delay in preparation of the action plan methodology. The scores from the audit were used to develop the action plan for this year which will lead ultimately to a prevention in falls.
- The Chair referred to the scores relating to visual impairment which were 96.7 for Gloucestershire Royal Hospital and 48.3 for Cheltenham General Hospital asking why that was not an area of priority. In response, the Director of Safety said that it is not possible to address all the areas but the lowest scores are being prioritised. This could be explained further in the report.
- The Director of Clinical Strategy said that a further report will be presented to the Committee in six months' time providing a clearer action plan with targets and bench marking. The Falls Group will be encouraged to look at falls numbers on both sites. **AS (MW TO NOTE FOR AGENDA)**

The Chair thanked the Director of Safety for the background to the report.

RESOLVED: That the report be noted and that a further report be presented to the Committee in six months' time.

114/16 COMPLAINTS AND CONCERNS Q1

The Senior Patient Experience Manager presented the report providing information on complaints and concerns reported to our Trust during quarter 1 2016/17. During the quarter our Trust received a total of 208 complaints equating to an average of approximately 16 complaints per week, a decrease of approximately 14% against the number of complaints received during the previous quarter. This reduction follows the pattern of previous years. This figure equates to 4.48 complaints per 1000 inpatient episodes, or 0.73 complaints per 1000 total episodes of care (including all inpatients, outpatients and ED attendances.) Our Trust's internal standard of written response within 35 working days in 95% of cases was met in 80% of cases during quarter 1. This was an improvement in performance compared to our Trust average for 2015/16 (72%) and probably reflects the fewer complaints received during the quarter. The response time is linked to clinical time to address complaints and access to patient records where the complaint involves numerous services. TrakCare will help in this regard.

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

- The Director of Clinical Strategy reported in her capacity of Deputy Chief Executive in dealing with complaints, said that there is now a different approach in the manner in which complaints are addressed. Rather than a descriptive response to complainants our Trust is taking a view based on standing back and responding by what we really think. The Senior Patient Experience Manager said that the role of lead investigator is being advocated; although it is acknowledged that this is a time consuming role the quality outcome is improved. The Chair asked how this will be taken forward and the Director of Clinical Strategy undertook to arrange for this to be considered by the **SP**

Trust Leadership Team. The Senior Patient Experience manager added that there is great transparency in the process if it considered by an individual not involved in the complaint. The Nursing Director emphasised that the learning from complaints is important.

- The Chair of the Trust referred to the number of compliments received and suggested that an analysis be undertaken of them rather than the numbers being logged with no detail. In response, the Director of Clinical Strategy suggested that one compliment could be considered per quarter and lessons learnt taken from that. The Senior Patient Experience Manager added that messages from the Friends And Family Test could be considered for learning. **MA**

The Chair thanked the Senior Patient Experience Manager for the report.

RESOLVED: That the quarter 1 2016/17 complaints and concerns report be noted.

115/16 MINUTES OF THE PATIENT SAFETY FORUM MEETING HELD ON 6 JULY 2016

The Director of Safety presented the minutes of the meeting of the Patient Safety Forum held on 6 July 2016. He highlighted the Nat SSIPs workshop where those attending had presented the potential for a generic checklist pro-forma which has now been issued throughout the organisation. The medicine safety thermometer data are now in a better format for providing assurance and the charts do not demonstrate any immediate cause for concern.

The Chair thanked the Director of Safety for the minutes.

RESOLVED: That the minutes be noted.

116/16 MINUTES OF THE PATIENT EXPERIENCE STRATEGIC GROUP MEETING HELD ON 11 MAY 2016

The Senior Patient Experience Manager presented the minutes of the meeting of the Patient Experience Strategic Group held on 11 May 2016.

The Chair thanked the Senior Patient Experience Manager for the minutes.

RESOLVED: That the minutes be noted.

117/16 MINUTES OF SCREENING PROGRAMME GOVERNANCE COMMITTEE MEETING HELD ON 17 JUNE 2016

The Director of Clinical Strategy presented the minutes of the screening Programme Governance Committee held on 17 June 2016. She drew attention to the outline of the proposed content for the Committee's Annual Report which will be further revised and presented to the Committee in October 2016. **SP (MW TO NOTE FOR AGENDA)**

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

RESOLVED: That the minutes be noted.

118/16 ANY OTHER BUSINESS

Industrial Action By Junior Doctors:
The Director of Clinical Strategy referred to the announcement by the British Medical Association of a series of three planned strikes by Junior Doctors for periods of five days. She reassured the Committee that the Trust has plans in place to cover the first period of industrial action. The plans are based on the previous industrial action although this was not for the duration of five days. The priority is to make services safe and to avoid significant cancellations. Any cancellations will need to be captured for access to the Sustainability and Transformation Fund as the industrial action is outside of our control. She acknowledged that it will be difficult to sustain cover over a period of five days of the industrial action.

Ward 9A:
The Nursing Director reported that following a routine testing of the water supply in ward 9a by the Estates and Facilities Division the samples revealed a high level of legionella. As a precaution the ward was closed overnight and was re-opened during the next morning. She provided assurance that there was no harm to patients. Public Health England had been notified. The Director of Safety added that he will be contacting the Health and Safety Executive on the afternoon of the committee meeting to stress that there are no patient concerns. All necessary organisations have been notified following agreed processes.

TrakCare:
The Director of Clinical Strategy referred to the decision taken earlier in the week to defer implementation of TrakCare, which had been communicated to staff and governors. Reviews are undertaken at each stage and the first review identified a safety risk with outpatient clinics not being replicated on the new system. This was a similar position to the Bristol Trust. Our Trust is to align with InterSystems for a slot to go-live which will fit in with our time frames.

119/16 QUALITY COMMITTEE WORK PLAN

The Committee invited the Trust Secretary to update the work plan as follows:-

- October 2016 – Delete Annual Report for Safeguarding Children and Adults and CQC Self-Assessment Care and Compassion under CQC self-assessment – safety. Review of quality priorities to be transferred to December 2016. **MW**

The work plan will need to be reviewed in the light of the changes agreed by the Board in August 2016 regarding the future Committee reporting arrangements.

120/16 COMMITTEE REFLECTION

The Chair invited Dr Zoe Jones to give her perspective on the meeting

as an observer. Dr Jones commented that there is much information to be brought together for the Committee to have oversight of the issues which is a big challenge. The issues are complex and are presented at a high level and not from the perspective of someone working with those issues in the organisation. Some of the issues, such as falls, take longer to come to fruition than staff would like.

Other reflections included that the Committee should celebrate successes including the presentations on acute kidney infection and resuscitation. The content of the Divisional reports should also be re-visited.

The Chair thanked Committee members for their contributions.

121/16 GOVERNOR REPRESENTATIVES ON THE COMMITTEE

The Chair said that this would be the last meeting of the Committee which Pam Adams, Chrissie Johnson and Fannie Storr will be attending before retiring as Governors at the beginning of October 2016. Ann Lewis was seeking re-election as a Governor in the forthcoming elections and Dr Peter Jackson has been re-elected unopposed. He thanked Governors for their contribution to the work of the Committee and wished them well for the future.

121/16 DATE OF MEETING

The next meeting of the **Quality Committee** will be held on **Friday 14 October 2016** in the **Board Room, Alexandra House, Cheltenham General Hospital** commencing at **9:30am.**

The meeting ended at 12:17pm.

Chair
26 October 2016

HOSPITALS NHS FOUNDATION TRUST GLOUCESTERSHIRE

MINUTES OF THE AUDIT COMMITTEE
MEETING HELD ON TUESDAY 6 SEPTEMBER 2016 AT 8.30AM
IN THE BOARDROOM, ALEXANDRA HOUSE, CHELTENHAM

PRESENT

Mrs Anne Marie Millar	(AM)	Non - Executive Director Chair
Mrs Helen Munro	(HM)	Non - Executive Director

IN ATTENDANCE (by invitation)

Mr Alan Thomas	(AT)	Lead Governor
Mr Kevin Henderson (part)	(KH)	Grant Thornton (GT), External Audit
Mr Andrew Seaton	(AS)	Director of Safety
Mrs Sarah Stansfield	(SS)	Director of Operational Finance
Mrs Alex Gent (part)	(AG)	Head of Shared Services
Mr Martin Wood	(MW)	Trust Secretary
Ms Geraldine Daly (part)	(GD)	Grant Thornton (GT), External Audit
Mrs Sarah Smith	(SS)	PA to Finance Director
Mrs Lynn Pamment	(LP)	Partner, Price Waterhouse Coopers (PWC), Internal Audit
Mr Lee Sheridan (part)	(LS)	Head of Counter Fraud
Mr Jonathan Brown	(JB)	KPMG Engagement Lead
Ms Deborah Lee (part)	(DL)	Chief Executive
Mr Stuart Diggles	(SD)	Finance Advisor (Interim)

APOLOGIES

Mr Rob Andrews	(RA)	KPMG Manager
Mr Tony Foster	(TF)	Non - Executive Director
Mrs Helen Simpson	(HS)	Finance Director

ACTION

053/16 DECLARATIONS OF INTEREST

Mr Thomas declared that he also attended the 2gether Trust Audit Committee as a Governor.

054/16 MINUTES OF MEETING HELD ON 17 MAY 2016

Mrs Stansfield confirmed that there is a significant increase to the Clinical Negligence premiums for 2016/17 and agreed to provide further explanation of the increase at the November meeting of the Committee. **SS**

Attendees noted that Mrs Munro had re-joined the membership of the Audit Committee.

RESOLVED: The minutes of the meeting held on the 17th May 2016 were agreed as a correct record and were signed by the Chair of the Audit Committee.

055/16 MATTERS ARISING

040/16 Annual Governance Statement

Mr Wood confirmed that amendments had been made as requested and a paragraph on the review undertaken by RSM had now been included.

To consider whether a draft report should be shared with Governors and the Audit Committee and to also consider whether a report on the work of the Committee should be included for future statements. Both actions will remain on matters arising to be undertaken at a future date.

041/16 Losses and Compensations - to provide further financial analysis for future reports. This action remained outstanding and Mrs Stansfield agreed to provide a more detailed report for November meeting. **SS**

042/16 External Audit - Audit Findings Report, to update on outstanding actions. ***Item Complete.***

043/16 Internal Audit Update - Tracker to be a rolling agenda item***. Item Complete.***

Draft Estates Procurement Review - agenda item for meeting. ***Item complete.***

044/16 - Revised Terms of Reference - to be reviewed at the November meeting of the Committee. **Action MW**

047/16 Transition Planning for External Auditors. Initial meetings had been held and KPMG were meeting the CEO later on 5 September. ***Item Complete.***

025/16 Nursing Rostering - item on agenda for meeting. ***Item Complete.***

RESOLVED: That the report be noted and revisited on the 9 November 2016.

056/16 REPORTS FROM THE DIRECTOR OF OPERATIONAL FINANCE

LOSSES AND COMPENSATIONS

Ex gratia payments to the value of £6,802.00 had been made. These payments have only been made after consultation with the ward and security manager.

The report recommended that 276 invoices totalling £2,259.20 are written off noting that all invoices related to prescription charges. A full review had been undertaken to ensure all steps had been taken to recover the debt before writing off.

Mrs Gent provided an update on prescription machines which have now been sourced with a project in place to implement; the project is being led by the Diagnostic and Specialties division. Mrs Gent agreed to provide an update on the project's progress at the November meeting. **AG**

The Chair of the Audit Committee ask for what assumptions were made in the budget for write offs. Mrs Stansfield commented that this was a minor amount and agreed to confirm the figure at the November meeting. **SS**

SINGLE TENDER ACTION

Two waivers were reported, the first related to the procurement of patient hoists where there is a clear benefit to be gained in maintaining continuity with an earlier project. Mrs Gent advised that renegotiations had taken place to ensure value for money.

The second waiver related to the supply of services for the delivery of staff training for Specialising/Breakaway Techniques/Safe Holding. Mrs Gent explained that that there had been a form of competitive process.

Attendees noted the report which covered single tender actions which had been signed and required disclosure. Mrs Stansfield confirmed that the report related to single tender actions agreed by the Trust up to the

end of July 2016.

RESOLVED: That the reports were noted by Audit Committee.

057/16 EXTERNAL AUDIT

ANNUAL AUDIT LETTER

Ms Daley presented the audit letter which had yet to be finalised at the May committee meeting, as at that stage there were a number of items which were being pursued and further testing to be undertaken. Ms Daley explained that a virtual meeting of the Audit Committee had taken place on the 27 May and the Annual Audit letter was then agreed by the Chair of the Audit Committee and Trust Finance Director. Ms Daley highlighted key areas of the Audit Letter for the attention of attendees and these were noted as :

- Grant Thornton issued an unqualified opinion on the Trusts financial statement and unqualified value for money conclusion on the 27 May 2016.
- In the audit of the Trust financial statements the materiality level for the audit of the accounts was confirmed at £8.7m (1.8%) and a lower level of materiality was set for certain areas. There was a threshold of £250k set, above which Grant Thornton would report errors to the Audit Committee in the Audit Findings Report. This is in line with national guidance.
- Attendees noted the risks identified by Grant Thornton in the audit plan and the summary of responses to these risks and the issues that the auditors identified.
- Review of information provided by the valuer on building valuations resulted in a possible understatement of £2.6m being identified by the audit team. The latest revaluation exercise had not been correctly reflected in notes to the accounts. These did not have an impact on the trust's operational surplus.
- The Trust retained a surplus resulting from a number of technical adjustments. There was a further net reduction to the Trust income resulting from mediation processes with NHS partners.
- There were a number of agreements of balances variances reported by Grant Thornton and detailed in Appendix A. Mrs Stansfield reported that year end income had been resolved with 2gether, the Trust is still pursuing income with NHS South Worcestershire which relates to an invoice for specialling of a patient and the outstanding income with NHS Hereford is likely to be resolved as part of the commissioning contract. During discussion Mrs Stansfield agreed to provide an update on outstanding debtors details at the November meeting. **SS**
- Committee members noted the recommendations from the audit and agreed management response/ action plan as detailed in Appendix B of the report. Mrs Stanfield updated on areas of work which included strengthened control arrangements within financial management around journals. The Agencies Task Force Group will provide significantly greater controls around agency expenditure and Mrs Stansfield agreed to provide a Cost Improvement Programme (CIP) report updating on agency expenditure and a report on the changes made between Month 9 and Month 12. **SS**
- Mrs Stansfield advised that the delay in the delivery of TrakCare would not lead to significant impairment cost.
- The audit letter will be presented at the September meeting of Main Board and will then be available on the Trust website; the

audit letter will also be presented at the Governors meeting in November.

Ms Daley and Mr Henderson left the meeting at 9.20am

PROGRESS REPORT AND TECHNICAL UPDATE
Mr Brown updated on progress since the result of the tender:

- Meetings have taken place with the Finance Director and Director of Operational Finance Director and also the Chair of the Audit Committee to discuss expectations and approach. There will also be quarterly meetings with the Director of Operational Finance and a meeting with the CEO is to take place.
- KPMG have agreed with Mr Wood that they will attend the Main Board meeting on the 28 October and meet with Governors. During discussion Mr Wood agreed that KMPG would attend the September meeting of the Main Board.
- There has been engagement with Grant Thornton and agreed file sharing.
- Mr Brown highlighted a number of technical updates which included the single oversight framework consultation which closed on the 4th August and the developments of the 2017/18 national tariff.
- During discussion attendees considered whether a more detailed audit at month 9 stage should be undertaken, this would need to be discussed with the Chief Executive before progressing. Mr Brown shared that KPMG would look to use a scale of critical estimation/judgement and will track the Trust to gain an overall feel of where the Trust is on the spectrum.
- The November external audit report will provide a more forward look.
- The Chair of the Audit Committee asked for a report on Accounting Policies to be prepared for the November meeting. **SS**

RESOLVED: That the reports be noted.

058/16 INTERNAL AUDIT UPDATE

INTERNAL AUDIT PROGRESS REPORT
There were a number of areas where there has been progress against the 2016/17 internal audit plan. Attendees noted the summary of audit assignments and Mrs Pamment advised that there would be an increased focus on cancer wait times. Mrs Pamment updated on the additional clinical coding review which has been requested as a jointly funded review with the Clinical Commissioning Group (CCG), terms of reference has been jointly agreed with the CCG and a scoping meeting had been held.

Internal audit had concluded their review of the financial governance arrangements of the Hereford project during 2011-2014. Due to the relatively high level of recorded information available it has been difficult to draw any real conclusion, following discussions with the Trust this work has now been concluded.

Ms Deborah Lee arrived at 9.45am

Attendees considered the number of management actions which were not completed and agreed that there is a need for a mechanism to close down actions in a timely way and hold Executives to account, particularly as some were old. Ms Lee agreed to discuss management actions with **DL**

Director colleagues and provide an update for the November meeting.

SMARTCARE FOLLOW-UP
The programme had made good progress and governance arrangements had improved, attendees noted that there has been a quick response to original report. Discussion took place around the programmes risk register and whether this was reviewed by the Board, noting that this would only be reviewed by the Main Board if risk rating of 15 is triggered.

Attendees discussed the audit scope and internal audit agreed to consider the use of clear success markers.

AGENCY NURSING FOLLOW-UP
There are a number of issues still to be resolved, and internal auditors shared their disappointment that a number of outcomes had not been implemented and had one high priority recommendation for completion by end November. Ms Lee advised that there has been poor implementation and compliance, discussions had taken place with the Nursing Director and compliance checks are now in hand.

ESTATES PROCUREMENT REVIEW
A draft report was reported at the May meeting and now presented as a completed review, noting that all management actions had now been signed up to. Mrs Gent advised that target dates had been set and that all actions had been competed with the exception of the action relating to the use of Quantity Surveyors (QS's), with the current lull in the capital programme there has been no current requirements for QS's. Report noted by the Committee.

NURSING ROSTERING
The main issues to be resolved relate to the cumulative time balance reordered in the system and inaccuracies in what is recorded on the system. Ms Lee updated that the Nursing Director is leading on the review and discussion were underway with staff side to agree a way forward and resolve the legacy issue and progress with a fit for purpose system.

RECOMMENDATION TRACKER
The report was noted by attendees.

Mrs Alex Gent left the meeting at 10.10am
Mr Lee Sheridan arrived at 10.15am

RESOLVED: That the reports be noted.

059/16 REPORT FROM THE HEAD OF COUNTER FRAUD

Mr Sheridan updated on the work undertaken to raise the profile of counter fraud which included the attendance of counter fraud at every Trust Induction to provide a fraud awareness presentations including the F1 Doctor Medical induction, attendees also noted the requirements to participate in the National Falls initiative.

Mr Sheridan provided a verbal update on current cases which included a member of staff who had been struck off, a leavers form had not been completed and the members of staff was continued to be paid. The money has been recovered and there will be joint learning countywide.

A formal member of staff and four co-defendants are due to appear at

Gloucester Crown Court on Thursday 8 September. Media attention is expected and Mr Sheridan assured attendees that the Trust's communications were in hand.

Attendees discussed processes in the Estates department and whether the Trust had done enough to provide assurance moving forward. Internal auditors agreed to provide a forward look and provide an update at the November meeting. **PwC**

The whistleblowing policy had been updated and is owned by the Director of HR. Mr Sheridan advised that counter fraud were now consulted on the policy process.

The Counter Fraud action plan will be completed by the end of the financial year. The Committee Chair thanked Mr Sheridan for the good work that he and the team were doing on fraud.

RESOLVED: That the reports be noted.

060/16 REVIEW OF THE TRUST RISK REGISTER

Attendees considered the current risk register , key points of discussion were noted as :

- Impact on timely payment of supplier invoices and reputational risk and suppliers who will not continue to provide services in the futures. Attendees agreed that this should be captured as part of the financial resilience. Mr Seaton agreed to access the risk to establish whether it would trigger a risk level of 15. **AS**
- Management capacity and retaining talent, the Chair of the Audit Committee asked whether the risk should be captured to ensure there is the scope to address challenges. Mr Seaton agreed to access the risk to establish whether it would trigger a risk level of 15 although Ms Lee advised that this would typically trigger a 12. **AS**
- Discussion took place around the resources within the finance function, Mrs Stansfield assured attendees steps had been taken to provide a dynamic structure to cope with the current challenges.
- Mr Seaton to consider the reputation and clinical risk associated with the Junior Doctor strike **AS**

RESOLVED: That the report be noted.

061/16 AUDIT COMMITTEE WORKPLAN 2016

Internal and External Auditors agreed to provide an update for the work plan. **KPMG/PwC**

Forward dates for the Committee were discussed agreeing that the committee should increase the number of meetings to six per year. Internal Auditors also requested that the county audit committee dates were considered in the scheduled and Mr Wood agreed to progress future dates. **MW**

Discussion took place around Shared Services Quarterly Management meetings noting that the chair of the Audit Committee had been invited to attend the October meeting; attendees considered whether it would be appropriate for internal auditors to attend to gain assurance agreeing that it would not be appropriate for internal audit to attend a performance meeting. Attendees agreed that the Audit Committee should receive an assurance report and minutes from the Shared Services Management **AG/SS**

meeting and an update on arrangements should be received at the November meeting of the Audit Committee.

The Chair of the Audit Committee requested to receive an update on a lower level risk on finance management at the November meeting. **SS**

RESOLVED: That the reports be noted.

062/1 COMMITTEE REFLECTION & DEVELOPMENT

Attendees reflected on the membership of the Committee and whether this should include the Chief Executive and also if the remaining Non - Executive Directors should be invited to join the Committee.

Agenda set up to be prioritised based on importance to ensure appropriate time is given for discussion.

Attendees consider management presence and directorate attendance to present their risk register, it was noted that this function was already covered by the Trust Leadership Team.

Workforce risk register was agreed as a forward agenda item for the Committee.

Early warning indicators, internal audit agreed give more thought to items outside of the plan and how to bring back to the Committee to provide assurance **PwC**

Training for Non - Executive Directors was considered to cover current topics and future themes. It was expected that KPMG would provide a finance update as part of their contract with the trust.

063/16 ANY OTHER BUSINESS

None.

064/16 DATE OF THE NEXT MEETING

Tuesday 9 November , 8.30am in the Boardroom at Alexandra House

Pre meet for members only – 8.15am

THE MEETING ENDED AT 11:15am

_____

CHAIR

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST WORKFORCE COMMITTEE HELD IN THE BOARD ROOM, ALEXANDRA HOUSE, CHELTENHAM GENERAL HOSPITAL ON WEDNESDAY 27 JULY 2016 AT 2PM

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	Keith Norton	Non-Executive Director (Chair)
	Deborah Lee	Chief Executive
	Dave Smith	Director of Human Resources and Organisational Development
	Maggie Arnold	Nursing Director
	Dr Sean Elyan	Medical Director
	Eve Russell	Associate Director of HR
	Sarah Stansfield	Director of Operational Finance
APOLOGIES	None	
IN ATTENDANCE	Martin Wood	Trust Secretary
	Dr Tom Barrett	Shadowing Dr Elyan

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

001/16	**DECLARATIONS OF INTEREST** There were none.	**ACTION**
002/16	**INTRODUCTION AND TERMS OF REFERENCE** The Chair welcomed members to the inaugural meeting of the workforce committee. He presented the report inviting the Committee to approve terms of reference for its operation. It was acknowledged that the terms of reference would be reviewed in the light of experience. He said that there will be an emphasis for the Committee to identify risks associated with workforce issues ensuring ownership with mitigating actions and escalation to the Board as necessary. **RESOLVED:** That the terms of reference as set out in the attached document to the report be approved.	
003/16	**THE TOP WORKFORCE PRIORITIES** The Chief Executive was invited to outline her main workforce priorities for the Committee which included:- • Addressing staff morale with engagement being a factor for this. She gaged a sense of purpose to improve in this area. • To achieve a sustainable workforce to avoid reliance on temporary staff but acknowledged that during peaks such staff will be required. Permanent staff should be delivering our Trust's core business. • To develop a culture where junior staff (by salary) feel	

	developed and can progress through the salary bands. • Retain our staff. For example, by supporting newly qualified nurses where there is a perception of limited support. This may be as a result of the language used particularly regarding pre-certificates. • Staff should feel invested in. • Staff roles should be examined to see how a better patient experience can be provided; for example, associate physicians working on junior doctor rotas. During the course of the discussion, remaining committee members were asked for their views on workforce priorities and the following were the points raised: - • The Director of Human Resources and Organisational Development said that staff morale is variable throughout our Trust. This has been addressed with the LNC. In many incidences a default position is adopted and he believed that it will take approximately one year to gain traction to address this issue. • The Associate Director of HR said that if the roles and development were right then addressing the rest of the issues would follow and this was the positive message. There are pockets of issues and support is required to address. • The Nursing Director said that time should be allocated for ward clerks to meet together as part of their development. Our Trust needs to look at the working arrangements for nurses so that they work in their speciality area. There also needs to be a focus on non-clinical staff; for example porters. • The Chair added that motivation is important to improve patient experience. • The Director of Operational Finance said that succession planning is crucial to staff development. • The Director of Human Resources and Organisational Development questioned the methods of communication from the Committee and it was agreed that a member of the communications team be invited to observe Committee meetings for that purpose. The Chair thanked the Chief Executive and Committee members for their contribution. **RESOLVED:** That the top workforce priorities identified be considered and further developed.	**MW/CM**
004/16	**WORKFORCE STRATEGY 2016-2021** The Director of Human Resources and Organisational Development presented the draft workforce strategy 2016-2021. This is an overarching document commissioning Sub-Committees to undertake the detailed work. During the course of the discussion, it was acknowledged that this draft required refinement with a further report being presented to the next meeting of the Committee in September 2016. Input on the draft strategy should be obtained from Divisional Boards, Chiefs of Service,	

	Divisional Directors of Nursing, Divisional Directors of Operations, Staff Governors and the Joint Staff Committee to assist in co-creating the strategy. The Chair thanked the Director of Human Resources and Organisation Development for the report. **RESOLVED:** That the draft workforce strategy 2016-2021 be noted and that it be widely circulated for input and an updated version presented to the next meeting of the committee in September 2016.	**DS** **(MW to note for Agenda)**
005/16	**WHAT DATA DOES THE COMMITTEE NEED?** The Committee considered the data which they required to be effective. It was reported that a dashboard exists in our Trust, Bristol and Salisbury and it was agreed that these dashboards be obtained with a view to formulating one appropriate to our Trust. The Chair thanked Committee members for their contributions. **RESOLVED:** That a dashboard be developed based on those available in other Trusts.	**DS/ER**
006/16	**ANY OTHER BUSINESS AND THE PLAN FOR THE MEETING FOR 16 SEPTEMBER 2016** There were no further items of business. It was agreed that the meeting on 16 September 2016 be limited to 1.5 hours to consider the following matters: - • Workforce Strategy • Data with a first draft of the dashboard • Reports from Sub-Committees. The Chair expressed the view that sub-committees should report progress and not activity and their reports should provide an opportunity for the Committee to undertake deep dives on specific issues.	
007/16	**COMMITTEE REFLECTION** Committee members reflected on the positive outcomes from the inaugural meeting.	
008/16	**DATE OF NEXT MEETING** The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Workforce Committee will be held on **Friday 16 September 2016** in the **Board Room, Alexandra House, Cheltenham General Hospital** commenced at **2pm.** **Papers for the next meeting:** completed papers for the next meeting are to be logged with the Trust Secretary no later than 3pm on **Tuesday 6 September 2016.** The meeting ended at 2:51pm.	

Chair
16 September 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – SEPTEMBER 2016

REPORT OF THE CHIEF EXECUTIVE

1. Introduction

Unsurprisingly, news regarding the deterioration in the Trust's financial position has dominated much of the month; either through preparation for the announcement or responding to the reactions thereafter.

Aside for the understandable concern expressed by staff and partners messages from these key stakeholders have been positive. From staff, I have heard them describe an overwhelming sense of relief that the concerns they have held for some time have been heard by the Board and swift action taken. They have welcomed the openness and honesty displayed by the Board in communicating the issues and the Board's decision to commission an independent review.

Positively, following staff briefings throughout the 20th September, which several hundred staff attended, the response has included numerous emails with suggestions from staff about how the Trust can save money, whilst improving the quality of care for patients. This offers a very positive platform from which to launch the Trust's Transforming Care Programme which we are now framing as *Doing Things Better and Doing Better Things.*

Partners have also responded positively. For myself, the personal expressions of support from the four STP Chief Executives has been overwhelmingly and I believe positions us well for working together across Gloucestershire, to ensure that the financial issues facing our Trust are resolved in the context of the wider system commitment to transformational working which has been the underpinning principle throughout the development of our plan.

2. National

2.1 The junior doctor dispute continues and regrettably more industrial action has been announced since the last Board. The proposed short notice action for September was stood down however, more action is planned for the period w/c 5th October, for 5 consecutive days and affecting both planned and urgent care. There is some disquiet amongst junior doctors, both locally and nationally, regarding the duration of the proposed action and there is hope that if the action does have to proceed, that it is reduced in length. Trust planning for the five day scenario is well advanced with an emphasis on maintaining safety throughout hospitals and minimising the interruption to routine care as much as is practical. It is however inevitable that we a significant proportion of our routine outpatient, day case and inpatient work will be cancelled.

2.2 The national regulator, NHS Improvement, have published a new oversight framework which is out to limited consultation. A helpful summary of the changes has been produced by NHS Providers and is available at https://www.nhsproviders.org/media/2220/nhs-providers-on-the-day-briefing-nhsi-single-oversight-framework-september-2016.pdf. The implications of the new framework are to place providers into 4 "segments", with declining autonomy (or enhanced freedoms) dependent upon performance against a set of defined national parameters relating to quality, finance, operational performance, strategic change and leadership & improvement capability. Our current regulatory status in respect of A&E performance assigns us to segment 3 – mandated support.

2.3 NHS Improvement have also published their latest operational planning guidance for the period 2017-2019 https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view.

The implications of the planning guidance will considered within the Executive Team and reported to the Board at a future date however, initial scanning presents a very challenging timeline for submission which is exacerbated by the work still required to understand the underlying financial position of the Trust which will be confirmed through the financial baselining work, which is not expected to report until December 2016.

3. Regional

3.1 As briefed last month, 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. I have been invited to Chair the South West Alliance and whilst mindful of the internal priorities for the Trust in the period ahead, have accepted this invitation on the basis of the wider benefits I believe it will bring to the Trust and Gloucestershire.

4. Our System

4.1 Work is in hand to develop the next submission of the Gloucestershire STP (Sustainability and Transformation Plan) which is due for submission at the end of October and work is progressing positively. STP partners are working together to understand the implication for the proposed plan, arising from deterioration of Gloucestershire Hospitals' financial position but importantly, the early messages are that this does not detract from the core direction of the plan or our commitment to transformational change, which arguably has never been more relevant.

5. Our Trust

5.1 The Trust met with NHS Improvement last week as part of the formal requirements associated with the recent regulatory action taken. The Trust was able to describe the performance improvement from 77% six months ago to current performance which is in excess of 90% and in line with our agreed recovery trajectory. The Trust has moved from a trough of 124/125 Trusts to regularly being above average and peaking at 32nd in the national position earlier in the month. Collectively, it was acknowledged that the forward challenge is to embed and thus sustain the recent improvements in practice and performance, particularly given the challenges which the winter period will present.

5.2 The Care Quality Commission has notified the Trust that it intends to undertake a full inspection of our services w/c 23rd January 2017. Whilst this will of course entail some preparation and a degree of focus from everyone across the Trust, we should embrace the opportunity to receive comprehensive feedback on our services and ways of working, and use this as part of our approach to be a continuously learning and improving organisation. The CQC will seek to find, and I believe we should consistently have, an unrelenting focus on quality. I also believe that in doing so, we will realise the cost benefits associated with high quality care which will support our messages earlier in the week regarding the belief that high quality care and strong financial stewardship, go hand in hand. Leadership for the inspection will rest with the Chief Nurse, supported by the Head of Patient Safety and plans are underway to mobilise our preparation.

5.3 Earlier this month, the Trust had the opportunity to showcase its work on endoscopy to Trusts from across the Country and very positively this education event attracted international interest, including attendance by Professor Jason Dominitz, National Program Director for Gastroenterology, Department of Veterans Affairs in the United States of America, who came to learn about the innovation and excellence in endoscopy services in our Trust.

5.4 Finally, as part of the leadership team's aim to ensure that we are as inclusive as possible in the way we do our business, the first "new style" Trust Leadership Team met this month with an expanded membership which included Divisional Directors of Nursing, Operations Directors, Speciality Directors and importantly our Head of Communications who has joined the team to ensure that key messages from the meeting are communicated widely throughout the organisation. Some away time is now planned for the team, to agree how best to use this forum.

6. Consultant Appointments

The following consultants have recently been appointed:

Ophthalmology – Antonios Kaintatzis

Obstetrics and Gynaecology (Foetal) – Rebecca Evans-Jones

Neurology – Rose Bosnell and Mara Sittampalam

Deborah Lee
Chief Executive Officer

September 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

PUBLIC BOARD MEETING FRIDAY 30th SEPTEMBER 2016

Gallery Room, Gloucestershire Hospital commencing at 9.00 a.m

Report Title									
Performance Management Framework									
Sponsor and Author(s)									
Eric Gatling, Director of Service Delivery									
Audience(s)									
Board members	✓	Regulators	✓	Governors	✓	Staff	✓	Public	✓

Executive Summary

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

Key issues to note
This month the Trust has met two of the four trajectories that it is required to meet in order to demonstrate improvement.

Conclusions
Performance against the national standards remains a key area of focus for the Trust.

Implications and Future Action Required
Delivery of agreed action plans are critical to return back to the minimum expected standards.

Recommendations

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

Impact Upon Strategic Objectives

No change.

Impact Upon Corporate Risks

Delivery of the 18 week referral to treatment target is now becoming a new issue especially with the potential for junior doctors industrial action.

Regulatory and/or Legal Implications

The Trust remains under regulatory intervention for the A&E 4-hour standard.

Equality & Patient Impact

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

No change.	

Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees					
Quality & Performance Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Trust Leadership Team**	**Other (specify)**

MAIN BOARD – SEPTEMBER 2016

INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK

EXECUTIVE SUMMARY

1. INTRODUCTION

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

2. PERFORMANCE AGAINST RECOVERY TRAJECTORIES

This month the Trust has met two of the four trajectories that it is required to meet in order to demonstrate improvement and to access the Strategic Transformation Fund. The two achieved are:
% of patients spending 4 hours or less in the Emergency Department
% of patients waiting over 6 weeks for 1 of the 15 key diagnostic tests.

3. PERFORMANCE

3.1 ARE WE SAFE?

KEY HIGHLIGHTS

- Dementia case finding has consistently met the >87% target for Q2 at 89.6% in July and 88.5% in August; this is a continued improvement when comparing to last year.
- No MRSA cases since the one case in April 2016.
- The percentage of women seen by a midwife by 12 weeks has met the target of >90% during August 2016; the first time the target has been met since January 2016.
- There was only one Clostridium Difficile infection during August, demonstrating a marked improvement on July 2016.
- The figures for Acute Kidney Infection performance has exceeded target to 63% in August, averaging 55% for July and August, which, if continuing in the same trend, will meet the target for Q2.

AREAS FOR IMPROVEMENT

- The percentage of patients triaged in ED within 15 minutes is still below the >99% quality measure, although it has shown improvement in August when comparing with July.
- The percentage of patients assessed by a doctor in ED within 60 minutes has remained considerably below target of ≥90%, although has demonstrated an increase when comparing to 43.9% in July, ending at 49.4% for August

3.2 ARE WE RESPONSIVE?

KEY HIGHLIGHTS

- Continual improvement to ambulance handovers delayed over 60 mins in Q1. The 3 reported in April have now been validated and are no longer breaches. There was 1 confirmed reported breach in August 2016. Further work is ongoing

with the Ambulance Service to improve the validation process with their new IT system.
- 5 out of the 9 cancer measures have met their target in August
- Continued improvement to 15 key diagnostic tests % waiting at month end, achieving the target of <1% for both July and August at 0.49%.
- The number of ambulance handovers delayed over 30 mins has shown improvement with 155 during August, compared to 199 in July

AREAS FOR IMPROVEMENT

- The percentage of patients waiting four hours or less in the Emergency Department has consistently not met the ≥95% standard. However, there has been improvement in the August position at 90.7%.
- Planned/surveillance endoscopy patients waiting at the month end have decreased slightly to 479 in August compared with 528 in July. There are no patients waiting more than 6 weeks for diagnostic endoscopy.
- Maximum 2 week wait for patients urgently referred by GP performance has decreased slightly during July at 89.9%. This does not meet the target of ≥93%. We are still experiencing an overall increase in referrals, and when comparing year to date referrals against last year's position, it is demonstrating an increase of 15.7%.
- Maximum wait 62 days from urgent GP referral to 1st treatment (excluding rare cancers) performance continues to be below target of ≥85% demonstrating 73.6% in July.

3.3 ARE WE EFFECTIVE?

KEY HIGHLIGHTS

- The percentage of patients spending 90% of time on stroke ward continues to exceed target each month, against a target of >80%, with August demonstrating the highest performance so far this year at 94%. .
- The percentage of patient discharge summaries continues to achieve the target of ≥85% in July, at 87.8%
- Records submitted nationally with valid GP codes and valid NHS numbers continue to exceed the ≥99% target at 100% and 99.8%, respectively, for July.
- Emergency spells has met the target of +/- 2.5% during the month of August at 1.3% above plan.

AREAS FOR IMPROVEMENT

- Outpatient attendances and procedures have increased to 3.0% over plan for the month of August, which exceeds ±2.5% variance target. However, the current overall year to date position is 0.7% above plan, which is within target.
- The percentage of eligible patients with VTE risk assessment remains consistently below the >95% in July and August at 93.2%. The VTE Committee are to initiate a ward by ward review of performance and visit areas to identify improvement.
- There were 4 mixed sex accommodation breaches in August, compared to 5 in July, which took place on high activity days. The number of Delayed Transfers of Care has continued to remain high at 37 in August, which exceeds the target of <14.
- The number of medically fit patients per day has increased slightly in August to 77, 37 patients above the agreed system wide level.
- The percentage of elective patients cancelled on day of surgery for a non-medical reason continues to not achieve the ≤0.8% target, but has improved during August at 1.3% from the 2.0% in July.

- There were 4 patients who had operations cancelled and not rebooked within 28 days in August, the same number as reported in July. This is being performance managed on a daily basis.
- In August GP referrals have increased to 4.7% when comparing with 2015/16, thus exceeding the 2.5% variance target.
- Length of Stay for non-elective IP spells is greater than the <5.4 days target in August at 5.8 days, which has increased slightly from 5.5 days in July. Increase in the numbers of medically fit has exacerbated the length of stay.
- Length of Stay for elective IP spells is greater than the ≤3.4 days target in August at 3.8 days, which is a slight decrease from the 3.5 days figure for July. However Q1 achieved the target, at 3.3 days.
- Elective spells year to date have shown a big increase against plan in August at 10.4%, which is considerably outside the ±2.5% variance target. This increase is due to coding movements and also the recruitment of a locum consultant in Gynaecology during the summer months to utilise the theatre lists. However, the overall year to date figure stands at 4.5% above plan.

3.4 ARE WE WELL LED?

KEY HIGHLIGHTS

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

AREAS FOR IMPROVEMENT

- NHS Improvements Financial Risk Rating has fallen from 2 to 1 during August. Please refer to the Trust announcement made on the 20th September 2016.

4. RECOMMENDATIONS

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

Author and Presenting Director **Eric Gatling, Director of Service Delivery**

Date: **September 2016**

Gloucestershire Hospitals NHS
NHS Foundation Trust

PERFORMANCE MANAGEMENT FRAMEWORK

2016/17

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TRUST OVERVIEW

August 2016

ARE WE SAFE?

	Last 3 mths	Now	Next 3 mths	Management Priority	Forecast status
Infection				Minor	Stable
Mortality				Significant	Improving
Safety				Moderate	Stable

ARE WE RESPONSIVE?

	Last 3 mths	Now	Next 3 mths	Management Priority	Forecast status
Emergency Department				Significant	At Risk
18 weeks				Significant	At Risk
Cancer				Significant	At Risk

ARE WE EFFECTIVE?

	Last 3 mths	Now	Next 3 mths	Management Priority	Forecast status
Clinical Operation				Significant	At Risk
Business Operation				Significant	At Risk

ARE WE WELL LED?

	Last 3 mths	Now	Next 3 mths	Management Priority	Forecast status
Financial Health				Significant	At Risk
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	2016/17 Jul	2016/17 Aug	NHSI Weighting	Estimated Current Position for Q2
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%	90.9%	90.9%	1.0	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%	86.3%	90.9%	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%	79.0%	78.2%	77.4%	81.2%	73.6%	78.1	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%	90.6%	91.7%	84.6%	95.0%	100%	88.2		
Max wait 31 days decision to treat to subsequent treatment : surgery %	94%	99.0%	100%	100%	98.8%	100%	100%	99.5%	99.5%	99.1%	98.1%	100%	100%	98%	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%	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%	100%	100%	100%	98.2		
Max wait 31 days decision to treat to treatment %	96%	99.6%	99.8%	99.5%	100%	99.5%	99.7%	100%	99.8%	99.1%	98.6%	99.6%	99.0%	99.2%	99.6	1.0	
Max 2 week wait for patients urgently referred by GP %	93%	90.5%	94.1%	94.3%	93.0%	91.5%	90.3%	92.4%	88.7%	84.9%	77.7%	86.5%	90.3%	89.9%	86.3	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%	93.1%	94.6%	94.3%	90.5%	91.2%	93.4		
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	5	1	1.0	

In month position therefore figures not validated.

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%	87.06%	86.00%	90.66%							
% 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%	86.34%	90.85%							
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%	90.90%	90.90%							
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%	0.49%	0.49%							
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%	81.1%	73.1%	78.1%							

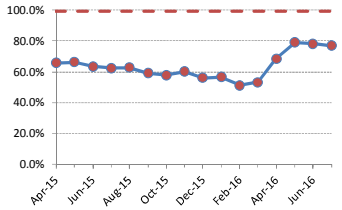
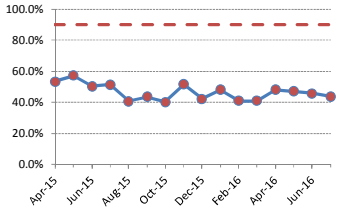
In month position therefore figures unvalidated.

TRUST PERFORMANCE & EXCEPTIONS (as at end August 2016)

ARE WE SAFE?

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q1	Q2	Q3	Q4	2016/17 Q1	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	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	2	5	1	3	3	3	5	4	3		37 cases/year	NHSI	M	Aug
Number of Methicillin-Resistant Staphylococcus Aureus (MRSA) infections - post 48 hours		0	0	2	1	1	0	0	0	0	0	0	0	0	0		0	GCCG	M	Aug
MORTALITY																				
Crude Mortality rates %		1.2%	1.0%	1.2%	1.4%	1.2%	1.1%	1.1%	1.1%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%		<2%	Trust	M	Aug
Summary Hospital-Level Mortality Indicator		109.9	109.7	110.7							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				arrears								Confidence interval	Dr Foster	M	Mar
SMR (rolling 12 months)		111.6	110.3	108.0	110.2				arrears								Confidence interval	Dr Foster	M	Mar
SAFETY																				
Number of Never Events		0	1	1	0	0	0	1	0	0	0	0	0	0	0		0	GCCG	M	Aug
% women seen by midwife by 12 weeks		90.3%	90.0%	90.0%	89.6%	87.2%	87.8%	85.9%	90.8%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%		>90%	GCCG	M	Aug
CQUINS																				
Acute Kidney Infection (AKI)		5%	19%	29%	50%	42%	38%	47%	63%	55.0%	55.0%	55.0%	55.0%	55.0%	55.0%		>90% by Q4	National	M	Aug
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%	90.0%	89.6%	88.5%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%		Q1>86%; Q2>87%; Q3>88%; Q4>90%	National	M	Aug
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	Aug
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	Aug
ED																				
% patients triaged in ED in 15 minutes		65.1%	61.4%	57.9%	53.7%	75.3%	78.1%	76.9%	80.8%								≥ 99%	Trust	M	Aug
% patients assessed by doctor in ED in 60 minutes		53.7%	45.4%	44.7%	43.3%	47.1%	46.0%	43.9%	49.4%								≥ 90%	Trust	M	Aug

ARE WE SAFE?

MEASURE		Q3	Q4	Q4	Q1	FOT	OWNER
% patients triaged in ED in 15 minutes **Standard is ≥ 99%**							Director of Nursing and Midwifery
	The actions to address this standard are part of 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
	The actions to address this standard are part of the Emergency Care Programme. Please refer to the Emergency Care Pathway Report for further information.						

TRUST PERFORMANCE & EXCEPTIONS (as at end August 2016)

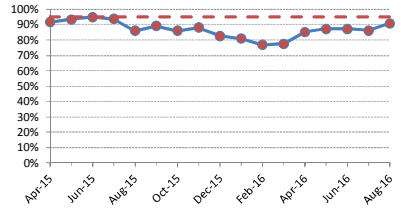
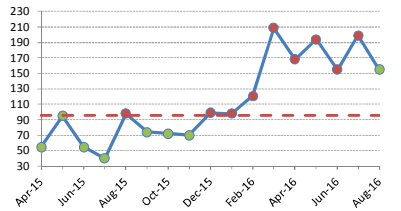
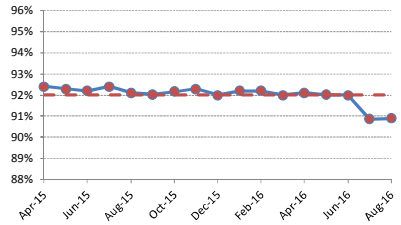
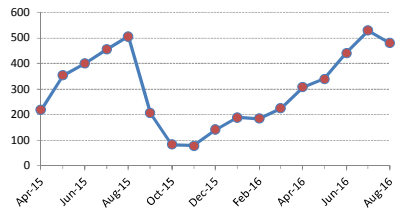
ARE WE RESPONSIVE?

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q1	Q2	Q3	Q4	2016/17 Q1	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	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%	86.9%	87.4%	86.3%	90.9%	91.9%	89.1%	91.2%	85.7%	85.1%	80.1%		≥ 95%	NHSI	M	Aug
Number of ambulance handovers delayed over 30 minutes		205	212	241	428	517	155	199	155	70	70	80	90	100	100		< previous year	GCCG	M	Aug
Number of ambulance handovers delayed over 60 minutes		13	21	28	33	3	0	0	1	10	10	10	11	11	11		< previous year	GCCG	M	Aug
18 WEEKS						**														
Incomplete pathways - % waited under 18 weeks		92.3%	92.1%	92.2%	92.0%	92.0%	92.0%	90.9%	90.9%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%		≥ 92%	NHSI	M	Aug
15 key Diagnostic tests : % waiting over 6 weeks at month end		5.4%	5.9%	1.5%	4.0%	2.6%	1.4%	0.49%	0.49%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%		<1% waiting at month end	GCCG	M	Aug
Planned/surveillance endoscopy patients - nos. waiting at month end with and without dates		400	341	142	225	0.0%	441	528	479	200	200	150	100	100	100		< 1% waiting at month end	GCCG	M	Aug
CANCER																				
Max 2 week wait for patients urgently referred by GP %		91.5%	90.3%	92.4%	88.7%	84.9%	90.3%	89.9%	86.3%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%		≥ 93%	NHSI	M	Jul
Max 2 week wait for patients referred with non cancer breast symptoms %		95.2%	91.8%	93.4%	95.3%	93.1%	90.5%	91.2%	93.4%	93.0%	93.0%	94.0%	94.0%	94.0%	94.0%		≥ 93%	NHSI	M	Jul
Max wait 31 days decision to treat to treatment %		99.5%	99.7%	100%	99.8%	99.1%	99.0%	99.2%	99.6%	100%	100%	100%	100%	100%	100%		≥ 96%	NHSI	M	Jul
Max wait 31 days decision to treat to subsequent treatment : surgery %		100%	100%	99.5%	99.5%	99.4%	100.0%	98.1%	100%	100%	100%	100%	100%	100%	100%		≥ 94%	NHSI	M	Jul
Max wait 31 days decision to treat to subsequent treatment : drugs %		100%	100%	100%	100%	100%	100.0%	100.0%	100%	100%	100%	100%	100%	100%	100%		≥ 98%	NHSI	M	Jul
Max wait 31 days decision to treat to subsequent treatment : Radiotherapy %		100%	100%	100%	100%	100%	100.0%	100.0%	98.2%	100%	100%	100%	100%	100%	100%		≥ 94%	NHSI	M	Jul
Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) %		73.9%	75.6%	79.5%	76.7%	79.0%	81.2%	73.6%	78.1%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%		≥ 85%	NHSI	M	Jul
Max wait 62 days from national screening programme to 1st treatment %		97.3%	94.0%	95.6%	94.9%	79%	95.0%	100.0%	88.2%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%		≥ 90%	NHSI	M	Jul
Max wait 62 days from consultant upgrade to 1st treatment %		60.0%	92.9%	100%	100%	0%	-	0.0%	100%	100%	100%	100%	100%	100%	100%		≥ 90%	NHSI	M	Jul

In month position, therefore figures not validated.

**Please note: The 3 ambulance delays, reported in April, have now been validated and are no longer breaches.

ARE WE RESPONSIVE?

MEASURE		Q3	Q4	Q1	FOT	OWNER
% patients spending 4 hours or less in ED Standard is ≥95%		🔴	🔴	🔴	🔴	Director of Service Delivery
		Please refer to Emergency Pathway Report. Recovery plan in place. Performance is improving in line with actions in the Emergency Care Pathway.				
Number of ambulance handovers delayed over 30 minutes Standard is < last year		🟢	🔴	🔴	🔴	Director of Service Delivery
		Please refer to the Emergency Pathway Report. Performance has improved during August 16.				
Incomplete pathways - % waited under 18 weeks Standard is ≥ 92%		🟢	🟢	🟢	🟢	Director of Service Delivery
		The key specialties that did not meet the standard in August are: Surgery (89.6%), Urology (82.9%), Trauma & Orthopaedic (90.0%), ENT (89.5%) , Oral Surgery (75.6%), Rheumatology (91.8%) and Gynaecology (89.4%). Each Division is in the process of developing comprehensive recovery plans. Increase in demand and lost capacity is driving the position.				
Planned/surveillance endoscopy patients - nos. waiting at month end with and without dates Standard is < 1% waiting at month end		🔴	🔴	🔴	🔴	Director of Service Delivery
		Additional activity is being undertaken including weekend lists being carried out by an external company. Based on the current demand and activity levels, the waiting list of patients will be cleared by the end of November 2016.				

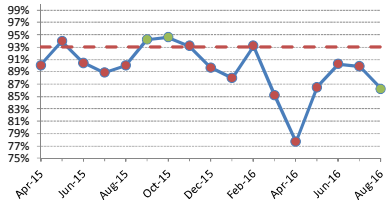
ARE WE RESPONSIVE?

MEASURE

Q3	Q4	Q1	FOT	OWNER
				Director of Service Delivery

Max 2 week wait for patients urgently referred by GP

Standard is ≥93%



Additional demand and capacity contraints is driving the performance. Additional clinics have been created to accommodate this.
The recovery plan is based upon delivery of the required standards from October 2016.

	July 16 - Final Position			August 16- Provisional In month Position			Q2 to date	Average treatments / month (rolling 12 months)
Target	Latest Position	Breaches	Treatments	Latest Position	Breaches	Treatments	88.0%	
93%	89.7%	176	1702	86.4%	237	1742		1616
Brain / CNS	94.4%	1	18	65.0%	7	20	78.9%	21
Breast	95.6%	11	251	97.8%	6	271	96.7%	259
Gynaecological	95.3%	7	148	93.3%	10	150	94.3%	111
Haematological*	53.3%	7	15	34.8%	15	23	42.1%	8
Head & Neck	85.3%	26	177	94.0%	10	168	89.6%	163
Lower GI	93.2%	22	325	95.5%	13	291	94.3%	317
Lung	97.4%	1	38	95.7%	2	46	96.4%	49
Skin	89.0%	41	372	76.9%	98	424	82.5%	288
Testicular	88.9%	2	18	75.0%	4	16	82.4%	15
Upper GI	91.0%	15	166	93.5%	10	153	92.2%	186
Urological	75.3%	43	174	65.6%	62	180	70.3%	199

* Excludes acute leukaemia

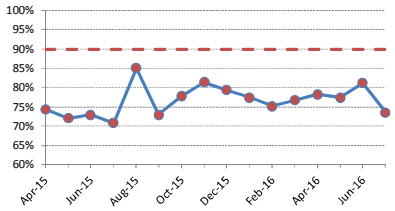
ARE WE RESPONSIVE?

MEASURE

Q3	Q4	Q1	FOT	OWNER
				Director of Service Delivery

Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers)

Standard is ≥85%



A detailed recovery plan was reviewed by the Finance & Performance Committee in August 2016. This indicates a return to compliance by January 2017.

Significant actions are underway and are being managed on a week by week basis. Urology is the main specialty where additional focus is being made to increase capacity to reduce the number of patients waiting.

	July 16 - Final Position			August 16- Provisional In month Position			Q2 to date	Average treatments / month
Target	Latest Position	Breaches	Treatments	Latest Position	Breaches	Treatments	75.3%	
85%	74.5%	37.5	147.0	76.7%	20.0	86.0		153
Breast	90.0%	2.0	20.0	100.0%	0.0	19.0	94.9%	26
Gynaecological	67.7%	5.0	15.5	69.2%	2.0	6.5	68.2%	10
Haematological*	42.9%	4.0	7.0	58.3%	2.5	6.0	50.0%	7
Head & Neck	66.7%	2.0	6.0	85.7%	0.5	3.5	73.7%	7
Lower GI	54.8%	9.5	21.0	88.9%	1.0	9.0	65.0%	17
Lung	82.6%	2.0	11.5	56.5%	5.0	11.5	69.6%	12
Other	33.3%	2.0	3.0	66.7%	1.0	3.0	50.0%	2
Sarcomas	66.7%	1.0	3.0				66.7%	1
Skin	100.0%	0.0	29.0	100.0%	0.0	8.0	100.0%	30
Upper GI	87.0%	1.5	11.5	78.9%	2.0	9.5	83.3%	13
Urological	51.4%	8.5	17.5	40.0%	6.0	10.0	47.3%	28

* Excludes acute leukaemia

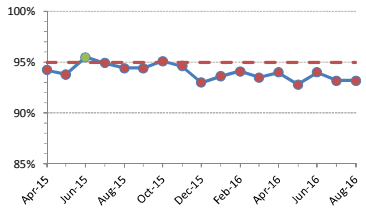
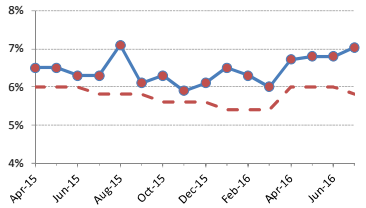
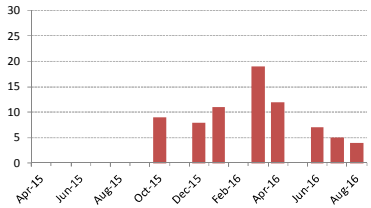
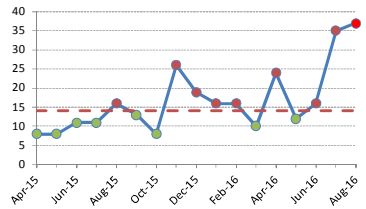
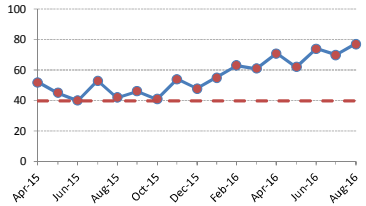
TRUST PERFORMANCE & EXCEPTIONS (as at end August 2016)

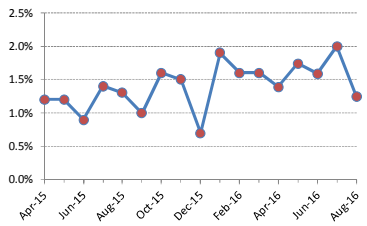
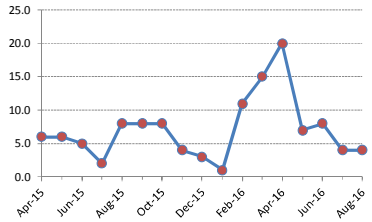
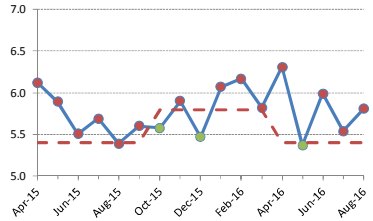
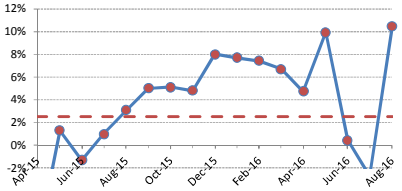
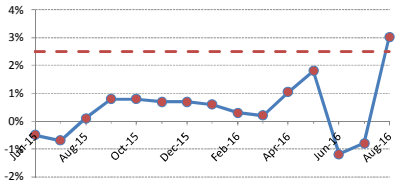
ARE WE EFFECTIVE?

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q1	Q2	Q3	Q4	2016/17 Q1	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	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%	85.1%	83.8%	86.2%	94.0%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%		> 80%	GCCG	M	Aug
% of eligible patients with VTE risk assessment		94.5%	94.6%	94.2%	93.7%	93.6%	94.0%	93.2%	93.2%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%		> 95%	GCCG	M	Aug
Emergency re-admissions within 30 days - elective & emergency		6.4%	6.4%	6.1%	6.4%	6.7%	6.8%	7.0%	arrears	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	Jul
Number of Breaches of Mixed sex accommodation		0	0	17	30	19	7	5	4	0	2	0	5	10	0		0	GCCG	M	Aug
Number of delayed discharges at month end (DTOCs)		11	13	19	10	16	16	35	37	12	14	14	16	16	16		<14	Trust	M	Aug
No. of medically fit patients - over/day		46	47	48	60	69	74	70	77	40	40	40	40	40	40		≤ 40	Trust	M	Aug
Bed days occupied by medically fit patients		1,384	1,446	1,457	1,791	2,086	2,230	2,159	2,398	1,450	1,450	1,450	1,450	1,450	1,450		None	Trust	M	Aug
Patient Discharge Summaries sent to GP within 24 hours		87.7%	89.1%	88.6%	85.6%	85.7%	85.7%	87.8%	89.0%	88.5%	88.5%	88.5%	88.5%	88.5%	88.5%		≥85%	GCCG	M	Jul
BUSINESS OPERATION																				
Elective Patients cancelled on day of surgery for a non medical reason		1.1%	1.2%	1.3%	2.0%	1.6%	1.6%	2.0%	1.3%								≤ 0.8%	Trust	M	Aug
Patients cancelled and not rebooked in 28 days		17	18	15	27	35	8	4	4								0	GCCG	M	Aug
GP referrals year to date - within 2.5% of previous year		4.9%	4.4%	2.9%	3.7%	7.9%	7.9%	3.7%	4.7%								range +2.5% to -2.5%	Trust	M	Aug
Elective spells year to date - within 2.5% of plan		-1.3%	5.1%	5.0%	7.3%	4.9%	0.4%	-2.7%	10.4%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%		range ≥-1% to plan	Trust	M	Aug
Emergency Spells year to date - within 2.5% of plan		2.4%	4.0%	6.9%	7.1%	7.7%	9.6%	7.2%	1.3%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%		range ≤2.5% over plan	Trust	M	Aug
LOS for general and acute non elective spells		5.8	5.6	5.7	6.0	5.9	6.0	5.5	5.8	5.4	5.4	5.4	5.4	5.4	5.4		Q1 /Q2 <5.4days, Q3 /Q4 <5.8days	Trust	M	Aug
LOS for general and acute elective IP spells		3.6	3.6	3.6	3.6	3.3	3.7	3.5	3.8	3.4	3.5	3.6	3.5	3.5	3.6		≤ 3.4 days	Trust	M	Aug
OP attendance & procedures year to date - within 2.5% of plan		-0.5%	0.6%	0.6%		0.5%	-1.2%	-0.8%	3.0%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%		range +2.5% to -2.5%	Trust	M	Aug
Records submitted nationally with valid GP code (%)		100%	100%	100%	99.9%		100%	100%	arrears	100%	100%	100%	100%	100%	100%		≥ 99%	Trust	M	Jul
Records submitted nationally with valid NHS number (%)		99.8%	99.7%	99.7%	99.8%		99.8%	99.8%	arrears	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%		≥ 99%	Trust	M	Jul

In month position, therefore figure not validated.

ARE WE EFFECTIVE?

MEASURE		Q3	Q4	Q1	FOT	OWNER
% of eligible patients with VTE risk assessment Standard is >95%		🔴	🔴	🔴	🔴	Trust Medical Director
		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
		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
		There were 14 breaches in same sex accommodation affecting 58 patients in August 2016, 10 of these breaches have been agreed as clinical exemptions with the Commissioners. From a Unify perspective we will be declaring 4 breaches affecting 12 patients. All breaches occurred in the Acute Care Units (3 x ACUC, 1 x ACUA). The breaches took place on 15th August (1 breach), 24 August (1 breach) and 25 August (2 breaches). Activity was high on 15th & 25th August but within parameters on 24 August. All breaches have been reviewed against the delivering same sex accommodation decision matrix agreed with the Commissioners.				
Number of delayed discharges at month end (DTOCs) Standard is <14		🔴	🟢	🔴	🔴	Director of Service Delivery
		Please refer to Emergency Care Report.				
No. of medically fit patients - over/day Standard is <40		🔴	🔴	🔴	🔴	Director of Service Delivery
		Please refer to Emergency Care Report. The main issue driving the medically fit is access to domicillary care and community hospital beds. Alternative options are being explored and developed as part of the Emergency Care Pathyway Plan.				

MEASURE		Q3	Q4	Q1	FOT	OWNER
Elective Patients cancelled on day of surgery for a non medical reason Standard is <0.8%		🔴	🔴	🔴	🔴	Director of Service Delivery
		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
		This is an improving position and performance managed daily.				
LOS for general and acute non elective spells Standard is Q1/Q2 <5.4days, Q3 Q4 ≤5.8days		🟢	🟡	🔴	🔴	Director of Service Delivery
		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. Increase 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. This involves close working with Gloucestershire Care Services and the Gloucestershire County Council.				
Elective spells year to date - Standard **is** within 2.5% of plan		🟢	🟡	🔴	🔴	Director of Service Delivery
		There has been a large increase in the 'in month' performance of Elective spells against plan for August 2016 at 10.4%. The over performance is due to a combination of factors: 1. As billing is run over a 2 month rolling period, the increase in clinical coding movements has demonstrated an iincrease in this area for the month of August. 2. A locum Consultant has been employed within the Women & Children's Division (Gynaecology) throughout the summer months in order to utilise theatre lists and outpatient clinics. However, the current year to date position for elective spells stands at 4.5% above plan.				
OP attendances & procedures year to date - Standard **is** within 2.5% of plan		🟢	🟡	🔴	🔴	Director of Service Delivery
		There has been a slight increase in the 'in month'position against plan for OP attendances & procedures for August 2016. However, the overall Year to Date position currently stands at 0.7% which is within the target of +/- 2.5%.				

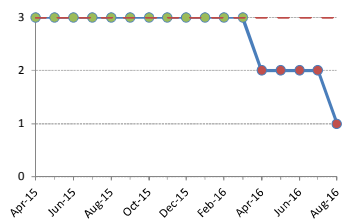
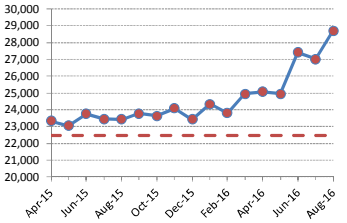
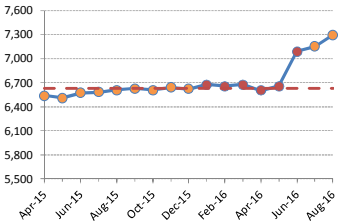
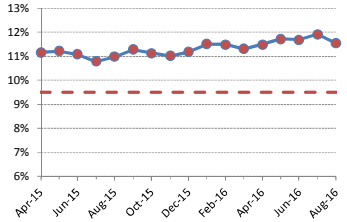
TRUST PERFORMANCE & EXCEPTIONS (as at end August 2016)

ARE WE WELL LED?

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q1	Q2	Q3	Q4	2016/17 Q1	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	FoT	Standard	Target Set By	How often	Data Month
FINANCIAL HEALTH																				
NHSI Financial Risk Rating (YTD)		3	3	3	3	2	2	2	1	TBC	TBC	TBC	TBC	TBC	TBC		Level 3	NHSI	M	Jul
Achieve planned Income & Expenditure position at year end		-£1.4m	-£1.6m	-£1.6m	-£1.6m	£18.2m	£18.2m	£18.2m	TBC	TBC	TBC	TBC	TBC	TBC	TBC		Achieved or better at year end	NHSI	M	Jul
Total PayBill spend £M		£76.3m	£77.5m	£78.0m	£78.7m	£82.1m	£27.4m	£27.0m	£28.7m	TBC	TBC	TBC	TBC	TBC	TBC		Target + 0.5%	Trust	M	Aug
Total worked WTE		6,961	7,071	7,098	7,153	7,121	7,088	7,156	7,295	TBC	TBC	TBC	TBC	TBC	TBC		Target + 0.5%	Trust	M	Aug
WORKFORCE HEALTH																				
Annual sickness absence rate (%)		3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.7%	3.8%	3.8	3.8	3.8	3.8	3.8	3.8		< 3.5	Trust	M	Jul
Turnover rate (FTE)		11.2%	11.3%	11.1%	11.7%	11.6%*	11.7%	11.9%	11.5%	11.7	11.7	11.7	11.7	11.7	11.7		7.5-9.5%	Trust	M	Jul
Staff who have annual appraisal (%)		85%	83%	83%	83%	83%	83%	80%	81%	85.0	85.0	85.0	85.0	85.0	85.0		> 90%	Trust	M	Aug
Staff having well structured appraisals in last 12 months (staff survey, on a 5 point scale)		38%	38%	38%	38%		3.0	3.0	3.0	3.1	3.1	3.1	3.1	3.1	3.1		> 3.8	Trust	A	Aug
Staff who completed mandatory training (%)		92%	92%	91%	91%	92%	92%	91%	92%	91.0	91.0	91.0	91.0	91.0	91.0		> 90%	Trust	M	Aug
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	3.71	3.71	3.8	3.8	3.8	3.8	3.8	3.8		> 3.8	Trust	A	Aug
Improve communication between senior managers & staff (staff survey) (%)		35%	35%	35%	34%	34%	34%	34%	34%	34.0	34.0	34.0	34.0	34.0	34.0		> 38%	Trust	A	Aug

In month position, therefore figure not validated.

ARE WE WELL LED?

MEASURE		Q3	Q4	Q1	FOT	OWNER
NHSI Financial Risk Rating Standard is Level 3						Director of Finance
		Please refer to Trust announcement made on 20th September 2016.				
Total PayBill spend £M Standard is Target + 0.5%						Director of Finance
		The total pay bill for the current month and previous months and quarters has been revised to ensure consistency with the NHSI plan. This figure now reflects the Trust Total which includes pay relating to the Hosted GP services and Shared Services. The total Trust pay bill for August is £28.6m. Excluding Hosted Services, this figure drops to £26.2m. The Trust total of £28.6m is running at £1.6m higher than the average for 2015/16. An element of the increased expenditure in permanent medical pay will be due to the cross-over of junior medical staff in the Trust. July's agency bill as submitted to NHSI has increased by circa £400k in the month to just over £2.2m. The additional expenditure is predominantly in medical agency with nursing remaining broadly consistent with July.				
Total worked WTE Standard is Target + 0.5%						Director of Service Delivery
		The worked WTEs has also been revised for current and previous months to ensure consistency with the NHSI plan and with the Total Pay Bill above. The figure now reflects the Trust Total which includes Hosted GP Services and Shared Services. The Trust Total WTEs for August is 7295 WTEs which is an increase of 139 from July. Most noticeably, the number of permanent WTEs has increased by 100 in the month. The junior doctor cross-over would account for about half of this movement				
Turnover rate (FTE) Standard is Target 7.5% - 9.5%						Director of Human Resources
		Turnover continues to run at high levels and a mix of corporate and local solutions (where appropriate) are being applied. Corporate solutions include focus groups for Nursing staff led by Leadership and OD to capture experience across the years. Particular focus is also being paid to other areas such as Haematology and Cardiac Physiology.				

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD MEETING FRIDAY 30th SEPTEMBER 2016

Gallery Room, Gloucestershire Hospital commencing at 9.00 a.m

Report Title
Financial Performance Report - Period to 31st August 2016
Sponsor and Author(s)
Author: Sarah Stansfield, Director of Operational Finance Sponsoring Director: Stuart Diggles, Interim Director of Finance

Audience(s)

Board members	✓	Regulators		Governors		Staff		Public	✓

Executive Summary

Purpose

This report provides an overview of the financial performance of the Trust as at the end of Month 5 of the 2016/17 financial year. It provides the three primary financial statements and a high level analysis of variances and movements against the planned position to NHS Improvement.

Key issues to note

- The financial position of the Trust at the end of Month 5 of the 2016/17 financial year is an operational deficit of £11.1m. This is an adverse variance to plan of £13.4m.
- There is a prior year impact included in the current YTD position of £5.6m.
- The NHSI Plan and the planning process that created it is not as robust as would be expected. The Plan lacks granular supporting detail and as such comparisons are not necessarily to be relied upon in isolation for decision making or performance management purposes. The Trusts internal budget does not reconcile, either by cost category or phasing, to the NHSI plan. The figures presented in this report as 'plan' reflect the figures as submitted to NHSI unless explicitly stated otherwise.

Conclusions

The financial position for M5 shows a significant adverse variance to plan of £13.4m (inclusive of the STF funding for Q1 of the financial year).

Implications and Future Action Required

The variance to financial plan for the year-to-date will mean an increased scrutiny of the Trust financial position and an increased focus on cost recovery in the form of both Cost Improvement Programmes and agency expenditure reductions.

Recommendations

The Board is asked to note the report.

Impact Upon Strategic Objectives

The financial position presented will lead to increased scrutiny over investment decision making.
Impact Upon Corporate Risks
Significant impact on deliverability of the financial plan for 2016/17.
Regulatory and/or Legal Implications
The adverse variance to plan year-to-date of the financial position presented in this paper will lead to increased regulatory activity by NHS Improvement around the financial position of the Trust
Equality & Patient Impact
None
Resource Implications

Finance	✓	Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees					
Quality & Performance Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

Gloucestershire Hospitals NHS
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Period to 31st August 2016

Introduction and Overview

This report provides an overview of the financial performance of the Trust as at the end of Month 5 of the 2016/17 financial year.
The Trust has delivered a year-to-date deficit position of £11.1m (including the Q1 STF funding of £3.3m). This represents an adverse variance to plan of £13.4 as at the year-to-date.

Statement of Comprehensive Income

Month 5 Financial Position	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's
SLA & Commissioning Income	179,004	177,931	(1,073)
PP, Overseas and RTA Income	2,379	2,262	(117)
Operating Income	26,133	26,903	770
Total Income	**207,516**	**207,096**	**(420)**
Pay	132,376	137,781	(5,405)
Non-Pay	65,301	74,353	(9,052)
Total Expenditure	**197,677**	**212,134**	**(14,457)**
EBITDA	**9,839**	**(5,038)**	**(14,877)**
EBITDA %age	**4.7%**	**-2.4%**	**-7.2%**
Non-Operating Costs	10,689	9,241	1,448
Surplus/(Deficit)	**(850)**	**(14,279)**	**(13,429)**
STF Funding	3,225	3,225	0
Surplus/(Deficit) (inc. SFT)	**2,375**	**(11,054)**	**(13,429)**

The table summarises (at a high level) the Trust position for Month 5 of the 2016/17 financial year against the plan as submitted to NHSI in June.

The year-to-date deficit of £14.3m has been mitigated by receipt of Q1 STF funding of £3.3m.

Month 5 actuals throughout this report contain the impact of prior year transactional adjustments which serve to worsen the overall deficit and summarise as follows:

Revenue	(£1.685m)
Costs	(£3.912m)
Total	**(£5.597m)**

NB: The NHSI Plan and the planning process that created it is not as robust as would be expected. The Plan lacks granular supporting detail and as such comparisons are not necessarily to be relied upon in isolation for decision making or performance management purposes. The Trusts internal budget does not reconcile, either by cost category or phasing, to the NHSI plan. The figures presented in this report as 'plan' reflect the figures as submitted to NHSI unless explicitly stated otherwise.

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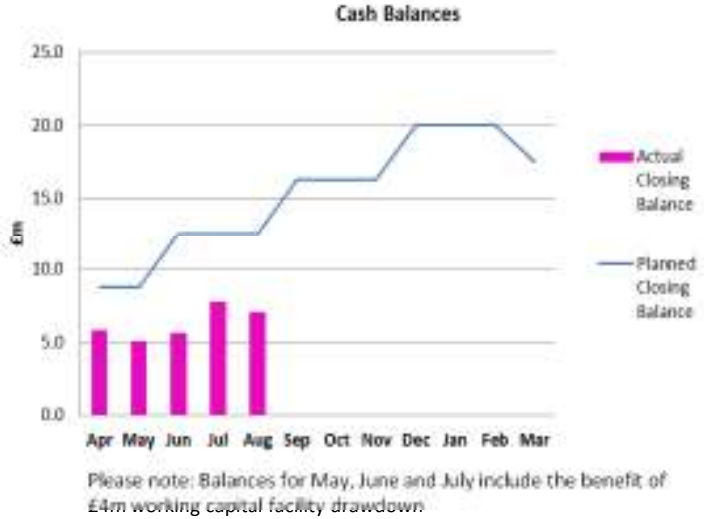
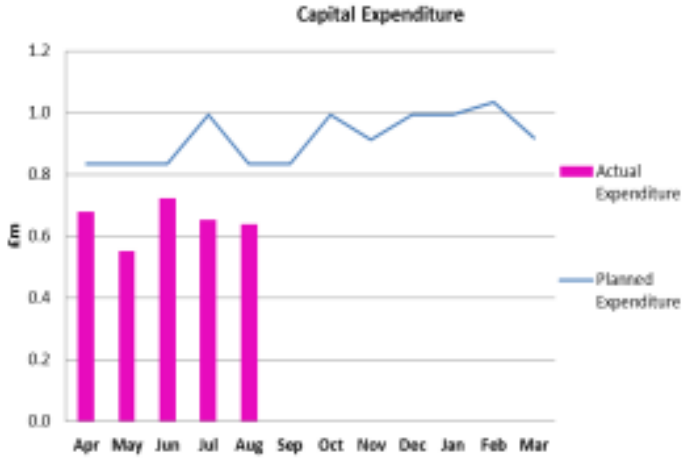
At A Glance – Month 5



Please note: Balances for May, June and July include the benefit of £4m working capital facility drawdown



	Plan £m	Actual £m	Variance £m
Cumualtive Capital Expenditure	4.3	3.2	(1.1)

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Income Analysis – by Commissioner

2016/17 Healthcare contracts position as at Month 5	Month 5 Contract £000	Month 5 Actuals £000	Variance £000
NHS Gloucestershire CCG	122,509	124,213	1,704
Specialist Commissioning Group	32,708	34,650	1,943
Worcestershire Health Community	4,372	4,579	207
Welsh Commissioners	1,713	1,866	152
NHS Hereford CCG	1,509	1,253	(257)
Other Commissioner Income	8,675	8,338	(336)
Non Contractual Agreements (NCAs)	1,720	1,636	(83)
Pre CQUIN	**173,206**	**176,535**	**3,330**
CQUIN	3,674	2,975	(699)
Post CQUIN	**176,880**	**179,510**	**2,630**
Phasing plan vs final contract agreement	2,124		(2,124)
Prior Year Adjustments		(1,579)	(1,579)
Commissioing and SLA Income	**179,004**	**177,931**	**(1,073)**

Income risk contained within M5 position	Month 5 Actuals £000s
CQUIN recovery - assume 80%	(744)
Coding Review	(956)
QIPP risk share	(790)
Hereford CCG contracting risk	(229)
Total risk adjustments	**(2,719)**

The table shows the Month 5 position on commissioning and SLA income by Commissioner. The contract value for each commissioner reflects the signed contract values for all commissioners except NHS Hereford CCG with whom negotiations are continuing. These values have been adjusted in line with the phasing in the NHSI plan which was submitted whilst contract values were still being finalised.

The Month 5 contract position includes an adjustment of £2.1m to ensure that the position is in line with the plan submitted to NHSI.

The actual position presented includes an adjustment for prior year impacts and also a number of adjustments for risk which are shown in the second table and explained in detail below:

- CQUIN Recovery – we have assumed that CQUIN is recoverable across all contracts at 80%. This reflects the experience of prior year under-delivery against the full target
- Coding Review – GCCG and the Trust commissioned a joint review of a number of specific coding issues at the start of 2016/17. This adjustment reflects the changes to activity classification that the Trust will need to make as a consequence of this review
- QIPP risk share – The Trust contract with GCCG contains £3.5m of income at risk if CCG QIPP activity reductions are not achieved. This adjustment reflects the risk year-to-date
- Hereford CCG contracting risk - there remain two significant issues with the Hereford CCG contract around radiotherapy and patient transport. This adjustment reflects the income that would be lost if both these adjustments are made as part of negotiations with Hereford

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Detailed income and expenditure (1)

Month 5 Financial Position	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's
SLA & Commissioning Income			
Elective (inc. Daycase)	31,911	31,434	(477)
Non-elective Spells	929	794	(135)
Outpatients	28,896	29,242	346
Emergency	37,727	39,125	1,398
Accident & Emergency	6,732	7,123	391
Excluded Drugs	18,968	21,277	2,309
CQUIN	3,674	2,975	(699)
Other (Includes risk adjustment)	50,168	45,962	(4,206)
Sub-Total	**179,004**	**177,931**	**(1,073)**
PP, Overseas and RTA Income	2,379	2,262	(117)
Operating Income	26,133	26,903	770
Total Income	**207,516**	**207,096**	**(420)**
Pay			
Substantive Staff	121,764	123,499	(1,735)
Bank Staff	3,801	4,727	(926)
Agency Staff	6,811	9,555	(2,744)
Non-Pay			
Drugs	22,548	23,532	(984)
Clinical Supplies	16,022	16,205	(183)
Other Non-Pay	26,731	34,616	(7,885)
Total Expenditure	**197,677**	**212,134**	**(14,457)**
EBITDA	**9,839**	**(5,038)**	**(14,877)**
EBITDA %age	**4.7%**	**-2.4%**	**-7.2%**
Depreciation	5,503	4,410	1,093
Public Dividend Capital Payable	3,286	3,220	66
Interest Receivable	(11)	(16)	5
Interest Payable	1,911	1,627	284
Surplus/(Deficit)	**(850)**	**(14,279)**	**(13,429)**
STF Funding	3,225	3,225	0
Surplus/(Deficit) (inc. SFT)	**2,375**	**(11,054)**	**(13,429)**

The table shows a more detailed income and expenditure analysis of the position presented on page 1 of this report. The key variances driving the position include:

SLA and Commissioning income – a number of risk based adjustments have been applied to the income position driving an adverse variance of £1.1m year-to-date. These are explained in further detail on page 3 of this report.

Operating Income – includes education, training and research flows and other income (which includes staff recharges for CITS, Shared services etc.). We are still investigating this variance to understand how much of it is a product of the NHSI plan and how much is related to budgetary over-recovery of income.

Pay – expenditure is showing a total adverse variance of £5.4m against plan as at month 5. Of the £5.4m adverse year-to-date variance, £2.7m (50%) is being driven by agency staffing.

Agency staffing as a percentage of the total paybill was planned to be 5.1% as at Month 5 (based on £12.1m cap) and is currently 6.9%.

Non-Pay – Drugs shows a small adverse variance of £1.0m to plan, in line with a favourable variance on income for excluded drugs.

Other non-pay shows a significant adverse variance of £7.9m for the year-to-date. Included within the YTD plan for M5 is £6.5m of the overall CIP target – delivery against this is £1.9m, thereby driving £4.6m of the adverse variance. Prior year adjustments of £3.3m.

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Detailed income and expenditure (2)

Month 5 Financial Position	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's
SLA & Commissioning Income			
Elective (inc. Daycase)	31,911	31,434	(477)
Non-elective Spells	929	794	(135)
Outpatients	28,896	29,242	346
Emergency	37,727	39,125	1,398
Accident & Emergency	6,732	7,123	391
Excluded Drugs	18,968	21,277	2,309
CQUIN	3,674	2,975	(699)
Other (Includes risk adjustment)	50,168	45,962	(4,206)
Sub-Total	**179,004**	**177,931**	**(1,073)**
PP, Overseas and RTA Income	2,379	2,262	(117)
Operating Income	26,133	26,903	770
Total Income	**207,516**	**207,096**	**(420)**
Pay			
Substantive Staff	121,764	123,499	(1,735)
Bank Staff	3,801	4,727	(926)
Agency Staff	6,811	9,555	(2,744)
Non-Pay			
Drugs	22,548	23,532	(984)
Clinical Supplies	16,022	16,205	(183)
Other Non-Pay	26,731	34,616	(7,885)
Total Expenditure	**197,677**	**212,134**	**(14,457)**
EBITDA	**9,839**	**(5,038)**	**(14,877)**
EBITDA %age	**4.7%**	**-2.4%**	**-7.2%**
Depreciation	5,503	4,410	1,093
Public Dividend Capital Payable	3,286	3,220	66
Interest Receivable	(11)	(16)	5
Interest Payable	1,911	1,627	284
Surplus/(Deficit)	**(850)**	**(14,279)**	**(13,429)**
STF Funding	3,225	3,225	0
Surplus/(Deficit) (inc. SFT)	**2,375**	**(11,054)**	**(13,429)**

Non-Operating expenditure

Depreciation – shows a £1.1m favourable variance to plan due to the underspend against capital plan in the early part of the year.

PDC Payable – shows a small favourable variance due to the actual calculation of net assets based on the current balance sheet (driven by a higher creditors figure than planned)

Interest Payable – shows a £0.3m favourable variance. The plan was set on a forecast outturn position which has since changed.

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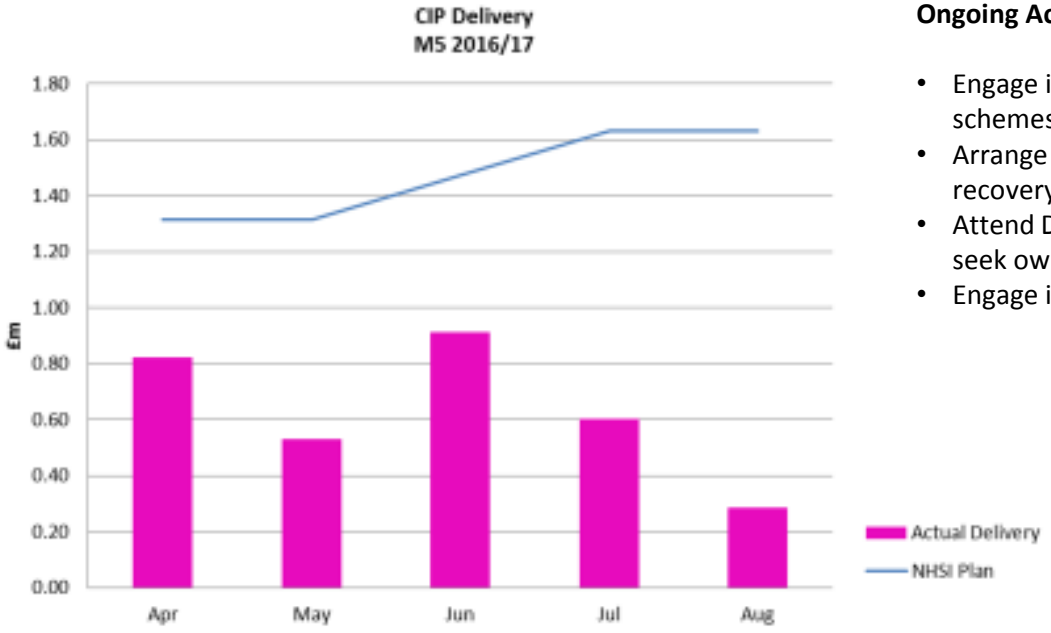
Cost Improvement Programme

CIP Analysis	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's
Medicine	824	307	(517)
Surgery	1,380	508	(872)
D&S	1,123	628	(495)
W&C	420	237	(183)
EFD	941	909	(31)
Corporate	181	0	(181)
Trustwide	1,962	561	(1,401)
Phasing adjustment to NHSI Plan	534		(534)
Total CIP	**7,365**	**3,151**	**(4,215)**



As at Month 5 the Trust has delivered £3.2m of CIP against the NHSI plan of £7.4m, an adverse variance of £4.2m.

Key Issues:

- All divisions are showing an adverse variance to plan as at Month 5
- The corporate division have not declared delivery of any CIP for the year-to-date
- Trustwide schemes, in particular outpatient Program, are reporting significant under-delivery
- The scheme around coding has provided no updated figures this month – to be rectified for month 6
- The scheme to reduce costs from Gloucestershire Care Services has been reduced for both plan and forecast by £250k

Ongoing Actions:

- Engage in discussions with relevant Directors around the corporate schemes in their areas
- Arrange further review meetings with each division to agree recovery and mitigation schemes
- Attend Divisional Boards to highlight the current performance and seek ownership and engagement
- Engage in discussion and agree a date to close escalation areas

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NHSI Continuity of Services Rating

			Plan	Actual	
Continuity of Services	Balance Sheet Sustainability	**Capital Service**			
		Revenue Available for Capital Service	13,074	(1,797)	
		Capital Service	(5,196)	(10,022)	
		Sum = (calc above)	**2.52**	**(0.18)**	**Scoring Key** **Capital Service Cover (25%)**
		Rating	**4**	**1**	**4**: >2.5 | **3**: 1.75-2.5 | **2**: 1.25-1.75 | **1**: <1.25
	Liquidity	**Liquidity**			
		Working capital balance	(7,054)	(39,749)	
		Operating expenses within EBITDA	(197,679)	(212,131)	
		Sum = (calc above x no. of days)	**(5.4)**	**(28.1)**	**Scoring Key** **Liquidity (25%)**
		Rating	**3**	**1**	**4**: <0 days | **3**: (7) - 0 days | **2**: (14) - (7) days | **1**: >(14) days
Financial efficiency	Underlying performance	**I & E Margin**			
		Normalised Surplus (deficit)	2,375	(11,053)	
		Total Income	210,754	210,335	
		I&E Margin	**1.1%**	**(5.3%)**	**Scoring Key** **I & E Margin (25%)**
		Rating	**4**	**1**	**4**: >1% | **3**: 0 - 1% | **2**: (1) - 0% | **1**: <(1)%
	Variance from plan	**I & E Margin Variance From Plan**	**Prior Year Outturn**		
		I & E Margin Variance from Plan	**(0.6%)**	**(6.4%)**	**Scoring Key** **I& E Margin Variance (25%)**
		Rating	**3**	**1**	**4**: >0% | **3**: (1) - 0% | **2**: (2) - (1)% | **1**: <(2)%
		OVERALL RATING	**4**	**1**	

As at Month 5 the Trust has delivered a Continuity of Services Rating (COSR) of 1 against a planned rating of 4.

Capital Service – the ratio generates a value of (0.18) for M5 – in practical terms we cannot have negative cover for capital service and as such the ratio is highlighting no cover.

Liquidity – the ratio generates a value of (28.1) days of liquidity at the year to date.

I&E Margin – reported as (5.3%) for month 5 and includes the impact of STF funding received in Q1.

I&E Margin Variance – reported as (6.4%) and reflects the material variance to planned delivery as at Month 5.
Note - the 'plan' for this metric is automatically generated by NHSI and is in fact the prior year outturn.

All ratios are generating 1 on the scale of 1-4 as it the overall COSR calculation.

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Balance Sheet (1)

Trust Financial Position	Opening Balance 31st March 2016 £000	NHSI Plan as at M5 £000	Balance as at M5 £000	Variance - M5 Plan vs Actual £000	B/S movements from 31st March 3016 £000
Non-Current Assests					
Intangible Assets	3,585	0	3,585	3,585	0
Property, Plant and Equipment	308,601	293,084	306,481	13,397	(2,120)
Trade and Other Receivables	4,505	7,510	4,523	(2,987)	18
Total Non-Current Assets	**316,691**	**300,594**	**314,589**	**13,995**	**(2,102)**
Current Assets					
Inventories	8,036	7,150	8,758	1,608	722
Trade and Other Receivables	30,611	33,410	28,655	(4,756)	(1,957)
Cash and Cash Equivalents	3,950	12,505	7,057	(5,448)	3,107
Total Current Assets	**42,597**	**53,065**	**44,470**	**(8,596)**	**1,873**
Current Liabilities					
Trade and Other Payables	(56,858)	(48,474)	(69,405)	(20,931)	(12,547)
Other Liabilities	(497)	0	(274)	(274)	223
Borrowings	(5,283)	(3,203)	(5,283)	(2,080)	0
Provisions	(186)	(1,292)	(182)	1,110	4
Total Current Liabilities	**(62,824)**	**(52,969)**	**(75,144)**	**(22,175)**	**(12,320)**
Net Current Assets	**(20,227)**	**96**	**(30,675)**	**(30,771)**	**(10,448)**
Non-Current Liabilities					
Other Liabilities	(7,987)	(8,270)	(7,557)	713	430
Borrowings	(54,538)	(59,870)	(53,431)	6,439	1,107
Provisions	(1,396)	(816)	(1,440)	(624)	(44)
Total Non-Current Liabilities	**(63,921)**	**(68,956)**	**(62,428)**	**6,528**	**1,493**
Total Assets Employed	**232,543**	**231,734**	**221,487**	**(10,248)**	**(11,057)**
Financed by Taxpayers Equity					
Public Dividend Capital	166,519	165,519	166,519	1,000	0
Reserves	67,543	66,827	67,543	716	0
Retained Earnings	(1,519)	(612)	(12,575)	(11,963)	(11,056)
Total Taxpayers' Equity	**232,543**	**231,734**	**221,487**	**(10,248)**	**(11,056)**

The table shows the M5 balance sheet and associated variance to the plan as submitted to NHSI – commentary is on the following page.

The table also splits the variance between movements from the 2015/16 closing balance sheet and those consequently at variance to plan. There are a number of issues with construction and reconciliation of the balance sheet plan. The planning process that created it is not as robust as would be expected. The Plan lacks granular supporting detail and as such comparisons are not necessarily to be relied upon in isolation for decision making or performance management purposes.

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Balance Sheet (2)

Commentary below reflects the Month 5 balance sheet position against the prior year outturn

Non-Current Assets

- There is a small reduction in non-current assets which reflects depreciation charges in excess of capital additions for the year-to-date.

Current Assets

- Inventories have increased slightly since the year-end. We are currently investigating the reasons for this.
- Debtor balances have fallen by £2.0m, largely due to the increased focus on credit control and the finalisation of year end settlements.
- Since Month 5 we have received a further £1.5m of cash receipts against our largest debtor balances.
- The bad debt provision has increased by £800k in Month 5 to better reflect the risk around the aged debtors currently carried.
- Cash has increased since the year-end. This is due to the ongoing management of working capital balances. The Trust is targeted by NHSI to maintain a minimum cash balance which never falls below £2.654m.

Current Liabilities

- Trade payables have increased significantly due to the ongoing cash pressures and the management of the supplier base
- Better Payment Practice Code performance is shown below:

	Cumulative for Financial Year		Current Month August	
	Number	£'000	Number	£'000
Total Bills Paid Within period	56,176	147,802	11,926	27,718
Total Bill paid within Target	22,528	94,430	4,624	18,121
Percentage of Bills paid within target	40%	64%	39%	65%

Non-Current Liabilities

- Borrowings have decreased slightly to reflect reduced finance lease obligations and the reduction of the long-term PFI contract lease

- **Reserves**
- The I&E reserve movement reflects the YTD deficit

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Cashflow

Cashflow Analysis	Apr-16 £000s	May-16 £000s	Jun-16 £000s	Jul-16 £000s	Aug-16 £000s	YTD - M5 £000s
Surplus (Deficit) from Operations	**401**	**308**	**3,441**	**(151)**	**(10,222)**	**(6,223)**
Adjust for non-cash items:						
Depreciation	882	883	882	881	882	4,410
Impairments within operating result	0	0	0	0	0	0
Gain/loss on asset disposal	0	0	0	0	0	0
Provisions	0	0	0	0	0	0
Other operating non-cash (income)/ expenses	(58)	(1,276)	1,011	(425)	648	(100)
Operating Cash flows before movements in working capital	**1,225**	**(85)**	**5,334**	**305**	**(8,692)**	**(1,913)**
Working capital movements:						
(Increase)/decrease in inventories	(198)	(13)	1,882	(1,880)	(539)	(748)
(Increase)/decrease in NHS trade receivables	(6,042)	4,983	(9,375)	5,321	6,857	1,744
Increase/(decrease) in current provisions	0	0	(4)	0	0	(4)
Increase/(decrease) in trade payables	5,104	(5,795)	3,983	(611)	6,768	9,449
Increase/(decrease) in other financial liabilities	3,000	(2,853)	0	127	0	274
Net cash inflow/(outflow) from wokring capital	**1,864**	**(3,678)**	**(3,514)**	**2,957**	**13,086**	**10,715**
Capital investment:						
Capital expenditure	(678)	(550)	(726)	(657)	(639)	(3,250)
Capital receipts	0	0	0	0	0	0
Net cash inflow/(outflow) from investment	**(678)**	**(550)**	**(726)**	**(657)**	**(639)**	**(3,250)**
Funding and debt:						
PDC Received	0	0	0	0	0	0
Interest Received	0	0	4	3	3	10
DH loans	0	0	0	0	0	0
Other loans	0	4,000	0	0	(4,000)	0
Finance lease capital	(256)	(256)	(256)	(256)	(256)	(1,280)
PFI/LIFT etc capital	(235)	(235)	(235)	(235)	(235)	(1,175)
Other	0	0	0	0	0	0
Net cash inflow/(outflow) from financing	**(491)**	**3,509**	**(487)**	**(488)**	**(4,488)**	**(2,445)**
Net cash inflow/(outflow)	**1,920**	**(804)**	**607**	**2,117**	**(733)**	**3,107**
Cash at Bank - Opening	**3,950**	**5,870**	**5,066**	**5,673**	**7,790**	**3,950**
Closing	**5,870**	**5,066**	**5,673**	**7,790**	**7,057**	**7,057**

The cashflow for the first five months of the 2016/17 financial year is shown in the above table.

The major movements are consistent with those already identified within income and expenditure and the balance sheet.

Key movements:

Current Assets – these movements are currently still being investigated

Trade Payables – reduced in May due to the drawdown of the working capital facility but have increased from this point forwards and were particularly impacted when the facility was repaid in August.

Other Loans – shows the drawdown and repayment of the Barclays working capital facility.

Working capital – this reflects the movements in receivables and payables balances as part of managing the challenging cash position.

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Recommendations

The Board are asked to note:

- The financial position of the Trust at the end of Month 5 of the 2016/17 financial year is an operational deficit of £11.1m. This is an adverse variance to plan of £13.4m.
- There is a prior year impact included in the current YTD position of £5.6m.
- The NHSI Plan and the planning process that created it is not as robust as would be expected. The Plan lacks granular supporting detail and as such comparisons are not necessarily to be relied upon in isolation for decision making or performance management purposes. The Trust's internal budget does not reconcile, either by cost category or phasing, to the NHSI plan. The figures presented in this report as 'plan' reflect the figures as submitted to NHSI unless explicitly stated otherwise.

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

Presenting Director: **Stuart Diggles, Interim Director of Finance**

Date: **August 2016**

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PUBLIC BOARD MEETING FRIDAY 30th SEPTEMBER 2016

Gallery Room, Gloucestershire Hospital commencing at 9.00 a.m

Report Title
Emergency Pathway Report

Sponsor and Author(s)
Eric Gatling, Director of Service Delivery

Audience(s)									
Board members	✓	Regulators	✓	Governors	✓	Staff	✓	Public	✓

Executive Summary

Purpose

To report quality, safety and performance indicators, key risks and validated performance against the Emergency Care Programme Board milestone plan. The report reflects data up to 31st August 2016.

Key issues to note

- Improved quality and safety metrics.
- Achievement of the agreed improvement trajectory.
- Continued rise of the number of patients who are medically fit.

Conclusions

Continue to implement and embed agreed plans and workstreams.

Implications and Future Action Required

Increased focus and engagement on external factors affecting discharges ahead of winter and junior doctors industrial action.

Recommendations

The Board is asked to review the report and endorse the actions.

Impact Upon Strategic Objectives

No change this month.

Impact Upon Corporate Risks

No change this month.

Regulatory and/or Legal Implications

The Trust remains under regulatory intervention for the A&E 4-hour standard.

Equality & Patient Impact

No change.

Resource Implications

Finance	✓	Information Management & Technology	
Human Resources		Buildings	
Additional investment has agreed to address the delivery of the work programme.			

Action/Decision Required							
For Decision		For Assurance	✓	For Approval		For Information	

Date the paper was presented to previous Committees					
Quality & Performance Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Trust Leadership Team**	**Other (specify)**

MAIN BOARD - SEPTEMBER 2016
EMERGENCY PATHWAY
MONTHLY PERFORMANCE REPORT: AUGUST 2016

Executive Summary

Report Purpose

To report quality, safety and performance indicators, key risks and validated performance against the Emergency Care Programme Board milestone plan. The report reflects data up to 31st August 2016.

The emergency pathway performance management metrics enable the Board to track where changes are delivering sustainable performance and identify where further focus and effort is needed against the 3 areas for improvement as identified within the enforcement undertakings:

1. Achievement of national standards of performance within Accident & Emergency, progress measured against a recovery trajectory agreed with NHS Improvement.
2. Ensuring appropriate workforce (resources and skills) and capacity management processes are in place to meet demand requirements.
3. Ensuring appropriate Trust Governance structures are in place to support achievement, sustainability and embedment of the improvement plan.

Key Messages

- The Trust **achieved** the agreed **improvement trajectory** of 87% for August 2016, with Trust-wide performance (includes GP in the Emergency Department activity) reported as **90.85%**.

- The forecast Trust-wide position for September (based on a straight line extrapolation from the ***unvalidated*** performance 'as at' the 18th September) is **89.78%**, against the trajectory of 91.90%. The forecast Trust-wide position for Quarter 2 is **88.94%,** against the trajectory of **88.50%**.

- The daily average number of **Emergency Department attendances** in August 2016 was **366 patients** (11,335 for the month), compared to August 2015 (342 per day), which is an **increase of 7%**. However, this is a reduction of 5% compared to July's attendance figures. 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 so the underlying increase is higher.

- The **daily average number of admissions** from the Emergency Department in August 2016 was 116 patients (3,587 for the month), which is **1.7%** higher than August 2015 (114 per day).

- General and Acute **average length of stay for non-elective admissions has increased** from 5.54 days in July 2016 **to 5.81** days in August 2016. This is an increase of nearly **8%** on the same period last year (average 5.39 days).

- The average number of patients on the **medically fit** list for one day and over in August 2016 is **77**. This is higher than the previous month (70) and is the highest number in this financial year and the previous financial year. This number has been above the system-wide plan of no more than 40 patients since June 2015.

Key Risks

- **Demand** significantly exceeds both the contractual plan and historical levels.

- The number of patients **medically fit** for discharge and increased **delayed transfers** of care occupying an acute hospital bed.

- **Capacity:** 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 county-wide projects to streamline the urgent care system, as detailed in the system-wide plan. This involves close working with health and social care partners.

Focus for the Programme Looking Ahead

- Internal Improvement Focus:
    - Focus on reduced admissions through presence of senior clinical decision maker in department and appropriate patient streaming;
    - Improved escalation and patient flow policy roll out to improve management of surge activity;
    - Relentless focus and management of outliers, Length of Stay, ward discharge standards and SAFER patient flow bundle, especially as autumn draws into winter;
    - Bed allocation and distribution.
- Whole system actions in development:
    - Focus on Discharge to Assess and reduction in Medically Fit For Discharge patients from acute beds, to improve capacity;
    - System-wide winter plans.

1. Quality & Safety

To deliver ***Best Care for Everyone***, the key is to achieve the quality indicators in the Emergency Departments, but also to look at the wider issues of quality and the soft intelligence from the department. The overall position is showing signs of improvement.

1.1 National Quality Indicators

Trust performance against 4 quality indicators is tabulated below, with observations on achievement following:

Measure	Target	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Unplanned reattendance rate	<5%	1.3%	1.5%	1.4%	1.6%	1.4%	1.3%	1.4%	1.7%	1.5%	1.3%	1.3%	1.6%	1.5%	1.7%
Total time in department	95th % < 4hrs	04:26	06:01	05:35	06:05	05:38	06:25	06:53	07:37	07:37	06:25	05:45	05:33	06:01	06:38
Patients left without being seen	<5%	1.5%	2.4%	2.0%	2.2%	1.2%	1.7%	1.4%	1.8%	1.9%	1.7%	1.8%	2.0%	2.3%	2.0%
Time to Treatment	Median = 60 mins	00:57	01:13	01:08	01:14	00:57	01:10	01:02	01:13	01:12	01:02	01:03	01:05	01:08	01:00

1.1.1 Total Time in the Department

The 95th percentile of total time in department (for all patients) in August 2016 was **6 hours, 38 minutes**, compared to 6 hours 1 minute in August 2015, and July 2016.

1.1.2 Time to Initial Assessment - Compliance with standard of 15 minutes from arrival *(target 90%)*

Although the performance in August 2016 remains below the target, there has been a significant improvement of nearly **30%** against the February baseline.

	Number of….	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	Jul-16	Aug-16
Trust Total	Patients	10895	10982	10600	10747	11079	10532	10844	10734	10603	11510	10777	11854	11343	11969	11335
	Patients seen <= 15 mins	6912	6864	6646	6350	6406	6328	6072	6076	5441	6127	7381	9353	8857	9209	9160
	Patients >15 mins	3983	4118	3954	4397	4673	4204	4772	4658	5162	5383	3396	2501	2486	2760	2175
	% Compliant	63.44 %	62.50 %	62.70 %	59.09 %	57.82 %	60.08 %	55.99 %	56.61 %	51.32 %	53.23 %	68.49 %	78.90 %	78.08 %	76.94 %	80.81 %

1.1.3 Time to Treatment - Compliance with standard of 60 minutes from arrival *(target 90%)*

Although the performance in August 2016 remains significantly below the target, there has been an improvement against the February baseline (8%) and an increase of **8.5%** compared to August 2015.

	Number of….	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	Jul-16	Aug-16
Trust Total	Patients	10895	10982	10600	10747	11079	10532	10844	10734	10603	11510	10777	11854	11343	11969	11335
	Patients seen <= 60 mins	5492	5649	4328	4683	4464	5459	4598	5162	4342	4727	5186	5601	5213	5259	5597
	Patients >60 mins	5403	5333	6272	6064	6615	5073	6246	5572	6261	6783	5591	6253	6130	6710	5738
	% Compliant	50.41 %	51.44 %	40.83 %	43.57 %	40.29 %	51.83 %	42.40 %	48.09 %	40.95 %	41.07 %	48.12 %	47.25 %	45.96 %	43.94 %	49.38 %

1.1.4 Hourly Board Rounds in the Emergency Departments

Implemented in June 2016 and led by the senior decision maker to support improvements in time to treatment. The logs are linked to actions within the Emergency Department Escalation Policy to ensure quick resolution and the Site Management Team can access these reports to inform decision-making.

An audit will be undertaken in September to assess the use of the log, including a collation of issues to be addressed.

1.1.5 Emergency Department Safety Checklist

A pilot checklist, devised for Trust EDs using the University Hospitals Bristol NHS Foundation Trust SHINE template, and which systematises the observations, tests and treatments in a time-based sequence for all patients other than those with minor complaints. Following an initial pilot in March 2016, a revised form was launched in Gloucestershire Hospitals EDs in June 2016.

A dashboard has been developed by the West of England Academic Health Service Network for use by all the Trusts involved in the project. July data at Cheltenham showed usage at 41% and 11% at Gloucester – this is a reduction in usage at both sites and the project team are implementing several actions to improve compliance, including:

- Using focus groups to re-engage with staff using actual Serious Incidents to create the narrative / background for the meetings.
- Nurses from Bristol (where the checklist was successfully implemented) will attend the Senior Nurse's meetings at both sites to promote the positive outcomes of using the checklist.
- A booklet-style checklist, to include other key documents, will be designed and tested by November 2016.

1.1.6 Patient Experience

The figures in the table below relate to the Emergency Departments:

Measure	Site	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Friends & Family Response Rate (%)	CGH	4.5	0.7	1.2	4.1	6.2	2.7	5.8	10.5	15.4	27.0
	GRH	1.1	3.7	0.4	1.4	3.5	2.0	4.2	7.0	9.1	26.4
	TRUST	**2.4**	**1.9**	**0.7**	**2.5**	**4.5**	**2.3**	**4.9**	**8.3**	**11.6**	**26.7**
Friends & Family Positive Response Rate (%)	CGH	83.2	48.0	40.7	89.4	90.5	83.6	95.1	96.7	90.9	91.1
	GRH	67.6	85.2	83.3	55.3	72.7	81.8	88.2	94.2	80.3	85.3
	TRUST	**78.8**	**76.4**	**53.8**	**78.0**	**82.2**	**82.6**	**91.5**	**95.0**	**85.9**	**87.6**
Number of Complaints	**TRUST**	**10**	**9**	**10**	**12**	**12**	**11**	**14**	**12**	**14**	**9**
Number of Concerns		**3**	**1**	**6**	**8**	**2**	**1**	**3**	**8**	**3**	**4**
Number of Compliments		**4**	**23**	**11**	**8**	**6**	**10**	**11**	**35**	**7**	**10**

The new digital methodology for the Friends & Family Test was launched in July 2016 and negates the need for Emergency Department staff to hand patients a card to complete on discharge. This has resulted in a big increase in the response rate for August (26.7% Trust-wide). Peer Trusts using the same methodology have reported response rates of circa 20%. The card methodology remains available to the patients in the department should they prefer to use this. However, the main methodology is now interactive voice messaging or text messaging.

Encouragingly, 87.6% of respondents stated that they were **extremely likely** or **likely** to recommend the department to friends and family if they needed similar care or treatment.

The majority of negative comments continue to be about waiting times.

The themes identified within the complaints and concerns raised included staff attitude, no doctor at night (at Cheltenham General) and waiting times.

1.2 Safety

- There were **no** Never Events or Serious Incidents reported in August.
- Sepsis screening in the Emergency Department continues, with 96% of patients being screened.
- Compliance with the Emergency Department Safety checklist remains low and short and medium-term actions have been identified (see section 1.1.5 for details).
- There are six risks on the Trust Risk Register, as detailed below.

Top ten categories for incident reporting by staff in Emergency Department:

Admission transfer – the peaks between Jan – July 2016 relate 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 and physical aggression involving patients / 3rd parties or for disruptive patients / 3rd parties. Emergency Department staff have received conflict resolution / safe-holding training and have access to the 2222 escalation security process.

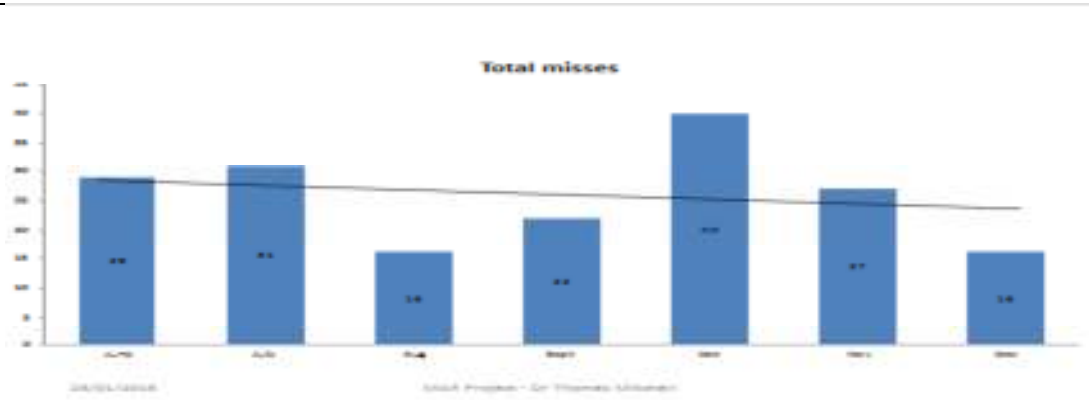
Care monitoring and review – monitoring of patients NEWS score supporting earlier intervention and informing the SAFER proforma project below and implementation of the hourly board rounds.

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.

	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016
Admission/ transfer	6	25	9	45	22	36	98	88	48	17	11	77	7	7
Abuse and Violence	15	18	9	19	12	17	7	6	20	3	19	6	4	8
Care, Monitoring, Review	6	5	6	11	28	4	1	6	8	5	3	8	3	7
Communication	4	7	2	4	5	6	3	4	6	7	6	4	5	5
Diagnosis & Assessment	3	3	5	3	7	7	3	6	8	6	4	3	4	0
Medication Incident	8	4	3	5	4	3	1	2	3	3	3	9	4	2
Staffing / Beds / Systems (no individual patient involvement)	0	3	5	4	8	4	2	4	4	2	2	7	1	3
Treatment/ Procedure	2	2	1	2	3	1	2	2	4	3	1	1	2	4
Falls	2	2	4	2	3	1	3	0	3	0	1	0	2	3
Discharge & Transfer	3	0	2	2	2	4	1	2	6	0	1	0	0	1

Current Improvement and Audit projects	
• **Patient Safety Checklist – part of the WEAHSN (Academy supported)** implemented in CGH in March 2016 and GRH in June 2016. **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** **The ED checklist** The ED checklist compliance in Gloucester over the first three months ranged from 29-6%, the project team have evaluated the compliance and the will be creating focus group meetings to re-engage the staff using actual Serious incidents to create the narrative for the meetings. Changes made to the environment will be re-evaluated using a series of quick Plan Do, Study, Act cycles. In the medium term the testing of a booklet style checklist with other key documents will be designed and tested by November. **Pain Management** The Care Quality Commission report and other audits highlighted our poor pain management in the Emergency Departments and this was the driver for the Quality Improvement Project. A baseline audit was performed and a questionnaire survey sent to all staff to identify areas for improvement. The changes implemented were: Rolling education programme for all staff – Feb - July Induction e learning package for new starters about pain relief 'Message of the week' posters in both departments – June 2016 Increased awareness of analgesia prescribing via PGD with aim to get all nursing staff who are triage trained to also prescribe analgesia Initial results have shown that: 100% recording of pain score on arrival Improved hourly recording of pain score – partly driven by the checklist Better documentation of non-pharmacological measures of analgesia and patients declining pain relief Improved pain relief prescribing but we still have a way to go to hit time limit targets. (PGD driven prescribing is better in CGH than GRH as triage nurses are more senior)

• **Missed Abnormal Radiology (NHSLA funded)** **Actions have included** – Teaching and education sessions contributing to a decrease in missed fractures – Identification of new pathways involving Trauma & Orthopaedics 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

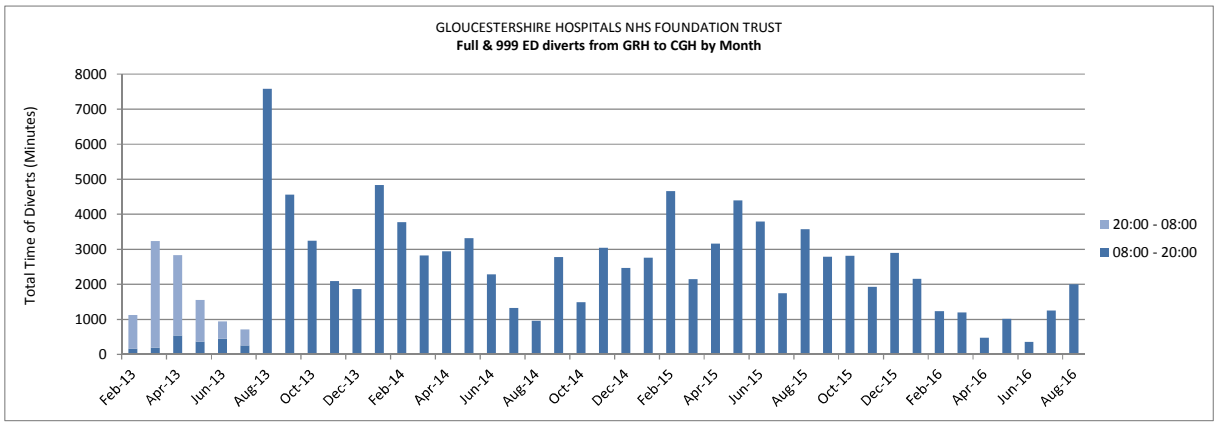
C12 **-** Delayed discharge of patients who are on the medically fit list above the agreed 40 limit leading to detrimental effects on capacity and flow of patients through the hospital from ED to ward

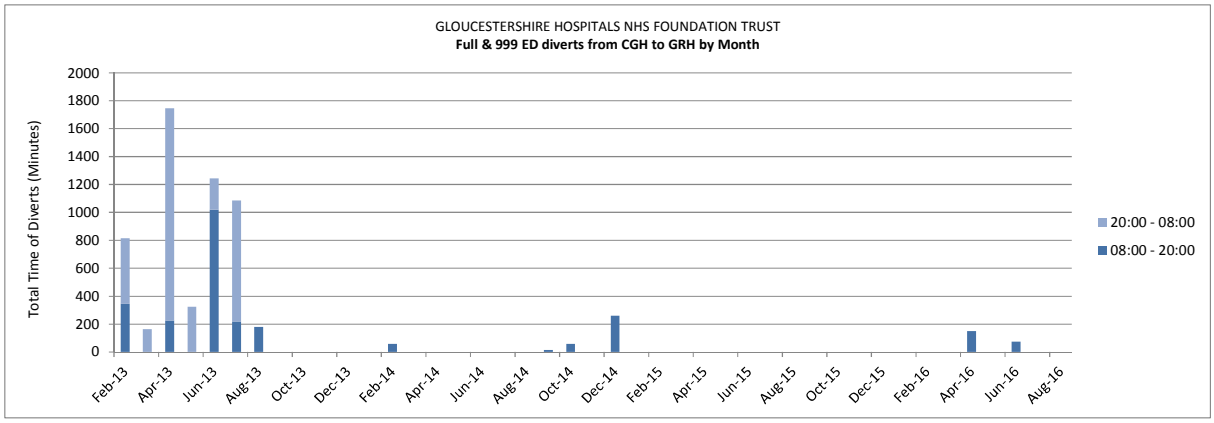
S118 **-** As consequence of increased emergency activity (see risk M1) the Day care unit and other similar non inpatient areas with beds are opened overnight to house inpatients causing an increased patient safety risk, a reduced patient experience and a negative effect on Day Surgery activity and efficiency and increased cancellations on the day

1.2.1 Diverts Between Gloucestershire Royal Hospital & Cheltenham General Hospital

There were 8 occasions when a Full/999 divert took place in August 2016 compared to 7 in July.

The total duration of the diverts increased from 20 hours and 55 minutes last month to 33 hours and 30 minutes in August 2016, due to the increased average hours duration for each divert at 4 hours 11 minutes, compared to 3 hours in July.





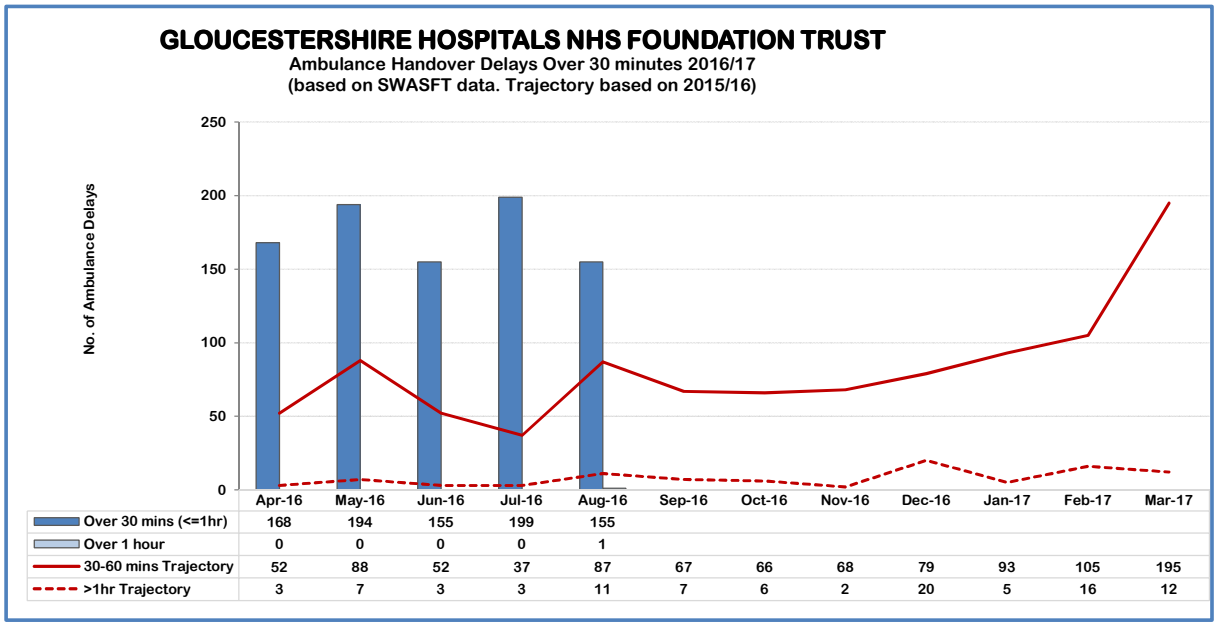
1.2.2 Ambulance Handover Delays

There has been just one ambulance delay in excess of 60 minutes since April 2016, much better than the trajectory, month on month, but, delays of 30-60 minutes remain spikey and significantly exceed plan. The figures tabulated below have been validated by the Unscheduled Care service.

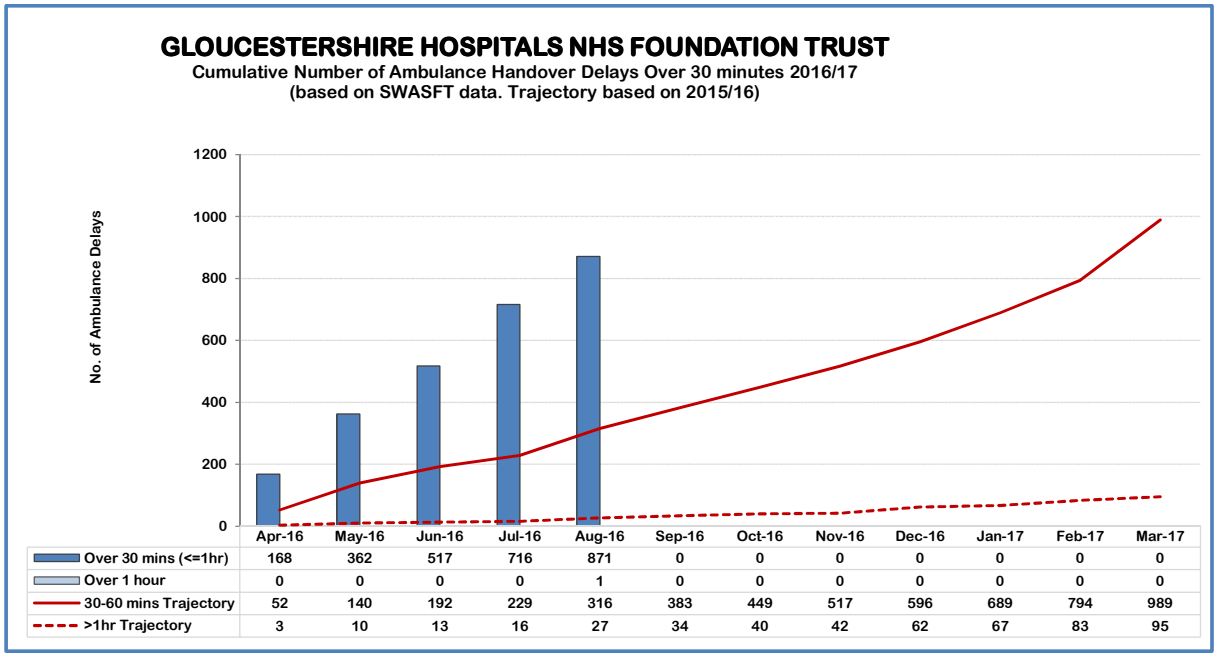
Performance against the 30 minute trajectory correlates with Emergency Department attendances, suggesting there is a critical tipping point at which waits of, or below, 30 minutes cannot be sustained.

The General Manager for Unscheduled Care attended a Regional Event regarding best practice for managing Ambulance Handover Delays, and several actions identified will be followed-up locally with system partners.

The Board is asked to note that the service has previously confirmed that figures from March to July 2016 are **unvalidated**. There has only been sufficient resource within the Trust to validate any waits >1hr. The 3 reported in April have subsequently been validated off. From September 2016, all delays over 30 minutes will be validated by the service, but historical delays will not.



	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)	168	194	155	199	155							
Over 1 hour	0	0	0	0	1							
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

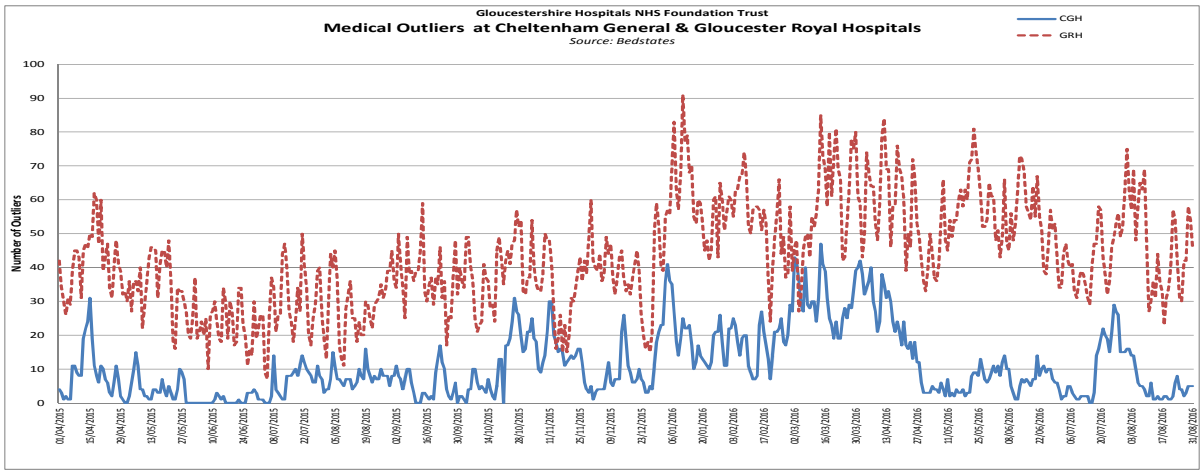


	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Over 30 mins (<=1hr)	168	362	517	716	871	0	0	0	0	0	0	0
Over 1 hour	0	0	0	0	1	0	0	0	0	0	0	0
30-60 mins Trajectory	52	140	192	229	316	383	449	517	596	689	794	989
>1hr Trajectory	3	10	13	16	27	34	40	42	62	67	83	95

1.2.3 Medical Outliers

The daily average number of medical outliers was 46 at Gloucestershire Royal and 5 at Cheltenham General in August 2016; compared to 43 and 10 respectively last month.

Surgical outliers are insignificant, but medical outliers remain an issue for the Trust. Average numbers of medical outliers per day may have reduced by some 29% since February 2016, but the placement of patients in a bed of a different specialty compounds recovery and early discharge through operational inefficiencies, in spite of improvements in estimated date of discharge accuracy, which has risen from circa 23% to 31% over the same timeframe.

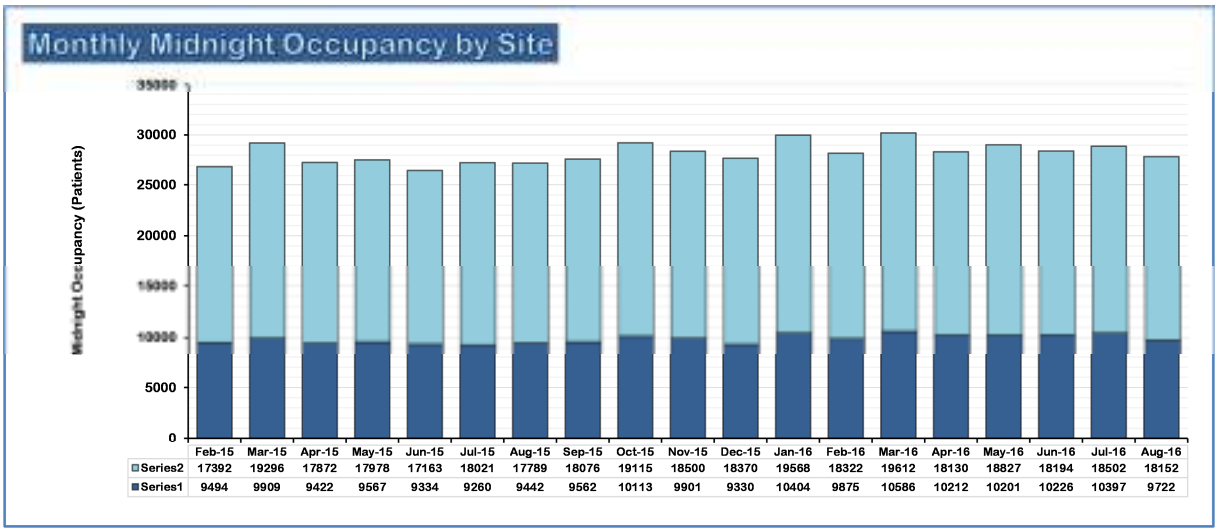


1.2.4 Midnight Bed Occupancy

The daily average number of beds occupied in August 2016 was 899. This is an improvement compared to July 2016 when the average was 932 per day, but is up on August 2015 (878).

Occupancy levels at Gloucestershire Hospitals have historically run at >95% for many years. The Trust considers this unacceptable and recognises the impact on the potential quality of care and the impact on staff.

The Trust recognises a significant piece of work is required to sustainably reduce occupancy rates to acceptable levels of 92.5%.

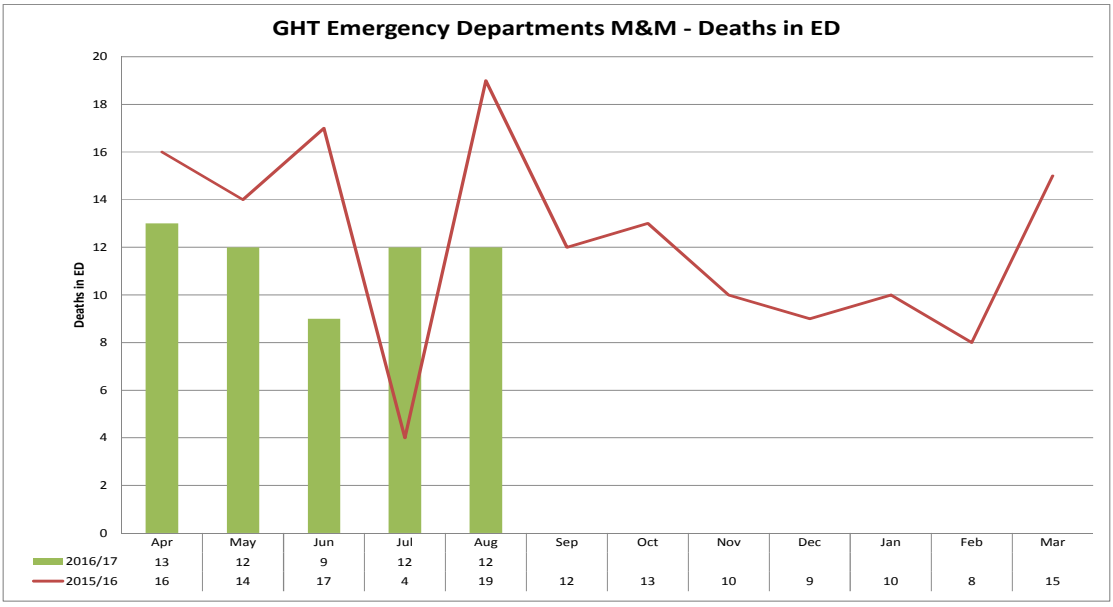


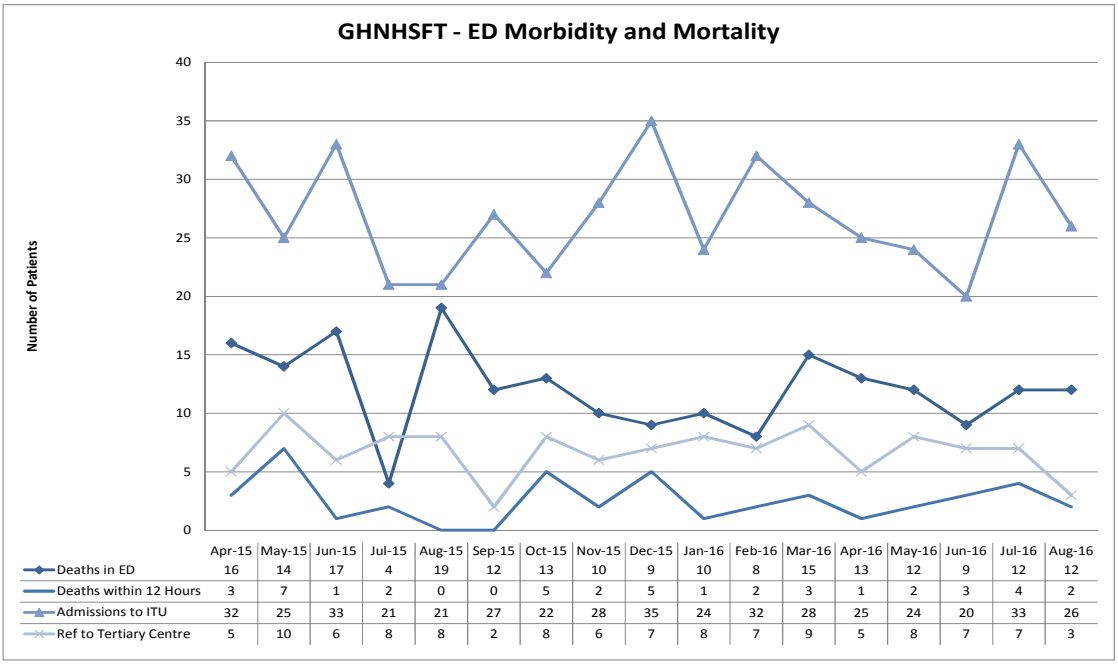
% Bed Occupancy (as at Thursday snapshot)

Week ending:	CGH	GRH	Total
07/08/2016	95.9%	98.5%	**97.5%**
14/08/2016	90.8%	95.1%	**93.4%**
21/08/2016	87.3%	95.8%	**92.4%**
28/08/2016	89.5%	96.8%	**93.9%**

1.2.5 Emergency Department Morbidity & Mortality

During August 2016 there were 12 deaths in the Emergency Department, which is lower than the 19 reported in August last year. There were 26 admissions to ITU and 3 referrals to tertiary centres. All of the deaths are reviewed in detail at the Service Line Morbidity and Mortality Reviews.





1.2.6 Medical Staffing

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

The number of trainee doctors in post is inflated in August due to the cross-over of contracted staff, this will reduce next month.

		Establishment (wte)	In Post August (wte)	Variance In Post vs. Establishment	Variance vs. in Post in July
Emergency Department	• Consultants	20.00	19.60	-0.40	+0.20
	• Trainee Doctors	37.00	37.30	+0.30	+7.0
Acute Medicine	• Consultants	11.03	8.33	-2.70	+0.20
	• Trainee Doctors	83.29	100.20	+16.91	+32.80

In assessing the demand and capacity issues within the Emergency Department (by day, and by hour), the Trust has recognised the need to maximise the use of multi-professionals and has already increased the number of orthopaedic middle grades and brought in GPs to increase assessment capacity.

Further skills' shortfalls against the 'diagnostic' have been identified and the actions in place to address them are as follows:

- Increase the consultant establishment to 20 whole time equivalents;
- Increase the number of junior doctors by 6 whole time equivalents to allow for an additional 4 posts overnight at Gloucester and to also provide prospective cover;
- Introduce 9.72 whole time equivalent Band 7 Emergency Nurse Practitioners (increasing the establishment by 5.76 whole time equivalents), plus 2.0 whole time equivalent new Physicians Assistants.

Additionally, the Trust has recognised that in order to drive improvement at pace, there is a requirement to increase capacity within Business Intelligence and Programme Management to ensure adequate support to the Work Stream activities and appropriate reporting and measurement of progress to identify variance against plan. Recruitment needs in these two key areas are therefore:

- 2x Project Manager / Service Improvement positions
- Recruit to 8 positions, across bands 4, 5, 6, 7, increasing the establishment by 4 whole time equivalents.

Progress against the above recruitment plans is as follows:

Vacant position	Grade	WLP approval date	New position or Replacement	Date advertised (may be multiples before one gets suitable candidates)	Applicant source (ad agency, on-line, etc)	Applicants (no.)	Interview dates	Offers made (no.)	Offers accepted	Start dates	Vacancies remaining	Next steps	Anticipated date of closure	Comment
Doctor	Consultant	03.08.2016	2N 1R	23.8.2016	BMJ; NHS Jobs	still open	19.11.2016				3		25.11.2016	
Doctor	ST3	25.04.16	5N	26.08.2016	NHS Jobs	Still open	TBC				5	re-advertise	on-going	
WLP	7	TBC	9.72N	TBC	TBC	Still open	TBC						ASAP	Anticipate will be filled internally leaving Band 6 vacancies
Staff	6	TBC	5.76R	05.09.2016	TBC	Still open	TBC							
Project Manager	8	01.08.2016	1R	01.08.2016	CV Reviewing	Still open	19.09.2016				1		19.09.2016	
Project Manager	8	29.04.2016	1R	29.04.2016	NHS Jobs	28	01.06.2016	1	1	29.09.2016	0		Closed	
BI Information Systems Analyst	4	25.08.2016	1R	01.08.2016	NHSjobs	23	14.09.2016				1		21.09.2016	
BI Information Systems Analyst	5	17.08.2016	1N 2R	20.07.2016	NHSjobs	40	15/29.01.08.2016				3		03.10.2016	
BI Information Systems Analyst	6	17.08.2016	2N	11.08.2016	NHSjobs	12	23/24.08.2016	2	2	01.09.2016			Closed	
BI Information Systems Analyst	7	17.08.2016	1N 1R	01.08.2016	NHSjobs	23	02.09.2016 29.09.2016	1		TBC	1		12.09.2016 06.10.2016	

N.b. the anticipated date of closure assumes offers are accepted within 1 week of the offer being made.

The expected outcomes of the recruitment are:

1. Performance against the 4 hour standard for minor patients is 99%;

2. The 15 minutes Time to Initial Assessment standard is achieved at least 90% of the time;

3. The 60 minutes Time to Treatment standard is achieved at least 90% of the time;

4. Reduction in the number of breaches attributed to *"Awaiting Assessment"*;

5. Reduction in agency and locum spend - specific targets will be set in line with the Trust agency reduction plan;

6. There is a full detailed review of the impact of these changes before consideration of any further changes to staffing.

2. Performance & Recovery Trajectory

Overall there has been an improvement in performance and the agreed recovery trajectory was achieved.

2.1 National 4 Hour Standard

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 Trust-wide performance including GP figures, please refer to the table in section 2.2.1.1.

August 2016 data shows that Cheltenham General achieved the 95% national standard at 97.29% but Gloucester Royal missed the standard, recording 86.89%. The Trust Total was **90.66%**, which is an **increase of 4.66%** compared to the previous month.

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
National std	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**
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%
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
National std	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**
CGH actual	87.98%	95.94%	92.93%	93.14%	97.29%							
GRH actual	83.93%	82.68%	83.87%	81.95%	86.89%							
Trust actual	85.39%	87.42%	87.07%	86.00%	90.66%							

Source: April 2016 onwards – Monthly SITREP return

NHS England (Type 1) Emergency Department performance for Quarter 1 2016/17 was 86.65%. The Trust-wide position (includes GP in ED activity) for Quarter 1 was 86.97%.

2.1.1 Recovery Trajectory

The Trust-wide performance for 2016/17 to date against the trajectory agreed with NHS Improvement is shown below.

The Trust achieved the agreed improvement trajectory of 87% for August 2016, with Trust-wide performance (includes GP in the Emergency Department activity) reported as 90.85%.

The projected Trust-wide position for September (based on a straight line extrapolation from the ***unvalidated*** performance 'as at' the 18th September) is **89.78%**, against the trajectory of 91.90%. However, the forecast position for Quarter 2 is 88.94% against the trajectory of 88.50%.

Metric	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16 (Projected)	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%	86.00%	90.66%	89.46%						
Trustwide Performance (incl. GP in ED)	85.71%	87.73%	87.37%	86.34%	90.85%	89.78%						

2.1.2 Majors and Minors Performance against the 95% standard

Whilst performance for minors in Cheltenham General Hospital is good, actions are in train to drive up performance in minors at Gloucester Royal Hospital, and majors at both locations.

	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%	98.29%	98.84%							
CGH Majors	73.03%	89.79%	83.57%	82.38%	94.10%							
GRH Minors	94.07%	94.83%	93.73%	93.00%	95.92%							
GRH Majors	74.27%	69.61%	73.21%	70.50%	77.29%							
Trust Minors	95.04%	96.57%	95.30%	95.27%	97.17%							
Trust Majors	73.93%	75.15%	76.04%	73.73%	81.94%							

2.1.3 Breach Analysis

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

August 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	111	15	34	27	2	33
GRH	948	236	331	93	126	162
Total	1059	251	365	120	128	195
%		23.70%	34.47%	11.33%	12.09%	18.41%

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

- Bed availability remains the biggest single cause of breaches.
- Assessment also remains high, and is on a rising trajectory. This correlates with the increase in demand and staffing gaps as the Trust seeks to increase establishment and change working arrangements

The weekly cross-divisional Breach Analysis meetings chaired by the Director of Service Delivery are addressing the key factors behind the breaches, these include:

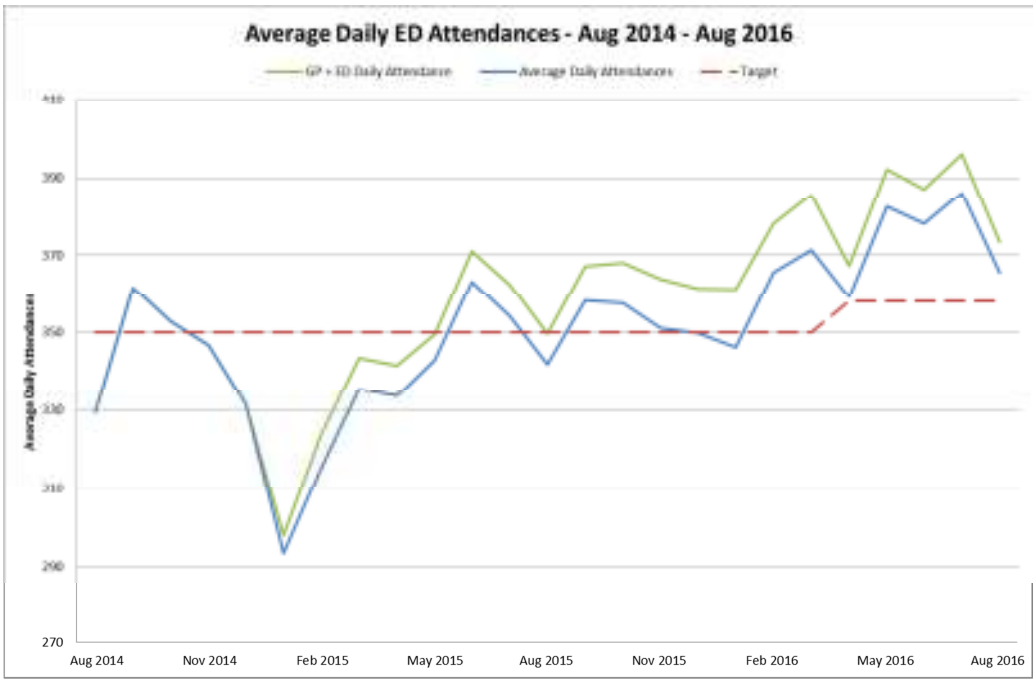
- Managing delays in clerking on Specialty wards, particularly at weekends;
- Increasing Orthopaedic presence in the Emergency Department at weekends;
- Review of the 'tablets to take out' process and provision of pharmacy support at the weekends.

2.2 Demand & Capacity

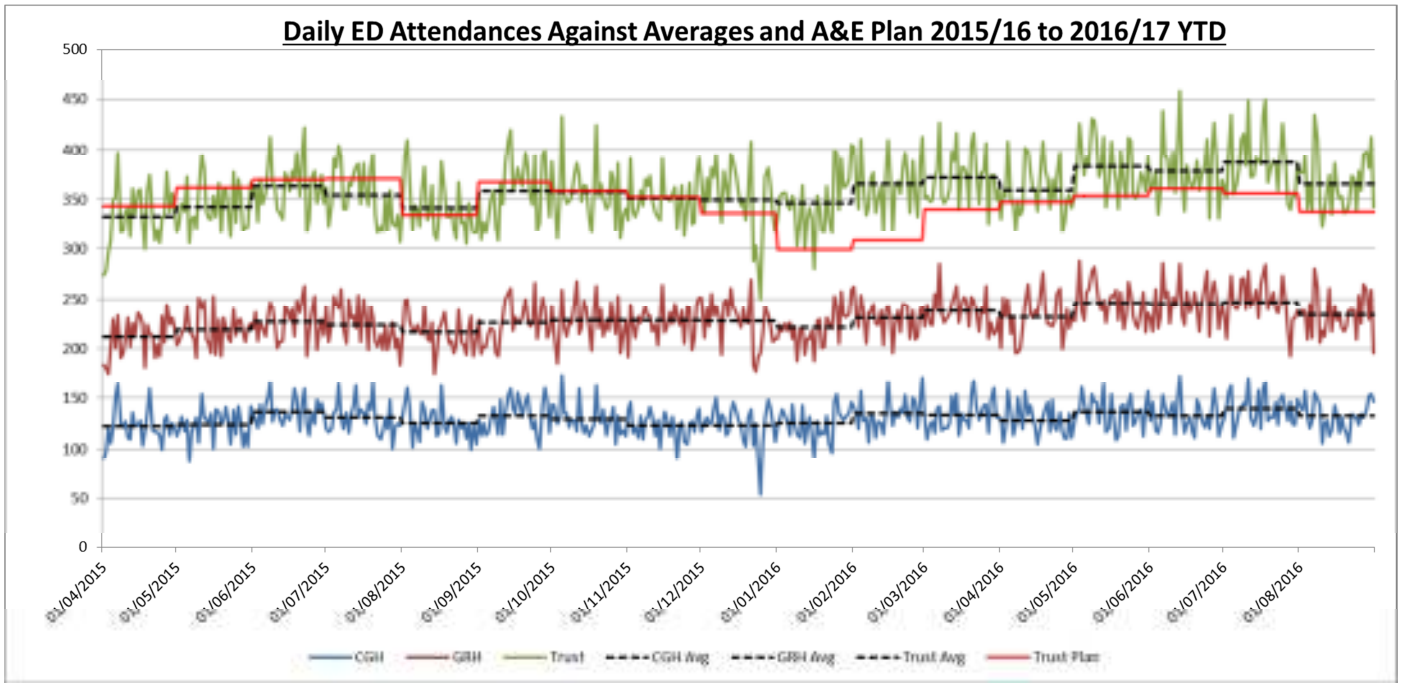
2.2.1 Emergency Department Attendances

There were 11,335 attendances in August 2016 (average of 366 per day) which is 20 less per day than the previous month and a **7% increase** on August 2015's average. This is 8 attendances higher than the 2016/17 plan of 358 per day pre-QIPP. Taking into account the level of planned attendances for 2016/17 the figure should be 330 a day.

Where appropriate, patients arriving at the Emergency Department are immediately repatriated to Primary Care. These patients are represented by the green line on the *Average Daily Attendances* chart below, and are in addition to Emergency Department attendances.



The following chart shows the average daily attendances against the plan, the green line represents the Trust Total.



2.2.1.1 Primary Care in Emergency Department

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

Following a one-week trial where a GP worked in the department working as part of the Emergency Department team to provide additional capacity, a three month pilot commenced 15th August 2016. The objective will be for the whole department to reduce admissions by 25 per day.

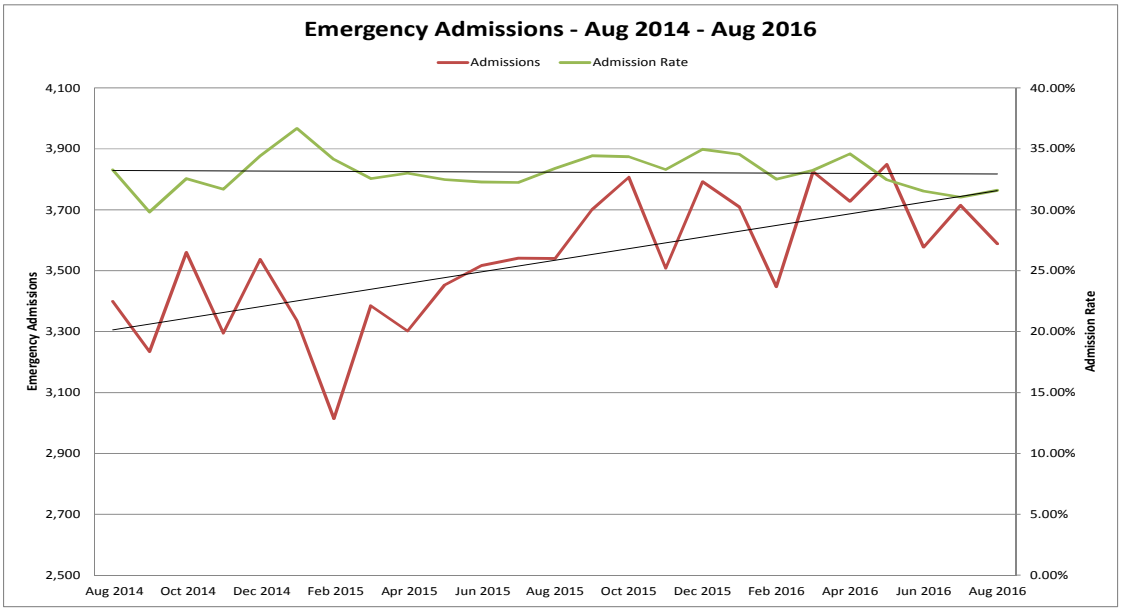
The table below shows a monthly breakdown of the impact of adding the number of Primary Care in Emergency Department cases (provided by Gloucestershire Clinical Commissioning Group), into the denominator of our Emergency Department performance calculation.

Arrival Month	ED Attendances	4 Hour Breaches	Performance	GP in ED Cases	Trust-wide Performance
Apr-15	10006	841	91.60%	239	91.79%
May-15	10632	687	93.54%	203	93.66%
Jun-15	10895	541	95.03%	234	95.14%
Jul-15	10982	679	93.82%	256	93.96%
Aug-15	10600	1481	86.03%	240	88.29%
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	1576	85.38%	244	85.70%
May-16	11854	1491	87.42%	301	87.73%
Jun-16	11343	1467	87.07%	271	87.37%
Jul-16	11969	1676	86.00%	303	86.34%
Aug-16	11335	1059	90.66%	243	90.85%

2.2.2 Emergency Admissions

The Emergency admission rate (from the Emergency Departments) in August 2016 was 31.60% compared to July 2016, when the admission rate was 31.04% and August 2015 which was 33.40%.

In August 2016 there were 11,335 Emergency Department attendances and 3,587 patients were admitted (average 116 per day), compared to August 2015 when there were fewer attendances (10,600), but the admission rate was higher. The chart below shows the admission rate remaining relatively static (within a narrow range) over the last 12 months, which considered against the increase in the number of Emergency Department Attendances, suggests the admission avoidance schemes may be having an impact.

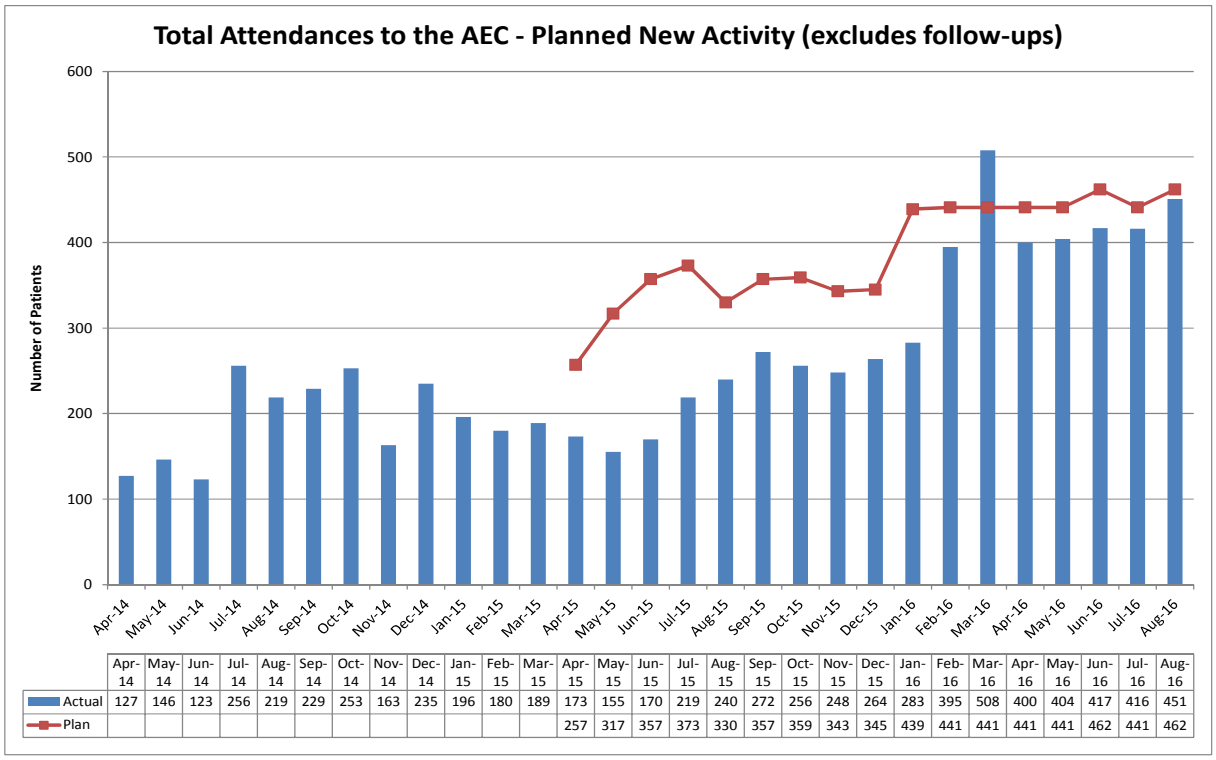


2.2.3 Ambulatory Emergency Care Attendances

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 Service Foundation 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 August 2016 was 20.5 compared to 19.8 last month and was just 11 patients below the plan of 462 for the month.

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 and the gap between actual and plan has diminished remarkably.



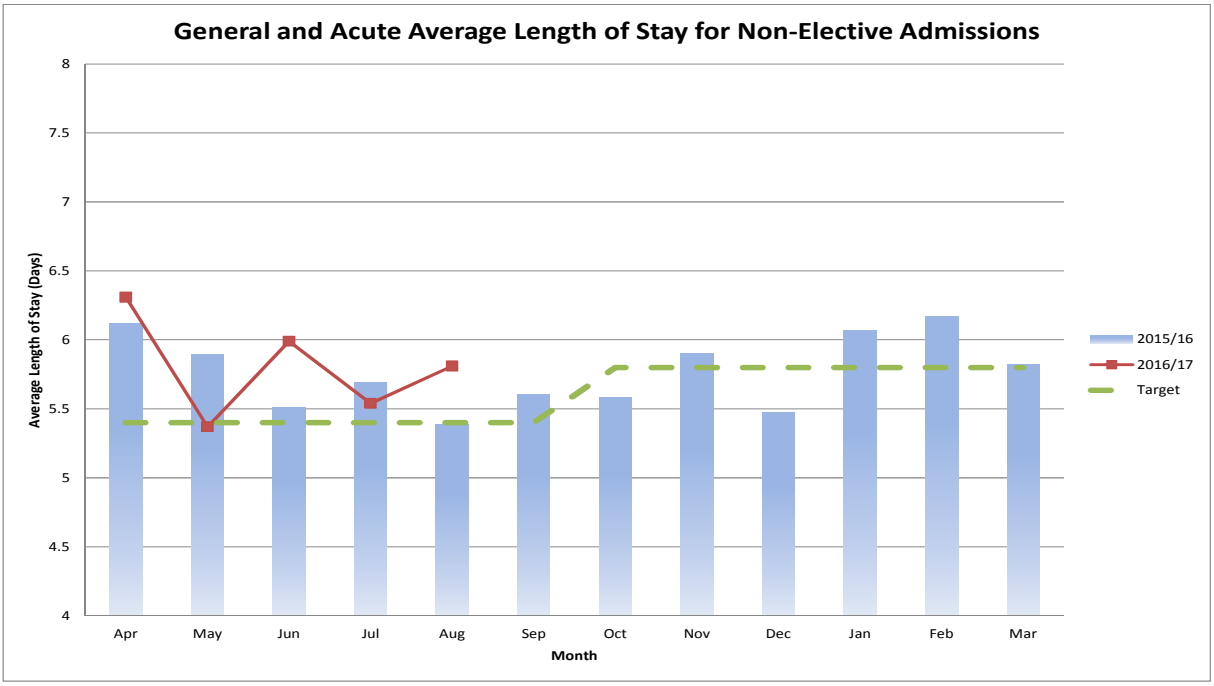
	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Actual	127	146	123	256	219	229	253	163	235	196	180	189	173	155	170	219	240	272	256	248	264	283	395	508	400	404	417	416	451
Plan													257	317	357	373	330	357	359	343	345	439	441	441	441	441	462	441	462

In addition, the service has seen a number of follow-up attendances. There were 162 follow-ups in August 2016, compared to 129 the previous month. Trust focus is now turning to reducing follow-ups in order to increase capacity for new patients.

2.2.4 General & Acute Emergency Admissions – Average Length of Stay

August 2016 shows a slight increase in the Average Length of Stay at 5.81 days compared to 5.54 days last month against the current target of 5.4 days.

The Trust-wide quarterly targets are being 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 (Workstream 3 – SAFER Patient Flow Bundle).



2.2.5 Average Number of Patients Medically Fit for Discharge

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 in an acute hospital longer than required represents a cost of £200 per patient.

2.2.5.1 Medically Fit: Average Number of Patients on the Medically Fit List for August 2016:

The number of medically fit for discharge patients has risen alarmingly, from an average of 63 per day in February, to an average of 77 per day in August, 2016 (18% rise).

- This number has been above the system-wide plan of no more than 40 patients since June 2015.

Coupled with broadly static numbers of patients with over 14 days Length of Stay, it is clear that length of stay and delays to discharge present the biggest internal challenges to the Trust:

- Daily Board rounds
- Increased use of discharge lounges
- Resolute focus on discharge arrangements, increased discharge before 12.00 and at weekends

are all active elements of work stream 3 (SAFER and the Patient Flow Bundle) but these are not enough in isolation.

The Trust is therefore also exploring (through work stream 6) alternative options to enable safe, prompt and timely discharge by utilising intermediate 'sub-acute' beds in the community, learning from the model engaged at the John Radcliffe Hospital in Oxfordshire, and engaging with community colleagues to develop an integrated solution.

The method of reporting weekly Medically Fit numbers is aligned with the Clinical Commissioning Group reporting so each financial week starts on a Friday. The table below shows the weekly averages, demonstrating lots of variation within August:

Week Commencing (Friday)	Fin. Week 2016	Average Per Day	Bed Days Lost
29/07/2016	Week 18	90	630
05/08/2016	Week 19	72	505
12/08/2016	Week 20	73	513
19/08/2016	Week 21	74	521
26/08/2016	Week 22	83	583

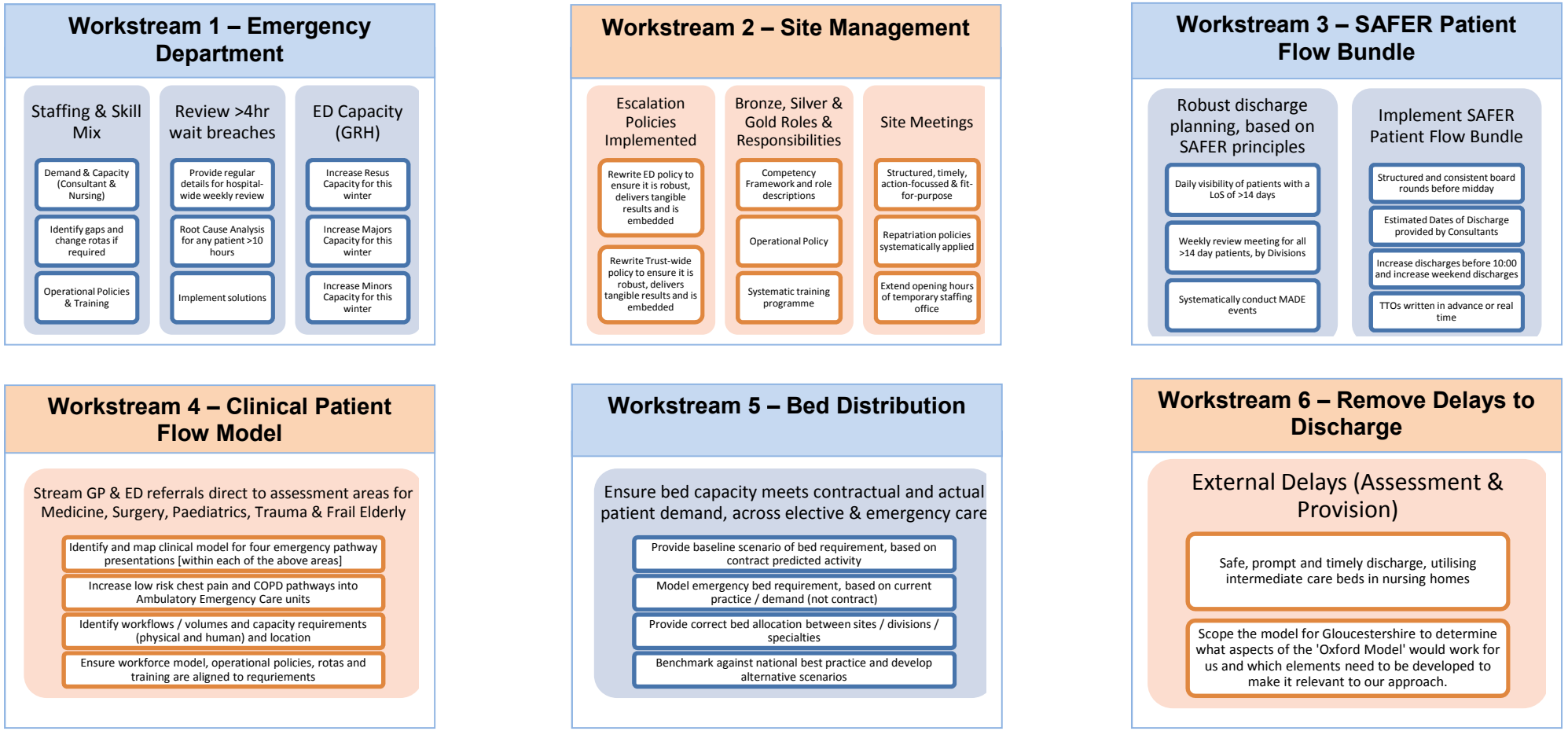
Source: InfoFlex and PAS (Integrated Discharge Team data)

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.

3. **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 A&E Delivery Board (previously 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.



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

3.1.1 Emergency Department:

ACTION BRAG STATUS				
Delivered	**Not on Track to Deliver**	**On Track to Deliver but Variance from Plan**	**On Track to Deliver Against Plan**	**Closed**
11	**2**	**6**	**7**	**3**

Note: Actions with start dates in the future have not been 'RAGged' and are excluded

- The development of the Operational Policy is not on track to deliver and has been delayed beyond the original end date of 15th July. The Policy is fit-for-purpose for Cheltenham General but needs to be finalised for Gloucestershire Royal. To date, no recovery date has been identified with the action lead.

- The development of the handover protocol from the Emergency Department to the wards was originally due to be delivered by 15 July, 2016. Feedback is currently awaited, and a revised target date of 16 September, 2016 was established to cover handover from the Ambulatory Care Unit to the wards

Measures (against February 2016 baseline):

For All Patients	CGH							GRH							TRUST						
	Feb	Mar	Apr	May	Jun	Jul	Aug	Feb	Mar	Apr	May	Jun	Jul	Aug	Feb	Mar	Apr	May	Jun	Jul	Aug
Avg. Time to Initial Assessment (mins)	17	16	13	10	11	11	10	26	21	16	13	14	14	13	22	19	15	12	13	13	12
% Assessed within 15 mins	57.7%	61.7%	74.7%	83.8%	84.5%	81.4%	85.7%	47.6%	48.4%	65.0%	76.2%	74.6%	74.4%	78.0%	51.3%	53.2%	68.5%	78.9%	78.1%	76.9%	80.8%
Avg. Time to Treatment (mins)	66	65	61	53	60	58	55	106	103	89	90	90	96	85	91	89	79	77	79	83	74
% Treated within 60 mins	53.9%	55.8%	59.8%	64.8%	59.6%	61.2%	63.2%	33.3%	32.8%	41.6%	37.5%	39.5%	34.2%	41.5%	40.9%	41.1%	48.1%	47.2%	46.6%	43.9%	49.4%
Number >6hrs (avg. per day)	4	7	7	2	2	3	1	34	34	15	14	11	16	11	38	41	22	16	14	20	12
% waiting >6hrs	3.0%	5.2%	5.7%	1.3%	1.8%	2.3%	0.5%	14.6%	14.3%	6.4%	5.8%	4.6%	6.6%	4.9%	10.3%	11.0%	6.1%	4.2%	3.6%	5.1%	3.3%
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	2	1	77	80	63	51	41	49	36	77	80	63	51	43	50	37

3.1.2 Site Management:

ACTION BRAG STATUS				
Delivered	**Not on Track to Deliver**	**On Track to Deliver but Variance from Plan**	**On Track to Deliver Against Plan**	**Closed**
12	**3**	**8**	**3**	**1**

Note: Actions with start dates in the future have not been 'RAGged' and are excluded

- The Patient Flow Policy was due to be finalised by 1st August, so this has been missed. However, it has now been widely consulted on and is due to be signed-off at the Programme Board on the 22nd September and the Trust's Policy Group on the 27th September.

- Training prioritisation had initially been given to the implementation of TrakCare, so not all staff on the Silver and Gold rota have received their training (Bronze is complete). However, the final Silver and Gold sessions are scheduled for 20th and 23rd September and the required staff have booked on.

- The review of the Integrated Discharge Team is being undertaken by external provider iMPOWER. The original end date of 31st July has been missed, but initial feedback was provided on the 7th September, with full feedback due in October.

Measures (against February 2016 baseline):

For All Patients	CGH							GRH							TRUST						
	Feb	Mar	Apr	May	Jun	Jul	Aug	Feb	Mar	Apr	May	Jun	Jul	Aug	Feb	Mar	Apr	May	Jun	Jul	Aug
Number of Surgical Outliers (avg. per day)	1	0	0	1	0	1	0	2	1	1	2	2	2	2	3	2	2	2	2	3	3
Number of Medical Outliers (avg. per day)	18	31	25	5	8	10	5	54	59	59	56	54	43	46	72	89	84	61	62	53	51
Number of days in Black Escalation (10:00 snapshot)	0	0	2	0	0	0	0	15	12	5	9	10	4	3	15	12	7	9	10	4	3
Number of days in Red Escalation (10:00 snapshot)	7	8	8	6	8	7	2	5	16	13	12	18	21	13	12	16	12	12	19	21	13

3.1.3 SAFER Patient Flow Bundle:

ACTION BRAG STATUS				
Delivered	**Not on Track to Deliver**	**On Track to Deliver but Variance from Plan**	**On Track to Deliver Against Plan**	**Closed**
8	**0**	**7**	**6**	**0**

Note: Actions with start dates in the future have not been 'RAGged' and are excluded

Measures (against February 2016 baseline):

For All Patients	CGH							GRH							TRUST						
	Feb	Mar	Apr	May	Jun	Jul	Aug	Feb	Mar	Apr	May	Jun	Jul	Aug	Feb	Mar	Apr	May	Jun	Jul	Aug
Number of >=14 days on list	69	64	65	59	75	66	71	153	147	133	116	131	120	138	222	211	198	176	206	186	209
Number of Bed Days Occupied by >=14 day patients (Average)	1821	1560	1596	1535	2021	1728	1892	3949	4584	4184	3284	3648	3606	4243	5770	6144	5779	4820	5668	5334	6135
Total Bed Days Occupied (Average)	3089	2860	2882	2752	3273	3010	3038	5867	6466	5985	5257	5486	5445	6031	8956	9326	8867	8009	8758	8455	9069
% of Bed Days Occupied by >=14 Los Patients	59.0%	54.5%	55.4%	55.8%	61.7%	57.4%	62.3%	67.3%	70.9%	69.9%	62.5%	66.5%	66.2%	70.3%	64.4%	65.9%	65.2%	60.1%	64.8%	63.1%	67.6%
EDD Accuracy	29.9%	27.8%	29.2%	31.3%	31.1%	32.1%	33.3%	19.4%	20.8%	25.6%	25.6%	25.7%	25.2%	29.0%	23.5%	23.6%	26.9%	27.7%	27.7%	27.8%	30.6%
Bed Allocation (from ED to ward) within 30 minutes *was previously measured from ACU, now measured from ED. Data changed retrospectively.	25.4%	25.5%	23.9%	38.2%	27.3%	30.1%	54.4%	24.0%	23.9%	40.1%	40.9%	44.0%	44.1%	48.8%	24.5%	24.4%	35.0%	40.1%	38.9%	40.0%	50.5%
Number of Discharges before 12pm (avg. per day)	30	29	32	29	30	27	31	44	41	47	41	42	41	43	74	70	78	70	72	69	74
% of Discharges before 12pm	18.1%	18.2%	19.4%	19.0%	18.2%	18.5%	19.1%	21.6%	20.8%	23.3%	21.4%	21.4%	21.7%	22.7%	20.1%	19.6%	21.5%	20.3%	19.9%	20.3%	21.1%
Number of Weekend Discharges	355	420	439	436	333	415	373	884	844	1015	970	701	961	834	1239	1264	1454	1406	1034	1376	1207
Number of Inpatients on DSU overnight	115	125	207	90	156	100	47	503	514	425	445	439	448	466	618	639	632	535	595	548	513
Number of Inpatients on DSU overnight (avg. per day)	4	4	7	3	5	3	2	17	17	14	14	15	14	15	21	21	21	17	20	18	17

3.1.4 Clinical Patient Flow Model:

ACTION BRAG STATUS				
Delivered	Not on Track to Deliver	On Track to Deliver but Variance from Plan	On Track to Deliver Against Plan	Closed
2	1	6	10	0

Note: Actions with start dates in the future have not been 'RAGged' and are excluded

- Clinical pathway designed for 1-hour TROP T tests, however, internal barriers are preventing this action from being delivered according to the plan. These will be identified and addressed during September. Actions to increase low risk chest pain and COPD pathways, plus implement the abdominal pain pathway in the Ambulatory Emergency Care units have been delayed to align with the STP and the launch of the generic clinical patient flow model being designed, respectively.

Measures are in development for this workstream.

3.1.5 Bed Distribution:

ACTION BRAG STATUS				
Delivered	Not on Track to Deliver	On Track to Deliver but Variance from Plan	On Track to Deliver Against Plan	Closed
6	0	0	2	1

Note: Actions with start dates in the future have not been 'RAGged' and are excluded

Measures are in development for this workstream.

3.1.6 Remove Delays to Discharge:

ACTION BRAG STATUS				
Delivered	**Not on Track to Deliver**	**On Track to Deliver but Variance from Plan**	**On Track to Deliver Against Plan**	**Closed**
2	**4**	**0**	**0**	**0**

Note: Actions with start dates in the future have not been 'RAGged' and are excluded

- Workstream is off track, However, the introduction of a new Operational Lead (effective 7th September) has helped in developing a recovery plan:
    - Scoping the model for Gloucestershire
    - Submitting the business case
    - Agreeing the contract
    - Recruiting the clinical team

Measures are in development for this workstream.

4. System-wide Update

The Trust continues to work closely with system partners across Gloucestershire

4.1 NHS Improvement Review of progress against the Enforcement Undertakings

NHS Improvement reviewed trust progress against the Enforcement Undertakings on 13th September 2016. The Trust was represented by:

- Deborah Lee, Chief Executive
- Eric Gatling, Executive Director of Service Delivery
- Dr Sean Elyan, Medical Director
- Maggie Arnold, Director of Nursing, and
- Sue Barnett, Improvement Director

The agenda, set by NHS Improvement, covered the following:

- Emergency Care Improvement Plan Delivery
- Workforce demand and capacity planning to support delivery
- Trust Governance arrangements to support delivery
- Engagement in the wider health care economy and preparation for winter

Feedback was encouraging. Further reviews will be conducted (broadly) monthly and it is anticipated that the next review will explore:

- The work stream metrics
- Length of stay
- Progress in managing Medically Fit for Discharge and Delayed Transfers of Care
- Assurance and embedment of actions completed to date
- Winter planning strategies

Support from Executives and their teams in maintaining progress and in embedding actions as business-as-usual will be essential.

4.2 Flow Coaching Programme

The West of England Academic Health Science Network presented the Flow Coaching Programme to Gloucestershire representatives on 16th September 2016. Delegates from condition pathways may attend the programme over 18 training days via 11 face-to-face teaching sessions, and dedicate 1.5-2.0 days per week to put their learning into practice at the Trust. For each condition-based pathway, a clinical flow coach and an operational/project management flow coach will be identified, from a single organisation, or from a clinical unit and system partner.

West of England Academic Health Science Network has guaranteed places on the programme for Gloucestershire. The condition pathways have to be agreed within the week, and delegates shortly afterwards. The Executive Director of Service Delivery and Medical Director are leading on behalf of the Gloucestershire Hospitals, along with colleagues from the Clinical Commissioning Group and Gloucestershire Care Services.

There is no cost to the programme other than time and travel.

4.3 System-wide Winter Plan

The Trust is working with system partners to develop the system-wide winter plan throughout September. The final plan will be presented to the system-wide A&E Delivery Board in October and will be followed by training workshops, and a full copy will be made available for the Trust Board.

Report Authors:
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Jackie Miller – Senior Information Analyst
Lou Porter – Programme Manager
Rebecca Wassell – Programme Director
Andrew Seaton – Director of Safety

Presenting Executive: Eric Gatling – Director of Service Delivery

Date: 20th September 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
PUBLIC BOARD MEETING FRIDAY 30th SEPTEMBER 2016
Gallery Room, Gloucestershire Hospital commencing at 9.00 a.m

Report Title									
NURSE AND MIDWIFERY STAFFING SEPTEMBER 2016									
Sponsor and Author(s)									
Maggie Arnold – Executive Director of Nursing and Midwifery									
Audience(s)									
Board members	**x**	Regulators	**x**	Governors	**x**	Staff	**x**	Public	**x**

Executive Summary

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 August 2016.

Key issues to note

The divisional nursing directors have analysed their department's data and have individually responded for the purpose of this report. We have also recently reviewed the data methodology from NHS England for the Safer

Staffing tool, including the denominator previously agreed. For the October report, the new methodology will be utilised, which will result in a much closer comparator, and therefore help remove the over percentaging seen in some wards, i.e. over the 120% staffing.

Conclusions

Numbers of deployed staff are reflective of the patients and their acuity in the clinical areas more analysis needs to be done on the data regarding harm and the safety thermometer.

Implications and Future Action Required

Recruitment continues to be our biggest challenge and ideas to employ others to do nursing type jobs needs to be escalated to release nurses to care for patients at the bedside.

Recommendations

The Board is asked to note progress made on the new reporting template and actions within.

Impact Upon Strategic Objectives

Patient numbers and the required increase staffing to care for them impacts both on patient experience and on finance.

Impact Upon Corporate Risks

As above

Regulatory and/or Legal Implications

Equality & Patient Impact

Resource Implications			
Finance	x	Information Management & Technology	
Human Resources	x	Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval	x	For Information	x

Date the paper was presented to previous Committees					
Quality & Perforamnce Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
				x	

MAIN BOARD – SEPTEMBER 2016

NURSE AND MIDWIFERY STAFFING AUGUST 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 August 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.

3.1 Findings

The Divisional Nursing Directors have analysed their Department's data and have individually responded for the purpose of this report. We have also recently reviewed the data methodology from NHS England for the Safer Staffing tool, including the denominator previously agreed. For the October report, the new methodology will be utilised, which will result in a much closer comparator, and therefore help remove the over percentaging seen in some wards, i.e. over the 120% staffing.

3.2 Surgical Division

3.2.1 Nursing Metrics Focus

From a nursing metrics performance, all areas scored GREEN

3.2.2 Safer Staffing Focus

All areas, except for both the Departments of Critical Care (DCC), are GREEN. The RED score within DCC does not indicate poor staffing, rather that due to flexing staff off during quieter periods, this calculates as RED against their set shift cover totals.

3.2.3 Care Hours per Nursed Day Focus

The Division are awaiting advice from NHS Improvement on how to benchmark the new additional collection of the Care Hours Per Nursed Day. The sum is the number of nursing hours within the 24 hour period divided by the bed occupancy for the area at Midnight.

3.2.4 Harm free Care Focus

Harm free care for Surgery was 94.22% overall, from a patient population of 277 audited. There were 16 patients (5.75%) with one harm. 9 were pressure ulcers (of which 3 were hospital acquired), 5 patients with catheter associated urinary tract infections, 1 fall and 1 new VTE.

	'All England' Median	GHNHSFT	Surgery GHNHSFT
Pressure Ulcers (All)	4.59%	3.78%	3.25%
Pressure Ulcers (New)	1%	0.86%	1.08%
Falls (All)	1.83%	1.69%	0.72%
Falls (With Harm)	0.7%	0.58%	0.36%
Catheterisation	12.87%	18.03%	27.0%
Catheter and UTI	0.82%	1.49%	1.81%
VTE Risk Assessment	45.99%	95.48%	98.19%
VTE Prophylaxis	35.4%	94.56%	93.5%
Patients with New VTE	0.41%	0.24%	0.36%
Harm Free Care (All Harms)	93.68%	93.92%	94.22%
Harm Free Care (New Harms)	97.57%	97.63%	98.19%

NB The comparison is against an "All England" median not an "All England Surgical" median

Green	Equal to or better than All England and GHNHSFT
Amber	Worse than either All England or GHNHSFT
Red	Worse than both All England & GHNHSFT

Focus continues on catheterisation, and associated UTI. The new Catheter Passport will help in reducing this number, as will Enhanced Recovery after Surgery (ERAS) schemes. There was a failed attempt to reduce catheterisation in hip and knee surgery, which resulted in post-operative incontinence. Work to reduce catheters in post-surgery orthopaedic surgery continues to find the right balance against catheterisation and patient incontinence. Prevention of pressure ulcer work continues alongside the trust strategy.

3.3 Medical Division

3.3.1 Nursing Metrics Focus

From a nursing metrics performance, all areas scored GREEN with the exception of 7A which triggered amber for EWS, falls and pressure ulcers.

Early Warning Score (EWS) - New staff are being booked to shadow the acute care response team to ensure they have a greater awareness of EWS scoring and the importance of accurate recording and documentation. Spot audits of 3 sets of patient documentation are done daily by the ward managers and the Matron Bruce is developing 'prompt cards 'which will include EWS.

Falls – Ongoing training on equipment and patient assessment continues on all wards across the division. 4A is focussing on falls action audits which aim to provide accelerated learning at the point of care delivery. Patient movement monitors are also in use on most wards.

3.3.2 Safer Staffing Focus

All areas scored green across the division.

3.3.4 Care Hours per Nursed Day Focus

Similar to all the Divisions advice from NHS Improvement is awaited on how to benchmark the new additional collection of the Care Hours Per Nursed Day. The sum is the number of nursing hours within the 24 hour period divided by the bed occupancy for the area at Midnight.

3.3.4 Harm free Care Focus

Harm free care for Medicine was 92.20% overall, from a patient population of 436 audited. There were 33 patients (7.57%) with one harm event and 1 patient 0.23% with two harm events. This was due to pressure ulcers and inpatient falls.

	'All England' Median	GHNHSFT	MEDICINE GHNHSFT
Pressure Ulcers (All)	4.59%	3.78%	6.65%
Pressure Ulcers (New)	1%	0.86%	1.83%
Falls (All)	1.83%	1.69%	1.61%
Falls (With Harm)	0.7%	0.58%	0%
Catheterisation	12.87%	18.03%	9.4%
Catheter and UTI	0.82%	1.49%	0.23%
VTE Risk Assessment	45.99%	95.48%	94.95%
VTE Prophylaxis	35.4%	94.56%	87.16%
Patients with New VTE	0.41%	0.24%	0.69%
Harm Free Care (All Harms)	93.68%	93.92%	92.02%
Harm Free Care (New Harms)	97.57%	97.63%	97.25%

NB The comparison is against an "All England" median not an "All England Medicine" median

Green	Equal to or better than All England and GHNHSFT
Amber	Worse than either All England or GHNHSFT
Red	Worse than both All England & GHNHSFT

The Division continue to focus on prevention of pressure ulcers, falls and VTE. Each month wards that have had cases of patients who develop a hospital acquired pressure ulcer are invited to share the root cause analysis and learning points with peers. VTE remains a challenge on the Acute Care Unit A at GRH. This is linked to the high turnover and current medical vacancies. Nursing staff and pharmacists are working the Consultant leads to improve performance which although is below GHFT target is performing substantially better than the all England median.

3.3.5 Finance and Vacancy Focus

In August 2016, the spend on agency is £696.5K in the month. Vacancy position in Medicine has improved slightly in month. The bottom line Nursing staffing vacancies within the division at month 5 is 116.28wte (11.2%). This includes bank funding of 50.25wte. The vacancy is split 112.30wte qualified staff vacancies offset by an over establishment of 46.17wte unqualified staff (these staff include overseas registered nurses awaiting NMC registration).

3.4 Women & Children's Division

3.4.1 Safer Staffing Focus

Within women and Children's Division currently safer staffing returns are reported for five areas only; Stroud Maternity, The Neonatal/Special Care Baby Unit, Children's in Patients, 2a and the Maternity ward at Gloucestershire Royal. Plans are in place to extend the collection of data to all intrapartum care areas in keeping with the latest guidance. However it is difficult to provide meaning full data for these areas namely the Delivery Suite and Birth Units at Stroud, Gloucester and Cheltenham as staffing levels fluctuate through the 24 hour period according to activity.

In August only Children's in Patients flagged as Red with an average fill rate of 48% based on the August data. As a result the Bonus payment previously piloted to incentivise staff to work additional hours has been re-launched to assist in addressing these shortfalls. All other areas were green and showing 100% compliance with Safer Staffing.

3.4.2 Care Hours per Nursed Day Focus

Further guidance is still awaited from NHS Improvement on how to benchmark the new additional collection of the Care Hours Per Nursed Day. The sum is the number of nursing hours within the 24 hour period divided by the bed occupancy for the area at Midnight. It is not clear how appropriate this will be as a measure particularly within Paediatrics Maternity services were mid night occupancy really reflects activity due to the rapid turnover of patients and short length of stay .

3.4.3 Harm free Care Focus

In August 2a the gynaecology ward reported 81.25% harm free care, 2 patients had a fall (12.50%), 1 had a urinary tract infection associated with catheterisation (6.25%). On a sample size of 16 it is difficult to make any meaningful comparisons with national or Trust bench marks on one month's data. The table below shows some bench marks but these should be interpreted with caution as they are not from similar services, more work is being done to obtain more comparable data from women and children's services for future reports comparisons. Falls have not been a trend in previous Harm free care reports, but the Divisional Nursing Director will review relevant datix reports to obtain a more accurate assessment of any possible trends. UTI associated with catheterisation have been more frequently reported in past months and further work is required to monitor and reduce such incidents

	'All England' Median	GHNHSFT	W & C GHNHSFT
Pressure Ulcers (All)	4.59%	3.78%	0%
Pressure Ulcers (New)	1%	0.86%	0%
Falls (All)	1.83%	1.69%	1.9%
Falls (With Harm)	0.7%	0.58%	1.9%
Catheterisation	12.87%	18.03%	13.33%
Catheter and UTI	0.82%	1.49%	0.95%
VTE Risk Assessment	45.99%	95.48%	54.29%
VTE Prophylaxis	35.4%	94.56%	31.43%
Patients with New VTE	0.41%	0.24%	0%
Harm Free Care (All Harms)	93.68%	93.92%	97.14%
Harm Free Care (New Harms)	97.57%	97.63%	97.14%

NB The comparison is against an "All England" median not an "All England Women & Children" median

Green	Equal to or better than All England and GHNHSFT
Amber	Worse than either All England or GHNHSFT
Red	Worse than both All England & GHNHSFT

3.4.4 Finance and Vacancy Focus

The ward currently has a six bed day case unit open to provide additional bed capacity for general medical and surgical patients in times of escalation and is relying on temporary staff to maintain staffing level for this area. Continued use of the Gynaecology Day Surgery Unit as an inpatient bed base during escalation continues to have had a negative impact on both moral and retention of staff on the ward and the pay budget making staffing the area and maintaining high standards of nursing care extremely challenging

The planned reduction in the bed base over the summer within children's in patients is continuing until October. 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 continues to be positive and we anticipate seeing a significant fall in the use of agency staff as a result.

3.5 Diagnostic & Specialist Division

3.5.1 Nursing Metrics Focus

From a nursing metrics perspective all areas were green. Lilleybrook ward has experienced a period of increased incidence of Clostridium Difficile, this remains under investigation, the outcome will be reported to the trust ICC in September.

3.5.2 Safer Staffing Focus

Both oncology wards scored green for staffing.

3.5.3 Care Hours per Nursed Day Focus

Our Trust are still waiting for advice from NHS Improvement on how to benchmark the new additional collection of the Care Hours Per Nursed Day.

3.5.4 Harm Free Care Focus

Lilleybrook was below the 100% target due to a pressure ulcer originally graded at 3. This was incorrect and has been regraded to 2. There were no moderate or significant harm falls during this period. The Division will continue to review its VTE workings to improve prophylaxis percentages.

	'All England' Median	GHNHSFT	D&S GHNHSFT
Pressure Ulcers (All)	4.59%	3.78%	7.5%
Pressure Ulcers (New)	1%	0.86%	2.5%
Falls (All)	1.83%	1.69%	2.5%
Falls (With Harm)	0.7%	0.58%	0%
Catheterisation	12.87%	18.03%	2.5%
Catheter and UTI	0.82%	1.49%	0%
VTE Risk Assessment	45.99%	95.48%	95%
VTE Prophylaxis	35.4%	94.56%	75%
Patients with New VTE	0.41%	0.24%	0%
Harm Free Care (All Harms)	93.68%	93.92%	92.5%
Harm Free Care (New Harms)	97.57%	97.63%	97.5%

NB The comparison is against an "All England" median not an "All England Diagnostics and Specialists" median

Green	Equal to or better than All England and GHNHSFT
Amber	Worse than either All England or GHNHSFT
Red	Worse than both All England & GHNHSFT

3.5.5 Finance and Vacancy Focus

The current establishment is showing over establishment; however maternity leave and other absence mean that in reality this enables minimal use of agency and bank for cover. The centre does flex staff according to acuity particularly on Rendcomb ward which has the 8 bedded Neutropenic unit and high dependency patients. The training pathway for oncology nurses in the centre is attributed as the reason retention in nursing is effective there.

4 Supporting the Registered Nursing Workforce

Divisional nursing directors have met and discussed options that could support the registered nurse vacancy challenge whilst ensuring positive patient care and experience and that of staff.

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.

The following table provides an update on the last Board report, on current position. As before, no nurse or midwife within our Trust has 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	0

			staff)	
JULY 2016	114	112	1 & 1	0
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 Domestic Recruitment

- There are currently 26 experienced UK-based Band 5 nurses in the recruitment pipeline, with start dates between August 2016 and March 2017, plus 11 nurses from the European Union due to start with us after completing their IELTS examinations.
- There are currently 12 live Band 5 Registered Nurse advertisements open on NHS Jobs.
- Advertisements for Newly-Qualified Nurses and ODPs were published on 08 August and will close on 04 September. At the time of writing (31 August), the number of applications was as follows:

Job	Applications	In Progress	Total
Adult Nurses	14	15	29
Paediatric Nurses	1	0	1
Neonatal Intensive Care Unit	5	5	10
Theatres, Recovery and Day Surgery Unit	9	3	12
Total	**29**	**23**	**52**

Note: It is not clear whether all applicants are eligible to apply. Some candidates may have applied for multiple positions.

6.2 Overseas Recruitment

6.2.1 <u>November 2015 Campaign</u>

- The first nurses joined the Trust on 16 May 2016, and since then there has been a total of six nurses commence employment. A further two nurses are joining the Trust on 19 September 2016, with three more nurses awaiting their visa issuance. It is hoped that all five nurses will start together in mid-September.
- Of the six nurses that have commenced employment, none have yet taken the OSCE examination. The OSCE examination must be passed within eight months of arriving in the United Kingdom.

Status	Candidates
Commenced employment	6
Awaiting deployment	2
Passed IELTS and CBT exams, accepted by the NMC, waiting for visa application	5
Passed IELTS and CBT exams, waiting for NMC decision letter	8
Passed IELTS examination, waiting for CBT examination	3
Not passed the IELTS examination	91
Total (minus withdrawn candidates)	**115**

6.2.2 May 2016 Campaign

Status	Candidates
Passed IELTS and CBT exams, waiting for NMC decision letter	4
Passed IELTS examination, waiting for CBT examination	7
Not passed the IELTS examination	73
Total (minus withdrawn candidates)	**84**

6.2.3 September 2016 Campaign

- A third recruitment campaign in the three main island groups in The Philippines takes place between 03 September and 18 September, with interviews planned in Manila (Luzon), Cebu (the Visayas) and Davao (Mindanao).
- There are currently 175 candidates identified for interview, with 28 in Davao, 26 in Cebu, and 121 in Manila. Our overseas recruitment partner is continuing to source candidates, with a target of at least 200 interviews over the two week period.
- The team interviewing in The Philippines will be:
    - Adam Kirton, Head of Recruitment
    - Sue McShane, Matron for General and Old Age Medicine
    - Jerome Ibarra, Senior Charge Nurse for Ward 9b
    - Louise Wiggins, Senior Sister for Alstone Ward
    - Rowena Bernardo, Sister for Endoscopy at CGH

6.3 Nursing Workforce Metrics

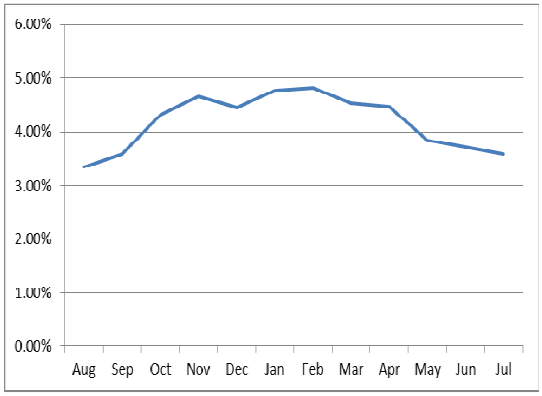
The vacancy data shows a significant increase in Band 2 staffing numbers, an increase in the over establishment from 48.67 WTE to 87.48 WTE. This is partly due to significant recruitment of Newly Qualified Nurses who have joined the Trust as a Band 2 Nurse Awaiting PIN in the first instance. The remaining additional Band 2 nursing staff have been specifically recruited to assist registered nurses in providing basic nursing care and helping to relieve some of the pressure on registered staff. Band 5 vacancies remain high across the Trust, and Band 6 vacancies continue at a manageable level.

Division	Band 2 Vacancies		Band 5 Vacancies		Band 6 Vacancies	
Diagnostic & Specialties	0.75	1.47%	-4.98	overestablished	4.08	10.38%
Medicine	-41.16	overestablished	106.26	22.79%	6.34	4.57%
Surgery	-41.25	overestablished	64.33	11.66%	0.03	0.03%
Women & Children	-5.82	overestablished	0.59	0.49%	17.37	7.39%

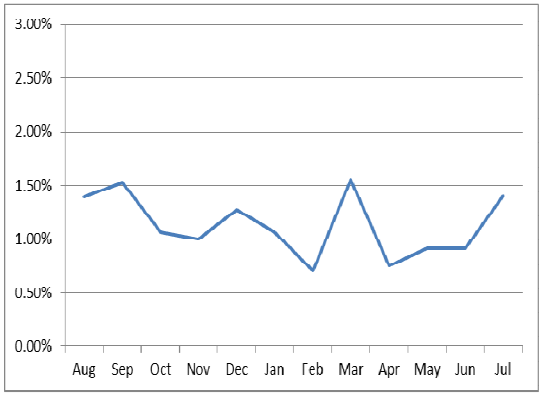
Data Note: Data for this table is from 31 July 2016. Women & Children data include Midwives.

Division	Sickness		Turnover		Maternity	
	RGNs	HCAs	RGNs	HCAs	RGNs	HCAs
Diagnostic & Specialties	4.42%	4.71%	9.14%	16.44%	3.77%	1.88%
Medicine	3.62%	5.45%	18.32%	19.35%	3.72%	3.91%
Surgery	4.50%	4.07%	11.54%	17.23%	4.17%	2.17%
Women & Children	4.13%	3.45%	14.43%	9.57%	3.76%	3.81%

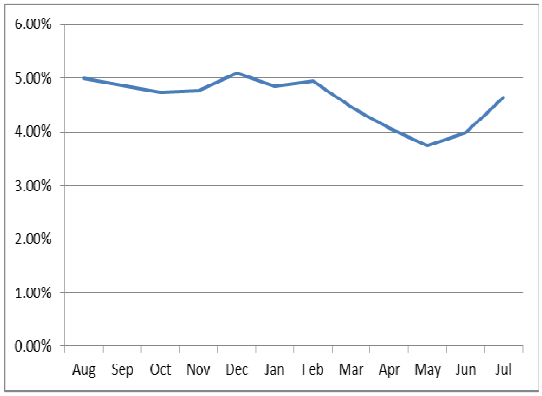
Data Note: 12 month rolling data.



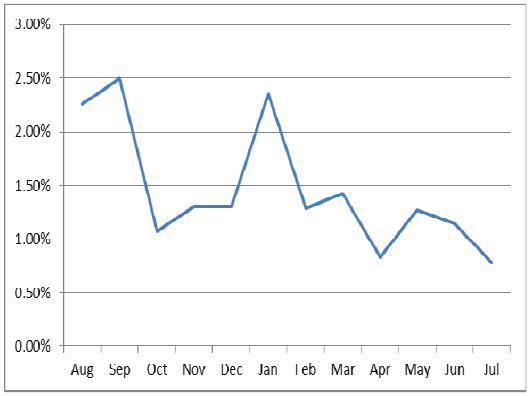
RGN: Sickness Absence by Month (Aug 15 – Jul 16)



RGN: Turnover by Month (Aug 15 – Jul 16)



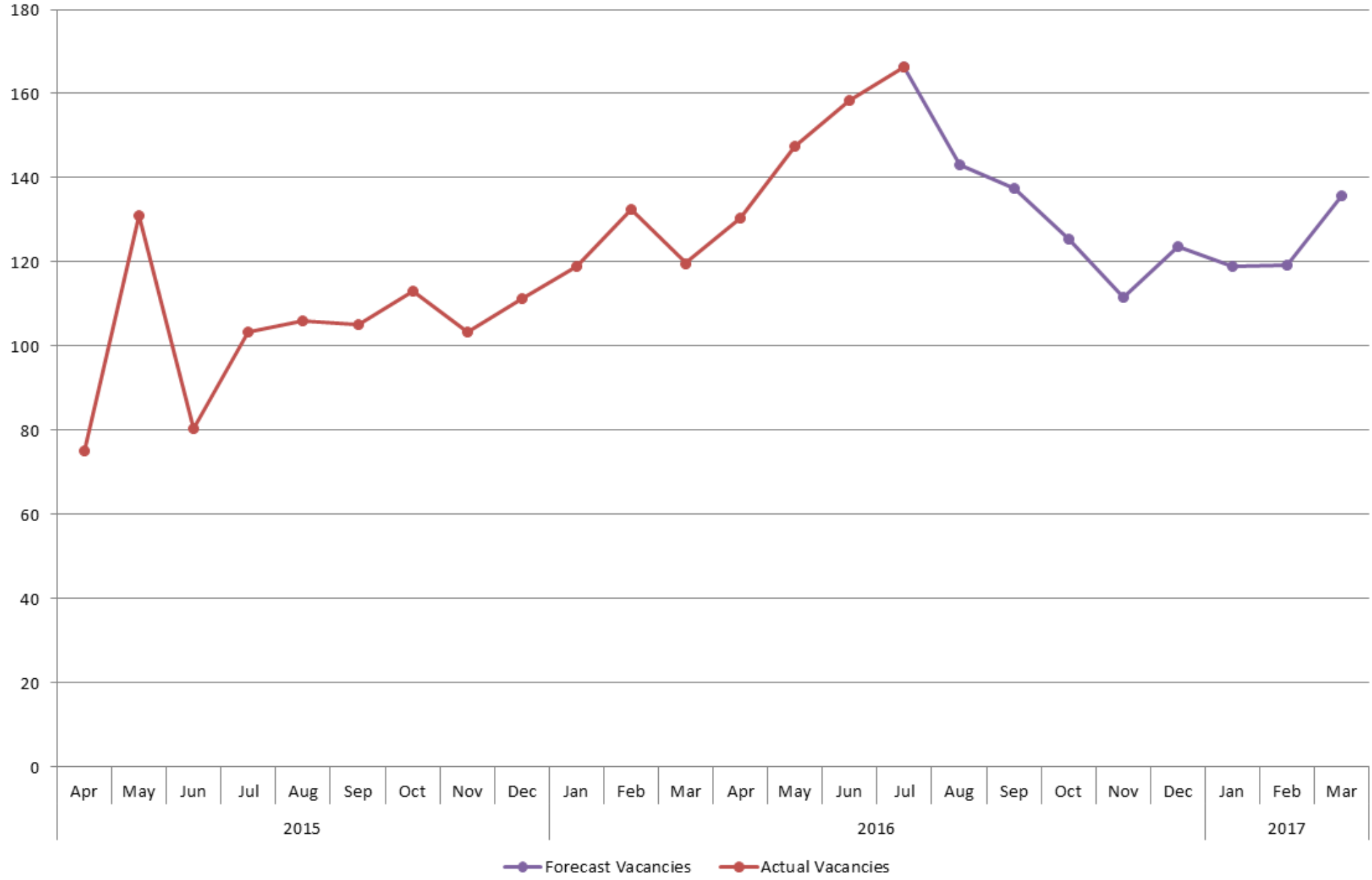
HCA: Sickness Absence by Month (Aug 15 – Jul 16)



HCA: Turnover by Month (Aug 15 – Jul 16)

6.4 Vacancy Forecast

- The number of Band 5 nurse vacancies has increased for the fourth successive month, in line with forecasted expectations. There are currently 166.20 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.
- A large number of Newly-Qualified Nurses have joined the Trust in the last eight weeks, and the data next month is expected to show the first decrease in vacancies since March 2016.
- The establishment has reduced by 1.93 WTE posts this month. This represents the first decrease in establishment since November 2015. During this same period, 42.34 WTE nursing posts have been added to the Trust at Band 5.


180
160
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Dec
Jan
Feb
Mar
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 endorse this report.

Authors:

Divisional Nursing Directors and Adam Kirton (Nursing Recruitment)

Presenting Director:

Maggie Arnold Director of Nursing & Midwifery

15th August 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
PUBLIC BOARD MEETING FRIDAY 30th SEPTEMBER 2016
Gallery Room, Gloucestershire Hospital commencing at 9.00 a.m

Report Title									
COMBINED BOARD ASSURANCE FRAMEWORK & TRUST RISK REGISTER									
Sponsor and Author(s)									
Andrew Seaton – Director of Safety									
Audience(s)									
Board members	√	Regulators		Governors		Staff		Public	

Executive Summary

Purpose

The Board Assurance Framework 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. 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.

Key issues to note

Trust risks have been associated with the risk to the Strategic objectives, updates have been added by Executive leads.

Conclusions

To note the potential risks to the 2016/17 objectives and the controls in place to mitigate these risks.

Implications and Future Action Required

To improve the assurance process a new executive group will be developed to oversee the BAF and Trust risk register.

Recommendations

To note the report

Impact Upon Strategic Objectives

The report identifies the risk and mitigation to the Strategic objectives

Impact Upon Corporate Risks

The Trust risk register is included in the report

Regulatory and/or Legal Implications

None

Equality & Patient Impact

None

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance	√	For Approval		For Information	

Date the paper was presented to previous Committees					
Quality & Performance Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD SEPTEMBERr 2016

COMBINED BOARD 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: **September 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? ↑ ↓ ↔
Potential Risk Exposure	**Related risks on Trust Risk Register**				
Key potential risks that may occur during the year and have a significant effect on achieving the annual plan.	Current risks that are related to the Principle risk and\or potential risks that have occurred.				

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	↔

Potential Risk Exposure	Related risks on Trust Risk Register				
1. Unexpected high mortality data linked to variation in practice. 2. Technical failure of TrakCare to deliver clinical benefits to reduce variation	N17 The risk of providing care outside of the licence or capacity of the Trust because of an increasing number of adolescents (12-17yrs) presenting with self harming behaviour.	S118 An increased patient safety risk, a reduced patient experience and a negative effect on Day surgery activity and efficiency, as a consequence of increased emergency activity	F7 The risk of delayed treatment and diagnosis causing harm because of a backlog of follow-up appointments in a number of specialities- Neurology, Cardiology Rheumatology and Ophthalmology	C3 Risk arising from the sequence of surgical related Never Events leading to potential regulatory intervention.	S127 The risk of potential suboptimal care standards as a cause of the higher than national average mortality for Fractured neck of femur
	M1a The clinical risk of delay in treating patients arriving at ED during periods of high demand or staff shortage	M1 The risk to the safety and efficiency of ED and the emergency pathway due to the inability of the local health and social care system to manage demand within the current capacity leading to a significant fluctuation of attendees in ED	DSP2288 The risk of failure to deliver required standards for End of Life care due to Inadequate staffing capacity to cover workload growth	Blank	Blank

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	↔

Potential Risk Exposure	Related risks on Trust Risk Register				
1. An unexpected political process leading to purdah. 2. Unexpected significant	S100 The risk of failure to manage rising demand without increased capacity leading to failure to meet	C12 Risk of significant affects to flow and statutory standards because of delayed discharge of patients who are on	F7 The risk of delayed treatment and diagnosis causing harm and because of a backlog of follow-up	M1b The risk of a deficit of appropriate skill mix to deliver safe and effective care	Blank

deterioration in clinical services requiring urgent service change	62day cancer standard with the consequence of delayed treatment and increasing risk of regulatory intervention	medically fit list above the agreed 40 limit	appointments in a number of specialities- Neurology, Cardiology Rheumatology and Ophthalmology	as a consequence of the lack of availability of key groups of staff.	
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	Ongoing
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	↔

Potential Risk Exposure	Related risks on Trust Risk Register				
1.Revised STP footprint that would challenge existing clinical networks	S100 The risk of failure to manage rising demand without increased capacity leading to failure to meet	C12 Risk of significant affects to flow and statutory standards because of delayed discharge of patients who are on	F7 The risk of delayed treatment and diagnosis causing harm and because of a backlog of follow-up	M1b The risk of a deficit of appropriate skill mix to deliver safe and effective care	Blank

	62day cancer standard with the consequence of delayed treatment and increasing risk of regulatory intervention	medically fit list above the agreed 40 limit	appointments in a number of specialities- Neurology, Cardiology Rheumatology and Ophthalmology	as a consequence of the lack of availability of key groups of staff.	
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
Potential Risk Exposure	**Related risks on Trust Risk Register**				
None	HR2b The risk of sub-optimal patient care due to high level of nursing vacancies, particularly in Medicine.	M1b The risk of a deficit of appropriate skill mix to deliver safe and effective care as a consequence of the lack of availability of key groups of staff.	F2 The risk of failure to reduce agency costs as a consequence of Workforce shortages	Blank	Blank

	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 beds and extra use of temporary 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) 9. Countywide system call 10. Infection control\Flu plan	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	**Director of Nursing** **Quality Committee**	1. Recruitment Standards(1) 2. Trust Education programmes (1) 3. Nursing & Midwifery Strategy (2)	1. Directors statement (2) 2. Divisional Quality Report (1) 3. Family & Friends Test (3) 4. Patient Surveys (3)	None	4x4=16

manage flow and bed pressures		4. Patient Experience 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)	5. Formal comments – 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	↑
Potential Risk Exposure	**Related risks on Trust Risk Register**				
1. Prolonged outbreak of Infection. 2. Industrial action	N17 The risk of providing care outside of the licence or capacity of the Trust because of an increasing number of adolescents (12-17yrs) presenting with self harming behaviour.	S118 An increased patient safety risk, a reduced patient experience and a negative effect on Day surgery activity and efficiency, as a consequence of increased emergency activity	F7 The risk of delayed treatment and diagnosis causing harm because of a backlog of follow-up appointments in a number of specialities- Neurology, Cardiology Rheumatology and Ophthalmology	M1a The clinical risk of delay in treating patients arriving at ED during periods of high demand or staff shortage	C11 The risk of suboptimal patient experience due to the failure of timely transport arrangements provided by the Commissioner lead contract with ARRIVA
	M1b The risk of a deficit of appropriate skill mix to deliver safe and effective care as a consequence of the lack of availability of key groups of staff.	Blank	Blank	Blank	Blank
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** **Quality & 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	**4x4=16** (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** **Quality & 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. Gloucestershire A&E Delivery Board (3) 9. Sustainability & Transformation Plan 10. 2016-17 QIPP plans	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 and actual activity.	None	↔

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 & Medical Director** **Quality & Performance committee**	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	↔
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** **Quality & Performance committee**	5. Planned Care Plan(2) 6. Individual specialty recovery plans (1) 7. CCG contract (3) 8. CCG performance review (3)	2. Performance Management Report (2)	None	4x3=12
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			2. Reporting line to F&P	None	↔

Potential Risk Exposure	Related risks on Trust Risk Register				
1. Prolonged outbreak of Infection. 2. Industrial action 3. Adverse weather	S118 An increased patient safety risk, a reduced patient experience and a negative effect on Day surgery activity and efficiency, as a	M1c The risk of suboptimal care and inability to meet statutory standards when the the hospital is at full capacity with limited ability to accommodate	C12 Risk of significant affects to flow and statutory standards because of delayed discharge of patients who are on	F7 The risk of delayed treatment and diagnosis causing harm because of a backlog of follow-up	M1 The risk to the safety and efficiency of ED and the emergency pathway due to the inability of the local

	consequence of increased emergency activity	surges in admissions	medically fit list above the agreed 40 limit	appointments in a number of specialities- Neurology, Cardiology Rheumatology and Ophthalmology	health and social care system to manage demand within the current capacity leading to a significant fluctuation of attendees in ED

	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	Now part of the Emergency Care Plan
3	Response to NHSI investigation	Director of Service Delivery	End of July 2016	Completed
4	Revise reporting arrangements to F&P	Director of Service Delivery	August 2016	Completed

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 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) 7. 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	↑

Potential Risk Exposure	Related risks on Trust Risk Register				
To be revised	HR2b The risk of sub-optimal patient care due to high level of nursing vacancies, particularly in Medicine.	M1b The risk of a deficit of appropriate skill mix to deliver safe and effective care as a consequence of the lack of availability of key groups of staff.	F2 The risk of failure to reduce agency costs as a consequence of Workforce shortages	Blank	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	

Potential Risk Exposure	Related risks on Trust Risk Register				
To be revised	M1b The risk of a deficit of appropriate skill mix to	F2 The risk of failure to reduce agency costs as a	Blank	Blank	Blank

	deliver safe and effective care as a consequence of the lack of availability of key groups of staff.	consequence of Workforce shortages			
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	**3x4=12** **(2x4=8)**
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			Blank	Blank	Blank
Potential Risk Exposure	**Related risks on Trust Risk Register**				
1. Unexpected decline or finding of unfit for purpose inspection of the estate. 2. Sudden damage to estate.	IT2246 The risk of Operational disruption caused by loss of critical business systems due to failure of the ageing IT network infrastructure.	DSP1347 The risk of the inability to maintain business continuity in a key clinical area(oncology) if the OPMAS computer systems fails prior to replacement	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	↔
Potential Risk Exposure	**Related risks on Trust Risk Register**				
1. Provider of Trakcare service being adversely	IT2246 The risk of Operational disruption caused by loss	DSP1347 The risk of the inability to maintain business continuity	Blank	Blank	Blank

affected. 2. Failure of system at other sites	of critical business systems due to failure of the ageing IT network infrastructure.	in a key clinical area(oncology) if the OPMAS computer systems fails prior to replacement			
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	↔
Potential Risk Exposure	**Related risks on Trust Risk Register**				
1. Capacity of L&OD to deliver plan	HR2b The risk of sub-optimal patient care due to high level of nursing vacancies, particularly in Medicine.	M1b The risk of a deficit of appropriate skill mix to deliver safe and effective care as a consequence of the lack of availability of key groups of staff.	F2 The risk of failure to reduce agency costs as a consequence of Workforce shortages		

	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 Oct 16	Divisions asked to submit plans by end July.
2	Triangulate appraisal scores with Talent pool nominations	DS	Sept 16 Oct 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	**3x4=12** 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)	↔
Potential Risk Exposure	**Related risks on Trust Risk Register**				
1. Inability to recruit sufficient nurses to plan 2. Failure of overseas staff to satisfy UK registration requirements. 3. Sudden or unplanned loss of specialist staffing that affects the delivery of a service 4. Industrial action	HR2b The risk of sub-optimal patient care due to high level of nursing vacancies, particularly in Medicine.	M1b The risk of a deficit of appropriate skill mix to deliver safe and effective care as a consequence of the lack of availability of key groups of staff.	F2 The risk of failure to reduce agency costs as a consequence of Workforce shortages	Blank	Blank
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			Dir HR&OD	August 16	

	Roles and Plan to close Escalation Areas			
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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Trust I Risk Register August 2016

Ref	Risk / Project Title	Controls	Gaps in controls	Assurances / Monitoring	Lead for Risk / Project	Review date	Highest scoring Domain	Consequence (current)	Likelihood (current)	Risk level (current)	Risk level (Target)
N17	The risk of providing care outside of the licence or capacity of the Trust because of an increasing number of adolescents (12-17yrs) presenting with self harming behaviour. These patients are admitted because of required medical care but stay longer periods of time in the acute (paediatric or adult) wards as there appears to be insufficient facilities for their mental health care.	1. The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients. 2. Relevant extra staff are brought in during admission periods to support the care and supervision of these patients. 3. CQC\commissioners have been made formally aware of the risk issues.	None	The Quality Committee will receive six monthly updates of the risk controls	Arnold, Maggie	30/09/2016	Patient, Staff Safety, Statutory Duty / Regulatory considerations	Catastrophic (5)	Will probably recur, but is not a persistent issue (4)	15 - 25 Extreme risk	8 -12 High risk
S118	An increased patient safety risk, a reduced patient experience and a negative effect on Day surgery activity and efficiency, as a consequence of increased emergency activity (see M1) the Day care unit and other similar non inpatient areas with beds are opened overnight to house inpatients causing	Emergency Care Plan	None	1.Day to day bed management systems including community wide capacity tele-conferences and escalation procedures 2. Available bed capacity based on staff availability 3. Daily senior clinical manager meetings to manage safety, experience and activity whilst unit is open at night 4. Revision of risk assessments evaluating the change in function of the areas	Gatling, Eric	22/09/2016	Patient, Staff Experience, Service / Business interruption, environmental impact	Major (4)	Will undoubtedly recur, possibly frequently (5)	15 - 25 Extreme risk	4 - 6 Moderate risk
F7	The risk of delayed treatment because insuffcient capacity planning in providing follow-up appointments in a number of specialities- Neurology, Cardiology Rhuematology and Ophthalmology	Each specialty has a recovery plan in place		Performance manage the specialties through the OPB Establish individual specialty recovery plans	Gatling, Eric	30/09/2016	Patient, Staff Safety	Major (4)	Will probably recur, but is not a persistent issue (4)	15 - 25 Extreme risk	8 -12 High risk
C12	Risk of significant affects to flow and statutory standards because of delayed discharge of patients who are on medically fit list above the agreed 40 limit	Emergency Care plan	Internal tracking of patient pathway	Monitoring by ECB, F&P and Systems resilience group Reports - Emergency Pathway report	Gatling, Eric	22/09/2016	Finance, Patient, Staff Experience, Patient, Staff Safety, Service / Business interruption, environmental impact	Major (4)	Will undoubtedly recur, possibly frequently (5)	15 - 25 Extreme risk	8 -12 High risk
C11	The risk of suboptimal patient experience due to the failure of timely transport arrangements provided by the Commissioner lead contract with ARRIVA	Agreed recovery plan and monitoring	None	Weekly performance dashboard Regular contract performance meetings Sharing of individual patient stories	Gatling, Eric	07/09/2016	Patient, Staff Experience	Moderate (3)	Will undoubtedly recur, possibly frequently (5)	15 - 25 Extreme risk	4 - 6 Moderate risk

F2	The risk of failure to reduce agency costs as a consequence of Workforce shortages	1. Overseas recruitment plan 2. Pilot of extended Bank office hours 3. Temporary staffing short life work group 4. Bank incentive payments 5. General and Old Age Medicine Recruitment and Retention Premium 6. Master vendor for medical locums 7. Temporary staffing tool self assessment	Workforce Committee to be created to provide monitoring and assurance	Establishing new Workforce Committee and reporting to Trust Board	Smith, David	30/09/2016	Finance, Human Resources / Workforce	Major (4)	Will undoubtedly recur, possibly frequently (5)	15 - 25 Extreme risk	8 -12 High risk
S127	The risk of potential suboptimal care standards as a cause of the Fractured neck of femur mortality rates being above national average for GRH	External review scheduled (end of June), MDT for Mortality instated.	None	MDT/M&M, external review, Detailed action plan based on internal and external review monitored by Div Surg Board and Quality Committee	Elyan, Sean	26/08/2016	Patient, Staff Safety, Statutory Duty / Regulatory considerations	Major (4)	Will probably recur, but is not a persistent issue (4)	15 - 25 Extreme risk	8 -12 High risk
DSp1347 OHPCLI	The risk of the inability to maintain business continuity in a key clinical area(oncology) if the OPMAS computer systems fails prior to replacement	Implementation of manual prescribing systems- resource issues Possiblity of external IT support for OPMAS if internal support not avaialble Programme for stable virtual server Back up server undertaken		Incidnets	Jewell, Frank	28/10/2016	Finance, Patient, Staff Experience, Patient, Staff Safety	Catastrophic (5)	May recur occasionally (3)	15 - 25 Extreme risk	4 - 6 Moderate risk
M1	The risk to the safety and efficiency of ED and the emergency pathway due to the inability of the local health and social care system to manage demand within the current capacity leading to a significant fluctuation of attendees in ED	1. Emergency care Plan, 2. Systems Resilience Group and actions 3. Appointment of Improvement Director 4. Planned Care Plan, 5. STP plans.	Current gap between contracted activity, reduction anticipated as part of QIPP and actual activity.	1. Weekly Emergency Care Board 2. Weekly ED Quality report 3. Monthly Emergency Pathway report	Gatling, Eric	22/09/2016	Patient, Staff Experience, Patient, Staff Safety, Statutory Duty / Regulatory considerations	Catastrophic (5)	Will undoubtedly recur, possibly frequently (5)	15 - 25 Extreme risk	8 -12 High risk

DSp2288 PALL	The risk of failure to deliver required standards for End of Life care due to Inadequate staffing capacity to cover workload growth	1)The band 7 hours have been covered by other team members doing additional hours and also acting up but this adds to the pressures on those individuals. 2)Consultant Locum cover being advertised 3)Issues escalated to Ops Director and Executives. IDT cover for Oncology/haematology requested from EG 4)Business case to increase staffing for palliative care 5)Identified this as a cost pressure 6)Glos Consultant spending time at CGH to support and supervise SpR. Reduced all non-clinical commitments and centralising how any such requests are managed to prioritise what can be done. 7)Other GHTNHSFT Consultant spending 50% of time on each site to support teams 8)Sue Ryder Consultant supporting the South Cotswold Community team 9)Requested IDT support from Ops	None	Agenda item on board meetings Weekly e-mail updates by Pall care consultant Dr Emma Husbands	Jewell, Frank	30/09/2016	Business / Project Objective, Human Resources / Workforce, Patient, Staff Experience	Major (4)	Will probably recur, but is not a persistent issue (4)	15 - 25 Extreme risk	4 - 6 Moderate risk
IT2246	The risk of ageing IT system and infrastructure causing significant Network Vulnerabilities leading to potentially significant breaks in business continuity	1. Secondary links are in place offering reduced capacity. 2. There is a 10 day lead time for replacement components for the out of support and end of life hardware	None	Using SNMPC toolset is used to monitor network connection, in addition components are monitored manually during working hours. IM&T Committee	Pandor, Zack	31/08/2016	Service / Business interruption, environmental impact	Major (4)	Will probably recur, but is not a persistent issue (4)	15 - 25 Extreme risk	4 - 6 Moderate risk
C3	Risk arising from the sequence of surgical related Never Events leading to potential regulatory intervention and the potential	1. Individual Never Events have policies\protocols in place supported by professional competence 2. Near miss Never Events and lessons learnt are reported and monitored at Patient safety Forum. 3. Individual Never Events are reported to the Board and receive a full RCA, action plan and are monitored by Safety & Experience Review Group 4. Standards related to Never Events are periodically reviewed to check compliance 5. Compliance to the WHO checklist in theatres is monitored by the Theatre team 6. Implementation of NatSSIPS programme underway	1. Up to date review of the National standard's related to Never Events 2. NatSSIPs to be fully implemented 3. Orthopaedic theatres FMEA to identify process weaknesses	1. Surgical Division Quality Report - WHO checklist 2. Monitoring of Near miss Never Events at PSF 3. SI Monthly report to TMT,QC & TB 4. SI Annual report and six monthly update 5. Safety & Experience Review Group monitoring SIs	Elyan, Sean	30/09/2016	Statutory Duty / Regulatory considerations	Catastrophic (5)	May recur occasionally (3)	15 - 25 Extreme risk	8 -12 High risk
M1a	The clinical risk of delay in treating patients arriving at ED during periods of high demand or staff shortage	Stream 1 improvement programme in place to address internal safety processes 2. Emergency Care Plan Addressing three main areas of concern: a) demand b) staffing (medical and nursing) c) Beds and capacity 3. Delivery of relevant QIPP plan to reduce attendances	None	1. Weekly Emergency Care Board 2. Weekly safety monitoring report 3. Monthly Emergency Care Pathway report	Gatling, Eric	22/09/2016	Patient, Staff Experience, Patient, Staff Safety	Major (4)	Will undoubtedly recur, possibly frequently (5)	15 - 25 Extreme risk	8 -12 High risk

M1c	The risk of suboptimal care and inability to meet statutory standards when the the hospital is at full capacity with limited ability to accommodate surges in admissions	1. Implement the LOS plan to reduce LOS as part of Emergency Care Plan. 2. Complete Capacity modelling exercise to identify further improvement. 3.Examine wider community alternatives to support capacity surges	None	1. Weekly Emergency Care board. 2. F&P monthly meetings 3. Monthly Emergency Pathway Report 4. PMF report 5. System Resilience Group	Gatling, Eric	22/09/2016	Patient, Staff Safety	Catastrophic (5)	Will undoubtedly recur, possibly frequently (5)	15 - 25 Extreme risk	8 -12 High risk
HR2b	The risk of high level of nursing vacancies, particularly in Medicine.	1. Proactive nurse recruitment strategy 2. Nurse recruitment business case 3. Trained nurse and HCA recruitment facility	Medical vacancies are currently very high Establish People Committee reporting	PMF Executive lead Divisional reviews People Committee	Smith, David	15/09/2016	Human Resources / Workforce	Major (4)	Will undoubtedly recur, possibly frequently (5)	15 - 25 Extreme risk	8 -12 High risk
M1b	The risk of a deficit of appropriate skill mix to deliver safe and effective care as a consequence of the lack of availability of key groups of staff.	1. Monitoring of Medical Locum spend at F&PC 2. Identification of new style medical posts (e.g Chief Registrar)by Medical Education Board. 3. Report to People Committee on progress of plan	1. People committee to be established	People Committee report F&P Locum costs	Elyan, Sean	14/09/2016	Human Resources / Workforce	Major (4)	Will undoubtedly recur, possibly frequently (5)	15 - 25 Extreme risk	8 -12 High risk
S100	The risk of rising demand without increased capacity leading to failure to meet 62day cancer standard with the consequence of delayed treatment and increasing risk of intervention.	1. Improve the access to Patient information on implications of missing appointments 2. Weekly meetings between AGM and MDT Coordinators to discuss pathway management and expedite patients as appropriate. 3. Performance Management at Cancer Management Board 4. Escalation procedure in place to avoid breaches 5. Performance trajectory report for each pathway	Patient choice Clinic capacity	Monitoring through Cancer Management Board 62 Day Recovery Plan	Gatling, Eric	30/09/2016	Statutory Duty / Regulatory considerations	Major (4)	Will undoubtedly recur, possibly frequently (5)	15 - 25 Extreme risk	4 - 6 Moderate risk

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
PUBLIC BOARD MEETING FRIDAY 30th SEPTEMBER 2016
Gallery Room, Gloucestershire Hospital commencing at 9.00 a.m

Report Title									
Staff Survey Action Plans Update									
Sponsor and Author(s)									
Dave Smith									
Audience(s)									
Board members	x	Regulators		Governors		Staff	x	Public	

Executive Summary

Purpose
To update the Board on progress with action plans on the 2015 staff survey.

Key issues to note
Plans for transport/parking solutions still in draft form. Recruitment to the 'handyman' role has not been successful as yet. A campaign has been launched to reduce bureaucracy (with an early example) and the CEO has led from the front with open and transparent communications.

Conclusions
To maintain traction we will need to regularly communicate progress on the 'top 3' issues and to role model the 4th issue of openness and transparency

Implications and Future Action Required
The 2016 staff survey is about to launch and it is important that we seek more frequent ways of testing the staff pulse across the year.

Recommendations

The Board is asked to note progress with the action plans

Impact Upon Strategic Objectives

Staff engagement is intrinsic to all of the strategic objectives given the proven links between employee engagement and patient experience

Impact Upon Corporate Risks

This is a mitigating action to the risk of reduced staff engagement

Regulatory and/or Legal Implications

N/A

Equality & Patient Impact

See above, engaged staff deliver an improved patient experience

Resource Implications

Finance	x	Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval		For Information	x

Date the paper was presented to previous Committees					
Quality & Perforamnce Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – SEPTEMBER 2016

STAFF SURVEY ACTION PLANS UPDATE

1. Aim

1.1 To update the Trust Board on the key corporate action plans agreed at the Trust Board in July 2016 in response to the 2015 annual staff survey findings.

2. Background

The national staff survey results from 2015 strongly reflected the progressive trend in results which had begun in 2012 and whilst this is laudable, these results did not reflect the step-change in engagement that the Trust Board had been seeking. This was particularly disappointing given that the Board had set out its very clear intention that our Trust 'transforms' itself to provide '*Best Care for Everyone*', a vision which itself had been developed following significant engagement with staff at all levels. Engagement continued to steadily improve however each staff survey resulted in an engagement score that had been achieved by the overall system the prior year, but was then surpassed by the continuing improvement nationally.

So why did there remain a disconnect with aspiration to achieve a step-change in engagement and actual delivery? It is true that if you establish a programme of improvement which is more akin to a flywheel than a transformation it is likely that is precisely what you will get. Many of the rolling action plans, whilst very important to building solid foundations and by themselves, quite 'worthy,' did not capture the imagination of staff in a way that caused them to fundamentally assess their engagement with the Trust in a different light. Therefore a new approach was needed and it was determined that the cascade of results and engagement on the findings generally would need to focus very heavily on what truly mattered to staff. In short, what are those issues that if we were able to fix, would really change the day to day experience of our staff in a fundamental and positive way? It was decided therefore to alight on a 'Top 3', mindful of course that our staff are diverse and may well view issues differently and prioritise different things. Notwithstanding that, there were 3 issues that seemed to drive coalescence of opinion and these were brought to the Trust Board for consideration in July;

- Transport/Parking
- Environment
- Reducing Bureaucracy.

Discussions at the Board provided the mandate for these to be adopted and developed as the main action plans for this year with a commitment to track and publicise progress across the year. It was also agreed that a 'fourth' issue be given equal prominence as it seemed to underpin all of the other issues – the need for openness and transparency in decision making with a willingness and ability of Board members to engage in dialogue with staff on how and why decisions had been reached.

3. Progress

3.1 Transport/Parking

This has been a challenging issue for some time and most previous attempts had focused on the parking element of the challenge, rather than recognising that this is more broadly about how all of our staff travel to and from work in a safe manner and eliminating some of those issues which staff find intolerable and stressful, eg arriving at work an hour before the shift starts as the only realistic way of obtaining a parking

spot. In her 'This Week' blog (announcing the staff survey action plan) the CEO cautioned that there would be no 'silver bullet' here, however there is a real commitment to make progress. The transport team within Estates therefore have been developing proposals which when ready, are expected to focus on;

- A completely revised system of permit allocations and classifications
- A rebadging of current spaces to match the new classifications.
- A fresh look at travel to work times and travel to work options
- Retendering of the '99' bus contract dealing with inter-site travel
- Expansion of 'park and ride' options across both Cheltenham and Gloucester not specifically linked to the 99 bus.
- Incentivising car shares
- Development of personal travel plans for those unable to access permits.

These plans will require challenge and refinement in their initial stages but will need to be shared with staff and their representatives at the earliest opportunity. It is expected that broader engagement will commence in October and November as this will enable us to keep testing with staff what is really important to them in this space.

3.2 Environment

One of the frustrations expressed by staff has been the inability to get simple fixes or improvements to their local environment, whether through a lack of resource or a lack of funding. This caused some staff to consider this as a reflection of how they were valued by the Trust. The Board rapidly agreed that two 'handymen' could be employed and assigned to wards and departments on a weekly basis to rapidly deal with those issues that have been building up. At the time of writing it has not been possible to recruit the two individuals, however efforts will now redouble to ensure that we honour this commitment.

3.3 Reducing Bureaucracy

This was articulated by staff in a number of different ways. Some saw it as an expression of unnecessarily convoluted decision making processes, adding both time and complexity. Others saw it as a reluctance to 'let go' of control and a failure to deliver under our promise of devolving leadership through service line management.
An early release of decision making freedom has been the removal of the need for 'Permission to Fill' recruitment forms to be considered at the weekly Directors Group. This has been a popular decision and places decision making in this regard, firmly in the control of the divisions. Whilst this is a 'quick win' it will have very little effect on staff at different levels in the organisation. In itself, it reduces a burden imposed by one set of managers on another which in turn will hopefully stimulate an environment where managers are prepared to cascade freedoms further down the organisation. The CEO has further aided this by making available a small sum of money for each division in the guise of a '*Just Sort it Fund'* which will enable some of the things (but not exclusively so) which may fit into the second work stream (environment) to be dealt with. It is not the quantum but the spirit behind the gesture. Reducing bureaucracy is still an area that requires greater traction and the CEO has issued a personal plea in the September edition of 'Outline', asking staff to provide their ideas on how we can make progress here (Appendix 1). In addition, we will develop this theme through Divisional Executive Reviews so that when we ask Divisions to review and report on their engagement plans, it would be helpful to see as a subset of these plans, how they had helped to simplify processes on a local basis.

3.4 Open and Transparent Decision Making

Much of this underpins the three previous work streams. For example, real engagement will be vital to progress of the first work stream on transport as some challenging decisions may have to be taken and certainly explained. One of the key complaints echoed across the Trust is an occasional lack of clarity as to where

decisions get made, particularly on business cases. Currently the relative positioning of Directors Group, Senior Leadership Team and Efficiency and Service Improvement Board (ESIB) is being established which will lead to greater involvement in and clarity of decision making. In particular, the invitation to 'deputies' to attend when the relevant executive is absent as well as the broadening of membership of the Senior Leadership Team to include divisional operational and nursing representation will aid this. Whatever happens structurally however, the most visible example of transparency comes through tangible actions and the willingness of the CEO to stand in front of staff this month and deliver an honest explanation of our financial situation is the clearest example of taking words and turning them into actions.

4. Next Steps

- CEO and HRD to present to Divisional Engagement Groups (end of September) on the 'top 3' and how they can support in their divisions
- Senior Leadership Team to make initial assessment/refinement of travel options before launching broader engagement in October.
- Outline articles September (Appendix 1) and October to launch 2016 staff survey, reconfirming commitments made by the Board and updating on progress.
- Divisions to consider via their engagement plans how they reduce bureaucracy on a local basis whilst flagging issues requiring a corporate approach
- Future article (November) to build on how 'Just Sort it Fund' has been utilised and how received in the divisions.

5. Conclusion

Continued communication is vital if we are to retain traction. There is a significant window of opportunity afforded via our new CEO in terms of pace and momentum. Early communications via both face to face meetings with staff and the openness of the 'This Week' blog have been very well received, however now staff will need to see the impact of the commitments made. Another key priority will be in agreeing the methodology for testing staff feedback on key issues on a much more regular basis across the year and a separate proposal for doing so will be developed and discussed over the next few months.

6. Recommendations

The Board is asked to **note** progress with the action plans arising from the 2015 staff survey.

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

STAFF ENGAGEMENT

Getting serious about staff engagement

It is a well-known fact that the more engaged staff are in a hospital setting, the better care is for patients.

The Board is absolutely determined to make progress in this area and while good engagement is a two-way process that is often led by individuals on the frontline, it is recognised that the Senior Leadership Team has a role to play in setting an example and encouraging increased participation.

To help on that front we have distilled the results of last year's staff survey and decided to focus our energy on three key outcomes going forward. These are:

- Car parking
- Maintenance
- Bureaucracy

> *"By targeting just three areas we can make maximum impact"*

The theory behind this approach is that by targeting just three areas we can make maximum impact. While some of these targets are complex, multi-faceted and in part out of our control, particularly car parking, we know these are frustrations that staff experience again and again. We also hope that by making real progress in these areas that will feed into a better staff survey result. You can read more about the staff survey on page 8.

For those of you who regularly read 'This Week' or attend the CEO staff meeting, you will be aware that we have already made some good progress in this space.

Car Parking - work in progress

The first issue is to tackle issues around parking - although realistically the actions will encompass a broad range of initiatives to support staff travel to work in the absence of a 'silver bullet' for the parking challenge.

Serious consideration is being given to:

- The regularity, times and size of bus used on the shuttle – particularly at peak times and for night staff
- An extension to park and ride facilities
- Facility to access additional car park capacity at times of system stress
- Plans/incentives for increasing sharers spaces
- Ensuring shift workers don't have to arrive on site at least an hour early to secure a space

Announcements about this issue will follow over the next few months, so watch this space.

Maintenance - Just Sort It!

The second area of focus is to make it easier to get simple things done. Walkabouts in wards and departments over the last few moltnhs have been characterised by staff reflecting how difficult it is to get simple things like shelves, chairs or toasters fixed.

To address this, we are creating a Just Sort It Fund and are in the process of recruiting handy persons who will be available to come to wards and departments to fix things.

Trust finances don't allow this to be significant but nevertheless, a nominated person in each Division (decided by the Division) will be allocated £15,000 to spend on sorting the things that frustrate and demoralise you every day – the sort of things that will never get to the top of a priority list when competing alongside medical equipment and the like but of themselves become expressions of the value we place (or don't place) on you, our staff.

> *"We will soon be looking to drive the programme and hear ideas"*

Chief Executive Deborah Lee said: "We are currently in the process of identifying the custodian of these pots across the organisation and we will soon be looking to drive the programme and hear ideas."

Break down bureaucracy

Thirdly, Deborah has undertaken a personal crusade to reduce the bureaucracy that seems to ensure even the simplest decisions can take weeks and months to make. She says: "I recognise that there can be a fine line between good governance and bureaucracy but from what I've seen we could remove quite a lot of the process and still by some way be the right side of the line."

One of the first initiatives relating to

this is that the Permission to Fill (PTF) process (whereby the Directors Group review all recruitment decisions from a new consultant post to the replacement of a Band 1) has been redesigned.

A review of the impact of PTF forms reviewed by Directors over the last 6 months, showed that less than 2% of requests were turned down and arguably these would have been rejected at Divisional level too. While this isn't permission to run and recruit indiscriminately, going forward, decisions to recruit, based on completed PTF forms, will be taken at Divisional level.

Deborah says: "My personal crusade to rid us of all bureaucracy that doesn't represent good governance continues!

"We want to hear from staff on the best three ways that we can bust bureaucracy. If you have examples of what feels to you like unnecessary bureaucracy, and ideas of how to reduce it, then please drop me a line on the usual email address (deborah.lee@glos.nhs.uk). View it as an amnesty!"

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
PUBLIC BOARD MEETING FRIDAY 30th SEPTEMBER 2016
Gallery Room, Gloucestershire Hospital commencing at 9.00 a.m

Report Title
Complaints and Concerns Quarter 1 2016-17
Sponsor and Author(s)
Heather Beer- Head of Patient Experience Mrs Maggie Arnold, Executive Director Nursing and Midwifery

Audience(s)

Board members	√	Regulators		Governors		Staff		Public	

Executive Summary

Purpose
The aim of this report is to provide information on the complaints and concerns reported to the Trust during Quarter 1 2016/17.

Key issues to note

- There was a reduction in the number of complaints received during Quarter 1 in comparison with previous quarters.
- During the quarter, 208 written complaints were received equating to approximately 0.7 complaints per 1000 total episodes of care
- 99% of complaints were acknowledged within the national standard of 3 working days
- 80% of complaints were formally responded to within our internal standard of 35 working days
- 512 concerns were dealt with via our PALS department during the same period
- The main areas of focus within both complaints and concerns were: communication (verbal and written); appointments (booking system, delays, cancellations); and aspects of clinical treatment
- 2542 compliments were received and formally logged during the quarter
- Learning from both complaints and comments remains a key focus of the complaints management process within the Trust.

Recommendations

To note the Q1 report on written complaints received.

Impact Upon Strategic Objectives

Learning from patient feedback, including complaints and comments, is a core quality objective of our Trust

Impact Upon Corporate Risks

None identified

Regulatory and/or Legal Implications

None identified

Equality & Patient Impact

No adverse impact identified. The Trust works closely with the local patient advocacy service (SEAP) who supports complainants where necessary. We also provide an interpretation service for both foreign language and sign language for complainants with require additional support.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	
None identified			

Action/Decision Required							
For Decision		For Assurance		For Approval		For Information	√

Date the paper was presented to previous Committees					
Quality & Performance Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**
02/09/2016					

MAIN BOARD SEPTEMBER 2016

COMPLAINTS AND CONCERNS QUARTER 1 APRIL TO JUNE 2016

1. Introduction

The aim of this report is to provide information on the complaints and concerns reported to the Trust during Quarter 1 2016/17.

2. Key points

- 208 written complaints received, 0.7/1000 total episodes of care.
- 99% acknowledgement within national standard of 3 days
- 80% response rate within local standard of 35 working days
- 512 concerns dealt with via our PALS department
- Main areas of focus within both complaints and concerns: communication (verbal and written); appointments (booking system, delays, cancellations) clinical treatment
- 2542 compliments received and formally logged during the same period of time

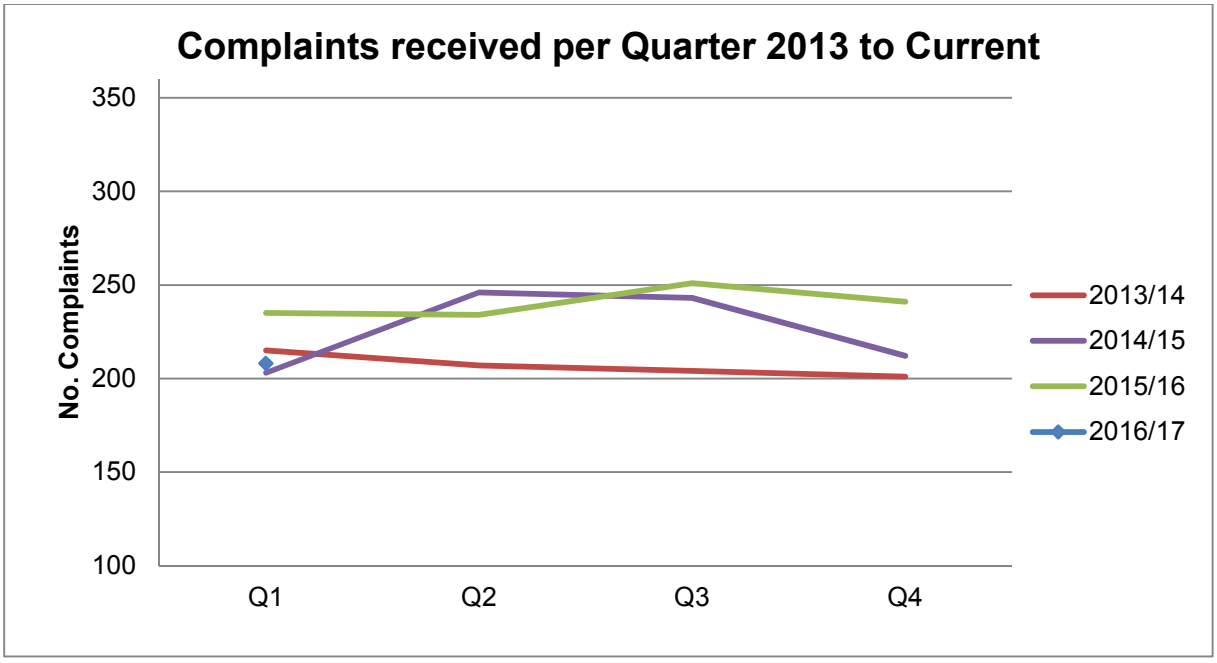
3. Complaints Received during Quarter 1 2016-17

3.1 Number of Complaints Received

During Quarter 1, 2016-17, the Trust received a total number of 208 complaints which equates to an average of approximately 16 complaints per week, a decrease of approximately 14% against the number of complaints received during the previous quarter.

This figure equates to 4.48 complaints per 1000 inpatient episodes or 0.73 complaints per 1000 total episodes of care (includes all inpatients, outpatients and ED attendances). The Trust received a total of 2542 compliments as notified by all hospital areas during Quarter 1.

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

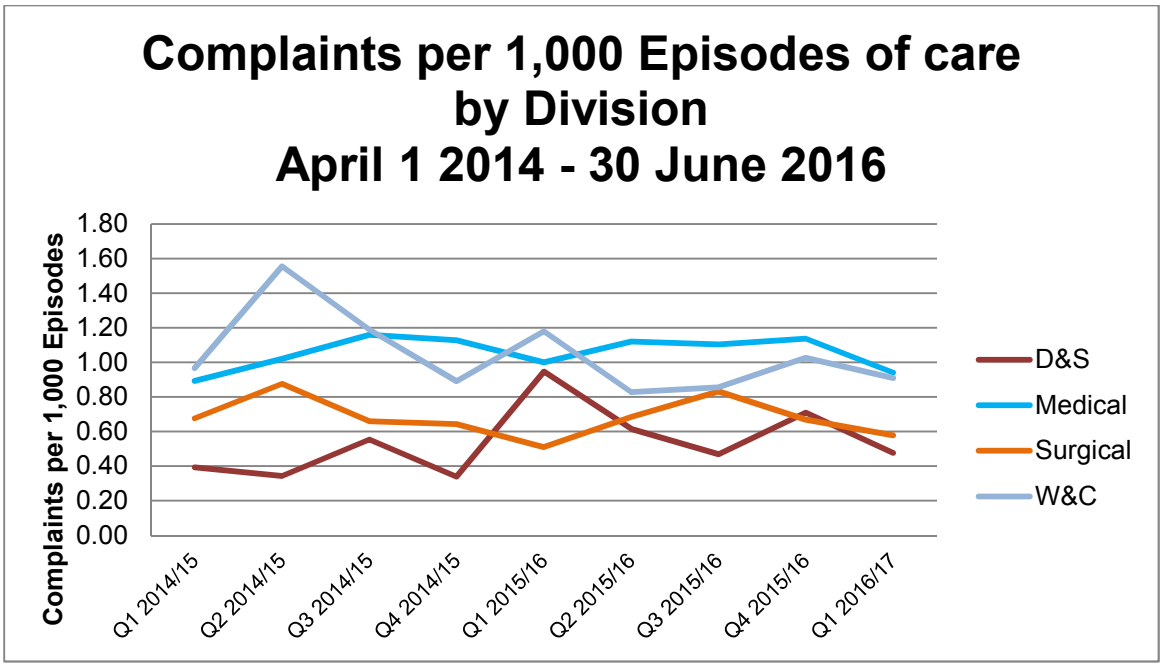


3.2 Upheld Complaints

Of the 208 complaints received in Quarter 1, 95 had been closed by the end of June, 71% were upheld either fully (23) or partly (44). This figure is slightly higher than previous quarters.

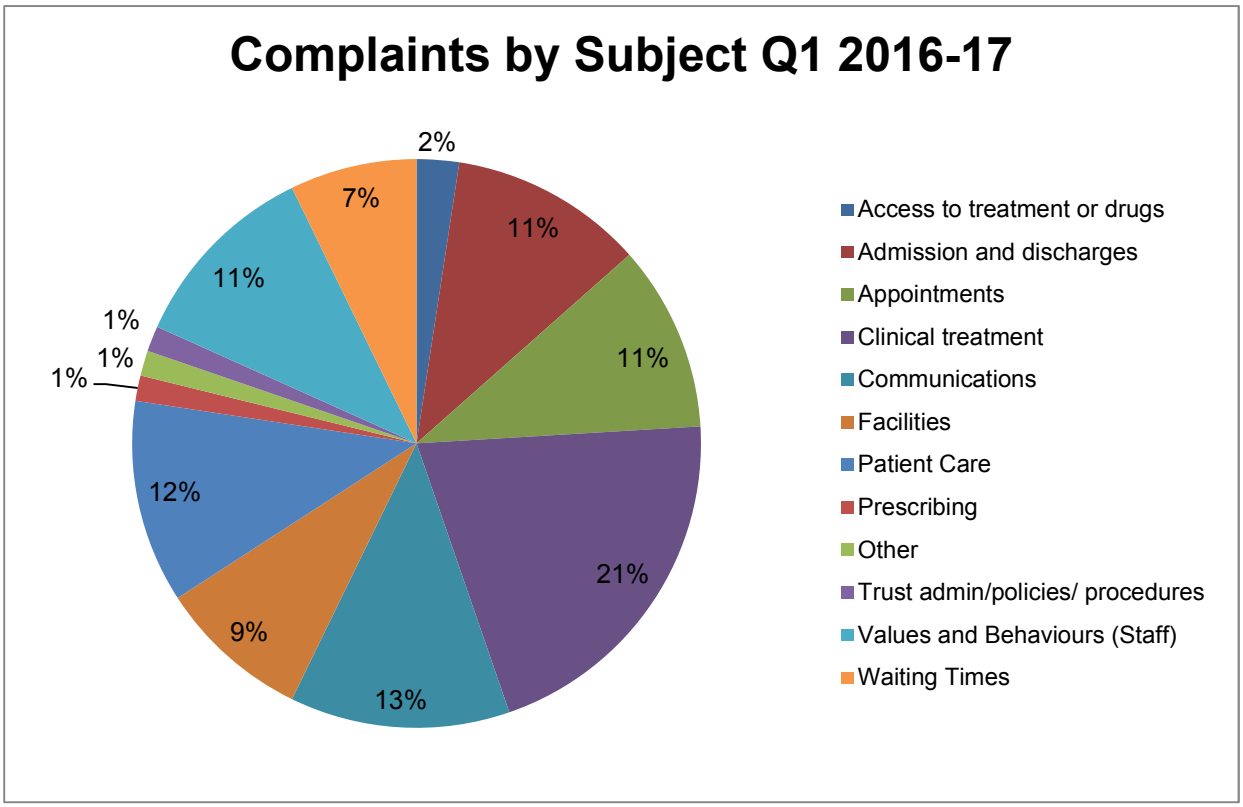
3.3 Complaints reported by Division

The graphs below show by Division the number and rate of complaints reported since 1 April 2014 and show that there has been a decrease in the number of complaints received by the Medical, Surgical, Women and Children's Division and Diagnostic and Specialties Division in Quarter 1. There is an increase in the complaints received within the Corporate (+3) and Estates and Facilities Divisions (+3), although small in number. A proportion of this increase relates to the hospital transport and parking.



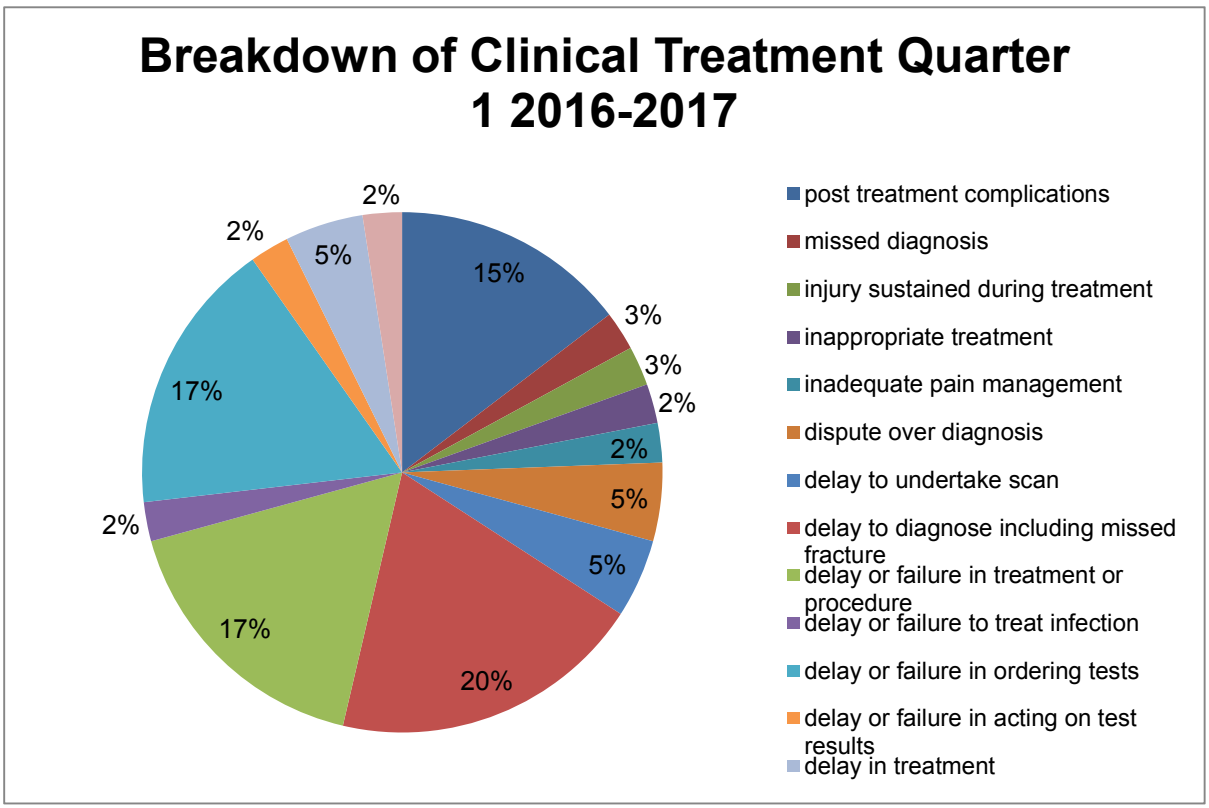
3.4 What do people complain about?

The chart below illustrates complaints received during Quarter 1 by category of issue.



The most frequent area of complaint to the Trust in Quarter 1 is clinical treatment (21%). The second most frequent category is communication (13%) followed by patient care (12%). "Other" includes complaints relating to privacy, dignity and wellbeing, staff numbers and transport.

Further breakdown of reasons for complaint under the broad category heading of "clinical treatment" is provided below and shows no significant variation from previous quarters.

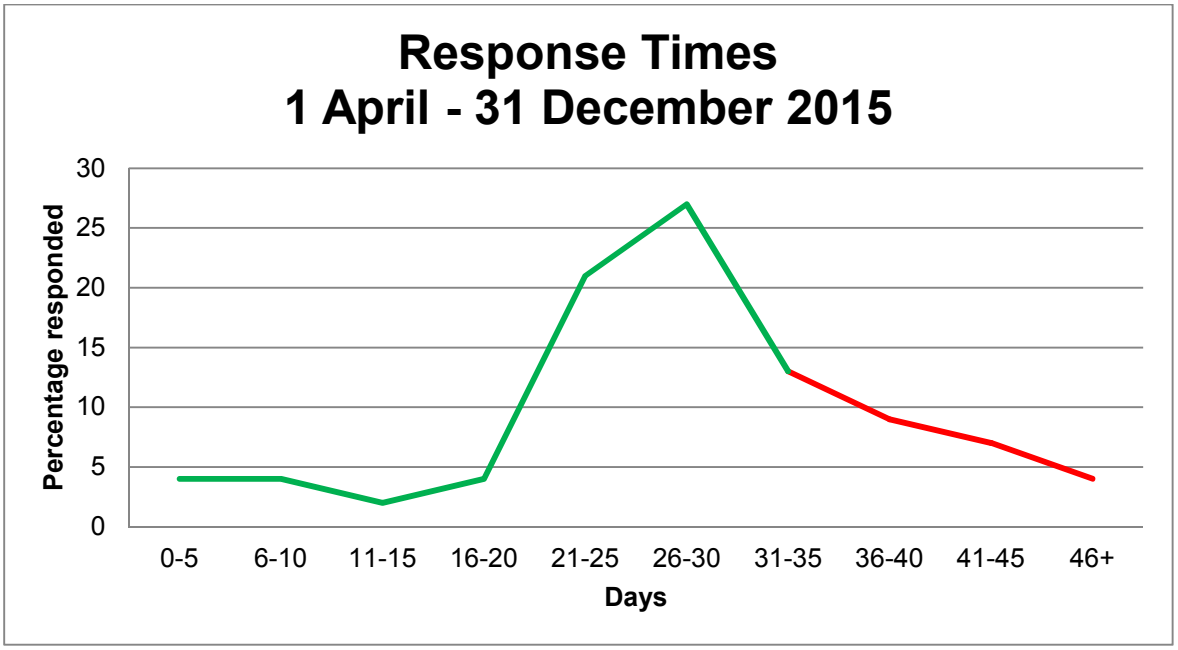


3.5 Complaint Acknowledgement and Response Times

There is a requirement under the current NHS Complaints regulations to respond to a written complaint with an acknowledgement letter within three working days. During Quarter 1 2016-17, this requirement was met in 99% (206) of cases. The other 2 cases (2%) were acknowledged within 4 and 5 working days respectively.

Our internal standard of written response within 35 working days in 95% of cases was met in 80% of cases during quarter 1. This is an improvement in performance compared to the Trust average for 2015-16 (72%) and probably reflects the fewer complaints received during the quarter.

The graph below displays Trust-level responses sent within time during Quarter 1. Sections shown as green are within our internally set response time; those shown in red are outside the response standard time. The graph shows that a large proportion of responses are sent between 16-31 days.



The table below shows response rate by Division during Quarter 1. Of the 208 complaints received during Quarter 1, 97 have been closed at the end of June 2016.

	Corp	D&S	E&F	Med	Surg	W&C	Trust Response
2015/16	78%	69%	79%	71%	78%	59%	72% 663/918
Q1 2016/17	88%	63%	83%	83%	96%	38%	86%
Total YTD 2016/17	88%	63%	83%	83%	96%	38%	86%

3.6 Local Resolution Meetings

During Quarter 1, five local resolution meetings were held with complainants and Trust staff. The aim of local resolution meetings is to provide an opportunity for the complainant to

explain what they are unhappy or unclear about and gives them and us the time to listen, discuss the complaint and provide information. We offer face to face meetings for complex or serious complaints or when the complainant specifically requests.

4. Parliamentary and Health Service Ombudsman Reviews (PHSO)

During Quarter 1 five new cases were referred by complainants to the Ombudsman for second stage resolution. Following investigation, decisions were received on six existing cases during the quarter, one of which was partly upheld, with the remainder not upheld.

Division	PHSO information	PHSO investigation looking at	Recommendation from PHSO
Medicine – Acute Care	Complaint received April 2014. PHSO investigation commenced December 2015	Alleged fracture of spine during transfer, withheld medications, pneumothorax caused during biopsy by breast surgeon	Partly upheld regarding the pneumothorax during biopsy.
Surgery – Lower GI	Complaint received February 2015. PHSO investigation commenced November 2015	Failure to detect and conduct investigations to appropriately treat bowel cancer	Not Upheld – clinical treatment managed appropriately
Surgery – T&O	Complaint received October 2014. PHSO investigation commenced November 2015	Verbal behaviour by staff. Diagnostic test not offered causing perception of diagnosis and worsening of condition	Not Upheld
Medicine – Respiratory	Complaint received April 2015. PHSO investigation commenced December 2015	Patient fell - The Trust failed to properly assess risk of falling following admission to hospital	Not Upheld – Trust carried out assessment and could not have taken any further action to prevent fall
Medicine – Winter Pressures	Complaint received November 2014. PHSO investigation commenced January 2016	Privacy and dignity – lack of compassion shown by Trust staff	Not Upheld – Trust's investigation, acknowledgement and apology was thorough and reasonable
W&C – Maternity (Stroud)	Complaint received November 2014. PHSO investigation commenced March 2016	Treatment during delivery – no scan to confirm position of baby, lack of consent for general anaesthetic for Caesarean section.	Not Upheld – Trust's response adequately dealt with complaint

The outcome of 11 cases referred to the Ombudsman is still awaited at the end of Quarter 1.

Since 2015/16, the PHSO has published quarterly reports that provide information on numbers of referrals to the Ombudsman for all NHSE organisations and the outcome of their

investigation. The report for Q4 2015/16 was published in July 2016 with the following highlighted for our Trust:

- Between Q1 and Q4 2015/16 the PHSO received 64 complaints. After investigation 15 (23%) were partly or fully upheld. The average % of cases upheld for acute trusts was 45%.
- There has been a reduction in the number of cases referred to the PHSO for second stage investigation; in Q4 2015/16 13 cases were referred compared with 27 in Q4 2014/15. There appears to be a small national reduction overall of cases referred to the PHSO.
- Of the 27 cases referred in Q4 2014/15, 9 cases were accepted for investigation with 3 cases fully or partially upheld. In Q4 2015/16 of the 13 cases referred 6 went on to be investigated with 3 of these cases were fully or partially upheld.

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

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

The Trust received four referrals from SEAP during Quarter 1 one of which was not upheld following investigation. Investigation has not yet been completed for the remaining three cases.

6. Concerns

During Quarter 1, our PALS team dealt with 512 concerns of which the top three themes were:

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

All concerns are also reviewed by the Divisions and feed into the consideration of improvement. Actions resulting from addressing of concerns include many individual level actions but some broader actions.

7. Learning from Complaints and Concerns

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

Issue	Actions taken/planned
Waiting times within clinical areas	• New system of informing patients of wait time in Cardiology clinics are running late • New display system in EDs which include estimated wait time
Environment	• Parking for disabled badge holders reviewed • Four new televisions set up in Gallery Ward for social activity
Condition-specific	• Teaching session for staff arranged regarding Motor Neurone Disease in order to improve ward knowledge

8. Recommendations

The Board is asked to note the Quarter 1 2016-17 Complaints and Concerns report.

Author: Heather Beer, Head of Patient Experience
Presenting Director, Maggie Arnold, Director of Nursing

Date: August 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
PUBLIC BOARD MEETING FRIDAY 30th SEPTEMBER 2016
Gallery Room, Gloucestershire Hospital commencing at 9.00 a.m

Report Title									
Financial Governance Review Terms of Reference									
Sponsor and Author(s)									
Deborah Lee, Chief Executive									
Audience(s)									
Board members	**x**	Regulators	**x**	Governors	**x**	Staff	**x**	Public	**x**

Executive Summary

Purpose
The purpose of this report is to present, for approval, the proposed Terms of Reference for the financial governance review, which the Board has previously resolved to commission.

Key issues to note
These terms have developed in close liaison with Board members, NHS Improvement and the Trust's legal advisers DACBeachcroft. They reflect the Board's commitment to openness and transparency in respect of its desire to understand the circumstances that led to the recent and sudden deterioration in the Trust's reported financial position.

It is the Trust's intention to make publically available the key findings from this review, including any recommendations for action.

Conclusion
In conclusion, the Terms of Reference reflect the Board's determination to understand how the current position came about, why it took so long to be uncovered and who was implicated in the apparent misrepresentation of the Trust's financial position.

Implications and Future Action Required
Once the Board has approved these Terms of Reference, it is the intention to make the Terms publically available, via the Trust's website and to proceed to procure a provider of services to undertake the review. It is anticipated that the review will commence late October and take 6-8 weeks to be completed resulting in the report being made available to the Trust and NHSI in early 2017.

Recommendations

The Board is recommended to approve the draft Terms of Reference.

Impact Upon Strategic Objectives

Impact Upon Corporate Risks

The findings of the review may represent a risk to the reputation of the Trust or individuals associated with the organisation, past and present.

Regulatory and/or Legal Implications							
The Review findings will feed the NHSI investigation into the Trust's financial governance and inform their decision in respect of any future regulatory action.							
Equality & Patient Impact							
No specific patient groups will be impacted above the general impact upon patients arising from the potential risk of a loss of Trust and confidence in the Trust Board and/or wider organisation.							
Resource Implications							
Finance	**x**	Information Management & Technology					
Human Resources	x	Buildings					
The costs of the Review are not yet known pending procurement but a provision has been made in the future budget. Significant staff time is likely to be expended through the course of the investigations as individuals provide information and give evidence to the Review team.							
Action/Decision Required							
For Decision	x	For Assurance		For Approval		For Information	

Date the paper was presented to previous Committees					
Quality & Performance Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

FINANCIAL GOVERNANCE REVIEW

Draft Terms of Reference

BACKGROUND

In late 2015 the Board became concerned about the robustness of its cash position, some of these concerns emanated from issues raised by staff through about the lack of timeliness with which the Trust was paying its supplier; by early 2016 these delays were beginning to have operational impacts due to interruptions in the supply of goods and services and concerns being raised directly with staff on wards and departments by suppliers.

In early 2016, upon the advice of the Finance Director, the Board established a working capital facility to support the cash position, believing this would address the issue.

In June 2016, a new Chief Executive joined the organisation and a month into post brought her serious concerns to the Board's attention in respect of cash balances and other matters. The Board responded immediately and commissioned Deloitte to undertake a high level review of the Trust's cash position and the approach to financial reporting.

Deloitte's high level findings described a cash decline from its peak in 2013 of £30.7m to £3.9m at 31st March 2016. The reviewed found that the main reasons for the cash decline were

- The Trust has achieved its financial plans over the last two years, in part by changing accounting assumptions which have improved the reported financial position without improving cash generated. These changes have offset an underlying loss of cost control and failure to deliver cost improvement plans.
- The Trust has expended significant resources on the capital programme which, in each of the last three years, which has significantly exceeded the levels of cash available from trading operations after servicing existing debts.

REVIEW PURPOSE

The Review has been commissioned to provide external assurance to the Trust Board and its regulator, in order that the risk of similar issues occurring and/or going undetected is minimised so far as is possible. The Review will explore 3 main lines of enquiry:

- Independently reviewing the factors that led to the recent findings in respect of the Trust's deterioration in its financial position, as summarised in the *Deloitte Review Findings* and provide a view on how the issues highlighted in the review occurred;
- Consider the effectiveness of the Trust's system of internal control and Board assurance and financial oversight, given the events described ; and
- Establish a root cause or causes of these events, based on available evidence, from a specific financial governance and assurance perspective.

PROPOSED SCOPE

<u>Retrospective</u>

1. Review the extent to which the Board (past and present members) and its relevant sub-committees fulfilled their respective responsibilities (with regard to financial governance) during the period FYE14 to FYE16, setting out any specific issues that contributed to the findings set out in the Deloitte Report. Specifically undertake

- a detailed review of accounting records relevant to the issues highlighted in the Deloitte review and (insofar as practicable) to any subsequent concerns of a similar nature identified by the Trust or the external financial baselining review also being commissioned by the Trust
- the authorisation of relevant accounting adjustments, and emails and other correspondence relevant to the items, above
- based on this review of evidence, provide a view on how the issues in the Deloitte review occurred and (insofar as evidence is available) on the individual or collective responsibility of Trust management or the Trust Board for the occurrence of these issues. Insofar as the evidence is available, it should be made clear whether, and if so, which individuals did not fulfil their roles in accordance with expectations.

2. Identify any specific aspects of corporate culture, board dynamics or ways of working that contributed to any identified deficiencies in financial governance in the period in question, with a view to identifying specific changes required to address them.

3. Review the robustness of the annual planning process and the extent to which it contributed to the apparently unrealistic 2016/17 plan, including the approach to developing and resourcing the Trust's capital programme. This should include a review of the alignment between plans submitted to the regulator and those submitted to the Board.

4. Through interview with audit partners, review the role of internal and external audit functions during the period in question, in order to understand the extent to which they could and/or should have alerted the Audit Committee to emerging concerns. Specifically, in respect of the escalating deterioration in the Trust's cash position, changes to the Trust's accounting practices such as the treatment of depreciation, capital projects and the reporting of finance to the Board and its sub-committees.

<u>Prospective</u>

1. Determine the adequacy of the capacity and capability of the Board, its sub-committees' and Executive structures to deliver the agreed financial recovery plan. This should include the Board's capability to scrutinise operational management and control in the areas where this is likely to impact the delivery of financial improvement.

2. Assess the capability of the non-executive function to adequately scrutinise, challenge and hold the Executive to account for delivery of the agreed financial and operational plan. Similarly, review the capacity and capability of the Executive function to develop robust plans, oversee their delivery and effectively identify and mitigate risks.

3. Review the effectiveness of the Governor function in holding NEDs to account for the appropriate execution of their role and determine their adequacy of their contribution in reviewing the Trust's Annual Plan in line with their statutory responsibilities.

4. Assess the adequacy of the accountability arrangements between the corporate finance and operations function; alongside the arrangements to provide the Board with assurance that Divisions are held to account for delivery of sound financial control, CIP delivery and financial forecasting.

5. Make recommendations to address any perceived weakness in current financial governance arrangements, as a result of the enquiries set out above.

Methodology Note

- The Trust will make available, the recent Deloitte Review, relevant Audit Committee reports, Well Led Governance Review and all other materials agreed to be relevant to the scope below. Bidders are therefore expected to take account of this existing information, when considering their own time requirements.
- This scope reflects the known requirements at this point in time; revisions or extensions to the scope may become necessary in response to emerging findings and it is expected that these will be dealt with through the usual variation to scope processes.
- The report should set out in summary and detail, the review findings and recommendations for both action and any further regulatory, investigatory or legal considerations that the Board should consider.
- Supplier selection will include representatives from both the Trust, NHS Improvement and an external partner.
- NHSI and the Trust expect to maintain direct access to the reviewer throughout the Review and reporting periods.
- The draft report will be made available to the Trust and NHSI in parallel
- An executive summary of findings in this review and recommendations, will become publically available

Deborah Lee, Chief Executive

23rd September 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
PUBLIC BOARD MEETING FRIDAY 30th SEPTEMBER 2016
Gallery Room, Gloucestershire Hospital commencing at 9.00 a.m

Report Title									
Financial Governance Review Terms of Reference									
Sponsor and Author(s)									
Deborah Lee, Chief Executive									
Audience(s)									
Board members	**x**	Regulators	**x**	Governors	**x**	Staff	**x**	Public	**x**

Executive Summary

Purpose
The purpose of this report is to present, for approval, the proposed Terms of Reference for the financial governance review, which the Board has previously resolved to commission.

Key issues to note
These terms have developed in close liaison with Board members, NHS Improvement and the Trust's legal advisers DACBeachcroft. They reflect the Board's commitment to openness and transparency in respect of its desire to understand the circumstances that led to the recent and sudden deterioration in the Trust's reported financial position.

It is the Trust's intention to make publically available the key findings from this review, including any recommendations for action.

Conclusion
In conclusion, the Terms of Reference reflect the Board's determination to understand how the current position came about, why it took so long to be uncovered and who was implicated in the apparent misrepresentation of the Trust's financial position.

Implications and Future Action Required
Once the Board has approved these Terms of Reference, it is the intention to make the Terms publically available, via the Trust's website and to proceed to procure a provider of services to undertake the review. It is anticipated that the review will commence late October and take 6-8 weeks to be completed resulting in the report being made available to the Trust and NHSI in early 2017.

Recommendations

The Board is recommended to approve the draft Terms of Reference.

Impact Upon Strategic Objectives

Impact Upon Corporate Risks

The findings of the review may represent a risk to the reputation of the Trust or individuals associated with the organisation, past and present.

Regulatory and/or Legal Implications

The Review findings will feed the NHSI investigation into the Trust's financial governance and inform their decision in respect of any future regulatory action.
Equality & Patient Impact
No specific patient groups will be impacted above the general impact upon patients arising from the potential risk of a loss of Trust and confidence in the Trust Board and/or wider organisation.

Resource Implications			
Finance	**x**	Information Management & Technology	
Human Resources	x	Buildings	
The costs of the Review are not yet known pending procurement but a provision has been made in the future budget. Significant staff time is likely to be expended through the course of the investigations as individuals provide information and give evidence to the Review team.			

Action/Decision Required							
For Decision	x	For Assurance		For Approval		For Information	

Date the paper was presented to previous Committees					
Quality & Performance Committee	**Finance Committee**	**Audit Committee**	**Remuneration & Nomination Committee**	**Senior Leadership Team**	**Other (specify)**

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

FINANCIAL GOVERNANCE REVIEW

Draft Terms of Reference

BACKGROUND

In late 2015 the Board became concerned about the robustness of its cash position, some of these concerns emanated from issues raised by staff through about the lack of timeliness with which the Trust was paying its supplier; by early 2016 these delays were beginning to have operational impacts due to interruptions in the supply of goods and services and concerns being raised directly with staff on wards and departments by suppliers.

In early 2016, upon the advice of the Finance Director, the Board established a working capital facility to support the cash position, believing this would address the issue.

In June 2016, a new Chief Executive joined the organisation and a month into post brought her serious concerns to the Board's attention in respect of cash balances and other matters. The Board responded immediately and commissioned Deloitte to undertake a high level review of the Trust's cash position and the approach to financial reporting.

Deloitte's high level findings described a cash decline from its peak in 2013 of £30.7m to £3.9m at 31st March 2016. The reviewed found that the main reasons for the cash decline were

- The Trust has achieved its financial plans over the last two years, in part by changing accounting assumptions which have improved the reported financial position without improving cash generated. These changes have offset an underlying loss of cost control and failure to deliver cost improvement plans.
- The Trust has expended significant resources on the capital programme which, in each of the last three years, which has significantly exceeded the levels of cash available from trading operations after servicing existing debts.

REVIEW PURPOSE

The purpose of the review is to identify how the drivers of deterioration in the trust's financial position arose, why they went unnoticed for such a sustained period and who was responsible for these inherent failings. The Review has been commissioned to provide external assurance to the Trust Board and its regulator, in order that the risk of similar issues occurring and/or going undetected by the systems of control and assurance is minimised so far as is possible. The Review will explore 3 main lines of enquiry:

- Independently reviewing the factors that led to the recent findings in respect of the Trust's deterioration in its financial position, as summarised in the *Deloitte Review Findings* and provide a view on how the issues highlighted in the review occurred;
- Consider the effectiveness of the Trust's system of internal financial control and Board governance assurance and financial oversight, given the events described ; and
- Establish a root cause or causes of these events, based on available evidence, from a specific financial governance and assurance perspective.

PROPOSED SCOPE

<u>Retrospective</u>

1. Review the extent to which the Board (past and present members), its relevant sub-committees (Audit and Finance & Performance) and staff fulfilled their respective responsibilities (with regard to financial governance) during the period FYE14 to FYE16,

setting out any specific issues that contributed to the findings set out in the Deloitte Review. Specifically undertake

- a detailed review of accounting records and any associated correspondence relevant to the issues highlighted in the Deloitte Review and any other drivers of the deterioration in the 2016/17 financial position identified by the trust', and notably the assumptions within the Annual Plan, and (insofar as practicable) to any subsequent concerns of a similar nature identified by the Trust or the external financial baselining review also being commissioned by the Trust
- the authorisation of relevant accounting adjustments, and emails and other correspondence relevant to the items, above
- based on this review of evidence, provide a view on how the issues in the Deloitte review occurred and (insofar as evidence is available) on the individual or collective responsibility of Trust management or the Trust Board for the occurrence of these issues. Insofar as the evidence is available, it should be made clear whether, and if so, which individuals did not fulfil their roles in accordance with expectations.

2. Identify any specific aspects of corporate culture, board dynamics or ways of working that contributed to any identified deficiencies in financial governance in the period in question, with a view to identifying specific changes required to address them.

3. Review the robustness of the annual planning process and the extent to which it contributed to the apparently unrealistic 2016/17 plan, including the approach to developing and resourcing the Trust's capital programme over the period of the Review. This should include a review of the alignment between plans submitted to the regulator and those submitted to the Board and where any misalignment is identified to provide a reconciliation.
4. Through interview with audit partners, review the role of internal and external audit functions during the period in question, in order to understand the extent to which they could and/or should have alerted the Audit Committee to emerging concerns. Specifically, in respect of the escalating deterioration in the Trust's cash position, changes to the Trust's accounting practices such as the treatment of depreciation, capital projects and the reporting of finance to the Board and its sub-committees.
5. Review the findings of the Well Led Governance Review to understand whether any issues indicating concerns regarding financial governance were advised and/or overlooked.

Prospective

1. Determine the adequacy of the capacity and capability of the Board, its sub-committees' and Executive structures to deliver the agreed financial recovery plan. This should include the Board's capability to scrutinise operational management and control in the areas where this is likely to impact the delivery of financial improvement.

2. Assess the capability of the non-executive function to adequately scrutinise, challenge and hold the Executive to account for delivery of the agreed financial and operational plan. Similarly, review the capacity and capability of the Executive function to develop robust plans, oversee their delivery and effectively identify and mitigate risks.

3. Review the effectiveness of the Governor function in holding NEDs to account for the appropriate execution of their role and determine their adequacy of their contribution in reviewing the Trust's Annual Plan in line with their statutory responsibilities.

4. Assess the adequacy of the accountability arrangements between the corporate finance and operations function; alongside the arrangements to provide the Board with assurance

that Divisions are held to account for delivery of sound financial control, CIP delivery and financial forecasting.

5. Make recommendations to address any identified weakness in current financial governance arrangements, as a result of the enquiries set out above.

Methodology Note

- The Trust will make available, the recent Deloitte Review, relevant Audit Committee reports, Well Led Governance Review and all other materials agreed to be relevant to the scope below. Bidders are therefore expected to take account of this existing information, when considering their own time requirements.
- In addition to detailed review of accounting records, correspondence and the like, it is expected that Board members, governors and staff (past and present) are interviewed in so far as their relationship with the matters under investigation is considered to be relevant.
- This scope reflects the known requirements at this point in time; revisions or extensions to the scope may become necessary in response to emerging findings and it is expected that these will be dealt with through the usual variation to scope processes.
- The report should set out in summary and detail, the review findings and recommendations for both action and any further regulatory, investigatory or legal considerations that the Board should consider.
- Supplier selection will include representatives from both the Trust, NHS Improvement and a third party.
- NHSI and the Trust expect to maintain direct access to the reviewer throughout the Review and reporting periods.
- The draft report will be made available to the Trust and NHSI in parallel
- An executive summary of findings in this review and recommendations, will become publically available

Deborah Lee, Chief Executive

23rd September 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL ON WEDNESDAY 3 AUGUST 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 P Adams	Staff, AHPs
	Mrs S Attwood	Staff, Nursing and Midwifery
	Prof C Dunn	Public, Stroud
	Dr P Jackson	Public, Forest of Dean
	Mrs A Lewis	Public, Tewkesbury
	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
	Mr R Randles	Staff, Nursing and Midwifery
	Mr A Thomas	Public, Cheltenham (Lead Governor)
Directors	Prof C Chilvers	Chair
	Dr S Elyan	Acting Chief Executive
	Mr G Mitchell	Senior Independent Director/Vice Chair
	Mr T Foster	Non-Executive Director
	Ms Anne Marie Millar	Non-Executive Director
	Mrs Helen Munro	Non-Executive Director
	Mr Keith Norton	Non-Executive Director
IN ATTENDANCE	Mr M Wood	Trust Secretary
APOLOGIES	Dr D Beard	Public, Tewkesbury
	Dr C Feehily	Appointed, Health Watch
	Mrs J Harley	Patient Governor
	Mrs J Hincks	Public, Cotswold
	Mrs C Johnson	Public, Forest of Dean
	Dr T Llewellyn	Medical and Dental
	Dr A Seymour	Appointed, Clinical Commissioning Group
	Ms F Storr	Public, Gloucester
PRESS/PUBLIC	Charlotte Hitchings	Public

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

076/16 DECLARATIONS OF INTEREST

There were none.

077/16 MINUTES OF THE MEETING HELD 6 JULY 2016

RESOLVED: That the minutes of the meeting held on 6 July 2016 were agreed as a correct record and signed by the Chair.

078/16 MATTERS ARISING

066/16 Any Other Business – Annual General Meeting: The Chair said that there will be an opportunity for Members and Governors to meet before the Annual General Meeting. Professor Dunn suggested that brightly coloured lanyards with the word "Governor" could be used. *The Trust Secretary reported that this is being taken forward for the Annual General Meeting. Completed as a matter arising.*

079/16 MINUTES OF THE MEETING OF THE GOVERNANCE AND NOMINATIONS COMMITTEE HELD ON 22 JUNE 2016

The Chair presented the minutes of the meeting of the Governance and Nominations Committee held on 22 June 2016.

The Lead Governor said that it will be necessary for an informal meeting of the Council of Governors to be held to consider the programme of development from the Governor Effectiveness sections of the Board Governance Review and it was suggested that this meeting take place on Wednesday 21 September 2016 at 5:30pm. He undertook to liaise with the Chair to identify topics for discussion. **AT/CC**

RESOLVED: That the minutes be noted

080/16 REPORT OF THE CHIEF EXECUTIVE

The Acting Chief Executive presented the report of the Chief Executive drawing attention to the content under each of the five headings. He added with regard to the Junior Doctors' contract that rotas are compliant but issues may remain about how workable they are. 3 August is the change-over of doctors. NHS Improvement has determined that our Trust is in breach of its licence following a prolonged period throughout which it failed to meet the national four hour A&E standard. Our Trust will have access to further support to ensure that this long standing issue is resolved. The Acting Chief Executive announced that Heather Beer, Head of Patient Experience was leaving our Trust and placed on record his support for the work which she has undertaken in taking forward patient experience and supporting Governors and Members.

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

- The Lead Governor expressed his delight that the parking policy has been revised and that parking penalty notices will no longer be issued to those displaying blue badge when forced to park in regular parking spaces. He asked which Committee/Non-Executive Director had oversight in this area to which he could submit further questions. In response, Mr Mitchell undertook to receive those questions and address the issues raised. **AT/GM**
- Prof Dunn asked with regard to Junior Doctors whether our Trust had filled all positions in line with national guidelines. In response, the Acting Chief Executive said that all F1 doctor positions had been filled although they may not remain in post for various reasons for the duration of their appointment. In the south-west region acute medicine and emergency registrar positions were down by about 50%. Trainees were allocated by the Deanery and Health Education South West with our Trust not making these appointments.

- Prof Dunn expressed his appreciation to staff in raising the child neglect case. He then referred to the consultation being undertaken by Gloucestershire Care Services to close all Minor Injuries Units in the County between the hours of 11pm and 8am stating that this will have implications on our Trust's Emergency Department. In response to the first part of the question, the Acting Chief Executive said that this would be subject to investigation. With regard to the Minor Injuries Unit, he said that it is not a Trust activity and that it is important for Governors and their constituents to engage in this consultation. He said that the number of patients attending those Units is small but the combined effect on the Emergency Department at Gloucestershire Royal Hospital will be significant. Our Trust needs to set up services to cope with those patients. A GP presence is being enhanced to align services with demand. It is difficult given the small number of patients to sustain staff at the Minor Injuries Units. Dr Jackson said that given the number of patients the Minor Injuries Unit in the Forest of Dean could not be sustained. Prof Dunn added that the consultation is structured to responding to one of three options and does not give an opportunity to disagree with all and suggest alternatives. Mr Marstrand expressed concern about the formulation of the questions, stating in his view that they were structured to achieve a desired outcome in what he described as a breach of the Clinical Commissioning's Group assurance in monitoring health care to support our Trust to ensure that patients go elsewhere for services. The Chair said that the outcome of the consultation will be discussed at the Health Overview and Scrutiny committee.

The Chair thanked the acting Chief Executive for the report.

RESOLVED: That the report be noted.

081/16 Q1 PERFORMANCE

The Director of Service Delivery presented the report summarising the key highlights and exceptions in Trust performance up until the end of the first quarter of the 2016/17 financial year. He stressed that not all performance figures have been validated for June data and are subject to change. He drew attention to national performance where the four hour Emergency Department target, the 18 week Referral to Treatment standard, cancer and diagnostic wait performance is not being met. Our Trust met some of those targets. He explained the background to the planning round where our Trust has been given a financial control total which it is important to deliver and a step plan has been prepared to improve our position over the next year. The Performance Management Framework report presented to the Board is now clearer and expressed more simply. It looks back over the last twelve months and, more importantly, looks forward over the next six months providing in total performance and anticipated performance over an eighteen month period. The arrangements for exception reporting have been improved. Non-Executive Directors are providing more challenge at the Finance and Performance Committee and the development of the Performance Management Framework report is work in progress.

The Director of Service Delivery reported on the activity levels in the Emergency Department where in July 2016 the average daily attendance was 390 with our Trust contracted for 350 and the Clinical

Commissioning Group planning for 330. This is placing pressure on our Trust together with the medically fit list which has been on average at 50+ patients per day. GP referrals have increased by 7.9% during the last twelve months with most referrals being under the cancer two week wait pathway necessitating our Trust having to move routine patients to take those referred to under the pathway. Cancer diagnosis, however, remains at between 9-10% of patients referred. This is a national issue.

The Director of Service Delivery drew attention to the key highlights and areas for improvement on the four domains (which follow the CQC Key Lines of Enquiry) with the fifth domain of caring being presented to the Quality Committee. He highlighted the following:-

- The Finance and Performance Committee were not assured with Acute Kidney Injury (AKI) performance and have asked that a more detailed report be presented to the Quality Committee.

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

- The Lead Governor supported the approach of the Non-Executive Directors in challenging and also the Chief Executive's approach to risk in looking at risk currently rated at amber noting that the 18 week Referral To Treatment standard may fail and he asked how the Non-Executive Directors are seeking assurance that it is not red risk rated. In response, Mr Foster said that Non-Executive Directors have not been satisfied with the performance in urology and have sought further information to provide assurance. There is now a change of culture in being more forward looking to identify areas of concern. The Director of Service Delivery added with regard to the 18 week Referral To Treatment standard that GP referrals have increased by 7.9% and if capacity is not increased at a similar rate then issues may arise. Looking forward he did not foresee any issues during the next two months but acknowledged that during the winter months there could be issues with the 18 week Referral To Treatment standard.
- Mrs Adams asked for information on the preparation of the winter plan. In response, the Director of Service Delivery said that there is now no distinction between winter and summer performance. The Improvement Director has established six key elements of a work programme which will effectively address the winter plan. Firstly, the Emergency Department are looking at capacity and demand including skill mix; secondly site management looking at policies to ensure that they are fit for purpose. A senior manager presence will now be available on site seven days a week with an increase in the number of night site managers. Thirdly, the SAFER patient flow bundle is looking at patients with a length of stay greater than 14 days where there are currently approximately 200 patients in this category. Our Trust is looking at alternatives to managing those patients. Fourthly, a clinical patient flow model looking at the Utopia model by keeping the same principle of patients being seen by a senior clinician but in an ambulatory care unit, thus removing some of the pressure on the Emergency Department and ensuring patient safety. Fifthly, bed distribution to ensure that the right beds are in the right speciality. Sixthly, remove delays to discharge looking at the model adopted in Oxford where patients are transferred to nursing homes and managed by the hospital. Step changes are

being made to improve performance during the winter months.

- The Lead Governor asked how assured the Non-Executive Directors are in the effectiveness of mandatory training. In response, the Chair said that this will picked up by the Workforce Committee. **KN**

The Director of Service Delivery referred to the questions set out below from Dr Feehily and the response:-

I had one or two questions that arise from the Q1 performance report, sec 2.2 Areas for Improvement.

The report refers to 79.4% performance against maximum wait of 62 days.

Presumably, this is a simple average within which there are waits of more and less than 62 days?

Would it be possible to confirm how the Board maintains oversight of the profile of >62 day waits.

So for example, what is the longest wait within the total?

How many people have waited for 65-70; 71-80; 81-90; etc?

It would be helpful to understand how the Board understands the incidence and composition of waits that are considerably longer than 62 days and what interventions the Trust makes to mitigate some of the adverse impacts for those who are experiencing very significant waits.

Finally, are such people subject to any form of risk assessment while waiting?

Response

It is acknowledged that performance against the standard is not where it should be and that we are taking action to address it. The July Finance and Performance Committee undertook a detailed review of performance and were not fully assured by the plan and a more comprehensive plan is coming back to the next meeting in August 2016.

It is confirmed that the measure is the % who wait over 62 days and have a confirmed diagnosis of cancer. The details by specialty are reported in the monthly Trust Board Performance Management Framework paper.

The waiting list for cancer treatments on the 62 day pathway includes patients with diagnosed cancer and those who may or may not have cancer and the total waiting time includes the time it takes to reach a definitive diagnosis or to rule out the diagnosis of cancer. Some diagnostic and treatment pathways are more complex and will take longer than 62 days and that, combined with patient choice, is the reason why the standard is not 100%.

This year a national maximum wait of 104 days for cancer patients has been introduced and we are internally working to ensure that this is achieved. These long waits are nearly all in urology and there is a regular clinical review by the relevant Consultant to ensure patients are

treated by clinical need and priority is given to them. For example those men with high PSA levels and therefore higher likelihood of cancer are prioritised ahead of those men with low levels.

Board oversight is through the Finance and Performance Committee and operationally through the Cancer Management Board. The Trust Board does not routinely see the numbers on any of our waiting list or by time waiting but this information would be available for a deep dive by a Board subcommittee.

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

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

082/16 REPORT OF THE CHAIR OF THE FINANCE AND PERFORMANCE COMMITTEE

The Chair of the Finance and Performance Committee, Mr Tony Foster, gave a presentation on the work of the Committee. He drew attention to the Committee membership, provided a summary of its terms of reference, the regular monthly reports presented, programmed items of business, one off studies and the future working arrangements. The future work would look at reducing the overlap between the Committee and the Board, reports containing more information and assurance rather than just data, some performance issues being addressed by the Quality Committee and reports being more forward looking to anticipate problems and produce detailed plans to address them and monitor achievement of change.

During the course of the discussion, Prof Dunn referred to the actions undertaken using the Audit Committee as an example and asked what arrangements are in place to monitor those actions to ensure that performance does not deteriorate. In response, Mr Foster said the monitoring needs to be based on quality not quantitative information and arrangements need to be in place universally to ensure that actions are monitored.

The Chair thanked Mr Foster for his presentation.

RESOLVED: That the presentation be noted.

(The Director of Service Delivery left the meeting).

083/16 REPORT OF THE CHAIR OF THE HEALTH AND WELLBEING COMMITTEE

The Chair of the Health and Wellbeing Committee, Mr Tony Foster, presented an overview of the work of the Committee. He said that Mrs Helen Munro had taken over as the Chair of the Committee. The presentation covered the national context in creating and sustaining an acute sector that supports the NHS five year forward view vision for prevention, the role for our Trust in the wider health and wellbeing agenda and opportunities to influence it, our Trust Health and Wellbeing Committee, our overarching Health and Wellbeing Strategy, our Staff Health and Wellbeing Strategy, the health and wellbeing of our patients and a strategy being developed to focus on our contribution to the local community. The work of the meetings has included maintaining a

healthy weight, mental wellbeing, improving health and wellbeing of older people, reducing harm caused by alcohol, smoking cessation, and tackling inequalities. In conclusion, he said that our Trust is amongst the first to recognise the potential for acute hospitals to contribute to the wider health and wellbeing agenda. He suggested that Governors may wish to receive the catering presentation and that the new Committee Chair may wish to provide a greater focus on mental wellbeing.

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

- Mrs Lewis asked on behalf Ms Storr why there was no spiritual welfare which was considered to be important. In response, the Chair said that the Lead Chaplin is a member of the Patient Experience Strategic Group and she will discuss with the new Chair of the Health and Wellbeing Committee where this is best placed to be discussed. Mrs Attwood added that staff use Chaplains for support for spiritual guidance irrespective of denomination and that support is readily forthcoming. **CC/HM**
- Dr Jackson observed that staff sickness records are poor and that there needs to visibility of the outcome of those measures to reduce staff sickness. In response, the Chair said that the Board sees that information and she will consider where a deep dive into that area best fits. **CC**
- Mr Marstrand said that there should be metrics developed for certain aspects of staff health and wellbeing giving a present position and what the plan is for example five years' time and the targets to achieve that. In response, the Chair said that such metrics exist in the take up of facilities for example, swimming facilities.
- Mr Marstrand asked how the Health and Wellbeing Committee interacts with the County Health and Wellbeing Board. In response, the Chair said that until recently the acute sector did not have a seat on the county Health and Wellbeing Board. That position has changed and she now is a member and the relationship needs to be further developed.

The Chair thanked Mr Foster for his presentation.

RESOLVED: That the presentation be noted.

084/16 PROPOSED REVISIONS TO THE CONSITUTION

The Trust Secretary presented the report inviting the Council of Governors to consider the recommendation from the Board that proposed revisions to our Trust's constitution be approved. One element of the Governor Effectiveness section of the Board Governance Review is to undertake a review of our Trust's constitution. The Council of Governors agreed that the constitution be updated in two phases; firstly, an initial set of amendments relating to updating terminology and clarification which would refresh the documentation in place in anticipation of our Trust achieving Foundation Trust status in 2004 and, secondly, a set of issues requiring wider discussion. Apart from updating terminology and clarification the main change relates to the appointment of Stakeholder Governors where the recommendation is that there should be up to four Stakeholder Appointed Governors, one from the Gloucestershire Clinical Commissioning Group, one from Gloucestershire County Council, and one from Health Watch Gloucestershire (or their successor organisations). The fourth position

could be an appointment from any other stakeholder or partner organisation as agreed at the time by the Board and the Council of Governors. The proposed changes to the constitution were shown in track changes in the document attached to the report. Revisions to the constitutions require the approval of both the Board of Directors and the Council of Governors.

The Trust Secretary then presented the supplemental report providing the Council of Governors with an opportunity to amend the definition in the constitution of the out of county patient constituency to give greater clarity of eligibility for membership of our Trust which in turn will allow those members, if they so wish, to seek election/appointment to other positions in our Trust. It was proposed that the current patient constituency be replaced by a public constituency; membership of the public constituency is open to individuals who are resident in an out of county geographical area where services are provided to the population living in that area. The required amendments to the constitution to give effect to this proposal were set out in the report. He said that the current patient constituency governor would remain eligible under the proposal to be the public constituency governor.

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

- The Chair said that the fourth Stakeholder Governor could be a young person filled by one or two young people.
- Dr Jackson whilst accepting the proposal expressed concern that the proposal to create a public constituency in place of the patient constituency should not be seen as the beginning of a relaxation of membership to the whole of the United Kingdom.
- Mrs Powell added that membership should relate to areas where services are provided by our Trust and sought a definition of where those services are currently provided. In response, the Chair said that the arrangements for the public constituency member will provide flexibility and the current services are provided in Herefordshire, Worcestershire and Swindon (including Wiltshire). The list of geographical areas will be maintained by the Trust Secretary and updated should there be any changes in the geographical areas out of county where services are provided. **MW**

The Chair thanked the Trust Secretary for the report.

RESOLVED: That the proposed revisions to the Trust's constitution as set out in the report and the supplemental report be approved.

085/16 UPDATE FROM GOVERNORS ON MEMBER ENGAGEMENT

The Chair invited Governors to report on any member engagement activities which they had undertaken and the following were reported:-

- Mr Pittaway reported on a meeting which he, Mrs Adams, and Ms McIndoe had with Mr Mitchell, emanating from the work plan discussing engagement with staff constituency members and the time allocated to engage. This would become a regular quarterly meeting with the Director of Human Resources and Organisational Development and was very worthwhile.
- Dr Jackson reported that he and Mrs Johnson attended the monthly drop-in sessions in the Forest of Dean which continue to be successful. Positive comments are received about our Trust.

The continuation of the drop-in sessions following the pilot is to be determined.

- Prof Dunn reported on his attendance at a resuscitation seminar for members and his contribution to the drafting of patient information leaflets. He said that he had received comments in his constituency both positive and negative about our Trust.
- Mr Marstrand reported that he had taken up with Mr Mitchell through PALS an issue raised by a relative of a patient.
- Mr Marstrand referred to a letter regarding the elections which a constituent in the Forest of Dean had received and the Trust Secretary undertook to discuss that letter with him. **MW**

The Chair thanked those Governors for the reports.

086/16 SUB-COMMITTEE REPORTS

Quality Committee – 10 June and 15 July 2016:
Mr Mitchell reported that the Committee in June 2016 considered the learning from serious untoward incidents and adjusted practice and processes to review those learnings. A discussion had taken place on the role of the Committee and it's interactions with other Committees. The July meeting considered various annual reports including safeguarding, serious untoward incidents and medicines optimisation. The Committee received an update on assurance on quality measures in particular safety and the work being undertaken to adjust the reporting to the CQC Key Lines of Enquiry format.

Finance and Performance Committee – 22 June and 27 July 2016:
Mr Foster reported that in June 2016 the five Divisions attended to present their Cost Improvement Programmes and the Committee were not assured. Changes in the governance arrangements for the Emergency Care Pathway were agreed where the weekly telephone calls have been replaced by an Emergency Care Programme Board chaired by the Chief Executive which considers the outputs form the six work streams. In July 2016 the Committee considered theatre efficiency, an update from the Cost Improvement Programme Director on the work undertaken by our Trust and a report by the Medical Director on temporary medical staffing highlighting the spend on doctors and a further report is to be presented to the Committee in August 2016.

Health and Wellbeing Committee – 5 July 2016:
This was covered in minute number 083/16 as part of the presentation of the Health and Wellbeing Committee.

Patient Experience Strategic Group – 11 May 2016:
The Chair reported that discussions are taking place on the future of the Group to increase its effectiveness. Divisional presentations are inspiring and this needs to be disseminated throughout the organisation. She would consider with the Trust Secretary the Lead Governor's request that the minutes of the Committee are made available to Governors. **CC/MW**

The Chair thanked the presenters for their reports.

087/16 GOVERNOR QUESTIONS

None Received.

088/16 ANY OTHER BUSINESS

Retiring Governors: The Chair wished to place on record her thanks to the contribution made by the following Governors who were not seeking re-election at the forthcoming elections: Ms Fanny Storr, Dr David Beard, Dr Andrew Seymour, Mrs Pam Adams, Mrs Chrissie Johnson and Mrs Sandra Attwood.

089/16 DATE OF NEXT MEETING

The next meeting of the Council of Governors will be held in the Lecture Hall, Sandford Education Centre, Keynsham Road, Cheltenham, on Wednesday 2 November 2016 commencing at 5:30pm. (An informal meeting is to be held on Wednesday 21 September 2016 at 5.30pm).

090/16 PUBLIC BODIES (ADMISSION TO MEETINGS) ACT 1960
RESOLVED:

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

The meeting ended at: 7:15pm.

Chair
2 November 2016

ITEM 24

ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

DISCUSSION

ITEM 25

STAFF QUESTIONS

Prof Clair Chilvers
Chair

ITEM 26

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