GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on Friday 28 October 2016 in the **Board Room, Alexandra House, Cheltenham General Hospital** commencing at 9.00 a.m. with tea and coffee. **(PLEASE NOTE VENUE FOR THIS MEETING)**

Professor Clair Chilvers
Chair

21 October 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 30 September 2016	**PAPER**	**To approve**	09:02
4.	Matters Arising	**PAPER**	**To note**	09:03
5.	Summary of the meeting of the Finance Committee to be held on 26 October 2016	**PAPER (To follow)** (Tony Foster)	**To note**	09:08
6.	Minutes of the meeting of the Finance Committee held on 26 September 2016	**PAPER** (Tony Foster)	**To note**	09:13
7.	Minutes of the meeting of the Health and Wellbeing Committee held on 4 October 2016	**PAPER** (Tony Foster)	**To note**	09:14
8.	Summary of the meeting of the Quality and Performance Committee to be held on 26 October 2016	**PAPER (To follow)** (Keith Norton)	**To note**	09:29
9.	Minutes of the meeting of the Workforce Committee held on 14 October 2016	**PAPER** (Keith Norton)	**To note**	09:24
	Chief Executive's Report and Environmental Scan			
10.	October 2016	**PAPER** (Deborah Lee)	**To note**	09:30
	EFFECTIVE			
11.	Board Sub-Committee Structure	**PAPER** (Clair Chilvers)	**To approve**	09:40
12.	Integrated Performance Framework Report	**PAPER** (Eric Gatling)	**To endorse**	09:45
13.	Financial Performance Report	**PAPER** (Stuart Diggles)	**To endorse**	10:00
14.	Emergency Pathway Report	**PAPER** (Deborah Lee)	**To endorse**	10:20
15.	Nurse and Midwifery Staffing	**PAPER** (Maggie Arnold)	**To approve**	10:35
16.	Board Assurance Framework	**PAPER** (Deborah Lee)	**To approve**	10:45
17.	Memorandum of Understanding for Gloucestershire's Sustainability and Transformation Plan	**PAPER** (Deborah Lee)	**To approve**	10:55
	SAFE			
18.	Winter Plan 2016/17	**PAPER (To follow)** (Eric Gatling)	**To approve**	11:00

19.	Seven Day Services Update	**PAPER** (Sean Elyan)	**To note**	11:10
	Next Meeting			
20.	Items for the next meeting and Any Other Business	**DISCUSSION (All)**	**To Discuss**	11:20
	Staff Questions			
21.	A period of 10 minutes will be provided to respond to questions submitted by members of staff		**To Discuss**	11:25
	Public Questions			
22.	A period of 10 minutes will be provided for members of the public to ask questions submitted in accordance with the Board's procedure.		**Close**	11:35 11:45
	Break			

Date of the next meeting: The next meeting of the Main Board will take place at on **Friday 25 November 2016** in the **LECTURE HALL, REDWOOD EDUCATION CENTRE GLOUCESTERSHIRE ROYAL HOSPITAL** at **9.00 am. (PLEASE NOTE VENUE FOR THIS MEETING)**

Public Bodies (Admissions to Meetings) Act 1960

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST BOARD HELD IN THE GALLERY ROOM, GLOUCESTERSHIRE ROYAL HOSPITAL ON FRIDAY 30 SEPTEMBER 2016 AT 9.00 AM

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

PRESENT	Prof Clair Chilvers	Chair
	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
	Stewart Diggles	Interim Director of Finance
	Tracey Barber	Non-Executive Director
	Tony Foster	Non-Executive Director
	Anne Marie Millar	Non-Executive Director
	Helen Munro	Non-Executive Director
	Keith Norton	Non-Executive Director
APOLOGIES	None	
IN ATTENDANCE	Martin Wood	Trust Secretary
	Mr Dhushy Mahendran	Chief of Service – Women and Children
PUBLIC/PRESS	Rob Blagden	Public
	Dawn Cooper	Staff
	Amy Callaghan-Page	Public
	Prof Chris Dunn	Governor – Stroud Constituency
	Craig Macfarlane	Head of Communications
	Bren McInerney	
	Gillian Steeles	Gloucestershire Care Services
	Svetlana Yates	CITS Admin/Projects
	Alan Thomas	Public Governor, Cheltenham

The Chair welcomed all to the meeting. In particular, she welcomed Tracey Barber who was attending her first formal Board meeting following her appointment as a Non-Executive Director.

ACTION

275/16 DECLARATIONS OF INTEREST

There were none.

276/16 MINUTES OF THE MEETING HELD ON 29 JULY 2016

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

277/16 MATTERS ARISING

151/16 Acting Chief Executive's Report and Environmental Scan – Trust Risk Register:
IT – 2246 – aging and out of support network hardware, single internet circuit causing increased likelihood of hardware failures,

decreasing likelihood and increase costs of finding replacement parts, reduction in resilience leading to loss of IT services in physical locations and systems, operational disruption, reduces efficiency of clinical delivery and patient throughfoot (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* 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.*

195/16 Annual Complaints Report 2015/16:
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 now a standing item on the Outpatient Delivery Team meeting from the meeting on 22 September 2016. Completed.*

229/16 Nurse and Midwifery Staffing:
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.*

232/16 Staff Survey Action Plans:
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. *This item appear later in the agenda. Completed*. [09:04]

278/16 SUMMARY OF THE MEETING OF THE FINANCE COMMITTEE HELD ON 28 SEPTEMBER 2016

The Chair of the Committee, Mr Tony Foster, presented a summary of the meeting held on 28 September 2016. He said that this was the first meeting in which the revised financial report had been considered. It contained greater detail than that presented to the Board. The next report would contain financial information to the year end. He appreciated the content of the report but acknowledged there were caveats which were still being worked through. This was a transformation to previous reports. The Committee had spent a

considerable amount of time going through the report on a line by line basis. The Committee had also considered an update on the recommendations contained in the Deloitte report and revised terms of reference had been approved for presentation to the Board in October 2016.

The Chair thanked Mr Foster for his report.

RESOLVED: That the summary be noted. [09:06]

279/16 MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 22 JUNE 2016

RESOLVED: That the minutes of the meeting of the Finance and Performance Committee held on 22 June 2016 be noted. [09:06]

280/16 MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 27 JULY 2016

RESOLVED: That the minutes of the meeting of the Finance and Performance Committee held on 27 July 2016 be noted. [09:07]

281/16 MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 24 AUGUST 2016

RESOLVED: That the minutes of the meeting of the Finance and Performance Committee held on 24 August 2016 be noted. [09:07]

282/16 MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING COMMITTEE HELD ON 5 JULY 2016

RESOLVED: That the minutes of the meeting of the Health and Wellbeing Committee held on 5 July 2016 be noted. [09:07]

283/16 MINUTES OF THE MEETING OF THE QUALITY COMMITTEE HELD ON 15 JULY 2016

RESOLVED: That the minutes of the meeting of the Quality Committee held on 15 July 2016 be noted. [09:08]

284/16 MINUTES OF THE MEETING OF THE QUALITY COMMITTEE HELD ON 2 SEPTEMBER 2016

The Chair of the Trust presented the minutes of the meeting of the Quality Committee held on 2 September 2016. She highlighted that the Committee had received a report from the Diagnostics and Specialties Division which highlighted the difficulties in recruiting Radiology consultants. The MRI scanners on both sites are nearing the end of their working lives and proposals for replacements are being considered. The Director of Safety reported that all positions in the Duty of Candour team have now been filled. The Committee received an informative presentation from Mr Ben King and Dr David Gabbott on the work of the deteriorating Patient and Resuscitation Committee. An informative presentation on acute kidney infection performance was made by Dr Preetham Boddana. The introduction of TrakCare will help to improve performance.

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

285/16 MINUTES OF THE MEETING OF THE AUDIT COMMITTEE HELD ON 6 SEPTEMBER 2016

The Chair of the Committee, Ms Anne Marie Millar, presented the minutes of the meeting of the Audit Committee held on 6 September 2016. She highlighted that it was Grant Thornton's last attendance before the appointment of KPMG. Grant Thornton had issued an unqualified opinion on the accounts. Planning meetings are taking place with KPMG regarding the current audit. The Committee is reviewing its forward work plan and plans to hold six meetings per year in future.

The Director of Clinical Strategy asked if the Board could be supplied with the internal audit work plan which the Chair of the Committee was happy to arrange. **SD**

The Chair thanked Ms Millar for her report.

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

286/16 MINUTES OF THE MEETING OF THE WORKFORCE COMMITTEE HELD ON 27 JULY 2016

The Chair of the Committee, Mr Keith Norton, presented the minutes of the meeting of the Workforce Committee held on 27 July 2016. He highlighted that the Committee had focussed on three topics, namely workforce strategy, policies and data. The Committee is to meet again on 14 October 2016 to consider the Workforce Strategy and action plan ensuring that they are fit for purpose.

The Chair thanked Mr Norton for his report.

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

287/16 CHIEF EXECUTIVE'S REPORT AND ENVIRONMENTAL SCAN

The Chief Executive presented her report and drew attention to our Trust's financial position, the Junior Doctors' industrial action, the establishment of cancer alliances, Emergency Department performance, the Care Quality Commission inspection and showcasing our endoscopy work.

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

- Ms Barber referred to the staff engagement on our Trust's financial position and suggested that this should not be considered as a one-off engagement but part of ongoing engagement and feedback. In response, the Chief Executive said that the importance of staff engagement has been recognised and her weekly narrative provides two way communication. The Executive Team are responding to questions with greater openness. She acknowledged that there is more work to do as email access is not available to all staff. The Director of Human Resources and Organisational Development added that the existing structures are being fully

used as a communications cascade. He suggested that the monthly Executive Walkabouts needed to be reported. He is meeting the staff side chairs in the weekly following the Board Meeting to gain their ideas on communication and how well it is being cascaded throughout the organisation.

The Chair thanked the Chief Executive for her report.

RESOLVED: That the report be noted. [09:30]

288/16 INTEGRATED PERFORMANCE FRAMEWORK REPORT

The Director of Service Delivery presented the report summarising the key highlights and exceptions in Trust performance up until the end of August 2016 for the financial year 2016/17. Given the changes to the Board Committee arrangements and the timing of those meetings, there has been no Committee consideration of the report on this occasion. In future, it will form part of the business of the Quality and Performance Committee. Nonetheless, the report provides an on-going opportunity to review the level of assurances. He highlighted that our 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 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%. Nonetheless, this is a considerable improvement in performance. The 18 week referral to treatment performance was considered in detail by the Finance and Performance Committee in August 2016. There has been a reduction in the number of patients waiting from 51,200 in May 2016 to 49,500 in August 2016. There has been an increase in the number of patients waiting in excess of 18 weeks in particular for oral surgery where the number of patients waiting over 18 weeks is in excess of 700 due to an increase in demand. Additional staff have been identified and it is estimated that it will take eight weeks to recover the position. Our Trust is not achieving the maximum wait of 62 days from urgent GP referral to first treatment (excluding rare cancers) with performance continuing to be below target of 85% demonstrating 73.6% in July 2016. This was also considered in detail by the Finance and Performance Committee in August 2016. The key issue is demand with increased referrals under the two week wait and capacity issues especially in urology. An improvement plan is in place but it is unlikely that the plan can be brought forward due to capacity issues. Private providers are taking outpatient appointments. The Cancer Management Board comprising representatives of the Clinical Commissioning Group, NHS Improvement and NHS England, are providing critical challenge to the recovery plan. The Elective Care Support Team had visited our Trust to provide quality assurance and a letter confirming their visit is expected shortly.

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

- The Chair sought an assurance on the level of confidence to deliver the Cancer Recovery Plan. In response, the Director of Service Delivery confirmed that this is subject to external

review and Urology is the main focus. If Urology performance improves to meet the target, then overall Trust performance should be achieved. The actions are being reviewed weekly. Referrals continue to increase. The Chief Executive stressed that the Recovery Plan is the most robust which our Trust has developed with the plan to deliver the two week wait performance during this calendar year. She stressed that the first assessment is important to patients and the 62 day appointment is not necessarily so. The plan is to achieve a 62 day performance from February 2017 onwards. The Director of Service Delivery added that referrals for skin cancer in August 2016 were beyond that anticipated.

- The Medical Director referred to the number of Clostridium Difficile infections post 48 hours which was red risk rated for Q1 of 2016/17. He explained that a case by case review has been undertaken as some cases were considered unavoidable. Following that review, four cases have been agreed as unavoidable which brings the number below the target.
- Mrs Munro sought an explanation to the decrease in the number of planned/endoscopy patients waiting at the end of September 2016. In response, the Director of Service Delivery said that additional capacity has been provided which only provides a short term solution. The capacity and demand for gastroenterology has been reviewed with a proposal for additional staff to reduce reliance on locums and overtime. There is a requirement for endocrinologists and not gastroenterologists.
- Mrs Munro highlighted that there had been on MRSA post 48 hour infections since April 2016.
- The Chief Executive said that our Trust is not as agile as it should be to respond to increases in demand. This was particularly the case with the 18 week referral to treatment target where actions were not taken until close to the 18 week timeframe. This was not a good approach for our organisation and the system needed to be looked at.

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. [09:47]

289/16 FINANCIAL PERFORMANCE REPORT

The Interim Finance Director presented the report providing an overview of the financial performance of our Trust as at the end of month five of the 2016/17 financial year. It provided the three primary financial statements and a high level analysis of variances and movements against the planned position to NHS Improvement. The key issues were that the financial position of our Trust at the end of month five of the 2016/17 financial year is an operational deficit £11.1M which is an adverse variance to plan of £13.4M. There is a prior year impact included in the current year to date position of £5.6M. The NHS Improvement 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. Our Trust's internal budget does not reconcile, either by cost category or phasing, to the NHS Improvement plan. The figures presented in the report as "planned" reflected the figures as submitted to NHS Improvement unless explicitly stated otherwise. The variance to the financial plan for the year to date position will mean an increased scrutiny of our Trust's financial position and an increased focus on cost recovery in the form of both Cost Improvement Programmes and Agency Expenditure Reductions.

The Interim Finance Director then presented each page of his report and reported additionally the following points:-

- The Trust is over performing on its contract but may not necessarily get the full tariffs and there is no assurance that it will be funded by the Clinical Commissioning Group.
- The Cost Improvement Programme is not delivering as designed as it is not a plan to deliver the required £18M savings during the current financial year. Good plans identify savings from the beginning of the financial year whereas there were minimal savings identified from that period. The agency cap overlaps with the Cost Improvement Programme.
- The prior year corrections were not recognised in the income and expenditure run rate. The month five figures reflect actual performance with the prior year costs.
- A working capital facility was taken out but our Trust has been slow and with deferred payment to suppliers to manage the cash position. This has been poorly planned.
- The Capital Programme was reduced to £11M and costs will increase as the plan was not designed with rigour for quality and risks.
- Our Trust's NHS Improvement continuity of service rating will remain a 1 for the foreseeable future due to the financial position.
- There has been a good movement on debtors in month five and planned for month 6.
- The cash flow position is important as our Trust has not been paying suppliers.

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

- The Chair expressed her appreciation to the Interim Finance Director and his Team for the work to design a report fit for purpose providing much clearer information.
- Mr Norton referred to the agency staff expenditure, whilst acknowledging the difficulties to manage this, said that it is 40% over budget in six months, indicating a lack of executive resolve and he asked what will be undertaken during the next six months to reduce expenditure. In response, the Director of Human Resources and Organisational Development said that an Agency Task Group has produced a plan and that challenge is to delivery it identifying areas of high impact to change the run rate figure. There is staff engagement to ensure that the correct processes are followed to assist. The Nursing Director has taken tough controls to cease the use of the expensive Thornbury agency staff. Our Trust is transferring locum appointments to substantive appointments.

Substantive bank staff are undertaking more shifts with incentives to become bank staff. The ideas generated are good and need to be delivered and are being taken back for Divisional review to apply locally. Procurement expertise has improved.

- The Chair asked how effective the rostering system is observing that one ward gave advance notice of a shift which existing staff can undertake because of that increased notice. In response, the Nursing Director said that our Trust is looking at quality and safer staffing to see what can be done differently to release time for nurses. As an example pharmacy technicians are issuing drugs which will help doctors and improve patients for discharge. Our Trust is looking at preventing moving staff to other Divisions so that patient experience is better. There is a real drive and commitment to stop agency staff and to reduce agency staff on difficult one to one cases.
- Ms Millar asked when the full year forecast will become available. In response, the Chief Executive said that the base-line work will take approximately six to eight weeks to complete and the figures in the report remain "Best Endeavours". In quarter four a sense will be gained of the figures for 2017/18 planning purposes.
- The Chief Executive said that the Workforce Committee should receive assurance on staff numbers and the Finance Committee on staff expenditure.
- In response to a question from Mr Foster about the planning process, the Chief Executive explained that the plans will be redesigned from the bottom up and financial assumptions and changes will be presented to the Board.
- Ms Barber asked if our Trust had the Team, capacity and capability to deliver the Financial Recovery Plan and the Cost Improvement Actions. In response, the Interim Finance Director said that the resources did not currently exist and he was looking at the structure a view of two or three people helping capacity. A tender process is being undertaken for the Cost Improvement Programme resourcing.
- Mrs Munro asked if our Trust had the workforce capacity and capability to recruit permanent staff. In response, the Director of Human Resources and Organisational Development said that we have the capacity and capability but, nonetheless, was open to suggestions for improvements. The project management approach adopted to deliver Emergency Department performance should be replicated. The Chief Executive explained that A&E performance is a clinically lead workstream with people as enablers.
- Mr Foster said that our Trust should ascertain why staff are leaving and encourage them to stay.
- The Chief Executive said that the Recovery Plan will be presented to the Board.

The Chair thanked the Interim Finance Director for the report.

RESOLVED: That the report be noted. [10:32]

290/16 EMERGENCY PATHWAY REPORT

The Chief Executive presented the report providing quality, safety and performance indicators, key risks and validated performance against the Emergency Care Programme Board Milestone Plan. The report reflected data up to 31 August 2016. The focus has been on Workstream 4 – Clinical Patient Flow Model and Workstream 6 – Remove Delays to Discharge. The former workstream has been reviewing the utopia model and preparing reconfiguration proposals for the medium term. Workstream 6 has been developing alternatives to care in addition to that provided by the system. Other Trusts have developed their own domiciliary care arrangements for patients to return home for assessment with intensive domiciliary care. Community care costs are lower and this provides a better patient experience. Our Trust needs to investigate this approach. Our Trust achieved the agreed improvement trajectory of 87% for August 2016 with Trust wide performance (including GP in the Emergency Department activity) reported as 90.85%.

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

- The Director of Service Delivery reported that the Winter Plan 2016/17 is to be presented to the Board in October 2016 with detailed plans to manage patient care in the community which have been tested. **EG (MW to note for Agenda)**
- The Nursing Director reported that following the visit to Oxford, that model is to be introduced here on 1 November 2016 to provide enhanced patient care which will impact favourably on agency numbers. The Director of Service Delivery added that this is both a Trust and system wide issue. The A&E Delivery Board is focussing on Emergency Department performance and partner organisations, particularly Gloucestershire Care Services and 2Gether Trust, have volunteered to help improve the situation.
- The Medical Director referred to the work of Workstream 3 – SAFER Patient Flow Bundle, to reduce the number of patients over 14 days. This situation is improving with support from partners. Staff engagement is being undertaken as to what changes would benefit their work and not just improving the four hour standard. The Director of Clinical Strategy added that staff should be empowered to make changes. The Chief Executive commented that the Intensive Discharge Team is not effective given that the numbers remain from when the Team was set up at a cost of approximately £2M. The Interim Finance Director said that the cost to our Trust of the 77 patients waiting for discharge is £6,000 per annum each. The Nursing Director added that there are 140 patients on the county pathway waiting to go home due to the absence of domiciliary caused by difficulties associated with staff recruitment. The Chief Executive added that a different employment model needs to be adopted to make the role attractive.

The Chair thanked the Chief Executive for the report.

RESOLVED: That the report be noted and that the actions being taken to improve performance be endorsed. [10:45]

291/16 NURSE AND MIDWIFERY STAFFING

The Nursing Director presented the report updating the Board on the Exception Reports made regarding compliance with the "Hard Truths" – Safer Staffing Commitments for August 2016. She explained that the RAG comparison is against an "All England" median and not an "All England Division" median. Green was equal to or better than All England and our Trust; amber was worse than either All England or our Trust and red was worse than both All England and our Trust. This classification identified the areas upon which to focus. She referred to the overseas recruitment campaigns in November 2015 and May 2016 and the considerable number of candidates who had not passed on each occasion the International English Language Testing System (IELTS) examination. Different roles are being considered to release nurses to perform increased nursing duties.

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

- Mr Foster referred to the nurse turnover rates of approximately 20% and asked if the recruitment campaigns to India would be effective. In response, the Director of Human Resources and Organisational Development said that the overseas recruitment campaigns to the Philippines have been a particular challenge with the high number of candidates not successful in the IELTS examination and the high candidate withdrawal rate. A recruitment campaign is planned to India with a campaign to Portugal taking place at the beginning of October 2016. Previous campaigns to Portugal have been successful in part both in terms of recruitment and retention; however, Portuguese candidates will now be required to undertake the IELTS examination. Staff retention is a high priority with a focus group established to capture staff experiences during employment as the exit interview is too late. More flexibly managed shifts are being considered but the Nursing Director added that 43 whole time equivalent staff left our Trust last year due to reduced hours emphasising the difficulty to introduce systems to retain all.
- The Director of Service Delivery suggested that in the vacancy forecast the newly-qualified nurses joining the Trust be treated as a separate group.
- The Chief Executive sought confidence in the procedures to reduce agency costs to ensure that budgets were not being released to create posts and backfill with agency staff. There appeared to be an absence of compliance with the control base. In response, the Nursing Director said that the acuity of patients often meant that it was difficult to track whether costs related to a new post or a vacancy. The Chief Executive invited the Nursing Director, the Director of Human Resources and Organisational Development and the Interim Finance Director to establish recruitment processes at ward level and that assurance be provided to the Workforce Committee. **DS/MA/SD**

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. [10:58]

292/16 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) stating that 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 October 2016. The BAF set out the controls to mitigate the potential risks to the delivery of the annual objectives and provided assurance that the controls are effective or described 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 three main risks were patient flow, service reconfiguration and the availability of capital and workforce. The risk surrounding the Trust's financial position was rated as 20 and not 25 as it was not considered to be catastrophic.

The Chair invited Board members to comment on the BAF and TRR to which there were none.

The Chair thanked the Chief Executive for the report.

RESOLVED: That the updated Assurance Framework be noted and the revised approach be endorsed and in doing so the potential risks to the 2016/17 objectives and the controls in place to mitigate those risks be noted. [10:59]

293/16 STAFF SURVEY ACTION PLANS – UPDATE

The Director of Human Resources and Organisational Development presented the report providing an update on the key corporate action plans agreed at the Board in July 2016 in response to the 2015 annual staff survey findings. The top three priorities agreed by the Board in July 2016 were transport/parking, environment and reducing beaurocracy. With regard to transport/parking, there is a real commitment to make progress. Proposals are being developed by the Estates and Facilities Transport Team which will need to be shared with staff and their representatives at the earliest opportunity. It is expected that broader engagement will commence in October 2016. On environment, the Board has agreed that to "handymen" could be employed and assigned to wards and departments on a weekly basis to rapidly deal with simple fixes or improvements to local environment. Unfortunately, it has not been possible to recruit the two individuals and efforts will now be doubled to ensure that the commitment is honoured. On reducing beaurocracy, the "Permission to Fill" recruitment form has been removed with the decision making firmly in the control of the Divisions. The Chief Executive has made available a small sum of money for each Division in the guise of a "just sort it" fund which will enable some things to be dealt with which may appear in the environment category. An open and transparent decision making culture underpins much of the three priorities. Continued communication is vital if our Trust is to retain traction in these areas.

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

- The Medical Director said that the original proposals were for a multi-story car park on both sites and the Chief Executive said that this would be picked up by the Director of Estates and Facilities as part of the work for the utilisation of both sites.
- Ms Barber undertook to speak separately to the Director of Human Resources and Organisational Development on developing staff engagement and culture. The Director of Human Resources and Organisational Development commented that the staff survey relates specifically to staff. **TB/DS**
- The Chief Executive referred to the "happy app" introduced in another Trust which the Director of Human Resources and Organisational Development undertook to pursue. This would also include other methods to seek feedback, for example, texting patients to rate their outpatient appointment. **DS**
- The Chair invited the Director of Human Resources and Organisational Development to provide a further update in December 2016. **DS (MW to note for agenda)**

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

RESOLVED: That progress with the action plans arising from the 2015 staff survey be noted. [11:14]

294/16 COMPLAINTS AND CONCERNS Q1 APRIL – JUNE 2016

The Nursing Director presented the reported providing information on the complaints and concerns reported to our Trust during Q1 2016/17. She highlighted that our Trust has seen a decrease of approximately 14% in the number of complaints against the number of complaints received during the previous quarter. She reported that Susie Crow has been appointed to the post of Head of Patient Experience replacing Heather Beer.

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

- Mr Foster referred to the procedure whereby the Chief Executive signs all letters of complaint. The Chief Executive said that there has been a change in the response to complaints with a role for Divisions to own complaints.
- Ms Barber said the level of quantitative data will provide a greater value to the assessment of complaints which the Nursing Director was happy to pick up stating that the bulk of complaints relate to discharges. **MA**

The Chair thanked the Nursing Director for the report.

RESOLVED: That the Q1 2016/17 Complaints and Concerns Report be noted. [11:19]

295/16 FINANCIAL GOVERNANCE REVIEW – TERMS OF REFERENCE

The Chief Executive presented the report seeking approval to the proposed terms of reference for the Financial Governance Review which the Board had previously agreed to co-commission with NHS Improvement. The terms of reference have been developed in close liaison with the Board, NHS Improvement and our Trust's legal advisers, DACBeechcroft reflecting 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 our Trust's reported financial position. It is intended to make publically available the key findings from this review, including any recommendations for action. A separate process will be followed if any recommendations are made in respect of individuals. Subject to approval by the Board, it is intended to commence a procurement exercise on 3 October 2016 with interviews on 20 October 2016 and a start of 1 November 2016 with emerging findings available before Christmas and the final report available in January 2017.

During the course of the discussion, the Chair suggested that the word "inherent" in the third line of the Purpose of the Review, be deleted as it was considered pre-emptive.

The Chair thanked the Chief Executive for the Report.

RESOLVED: That the terms of reference for the Financial Governance Review incorporating the above amendment and as appended to these minutes be approved. [11:25]

296/16 MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD ON 3 AUGUST 2016

The Chair presented the minutes of the meeting of the Council of Governors held on 3 August 2016.

RESOLVED: That the minutes be noted. [11:25]

297/16 ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

Items for the next meeting:

No additional items were identified for the next meeting.

Any Other Business:

Board Reports
Mr Norton thanked report authors for the improvement in the information contained in reports re-stating that there should be a conclusion to the information provided supported by graphs as necessary with appropriate text provided.

Mr Gordon Mitchell
The Chair wished to place on record her thanks to Gordon Mitchell for his work to the Board and the Trust following his decision to stand down with immediate effect. His decision had created a vacancy for the recruitment of an interim Non-Executive Director with financial expertise. The recruitment will begin for two further Non-Executive Directors with financial expertise. She thanked Mr Mitchell for his work as Chair of the Finance and Performance and Quality

Committees and with his work with the Lead Governor on the governor effectiveness elements of the Board Governance Review and with the Director of Clinical Strategy on the Stakeholder Engagement Strategy. He was appointed Vice Chair in 2012.

Mr Clive Lewis
The following is an extract from the August Board meeting minutes.

The Chair said that this will be the last Board meeting which Clive Lewis will be attending before the end of his term of office at the end of the month. Clive was appointed Non-Executive Director for a three year term in 2010 and re-appointed in 2013 for a further three years. She expressed her appreciation for the way in which he had brought his human resources and business experience to our Trust which had been invaluable. He had challenged the Board on specific issues and as Chair had developed the former Equality and Diversity Committee and the Innovation Panel. She made a presentation to Clive which was applauded by the Board.

Clive thanked the Board for the experience which the appointment had offered and he wished the Trust well for the future. [11:30]

298/16 STAFF QUESTIONS

There were none. [11:30]

299/16 PUBLIC QUESTIONS

There were no public questions submitted in accordance with the Board's procedure however, the Chair invited questions from the members of the public present.

Mr Thomas, Lead Governor, said that the Board discussion had been positive and more open and transparent which was to be welcome.

The Board agreed that future Gloucester meetings be held in the Redwood Education Centre. [11:30]

300/16 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at **9.00am** on **Friday 28 October 2016** in the **Board Room, Alexandra House, Cheltenham General Hospital.**

301/16 EXCLUSION OF THE PUBLIC

RESOLVED: That in accordance of 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 11.30am.

Chair
28 October 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

FINANCIAL GOVERNANCE REVIEW

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 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

30th September 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – OCTOBER 2016

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
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. *This item appears later in the Agenda. Completed.*
October 2016	September 2016 Minute 285/16 Minutes of the meeting of the Audit Committee held on 6 September 2016	**SD**	The Director of Clinical Strategy asked if the Board could be supplied with the internal audit work plan which the Chair of the Committee was happy to arrange. *Ongoing.*
October 2016	September 2016 Minute 290/16 Emergency Pathway Report	**EG**	The Director of Service Delivery reported that the Winter Plan 2016/17 is to be presented to the Board in October 2016 with detailed plans to manage patient care in the community which have been tested. *This item appears later in the Agenda. Completed.*
October 2016	September 2016 Minute 291/16 Emergency Nurse and Midwifery Staffing	**DS/MA/SD**	The Chief Executive invited the Nursing Director, the Director of Human Resources and Organisational Development and the Interim Finance Director to establish recruitment processes at ward level and that assurance be provided to the Workforce Committee. *Ongoing.*
October 2016	September 2016 Minute 293/16 Staff Survey Action Plans - Update	**TB/DS**	Ms Barber undertook to speak separately to the Director of Human Resources and Organisational Development on developing staff engagement and culture. *Ongoing.* The Chief Executive referred to the "happy app" introduced in another Trust which the Director of Human Resources and Organisational Development undertook to pursue. *Ongoing.*
October 2016	September 2016 Minute 294/16 Complaints and Concerns Q1 April – June 2016	**MA**	Ms Barber said the level of quantitative data will provide a greater value to the assessment of complaints which the Nursing Director was happy to pick up stating that the bulk of complaints relate to discharges. *Ongoing.*

FUTURE TARGETS

December 2016	September 2016 Minute 293/16 Staff Survey Action Plans - Update	**DS**	The Chair invited the Director of Human Resources and Organisational Development to provide a further update in December 2016. *Ongoing.*

COMPLETED 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 throughfoot (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* 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 reported 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	**HM**	Mrs Munro referred to the increased sickness levels with RGNs and said that she would feed this into the Health

	Midwifery Staffing		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. *This item appear later in the agenda. Completed*.

ITEM 5

SUMMARY OF THE MEETING OF THE FINANCE COMMITTEE TO BE HELD ON 26 OCTOBER 2016

PAPER (To follow)

Tony Foster
Chair

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST FINANCE COMMITTEE HELD IN THE BOARDROOM, ALEXANDRA HOUSE, CHELTENHAM GENERAL HOSPITAL ON WEDNESDAY 28 SEPTEMBER 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
	Keith Norton	Non-Executive Director
	Stuart Diggles	Interim Director of Finance
APOLOGIES	Eric Gatling	Director of Service Delivery
IN ATTENDANCE	Martin Wood	Trust Secretary
	Sarah Stansfield	Director of Operational Finance

The Chair welcomed all to the meeting.

129/16 DECLARATIONS OF INTEREST **ACTION**

There were none.

130/16 MINUTES OF THE MEETING HELD ON 24 AUGUST 2016

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

131/16 MATTERS ARISING

The outstanding matters arising which related to performance issues would transfer to the Quality and Performance Committee and the Chief Executive had met Mr Mitchell and the Director of Safety as to how that might work.

132/16 FINANCIAL PERFORMANCE REPORT

The Chair expressed his appreciation to the Interim Director of Finance and his team for the work undertaken in revising the format of the Financial Performance Report which was a transformational step. He invited Committee members to consider the report on a line by line basis.

The Interim Finance Director presented the report providing an overview of the financial performance of our Trust as at the end of month 5 of the 2016/17 financial year. It provided the three primary financial statements along with a detailed analysis of the financial position, including income and expenditure, balance sheet and cash. The report also included a "Best Endeavours" financial forecast for the 2016/17 financial year. The key issues to note were that the finance position of our Trust at the end of month 5 of the 2016/17 financial year

is an operational deficit £11.1M which is an adverse variance to plan of £13.4M. There is a prior year impact included in the current year to date position of £5.6M. The NHS Improvement 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. Our Trust's internal budget does not reconcile, either by cost category or phasing, to the NHS Improvement Plan. The figures presented in the report as "planned" reflect the figures as submitted to NHS Improvement unless explicitly stated otherwise. Our Trust is forecasting an income and expenditure deficit of £26.6M against a planned surplus £18.2M, representing a £44.8M adverse variance to the NHS Improvement Plan. A negative available cash balance is also forecast of £40M based on no borrowing at the end of December 2016. Since the forecast was constructed our Trust has received £19.9M of borrowed funds from the Department of Health.

The Chair and Mr Norton expressed their appreciation to the Interim Finance Director, the Director of Operational Finance and their Team for the detailed revised report format and clear conclusions. In response to a question from Mr Norton about our Trust's statements of financial policies, the Chief Executive said that the Audit Committee has oversight for all accounting policies and some of the revisions will be presented to the Committee in November 2016 with the remainder in January 2017. The Interim Finance Director added that there may be policies in existence but not applied appropriately. He said that our Trust's Financial Plan was unsatisfactory, ill-informed and not deliverable. The actual figures set out in the report were as close as could be but he was uncertain at this stage of the relationship to the original plan. The Interim Finance Director stressed that he did not know whether everything had been uncovered in particular with regard to bad debts which could be a prior year adjustment. The approach to pursuing income was weak. This process has now changed to one of more rigour in that the process has begun to get all invoices presented to Shared Services rather than Divisions and staff practice had to change. Mr Norton asked if financial performance was included as an objective for the previous Finance Director to which the Chief Executive said it was not.

The Chair invited the Interim Finance Director to present his report on a page by page basis and the following were the points raised:-

<u>Introduction and Overview – Statement of Comprehensive Income</u>

- Mr Foster asked if our Trust's external auditors concurred with the income and expenditure position. In response, the Interim Finance Director said that further baselining work is to take place over the next two to three months which will take into account the debt provisions. The Chief Executive said that the 2017/18 plan will be based on the outcome of the base-line review. Following the outcome of the review it may be necessary to apply to the courts to re-open the 2015/16 accounts for a re-file.

At A Glance – Month Five

- The Interim Finance Director said that there is a gap in the delivery of the Cost Improvement Programme of £9M and he expressed a view that the plan was poorly prepared to achieve the savings target of £18M.
- The Chief Executive said that there had been issues in relation to the approach adopted for income and coding. Agency spend is high and the Cost Improvement Programme assumed an agency spend reduction from no plan. The requirement is to reduce agency expenditure with a need to appoint staff on a permanent basis. The Interim Finance Director explained that it was necessary to undertake a procurement exercise to get advice on a more forward looking basis to deliver Cost Improvement Plans during the current financial year and 2017/18. There have already been changes to the reporting arrangements.
- The Interim Finance Director said that the cash balances were fundamentally wrong and that capital expenditure has progressed slowly but there was no cash to back up that plan.

Income Analysis – By Commissioner

- The Interim Finance Director clarified that the pre-CQUIN and post-CQUIN required £2.124M to return to a balance. The total risk adjustment amount to £2.719M and it may be possible to recoup some of that income either by delivery or agreement of a percentage to be paid back.
- The Chief Executive said that for the next financial year the contract position will be determined earlier.
- Mr Norton asked for information on our relationship with partners to recover income. In response, the Chief Executive said that County partners have been supportive and the financial position will be shown in the County Sustainability and Transformation Plan. A relationship needs to be developed with the new Chief Executive at the Hereford Trust but there is no flexibility to recover income due to the severe financial situation in that Trust.

Income Analysis – By Point of Delivery

- The Interim Finance Director said that outpatient activity is above plan but less income is received.
- The Director of Operational Finance said that our Trust is addressing the issues raised by CKS following the coding review and it is too early to say whether the position may change.
- The Chief Executive said that our Trust is approximately two years away from full introduction of service line reporting. The Interim Finance said that he would like to undertake the HRG Analysis as the income and expenditure part of the report is presented to Divisional Management Teams to see the detailed income level of analysis.
- Mr Norton asked if Divisions understand that they are accountable for the income position to which the Chief Executive said that it is part of their objectives.
- The Interim Finance Director said that un-coded spells accounted in month 5 total £3.9M and work is in progress to

understand the reasons for this.

Detailed Income and Expenditure

- The Interim Finance Director said that the agency cap of £12M could never be achieved. The Chief Executive added that NHS Improvement could not understand how our Trust submitted a plan of £12M against a prior year agency expenditure of £24M. The amount will be reset for next year and it will be difficult for our Trust to achieve the revised internal figure of £16M for the current financial year.
- The Chief Executive said that there is a different focus for the Executive Team to reduce agency spend.

Pay Expenditure – Trust Total

- No comments were made.

Pay Expenditure – By Division

- The Interim Finance Director said that further work will be undertaken on the pay position in Medicine Division which showed the greatest year to date variance.

Agency Expenditure

- The Interim Finance Director said our Trust has currently spent 60.5% of the £16M internal target as at month 5.

Non-Pay Expenditure

- The Interim Finance Director said that other non-pay shows a significant adverse variance of £7.9M for the year to date. Included within the year to date plan for month 5 is £6.5M of the overall Cost Improvement Programme target of which delivery against is £1.9M, thereby driving £4.6M of the adverse variance. Prior year adjustments of £3.3M also account for the increase in expenditure for month 5 in other non-pay expenditure.
- The Chief Executive said that the Cost Improvement Plan was not recognised by Divisions and therefore there was no ownership of the detail of the plan. The Interim Finance Director said that the Cost Improvement Programme requirements should build on the earlier months of the financial year but this was not the case in our Trust.

Cost Improvement Programme

- The Chief Executive said that the Trust-wide element should be incorporated within the Divisions.

NHS Improvement Continuity of Services Rating

- The Chief Executive said that the overall rating will be a 1 for the financial year due to our Trust's financial position. The Chief Executive explained that our Trust is in segment 4 of the Single Oversight Regime and is likely to be placed in special measures.
- Mr Norton questioned whether the real financial position is known at this stage.

Balance Sheet

- The Interim Finance Director drew attention to the balance sheet

movements from 31st March 2016. The table showed the month 5 balance sheet and associated variance to the plan as submitted to NHS Improvement. The table also divided the variance between movements from the 2015/16 closing balance sheet and those consequently at variance to plan.

Current Assets – Debtors

- The Interim Finance Director said that within "other English NHS", the single largest debtor in the 120+ days is Gloucestershire Care Services. Our Trust has now agreed a final position on prior year debt in line with the mediation decision issued by NHS Improvement. The transaction processing will be actioned during month 6 this then leaves a total of approximately £14M of debt of which £4 million is classified as old debt.

Current Assets – Cash

- The Interim Finance Director drew attention to our Trust's cash balances for 2016/17 and the analysis between reserved and unreserved balances. Reserved balances were mainly for SmartCare, internal funds and joining up your information. He was aware of reserved funds of approximately £2.5M of which £1.5M was from the Clinical Commissioning Group made available since 2013/14 as capital funding for emergency care improvements. NHS Improvement expect an improvement in our cash position with an expectation to borrow less. Our Trust needs approximately £10M of cash per day to operate.

Current Liabilities – Trade and Other Payables

- The Interim Finance Director said that this is a progressive piece of work to reduce the trade and other payables. Approximately £49M is located on the purchase ledger of which approximately £20M is already overdue.

Better Payment Practice Code

- The Interim Finance Director said that the Better Payment Practice Code performance currently only includes those invoices that are part of the creditors ledger balance. It is likely that this represents only 50% of the invoices. Further work is being undertaken to fully understand the position.

Liabilities – Borrowing

- The Interim Finance Director drew attention to the two major loans outstanding with the Independent Trust Financing Facility. The first loan from 2007 was to facilitate improvements relating to back log maintenance and the second was for the building of the Hereford Radiotherapy Unit in 2012. The Chair observed that the total loan was approximately £100M.
- The Interim Finance Director explained that this level of borrowing will impact on our Trust's ability to borrow for service reconfiguration proposals. He undertook to ascertain the duration of the loan under the Private Finance Initiative contracts.

Cash Flow

- The Interim Finance Director said that the major movements are consistent with those already identified within income and expenditure and balance sheets with the key movements in current assets, trade payables, other loans and working capital.

Forecast Outturn – Income and Expenditure

- The Interim Finance Director said that the forecast outturn assumed no further Sustainability and Transformation Fund monies.
- The Chief Executive said that our Trust should aim to be in the lower quartile nationally during quarter 3.

Initial Short Term Cash Flow Forecast

- The Interim Finance Director said that the forecast does not include the impact of the £20M working capital facility which has now been agreed.

The Interim Finance Director said that the report will be developed for future Committee meetings showing more granular detail which can then be taken to Divisional meetings.

The Chair thanked the Interim Finance Director for the report.

RESOLVED: That:-

1) 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 which is an adverse variance to plan of £13.4M be noted.
2) There is a prior year impact included in the current year to date position of £5.6M be noted.
3) The NHS Improvement plan and 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 NHS Improvement plan. The figures presented in the report as "planned" reflect figures as submitted to NHS Improvement unless explicitly stated otherwise.
4) The Trust is forecasting:

- An income and expenditure deficit of £26.6M against a planned surplus of £18.2M representing a £44.8M adverse variance to the NHS Improvement Plan.
- A negative available cash balance of £40M based on no borrowing.
- Since the forecast was constructed our Trust has received £19.9M of borrowed funds from the Department of Health. There will be a further borrowing requirement above this amount.

133/16 DELOITTE FINANCIAL REPORTING REVIEW RECOMMENDATIONS

The Interim Finance Director presented the report providing an update on the progress to date against the 34 recommendations resulting from the Deloitte review: Financial Reporting – Enhancing Transparency

dated 17 August 2016. He highlighted that of the key issues to note a considerable amount of activity in relation to the recommendations has been completed in the last month. The summary of progress is that 8 recommendations have not started; 21 recommendations are in progress and 5 actions have been completed. It must be noted that a number of the recommendations which are shown as in progress have had an initial piece of work completed but will continue to be progressively developed for a number of months. Three of the recommendations are the subject of external support which is subject to procurement.

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

- Mr Norton enquired whether there were any particular issues with the recommendations and in particular those with a status of not started. In response, the Chief Executive said that the issue with the recovery of the long term debtor in respect of the Hereford Radiotherapy Unit has not started as a new Chief Executive is about to be appointed for that Trust and when in place discussions with commence.
- The Interim Finance Director said that there is a balance to be taken between undertaking the work associated with the recommendations with the capacity to do so.

134/16 PREPARATION FOR THE OCTOBER MEETING

The Chief Executive reported that it was not considered to be good practice to have all Divisions attending on one occasion and that the most appropriate reason would be for attendance by exception.

135/16 FINANCE COMMITTEE WORK PLAN

The Committee's work plan would be reviewed taking into account the changes in responsibility for the Committee and that for the Quality and Performance Committee.

136/16 COMMITTEE REFLECTION

The Committee reflected on the positive impact of the revised format of the Finance report.

137/16 ANY OTHER BUSINESS

Terms of Reference

The Committee considered the draft Terms of Reference and made the following amendments:-

- One Non-Executive Director member to also be a member of the Audit Committee
- Two of the three Non-Executive Directors and ideally the Chair should have relevant financial expertise
- The Director of Service Delivery be replaced by the Chief Operating Officer
- The Director of Human Resources and Organisational Development be added to the list of members
- The Cost Improvement Programme Director, Medical Director

and Nursing Director be added to the list of invitees
- One non-voting Governor representative to be invited to meetings of the Committee.

Mr Norton said that the role of the Committee is to hold the Chief Executive to account for the performance of the Executives and the Chief Executive confirmed that Executive Directors have individual objectives.

RESOLVED: That with the above amendments, the draft Terms of Reference be circulated to Committee members before being presented to the Board for approval in October 2016.

138/16 DATE OF NEXT MEETING

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Finance Committee will be held on **Wednesday 26 October 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 17 October 2016.**

The meeting ended at 12:05pm.

Chair
26 October 2016

GLOUCESTERSHIRE HOSPITALS NHS TRUST

MEETING OF THE HEALTH AND WELLBEING COMMITTEE
TUESDAY 4 OCTOBER 2016
9.30 AM REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL

PRESENT:

Helen Munro	HM	Non-Executive Director (Chair)
Tony Foster	TF	Non-Executive Director
Sally Pearson	SP	Director of Clinical Strategy
Dave Smith	DS	Director of HR and Organisational Development
Kate Jeal	KJ	Communications Specialist
Catherine Boyce	CB	Clinical Strategy Manager
Fiona Brown	FB	Senior Dietician
Heather Beer	HB	Head of Patient Experience
Karen Tomasino	KT	Lead Nurse, Paediatrics
Jane Evans	JE	Associate Director of Facilities
Julie Shepherd	JS	Physiotherapy Manager CGH
Joanna Glasscock	JG	Service Manager/Specialist Advisor Smoking Cessation (GSSS)
Coral Hollywood	CH	Heptology Consultant
Philip Lort	PL	Practice Development Nurse, Surgery (for P Garrett)
Karina Stallard	KS	HR Advisor
Jennifer Taylor	JT	Lead Commissioner (Public Health Commissioned Services) GCC
Emily Van de Venter	EV	Specialist Registrar in Public Health.

APOLOGIES:

Den Powell	DP	Trust Governor (Public)
Sue Maxwell	SM	Infant Feeding Specialist Midwife
Carol MacIndoe	CM	Trust Governor (Staff)
Sarah Scott	SS	Director of Public Health (GCC)
Lisa Riddington	LR	Library Services Manager
Tanya Richardson	TR	Public Health Consultant and SEND provision
Claire Knights	CK	Staff side representative
Jenny Bowker	JW	Associate Director of Strategic Planning (GCCG)
Jane Hadlington	JH	Staff side, Chair Staff H&WB Group
Elaine Watson	EW	Interim Manager Countywide Services/Head of Health Improvemt.(GCS)
Kay Davis	KD	Senior Midwifery Manager
Matt Pearce	MP	Senior Commissioning Manager, GCCG for J Bowker

IN ATTENDANCE:

Simon Aquilina	SP	Trust Food and Beverage Manager
Bridget Hooper	BH	Site Catering Manager CGH

ACTION

52/16 **APOLOGIES –** noted as above.

53/16 **MINUTES OF MEETING HELD ON 5 JULY 2016** – agreed without amendment.

54/16 **MATTERS ARISING** – covered elsewhere on the agenda

THE WIDER COMMUNITY

55/16 **SUSTAINABILITY & TRANSFORMATION PLAN (STP) UPDATE**

SP reported on progress with Gloucestershire's STP. Currently in draft form, this involved providers and commissioner organisations. Its purpose was to identify means of addressing the challenging gaps identified in the Five Year Forward View (FYFV) - H&WB gap, the care and quality gap, the finance and efficiency gap. Without transformational solutions services would be unsustainable in the future. There were four key themes.

Enabling Active Communities – Prevention and Self-care Strategy; asset based community models; focus on carer and user support; social and cultural commissioning.
Clinical Programmes Approach – transforming care (respiratory, dementia) Clinical programme approach developing pathways focusing on prevention; mental health FYFV.
Reducing Variation – medicines optimisation; reducing clinical variation; diagnostic, pathology and follow-up care.
One Place, One Budget, One System – Urgent care models and 7-day services; People and Place – 30,000 community model; devolution and integrated commissioning; personal health budgets.
These key areas would be underpinned by a system development programme and a number of system enabling projects.

ACTION

56/16 COUNTYWIDE H&WB BOARD

JT reported on a number of activities associated with the countywide H&WB Board.:

- ***Countywide Healthy Weight Work Programme -*** The first progress report on the work programme had been well-received and the contribution from across the county had been recognised. The next stage was to take forward some transformation work. A number of workshops focussed on specific tiers of service or client groups were scheduled over the next 9 months. JT would forward details. Anyone wishing to be involved should contact S Weaver. SP would discuss with Trust colleagues involved in the obesity agenda who would be best placed to attend the new Programme Board. JT would also raise the possibility of involving catering expertise in the group. It was noted that the Leeds Beckett project had now recommenced. **JT** **SP** **JT**

- ***Tendering process for the provision of Healthy Lifestyle Support Services*** – The evaluation of tenders had recently been completed. The outcome would be made public later in the month and the new contract would start in January 2017. The importance of early communication and open engagement with partners was highlighted, to understand how the new service would work and the implications of the changes. JT would raise this with PH colleagues. It was noted that the closure of the Health Promotion Resource was associated with the tendering exercise and not due the Trust's financial position. JT

- ***Minutes of the July meeting of the H&WB Board*** - noted.

- ***Trust "Health and Wellbeing of our Community Strategy" –*** SP reminded colleagues that this would be the third of the more focussed documents supporting the Trust H&WB Strategy, and due to be produced by the end of the year. The two previous documents had covered the H&WB of staff and of patients. The intention was to use this to draw together the contribution of the Trust to H&WB activities in wider community – reflecting relevant elements of the STP and other local plans.

PATIENTS' HEALTH AND WELLBEING

57/16 SMOKING CESSATION MONITORING REPORT

JG presented the latest report and highlighted a number of key points.

- **General acute referrals to GSSS** – whilst referrals from CGH had increased slightly in comparison with the previous years, the figures for GRH showed a decline of 46%. Action agreed by the Smoking Cessation Group included, further update training for Smoking Champions and targeting areas with a significant decline in referrals.
- **Maternity** – although the position had improved slightly, a significant proportion of women reported as smoking at booking were not being referred to GSSS. CO readings were also only currently recorded in around 71% of women referred, against a standard of 100%. KT would raise these continuing concerns with colleagues. It was suggested that behavioural factors might have a part to play and SP proposed that L Morrison be approached to undertake some work with midwifery colleagues. The current action plan was noted. It was also noted that although other elements of smoking cessation support were likely to change in future, smoking cessation in pregnancy remained a key element of the new healthy lifestyle support specification. **KT**

58/16 SMOKING SHELTERS ON HOSPITAL SITES

Following her arrival in the Trust, the new CEO expressed concern about the impact and poor and inappropriate image of the Trust from patients and visitors smoking outside the hospital – particularly the entrance to the Tower Block. It had been agreed that Paul Garrett and the Smoking Cessation Group should be asked to review the evidence, to consider the possibility of re-introducing smoking shelters and to share their findings with the H&WB Committee with a view to the Committee taking a decision on the proposal.

Colleagues recognised that this was a challenging problem. There was general acknowledgment that smoking on site and the Tower entrance provided an unacceptable image for the Trust and that patients, visitors and staff should not be subjected to second hand smoke. At the same time views on installing smoking shelters were extremely polarised. Points made during the discussion are summarised briefly below.

- For the greater good and to protect the health and wellbeing of the greater numbers who did not smoke, a shelter should be installed and compliance should be very actively enforced.
- Providing shelters was a pragmatic solution for those who were unwilling to desist from smoking whilst in hospital. The level of complaints received and concern at the

abuse often received by staff who requested people not to smoke was also seen by some colleagues as a driver for installing shelters. It was suggested that shelters would enable staff and others to feel more secure in confronting smokers.

- A literature review of the effectiveness of smoking shelters on hospital sites, undertaken by the librarians had revealed no strong evidence of their effectiveness.
- In the NICE Quality Standards (2015) on "Smoking reduction and preventing tobacco use" the statement for Standard 6 is *"healthcare settings do not allow smoking anywhere in their grounds and remove any areas previously designated for smoking".*
- Providing smoking shelters would give the message that the Trust officially condoned smoking and that this was not appropriate for a healthcare setting. It was also recognised that current arrangements might be seen to condone the practice.
- The poor fabric of the Tower Block was felt to be a contributory factor to people smoking in its entrance, but this was unlikely to be addressed in the short term.
- The Trust had provided shelters in the past, and these had not prevented smoking in other areas of the site. An example was also given of a Liverpool hospital where, following their installation, shelters had subsequently been removed because they were ineffective.
- It was understood that 2Gether NHSFT was likely to go smoke free in 2017 and did not envisage providing smoking shelters.
- The attitude of people who currently smoked at the entrance and were resistant to requests to stop smoking would suggest that they would be unlikely to move to a distant shelter. Proximity of a shelter close to the entrance was felt by some colleagues to be unacceptable. Multiple shelters would be required across both sites.

Following discussion and in light of the complexity of the issues, HM proposed that colleagues be asked to indicate with a show of hands whether they would support the re-introduction of smoking shelters on site. The majority of colleagues were against the installation of shelters. Three colleagues were in favour. As a consequence, the recommendation from the Committee is not to reintroduce smoking shelters.

Other options to encourage people not to smoke were suggested. These included:

- a very active and on-going media campaign to enrol the support of the community in creating a smokefree site
- revisiting the proposal to update the smokefree site signage (currently on hold)
- installing smoke-operated loud speakers – asking people to move away and desist from smoking (previously installed and vandalised)
- including the role of policing the smokefree policy in future tenders for security services or car parking contracts
- encouraging "vaping" as an alternative to smoking
- enhancing the entrance area to the Tower Block.

HM thanked colleagues for their wide-ranging and in depth discussion.

59/16 MEDICAL STUDENT AUDIT PROJECT

The Committee noted the results of the audit which Alice James, a 5th year Medical Student, had undertaken during her attachment with the Trust against elements of *NICE Quality Standards on Obesity in Children and Young People.* Key findings included:

- the availability of healthy options in all locations with vending machines – albeit that only 19% of products in total could be classified as healthy;
- limited nutritional information currently displayed in the hospital restaurants on the menus offered and cooking methods employed – although staff could generally provide information for customers if asked;
- good examples of innovative practice in the hospital restaurants, e.g. the farm shop;
- disappointing findings with regard to the prominence given to healthy options in displays in non-Trust retail concessions.

Colleagues acknowledged the work which had been put into the audit and recognised that its findings would be very valuable to the catering department in informing work which they were planning to do – with retail concessions and when vending contracts were reviewed.

60/16 THE HEALTH AND WELLBEING OF OUR PATIENTS STRATEGY

It was noted that the work programme would be revised in the light of the recent publication of the countywide "Prevention and Self Care Plan" and other plans.

61/16 BREASTFEEDING

The Committee noted the most recent quarterly report.

ACTION

62/16 FOCUS ON ALCOHOL AND REDUCING HARM FROM ALCOHOL

Jennifer Taylor, Lead Commissioner (Public Health), and Coral Hollywood, Consultant Heptologist, made presentations on the H&WB priority of reducing harm from alcohol.

JT set out the wider context, including the national and countywide picture, the impact of alcohol on health and local services and the disproportionate impact on the poorest in society. She drew attention to the countywide Alcohol Reduction Action Plan (2016-2019) and its key priority areas, outlined the range of PH commissioned services and developments. She identified a number of challenges for the future - including the need for culture change, developing prevention and community approaches, keeping a partnership focus and evaluating the impact of interventions.

CH described a range successes and issues from the perspective of a Trust clinician.

- **Management of alcohol withdrawal** – the introduction at the end of 2013 of new alcohol withdrawal guidelines, staff education programme and symptom triggered regimen – resulting in improved delivery of medication and reduced length of stay and which was well received within the Trust.
- **Alcohol Liaison Service** – the role and value of the service, but also the frustration that this was only available during office hours when the alcohol related attendances peaked between 5pm to 5am and particularly Friday pm to Monday am.
- **Community Services** – the need for a more seamless transfer from hospital to community, the lack of any inpatient facility for detox by community providers within the county for Gloucestershire residents, the need for a greater presence from community providers around the time of discharge to support individuals.
- **Data collection** – the need for improved coding in the hospital, incomplete completion of Audit C – part of the initial assessment of all patients in ED - resulting in failure to pick up problems early and alert the Alcohol Liaison Team; the need to share data across providers, and identify when alcohol is a cause of death.
- **Future plans** – included, on-going education of staff, identification of a nurse on each ward to champion the need to manage patients who need detox.

In the course of a brief discussion a number of points were highlighted:

- the complexity of some of the commissioning arrangements and lack of clarity of how to put forward business cases (JT would raise with commissioner colleagues) **JT**
- ensuring representation from the Trust in relevant countywide groups.

HM thanked JT and CH for their presentations which had greatly increased the group's understanding of this H&WB priority area. (CB to circulate copies of the presentations) **CB**

STAFF HEALTH AND WELLBEING

63/16 STAFF HEALTH AND WELLBEING GROUP (SHWBG)

DS reported on a number of points arising from a recent meeting of the SHWBG.

- a short survey for staff to identify which H&WB activities the SHWBG should prioritise;
- an approach from a firm willing to fit out a gym on site if space could be found;
- a Staffside suggestion that space should be allocated to enable staff to take time away from their desks during breaks.

It was suggested that there might be spare space in the Orchard Centre. DS to investigate. KT identified a need for suitable office space for members of her team. **DS**

64/16 WORKPLACE WELLBEING CHARTER

KS made a short presentation on the purpose the Charter. This encouraged organisations to audit and benchmark against an independent set of standards. DS highlighted the need to demonstrate improvement and for gaining evidence from staff to substantiate this.

65/16 COMMUNICATIONS UPDATE

KJ shared examples of recent initiatives. Social media and Facebook were increasingly effective in spreading H&WB messages, particularly for staff without computer access. HM highlighted the forthcoming *Walk for Wards* initiative.

66/16 NICE PUBLIC HEALTH RELATED GUIDANCE – no recent relevant guidance to report.

67/16 ANNUAL DIVISIONAL H&WB PRESENTATIONS

It was agreed the purpose should be for Divisions to have the opportunity to share their achievements and identify areas for support, but not be a formal accountability exercise.

68/16 DATE AND TIME OF NEXT MEETING – To be confirmed

ITEM 8

SUMMARY OF THE MEETING OF THE QUALITY AND PERFORMANCE COMMITTEE TO BE HELD ON 26 OCTOBER 2016

PAPER (To follow)

Keith Norton
Chair

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE RE-CONVEINED MEETING OF THE TRUST WORKFORCE COMMITTEE HELD IN THE BOARD ROOM, ALEXANDRA HOUSE, CHELTENHAM GENERAL HOSPITAL ON FRIDAY 14 OCTOBER 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)
	Tracey Barber	Non-Executive Director
	Dave Smith	Director of Human Resources and Organisation Development
	Maggie Arnold	Nursing Director
	Eve Russell	Associate Director of HR
APOLOGIES	Dr Sean Elyan	Medical Director
	Sarah Stansfield	Director of Operational Finance
IN ATTENDANCE	Martin Wood	Trust Secretary
	Sarah Brown	Communications Specialist

The Chair welcomed the members of the Committee to the meeting. He apologised for the adjournment but it was necessary for the Board to consider those matters which are now in the public domain.

010/16 DECLARATIONS OF INTEREST **ACTION**

There were none.

011/16 MINUTES OF THE MEETING HELD ON 27 JULY 2016

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

012/16 MATTERS ARISING

003/16 THE TOP WORKFORCE PRIORITIES:
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 Trust Secretary reported that a member of the Communications Team has been invited to attend future Committee meetings. Completed.*

004/16 WORKFORCE STRATEGY 2016-2021:
The Committee agreed 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. *This item appears later in the Agenda. Completed.*

005/16 WHAT DATA DOES THE COMMITTEE NEED?
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. *This item appears later in the Agenda. Completed.*

GOVENOR REPRESENTATION ON THE COMMITTEE:

The Director of Human Resources and Organisational Development reported that at the Board Seminar on 5 October 2016 it was agreed there be one Governor on each Board Committee. On this basis, it was agreed that Ms McIndoe would be a member of the Committee and that Mr Randles would be a member of the reporting Education Committee. *Completed.*

013/16 WORKFORCE STRATEGY

The Chair introduced the Workforce Strategy and the four questions which the Committee needed to address; namely, what feedback have we received? Is the Workforce Strategy good enough for now? What are our top two/three priorities for this coming year? And what is our communication plan? He invited the Committee to consider the strategy on the basis of these questions.

What feedback have we received?
The Director of Human Resources and Organisational Development said that the strategy was widely circulated and not a significant volume of comments were received. Those comments received formed part of the Committee's papers. Ms McIndoe said that she had provided comments on equality and diversity.

The Director of Human Resources and Organisational Development had concluded that the comments received were sufficiently included in the strategy and that no changes were necessary.

Is the Workforce Strategy good enough for now?
The Chair said that the strategy is more than good enough to be published and that it can be reviewed again in March 2017.

DS (MW to note for agenda)

The Communications Team will take forward the strategy to be presented to the Board in November 2016 and launched in December 2016. In response to a question from Ms Barber about how the strategy will be launched, the Senior Communication Specialist said that there will be generic communications, blog intranet and outline. This approach was supported by the Committee.

SB (MW to note for agenda)

What are our top two/three priorities for this coming year?
The Director of Human Resources and Organisational Development said that the top three priorities for the forthcoming year should be workforce supply and retention, costs including financial management of those costs and engagement. The Chair added that the Chief Executive is supportive of these three priorities. Ms Barber observed that it is critical how the priorities are measured to ensure success.

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

- The Director of Human Resources and Organisational Development said that the current Workforce Plan is flawed as there are so many staff vacancies with increasing expenditure on internal bank staff to prevent the use of agency staff to prevent our Trust spending above the overall pay bill. The Chair

said that the run rate should be determined by March 2017 to ensure delivery of next year's run rate.

- The Chair asked how agency spend is managed. In response, the Director of Human Resources and Organisational Development said that a Task Force was established three months ago under his remit with leadership by the Cost Improvement Programme Director. The Delivery Board meets on a fortnightly basis and alternate meetings focus on the work of the Agency Task Force with ownership of the work lead by the Associate Director of Human Resource and Divisional representatives.
- The Director of Human Resources and Organisational Development tabled the Agency Action Plan which had been submitted to NHS Improvement. The owning workstreams are to develop detailed action plans and provide challenge. Some assumptions were made and some have dependencies on other workstreams. As an example he drew attention to the reduction in the number of ad-hoc and out of hours bookings which can relate to sickness and are higher at the weekend. The original plan submitted to NHS Improvement was for an agency spend cap of £12M. Our Trust has agreed a local plan of £16M and the Director of Human Resources and Organisational Development said that an accurate position had to be presented to NHS Improvement. Ms Barber asked how this task was tracked on a weekly basis. In response, the Nursing Director said that she was the owner of this task and had the data presented to her and she would report to the Committee as workstream lead on red risk areas and the reasons. Ms Barber asked what happened between meetings to ensure our Trust acted speedily if necessarily. In response, the Director of Human Resources and Organisational Development said that he has monthly meetings with the Nursing and Medical Directors and it is essential that weekly catch up calls take place to ensure that the actions are on track and if not remedial action is undertaken swiftly. The Chair stressed that it is essential for weekly catch up arrangements to be in place.
- The Chair referred to the task of no booking of agency HCAs (exceptions for specialising) which had an end date of 30 September 2016. Mr Randles said that in his view the number of internal bank staff was sufficient. The only alternative to agency nurses was to use HCAs. He would like to see a programme of bank recruitment for HCAs on a generic recruitment basis. The Associate Director of Human Resources asked Mr Randles to share with her examples of where there were issues regarding generic recruitment. The Associate Director of Human Resources reported that there was no HCA agency used in the last two weeks. The Chair said that these circumstances should be considered further at the next meeting of the Committee. **RR/ER**
- The Chair referred to the available resources required to deliver the Agency Action Plan. In response, the Director of Human Resources and Organisational Development said that there are insufficient resources to provide traction and momentum and in his view project management support is required to take forward the work of the workstreams. This view was supported by the Committee noting that a similar project management approach **ER** ***(MW to note for agenda)***

should be adopted to that for the Emergency Care Recovery Plan. The Director of Human Resources and Organisational Development said that the Agency Action Plan will be considered by the Recovery Board and the Finance Committee.

RESOLVED TO RECOMMEND: That project management support be provided to the Agency Action Plan on the basis of formal dependencies with other Trust Action Plans.

- Ms Barber asked how the Committee will ensure that the priorities are being delivered and on what basis the reporting Committees will provide data. In response, the Director of Human Resources and Organisational Development tabled the Workforce priorities of supply, cost and engagement with the priority tracker. The key objectives will include success and what that will look like. The Director of Human Resources and Organisational Development undertook to develop the tracker and circulate it to the Committee for comment during the forthcoming week so that it could be completed by the end of October 2016. **DS**

What Is Our Communication Plan?
This was addressed earlier in the discussion.

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

RESOLVED TO RECOMMEND: That the Workforce Strategy 2016-2021 be approved.

014/16 DATA DASHBOARD

The Chair expressed his appreciation to Gillian Egan, Workforce Information Manager for the presentation of the Workforce Dashboard and for including by graphs depicting trends with conclusions.

The Director of Human Resources and Organisational Development presented the Workforce Dashboard for August 2016. He explained by way of an example of the dashboard the first item relating to sickness absence and turnover. The data showed that our Trust is better at managing short-term sickness and there is a lack of focus on long-term sickness absence. Divisions are being asked to manage long-term sickness absence in an improved way and making arrangements for staff to return to work.

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

- The Chair asked how many staff are on long-term sickness absence. In response, the Director of Human Resources and Organisational Development said that some staff receive a 3% payment premium and are not eligible for sickness pay. It is necessary to capture the absence rate and triangulate that with the table identifying reasons for sickness.
- The Chair sought the views of Committee members on whether the Dashboard is sufficient to enable the Committee to track

priorities. Ms Barber questioned whether the Dashboard reinforced priorities observing that the driver to improve turnover rates is engagement and how those priorities are reported and the results interpreted. Ms McIndoe stressed that engagement is key which the Director of Human Resources and Organisational Development acknowledged should be at pace. The Chair observed that greater engagement will help achieve priorities in other areas. Ms Barber asked how success for staff engagement is to be judged and whether it would be a reduction in turnover in specific areas noting that if engagement is successful it would help in taking forward the other Workforce priorities of supply and cost. The Associate Director of Human Resources observed that the reports from Committees will enable triangulation of the data. It will be for the reporting Committees to undertake the detailed analysis with trends reported to the Committee at a high level.

- The Director of Human Resources and Organisational Development reported that the pay bill analysis for medical and dental staff should replicate that for registered nursing and midwifery staff to ensure that all costs are captured.
- The Chair concluded that the Dashboard is sufficient for the Committee's purposes and can be reviewed subsequently.

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

RESOLVED: That the Data Dashboard be noted.

015/16 REPORTS FROM COMMITTEES

In the light of the discussion in minute number 014/16 relating to the data dashboard, the format of Committee reports will be based on the priority tracker.

016/16 ANY OTHER BUSINESS AND DATES FOR FUTURE MEETINGS IN 2016

Any Other Business

Risk Management Group

DS
(MW to note for agenda)

The Director of Human Resources and Organisational Development reported that a new Risk Management Group has been established reporting to the Trust Leadership Team. The Committee at their next meeting should consider workforce risks.

Chair of the Committee

The Chair reported that Tracey Barber will be Chairing future Committee meetings and that he will remain a member of the Committee.

Date of Next Meeting

The Committee agreed to hold their next meeting on Friday 2 December 2016 at 3pm in the Board Room at Alexandra House, Cheltenham General Hospital.

The Committee agreed that thereafter and for the remainder of the

current financial year meetings should be held monthly before reverting to bi monthly.

017/16 COMMITTEE REFLECTION

The Committee reflected on the meeting with views of productive, engagement focus and the sharing of information with the Committees.

018/16 DATE OF NEXT MEETING

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Workforce Committee will be held on **Friday 2 December 2016 at 3pm** in the Board Room, Alexandra House.

Papers for the next meeting:
Completed papers for the next meeting are to be logged with the Trust Secretary than no later than 3pm on **Wednesday 23 November 2016.**

The meeting ended at 4:15pm.

Chair
2 December 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – OCTOBER 2016

REPORT OF THE CHIEF EXECUTIVE

1. Current Context

1.1 The repercussions, associated with the recent news regarding the Trust's financial position, continue to be felt. On the 14th October, NHS Improvement (NHSI) concluded its investigation into the circumstances which led to the sudden and unexpected deterioration of Trust's financial position and subsequently confirmed that it had reasonable grounds to conclude that the Trust was in breach of its provider license and as such intended to seek "undertakings" (under s106 of the Health and care Act 2012) from the Trust to ensure a sustained and timely recovery of the current financial position.

1.2 Regrettably, NHS Improvement subsequently announced its intention to put the Trust into Financial Special Measures (FSM) under the recently issued framework *Strengthening Financial Performance & Accountability in 2016/17,* published by NHSI and NHS England (NHSE) in July of this year. Gloucestershire Hospitals is one of three Trusts who will be put into special measures in the coming weeks; there are presently five Trusts in England already under the FSM regime.

1.3 Whilst this action signals the seriousness of the Trust's position it also affords the Trust access to specialist skills and additional capacity to ensure the Trust returns to financial balance as soon as possible, and most importantly, without detriment to the safety and quality of the services we provide.

1.4 Further information is awaited in respect of the precise nature of the measures that will be put in place. In the meantime the executive team continues to develop its financial recovery strategy and delivery plans, whilst taking all immediate steps open to it, to reduce the deficit in year and ensure a more positive monthly "run-rate" going into 2017/18.

2. National

2.1 Following submission of the Trust's capital bid, for the development of its estate, through the Sustainability and Transformation Planning (STP) process, the Trust was invited to develop its bid further and submit to the treasury through NHS England. The Trust achieved this, despite very short timelines. We are still awaiting a decision regarding award of the available capital but the Trust has been requested to submit two further tranches of information.

2.2 The Care Quality Commission (CQC) published its annual *State of Care* report earlier this month which has received considerable coverage. In the main, the report described a context of improving health and social care with more than 70% of those services previously rated as "inadequate", by the CQC, having improved at subsequent inspection however, less positively, more than 50% of those that "required improvement" had not been able to achieve a "good" or "outstanding" rating and emergency care services were signalled out as been of particular concern. This latter issue was described as reflecting the consequences on health services of changes to the availability of social care and other services which respond to the ever increasing needs of vulnerable and /or older people.

2.3 Finally, of note, the CQC observed that eight out of ten hospitals had less money than required and that hospitals that looked after their money, tend to give better care. This observation chimes well with the Trust's own message to staff that good financial stewardship and high quality care go hand in hand.

3. Regional

3.1 I am delighted to report that Dr Rebecca Swingler has been awarded the accolade of Obstetrics & Gynaecology Trainer of the Year in the Severn Deanery. Becca works in the Trust's obstetrics and gynaecology service and was nominated by those that had been supported by her, whilst in training at our Trust. The Board's congratulations have been forwarded to Rebecca.

4. Our System

4.1 Work continues to finalise the next submission of the Gloucestershire STP (Sustainability and Transformation Plan) which is due for submission on the 21st October 2016. The revised financial position of our Trust means that, without further savings (or less investment), the STP is no longer in financial balance. The impact of our forecast deficit would require a 3.5% improvement in the overall plan. At the time of writing the report, discussions between STP partners and NHS England about how to present the impact of Gloucestershire Hospitals' deficit are ongoing.

4.2 Furthermore, the national transformation funding available to support delivery of the STP vision and plan is now unlikely to be available as previously thought; this means the funding will not be able to be accessed by the system until the end of the five year planning period i.e. 2019/20 as opposed to across each of the constituent years.

4.3 STP partners have made a commitment to publish the Gloucestershire STP and this will be made publically available in due course. Of note, NHS England has stressed the importance of plans being clear on any issues that may require public consultation. The Gloucestershire systems vision for responding to the national guidance on urgent and emergency care is expected to result in changes to the model of care and associated pathways and will be flagged through the STP submission as something around which we wish to engage the public – the necessity for more formal public consultation will not be understood until the end of the engagement exercise.

4.4 Current timeline for this work is December 2016 to March 2017 for staff and public engagement, followed by consultation (if required) late May 2017 to end of August 2017. STP Communications Group is leading on the development of plans for this engagement piece.

4.5 In response to ongoing delays in the discharge of patients' who are ready to leave hospital, I have convened a "summit" of partners with the aim of bringing about a step change in the systems response to what appears to be an intractable issue. Chief Executives from the five STP organisations will attend the facilitated session alongside a small number of key front line staff (from each organisation) who can speak about their experiences of trying to discharge patients and the blocks they come up against. The aims of the session are to create a single system "narrative" which describes the key issues preventing timely discharge from hospital and a set of high impact changes, each organisation will commit to implement, in order to bring about a step change in performance. The meeting will take place on the 20th October and a verbal update will be provided to the Board when it meets later in the month.

5. Our Trust

5.1 The Trust met with NHS Improvement last week as part of the formal requirements associated with the regulatory enforcement action taken in August this year following a period of sustained failure to meet the national A&E standard. Although the Trust is not yet meeting the national A&E standard of 95% of patients being seen within four hours, NHSI were assured that the Trust continues to embed recent improvements and prepare for the Winter challenges ahead. Of particular note, the Trust met the recovery trajectory for Q2 and were commended for this progress.

5.2 Preparation has commenced in earnest for the Care Quality Commission inspection due to take place w/c 23rd January 2017. Staff have welcomed this focus on quality as we begin our financial turnaround and appear to recognise the interdependence of care quality and financial health.

5.3 Earlier this month, I had the pleasure of attending and addressing our annual Medical Education Conference organised by Dr Kim Benstead, Director of Medical Education and her team. It was phenomenal to see and hear about the things the Trust's educationalists and learners are achieving. The mission for any healthcare institution such as ours, is to realise the synergy that can come from aligning teaching, research and care delivery to give patients and staff the very best opportunities – last week's conference was a great insight into how our Trust is rising to this tripartite mission.

5.4 The Trust's 100 Leaders forum met on the 7th October to work together to explore how we will respond to the opportunities and challenges ahead. It was the best attended meeting of this group that anyone present could remember and the energy in the room was palpable. Those present heard from a number of speakers, both clinical and non-clinical; topics covered included a presentation from the Trust's new Interim Director of Finance on our approach to financial recovery, an overview of the new business planning approach from Dr Sally Pearson and a very interesting session from Dr Kate Hellier on a new initiative aimed at reducing the number of days that patients spend in hospital by eliminating those days that add "no clinical value". This is an initiative that has been rolled out elsewhere in England and the Trust has visited other sites to develop this best practice approach. Roll out to wards at both Gloucester Royal Hospital and Cheltenham Hospital is underway and expected to be completed by the end of November at the latest.

5.5 Finally, the Board has recently agreed a revised structure for the executive team which sees some changes to individual director responsibilities and also the creation of a new Chief Operating Officer role. Interviews for the latter will take place on the 20th October (Interim COO) and existing directors will transition to their new portfolios over the course of November with the transition being complete by the end of that month.

6. Consultant Appointments

The following consultants have recently been appointed:

Acute Medicine	Dr Mark Pietroni

Deborah Lee
Chief Executive Officer

October 2016

MAIN BOARD – OCTOBER 2016
BOARD ROOM, ALEXANDRA HOUSE

Report Title									
BOARD COMMITTEE STRUCTURE									
Sponsor and Author(s)									
Sponsor – Clair Chilvers – Chair. Report Author – Martin Wood – Trust Secretary									
Audience(s)									
Board members	**X**	Regulators	**X**	Governors	**X**	Staff	**X**	Public	**X**

Executive Summary

Purpose To invite the Board to approve a revised Board Committee Structure

Key issues to note The proposal reflects the Trust's response to concerns regarding the effectiveness of the Board's governance arrangements and notably it's committee model. The proposal aims to address weaknesses in governance identified through recent reviews, including the Deloitte Governance Review and NHSI investigations, resulting in Enforcement Undertakings.

The proposal also seeks to clarify the role of governors on Board sub-committees to ensure consistency of approach and enable a development programme to be mobilised to support them in executing their role and responsibilities.

Conclusions The proposals presented address identified weaknesses in the former Board Committee arrangements. It is possible that further iterations may be required following the Financial Governance Review.

Implications and Future Action Required Implementation of revised arrangements and review of effectiveness, three months hence.

Recommendations
To approve the Revised Board structure
Impact Upon Strategic Objectives
None
Impact Upon Corporate Risks
Addresses risks identified in corporate governance arrangements
Regulatory and/or Legal Implications
The Trust's regulator, NHSI, has welcomed the proposed changes as a means of addressing their concerns regarding the effectiveness of the Board to effectively govern its business and key risks
Equality & Patient Impact
None

Resource Implications			
Finance		Information Management & Technology	

Human Resources		Buildings					
Action/Decision Required							
For Decision		For Assurance		For Approval	X	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)**
					Board development session
Outcome of discussion when presented to previous Committees					
Proposal was welcomed and endorsed for presentation to the Board					

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – OCTOBER 2016

BOARD COMMITTEE STRUCTURE

1 Purpose of Report

1.1 The purpose of this report is to invite the Board to approve a revised Board Committee Structure.

2 Background

2.1 In August 2016 the Chief Executive presented to the Board a proposal to amend the form and function of the Board Committee structure following the recent regulatory action taken by NHS Improvement. The Workforce Committee has been established to enable enhanced scrutiny of the workforce agenda, and it was proposed that the focus of the current Finance and Performance Committee be narrowed to one which is focused on finance whilst continuing to recognise the important relationship between operational finance and operational performance. It was also proposed that the performance and quality agendas be governed through a single Quality and Performance Committee. The Finance Committee held its first meeting in September 2016 and the Quality and Performance Committee held its first meeting in October 2016.

2.2 The Board at its Seminar in October 2016 made further revisions to the Board Committee structure as follows:-

a) The Audit Committee to be renamed Audit and Assurance Committee to reflect the important assurance focus.
b) The Health and Wellbeing Committee to no longer be a Board Committee and renamed the Health and Wellbeing Steering Group.
c) The Innovation Panel role to be incorporated with the remit of the transformation programme.
d) The establishment of a transformation programme and associated governance structure, which will report directly to the Board but not established as a Board Committee, in keeping with its role and remit
e) The ongoing requirement for Patient Experience Strategic Group to be reviewed and if retained, its incorporation in the quality committee sub-group arrangements.
f) The establishment of a Risk Management Group reporting to the Trust Leadership Team providing a dedicated forum to oversee risk management arrangements..

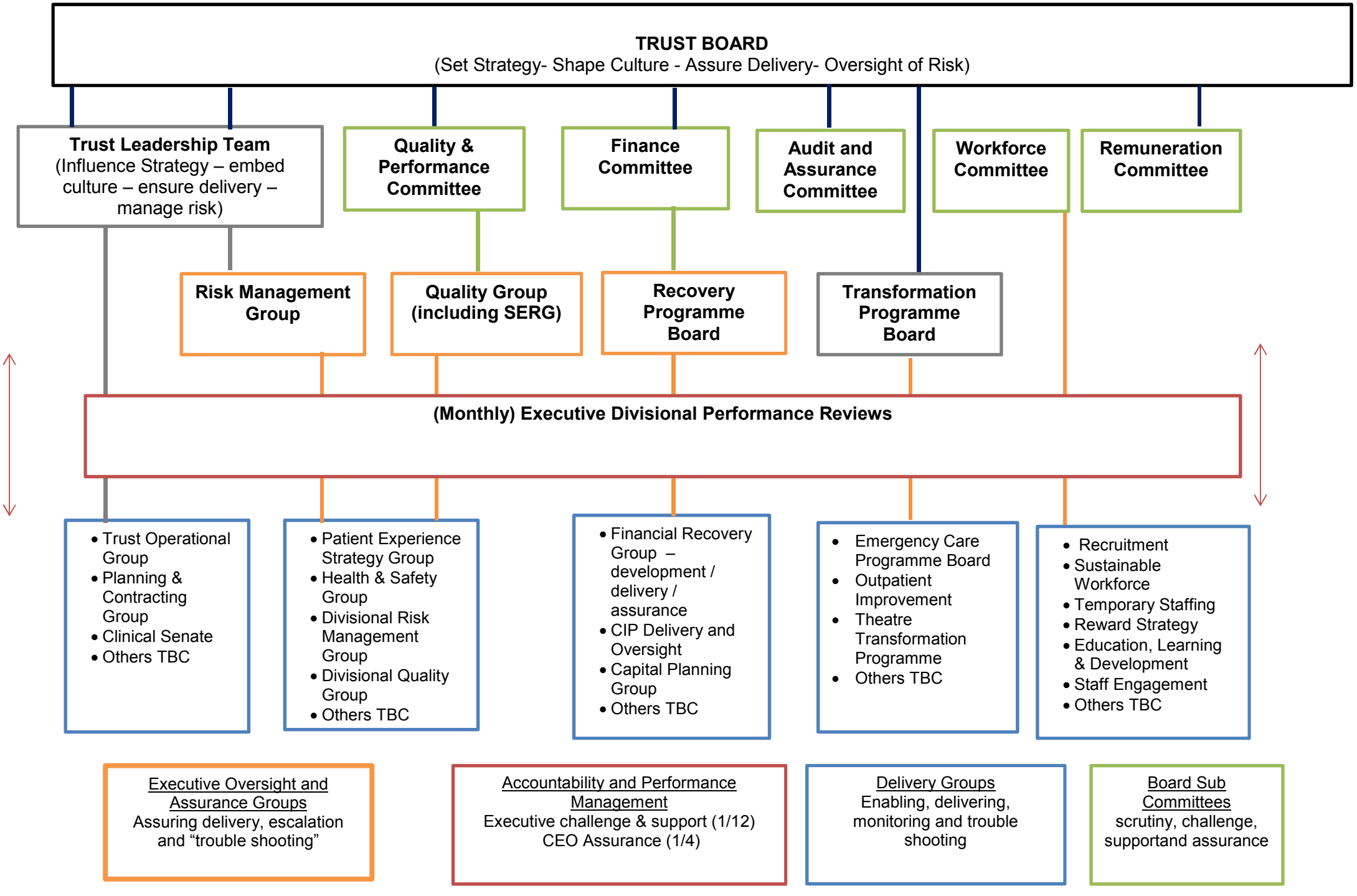
2.3 The new Board structure is attached. This also shows bodies below the Board which is subject to further revision.

2.4 The Seminar considered the membership of these Committees in terms of Executive and Non Executive Directors and Governors. With regard to Governor representation, it was concluded that there should be one Governor representative on each Board Committee. The role of the Governor on Committees has been clarified. (see attachment).The membership is shown in the revised terms of reference which have been updated for each Board Committee and are attached to this report.

3 Recommendation

3.1 The Board is invited to approve the revised Board Committee structure and the terms of reference appended to this report.

Author: **Martin Wood, Trust Secretary**
Presenting Director: **Clair Chilvers, Chair**
October 2016


TRUST BOARD
(Set Strategy- Shape Culture - Assure Delivery- Oversight of Risk)
Trust Leadership Team
(Influence Strategy – embed culture – ensure delivery – manage risk)
Quality & Performance Committee
Finance Committee
Audit and Assurance Committee
Workforce Committee
Remuneration Committee
Risk Management Group
Quality Group (including SERG)
Recovery Programme Board
Transformation Programme Board
(Monthly) Executive Divisional Performance Reviews
• Trust Operational Group
• Planning & Contracting Group
• Clinical Senate
• Others TBC
• Patient Experience Strategy Group
• Health & Safety Group
• Divisional Risk Management Group
• Divisional Quality Group
• Others TBC
• Financial Recovery Group – development / delivery / assurance
• CIP Delivery and Oversight
• Capital Planning Group
• Others TBC
• Emergency Care Programme Board
• Outpatient Improvement
• Theatre Transformation Programme
• Others TBC
• Recruitment
• Sustainable Workforce
• Temporary Staffing
• Reward Strategy
• Education, Learning & Development
• Staff Engagement
• Others TBC
Executive Oversight and Assurance Groups
Assuring delivery, escalation and "trouble shooting"
Accountability and Performance Management
Executive challenge & support (1/12)
CEO Assurance (1/4)
Delivery Groups
Enabling, delivering, monitoring and trouble shooting
Board Sub Committees
scrutiny, challenge, supportand assurance

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

QUALITY AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

Policy	✓
Review of Policy	✓
Review of Trust Area of Activity	✓
Operations	X
Resource Management	X

Constitution of the Committee
The Quality and Performance Committee is a non-statutory committee of the Trust Board established to support the Board in discharging its responsibilities for ensuring the quality of the services which the Trust provides.

Purpose

1. To provide assurance to the Trust Board on the effectiveness of the Trust's arrangements for ensuring the quality of services throughout the Trust. Quality is defined across the three domains of:

    - Safety
    - Clinical Effectiveness
    - Patient Experience

2. To shape and influence the Trust's Quality Strategy and associated objectives, including overseeing the development and production of the statutory Quality Account.

3. To ensure that the Trust's services are compliant with the Fundamental Standards set out by the Care Quality Commission and where this is not the case to oversee action which address areas of non-compliance.

4. To ensure the Trust delivers services which consistently meet the nationally defined minimum standards and notably the four key standards required by the Trust's regulator. Where performance is below the standard required the Committee will ensure that robust recovery plans are developed and implemented

    - A&E Four Hour Wait
    - Cancer Waiting Time
    - Referral To Treatment (RTT)
    - 6 Week Diagnostic

Membership and Responsibilities

Chair
Non-Executive Director

Vice Chair
Non-Executive Director

Members
One further Non-Executive Director
Nursing Director
Medical Director
Chief Operating Officer
CCG Representative
Director of Safety
Head of Patient Experience

Governor Representative – Non-voting
Governor

Officer
Trust Secretary

Quorum
The Committee shall be quorate when a minimum of 50% of members are present which must include two non-executive members and two executive members (one of whom should have a clinical background) are present

Frequency
Monthly

Accountable To
Trust Main Board

Responsible for
Quality Group
Patient Safety Forum
Patient Experience Strategic Group

5. To have oversight of the Trust's systems and processes for investigating, responding and learning from incidents and complaints to ensure services develop and improve as a result of these insights.

6. To commission "deep dives" into any area where there is a quality concern & oversee the development and implementation of remedial action plans where these are required. On occasions this may require personnel from the Trust's clinical divisions to attend the committee.

7. To support the Trust's objective to strive for continuous quality improvement through the work of the quality academy and any other ad hoc activities.

8. To ensure that staff effectively involve patients and their carers in the planning and evaluation of services so as to ensure that services meet the needs and preferences of patients, so far as is possible.

9. Work with the Board's Workforce Committee to ensure that staff education, learning and development is aligned with the Trust's quality priorities.

10. Work with the Board's Finance Committee to ensure that the availability of resources does not adversely impact upon the quality of services to the extent that patient safety is compromised or care is delivered that doesn't meet the required mandatory quality standards as defined by the CQC and NHSI.

11. Champion and celebrate high quality care throughout the organisation.

(Under review)
Medicines Optimisation Management Committee
Screening Programme Governance Committee
Hospital Mortality Indicators Group
End of Life Care Steering Group

Submission/availability of Minutes
Minutes reported to the next available Board meeting.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

FINANCE COMMITTEE

TERMS OF REFERENCE

Policy	✓
Review of Policy	✓
Review of Trust Area of Activity	✓
Operations	✓
Resource Management	✓

The purpose of the Finance Committee is to support the Board's strategic direction and stewardship of the Trust's finances, investments and financial sustainability. In particular, the Committee is to provide the Board with assurance concerning all aspects of finance and operational performance relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients, within the resources set out in the annual plan. The function of the Committee is to scrutinise and ensure delivery of, on behalf of the Trust Board, the strategic principles, priorities and performance parameters for:

1. Delivery of the financial aspects of the Operational Plan.
2. The annual financial plans: income and expenditure plans/budgets, revenue investment, capital investment, working capital, statement of financial position and cash flow, and associated targets for savings to ensure sustainability going forward.
3. The availability and quality of financial management information (to ensure a consistent approach to financial management).
4. Sustainable service commissioning from a financial and funding perspective.
5. Review and maintain an overview of financial and service delivery agreements and key contractual arrangements.
6. Oversee the development, management and delivery of the Trust's annual capital programme.
7. Review and approve as appropriate on behalf of the Board business cases developed by the Trust
8. Consider key financial policies e.g. investment policy, issues and developments to ensure that they are shaped, developed and implemented in the Trust appropriately.
9. To consider and recommend for approval by the Trust Board any proposed changes to Trust Standing Financial Instructions.
10. Any other relevant matters as referred by the Board.

Membership and Responsibilities

Chair
Non Executive Director

Vice Chair
Non Executive Director

Members
Non Executive Directors x 3 (including the Chair and Vice Chair) (Two and ideally the Chair should have recent relevant finance expertise) (One Non-Executive Director should also be a member of the Audit and Assurance and Quality and Performance Committees)
Chief Executive
Director of Finance
Director of Human Resources and Organisational Development
Chief Operating Officer

Invitees
Director of Operational Finance
Medical Director
Nursing Director
Cost Improvement Programme Director
Other staff at the invitation of the Chair

Governor Representative – Non-Voting
Lead Governor

Officer
Trust Secretary

The Duties of the Committee are to consider and examine:-

(a) Key financial performance indicators.
(b) Monthly/annual consolidated financial performance summaries and related plans/budgets.
(c) Cost improvement plans
(d) The monthly/annual statement of financial position.
(e) Working capital performance.
(f) Cash flow status.
(g) Capital Programme.
(h) Risks associated with financial plans.
(i) Financial relationships with Trust Commissioners.
(j) Financial Risk Ratings applied by NHS Improvement.
(k) Financial performance forecasts.
(l) Cash flow forecasts
(m) Financial aspects of the Board Assurance Framework.
(n) Business cases classified as "major" or "high risk" and making recommendations to the Board

The Committee are to:-

(a) Approve the investment and borrowing strategy and associated policies
(b) Set financial performance benchmarks and monitor the performance of investments.
(c) Review proposed revisions to the Capital Investment Policy for approval by the Board each year
(d) Seek and consider evidence of organisational compliance with the Capital Investment Policy

Quorum
3 members of whom 1 must be a Non Executive Director
Meeting Frequency
Monthly

Reporting Line
Trust Board

Sub-Committees
Capital Control Group

Submission/Availability of Minutes
Minutes reported to the next available Board meeting

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

AUDIT AND ASSURANCE COMMITTEE

TERMS OF REFERENCE

Policy	X
Review of Policy	✓
Review of Trust Area of Activity	✓
Operations	X
Resource Management	X

The Audit Committee is authorised by the Trust Main Board:

1. To investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee (both directly and indirectly employed) and all employees are directed to co-operate with any request made by the Committee. Members of other NHS organisations may also be invited to co-operate with the Committee.

2. To obtain outside legal or other independent professional advice and to secure attendance of outsiders with relevant experience and expertise if it considers this necessary.

The Audit Committee is responsible to the Main Board for the following main functions:

3. To consider, with Governors, the appointment of the external auditor, in line with the Code of Conduct for Foundation Trusts, and the audit fee. It is the role of the Council of Governors to appoint or remove the Trust's external auditor.

4. To discuss with the external auditor before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the health economy and with the Trust's internal auditors.

5. To review external audit reports, including value for money reports and annual audit letters, together with the management response.

Membership & Responsibilities

Not less than three Non-Executive Directors

Chair
A Non-Executive Director

Vice Chair
A Non-Executive Director

Members
A Non-Executive Director

(One Non-Executive Director should also be a member of the Finance Committee)

Attendees
Chief Executive
Finance Director
Chief Operating Officer
Trust Secretary
Director of Safety
Director of Operational Finance
Representatives of the External Auditors
Representatives of the Internal Auditors
A representative of the Local Counter Fraud Service
One Governor

Officer
PA to Director of Finance

Quorum
The Committee shall be quorate when at least two Non-Executive Directors are present

Frequency of Meetings
Not less than six times a year, including at least one meeting a year with both the internal and external auditors but without executive Board members and including at least one meeting at which the Chief Executive and/or the Chair is present as an observer. The external auditors or internal auditors

6. To consider the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal.

may request a meeting if they consider that one is necessary.

Reporting Line
Trust Main Board

Sub-Committees
None

Submission/Availability of Minutes
Minutes are held by the PA to Director of Finance and are circulated to members and attendees following the meeting.

7. To approve and review the internal audit programme in line with the Assurance Framework, consider the major findings of internal audit investigations and management's response, to receive and review the Head of Internal Audit opinion and ensure co-ordination between the internal and external auditors.

8. To ensure that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.

9. To prepare an Annual Report that sets out how the Committee has met its Terms of Reference.

10. To offer assurance to the Board that the Trust has a robust Assurance Framework which is operating satisfactorily and which ensures that the same level of scrutiny is given to clinical risks as to strategic, financial and operational risks. This will be done through consideration of the annual report of the Quality Committee and an annual review of the Assurance Framework prior to the preparation of the Annual Governance Statement.

11. To review the annual financial statements before submission to the Board, focusing particularly on:
    - changes in, and compliance with, accounting policies and practices;
    - major judgemental areas
    - significant adjustments resulting from the audit.

12. To review the adequacy of the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as requested by the Directorate of Counter Fraud Services; and to review any instances of fraud logged.

13. To ensure that the Standing Financial Instructions (SFIs) and Standing Orders (SOs) are maintained and are kept up to date, with an annual review.

14. To review any instances where the SFIs/SOs have been overruled by any individual within the Trust; or any occasions where SOs have been suspended at a meeting.

15. To review any instances where the Chief Executive has waived competitive tendering or competitive quotation requirements, or has given approval to a tender invitation to a firm not on the approved list.

16. To consider any instances of Director's interests in any potential contracts.

17. To review any changes to the internal controls within the Trust.
18. To review any special payments made with respect to compensation for any losses.
19. To consider other topics as defined by the Board from time to time.
20. To present the minutes of Committee meetings to the Board following each meeting of the Committee.

WORKFORCE COMMITTEE
Terms of Reference & Governance Structure

High-Level Priorities Plan	✓
Detailed Action Plans	✓
Operational Issues	✓
Resource Management	✓
Policy	✓

Terms of Reference

The purpose of the Workforce Committee is to ensure that the Trust attracts and retains a high performing workforce capable of delivering the Trust operational and clinical strategies.

The Committee will:

1. Ensure sustainability and affordability of workforce supply on a short, medium and long term basis including workforce planning, development, redesign, recruitment and retention.

2. Ensure an effective and equitable reward package positively impacts performance (including consideration of pay issues).

3. Ensure strategic education issues and external relationships which impact on supply and engagement are included in Trust planning.

4. Improve employee engagement and ensure appropriate mechanisms for the employee voice are adopted from Ward to Board, including a focus on equality and diversity, and staff health and wellbeing issues across the Trust, ensuring progress against agreed Trust objectives.

5. Agree the Trust Workforce Strategy and establish, monitor and report to the Trust Board on an annual programme of work to implement the strategy.

6. Identify risks associated with workforce issues ensuring ownership with mitigating actions, escalating to Trust Board as required.

Membership & Responsibilities

Chair:
- Keith Norton, Non-Executive Director

Vice Chair:
- Tracey Barber, Non-Executive Director

(One Non-Executive Director should also be a member of the Finance and Quality and Performance Committees)

Members:
- Dave Smith, Director of HR and OD
- Maggie Arnold, Director of Nursing
- Sean Elyan, Medical Director
- Eve Russell, Associate Director of HR
- Sarah Stansfield, Director of Operational Finance

Governor Representative – Non Voting:
- Carol McIndoe

Officer:
- Trust Secretary

Support:
- PMO

Quorum:
- One NED and at least 2 other members

Reporting Line:
Trust Board

Sub-Committees:
- Recruitment Strategy Group
- Sustainable Workforce Group
- Temporary Staffing Taskforce
- Reward Strategy Group
- Education, Learning and Development Committee
- Staff Engagement Groups
- Equality and Diversity Steering Group

Frequency of Meetings:
Bi-Monthly, 3 hours per meeting (for the first 6 months)

Submission / Availability of Minutes:
The Minutes will be presented to the next available Board meeting.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

REMUNERATION AND TERMS OF SERVICE COMMITTEE

TERMS OF REFERENCE

Policy	X
Review of Policy	X
Review of Trust Area of Activity	✓
Operations	X
Resource Management	✓

1. The Committee has delegated authority to act on behalf of the Board on matters concerning the remuneration and terms of service of Executive Directors. Executive Directors include both voting and non-voting Main Board Executive Directors.

2. The Committee is authorised by the Board to require such internal information as it may need to achieve its purpose. The Committee is authorised to make recommendations to the Board to secure external assistance and information if it considers this necessary.

3. Policies relating to the terms and conditions of all staff, including Executive Directors, will be considered and determined by the full Board. The Remuneration Committee will concern itself with the application of these policies to Executive Directors but may wish to propose amendments to the full Board.

4. The Committee shall determine pay rises and review the need for any other adjustments. If a performance related pay scheme is in operation then a meeting of the Committee will review the performance of individual directors prior to the award of any bonus payments. (If a group PRP scheme is in place covering the most senior managers as well as Executive Directors then the Committee will determine membership of the scheme and payments for the scheme as a whole).

5. The Committee shall
   - determine the remuneration and terms of service of Executive Directors
   - monitor and evaluate the performance of individual Executive Directors
   - discuss and if appropriate confirm the assessments made of performance related pay by
     - the Chair for the Chief Executive
     - the Chief Executive for the other Executive Directors
   - to advise on and oversee appropriate contractual arrangements for Executive Directors, including any termination payments.

6. The Committee will report to the Board if matters of principle or detail cannot be agreed by the Committee with one or more Executive Directors.

Membership & Responsibilities

Chair
Chair of the Trust

Vice Chair
Vice Chair of the Trust

Members
Non-Executive Directors

Attendees
The Chief Executive
Others at the request of the Chair

Officer
At the request of the Chair

Quorum
The Chair plus two other members

Frequency of Meetings
At least once a year

Reporting Line
Exceptionally to the Main Board

Sub-Committees
None

Submission/Availability of Minutes
Minutes will be retained by the Chair (these will not be available to Executive Directors).

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

ROLE AND MANDATE OF GOVERNORS ON BOARD SUB-COMMITTEES

Gloucestershire Hospitals was at the forefront of practice in inviting Governors to attend Board sub-committees. However, since this original innovation, limited development of the role has happened and Governors "added value" to the traditional Committee structures is now uncertain to both parties.

The key objectives of Governor involvement in sub-committees is to enable governors to fulfil their statutory function of holding NEDs to account through observing NEDs exercising their scrutiny, challenge and assurance functions. It also reflects the Board's desire to operate, and be seen to operate in an open and transparent manner. It is not intended to provide governors with the opportunity for governor engagement in the sub-committee "topic".

This note is intended to guide Governors, and other sub-committee members, to ensure Governors are enabled to maximise their contribution to committee business. It is recognised that Governors, new and long serving, will benefit from tailored training and development to fulfil their role.

Core Role

i. To provide the Council of Governors with assurance that the views of governors have been taken into account when developing the Trust's Annual Plan, in line with the statutory role of Governors, in respect of quality.
ii. To observe the Non-Executive Directors fulfilling their scrutiny roles in order to inform the Council of Governors assessment of Non-Executive Directors performance, reflecting the requirement for governors to hold NEDs to account for the effective execution of their role.
iii. To act as a conduit for communication back to the Council of Governors, to ensure governors are informed with regard to the business of the sub-committee
iv. To link with the Lead Non-Executive Director and Lead Executive(s) to influence the priorities and focus within the sub-committee agenda in response to issues and concerns raised by the Council of Governors.
v. To act as the governor lead for review of the relevant statutory reports produced by the sub-committee e.g. Quality Account

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

PUBLIC BOARD MEETING FRIDAY 28th OCTOBER 2016

Board Room, Alex House, Cheltenham General 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

The purpose of this report is to provide assurance to the Board in respect of the Trust's actions to deliver care in line with the mandated national standards. It summarises the key highlights and exceptions in Trust performance up until the end of September 2016 for the financial year 2016/17.

Key issues to note

- The Trust continues to fail to meet three of the four national access standards including A&E 4 Hour standard, two cancer standards and the Referral To Treatment (RTT) standard.
- The Trust has achieved the internal recovery trajectory for Cancer 62 Day GP Referral to Treatment standard and the quarter 2 Accident and Emergency 4 hour trajectory.
- Additional Divisional oversight arrangements are to be established to ensure more robust development and delivery plans in the area of cancer and RTT standards, under the leadership of the Director of Service Delivery.
- The Trust continues to work closely with its commissioners and NHS Improvement to maintain confidence in the Trust's ability to recover current poor performance.

Conclusions

Performance against the national standards remains unacceptable and as such is a key area of focus for the Trust. However, there is evidence that current oversight arrangements are not sufficiently robust and this is being addressed.

Implications and Future Action Required

Delivery of agreed action plans are critical to return back to the minimum expected standards however, there is evidence that current oversight arrangements are not sufficiently robust to ensure timely delivery and this is being addressed by the Director of Service Delivery...

Recommendations

The Trust Board is requested to receive the Integrated Performance Framework Report as a source of assurance that the executive team and divisional leaders are addressing the performance deficits highlighted in the report.

Impact Upon Strategic Objectives

No change.

Impact Upon Corporate Risks
Delivery of the 18 week referral to treatment target is a new risk and this is currently being assessed for future incorporation into the appropriate risk register.
Regulatory and/or Legal Implications
The Trust remains under regulatory intervention for the A&E 4-hour standard and the recent failure of the RTT standard puts the Trust at further risk of regulatory action.
Equality & Patient Impact
Patients are adversely impacted by the failure of the Trust to deliver care that meets national standards.

Resource Implications			
Finance	**X**	Information Management & Technology	
Human Resources	X	Buildings	
Additional activity will need to be undertaken to recover the RTT standard.			

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)**
				October 12th 2016 Report ratified for progress to Board	

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK

EXECUTIVE SUMMARY

MAIN BOARD – OCTOBER 2016

1. INTRODUCTION

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

2. PERFORMANCE AGAINST RECOVERY TRAJECTORIES

This month the Trust has not yet met the four trajectories (as validation is still underway) that it is required to meet in order to demonstrate improvement and to access the Strategic Transformation Fund. However, the Trust has achieved the internal recovery trajectory for Cancer: Max wait 62 days from urgent GP referral to first treatment in August 2016 and the quarter 2 Accident and Emergency 4 hour trajectory.

3. PERFORMANCE

3.1 ARE WE SAFE?

KEY HIGHLIGHTS

- The percentage of women seen by a midwife by 12 weeks has met the target of >90% during September 2016; for the second consecutive month since January 2016.
- Acute Kidney Infection performance has achieved the target in 2016/17 quarter 2, at 60% for the quarter. This is a marked improvement on the quarter 1 performance of 42%.

AREAS FOR IMPROVEMENT

- There were four Clostridium Difficile infection cases in September; this has increased from one case reported in August.

3.2 ARE WE RESPONSIVE?

KEY HIGHLIGHTS

- 6 out of the 9 cancer measures have met their target in August, with performance in 2 week waits for non-cancer breast symptoms increasing from 91.2% in July to 93.4% in August.
- In line with the Trust's action plan and internal trajectory to recover the 62 day performance by January 2017, urgent GP referral to first treatment (excl. rare cancers) performance has risen to 79.0% in August, therefore, achieving the recovery trajectory of 73.46%.

AREAS FOR IMPROVEMENT

- Maximum wait 62 days from national screening programme to first treatment performance has fallen to 89.9% in August, from 100% in July. However, provisional data for September indicates that the performance is improving in line with the 90% target.

3.3 ARE WE EFFECTIVE?

KEY HIGHLIGHTS

- There were no mixed sex accommodation breaches in September. Performance in this measure has shown improvement in 2016/17, with quarter 2 performance finishing at 9 breaches, compared to 19 breaches in quarter 1.

AREAS FOR IMPROVEMENT

- As a result of implementing the CHKS audit, April to September activity adjustments have fallen into September's reporting. This has impacted September's performance for the following measures: elective spells year to date within 2.5% of plan (-2.8% in September), emergency spells year to date within 2.5% of plan (+2.9% in September), outpatient attendances and procedures year to date within 2.5% of plan (-6.1% in September).

3.4 ARE WE WELL LED?

KEY HIGHLIGHTS

- Staff who have completed mandatory training in September continues to achieve the >90% standard at 91%.

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.

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: **October 2016**

Gloucestershire Hospitals NHS
NHS Foundation Trust

PERFORMANCE MANAGEMENT FRAMEWORK

2016/17

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TRUST OVERVIEW

September 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 Q2	Apr	May	Jun	Jul	Aug	Sep	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%	90.6%	92.1%	92.0%	92.0%	90.9%	90.9%	90.1%	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%	88.5%	85.4%	87.4%	87.1%	86.3%	90.9%	88.9%	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%	75.4%	78.2%	77.4%	81.2%	73.6%	79.0%	74.5%	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%	94.8%	91.7%	84.6%	95.0%	100%	89.9%	98.5%		
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%	99.3%	98.1%	100%	100%	98.1%	100%	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%	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%	99.0%	100%	100%	100%	100%	100%	98.5%		
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%	99.1%	98.6%	99.6%	99.0%	99.2%	99.7%	98.6%	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%	88.2%	77.7%	86.5%	90.3%	89.9%	86.2%	88.5%	1.0	1.0
Max 2 week wait for patients referred with non cancer breast symptoms %	93%	66.1%	93.6%	96.6%	94.9%	95.2%	91.8%	93.4%	95.3%	93.1%	93.7%	94.6%	94.3%	90.5%	91.2%	93.4%	96.4%		
INFECTION CONTROL																			
Number of Clostridium Difficile (C-Diff) infections - post 48 hours	37/yr	9	6	8	13	8	10	10	13	10	10	5	3	2	5	1	4	1.0	1.0

In month position therefore figures not validated.

PERFORMANCE MONITORING AGAINST THE SUSTAINABILITY AND TRANSFORMATION PLAN

2016/17

		Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4
ED																	
% patients spending 4 hours or less in ED	Trajectory	80.00%	85.00%	85.00%	83.50%	87.00%	87.00%	91.90%	88.50%	89.10%	91.20%	85.70%	88.70%	85.10%	80.10%	89.60%	85.19%
	Actual	85.38%	87.41%	87.06%	86.90%	86.00%	90.66%	88.94%	88.48%								
% patients spending 4 hours or less in ED (incl. Primary Care ED cases)	Trajectory	80.00%	85.00%	85.00%	83.50%	87.00%	87.00%	91.90%	88.50%	89.10%	91.20%	85.70%	88.70%	85.10%	80.10%	89.60%	85.19%
	Actual	85.70%	87.73%	87.36%	86.96%	86.34%	90.85%	89.28%	88.78%								
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%	92.04%	90.90%	90.90%	90.12%	90.62%								
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%	1.40%	0.49%	0.49%	1.14%	1.14%								
CANCER																	
Cancer: Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) % *RAG rated against the STP Trajectory*	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%	79.0%	73.1%	79.0%	74.5%	75.4%								
Cancer: Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) % *RAG rated against the internal recovery trajectory*	Trajectory					78.26%	73.46%	80.92%		72.21%	74.77%	76.77%		84.98%	85.30%	85.76%	
	Actual	78.2%	77.4%	81.1%	79.0%	73.1%	79.0%	74.5%	75.4%								

In month position, therefore figure not validated.

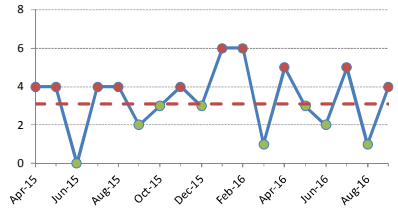
TRUST PERFORMANCE & EXCEPTIONS (as at end September 2016)

ARE WE SAFE?

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q2	Q3	Q4	2016/17 Q1	Q2	Jul	Aug	Sep	FORECAST Oct	Nov	Dec	Jan	Feb	Mar	FoT	Standard	Target Set By	How often	Data Month
INFECTION																				
Number of Clostridium Difficile (C-Diff) infections - post 48 hours		10	10	13	10	10	5	1	4	3	3	5	4	3	3		37 cases/year	NHSI	M	Sep
Number of Methicillin-Resistant Staphylococcus Aureus (MRSA) infections - post 48 hours		0	2	1	1	0	0	0	0	0	0	0	0	0	0		0	GCCG	M	Sep
MORTALITY																				
Crude Mortality rates %		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%	1.2%		<2%	Trust	M	Sep
Summary Hospital-Level Mortality Indicator		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)		110.8	107.5	106.8	108.0												Confidence interval	Dr Foster	M	Jun
SMR (rolling 12 months)		110.3	108.0	110.2	112.3												Confidence interval	Dr Foster	M	Jun
SAFETY																				
Number of Never Events		1	1	0	0	1	1	0	0	0	0	0	0	0	0		0	GCCG	M	Sep
% women seen by midwife by 12 weeks		90.0%	90.0%	89.6%	87.2%	92.3%	85.9%	90.8%	91.5%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%		>90%	GCCG	M	Sep
CQUINS																				
Acute Kidney Infection (AKI)		19%	29%	50%	42%	60%	47%	63%	69%	55.0%	55.0%	55.0%	55.0%	55.0%	55.0%		>90% by Q4	National	M	Sep
Sepsis Screening 2a		83%	96%	92%	96%					90%	90%	90%	90%	90%	90%		>90% of eligibles	National	M	Jun
Sepsis Antibiotic Administration 2b		32%	43%	49%	55%					90%	90%	90%	90%	90%	90%		>90% of eligibles	National	M	Jun
Dementia - Seek/Assess		87.5%	88.8%	86.3%	88.1%	88.3%	89.6%	88.5%	86.3%	88%	88%	88%	90%	90%	90%		Q1>86%; Q2>87%; Q3>88%; Q4>90%	National	M	Aug
Dementia - Investigate		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Q1>86%; Q2>87%; Q3>88%; Q4>90%	National	M	Sep
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	Sep
ED																				
% patients triaged in ED in 15 minutes		61.4%	57.9%	53.7%	75.3%	78.6%	76.9%	80.8%	78.2%								≥ 99%	Trust	M	Sep
% patients assessed by doctor in ED in 60 minutes		45.4%	44.7%	43.3%	47.1%	46.0%	43.9%	49.4%	44.9%								≥ 90%	Trust	M	Sep

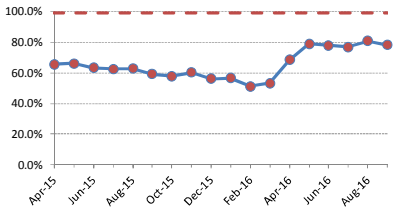
In month position, therefore figure not validated.

ARE WE SAFE?

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

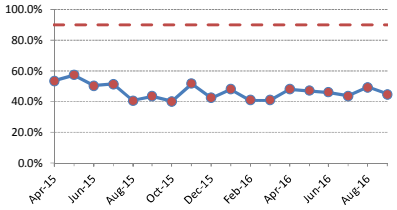
Commentary on what is driving the performance & what actions are being taken

There is an overall increase in the carriage of CDiff in the community, and therefore these patients form part of the potential admission population. This is complicated by increase in patient frailty and increased emergency admission rates for September.

% patients triaged in ED in 15 minutes Standard is ≥ 99%								Director of Nursing and Midwifery

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

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

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

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 September 2016)

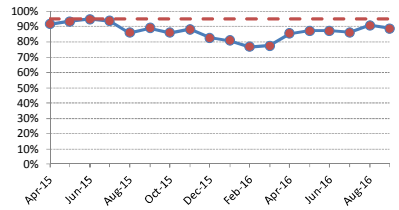
ARE WE RESPONSIVE?

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q2	Q3	Q4	2016/17 Q1	Q2	Jul	Aug	Sep	FORECAST Oct	Nov	Dec	Jan	Feb	Mar	FoT	Standard	Target Set By	How often	Data Month
ED																				
% patients spending 4 hours or less in ED		89.7%	85.6%	78.5%	86.9%	88.5%	86.3%	90.9%	88.9%	89.1%	91.2%	85.7%	85.1%	80.1%	89.6%		≥ 95%	NHSI	M	Sep
Number of ambulance handovers delayed over 30 minutes		212	241	428	517	541	199	155	187	70	80	90	100	100	90		< previous year	GCCG	M	Sep
Number of ambulance handovers delayed over 60 minutes		21	28	33	3 **	1	0	1	0	10	10	11	11	11	9		< previous year	GCCG	M	Sep
18 WEEKS																				
Incomplete pathways - % waited under 18 weeks		92.1%	92.2%	92.0%	92.0%	90.6%	90.9%	90.9%	90.1%	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		5.9%	1.5%	4.0%	2.6%	1.14%	0.49%	0.49%	1.14%	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		341	142	225	441	405	528	479	405	200	150	100	100	100	100		< 1% waiting at month end	GCCG	M	Sep
CANCER																				
Max 2 week wait for patients urgently referred by GP %		90.3%	92.4%	88.7%	84.9%	88.2%	89.9%	86.2%	88.5%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%		≥ 93%	NHSI	M	Aug
Max 2 week wait for patients referred with non cancer breast symptoms %		91.8%	93.4%	95.3%	93.1%	93.7%	91.2%	93.4%	96.4%	93.0%	94.0%	94.0%	94.0%	94.0%	94.0%		≥ 93%	NHSI	M	Aug
Max wait 31 days decision to treat to treatment %		99.7%	100%	99.8%	99.1%	99.1%	99.2%	99.7%	98.6%	100%	100%	100%	100%	100%	100%		≥ 96%	NHSI	M	Aug
Max wait 31 days decision to treat to subsequent treatment : surgery %		100%	99.5%	99.5%	99.4%	99.3%	98.1%	100.0%	100%	100%	100%	100%	100%	100%	100%		≥ 94%	NHSI	M	Aug
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	Aug
Max wait 31 days decision to treat to subsequent treatment : Radiotherapy %		100%	100%	100%	100%	99.0%	100.0%	100.0%	98.5%	100%	100%	100%	100%	100%	100%		≥ 94%	NHSI	M	Aug
Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) %		75.6%	79.5%	76.7%	79.0%	75.4%	73.6%	79.0%	74.5%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%		≥ 85%	NHSI	M	Aug
Max wait 62 days from national screening programme to 1st treatment %		94.0%	95.6%	94.9%	79.0%	94.8%	100.0%	89.9%	98.5%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%		≥ 90%	NHSI	M	Aug
Max wait 62 days from consultant upgrade to 1st treatment %		92.9%	100%	100%	0%	66.7%	0.0%	100.0%	100%	100%	100%	100%	100%	100%	100%		≥ 90%	NHSI	M	Aug

**Please note: The 3 ambulance delays reported in April 2016, have now been validated and are no longer breaches.

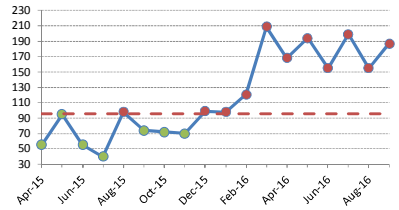
In month position, therefore figure not validated.

ARE WE RESPONSIVE?

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

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

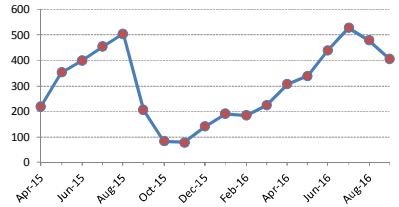
Please refer to Emergency Pathway Report. Recovery plan in place.
Performance is improving in line with actions in the Emergency Care Pathway.

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

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

Please refer to the Emergency Pathway Report.

Note: New IT system started in April 2016 by South Western Ambulance. Data is not fully validated.

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

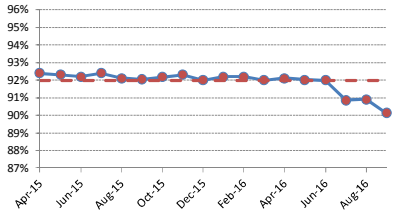
Commentary on what is driving the performance & what actions are being taken

August – October (Work completed)
Additional activity has been completed throughout August, September and October (MTD) in order to stabilise the Diagnostic 6ww position and reduction of the overdue Planned Surveillance patient backlog. To date 56 additional WLI sessions have been completed by staff and an additional seven sessions were completed by an external endoscopy company.
This means we have had a net reduction of: 157 colonoscopies, 57 gastro OGDs, 12 flexi sigmoidoscopies
For some areas we are down at a zero position for Gastro backlog OGD and Flexi's; there is significant pressure on the Surgical Division to reduce their backlog (95 OGD's) but this has reduced by 40 patients between August and October.

October onwards (Future planning)
The Trust are going out to tender formally for Endoscopy insource support which following advert and tender bid review is scheduled to commence w/c 5th December 2016. In order to make up for the lag in planned recovery time in October the organisation will look to run Endoscopy insource lists at both Cheltenham and Gloucester sites enabling 138 cases to be completed each weekend (combined both sites). Anticipated recovery by mid-January 2017 is owing to additional pressures on the Gastroenterology team to support patient flow through the cancellation of planned endoscopy lists to double up ward rounds over the winter period. The team went out for a second time for a Clinical Fellow and had no suitable applicants; the service will go out for a third time imminently at the same time as recruiting to two vacancies.

ARE WE RESPONSIVE?

MEASURE	QUARTERLY PROGRESS Q3	Q4	Q1	Q2	NOW	FOT	OWNER
Incomplete pathways - % waited under 18 weeks Standard is ≥ 92%							Director of Service Delivery



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

Under-performance in the standard is in the main attriutbale to oral surgery with underlying pressures in urology, general surgery, gynaecology and ENT. September's performance is incomplete and is still being validated with early indications showing the standard will not be met with the same areas of concerns.

The CCG have requested an overall recovery plan of the standard and this is currently being developed. A separate oral surgery plan has been developed in conjunction with the Commissioner NHSE.

RTT 18 Week Reporting September 2016

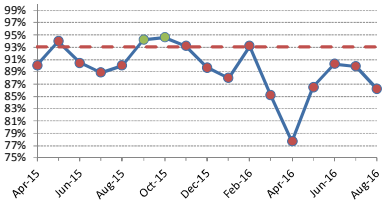
Incomplete - Target 92%		Admitted Pathways				Non Admitted Pathways				TOTAL					
Specialty		<18 wks	>18 wks	TOTAL	% <18 wks	<18 wks	>18 wks	TOTAL	% <18 wks	<18 wks	>18 wks	>35 wks	>52 wks	TOTAL	% <18 wks
100	General Surgery	1517	573	2090	72.6%	4922	186	5108	96.4%	6439	759	65	0	7198	89.5%
101	Urology	521	335	856	60.9%	1748	172	1920	91.0%	2269	507	96	1	2776	81.7%
110	Trauma and	1891	551	2442	77.4%	3480	166	3646	95.4%	5371	717	52	0	6088	88.2%
120	ENT	319	47	366	87.2%	2954	356	3310	89.2%	3273	403	2	0	3676	89.0%
130	Ophthalmology	1222	126	1348	90.7%	3734	119	3853	96.9%	4956	245	2	0	5201	95.3%
140	Oral Surgery	321	185	506	63.4%	2504	798	3302	75.8%	2825	983	186	1	3808	74.2%
170	Cardiothoracic Surgery	0	0	0	N/A	25	0	25	100.0%	25	0	0	0	25	100.0%
300	General Medicine	0	0	0	N/A	646	23	669	96.6%	646	23	2	0	669	96.6%
301	Gastroenterology	636	92	728	87.4%	2126	142	2268	93.7%	2762	234	14	0	2996	92.2%
320	Cardiology	120	14	134	89.6%	1758	155	1913	91.9%	1878	169	24	0	2047	91.7%
330	Dermatology	3	0	3	100.0%	3167	189	3356	94.4%	3170	189	3	0	3359	94.4%
340	Respiratory Medicine	12	4	16	75.0%	981	72	1053	93.2%	993	76	8	0	1069	92.9%
400	Neurology	12	9	21	57.1%	1527	68	1595	95.7%	1539	77	8	0	1616	95.2%
410	Rheumatology	30	2	32	93.8%	876	97	973	90.0%	906	99	2	0	1005	90.1%
430	Geriatric Medicine	0	0	0	N/A	2	0	2	100.0%	2	0	0	0	2	100.0%
502	Gynaecology	409	102	511	80.0%	1896	200	2096	90.5%	2305	302	6	0	2607	88.4%
X01	Other	296	2	298	99.3%	5034	117	5151	97.7%	5330	119	9	1	5449	97.8%
TOTAL		7309	2042	9351	78.2%	37380	2860	40240	92.9%	44689	4902	479	3	49591	90.12%

ARE WE RESPONSIVE?

MEASURE

Max 2 week wait for patients urgently referred by GP

Standard is ≥93%



QUARTERLY PROGRESS

Q3	Q4	Q1	Q2	NOW	FOT
●	●	●		●	●

OWNER

Director of Service Delivery

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

Under-performance in the standard is in large due to breaches in Upper Gastro-intestinal, Colorectal and Urological cancers. 2 week wait demand continues to be a pressure across most with a 15.3% increase in referrals (1,344 referrals) in the year to date compared to the same period in 2015/16. Services have been reviewing their clinic templates to align 2week wait demand with clinic structures. September's performance is 88.5% - lower than the projected position of 91.4%. The Trust has agreed a recovery trajectory plan with the CCG and NHSI with the standard being met and sustained from October 2016.

	July 16 (current)			August 16 (current)			September 16 (current)			Q2 to date	Average treatments / month (rolling 12 months)
Target	Latest Position	Breaches	Treatments	Latest Position	Breaches	Treatments	Latest Position	Breaches	Treatments		
93%	89.9%	172	1699	86.3%	242	1769	88.5%	193	1684	88.2%	1644
Brain / CNS	94.4%	1	18	65.0%	7	20	73.1%	7	26	76.6%	22
Breast	96.0%	10	250	97.0%	8	270	97.4%	6	233	96.8%	261
Gynaecological	95.3%	7	148	93.4%	10	151	96.3%	4	108	94.8%	119
Haematological*	53.3%	7	15	36.4%	14	22	90.9%	1	11	54.2%	10
Head & Neck	85.3%	26	177	94.1%	10	170	94.3%	11	194	91.3%	166
Lower GI	93.5%	21	325	95.5%	14	309	92.1%	26	331	93.7%	317
Lung	97.4%	1	38	95.7%	2	47	95.7%	2	46	96.2%	47
Skin	89.0%	41	372	76.7%	99	424	94.0%	22	369	86.1%	304
Testicular	88.9%	2	18	75.0%	4	16	77.3%	5	22	80.4%	16
Upper GI	92.1%	13	165	93.7%	10	159	87.0%	21	162	90.9%	186
Urological	75.1%	43	173	64.6%	64	181	51.6%	88	182	63.6%	196

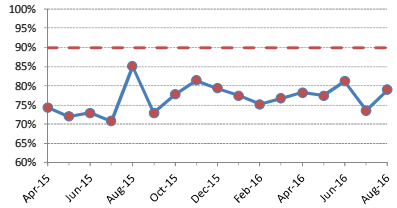
* Excludes acute leukaemia

ARE WE RESPONSIVE?

MEASURE

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

Standard is ≥85%



QUARTERLY PROGRESS

Q3	Q4	Q1	Q2	NOW	FOT
●	●	●		●	●

OWNER

Director of Service Delivery

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

The Trust had 21.5 fewer treatments and 13.5 fewer breaches than projected in August (140.5 treatments and 29.5 breaches) giving an overall performance of 79.0% against a trajectory of 73.5%. September's data is still incomplete, however early indications show that this is on trajectory (72.2%). The Trust has agreed a recovery trajectory plan with the CCG and NHSI with the standard being met and sustained from January 2017.

In addition, recovery plan has been reviewed by the NHS Intensive Support Team who have fed back that overall the plan is good. Performance against the plan is being performance managed by the Trust's Cancer Services Manager on a weekly basis.

	July 16 (current)			August 16 (current)			September 16 (current)			Q2 to date	Average treatments / month
Target	Latest Position	Breaches	Treatments	Latest Position	Breaches	Treatments	Latest Position	Breaches	Treatments	75.4%	
85%	73.6%	37.5	150.0	79.0%	30.5	145.0	71.9%	36.0	128.0		152
Breast	90.0%	2.0	20.0	96.4%	1.0	28.0	87.5%	3.0	24.0	91.7%	25
Gynaecological	67.7%	5.0	15.5	76.5%	2.0	8.5	79.3%	3.0	14.5	74.0%	10
Haematological*	42.9%	4.0	7.0	57.9%	4.0	9.5	65.0%	3.5	10.0	56.6%	8
Head & Neck	66.7%	2.0	6.0	88.9%	1.0	9.0	85.7%	0.5	3.5	81.1%	8
Lower GI	54.8%	9.5	21.0	88.9%	1.0	9.0	68.4%	6.0	19.0	66.3%	17
Lung	82.6%	2.0	11.5	57.7%	5.5	13.0	84.0%	2.0	12.5	74.3%	12
Other	33.3%	2.0	3.0	100.0%	0.0	4.0	66.7%	1.0	3.0	70.0%	2
Sarcomas	66.7%	1.0	3.0							66.7%	1
Skin	100.0%	0.0	34.0	100.0%	0.0	30.0	85.7%	1.5	10.5	98.0%	30
Upper GI	87.0%	1.5	11.5	76.0%	3.0	12.5	95.0%	0.5	10.0	85.3%	13
Urological	51.4%	8.5	17.5	38.1%	13.0	21	28.6%	15.0	21.0	38.7%	27

* Excludes acute leukaemia

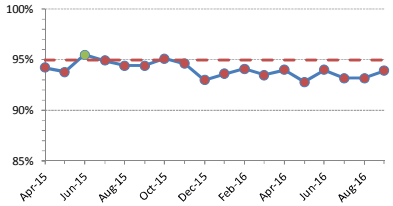
TRUST PERFORMANCE & EXCEPTIONS (as at end September 2016)

ARE WE EFFECTIVE?

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q2	Q3	Q4	2016/17 Q1	Q2	July	Aug	Sep	FORECAST Oct	Nov	Dec	Jan	Feb	Mar	FoT	Standard	Target Set By	How often	Data Month
CLINICAL OPERATION																				
% stroke patients spending 90% of time on stroke ward		78.7%	91.4%	86.0%	85.1%	90%	86.2%	96.2%	84.0%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%		> 80%	GCCG	M	Aug
% of eligible patients with VTE risk assessment		94.6%	94.2%	93.7%	93.6%	93.7%	93.2%	93.2%	93.9%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%		> 95%	GCCG	M	Sep
Emergency re-admissions within 30 days - elective & emergency		6.4%	6.1%	6.4%	6.7%	arrears	7.0%	6.3%	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	Aug
Number of Breaches of Mixed sex accommodation		0	17	30	19	9	5	4	0	2	0	5	10	0	0		0	GCCG	M	Sep
Number of delayed discharges at month end (DTOCs)		13	19	10	16	36	35	37	36	14	14	16	16	16	16		<14	Trust	M	Sep
No. of medically fit patients - over/day		47	48	60	69	73	70	77	73	40	40	40	40	40	40		≤ 40	Trust	M	Sep
Bed days occupied by medically fit patients		1,446	1,457	1,791	2,086	2,252	2,159	2,398	2,198	1,450	1,450	1,450	1,450	1,450	1,450		None	Trust	M	Sep
Patient Discharge Summaries sent to GP within 24 hours		89.1%	88.6%	85.6%	85.7%	88.1%	87.8%	89.5%	87.1%	88.5%	88.5%	88.5%	88.5%	88.5%	88.5%		≥85%	GCCG	M	Aug
BUSINESS OPERATION																				
Elective Patients cancelled on day of surgery for a non medical reason		1.2%	1.3%	2.0%	1.6%	1.6%	2.0%	1.3%	1.6%								≤ 0.8%	Trust	M	Sep
Patients cancelled and not rebooked in 28 days		18	15	27	35	10	4	4	2								0	GCCG	M	Sep
GP referrals year to date - within 2.5% of previous year		4.4%	2.9%	3.7%	7.9%	5.1%	3.7%	4.7%	5.3%								range +2.5% to -2.5%	Trust	M	Sep
Elective spells year to date - within 2.5% of plan		5.1%	5.0%	7.3%	4.9%	1.6%	-2.7%	10.4%	-2.8%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%		range ≥-1% to plan	Trust	M	Sep
Emergency Spells year to date - within 2.5% of plan		4.0%	6.9%	7.1%	7.7%	3.8%	7.2%	1.3%	2.9%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%		range ≤2.5% over plan	Trust	M	Sep
LOS for general and acute non elective spells		5.6	5.7	6.0	5.9	5.8	5.5	5.8	6.0	5.4	5.4	5.4	5.4	5.4	5.4		Q1 /Q2 <5.4days, Q3 /Q4 <5.8days	Trust	M	Sep
LOS for general and acute elective IP spells		3.6	3.6	3.6	3.3	3.7	3.5	3.8	3.7	3.5	3.6	3.5	3.5	3.6	3.6		≤ 3.4 days	Trust	M	Sep
OP attendance & procedures year to date - within 2.5% of plan		0.6%	0.6%		0.5%	-1.5%	-0.8%	3.0%	-6.1%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%		range +2.5% to -2.5%	Trust	M	Sep
Records submitted nationally with valid GP code (%)		100%	100%	99.9%	99.9%	arrears	100%	100%	arrears	100%	100%	100%	100%	100%	100%		≥ 99%	Trust	M	Aug
Records submitted nationally with valid NHS number (%)		99.7%	99.7%	99.8%	99.8%	arrears	99.8%	99.8%	arrears	99.6%	99.6%	99.6%	99.6%	99.6%	99.6%		≥ 99%	Trust	M	Aug

In month position, therefore figure not validated.

ARE WE EFFECTIVE?

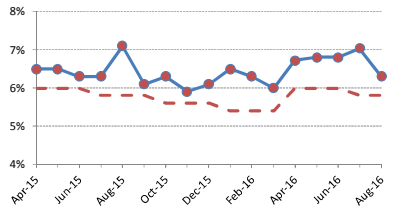
MEASURE		QUARTERLY PROGRESS Q3	Q4	Q1	Q2	NOW	FOT	OWNER
% of eligible patients with VTE risk assessment Standard is >95%								Trust Medical Director

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

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

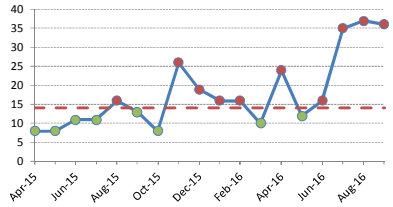
This has been through regular multidisciplinary team, doctors, nurses, pharmacists and ward clerks, improving the rate of prescription charts arriving with the patient from ED and optimising specific roles, pharmacists, ward clerk, doctors, nurses.

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

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

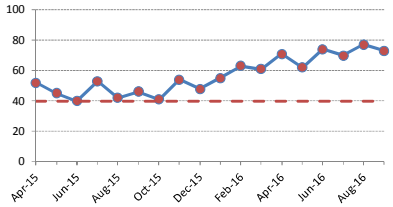
Commentary on what is driving the performance & what actions are being taken

Readmissions are an important indicator as a balancing measure in our PMF. We will continue to monitor this closely and review readmissions to ensure any learning from these cases is used to improve patient care.

Number of delayed discharges at month end (DTOCs) Standard is <14								Director of Service Delivery

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

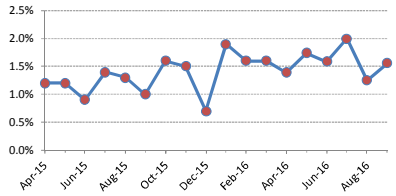
Please refer to Emergency Care Report.

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

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

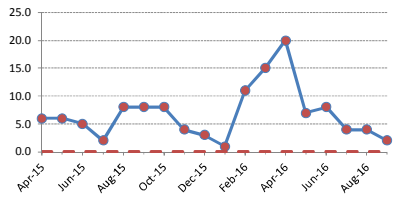
Please refer to Emergency Care Report.
The main issue driving the medically fit is access to domicillary care and community hospital beds. Alternative options are being explored and developed as part of the Emergency Care Pathyway Plan.

ARE WE EFFECTIVE?

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

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

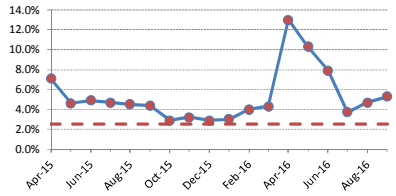
The increase in the number of medically fit patients and level of emergency admissions impacted on this measure. The Surgical Division focus has been adjusted to reduce the number of cancellations on the day with a process established to review all elective activity daily. Out of 100 cancellations in September the largest volumes were: 22 trauma and orthopaedics, 14 gynaecology, 13 surgical endoscopy, 10 ophthalmology.

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

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

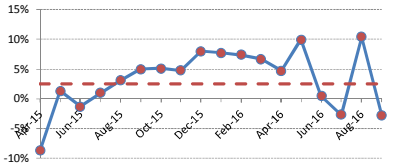
This is an improving position and performance managed daily.

The two patients reported in September are under the specialty of Pain Management. The reason for the cancellation not being rebooked within 28 days was down to administrative errors being made when there were vacancies in the admin team. All posts have now been filled and the new supervisor has put a process in place to address checks and rebooks for cancellations on the day.

GP referrals year to date - within 2.5% of previous year Standard is range +2.5% to -2.5%								Director of Service Delivery

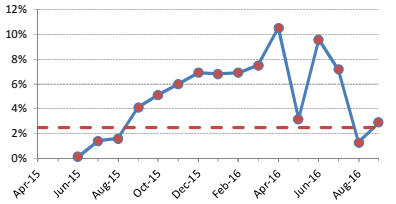
Commentary on what is driving the performance & what actions are being taken

GP referrals continue to rise and there is ongoing dialog with Gloucestershire CCG in respect of demand management.

Elective spells year to date - Standard is within 2.5% of plan								Director of Service Delivery

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

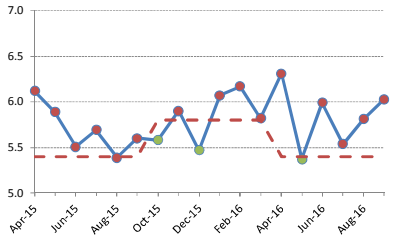
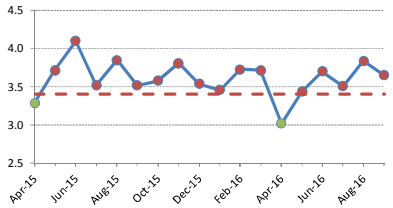
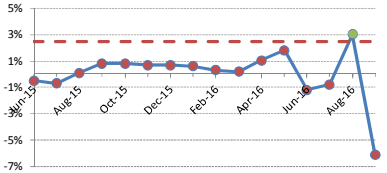
Impact of implementing CHKS audit results. The activity quoted below relates to month 1-6 activity adjustments falling into September reporting.
Foam sclerotherapy activity moved from daycases to outpatients (-254 in September 2016)
Allergic rhinitis activity moved to non-PbR outpatients (-102)
Surgical management of miscarriage activity moved from emergency to elective (+99)

Emergency spells year to date - Standard is within 2.5% of plan								Director of Service Delivery

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

Impact of implementing CHKS audit results. The activity quoted below relates to month 1-6 activity adjustments falling into September reporting.
Surgical management of miscarriage activity moved from emergency to elective (-99)

ARE WE EFFECTIVE?

MEASURE		QUARTERLY PROGRESS Q3	Q4	Q1	Q2	NOW	FOT	OWNER
LOS for general and acute non elective spells Standard is Q1/Q2 <5.4days, Q3 Q4 ≤5.8days								Director of Service Delivery
								Commentary on what is driving the performance & what actions are being taken
								Length of stay has increased in the winter months and remains an issue. The Gloucestershire wide action plan has been reviewed across the health community to reflect the urgent requirement to improve performance. 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. The Trust has comenced in October 2016 the use of red and green days to identify any internal delays that may affect patient flow.
LOS for general and acute elective IP spells Standard is ≤3.4 days								Director of Service Delivery
								Commentary on what is driving the performance & what actions are being taken
								The Trust has commenced in October 2016 the use of red and green days to identify any internal delays that may affect patient flow.
OP attendances & procedures year to date - Standard is within 2.5% of plan								Director of Service Delivery
								Commentary on what is driving the performance & what actions are being taken
								Impact of implementing CHKS audit results. The activity quoted below relates to month 1-6 activity adjustments falling into September reporting. Foam sclerotherapy activity moved from daycases to outpatients (+254 in September 2016) Non-billable Lucentis procedures removed (-608)

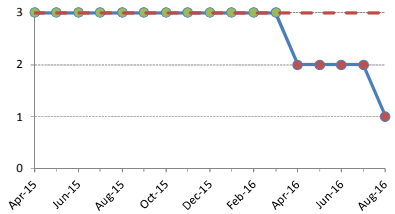
TRUST PERFORMANCE & EXCEPTIONS (as at end September 2016)

ARE WE WELL LED?

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q2	Q3	Q4	2016/17 Q1	Q2	Jul	Aug	Sep	FORECAST Oct	Nov	Dec	Jan	Feb	Mar	FoT	Standard	Target Set By	How often	Data Month
FINANCIAL HEALTH																				
NHSI Financial Risk Rating (YTD)		3	3	3	2		2	1		TBC	TBC	TBC	TBC	TBC	TBC		Level 3	NHSI	M	Aug
Achieve planned Income & Expenditure position at year end		-£1.6m	-£1.6m	-£1.6m	£18.2m		£18.2m	TBC		TBC	TBC	TBC	TBC	TBC	TBC		Achieved or better at year end	NHSI	M	Jul
Total PayBill Spend (£K)		£77.5m	£78.0m	£78.7m	£82.1m		£27.0m	£28.7m		TBC	TBC	TBC	TBC	TBC	TBC		Target + 0.5%	Trust	M	Aug
Total worked WTE		7,071	7,098	7,153	7,121		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%	3.7%	3.9%	3.8%	3.8	3.8	3.8	3.8	3.8	3.8		green < 3.6% red >4%	Trust	M	Aug
Turnover rate (FTE)		11.3%	11.1%	11.7%	11.6%	11.8%	11.9%	11.9%	11.5%	11.7	11.7	11.7	11.7	11.7	11.7		7.5-9.5%	Trust	M	Aug
Staff who have annual appraisal (%)		83%	83%	83%	83%	80%	80%	81%	80%	85.0	85.0	85.0	85.0	85.0	85.0		green >89% red < 80%	Trust	M	Sep
Staff having well structured appraisals in last 12 months (staff survey, on a 5 point scale)		38%	38%	38%	3.0	3.0	3.0	3.0	3.0	3.1	3.1	3.1	3.1	3.1	3.1		> 3.8	Trust	A	Sep
Staff who completed mandatory training (%)		92%	91%	91%	92%	92%	91%	92%	91%	91.0	91.0	91.0	91.0	91.0	91.0		> 90%	Trust	M	Sep
Staff Engagement indicator (measured by the annual staff survey on a 5 point scale)		3.66	3.66	3.69	3.71	3.71	3.71	3.71	3.71	3.8	3.8	3.8	3.8	3.8	3.8		> 3.8	Trust	A	Sep
Improve communication between senior managers & staff (staff survey) (%)		35%	35%	34%	34%	34%	34%	34%	34%	34.0	34.0	34.0	34.0	34.0	34.0		> 38%	Trust	A	Sep

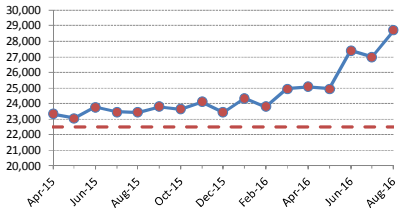
In month position, therefore figure not validated.

ARE WE WELL LED?

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

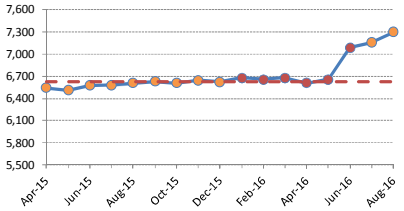
Commentary on what is driving the performance & what actions are being taken

Please refer to Trust announcement made on 20th September 2016.

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

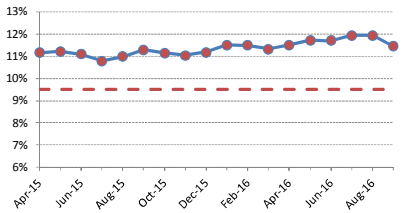
Commentary on what is driving the performance & what actions are being taken

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

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

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

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

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
PUBLIC BOARD MEETING FRIDAY 28th OCTOBER 2016
Board Room, Alexandra House, CGH commencing at 9.00 a.m.

Report Title
Financial Performance Report - Period to 30th September 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 6 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 6 of the 2016/17 financial year is an operational deficit of £8.7m. This is an adverse variance to plan of £15.1m.
- There is a prior period adjustment reversed out of the current YTD position of £6.0m.
- 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 M6 shows a significant adverse variance to plan of £15.1m (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.

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
PUBLIC BOARD MEETING FRIDAY 28th OCTOBER 2016
Board Room, Alexandra House, CGH commencing at 9.00 a.m.

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 should 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 30th September 2016

Introduction and Overview

This report provides an overview of the financial performance of the Trust as at the end of Month 6 of the 2016/17 financial year.
The Trust has delivered a year-to-date deficit position of £8.7m (including the Q1 STF funding of £3.3m). This represents an adverse variance to plan of £15.1m as at the year-to-date.

Statement of Comprehensive Income

Month 6 Financial Position	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's
SLA & Commissioning Income	213,030	215,245	2,215
PP, Overseas and RTA Income	2,826	2,991	165
Operating Income	31,259	33,410	2,151
Total Income	**247,115**	**251,646**	**4,531**
Pay	158,851	165,172	(6,321)
Non-Pay	75,461	87,377	(11,916)
Total Expenditure	**234,311**	**252,549**	**(18,238)**
EBITDA	**12,804**	**(903)**	**(13,707)**
EBITDA %age	**5.2%**	**-0.4%**	**-5.5%**
Non-Operating Costs	12,823	11,024	1,799
Surplus/(Deficit)	**(19)**	**(11,927)**	**(11,908)**
STF Funding	6,450	3,225	(3,225)
Surplus/(Deficit) (inc. SFT)	**6,431**	**(8,702)**	**(15,133)**

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.

The table summarises (at a high level) the Trust position for Month 6 of the 2016/17 financial year against the plan as submitted to NHSI in June. The year-to-date deficit of £11.9m has been mitigated by receipt of Q1 STF funding of £3.3m. The Month 6 position against the forecast produced last month is shown in detail on pages 20 and 21.

This report for Month 5 highlighted a number of prior year transactional adjustments. It has now been agreed with both the Trust's external auditors (KPMG) and NHS Improvement (NHSI) that these should be accounted for as a prior period adjustment (PPA) to the 2015/16 financial year. These transactions have therefore been reversed from the Month 6 financial position. A total of £6.0m of adjustments have been reversed. As work continues on assessment of bad debt and baselining we expect the prior period adjustment to increase, although this should have minimal impact on the current year's I&E position from this point forward.

The movement between months is shown below:

Month 5 Surplus/(Deficit)	**(11,054)**
Deficit for month 6	(3,694)
Prior Period Adjustment	6,046
Month 6 Surplus/(Deficit)	**(8,702)**

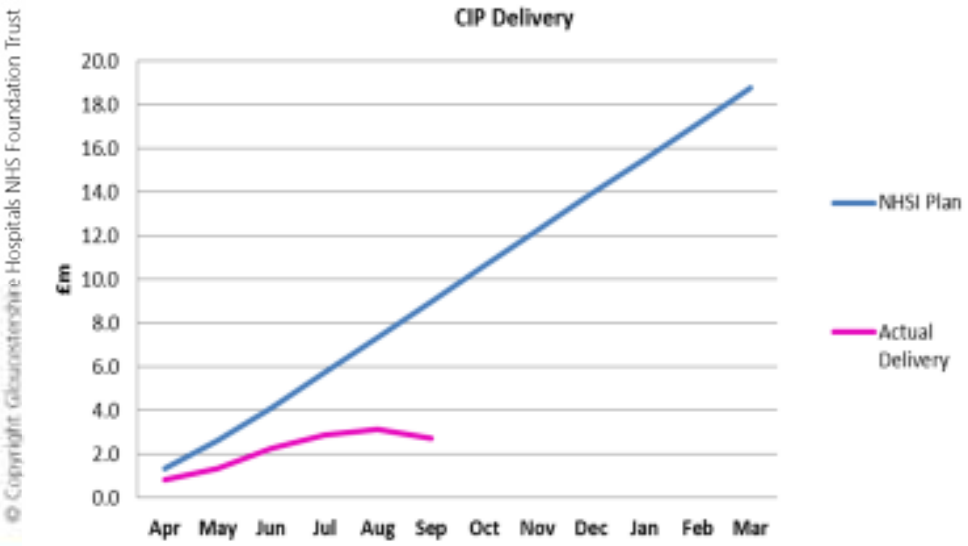
At A Glance – Month 6

Gloucestershire Hospitals NHS
NHS Foundation Trust

The I&E cumulative deficit as at Month 6 is £8.7m against a surplus NHSI plan of £6.4m – an adverse variance of £15.1m.

The in-month surplus position of £2.4m is impacted by the PPA of £6.0. The underlying in-month deficit is £3.7m once the impact of the PPA is removed.

The drivers of this position are explained in more detail in the income and expenditure sections of this report



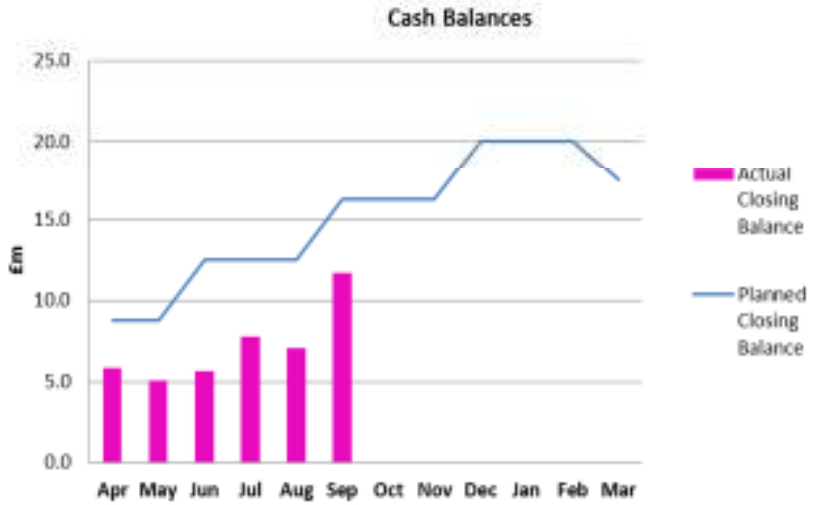
CIP delivery shows a cumulative achievement for the year-to-date of £2.7m against an NHSI plan of £9.0m – an adverse variance of £6.3m.

Cumulative delivery has fallen from the Month 5 position for a number of reasons:

- Reclassification of run-rate reductions (Cost avoidance) out of CIP
- Corrections to previous months reporting
- Re-assessment of full-year impacts

At A Glance – Month 6

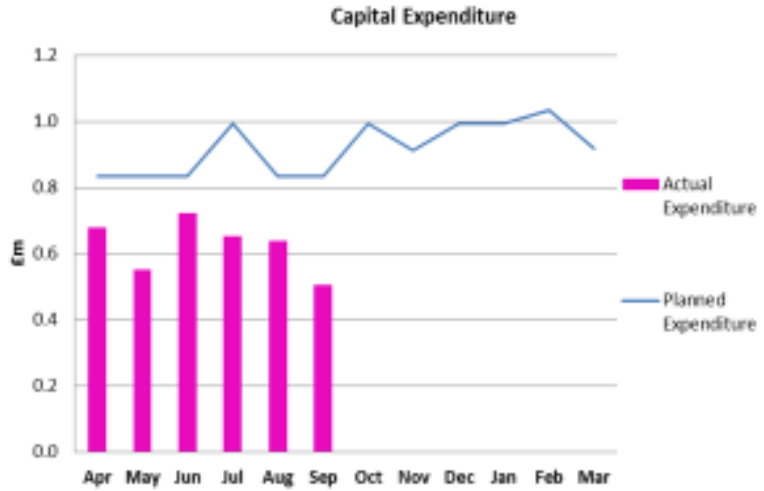
Gloucestershire Hospitals NHS
NHS Foundation Trust



The cash balance as at 30th September 2016 was £11.7m against an NHSI planned balance of £16.3m for the month – an adverse variance of £4.6m.

Please note:

- Balances for May, June and July include the benefit of £4m working capital facility drawdown
- September includes the impact of drawdown of £19.9m of distress funding and associated increased creditor payments



Capital spend in month 6 was £0.5m against an NHSI plan of £0.8m.

This brings the cumulative spend for the YTD to £3.7m against a total plan of £5.2m – an adverse variance of 1.4m.

Capital spend has slipped in the first half of the financial year due to availability of cash resource to fund the programme.

	Plan £m	Actual £m	Variance £m
Cumulative Capital Expenditure	5.2	3.7	(1.4)

Income Analysis – by Commissioner

Gloucestershire Hospitals NHS
NHS Foundation Trust

2016/17 Healthcare contracts position as at Month 6	Month 6 Contract £000	Month 6 Actuals £000	Variance £000
NHS Gloucestershire CCG	147,856	148,571	715
Specialist Commissioning Group	39,478	41,279	1,801
Worcestershire Health Community	5,297	5,470	173
Welsh Commissioners	2,015	2,319	304
NHS Hereford CCG	1,823	1,771	(52)
Other Commissioner Income	10,476	10,335	(141)
Non Contractual Agreements (NCAs)	2,065	1,959	(106)
Pre CQUIN	**209,010**	**211,704**	**2,694**
CQUIN	4,415	3,541	(874)
Post CQUIN	**213,425**	**215,245**	**1,820**
Phasing plan vs final contract agreement	(395)		395
Commissioing and SLA Income	**213,030**	**215,245**	**2,215**

Income risk contained within M5 position	Month 6 Actuals £000s
CQUIN recovery - assume 80%	(902)
Coding Review	(1,149)
QIPP risk share	(948)
Hereford CCG contracting risk	(275)
Total risk adjustments	**(3,274)**

The table shows the Month 6 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 Trust is showing a favourable variance to plan of £2.2m on commissioning income as at Month 6. As at month 5 this variance was adverse to the value of £1.1m. The Month 6 contract position includes an adjustment of (£0.4m) to ensure that the position is in line with the plan submitted to NHSI. This adjustment, as compared to £2.1m last month is one of the drivers of the movement from adverse to favourable between Month 5 and Month 6.

The actual position presented includes 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%.
- Coding Review – GCCG and the Trust commissioned a joint review of a number of specific coding issues at the start of 2016/17.
- QIPP risk share – The Trust contract with GCCG contains £3.5m of income at risk if CCG QIPP activity reductions are not achieved.
- Hereford CCG contracting risk - we expect negotiations on the Hereford contract to be completed during October

Detailed income and expenditure

Gloucestershire Hospitals NHS
NHS Foundation Trust

Month 6 Financial Position	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's
SLA & Commissioning Income			
Elective (inc. Daycase)	38,836	37,986	(850)
Non-elective Spells	1,117	937	(180)
Outpatients	35,209	35,098	(111)
Emergency	44,916	46,547	1,631
Accident & Emergency	8,097	8,503	406
Excluded Drugs	23,014	25,194	2,179
CQUIN	4,415	3,541	(874)
Other (Includes risk adjustment)	57,425	57,440	15
Sub-Total	**213,030**	**215,245**	**2,215**
PP, Overseas and RTA Income	2,826	2,991	165
Operating Income	31,259	33,410	2,151
Total Income	**247,115**	**251,646**	**4,531**
Pay			
Substantive Staff	146,433	148,581	(2,148)
Bank Staff	4,561	5,260	(699)
Agency Staff	7,857	11,331	(3,474)
Non-Pay			
Drugs	26,976	28,049	(1,074)
Clinical Supplies	19,676	20,368	(692)
Other Non-Pay	28,809	38,959	(10,150)
Total Expenditure	**234,311**	**252,549**	**(18,238)**
EBITDA	**12,804**	**(903)**	**(13,707)**
EBITDA %age	**5.2%**	**-0.4%**	**-5.5%**
Depreciation	6,604	5,292	1,312
Public Dividend Capital Payable	3,943	3,802	141
Interest Receivable	(16)	(18)	2
Interest Payable	2,293	1,948	345
Surplus/(Deficit)	**(19)**	**(11,927)**	**(11,908)**
STF Funding	6,450	3,225	(3,225)
Surplus/(Deficit) (inc. SFT)	**6,431**	**(8,702)**	**(15,133)**

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 £2.2m favourable variance on commissioning income. One of the main drivers of the favourable variance is a £2.2m favourable price variance on excluded drugs which should be matched by increased drugs expenditure.

Operating Income – includes education, training and research flows and other income (which includes staff recharges for CITS, Shared services etc.). This line is currently showing over-recovery of £2.2m, but against internal budget is showing an over-recovery of £0.8m. The main driver of the variance reported here is the planning assumption.

Pay – expenditure is showing an adverse variance of £6.3m against plan as at month 6. This is largely driven by higher than planned levels of agency expenditure for both medical and nursing staff.

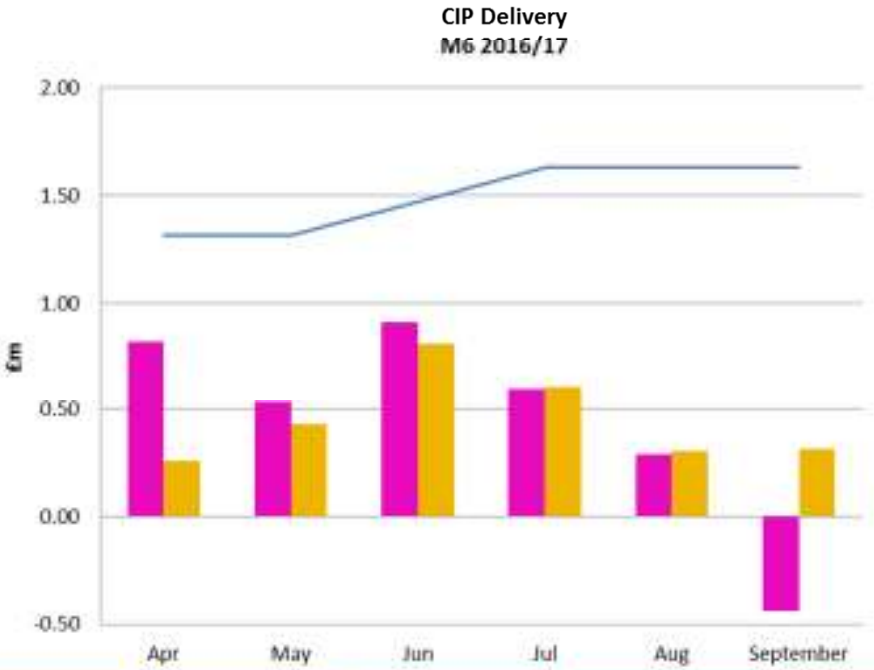
Non-Pay – Drugs shows a small adverse variance of £1.0m to plan, in line with a favourable financial variance on drugs activity. Other non-pay shows a significant adverse variance for the year-to-date largely driven by undelivered CIP, allocated to this line in the plan.

Non-Operating expenditure
Depreciation – shows a £1.3m 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.

Cost Improvement Programme

Gloucestershire Hospitals NHS
NHS Foundation Trust

CIP Analysis	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's
Medicine	2,133	307	(1,826)
Surgery	2,448	631	(1,817)
D&S	2,109	356	(1,753)
W&C	724	287	(437)
EFD	774	529	(245)
Corporate	516	39	(477)
Trustwide	0	561	561
Phasing adjustment to NHSI Plan	292	0	(292)
Total CIP	**8,996**	**2,711**	**(6,285)**



As at Month 6 the Trust has delivered £2.7m of CIP against the NHSI plan of £9.0m, an adverse variance of £6.3m. During Month 6 Divisions have made a number of retrospective reclassifications and corrections which have impacted the Month 6 position. The chart also shows the monthly run-rate performance restated for corrections.

Key Issues:

- All divisions are showing an adverse variance to plan as at Month 6
- Trustwide schemes, in particular the outpatient programme, are reporting significant under-delivery
- Medicine reported zero delivery in Month 6 due to reclassification of CIP as cost avoidance
- D&S have removed misstated actuals from Months 1 to 3 against their divisional expenditure scheme
- EFD have restated performance to correct the treatment of full year effect schemes which has significantly impacted restated delivery in April

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
- Engage in discussion and agree a date to close escalation areas

CIP Review Work:

- KPMG have been engaged by the Trust to support a programme of work the aims of which are:
- To strengthen governance and reporting of CIP
- To aid identification of further schemes for 2016/17
- To support development of a full programme for 2017/18

NHSI Continuity of Services Rating

Gloucestershire Hospitals NHS
NHS Foundation Trust

			Plan	Actual	
Continuity of Services	Balance Sheet Sustainability	**Capital Service**			
		Revenue Available for Capital Service	19,269	2,054	
		Capital Service	(6,236)	(12,536)	
		Sum = (calc above)	**3.09**	**0.16**	**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	(5,562)	(23,118)	
		Operating expenses within EBITDA	(234,312)	(252,834)	
		Sum = (calc above x no. of days)	**(4.3)**	**(16.5)**	**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)	6,430	(8,987)	
		Total Income	253,581	254,888	
		I&E Margin	**2.5%**	**(3.5%)**	**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%)**	**(6.1%)**	**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 6 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 0.16 for M6.

Liquidity – the ratio generates a value of (16.5) days of liquidity at the year to date.

I&E Margin – reported as (3.5%) for month 6 and includes the impact of STF funding received in Q1.

I&E Margin Variance – reported as (6.1%) and reflects the material variance to planned delivery as at Month 6.
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.

Balance Sheet(1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2016 £000	NHSI Plan as at M6 £000	Balance as at M6 £000	Variance - M6 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	294,393	306,425	12,032	(2,176)
Trade and Other Receivables	4,505	7,447	4,526	(2,921)	21
Total Non-Current Assets	**316,691**	**301,840**	**314,536**	**12,696**	**(2,155)**
Current Assets					
Inventories	8,036	7,150	7,139	(11)	(897)
Trade and Other Receivables	30,611	35,644	22,661	(12,983)	(7,950)
Cash and Cash Equivalents	3,950	16,247	11,715	(4,532)	7,765
Total Current Assets	**42,597**	**59,041**	**41,515**	**(17,526)**	**(1,082)**
Current Liabilities					
Trade and Other Payables	(62,906)	(52,958)	(51,755)	1,203	11,151
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	**(68,872)**	**(57,453)**	**(57,494)**	**(41)**	**11,378**
Net Current Assets	**(26,275)**	**1,588**	**(15,979)**	**(17,567)**	**10,296**
Non-Current Liabilities					
Other Liabilities	(7,987)	(8,270)	(7,525)	745	462
Borrowings	(54,538)	(58,553)	(71,793)	(13,240)	(17,255)
Provisions	(1,396)	(816)	(1,445)	(629)	(49)
Total Non-Current Liabilities	**(63,921)**	**(67,639)**	**(80,763)**	**(13,124)**	**(16,842)**
Total Assets Employed	**226,495**	**235,789**	**217,794**	**(17,995)**	**(8,701)**
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	(7,567)	3,443	(16,268)	(19,711)	(8,701)
Total Taxpayers' Equity	**226,495**	**235,789**	**217,794**	**(17,996)**	**(8,701)**

The table shows the M6 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.

Balance Sheet(2)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Commentary below reflects the Month 6 balance sheet position against the prior year outturn

Note: The opening balance sheet has been restated for the prior period adjustment of £6.0m impacting on the trade and other payables balance in total assets employed and the income and expenditure reserve balance in reserves. As work continues on assessment of bad debt and baselining we expect the prior period adjustment to increase, although this should have minimal impact on the current year's I&E position from this point forward.

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 decreased since the year-end. This reflects movements in drug stocks. These are charged to the I&E on issue and so this change reflects a movement between inventories and creditors.
- Debtor balances have fallen significantly due to the increased focus on credit control, the transacting of the GCS mediation results and the finalisation of year end settlements.
- Cash has increased since the year-end. This is due to the ongoing management of working capital balances alongside receipt of distress funding.

Current Liabilities

- Trade payables have reduced significantly due to the managed payment arrangements now in place post the receipt of distress funding.
- Better Payment Practice Code performance is shown below:

	Cumulative for Financial Year		Current Month September	
	Number	£'000	Number	£'000
Total Bills Paid Within period	72,290	194,424	16,114	46,621
Total Bills paid within Target	27,616	126,597	5,088	32,166
Percentage of Bills paid within target	38%	65%	32%	69%

The BPPC performance is not showing significant improvement for the following reasons:

- A high proportion of recent creditor payments have been those outstanding for a significant period and so already outside of 30 day terms
- Whilst driving down creditor days as far as possible we are not yet compliant with 30 day terms across all suppliers

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.

Cashflow

Gloucestershire Hospitals NHS
NHS Foundation Trust

Cashflow Analysis	Apr-16 £000s	May-16 £000s	Jun-16 £000s	Jul-16 £000s	Aug-16 £000s	Sep-16 £000s	YTD - M6 £000s
Surplus (Deficit) from Operations	**401**	**308**	**3,441**	**(151)**	**(10,222)**	**2,967**	**(3,256)**
Adjust for non-cash items:							
Depreciation	882	883	882	881	882	882	5,292
Impairments within operating result	0	0	0	0	0	0	0
Gain/loss on asset disposal	0	0	0	0	0	0	0
Provisions	0	0	0	0	0	0	0
Other operating non-cash (income)/ expenses	(58)	(1,276)	1,011	(425)	648	(5,043)	(5,143)
Operating Cash flows before working capital	**1,225**	**(85)**	**5,334**	**305**	**(8,692)**	**(1,194)**	**(3,107)**
Working capital movements:							
(Increase)/decrease in inventories	(198)	(13)	1,882	(1,880)	(539)	1,619	871
(Increase)/decrease in current assets	(6,042)	4,983	(9,375)	5,321	6,857	5,994	7,738
Increase/(decrease) in current provisions	0	0	(4)	0	0	0	(4)
Increase/(decrease) in trade and other payables	5,104	(5,795)	3,983	(611)	6,768	(14,471)	(5,022)
Increase/(decrease) in other financial liabilities	3,000	(2,853)	0	127	0	5	279
Net cash inflow/(outflow) from wokring capital	**1,864**	**(3,678)**	**(3,514)**	**2,957**	**13,086**	**(6,853)**	**3,862**
Capital investment:							
Capital expenditure	(678)	(550)	(726)	(657)	(639)	(506)	(3,756)
Capital receipts	0	0	0	0	0	0	0
Net cash inflow/(outflow) from investment	**(678)**	**(550)**	**(726)**	**(657)**	**(639)**	**(506)**	**(3,756)**
Funding and debt:							
PDC Received	0	0	0	0	0	0	0
Interest Received	0	0	4	3	3	2	12
DH loans - received	0	0	0	0	0	19,900	19,900
DH loans - repaid	0	0	0	0	0	(2,061)	(2,061)
Other loans	0	4,000	0	0	(4,000)		0
Finance lease capital	(256)	(256)	(256)	(256)	(256)	(256)	(1,536)
PFI/LIFT etc capital	(235)	(235)	(235)	(235)	(235)	(235)	(1,410)
PDC Dividend paid	0	0	0	0	0	(3,864)	(3,864)
Other	0	0	0	0	0	0	0
Net cash inflow/(outflow) from financing	**(491)**	**3,509**	**(487)**	**(488)**	**(4,488)**	**13,486**	**11,041**
Net cash inflow/(outflow)	**1,920**	**(804)**	**607**	**2,117**	**(733)**	**4,933**	**8,041**

Cash at Bank - Opening	**3,950**	**5,870**	**5,066**	**5,673**	**7,790**	**7,057**	**3,950**
Closing	**5,870**	**5,066**	**5,673**	**7,790**	**7,057**	**11,991**	**11,991**

The cashflow for the first six months of the 2016/17 financial year is shown in the table. The major movements are consistent with those already identified within income and expenditure and the balance sheet.

Key movements:

Inventories – Stock movements, other than at year-end, reflect movements in drug stocks. These are charged to the I&E on issue and so this change reflects a movement between inventories and creditors

Current Assets – reflects a reduced value of debtors due to the transacting of the agreement with GCS and the reduction in debt for Worcestershire Acute

Trade Payables – reduced significantly in September due to the drawdown of distress funding

DH Loans Received – reflects the drawdown of distress funding from the DH

DH Loans Repaid – reflects the half yearly payment of the existing ITFF loans

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Board is asked to note:

- The financial position of the Trust at the end of Month 6 of the 2016/17 financial year is an operational deficit of £8.7m. This is an adverse variance to plan of £15.1m.
- There is a total prior period adjustment reversed from the current YTD position of £6.0m.
- CIP performance has deteriorated in-month from a total delivery at Month 5 of £3.2m to a delivery at Month 6 of £2.7m. This reflects both reclassification of schemes from CIP to cost avoidance and also correction of errors reported in prior months.
- 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.

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

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

Date: **September 2016**

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – 28 October, 2016
Board Room, Cheltenham General Hospital

Report Title									
EMERGENCY PATHWAY MONTHLY PERFORMANCE REPORT									
Sponsor and Author(s)									
Eric Gatling, Executive Director of Service Delivery									
Audience(s)									
Board members	**x**	Regulators	**x**	Governors	**x**	Staff	**x**	Public	**x**

Executive Summary

Purpose

The purpose of the report is to provide the Board with assurance that the Trust continues to address the previously identified concerns relating to delivery of emergency care, within the Trust. The report provides evidence of progress against key quality, safety and performance indicators, describes key risks and provides a progress update against the Emergency Care Programme Board milestone plan. The report reflects data up to 30th September 2016.

Key issues to note

- Improved performance across the pathway against continually rising demand – despite not meeting the national standard, the most recent national relative performance places the Trust in the upper quartile of Trusts nationally for the most recent week and the Trust has not fallen below median performance since the last report.
- Whilst the NHSI recovery trajectory was met for the most recent quarter; this is at risk for Q3 due to continued excess demand and high levels of patient delay which both impact of the key success criterion of optimal occupancy.
- Good progress is being made across all work streams with the exception of work stream 6 where concerns expressed by key partners have resulted in delays to progress the original plan – discussions with partners to resolve the direction of travel are on-going.
- Impact of high occupancy levels, average length of stay, medically fit for discharge patients and delayed transfers of care continue to be felt and a *Discharge Summit* has been convened by the Trust Chief Executive as a means of bringing partners back together to address this issue collectively.
- A new nationally endorsed initiative *Red & Green Days* has been launched in period and roll out is now underway.

Conclusions

Good progress is being made against the milestones set out in the Emergency Care , with the exception of the issue set out above. Governance arrangements are considered robust and effective and continue to benefit from good engagement. The key risk to performance delivery remains high occupancy and actions to address this remain the key focus of all work streams.

Implications and Future Action Required

Increased focus and engagement on external factors affecting discharges ahead of winter and full implementation of red/green days

Recommendations

The Board is asked to receive this report as a source of assurance that good progress continues to be in this programme and that all major risks to meeting the performance recovery trajectiory are being actively managed.

Impact Upon Strategic Objectives

Supports delivery of the strategic objective of high quality care

Impact Upon Corporate Risks							
Impacts upon the risk associated with high quality care arising from failure to meet national standards							
Regulatory and/or Legal Implications							
The Trust remains under regulatory intervention for performance against the national A&E 4-hour standard							
Equality & Patient Impact							
No specific patient groups are affected by the issues raised in this report.							
Resource Implications							
Finance	**x**	Information Management & Technology					
Human Resources	x	Buildings					
Additional investment and staffing has agreed to address the delivery of the work programme.							
Action/Decision Required							
For Decision		For Assurance	**x**	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)**
x				12th October 2016	October Emergency Care Programme Board
Outcome of discussion when presented to previous Committees					
Endorsed for review by the Trust Board					

MAIN BOARD - OCTOBER 2016
EMERGENCY PATHWAY
MONTHLY PERFORMANCE REPORT: SEPTEMBER 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 30th September 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 2016/17 Quarter 2 agreed improvement trajectory of 88.50%, with Trust-wide performance (including GP in the Emergency Department activity) reported as 88.78%. However, in September 2016 the Trust did not achieve the improvement trajectory of 91.90%, with Trust-wide performance reported as 89.28%.

- The forecast Trust-wide position for October (based on a straight line extrapolation from the *unvalidated* performance 'as at' the 16th October) is 86.06%, against the trajectory of 89.10%.

- The number of patients seen, treated and admitted or discharged within four hours in September 2016 was 10,053 compared to 9,572 in the same period last year, despite attendances being 5% higher.

- The daily average number of Emergency Department attendances in September 2016 was 377 patients (11,303 for the month), compared to September 2015 (358 per day), which is an increase of 5%. This is an increase of 3% compared to August 2016's attendance figures.

- The daily average number of admissions from the Emergency Department in September 2016 was 114 patients (3,418 for the month), which is 8% lower than September 2015 (123 per day).

- General and Acute average length of stay for non-elective admissions has increased from 5.81 days in August 2016 to 6.03 days in September 2016. This is an increase of 7.7% on the same period last year (average 5.6 days).

- The average number of patients on the medically fit list for one day and over in September 2016 is 73. This is lower than the previous month (77). 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 continued signs of improvement.

1.1 National Quality Indicators

Trust performance against four quality indicators is tabulated below, with reports by exception below:

Measure	Target	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	Sep-16
Unplanned reattendance rate	<5%	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%	1.8%
Total time in department	95th % <4 hrs	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	05:40
Patients left without being seen	<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%	1.9%
Time to treatment	Median = 60 mins	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	01:06

1.1.1 Total Time in the Department & Time To Treatment

Despite the Median Time to Treatment metric increasing slightly in September 2016 by six minutes compared to August, the 95th percentile total waiting time was 5 hours and 40 minutes. Although this is above the threshold of four hours, it is a significant improvement compared to the previous month, and is the second lowest time recorded in 2016/17.

12-hour Trolley Wait

In September 2016, one patient waited over 12 hours between the Decision to Admit and the Bed Allocation times. A Root Cause Analysis was conducted by the Medical Division, with the Director of Service Delivery, which identified the following outcomes:

- Lack of timely escalation;
- Confusion over responsibilities;
- Incomplete action.

The following action has been taken:

- Standard Operating Procedure issued for escalation at 8 hours;
- Individual involved seen by the Director of Service Delivery;
- Harm review undertaken, which determined that the outcome for the patient was not caused by the delay. However, it is recognised that the patient experience was poor.

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

Although the performance in September 2016 remains below the target, there has been a significant improvement of nearly **27%** against the February baseline (Trustwide).

The Unscheduled Care service is tracking weekly performance against internally-set trajectories (by site). Cheltenham General Hospital met its trajectory (ranging from 80 – 85%) in two of the four weeks of September, whereas Gloucestershire Royal met its trajectory every week (ranging from 70 – 78%).

	Number of….	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	Sep-16
Trust Total	Patients	10982	10600	10747	11079	10532	10844	10734	10603	11510	10777	11854	11343	11969	11335	11303
	Patients seen <= 15 mins	6864	6646	6350	6406	6328	6072	6076	5441	6127	7381	9353	8857	9209	9160	8834
	Patients >15 mins	4118	3954	4397	4673	4204	4772	4658	5162	5383	3396	2501	2486	2760	2175	2469
	% Compliant	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%	78.16%

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

Although the performance in September 2016 remains significantly below the target, there has been an improvement against the February baseline (4%) and an increase of 1.3% compared to September 2015.

The internal trajectories by site show that Cheltenham General Hospital met its trajectory (ranging from 50 – 61%) in two of the four weeks of September, whereas Gloucestershire Royal Hospital were unable to meet trajectory (ranging from 42 – 58%) in any week.

	Number of….	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	Sep-16
Trust Total	Patients	10982	10600	10747	11079	10532	10844	10734	10603	11510	10777	11854	11343	11969	11335	11303
	Patients seen <= 60 mins	5649	4328	4683	4464	5459	4598	5162	4342	4727	5186	5601	5213	5259	5597	5076
	Patients >60 mins	5333	6272	6064	6615	5073	6246	5572	6261	6783	5591	6253	6130	6710	5738	6227
	% Compliant	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%	44.91%

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. On an hourly basis the escalation status of Emergency Department is calculated using a score system that takes into account: Incoming ambulance arrivals, total arrivals, Major cubicles in use, and Resus cubicles in use and total patients in department.

An audit of the hourly logs completed between 22nd and 28th August 2016 was undertaken in September. The purpose of the audit was to determine utilisation and collate issues to be addressed.

Utilisation: 69% at GRH (116 logs completed out of a possible 168);
79% at CGH (132 logs completed out of a possible 168).

1.1.5 Emergency Department Safety Checklist

A pilot checklist, devised for Trust Emergency Departments 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 Emergency Departments 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.

Compliance by Site:

Cheltenham General Hospital:

	Median of CGH Baseline Data	Month 1	Month 2	Month 3	Month 4	Month 5
		Mar-16	Apr-16	May-16	Jun-16	Jul-16
Total Notes Pulled		30	57	59	55	59
Total Applicable Notes		9	18	34	26	24
% Compliance		30%	32%	58%	47%	41%

Gloucestershire Royal Hospital:

	Mean of GRH Baseline Data	Month 1	Month 2	Month 3
		Jun-16	Jul-16	Aug-16
Total Notes Pulled		162	164	164
Total Applicable Notes		47	18	10
% Compliance		29%	11%	6%

Action Plans:

The Emergency Department Checklist is part of an ongoing project which is due to run until October 2017, by which stage it is anticipated that the Emergency Department checklist will be part of the standard Emergency Department paperwork and process. Uptake is lower in Gloucestershire Royal Hospital and the following actions have been put in place to address:

Summary of Action	Due by
Email to be sent out reminding staff of the requirement to complete the Emergency Department Checklist	Immediately
Re-evaluate changes made to the environment will using a series of quick Plan, Do, Study, Act (PDSA) cycles	October 16
Creating focus groups to re-engage with staff using actual Serious Incidents to create the narrative / background for the meetings	September 16 - Ongoing
Nurses from Bristol (where the checklist was successfully implemented) to be invited to attend the Senior Nurse's meetings at both sites to promote the positive outcomes of using the checklist.	October 16
A booklet-style checklist which will include other key documents will be designed and tested by November 2016	Pilot in November

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	Sep-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	27.5
	GRH	1.1	3.7	0.4	1.4	3.5	2.0	4.2	7.0	9.1	26.4	24.9
	TRUST	**2.4**	**1.9**	**0.7**	**2.5**	**4.5**	**2.3**	**4.9**	**8.3**	**11.6**	**26.7**	**26.0**
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	89.5
	GRH	67.6	85.2	83.3	55.3	72.7	81.8	88.2	94.2	80.3	85.3	82.3
	TRUST	**78.8**	**76.4**	**53.8**	**78.0**	**82.2**	**82.6**	**91.5**	**95.0**	**85.9**	**87.6**	**85.0**
Number of Complaints	**TRUST**	**10**	**9**	**10**	**12**	**12**	**11**	**14**	**12**	**14**	**9**	**9**
Number of Concerns		**3**	**1**	**6**	**8**	**2**	**1**	**3**	**8**	**3**	**4**	**4**
Number of Compliments		**4**	**23**	**11**	**8**	**6**	**10**	**11**	**35**	**7**	**10**	**3**

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 September (26.0% Trust-wide). Peer Trusts using the same methodology have reported response rates of circa 20%.

Encouragingly, 85% 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 including the waiting time for treatment.

1.2 Safety

- There were **no** Never Events recorded in September.
- There was one Serious Incident which has been confirmed with a multi-organisational review with South Western Ambulance NHS Foundation Trust and led by the Trust.
- Sepsis screening in the Emergency Department continues, with 96% of patients being screened, time to antibiotics remains around 50%.

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.

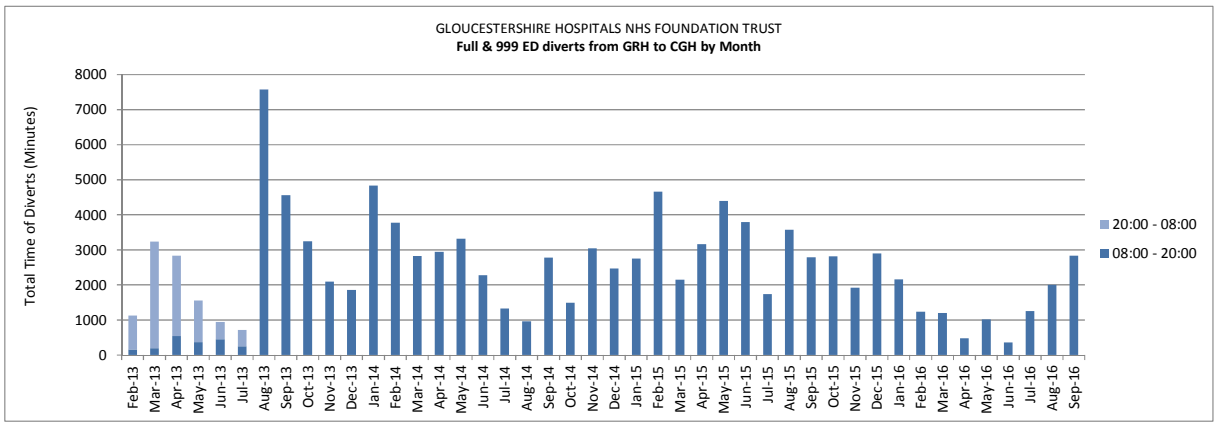
	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016
Admission/ transfer	9	45	22	35	98	88	48	17	11	74	7	7	7
Abuse and Violence	9	19	12	17	7	6	20	3	19	6	4	8	7
Care, Monitoring, Review	6	11	28	4	1	6	8	5	3	8	3	6	3
Diagnosis & Assessment	5	3	7	7	3	6	8	6	4	3	4	1	5
Communication	2	4	5	6	3	4	6	7	6	4	4	5	6
Staffing / Beds / Systems (no individual patient involvement)	5	4	8	4	2	4	4	2	2	7	1	4	2
Medication Incident	3	5	4	3	1	2	3	3	3	9	4	3	1
Treatment/ Procedure	1	2	3	1	2	2	4	3	1	1	2	4	1
Falls	4	2	3	1	3	0	3	0	1	0	2	2	3
Discharge & Transfer	2	2	2	4	1	2	6	0	1	0	0	1	1

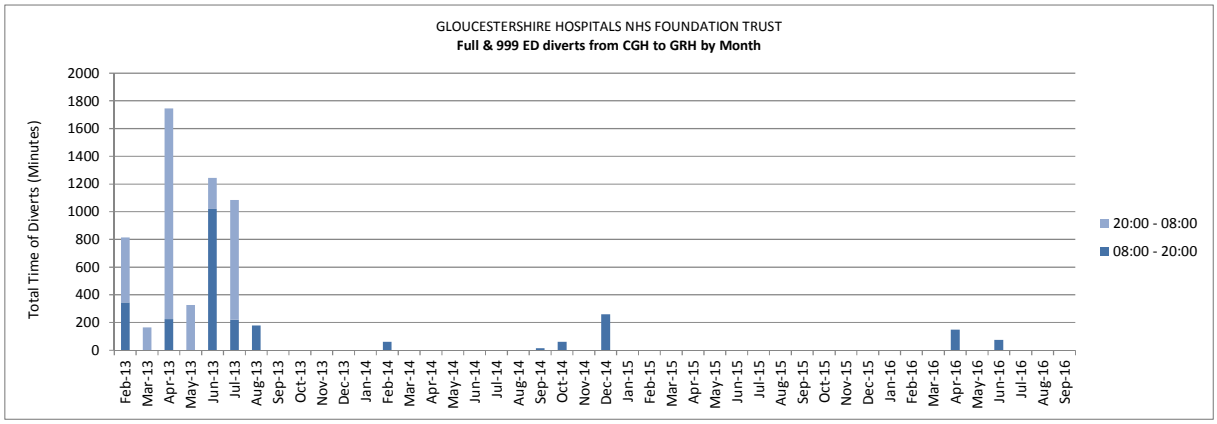
Current Improvement and Audit projects	
• **Patient Safety Checklist – part of the WEAHSN (Academy supported)** implemented in CGH in March 2016 and GRH in June 2016. **Actions planned include** - Link earlier sepsis screening to checklist - Improve refreshment and clinical pathway recording • **Improve 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 & Pain Management** The ED checklist compliance in Gloucester over in September has marginally improved to 14%, Cheltenham data for August had improved to 51% (Sept data awaited) of those audited there was excellent compliance to EWS and other safety related metrics (90-100%). The project team has designed a new style booklet for testing, the booklet brings together all nursing documentation rather than individual sheets. Changes made to the environment will be re-evaluated using a series of quick Plan Do, Study, Act cycles. The pain management related improvement project has ended and will be reported in the next month with recommendations for further areas of improvement.
• **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	The current data shows that the main aim to reduce the time from missed diagnosis to action has not been achieved, this is mainly due to a backlog of radiology reporting preventing the miss to be identified in a timely way, the D&S Division have plan in place to reduce this backlog. The interventions within the department have been effective and now there are less major categorised misses and less overall misses.
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

1.2.1 Diverts Between Gloucestershire Royal Hospital & Cheltenham General Hospital

There were 13 occasions when a Full/999 divert took place in September 2016 compared to 8 in August 2016.

The total duration of the diverts increased from 33 hours and 30 minutes last month to 47 hours and 10 minutes in September 2016 (however, the average hours duration for each divert was 3 hours 38 minutes, compared to 4 hours 11 minutes in August).



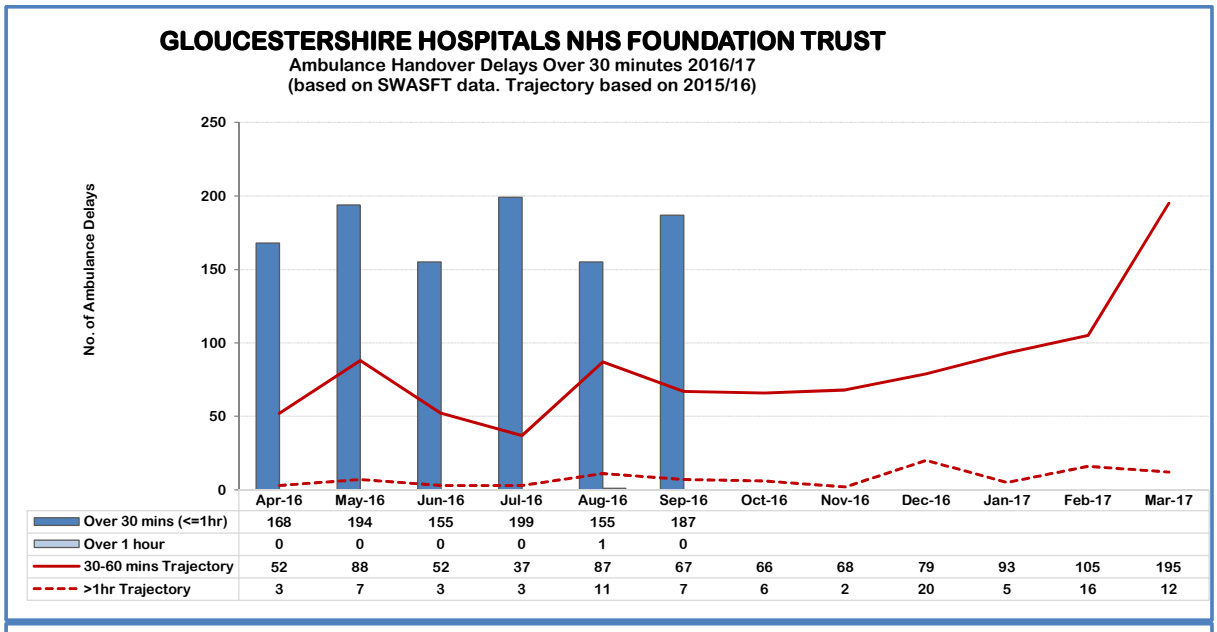


1.2.2 Ambulance Handover Delays

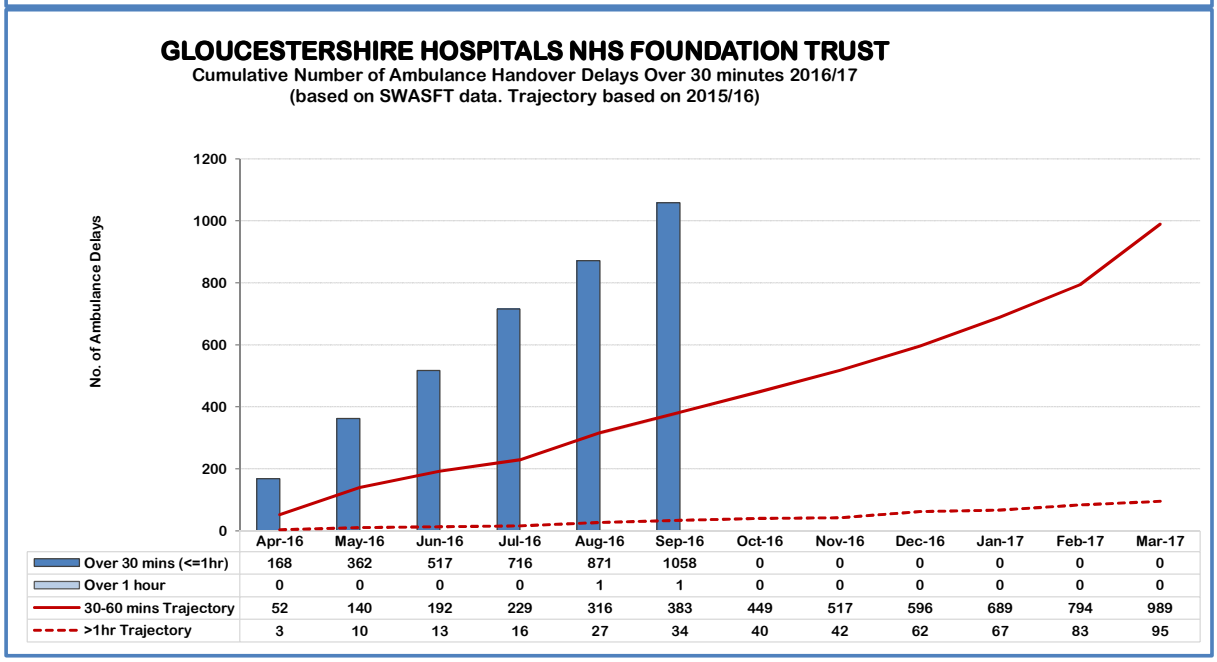
There has been just one ambulance delay in excess of 60 minutes since April 2016, much better than the trajectory, and month on month.

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 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	187						
Over 1 hour	0	0	0	0	1	0						
30-60 mins Trajectory	52	88	52	37	87	67	66	68	79	93	105	195
>1hr Trajectory	3	7	3	3	11	7	6	2	20	5	16	12

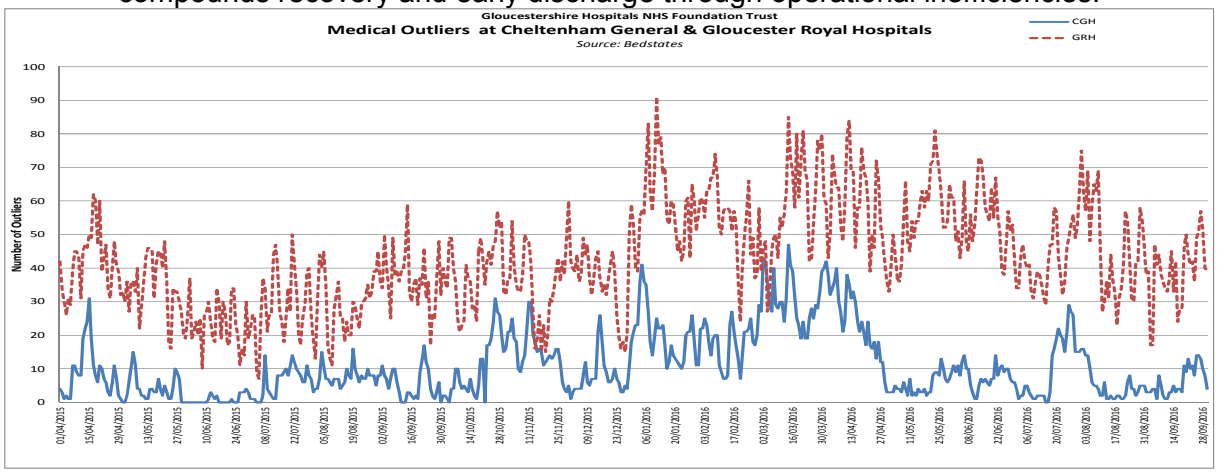


	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Over 30 mins (<=1hr)	168	362	517	716	871	1058	0	0	0	0	0	0
Over 1 hour	0	0	0	0	1	1	0	0	0	0	0	0
30-60 mins Trajectory	52	140	192	229	316	383	449	517	596	689	794	989
>1hr Trajectory	3	10	13	16	27	34	40	42	62	67	83	95

1.2.3 Medical Outliers

The daily average number of medical outliers was 39 at Gloucestershire Royal and 6 at Cheltenham General in September 2016; compared to 46 and 5 respectively last month.

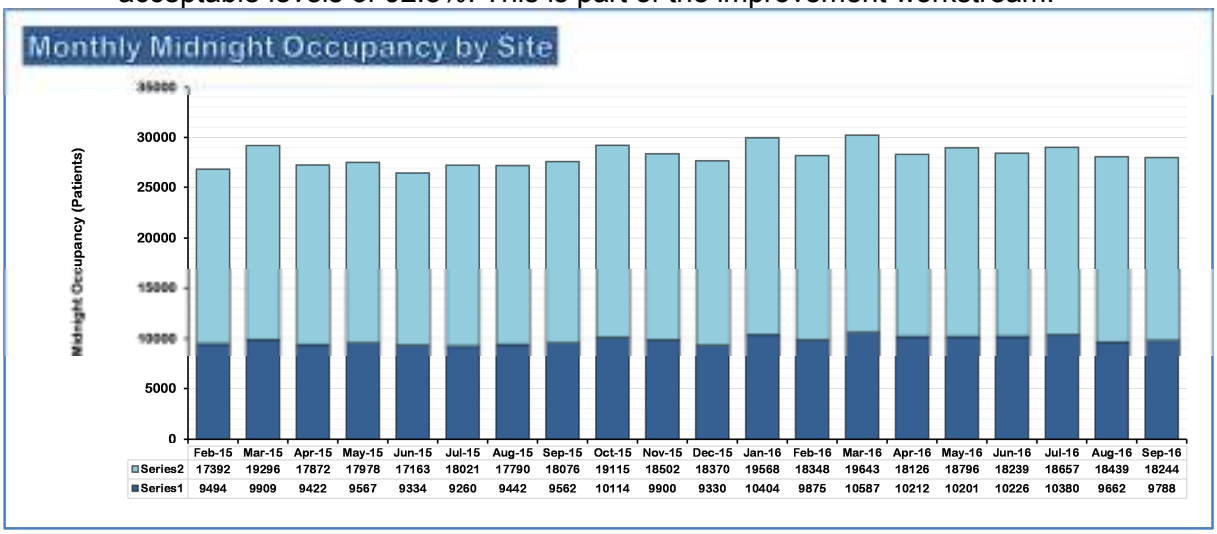
Surgical outliers are insignificant, but medical outliers remain an issue for the Trust. Average numbers of medical outliers per day may have reduced by some 29% since February 2016, but the placement of patients in a bed of a different specialty compounds recovery and early discharge through operational inefficiencies.



1.2.4 Midnight Bed Occupancy

The daily average number of beds occupied in September 2016 was 934. This is an increase from August 2016 when the average was 907 per day, and September 2015 (921).

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%. This is part of the improvement workstream.

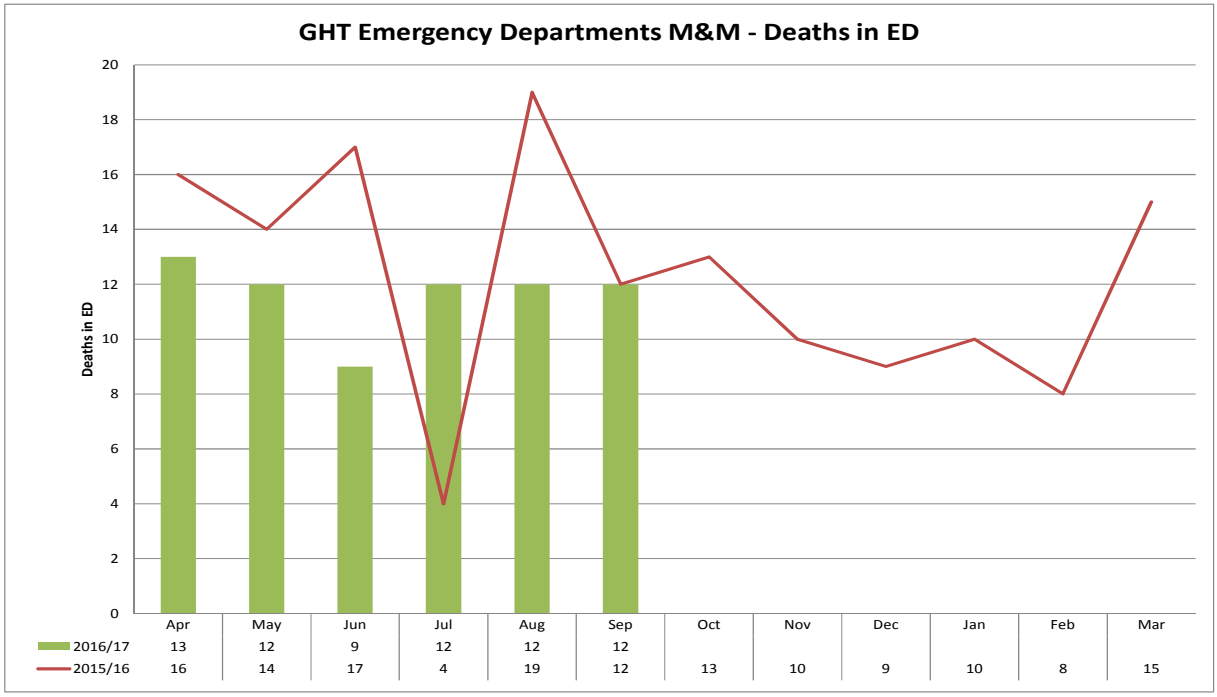


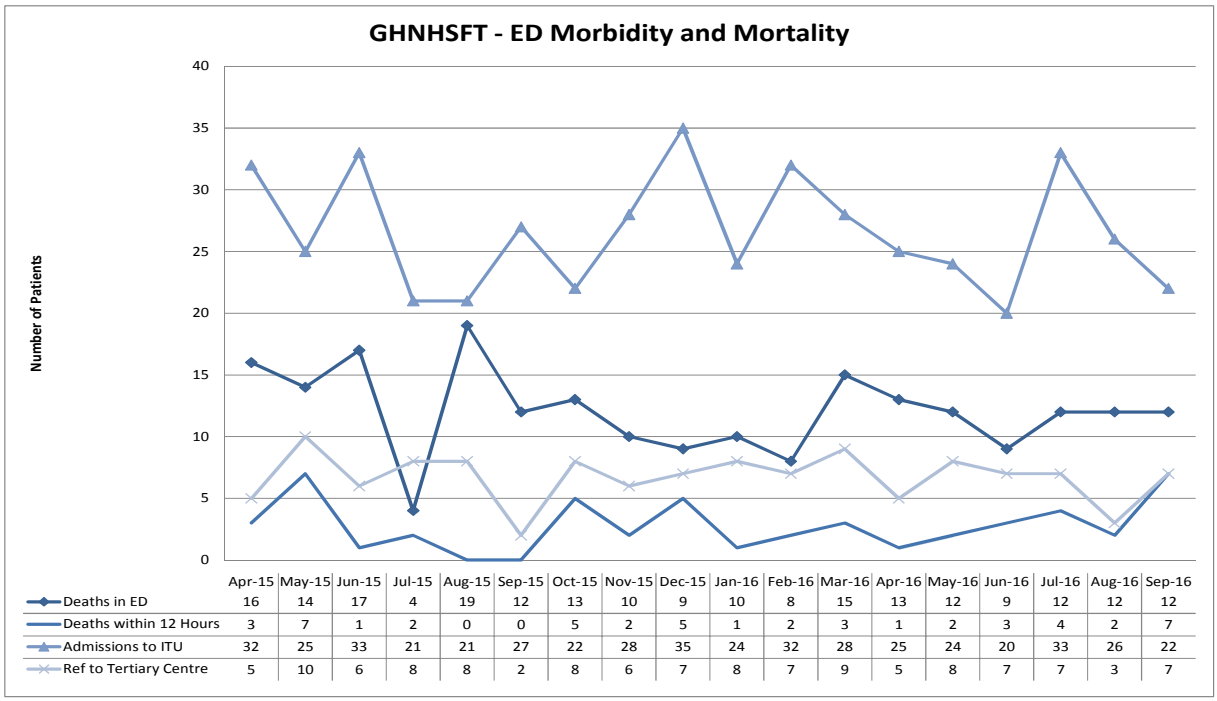
% Bed Occupancy (as at Thursday snapshot)

Week ending:	CGH	GRH	Total
04/09/2016	90.6%	97.9%	**95.0%**
11/09/2016	93.3%	99.6%	**97.1%**
18/09/2016	91.9%	98.9%	**96.2%**
25/09/2016	94.2%	98.5%	**96.8%**
02/10/2016	96.4%	97.9%	**97.3%**

1.2.5 Emergency Department Morbidity & Mortality

During September 2016 there were 12 deaths in the Emergency Department, which is the same as September last year. There were 22 admissions to ITU and 7 referrals to tertiary centres. All of the deaths are reviewed in detail at the Service Line Morbidity and Mortality Reviews. Any issues are highlighted in the quality report.





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.

There remains a significant number of vacancies against establishment, particularly for Trainee Doctors (-7.8 in the Emergency Department and -17.49 in Acute Medicine).

The Board are asked to note that there is a large variance shown for the number of Trainee Doctors in post in September 2016 compared to the previous month. This is because the numbers are artificially inflated in August 2016 due to the cross-over of contracted staff.

		Establishment (wte)	In Post September (wte)	Variance In Post vs. Establishment	Variance vs. in Post in August
Emergency Department	• Consultants	20.00	19.60	-0.40	0.00
	• Trainee Doctors	37.00	29.20	-7.8	-8.1
Acute Medicine	• Consultants	11.03	8.33	-2.70	0.00
	• Trainee Doctors	87.29	69.80	-17.49	-30.4

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. Progress against this recruitment is shown below:

Type of Staff	Establish-Ment (wte)	Current in post (wte)	% in post (Oct 16)	Oct	Nov	Dec	Jan	Feb	Mar	Comments
Cons.	20	19	95%		-1		+1		+1	With 20 we can offset effects of acting down and put in some extra shifts at key times eg Monday day and evening shifts
Middle grades	10.5	7	66.7%							Only one response to recent advert, though weak we will probably employ Plan is to re-advertise, to include physicians assistants
Juniors	28	20	71.4%							
ENPs	19.86 (B7 – 9.72 B6 -10.14)	B7 9.72 B6 8.14	90%	+2 (B6)						3 good applicants in the pipeline. More applicants out there coming from MIUs
Nurses	82.58	71.97	87%							
AEC	4 ANPs	3.6 ANPs	90%							
Total	164.94	139.43	84.27%	141.43 (85.7%)	140.43 (85.1%)	140.43 (85.1%)	141.43 (85.7%)	141.43 (85.7%)	142.43 (86.3%)	

The expected outcomes of the recruitment are:

1. Performance against the 4 hour standard for minor patients is 98%;

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.

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: 1x project Manager commenced 26th September and the second post-holder commenced 17th October.
- Additional part-time support has also been provided by the Clinical Commissioning Group, this post will commence on 18th October.
- Recruit to 8 positions, across bands 4, 5, 6, 7, increasing the establishment by 4 whole time equivalents.

2. Performance & Recovery Trajectory

Overall there has been a slight decline in performance in September 2016, but the trajectory was achieved for Quarter 2. Continued focus through the workstreams and Business-as-usual is required to address the decline and get back to trajectory performance.

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.

September 2016 data shows that Cheltenham General achieved the 95% national standard at 96.06% but Gloucester Royal missed the standard, recording 84.78%. The Trust Total was **88.94%**, which is a decrease of 1.72% 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%	96.06%						
GRH actual	83.93%	82.68%	83.87%	81.95%	86.89%	84.78%						
Trust actual	85.39%	87.42%	87.07%	86.00%	90.66%	88.94%						

Source: April 2016 onwards – Monthly SITREP return

NHS England (Type 1) Emergency Department performance for Quarter 2 2016/17 was 88.48% which is an increase of 1.83% compared to the previous quarter. The Trust-wide position (includes GP in ED activity) for Quarter 2 was 88.78%, which is an increase of 1.81% compared to the previous quarter.

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 2016/17 Quarter 2 agreed improvement trajectory of 88.50%, with Trust-wide performance (including GP in the Emergency Department activity) reported as 88.78%. However, in September 2016 the Trust did not achieve the improvement trajectory of 91.9%, with Trust-wide performance reported as 89.28%.

The forecast Trust-wide position for October (based on a straight line extrapolation from the ***unvalidated*** performance 'as at' the 16th October) is **86.06%**, against the trajectory of 89.10%

	Apr-16	May-16	Jun-16	Q1 16/17	Jul-16	Aug-16	Sep-16	Q2 16/17	Oct-16 (Projected)
NHSI Trajectory	80.00%	85.00%	85.00%	83.50%	87.00%	87.00%	91.90%	88.50%	89.10%
GHFT Performance (excluding GP in ED Figures)	85.39%	87.42%	87.07%	86.90%	86.00%	90.66%	88.94%	88.48%	85.71%
Performance Including GP in ED Figures Against NHSI Trajectory	85.71%	87.73%	87.37%	86.96%	86.34%	90.85%	89.28%	88.78%	86.06%

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%	98.06%						
CGH Majors	73.03%	89.79%	83.57%	82.38%	94.10%	91.81%						
GRH Minors	94.07%	94.83%	93.73%	93.00%	95.92%	95.53%						
GRH Majors	74.27%	69.61%	73.21%	70.50%	77.29%	72.55%						
Trust Minors	95.04%	96.57%	95.30%	95.27%	97.17%	96.61%						
Trust Majors	73.93%	75.15%	76.04%	73.73%	81.94%	78.04%						

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:

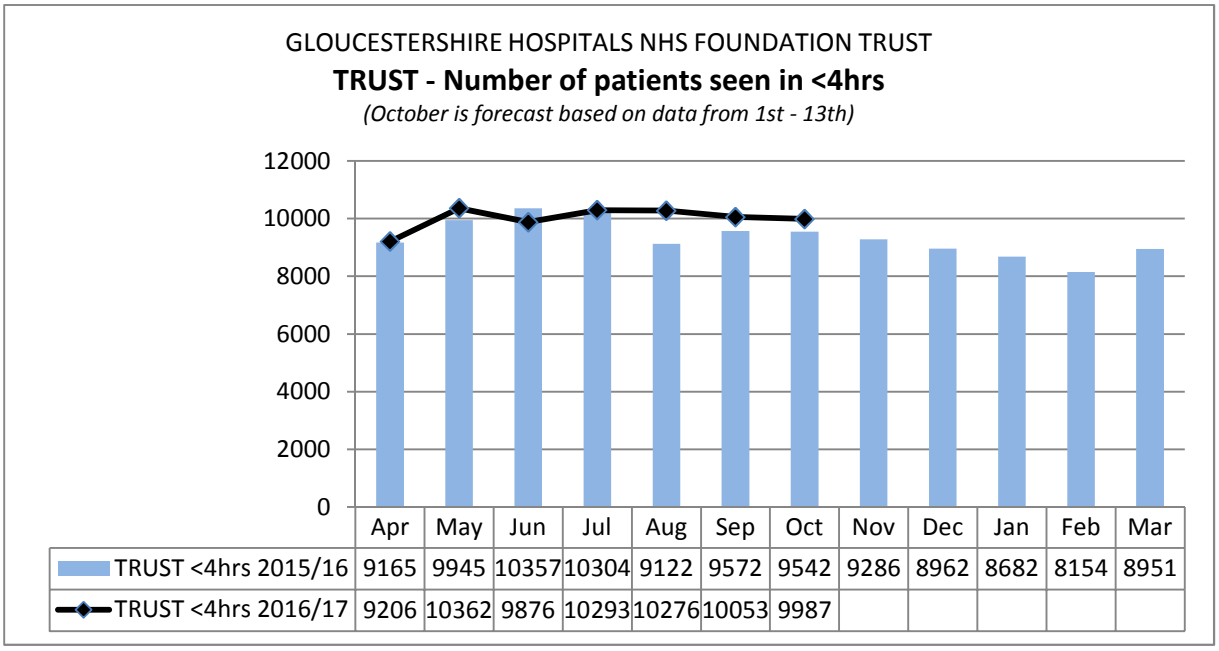
September 2016						
	Total Breached	**Breach due to Awaiting Assessment**	**Breach due to Awaiting Bed**	**Breach due to Undergoing Treatment**	**Breach due to ED Capacity**	**Others***
CGH	164	30	52	20	2	60
GRH	1086	241	468	67	136	174
Total	1250	271	520	87	138	234
%		21.68%	41.60%	6.96%	11.04%	18.72%

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

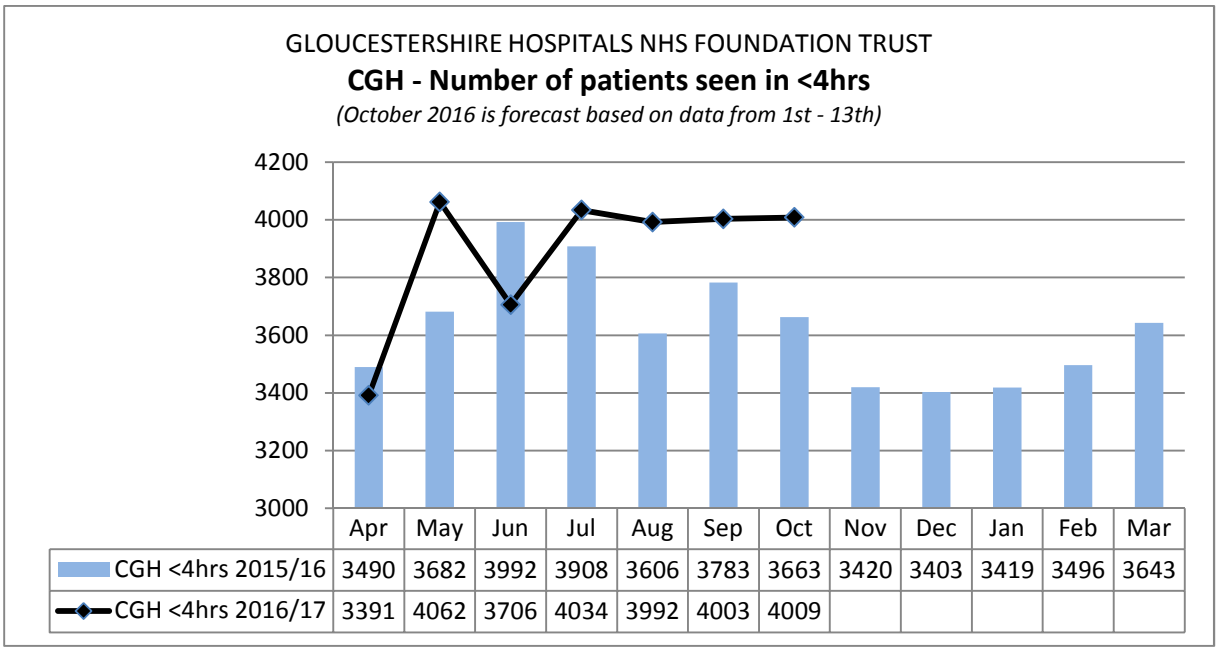
- Bed availability remains the biggest single cause of breaches.
- Assessment also remains high, and is on a rising trajectory. This correlates with the increase in demand and staffing gaps as the Trust seeks to increase establishment and change working arrangements

2.1.4 Patients seen within 4 hours

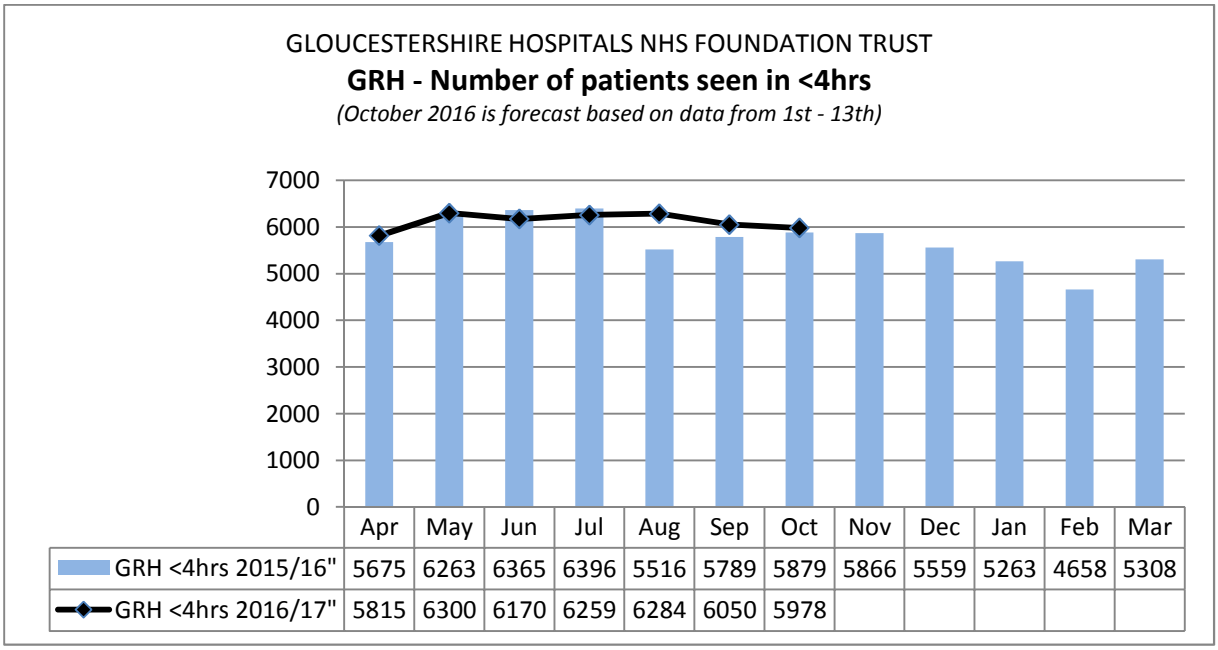
The chart below shows that despite an increase in attendances, the Emergency Departments are managing to discharge or admit more patients within the four hour standard, compared to last year.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
TRUST <4hrs 2015/16	9165	9945	10357	10304	9122	9572	9542	9286	8962	8682	8154	8951
TRUST <4hrs 2016/17	9206	10362	9876	10293	10276	10053	9987					



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CGH <4hrs 2015/16	3490	3682	3992	3908	3606	3783	3663	3420	3403	3419	3496	3643
CGH <4hrs 2016/17	3391	4062	3706	4034	3992	4003	4009					



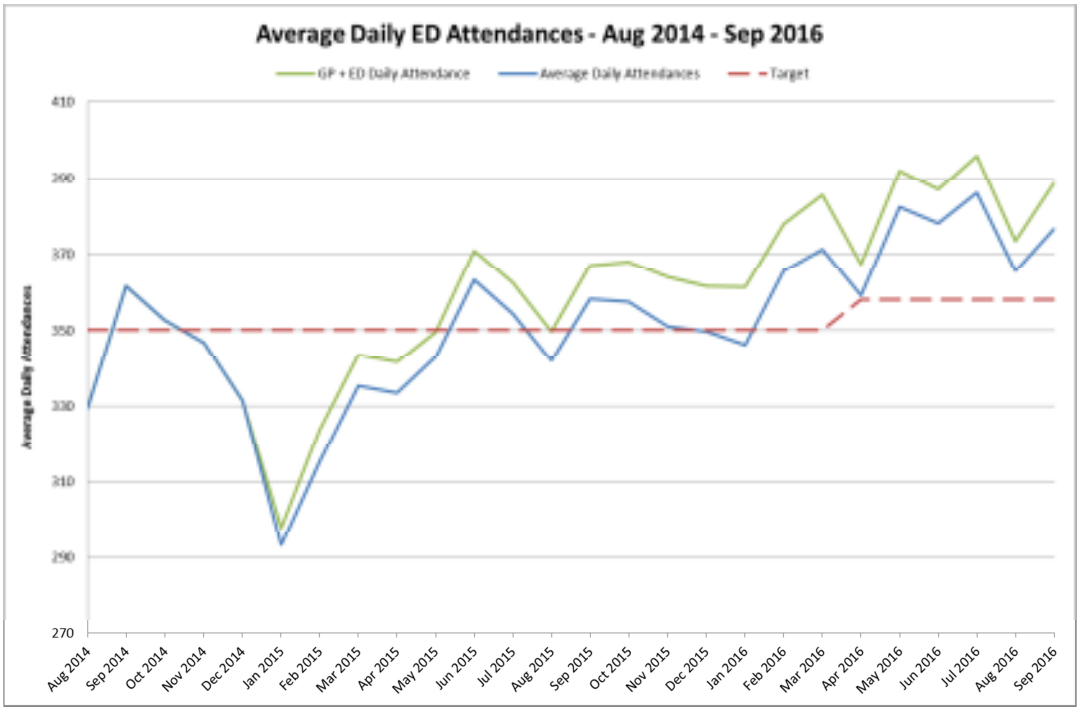
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
GRH <4hrs 2015/16"	5675	6263	6365	6396	5516	5789	5879	5866	5559	5263	4658	5308
GRH <4hrs 2016/17"	5815	6300	6170	6259	6284	6050	5978					

2.2 Demand & Capacity

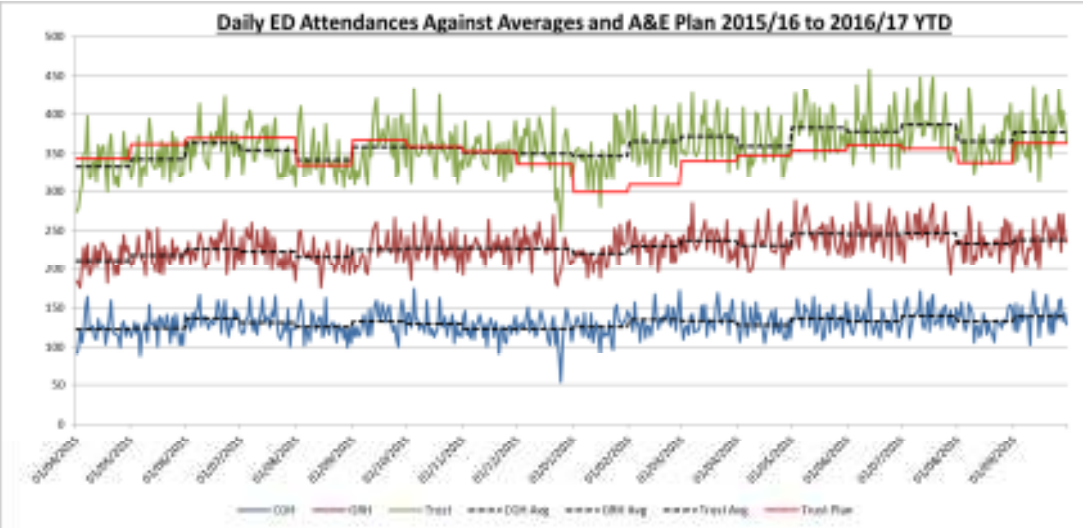
2.2.1 Emergency Department Attendances

There were 11,303 attendances in September 2016 (average of 377 per day) which is 11 more per day than the previous month and a **5% increase** on September 2015's average. This is 19 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 363 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.

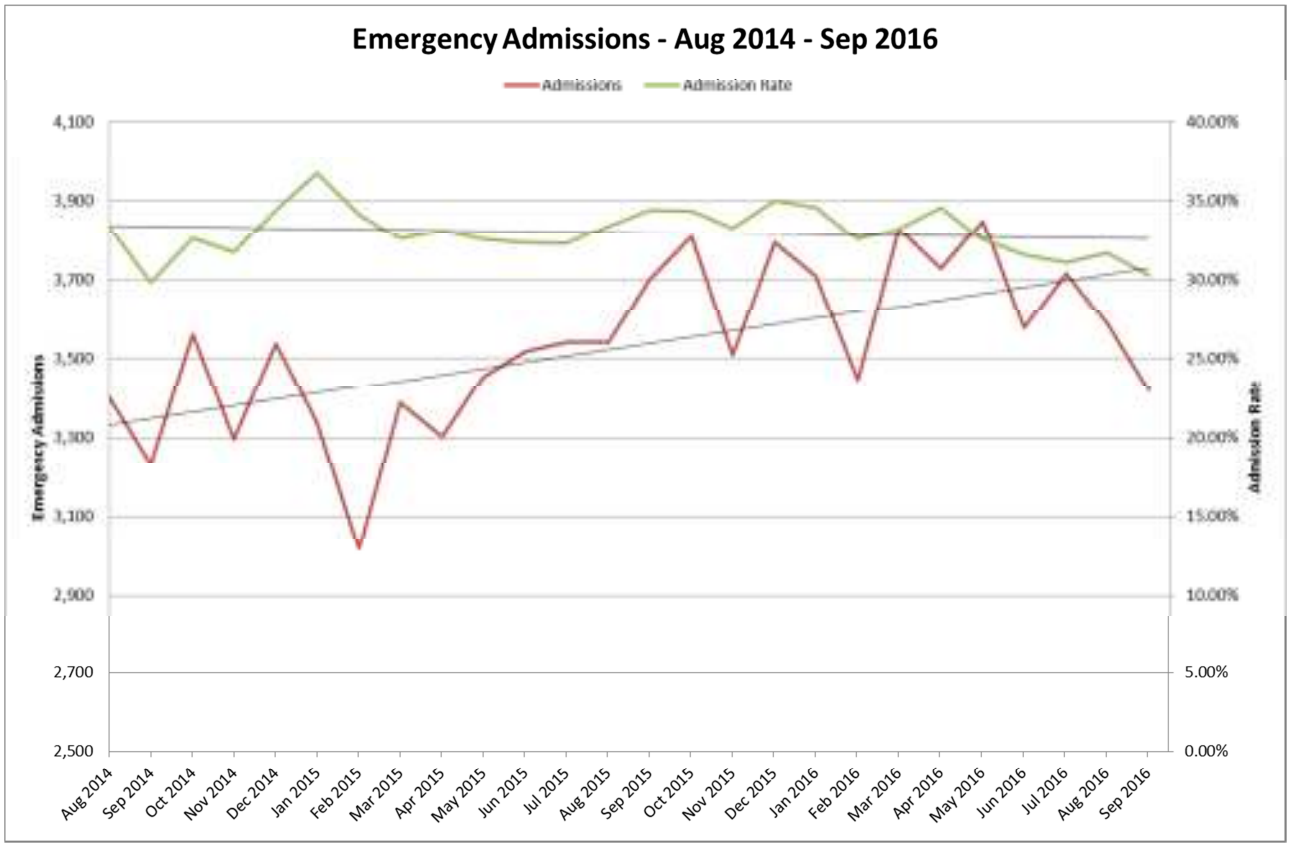
The table below shows a monthly breakdown of the impact of adding the number of Primary Care in Emergency Department cases (provided by Gloucestershire Clinical Commissioning Group), into the denominator of our Emergency Department performance calculation.

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%
Sep-16	11303	1250	88.94%	356	89.28%

2.2.2 Emergency Admissions

The Emergency admission rate (from the Emergency Departments) in September 2016 was 30.24% compared to August 2016, when the admission rate was 31.65% and September 2015 which was 34.43%.

In September 2016 there were 11,303 Emergency Department attendances and 3,418 patients were admitted (average 114 per day), compared to September 2015 when there were fewer attendances (10,747), but the admission rate was higher (34.43%). 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.

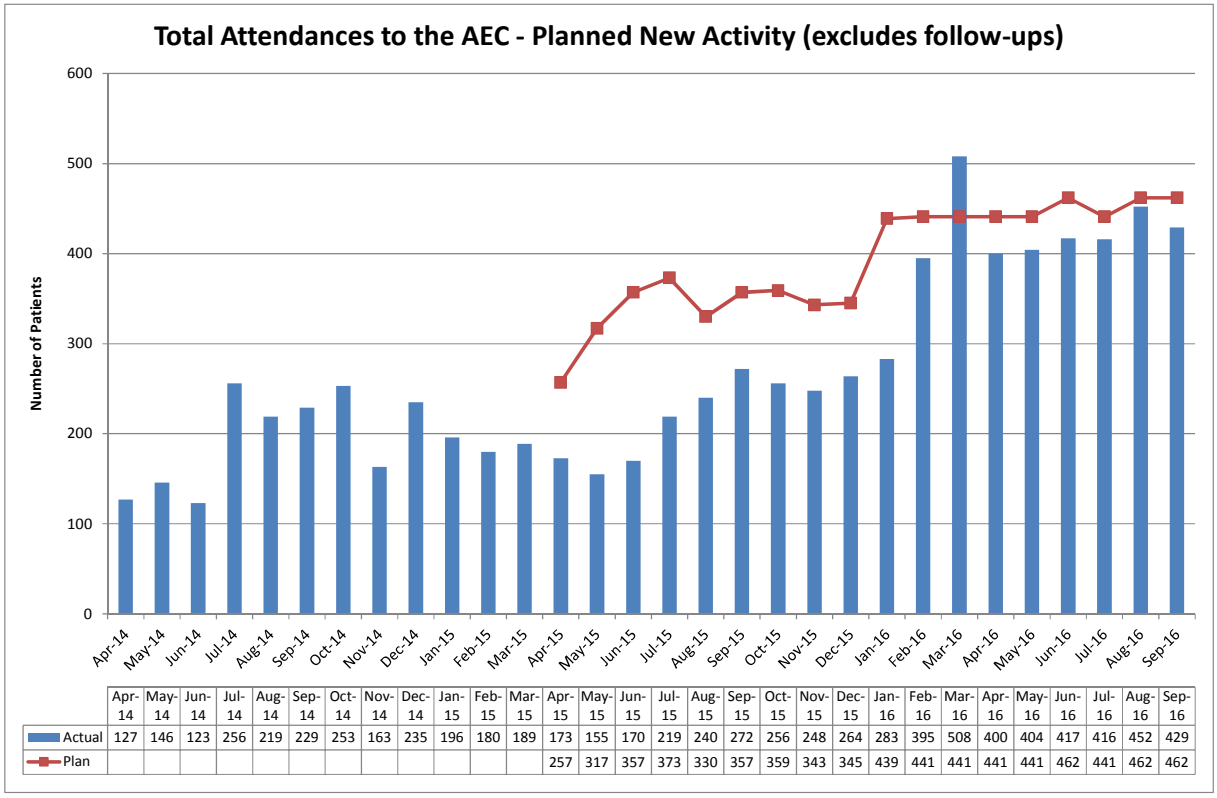


2.2.3 Ambulatory Emergency Care Attendances

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 September 2016 was 19.5 compared to 20.5 last month and was 33 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. A key focus for winter 2016/17 is to increase the utilisation of the Ambulatory Emergency Care units.



	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	Sep-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	452	429
Plan													257	317	357	373	330	357	359	343	345	439	441	441	441	441	462	441	462	462

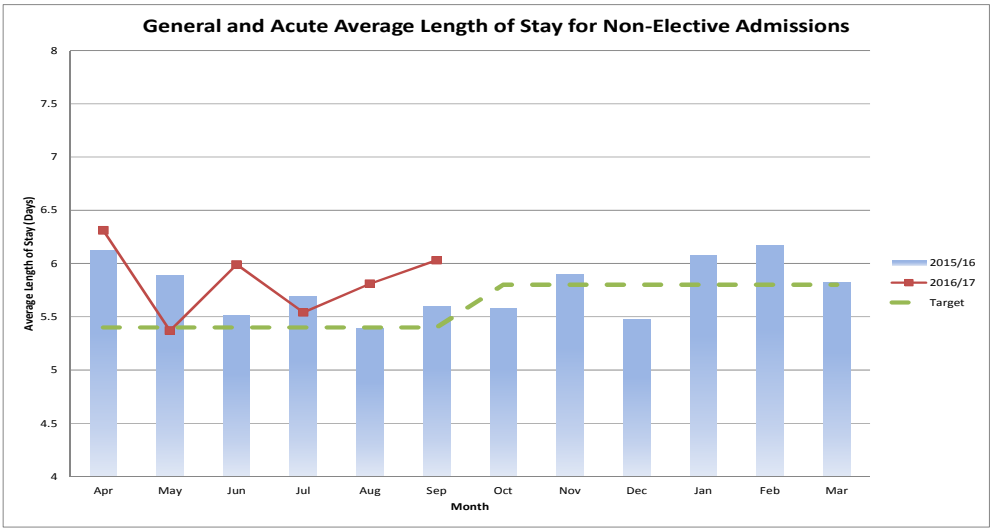
In addition, the service has seen a number of follow-up attendances. There were 158 follow-ups in September 2016, compared to 168 the previous month. Trust focus is now turning to reducing follow-ups in order to increase capacity for new patients.

2.2.4 General & Acute Emergency Admissions – Average Length of Stay

September 2016 shows an increase in the Average Length of Stay at 6.03 days compared to 5.81 days last month against the current target of 5.4 days.

Workstream 5 – Bed Distribution is undertaking a Length of Stay comparison against the Better Care Better Value benchmarks. Specialties with the largest variance against the benchmarks will be given priority focus to address. This information will be shared with specialities by mid-November 2016.

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 September 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 73 per day in September, 2016 (16% 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 workstream 6 – Remove Delays to Discharge) alternative options to enable safe, prompt and timely discharge by opening a nurse-led Medically Fit ward at Gloucestershire Royal Hospital with designated therapy support and social care. This will release beds on the acute wards to improve flow for unwell patients as well as focusing on supporting discharge of medically fit patients within a designated ward. There will be specified criteria to ensure only patients suitable for this model are accepted onto this pathway.

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 September:

Week Commencing (Friday)	Fin. Week 2016	Average Per Day	Bed Days Lost
02/09/2016	Week 23	83	584
09/09/2016	Week 24	80	557
16/09/2016	Week 25	62	435
23/09/2016	Week 26	67	471

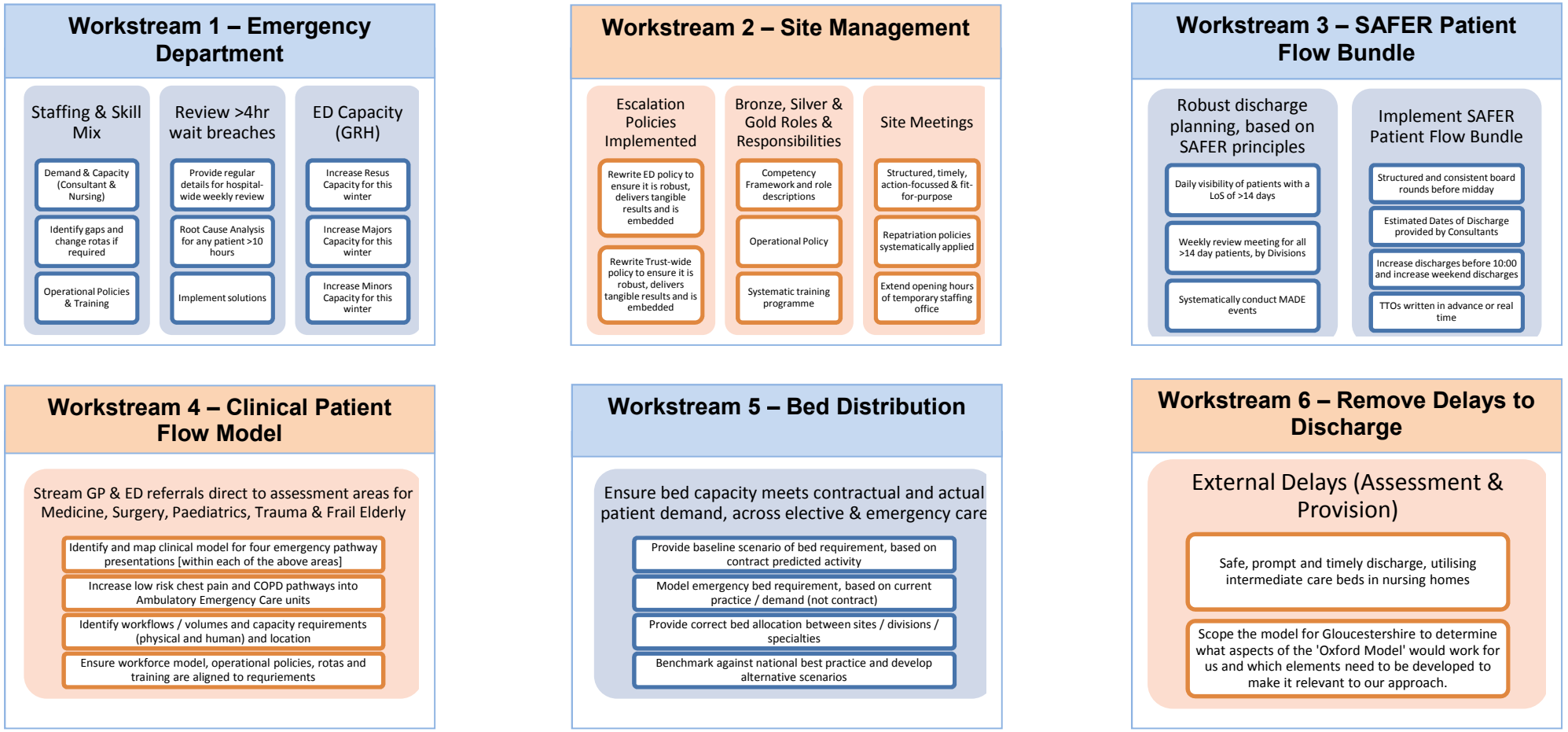
Source: InfoFlex and PAS (Integrated Discharge Team data)

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.



There are also five cross-cutting corporate workstreams and the following section provides an overview of programme progress and update by exception.

3.1.1 Programme Progress Review and Update by Exception

ACTION BRAG STATUS				
Delivered	**Not on Track to Deliver**	**On Track to Deliver but Variance from Plan**	**On Track to Deliver Against Plan**	**Closed**
67	**23**	**28**	**49**	**15**

Actions 'Not on Track to Deliver' with Remedial Actions & Dates

Workstream 1 – Emergency Department

1.1.2.1 Write handover protocol ED to wards (nursing):

Currently being reviewed by Modern Matron Unscheduled Care, GLOUCESTERSHIRE ROYAL HOSPITAL and Director of Nursing, Medicine.

1.1.2.2 Ensure operational policy for the EDs is fit for purpose:

In progress by General Manager - Policy requires input from other specialties, site management etc. New deadline end of October 2016.

Workstream 2 – Site Management

2.1.2.2 – Trust patient flow policy agreed and implemented:

The policy has been agreed and published but not formally implemented. An action plan has now been developed and implementation will complete by 31.10.16.

2.4.1.1 and 2.4.1.2 – Review provision of IDT in line with best practice:

System wide review received on 05.10.16 at the Monthly IDT steering board. And actions agreed at the Trust IDT meeting on 13.10.16 and system wide meeting on 20.10.16.

Workstream 3 – SAFER Patient Flow Bundle

3.1.3.1 – Roll out ward round checklists across the Trust:

Review with accelerated implementation of Red / Green days.

Workstream 6 – Removing Delays to Discharge

6.1.1.4 – Business Case:

Recovery plan is to have a proposal presented to TLT to proceed on 19.10.16 with plans for its Implementation finalised for a November launch by 21.10.16.

Workstream 7 – Information

7.1.2.1 - Identify the measures for each workstream, including tolerances, improvement requirement and definition of measurement:

Information are working with the Programme Director to build the definitions and metrics for each workstream. Awaiting an agreed final version to start build of dashboard / scorecard. Commence when metrics are agreed.

7.1.2.2 - Agree the format, construct and visualisation required (e.g. by Department, Ward, Consultant, etc) and trend:

Format to be agreed on receipt of the final version of signed off KPIs by 28/10/16.

7.1.2.3 - Benchmark against best practice, where applicable, to identify scope for change:

This will be agreed post the definition of the measures.

7.1.2.4 - Roll-out plans for workstream requirements systematically:

One point of contact within the Information Department for the programme has now been allocated and will start to understand the full reporting requirements of the workstreams and seek to develop a roll-out plan.

7.1.2.5 - Ensure run-charts, SPC charts and adhoc requests can be fulfilled to embed change practices as schemes develop:

This has been put on hold while the department determined what would be able to be replicated following TrakCare ‘go-live’.

Workstream 10 – Governance

10.1.5 - Revise risk management process to create a standardised organisational Board response to risks rated red:

Due to go the Audit committee on 8th November. Changes to the Risk Management process have been agreed 12.10.16 at TLT (Paper available). 1st Executive Assurance & Risk meeting arranged for December 2016.

10.1.6 - Revise Quality reports to create a programme of reporting linked to the current Quality Framework reflecting the Emergency Pathway and key indicators:

The Quality section still needs to be determined by the Director of Safety. Quality metrics are within the Emergency Pathway report each month, key metrics have been added to the Trust Quality Report. New Quality & Performance committee meeting in October 2016.

10.2.1 - PMF for the Trust to be written, which will include the transition to Business as Usual:

Draft PMF framework available for discussion within the new frameworks.

Workstream 11 – Safety

11.1.1.1 – 11.1.1.4 - Implement Internal Professional Standards for all specialties:
As agreed on ECPB on 13.10.16 draft standards to be circulated immediately. Confirmation of standards and implementation plan for October 2016.

11.1.2.1 – 11.1.2.4 - Ensure all IPS are measurable and set up the system to capture the metrics: As above.

3.1.2 Programme Dashboard

Metrics are rag-rated against the February baselines, unless otherwise stated

	For All Patients	CGH								GRH								TRUST							
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Workstream 1: Emergency Department	Avg. Time to Initial Assessment (mins)	17	16	13	10	11	11	10	12	26	21	16	13	14	14	13	13	22	19	15	12	13	13	12	13
	% Assessed within 15 mins	57.7%	61.7%	74.7%	83.8%	84.5%	81.4%	85.7%	81.5%	47.6%	48.4%	65.0%	76.2%	74.6%	74.4%	78.0%	76.2%	51.3%	53.2%	68.5%	78.9%	78.1%	76.9%	80.8%	78.2%
	Avg. Time to Treatment (mins)	66	65	61	53	60	58	55	66	106	103	89	90	90	96	85	84	91	89	79	77	79	83	74	78
	% Treated within 60 mins	53.9%	55.8%	59.8%	64.8%	59.6%	61.2%	63.2%	52.1%	33.3%	32.8%	41.6%	37.5%	39.5%	34.2%	41.5%	40.7%	40.9%	41.1%	48.1%	47.2%	46.6%	43.9%	49.4%	44.9%
	Number >6hrs (avg. per day)	4	7	7	2	2	3	1	1	34	34	15	14	11	16	11	15	38	41	22	16	14	20	12	16
	% waiting >6hrs	3.0%	5.2%	5.7%	1.3%	1.8%	2.3%	0.5%	0.8%	14.6%	14.3%	6.4%	5.8%	4.6%	6.6%	4.9%	6.2%	10.3%	11.0%	6.1%	4.2%	3.6%	5.1%	3.3%	4.2%
	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	0	77	80	63	51	41	49	36	44	77	80	63	51	43	50	37	44

	For All Patients	CGH								GRH								TRUST							
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Workstream 2: Site Management	Number of Surgical Outliers (avg. per day)	1	0	0	1	0	1	0	0	2	1	1	2	2	2	2	4	3	2	2	2	2	3	3	4
	Number of Medical Outliers (avg. per day)	18	31	25	5	8	10	5	6	54	59	59	56	54	43	46	39	72	89	84	61	62	53	51	45
	Number of days in Black Escalation (10:00 snapshot)	0	0	2	0	0	0	0	0	15	12	5	9	10	4	3	2	15	12	7	9	10	4	3	2
	Number of days in Red Escalation (10:00 snapshot)	7	8	8	6	8	7	2	1	5	16	13	12	18	21	13	21	12	16	12	12	19	21	13	21

	For All Patients	CGH								GRH								TRUST							
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Workstream 3: length of Stay >=14 Days (includes SAFER)	Number of 7–13 days on list (avg. patients per day)	79	82	82	75	82	83	74	78	115	128	117	129	123	121	118	130	194	210	200	204	205	204	192	207
	Number of >=14 days on list (avg. patients per day)	69	64	65	59	75	66	71	61	153	147	133	116	131	120	138	150	222	211	198	176	206	186	209	212
	Number of Bed Days Occupied by >=14 day patients (average)	1821	1560	1596	1535	2021	1728	1892	1696	3949	4584	4184	3284	3648	3606	4243	4413	5770	6144	5779	4820	5668	5334	6135	6109
	Total Bed Days Occupied (average)	3089	2860	2882	2752	3273	3010	3038	2907	5867	6466	5985	5257	5486	5445	6031	6276	8956	9326	8867	8009	8758	8455	9069	9182
	% of Bed Days Occupied by >=14 Los Patients	59.0%	54.5%	55.4%	55.8%	61.7%	57.4%	62.3%	58.3%	67.3%	70.9%	69.9%	62.5%	66.5%	66.2%	70.3%	70.3%	64.4%	65.9%	65.2%	60.1%	64.8%	63.1%	67.6%	66.5%
	EDD Accuracy	29.9%	27.8%	29.2%	31.3%	31.1%	32.1%	33.3%	31.8%	19.4%	20.8%	25.6%	25.6%	25.7%	25.2%	29.0%	28.4%	23.5%	23.6%	26.9%	27.7%	27.7%	27.8%	30.6%	29.7%
	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%	45.7%	24.0%	23.9%	40.1%	40.9%	44.0%	44.1%	48.8%	39.6%	24.5%	24.4%	35.0%	40.1%	38.9%	40.0%	50.5%	41.5%
	Number of Discharges before 12pm (avg. per day)	30	29	32	29	30	27	31	29	44	41	47	41	42	41	43	43	74	70	78	70	72	69	74	72
	% of Discharges before 12pm	18.1%	18.2%	19.4%	19.0%	18.2%	18.5%	19.1%	18.2%	21.6%	20.8%	23.3%	21.4%	21.4%	21.7%	22.7%	22.1%	20.1%	19.6%	21.5%	20.3%	19.9%	20.3%	21.1%	20.3%
	Number of Weekend Discharges	355	420	439	436	333	415	373	349	884	844	1015	970	701	961	834	869	1239	1264	1454	1406	1034	1376	1207	1218
	Number of Inpatients on DSU overnight	115	125	207	90	156	100	47	11	503	514	425	445	439	448	466	492	618	639	632	535	595	548	513	503
	Number of Inpatients on DSU overnight (avg. per day)	4	4	7	3	5	3	2	0	17	17	14	14	15	14	15	16	21	21	21	17	20	18	17	17

	For All Patients	CGH								GRH								TRUST							
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Emergency Department Performance	Emergency Department Performance (incl. GP in ED attendances) *RAG rated against Feb baseline	89.2%	87.8%	88.1%	96.0%	92.9%	93.1%	97.3%	96.1%	71.3%	73.7%	84.5%	83.3%	84.5%	82.6%	87.3%	85.5%	77.7%	78.6%	85.7%	87.7%	87.4%	86.3%	90.9%	89.3%
	NHSI Trajectory																			80.0%	85.0%	85.0%	87.0%	87.0%	91.9%
	Emergency Department Performance (incl. GP in ED attendances) *RAG rated against NHSI trajectory	89.2%	87.8%	88.1%	96.0%	92.9%	93.1%	97.3%	96.1%	71.3%	73.7%	84.5%	83.3%	84.5%	82.6%	87.3%	85.5%	77.7%	78.6%	85.7%	87.7%	87.4%	86.3%	90.9%	89.3%
	Minors Performance *RAG rated against Feb baseline	97.3%	96.8%	96.4%	99.0%	97.6%	98.3%	98.8%	98.1%	88.8%	91.9%	94.1%	94.8%	93.7%	93.0%	95.9%	95.5%	92.5%	93.9%	95.0%	96.6%	95.3%	95.3%	97.2%	96.6%
	Minors Performance *RAG rated against internal trajectory of 98%	97.3%	96.8%	96.4%	99.0%	97.6%	98.3%	98.8%	98.1%	88.8%	91.9%	94.1%	94.8%	93.7%	93.0%	95.9%	95.5%	92.5%	93.9%	95.0%	96.6%	95.3%	95.3%	97.2%	96.6%

	For All Patients	CGH								GRH								TRUST							
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Delays	Medically Fit (avg. per day) *RAG rated against Feb baseline	23	20	26	23	27	28	26	20	40	42	45	39	47	41	51	53	63	61	71	62	74	70	77	73
	Medically Fit (avg. per day) *RAG rated against Trust target of ≤40	23	20	26	23	27	28	26	20	40	42	45	39	47	41	51	53	63	61	71	62	74	70	77	73
	Delayed Transfers of Care (month end snapshot of patients) *RAG rated against Feb baseline	6	4	17	6	8	18	8	11	10	6	7	6	8	17	29	25	16	10	24	12	16	35	37	36
	Delayed Transfers of Care (month end snapshot of patients) *RAG rated against Trust target of <14	6	4	17	6	8	18	8	11	10	6	7	6	8	17	29	25	16	10	24	12	16	35	37	36

4. System-wide Update

The Trust continues to work closely with system partners across Gloucestershire. Further work is required to ensure the System and the Trust is ready for winter 2016/17.

4.1 NHS Improvement Review of progress against the Enforcement Undertakings

NHS Improvement reviewed trust progress against the Enforcement Undertakings on 14th October 2016. The Trust was represented by:

- Eric Gatling, Executive Director of Service Delivery
- Maggie Arnold, Director of Nursing
- Sally Pearson, Director of Clinical Strategy
- Sue Barnett, Improvement Director

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

- Emergency Care Improvement Plan Delivery;
- 'Deep Dive' into ED Recruitment; Integrated Discharge Team Review and Winter Capacity Risks & Mitigations;
- ED Quality & Safety (including the ED Safety Checklist and 12-hour Trolley wait in September);
- Performance update.

This was the second review meeting held for Emergency Care and feedback was encouraging. The next meeting on 11th November is likely to focus on:

- Our progress on the implementation of Red & Green days;
- Effectiveness of the weekly breach analysis meetings and the transfer of information from this to the directorates;
- Improvement in the ED Time to Initial Assessment, Time to Treatment and Total Time standards;
- Integrated Discharge Team review and outcomes.

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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Andrew Seaton – Director of Safety

Presenting Executive: Eric Gatling – Director of Service Delivery

Date: 17th October 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
PUBLIC BOARD MEETING FRIDAY 30th SEPTEMBER 2016
Board Room, Cheltenham General 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 purpose of this report is to provide assurance to the Trust Board in respect of nurse staffing levels for September 2016, against the compliance framework *'Hard Truths' – Safer Staffing Commitments*.

Key issues to note

- There are no major safety concerns arising from the staffing levels, however the requirement for staffing establishments to be fulfilled by temporary staffing solutions remains suboptimal and presents risks to the quality of care and team working on wards.
- The divisional nursing directors have analysed their department's data and have individually responded for the purpose of this report.
- All Divisions with RED rated harm indicators are required to bring a recovery plan to their next Executive Performance Review, setting out how they will improve performance in this area
- Increasing evidence that nursing directors are proactively reviewing skills and numbers in relation to safer staffing and agency use and this is expected to reduce expenditure from October onwards.
- Work continues to develop the role mix of staff on wards and this has the potential to improve care and reduce spend on temporary staffing however, this approach will also result in non-compliance with *Safer Staffing* levels are not sensitive enough to address this. Discussions with national leads have endorsed the Trust's approach and it is believed that the national compliance framework will evolve and move towards "care hours" rather than qualified nurse staffing as currently.

Conclusions, implications and Next Steps

Staffing levels remain safe and the focus on agency controls is starting to show both cost and care benefits. Some wards are not consistently delivering *Harm Free Care* to the levels being achieved either nationally or elsewhere in the Trust and this is a focus for action.

Recommendations

The Board is asked to receive this report as a source of assurance that staffing levels across the Trust are delivering safe care.

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

Delivery of safe, substantive staffing impacts of a number of identified risks including quality of care and financial risks.
Regulatory and/or Legal Implications
The Trust's regulator, NHSI have set a cap for Trust spending on agency staffing, which the Trust is currently breaching.
Equality & Patient Impact
No specific patient group is impacted by this report.

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

Action/Decision Required							
For Decision		For Assurance	**X**	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)**
				x	

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – OCTOBER 2016

NURSE AND MIDWIFERY STAFFING OCTOBER 2016

1 Purpose

The aim of this paper is to provide assurance to the Trust Board in respect of nurse staffing levels for September 2016, against the compliance framework *'Hard Truths' – Safer Staffing Commitments*.

2 Background

Monthly reports have been submitted to our Board on our nursing and midwifery staffing numbers since the publication of the safer staffing guidance. Information has been uploaded onto the UNIFY system, with a link to NHS Choices, as required by NHS Improvement. Information is also available on our own Trust website and now includes data regarding contact time per nurse, as explained in last month's Board paper.

3 Findings

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

CGH – Dixton was RED against HCA staff due to vacancies, but a clinical decision that overall staffing was safe without temporary staff replacement. Guiting ward was in excess of 100% RGN due to use of agency to special TPN patients, plus some readjusting of shift cover (within the budget) to support workload, for example the high number of patient wound dressings required. DCC flex their staff off in quieter periods so scores red against their funded shift cover, but in reality are not. This is the same as DCC at GRH. GRH – 2a are over with HCA shifts at night, but reflects a high number of medical patients during September, and the agreed decision to provide more cover to nurse these patients safely. Ward 5b were over on RGN staff, but reflect a particularly high patient acuity during September, and the need to provide an enhanced level of care. Ward 5a struggled with RGN cover due to vacancies, which have improved through recent recruitment exercises, with harm free care achieving 95%

3.2.3 Care Hours per Nursed Day Focus

We are still 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 (new harms) 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.

3.2.5 Finance and Vacancy Focus

The spend on Agency continues to be high at £257.7k for August, but is below the trajectory set for nursing agency. Again, agency use in the main, is from the continued use of Day Surgery Units on both hospitals sites as part of the bed contingency. The Trust wide approaches of pay enhancements, of particularly RGN staff to work additional bank shifts, continues.

Sickness levels, whilst above the Trust set average has reduced for this month.

The bottom line nursing staffing funded vacancy position within the division is 34.77 fte. However, this relatively low level of vacancies (3.2%) against the 1009.98 fte funded is offset by an over-establishment in the band 2 lines of 40.37 fte, which includes overseas/newly qualifying registered nurses awaiting NMC registration. Band 5 vacancies have remained relatively stable over the July total at 65.66 fte. However, this is still disappointing given the recent commencement of newly qualified nurses, and overseas nurses. There may be a time lag before these new staff are reflected in the budget, and the month 6 position should show the impact of this recruitment. Ongoing recruitment exercises continue.

3.3 Medical Division

3.3.1 Nursing Metrics Focus

The main focus for Nursing Metrics in the division is falls with 9 wards scoring red – ie; that a fall/falls have taken place during the month. A divisional work stream on falls reduction headed by Matron Attwood meets regularly and links in with the Trust Falls Prevention Group. A study afternoon is due to be held on Oct 24th focusing on preventing falls. In triangulating this data with the Safety Thermometer, which takes a snap shot of one day a month, - falls with harm was reported as 0.23% of harm reported.

5 wards scored red for medication errors – and this will be discussed at the new Matrons/Divisional Nursing Director meeting on Friday.

In Unscheduled care, both EDs score red for actioning EWS (early warning scores).

This has been addressed by work stream 1 – and now hourly safety rounds in ED take place.

3.3.2 Safer Staffing Focus

6B triggered due to new VTE and Cather related UTI
7B due to new pressure ulcer development and established catheter related UTI
GW1 triggered due to new pressure area damage and new catheter related UTI
Cardiology at GRH due to new catheter related UTI.

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.

3.3.5 Harm free Care Focus

Harm free care for Medicine was 92.34% overall, from a patient population of 431 audited. There were 33 patients (7.66%) with one harm event – with 5.1% being attributed to pressure area damage, and 2.09% catheter related UTI

	'All England' Median	GHNHSFT	Medicine GHNHSFT
Pressure Ulcers (All)	4.59%	3.78%	5.10%
Pressure Ulcers (New)	1%	0.86%	0.23%
Falls (All)	1.83%	1.69%	3.02%
Falls (With Harm)	0.7%	0.58%	0.23%
Catheterisation	12.87%	18.03%	16.240%
Catheter and UTI	0.82%	1.49%	0.46%
VTE Risk Assessment	45.99%	95.48%	98.38%
VTE Prophylaxis	35.4%	94.56%	82.6%
Patients with New VTE	0.41%	0.24%	0.23%
Harm Free Care (All Harms)	93.68%	93.92%	92.34%
Harm Free Care (New Harms)	97.57%	97.63%	98.84%

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 continues to focus on prevention of pressure ulcers, falls and VTE. Each month wards where patients have developed a hospital acquired pressure ulcer are invited to share the root cause analysis and learning points with peers.

3.3.6 Finance and Vacancy Focus

To ensure scrutiny of staffing across the division, the Matrons host a daily staffing conference call – 8am for GRH and 8:30 for CGH. All medical wards participate and this has allowed sharing of staff, management of staffing gaps, and scrutiny of patients being specialled. It is too early to demonstrate a difference in bank and agency spend, however anecdotally the division is using less temporary staffing as a result and the division has a better overview at the start of the day.
A rolling programme of recruitment is ongoing – including a recent trip to the Philippines. The division has recruited overseas qualified nurses and is supporting them in acquiring their NMC pin through study and support with IELTS and OSCI.

Total nursing vacancies in medicine are 106 WTE inc bank.
In September 2016 spend on agency was £415k compared with £696k the previous month.

3.4 Women & Children's Division

3.4.1 Safer Staffing Focus

Safer staffing returns are reported for five areas only at present; 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 meaningful 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.

Children's In Patients flagged as Red with an average total fill rate of 78.9% Registered Nurses and Health Care Assistants based on the September data and 90.9% for Registered Nurses, this is an improvement on last month's fill rate. Sickness within the Health Care assistants explains the lower fill rate in this group, but it is worth noting that because of dependency of the children on the ward these shift may not always be filled. The Bonus payment of £500 pounds to incentivise Registered Nurses to work an additional 30 hours over six weeks continues to assist in addressing short falls, and reducing agency. The recruitment picture is positive and continues to show improvement with 1 WTE Registered Nurse Vacancy,3.5 WTE Registered Nurses who have accepted positions ,but are yet to start and 2.0 WTE Registered Nurses starting in October. However the service has received 1 resignation and there are issues around Sickness and Maternity Leave which offer further challenges

2a shows significant total over fill across all staff groups of 235%. This is explained by the additional 6 bed day case area which has been used as part of escalation and remains open 24/7. To date temporary nursing staff have been used to manage this area and consequently there has been a reliance on agency to fill the gaps. The Nursing Director has agreed a known budget variance and instructed the ward to proceed to recruit the staff to cover this area. The ward is interviewing Registered Nurses on October 12th and will look to fill these additional posts (3.48 WTE) as well as existing vacancies (6 WTE). The plan should reduce agency costs and more importantly improve patient and staff experience.

The Maternity Ward are showing a total Midwife and Health Care Assistants 24.58% overfill, a reflection of under fill on Midwifery staff of 91.46% and use of Maternity Care Assistants to fill the gaps (overfill 47.50 %). There are however no concerns at present in relation to recruitment into Midwifery posts and 12 newly qualified midwives have recently been offered positions which will take the service up to full establishment.

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 and Maternity services where midnight occupancy often fails to reflect activity due to the rapid turnover of patients and short length of stay.

3.4.3 Harm free Care Focus

Across the Division all areas reported harm free care. It was reassuring to see that despite the challenges in September 2a the Gynaecology Ward also reported 100% harm free care. However work is being done and an action plan drawn up to reduce catheter related urinary tract infections and falls are being carefully monitored through Datix reporting.

3.5 Diagnostic & Specialist Division

3.5.1 Nursing Metrics Focus

From a nursing metrics perspective all areas were green. An action plan around the increased incidence of Clostridium Difficile is being implemented.

3.5.2 Safer Staffing Focus

Overall the oncology wards scored green for staffing. Lilleybrook is red at over 133% although this is relating to flexing of staff across the centre between the wards and outpatients reacting to patient acuity and staff sickness. This enables the minimal use of agency nursing in the division.

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

Rendcomb ward was below the 100%. Rendcomb ward has been working actively with the divisional risk manager in relation to falls prevention and management of clinical incidents. 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%

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 training pathway for oncology nurses in the centre is attributed as the reason retention in nursing is effective there.

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 Recruitment Update

4.1 UK / EU Recruitment

- There are currently 26 experienced UK-based Band 5 nurses in the recruitment pipeline, with start dates between October 2016 and March 2017, plus five nurses from our Dutch recruitment partner due to start with us after completing their IELTS examinations.
- Interviews for Newly-Qualified Nurses were held on Saturday 24 September 2016, and 26 conditional offers of employment have been made (12 for Medicine, 12 for Surgery, and 2 for Ward 2a (Gynaecology)). Separate interviews have also been conducted for Theatres, NICU, and Paediatrics.
- There are currently 11 advertisements live for Band 5 Registered Nurses, and another 2 advertisements for Band 6 Registered Nurses on NHS Jobs.

- Interviews were held on 05 & 06 October with a new Portugal-based recruitment agency. From an initial offer of 31 candidates, only 15 candidates were made available for interview, and the majority of those had sub-standard English. Nine offers have been made on the condition that the candidates pass their IELTS examination before arriving at the Trust.

4.2 Overseas Recruitment

4.2.1 November 2015 Campaign

- Of the nurses that have commenced employment, the first six will take their OSCE examination on 17/18 October, and the remaining five will commence their OSCE training on 07 November.
- Our overseas recruitment partner is currently ascertaining whether or not the candidates on hold intend to take the IELTS examination in the near future, and candidates are being withdrawn as necessary.

Status	Candidates
Commenced employment	11
Passed IELTS and CBT exams, accepted by the NMC, waiting for visa application	3
Passed IELTS and CBT exams, waiting for NMC decision letter	10
Passed IELTS examination, waiting for CBT examination	2
Not passed the IELTS examination – waiting for exam	69
Not passed the IELTS examination – candidate on hold	14
Total (minus withdrawn candidates)	**109**

4.2.2 May 2016 Campaign

Status	Candidates
Passed IELTS and CBT exams, waiting for NMC decision letter	5
Passed IELTS examination, waiting for CBT examination	8
Not passed the IELTS examination – waiting for exam	66
Not passed the IELTS examination – candidate on hold	5
Total (minus withdrawn candidates)	**84**

4.2.3 September 2016 Campaign

Status	Candidates
Passed IELTS examination, waiting for CBT examination	4
Not passed the IELTS examination – waiting for exam	159
Not passed the IELTS examination – candidate not yet accepted offer	9
Total (minus withdrawn candidates)	**172**

4.3 Nursing Workforce Metrics

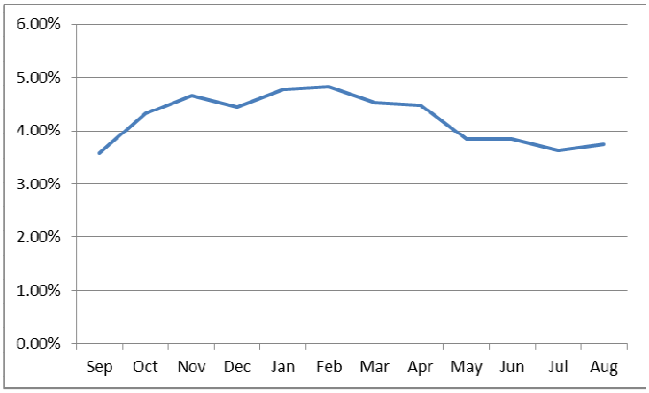
The vacancy data continues to show a significant investment in Band 2 staffing numbers. This is partly due to significant recruitment of Newly Qualified Nurses who have joined the Trust as a Band 2 Nurse Awaiting PIN in the first instance. The remaining additional Band 2 nursing staff have been specifically 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. From 01 October 2016, Newly Qualified Nurses awaiting their PIN will be paid at Band 3 to bring this group into line with Overseas Qualified Nurses. The only pre-registration nurses paid at Band 2 will now be those on a Return to Practice course. This decision has been made to make the Trust more marketable to future nurses, and ensure equity between staff recruited from different sources.

Division	Band 2 Vacancies		Band 5 Vacancies		Band 6 Vacancies	
Diagnostic & Specialties	-0.03	overestablished	-4.47	overestablished	4.44	11.19%
Medicine	-42.27	overestablished	106.26	22.79%	6.34	4.57%
Surgery	-40.37	overestablished	65.66	11.87%	-1.76	overestablished
Women & Children	-5.82	overestablished	0.59	0.49%	17.37	7.39%

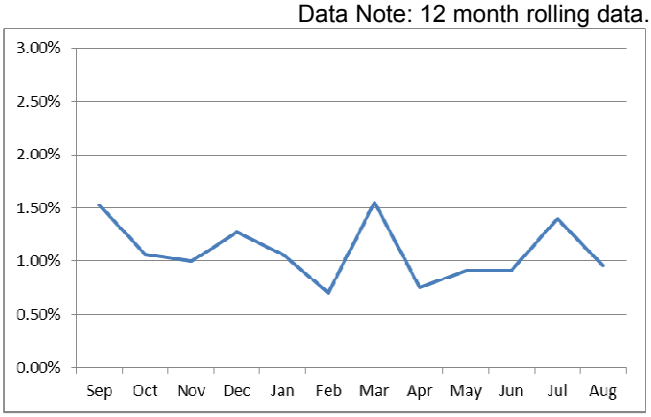
Data Note: Data for this table is from 31 August 2016. Women & Children data include Midwives.

Division	Sickness		Turnover		Parental Leave	
	RGNs	HCAs	RGNs	HCAs	RGNs	HCAs
Diagnostic & Specialties	4.63%	4.73%	9.19%	15.49%	3.83%	2.04%
Medicine	3.56%	5.15%	16.64%	21.04%	3.83%	3.77%
Surgery	4.55%	3.96%	11.32%	17.01%	4.19%	2.23%
Women & Children	4.22%	3.41%	13.33%	10.34%	3.88%	3.43%

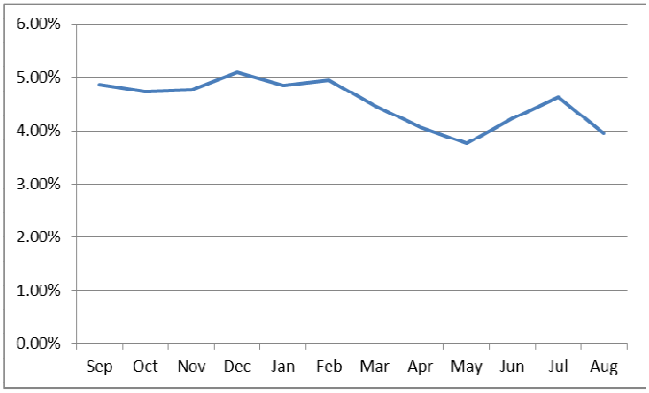
Data Note: 12 month rolling data.



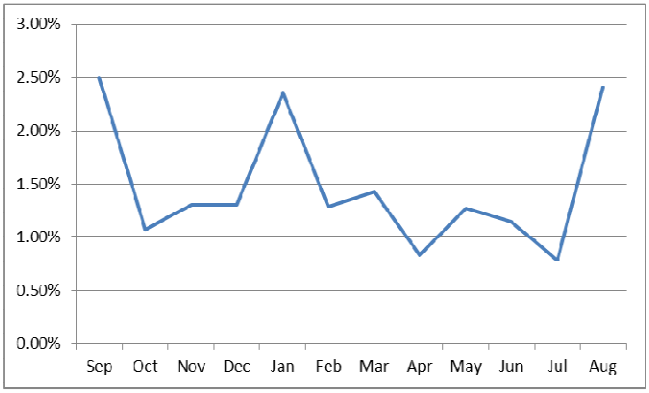
RGN: Sickness Absence by Month (Sep 15 – Aug 16)



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



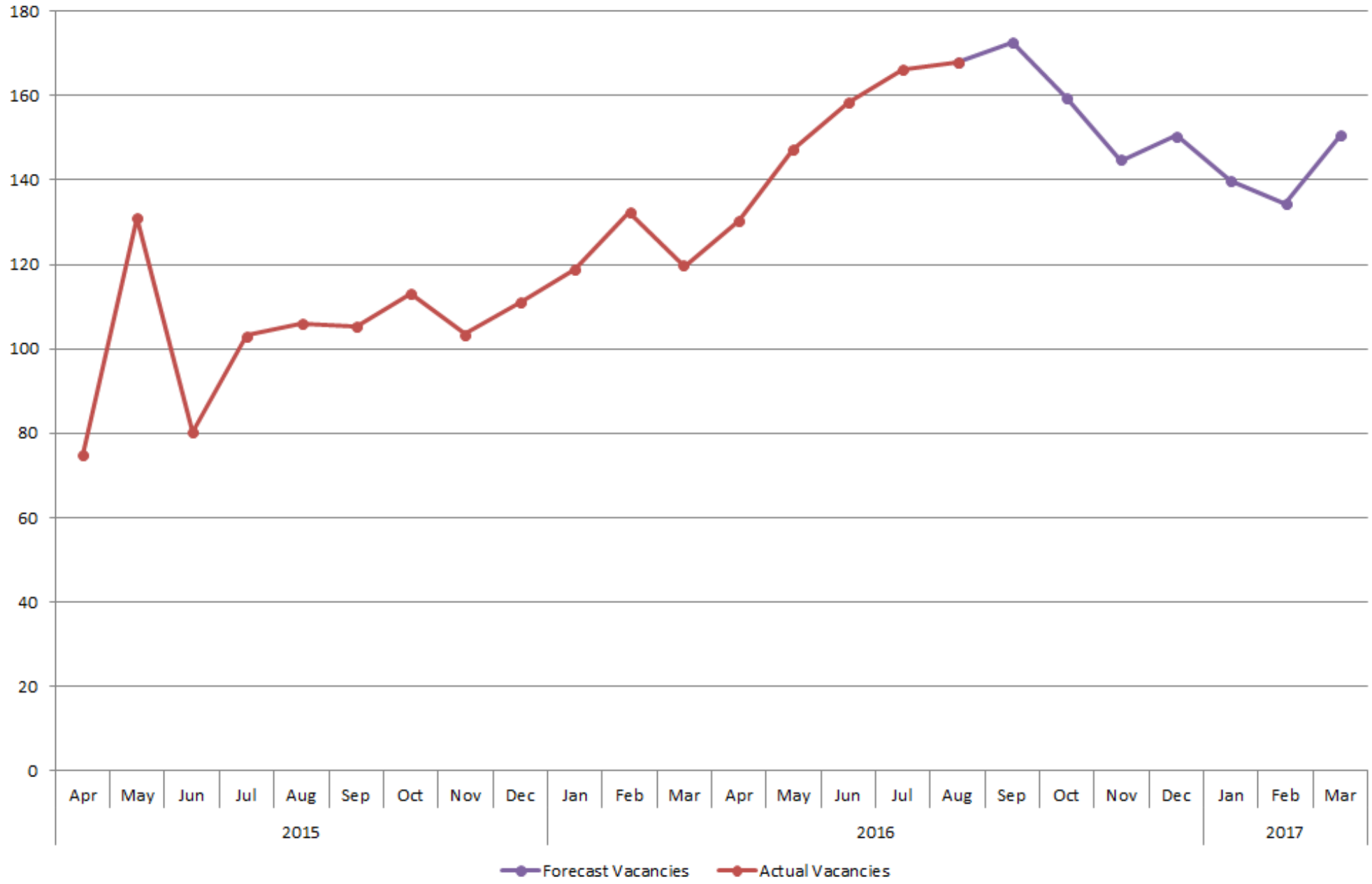
HCA: Sickness Absence by Month (Sep 15 – Aug 16)



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

4.4 Vacancy Forecast

- August was the first month since April 2016 where more Band 5 Registered Nurses joined the organisation than left. Unfortunately, due to an increase in the establishment, the total number of vacancies has continued to increase.
- There are currently 168.04 WTE vacancies for Band 5 Registered 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 (providing that the establishment does not increase further).
- There are currently 28.40 WTE staff awaiting PIN, plus a further 31.40 WTE overseas qualified staff that are taking examinations to gain their registration in the UK.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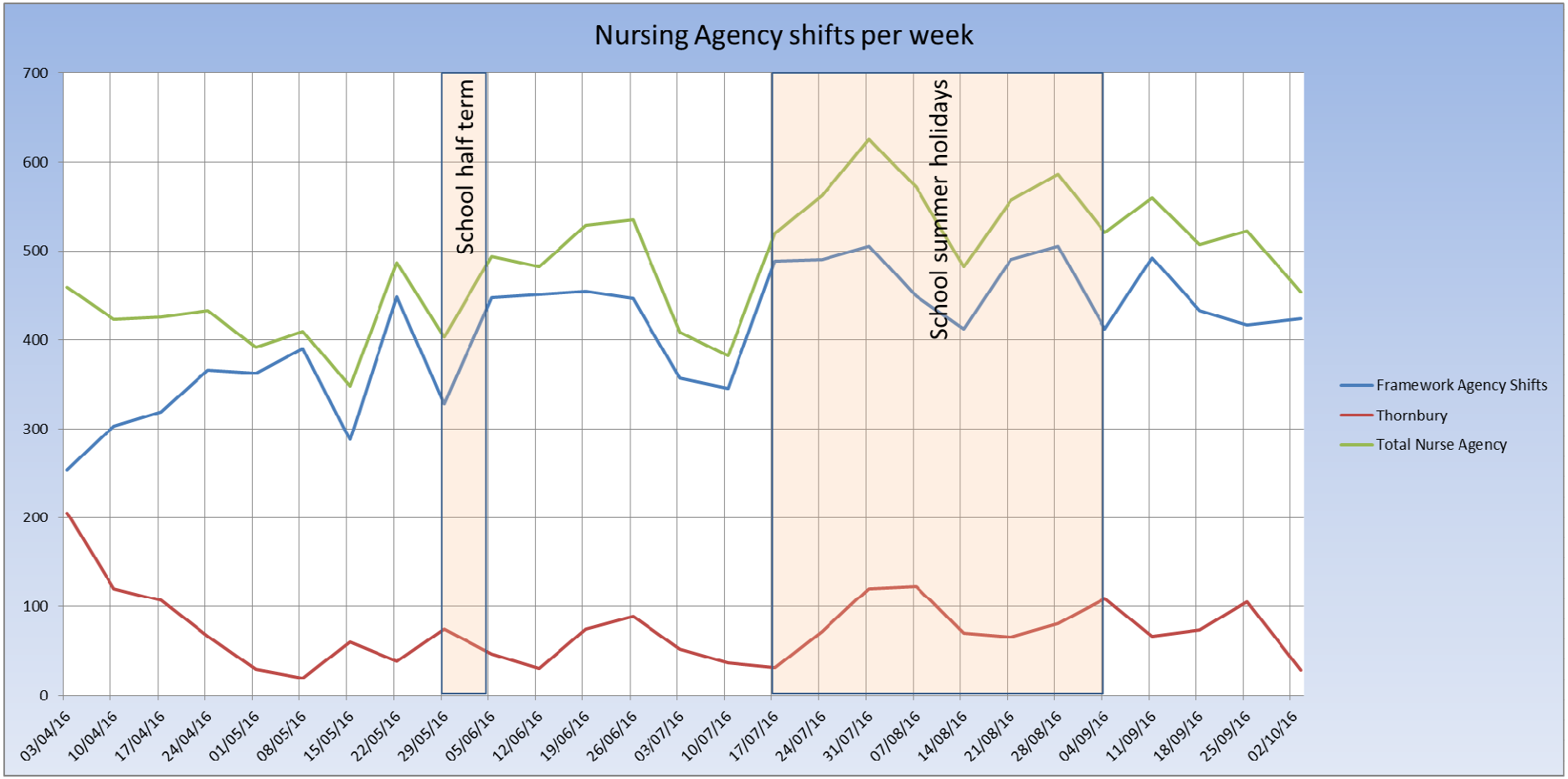
Forecast Vacancies
Actual Vacancies



Shift requests per week have increased since April, ranging from averages of 1457 per week in early May to 1902 per week in late July. Framework (i.e. non-Thornbury) agency use shows significant fluctuations, most of which reflect overall agency usage/demand trends especially during school holidays. Fill rates have increased from 82% to 87% over the period – while this is a positive trend in terms of patient care and safety, it does contribute to increased agency usage figures.

The increases in framework agency use can also be partly attributed to the reduction in non-framework agency use (i.e. Thornbury), dropping from highs of 200 shifts per week to lows of 20 shifts per week. This is shown by the closing gap between the green and blue lines near the beginning of the year, and the increasing correlation between them as the year progresses, showing that use of non-framework (Thornbury) only exacerbates existing trends of agency usage. As a root cause example, the school summer holiday period remains a source of concern,

with both framework and non-framework agency use increasing disproportionately, suggesting ongoing issues of annual leave management and authorisation. While this does not address the issue of reducing overall agency usage it does have a positive impact on agency spend, though this may be masked by overall increases.

5 Next Steps and Communication

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

6 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 & Midwife
11th October 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
PUBLIC BOARD MEETING FRIDAY 28th OCTOBER 2016
Boardroom, Alexandra House, Cheltenham General Hospital commencing at 9.00 a.m

Report Title									
COMBINED BOARD ASSURANCE FRAMEWORK									
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

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 / OCTOBER 2016

COMBINED BOARD ASSURANCE FRAMEWORK

1 Purpose of Report

1.1 To receive the 2016/17 Board Assurance Framework (BAF).

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: **October 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** **Quality and Performance Committee**	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** **Quality and Performance Committee**	1. Maintaining involvement in the Reducing Clinical Variation workstream of the Gloucestershire STP 2.Maintaining involvement through the Clinical design authority who are responsible for the clinical design of Trakcare (1)	1. Monitored STP governance arrangements 2.Progress with clinical design of phase 2 Trakcare 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. Delay in delivery of clinical benefits to reduce variation from Trakcare	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 being unable to implement the Trust's clinical strategy and preferred model of care.	**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) 3. Bid to NHSE for capital allocation 4. Stakeholder engagement plan	1. Progress reports on site development plans (2) 2. Sustainability and Transformation Plan programme reports	Board endorsement of outline business cases.	3X3=9
			Gaps in Control	**Gaps in Assurance**	**Direction of Travel**
			1. Availability of capital		
Potential Risk Exposure	**Related risks on Trust Risk Register**				
1. An unexpected political process leading to purdah. 2. Unexpected significant deterioration in clinical services requiring urgent service change	S100 The risk of failure to manage rising demand without increased capacity leading to failure to meet 62day cancer standard with the consequence of delayed treatment and increasing risk of regulatory intervention	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	F7 The risk of delayed treatment and diagnosis causing harm and because of a backlog of follow-up appointments in a number of specialities- Neurology, Cardiology Rheumatology and Ophthalmology	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

	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	December 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 LeadershipTeam**	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 LeadershipTeam**	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 with patients being placed in outlying beds different to their required specialty to manage flow and bed pressures	**Director of Nursing** **Quality and Performance 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 arising from staff who fail to demonstrate the appropriate skills in respect of care, compassion and communication	**Director of Nursing** **Quality and Performance 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

		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 commissioner 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 commissioner 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. Quarterly Review by Monitor (3) 4. Executive Divisional Reviews (1) 5. CIP Delivery Board (1) 6. 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)	Deloitte Financial Review and delivering agreed recommendations	**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. Loss of business critical systems	IT2246 The risk of Operational disruption caused by loss	DSP1347 The risk of the inability to maintain business continuity	Blank	Blank	Blank

2.	Loss of business critical systems to other providers due to shared nature of the infrastructure	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 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	November 2016	Divisions asked to submit plans by end July and requested again in September.
2	Triangulate appraisal scores with Talent pool nominations	DS	November 2016	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 Dir HR&OD	September 16 August 16	Priorities agreed by Workforce Committee at October meeting

				(adjourned from September)
2	Establish focused strategy for reduction of agency costs focusing on Controls, Alternative Roles and Plan to close Escalation Areas	Dir HR&OD	October 16	Plan agreed
3	Share plans with NHSI for assessment/additions	Dir HR&OD	October 16	Shared with Mark Hackett and Tom Edgell
4	Establish campaign headed up by CEO to resolve 'top 3' issues relating to staff engagement (Parking/Repairs/Bureaucracy)	Dir HR&OD	July 16	Launched and Board updated in September

MAIN BOARD – OCTOBER 2016
(BOARD ROOM, ALEXANDRA HOUSE)

Report Title									
Memorandum of Understanding for the Development of Gloucestershire's Sustainability and Transformation Plan									
Sponsor and Author(s)									
Sponsor - Deborah Lee, Chief Executive. Author – Martin Wood, Trust Secretary									
Audience(s)									
Board members	**X**	Regulators		Governors		Staff		Public	**X**

Executive Summary

Purpose
To present a revised Memorandum of Understanding (MOU) between the partners of Gloucestershire's Sustainability and Transformation Plan (STP) footprint, aimed at governing the way the partners work to deliver the plan.

Key issues to note
The key revision to the previous MOU is further detail (and clarity) to reflect national and local governance concerns about STPs.

Conclusions and Implications
The MOU is a positive attempt to provide a framework within which partners can work constructively for the betterment of health and social care in Gloucestershire.

Recommendations

To approve the revised MOU and to authorise signing by the Chief Executive and Trust Secretary

Impact Upon Strategic Objectives

N/A

Impact Upon Corporate Risks

Provides a mitigation to the risks associated with multi-organisation working by providing clarity on the governance arrangements.

Regulatory and/or Legal Implications

The MOU is not legally binding.

Equality & Patient Impact

N/A

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required

For Decision		For Assurance		For Approval	X	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)**
					Earlier version presented to Board in July 2016
Outcome of discussion when presented to previous Committees					
Concerns expressed regarding governance arrangements of STP.					

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – OCTOBER 2016

MEMORANDUM OF UNDERSTANDING FOR THE DEVELOPMENT OF GLOUCESTERSHIRE'S SUSTAINABILITY AND TRANSFORMATION PLAN

1 Purpose of Report

1.1 The purpose of this report is to provide the Board with an opportunity to approve the revised Memorandum of Understanding (MOU) which has been prepared for the development of Gloucestershire's Sustainability and Transformation Plan.

2 Background

2.1 In July 2016 the Board approved the MOU subject to the satisfactory resolution of the textural amendments and satisfactory clarification of points raised. The Chief Executive and Trust Secretary were authorised to sign the final document.

2.2 Since that meeting a number of changes have been made, none of which are contentious. The changes made are:-

a) A tidy up all of the grammar and spelling so that single and plurals are correct etc.
b) Remove the Appendix relating to the individual pieces of work. These will now be contained in attached schedules.
c) Inserted a new Appendix. This describes the legislation which governs each of the elements and organisations which make up the STP. This has been done because of the concerns which have been raised about governance and organisational sovereignty. Similar discussions have been taking place across the country and this simple articulation makes clear that engaging in the STP process does not change, alter or do away with any of the legal obligations we all have as organisations.
d) There is a chart in the Appendix which each organisation will be asked to complete. This simply acts as an aide memoire so we all know who to go to in each organisation for STP matters
e) The wording around doctors has been changed and the term "lead clinician" is now being used for legal reasons to do with how medical responsibility is described.

2.3 The points raised previously by the Board have been incorporated into the revised document.

3 Recommendation

3.1 The Board is invited to approve the revised MOU for the Gloucestershire Sustainability and Transformation Plan and to authorise the Chief Executive and Trust secretary to sign the final document.

Author: **Martin Wood, Trust Secretary**

Presenting Director: **Deborah Lee, Chief Executive**

October 2016

13th October 2016

1. Gloucestershire Care Services NHS Trust

2. Gloucestershire Clinical Commissioning Group

3. Gloucestershire County Council

4. Gloucestershire Hospitals NHS Foundation Trust

5. South Western Ambulance Service NHS Foundation Trust

6. 2gether NHS Foundation Trust

MEMORANDUM OF UNDERSTANDING FOR THE DEVELOPMENT OF GLOUCESTERSHIRE'S SUSTAINABILITY AND TRANSFORMATION PLAN

No	Date	Version Number	Author
1	01.04.16	1	JRK
2	17.05.2016	0.02	KM
3	26.5.2016	0.03	HE
4	27.5.2016	0.04	HE
5	27.5.2016	0.05	PJ and HE
6	13.06.2016	0.06	HE
7	23.06.2016	0.07	HE and KM
8	08.07.2016	0.08	HE
9	29.07.2016	0.09	HE/DL
10	07.09.2016	0.10	PJ/KM
11	22.09.2016	0.11	SML/ALD
12	28.09.2016	0.12	KM
13	04.10.2016	0.13	HE/CL
14	13.10.2016	0.14 FINAL	HE/PJ/ER/ AP

Note: This MOU has been produced in partnership with Capsticks Solicitors LLP model

CONTENTS

Date: 13th October 2016

This MoU is made between:

1. Gloucestershire Care Services NHS Trust of Edward Jenner Court, 1010 Pioneer Avenue, Gloucester Business Park, Brockworth, Gloucester, Gloucestershire GL3 4AW;
2. Gloucestershire Clinical Commissioning Group of Sanger House, 5220 Valiant Court, Gloucester Business Park, Brockworth, Gloucester GL3 4FE;
3. Gloucestershire County Council of Shire Hall, Gloucester, GL1 2TG;
4. Gloucestershire Hospitals NHS Foundation Trust of Gloucestershire Hospitals NHS Foundation Trust of Alexandra House, Cheltenham, Gloucestershire, GL53 7AN;
5. South Western Ambulance Service NHS Foundation Trust of Abbey Court, Eagle Way, Exeter, EX2 7HY; and
6. 2gether NHS Foundation Trust of Rikenel, Montpellier, Gloucester GL1 1LY.

(together the "**Parties**").

JOINT STATEMENT

The Parties share the objectives of facilitating high-quality care for all and improving patient outcomes both now and in the future through joint working to provide clinically effective and cost-effective practice. We are all working to a common goal of providing the best care for our patients within the resources available to us.

The Parties support the ambition set out in the Gloucestershire STP using a system of collaborative leadership to "take decisive steps to break down the barriers in how care is provided" and the rapid adoption and diffusion of the best, transformative, most innovative ideas, products, services and clinical practice for the people of Gloucestershire.

RECITALS

1. The Five Year Forward View published in October 2014 (the "**Forward View**") sets out a clear goal that "the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care."
2. Following a review of health and social care services in 2014, Gloucestershire CCG set out its five year plan; "Joining Up Your Care" ("**JUYC**") to improve the quality of care for patients living in Gloucestershire. The Parties are committed to enabling individuals to take greater control of their health and wellbeing through delivering greater patient support in patients' homes and local communities.
3. The Parties' shared vision is to improve health and wellbeing by working better together in a more integrated way and using the strengths of individuals, carers and local communities to transform the quality of care and support provided to people living in Gloucestershire.
4. In entering into and performing their obligations under this memorandum of understanding, the Parties are working towards the implementation of the integrated care models highlighted in the Forward View. In particular, this memorandum of understanding is intended to support the Parties' ongoing work towards the

establishment of a model of integrated health and social care services in Gloucestershire. This model will build upon the ambitions set out in the Sustainability and Transformation plan (building on the JUYC five year plan).

OPERATIVE PROVISIONS

1. Definitions and interpretation

1.1 In this MoU, capitalised words and expressions shall have the meanings given to them in this memorandum of understanding (the "**MoU**").

1.2 In this MoU, unless the context requires otherwise, the following rules of construction shall apply:

1.2.1 a person includes a natural person, corporate or unincorporated body (whether or not having separate legal personality);

1.2.2 a reference to a "**Party**" is a reference to a party to this MoU and includes its personal representatives, successors or permitted assigns and a reference to "**Parties**" is a reference to all parties to this MoU;

1.2.3 a reference to a statute or statutory provision is a reference to such statute or provision as amended or re-enacted. A reference to a statute or statutory provision includes any subordinate legislation made under that statute or statutory provision, as amended or re-enacted;

1.2.4 any phrase introduced by the terms "**including**", "**include**", "**in particular**" or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms;

1.2.5 documents in "**agreed form**" are documents in the form agreed by the Parties and initialled by them for identification and attached to this MoU; and

1.2.6 a reference to writing or written includes faxes and e-mails.

2. Purpose and effect of MoU

2.1 The Parties have agreed to work together on the development of more integrated care for service users in line with the Gloucestershire STP (the "**Gloucestershire STP**").

2.2 The MoU provides further detail with respect to the components of the priority programmes of work, to be supplemented by the accompanying schedules for each programme of work, which will be incorporated into this MoU in accordance with clause 15.2.

2.3 The Parties wish to record the basis on which they will collaborate with each other on the Gloucestershire STP.

2.4 This MoU sets out:

2.4.1 the key objectives of the Gloucestershire STP;

2.4.2 the principles of collaboration;

2.4.3 the governance structures the Parties will put in place; and

2.4.4 the respective roles and responsibilities the Parties will have during the Gloucestershire STP.

2.5 The Parties agree that, notwithstanding the good faith consideration that each Party has afforded the terms set out in this MoU, this MoU shall not be legally binding.

3. Key Objectives and Outcomes for the Project

3.1 The Parties shall support the Gloucestershire STP to achieve the key objectives set out below (the "**Key Objectives**"). The long-term ambition is to have a Gloucestershire population, which is:

- Less dependent on health and social care services;
- Living in healthy communities and benefitting from strong networks of community support; and
- Able to access high quality care when needed in the right place, at the right time.

3.2 In addition the Parties will work together through the following principles:

- We will ensure commitment to a risk share approach aligned to our priorities. This should be underpinned by an open, transparent approach to the development of opportunities for change;
- We will commit to the principles of 'One Place, One Budget, One System' to improve services and outcomes for our population, whilst working to ensure financial stability across our system;
- We will work to the principle of moving care 'upstream', and will be aiming to prioritise resources within our care pathways towards primary care and prevention where possible;
- We will work to the principle of commissioning through a care pathways approach, and within commissioned pathways we will work together to identify opportunities for increased cost effectiveness, minimising the number of steps and driving greater efficiency;
- We will consider whether the pilot(s) of innovative organisational forms in line with the Forward View new models for delivery of care will require us to develop any new organisational forms or innovative approaches to contracting;
- We will not commission or provide services that are deemed by evidence to not be cost-effective or clinically effective; and
- We will endeavour to minimise our infrastructure costs by sharing facilities and support wherever it is feasible and represents value for money.

3.3 The Parties acknowledge that the current position with regard to the Gloucestershire STP framework is set out within this MoU. Programmes of work will utilise schedules, to be incorporated into this MoU in accordance with clause 15.2.

4. Principles of collaboration

4.1 The Parties agree to adopt the following principles when carrying out the Gloucestershire STP:

4.1.1 collaborate and co-operate. Establish and adhere to the governance structure set out in this MoU to ensure that activities are delivered and actions taken as required;

4.1.2 be accountable. Take on, manage and account to each other for performance of the respective roles and responsibilities as referred to within this MoU;

4.1.3 be open. Communicate openly about major concerns, issues or opportunities relating to the Gloucestershire STP;

4.1.4 adhere to statutory requirements and best practice. Comply with applicable laws and standards including EU procurement rules, competition law, data protection and freedom of information legislation;

4.1.5 act in a timely manner. Recognise the time-critical nature of the Gloucestershire STP and respond accordingly to requests for support;

4.1.6 work constructively with stakeholders with the aim of securing their support for the Gloucestershire STP and its delivery;

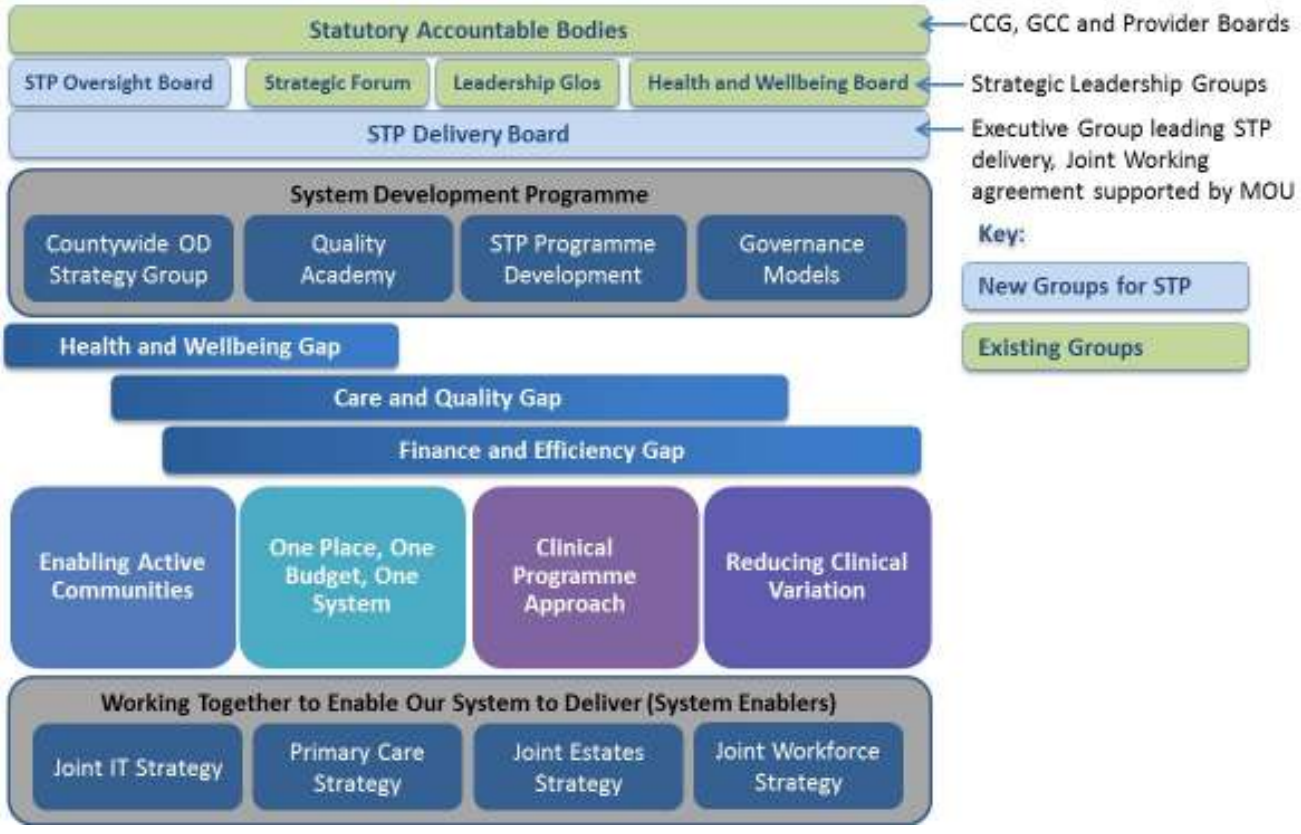
4.1.7 deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this MoU; and

4.1.8 act in good faith to support achievement of the Key Objectives and compliance with these Principles.

5. Governance and reporting

5.1 The programme structure defined below provides the governance approach for the development and delivery the Gloucestershire STP

5.2



5.3 The parties agree to act in accordance with the principles of decision-making set out in Schedule 1 to this MoU.

5.4 As defined within the King's Fund's 10 overarching principles of integration within a place based care model [1]we will

- Define the population group served and the boundaries of the system;
- Identify the right partners and services that need to be involved;
- Develop a shared vision and objectives reflecting the local context and the needs and wants of the public identified through feedback and engagement;
- Develop an appropriate governance structure for the system of care, which must meaningfully involve patients and the public in decision-making;
- Identify the right leaders to be involved in managing the system and develop a new form of system leadership;
- Agree how conflicts will be resolved and what will happen when people fail to play by the agreed rules of the system;
- Develop a sustainable financing model for the system across three different levels:
    1. the combined resources available to achieve the aims of the system;
    2. the way that these resources will flow down to providers;
    3. how these resources are allocated between providers and the way that costs, risks and rewards will be shared;
- Create a dedicated team to manage the work of the system;
- Develop 'systems within systems' to focus on different parts of the group's objectives; and
- Develop a single set of measures to understand progress and use for improvement.

[1] Ham, C., and Alderwick, H. (2015). Place based systems of care: A way forward for the NHS in England. Kingsfund.

6. Information Sharing and Information Governance

6.1 The Parties:

6.1.1 acknowledge that they are statutory bodies subject to primary and secondary legislation and guidance; and

6.1.2 agree that the provisions of this clause 6 are subject always to the Parties' statutory obligations under competition law and procurement law.

6.2 The Parties will freely share business and anonymised information to support integration and transformation discussions where such sharing is in the best interests of patients. There will be total transparency between us in sharing information on operational pressures, quality issues and finance.

6.3 Key system wide measures will be agreed and shared with all Parties to include activity, finance, workforce and outcomes. In addition programmes will have specific requirements which will be detailed in the Schedules.

6.4 All parties will ensure that any sharing of personal identifiable data is compliant with information governance requirements and is covered by the Gloucestershire Information Sharing Partnership Agreement.

7. Complaint, Claims and Requests (including Freedom of Information)

7.1 The Parties acknowledge that the provisions of this clause 7 are subject always to the Parties' obligations set out in primary and secondary legislation and guidance.

7.2 If any Party receives any formal inquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000 ("**FOIA**")) in relation to the Gloucestershire STP, the matter shall be promptly referred to the STP Programme Director.

7.3 The Parties acknowledge and confirm that no action shall be taken in response to any inquiry, complaint, claim or action as described in paragraph 7.2 above, to the extent that such response would adversely affect the Gloucestershire STP, without the prior approval of the STP Delivery Board (led by an independent chair).

7.4 Each Party acknowledges that the other Parties are public authorities for the purposes of FOIA.

7.5 Each Party may be statutorily required to disclose information about the MoU in response to a specific request under FOIA, in which case:

7.5.1 each Party shall provide the others with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA;

7.5.2 each Party shall consult the others regarding the possible application of exemptions in relation to the information requested; and

7.5.3 each Party acknowledges that the final decision as to the form or content of the response to any request is a matter for the Party to whom the request is addressed.

8. Clinical Governance in integrated services

8.1 Parties have agreed that clinical governance comprises 3 separate elements:

8.1.1 Clinical Accountability for the Service

This is an organisational responsibility which would include but not be limited to:

- developing the clinical governance framework;
- developing and maintaining protocols of care; and
- developing the competency framework for staff delivering the service.

8.1.2 Operational Management of the Service

This is an organisational responsibility which would include but not be limited to:

- Application of governance and competency frameworks;
- Reporting on compliance with the protocols and frameworks;
- Management of staff; and
- Supporting the role of the lead clinician.

8.1.3 Clinical Accountability for the Patient

It is recommended that the term lead clinician is adopted across all services.

- The role includes overall responsibility for the management, coordination and continuity of a patient's care. The lead clinician will also be likely to have some direct personal clinical responsibility for the patient.
- The role does not undermine the concept of multidisciplinary team ("**MDT**") care and working, where many clinical decisions arise. It is paramount that the multidisciplinary team and the lead clinician work together to ensure all the links are made to enable safe and appropriate coordination of care. Team members within the MDT will be expected to continue to give appropriate advice. It is not intended that all issues are automatically referred to the lead clinician.
- The lead clinician is the person to whom a patient or their relative/carer would ultimately address concerns about any aspect of care. This means they will take overall responsibility for ensuring that any clinical issues, reports of specialised tests or investigations, difficulties or complaints are addressed appropriately.

8.2 **What does this mean in practice**

Seamless clinical pathways inevitably require that a patient's care be transferred between individuals, teams and organisations. It is vital that the accountabilities for all the stages above are clearly assigned and recognised at all stages of a pathway.

The assignment of roles in any pathway should have regard to:

- the competence and capacity required to fulfil the roles
- minimising the number of transitions in any pathway
- ensuring the lead clinician is recognised and legitimised in the organisation with operational accountability
- that fulfilling the role of lead clinician should be recognised in the planning and resourcing of the individual's workload and activity.

9. Communications and Publicity

9.1 The Parties will ensure a joint approach to communications; agreeing key messages and authorising the approach through the STP Delivery Board.

9.2 It will be the role of the STP Delivery Board to make an assessment on whether changes are likely to constitute a substantial service change, requiring consultation under applicable legislation (including, but not limited to, Section 14Z2 and Section 242(1B) of the National Health Service Act 2006 (as amended)) and advise on the process accordingly.

9.3 The Parties accept responsibility for the cascade of agreed messages within their own organisations.

10. Escalation

10.1 If any Party has any issues, concerns or complaints about the Gloucestershire STP, or any matter in this MoU, such Party shall notify the other Parties and the Parties acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

10.2 If an issue identified in accordance with paragraph 10.1 above cannot be resolved within a reasonable period of time, the matter shall be escalated to the STP Programme Director who shall decide on the process to take for resolution.

10.3 If the matter cannot be resolved by the STP Programme Director, within five Operational Days (an "**Operational Day**" being a day other than a Saturday, Sunday or bank holiday in England), the matter shall be escalated to the STP Delivery Board (led by an independent chair) for resolution.

10.4 Subject always to the Parties' statutory decision-making constraints, where any matter is not resolved under clauses 10.1, 10.2 or 10.3 above, any Party or the STP Programme Director may refer the matter for mediation arranged by an independent third party to be appointed by the STP Delivery Board. Any agreement reached through mediation must be set out in writing but will be non-binding on the Parties.

10.5 Any issues, concerns or complaints with regards to the schedules should be discussed within the work programme for which it relates. If an issue cannot be resolved it should be escalated to the relevant programme board within the Gloucestershire STP governance structure.

11. Intellectual property

11.1 The Parties intend that any intellectual property rights created in the course of the Gloucestershire STP shall vest in the Party whose employee created them (or in the case of any intellectual property rights created by employees of more than one Party, in the Party that is lead party for the part of the Gloucestershire STP that the intellectual property right relates to).

11.2 Where any intellectual property right vests in any one Party in accordance with the intention set out in paragraph 11.1 above, that Party shall grant a royalty free irrevocable licence to the other Parties to use that intellectual property for the purposes of the Gloucestershire STP.

12. Shared Resources to deliver the STP

12.1 The Parties will commit to the principles of the Gloucestershire STP (as listed in section 3.2) to improve services and outcomes for our population, whilst working to ensure financial stability across our system.

12.2 The Parties will provide non financial support to ensure a dedicated team is in place to deliver the components of the Gloucestershire STP under the collaborative leadership model.

12.3 Except as otherwise provided, the Parties shall each bear their own costs and expenses incurred in complying with their obligations under this MoU including in respect of any losses or liabilities incurred due to their own or their employee's actions.

12.4 Any costs associated with STP delivery will be transparent and overseen by the STP Delivery Board

13. Procurement and contracting principles

13.1 Section 7 of the Gloucestershire CCG operating plan for 2016/17 outlines the intended procurements for the year. (Gloucestershire STP does not envisage any addition to these priorities within the same time period). Gloucestershire STP work streams will be required to flag any risk to this through the agreed governance structure, including where any provider procurement would impact on the Gloucestershire STP. Intended procurements for 2017/18 will be considered once known.

13.2 2017/18 is the first year of our System Transformation and the decisions we take in setting 2017/18 contracts will be consistent with our STP (or at the very least not taking us in the wrong direction).

13.3 There is one pot of money and our collective task is to get the best value from that pot. Our aim will be to maximise the value and take out high cost, low value activity where possible.

13.4 We will agree the priorities for improving the quality of services and the resources to be invested in these priorities.

13.5 Our investment decisions will be consistent with our STP.

13.6 Investment (defined as funding above 2016/17 plans) is dependent on agreed service changes being identified and delivered.

13.7 Each organisation will achieve the financial control totals which are set by regulators. For the CCG this will be to achieve a 1% surplus.

13.8 Financial risk in year will be a shared responsibility.

13.9 There will be a shared responsibility for redesigning pathways.

14. Term and termination

14.1 This MoU shall commence on the date of signature by all the Parties, and shall be in place for a period of 12 months.

14.2 Any Party may terminate this MoU by giving at least three months' notice in writing to the other Parties.

15. Variation

15.1 This MoU may only be varied by written agreement of the STP Delivery Board.

15.2 The Parties acknowledge and agree that, as at the date of this MoU, the details of the Gloucestershire STP programmes of work are still to be agreed. The STP Delivery Board shall agree in writing the detail and components of each programme of work and, once agreed:

15.2.1 the detail of each programme of work shall be signed by an authorised representative of each Party; and

15.2.2 on the date that a programme of work is signed by an authorised representative of each Party, this MoU shall have effect as though the agreed programme of work had been originally contained in this MoU as a schedule and the MoU shall be amended accordingly.

16. Charges and liabilities

16.1 There will be transparency over any gain or loss attributable to any individual Party, whilst working to ensure financial stability across our system.

16.2 Whilst each Party shall be responsible for its own costs and liabilities, the system will work collectively to manage these during the transitional phase.

17. No partnership

17.1 Nothing in this MoU is intended to, or shall be deemed to, establish any partnership or joint venture between the Parties, constitute any Party as the agent of any other Party, nor authorise any of the Parties to make or enter into any commitments for or on behalf of the other Parties.

18. Counterparts

18.1 This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same agreement.

18.2 The expression “counterpart” shall include any executed copy of this memorandum of understanding transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

18.3 No counterpart shall be effective until each Party has executed at least one counterpart.

19. Governing law and jurisdiction

19.1 This MoU shall be governed by and construed in accordance with English law and, without affecting the escalation procedure set out in section 10, each Party agrees to submit to the exclusive jurisdiction of the courts of England and Wales.

_____

Signed on behalf of **Gloucestershire Care Services NHS Trust**

_____

Signed on behalf of **Gloucestershire Clinical Commissioning Group**

_____

Signed on behalf of **Gloucestershire County Council**

_____

Signed on behalf of **Gloucestershire Hospitals NHS Foundation Trust**

_____

Signed on behalf of **South Western Ambulance Service NHS Foundation Trust**

_____

Signed on behalf of **2gether NHS Foundation Trust**

SCHEDULE 1: PRINCIPLES OF DECISION-MAKING

1. Principles of decision-making

1.1. The Parties will:

1.1.1. collaborate in accordance with the principles set out in this MoU to enable the development and delivery of the Gloucestershire STP;

1.1.2. take into account their statutory constraints and parameters, acknowledging that they are all separate statutory bodies subject to primary and secondary legislation and guidance as detailed in Appendix 1 (Constraints on Parties' Decision-Making); and

1.1.3. taking into account their statutory constraints and flexibilities, work together for the benefit of the health and social care economy in Gloucestershire as a whole taking into account patients and the public in the wider area.

1.2. The Gloucestershire Strategic Forum (GSF) and the STP Delivery Board shall operate to advise, co-ordinate and facilitate decision-making between the Parties in support of the Gloucestershire STP.

1.3. Notwithstanding clauses 1.1 to 1.2 above, the Parties acknowledge and agree that:

1.3.1. no statutory functions or powers are being delegated by any Party to any other Party under this MoU;

1.3.2. each Party remains responsible and accountable for its statutory responsibilities and nothing in this MoU is a divestment or delegation of any Party's decision-making powers; and

1.3.3. accordingly, the Gloucestershire Strategic Forum and the STP Delivery Board do not have delegated responsibility to make decisions that bind the Parties.

1.4. The Parties acknowledge that, depending on the subject matter of the STP programmes of work in question, some or all of the Parties may be required to make a statutory decision in respect of implementation of that programme of work and that, in order to act efficiently and effectively, it is important to take into account the various statutory roles and responsibilities at an early stage. Accordingly, the Parties will, in respect of each programme of work, review the table set out in Appendix 2 (STP Programme of Work: Role and Relevant Approvals) and use the outcome of that review to ensure that the relevant Parties are engaged and involved at the appropriate times and stages in order to ensure that decisions are reached timeously and collaboratively.

Appendix 1
Constraints on Parties' Decision-Making

	Constraints on Decision-Making
NHS Commissioners	National Health Service Act 2006 (as amended) and related legislation
	CCG constitution
	Procurement law
	Guidance for commissioners, including on conflicts of interest and reconfiguration
	Case law
Local Authorities	Local Government Act 1972 and related legislation
	National Health Service Act 2006 (as amended) and related legislation
	Procurement law
	Competition law
NHS Providers	National Health Service Act 2006 (as amended) and related legislation
	NHS provider licence / Foundation Trust constitution and/or SOs/SFIs
	Procurement law
	Competition law
	Guidance for providers, including from NHS Improvement
	Case law

Appendix 2
STP Programme of Work: Role and Relevant Approvals

[Insert name and nature of programme of work]

	Gloucestershire CCG	Gloucestershire County Council	Gloucestershire Care Services NHS Trust	Gloucestershire Hospitals NHS Foundation Trust	2gether NHS Foundation Trust
Role (including meeting and support)	[insert details]	[insert details]	[insert details]	[insert details]	[insert details]
Internal approvals process and governance issues (if any)	[insert details]	[insert details]	[insert details]	[insert details]	[insert details]
External approvals process (if any)	[insert details]	[insert details]	[insert details]	[insert details]	[insert details]
Key dates to note	[insert details]	[insert details]	[insert details]	[insert details]	[insert details]

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – OCTOBER 2016
BOARDROOM, ALEXANDRA HOUSE, CGH

Report Title									
PREPARATIONS FOR WINTER 2016/17									
Sponsor and Author(s)									
Eric Gatling, Executive Director of Service Delivery									
Audience(s)									
Board Members	**X**	Regulators	**X**	Governors	**X**	Staff	**X**	Public	**X**

Executive Summary

Purpose

To present to the Board the details of how the Trust is preparing for winter 2016/17. This paper is to assure the Board that actions are being taken to ensure that services will be safe and operationally resilient to the anticipated pressures places on health services during the winter period.

Key issues to note

The overriding objectives of the winter plan is to:

- Maintain safe, high quality services for patients including, ensuring patients are seen in the right place and right time, whilst maintaining privacy and dignity. This includes the effective management of infection
- Achieve key areas of service performance in line with agreed recovery plan trajectories; including A&E 4 hour performance, the waiting times standards for patients with suspected cancer and 18 week referral to treatment.

The work streams in the Trust emergency care programme are designed to ensure that the Trust is better prepared to manage emergency care the forthcoming winter.

The planning process within the Trust and across Gloucestershire with system partners is well underway and is an iterative process and there is still further work ongoing to finalise elements of the plan in respect of managing safe and effective hospital discharge arrangements and specific operational plans for the mid December 2016 to mid January 2017 period including Christmas and New Year bank holiday weekends. Bed capacity and staffing levels are the biggest risks to the delivery of the plan.

Conclusions

Whilst we are better prepared than previous years, the winter period remains at a heightened level of risk pending a solution to managing the actual and predicted excess demand. This could result in bed and staffing capacity constraints to accommodate all our emergency and elective patients that will require treatment at the Trust this winter. Work is ongoing with our system partners to address this.

Implications and Future Action Required

A further report will be brought back to the next Trust Board meeting in November detailing the latest position.

Recommendations

The Board is asked to:

- Approve this report.
- Endorse the actions being taken.
- Note that there is ongoing work with our partners across the health and social care

	services in Gloucestershire to assure system wide solutions to the pressures likely to be faced.
Impact Upon Strategic Objectives	
Supports delivery of the strategic objective of high quality care	
Impact Upon Corporate Risks	
Impacts upon the risk associated with high quality care arising from failure to meet national standards	
Regulatory and/or Legal Implications	
The Trust remains under regulatory intervention for performance against the national A&E 4-hour standard	
Equality & Patient Impact	
No specific patient groups are affected by the issues raised in this report	
Resource Implications	

Finance	**X**	Information Management & Technology	
Human Resources	X	Buildings	

Action/Decision Required							
For Decision		For Assurance	**X**	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)**
26 October 2016					

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

PREPARATIONS FOR WINTER 2016/17

MAIN BOARD – OCTOBER 2016

1. AIM

1.1 To present to the Board the details of how the Trust is preparing for winter 2016/17. This paper is to assure the Board that actions are being taken to ensure that services will be safe and operationally resilient to the anticipated pressures places on health services during the winter period.

1.2 In managing this coming winter, the overriding objectives are to:

- Maintain safe, high quality services for patients including, ensuring patients are seen in the right place and right time, whilst maintaining privacy and dignity. This includes the effective management of infection
- Achieve key areas of service performance in line with agreed recovery plan trajectories; including A&E 4 hour performance, the waiting times standards for patients with suspected cancer and 18 week referral to treatment.

1.3 This plan has been produced based on historical experience, the learning from previous winters, the current experience of the Trust Emergency Care Programme within the Trust and across Gloucestershire, and guidance from NHS Improvement and NHS England. The last guidance of which was a communication on 13 October 2016 which set out priorities and expectations for system wide A&E Delivery Boards.

2. INTRODUCTION

2.1 The winter period for planning purposes covers October 2016 to March 2017 within our plans there is enhanced focus on the period mid December 2016 to mid-January 2017 and a further enhanced focus on the Christmas and New Year bank holiday weekends.

2.2 The approach to winter planning this year has been:

- A detailed demand and capacity model building upon 2015/16 actual activity uplifted to reflect 2016/17 projected actual demand. This has resulted in a detailed model that has been validated with the Divisions and then shared in full with Gloucestershire Clinical Commissioning Group and summary results shared with all system wide partners at the October 2016 Gloucestershire A&E Delivery Board.
- Divisional plans built up from the Service Line plans. During October 2016 these plans have been peer reviewed together to ensure alignment across the Trust by the Director of Service of Delivery, Improvement Director and the Divisional Director of Operations. Based on this peer review additional work is underway to strengthen the resilience in the mid December to mid-January period as well as the Christmas and New Year bank holiday weekends.
- A system wide Chief Executive led summit held on 20 October 2016 to focus on the additional actions that will be taken to address the discharge of patients that impact onto the current and anticipated bed capacity gaps.

2.3 The winter plan compliments other Trust plans including:

- Patient flow and Escalation Policy.
- Business Continuity Plan
- Pandemic Flu plan.
- Major Incident Plan.

2.4 The Executive Lead for producing the Winter Plan was the Director of Service Delivery. The responsibility will move to the new Chief Operating Officer upon appointment.

3. KEY PRESSURES

3.1 The key pressures posed by winter include:

- A tendency for a more complex/dependant case mix leading to an increase in length of stay, higher occupancy rates and a subsequent reduction in capacity.
- Reductions in timely discharge of patients due to increased demand from the hospital Trust and primary care for capacity in community/social care. This particularly evident in late December and early January.
- Increased levels of staff absence over extended holiday period in the Trust and system wide partners.
- Increased demand for acute services due to higher levels of infection within the community.
- Significant peaks of bed closures due to sustained infection (e.g. Norovirus) outbreaks.
- Potential for an increase in medical outliers, cancelled operations and ambulance handover delays.
- Pressure on adult critical care and paediatric high dependency capacity across the network.
- Unplanned absence of staff due to seasonal illnesses e.g. flu like symptoms and winter vomiting (Norovirus).
- Adverse weather resulting in difficulty in discharging patients and affecting staff getting to and from work.

3.2 In 2015/16 the NHS nationally and locally experienced unprecedented and sustained demand resulting in considerable operational pressure across all healthcare organisations.

3.3 Within Gloucestershire Hospitals NHS Foundation Trust the 4 hour A&E standard was not achieved and performance fell to a low of 76.90% for the month of February 2016. There was also an increase in the number of elective operations cancelled and an increase of the number of patients medically fit awaiting onward care. At the peak of demand in January 2016 the number of patients exceeded 100 on the medically fit list.

4. ACTIONS TAKEN

4.1 In response to the regulatory action taken by NHS Improvement earlier in the year for emergency care, the Trust has developed a robust Emergency Care Improvement Programme. This plan and the 11 work streams are all designed to ensure that the Trust is making improvements and therefore will be better prepared for the forthcoming winter. Progress and delivery of the programme is performance managed monthly at the Emergency Care Board chaired by the Trust Chief Executive.

4.2 In August 2016 NHS Improvement and NHS England issued Rapid Improvement Guidance for A&E improvement. This covered five priorities for local health systems. Of these three directly related to acute hospitals. All of these three priorities have been included in the Trust Emergency Care programme and will be in place for this winter. These are:

- A&E streaming at the front door – in work stream 4
- Patient flow – in work stream 3
- Improving discharge processes – in work stream 3 and 6

5. Bed Modelling

5.1 The capacity and demand modelling work has been undertaken to forecast the impact of demand on the bed capacity in each of the two hospitals. This is a key part of work stream 5 of the Emergency Care Programme and the results have been validated by the Divisions and the Clinical Commissioning Group.

5.2 The key assumptions are:

- Each of the two hospitals has been treated as a separate hospital accepting patient flows as they currently occur.
- Occupancy levels are based on an average 85% for elective cases and 90% for emergency cases. This should give sufficient head room for surges in demand.
- Day cases, critical care, maternity, children and neonates are treated separately.
- Length of stay is no change to 2015/16 actual levels.
- The impact of seasonal infections and adverse weather is the same as 2015/16.
- The number of acute and general beds, available for all emergency and elective adult cases are 876 beds. This is the total number of beds in use now as there is no physical capacity for escalation beds on either site except for the day case surgery units.

5.3 Further sensitivity analysis is underway to review impact of surges in demand and combined with increases in occupancy rate and length of stay.

5.4 On the baseline assumptions and without taking into account any mitigating action the bed deficit is

	Gloucester Royal Hospital	Cheltenham General Hospital	Trust total
November 2016	-50 beds	-9 beds	-59 beds
December 2016	-51 beds	-9 beds	-60 beds
January 2017	-72 beds	-6 beds	-78 beds
February 2017	-91 beds	-19 beds	-110 beds
March 2017	-64 beds	-26 beds	-90 beds

5.5 There is no capacity to open escalation capacity in either hospital and it is therefore necessary to deliver capacity alternatives through three main objectives. Admissions avoidance

- Effective and efficient flow through the hospitals.
- Reduction in the number of medically fit patients and an associated reduction in the length of time that a patient is medically fit.

5.6 The exact details of the schemes and their impact will be brought to the next Board meeting alongside the impact of the system wide schemes with particular emphasis on the delays to discharge as described in the Emergency Care Programme work stream 6.

5.6 A range of existing actions and some new additional actions are being progressed through the Emergency Care Programme and the 11 work streams. Full details are in the separate Emergency Care Board paper. However bed capacity especially in view of the current number of medically fit patients and high occupancy levels remains a key risk going into the winter unless the actions of our system wide partners delivers as

proposed.

6. Elective Activity

6.1 The Divisions are planning to reduce elective activity from 23 December 2016 to 14 January 2017 to enable elective surgery beds to be used for emergency cases. During this time period additional outpatient clinics and minor procedures will be undertaken. Elective orthopaedic beds will remain ring fenced. The impact on referral to treatment times are currently being modelled as part of the referral to treatment recovery plan.

6.2 In previous years a contingency plan was developed to use the private hospitals to transfer cases to. This did not result in any significant number of cases transferred. As a result this is not a key part of the plan this year however conversations are underway with the private hospital managers to see what marginal capacity can be secured.

7. Maternity and Paediatrics

7.1 Based on the known known of bookings, maternity services are not predicting any significant surge in demand.

7.2 Paediatrics are always busier in the winter months with the impact of respiratory conditions. As a result additional paediatric high dependency capacity has been opened and the Consultant medical staff will increase the frequency of ward rounds.

8. EXTERNAL IMPROVEMENT SCHEMES AND ACTIVITIES

8.1 In addition to all the existing activities to improve emergency care. The Gloucestershire A&E Delivery Board at the meeting on 11 October 2016 committed to focus on eleven key actions that will have a significant impact on system level performance and the ability to manage demand during the winter. These were:

- Implementation of the principles of the Onward Care procedure so that no patient has an unnecessary delay.
- All major specialties with have a Consultant immediately available on the telephone to provide advice and streaming for the emergency departments and primary care.
- Extension of the Older Peoples Assessment and Liaison service to anyone over 60 years old.
- Implementation of changes to the Integrated Discharge Team for ward discharge.
- Review and escalation of any patient with a length of stay over 10 days.
- Development of a Home First offer.
- Improved responsiveness for mental health patients in the emergency departments.
- Use of alternatives to the emergency departments and maintain non conveyance rates to the emergency departments.
- Primary Care to provide additional capacity to manage demand and respond to feedback from the emergency departments.
- 111 and Out of Hours to maintain clinical staffing levels and use alternatives to 999 ambulances and emergency departments.
- Arriva to maintain operational fleet capacity and provide a responsive service.

9. STAFFING

9.1 Nursing

With the high number of nursing vacancies, nurse staffing, especially in the medical division, remains a vulnerable area in the preparations for winter. All of the actions in the Agency Staff Reduction Plan are designed to ensure that there is sufficient nursing

staff are available to meet the anticipated needs without the reliance on agency staff.

Changes are being made to increase the opening hours of the nurse bank office into the evening and at weekends. This is to increase the use of bank nurses as opposed to agency nurses. The new opening hours start

9.2 Medical Staffing

The Division of Medicine have gaps in both acute medicine and emergency care. Both of these are hard to recruit areas. As a result the Division have agreed that all relevant accredited Consultants will contribute an occasional additional evening weekday session. This starts on 31 October 2016 and will run until 27 April 2017.

Weekend Consultant ward rounds will also take on both sites every day, this includes all specialties. For cardiology and gastroenterology this is an increase on their current arrangements.

A number of action in the Agency Reduction Plan also relate to medical staff as the Trust is carrying substantive vacancies which are covered by long term and short term agency locums. Conversion to NHS locums is one of the key actions for this winter.

10. INFECTION CONTROL

10.1 During winter the levels of community acquired infections (predominantly Norovirus) are higher. In previous years there has been over 600 bed days lost due to the outbreaks with a total of over 400 patients affected and the trust has seen an increase in the number of inpatient clinical areas closed in February and March for the past four years. February is known to peak in the number of outbreaks year on year. From review of last year's data it is anticipated that most outbreaks of infection will occur at Gloucester Royal Hospital.

10.2 Infection Control measures need to be reinforced following trust policy. Early identification and isolation of patients symptomatic with diarrhoea and/ or vomiting or respiratory symptoms on admission must be enforced. This should include travel history to identify potential infections including respiratory symptoms to prevent outbreaks of infection. Priority for isolation will follow trust policy using the priority for isolation matrix and the inability to isolate patients will be escalated.

10.3 Outbreaks of diarrhoea and vomiting will be managed using the Southwest Norovirus toolkit detailing the escalation procedure for the management and communication of norovirus outbreaks within the Trust. There has been a programme of deep cleaning instigated over the summer in preparation for the winter. An enhanced programme of cleaning will be implemented as required. The Combat Norovirus campaign has been refreshed and continued highlighting the with key messages aimed at visitors, patients and staff detailing symptoms, promoting hand washing and restricted visiting and restrictions for returning to work.

10.4 From October 2016 to May 2017 the Infection Control Nurses will provide an additional service to review outbreaks of diarrhoea and vomiting at weekends and bank holidays from 0830-1215 hours by telephone from home. This is a limited and unfunded service so the infection control nurses work flexibly over the winter to cover. It is recognised that the availability of an Infection Control Nurse at these times has been beneficial and has contributed to managing the outbreaks and the operational pressures that occur as a result of ward closures. To provide this service there will be a reduction in Infection Control Nurses availability for some meetings and normal working hours' activity. The Director of Infection Prevention and Control is working closely with our local Public Health team to provide extra information and training to private care home staff to try and prevent unnecessary admissions from them and reduce infection.

11. SEASONAL FLU

11.1 The Trust has a comprehensive seasonal Flu plan. A key part of this is staff vaccination and an internal communications strategy will be launched ahead of vaccination roll-out. A proactive roll-out of the Trust vaccination programme commenced in October 2016, with Occupational Health targeting and vaccinating front-line staff in high risk areas locally, including evening sessions for maximum uptake and the use of flu champions giving vaccines in the high risk areas.

11.2 The aim is to vaccinate more staff than were vaccinated in previous years with a target of 4000 staff. The Trust has considered mandating staff to have the vaccine and this advice is that this is not advisable. Instead a proactive campaign will be launched and staff will be strongly encouraged to take up the vaccine. Uptake of the flu vaccination will be regularly reviewed by staff group and clinical areas.

11.3 As part of the plans for Pandemic Flu and Viral Haemorrhagic Fever (Ebola), there are robust plans so that additional Critical Care capacity can be activated if needed.

12. COMMUNICATIONS AND MARKETING CAMPAIGN

12.1 *Stay Well This Winter* is an integrated multi-channel campaign aimed at easing seasonal pressure on NHS urgent care and emergency services. For only the second year the campaign will be jointly commissioned by NHS England, Public Health England and the Department of Health. This is important because it means that previous campaigns such as Public Health England's flu vaccination programmes '*Catch it, kill it, bin it'* and '*Keep Warm, Keep Well',* NNS England's *'Feeling under the Weather Winter Plan'* and NHS 111, will again be brought into one combined strategy. This collaborative approach maximises the scope and opportunity for key messages to reach their target audience through better integration, which, in turn, supports stronger brand recognition and association. This focused behaviour change programme developed through a single campaign approach will cover a variety of media including television, radio, outdoor and digital. To ensure that this campaign is as effective as possible, commissioners and providers including the Trust will use nationally consistent messaging to guide patients and the public. The Trust has aligned its local activity with Gloucestershire Clinical Commissioning Group and the national approach**.**

12.2 There is a full Gloucestershire wide communications plan for winter and this campaign and other communications and marketing activities are designed to encourage appropriate use of services in Gloucestershire and provides care advice by condition. Key elements have already been launched such as the website and app.

13. ADVERSE WEATHER

13.1 The Trust receives severe weather warnings as well as weather alerts and forecasts from the Local Resilience Forum and the Meteorological Office. This allows the Trust to put into operation the appropriate plans in a timely fashion. In the event of adverse weather such as snow, ice and flooding, a control room will be activated so there is a single point of focus.

13.2 In addition this year we are encouraging staff to plan ahead and develop their own personal contingency plans.

14. FINANCE

14.1 There is no separate allocation or additional non recurrent funding this year for winter. Any funding was built into the contract with Gloucestershire Clinical Commissioning Group at the start of the year to pay for existing system resilience schemes. .

14.2 Within the overall Trust Emergency Care Programme, £2 million has been identified as

being required to meet the needs of delivering the programme on a sustainable basis. This includes funding existing services which were not funded as part of budget setting and new services. This is included as part of the overall financial recovery plan.

15. MORTUARY SERVICES

15.1 The Trust has additional temporary capacity to ensure Mortuary Services are maintained throughout the winter period and escalation plans are in place to meet increased demand over the Bank Holiday periods.

16. RISK AND MITIGATION

16.1 The following risks have been identified with mitigating actions described. These risks and mitigations will be reviewed constantly throughout winter period.

Serial	Risk	Mitigation
1	Trust emergency Care Programme does not deliver to plan	Performance management through Trust Emergency Care Board
2	System-wide improvement schemes do not deliver to plan	Review and escalation through Gloucestershire A&E Delivery Board
3	Insufficient capacity (beds or staff) to cope with emergency demand	Implementation of agreed actions and the system wide reset plan.
4	Patients remaining in hospital who no longer require acute care	Proactive management of patients on the Medically Stable List by the Integrated Discharge Team and through engagement with system wide partners.
5	Emergency Department attendances increase above plan	Ongoing engagement with system wide partners. Communications plan.
6	Number of admissions exceeds plan	Implementation of Patient Flow and Escalation Policy with early escalation to system wide partners. Improve discharge arrangements.
7	Lack of uptake for seasonal flu vaccination	Early communications campaign Regular data on vaccination rates by clinical area. Example shown by clinical leaders.
8	Loss of capacity (beds or staff) for prolonged periods of time due to adverse weather, staff absence, norovirus	Trust Patient Flow and Escalation policy Trust adverse weather policy Trust Business Continuity Plan. Norovirus plan.
9	Loss of elective capacity over and above planned reductions	Explore potential for capacity in private hospitals. Additional day case capacity at Cirencester Hospital.
10	Out of Hours provider withdrawing from contract and contract being put in place from April 2017	Close working with outgoing provider South Western Ambulance NHS Foundation Trust and the Clinical Commissioning Group to ensure smooth transition and no loss of services.
11	Changes to key operational leadership positions at Board and Division level.	Comprehensive plan put in place with a good handover.

17. MONITORING and ESCALATION

17.1 Daily operational situation reports of bed capacity, emergency department attendances, daily admission and discharge predictors, infection outbreaks and staffing issues are communicated internally and externally, in accordance with the Patient Flow and Escalation Policy.

17.2 Daily Situation Reports to NHS England commenced in October 2016 and will continue throughout the winter period.

17.3 Emergency admissions and average length of stay will be performance managed weekly against the winter capacity and demand model.

17.4 Whole system performance is to be reviewed at the weekly meeting of executives from Acute, Ambulance, Community, Social Care and Commissioner. This is additional to the daily system wide operational call.

18. NEXT STEPS

18.1 The Gloucestershire A&E Delivery Board received draft proposals for the system wide winter plan. Following this additional work was required to finalise actions. The resultant system wide plan is still awaited at the time of writing this report.

18.2 Following the system wide Chief Executive led Summit on 20 October 2016 a range of actions were agreed to take place over the next four weeks with the emphasis on improving discharge arrangements. This will be followed a system wide reset to ensure that patients are being cared for in the most appropriate place. The outcome is expected to be a reduction of 100 patients in Gloucestershire Hospitals and as a result the Trust will have an occupancy of 85% before it enters the Christmas and New Year bank holiday period.

18.3 A system wide resilience and escalation workshop is being held on 14 November 2016 to test out the response from each organisation in escalation.

18.4 This will be followed a further event on 25 November 2016 at which the Clinical Commissioning Group and all providers will review Christmas and New Year bank holiday assurance.

18.5 An updated plan will be given to the November 2016 Trust Board.

19. RECOMMENDATION

19.1 The Board is asked to:

- Approve this report.
- Endorse the actions being taken.
- Note that there is ongoing work with our partners across the health and social care services in Gloucestershire to assure system wide solutions to the pressures likely to be faced.

Author & Presenting Director: Eric Gatling, Director of Service Delivery
October 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – OCTOBER 2016
BOARD ROOM, ALEXANDRA HOUSE

Report Title									
7 Day Services Update									
Sponsor and Author(s)									
Sponsor: Dr Sean Elyan Author: Bob Pearce									
Audience(s)									
Board members	**x**	Regulators		Governors	**X**	Staff		Public	**X**

Executive Summary

Purpose

The purpose of this report is to provide **assurance** to the Board regarding the progress being made to provide seven day services aimed at ensuring patients discharge from hospital is not delayed due to a lack of specialist care at weekends.

Key issues to note

- Identified as a national exemplar for work done in the seven day services arena
- Six monthly National Audit completed in October and results will be provided in the next Board update
- Introduction of weekend board and ward rounds in gastroenterology and cardiology (non-compliant service areas) in principle but requires investment.
- CCG growth allocations include investment in developing *seven day services*
- Seven day service programme now governed within Emergency Care Programme Board
- NHSE Phase 2 cohort of Trusts are soon to be identified and the Trust is aiming to become a phase 2 Trust, which will attract national funding.

Conclusions and Next Steps

The Trust is making good progress on the *seven day services* agenda and becoming nationally recognised for some of the work done to date. The Trust is still not fully compliant with the four core standards and plans have been developed to further roll out services but these are contingent on investment and as such will be considered in the annual business planning cycle.

Recommendations

The Board is requested to receive this report as a source of **assurance** of the progress being made to meet the national standards in relation to *7 day services* and to note the ongoing work to further develop our service offer which is aimed at ensuring patients do not remain in hospital unnecessarily due to lack of specialist care at weekends.

Impact Upon Strategic Objectives

Supports the Emergency Care Programme priorities

Impact Upon Corporate Risks

Mitigates the identified risk of delays to discharge attributed to a lack of services at weekends

Regulatory and/or Legal Implications

N/A

Equality & Patient Impact

No specific patient or staff groups are affected by this initiative

Resource Implications

Finance	**x**	Information Management & Technology	

Human Resources			**x**	Buildings			
Action/Decision Required							
For Decision		For Assurance	**X**	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)**
					October Emergency Care Programme Board

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – OCTOBER 2016

7 DAY SERVICES UPDATE

1 Background

1.1 The Main Board was last updated on the *7 day services* initiative in July 2016 and is updated quarterly. This report will comment on progress as part of the Trust Emergency Care Programme and the six-monthly National Survey conducted in early October 2016.

1.2 The Board is requested to receive this report as a source of assurance that the Trust continues to make progress against the 7 day service agenda.

2 National Picture

2.1 Following the visit by the Department for Health and NHS England on 27 July to conduct a 'deep dive' into the work conducted in the Trust developing the 7 day Services programme a request was received to lead a Webinar to show how we conducted the programme, identified gaps in service provision and made progress to deliver improvements. The Webinar was led by the Executive Medical Director and delivered on Friday 19 August 2016. It took the form of a presentation and discussion in order to share our learning.

2.2 National Survey. The Trust took part in the national 7 day Services audit in March and these audits are now conducted every 6 months for Acute Trusts. The next round will be uploaded to the NHSE 7 Day Services Website by 19 October following a review of records conducted on the 12 and 13 October. Results will be available by early November and a summary will be presented in the next report to the Board. The survey results are used to help inform providers of their gap analysis and NHSE will also use them to help shape the Phase 2 cohort of providers for development of their 7 Day Services.

3 Emergency Care Programme

3.1 The lead for developing 7 Day Services is now absorbed into the Emergency Care Programme. Since the last report progress has been made on the business cases to support the introduction of 7 day board and ward rounds in gastroenterology and cardiology which are the main services who are non-compliant with the national standard for senior review following admission.

3.2 From the end of October the gastroenterology team will deliver ward rounds at weekends in both hospitals. They will also conduct weekend endoscopy lists. The proposed approach has readjusted the job planning and will not require additional consultant cover but will require additional hours in reception (Band 2) and nursing (for Bands 3 – 5).

3.3 In Cardiology the approach is to employ an additional interventionist cardiologist to support both weekend ward rounds and the introduction of 24/7 PPCI. The intention is to introduce the weekend cover in December 2016 but is subject to business case approval.

4 County-wide Activity

4.1 Following the (Multi-disciplinary Accelerated Discharge Event) MADE in August a number of actions have been followed up; the Trust identified that whilst we had and approach to delivering Board Rounds (the SORT Poster developed last year) we did not have a Standing Operating Procedure (SOP) for them. An SOP has

been developed and the draft is being reviewed in Work-stream 3 of the Emergency Care Programme. The MADE activity has also been reviewed by NHSE and they have asked for a webinar to share our learning as well as indicated they would like a representative to attend our next event which is likely to be held over a weekend before the end of the year.

4.2 The previous county-wide workshop called for representatives to identify activity that was needed at weekends to support flow through all provider organisations and the intent is to hold the next workshop following the weekend MADE event.

5 The Future

5.1 We continue to develop the delivery of *7 day services* through the Emergency Care Programme. A weekend MADE event is being planned before the end of the year. A NHSE Webinar will be held following this event to share learning.

5.2 During the next quarter we will look to engage with NHSE in order to be considered as a Phase 2 Trust in order to secure funding in 2017. The national allocation to commissioners includes a resource targeted (but not ring fenced) for development of the 7 day offer.

6 Recommendation

6.1 The Board is requested to receive this report as a source of assurance of the progress being made to meet the national standards in relation to *7 day services* and to note the ongoing work to further develop our service offer which is aimed at ensuring patients do not remain in hospital unnecessarily due to lack of specialist care at weekends.

Author:	Bob Pearce
Presenting Director:	Dr Sean Elyan
Date:	October 2016

ITEM 20

ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

DISCUSSION

ITEM 21

STAFF QUESTIONS

Prof Clair Chilvers
Chair

ITEM 22

PUBLIC QUESTIONS

(Procedure attached)

Prof Clair Chilvers
Chair

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

PROCEDURE FOR PUBLIC QUESTIONS AT BOARD MEETINGS

The Trust welcomes feedback from members of the public. We are committed to delivering the best care and constantly looking at ways to improve the services we provide at out hospitals. There are a variety of ways in which you can give your feedback. These are:-

- As a patient or visitor to the hospital by completing a comment card which is available on wards and departments.
- By contacting the Patient and Liaison Service (PALS) who offer confidential, impartial help, advice or support to any aspect of a patient's care. The team aim to help resolve issues and concerns speedily by liaising with appropriate staff on your behalf. PALS can be contacted by phone on 0800 019 3282; by text on 07827 281 266; by e-mail pals@gloucestershirehospitals@glos.nhs.uk or by writing to the PALS Office, Gloucestershire Royal Hospital, Great Western Road, Gloucester GL1 3NN. Complaints can be made to the Complaints Team by phoning 0300 422 5777, by e-mail complaints.team@glos.nhs.uk of by writing to the Complaints Team at Gloucestershire Royal Hospital/at the above address.
- By asking a question at our Board meeting by following the procedure below. Board meetings are open to the public and are normally held on the last Friday of the month at Trust HQ, 1 College Lawn, Cheltenham. Meetings normally start at 9.00am

All feedback is taken seriously and is used to either praise staff for the excellent care or service they have provided or used to make improvements where needed.

Written questions for the Board Meeting

People who live or work in the county or are affected by the work of the Trust (including members of the Trust who live outside of the County) may ask the Chair of the Trust Board a question on any matter which is within the powers and duties of the Trust.

Ten minutes will be allocated at the end of the public section of each Board meeting for written questions from the public to be answered. Where it is not possible for all written questions to be dealt with within this timeframe a written response will be provided to the questioner and copied to all Board members within 7 working days of the meeting. In exceptional circumstances, the Chair may extend the time period for public questions.

Notice of questions

A question may only be asked if it has been submitted in writing to the Trust Secretary by 12.00 noon 3 clear working days before the date of the Board meeting. Each question must give the name and address of the questioner. If a question is being asked on behalf of an organization then the name of the organization must be stated. Written questions are to be submitted to the Trust Secretary, 1 College Lawn, Cheltenham, GL53 7AT or by e-mail to martin.wood@glos.nhs.uk No more than 3 written questions may be submitted by each questioner.

Procedure

At the Board meeting the questioner, if present, will be invited to read out the question. If absent, the Chair may read out the question. A written answer will be provided to a written question and will be given to the questioner and to members of the Trust Board before being read out at the meeting by the Chair. Copies of the questions and the responses will be recorded in the minutes.

Additional Questions

A questioner who has submitted a written question may, with the consent of the Chair, ask an additional oral question arising directly out of the original question or the reply.

An answer to an oral question will take the form of either:

- a direct oral answer; or
- if the information required is not easily available a written answer will be sent to the questioner and circulated to all members of the Trust Board.

Unless the Chair decides otherwise there will not be discussion on any public question.

Written questions may be rejected and oral questions need not be answered when the Chair considers that they:

- are not on any matter that is within the powers and duties of the Trust;
- are defamatory, frivolous or offensive;
- are substantially the same as a question that has been put to a meeting of the Trust Board and been answered in the past six months; or
- would require the disclosure of confidential or exempt information.

For further information, please contact Martin Wood, Trust Secretary on 0300 422 2932 by e-mail martin.wood@glos.nhs.uk