# GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on Friday 25 November 2016 in the **Lecture Hall, Redwood Education Centre Gloucestershire Royal Hospital** commencing at 9.00 a.m. with tea and coffee. **(PLEASE NOTE VENUE FOR THIS MEETING)**

Peter Lachecki
Chair

18 November 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 28 October 2016 | **PAPER** | **To approve** | 09:02 |
| **4.** | Matters Arising | **PAPER** | **To note** | 09:05 |
| | **Chief Executive's Report and Environmental Scan** | | | |
| **5.** | November 2016 | **PAPER** (Deborah Lee) | **To note** | 09:10 |
| | **EFFECTIVE** | | | |
| **6.** | Quality and Performance Report<br>• Report of the Chair of the Quality and Performance Committee on the meeting held on 23 November 2016<br>• Report of the Director of Service Delivery<br>• Minutes of the meeting of the Quality and Performance Committee meeting held on 26 October 2016 | **PAPER (To follow)** (Keith Norton)<br>**PAPER** (Eric Gatling)<br>**PAPER** (Keith Norton) | **For Assurance** | 09:20 |
| **7.** | Financial Performance Report<br>• Report of the Chair of the Finance Committee on the meeting held on 23 November 2016<br>• Report of the Finance Director<br>• Minutes of the meeting of the Finance Committee held on 26 October 2016 | **PAPER (To follow)** (Tony Foster)<br>**PAPER** (Stuart Diggles)<br>**PAPER** (Tony Foster) | **For Assurance** | 09:40 |
| **8.** | Audit and Assurance Committee – 8 November 2016<br>• Report of the Chair of the Audit and Assurance Committee<br>• Minutes of the meeting of the Audit Committee held on 8 November 2016 | **PAPER** (Rhona Macdonald)<br>**PAPER** (Rhona Macdonald) | **To note** | 10:00 |
| **9.** | Nurse and Midwifery Staffing Report | **PAPER** (Maggie Arnold) | **For Assurance** | 10:05 |
| **10.** | Board Assurance Framework and Trust Risk Register | **PAPER** (Deborah Lee) | **For Assurance** | 10:15 |
| **11.** | Workforce Strategy | **PAPER** (Dave Smith) | **To approve** | 10:25 |
| **12.** | SmartCare Progress Report | **PAPER** (Sally Pearson) | **For Assurance** | 10:35 |

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|---|---|---|---|---|
| **13.** | NHS Improvement Assurance Template on Temporary Staffing | **PAPER** (Dave Smith) | **To approve** | 10:45 |
| | **SAFE** | | | |
| **14.** | Preparations for Winter 2016/17 | **PAPER** (Eric Gatling) | **To approve** | 10:55 |
| **15.** | Emergency Preparedness Resilience and Response | **PAPER** (Sally Pearson) | **For Assurance** | 11:05 |
| | **FOR INFORMATION** | | | |
| **16.** | Minutes of the meeting of the Council of Governors held on 2 November 2016 | **PAPER** (Peter Lachecki) | **To note** | 11:15 |
| | **Next Meeting** | | | |
| **17.** | Items for the next meeting and Any Other Business | **DISCUSSION (All)** | **To Discuss** | 11:20 |
| | **Staff Questions** | | | |
| **18.** | A period of 10 minutes will be provided to respond to questions submitted by members of staff | | **To Discuss** | 11:25 |
| | **Public Questions** | | | |
| **19.** | 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<br>11:45 |
| | **Break** | | | |

**Date of the next meeting:** The next meeting of the Main Board will take place in January 2017. The date of the meeting will be published.

**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 BOARD ROOM, ALEXANDRA HOUSE, CHELTENHAM GENERAL HOSPITAL ON FRIDAY 28 OCTOBER 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**

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| **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 |
| | Tracey Barber | Non-Executive Director |
| | Tony Foster | Non-Executive Director |
| | Rhona Macdonald | Non-Executive Director |
| | Helen Munro | Non-Executive Director |
| | Keith Norton | Non-Executive Director |
| **APOLOGIES** | Stuart Diggles | Interim Director of Finance |
| **IN ATTENDANCE** | Martin Wood | Trust Secretary |
| | Sarah Stansfield | Director of Operational Finance |
| | Dr Frank Jewel | Chief of Service – Diagnostics and Specialities |
| | Craig Macfarlane | Head of Communications |
| **PUBLIC/PRESS** | Dorothy Awege-Elkington | Governor – Forest of Dean Constituency |
| | Rob Andrews | KPMG |
| | Jonathan Brown | KPMG |
| | Anne Davies | Governor – Cotswolds Constituency |
| | Pat Eagle | Governor – Stroud Constituency |
| | Suzie Gleeson | Public |
| | Bren McInerney | Public |
| | Natasha Swinscoe | WEAHSN |
| | Alan Thomas | Governor - Cheltenham Constituency |
| | Craig MacFarlane | Head of Communications |
| | Matt Discombe | Gloucestershire Life |

*The Chair welcomed all to the meeting. In particular, she welcomed Rhona Macdonald to her first meeting following her appointment as Interim Non-Executive Director. She also welcome Natasha Swinscoe who would shortly be taking up the post of Interim Chief Operating Officer, the three new public governors and the representatives of KPMG, the Trust's new external auditors.*

**ACTION**

### 317/16 DECLARATIONS OF INTEREST

There were none.

### 318/16 MINUTES OF THE MEETING HELD ON 30 SEPTEMBER 2016

**RESOLVED:** That the minutes of the meeting held on 30 September 2016 were agreed as a correct record and signed by the Chair.

**319/16 MATTERS ARISING**

**234/16 Seven Day Services Update:**
The Chair said that the update report should continue to be presented to the Board quarterly. *This item appears later in the Agenda. Completed.*

**285/16 Minutes of the Meeting of the Audit Committee held on 6 September 2016:**
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. *The Director of Operational Finance undertook to provide this to the Board.* **SS/SD**

**290/16 Emergency Pathway Report:**
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 appeared later in the Agenda. Completed.*

**291/16 Nurse and Midwifery Staffing:**
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. *The Nursing Director reported that nursing working arrangements had been updated to show when they were off duty and available for bank. The Medicine Division has introduced a scheme to deploy off duty nurses. The Finance Team are aware of the adjusted rostering and staffing is provided in accordance with the Keith Hurst benchmarking. Completed as a Matter Arising.*

**293/16 Staff Survey Action Plans:**
Ms Barber undertook to speak separately to the Director of Human Resources and Organisational Development on developing staff engagement and culture. *Ms Barber reported that she is meeting the Director of Human Resources during the week following the Board meeting and this will form part of the work of the Workforce Committee. Completed as a Matter Arising.*

The Chief Executive referred to the "happy app" introduced in another Trust which the Director of Human Resources and Organisational Development undertook to pursue. *The Director of Human Resources and Organisational Development reported that there are several options available which are currently being reviewed with a decision being taken in November 2016. Ongoing.*

**294/16 Complaints and Concerns Q1 April – June 2016:**
Ms Barber said the level of qualitative 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. *The Nursing Director reported that this has been addressed for future reports. Completed.* [09:05]

**320/16 SUMMARY OF THE MEETING OF THE FINANCE COMMITTEE HELD ON 26 OCTOBER 2016**

The Chair of the Committee, Mr Tony Foster, presented the summary of the meeting of the Finance Committee held on 26 October 2016. He said that the Committee had considered the financial performance report on a page by page basis. The new format of the report made reconciliation with the plan submitted to NHS Improvement more difficult. The report presented to the Committee contained data for each Division. Should the Committee decide to look in depth at financial performance at a Divisional level, they would first look at Medicine and Surgery. The Committee received an update on the progress to date against the thirty-four recommendations resulting from the Deloitte Review: Financial Reporting – Enhancing Transparency dated 17 August 2016. Of those thirty-four recommendations, five have not started (eight last month), eleven recommendations are in progress (twenty-one last month), and eighteen actions completed (five last month). The update on the Cost Improvement Programme highlighted areas of concern which require further work. The membership of the Committee has been strengthened with the Director of Human Resources and Organisational Development being a member with support from the Nursing Director, Medical Director, Cost Improvement Programme Director and the Director of Estates and Facilities. Duncan Calverley from KPMG observed the meeting for Cost Improvement Programme purposes.

The Chair thanked Mr Foster for his report.

**RESOLVED**:- That the summary be noted. [09:07]

**321/16 MINUTES OF THE MEETING OF THE FINANCE COMMITTEE HELD ON 26 SEPTEMBER 2016**

**RESOLVED:** That the minutes of the meeting of the Finance Committee held on 26 September 2016 be noted. [09:07]

**322/16 MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING COMMITTEE HELD ON 4 OCTOBER 2016**

The Chair of the Committee, Mrs Helen Munro, presented the minutes of the meeting of the Health and Wellbeing Committee held on 4 October 2016. This was the first meeting she had attended as Chair. The Committee received a presentation on the Committee's priority of reducing harm from alcohol. There is frustration that the Alcohol Liaison Service is only available during office hours when alcohol related attendances peak between 5.00pm to 5.00am and particularly Friday afternoon to Monday morning. The Committee received the latest Smoking Cessation Monitoring Report and a proposal for smoking shelters on hospital sites. The Committee is not in favour of re-introducing smoking shelters and is looking at other options to eliminate smoking outside hospital entrances.

The Chair referred to the membership of the Committee noting that apologies were received from approximately one third of the membership urging that it be reviewed although acknowledging that it was no longer a Board Committee. In response, the Director of

Clinical Strategy said that the broader membership has been of benefit to developing the Health and Wellbeing agenda and it will be difficult to reduce the membership to provide assurance.

The Chair thanked Mrs Munro for her report.

**RESOLVED**:- That the minutes be noted. [09:10]

**323/16 SUMMARY OF THE MEETING OF THE QUALITY AND PERFORMANCE COMMITTEE HELD ON 26 OCTOBER 2016**

The Chair of the Committee, Mr Keith Norton, presented the summary of the meeting of the Quality and Performance Committee held on 26 October 2016. The Committee had considered the Performance Management Framework Report focussing on performance in the Emergency Department and cancer. The challenge is to measure performance by outcomes. Some targets had dipped. Changes have been made to services and the impact of those changes will be known over time. The Committee were informed of a backlog of approximately 100,000 radiology scans which, upon clarification, was approximately 30,000. The Committee have been reassured that this backlog can be addressed in two months' time. Exception reports will be made to the Committee where there are backlogs in other services. With regard to the performance areas of "Are we safe?", "Are we responsive?", "Are we effective?", and "Are we well led?", the Committee is not able to provide assurance in these areas as some performance is dipping. The issue is to make and sustain improvements.

The Chair invited the Board to consider whether verbal reports from the Finance Committee and the Quality and Performance Committee which met two days before the Board meeting, provided sufficient assurance. The Chairs of the respective committees were content to provide verbal reports but there were concerns that a written report should be provided. This was an area which would be considered further. **DL**

The Chair thanked Mr Norton for his report.

**RESOLVED**:- That the report be noted. [09:17]

**324/16 MINUTES OF THE MEETING OF THE WORKFORCE COMMITTEE HELD ON 14 OCTOBER 2016**

The Chair of the Committee, Mr Keith Norton, presented the minutes of the reconvened meeting of the Workforce Committee held on 14 October 2016. The Committee had agreed the Workforce Strategy which will be presented to the Board in November 2016. The top three priorities for the forthcoming year are workforce supply and retention, costs including financial management of those costs, and engagement. The work plan to support the strategy is in the course of preparation. **DS (MW to note for agenda)**

The Director of Human Resources and Organisational Development said that he had written to the Chairs of the various groups which report to the Committee setting out the priorities and the arrangements by which those groups will report back to the

Committee on those priorities.

The Chair thanked Mr Norton for his report.

**RESOLVED**:- That the minutes be noted. [09:19]

**325/16 CHIEF EXECUTIVE'S REPORT AND ENVIRONMENTAL SCAN**

The Chief Executive presented her report and drew attention to the following:-

- The announcement by NHS Improvement of its intention to put our Trust into Financial Special Measures under the recently issued framework "Strengthening Financial Performance and Accountability in 2016/17". Whilst this action signals the seriousness of our Trust's financial position, it also affords our Trust access to specialist skills and additional capacity to ensure our Trust returns to financial balance as soon as possible and, most importantly, without detriment to the safety and quality of services provided. The Chair, Chief Executive and Interim Director of Finance had met NHS Improvement on 21 October 2016 regarding financial special measures. An Improvement Director is to be appointed who has experience of working in financially challenged organisations. The decision to put our Trust in Financial Special Measures is not due to long standing financial issues but the significant variance from our financial plan which is considered not to be sufficiently robust. The failures in the financial governance arrangements of the Board have been acknowledged. Our Trust expects to be "back in the pack" next year with a balanced plan in approximately two years' time. Between 5 and 6% per annum is required to be reduced from the cost base (including the 2% national reduction). Nonetheless, our aim is to deliver safe services.

- **National:** Our Trust is still awaiting a decision regarding the award of available capital through the Sustainability and Transformation Planning process for the development of our estate. She expressed her appreciation to the Director of Clinical Strategy and the Director of Operational Finance for the speed in which they gathered the information to support ourbid.

  The Care Quality Commission (CQC) is to undertake a full inspection of our Trust during January 2017. The Nursing Director, with the support of the Director of Service Delivery, is preparing our Trust for this inspection. It is acknowledged that patient flow is an area of challenge during an inspection during the winter months. Consideration had been given to seek a deferment of the inspection but the decision has been made that it should take place given our view that good quality care and good financial management go hand in hand.

- **Our Trust**: The Chief Executive had the pleasure of attending and addressing our Annual Medical Education Conference and the mission for our organisation is to realise the synergy that can come from aligning teaching, research and care

delivery to give patients and staff the very best opportunities.

The Chair thanked the Chief Executive for her report.

**RESOLVED**:- That the report be noted. [09:29]

## 326/16 BOARD COMMITTEE STRUCTURE

The Chair presented the report inviting the Board to approve a revised Board Committee structure. The proposal reflects the Trust's response to concerns regarding the effectiveness of the Board's governance arrangements and notably the Committee structure. The proposal aims to address weaknesses in governance identified through recent reviews, including the Deloitte governance review and NHS Improvement investigations, resulting in enforcement undertakings. The proposal also seeks to clarify the role of governors on Board Committees to ensure consistency of approach and enable a development programme to be mobilised to support them in executing their role and responsibilities. The proposed revisions to the Board Committee structure were set out in the report and Terms of Reference for each Board Committee were appended to the report. The membership of each committee was tabled. The Chair also referred to the Chief Executive's challenge to reduce meetings by 50%. The Chief Executive gave as an example conference calls to focus on issues to reduce meeting time. She acknowledged that this approach was not appropriate for all meetings.

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

- Mr Norton said that the challenge is to ensure that Committees have the right level of data for detailed consideration to provide assurance and that the Board receives that assurance without the necessity to consider the detail.
- The Chief Executive said that the terms of reference of the Finance Committee need to be amended by the addition of point 11 regarding the approval of business cases above £500k. **MW**
- The Board considered the Non-Executive Director linkages between the Finance, Quality and Performance and Audit and Assurance Committees in terms of clarity of purpose for the meetings. It was suggested that the Committee Chairs should meet regularly and Ms Barber undertook to provide a process for providing clarity. **MW/TB**
- The Chair invited members to provide any textual amendments to the Terms of Reference to the Trust Secretary. **ALL**

**RESOLVED**:- That the revised Board Committee Structure and Terms of Reference appended to the report subject to the above amendments be approved. [09:36]

## 327/16 INTEGRATED PERFORMANCE FRAMEWORK REPORT

The Director of Service Delivery presented the report to provide assurance to the Board in respect of our Trust's actions to deliver

care in line with mandated national standards. It summarised key highlights and exceptions in Trust performance up until the end of September 2016 for the financial year 2016/17. The key issues to note were that our Trust continues to fail to meet three of the four national access standards including the A&E four hour standard, two cancer standards and the Referral to Treatment (RTT) standard. 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. An initial meeting with the Chief Executive and Director of Service Delivery is to take place with Surgery Division during the week following the Board meeting to determine the required actions. The particular areas of concern are Oral Surgery and Trauma and Orthopaedics with General Surgery performance beginning to deteriorate. Our Trust has achieved the internal recovery trajectory for Cancer 62 Day GP Referral to Treatment standard and the Q2 A&E four hour trajectory although the four hour trajectory was not met in September 2016. The cancer two week wait performance target is unlikely to be met during September 2016 largely due to patient choice where bookings are made beyond the two week timeframe and there are 32 clinics in the community on the two week pathway and the position needs to be managed. To date for October 2016, Urology performance on the two week pathway will not be met and is being addressed with daily targets managed by the Cancer Team. The Cancer 62 Day Referral to Treatment standard is on track with the recovery plan and there is currently no reason why the standard will not be met in January 2017. All the 15 key diagnostic tests were met in September 2016 with the exception of Audiology which was not foreseen resulting in the overall standard for September 2016 not being met. To assist in the presentation of the report, the Executive Summary will no longer be presented as the information is contained in the cover sheet.

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

- Mrs Munro commended the improvement in acute kidney infection performance which had risen to 60% from 42%.
- The Chief Executive invited the Board to consider the format of the report to ensure that assurance can be given that services are safe. Mr Norton commented that from the consideration of the report at the Quality and Performance Committee there was no evidence that services were not being provided safely. The Medical Director added that high level data are provided for assurance. He gave an example with ED performance where there is evidence that the service is provided safely. Processes are in place to ensure mitigation to patient safety. It is important to get the balance right between the evidence for safety and assurance. The Director of Service Delivery said that the discussion of the report at the Quality and Performance Committee was around how the performance measures were devised which is subjective with assurance provided from other forms and hard evidence with exceptions reported. The focus was on high level exception reporting.
- Ms Barber referred to the presentation of the Trust overview data which in her view raised serious concerns as to whether

it was presented accurately and provided assurance. Mr Norton added that the challenge is to sustain performance improvements and the evidence to date may indicate that this is not so which is a challenge for our Trust.
- The Chief Executive commented that General Managers should have input to the report. Work will be undertaken to revise the report format which should be completed within the next three months.

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

**RESOLVED**:- That the Integrated Performance Framework Report be noted as a source of assurance that the Executive Team and Divisional leaders are addressing the performance deficits highlighted in the report. [09:50]

**328/16 FINANCIAL PERFORMANCE REPORT**

The Director of Operational Finance presented the report providing an overview of the financial performance of our Trust as at the end of month six of the 2016/17 financial year. It provided the three primary financial statements and a high level analysis of variance and movements against the planned position to NHS Improvement. The key issue to note is that the financial position of our Trust at the end of month six of the 2016/17 financial year is an operational deficit of £8.7M which is an adverse variant to plan of £15.1M. There is a prior period adjustment reversed out of the current year to date position of £6.0M. Pay expenditure is showing an adverse variance of £6.3M against plan as at month six. This is largely driven by higher than planned levels of agency expenditure for both medical and nursing staff. As at month six, our Trust had delivered £2.7M of Cost Improvement Programme against the NHS Improvement plan of £9.0M; an adverse variance of £6.3M. During month six, Divisions have made a number of retrospective reclassifications and corrections which have impacted on the month six position. KPMG have been engaged to support a programme of work aimed at strengthening governance and reporting of the Cost Improvement Programme, to aid identification of further schemes for 2016/17 and support development of a full programme for 2017/18.

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

- Mr Foster asked for information on the payment of outstanding creditors. In response, the Director of Operational Finance said that many of the overdue payments have been made but the Better Payment Practice Code performance has not improved due to the oldest creditors being greater than the standard target. The Department of Health will not fund significant creditor reductions and these will need to be managed with supplier confidence. Mr Foster considered that this provided sufficient assurance.
- Mr Norton referred to the increase in agency expenditure and asked if this was under control. In response, the Director of Human Resources and Organisational Development believed so as this had been accepted by NHS Improvement. Our Trust is required to save £1M during the current financial year

and £5M in 2017/18. An Agency Programme Board has been established and that work is being assisted by KPMG. There are issues regarding the absence of real time data which is being addressed. Daily staff meetings are taking place to control expenditure. The use of Thornbury nurses will cease in November 2016. Surgery Division is transferring locum appointments to substantive appointments. Consistent reward mechanisms are being developed. Our Trust needs to continue with the work to make substantive appointments and increase bank staffing to reduce agency expenditure. There are currently 300 vacancies and the recruitment to substantive posts and banks, will offset agency expenditure. The use of management interims is being reviewed. Checks are being made to ensure that breaks are being logged correctly. The work being undertaken by KPMG is looking at reductions in the whole pay bill.

- In response to a question from Ms Macdonald, the Director of Operational Finance said that there is a deficit of £37M in month 6 and the prior year adjustment will be taken out in month seven.
- Ms Macdonald said that it was important to examine workforce numbers even if it was not possible at this stage to reconcile the financial position. The Director of Service Delivery suggested that our Trust should track cost per staff band to see movement. In response, the Director of Human Resources and Organisational Development said the data are currently six months behind. A weekly headcount tracker for agency staff is being introduced.

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

**RESOLVED**:- That:-

1) The financial position of the Trust at the end of month six of the 2016/17 financial year, an operational deficit of £8.7M which is an adverse variance to plan of £15.1M be noted.
2) The total prior period adjustment reversed from the current year to date position of £6.0M be noted.
3) Cost Improvement Programme performance has deteriorated in-month from a total delivery at month five of £3.2M to a delivery at month six of £2.7M reflecting both reclassification of schemes from cost improvement programme to cost avoidance and also correction of errors reported in prior months be noted.
4) The NHS Improvement Plan and the planning process that created it is not robust. 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 "plan" reflect the figures as submitted to NHS Improvement unless explicitly stated otherwise. [10:11]

## 329/16 EMERGENCY PATHWAY REPORT

The Director of Service Delivery presented the report providing the

Board with assurance that our Trust continues to address the previously identified concerns relating to delivery of emergency care within our Trust. The report provided evidence of progress against key quality, safety and performance indicators describing key risks and providing a progress update against the Emergency Care Programme Board milestone plan. The key issue to note is improved performance across the Emergency Care Pathway against continually rising demand despite not meeting the national standard. Whilst the NHS Improvement recovery trajectory was met for Q2; this is at risk for Q3 due to continued excess demand which both impact on the key success criterion of optimal occupancy. He said that there were seven days in September 2016 where there were over 400 attendances compared to two years' ago where 400 was attendances was exceptional. The issue for our Trust is to manage attendance peaks and troughs. Our Trust is seeing more patients within four hours than during last year. He acknowledged that some work had plateaued and there is a need to drive improvements and there is a link to Emergency Department performance and the Winter Plan. A new nationally endorsed initiative ""Red and Green Days" was launched at the 100 Leaders meeting for roll out in all wards during November 2016.

The Director of Service Delivery referred to the recent Discharge Summit with partner organisations where a strong commitment to work together was demonstrated with shared understanding. There is a system-wide reset during the next four weeks to enable patients to return home or to their place of residence when medically fit to do so. The Emergency Care Programme Board meets monthly to review progress with monthly meetings with NHS Improvement.

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

- The Chair asked if the Oxford model of discharging patients to their home or community hospital was being introduced in our County. In response, the Nursing Director said that our Trust supported this approach but there were concerns raised by other partners. However, the model is being progressed.
- The Chair asked if the physical capacity at Gloucestershire Royal Hospital is of the right size. In response, the Director of Clinical Strategy said that the Board had previously rejected a proposal to increase physical capacity of ED at GRH as it was considered that it would not improve space requirements. A capital bid was prepared designed to resolve ED capacity. Work stream 4 – Clinical Patient Flow Model – is designing new models of care with a community assessment and access service within ED where approximately 30% of patients arriving at ED could be referred and the issue is to identify space for those staff.
- Mr Norton referred to the new digital methodology for the Friends and Family Test launched in July 2016 which 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 2016 to 26% Trust-wide. Peer Trusts using the same methodology have reported response rates of about 20%.
- The Nursing Director reported on her meeting with NHS

Improvement on providing safe care and patient experience in ED. The 12 hour breach had been considered in great detail and the conclusion reached was that a safe service had been provided. Patients have indicated that the service is safe when the department is full. NHS Improvement is undertaking further work in relation food, drink, pain control and mattresses in ED.

- The Medical Director referred to the time to initial assessment and compliance with the standard of 15 minutes from arrival and although performance in September 2016 remains below the 90% target, there has been a significant improvement of approximately 27% against the February 2016 Trust-wide baseline. This improvement is against a backdrop of increasing demand. The Chief Executive observed that improvement needs to continue as our Trust is not seeing approximately 20% of patients within the standard. The Director of Service Delivery added that he will raise this issue with the next Operations Group as data are required as to whether this standard is being missed by one or two minutes or by thirty minutes. An analysis also needs to be undertaken as to time of day and which site to factor into the capacity and demand work regarding triage staff and the maximum number of patients who can be treated in fifteen minutes.
- The Chief Executive enquired whether Emergency Nurse Practitioners have been appointed in ED. In response, the Nursing Director said that such staff have been appointed but vacancies remain.

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

**RESOLVED**:- That the report be noted as a source of assurance that good progress continues to be made in the Emergency Care Programme Board and that all major risks to meeting the performance recovery trajectory are being actively managed. [10:26]

**330/16 NURSE AND MIDWIFERY STAFFING**

The Nursing Director presented the report providing assurance to the Board in respect of nurse staffing levels for September 2016 against the Compliance Framework "Hard Truths" – Safer Staffing Commitments. The key issues to note are that there were no major safety concerns arising from the staffing levels; however, the requirement for staffing establishments to be filled by temporary staffing solutions remained suboptimal and presented risks to the quality of care and team working on wards. 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 those areas. There is increasing evidence that the 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 2016. There is a pilot in Medicine Division where other staff are being used for non-nursing duties to release nurses for nursing duties. Skype is being increasingly used for overseas recruitment with positive results. Medicine Division is also undertaking a review of staffing at 8.00am which is significantly reducing agency expenditure as cover for sickness absence is being better managed with support being provided for staff on sick leave. A

pool of nurses with fixed off duty arrangements is being developed to provide more flexible cover. The KPMG Quality Impact Assessment is being used.

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

- The Chair referred to high turnover rate for both nurses and HCAs in Medicine Division. In response, the Director of Human Resources and Organisational Development said that turnover for nurses has been reduced to 16.64% (from 20.8%) and for HCAs to 21.04% (from 30%). The results from exit interviews in the Division have shown a lack of flexibility as a reason for leaving. The challenge is to balance individual working requirements and the service to be provided. Other issues are promotion and opportunities for career progression. The issue is not to lose staff but to encourage them to go on the bank.
- The Nursing Director commented on the learning on the roles for agency nurses. There are examples of where substantive staff members do not wish to work additional hours due to agency staff being used as they are unfamiliar with the wards. Some newly qualified nurses do not feel comfortable or qualified to run a ward shift. Our Trust is looking to support student nurses in their final placement with an approach being made to the University to provide an element for running a shift with support.
- The Chief Executive said that the number of Band 2 nursing vacancies is over establishment and she sought assurance that services are provided safely and that bank shifts are not being recorded as agency. In response, the Nursing Director said that many Band 2 nurses are from the Philippines. They have not yet completed the registration process and move to Band 5 when qualified. There is uncertainty as to how many times a nurse can fail the registration process before they are required to return to their country of origin. The Chief Executive added that this is a matter on which the Workforce Committee should seek assurance.
- The Medical Director referred to the harm free care in Surgery Division illustrating a beneficial impact on patient care.

The Chair thanked the Nursing Director for the report.

**RESOLVED**:- That the report brought assurance that our Trust is delivering safe staffing levels and has plans to maintain and improve upon this position be noted. [10:39]

**331/16 BOARD ASSURANCE FRAMEWORK**

The Chief Executive presented the report inviting the Board to note the 2016/17 Board Assurance Framework (BAF) stating that the BAF 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 the 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. Work is in progress to further refine the BAF

and the Trust Secretary has now undertaken a training course in preparation for assuming responsibility for the BAF. The Chief Executive stressed that the further refinement work does not affect the principle risks.

The Chair invited the Board to consider the risk ratings in the BAF and the following comments were made:-

- The Chair questioned whether the risk rating of 4 x 4 = 16 was appropriate for the risk of a poor patient experience arising from staff who failed to demonstrate the appropriate skills in respect of care, compassion and communication. In response, the Chief Executive said that further consideration would be given to assess whether the likelihood was a 2 or a 3.
- The Chair questioned whether the risk rating of 5 x 4 = 20 was appropriate for the risk of the inability to delivery financial targets caused by a failure to reduce expenditure as per plan particularly agency costs, reducing the ability to invest in our estate, affecting our monitor risk rating and Sustainability and Transformation Programme. In response, the Chief Executive said that it did not trigger a 5 x 5 = 25 but that the current risk rating will be reviewed.
- The Chief Executive said that the Board at a seminar should consider how the risks in the BAF are to be effective. **DL (MW to note for work plan)**

The Chair thanked the Chief Executive for the report.

**RESOLVED**:- That the updated Board Assurance Framework and the potential risks to the 2016/17 objectives and the controls in place to mitigate those risks be noted. [10:42]

**332/16 MEMORANDUM OF UNDERSTANDING FOR GLOUCETERSHIRE'S SUSTANABILITY AND TRANSFORMATION PLAN**

The Chief Executive presented the report providing an opportunity to approve the revised Memorandum of Understanding (MoU) which has been prepared for the development of Gloucestershire's Sustainability and Transformation Plan. In July 2016, the Board approved the MoU subject to the satisfactory resolution of textual amendments and satisfying clarification of the points which were raised then. Since that meeting a number of non-contentious changes have been made. The points previously raised by the Board have been incorporated into the revised document. The notable changes related to the introduction of the Gloucestershire Strategic Forum to provide a reporting line to partner organisations and changes to the wording around doctors with the introduction of the term "Lead Clinical" which is now being used for legal reasons to do with how medical responsibility is described.

The Chair commented that the revised MoU was now fit for purpose.

The Chair thanked the Chief Executive for the report.

**RESOLVED**:- That the revised MoU for the Gloucestershire Sustainability and Transformation Plan be approved and that the

Chief Executive and Trust Secretary be authorised to sign the final document. [10:46]

**333/16 PREPARATIONS FOR WINTER 2016/17**

The Director of Service Delivery presented the report informing the Board of the details of how our Trust is preparing for winter 2016/17. The report is to assure the Board that actions are being taken to ensure that services will be safe and operationally resilient to the anticipated pressures place on health services during the winter period. He apologised for the late submission of the report which was due to the outcome of the NHSI summit and the system-wide review held immediately before dispatch of the papers. The overriding objectives of the Winter Plan 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. Also, to achieve key areas of service performance in line with agreed recovery plan trajectories; including ED four hour performance, the waiting times standards for patients with suspected cancer and 18 week referral to treatment. The plan has been produced based on historical experience, the learning from previous winters, the current experience of our Trust's Emergency Care Programme both within our Trust and across Gloucestershire, and guidance from NHS Improvement and NHS England. The Director of Service Delivery said that the plan was not final as it depended on approval of the system-wide plan which will impact upon our plan. NHS England and NHS Improvement have reviewed the current documentation and have classified the risk rating as amber demonstrating not complete confidence.

The Director of Service Delivery said that the winter period for planning purposes covers October 2016 to March 2017 and 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. If nothing different is undertaken, the bed deficit is approximately 100 beds. The plan assumes maximum bed occupancy of 85% but current bed occupancy levels in the high 90s. The plan will be presented to the Quality and Performance Committee and the Board in November 2016 demonstrating mitigation on bed capacity. A Trust Communications Plan will be incorporated. The winter period remains at a heightened level of risk pending a solution to managing the actual and predicted excess demand.

**EG**
**(MW to note for Agenda)**

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

- Mr Norton asked if elective activity will be reduced. In response, the Director of Service Delivery said that not all operations will be cancelled as this will impact on referral to treatment performance. Consultants released from those operations which are cancelled will be reallocated to Outpatients and other areas. The Chief Executive added that this will be considered as part of the output from the Referral to Treatment Plan.
- Mrs Munro referred to the deficit bed capacity of

approximately 100 beds and asked what alternatives are in place should the system fail to deliver that capacity. In response, the Director of Service Delivery said that mitigation actions are being worked through with all partners. The Oxford model of providing care at home is not being progressed in our county and the issue is whether our Trust presses for the introduction of a similar model.

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

**RESOLVED**:- That:-

1) The report be approved;
2) The actions being taken be endorsed;
3) There is ongoing work with our partners across the health and social care services in Gloucestershire to ensure system-wide solutions to the pressures likely to be faced be noted. [10:55]

**334/16 SEVEN DAY SERVICES UPDATE**

The Medical Director presented the report providing assurance to the Board regarding the progress being made to provide a seven day service aimed at ensuring patients' discharge from hospital is not delayed due to a lack of specialist care at weekends. Our Trust has been identified as a national exemplar for work undertaken in the seven day services arena. NHS England is about to identify the Phase 2 cohort of Trusts and our Trust is aiming to become a Phase 2 Trust which will attract national funding. From the end of October 2016, the Gastroenterology Team will deliver ward rounds at weekends in both hospitals. They will also conduct weekend endoscopy lists. This approach has required the readjustment of job plans and will not require additional consultant cover but will require additional hours in reception and nursing.

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

- The Chief Executive enquired whether future proposals to deliver seven day services required investment. The Medical Director said in response that additional hours in reception and nursing will be required for the Gastroenterology Team. 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. The Director of Service Delivery added that an interim solution is being considered to provide cardiology services on one site and at weekends. The Medical Director stressed that there is no risk to patients and the evidence is that length of stay is reduced with patients being seen and discharged by a consultant if they are fit to do so.

The Chair thanked the Medical Director for the report.

**RESOLVED**:- That the report as a source of assurance of the progress being made to meet the national standards in relation to

seven day services and 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 be noted. [11:02]

**335/16 ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS**

**Any Other Business:**

Chair's Announcements:
The Chair informed the Board that:-

- She had attended the recent Annual Volunteers' Luncheon which was now combined for both sites. It was an enjoyable yet humbling event. Two certificates were presented to volunteers who had each achieved thirty years' service. There were many volunteers who had achieved between twenty and twenty-five years' service.
- The engagement enthusiasm demonstrated at the recent meeting of the 100 Leaders was exceptional.
- She had attended the opening of the Fairview Ophthalmology Outpatients Ward demonstrating the benefits of partnership working to provide an excellent standard of accommodation.

**Items for the next meeting:**
No further items were identified for the next meeting. [11:03]

**336/16 STAFF QUESTIONS**

There were none. [11:06]

**337/16 PUBLIC QUESTIONS**

There were none. [11:06]

**338/16 PROFESSOR CLAIR CHILVERS, CHAIR OF THE TRUST**

The Chief Executive said that this would be the last meeting which Professor Clair Chilvers would be attending as our Chair. She paid tribute to the considerable work undertaken by Professor Chilvers during her time with the Trust. On a personal level, she thanked Clair for the opportunity to be Chief Executive for which she would be always be grateful. The Medical Director thanked Professor Chilvers for her support and time. On behalf of the Board, he made a presentation to Professor Chilvers which was applauded.

Professor Chilvers said that she was sorry to be leaving the Trust in the current circumstances. She said that it had been a great privilege to work with the Board. She expressed confidence going forward that the Board will turn round the position as quickly as possible.

**339/16 DATE OF NEXT MEETING**

The next **Public** meeting of the **Main Board** will take place at **9.00am** on **Friday 25 November 2016** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital**.

**340/16 EXCLUSION OF THE PUBLIC**

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

The meeting ended at 11.07am.

**Chair**
**25 November 2016**

# GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

## MAIN BOARD – NOVEMBER 2016

## MATTERS ARISING

**CURRENT TARGETS**

| Target Date | Month/Minute/Item | Action with | Detail & Response |
|---|---|---|---|
| November 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. *The Director of Operational Finance undertook to provide this to the Board. Ongoing.* |
| November 2016 | October 2016 Minute 323/16 Summary of the meeting of the Quality and Performance Committee held on 26 October 29016 | **DL** | The Chair invited the Board to consider whether verbal reports from the Finance Committee and the Quality and Performance Committee which met two days before the Board meeting, provided sufficient assurance. The Chairs of the respective committees were content to provide verbal reports but there were concerns that a written report should be provided. This was an area which would be considered further. *It has now been agreed that written reports will be provided. Completed.* |
| November 2016 | October 2016 Minute 324/16 Minutes of the meeting of the Workforce Committee held on 14 October 2016 | **DS** | The Committee had agreed the Workforce Strategy which will be presented to the Board in November 2016. *This item appears later in te Agenda. Completed.* |
| November 2016 | October 2016 Minute 326/16 Board Committee Structure | **MW** | The Chief Executive said that the terms of reference of the Finance Committee need to be amended by the addition of point 11 regarding the approval of business cases above £500k.*This has been included in the Terms of Reference. Completed.*<br><br>The Board considered the Non-Executive Director linkages between the Finance, Quality and Performance and Audit and Assurance Committees in terms of clarity of purpose for the meetings. It was suggested that the Committee Chairs should meet regularly and Ms Barber undertook to provide a process for providing clarity. *Ongoing.*<br><br>The Chair invited members to provide any textual amendments to the Terms of Reference to the Trust Secretary. *No* |

| | | | |
|---|---|---|---|
| | | | *amendments were made. Completed.* |
| November 2016 | October 2016 Minute 331/16 Board Assurance Framework | **DL** | The Chief Executive said that the Board at a seminar should consider how the risks in the BAF are to be effective. *This has been included in the workplan. Completed as a Matter Arising.* |
| November 2016 | October 2016 Minute 333/16 Preparations for Winter 2016/17 | **EG** | The plan will be presented to the Quality and Performance Committee and the Board in November 2016. *This item appears later in the Agenda. Completed.* |

**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 |
|---|---|---|---|
| October 2016 | May 2016 Minute 234/16 Seven Day Services Update | **SE** | The Chair said that the 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 appeared 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. *The Nursing Director reported that nursing working arrangements had been updated to show when they were off duty and available for bank. The Medicine Division has introduced a scheme to deploy off duty nurses. The Finance Team are aware of the adjusted rostering and staffing is provided in* |

| | | | |
|---|---|---|---|
| | | | *accordance with the Keith Hurst benchmarking. Completed as a Matter Arising.* |
| 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. *Ms Barber reported that she is meeting the Director of Human Resources during the week following the Board meeting and this will form part of the work of the Workforce Committee. Completed as a Matter Arising.* |
| October 2016 | September 2016 Minute 294/16 Complaints and Concerns Q1 April – June 2016 | **MA** | Ms Barber said the level of qualitative 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. *The Nursing Director reported that this has been addressed for future reports. Completed.* |

# GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

## MAIN BOARD – NOVEMBER 2016

## REPORT OF THE CHIEF EXECUTIVE

### 1. Current Context

1.1 This month the Trust said goodbye to Professor Clair Chilvers, following two terms of office and whilst Professor Chilvers departed during challenging times in the Trust's recent history, many staff and partners gathered to recognise the very many positive things that Clair achieved during her tenure.

1.2 Peter Lachecki joined us as new Chair on the 7th November and I am personally looking forward to working positively with Peter, for the benefit of our staff and the patients we serve. Peter brings a wealth of both commercial and NHS experience and is already demonstrating his passion for health services and his commitment to support myself and the wider team through the challenges ahead.

1.3 The repercussions, associated with the news regarding the Trust's financial position, continue to be felt. In early November, the independent Financial Governance Review commenced. The Review, which aims to ensure that the Trust and its regulator, NHSI, learn from the recent failings in governance in order to ensure such a situation could not reoccur, is expected to report its findings in the second half of January 2017.

1.4 On the 15th November the Chief Executive and Mr Keith Norton, non-executive director, attended the Health and Care Overview and Scrutiny Committee meeting to provide an update on the Trust's financial position, our approach to recovery and the status of the independent review. The Trust has committed to return to the HCOSC on the 30th January, when the findings of the review will be made publically available.

### 2. National

2.1 There have been a number of national consultations launched in month and notably a consultation by the National Institute for Health and Care Excellence (NICE) and NHS England on changes to the arrangements for evaluating and funding new drugs and technologies. The consultation closes on the 13th January and the Trust executive lead will consider whether a Trust response is warranted.
https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-technology-appraisal-guidance/consultation-on-changes-to-technology-appraisals-and-highly-specialised-technologies

2.2 Nationally, the focus this month has been on the publication of Sustainability and Transformation Plans (STP) and commentators have been critical of the perceived reluctance of NHS England to advocate the early publication of plans. Gloucestershire published its STP on the 11th November and was one of a minority of health and care systems publishing the report this month.

### 3. Our System

3.1 As described above, partners have been working together to prepare for publication of the Gloucestershire STP. Our plan, called *One Gloucestershire – Transforming Care, Transforming Communities* sets out an ambitious vision and range of initiatives to address the challenges that we know will arise as a result of a growing and aging population.

3.2 The Plan has been positively welcomed by the majority of stakeholders and was described by members of the HCOSC to represent an exciting and innovative approach to the challenges ahead. Unsurprisingly, there have been calls for more detail on the plan and specifically any impact on the nature and location of health services. These plans will be the subject of public engagement over coming weeks, with options for any specific service change being consulted upon in the Summer of next year.

3.3 Key messages in the plan from Gloucestershire Hospitals are firstly a commitment to deliver services from both of our acute hospital sites; a recognition that the growing demands on acute health services mean that our more specialist services will be reserved for those that cannot be delivered at home or in the community – this means that services around us will need to adapt and develop and secondly, the message that if Gloucestershire people are to receive the very best care, with outcomes comparable to the best in the country, then we will need to bring some of our services together into centres of excellence where we can concentrate often scare expertise; without such an approach, patients run the risk of being required to travel further afield for their care.

3.4 I previously updated the Board on the Trust's bid for £69m of STP capital, to support the development of our estate and in so doing, enable the transformation of services. More questions have been asked of the Trust, by NHS England which I view to be a positive development though we have been advised that decisions are not likely until Q4 of the year.

## 4. Our Trust

4.1 The past month has seen a very significant focus on developing the Trust's financial recovery plan. This plan has to be presented before the regulator on the 29th November 2016, in line with the requirements of Financial Special Measures (FSM), having been shared with both the Board and its governors. This plan will form the basis of discussions with NHS improvement in respect of next year's control total, to which Sustainability and Performance funding will be linked.

4.2 The Plan requires the Trust to identify cost reductions in the order of 5-6% which whilst challenging reflects the scale of reductions other Trust's in FSM have achieved. The message remains clearly focused on reducing waste and promoting efficiency in the context that high quality care and good financial management, go hand in hand. In support of this approach we launched ideas@glos.nhs.uk in mid-November and received more than 30 ideas from staff in the first few days post launch – all of which are now being reviewed and hopefully developed into schemes which will save money whilst promoting best care.

4.3 The Trust Leadership Team met this month, to consider the plans for next year. In light of the current context, only those proposals which address intolerable risk, generate income above the investment or lead to net cost reduction were invited. The Leadership Team is now reviewing all of these proposals which will inform the Operational Plan for 2017/18. The team also received a "micro teaching" session on risk management reflecting the renewed focus on risk managements systems and processes, which will be driven by the new chaired Risk Management Group.

4.4 The Chief Executive and Chair represented the Trust at the inaugural Gloucestershire Health and Social Care Awards and were delighted to cheer on the Trust's Critical Care team who won the award for *Clinical Team of The Year,* Deborah Durrant, Clinical Nurse Specialist in liver services who won the *Health Care Professional of the Year* and Leela Terry, Pharmacist who was runner up and the Musculoskeletal Clinical Programme Group who won the *Together We Achieve* award and in which we have contributed significantly in developing the work.

4.5 How we care for the most vulnerable is a real test of how we care overall. If we get it right for these patients and their families, then the evidence tells us we will be getting it right for the majority. It was fantastic therefore to hear that two of our staff Sue Higgins, Epilepsy Nurse Specialist and Dr Emma Husbands, Consultant in Palliative Care were part of the team who won this year's Linda McEnhill award. This is given to those who excel in providing end-of-life care for patients with a learning disability.

4.6 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. This month we have undertaken a number of mock inspections visits, using "fresh eyes" from outside the organisation. As you'd expect, there was much positive feedback and also some very helpful insights into where we have further opportunities for improvement.

4.7 Finally, we have welcomed three new members into the operational team of the Trust. All have taken up interim roles, pending our recruitment into substantive posts early next year. Tasha Swinscoe joins us as Interim Chief Operating Officer (COO), Arshiya Khan as Director of Operations & Deputy COO and Wasique Chaudhry as Divisional Operations Director for Medicine.

**Deborah Lee**
**Chief Executive Officer**

November 2016

# ITEM 6

# REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE ON THE MEETING TO BE HELD ON 23 NOVEMBER 2016

## PAPER (To follow)

**Keith Norton**
Chair

## GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

## PUBLIC BOARD MEETING FRIDAY 25th NOVEMBER 2016

**Lecture Hall, Redwood Education Centre, Gloucester** 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 October 2016 for the financial year 2016/17. Please note due to the timing of the Board meeting in the month some performance data is invalidated.

Key issues to note

- The Trust continues to fail to meet the 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.
- Additional Divisional oversight arrangements are now established to ensure more robust development and delivery plans in the area of six week diagnostics, 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.
- Demand is rising in all key performance areas and this has been escalated to the Clinical Commissioning Group and NHS England to help us manage.
- The Executive Team and Quality and Performance Chair are currently developing a revised Performance Assurance Report

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 has been 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** |
| No change. |
| **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)** |
| 23 November 2016 | | | | 9 November 2016 | |

Gloucestershire Hospitals NHS
NHS Foundation Trust

# PERFORMANCE MANAGEMENT FRAMEWORK

2016/17

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## 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 | Oct | NHSI Weighting |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ***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% | 90.2% | 86.7% | 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% | 86.38% | 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% | 76.9% | 78.2% | 77.4% | 81.2% | 73.6% | 79.0% | 76.8% | 71.3% | 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% | 96.0% | 91.7% | 84.6% | 95.0% | 100% | 89.9% | 100% | 85.7% | |
| 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% | 100.0% | 98.1% | 100% | 100% | 98.1% | 100% | 100% | 97.9% | 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% | 100% | |
| Max wait 31 days decision to treat to subsequent treatment : Radiotherapy % | 94% | 100% | 98.6% | 99.8% | 100% | 100% | 100% | 100% | 100% | 100% | 98% | 100% | 100% | 100% | 100% | 100% | 98% | 100% | |
| Max wait 31 days decision to treat to treatment % | 96% | 99.6% | 99.8% | 99.5% | 100% | 99.5% | 99.7% | 100% | 99.8% | 99.1% | 99.2% | 98.6% | 99.6% | 99.0% | 99.2% | 99.7% | 98.8% | 97.1% | 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% | 88.6% | 88.4% | 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% | 95.7% | |
| ***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 | 1.0 |

In month position, therefore figure 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% | 86.00% | | | | | | | |
| % 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% | 86.38% | | | | | | | |
| *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% | 90.20% | 90.60% | 86.7% | | | | | | | |
| *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% | 1.40% | 1.14% | 1.85% | | | | | | | |
| *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% | 76.8% | 76.9% | 71.3% | | | | | | | |
| 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% | 73.1% | 71.3% | 71.3% | | | | | | | |

In month position, therefore figure not validated.

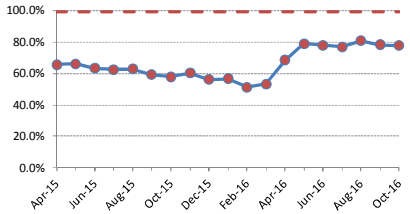
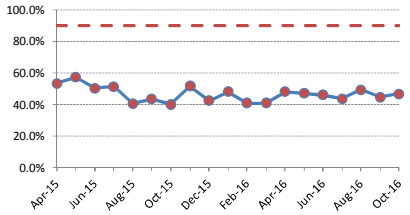
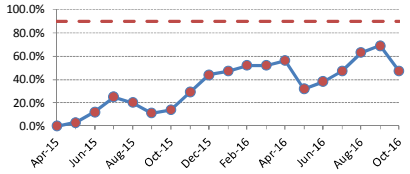
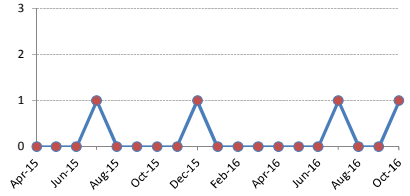
## TRUST PERFORMANCE & EXCEPTIONS (as at end October 2016)

### SAFETY

| MEASURE | LAST 12 MTHS | ACTUAL 2015/16 Q2 | Q3 | Q4 | 2016/17 Q1 | Q2 | Aug | Sep | Oct | FORECAST 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 | 1 | 4 | 1 | 3 | 5 | 4 | 3 | 3 | | 37 cases/year | NHSI | M | Oct |
| 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 | GCCG | M | Oct |
| *MORTALITY* | | | | | | | | | | | | | | | | | | | |
| Crude Mortality rates % |  | 1.0% | 1.2% | 1.4% | 1.2% | 1.1% | 1.1% | 1.2% | 1.1% | 1.2% | 1.2% | 1.2% | 1.2% | 1.2% | | <2% | Trust | M | Oct |
| Summary Hospital-Level Mortality Indicator |  | 109.7 | 110.7 | | | | | | | | | | | | | ≤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 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | | 0 | GCCG | M | Oct |
| % women seen by midwife by 12 weeks |  | 90.0% | 90.0% | 89.6% | 87.2% | 92.3% | 90.8% | 91.5% | 91.6% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | | >90% | GCCG | M | Oct |
| *CQUINS* | | | | | | | | | | | | | | | | | | | |
| Acute Kidney Infection (AKI) |  | 19% | 29% | 50% | 42% | 60% | 63% | 69% | 47.0% | 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% of eligibles | National | M | Jun |
| Sepsis Antibiotic Administration 2b |  | 32% | 43% | 49% | 55% | | | | | 90% | 90% | 90% | 90% | 90% | | >90% of eligibles | National | M | Jun |
| Dementia - Seek/Assess |  | 87.5% | 88.8% | 86.3% | 88.1% | 88.3% | 88.5% | 86.3% | 88.0% | 88% | 88% | 90% | 90% | 90% | | Q1>86%; Q2>87%; Q3>88%; Q4>90% | National | M | Sep |
| Dementia - Investigate |  | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | Q1>86%; Q2>87%; Q3>88%; Q4>90% | National | M | Oct |
| Dementia - Refer |  | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | Q1>86%; Q2>87%; Q3>88%; Q4>90% | National | M | Oct |
| *ED* | | | | | | | | | | | | | | | | | | | |
| % patients triaged in ED in 15 minutes |  | 61.4% | 57.9% | 53.7% | 75.3% | 78.6% | 80.8% | 78.2% | 77.7% | | | | | | | ≥ 99% | Trust | M | Oct |
| % patients assessed by doctor in ED in 60 minutes |  | 45.4% | 44.7% | 43.3% | 47.1% | 46.0% | 49.4% | 44.9% | 46.8% | | | | | | | ≥ 90% | Trust | M | Oct |

In month position, therefore figure not validated.

## SAFETY

| MEASURE | | Q4 | Q1 | Q2 NOW | FOT | OWNER |
|---|---|---|---|---|---|---|
| **% patients triaged in ED in 15 minutes**<br>Standard is ≥ 99% |  | | | | | Director of Nursing and Midwifery |
| | | | | | | The actions to address this standard are part of the Emergency Care Programme. Please refer to the Emergency Care Pathway Report for further information. |
| **% patients assessed by doctor in ED in 60 minutes**<br>Standard is ≥ 90% |  | | | | | Director of Safety |
| | | | | | | The actions to address this standard are part of the Emergency Care Programme. Please refer to the Emergency Care Pathway Report for further information. |
| **Acute Kidney Infection (AKI)**<br>Standard is >90% by Q4 |  | | | | | Director of Safety |
| | | | | | | The October figure of 47 has not yet been ratified. The target is a quarterly target but this puts us at risk of non-achievement.<br>Current actions to improve performance:<br>Restart AKI reports from Path lab for AKI 2-3 for pharmacist to follow up<br>Continue the Renal team using stickers for referrals (For AKI 2&3)<br>Continue feeding back results - Directly.<br>Create a performance based monthly award<br>Deliver December education slots to F1 & F2<br>New series of testing to improve use of AKI alert stickers<br>Update Education module. |
| **Number of Never Events**<br>Standard is 0 |  | | | | | Director of Safety |
| | | | | | | One Never event in October in Ophthalmology/Surgery - Insertion of wrong implant.<br>A full investigation is underway following Serious Incident and Duty of Candour processes.<br>Trust board informed.<br>Reported to CCG |

## TRUST PERFORMANCE & EXCEPTIONS (as at end October 2016)

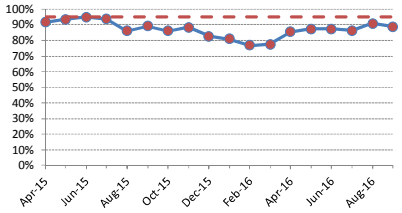
## RESPONSIVE

| MEASURE | LAST 12 MTHS | ACTUAL 2015/16 Q2 | Q3 | Q4 | 2016/17 Q1 | Q2 | Aug | Sep | Oct | FORECAST 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% | 90.9% | 88.9% | 86.38% | 91.2% | 85.7% | 85.1% | 80.1% | 89.6% | | ≥ 95% | NHSI | M | Oct |
| Number of ambulance handovers delayed over 30 minutes |  | 212 | 241 | 428 | 517 | 541 | 155 | 187 | 186 | 80 | 90 | 100 | 100 | 90 | | < previous year | GCCG | M | Oct |
| Number of ambulance handovers delayed over 60 minutes |  | 21 | 28 | 33 | 3 ** | 1 | 1 | 0 | 1 | 10 | 11 | 11 | 11 | 9 | | < previous year | GCCG | M | Oct |
| *18 WEEKS* | | | | | | | | | | | | | | | | | | | |
| Incomplete pathways - % waited under 18 weeks |  | 92.1% | 92.2% | 92.0% | 92.0% | 90.6% | 90.9% | 90.2% | 86.7% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | | ≥ 92% | NHSI | M | Sep |
| 15 key Diagnostic tests : % waiting over 6 weeks at month end |  | 5.9% | 1.5% | 4.0% | 2.6% | 1.1% | 0.47% | 1.5% | 1.85% | 1.0% | 1.0% | 1.0% | 1.0% | 1.0% | | <1% waiting at month end | GCCG | M | Sep |
| Planned/surveillance endoscopy patients - nos. waiting at month end with and without dates |  | 341 | 142 | 225 | 441 | 405 | 479 | 405 | 350 | 150 | 100 | 100 | 100 | 100 | | < 1% waiting at month end | GCCG | M | Oct |
| *CANCER* | | | | | | | | | | | | | | | | | | | |
| Max 2 week wait for patients urgently referred by GP % |  | 90.3% | 92.4% | 88.7% | 84.9% | 88.2% | 86.2% | 88.6% | 88.4% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | | ≥ 93% | NHSI | M | Sep |
| Max 2 week wait for patients referred with non cancer breast symptoms % |  | 91.8% | 93.4% | 95.3% | 93.1% | 93.7% | 93.4% | 96.4% | 95.7% | 94.0% | 94.0% | 94.0% | 94.0% | 94.0% | | ≥ 93% | NHSI | M | Sep |
| Max wait 31 days decision to treat to treatment % |  | 99.7% | 100% | 99.8% | 99.1% | 99.2% | 99.7% | 98.8% | 97.1% | 100% | 100% | 100% | 100% | 100% | | ≥ 96% | NHSI | M | Sep |
| Max wait 31 days decision to treat to subsequent treatment : surgery % |  | 100% | 99.5% | 99.5% | 99.4% | 99.4% | 100.0% | 100.0% | 97.9% | 100% | 100% | 100% | 100% | 100% | | ≥ 94% | NHSI | M | Sep |
| 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% | | ≥ 98% | NHSI | M | Sep |
| Max wait 31 days decision to treat to subsequent treatment : Radiotherapy % |  | 100% | 100% | 100% | 100% | 99.5% | 100.0% | 98.3% | 100% | 100% | 100% | 100% | 100% | 100% | | ≥ 94% | NHSI | M | Sep |
| Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) % |  | 75.6% | 79.5% | 76.7% | 79.0% | 76.9% | 79.0% | 76.8% | 71.3% | 85.0% | 85.0% | 85.0% | 85.0% | 85.0% | | ≥ 85% | NHSI | M | Sep |
| Max wait 62 days from national screening programme to 1st treatment % |  | 94.0% | 95.6% | 94.9% | 90.6% | 96.0% | 89.9% | 100.0% | 85.7% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | | ≥ 90% | NHSI | M | Sep |
| Max wait 62 days from consultant upgrade to 1st treatment % |  | 92.9% | 100% | 100% | 100% | 71.4% | 100.0% | 100.0% | arrears | 100% | 100% | 100% | 100% | 100% | | ≥ 90% | NHSI | M | Sep |

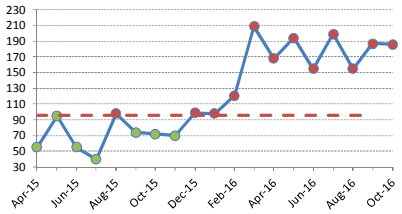
**Please note: The 3 ambulance delays reported in April 2016, have now been validated and are no longer breaches.

In month position, therefore figure not validated.

**RESPONSIVE**

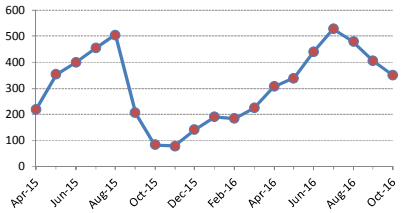
| MEASURE | | Q4 | Q1 | Q2 | NOW | FOT | OWNER |
|---|---|---|---|---|---|---|---|
| **% patients spending 4 hours or less in ED**<br>**Standard is ≥95%** |  | | | | | | Director of Service Delivery |

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Number of ambulance handovers delayed over 30 minutes**<br>**Standard is < last year** |  | | | | | | Director of Service Delivery |

Please refer to the Emergency Pathway Report. There was one over 60 minute ambulance delay on 21st October 2016 in CGH.

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**<br>**Standard is < 1% waiting at month end** |  | | | | | | Director of Service Delivery |

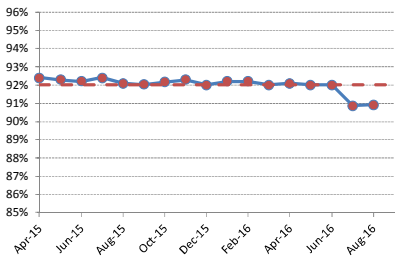
August – October (Work completed)
Additional activity has been completed throughout August, September and October in order to stabilise the Diagnostic 6ww position and reduction of the overdue Planned Surveillance patient backlog. To date 56 additional WLI sessions have been completed by staff and an 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.

November 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 additional Endoscopy 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.

## MEASURE

| Q4 | Q1 | Q2 NOW | FOT | OWNER |
|---|---|---|---|---|
| | | | | Director of Service Delivery |

**Incomplete pathways - % waited under 18 weeks**
Standard is ≥ 92%




Under performance in the standard is in the main attributable to oral surgery with underlying pressures in Urology, General Surgery, Gynaecology and ENT. Please note, that due to the timing of the board meeting, the data is not fully validated for October. However, early indications for October's performance is showing the standard will not be met with the same area 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 October 2016

Gloucestershire Hospitals NHS
NHS Foundation Trust

| 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 | 1575 | 544 | 2119 | 74.3% | 4910 | 221 | 5131 | 95.7% | 6485 | 765 | 81 | 0 | 7250 | 89.4% |
| 101 | Urology | 585 | 366 | 951 | 61.5% | 1699 | 220 | 1919 | 88.5% | 2284 | 586 | 120 | 3 | 2870 | 79.6% |
| 110 | Trauma and | 1889 | 571 | 2460 | 76.8% | 3514 | 189 | 3703 | 94.9% | 5403 | 760 | 49 | 0 | 6163 | 87.7% |
| 120 | ENT | 313 | 46 | 359 | 87.2% | 2895 | 325 | 3220 | 89.9% | 3208 | 371 | 12 | 0 | 3579 | 89.6% |
| 130 | Ophthalmology | 1224 | 116 | 1340 | 91.3% | 3500 | 103 | 3603 | 97.1% | 4724 | 219 | 4 | 0 | 4943 | 95.6% |
| 140 | Oral Surgery | 317 | 168 | 485 | 65.4% | 2480 | 767 | 3247 | 76.4% | 2797 | 935 | 192 | 1 | 3732 | 74.9% |
| 170 | Cardiothoracic Surgery | 0 | 0 | 0 | N/A | 27 | 0 | 27 | 100.0% | 27 | 0 | 0 | 0 | 27 | 100.0% |
| 300 | General Medicine | 0 | 0 | 0 | N/A | 648 | 29 | 677 | 95.7% | 648 | 29 | 2 | 0 | 677 | 95.7% |
| 301 | Gastroenterology | 675 | 90 | 765 | 88.2% | 2119 | 137 | 2256 | 93.9% | 2794 | 227 | 24 | 0 | 3021 | 92.5% |
| 320 | Cardiology | 113 | 13 | 126 | 89.7% | 1726 | 164 | 1890 | 91.3% | 1839 | 177 | 25 | 0 | 2016 | 91.2% |
| 330 | Dermatology | 3 | 0 | 3 | 100.0% | 3120 | 207 | 3327 | 93.8% | 3123 | 207 | 3 | 0 | 3330 | 93.8% |
| 340 | Respiratory Medicine | 22 | 2 | 24 | 91.7% | 952 | 90 | 1042 | 91.4% | 974 | 92 | 6 | 0 | 1066 | 91.4% |
| 400 | Neurology | 15 | 4 | 19 | 78.9% | 1532 | 70 | 1602 | 95.6% | 1547 | 74 | 6 | 0 | 1621 | 95.4% |
| 410 | Rheumatology | 44 | 3 | 47 | 93.6% | 880 | 125 | 1005 | 87.6% | 924 | 128 | 4 | 0 | 1052 | 87.8% |
| 430 | Geriatric Medicine | 0 | 0 | 0 | N/A | 1 | 0 | 1 | 100.0% | 1 | 0 | 0 | 0 | 1 | 100.0% |
| 502 | Gynaecology | 364 | 70 | 434 | 83.9% | 1914 | 237 | 2151 | 89.0% | 2278 | 307 | 8 | 0 | 2585 | 88.1% |
| X01 | Other | 326 | 10 | 336 | 97.0% | 4789 | 887 | 5676 | 84.4% | 5115 | 897 | 12 | 0 | 6012 | 85.1% |
| TOTAL | | 7465 | 2003 | 9468 | 78.8% | 36706 | 3771 | 40477 | 90.7% | 44171 | 5774 | 548 | 4 | 49945 | 88.44% |

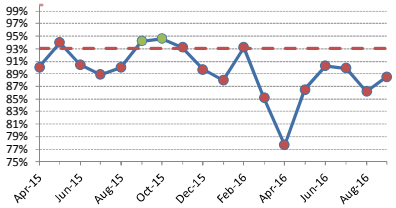
**RESPONSIVE**

## MEASURE

| Q4 | Q1 | Q2 NOW | FOT | OWNER |
|---|---|---|---|---|
| | | | | Director of Service Delivery |

**Max 2 week wait for patients urgently referred by GP**

**Standard is ≥93%**




October's performance is 88.4% against a trajectory plan to meet the standard of 93%. Under-performance in the main is due to patient choice, availability and cancellations with some capacity issues within Urology. The capacity issues within Urology have now been addressed. Higher than expected breaches were experienced in Gastro-intestinal, Colorectal and Urological cancers. 2 week wait demand continues to be a pressure across most tumour sites with a 15% increase in referrals (1,544 referrals) in the year to date compared to the same period in 2015/16. Services have been reviewing their clinic templates to align 2 week wait demand with clinic structures. There have been no breaches since mid October due to capacity reasons, all breaches to date are due to patient choice, availability or patient cancellations. The Trust is working with the CCG to address these patient choice issues.

| | July 16 (current) | | | August 16 (current) | | | September 16 (current) | | | Q2 to date | October 16 | | | Average treatments / month (rolling 12 months) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Target | Latest Position | Breaches | Treatments | Latest Position | Breaches | Treatments | Latest Position | Breaches | Treatments | | Latest Position | Breaches | Treatments | |
| 93% | 89.9% | 172 | 1699 | 86.2% | 243 | 1766 | 88.6% | 191 | 1685 | 88.2% | 88.4% | 199 | 1721 | 1644 |
| Brain / CNS | 94.4% | 1 | 18 | 65.0% | 7 | 20 | 73.1% | 7 | 26 | 76.6% | 95.8% | 1 | 24 | 22 |
| Breast | 96.0% | 10 | 250 | 97.0% | 8 | 269 | 97.4% | 6 | 233 | 96.8% | 96.7% | 8 | 245 | 261 |
| Gynaecological | 95.3% | 7 | 148 | 94.0% | 9 | 149 | 96.3% | 4 | 107 | 95.0% | 96.8% | 4 | 124 | 119 |
| Haematological * | 53.3% | 7 | 15 | 34.8% | 15 | 23 | 90.9% | 1 | 11 | 53.1% | 75.0% | 4 | 16 | 10 |
| Head & Neck | 85.3% | 26 | 177 | 94.0% | 10 | 167 | 94.9% | 10 | 196 | 91.5% | 89.9% | 18 | 179 | 166 |
| Lower GI | 93.5% | 21 | 325 | 95.1% | 15 | 308 | 92.1% | 26 | 331 | 93.6% | 91.8% | 26 | 319 | 317 |
| Lung | 97.4% | 1 | 38 | 95.7% | 2 | 47 | 95.7% | 2 | 46 | 96.2% | 100.0% | 0 | 34 | 47 |
| Skin | 89.0% | 41 | 372 | 76.6% | 98 | 418 | 94.0% | 22 | 368 | 86.1% | 90.0% | 32 | 321 | 304 |
| Testicular | 88.9% | 2 | 18 | 75.0% | 4 | 16 | 77.3% | 5 | 22 | 80.4% | 68.2% | 7 | 22 | 16 |
| Upper GI | 92.1% | 13 | 165 | 93.7% | 10 | 159 | 87.7% | 20 | 163 | 91.2% | 80.1% | 42 | 211 | 186 |
| Urological | 75.1% | 43 | 173 | 64.6% | 64 | 181 | 51.6% | 88 | 182 | 63.6% | 74.8% | 57 | 226 | 196 |

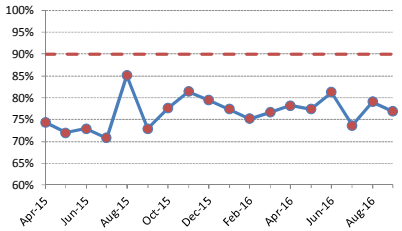
* Excludes acute leukaemia

**RESPONSIVE**

## MEASURE

**Max wait 62 days from national screening programme to 1st treatment**

**Standard is ≥90%**




| Q4 | Q1 | Q2 NOW | FOT |
|---|---|---|---|
| | | | |

**OWNER**

Director of Service Delivery

September's performance is 76.8% against a trajectory of 80.8%. The Trust had 0.5 more treatments and 6 more breaches than projected in September (163 treatments and 37 breaches) with more breaches than projected in Haematology, Breast and Urology. October's data is still incomplete, however early indications show that this is just behind trajectory (71.4% vs 72.2%). This is due to a backlog clearance, particularly in Urology. The number of patients waiting more than 62 weeks is reducing week on week with a 16% (-36) reduction since the recovery plan started, which is driving the under-performance. The Trust has agreed a recovery trajectory plan with the CCG and NHSI with the standard being met and sustained from January 2017.

| | July 16 (current) | | | August 16 (current) | | | September 16 (current) | | | Q2 to date | October 16 | | | Average treatments / month |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Target | Latest Position | Breaches | Treatments | Latest Position | Breaches | Treatments | Latest Position | Breaches | Treatments | | Latest Position | Breaches | Treatments | |
| 85% | 73.6% | 37.5 | 150.0 | 79.0% | 29.5 | 140.5 | 76.8% | 37.0 | 163.0 | 77.1% | 71.3% | 41.0 | 143.0 | 152 |
| Breast | 90.0% | 2.0 | 20.0 | 100.0% | 0.0 | 27.0 | 91.7% | 2.0 | 24.0 | 94.4% | 100.0% | 0.0 | 17.0 | 25 |
| Gynaecological | 67.7% | 5.0 | 15.5 | 70.6% | 2.5 | 8.5 | 80.6% | 3.0 | 15.5 | 73.4% | 68.8% | 5.0 | 16.0 | 10 |
| Haematological* | 42.9% | 4.0 | 7.0 | 55.6% | 4.0 | 9.0 | 59.1% | 4.5 | 11.0 | 53.7% | 50.0% | 4.0 | 8.0 | 8 |
| Head & Neck | 66.7% | 2.0 | 6.0 | 94.1% | 0.5 | 8.5 | 85.7% | 0.5 | 3.5 | 83.3% | 58.3% | 2.5 | 6.0 | 8 |
| Lower GI | 54.8% | 9.5 | 21.0 | 88.9% | 1.0 | 9.0 | 68.4% | 6.0 | 19.0 | 66.3% | 90.3% | 1.5 | 15.5 | 17 |
| Lung | 82.6% | 2.0 | 11.5 | 57.7% | 5.5 | 13.0 | 84.0% | 2.0 | 12.5 | 74.3% | 64.7% | 6.0 | 17.0 | 12 |
| Other | 33.3% | 2.0 | 3.0 | 100.0% | 0.0 | 4.0 | 66.7% | 1.0 | 3.0 | 70.0% | 100.0% | 0.0 | 2.0 | 2 |
| Sarcomas | 66.7% | 1.0 | 3.0 | | | | | | | 66.7% | | | | 1 |
| Skin | 100.0% | 0.0 | 34.0 | 100.0% | 0.0 | 28.0 | 95.8% | 1.5 | 35.5 | 98.5% | 95.0% | 1.0 | 20.0 | 30 |
| Upper GI | 87.0% | 1.5 | 11.5 | 75.0% | 3.0 | 12 | 95.5% | 0.5 | 11.0 | 85.5% | 89.5% | 1.0 | 9.5 | 13 |
| Urological | 51.4% | 8.5 | 17.5 | 38.1% | 13.0 | 21 | 42.9% | 16.0 | 28.0 | 43.6% | 37.5% | 20.0 | 32.0 | 27 |

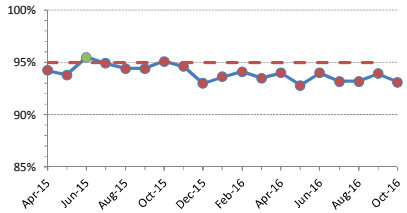
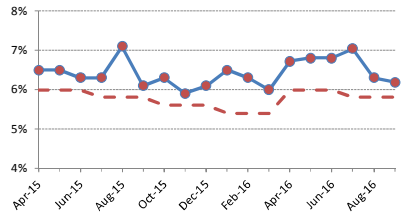
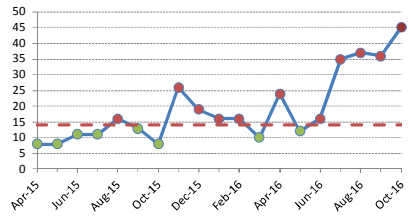
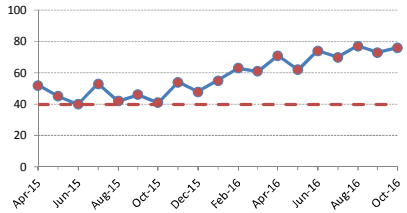
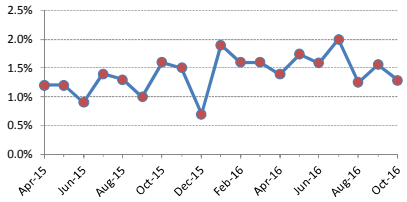
## TRUST PERFORMANCE & EXCEPTIONS (as at end October 2016)

## EFFECTIVE

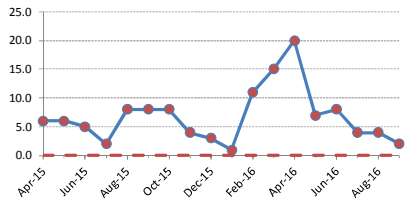
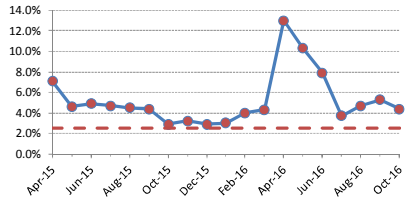
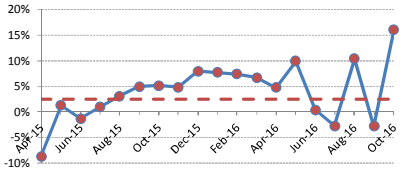
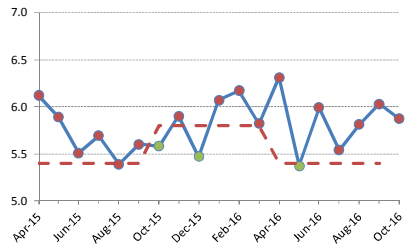
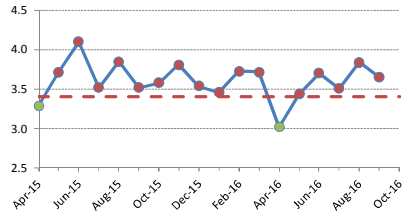
| MEASURE | LAST 12 MTHS | ACTUAL 2015/16 Q2 | Q3 | Q4 | 2016/17 Q1 | Q2 | Aug | Sep | Oct | FORECAST Nov | Dec | Jan | Feb | Mar | FoT | Standard | Target Set By | How often | Data Month |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *CLINICAL OPERATION* | | | | | | | | | | | | | | | | | | | |
| % stroke patients spending 90% of time on stroke ward |  | 78.7% | 91.4% | 86.0% | 85.1% | 90% | 96.2% | 84.0% | 85.7% | 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% | 93.9% | 93.1% | 93.0% | 93.0% | 93.0% | 93.0% | 93.0% | | > 95% | GCCG | M | Oct |
| Emergency re-admissions within 30 days - following an elective or emergency spell |  | 6.4% | 6.1% | 6.4% | 6.7% | arrears | 6.3% | 6.2% | arrears | 6.4% | 6.4% | 6.4% | 6.4% | 6.4% | | Q1<6%; Q2<5.8%; Q3<5.6%; Q4<5.4% | Trust | M | Sep |
| Number of Breaches of Mixed sex accommodation |  | 0 | 17 | 30 | 19 | 9 | 4 | 0 | 0 | 0 | 5 | 10 | 0 | 0 | | 0 | GCCG | M | Oct |
| Number of delayed discharges at month end (DTOCs) |  | 13 | 19 | 10 | 16 | 36 | 37 | 36 | 45 | 14 | 16 | 16 | 16 | 16 | | <14 | Trust | M | Oct |
| No. of medically fit patients - over/day |  | 47 | 48 | 60 | 69 | 73 | 77 | 73 | 76 | 40 | 40 | 40 | 40 | 40 | | ≤ 40 | Trust | M | Oct |
| Bed days occupied by medically fit patients |  | 1,446 | 1,457 | 1,791 | 2,086 | 2,252 | 2,398 | 2,198 | 2,355 | 1,450 | 1,450 | 1,450 | 1,450 | 1,450 | | None | Trust | M | Oct |
| Patient Discharge Summaries sent to GP within 24 hours |  | 89.1% | 88.6% | 85.6% | 85.7% | 88.3% | 89.5% | 87.6% | 88.2% | 88.5% | 88.5% | 88.5% | 88.5% | 88.5% | | ≥85% | GCCG | M | Sep |
| *BUSINESS OPERATION* | | | | | | | | | | | | | | | | | | | |
| Elective Patients cancelled on day of surgery for a non medical reason |  | 1.2% | 1.3% | 2.0% | 1.6% | 1.6% | 1.3% | 1.6% | 1.3% | | | | | | | ≤ 0.8% | Trust | M | Oct |
| Patients cancelled and not rebooked in 28 days |  | 18 | 15 | 27 | 35 | 10 | 4 | 2 | 3 | | | | | | | 0 | GCCG | M | Oct |
| GP referrals year to date - within 2.5% of previous year |  | 4.4% | 2.9% | 3.7% | 7.9% | 5.1% | 4.7% | 5.3% | 4.4% | | | | | | | range +2.5% to -2.5% | Trust | M | Oct |
| Elective spells year to date - within 2.5% of plan |  | 5.1% | 5.0% | 7.3% | 4.9% | 1.6% | 10.4% | -2.8% | 16.1% | 1.0% | 1.0% | 1.0% | 1.0% | 1.0% | | range ≥-1% to plan | Trust | M | Oct |
| Emergency Spells year to date - within 2.5% of plan |  | 4.0% | 6.9% | 7.1% | 7.7% | 3.8% | 1.3% | 2.9% | 1.7% | 1.0% | 1.0% | 1.0% | 1.0% | 1.0% | | range ≤2.5% over plan | Trust | M | Oct |
| LOS for general and acute non elective spells |  | 5.6 | 5.7 | 6.0 | 5.9 | 5.8 | 5.8 | 6.0 | 5.9 | 5.4 | 5.4 | 5.4 | 5.4 | 5.4 | | Q1 /Q2 <5.4days, Q3 /Q4 <5.8days | Trust | M | Oct |
| LOS for general and acute elective IP spells |  | 3.6 | 3.6 | 3.6 | 3.3 | 3.7 | 3.8 | 3.7 | 3.5 | 3.6 | 3.5 | 3.5 | 3.6 | 3.6 | | ≤ 3.4 days | Trust | M | Oct |
| OP attendance & procedures year to date - within 2.5% of plan |  | 0.6% | 0.6% | | 0.5% | -1.5% | 3.0% | -6.1% | 0.4% | 0.2% | 0.2% | 0.2% | 0.2% | 0.2% | | range +2.5% to -2.5% | Trust | M | Oct |
| Records submitted nationally with valid GP code (%) |  | 100% | 100% | 99.9% | 99.9% | arrears | 100% | 100% | arrears | 100% | 100% | 100% | 100% | 100% | | ≥ 99% | Trust | M | Sep |
| 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% | Trust | M | Sep |

In month position, therefore figure not validated.

**EFFECTIVE**

| MEASURE | | Q4 | Q1 | Q2 | NOW | FOT | OWNER |
|---|---|---|---|---|---|---|---|
| **% of eligible patients with VTE risk assessment**<br>Standard is >95% |  | | | | | | Trust Medical Director |
| | | Further improvements to embed the system changes in the process and team ownership in ACUA are being made to improve the position.<br><br>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.<br><br>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**<br>Standard is Q1<6%; Q2<5.8%; Q3<5.6%; Q4<5.4% |  | | | | | | Trust Medical Director |
| | | Readmissions are an important indicator as a balancing measure in our PMF. We will continue to monitor this closely and review readmissions to ensure any learning from these cases is used to improve patient care. | | | | | |
| **Number of delayed discharges at month end (DTOCs)**<br>Standard is <14 |  | | | | | | Director of Service Delivery |
| | | Please refer to Emergency Care Report. | | | | | |
| **No. of medically fit patients - over/day**<br>Standard is <40 |  | | | | | | Director of Service Delivery |
| | | Please refer to Emergency Care Report.<br>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. | | | | | |
| **Elective Patients cancelled on day of surgery for a non medical reason**<br>Standard is <0.8% |  | | | | | | Director of Service Delivery |
| | | The increase in the number of medically fit patients and level of emergency admissions impacted on this measure. The Surgical Division focus has been adjusted to reduce the number of cancellations on the day with a process established to review all elective activity daily. Out of 81 cancellations in October the largest volumes were: 15 trauma and orthopaedics, 14 ophthalmology. | | | | | |

**EFFECTIVE**

| MEASURE | | Q4 | Q1 | Q2 | NOW | FOT | OWNER |
|---|---|---|---|---|---|---|---|
| **Patients cancelled and not rebooked in 28 days**<br>Standard is 0% |  | 🔴 | 🔴 | 🔴 | 🔴 | 🟢 | Director of Service Delivery |
| | | This is an improving position and performance managed daily.<br><br>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**<br>Standard is range +2.5% to -2.5% |  | 🟡 | 🔴 | 🔴 | 🔴 | 🔴 | Director of Service Delivery |
| | | GP referrals continue to rise and there is ongoing dialog with Gloucestershire CCG in respect of demand management. | | | | | |
| **Elective spells year to date -**<br>Standard is within 2.5% of plan |  | 🔴 | 🔴 | 🔴 | 🔴 | 🔴 | Director of Service Delivery |
| | | Impact of implementing CHKS audit results. The activity quoted below relates to month 1-7 activity adjustments falling into October reporting.<br>Foam sclerotherapy activity moved from daycases to outpatients (-263 in October 2016)<br>Allergic rhinitis activity moved to non-PbR outpatients (-118)<br>Surgical management of miscarriage activity moved from emergency to elective (+99) | | | | | |
| **LOS for general and acute non elective spells**<br>Standard is Q1/Q2 <5.4days, Q3 Q4 ≤5.8days |  | 🟡 | 🔴 | 🔴 | 🔴 | 🔴 | Director of Service Delivery |
| | | Length of stay has increased in the winter months and remains an issue. The Gloucestershire wide action plan has been reviewed across the health community to reflect the urgent requirement to improve performance. Increase in the numbers of medically fit patients has exacerbated the length of stay.<br><br>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.<br><br>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**<br>Standard is ≤3.4 days |  | 🔴 | 🟢 | 🔴 | 🔴 | 🔴 | Director of Service Delivery |
| | | The Trust has commenced in October 2016 the use of red and green days to identify any internal delays that may affect patient flow. | | | | | |

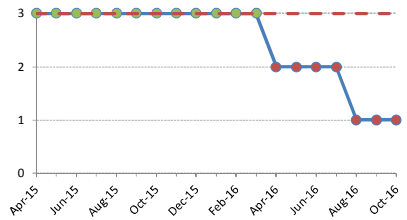
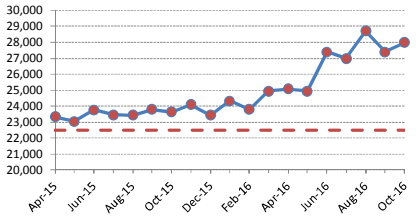
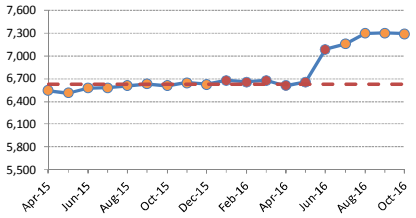
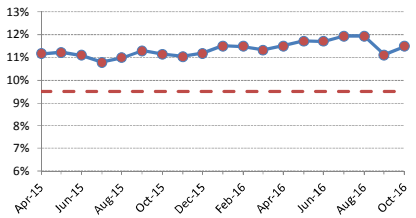
## TRUST PERFORMANCE & EXCEPTIONS (as at end October 2016)

### WELL LED

| MEASURE | LAST 12 MTHS | ACTUAL 2015/16 Q2 | Q3 | Q4 | 2016/17 Q1 | Q2 | Aug | Sep | Oct | FORECAST 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 | 1 | 1 | 1 | 1 | 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 | -£23.8 | TBC | -£23.8 | -£23.9 | 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 | £83.1m | £28.7m | £27.4m | £28.0m | TBC | TBC | TBC | TBC | TBC | | Target + 0.5% | Trust | M | Aug |
| Total worked WTE |  | 7,071 | 7,098 | 7,153 | 7,121 | 7,299 | 7,295 | 7,299 | 7,290 | 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% | 3.9% | 3.8% | 3.6% | 3.8 | 3.8 | 3.8 | 3.8 | 3.8 | | green < 3.6% red >4% | Trust | M | Sep |
| Turnover rate (FTE) |  | 11.3% | 11.1% | 11.7% | 11.6% | 11.8% | 11.9% | 11.1% | 11.5% | 11.7 | 11.7 | 11.7 | 11.7 | 11.7 | | 7.5-9.5% | Trust | M | Sep |
| Staff who have annual appraisal (%) |  | 83% | 83% | 83% | 83% | 80% | 81% | 80% | 80% | 85.0 | 85.0 | 85.0 | 85.0 | 85.0 | | green >89% red < 80% | Trust | M | Oct |
| 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 | | > 3.8 | Trust | A | Oct |
| Staff who completed mandatory training (%) |  | 92% | 91% | 91% | 92% | 92% | 92% | 91% | 91% | 91.0 | 91.0 | 91.0 | 91.0 | 91.0 | | > 90% | Trust | M | Oct |
| 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 | Trust | A | Oct |
| 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 | | > 38% | Trust | A | Oct |

In month position, therefore figure not validated.

**WELL LED**

| MEASURE | | Q4 | Q1 | Q2 | NOW | FOT | OWNER |
|---|---|---|---|---|---|---|---|
| **NHSI Financial Risk Rating**<br>Standard is Level 3 |  | | | | | | Director of Finance |
| | | | | | | | Please refer to the Trust Finance report for a full explanation of the drivers of the Trust financial performance. |
| **Total PayBill spend £M**<br>Standard is Target + 0.5% |  | | | | | | Director of Finance |
| | | | | | | | The Trust total PayBill for October is £28.0m. This is in line with the last two months once prior year accounting adjustments have been taken into account. |
| **Total worked WTE**<br>Standard is Target + 0.5% |  | | | | | | Director of Service Delivery |
| | | | | | | | The worked WTEs has also been revised for current and previous months to ensure consistency with the NHSI plan and with the Total Pay Bill above. The figure now reflects the Trust Total which includes Hosted GP Services and Shared Services.<br>The Trust total WTEs for October is 7290 WTEs which is in line with both August and September. |
| **Turnover rate (FTE)**<br>Standard is Target 7.5% - 9.5% |  | | | | | | Director of Human Resources |
| | | | | | | | Turnover continues to run at high levels and a mix of corporate and local solutions (where appropriate) are being applied. Corporate solutions include focus groups for Nursing staff led by Leadership and OD to capture experience across the years. Particular focus is also being paid to other areas such as Haematology and Cardiac Physiology. |

# ITEM 7

# REPORT OF THE CHAIR OF THE FINANCE COMMITTEE ON THE MEETING TO BE HELD ON 23 NOVEMBER 2016

## PAPER (To follow)

**Tony Foster**
Chair

**GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST**
**PUBLIC BOARD MEETING FRIDAY 25th NOVEMBER 2016**

| **Report Title** |
|---|
| Financial Performance Report - Period to 31st October 2016 |
| **Sponsor and Author(s)** |
| Author: Sarah Stansfield, Director of Operational Finance<br>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 7 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. It also provides an overview of a revised 'best endeavours' financial forecast associated with the Month 7 financial position.

Key issues to note

- The financial position of the Trust at the end of Month 7 of the 2016/17 financial year is an operational deficit of £11.6m. This is an adverse variance to plan of £18.9m.
- There is a prior period adjustment reversed out of the current YTD cumulative 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.
- The Trust is forecasting:
    - An I&E deficit of £23.9m against a planned surplus of £18.2, representing a £42.1m adverse variance to the NHSI plan.
    - Since the date of this report we have received a further £5.3m of borrowed funds from DH. There will be further borrowing requirements above this amount.

Conclusions

The financial position for M7 shows a significant adverse variance to plan of £18.9m (inclusive of the STF funding for Q1 of the financial year).

Implications and Future Action Required

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

| **Recommendations** |
|---|
| The Board is asked to note the report. |
| **Impact Upon Strategic Objectives** |
| The financial position presented will lead to increased scrutiny over investment decision making. |
| **Impact Upon Corporate Risks** |
| Significant impact on deliverability of the financial plan for 2016/17. |
| **Regulatory and/or Legal Implications** |
| The adverse variance to plan year-to-date of the financial position presented in this paper 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 Main Board

## Financial Performance Report
## Period to 31st October 2016

## Introduction and Overview

This report provides an overview of the financial performance of the Trust as at the end of Month 7 of the 2016/17 financial year.
The Trust has delivered a year-to-date deficit position of £11.6m (including the Q1 STF funding of £3.3m). This represents an adverse variance to plan of £18.9m as at the year-to-date.

## Statement of Comprehensive Income

| Month 7 Financial Position | YTD Plan £000's | YTD Actual £000's | YTD Variance £000's |
|---|---|---|---|
| SLA & Commissioning Income | 249,340 | 251,040 | 1,700 |
| PP, Overseas and RTA Income | 3,304 | 3,531 | 227 |
| Operating Income | 36,554 | 39,292 | 2,738 |
| **Total Income** | **289,198** | **293,863** | **4,665** |
| Pay | 185,326 | 193,180 | (7,854) |
| Non-Pay | 88,042 | 102,654 | (14,612) |
| **Total Expenditure** | **273,368** | **295,834** | **(22,466)** |
| **EBITDA** | **15,830** | **(1,971)** | **(17,801)** |
| **EBITDA %age** | **5.5%** | **-0.7%** | **-6.1%** |
| Non-Operating Costs | 14,960 | 12,852 | 2,108 |
| **Surplus/(Deficit)** | **870** | **(14,823)** | **(15,693)** |
| STF Funding | 6,450 | 3,225 | (3,225) |
| **Surplus/(Deficit) (inc. SFT)** | **7,320** | **(11,598)** | **(18,918)** |

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 7 of the 2016/17 financial year against the plan as submitted to NHSI in June.

The year-to-date deficit of £14.8m has been mitigated by receipt of Q1 STF funding of £3.3m.

The Month 7 position against the forecast produced last month is shown in detail on pages 20 and 21.

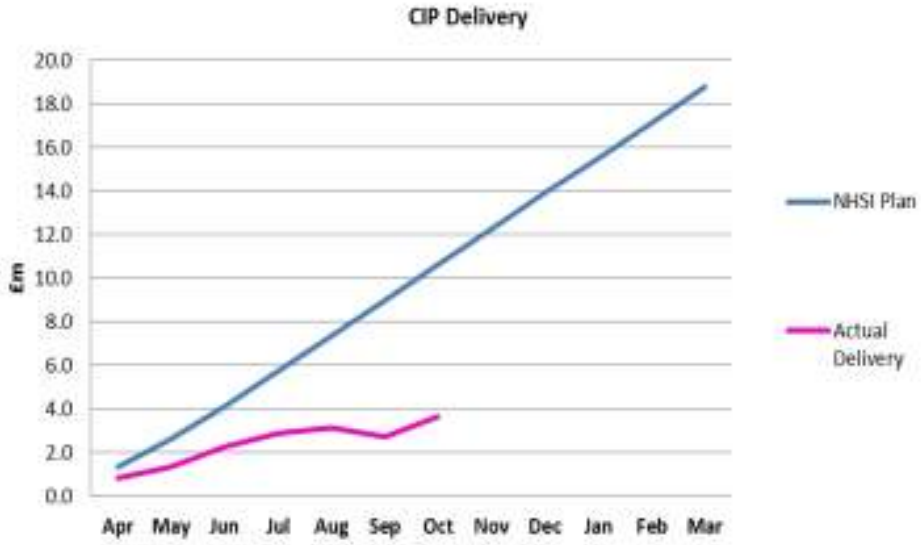
## At A Glance – Month 7

Gloucestershire Hospitals NHS
NHS Foundation Trust


The I&E cumulative deficit as at Month 7 is £11.6m against a surplus NHSI plan of £7.3m – an adverse variance of £18.9m.

The position is shown both inclusive and exclusive of prior period adjustments.

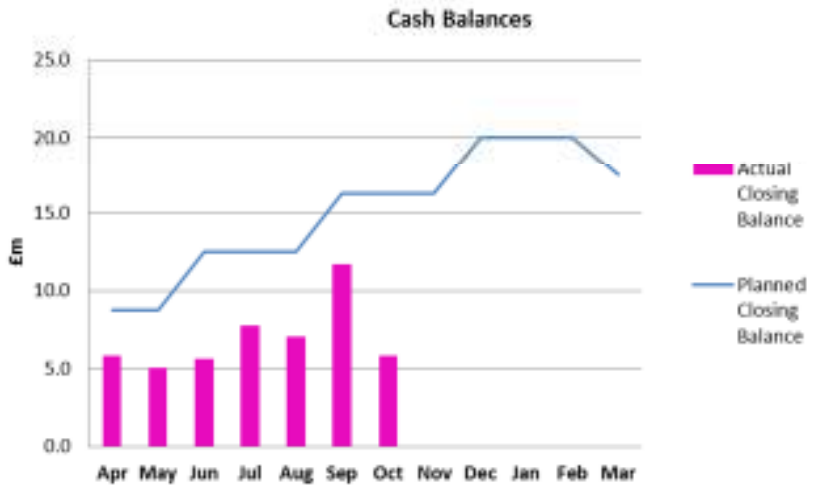
The drivers of this position are explained in more detail in the income and expenditure sections of this report.




CIP delivery shows a cumulative achievement for the year-to-date of £3.6m against an NHSI plan of £10.6m – an adverse variance of £7.0m.

## At A Glance – Month 7

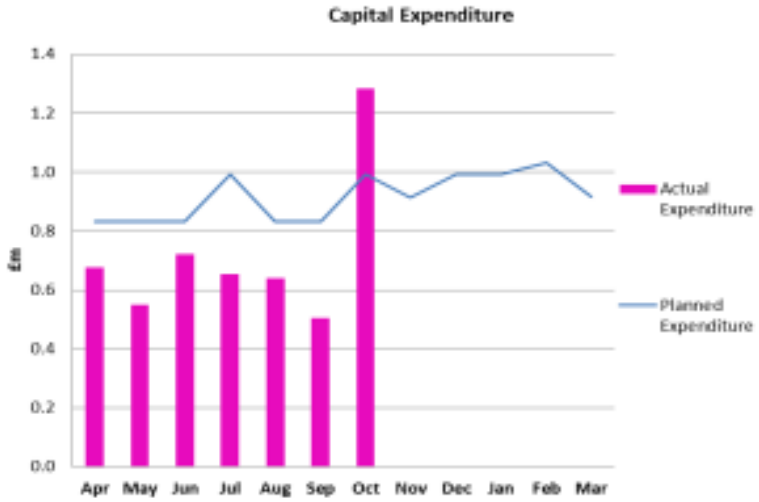
Gloucestershire Hospitals NHS
NHS Foundation Trust




The cash balance as at 31st October was £5.9m against an NHSI planned balance of £16.2m for the month – an adverse variance of £10.6m.

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
- October includes further drawdown of £6.7m of distress funding and continued correction of creditor payments position.




Capital spend in month 6 was £1.3m against an NHSI plan of £1.0m.

This brings the cumulative spend for the YTD to £5.0m against a total plan of £6.2m – an adverse variance of £1.2m.

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 | 6.2 | 5.0 | (1.2) |

## Income Analysis – by Commissioner

| 2016/17 Healthcare contracts position as at Month 7 | Month 7 Contract £000 | Month 7 Actuals £000 | Variance £000 |
|---|---|---|---|
| NHS Gloucestershire CCG | 172,527 | 173,482 | 954 |
| Specialist Commissioning Group | 46,038 | 47,793 | 1,755 |
| Worcestershire Health Community | 6,172 | 6,406 | 234 |
| Welsh Commissioners | 2,348 | 2,664 | 316 |
| NHS Hereford CCG | 2,307 | 2,300 | (7) |
| Other Commissioner Income | 12,212 | 11,999 | (213) |
| Non Contractual Agreements (NCAs) | 2,415 | 2,259 | (157) |
| **Pre CQUIN** | **244,020** | **246,902** | **2,882** |
| CQUIN | 5,148 | 4,138 | (1,010) |
| **Post CQUIN** | **249,168** | **251,040** | **1,872** |
| Phasing plan vs final contract agreement | 172 | | (172) |
| **Commissioing and SLA Income** | **249,340** | **251,040** | **1,700** |

| Income risk contained within M5 position | Month 7 Actuals £000s |
|---|---|
| CQUIN recovery - assume 80% | (1,010) |
| Coding Review | (1,271) |
| QIPP risk share | (1,106) |
| Hereford CCG contracting risk | (275) |
| **Total risk adjustments** | **(3,662)** |

Gloucestershire Hospitals NHS
NHS Foundation Trust

The table shows the Month 7 position on commissioning and SLA income by Commissioner. The contract value for each commissioner reflects the signed contract values, now including Hereford CCG which was agreed during the month. The Month 7 phasing adjustment reflects the difference between the NHSI submitted plan and finalised agreements with Commissioners.

The Trust is showing a favourable variance to plan of £1.7m on commissioning income as at Month 7. The Month 7 contract position includes an adjustment of (£0.2m) to ensure that the position is in line with the plan submitted to NHSI.

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 - removed now contract value agreed

## Detailed income and expenditure

| Month 6 Financial Position | YTD Plan £000's | YTD Actual £000's | YTD Variance £000's |
|---|---|---|---|
| **SLA & Commissioning Income** | | | |
| Elective (inc. Daycase) | 45,075 | 44,637 | (439) |
| Non-elective Spells | 1,310 | 1,152 | (158) |
| Outpatients | 41,044 | 40,932 | (112) |
| Emergency | 52,630 | 54,223 | 1,593 |
| Accident & Emergency | 9,494 | 9,947 | 453 |
| Excluded Drugs | 26,818 | 28,887 | 2,069 |
| CQUIN | 5,148 | 4,138 | (1,010) |
| Other (Includes risk adjustment) | 67,820 | 67,125 | (695) |
| **Sub-Total** | **249,340** | **251,040** | **1,700** |
| PP, Overseas and RTA Income | 3,304 | 3,531 | 227 |
| Operating Income | 36,554 | 39,292 | 2,738 |
| **Total Income** | **289,198** | **293,863** | **4,665** |
| **Pay** | | | |
| Substantive Staff | 171,429 | 173,571 | (2,142) |
| Bank Staff | 5,321 | 6,065 | (744) |
| Agency Staff | 8,575 | 13,544 | (4,969) |
| **Non-Pay** | | | |
| Drugs | 31,859 | 32,622 | (763) |
| Clinical Supplies | 22,910 | 24,267 | (1,358) |
| Other Non-Pay | 33,273 | 45,764 | (12,491) |
| **Total Expenditure** | **273,368** | **295,834** | **(22,466)** |
| **EBITDA** | **15,830** | **(1,971)** | **(17,801)** |
| **EBITDA %age** | **5.5%** | **-0.7%** | **-6.1%** |
| Depreciation | 7,704 | 6,175 | 1,529 |
| Public Dividend Capital Payable | 4,600 | 4,435 | 165 |
| Interest Receivable | (19) | (20) | 1 |
| Interest Payable | 2,675 | 2,262 | 413 |
| **Surplus/(Deficit)** | **870** | **(14,823)** | **(15,693)** |
| STF Funding | 6,450 | 3,225 | (3,225) |
| **Surplus/(Deficit) (inc. SFT)** | **7,320** | **(11,598)** | **(18,918)** |

Gloucestershire Hospitals NHS
NHS Foundation Trust

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 £1.7m over-recovery on commissioning income. One of the main drivers of the over-recovery is a £2.1m price variance above plan 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 £2.7m, but against internal budget is showing an over-recovery of £1.0m. The main driver of the variance reported here is the planning assumption.

**Pay** – expenditure is showing an adverse variance of £7.9m against plan as at month 7. This is largely driven by higher than planned levels of agency expenditure for both medical and nursing staff.

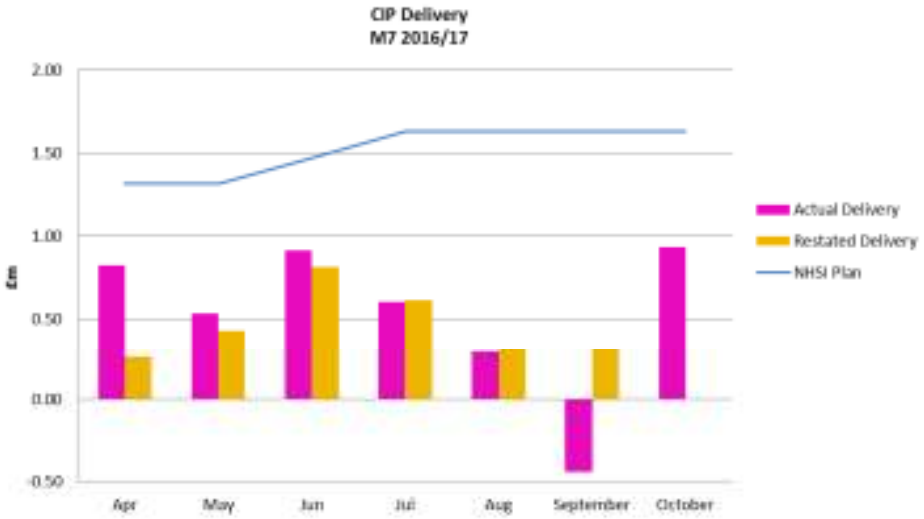
**Non-Pay** – Drugs shows a small adverse variance of £0.8m to plan, in line with a favourable financial variance on drugs activity. Other non-pay shows a significant adverse variance for the year-to-date largely driven by undelivered CIP, allocated to this line in the plan.

**Non-Operating expenditure**
**Depreciation** – shows a £1.5m 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 £0.4m 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 | 2,520 | 307 | (2,213) |
| Surgery | 2,892 | 742 | (2,150) |
| D&S | 2,492 | 444 | (2,048) |
| W&C | 856 | 310 | (546) |
| EFD | 914 | 634 | (280) |
| Corporate | 610 | 1,205 | 595 |
| Phasing adjustment to NHSI Plan | 343 | 0 | (343) |
| **Total CIP** | **10,627** | **3,642** | **(6,985)** |




As at Month 7 the Trust has delivered £3.6m of CIP against the NHSI plan of £10.6m, an adverse variance of £7.0m.

**Key Issues:**

- All divisions are showing an adverse variance to plan as at Month 7
- In month trust wide schemes have been re-allocated to Executive owners and moved to relevant divisions
- 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 | 22,299 | 1,251 | |
| | | Capital Service | (7,275) | (8,957) | |
| | | **Sum = (calc above)** | **3.07** | **0.14** | **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 | (3,418) | (21,224) | |
| | | Operating expenses within EBITDA | (273,368) | (295,837) | |
| | | **Sum = (calc above x no. of days)** | **(2.6)** | **(15.1)** | **Scoring Key** **Liquidity (25%)** |
| | | **Rating** | **3** | **1** | **4**: <0 days / **3**: (7) - 0 days / **2**: (14) - (7) days / **1**: >(14) days |
| Financial efficiency | Underlying performance | **I & E Margin** | | | |
| | | Normalised Surplus (deficit) | 7,320 | (11,599) | |
| | | Total Income | 295,667 | 297,088 | |
| | | **I&E Margin** | **2.5%** | **(3.9%)** | **Scoring Key** **I & E Margin (25%)** |
| | | **Rating** | **4** | **1** | **4**: >1% / **3**: 0 - 1% / **2**: (1) - 0% / **1**: <(1)% |
| | Variance from plan | **I & E Margin Variance From Plan** | **Prior Year Outturn** | | |
| | | I & E Margin Variance from Plan | **0.6%** | **(6.4%)** | **Scoring Key** **I& E Margin Variance (25%)** |
| | | **Rating** | **3** | **1** | **4**: >0% / **3**: (1) - 0% / **2**: (2) - (1)% / **1**: <(2)% |
| | | **OVERALL RATING** | **4** | **1** | |

As at Month 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 0.14 for M7.

**Liquidity** – the ratio generates a value of (15.1) days of liquidity at the year to date.

**I&E Margin** – reported as (3.9%) for month 7 and includes the impact of STF funding received in Q1.

**I&E Margin Variance** – reported as (6.4%) and reflects the material variance to planned delivery as at Month 7.
*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 M7 £000 | Balance as at M7 £000 | Variance - M7 Plan vs Actual £000 | B/S movements from 31st March 3016 £000 |
|---|---|---|---|---|---|
| **Non-Current Assests** | | | | | |
| Intangible Assets | 3,585 | 0 | 3,585 | 3,585 | 0 |
| Property, Plant and Equipment | 308,601 | 293,202 | 306,828 | 13,626 | (1,773) |
| Trade and Other Receivables | 4,505 | 7,384 | 4,529 | (2,855) | 24 |
| **Total Non-Current Assets** | **316,691** | **300,586** | **314,942** | **14,356** | **(1,749)** |
| **Current Assets** | | | | | |
| Inventories | 8,036 | 7,150 | 8,132 | 982 | 96 |
| Trade and Other Receivables | 30,611 | 36,064 | 28,252 | (7,812) | (2,359) |
| Cash and Cash Equivalents | 3,950 | 16,247 | 5,860 | (10,387) | 1,910 |
| **Total Current Assets** | **42,597** | **59,461** | **42,244** | **(17,217)** | **(353)** |
| **Current Liabilities** | | | | | |
| Trade and Other Payables | (62,906) | (51,234) | (49,597) | 1,637 | 13,309 |
| 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)** | **(55,729)** | **(55,336)** | **393** | **13,536** |
| **Net Current Assets** | **(26,275)** | **3,732** | **(13,092)** | **(16,824)** | **13,183** |
| **Non-Current Liabilities** | | | | | |
| Other Liabilities | (7,987) | (8,270) | (7,494) | 776 | 493 |
| Borrowings | (54,538) | (58,553) | (78,273) | (19,720) | (23,735) |
| Provisions | (1,396) | (816) | (1,418) | (602) | (22) |
| **Total Non-Current Liabilities** | **(63,921)** | **(67,639)** | **(87,185)** | **(19,546)** | **(23,264)** |
| **Total Assets Employed** | **226,495** | **236,679** | **214,665** | **(22,014)** | **(11,830)** |
| **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) | 4,333 | (19,397) | (23,730) | (11,830) |
| **Total Taxpayers' Equity** | **226,495** | **236,679** | **214,665** | **(22,015)** | **(11,830)** |

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 are now relatively flat in comparison with the year-end. This minor movement reflects changes 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 risen in month by £2.6m. This is driven by late payment of invoices raised in month, the continuing dispute of historic invoices and the ongoing current issues with GCS.
- Pre-payments have also risen significantly in month by £1.2m.
- 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:

| | Financial Year 2016/17 | | Current Month October | |
|---|---|---|---|---|
| | Number | £'000 | Number | £'000 |
| Total Bills Paid Within period | 88,292 | 232,902 | 16,002 | 38,479 |
| Total Bill paid within Target | 37,500 | 154,205 | 9,884 | 27,608 |
| Percentage of Bills paid within target | 42% | 66% | 62% | 72% |

The BPPC performance is beginning to show improvement but is not compliant 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 | Oct-16 £000s | YTD - M7 £000s |
|---|---|---|---|---|---|---|---|---|
| **Surplus (Deficit) from Operations** | **401** | **308** | **3,441** | **(151)** | **(10,222)** | **2,967** | **(1,952)** | **(5,208)** |
| **Adjust for non-cash items:** | | | | | | | | |
| Depreciation | 882 | 883 | 882 | 881 | 882 | 882 | 882 | 6,174 |
| Impairments within operating result | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Gain/loss on asset disposal | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Provisions | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other operating non-cash (income)/ expenses | (58) | (1,276) | 1,011 | (425) | 648 | (5,043) | (593) | (5,736) |
| **Operating Cash flows before working capital** | **1,225** | **(85)** | **5,334** | **305** | **(8,692)** | **(1,194)** | **(1,663)** | **(4,770)** |
| **Working capital movements:** | | | | | | | | |
| (Increase)/decrease in inventories | (198) | (13) | 1,882 | (1,880) | (539) | 1,619 | (993) | (122) |
| (Increase)/decrease in current assets | (6,042) | 4,983 | (9,375) | 5,321 | 6,857 | 5,994 | (5,590) | 2,148 |
| 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) | (2,815) | (7,837) |
| Increase/(decrease) in other financial liabilities | 3,000 | (2,853) | 0 | 127 | 0 | 5 | (27) | 252 |
| **Net cash inflow/(outflow) from wokring capital** | **1,864** | **(3,678)** | **(3,514)** | **2,957** | **13,086** | **(6,853)** | **(9,425)** | **(5,563)** |
| **Capital investment:** | | | | | | | | |
| Capital expenditure | (678) | (550) | (726) | (657) | (639) | (506) | (1,285) | (5,041) |
| Capital receipts | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Net cash inflow/(outflow) from investment** | **(678)** | **(550)** | **(726)** | **(657)** | **(639)** | **(506)** | **(1,285)** | **(5,041)** |
| **Funding and debt:** | | | | | | | | |
| PDC Received | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Interest Received | 0 | 0 | 4 | 3 | 3 | 2 | 2 | 14 |
| DH loans - received | 0 | 0 | 0 | 0 | 0 | 19,900 | 6,700 | 26,600 |
| DH loans - repaid | 0 | 0 | 0 | 0 | 0 | (2,061) | 0 | (2,061) |
| Other loans | 0 | 4,000 | 0 | 0 | (4,000) | | 0 | 0 |
| Finance lease capital | (256) | (256) | (256) | (256) | (256) | (256) | (256) | (1,792) |
| PFI/LIFT etc capital | (235) | (235) | (235) | (235) | (235) | (235) | (235) | (1,645) |
| PDC Dividend paid | 0 | 0 | 0 | 0 | 0 | (3,864) | 0 | (3,864) |
| Other | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Net cash inflow/(outflow) from financing** | **(491)** | **3,509** | **(487)** | **(488)** | **(4,488)** | **13,486** | **6,211** | **17,252** |
| **Net cash inflow/(outflow)** | **1,920** | **(804)** | **607** | **2,117** | **(733)** | **4,933** | **(6,162)** | **1,879** |
| **Cash at Bank - Opening** | **3,950** | **5,870** | **5,066** | **5,673** | **7,790** | **7,057** | **11,991** | **3,950** |
| **Closing** | **5,870** | **5,066** | **5,673** | **7,790** | **7,057** | **11,991** | **5,829** | **5,829** |

The cashflow for the first seven 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** – Debtor balances have risen in month by £2.6m. This is driven by late payment of invoices raised in month, the continuing dispute of historic invoices and the ongoing current issues with GCS. Pre-payments have also risen significantly in month by £1.2m, although not necessarily backed by cash payments.

**Trade Payables** – reduced further in October 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

## Forecast Outturn – Month 7 Performance

| Month 7 YTD | M7 Forecast* £000's | M7 Actual £000's | Movement Fav/(Adv) £000's |
|---|---|---|---|
| SLA & Commissioning Income | 251,187 | 251,040 | (147) |
| PP, Overseas and RTA Income | 3,506 | 3,531 | 25 |
| Operating Income | 38,826 | 39,292 | 466 |
| **Total Income** | **293,519** | **293,863** | **344** |
| Pay | 193,238 | 193,180 | 58 |
| Non-Pay | 102,184 | 102,654 | (470) |
| **Total Expenditure** | **295,422** | **295,834** | **(412)** |
| **EBITDA** | **(1,903)** | **(1,971)** | **(68)** |
| EBITDA %age | (0.6%) | (0.7%) | |
| Non-Operating Expenditure | 12,937 | 12,852 | 85 |
| **Surplus/(Deficit)** | **(14,840)** | **(14,823)** | **17** |
| | | | |
| STF Funding | 3,225 | 3,225 | 0 |
| | | | |
| **Surplus/(Deficit) (inc. STF)** | **(11,615)** | **(11,598)** | **17** |

* Reflects the cumulative forecast produced as part of Month 6 reporting

As at Month 6 the Trust produced a 'best endeavours' forecast outturn for the 2016/17 financial year. The table shows the year-to-date forecast for Month 7 against the actual in-month performance for comparison purposes. The movement shown is that between the forecast position and Month 7 actual.

Gloucestershire Hospitals NHS
NHS Foundation Trust

The position in Month 7 is a year-to-date deficit of £11.60m against a forecast deficit of £11.62m, a favourable movement of £0.02m.

**Key movements:**

**There are some minor variances to forecast on both other operating income and non-pay but overall the position for Month 7 is in line with forecast**

## Forecast Outturn – Full Year

Gloucestershire Hospitals NHS
NHS Foundation Trust

| Forecast Outturn - against plan | NHSI Plan £000's | M7 Forecast Outturn* £000's | Movement Fav/(Adv) £000's |
|---|---|---|---|
| SLA & Commissioning Income | 431,287 | 433,091 | 1,804 |
| PP, Overseas and RTA Income | 5,722 | 5,910 | 188 |
| Operating Income | 62,518 | 65,755 | 3,237 |
| **Total Income** | **499,527** | **504,756** | **5,229** |
| Pay | 317,703 | 332,554 | (14,851) |
| Non-Pay | 150,863 | 177,052 | (26,189) |
| **Total Expenditure** | **468,566** | **509,606** | **(41,040)** |
| **EBITDA** | **30,961** | **(4,850)** | **(35,811)** |
| EBITDA %age | 6.2% | (1.0%) | (7.2%) |
| Non-Operating Expenditure | 25,646 | 22,308 | 3,338 |
| **Surplus/(Deficit)** | **5,315** | **(27,158)** | **(32,473)** |
| STF Funding | 12,900 | 3,225 | (9,675) |
| **Surplus/(Deficit) (inc. STF)** | **18,215** | **(23,933)** | **(42,148)** |

* Reflects the re-forecast outturn position produced alongside Month 7 Plan

| Forecast Outturn - against prior month forecast | M6 Forecast Outturn* £000's | M7 Forecast Outturn** £000's | Movement Fav/(Adv) £000's |
|---|---|---|---|
| SLA & Commissioning Income | 432,817 | 433,091 | 274 |
| PP, Overseas and RTA Income | 5,921 | 5,910 | (11) |
| Operating Income | 66,290 | 65,755 | (535) |
| **Total Income** | **505,028** | **504,756** | **(272)** |
| Pay | 333,526 | 332,554 | 972 |
| Non-Pay | 175,690 | 177,052 | (1,362) |
| **Total Expenditure** | **509,216** | **509,606** | **(390)** |
| **EBITDA** | **(4,188)** | **(4,850)** | **(662)** |
| EBITDA %age | (0.8%) | (1.0%) | (0.1%) |
| Non-Operating Expenditure | 22,808 | 22,308 | 500 |
| **Surplus/(Deficit)** | **(26,996)** | **(27,158)** | **(162)** |
| STF Funding | 3,225 | 3,225 | 0 |
| **Surplus/(Deficit) (inc. STF)** | **(23,771)** | **(23,933)** | **(162)** |

* Reflects the full-year forecast outturn produced as part of Month 6 reporting
** Reflects the re-forecast outturn position produced alongside Month 7

As at Month 6 the Trust produced a 'best endeavours' forecast outturn for the 2016/17 financial year. The tables above show the revised forecast against the NHSI plan and the full year forecast produced at Month 6 against the new forecast for Month 7.

**Against Plan**

The forecast outturn for the 2016/17 financial year as at Month 7 is a deficit of £23.9m against a planned surplus position of £18.2m, an adverse variance of £42.1m.

**Against Prior Month Forecast**

The forecast outturn for the 2016/17 financial year as at Month 7 is a deficit of £23.9m against a position form the prior month of £23.8m, an adverse movement of £0.1m.
The forecast outturn has deteriorated slightly driven by a higher than expected level of non-pay, compensated for in large part by a positive improvement to the pay forecast.

## Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Committee are asked to note:

- The financial position of the Trust at the end of Month 7 of the 2016/17 financial year is an operational deficit of £11.6m. This is an adverse variance to plan of £18.9m.

- There is a total prior period adjustment reversed from the current YTD cumualtive 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.

- The Trust is forecasting:

    - An I&E deficit of £23.9m against a planned surplus of £18.2, representing a £42.1m adverse variance to the NHSI plan. This forecast has moved by £0.1m since the prior month.
    - Since the date of this report we have received a further £5.3m of borrowed funds from DH. There will be further borrowing requirements above this amount.

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

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

**Date:** **September 2016**

# 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 26 OCTOBER 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** | Tony Foster | Non-Executive Director (Chair) |
| | Keith Norton | Non-Executive Director |
| | Rhona Macdonald | Non-Executive Director |
| | Stuart Diggles | Interim Director of Finance |
| | Eric Gatling | Director of Service Delivery |
| **APOLOGIES** | Dave Smith | Director of Human Resources and Organisational Development |
| **IN ATTENDANCE** | Martin Wood | Trust Secretary |
| | Peter Lachecki | Chair of the Trust Designate |
| | Sarah Stansfield | Director of Operational Finance |
| | Duncan Calverley | KPMG |

*The Chair welcomed all to the meeting. In particular, he welcomed Peter Lachecki who was attending the meeting as an observer; Rhona Macdonald who was attending her first meeting following her appointment as a Non-Executive Director, and Duncan Calverley who was observing the meeting from the perspective of KPMG's work on the baselining and Cost Improvement Programme tasks.*

### 139/16 DECLARATIONS OF INTEREST — ACTION

There were none.

### 140/16 MINUTES OF THE MEETING HELD ON 28 OCTOBER 2016

**RESOLVED:-** That the minutes of the meeting of the Finance Committee held on 28 September 2016 were agreed as a correct record and signed by the Chair subject to the following amendments:-

- Minute 132/16 – Financial Performance Report – Current Assets – Cash – the last sentence to read "Our Trust needs approximately £10M of cash per week to operate".
  Current Liabilities – Trade and Other Payables – last sentence to read "Approximately £49M is located off the purchase ledger of which approximately £20M is already overdue".

### 142/16 MATTERS ARISING

There were none. Those matters arising previously related to performance issues have been referred to the Quality and Performance Committee.

### 143/16 FINANCIAL PERFORMANCE REPORT

The Interim Finance Director presented the report providing an overview of the financial performance of our Trust at the end of month

six 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 revised "best endeavours" financial forecast for the 2016/17 financial year. The key issues to note were that the financial position of our Trust at the end of month six of the 2016/17 financial year is an operational deficit of £8.7M which is an adverse variance to plan of £15.1M. There is a prior period adjustment reversed out of the current year to date position of £6.0M. 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. 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 "plan" reflect the figures as submitted to NHS Improvement unless explicitly stated otherwise. Our Trust is forecasting an income and expenditure deficit of £23.8M against a planned surplus of £18.2M representing a £42.0M adverse variance to the NHS Plan. Our Trust is also forecasting a negative available cash balance of £22.0M based on borrowing received to date. Since the date of the report, our Trust has received a further £6.7M of borrowed funds from the Department of Health. There will be a further borrowing requirement above this amount.

With regard to the prior period adjustment reversed out of the current year to date position, our external auditors, KPMG, have agreed that the 2015/16 final accounts be restated rather than reopened. It is normal audit practice for outgoing auditors to enable incoming auditors to look at their files to enable them to bring forward the necessary financial information.

Ms Macdonald said the underlying forecast position has deteriorated and the Plan needs to demonstrate the trend line for this financial year. The Interim Finance Director said that his focus will be on undertaking a more detailed forecast rather than understanding the financial plan.

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

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

- The month end September 2016 cash balances were higher than previous months due to the impact of the draw down of £19.9M of distressed funding and associated increased creditor payments. There was no working capital facility drawdown during the month.
- The cumulative capital spend for the year to date is £3.7M against a total plan of £5.2M which is an adverse variance of £1.4M. Capital spend has slipped in the first half of the financial year due to the availability of cash resource to fund the Programme. The Capital Programme is now £12.6M (from £11M) which was reduced from a plan of £18M. The Plan had been reduced largely on the basis of cost, the increase from £11.0M to £12.6M was based on a further assessment of risk rather than cost.

Income Analysis – by Commissioner

- The Trust is showing a favourable variance to plan of £2.2M on commissioning income as at month six.
- The month six income risk of £3.274M has already been taken out of the financial position.
- The Chair observed that the largest variance related to the Specialist Commissioning Group. The Director of Service Delivery explained that referrals are increasing and the discussion to be had is how our Trust manages a return to plan to ensure that it does not cost our Trust.

Income Analysis – by Point of Delivery

- The Interim Finance Director chose by way of example emergency spells to demonstrate the split of variance between volume and price which was as a result of the higher rate of "minors" to "majors".

Detailed Income and Expenditure

- Pay expenditure is showing an adverse variance of £6.3M against plan as at month six. This is largely driven by higher than planned levels of agency expenditure for both medical and nursing staff. This is a deteriorating position.
- The Chair enquired whether the Cost Improvement Programme should be separate from the income and expenditure position. In response, the Interim Finance Director said that there had been no Cost Improvement Programme plan. A full Cost Improvement Programme will be developed for the next financial year.

Pay Expenditure – Trust Totals

- The Interim Finance Director explained the chart detailing the total pay expenditure by month against the NHS Improvement planned levels. Expenditure in September 2016 included the reversal of prior period adjustments. The analysis shows an underlying increase in the pay run-rate which has been sustained into month six. This is being driven by increased expenditure on hosted medical services (matched by over-performance on income) and increased medical staffing spend in Medicine Division largely due to increasing agency staffing.
- The Interim Finance Director said that the Workforce paper will now be presented to the Committee in November 2016. He indicated that there is a clear increase in employed staff from August 2016. He undertook, in response to a suggestion from the Director of Service Delivery, to ensure that the report contained the number of whole time equivalents and the average cost per whole time equivalent. **SD/DS (MW to note for agenda)**
- Ms Macdonald asked if Operational Managers have details of the staffing figures and budgets to manage their workforce. The Chair of the Trust Designate asked if there was a Trust wide agency reduction plan. In response, the Interim Finance Director said that the Director of Human Resources and Organisational Development is the plan holder with the Medical Director and the Nursing Director to deliver. The Director of Service Delivery added that the agency taskforce is looking at expenditure in terms of Medical, Nursing, AHP and

administrative staff. This information should be scrutinised both at the Committee and the Workforce Committee. He explained that the focus on agency spend has gathered momentum within the last six weeks although it has been an ongoing priority. The Interim Finance Director said that the requirement within the forecast outturn is to reduce agency expenditure by £900k in the current financial year (this saving being net of substantive cost increases). Approximately £5M is to be taken forward to be found from the next financial year. The plan to be submitted to NHS Improvement will require a run rate to get close to the £12M internal target. The Director of Service Delivery explained that there is a lead time to convert agency doctors to substantive posts due to breaks in contracts.

Pay Expenditure – by Division
No comments made.

Agency Expenditure

- The month six cumulative agency spend is £11.3M with an in-month value of £1.8M. Our Trust has currently spent 70.8% of the £16M internal target as at month six. On this basis, the end of year position is likely to be approximately £20M. The basis for the £16M internal target is not clearly understood. The current plan is near to £16M on an annualised basis and there is anecdotal evidence that the plan is moving in the right direction with a reduction in agency expenditure. The Interim Finance Director said that the reductions in agency bookings should translate into financial savings from the next month.

Non-Pay Expenditure

- Drug expenditure shows a small adverse variance to plan of £1.0M in line with a favourable variance on income for excluded drugs. There are increases in medical and surgical equipment expenditure in March and September which need to be understood. There are also increases in clinical expenditure in September which again need to be understood.

Cost Improvement Programme

- Some cost improvement programme schemes have been re-classified as cost avoidance particularly in Medicine Division thus impacting on the adverse variance. There is now greater honesty in reporting schemes.
- Mr Calverley said that our Trust needs to be clear on the definitions for cost avoidance and cost improvement programme schemes to reduce the run rate. The Interim Finance Director suggested that there may need to be some form of amnesty to get to the right position.
- Mr Calverley said that the structure needs to be looked at with the Cost Improvement Programme Director reporting to the new Chief Operating Officer role from the current Interim Finance Director and non-cost improvement schemes are reporting to the Director of Clinical Strategy. The Interim Finance Director added that Cost Improvement Programme work should sit in each division and aligned to the Chief Operating Officer. There is a review of the process for signing off cost improvement

schemes.

NHS Improvement Continuity of Services Rating

- This will remain 1 for the foreseeable future.

Balance Sheet (1)

- It is likely to be three years before our Trust is able to pay creditors on contract terms. This can only be achieved when our Trust has generated sufficient cash to do so. The Independent Trust Financing Facility (ITFF) is a long term solution which will not address payables and hence why our Trust is focussing on payments now. The risks of payments 120+ days are being investigated.

Balance Sheet (2)

No comments were made.

Current Assets – Debtors

- 120+ debt has reduced significantly in month six as the final position on the Gloucestershire Care Services (GCS) mediation decision has been transacted. GCS continue to be the highest debtor due to ongoing negotiation of the revised SLA baseline for 2016/17. The 91-120 day debt needs to be understood as this is current year debt that is aging with the aim to reduce to 30 days. In response to a question from the Chair of the Trust Designate, the Interim Finance Director said that the major debtor risks will be reported to the Committee in November 2016. The credit control function has now been bought back in-house and there is an expectation to see improvement which needs to be at a greater pace. Mr Foster said that he would still like to know what a good debtor position should look like. In response, the Interim Finance Director said that this should be divided between contract and non-contract income with non contract of around 40 to 60 days. **SD**
- Work needs to be undertaken to understand the income and expenditure position. Ms Macdonald suggested that our Trust try and agree a position with GCS given their reported surplus. The Director of Service Delivery added that the contract position should be examined to ascertain why it has not been honoured or interpreted correctly. The Interim Finance Director said that he will report to the January 2017 meeting a summary of the SLA and current status. **SD**
- The Chair referred to the overseas and private patients asking how that debt arose. In response, Director of Operational Finance said that from a benchmarking analysis, our recovery rate is above the average and is strengthened where a deposit is taken before treatment. A number of write-offs will be presented to the Audit and Assurance Committee in November 2016. (Post meeting mote – this is now to be presented to the January 2017 Committee meeting as all data was not available for the November 2016 Committee meeting). A new member of staff is looking to renegotiate the insurance policies.

Current Assets – Cash

- The cash position is funded to meet liabilities.

Current Liabilities – Trade and Other Payables

- There has been a movement of approximately £4M from month five.

Better Payment Practice Code

- Current performance only includes those invoices that are part of the creditors' ledger balance.

Liabilities – Borrowings

- The liabilities now include the Department Loan of £19.9M.

Cashflow

No comments were made.

Forecast Outturn – Month Six Performance

- Given that the prior period adjustment materially impacts on the month six actual performance, the month has also been restated. Income is £1.9M lower that month five.
- Ms Macdonald said that elective activity is not increasing and asked which area(s) were not improving. In response, the Director of Service Delivery said that this needs to be looked into. Commissioning income is lower than forecast by £1.2M.

Forecast Outturn – For Year

- The forecast outturn for the 2016/17 financial year as at month six is a deficit of £23.8M against a position from the previous month of £26.6M, a favourable movement of £2.8M. There is an adverse movement of £2.8M in the underlying position after the benefit of removing prior year amounts.

Forecast Outturn – Income and Expenditure (Profile)

- The position between months five and six has been adjusted for the prior year movement.

Short Term Cash Flow Forecast

- The payables are considerably higher in September and October 2016 which results from using funding received to reduce payment arrears.

Divisional Reports

- These were presented for information. The main areas of concern are Medicine and Surgery Divisions and the Committee concluded that they may wish representatives of those Divisions to attend after the work being undertaken by KPMG has concluded.

The Chair thanked the Interim Finance Director for the report.

**RESOLVED:-** That:-

1) The financial position of the Trust at the end of month six of the 2016/17 financial year is an operational deficit of £8.7M which is an adverse variance to plan of £15.1M be noted.
2) There is a total prior period adjustment reversed from the current year to date position of £6.0M be noted.

3) Cost Improvement Programme performance has deteriorated in-month from a total delivery at month five of £3.2M to a delivery at month six of £2.7M reflecting both reclassification of schemes from cost improvement to cost avoidance and also correction of errors reported in prior months.
4) 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. 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 "plan" reflect the figures as submitted to NHS Improvement unless explicitly stated otherwise.
5) The Trust is forecasting an income and expenditure deficit of £23.8M against a planned surplus of £18.2M representing a £42.0M adverse variance to the NHSI Plan. A negative available cash balance of £22.5M based on borrowing received to date is also forecast. Since the date of the report, our Trust has received a further £6.7M of borrowed funds from the Department of Health. There will be a further borrowing requirement above this amount.

**144/16 FINANCIAL RECOVERY PLAN**

The Interim Finance Director said that a proposal to combine the Operational Plan and the Financial Recovery Plan is to be presented to the Board on 28 October 2016. There remain conflicts between the submission timetables which it is hoped can be resolved to enable a combined plan to be prepared.

**145/16 REGULATORY REVIEW UPDATE**

The Interim Finance Director presented the report providing an update on current regulatory action and associated review work being undertaken in our Trust. The guidance on the implications of the financial special measures regime is currently limited but indications are that it will be a supportive model aimed at expediting the Financial Recovery Programme. Our Trust has now commissioned three pieces of work all of which have been subject to a competitive tendering process; Financial Governance Review, Financial Baselining and Cost Improvement Programme support. Deloitte have been appointed to lead the Financial Governance Review and work is expected to begin by the end of October 2016. KPMG have been appointed as the supplier for both the Financial Baselining and Cost Improvement Programme support and begin their work on 17 October 2016. The outcome of the Financial Governance Review will be presented to the Board and the Baselining and Cost Improvement Programme support will be presented to the Committee prior to the Board.

The Chair thanked the Interim Finance Director for the report.

**RESOLVED**:- That the report be noted.

## 146/16 DELOITTE FINANCIAL REPORT REVIEW RECOMMENDATIONS

The Interim Finance Director presented the report providing an update on the progress to date against the thirty-four recommendations resulting from the Deloitte review: Financial Reporting – Enhancing Transparency dated 17 August 2016. The summary of progress is that five recommendations have not started (eight from the previous month), eleven recommendations are in progress (twenty-one previously) and eighteen actions completed (five previously). A number of the recommendations indicated as in progress have had an initial piece of work completed but will continue to be progressively developed for a number of months. Good progress has continued to be made against the recommendations, especially in relation to those that are identified as being in progress but for which initial pieces of work have been completed.

The Chair of the Trust Designate invited the Interim Finance Director to annotate those actions identified as completed which have become business as usual. **SD**

The Chair thanked the Interim Finance Director for the report.

**RESOLVED**:- That the content of the report and the external support that has been awarded be noted.

## 147/16 COST IMPROVEMENT PROGRAMME UPDATE

The Interim Finance Director presented the report providing an update on progress of our Trust's Cost Improvement Programme as at the end of month six and highlighting areas of concern which require further work. The key issue to note is that our Trust has delivered a Cost Improvement Programme for the year to date of £2.7M against a planned value of £9.0M representing an adverse variance to plan £6.3M as at the year to date. During month six, Divisions have made a number of retrospective reclassifications and corrections which have impacted on the month six position. Divisional performance is significantly behind the year to date target. The programme of work being undertaken by KPMG aims to strengthen governance and reporting of the Cost Improvement Programme, to aid identification of further schemes for 2016/17 and to support development of a full programme for 2017/18. Support is being provided to Divisions to ensure that they fully understand the requirement to delivery cost improvements. The issues in Medicine Division are linked to the lack of available staff.

During the course of the discussion, the Chair said that he would like to know what the initiatives are; to which the Interim Finance Director said that the top twenty schemes are being prepared. Mr Norton added that there needs to be a mindset of ownership of the schemes to be addressed for the long term.

The Chair thanked the Interim Finance Director for the report.

**RESOLVED**:- That the report be noted.

## 148/16 THE CAPITAL PROGRAMME UPDATE

The Interim Finance Director presented the report providing an overview of the Capital Programme progress to date and current forecasts for the year end. The 2016/17 Capital Programme is now clearly defined and underway. Some flexibility remains for ensuring the programme is within the target outturn of approximately £12.6M. This, however, has been achieved in part by delaying items until 2017/18 thereby increasing the backlog and finance pressure in future years. This impact is being partly mitigated by pursuing alternative funding arrangements subject to those offering value for money. He gave as an example the leasing of scanners from revenue.

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

- Mr Foster asked where the risks associated with the Capital Programme are assessed and where the ownership is determined. In response, the Interim Finance Director said that risks are assessed by the Capital Control Group who also own the programme which is presented to the Committee and to the Board.
- The Director of Service Delivery said that risks associated with a Capital Programme are captured within the Estates and Facilities Division risk register.

The Chair thanked the Interim Finance Director for the report.

**RESOLVED**:- That the report be noted.

## 149/16 THE SUSTAINABILITY AND TRANSFORMATION FUND (STF)

The Interim Finance Director reported that the Clinical Commissioning Group had submitted the Gloucestershire Sustainability and Transformation Plan to NHS Improvement on 21 October 2016. This included our Trust's latest financial forecast. There is a gap in the STP of approximately £56M over four years which has not been fully explained. The narrative does mention our Trust's change of financial position.

Ms Macdonald said that there has been no Board involvement in the preparation of the plans which is a governance issue. The Interim Finance Director added that there are ownership and capacity issues surrounding the Sustainability and Transformation Plan.

The Chair thanked the Interim Finance Director for the update.

**RESOLVED**:- That the update be noted.

## 150/16 NOTES OF THE MEETING OF THE CAPITAL CONTROL GROUP HELD ON 19 SEPTEMBER 2016

The Interim Finance Director presented the minutes of the meeting of the Capital Control Group held on 19 September 2016. In response to a question from the Chair, he undertook to review the presentation of

the outcome of meetings of the Capital Control Group to ensure that further information on individual schemes was provided to the Committee. **SD**
The Chair thanked the Interim Finance Director for the minutes.

**RESOLVED**:- That the minutes be noted.

**151/16 FINANCE COMMITTEE WORKPLAN**

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

- November 2016 add Workforce Report and Cost Improvement Programme update from KPMG. **MW**

**152/16 COMMITTEE REFLECTION**

The Committee reflected on the meeting noting that was necessary for a considerable level of detail to be provided by the Interim Finance Director. The level of reporting was considered good. The reports provided the right level of understanding to enable Non-Executive Directors to focus, challenge and seek assurance. It was considered that the Director of Estates and Facilities should attend meetings when the Capital Programme is considered and the Cost Improvement Programme Director when KPMG present their report in November 2016 on the Cost Improvement Programme. In time, the Committee will need to link with other Committees.

**153/16 ANY OTHER BUSINESS**

There were no further items of business.

**154/16 DATE OF NEXT MEETING**

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Finance Committee will be held on **Wednesday 23 November 2016** in the **Board Room, Alexandra House, Cheltenham General Hospital** commencing at **9.00 am**.

**Papers for the next meeting:**

Completed papers for the next meeting are to be logged with the Trust Secretary no later than 3.00 pm on **Monday 14 November 2016.**

The meeting ended at 11.46 am.

**Chair**

**23 November 2016**

## REPORT TO MAIN BOARD - NOVEMBER 2016

**From Audit and Assurance Committee Chair –** Ms Rhona Macdonald, Non-Executive Director

This report describes the business conducted at the Audit and Assurance Committee held 8th November 2016, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / gaps in controls or assurance |
|---|---|---|---|---|
| **Introduction to meeting** | The Chair noted that this was the first meeting of the Committee with its wider remit of Audit and Assurance and, membership was relatively new and there was a need to review ways of working.<br><br>- a requirement for the Audit and Assurance Committee to have time, support and training to enable them to have effective oversight of the agenda<br><br>- Members meeting with internal and external auditors was a regular part of business and would occur at beginning of meeting and be minuted. | | During deliberations and at the end of the meeting the opportunity was taken to agree<br>The need for the organisation to clearly articulate its assurance arrangements and map the work that was underway to strengthen these. | |
| **Matters Arising** | Outstanding and ongoing items were reviewed by attendees | | The Committee were assured that actions were being followed up and reported. | |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / gaps in controls or assurance |
|---|---|---|---|---|
| **External Audit** | The Committee received a brief update and the impact of the Deloittes review on shaping the 2016/17 plan was noted. | | | |
| **Internal Audit** | A number of reports were reviewed. It was noted that the most significant items had already received consideration at Finance Committee or Main Board.<br><br>Proposed changes to Internal Audit plan, to better reflect immediate priorities , were agreed subject to restricting spend to budgeted levels | Common challenges were about clarity on accountability for actions at levels below the lead Director and the importance of tracking required actions through to completion. | The existing 2017 audit plan was accepting that it would be subject to change and develop a coherent approach to creating an organisation wide audit and assurance programme driven by intelligence such as a risk assessment of key controls and the use of comparative data to identify performance outliers. | |
| **Risk Management** | Particular note was taken of the Internal Audit report on risk management and the weaknesses identified | | CEO undertook to ensure the tracking system would be updated<br><br>The CEO reported that work was already underway to | |

| Item | Report/Key Points | Challenges | Assurance | Residual Issues / gaps in controls or assurance |
|---|---|---|---|---|
| | | | overhaul the risk management system and progress would be reported to the Committee. | |
| **Reports from the Head of Counter Fraud** | Members requested trend information on the incidence and type of fraud reporting to be included in future reports. | | It was agreed to include messaging about fraud in other communications as well as counter fraud newsletter. | |
| **Reports from Interim Finance Director** | Members received reports on Losses and Compensations and SingleTenders | | Members were assured on a number of issues such as single tender actions and the follow up work on credit notes | |

# MINUTES OF THE AUDIT COMMITTEE MEETING HELD ON TUESDAY 8 NOVEMBER 2016 AT 8.30AM IN THE BOARDROOM, ALEXANDRA HOUSE, CHELTENHAM

**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**

| | | |
|---|---|---|
| Ms Rhona Macdonald | (RM) | Non - Executive Director (Chair) |
| Mrs Helen Munro | (HM) | Non - Executive Director |
| Mr Tony Foster | (TF) | Non - Executive Director |

**IN ATTENDANCE (by invitation)**

| | | |
|---|---|---|
| Mr Alan Thomas | (AT) | Lead Governor |
| Mr Andrew Seaton | (AS) | Director of Safety |
| Mrs Sarah Stansfield | (SS) | Director of Operational Finance |
| Mr Martin Wood | (MW) | Trust Secretary |
| Mrs Sarah Smith | (SS) | PA to Finance Director |
| Mr Lee Sheridan | (LS) | Head of Counter Fraud |
| Mr Jonathan Brown | (JB) | KPMG Engagement Lead |
| Ms Deborah Lee | (DL) | Chief Executive |
| Mr Stuart Diggles | (SD) | Interim Finance Director |
| Mr Peter Stephenson | (PS) | Price Waterhouse Coopers (PWC), Internal Audit |
| Mr Rob Andrews | (RA) | KPMG Manager |
| Ms Dominque Lord | | Price Waterhouse Coopers (PWC), Internal Audit |

**APOLOGIES**

| | | |
|---|---|---|
| Mrs Lynn Pamment | (LP) | Partner, Price Waterhouse Coopers (PWC), Internal Audit |

**ACTION**

Attendees noted that this was the first meeting of the Audit and Assurance Committee with its wider remit, with its wider role there is need for further discussions to review ways of working. During discussion the following actions were agreed :

The Trust will need to develop its assurance arrangements and map the work that is underway to strengthen these. Mr Stephenson agreed to provide an example of assurance mapping. **PS**

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To provide training and support to the Audit and Assurance Committee to enable them to have effective oversight of the remit and a future date will be identified for a training session. **SS**

An Audit and Assurance Development session will be arranged to work up the future framework ahead of the next meeting date for the Committee. Agreed attendees were noted as members, Internal and External Auditors, Ms Lee, Mr Diggles and Mr Wood. **SS**

Attendees agreed that the pre meet for members, internal and external auditors should remain a regular part of business and would take place ahead of Audit and Assurance Committee at 8.30am and would now be part of the formal meeting and be minuted.

**065/16 DECLARATIONS OF INTEREST**

None.

**066/16 MINUTES OF MEETING HELD ON 6 SEPTEMBER 2016**

With minor amendment to two spelling errors the minutes were agreed as a correct record.

**RESOLVED:** The minutes of the meeting held on the 6th September 2016 were agreed as a correct record.

**067/16 MATTERS ARISING**

**054/16 Clinical Negligence Premiums**

Mrs Stansfield reported the increase in premiums was largely inflationary, was in line with expectation and is not a reflection of Trust performance. ***Action agreed as closed.***

**056/16 Project Implementation of Prescription machines** **SS**

An update is to be provided at the next meeting.

**Shared Services Partnership Board**

It was noted that the meeting had not gone ahead and another meeting date will be rearranged. **SS**

All other outstanding items were agenda items for the meeting. Attendees agreed that all action owners should provide an update for future meetings.

**RESOLVED:** That the report be noted and revisited on the 18 January 2017.

**068/16 EXTERNAL AUDIT**

**PROGRESS REPORT AND TECHNICAL UPDATE**

Attendees were updated on the work undertaken since the last Audit Committee and discussion took place around the potential prior year adjustment and the level of materiality which is currently under review. Ms Lee commented that the Financial recovery plan needs to be submitted and required confirmation of the prior year adjustment to include in the Forecast Outturn. Attendees noted that the individual breakdown work has been completed and will be presented at the next Finance Committee, once the debt recovery work is completed the prior year adjustments will be confirmed and will also be reported to the Committee for information.

The Chair of the Committee asked for external audit opinion on the level of confidence in underlying culture and robustness of systems. Mr Brown responded that the culture feels improved, open and transparent and advised that the underlying systems have not yet been reviewed. Mrs Munro expressed her concerns around the oversight of systems and how they had been changed and Mr Diggles advised that in his view the recent reporting issues were less to do with systems flaws and more about application of policies and influence of people.

**APPROACH TO THE 2016/17 AUDIT AND OUTLINE TIMETABLE**

Attendees noted the approach will need to include the impact of the Deloitte review on the development of a 2016/17 plan.

**069/16 INTERNAL AUDIT**

The Chair of the Committee encouraged internal audit to think about their role and how they can help with the cultural change.

**INTERNAL AUDIT PROGRESS REPORT 2016/17**

Attendees noted progress against the plan which included the reports which have been completed; Temporary Staffing, Clinical Coding and Consultant Job planning. Four additional reviews were noted; Locum Doctors Financial Controls, Centralised Outpatients Clinic Booking, Waiting List Initiatives and Cirencester benefits Realisation. Four reviews which had been removed from the plan were noted as; Core Financial Systems mid-year review, Sustainability and Financial Resilience. Mr Stephenson reported that this represented a 10 day net increase with an associate cost increase. Ms Lee commented that the expectation is that the changes to the plan were resource neutral and needed to remain within the existing budget and it was agreed further discussion would take place to agree this position .

**COST IMPROVEMENT PROGRAMME FINAL REPORT**

Ms Lee reported that arrangements are in train with KPMG support to address findings and redesigned the model of PMO around CIP. Mr Diggles confirmed that the Internal Audit report had been shared with KPMG.

Mrs Munro commented that clinical coding has been raised several times and Ms Lee advised that this related to specific areas around the creation of dummy wards and incorrect coding. Discussions are underway with Commissioners to strategically correct.

**CANCER WAITING TIMES FINAL REPORT**

The report was noted as high risk. Key findings included 41 of 200 cases which could not be validated, key areas of differences included pauses applied, identified dates and IT issues which caused further problems. It was noted that TrakCare would address IT issues. Ms Lee commented that training was fundamental to issues and training had been commissioned to enhance understanding, attendees also noted that there is currently no performance function within the organisations architecture.

**CORE FINANCIAL SYSTEMS FINAL REPORT**

Authorised Signatory list has been noted as a regular issue by the Committee and Mrs Stansfield updated that there is now an annual process in place to update signatories; standing orders and SFIs are also under review.

The number of credit notes processed was raised as being unnecessarily high leading to significant extra work. Mr Stansfield advised that although there are a large amount of credit notes they are of a low value and work with Shared Services is underway to address.

Mrs Stansfield reported that the aged debt figure which the report noted had increased had now been resolved and had now reduced.

**CONTROLLED DRUGS FINAL REPORT**

The report was noted as low risk with a number of good practices identified.

**CATERING STOCK & CASH CONTROLS**

Procedures and Policies had been recently updated and had not yet had time to fully embed. The Chair of the Trust asked whether the timing of audits could be considered. Ms Lee commented that Audit review should be acted upon and reviewed at the monthly Divisional Executive Review

meetings to provide assurance to the Committee.

**HEREFORD PROJECT MANAGEMENT LETTER**
Discussion took place around the concluding letter and the basis for the review, Mrs Stansfield clarified that the Internal audit had been advised that the Trust did not require any further work to be undertaken on the review as there is no basis for the review of the Hereford Project over other capital programmes.

**RISK MANAGEMENT FINAL REPORT 2015/16**
Mr Stephenson highlighted the two medium level risks in the report which related to missing mitigation actions and target dates and risk scores where scores less than 15 are not subject to the same level of scrutiny by the Trust Leadership Team as those recorded on the Trust Risk Register. Ms Lee shared a report to the Trust Leadership Team which expressed her concerns in respect of the audit findings and highlighted the lack of sufficient ownership within the organisation and rigour around risk. Ms Lee commented that the Trust Risk Register is not currently fit for purpose, although not atypical the Trust needs a coherent Risk Register that is owned by the Executive and provides assurance to the Committee. Attendees noted that a Risk Management Group had been newly established and will be chaired by Ms Lee.

**CQC REVIEW FOLLOW UP FINAL REPORT 2015/16**
Attendees noted the status update. All 'must do' actions highlighted in the CQC report were reviewed for progress and were either completed or progress is ongoing.

**2015/16 INTERNAL AUDIT ANNUAL REPORT**
Mr Stephenson presented the report for the information of attendees.

**RECOMMENDATIONS TRACKER**
Discussion took place around the reports received by the Committee to avoid repetition and a common challenge related to accountability for actions and tracking through to completion. Ms Lee agreed to ensure the tracking system is updated. **Ms Lee**

**RESOLVED:** That the reports be noted.

*Dominque Lord left the meeting at 10.10am*

**070/16 REVIEW OF THE TRUST RISK REGISTER**

Discussed under item ' Risk Management Final Report 2015/16 '

**RESOLVED:** That the reports be noted.

**071/16 REPORTS FROM THE INTERIM FINANCE DIRECTOR**

**LOSSES AND COMPENSATIONS**

Mr Diggles presented the report which reported the Ex gratia payments made to the value of £885.00.

**SINGLE TENDER ACTION**

Mr Diggles advised that that had been greater scrutiny of tender actions to ensure suppliers are the most competitive in the market. Mr Diggles also commented charitable funded tenders need to follow the same process to ensure value for money.

**COST IMPROVEMENT PROGRAMME UPDATE**

Attendees noted the report. KPMG have been engaged to support a programme of work and this piece of work is currently progressing.

**RESOLVED:** That the reports be noted.

**072/16 REPORT FROM THE HEAD OF COUNTER FRAUD**

Mr Sheridan updated on progress in raising the profile of Counter Fraud which included attendance at inductions and strengthening relationships with the internal and external auditors, counter fraud also now attend the HR policy group.

Mr Sheridan updated on current cases which included a former member of staff and four co-defendants which is scheduled to be heard at Bristol on 16 November, defendants will enter a plea for the first time.

Mr Sheridan agreed to include trend information on incidences and type of fraud in future reports to the Committee and Ms Lee is to consider including a counter fraud case update in her CEO report to Main Board. Messaging around counter fraud also needs to be included in wider communications as well as the counter fraud newsletter. **LS**

**RESOLVED:** That the reports be noted.

**073/16 AUDIT AND ASSURANCE COMMITTEE WORKPLAN 2017**

Attendees agreed to following amendments:

- Accounting Policies to be added as an agenda item for the January meeting.
- Debt Report to be added as an agenda item for the January meeting.
- Discussion took place around the inclusion of Governance and National reporting which should be included on the work plan. Mr Wood undertook to develop a statutory business plan which should be reviewed by the Committee. **MW**
- Self-Assessment Checklist of the Audit and Assurance Committee to be included on the workplan.
- External Audit plan and report on prior year adjustment to presented to the January meeting.
- Review of Internal and External Performance to move to the July meeting.

**RESOLVED:** That the reports be noted.

**074/16 COMMITTEE REFLECTION & DEVELOPMENT**

The agenda for the Audit and Assurance Committee will develop for future meeting and become more strategic.

**075/16 ANY OTHER BUSINESS**

**BOARD REPORT FROM BOARD COMMITTEE**

Ms Lee tabled a report for consideration. The Audit and Assurance Committee agreed to use the template with immediate effect. The report which will be completed by the NED Chair together with the lead Executive and minute taker of the Committee following each meeting to provide written assurance from the Board Committees to Board without duplicating the minutes of the Committee.

**RESOLVED:** That the report be completed

**076/16 DATE OF THE NEXT MEETING**

Wednesday 18 January 2017 8.45 am in the Boardroom at Alexandra House

Pre meet for members only – 8.30am

THE MEETING ENDED AT 10.30am

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**CHAIR**

Attendees use the remaining time allocated for the Committee meeting to discuss the development Audit and Assurance Programme plan.

**GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST**
**PUBLIC BOARD MEETING FRIDAY 25th NOVEMBER 2016**
**Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at 9.00 a.m

| **Report Title** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **NUREE AND MIDWIFERY STAFFING NOVEMBER 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 October 2016, against the compliance framework *'Hard Truths' – Safer Staffing Commitments*.

Key issues to note

- Whilst there are no major safety concerns arising from the staffing levels, the individual divisional reports comment in detail where staffing hours are either lower than the centile set by NHS England, or over, and the rationale behind these findings.
- This month's report also includes information and update on nurses' revalidation. It is pleasing to see that the strategy to support our staff in the new NMC processes of revalidation and registration has been well received with good outcomes with only one nurse not revalidating.
- There continues to be close scrutiny of agency spend and recruitment
- As stated, the divisional nursing directors have analysed their department's data and have individually responded for the purpose of this report.
- 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.
- Weekly meetings were commenced at the start of October to review agency spend and actions, and included support from KPMG colleagues.
- The Care Hours per Patient Day work requested by NHSI is collected but as yet there is no national comparator with regard to using this data to benchmark local staffing, but is expected to be a significant development next financial year.
- Recruitment of staff continues, including European and international nurses. The International English Language Test System (IELTS) continues to be challenging to our overseas nurses, in passing this high level test.

Conclusions, implications and Next Steps

Staffing levels remain safe and the focus on agency controls is starting to show both cost and care benefits. There is some improvement on the *Harm Free Care* percentages but this needs further scrutiny and monitoring. Likewise, further data financial analysis is required on the improvement / reduction in the use of agency staff

**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

## NURSE AND MIDWIFERY STAFFING
## NOVEMBER 2016

## 1 Purpose

The aim of this paper is to update our Trust Board on the exception reports made regarding compliance with the 'Hard Truths' – Safer Staffing Commitments for October 2016.

## 2 Background

Monthly reports have been submitted to our Board on our nursing and midwifery staffing numbers. Information has been uploaded onto the UNIFY system as required as have links to NHS Choices. Information is also available on our own Trust website and now includes data regarding care hours per patient day as per as explained in last month's Board paper.

## 3 Findings

There are no exceptions to report this month, however the divisional nursing directors have been asked to review and report in divisions on their data sets. This includes commenting on where staffing hours are under or over the centile set by NHS England. In addition comments around 'harm free care' are also included. Again individual comments have been made to explain outlying components, but should be remembered that 'harm-free' care includes all harm, including that inherited from other organisations, or the community.

## 3.2 Surgical Division

### 3.2.1 Nursing Metrics Focus

From a nursing metrics performance, all areas scored GREEN, except for ward 5a which triggered an AMBER score of 26, due to cleanliness, (N)EWS scoring, falls, pressure ulcer development, staffing, and complaints. The matron for the area will review the overall with the ward sister.

### 3.2.2 Safer Staffing Focus

The following wards are reported due to being exceptional from either an under or over provision.

| | | |
|---|---|---|
| Alstone | Day 140% all care staff. | Specialing of a patient who was falls risk |
| DCC CGH | Day 66.4% Night 58.9% all care staff | Due to flexing staff off in quieter shifts |
| Guiting | Day 149.5% Night 143.6% | RGN due to TPA patients needing one to one care. HCA due to some specialing |
| DCC GRH | Night 72.8% all care staff | As for CGH |
| 2b | Night 146.7% care staff | Due to medical outliers needing greater care needs than pure H&N patients at night, additional HCA's were used. |

### 3.2.3 Care Hours per Patient Day Focus

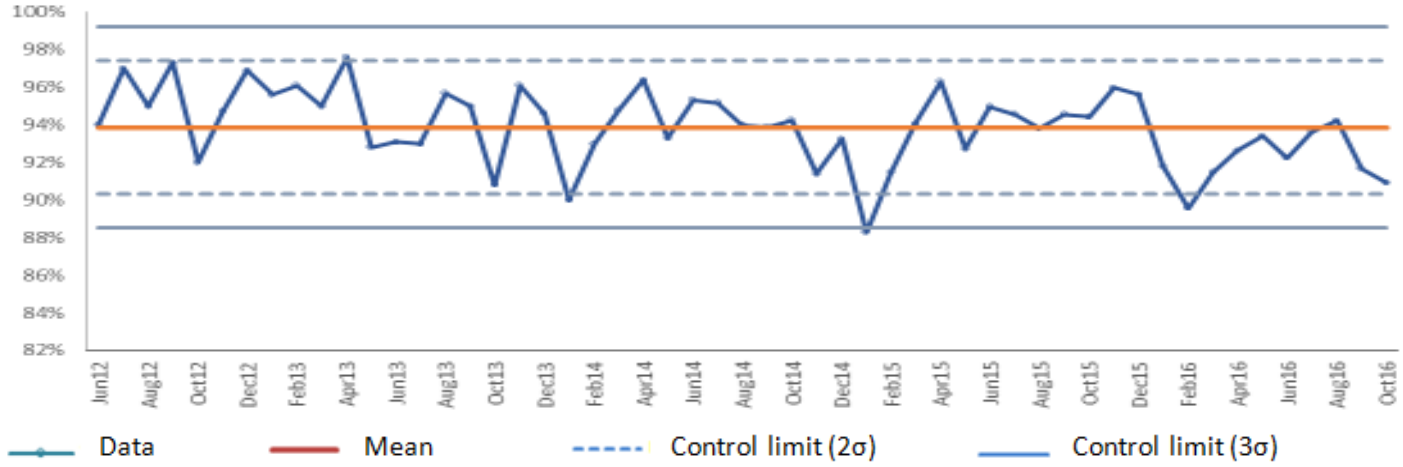
We are still awaiting advice from NHS Improvement on how to benchmark the new additional collection of the Care Hours Per Patient Day. The sum is the number of nursing hours within the 24-hour period divided by the bed occupancy for the area at Midnight.

### 3.2.4 Harm free Care Focus

A full quarter report will be available for end quarter 3 on national comparisons. Seven Surgical wards scored below 100% for Harm Free Care. Importantly, it should be remembered that the national reporting includes ALL harm, whether attributed to the Trust or

to the wider community. For example, pressure ulcers which develop in the community are reported as harm events, but clearly not caused within this organisation.

*SPC - Surgery Harm Free Care*




Trigger reasons follow: -

| | | |
|---|---|---|
| Alstone | 92.8% | Falls |
| Bibury | 80.9% | Falls |
| DCC CGH | 87.5% | Pressure Ulcer |
| Dixton | 91.6% | Pressure Ulcer, Catheterisation |
| DCC GRH | 93.7% | Pressure ulcer |
| 2b | 90% | Pressure ulcer |
| 3b | 91.4% | Falls, Catheterisation |

### 3.2.5 Finance and Vacancy Focus

The spend on Agency fell again, to £107.41k for September (£1.244m to date), and is below the trajectory set but both the Trust and NHS I. This is despite on ongoing use of unfunded areas to support high bed occupancy requirements. Bank spend is at £166.05k and again is mostly to support vacancies within RGN lines, where professional judgement has replaced shift by shift registered staff with HCA's and again supporting unfunded area opening.

Sickness levels, whilst above the Trust set average has, again, reduced for this month. Turnover for RGN is within the national average. HCA turnover reflects a number of staff entering nurse training.

The bottom line nursing staffing funded vacancy position within the division has fallen to 10.02 fte. However, it must be remembered that the band 2 lines are over established with mainly overseas nurses (37.86 fte over) awaiting NMC registration. Band 5 vacancies have fallen over the October figures and sit currently at 48.85 fte, and reflects the newly qualified nurses coming into the Division during August and September. Theatres remain an area of focus regarding recruitment. There are a number of wards with plus 4 to 5 fte RGN vacancies, again, ongoing recruitment exercises continue.

## 4. Medical Division

### 4.4.1 Nursing Metrics Focus

Two wards failed to submit data for their metrics, Cardiology and ward 6b. This has been addressed with the Ward Sister and Matron for the respective areas. Of the other clinical care areas, the following observation can be made from the last Metrics Dataset: -

- 7A triggered red in 7 areas. This is now being reviewed by the Matron & Divisional Nursing Director.

- Cleanliness remains the biggest challenge on medical wards; the overall score has risen from 38 in September to 41 in October.
- Hand hygiene also stands out in October as a challenging metric, 9 wards are RAG rated as red, an increase from 6 wards in September.
- (N)EWS Score and Action has improved with 18 wards rag rated as green.
- Medication Errors have halved since September, bringing the rag rating to Amber.
- Stroke and GOAM areas the trust falls co-ordinator will deliver training throughout November.
- The overall pressure ulcer score increased from 18 to 32 in October 2016. Pressure Ulcer stamps are being introduced in all areas of the medical division throughout November to assess patients skin integrity on admission to the ward and document an accurate assessment.

**4.4.2 Safer Staffing Focus**

The following wards are reported due to being exceptional from either an under or over provision.

| | | |
|---|---|---|
| Cardiac Ward | Day 122.58% Care staff<br>Night 75% RGN's | The increased fill rate for HCAs is a result of ensuring sufficient staff to support shifts where qualified gaps have not been filled by bank or agency and have been risk assessed. |
| Ryeworth | Night 124.19% Care staff | Specialing of patients who are risk assessed as requiring enhanced observation to prevent harm to self or others |
| ACUA | Day 79.03% RGNs<br>Night 79.35% RGNs | Difficulty recruiting to RGN vacancies. Each shift is risk assessed on a shift by shift basis taking in consideration bed base, skill mix, patient acuity and dependency. |
| 4A | Night 122.58% Care staff | Specialing of patients |
| 7B | Day 78.85% RGN's | The data provided is under review as there appears to be inaccuracies. |
| 8A | Night 124.19% Care staff | Specialing of patients who are risk assessed as requiring enhanced observation to prevent harm to self or others |
| 9B | Day 126.88% Care staff<br>Night 154.84% Care staff | Specialing of patients who are risk assessed as requiring enhanced observation to prevent harm to self or others. Two patient bays cohorted. Multiple V&A calls. |
| GW1 | Day 128.49% Care staff<br>Night 67.74% Care staff | Specialing of patients who are risk assessed as requiring enhanced observation to prevent harm to self or others |

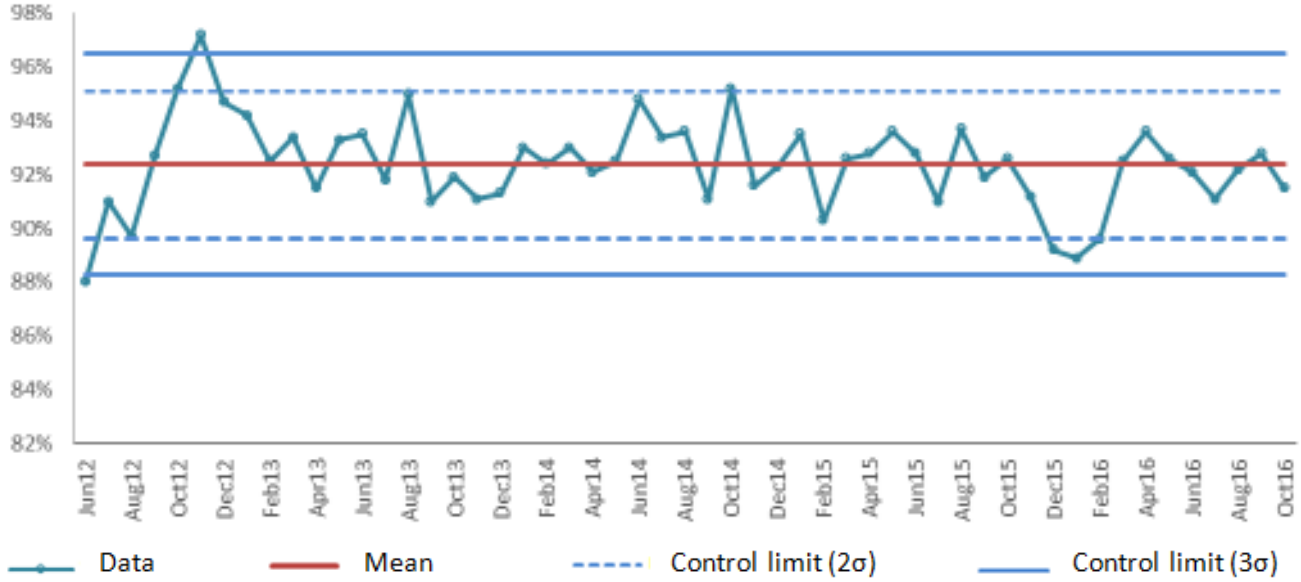
**4.4.3 Care Hours per Patient Day Focus**

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

**4.4.5 Harm free Care Focus**

A full quarter report will be available for end quarter 3 on national comparisons. Of the 24 Medical wards 17 scored 100% and 7 scored below 100% for Harm Free Care. Importantly, it should be remembered that the national reporting includes ALL harm, whether attributed to the trust or to the community. For example, pressure ulcers which develop in the community are reported as harm but are not caused within this organisation.

*SPC - Medicine Harm Free Care*




Trigger reasons follow: -

| | | |
|---|---|---|
| Hazelton | 95.0% | Falls |
| Ryeworth | 87.5% | Falls |
| Woodmancote | 88.0% | Falls |
| Cardiology | 96.67 | Pressure Ulcer |
| 7A | 92.86% | Falls |
| 8B | 96.55% | Pressure Ulcer |
| 9B | 97.5% | Falls |

Falls remain the greatest area of concern for the division. The division is currently undertaking an analysis of falls by location and time of day. This is to understand what factors if any are contributing to falls i.e. environment, nursing handover periods. Once this analysis is completed actions will be sort to mitigate risk and minimise harm to patients. Several wards are undertaking weekly falls audits with the aim of increasing knowledge and awareness of how to reduce the risk of falls for our vulnerable patients. The trust falls coordinators have been undertaking bespoke training on several wards between GRH and CGH.

### 4.4.6 Finance and Vacancy Focus

The spend on Qualified & Unqualified Agency is overall reducing, in Month 1 the spend in the month was £818k, in M7 in the month it is £587k (£4.406m to date). The actual agency hours worked in Month 1 were 11,406 hrs and in Month 7 they were 8,751hrs.

The bottom line nursing staffing funded vacancy position, when comparing substantive funding against contracted, has fallen to 37.12 fte. However, it must be remembered that the band 2/3 lines are over established with mainly overseas nurses awaiting NMC registration (total unqualified over-established is 43.82 fte over). Band 5 vacancies have reduced by 6.62wte and reflects the newly qualified nurses coming into the Division. Ongoing recruitment exercises continue.

## 5. Diagnostics and Specialties Division

### 5.5.1 Nursing Metrics Focus

From a nursing metrics performance, Rendcome & Lilleybrook both scored Green. Lilleybrook has had significant building works in two side rooms which have impacted on ward activity and at times cleanliness. The matron for the area will review the overall with the ward sister.

### 5.5.2 Safer Staffing Focus

The following wards are reported due to being exceptional from either an under or over provision.

| | | |
|---|---|---|
| Lilleybrook | Day 121% all care staff. | This was due to ward acuity and the ward helpline service. The ward also was undertaking some specialing. |

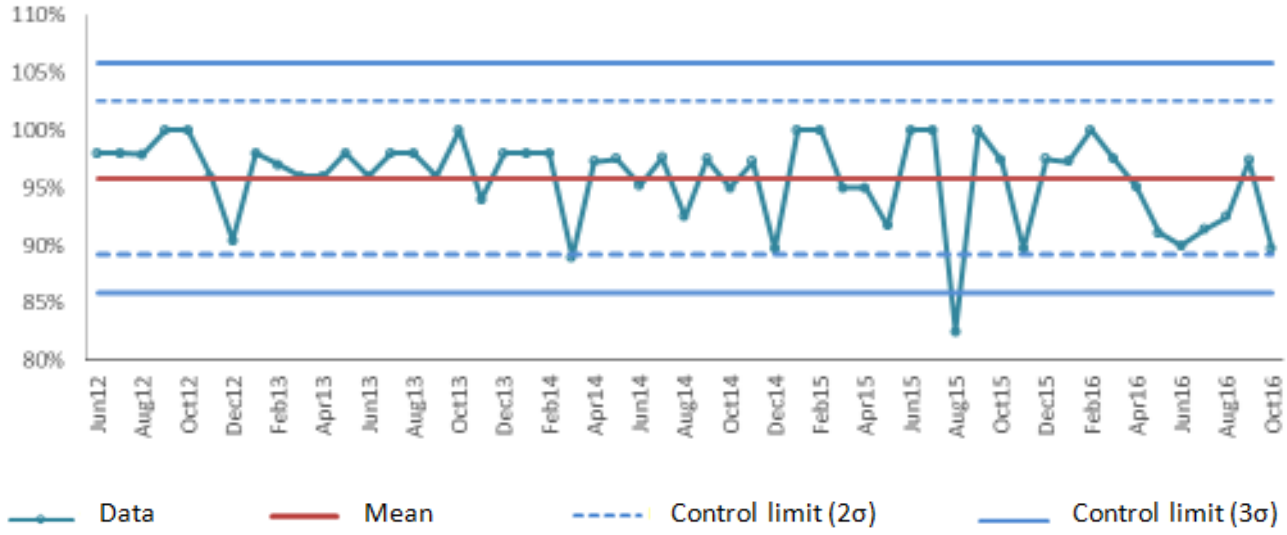
### 5.5.3 Care Hours per Patient Day Focus

We are still awaiting advice from NHS Improvement on how to benchmark the new additional collection of the Care Hours Per Patient Day. Ruth May has indicated at a regional nursing director forum that NHSI will stop reporting safer staffing and concentrate on care hours per patient day when they have finalised their approach for the UK, however what we do know at this point is that The sum is the number of nursing hours within the 24-hour period divided by the bed occupancy for the area at Midnight.

### 5.5.4 Harm free Care Focus

A full quarter report will be available for end quarter 3 on national comparisons. Two oncology wards triggered below the 100 all harm free care indicator. All harm is attributed to harms that may have originated in primary care and therefore not caused by a secondary care episode.

*SPC – D&S Harm Free Care*




Trigger reasons follow: -

Lilleybrook 88% Grade 2 Pressure Ulcer and Falls.
Rendcome 95% Catheter UTI & Grade 2 Pressure Ulcer.

### 5.5.5 Finance and Vacancy Focus

The spend on Agency fell again in month 7, to £6.6K for September (£36.8K to date), and is below the trajectory set but both the Trust and NHS I.

Sickness levels,
Are at around 4% for nursing. Management plans are in place for staff who are breaching targets set by ward managers and HR.

## 6. Women & Children's Division

### 6.6.1 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 in one area only, average fill rate of care staff on day duty 79.5%, this is an improvement on last month's fill rate. It is pleasing to see that all other areas were green and average fill rate of registered staff on day duty was 95.85%. Recruitment remains positive, there is currently 1 registered nurse vacancy (with 1 nurse from the Philippines starting without her NMC registration in November and a further 2.6 WTE staff appointed to start in the new year), 2 band 3 vacancies, with 1 band 2 vacancy awaiting to be filled by an apprentice. The department continues to advertise for additional staff which will result in over-recruitment in both areas to take into account staff turnover and maternity leave. Long term sick has reduced in November and maternity leave remains at 5 WTE registered nurses.

2a is now green across all areas this is explained a readjustment in agreed staffing to take into account the additional staff required for the 6 bed day case area which has been used as part of escalation and remained open 24/7. The ward has recruited to fill these additional posts (3.48 WTE) on a substantive basis and currently only has one vacancy that has not been offered. Two RGNs are due to start in December and a further two in the new year. The plan should reduce agency costs and more importantly improve patient and staff experience.

The Maternity Ward are showing overfill of health care assistants 150% on day duty which demonstrates that these care assistants are being used to offset under fill in trained midwifery cover (overall 92.14%), resulting in an overall overfill rate of 123.39%. There are however no concerns at present in relation to recruitment into Midwifery posts. 12 newly qualified midwives have recently been offered positions which will take the service up to full establishment. The service is working with HR to review recruitment processes to ascertain how recruitment and induction of staff can be improved to reduce the delay between interview and appointment.

Stroud Maternity show an overfill of 120% on registered staff on day duty which can be explained by the fact that the area only has one midwife on duty unless activity requires a second, any additional staff allocated for this activity would show as overfill.

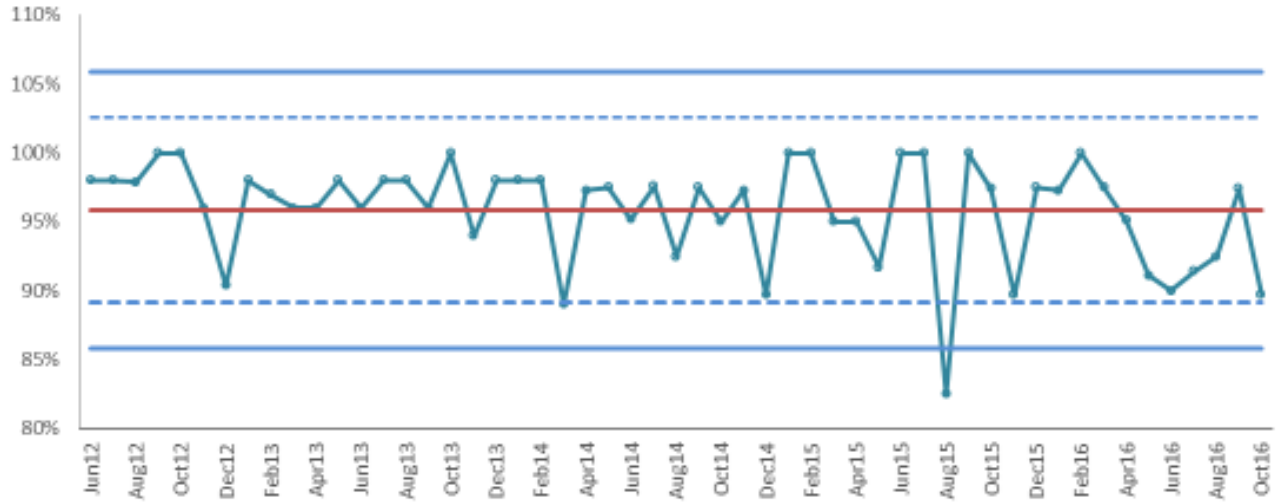
### 6.6.2 Care Hours per Patient Day Focus

Further guidance is still awaited from NHS Improvement on how to benchmark the new additional collection of the Care Hours Per Pateint 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.

### 6.6.3 Harm free Care Focus

Across the Division all areas reported harm free care. However 2a did not submit data and this has been followed up by the Divisional Nursing Director. Children's Inpatients did not submit data as agreed as they move to implement the Paediatric safety thermometer.

*SPC – Women and Childrens Harm Free Care*




### 6.6.4 Establishment Paediatric Nursing - 2016

| **Qualified:**73 wte | Jan | Feb | Mar | April | May | June | July | August | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Vacancies | 5 | 5 | 5 | 4 | 4 | 3.5 | 3.8 | 3.5 | .3 | 0.6 + | 1 | |
| Maternity Leave | 8.5 | 8.5 | 6.3 | 7 | 7 | 6.2 | 6.4 | 5.6 | 4.8 | 4.2 | 5.2 | |
| Long term sick | 0.6 | 3.5 | 3.5 | 3.4 | 3.4 | 2.6 | 3 | 4 | 4 | 4 | 1 | |
| Actual Gaps | 14.1 | 17 | 14.8 | 14.4 | 13.4 | 12.3 | 13.2 | 13.1 | 8.3 | 7.6 | 7.2 | |
| Accepted Posts | | 15.6 | 14.6 | 14.6 | 12 | 13 | 11 | 8 | 3 (1 from Philippines) | 3.6 ( 2from Philippines) | 3.6-1 Nov and 2.6 Jan) | |
| Ready to start | | 1.0 | 1.8 | 3 | 1 | 2 – 1 WITHDREW | 3 | 4 | 2 | 2 | 1 – no pin | |
| Resignations | | 0 | 0 | 1.6 | 0.4 | 1.2 | 1.4 | 1.6 | 1 | 2 | 1 | |

| **HCAs :23 wte** | Jan | Feb | Mar | April | May | June | July | *August* | *Sept* | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Vacancies | 2 | 2.3 | 2.3 | 1 | 0.6 | 0 | +1 | +1 | 0 | 1 | 1 | |
| Maternity Leave | | | | | | | | | | | | |
| Long term sick | | | | | | | | | | 2 | 1 | |
| Actual Gaps | 2 | 2.3 | 2.3 | 1 | 0 | 0 | +1 | +1 | 0 | 3 | 2 | |
| Ready to start | | | 2 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | |
| Resignations | | | 0.6 | 0.6 | 0.4 | 0 | 1 | 0 | 0 | 1imed effect | 1 | |

## 7 Recruitment Update

### 7.1 UK/EU Recruitment

- There are currently 29 experienced UK-based Band 5 nurses in the recruitment pipeline, with start dates between 31 October 2016 and March 2017.
- There are 9 Band 6 registered nurses in the recruitment for Critical Care (5.29 WTE), Paediatrics (1.49 WTE) and General Theatres (1.0 WTE).
- Our European recruitment partners have 6 nurses from the Netherlands (TMI), plus nine nurses from Portugal (PCQ). These candidates are currently taking their IELTS examinations. PCQ are planning further events in Portugal, Italy and Poland for the Trust.
- There are currently 15 advertisements live for Band 5 Registered Nurses, plus 5 advertisements at Band 6 and one at Band 7 (Prescott Ward Manager) on NHS Jobs.

### 7.2 Overseas Recruitment

#### 7.2.1 November 2015 Campaign

- Of the nurses that have commenced employment, the first six took their OSCE on 17/18 October, with one candidate passing successfully. Three of the candidates who failed require full retakes, and two candidates require partial retakes. These exams are scheduled for 16 November, and if a candidate fails for a second time, their visa will be curtailed.

| Status | Candidates |
|---|---|
| Commenced employment | 11 |
| Visa issued / awaiting deployment | 1 |
| Passed IELTS and CBT exams, accepted by the NMC, waiting for visa application | 2 |
| Passed IELTS and CBT exams, waiting for NMC decision letter | 10 |
| Passed IELTS examination, waiting for CBT examination | 4 |
| Not passed the IELTS examination – waiting for exam | 67 |
| **Total (minus withdrawn candidates)** | **95** |

#### 7.2.2 May 2016 Campaign

| Status | Candidates |
|---|---|
| Passed IELTS and CBT exams, accepted by the NMC, waiting for visa application | 1 |
| Passed IELTS and CBT exams, waiting for NMC decision letter | 7 |
| Passed IELTS examination, waiting for CBT examination | 6 |
| Not passed the IELTS examination – waiting for exam | 70 |
| **Total (minus withdrawn candidates)** | **84** |

#### 7.2.3 September 2016 Campaign

| Status | Candidates |
|---|---|
| Passed IELTS and CBT exams, accepted by the NMC, waiting for visa application | 1 |
| Passed IELTS and CBT exams, waiting for NMC decision letter | 0 |
| Passed IELTS examination, waiting for CBT examination | 5 |
| Not passed the IELTS examination – waiting for exam | 155 |
| Not passed the IELTS examination – candidate not yet accepted offer | 7 |
| **Total (minus withdrawn candidates)** | **168** |

## 7.3 Nursing Workforce Metrics

### 7.3.1 Vacancy Metrics

The vacancy data continues to show a sustained investment in Band 2 and Band 3 staffing numbers, with 71.52 WTE additional healthcare assistants at Band 2, and a further 31.40 WTE additional unregistered nursing staff at Band 3. The vacancy level at Band 5 has reduced from 168.04 WTE to 118.07 WTE (includes midwives and excludes Corporate Services). This reduction of 50 WTE is due to a large number of the newly qualified nurses and midwives receiving their PINs during this reporting month. The greatest benefits have been seen in Medicine and Surgery, where vacancies are reduced considerably from 22.79% to 17.63% and 11.87% to 8.87% respectively. Vacancies have also reduced at Band 6 and Bands 7+ over the last month, and over-establishments are now recorded in Diagnostics and Specialties (Bands 7+) and Surgery (Band 6 and Bands 7+). There is a very high vacancy rate for Apprentice HCAs, despite an intake of new candidates joining the Trust during this reporting month.

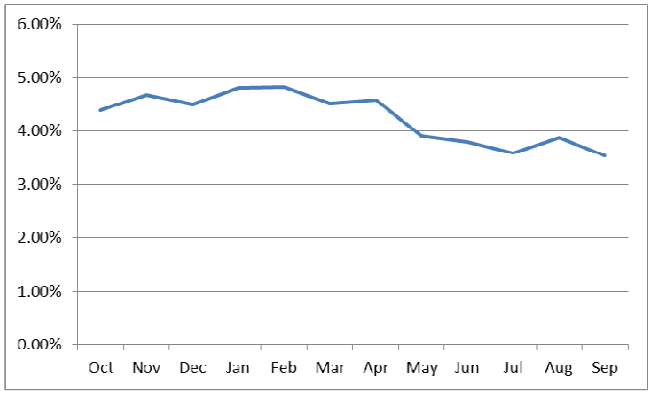
| | Diagnostics & Specialties | | Medicine | | Surgery | | Women & Children | |
|---|---|---|---|---|---|---|---|---|
| | WTE | % | WTE | % | WTE | % | WTE | % |
| Apprentice HCA | 2.00 | 25.00% | 5.00 | 27.78% | 7.20 | 28.80% | 1.00 | 20.00% |
| Band 2 | 0.00 | est. | -26.48 | over | -37.86 | over | -7.18 | over |
| Band 3 | 0.00 | est. | -21.96 | over | -3.66 | over | -5.78 | over |
| Band 4 | 1.03 | 21.64% | 2.66 | 15.29% | -0.91 | over | 0.60 | 6.26% |
| Band 5 | -3.31 | over | 82.20 | 17.63% | 48.85 | 8.87% | -9.67 | over |
| Band 6 | 3.44 | 8.67% | 4.71 | 3.39% | -0.71 | over | 14.34 | 6.10% |
| Bands 7+ | -2.86 | over | 3.40 | 5.97% | -2.84 | over | 4.82 | 6.49% |

Data Note: Data for this table is from 30 September 2016. Women & Children data include Midwives. Data does not include re-banding Nurses Awaiting PIN to Band 3 (from 01 October). est. = established, over = over-established

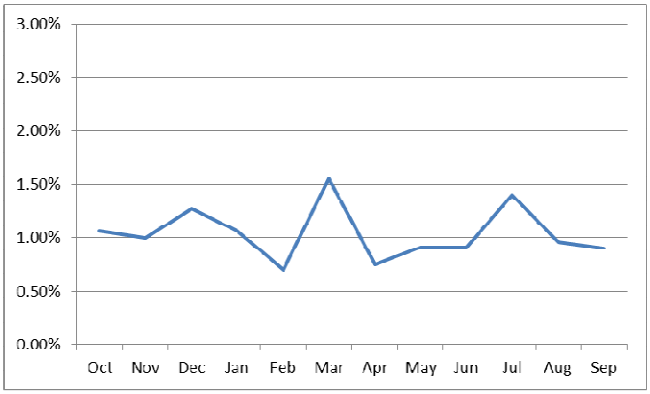
### 7.3.2 Staffing Metrics

| Division | Sickness | | Turnover | | Parental Leave | |
|---|---|---|---|---|---|---|
| | RGNs | HCAs | RGNs | HCAs | RGNs | HCAs |
| Diagnostic & Specialties | 4.72% | 5.29% | 8.65% | 12.33% | 3.84% | 2.11% |
| Medicine | 3.57% | 4.91% | 15.53% | 18.72% | 3.94% | 3.62% |
| Surgery | 4.57% | 3.91% | 10.53% | 17.16% | 4.20% | 2.27% |
| Women & Children | 4.26% | 3.55% | 13.13% | 9.65% | 3.93% | 2.92% |

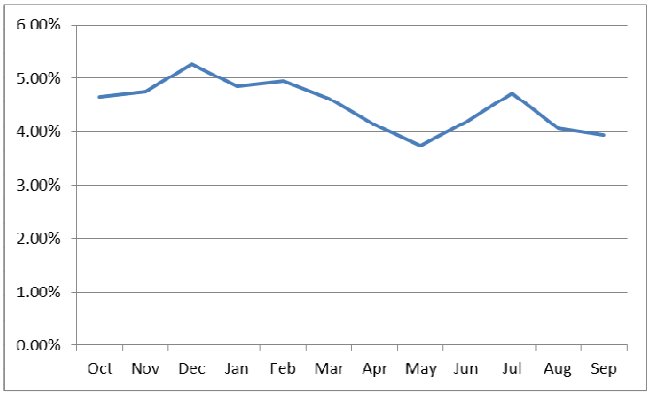
Data Note: 12 month rolling data.



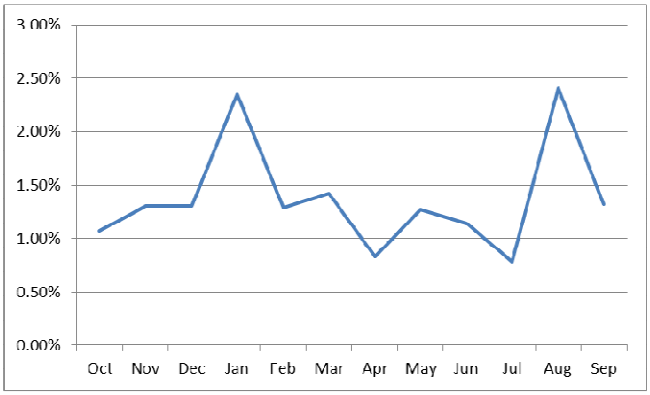

**RGN:** Sickness Absence by Month (Oct 15 – Sep 16)




**RGN:** Turnover by Month (Oct 15 – Sep 16)




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

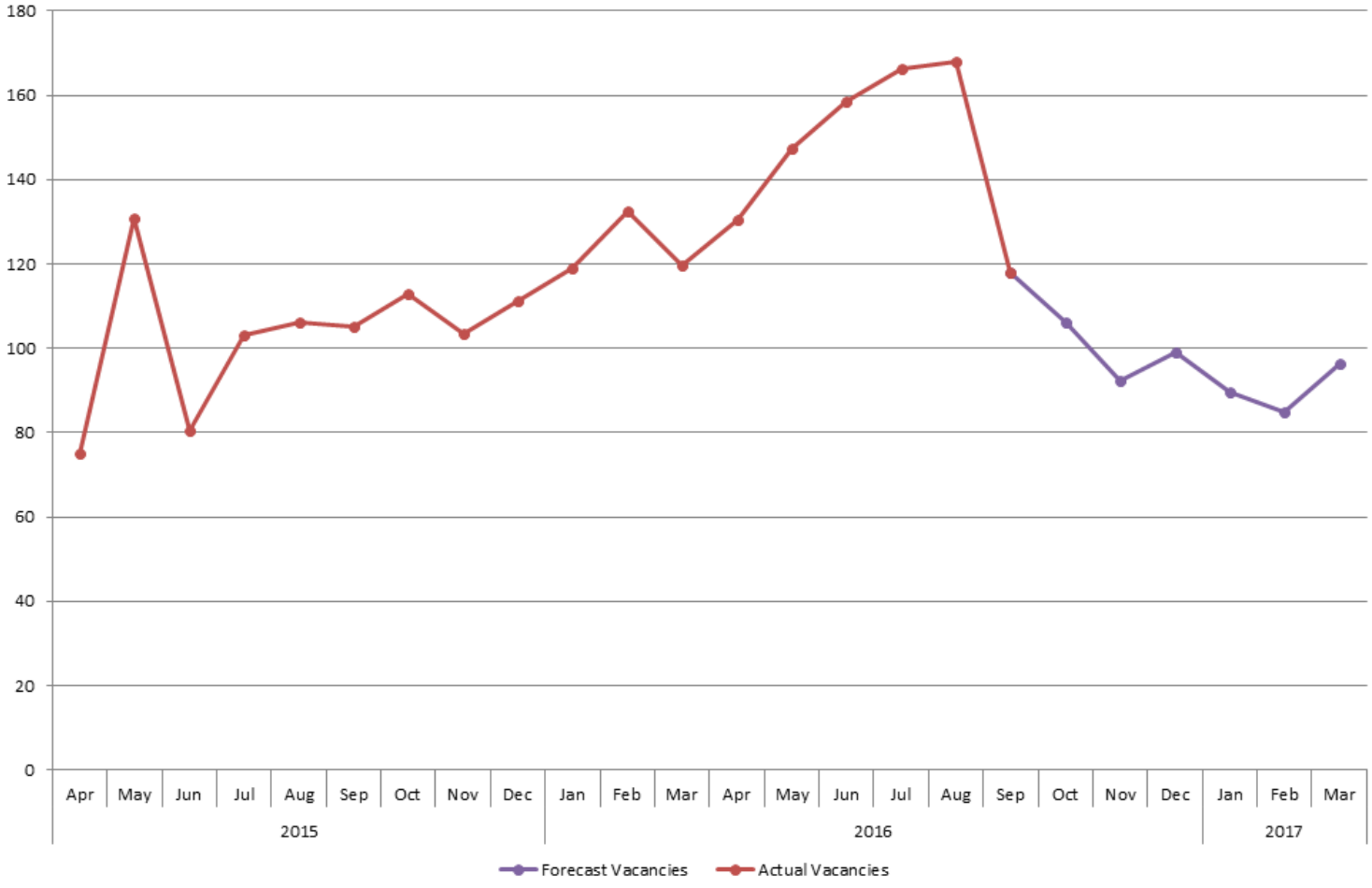



**HCA:** Turnover by Month (Oct 15 – Sep 16)

## 7.4 Vacancy Forecast

- The establishment for Band 5 registered nurses decreased by 2.36 WTE since 31 August, which was coupled with a relatively low number of leavers and a high number of nurses Awaiting PIN achieving registration.
- There are currently 1099.06 WTE Band 5 registered nurses employed by the Trust (exc. Corporate Services), which is the most staff ever employed.
- The vacancy rate of 118.07 WTE is the lowest it has been since December 2015, and this is expected to decrease further in the coming months, and is expecting to be below 100 WTE in November 2016 (to be reported in the January 2017 Safer Staffing Report).

Registered Nursing Vacancies – All Services all Sites



## 8 Revalidation update-

From April 2016-October 2016 463 nurses were due to revalidate in our Trust.

1 did not revalidate - non-compliant
4 retired not due to revalidation
1 left the Trust
2 had NMC extensions
3 people were also due for retirement in this time but have since decided not to retire after having Revalidation explained to them with guidance and support.
= 462 in our Trust Revalidating or were accountable

Workshops are still busy and well attended as are 1-1 sessions. More recognisable handouts have been created which explain Revalidation in a simpler way as requested by staff from feedback sheets that have also been created. The Revalidation team are now visiting areas not just to do sessions but to support ward managers with discussions and confirmation sessions required for Revalidation. An action card has now been produced which links in with the Professional Staff Registration Policy and is being taken to Policy Group this month. A risk assessment form is being created for Revalidation.

The NMC have just produced a quarterly report and over 110,000 nurses and midwives have now revalidated with the NMC and Revalidation represents a significant change to the way nurses and midwives are regulated so in our Trust it is a pleasing result that so far we have only one person from nearly 500 hundred not Revalidating.

## 9 Next Steps and Communication

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

## 10 Recommendations

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

**Authors:** **Divisional Nursing Directors**

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

**November 2016**

**GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST**
**PUBLIC BOARD MEETING FRIDAY NOVEMBER 2016**
**Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at 9.00 a.m

| **Report Title** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **BOARD ASSURANCE FRAMEWORK** | | | | | | | | | |
| **Sponsor and Author(s)** | | | | | | | | | |
| Deborah Lee, Chief Executive | | | | | | | | | |
| **Audience(s)** | | | | | | | | | |
| Board members | **x** | Regulators | | Governors | **x** | Staff | **x** | Public | **x** |

**Executive Summary**

Purpose

The Board Assurance Framework is the means through which the Board assures delivery of its stated annual objectives through the oversight 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 and mitigate the risk.

Key issues to note

- Since the last report, Trust operational risks have been added and aligned with the risk to the Strategic Objectives.
- Changes to the risk scores have been effected following the Board review in October.
- The risk rating associated with the internal efficiency strategic objective *Inability to deliver financial targets caused by a failure to reduce expenditure as per plan* has been escalated as the existing plan doesn't mitigate the risk and, consequently, the loss meets the financial assessment criteria for 5 * 5. This will be reviewed in the very near future and reassessed once a new plan has been agreed and is expected to reduce.
- Further work is underway to ensure risks have been appropriately rated given the BAF risk assessment is the assessment of the quality of the controls to manage the risk (not assessment of the risk itself)
- The Trust's new External Auditors (KPMG) have recently undertaken a review of BAFs across Foundation Trust's in the south and the Trust will undertake a review of our own approach, against the KPMG model of best practice.
- Responsibility for the BAF will migrate to the Trust Secretary, once the new administrative arrangements are bedded in and capacity to released to take this on.

Conclusions

The Board Assurance Framework continues to develop and improve though it has yet to achieve its full potential to support the Board in understanding the risks to delivery of the annual objectives. There are four principals risks rated 15 or higher, which therefore have the potential to undermine delivery of key strategic objectives. These are

- Risk of not being able to recruit and retain a workforce with the right profile to deliver the clinical services (4*5 = 20) – this risk is being actively managed in the Workforce Committee
- Risk of not meeting financial targets (5*5=25) – this risk is being actively managed by the Finance Committee
- Risk of delays to patient discharge impacting on patient experience and the timely delivery of care closer to home (4*4) – this risk is being actively managed through the Emergency Care Programme Board and A&E (system) Delivery Board
- Risk of the failure of the local health and social care system to manage demand with agreed

levels (5*4) this risk is being actively managed through the Emergency Care Programme Board and A&E (system) Delivery Board

Implications and Future Action Required

Review the BAF against the KPMG best practice review and notably, review the appropriateness of the strategic objectives as part of the annual planning process.

**Recommendations**

To receive the Board Assurance Framework as evidence that the executive team is tracking the principle risks to delivery of the strategic objectives and that assurance in respect of mitigating actions and controls are in place with Board committee oversight.

**Impact Upon Strategic Objectives**

The report identifies the risk and mitigation to the Strategic objectives

**Impact Upon Corporate Risks**

A number of corporate risks map to the principle risks set out in the BAF and this is noted under each strategic objective.

**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) |
|---|---|---|---|---|---|
| | | 8\11\16 | | | |

**GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST**

**MAIN BOARD / NOVEMBER 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:** **November 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?<br><br>You may have more than 1 risk<br><br>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<br><br>The controls and assurance are rated by level of assurance<br><br>**Management Reviewed Assurance = 1**<br><br>**Board Reviewed Assurance = 2**<br><br>**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?<br><br>↑ ↓ ↔ |
| **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 safe standard approaches to patient care not being applied consistently. | **Medical Director**<br><br>**Quality and Performance Committee** | 1. Development of internal professional standards for clinicians. (1)<br>2. Clinical leadership in the SAFER ward based project (1)<br>3. Maintaining involvement through the Clinical design authority who are responsible for the clinical design of Trakcare (1) | 1. Emergency pathway report (Stream 11)<br>2. Emergency pathway report (Stream 3)<br>3. Progress monitored in the Smartcare Board(2) | 1. Emergency pathway report to Board (2)<br>2. Smartcare Board report (2)<br>3. Quality & Performance report (1) | 2x4=8 |
| | | | **Gaps in Control** | **Gaps in Assurance** | **Direction of Travel** |
| | | | 1. Required funding to support clinical back fill to facilitate time to engage<br>2. Insufficient real time data | 1. Available real time data. | ↔ |

| Principal Risk to the plan | Risk Owner (Executive Director & Committee) | Key Controls | Assurance on Controls | Current Assurances | Risk Rating (Likelihood x Impact) |
|---|---|---|---|---|---|
| Risk to safety due to 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**<br><br>**Quality and Performance Committee** | 1. Maintaining involvement in the Reducing Clinical Variation workstream of the Gloucestershire STP<br>2.Maintaining involvement through the Clinical design authority who are responsible for the clinical design of Trakcare (1)<br>3. Reducing Clinical variation | 1. Monitored STP governance arrangements<br>2.Progress with clinical design of phase 2 Trakcare monitored in the Smartcare Board | 1.Monthly reports to board on progress | 2x4=8<br>(3x4=12) |
| | | | **Gaps in Control** | **Gaps in Assurance** | **Direction of Travel** |

| | | | | | |
|---|---|---|---|---|---|
| | | Board as part of STP | None | None | ↔ |
| **Potential Risk Exposure** | **Related risks on Trust Risk Register** | | | | |
| 1. Unexpected high mortality data linked to variation in practice.<br>2. Delay in delivery of clinical benefits to reduce variation from Trakcare | N17<br>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<br>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<br>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<br>Risk arising from the sequence of surgical related Never Events leading to potential regulatory intervention. | S127<br>The risk of potential suboptimal care standards as a cause of the higher than national average mortality for Fractured neck of femur |
| | M1a<br>The clinical risk of delay in treating patients arriving at ED during periods of high demand or staff shortage | M1<br>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<br>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** |
| Extra investment to be agreed to provide backfill to support Emergency Pathway | | Medical Director | October 2016 | | Agreed at Board Seminar |
| Discuss real time data capture methods from current sources | | Medical Director | December 2016 | | None |

## 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**<br><br>**Trust Board** | 1. Outline Site Development plans agreed by Board (2)<br>2. Site Development plans reflected in the emerging Sustainability and Transformation Plan the STP submission (2)<br>3. Bid to NHSE for capital allocation<br>4. Stakeholder engagement plan | 1. Progress reports on site development plans (2)<br>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.<br>2. Unexpected significant deterioration in clinical services requiring urgent service change | S100<br>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<br>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<br>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<br>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**<br><br>**Trust Leadership Team** | 1. Regular executive level meetings with neighbouring trusts (2) | 1.Review of clinical services by clinical senates and Strategic Clinical Networks (1) | None | 2X4=8 |
| | | | **Gaps in Control** | **Gaps in Assurance** | **Direction of Travel** |
| | | | 1.Links with neighbouring STPs | None | ↔ |

| Principal Risk to the plan | Risk Owner (Executive Director & Committee) | Key Controls | Assurance on Controls | Current Assurances | Risk Rating (Likelihood x Impact) |
|---|---|---|---|---|---|
| Risk of key stakeholders not supporting any significant service changes required | **Director of Clinical Strategy**<br><br>**Trust Leadership Team** | 1. Participation in system wide engagement activities (1)<br><br>2. Stakeholder engagement plan (2) | 1. Board report on progress of changes.(2)<br>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<br>The risk of failure to manage rising demand without increased capacity leading to failure to meet | C12<br>Risk of significant affects to flow and statutory standards because of delayed discharge of patients who are on | F7<br>The risk of delayed treatment and diagnosis causing harm and because of a backlog of follow-up | M1b<br>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**<br><br>**Health & Wellbeing Committee** | 1. Staff survey (3)<br>2. Monitoring of impact of healthy living services (1)<br>3. Participation in Healthiest Workplace Initiative (2)<br>4. Representation on Gloucestershire Health and Wellbeing Board (2) | 1. Staff survey results (3)<br>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 | ↔ |

| Potential Risk Exposure | Related risks on Trust Risk Register | | | | |
|---|---|---|---|---|---|
| None | HR2b<br>The risk of sub-optimal patient care due to high level of nursing vacancies, particularly in Medicine. | M1b<br>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<br>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**<br><br>**Quality and Performance Committee** | 1. Recruitment Standards(1)<br>2. Trust Education programmes (1)<br>3. Nursing & Midwifery Strategy (2)<br>4. Patient Experience Strategy (2)<br>5. Management of the 4Cs (1)<br>6. Senior Nurse and Midwifery Committee (1)<br>7. Safer Staffing Report including recruitment & Retention(2)<br>8. ECB workstream action plans particularly 3&6 (2)<br>9. Countywide system call<br>10. Infection control\Flu plan | 1. Directors statement (2)<br>2. Divisional Quality Report (1)<br>3. Family & Friends Test (3)<br>4. Patient Surveys (3)<br>5. Formal comments – Health watch, Governors (3)<br>6. Local Supervisors of Practice Annual report(3)<br>7. ECB report (2) | None | 3x4=12 |
| | | | **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**<br><br>**Quality and Performance Committee** | 1. Recruitment Standards(1)<br>2. Trust Education programmes (1)<br>3. Nursing & Midwifery Strategy (2) | 1. Directors statement (2)<br>2. Divisional Quality Report (1)<br>3. Family & Friends Test (3)<br>4. Patient Surveys (3) | None | 3x4=12 |

| | | | | | |
|---|---|---|---|---|---|
| | | 4. Patient Experience Strategy (2)<br>5. Management of the 4Cs (1)<br>6. Senior Nurse and Midwifery Committee<br>7. Safer Staffing Report including recruitment & Retention(2)<br>8. ECB workstream action plans particularly 3&6 (2) | 5. Formal comments – Health watch, Governors (3)<br>6. Local Supervisors of Practice Annual report(3)<br>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.<br>2. Industrial action | N17<br>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<br>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<br>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<br>The clinical risk of delay in treating patients arriving at ED during periods of high demand or staff shortage | C11<br>The risk of suboptimal patient experience due to the failure of timely transport arrangements provided by the Commissioner lead contract with ARRIVA |
| | M1b<br>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**<br><br>**Quality & Performance Committee**<br><br>**Emergency Care Board** | 1. System Resilience Group (3)<br>2. Emergency Care Board (1)<br>3. Emergency Care plan(2)<br>4. Integrated Discharge Team Implementation Plan & Steering Board(1) | 1. PMF (2)<br>2. Emergency Care Report (2)<br>3. Weekly system wide call of all Nursing Directors to review medically fit list | Blank | 4x4=16 |
| | | | **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**<br><br>**Quality & Performance Committee** | 1. Emergency Care Plan(2)<br>2. Planned Care Plan(2)<br>3. Winter plan (2)<br>4. Improvement Director post.(1)<br>5. CCG Contract(3)<br>6. CCG Contract Review Board(3)<br>7. Financial & Performance Committee(2)<br>8. Gloucestershire A&E Delivery Board (3)<br>9. Sustainability & Transformation Plan<br>10. 2016-17 QIPP plans | 1. Emergency care Board & Report (2)<br>2. Planned Care Board (1)<br>3. Finance & Performance Committee<br>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**<br><br>**Quality & Performance committee** | 1. Planned Care Plan(2)<br>2. Individual specialty recovery plans (1)<br>3. CCG contract (3)<br>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**<br><br>**Quality & Performance committee** | 5. Planned Care Plan(2)<br>6. Individual specialty recovery plans (1)<br>7. CCG contract (3)<br>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.<br>2. Industrial action<br>3. Adverse weather | S118<br>An increased patient safety risk, a reduced patient experience and a negative effect on Day surgery activity and efficiency, as a | M1c<br>The risk of suboptimal care and inability to meet statutory standards when the hospital is at full capacity with limited ability to accommodate surges | C12<br>Risk of significant affects to flow and statutory standards because of delayed discharge of patients who are on | F7<br>The risk of delayed treatment and diagnosis causing harm because of a backlog of follow-up | M1<br>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 | 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**<br><br>**Finance Committee** | 1. Operational Plan (3)<br>2. Divisional & Corporate Budgets (1)<br>3. Quarterly Review by Monitor (3)<br>4. Executive Divisional Reviews (1)<br>5. Turnaround Implementation Board<br>6. Recovery Board<br>7. Vacancy Control panel<br>8. Agency Programme Board | 1. PMF<br>2. Finance Report(2)<br>3. Audit reports (3)<br>4. Carter Review outputs (1)<br>5. Cost Improvement Report (1)<br>6. Approved recruitment report | Deloitte Financial Review and delivering agreed recommendations | **5x5=25**<br>**(5x4=20)** |
| | | | **Gaps in Control** | **Gaps in Assurance** | **Direction of Travel** |
| | | | Blank | Blank | ↑ |

| Potential Risk Exposure | Related risks on Trust Risk Register | | | | |
|---|---|---|---|---|---|
| 1. Changes to national financial assumption | HR2b<br>The risk of sub-optimal patient care due to high level of nursing vacancies, particularly in Medicine. | M1b<br>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<br>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**<br><br>**Private Patient Committee** | 1. Short-term: Differentiation of GH NHS FT private patient offer on price point (1)<br><br>2. Medium term: Differentiation of GH NHS FT on environment and service provision (1) | 1. Regulator Reports from PP (1)<br>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**<br><br>**Private Patient Committee** | 1. Recruitment to key posts as expansion progresses (1) | 1. Regulator Reports from PP (1)<br>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<br>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<br>The risk of failure to reduce agency costs as a consequence of Workforce shortages | Blank | Blank | Blank |
| **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**<br><br>**Capital Control Group** | 1. Backlog maintenance programme (1)<br>2. Estates strategy (2)<br>3. Management of Space process (1)<br>4. Oversite of the service reconfiguration programme (Infrastructure workstream) (2) | 1.Risk identification from programmes. (1)<br>2. Annual update on estates strategy (2)<br>3, E&F Risk Register (1) | 1.Quality of space management information<br>2.Back log maintenance programme | 3x4=12 |
| | | | **Gaps in Control** | **Gaps in Assurance** | **Direction of Travel** |
| | | | Blank | Blank | ↔ |
| **Potential Risk Exposure** | **Related risks on Trust Risk Register** | | | | |
| 1. Unexpected decline or finding of unfit for purpose inspection of the estate.<br>2. Sudden damage to estate. | IT2246<br>The risk of Operational disruption caused by loss of critical business systems due to failure of the ageing IT network infrastructure. | DSP1347<br>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**<br><br>**Smartcare Programme Board** | 1. Implementation Plan reviewed by HSCIC and Internal Audit (3)<br><br>2. Authority to Proceed processes reviewed by Internal Audit (3)<br><br>3. Learning from successful implementations in other Trusts (1) | 1. HSCIC/DH Gateway Review (3)<br>2. Internal Audit (3)<br>3. Programme report to Board (2)<br>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**<br><br>**Trust IM&T Board** | 1. IT Blueprint strategy (1)<br><br>2. Network Business Case (1)<br><br>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<br>2. Loss of business critical | IT2246<br>The risk of Operational disruption caused by loss of critical business systems | DSP1347<br>The risk of the inability to maintain business continuity in a key clinical area(oncology) | Blank | Blank | Blank |

| | | | | | |
|---|---|---|---|---|---|
| systems to other providers due to shared nature of the infrastructure | due to failure of the ageing IT network infrastructure. | 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**<br><br>**Workforce Committee**<br><br>**Education, Learning and Development Committee** | 1. Objectives and workplan for Leadership reviewed by Workforce Committee (1)<br>2. Coaching Faculty established internally (1)<br>3. Access to national programmes via Leadership Academy(2)<br>4. Periodic reviews of talent/succession by senior team (1)<br>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**<br><br>**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)<br>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<br>The risk of sub-optimal patient care due to high level of nursing vacancies, particularly in Medicine. | M1b<br>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<br>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**<br><br>**Workforce Committee Fed by;**<br><br>**Sustainable Clinical Services Group**<br><br>**Education, Learning and Development Committee**<br><br>**Seven day services Project Board**<br><br>**Recruitment Strategy Group** | 1. Workforce plans produced by each division/specialty in alignment with operational plans. (1)<br><br>2. Individuals (and HRBP's) trained within divisions on workforce planning(1)<br><br>3. 6 monthly review of safer staffing metrics (2)<br><br>4. Annual job planning process in place (1)<br><br>5. Workforce Strategy (2)<br><br>6. Annual programme of work for sub-groups of Workforce Committee (1)<br><br>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)<br>2. Impact of removal of Nursing Bursaries not clear. | .<br>↔ |

| 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**<br><br>Workforce Committee<br>Divisional Engagement Group | 1. Staff Survey Action Plan (2)<br>2. Divisional/Department Action Plans (1)<br>3. Joint working programme with Staff Side/LNC (1)<br>4. Executive Walkabouts (1)<br>5. Involve (1) | 1. Staff Survey results (3)<br>2. Divisional Engagement Group feedback (2) | 1. Current Staff survey results showing moderate improvement | 3x4=12 |
| | | | **Gaps in Control** | **Gaps in Assurance** | **Direction of Travel** |
| | | | 1. Survey does not capture sufficient 'real time' feedback<br>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<br>2. Failure of overseas staff to satisfy UK registration requirements.<br>3. Sudden or unplanned loss of specialist staffing that affects the delivery of a service<br>4. Industrial action | HR2b<br>The risk of sub-optimal patient care due to high level of nursing vacancies, particularly in Medicine. | M1b<br>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<br>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<br><br>Dir HR&OD | September 16<br><br>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 |

**GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST**
**PUBLIC BOARD MEETING FRIDAY 25 NOVEMBER 2016**
**Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at 9.00 a.m

## Report Title

Workforce Strategy

## Sponsor and Author(s)

Dave Smith – Director of Human Resources and Organisational Development

## Audience(s)

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Board members | x | Regulators | x | Governors | x | Staff | x | Public | |

## Executive Summary

Purpose
To present the Trust's Workforce Strategy for Board approval prior to the planned launch in December 2016.

Key issues to note
A draft Workforce Strategy setting out both aspirations for our workforce and the key actions required to deliver on the strategy was shared with different stakeholders earlier this year. Following feedback the Workforce Committee have now endorsed this strategy for launch.

- The plan is developed to ensure we have a workforce that is able to deliver *Best care For Everyone,* whilst delivering a positive employee experience
- There are nine key strands to the strategy, set out in the document each with an underpinning work plan and key metrics to track progress and delivery
- Oversight of strategy implementation sits with the Board's Workforce Committee
- A communication and engagement plan underpins the strategy, which will be formally launched in December this year.

Conclusions
The strategy aims to ensure that the Trust attracts and retains a high-performing workforce capable of delivering our operational and clinical strategies. The Trust is competing in a challenging labour market and this strategy aims to position the Trust as employer of choice to staff locally, regionally and nationally by ensuring we meet their education learning needs, support their health and wellbeing and provide opportunities for growth, development and succession

Implications and Future Action Required
The strategy now requires rigorous implementation planning and delivery and a governance architecture has been delivered to oversee this. Finally, staff engagement in promoting and delivering the strategy is key and work is in hand to ensure all staff are aware of the strategy and its implications for them individually.

## Recommendations

The Board is asked to approve the workforce strategy, as recommended by the Workforce Committee and note the planned launch in December 2016.

## Impact Upon Strategic Objectives

Our staff are key to the delivery of all of our strategic objectives

**GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST**
**PUBLIC BOARD MEETING FRIDAY 25 NOVEMBER 2016**
**Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at 9.00 a.m

| **Impact Upon Corporate Risks** |
|---|
| This is a mitigating action to the risks of challenges to workforce supply and reduced reduced staff engagement. |
| **Regulatory and/or Legal Implications** |
| N/A |
| **Equality & Patient Impact** |
| See above, engaged staff deliver an improved patient experience and it is vital that we have access to and develop the potential of all elements of the current and future potential workforce, irrespective of background. |

| **Resource Implications** | | | |
|---|---|---|---|
| Finance | **x** | Information Management & Technology | |
| Human Resources | x | Buildings | |
| | | | |

| **Action/Decision Required** | | | | | | | |
|---|---|---|---|---|---|---|---|
| For Decision | | For Assurance | | For Approval | | For Information | x |

| **Date the paper was presented to previous Committees** | | | | | |
|---|---|---|---|---|---|
| **Quality & Performance Committee** | **Finance Committee** | **Audit Committee** | **Remuneration & Nomination Committee** | **Senior Leadership Team** | **Workforce Committee** |
| | | | | | 14/10/16 |

# GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

## MAIN BOARD – NOVEMBER 2016

## WORKFORCE STRATEGY

### 1. Aim

To inform the Board of the launch of the Trust Workforce Strategy and the governance arrangements to track performance and review fitness for purpose.

### 2. Background

Consideration of workforce issues historically within the NHS has primarily involved a concentration on transactional issues such as policy design, pay and conditions, national mechanisms for workforce planning (including the design, commissioning, quality assurance and administration of the education and training system as well as professional education. In more recent years there has been a shifting of focus to perceived 'softer' issues such as staff health and wellbeing, supportive leadership, equality and diversity and employee engagement. These involve a recognition that having a 'vocation' in itself may not be enough to sustain individuals throughout their career and that the patient experience is directly influenced by the experience of staff. In their 2016 paper '*Fit for Purpose – Workforce policy in the NHS'*, the Healthcare Foundation observe that 'working with the grain of intrinsic personal and professional motivation of staff is likely to deliver faster and more sustainable change' however 'recognising the importance of behaviours, values, feelings and relationships when dealing with people has been a marginal consideration in policy making.'

Of course, much of this is obvious. Healthcare remains a people business despite remarkable improvements in technology. There are many industries where the oft repeated mantra 'people are our greatest asset' may be challenged as customers seek ever more efficient ways of accessing services at lowest cost. And healthcare has witnessed a number of changes in terms of how and where services are delivered and will continue to do so in order to be sustainable. But there is absolutely no doubt that the 1.4 million people who work in the English NHS (and make up almost two thirds of the budget for hospitals) are its 'greatest asset'. It is also true that what these staff say to their patients, families and friends about their working environment will hugely shape opinions more widely.

What is clear is that workforce issues are surfacing like never before. The UK, unlike healthcare systems in other developed countries is beset by problems of supply and a very high dependence upon overseas recruitment. At a time of challenged supply, staff have more opportunities than ever before to change employer moving across and out of the public sector. Staff turnover is typically felt to be a symptom of staff unhappiness and there are clear links. However, currently one of the highest turnover rates locally and nationally is within the nursing profession who also frequently score (in comparative terms) as the staff group with the highest engagement scores. This suggests that other issues such as 'opportunity' also play a significant role. So clearly, the issues and the solutions can be complex. These issues also manifest themselves to greater or lesser degrees across the sector with social and demographic factors playing a role. This means that organisations, whilst bound by national frameworks and policies do have the opportunity to differentiate themselves from other organisations by having a strategic approach to their workforce as they do to other issues. This approach means that workforce may be an enabling factor as opposed to its current status as a limiting factor in service change.

### 3. Development of the Strategy

The strategy was developed following a series of discussions within the HR senior team about the type of Trust that we aspired to be, linking in to other discussions about how

the Trust would transform itself to deliver on its vision of *Best Care for Everyone*. Recognising that our workforce was a significantly enabling element of transformation, we set out to construct not a strategy for the HR team, but a workforce strategy within which the HR team would have a fundamental enabling role. As a consequence it is constructed around the following key elements;

- The strategic aims for each of the delivery arms - Workforce Planning, Education, Learning and Development, Leadership, Reward, Employee Engagement, HR Operations, Staff Health and Wellbeing, Equality and Diversity and Spiritual Care
- Activities thus far within these areas badged as '*We Have'*
- Planned activities badged as '*We will'*

The draft strategy was presented to the Workforce Committee in July as the overseeing committee and received direct feedback from members including non-executive directors, the CEO, executive directors and staff governors. The Director of HR&OD was requested to seek further feedback from other stakeholders including other Staff Governors and Staff Side colleagues before feeding back to the next Workforce Committee in October (adjourned from September). Limited feedback was received and is summarised as follows;

Staff Governors – '*It is easy to put the words down on paper but important that we take meaningful actions to ensure that our commitments on taking action when staff raise concerns and our commitment to improving the working experience of BME and disabled staff is acted upon'*.

Staff Side – '*A focus on management skills will be required and we should aim to be less hierarchical. Frequently staff have the answers but we don't listen to them and we should improve the physical working environment'*.

Junior Doctor – '*Ambitious, which is positive but is there a feeling that clinical staff may believe that there is a lack of comprehension from managers about the pressures they are facing on a day to day basis. Also the Reward section is challenging when there is limited flexibility in terms of financial reward'*.

All of this feedback was very useful and has been included (as much as possible) within the final version. But the underlying message was one of delivery, not words. In addition, at the time the strategy was conceived, the STP was no more than a possibility. Twelve months on it is likely to form a really significant part in the future of health and social care delivery in our county. In similar vein, the financial picture internally has undergone significant change and informs priorities accordingly. As a consequence the strategy has undergone a number of reviews and revisions, informed both by the stakeholder feedback (above) and unfolding events. The broader aspirations for our workforce transcend short term pressures however it is recognised that the emphasis on certain aspects and the pace at which these develop will be more closely linked to what is happening currently. At the October meeting of the Workforce Committee, it was confirmed that the strategy (Appendix 1) was now ready to launch and that this should be presented to the Trust Board for information in November.

## 4. Launch Plan

Key dates include;

- Involve Sessions 21/24 November
- Divisional Engagement Steering Group on 23rd November
- JSCC meeting 24th November
- Trust Board 25th November
- Placing on Trust website 26th November.
- This Week CEO message w/c 28th November

- Outline (December most likely) and to include article/quotes from Chair, Chair Workforce Committee, Director HR&OD and Staff Side Chair/Staff Governors.

## 5. Oversight of the Strategy

It is vital to ensure that this becomes an active strategy, constantly reviewed, refreshed and determined as fit for purpose. It is meant to be an enabler for the overall trust strategy, not an achievement in its own right and will need to respond quickly and positively to changes in that overall strategy. The Workforce Committee are responsible for overseeing the delivery of the strategy and establishing suitable objectives and the metrics/KPI's around delivery of these objectives for the various sub-groups which report into the Workforce Committee. Within the structure of the Workforce Strategy and mindful of our current overall position, the Workforce Committee has established a series of overarching objectives for the remainder of this financial year. These are focused on supply cost and engagement and do not detract from the 'we will' aspirations expressed in the broader workforce strategy but ensure that targeted efforts are made between now and the year end to help move the dial both strategically and tactically;

*Supply – To sponsor and track all actions which improve supply of key workforce groups on a short, medium and long term basis*

*Cost – To maintain and develop a sustainable, quality workforce within the financial envelope.*

*Engagement – To engage with staff on a level that is meaningful to them and to develop mechanisms to test that engagement on a frequent basis.*

The more granular actions for each of the sub-groups are contained within Appendix 2 and progress will be reviewed against each of the objectives at each monthly Workforce Committee meeting. A formal review of progress will be made at the committee in March which will then result in a new annual work programme being designed which will balance long term actions within the strategy with short term actions focused on recovery.

## 6. Conclusion

It would be possible to conclude that given the particular regulatory environment we find ourselves in, that an aspirational workforce strategy lands at the wrong time, particularly as we have to make challenging decisions. As our Chair says in the foreword to the strategy, that would be the wrong approach. Our staff will be our most important asset as we work our way through these issues and whilst the focus around workforce will involve narrowing in the short term to those issues that will move us towards recovery, these will still be in line with our strategic direction. Our recovery is intrinsically bound up with having the right sized, right skilled and engaged workforce and whilst the majority of staff are seldom excited by strategy documents, being much more interested in outcomes, our responsibility will be in answering the 'so what' question which demonstrates the link between the things that we do and why they make a difference. Therefore regular communication will have to be a feature including pulse testing on how/if it feels different for staff.

## 7. Recommendations

The Board is asked to **note** the launch of the Workforce Strategy and support the launch activities.

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

# Workforce Strategy

2016

# what is a workforce strategy?

**Our workforce strategy is encompassed by the following statement - that every member of staff is:**

***Committed to being the best that we can be every day; for our patients, for our colleagues and for ourselves***



# 1. Foreword

**The NHS is experiencing a period of change like no other in its history. The political, economic, social and technological context within which we operate is evolving rapidly, presenting with it a series of challenges but also significant opportunities.**

The challenges have been articulated fully in a range of other documents concerning the NHS and so will not be repeated here, save for saying that they reinforce the argument for positive action.

Our Board, in consultation with staff at all levels, has agreed a vision for the future where we wish to deliver;

## Best Care for Everyone

With any vision statement it is possible to pick out individual words and question their place however we have been very deliberate in our choices. This is not a vision that aspires to be 'good' or 'good enough' or even 'to improve'. It sets out very clearly that this is about being the 'best' and a willingness to be assessed against our delivery of that vision. It doesn't talk about money, buildings or equipment, all of which are going to be hugely important in the delivery of the vision. It talks, deliberately so, about 'best care'. Adding that this is 'for everyone' means that everybody who reads this statement, whether a patient, carer, relative or staff member should have no doubt where our priorities lie.

To deliver this vision requires a strategic perspective on a range of issues; clinical direction, sound financial management, support for innovation, research and maximisation of our estate, to name but a few. However to translate all of these strategies into delivery of the vision will require our most important component 'Our Staff', and this has been true within the NHS since its inception. Our staff truly do make the difference to our patients and therefore our aspirations for 'Our Staff', the people who will ultimately deliver the vision of best care for everyone, must be equally high.

We will need to attract and retain extraordinary people who could easily find work in other organisations.

We will need to reward them appropriately, recognising that 'reward' takes many different forms and is not simply financial. We will help them develop their careers and provide them with challenging and stimulating roles (roles which may change in the context of an increasingly dynamic landscape). We need to continually engage with them about what is happening in our trust and to hear and respond to their voice, especially when they speak out about things that need to improve. We will in particular engage with them about how they can maintain their physical and mental wellbeing. We need to be clear that morale, and improving morale, is a key focus for all of us as we strive to achieve our vision. We will seek to lead and follow with clarity of purpose and will encourage leadership behaviours and values at all levels, not linking leadership to titles and status. In return, we will require all of our people to be 'committed to being the best that we can be every day, for our patients, for our colleagues and for ourselves'.

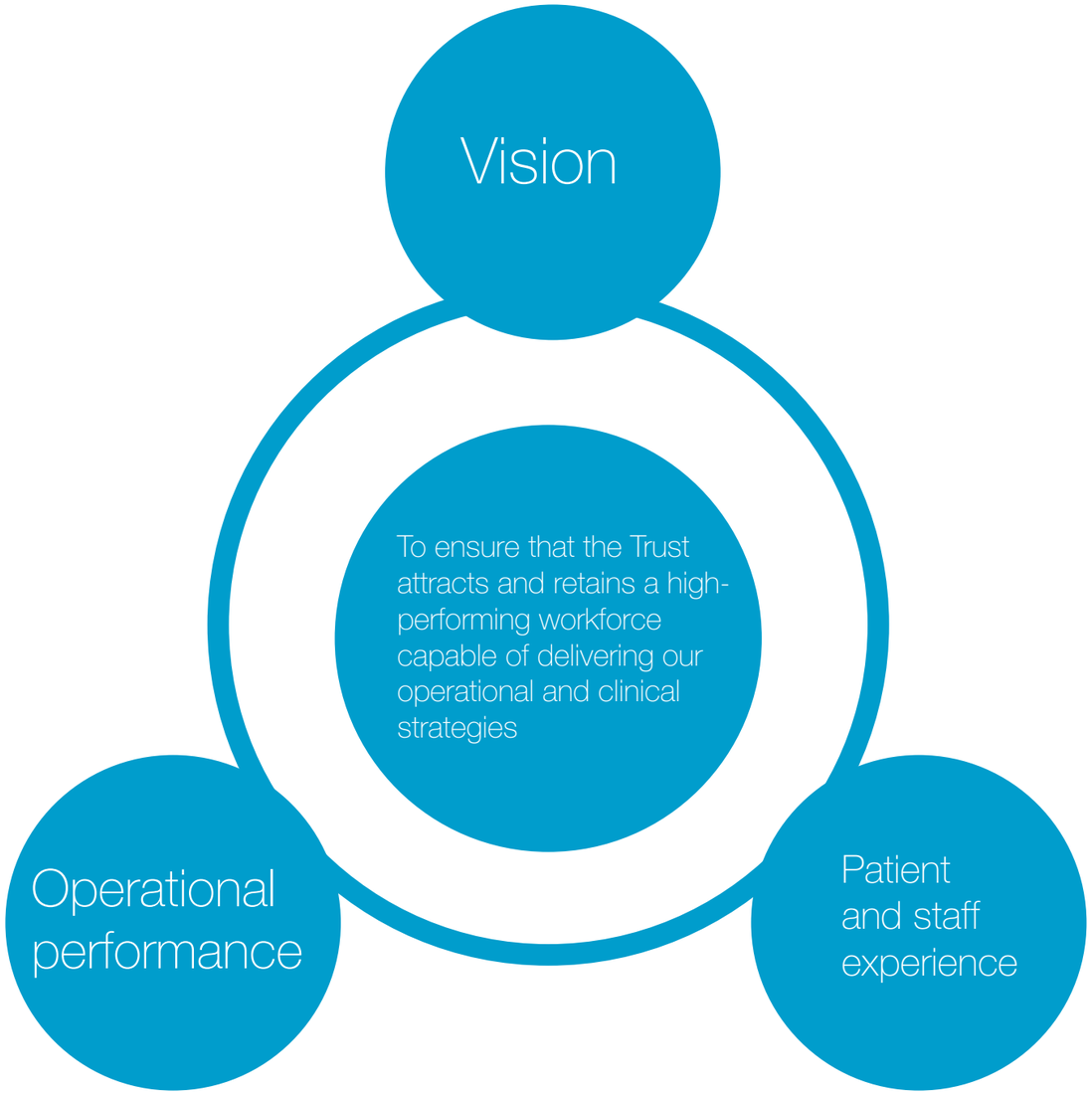
This creates a set of mutual expectations and responsibilities and we must be prepared to challenge ourselves and each other if we fall short of these. We will set these out for staff as an 'Employee Proposition' which clearly states for existing staff and potential new recruits, what they can expect from our trust and what is required from them in return.

In brief, this is about cultural change and the values that will sustain and develop our organisation, and indeed our local health economy, going forward. Above all, our objective is to ensure that the Trust attracts and retains a high performing workforce capable of delivering the Trust operational and clinical strategies.

Given our current financial challenges, it would be quite easy to set aside our aspirations for our staff on the basis that this is 'the wrong time'. However, it is precisely the right time to do this as our staff are pivotal to our delivery of quality, safe services and as such also pivotal to our financial recovery.

The following pages set out the evolving priorities of the 'Workforce Strategy', and how these overarching themes are broken down and woven into a more granular perspective, including an assessment of current status and future plans. Every year an in-year action plan will be published and shared with staff as actions truly do speak louder than words. This strategy is intended to be a living document that will change over time to take account of our progress and development and changes (both internal and external). We look forward to working with you on its delivery.

**Peter Lachecki, Trust Chair**




**Delivering Best Care for Everyone**

**Delivering an Excellent Employee Experience**



# 2. Our Workforce Strategy

## 2.1 Workforce

**Delivering the right sized, right skilled workforce, as well as achieving a balance between our substantive workforce and our flexible workforce, both for now and in the future, across the full range of professional disciplines is becoming ever more challenging.**

There are issues of supply in different professions, particularly for clinical staff and as a consequence, the procurement of our workforce becomes a much more strategic issue requiring comprehensive planning, creative solutions and our ability to differentiate ourselves as an employer. We have therefore established three strategic aims with regards to workforce:

→ 1. To embed workforce planning within operational and strategic planning to enable appropriate short, medium and long term actions to take place which ensure that our workforce supply is secure, commensurate with need and representative of best value.

→ 2. To develop a compelling employment proposition that enables us to attract and retain the highest quality staff in all areas and to deliver the best possible service to our internal customers.

→ 3. To develop a Temporary Staffing function which enables our Trust to access a highly skilled and engaged flexible workforce who provide excellent levels of care at an appropriate cost.

Underpinning each of these strategic aims (as with those that follow, below) is an assessment of current progress and future plans. The workforce assessment is found in Appendix 1.

## 2.2 Education, Learning and Development

**This is a vital component of any 'workforce strategy' given that the delivery of 'best care' relies on the skills, ability and motivation of our staff.**

We believe staff at all levels and in all roles place great value on their career and personal development, so the wide range of education, training and development opportunities we provide allows us to demonstrate the value that we place on our staff and to differentiate ourselves from others. Establishing our trust as a 'learning' organisation will require identification and publicising of all of those activities that constitute development, greater transparency of educational spend and a balance between a perceived focus on mandatory training and 'development'. Healthcare education is facing unprecedented changes due to the fast-changing political landscape: We will ensure we are at the heart of every opportunity to help shape and design new ways of educating our healthcare workforce and in the commissioning of education and development within the South West region; through that, we will be better able to provide the best education for our staff – now and in the future.

Our strategic Education, Learning and Development aims are:

→ 1. To influence patient experience and outcomes as a result of our education, teaching and training

→ 2. To position ourselves within the heart of the changing NHS landscape in order to influence future direction locally and nationally.

→ 3. To become known and renowned for the quality of our education and development.

An assessment of current progress and future plans is provided in Appendix 2.

## 2.3 Leadership

**This is a priority for our Trust and is a major challenge right across the NHS. We must aspire to lead well at every level and this includes being willing to be led and to be part of a team.**

It requires us to define in simple terms, what good leadership looks like in practice. It compels us to create a compulsory core curriculum for team leaders and managers as well as creating a shared leadership language and experience for clinical and non-clinical leaders. It requires a strategic approach to succession planning and talent management, recognising where these coalesce and where they diverge. It also requires us to embed assessment about leadership capabilities, particularly around 'care and compassion', firmly in the appointment and promotion processes for leaders at all levels. The main strategic aims are:

→ 1. To maximise the capability of our leaders at all levels through the provision of relevant leadership development aligned to our leadership behaviours framework;

→ 2. To embed talent management and succession planning at all levels, aligning with performance management systems

→ 3. To extend the use of coaching and mentoring internally, ensuring greater linkage with organisational outcomes.

An assessment of current progress and future plans is provided in Appendix 3.

## 2.4 Reward and retention

**There are a number of benefits associated with working in the NHS, not least the opportunity to make a difference to our patients and to work with extraordinary colleagues.**

Many of the more tangible benefits need to be enveloped in a localised 'Total Reward' approach (which has gathered some traction with the development of Reward Statements for NHS staff; iitemising, in particular, pension benefits). There are further opportunities to identify local benefits (including access to healthcare, flexible working, learning and development opportunities) as well as building on the joint work with Staff Side colleagues, reviewing the links between reward, performance and culture. The main strategic aims are;

→ 1. To develop a Total Reward Strategy distinguishing our trust as a place to work which attracts and retains high calibre staff.

→ 2. To develop performance/behaviour/ values linked to non-monetary rewards ensuring those who consistently perform well and role model our values feel appropriately rewarded.

An assessment of current progress and future plans is provided in Appendix 4.

## 2.5 Employee Engagement and Cultural Change

**The building blocks for improved employee engagement were put in place some years ago and whilst results in the annual staff survey have continuously improved, we recognise that this is a journey which will bring significant reward to our patients and our staff in equal measure if progress is not only maintained but undergoes a step-change.**

With the launch of our new vision, 'Best Care for Everyone', our Trust has demonstrated that the voice of our stakeholders is heard and responded to; morale is a key priority for us. It marks the next phase of our transformation and creates the opportunity to include staff from all sectors of the Trust, regardless of level. Key to our success will be the empowerment of staff through devolved leadership and responsibility, creating a more responsive, agile and accountable organisation, one able to adapt to its economic environment and be recognised for the delivery of exceptional



services within Gloucestershire and beyond, with an engaged, motivated workforce at its heart. Key to this will be a leadership group prepared to engage and consult at the earliest opportunity, actively prepared to explain decisions, with an open and transparent approach to information and a real desire to act as role models by eliminating defensive behaviours at all levels.

The main strategic aims are:

→ 1 To develop an identity and culture within our Trust which delivers best care for everyone through the engagement of leaders and the wider workforce in a series of transformational activities.

→ 2. To develop the concept of devolved leadership and engagement through the divisional structure;

→ 3. To develop the employee voice from 'Ward to Board' including the opportunity to raise issues of concern safely, confident they will be responded to.

An assessment of current progress and future plans is provided in Appendix 5.

## 2.6 HR Operations

**Exceptional employee relations sit at the heart of any Workforce Strategy.**

Managing employee relations effectively does not simply mean responding to issues such as grievances, disputes and disciplinaries, but forging a climate and creating systems where people are engaged, empowered to challenge when necessary, and where lessons are learned. It involves timely management of issues whether on conduct or performance and a sense of equity created through our policies and their implementation, establishing clear frameworks on how all staff can expect to treat others and be treated. It further involves proactive, partnership working with staff and their representatives on a range of issues over and above statutory requirements and similarly a partnership with line managers to help them lead and manage their staff effectively. It is also key that both our staff and line managers are able to access expert central support and guidance in as timely and consistent a fashion as possible. The main strategic aims are:

→ 1. To provide proactive and strategic 'Business Partnership' arrangements to clinical and corporate divisions to support the delivery of Best Care for Everyone.

→ 2. To provide proactive and responsive Employee Relations services which enable effective performance management, resulting in improved patient care, service delivery and staff experience.

→ 3. To significantly improve medical engagement.

An assessment of current progress and future plans is provided in Appendix 6.

## 2.7 Staff Health and Wellbeing

**The health and wellbeing of our staff is an integral part of our employee proposition. The Five Year Forward View proposed by NHS England Chief Executive Simon Stevens points to the responsibilities of organisations to be 'exemplars' in their communities in terms of staff health and wellbeing.**

If organisations expect their healthcare professionals to have meaningful conversations with patients and the public generally about proactively maintaining their health, it must be from a position of strength, having addressed the same issues with their own staff already. This places a mutual responsibility on the Trust and on our employees. The link between improved health for staff and improved health for patients has been made by a number of august commentators and include Lord Darzi, Dame Carol Black and Professor Steve Boorman. There is clearly a financial argument for reducing sickness absence which when combined with opportunities for greater consistency of care resulting from increased attendance, is quite compelling. But, the most compelling argument for doing this is that we have a genuine interest in the health and wellbeing of our staff and not one based on expediency. This includes being as concerned with mental and emotional wellbeing as physical health and has to be reflected in tangible actions.

A staff health and wellbeing strategy has already been accepted by the Board and includes the following strategic aims;

→ 1. Every employee will be supported to improve their health and wellbeing and encouraged to act as role models to their colleagues and the broader community

→ 2. De-stigmatise issues surrounding mental health by providing training which helps staff identify issues in themselves and others, signposting to appropriate services and support

→ 3. Ensure our staff are able to access appropriate clinical care which will enable them to remain in work or return to their duties at the earliest opportunity.

An assessment of current progress and future plans is provided in Appendix 7.

## 2.8 Equality and Diversity

**As a trust we believe that the experience of our patients is significantly enhanced by the richness and diversity of our staff.**

The NHS and our trust must be a meritocracy providing equal access to employment, development and promotion, irrespective of background and should seek to identify and break down any barriers that prevent this from happening. It is crucial that we consider equality and diversity in everything that we do and not consider it to be a 'standalone' activity. This involves a proactive approach to monitoring, supporting and educating our staff. We know that in common with other organisations that we need to improve our performance with regard to our staff from black and minority ethnic (BME) backgrounds and those who regard themselves as disabled or have a long term condition. The steps required to make improvements in these areas will ensure that the experience of all of our staff is improved. Our main strategic aims are;

→ 1. Embed equality and diversity as part of our Trust 'DNA' extending the opportunity to hear from staff about their real experience of working in our Trust.

→ 2. Introduce and track performance against the Workforce Race Equality Standard (WRES), taking appropriate actions to improve performance.

→ 3. Improve the experience and contribution of staff with a disability or long term condition.



An assessment of current progress and future plans is provided in Appendix 8.

## 2.9 Spiritual Care

**Any good workforce strategy or employee proposition will consider the many dimensions associated with delivering person centred care.**

Care of staff, patients, relatives and carers is fundamental to everything we do as an organisation and to achieving best care for everyone. The provision of spiritual care in the Trust underpins each of these principles by seeing every individual in a totally person centred way. Through their involvement at every level of the organisation, the spiritual care team are able to support the Trust values and vision and support people in their religious requirements, spiritual needs or pastoral concerns. In addition to providing teaching and training for staff in a broad range of subjects, chaplains also provide staff support and a confidential listening service as part of our care for staff. Key objectives which support the wider Trust are set each year and current areas for development are highlighted in an appendix. The strategic objectives are;

→ 1. Develop and deliver the Trust Equalities Agenda and support the person centred care of staff.

→ 2. Develop integrated End of Life Care programmes and activities to support patient care.

→ 3. Develop integrated Dementia Care and Frail Elderly programmes and activities to support patient care.

An assessment of current progress and future plans is provided in Appendix 9.

# 3. Appendices

**The appendices on the following pages give a more detailed insight into each of the areas covered in this strategy.**

# 1. Workforce

**The Workforce function encompasses Workforce Planning and Information, Workforce Resourcing (Permanent) and Workforce Resourcing (Temporary).**

| **Strategic Aim 1 - Workforce Planning and Projects:** To embed workforce planning within operational and strategic planning which ensures that our workforce supply is secure, commensurate with need and representative of best value. | **Strategic Aim 2 - Workforce Resourcing (Permanent):** To develop a compelling employment proposition that enables us to attract and retain the highest quality staff and to deliver the best possible service to our internal customers. | **Strategic Aim 3 - Workforce Resourcing (Temporary):** To develop a Temporary Staffing function which enables our Trust to access a highly skilled and engaged flexible workforce who provide excellent levels of care at an appropriate cost. |
|---|---|---|
| **We have:**<br>→ Implemented a Trust-wide approach to Workforce Planning, including a network of Trust Workforce Planning Champions.<br>→ Developed our Workforce Intelligence offering, providing a wide range of reports and dashboards on a regular basis. | **We have:**<br>→ Set up the Recruitment Strategy Group.<br>→ Developed a Nurse Resourcing Strategy based on a full review of nursing establishment, supply and demand. | **We have:**<br>→ Harmonised the team to create a unified Temporary Staffing Service for our Trust.<br>→ Recruited additional staff onto our Trust bank (Nursing and Medical staff). |
| **We will:**<br>→ Use the intelligence gathered to inform Trust-wide planning, addressing specific issues and opportunities, and create new career pathways to support the development of our future workforce.<br>→ Support and initiate the development of CIP and workforce-related savings projects.<br>→ Engage fully with partners and colleagues in the local and regional health community to support the delivery of the STP and the development of strategic workforce plans. | **We will:**<br>→ Adopt a high quality, commercial, values-based approach to recruitment, supported by the development of a Trust recruitment brand and proposition.<br>→ Maximise our ability to attract and retain high quality staff through a full understanding of the workforce supply issues and market.<br>→ Review all processes in order to streamline and publish KPIs for the function.<br>→ Continually monitor and understand the reasons why staff join, stay and leave our Trust, using this feedback to improve our attraction and retention. | **We will:**<br>→ Ensure our internal bank is fully aligned to demand and fit for purpose.<br>→ Working collaboratively with colleagues in procurement, continue to explore new models and ways of working such as neutral and master vendor.<br>→ Significantly reduce expenditure on medical locums, and an elimination of (nurse) agency in all but highly exceptional circumstances, in compliance with NHSI regulations. |



# 2. Education, learning & development

**We are developing as a learning organisation with a clear set of attitudes, values and practices which enable continuous improvement, successful career development and a commitment to being patient, service and solution-focused at all times.**

| **Strategic Aim 1: Influence patient experience and outcomes as a result of our education, training and teaching** | **Strategic Aim 2: Position ourselves within the heart of the changing NHS landscape in order to influence future direction locally and nationally** | **Strategic Aim 3: Become known and renowned for the quality of our education and development** |
|---|---|---|
| **We have:**<br>→ Ensured our value of compassionate care is woven into our education and development programmes and that all our work contributes to better patient care<br>→ Developed education and training that is delivered in 'real-time' at the work place, including skilled Lecturer Practitioners and an exciting new Simulation Faculty. | **We have:**<br>→ Played an active part in regional and national work streams to help shape the future direction of healthcare education<br>→ Developed positive partnerships with our Higher and Further Education colleagues and our excellent Library services to enrich and improve our many learning opportunities | **We have:**<br>→ Won many awards for the quality of our education - including apprenticeships, leadership development, simulation, eLearning & coaching and been invited to present at national conferences and seminars to share examples of our successes.<br>→ Developed excellent accredited programmes both as an approved centre and working in close partnerships with external providers. |
| **We will:**<br>→ Provide high quality opportunities to learn and develop – both at the point of care and on dedicated programmes. These will be far more than mandatory training and always patient-centred, targeted at providing 'best care for everyone'.<br>→ Develop annual training plans that respond to the wide-ranging organisational and healthcare priorities and to make the most of all funding opportunities available to increase the opportunities for our staff | **We will:**<br>→ Ensure we contribute to strategy and policy development for the benefit of our patients and colleagues and in the context of the Five Year Forward View<br>→ Establish strong partnerships nationally and locally to contribute to the design and reshaping of healthcare education, particularly during the unprecedented reforms to healthcare education and the establishment of new roles | **We will:**<br>→ Continue to build on our reputation as an excellent provider of healthcare education and development<br>→ Provide as many opportunities as possible to support the careers and personal/ professional development of our hard-working staff |

# 3. Leadership

**We are committed to appointing and developing the best leaders possible and ensuring they are engaged and challenged accordingly.**

| **Strategic Aim 1:** To maximise the capability of our leaders at all levels through the provision of relevant leadership development aligned to our leadership behaviours framework. | **Strategic Aim 2:** To embed talent management at all levels, aligning with performance management systems. | **Strategic Aim 3:** To extend the use of coaching and mentoring internally, ensuring greater linkage with organisational outcomes. |
|---|---|---|
| **We have:**<br>→ Developed a leadership behaviours framework for all staff and a suite of internal leadership development programmes, including bespoke support for our clinical leadership model.<br>→ Established a Leadership Welcome Day for all those new to a supervisory/ managerial role to provide support and development at that crucial time in their careers. | **We have:**<br>→ Undertaken a review of talented individuals at senior levels. | **We have:**<br>→ Developed an in-house faculty of ILM level 7 accredited Executive Coaches to support the performance potential of our leaders.<br>→ Developed an internal training module to aid the dissemination of coaching as a leadership approach. |
| **We will:**<br>→ Ensure that we are recruiting high calibre leaders by making our leadership behaviours a key part of both internal and external recruitment.<br>→ Support the model of collective and system wide leadership with everyone taking responsibility for the success of our Trust.<br>→ Collaborate with colleagues across the healthcare community to agree shared values and behaviours and to develop programmes which support distributed leadership across the wider system in support of the STP. | **We will:**<br>→ Further develop our Talent Pool through Executive ratification of entrants and next steps.<br>→ Cascade talent management deeper into the organisation and work closely with our defined cohort of talented leaders to further develop and enhance capability.<br>→ Through targeted intervention, continue to build the capability of our leaders and managers in managing performance across our organisation.<br>→ Audit our leadership capability with regular, comprehensive succession planning exercises, recognising our strengths and our gaps, taking action to address as appropriate. | **We will:**<br>→ Via our Coaching Steering Group, further develop and clearly define our internal coaching service in order to fully support our leaders to continually enhance their performance and disseminate a coaching style culture.<br>→ Further develop and refresh our existing mentoring system to ensure greater accessibility. |



# 4. Reward & retention

**Reward in the NHS is all encompassing, however is too frequently linked simply with pay. It is vital that we identify and build on all of the elements of a Reward package that attracts, retains and makes staff feel valued, as well as giving of their best.**

| **Strategic Aim 1:** To develop a Total Reward Strategy which distinguishes our trust as a place to work which attracts and retains high calibre staff. | **Strategic Aim 2:** To develop performance/behaviour/values linked to non-monetary rewards, ensuring those who consistently perform well and role model our values feel appropriately rewarded. |
|---|---|
| **We have:**<br>→ Launched and publicised the Total Reward Statement which provides detail on pensions<br>→ Re-energised the list of local benefits available to staff, centralising them on one site. | **We have:**<br>→ Launched a Reward Strategy Group to ensure fair consideration of Reward decisions and oversight of strategy.<br>→ Assisted by Staff Side colleagues, implemented the national pay award for 2013/14 with links to performance, behaviour and attendance.<br>→ Improved 'tangible' reward mechanisms such as the Staff Awards Ceremony. |
| **We will:**<br>→ Increase staff numbers accessing and understanding their Total Reward Statements by increased publicity and meaningful content.<br>→ Quantify and evaluate other benefits such as childcare, salary sacrifice, access to development etc, incorporating into future statements.<br>→ Talk to staff about what they value and crucially, 'what attracts them and retains them', publicising in our recruitment materials.<br>→ Using the staff survey questions on Reward as a launch point, hold regular Reward 'focus groups' on themed issues such as 'recognition'.<br>→ Use all of the above to develop and publish a local Reward strategy which clearly sets out our offering in terms of monetary and non-monetary reward. | **We will:**<br>→ Develop localised awards and encourage managers to recognise staff on a more frequent basis.<br>→ Revise appraisal systems to focus more on quality and 'how' things are done, linking with access to development and research.<br>→ Develop an annual workplan for the Reward Strategy Group. |

# 5. Employee engagement & cultural change

**We see employee engagement as the key to improving both patient and staff experience and as the responsibility of all leaders.**

| **Strategic Aim 1:**<br>**To develop an identity and culture within our Trust which delivers best care for everyone through the engagement of leaders and the wider workforce in a series of transformational activities.** | **Strategic Aim 2**<br>**To develop the concept of devolved leadership and engagement through the Divisional structure.** | **Strategic Aim 3:**<br>**To develop the employee voice from 'Ward to Board' including the opportunity for staff to raise concerns securely confident they will be responded to.** |
|---|---|---|
| **We have:**<br>→ Consulted widely with internal and external stakeholders to develop and launch a new, inspiring vision for our Trust.<br>→ Launched a series of transformational activities with process and enabling work streams designed to drive change across the organisation. | **We have:**<br>→ Established divisional engagement groups working together on the results of the staff survey to make improvements for our staff and our patients and providing opportunities for our staff to have their say.<br>→ Asked divisional management teams to identify and work on their localised engagement plans, including their 'top 3' issues. | **We have:**<br>→ Ensured key messages from the Trust Board are disseminated to our staff via the Divisional Engagement Groups and enabled a process for staff to pose questions direct to our Trust Board.<br>→ Implemented our Raising Concerns policy (co-authored with staff side) and piloted Speak in Confidence (an anonymised email system for staff to raise concerns). |
| **We will:**<br>→ Seek to act inclusively to engage and involve our staff in our Trust's cultural development by testing progress with them at regular intervals.<br>→ Develop the accessibility and visibility of our leaders across the organisation to increase understanding of Trust deliverables and performance.<br>→ Actively foster a culture of openness and transparency where leaders explain their decisions and eliminate defensiveness. | **We will:**<br>→ Engage with our clinical leaders on the tools and support they need to be effective.<br>→ Regularly explore with our divisional engagement groups action that can be taken to foster a culture where everyone is committed to being the best they can be. | **We will:**<br>→ Simplify the trust response to the staff survey with 3 key actions agreed and sponsored by the Board following input from staff.<br>→ Appoint a Raising Concerns Guardian and build on the Speak in Confidence system by tendering for a new system and encouraging staff to use it by demonstrating outcomes/lessons learned. |



# 6. HR Operations

**We are committed to providing high standard strategic, responsive and customer focused services relevant to maximising effective patient care, service delivery and positive staff experience.**

| **Strategic Aim 1:**<br>**To provide proactive and strategic 'Business Partnership' arrangements to clinical and corporate divisions to support the delivery of Best Care for Everyone.** | **Strategic Aim 2:**<br>**To provide proactive and responsive Employee Relations services which enable effective performance management, resulting in improved patient care, service delivery and staff experience.** | **Strategic Aim 3:**<br>**To significantly improve medical engagement.** |
|---|---|---|
| **We have:**<br>→ Established a HR Business Partner model.<br>→ Started the integration of the HR Business Function into Divisions/Service Lines. | **We have:**<br>→ Established the HR Advisory Centre and HR Admin Support Team.<br>→ Established a Health Professions Governance Committee and implemented HR metric reporting.<br>→ Continued to provide transactional and transformational HR services.<br>→ Improved sickness absence management. | **We have:**<br>→ Worked in partnership with external and internal stakeholders e.g. HESW, NHSE, MOD, Trade Unions to move the dial on collaboration.<br>→ Successfully become lead employer for GP and Public Health trainees.<br>→ Established the Medical Revalidation team and processes.<br>→ Established e-job plans and e-leave for Consultants and Junior Doctors. |
| **We will:**<br>→ Fully embed HR Business Partner model into Divisions, working as strategic partners and critical friends to senior colleagues.<br>→ Actively support and influence divisions with CIP achievement, and the development of People-related projects and transformation programmes.<br>→ Work to ensure that Divisions are making short, medium and long term plans in relation to workforce supply and development.<br>→ Support divisional colleagues in engaging and consulting with staff at the earliest opportunity on key issues adopting the principle of 'no decision about me, without me'. | **We will:**<br>→ Streamline processes for managing formal casework and significantly improve<br>→ Develop processes for effective and equitable performance management.<br>→ Ensure timely, consistent and accurate advice for all users of the service | **We will:**<br>→ Support the medical engagement agenda, by increasing opportunities for management/medical staff meetings<br>→ Jointly appoint a Guardian of Safe Working and help establish/support the junior doctor forum.<br>→ Establish an annual collaborative programme of work between medical staff representatives and trust management, mirroring the current joint working with Staff Side |

# 7. Staff Health & Wellbeing

**A healthy workforce both physically and mentally, where staff are engaged on solutions and ideas to help them maintain and improve their health, will have a significant impact on patient outcomes and staff morale**

| **Strategic Aim 1:** Every employee will be supported to improve their health and wellbeing and encouraged to act as role models to their colleagues and the broader community. | **Strategic Aim 2:** De-stigmatise issues surrounding mental health by providing training which helps staff identify issues in themselves and others, signposting to appropriate services and support. | **Strategic Aim 3:** Ensure our staff are able to access appropriate clinical care which will enable them to remain in work or return to their duties at the earliest opportunity. |
|---|---|---|
| **We have:**<br>→ Co-authored a staff health and wellbeing strategy with Staff Side.<br>→ Signed up to the Public Health Responsibility Deal and developed an action plan against a range of pledges.<br>→ Formed a Staff Health and Wellbeing Group, reporting in to the Trust Health and Wellbeing Group | **We have:**<br>→ Developed stress risk assessments and built into the trust annual R.A programme.<br>→ Piloted 'Resilience Training' and rolled out Identification of Mental Health Issues training to managers.<br>→ Signed a public commitment to support the 'Time to Talk' campaign with an associated action plan. | **We have:**<br>→ Contracted occupational health services providing advice/interventions for staff and managers.<br>→ An internal Staff Support Service which provides counselling and signposting to staff in need.<br>→ Implemented a policy for ensuring that staff are referred for and can access clinical care internally as quickly as possible |
| **We will:**<br>→ Promote and publicise the 'It's Better for You' campaign, ensuring staff are aware of all opportunities to manage their health.<br>→ Develop an annual work plan, reporting on progress directly to the Health & Wellbeing Group, using a range of quantitative and qualitative metrics.<br>→ Sign up to the Workplace Wellbeing Charter and achieve the standards for accreditation. | **We will:**<br>→ Continue the development of Resilience Training to ensure it trains staff at an earlier point in the cycle.<br>→ Review all processes in order to streamline and publish KPIs for the function. | **We will:**<br>→ Use our data on staff sickness to target appropriate interventions |



# 8. Equality & Diversity

**A diverse and engaged workforce where every employee is valued for the contributions they bring to improving person-centred care, as well as bringing solutions and ideas, will have a significant impact on patient outcomes and staff morale.**

| **Strategic Aim 1:** Embed equality and diversity as part of our Trust 'DNA' extending the opportunity to hear from staff about their real experience of working in our Trust | **Strategic Aim 2:** Introduce and track performance against the Workforce Race Equality Standard (WRES), taking appropriate actions to improve performance. | **Strategic Aim 3:** Improve the experience and contribution of staff with a disability or long term condition. |
|---|---|---|
| **We have:**<br>→ A Trust Equality and Diversity Steering Group.<br>→ Supported the introduction of Personal, Fair and Diverse (PFD) champions.<br>→ Launched Equality and Diversity e-learning.<br>→ Redesigned our 'equality impact assessment' procedure.<br>→ Launched new Equality, Diversity and Inclusion Training as part of Management Essentials Programme. | **We have:**<br>→ Implemented EDS 1 and 2.<br>→ Assessed and published our performance against the WRES for two years. | **We have:**<br>→ Reviewed our performance annually against equality and diversity indicators on the staff survey on disability and used to set objectives.<br>→ Sponsored a project to understand and improve the experience of disabled ('differently abled') staff. |
| **We will:**<br>→ Seek to recruit more PFD champions as a bridge to the Steering Committee.<br>→ Develop and publish a calendar of activities to support this agenda.<br>→ Support the EDS framework with a full Trust Equality Policy. | **We will:**<br>→ Attend the national WRES Conference to gain insights on how to improve our performance.<br>→ Support the EDS framework with a full Trust Equality Policy..<br>→ Ask current BME leaders to act both as role models and conduits for BME staff at all levels to the Steering Group. | **We will:**<br>→ Create opportunities for staff with disabilities to stay in work and make as productive a contribution as possible by working with external agencies to understand and use the resources available to us.<br>→ Create opportunities for individuals with learning disabilities to be employed in our trust by working with external agencies with expertise in this area.<br>→ Prepare for the implementation of the Workforce Disability Equality Standards in 2017 (to add to the WRES) |

# 9. Department of Spiritual Care

**The Department of Spiritual Care serves our Trust through its shared core values, engagement at every level of the organisation and its role in offering spiritual, religious and pastoral support to all. This is supported by a philosophy of compassion, care, acceptance and availability.**

| Strategic Aim 1: Develop and deliver the Trust Equalities Agenda and support the person centred care of staff. | Strategic Aim 2: Develop integrated End of Life Care (EoLC) programmes and activities to support patient care | Strategic Aim 3: Develop integrated Dementia Care and Frail Elderly programmes and activities to support patient care. |
|---|---|---|
| **We have:**<br>→ Delivered Equality, Diversity and Inclusion Training for various staff groups.<br>→ Provided specialist advice and liaison services in respect of religion and belief in the workplace.<br>→ Enabled staff to reflect on and develop coping strategies to manage stress encountered through the day to day demands of their work. | **We have:**<br>→ Joined existing networks and groups promoting EoLC in the Trust and helped to establish new activity.<br>→ Become the lead for EoLC Champions in the Trust, revived the group and established a new rolling programme with a fresh focus.<br>→ Delivered a range of teaching, training and specialist workshops on EoLC to a wide range of staff. | **We have:**<br>→ Reviewed and refocused the provision of 'Reminiscence Services' on dementia and frail elderly wards, including the provision of seasonal events to mark significant dates and occasions.<br>→ Joined the Dementia Champions Group and made contact with a variety of staff to improve service delivery.<br>→ Begun to develop new spiritual care dementia resources and packs for use by the chaplaincy team. |
| **We will:**<br>→ Further develop and support the delivery of the Trust Equality agenda with ongoing training sessions.<br>→ Support the development of Equality (PFD) Champions and their role in the Trust.<br>→ Continue to offer a flexible, inclusive and accepting approach to all staff through 24/7 availability and the offering of our skills as spiritual and religious healthcare specialists. | **We will:**<br>→ Further develop and support the Trust wide EoLC champions group with relevant teaching input and support.<br>→ Develop the knowledge, skills and delivery of specialist spiritual care by the chaplains and chaplaincy volunteers within EoLC.<br>→ Actively participate in new 'Living Well to the Very End' Care Project with The Point of Care Foundation. | **We will:**<br>→ Continue to network with key staff and groups to improve and promote the spiritual care of patients with dementia and the frail elderly.<br>→ Engage and participate in a new Trust Listening and Learning Project for the Frail Elderly in conjunction with Age UK. |



"Choose a job you love, and you will never have to work a day in your life."

Confucius

| **Workforce Priorities** |
|---|
| **Supply**<br>To sponsor and track all actions which improve supply of key workforce groups on a short, medium and long term basis. |
| **Cost**<br>To maintain and develop a sustainable, quality workforce within the financial envelope. |
| **Engagement**<br>To engage with staff on a level that is meaningful to them and to develop mechanisms to test that engagement on a frequent basis. |

| **Sub Group** | **What does success look like?** | **Link to Workforce Priorities** |
|---|---|---|
| Recruitment Strategy | 1) Reduce Band 5 vacancies from 15.5% to 13% by 31 March 2017. | Supply and cost |
| | 2) Reduce turnover of Band 5 Nurses from 16.2% to 15% (run rate) by 31 March 2017. | Supply, cost and engagement |
| Sustainable Workforce | 1) To identify and set a plan for recruitment and development of 'alternative' healthcare roles where recruiting 'harder and faster' is not achievable. | Supply and engagement |
| | 2) To identify and define a strategy for the 'hard to recruit' professions (where alternative roles are not feasible) – linked with Recruitment Strategy Group. | Supply and engagement |

| | | |
|---|---|---|
| | 3) Ensure Divisional engagement through the preparation of locally agreed workforce plans to meet the anticipated needs. | Supply and engagement |
| Agency Programme Board | 1) Reduce agency costs by minimum £866k (net) by end of financial year. | Cost |
| | 2) Ensure run rate for agency costs for 2017/18 on track for £4.8m (net) reduction. | Cost |
| Reward Strategy | 1) To agree and implement a payment offering that increases bank shift take up by 10%. | Supply, cost and engagement |
| | 2) To review all current temporary payment systems and assess if delivering to original plan, resetting as required. | Cost |
| | 3) To identify and implement a range of non-monetary incentives that can be used to improve engagement. | Engagement |
| Education, Learning & Development | 1) Develop and implement a strategy for apprenticeship recruitment and education to maximise our returns under the Apprenticeship Levy. | Supply and cost |
| | 2) To develop educational pathways to support recruitment of the 'new roles' identified by the Sustainable Workforce Group. This includes the educational support required to implement the Nursing Associate pathway (ready for launch in April 2017.) | Supply and cost |

| | | |
|---|---|---|
| | 3) To update the range of education opportunities and development pathways that support the retention and sustainability of our workforce, particularly in the hard-to-recruit-to professions such as nursing and healthcare sciences. | Cost and Engagement |
| Staff Engagement Groups | 1) To have agreed and implemented a tool for real time employee feedback. | Engagement |
| | 2) By consulting with staff representatives, to have agreed a revised strategy for travel and parking. | Engagement |
| | 3) To have appointed a Freedom to Speak Up Guardian who will ensure staff concerns are logged, listened to and appropriately handled. | Engagement |
| Staff Health & Wellbeing | 1) To have engaged with staff in identifying the top 3 interventions or support they need to help them manage their own health | Supply, cost and engagement |
| | 2) To achieve accreditation via the Workplace Wellbeing Charter. | Supply, cost and engagement |
| Equality and Diversity | 1) To take actions which improve our performance on the Workforce Race Equality Standard (WRES) and ensures we are ready to publish our first set of data under the Workforce Disability Equality Standard. | Engagement |
| | 2) To have designed and implemented a training programme that enables managers to recognise and equitably manage individual differences across the workforce. | Engagement |

| | | |
|---|---|---|
| | 3) Create an engagement mechanism for BME and Disabled staff which enables full dialogue on those enablers/disablers to an improved working experience for both groups as reflected in the staff survey. | Engagement |

## GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

**MAIN BOARD – Friday 25th November 2016**

| Report Title |
|---|
| SMARTCARE PROGRESS REPORT |
| **Sponsor and Author(s)** |
| Sponsor: Dr Sally Pearson<br>Author: Gareth Evans: Smartcare Programme Manager |

| Audience(s) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Board members | X | Regulators | | Governors | | Staff | | Public | |

**Executive Summary**

Purpose

To provide assurance to the Board, from the Smartcare Programme Board, on progress towards the implementation of TrakCare, phase 1 and 1.5

Key issues to note

- The programme has progressed to an "amber" status in this report in accordance with the decision from within the Programme and Operational teams to support the go live date of 5th December based upon evidence of satisfactory progress within the reporting and clinic build and validation workstreams.
- The training offer has been redesigned and is active. Encouragement has seen an increase to 5,541 trained either face-to-face or via eLearning. There is an ongoing need for encouragement of training and prioritisation is to be made for staff on shift in week 1 of go-live.
- Ownership for the programme within the organisation remains good and resources continue to be mobilised from across the trust to meet 5th December go live
- The Technical LIVE System has been prepared and issued to identified staff for further test and validation. This is a significant step in progress toward an operationally live system.
- Finance has acknowledged the impact of the delays incurred and forecast expenditure for the SmartCare programme.

Conclusions

Progress with Phase 1 is on plan for the Go-Live weekend of 2nd – 5th December.

Implications and Future Action Required

The programme will continue to provide assurance to the Smartcare Programme Board
A further update for the Board will be provided in December.

**Recommendations**

The Board is asked to note this report as a source of assurance that the programme to mobilise go-live on the 2nd – 5th December is robust.

**Impact Upon Strategic Objectives**

Contributing to ensuring our organisation is stable and viable with the resources to deliver its vision,

| |
|---|
| through harnessing the benefits of information technology |
| **Impact Upon Corporate Risks** |
| Implementation of phase 2 of Smartcare will reduce the risk on the corporate risk register associated with the instability of the Oncology Prescribing system |
| **Regulatory and/or Legal Implications** |
| The implementation is covered by a contractual agreement with InterSystems. At present the delays to implementation are not impacting on the contract |
| **Equality & Patient Impact** |
| The patient benefits from the implementation of Smartcare will be realised across all patient groups |

| **Resource Implications** | | | |
|---|---|---|---|
| Finance | **X** | Information Management & Technology | X |
| 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)** |
| | | | | | SmartCare Programme Board |
| **Outcome of discussion when presented to previous Committees** | | | | | |
| | | | | | |

# GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

## MAIN BOARD NOVEMBER 2016

## SMARTCARE PROGRESS REPORT

### 1. Background

SmartCare is the Trust's Programme of work based around the replacement of the existing HP SWIFT Patient Administration System (PAS) that supports Maternity, Theatres, Pharmacy and Pathology as well as ancillary systems such as Patient First (ED) and associated reporting. The Programme will also provide the Trust with Advanced Clinical Information in the form of Electronic Order Communications, Electronic Prescribing and Medicines Administration, Clinical Decision Support and advanced Electronic Clinical Noting. This will support a wide remit of clinical engagement throughout the organisation as well as replacing current Oncology systems (OPMAS).

### 2. Programme Status & Timetable

The Programme is working toward a confirmed revised go-live for Phase 1 of 5th December 2016. Activity to meet the Phase 1 go-live of 5th December is progressing in all workstreams in terms of resolution of Jira's and build to be confirmed as part of the Authority To Proceed (ATP) process which is due to commence formally on 23/11/2016.

The overall RAG status for the Programme has been reduced from its previously reported RED to **AMBER** with progress to **GREEN** being based upon the ongoing review of the corresponding AMBER workstream items as described below.

The provision of a LIVE environment has been released for use by identified staff within the Trust in extended user acceptance testing and familiarisation. It has been built and configured based upon current operational requirements. The LIVE system is populated with live patient data from the Data Migration exercises and will be considered as usable within normal usage rules for live patient systems with specific regard to Information Governance. i.e. legitimate patient relationships need to be applied to use unless 'Test Patients' are registered for alternative testing.

Build related to the Operationally Live environment for December 2 – 5 continues in line with reconciliation of issues discovered during the Clinic Validation exercise being carried out by the Operational staff across all specialties.

It should be positively stressed that we have received tremendous support from the Operational teams in the request for staff involvement and the Programme Team wish to extend appreciation for this.

#### Reporting

The report development is progressing as agreed. The RAG status for the individual report is compiled on weekly basis and send to Khalil Aslam for review and then discussion with Eric Gatling after.

Statutory reporting is planned for acceptable levels of reporting from day 1 of go-live. 95 % of the Daily and weekly Statutory report requirement has been tested and confirmed ok for the go-live of TrakCare.

Areas for additionally resourced work include RTT and Maternity MSDS reporting. This is being handled within the BI team with respective additional resources engaged to complete the requirement. Additional resources have been provided to progress RTT and Maternity.

Key Business Reports with a prioritised set from the reports currently produced on Insight have been identified. This is approximately 128 out of a total 1,000 generated reports. Reviews are being carried out with the Operational Areas to ensure this number and type of report is correct and a continuing review is taking place. Currently, we have re-designed the report portal for TrakCare go-live. The successful reports will be attached by the end of the week commencing 14/11/16 while those that require additional work will be completed week commencing 21/11/16 and ahead of go-live. This will include any redevelopment aspect rather than amendments to existing in order to make more efficient use of the time available.

Overall Reporting progress is that this is able to meet the go-live date of 5th December.

Additional resources requested to support BI in terms of Clinical Coding and Senior Information Analysts have been made against the SmartCare budget and this cost is reflected in the forecast provided to Finance. The additional resources will be used to support the requirements gathering and report development as indicated above plus providing additional capability to support the expected increase in reporting activity both during and after go-live.

**Clinic Reconciliation**

The Clinic Reconciliation/Validation process is in progress.

The process is split into 5 task areas, one of which is post go-live.

1. Schedule/Clinic Realignment in TrakCare - Complete
2. Schedule/Clinic Maintenance in TrakCare – Ongoing to go-live
3. Schedule Validation and Schedule update in TrakCare – In progress – 92%
4. Slot availability cancellations for Annual Leave and other unavailability issues - ongoing and in progress with CBO & operations.
5. Programme of Schedule rebuilds post go live of TrakCare – Pending.

**Task 1** has been completed within the planned timescale. The post task data migration has shown specific issues for resolution that are currently under way. This will continue throughout the follow-on tasks.

**Task 2** is the continuation of Task 1 to maintain integrity of the PAS/TrakCare mirroring with changes actioned in real time through to go-live. The number of changes required are currently suffering a backlog of approximately 500 (1-week) but the plan to include Central Booking Office and Operational staff will alleviate this issue as it progresses.

**Task 3** is split into two distinct actions. The first is the ability for operational staff to reconcile that the clinics are set up correctly with Care Provider, Operational start/finish times and days, location and specific Appointment Types confirmed. This is at 92% completion in terms of validation with ongoing reconciliation and fixes enabling improvement to the Data Migration of future appointments.

The second task is for operational staff to be able to access TrakCare and select their patients from the Pending List followed by processing through to their respective clinic activity, ensuring that all aspects of care are incorporated with the appointment type and clinic slot information. Specialties may require clinician support in the validation process dependent upon current process. The use of the LIVE system is enabling this activity to be carried out with feedback to the Programme Team in respect of any required changes.

**Task 4** is related to those clinics and appointments that are subject to cancellation. This is an activity that impacts correct migration and results in potentially open ERS (formerly Choose & Book) appointments being available but with no clinician or clinic availability supporting them. This activity needs to be undertaken by the BAU clinic management teams in TrakCare as well as any changes made to PAS. This is run in parallel with Task 3. – In progress across divisions.

**Task 5** will be a planned approach to structural and Operational Change in respect of how clinics are run and managed. For example, the use of 'front loading' where patients are currently given appointments that are 10 minutes apart but in reality, each appointment is 30 minutes. This is used to ensure that patients are in the waiting room but does not provide any benefit to the patient. In fact some may be waiting an hour and a half longer than necessary. This is not a simple change to make and enable data migration to work so needs to be actioned post go-live. This will be an ongoing evolutionary process for the Trust and is anticipated to continue for at least 12-months,

Corresponding Data Migration statistics for 11/11/16 indicate that "Active appointments" (from go-live onward) are within the expected tolerance for final reconciliation during the clinic change control to be made effective from 21st November.

**Technical Go-Live**

As stated above, the LIVE system in use for continued Task 3 validation is the Technical Go-Live as referred to in the last report.

The LIVE system is fully operational and supported by InterSystems. It is based upon the suite of TrakCare product that will be used for the Operationally live system in December. There is a difference of one minor maintenance release which impacts Maternity so testing of this environment will continue in the TEST system pending update over the period 16th/17th November.

The LIVE system will continue to be used through to go-live with only non-availability to access due to technical reasons such as the requirement to bring all technical environments into a collective group for ongoing change management. The scheduled change to complete this operation will be undertaken on Thursday/Friday 16th & 17th November.

## 2.1 Key Milestones

Key milestones and deliverables in the Programme Plan relevant to the current work profile for Phase 1. GREEN identifies on plan, AMBER identifies areas subject to managed resolution. RED will indicate significant areas of concern.

| Milestone | Status/Progress | Rating |
|---|---|---|
| Testing & Validation | • Testing iteration 3 completed.<br><br>Test Iteration 4 completed.<br><br>Locked down TEST facility including SPINE and Analytics is ready for use in testing including RTT. | GREEN |
| InterSystems provision of software v.2016.MR4.x | MR4 Software delivered.<br>MR4.1 rescheduled for Monday 7th November following cancelled implementation planned for Thursday 3rd November due to quality issue identified during process. Implementation complete on 7th November – status set to GREEN. | GREEN |
| Build/Configuration: | Significant progress made. Set to AMBER pending | AMBER |

| | | |
|---|---|---|
| Clinic Set-up | review during week commencing 14/11/16 for progress to be established before setting to GREEN. | |
| Build/Configuration: Outpatient letters | Software fixes provided as planned; configuration and set-up now in main programme plan. | GREEN |
| Build/Configuration: Inpatient Discharge Summaries (IPDS) | IPDS approaching completion in terms of Clinical Safety Review. eLearning completed. | GREEN |
| Data Migration | Direct connection to Clinic Build Progress. Set to AMBER pending review during week commencing 14/11/16 for progress to be established before setting to GREEN | AMBER |
| Emergency Department | To-Be Process Mapping completed. ED department face-to-face training completed. | GREEN |
| Maternity | A number of issues determined in Testing of items previously fixed but now erroring. These are in addition to known textual representation issue being worked by InterSystems.<br><br>MR4.1 Testing in progress and fix cycle under way. RAG status maintained as Amber pending results of testing in MR4.1. | AMBER |
| Theatres | To-Be Process Mapping completed in readiness for training. Training being scheduled.<br><br>Very recent P1 bug identified on multiple procedures and missing procedures from booking form. In progress with ISC. Status set to AMBER pending provision of ad-hoc fix. | AMBER |
| Reporting | Acceptable plan established with Eric Gatling. Continued progress with Business Reports. RAG status set to GREEN based upon revised scope and plan as reviewed with Eric. | GREEN |
| Training | Training review completed. Training re-started October 3rd. RAG status remains at AMBER pending review of training take-up. | AMBER |
| Cut-Over Planning | Cut-over planning in progress with the definition of the revised go-live schedule and phasing. | GREEN |

### 2.2 Risks & Contingencies

Risks identified within the programme are being proactively managed and a full review of the project risk/issue register and Datix continue. All risks follow Trust guidelines for Risk Score with appropriate escalation in place.

Based upon current activity there is no perceived increase in risk or additional items.

All risks have been reviewed including those identified within the Clinic and Reporting areas.

#### 2.2.1 Phase 1A – Pathology, Order Comms and Pharmacy

**Pathology**

At the November SmartCare Programme Board, Phase 1A – Pathology was identified by the Trust as at an **AMBER** status based upon progress to date. Concerns around testing of workflows and corresponding software provision/build configuration were highlighted by InterSystems.

Pathology validation and testing has been further clarified and as previously identified, will not exceed 3-months on the proviso that all system related functionality is delivered and built to agreed plan timescales. Validation planning is ongoing. Current evaluation of MR4.1 release is undergoing test.

Pathology are continuing with resource plan reviews and is locally considered as sufficient to meet a forecast go-live of 6th March 2017 on the assumption that Build is completed to schedule.

Specific project management and test management resource has been assigned to Pathology in order to maintain progress.

Order Communications is planned for March 6th go-live both in terms of Radiology and Pathology.

The March 6th go-live is also dependent upon timely delivery of software in MR5 in mid-December for Phase 1.5 environments. This will not be placed in the LIVE environment at that stage. This will only be implemented in LIVE as part of the Phase 1.5 go-live plan.

In respect of Pharmacy, the Inpatient Discharge Summary element for Phase 1 is on schedule. Work to be completed includes manual addition of non-drug items into FDB database by local staff. Phase 1.5 requirements continue to be worked through with InterSystems.

Pharmacy is in its Build and Configuration stage with additional reporting and financial reconciliation work progressing to meet the 6th March go-live. Validation and testing is to be undertaken in parallel.

**Order Communications**

Order Communications is progressing in both Radiology and Pathology provide a more focussed management of the tasks identified to be completed in conjunction with the Labs and Radiology leads both within the Trust and InterSystems.

**Pharmacy**

The Pharmacy implementation is on target for a planned March go-live. Activity relating to the configuration of the FDB drugs database including the addition of non-drug items has progressed with additional support from InterSystems. Additional resource within the Trust Pharmacy team is being engaged with the project.

## 3. Governance

General governance of the Programme is under the direction and oversight of the Programme Board. Eric Gatling is to maintain oversight of overall operational progress including the clinic reconciliation and reporting issues. Regular weekly meetings with the Operational Directors are progressing and are effective in terms of decision making and engagement.

Project Change Control is actively being used. Any uncontrolled ‘changes’ are notified and actioned appropriately to ensure priority is maintained on activity to meet planned progress.

A further enhancement to Change Control is to be implemented prior to go-live. This will set-up the necessary development and operational controls to ensure a consistent approach is taken with change across all aspects of the system, especially the LIVE service. A variant of established CITS based change control processes will be set-up to handle this approach together with a suitable represented Change Board.

## 4. Change Management

No new changes raised in this reporting period.

## 5. Phases 1, 1A and 2 Planning

Planning is continuing with the focus on cut-over preparation and readiness for the go-live.

Phase 1A planning is progressing as defined in the Phase 1A section above.

Phase 2 planning is to commence upon completion of the Phase 1.5 planning exercise.

## 6. Training

The training programme is progressing with increased numbers booking and attending.

eLearning continues to progress with additional modules and is also undergoing a content review between the Trust and InterSystems to ensure accuracy and completeness of information together with clinical safety reviews.

Training attendance status is currently at the following levels:

Current total trained/booked face-to-face – 3,323
Current total trained eLearning – 2,100
eLearning modular training in progress - 118
**Total** – **5,541**

Training needs to be further encouraged. With the commencement of SuperUser training from 21st November, training will predominantly be eLearning based for all other users through to go-live.

The Operational Engagement group is to identify staff who will be working over the go-live period and the first week to ensure all are appropriately trained prior to go-live.

## 7. Finance Update

### 7.1 Trust Budgeted Expenditure

The table below details the M7 position for the project, the forecast spend for 2016/17 and the overall project:

**SmartCare Financial Position & Forecast**

| | Actual £k | | | Forecast £k | | Forecast |
|---|---|---|---|---|---|---|
| | 2014/15 | 2015/16 | 2016/17 | 2016/17 | 2017/18 | Project Spend |
| | Full Year | Full Year | YTD M7 | M8-M12 | Full Year | £000 |
| Internal Recharges | 266.4 | 1,329.7 | 871.1 | 573.6 | 716.2 | 3,757.0 |
| External suppliers | 318.6 | 1,063.0 | 1,085.3 | 714.7 | 892.3 | 4,073.8 |
| Un-reclaimed VAT | 9.0 | 192.3 | 200.2 | 131.8 | 164.6 | 697.9 |
| | **594.0** | **2,585.0** | **2,156.6** | **1,420.1** | **1,773.0** | **8,528.7** |
| Business Case Capital Allocation (incl contingency) | | | | | | 7,693.0 |
| **Variance from BC allocation** | | | | | | **835.7** |

The 2016/17 year to date spend for the project is £2.2m and the forecast for the remaining months of the year is £1.4m giving a total spend for the year of £3.6m. The indicative capital plan is £2.9m so the current forecast is that expenditure will be £0.7m over the indicative plan. This potential overspend will need to be considered in the context of the overall capital plan; there may be slippage in other schemes to accommodate this however efforts will be made to reduce spend where ever possible.

It was envisaged that the TrakCare system would be fully operational with 24 months of the start of the project however current indications are that the project will run to March 2018 which will put the duration of the project in excess of 36 months. This is reflected in the forecast of £1.7m for 2017/18 and the overall projected capital spend therefore rises to £8.5m which represents an overspend of £0.8m against the capital budget approved.

The overspend amounts to 11% of the business case plan and is driven by the delays to the project along with the additional VAT costs (the original business case assumed that VAT would be recoverable for contract staff, which was an incorrect assumption at the time). The project has performed well to contain these two cost pressures at 11%, however all efforts must be redoubled to reduce spend where possible.

### 7.2 NHS Central Funding

A meeting with NHS Digital (formerly HSCIC) has been held in which a review of the funding requirements has been agreed with a revised quarterly report to be issued by 30th November.

An invoice for the current 'funding download' advised by NHSD is to be raised upon NHS England - £291,678.

A revised status of planned benefit realisation is to be included in the updated quarterly report.

### 7.3 Central Funding Status

Milestone Achievement Certificates for the following milestones have been agreed and signed for invoice representation by InterSystems.

Build Complete
ATP (Technically LIVE)

## 8. Benefit Realisation

Detail of planned Benefit Realisation in line with the Programme Phasing is to be reviewed with the Service Leads. A delivery plan based upon service line detail is to be provided to support those discussions. The benefit realisation within Phase 1 is primarily restricted to reduction of legacy system use. Phase 1.5 will incorporate benefits to be realised within FY17/18.

Phase 2 will present the optimum opportunity for benefit realisation and this will be further considered in the detailed planning for that stage.

## 9. Service Impact

As may be expected, the requirement for Operational involvement with the Clinic Reconciliation has an immediate impact on available resources. However, it is imperative that the full requirement of WTE provision is maintained for the respective tasks as outlined in this report. The application of resource continues to be provided and is well received by the team.

## 10. Collaborative Partner Update (No change from previous report)

There are three partner organisations in the SmartCare procurement – GHNHSFT; Yeovil District Hospital and Northern Devon Healthcare.

**Yeovil** has continued with successful implementation of TrakCare. They are in the on-going process of review in terms of process change.

**Northern Devon** is in discussion with InterSystems regarding re-planning of their potential go-live arrangements. No date has been fixed at this time.

## 11. Project Support from the Trust Board

The Trust Board is asked to note the continued requirement for resource in terms of the Clinic processes and Information reporting.

The Trust Board is asked to reinforce the message that Training needs to be encouraged in order to meet an acceptable level for go-live.

## 12. Stakeholder Engagement

Engagement within the Trust has been enhanced due to the nature of the issues leading to the decision to delay. As a result of the training review and in terms of the provision of the Technically Live environment in November, effective engagement and education is becoming more widely spread.

Engagement with Community partners is also serving to ensure preparedness for the go-live in December.

**Author:** **Gareth Evans, SmartCare Programme Manager**

**Presenting Director:** **Dr Sally Pearson, Director of Clinical Strategy and SRO**

**Date:** **November 2016**

**GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST**
**PUBLIC BOARD MEETING FRIDAY 25th NOVEMBER 2016**
**Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at 9.00 am

| **Report Title** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| NHS Improvement Assurance Template on Temporary Staffing | | | | | | | | | |
| **Sponsor and Author(s)** | | | | | | | | | |
| Dave Smith – Director of Human Resources and Organisational Development | | | | | | | | | |
| **Audience(s)** | | | | | | | | | |
| Board members | x | Regulators | x | Governors | x | Staff | x | Public | x |

**Executive Summary**

Purpose
To present to the Board for consideration and approval a self-certification checklist against a set of key actions identified as being instrumental in reducing agency expenditure.

Key issues to note
Agency spend across the NHS is running at £2.5bn annually with our Trust spending in excess of £20m. Whilst nationally, concerted efforts have seen a £600m reduction from the previous high, our Trust has not delivered a similar level of performance. In the first quarter of the year NHSI set a cap for Gloucestershire Hospitals Foundation Trust in terms of agency expenditure which represented a reduction in excess of 40% of the prior year expenditure. Our current trajectory has us repeating the same level of spend as the prior year and our current performance regionally and nationally is poor. As a consequence NHSI have written to Trusts seeking assurance that Board members are sighted on this crucial issue and have the tools to hold executive directors to account. One of the assurance tools is the self-certification checklist which is the subject of this paper and is required to be returned to NHSI following Board approval by the 30th November.

Conclusions
Assurance is provided across a range of areas and where this is limited, action plans are referenced to address. The checklist is a strong aid, however it is the development of granular action plans within each of the work streams referenced in the overarching action plan (attached), in addition to the focus and ownership provided by the executive team, that will develop the traction required. There is evidence, particularly in nursing, that spend is reducing following an increase in staffing numbers recently and we need to ensure focus is maintained and this translates into the other work streams. The paper sets out the governance arrangements for reviewing progress.

Implications and Future Action Required
The executive team (led on this theme of financial recovery by the Director of HR&OD), clearly understand their responsibilities in this area and the need to deliver a significantly improved performance in-year and throughout 2017-18

**Recommendations**

The Board is asked to approve the assurance template for submission to NHSI.

**Impact Upon Strategic Objectives**

A failure to control agency utilisation will impact on financial stability, continuity of patient care and employee engagement and retention.

**GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST**
**PUBLIC BOARD MEETING FRIDAY 25th NOVEMBER 2016**
**Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at 9.00 am

| **Impact Upon Corporate Risks** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Poor control in this area will increase the risks on workforce supply. | | | | | | | |
| **Regulatory and/or Legal Implications** | | | | | | | |
| This area has already received significant attention from NHSI and will continue to do so. Our efforts to reduce agency must contain assurances that quality and safety is not being compromised in any way and both NHSI and the CQC will be seeking assurance that this is the case. | | | | | | | |
| **Equality & Patient Impact** | | | | | | | |
| It is recognised that optimum care is provided by a consistent, engaged workforce and reducing the number of agency shifts worked and substituting them with substantive or internal bank shifts will contribute significantly to that. | | | | | | | |
| **Resource Implications** | | | | | | | |
| Finance | **x** | Information Management & Technology | | | | | |
| Human Resources | x | 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** | **Workforce Committee** |
| | | | | | 14/10/16 |

# GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

## MAIN BOARD – NOVEMBER 2016

## NHS IMPROVEMENT BOARD ASSURANCE TEMPLATE ON TEMPORARY STAFFING

### 1. Aim

1.1 To present to the Board for consideration and approval a self-certification checklist in relation to the key actions identified by NHSI as being instrumental in reducing agency expenditure.

1.2 To ensure that the Board is sighted on all issues related to Temporary Staffing utilisation, and is receiving appropriate assurance from Executives on this critical aspect of performance.

### 2. Background

2.1 Under-performance on control of agency expenditure is a key factor in the current financial challenge facing many NHS organisations. There are a number of factors driving this, the majority of which are linked to workforce supply. Currently the NHS is on track to spend £2.5bn annually on agency staff with our contribution to this total running at circa £20m. Whilst the sector has delivered reductions in this area of £600m we have not witnessed local savings in anything like this proportion as we are currently tracking towards a similar spend as in the prior year.

2.2 At the beginning of the year we were set an agency spend ceiling of £12.1m which reflected a savings target of in excess of 40%. As disproportionate as such a target may seem, we have failed to deliver an acceptable trajectory of savings and this failure has understandably become a major concern for NHSI. In addition to the prior scrutiny which involved weekly reporting on all shifts worked which were paid at a rate above the NHSI cap, additional scrutiny is now being brought to bear through direct communications from NHSI with provider Chairs, Chief Executives and Finance Directors. Correspondence was received from Anne Eden, NHSI Executive Regional Managing Director (South) on the 17th October. This letter **(Appendix 1)** was particularly aimed at ensuring Trust Boards had access to tools that would enable them to hold Executive Directors to account. Specifically this included a self-certification template against a number of key actions that is required to be signed off by the Board and returned to NHSI by the 30th November. This template is presented in **Appendix 2** with key issues for consideration highlighted in section 4 (below). The template does not represent the totality of efforts to reduce expenditure and the current agency plan (**Appendix 3**) and the governance arrangements are set out in the following section.

### 3. Overarching Plan and Governance Arrangements

3.1 In recognition of the importance of this issue, an Agency Task Force was set up at the beginning of this financial year by the CIP Director under the sponsorship of the Director of HR&OD. The strategy was to devolve the required agency trajectory spend into the divisions, agreeing divisional spend trajectories and confirming the actions that would deliver the trajectory. This group met fortnightly in the guise of the 'Delivery Board' and in turn reported progress to the Efficiency, Savings and Improvement Board. It became clear that this was not delivering with anything like the traction required.

3.2 Following a visit from NHSI it was agreed that we would submit a revised plan and that this would include revised governance arrangements. The plan (Appendix 3) was submitted to NHSI in early October and has received initial approval, subject to a more detailed sub-plan being developed. In terms of governance arrangements, a new Agency Programme Board was formed, chaired by the Executive Director of HR and

OD. Four core work streams are involved (Nursing, Medical, Operations and Workforce) and these are chaired by the Executive Medical, Nursing and Operational Directors, with the workforce stream chaired by the Associate Director of Workforce.

3.3 The Agency Programme Board meets on a weekly basis and each of the work stream leads are translating their high level actions into a granular plan with clear deliverables. The Programme Board reports directly into the Turnaround Implementation Board on a fortnightly basis with additional elements of reporting into the Workforce Committee and Finance Committee. Thus far the Agency Programme Board has focussed on key priorities which will deliver a tangible movement in our position in the short term, but there are also a number of longer-term objectives within scope; these will come into focus during 2017.

## 4. Self-Certification Template

The template is split into a number of key areas;

a. Governance and Accountability

As indicated in the previous section, strong assurance can be given in this area. It is a significant priority for the CEO and the Executive Directors, particularly those who are leading on a work stream within the Agency Programme Board structure. However, such assurance cannot be currently provided in terms of the specific point relating to 'workarounds to the agency rules'. Whilst we are operating with approved framework suppliers in all but a few cases (where the demand or the requirement is exceptional), the vast majority of shifts remain at a rate in excess of the agency cap. Support has been sought from Procurement, although we are awaiting the appointment of a dedicated Procurement specialist to lead in this area in term of supplier engagement and rate negotiation.

b. High Quality Timely Data

We have recently secured access to "Tableau", a reporting tool which provides high quality, real time data on agency locum spend. This should significantly enable our capacity in terms of understanding patterns and trends in usage and spend, and being positioned to take pre-emptive action to reduce expenditure for agency locums.

In terms of nursing agency activity and spend; whilst the data exists we are currently working to make it more accessible and timely, recognising the criticality of this to our ability to understand and manage spend in this area.

c. Clear process for approving agency use

We have a centralised team for booking bank and agency staff. Funding has been agreed to extend the hours of this team to evenings/weekends and this will be in place from January. In conjunction with this, we are also planning to co-locate the Temporary Staffing Team with the Site Management Service (subject to the availability of appropriate space).

With regards to a clearly defined approvals process, there is no doubt that the divisional nursing directors are implementing significantly greater control and challenge to requests. This is vital to ensure a realistic assessment of each situation, effective deployment of staff and a focus on safety and quality.

d. Actions to reducing demand for agency staffing.

With regards to point 9, 'tough plans in place for unacceptable spending' this is a work in progress and greater traction is required in this area. The plans exist but require implementation.

With regards to a 'functional bank', there are improvements that need to be made in terms of simplifying recruitment processes and increasing the size and more importantly, utilisation levels of the nurse bank. It will be equally important to obtain similar assurance regarding medical and AHP staff and their availability for bank work.

With regards to rostering, a key control element will be increasing the percentage of nursing rosters that are completed 6 weeks in advance to consistently beyond 80%. A current weakness in our rostering arrangements is the lack of a common system across all staff groups. We are progressing a tender process to appoint a suitable supplier as soon as possible, with the support of Procurement.

With regards to filling vacancies swiftly, only limited assurance can be provided against this standard. There are a number of factors which impact the speed of recruitment. The biggest areas of agency spend are in Nursing and Medicine where supply issues can frequently determine the speed of recruitment.

In terms of supporting staff to design innovative solutions, workforce planning recognises the role of service lines in best understanding the pressures relating to their services and to consider/propose alternatives. Roles under consideration include Nurse Associates (to be implemented from 2017), Physicians Assistants, Advanced Nurse Practitioners and ward based Pharmacists. Research posts are also actively considered. The Chief Executive Chairs the Sustainable Clinical Workforce Group where a number of these ideas are considered.

To support workforce planning more generally, a number of staff across the divisions have been trained in workforce planning techniques. Divisions are supported with key workforce information and trends and are encouraged to build their plans 'bottom up'.

e. Working with your local health economy.

We have attended meetings with Trusts from Bristol, Bath and Weston to agree rates although have found supply challenged as their geography lends itself to closer collaboration. We have meetings planned with Great Western and are also talking to Royal Devon and Exeter as they are performing excellently amongst their peers in the South West. We have also taken advice from as far afield as Derby who have done excellent work in recruiting and retaining acute middle grades, an area in which we have been significantly challenged.

Within the County, we continue to work very closely with colleagues at 2Gether and Gloucestershire Care Services, although the true scope for collaboration with these Trusts is somewhat limited given our very distinct focus.

## 5. Conclusion

Using any set of metrics the current performance of this Trust in relation to agency utilisation is unacceptable. Significant focus to date has been placed on the obvious key areas of recruitment and retention. Whilst we have witnessed some slowing of turnover in medicine and increased recruitment levels, both are fragile and cannot be relied upon to turn the dial sufficiently, particularly given the continued increasing of the overall establishment, and the ongoing pressures in terms of activity.

The Board can have confidence that the Executive team understand this issue, and accept the responsibility for delivering a significant improvement in this area. The Board can also be assured that the governance and management infrastructure is now in place to ensure this happens, in line with the recommendations from NHSI.

## 6. Recommendations

The Board is asked to **approve** the template for submission to NHSI.

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

17 October 2016

Provider Chairs, Chief Executives and Finance Directors

Wellington House
133-155 Waterloo Road
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T: 0203 747 000
E: nhsi.enquiries@nhs.net
W: improvement.nhs.uk

Dear Colleague

**Taking further action to reduce agency spending**

I am writing to provide further detail on the actions on agency spending outlined in Jim Mackey's letter to trusts dated 7 October 2016.

It has been one year since NHS Improvement introduced the agency rules, at trusts' request, and the sector has delivered reductions in agency spending of over £600 million. Spending on agency staffing across England is now 20% lower than the same period last year. We know of many trusts across the country that have overcome workforce challenges and used the rules as a springboard to improve governance and processes, negotiate lower rates and reduce demand across every staff group. This is an excellent and important achievement.

However, agency staff still cost the NHS around £250 million a month – at present the sector is falling short of what is needed. Over-reliance on agency staff can put the quality and sustainability of services at risk. In order to retain costs within the available resources for the NHS, we need to ensure that boards, led by yourselves, are doing all you can to take control of agency spending. We need to bring an end to unacceptable behaviour such as paying over the odds for very expensive individuals or relying on the same agency staff members for very long periods of time.

Much more can be done across our region. The South region is already £24m (10%) above the aggregate agency spending ceiling this financial year and I will need to be assured that every trust board has implemented all appropriate controls to meet their ceilings. Your trust has exceeded its agency ceiling in the first five months of 2016/17. I therefore need to be confident that you are taking urgent action to correct this to bring your spending below your ceiling in order to reduce excess cost to the NHS.

Jim Mackey's letter on 7 October highlighted further actions to reduce agency spending, which include promoting transparency, better data, stronger accountability to boards and additional reporting of high-cost overrides. Further details on these expectations are set out below.

**Promoting transparency and collaboration**

Trusts have been asking for more information on agency spending to allow them to benchmark against their peers and work more collaboratively within the region. To support this, from November my team will be sharing data on agency expenditure (in relation to ceilings and total workforce costs) for all trusts in the region.

To further support collaboration, starting in November 2016 we will be holding further regional workshops and working to ensure that agency spending forms a key component of STP discussions. We will expect STPs to ensure the agency rules and these controls are implemented across the footprint to reduce excess cost and provide services within the System Control Total. These workshops will be led by your NHS Improvement regional relationship management team who will contact you shortly with further details.

In addition, as part of the broader approach to transparency, from Quarter 2 we will publish in NHS Improvement's quarterly finance report trust level data on agency expenditure. This is likely to include the best and worst performing trusts against ceiling and relative to workforce costs.

**Data on your agency spending at Quarter 2**

Jim Mackey's letter set out additional data for all NHS trusts and foundation trusts to provide at Quarter 2. This will help your trust and the NHS Improvement relationship team to better understand your agency usage. For clarity, I have summarised the data request and where to submit the data on the last page of this letter.

**Further support on medical agency staffing**

I am pleased that many trusts have been using the medical locum guide to reduce the reliance on premium medical agency spending. The guide is on our website: https://improvement.nhs.uk/resources/reducing-reliance-medical-locums-practical-guide-medical-directors/

We expect trusts to fully implement this guidance and to support this NHS Improvement will be holding a webinar to run through this guide. We have medical directors from the sector sharing their experiences and I would I strongly encourage you and your medical director to join the webinar which is from 2pm to 3pm on 18 October. You can register to take part here: http://www.workcast.com/register?pak=5635436120063143

**Helping boards to hold executives to account on agency spending**

It is very important that boards are systematically holding executive directors to account to reduce excess costs associated with agency spending, informed by high quality information. Some trust board members have asked us for more support on how to do this.

I attach a self-certification checklist for your board to complete to be assured that the trust is taking all appropriate actions on agency spending and to identify additional steps you can take. The checklist includes actions that can have an immediate impact: establishing governance, accessing accurate and timely data to inform your decisions and using appropriate tools and processes – such as rapid recruitment processes and eRostering. We expects trusts to have tough plans to tackle unacceptable spending, including exceptional over-reliance on agency staff in services such as radiology or very high spending on on-call staff.

I recognise that some services provided by trusts in our region are heavily reliant on agency staff resulting in them being financially unsustainable. If this is the case, you need to consider changing the way you deliver services, such as by changing roles or implementing shared service models, to achieve more sustainable staffing over the short to medium term. The checklist also challenges whether your trust is taking these actions.

This will be an area of particular focus where trusts are incurring costs in excess of their agency ceiling or are outliers relative to other trusts.

This checklist needs to be reviewed by your board working with your CFO, HR director and medical and nursing directors. All trusts should send the completed form to us (NHSI.agencyrules@nhs.net) by 30 November 2016. We will be following up with some trusts to ensure that the relevant board-level discussions have taken place with sufficient challenge and assurances that actions have been taken or will be taken by executive directors.

**Additional reporting on unacceptable applications of the agency rules**

Some trusts have advised us that they consider a lack of compliance by local partners results in an overall inflationary effect. We have also been advised that in some cases, when the agency price cap or maximum wage rates are exceeded on exceptional patient safety grounds, trusts no longer endeavour to negotiate the best rates for staff. This is not acceptable; trusts should always seek to negotiate the best price possible whether price caps are exceeded or not.

In addition, frameworks have been designed to support trusts in negotiating with agencies, managing down prices and collaborating with neighbours. Often going off-framework is indicative of poor planning and agency procurement behaviour resulting in trusts paying significantly higher prices for agency staff. Collective action is the most effective way of tackling high agency spending and we expect providers to operate in a way which secures this aim.

To ensure that chief executives have full sight of these significant overrides, we will now require in all trusts that the trust chief executive personally sign off on:

- All agency shifts by individuals costing more than £120 per hour.
- All framework overrides above price cap.

Chief executives should endeavour to sign off on any of these overrides prospectively although in exceptional circumstances retrospective sign off, within at most one week, may be necessary. A suggested template is provided in Appendix 4.

We will not ask trusts that are meeting their agency expenditure ceiling to report systematically to NHS Improvement on this (although they are still expected to follow the internal process).

However, all trusts that have year-to-date agency spending higher than ceiling are required to submit weekly signed off shift-level data on these overrides from 22 November 2016. This will be incorporated as part of the agency weekly returns.

In addition, we may be asking trusts across some regions with spending higher than ceiling to submit shift-level data on all non-clinical overrides. You will be informed shortly if you are required to submit this information.

**Senior managers**

Trusts need to reduce their reliance on agency staff at all levels and across all areas and this includes managerial staff.  While senior managers play a pivotal role in guiding NHS

organisations through important operational and strategic improvements, the NHS often achieves poor value for money from recruiting agency managerial staff. We should be aiming to radically reduce and ideally eliminate reliance on agency managerial staff and use internal NHS solutions.

From 31 October 2016 trusts will be required to secure approval from NHS Improvement in advance of:

- Signing new contracts with agency senior managers where the daily rate exceeds £750, including on costs.
- Extending or varying existing contracts where the daily rate exceeds £750, including on costs or incurring additional expenditure to which they are not already committed.

Trusts will need to demonstrate that they first tried to fill the role internally, within their STP footprint or within the NHS. Guidance on this new process will be published on NHS Improvement's website later this week and also in the Provider Bulletin on Wednesday 26 October. Updated guidance on the use of interims through on-payroll arrangements or board-officer roles will also follow shortly.

Recognising the significant challenge that remains, I wanted to thank you and your teams for all your work so far in implementing the agency rules. I hope these actions, summarised at the end of this letter, will help you to go further by ensuring you have your board's attention, support and understanding of the challenges your trust faces, to implement the changes needed to reduce your spending.

Yours sincerely,

Anne Eden

Executive Regional Managing Director (South)

**Summary of actions required**

For all trusts

| Action | Template | Steps to take |
|---|---|---|
| Submit data: monthly agency spending broken down by cost centre/service line (request sent 3 October 2016). | Appendix 1 | Submit data to Finance inbox (NHSItrustfinance@dh.gsi.gov.uk) by 12pm on 24 October 2016 |
| Submit data:<br>• A list of your 20 highest-earning agency staff (anonymised)<br>• A list of agency staff that have been employed for more than 6 consecutive months (anonymised) | Appendix 2 | Submit data to Agency inbox (NHSI.agencyrules@nhs.net) by 12pm on 31 October 2016 |
| Board, together with CFO, HR director and nursing and medical directors to discuss and complete agency self-certification checklist. | Appendix 3 | Submit completed checklist to Agency inbox (NHSI.agencyrules@nhs.net) by 30 November 2016 |
| Chief executives to personally sign off on:<br>• All shifts by individuals costing more than £120 per hour.<br>• All framework overrides above price cap. | Example sign off template in Appendix 4 | Embed action in trust. |
| From 31 October 2016 trusts will be required to secure approval from NHS Improvement in advance of:<br>• Signing new contracts with agency senior managers where the daily rate exceeds £750, including on costs.<br>• Extending or varying existing contracts where the daily rate exceeds £750, including on costs or incurring additional expenditure to which they are not already committed. | Guidance, including template, to be published on NHSI website on 19 October 2016 | Submit requests to Agency inbox (NHSI.agencyrules@nhs.net) |

In addition, if your trust has year to date agency spending higher than ceiling, you are also required to do the following.

| Action | Template | Steps to take |
|---|---|---|
| Submit data: weekly shift level data, signed off by your chief executive, on:<br>• All shifts by individuals costing more than £120 per hour.<br>• All framework overrides above price cap. | Reporting as part of weekly override reporting returns | Submit data on these shifts through the agency weekly returns 23 November 2016 |

# Gloucestershire Hospitals NHS Foundation Trust - Agency Action Plan

| Update | | 05/10/2016 |
|---|---|---|

| | | |
|---|---|---|
| FYE Total Plan Value £k | | £ 7,645 |
| PYE Total Plan Value £k | | £ 1,350 |

**Objectives**

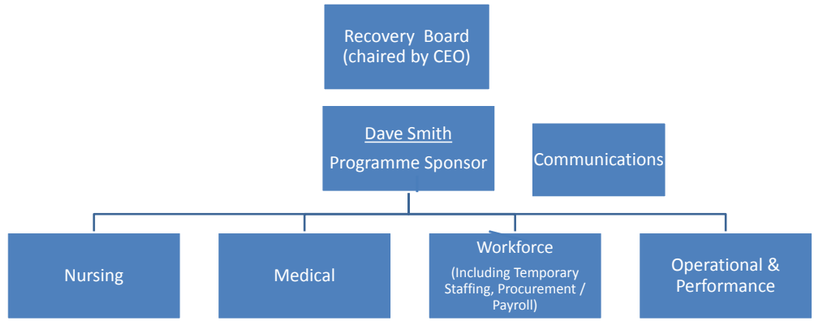
Ob1/ Deliver the Agency Financial Ceiling in accordance with agreed trajectories £16m cap
Ob2/ Maintain and improve Best Care For Everyone
Ob3/ Enhance the Trust's Process and Controls
Ob4/ Development of new roles
Ob5/ Recruitment and Retention

**Key Performance Indicators (KPIs)**

KPI1/ Financial - Agency spend & forecast each month against trajectories
KPI2/ Financial - Agency rates and commission monthly improvement (unit price reductions)
KPI3/ Activity - Decrease in Agency & Locum hours used
KPI4/ Rostering - Achieve 80% fill rates 6 weeks before roster commences
KPI5/ Staffing - Decrease in vacancy rate and turnover through increased substantive proportion
KPI6/ Staffing - Decrease in sickness absence rates (with no increase in other absence types)
KPI7/ Staffing - Annual leave levels consistent across year
KPI8/ Staffing - Increase in bank usage as proportion of total non-substantive resource

**Agency Task Force Programme Governance Structure**

Executive Sponsor & Programme Board Chair : (To be confirmed)
Programme Manager : To be agreed
Programme Board report to be confirmed




Workstreams to deliver Tasks on plan and to provide Exception reports to the Programme Board

| Deliverable | Owning workstream | Full Year Task Value savings £k | | Tasks | Full Year Gross Impact £k | Full Year Net Impact £k | Part Year Gross Impact £k | Part Year Net Saving £k | Outcomes | KPI Measure(s) | Objective | Start date | End date | Costing Assumption | Measurement | Defined Measurement Criteria Y-Yes, C-Measurable in combination with other tasks, N-Not Measurable |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Nursing & AHPs | Nursing | £1,013 | Nur01 | Reduce the number of ad-hoc and out of hours bookings | £ 101 | £ 30 | £ 34 | £ 10 | Number of ad-hoc and out of hours booking reduced | 1,3,8 | 1,2,3 | 01/10/2016 | 30/11/2016 | Assumptions:<br>Agency booked for covering staff sickness has been used as the driver for ad-hoc and out of hours bookings<br>A 10% reduction in current spend has been assumed | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Nur02 | Develop minimum staffing levels based on a risk assessment on acuity | £ - | £ - | £ - | £ - | Numbers agreed and savings to be quantified (if any) | 1,3,4,5 | 1,2,3 | 01/07/2016 | 31/07/2016 | | | |
| | | | Nur03 | Realign HCA over establishment, and improve mobility of staff between specialties | £ - | £ - | £ - | £ - | Plan agreed and implemented; baseline of HCA levels across Divisions | 1,3,4,5,6,7 | 1,2,3 | 01/10/2016 | 30/11/2016 | | | |
| | | | Nur04 | Review bookings of staff for specialling patients | £ 60 | £ 60 | £ 20 | £ 20 | Review completed, and action plan agreed; update to policy/process/procedures, and publish/enforce | 1,3,4,8 | 1,2,3 | 01/10/2016 | 30/11/2016 | Assumptions:<br>Agency booked for specialling has been used as the driver<br>A 5% reduction in current spend has been assumed | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Nur05 | Review of Nursing contact time / hours | £ - | £ - | £ - | £ - | Contact time reviewed and saving to be quantified | 1,4,5,6,7 | 1,2,3 | 01/12/2016 | 31/12/2016 | | | |
| | | | Nur06 | Refresh 'Back to Nursing' courses | £ - | £ - | £ - | £ - | Course reviewed and promoted | 1,3,4,5,6,8 | 1,2,3,5 | 01/10/2016 | 31/12/2016 | | | |
| | | | Nur07 | Improve fill rates for rosters for nurses to 80% 6 weeks before roster commences, by reviewing and actioning the Rosterpro data analysis | £ 149 | £ 45 | £ 50 | £ 15 | Decrease in agency hours & spend required | 1,3,4,7 | 1,2,3 | 01/10/2016 | 30/11/2016 | Assumptions:<br>Agency booked for covering unfilled vacancies has been used as the driver<br>A 2.5% reduction in current spend has been assumed | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Nur08 | Ensure all nursing rosters match demand requirements and a process is agreed to ensure these are updated as required | £ 149 | £ 45 | £ 50 | £ 15 | Decrease agency hours and spend | 1,3,4,7 | 1,2,3 | 01/09/2016 | 31/10/2016 | Assumptions:<br>Agency booked for covering unfilled vacancies has been used as the driver<br>A 2.5% reduction in current spend has been assumed | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Nur09 | All clinical staff need to be on rostering, to match workload with staffing demand (post system change) | £ - | £ - | £ - | £ - | Decrease agency hours and spend | 1,3,4,5,7 | 1,2,3 | 01/04/2017 | 30/06/2016 | | | |
| | | | Nur10 | Agree escalation and levels of approval | £ 36 | £ 36 | | | Escalation policy agreed | 3,4,8 | 2,3 | 01/07/206 | 31/07/2016 | Assumptions:<br>Agency booked for additional beds opened, internal incident extra capacity and patient acuity has been used as the driver<br>A 5% reduction in current spend has been assumed | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Nur11 | Develop a process for ward level / service level management of caps | £ - | £ - | £ - | £ - | Process developed | 1,3,8 | 2,3 | 01/08/2016 | 31/08/2016 | | | |
| | | | Nur12 | No booking of Agency HCAs (exceptions for specialling) | £ 269 | £ 237 | £ 112 | £ 99 | Directive communicated | 1,3,7,8 | 1,2,3 | 01/09/2016 | 30/09/2016 | Assumptions:<br>£100k reduction in current spend for specialling cover<br>£100k reduction in current spend for vacancy cover<br>£69 reduction in current spend for sickness cover | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Nur13 | Cease all use of Thornbury not approved by executive director | £ 250 | £ 250 | £ 104 | £ 104 | Directive communicated | 1,3,7,8 | 1,2,3 | 01/10/2016 | 31/10/2016 | Assumptions:<br>Current Thornbury spend assessed and assumed 3 in all 4 requests will still be authorised | This can be measured by the reduction in use of a single supplier | Y |
| | | | Nur14 | Peer Review with Chief Nurse at Epsom & St Helier | £ - | £ - | £ - | £ - | Agree further actions and Implement | 1,3,5,8 | 1,2,3,4,5 | 01/10/2016 | 31/01/2017 | | | |


Updated by Paula Perks
Cost Improvement Manager
12/09/2016

| Deliverable | Owning workstream | Full Year Task Value savings £k | | Tasks | Full Year Gross Impact £k | Full Year Net Impact £k | Part Year Gross Impact £k | Part Year Net Saving £k | Outcomes | KPI Measure(s) | Objective | Start date | End date | Costing Assumption | Measurement | Defined Measurement Criteria Y-Yes, C-Measurable in combination with other tasks, N-Not Measurable |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Nur15 | Review of AHP contact time / hours | £ - | £ - | £ - | £ - | Revised contact hours agreed & Decrease in Agency spend to be quantified | 1,3,5,7,8 | 1,2,3,5 | 01/10/2016 | 31/12/2016 | | | |
| | | | Nur16 | Introduce ward housekeeper roles | £ - | £ - | £ - | £ - | Job Description agreed, savings to be quantified | 1,3,5,7 | 1,2,4,5 | | ONGOING | | | |
| | | | Nur17 | Development of Ward Pharmacy prescribers | £ - | £ - | £ - | £ - | Job Description agreed, savings to be quantified | 1,3,5,7 | 1,2,4,5 | | ONGOING | | | |
| | | | Nur18 | Development of nursing administration role to increase contact time - If pt information in Trak, must be real time. | £ - | £ - | £ - | £ - | Job Description agreed, savings to be quantified | 1,3,5,7 | 1,2,4,5 | 01/01/2017 | 31/03/2017 | | | |
| | | | Nur19 | Ref WF05 - reduce nursing turnover | | | | | | | | | | | | |
| | | | Nur20 | Reduce Weekend and Bank Holiday sickness levels | | | | | | | | | | | | |
| Medical | Medical | £1,233 | Med01 | Reduce the number of ad-hoc and out of hours bookings | | | | | Number of ad-hoc and out of hours booking reduced | 1,3,8 | 1,2,3 | 01/10/2016 | 30/11/2016 | | | |
| | | | Med02 | Job Planning review and rigour - Implementation of electronic task allocation for medical staff, to understand and align staffing to need and reform working practice. | £ 397 | £ 119 | £ 66 | £ 20 | Tool implemented, savings quantified and action plan agreed | 1,3,4,5,7 | 1,2,3,5 | 01/04/2017 | 30/06/2017 | Assumptions:<br>5% reduction assumed in the current baseline for locum expenditure | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Med03 | Ensure the Deaneries notify the Trust of fill rates at least 4 months ahead and agree resource transfer to Trusts to fund vacant slots upfront | £ - | £ - | £ - | £ - | Confirmation process is in place and managed | 1,3,4,5,7,8 | 1,2,3,5 | 01/09/2016 | 31/10/2016 | | | |
| | | | Med04 | 1. Agree and Implement Top 10 ideas to encourage Drs to move from agency to permanent contracts.<br>2. *A process and procedure to get this right is required to ensure avoidance of introduction fee.* | £ 199 | £ 60 | £ 33 | £ 10 | Top 10 Ideas agreed and communicated. Process and procedure produced and communicated. | 1,3,4,5,7 | 1,2,3,5 | 01/10/2016 | 30/11/2016 | Assumptions:<br>2.5% reduction assumed in the current baseline for locum expenditure | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Med05 | WLI Saturday through Job Planning to look like a regular working day | £ - | £ - | £ - | £ - | Savings Quantified and implementation plan agreed<br>Appropriate review of consultant contract required. | 1,3,4,5,7 | 1,2,3,5 | 01/02/2017 | 30/06/2017 | | | |
| | | | Med06 | Group job planning move to 1.5 PAs to increase DCC (applied only to consultants not recently employed under new T&Cs) | £ - | £ - | £ - | £ - | Job Planning Policy and Process updated to include, savings to be quantified | 1,3,4,5,7 | 1,2,3,5 | 01/01/2017 | 31/03/2017 | | | |
| | | | Med07 | Review of Hospital at night to consider medical staff workload, with pooling of acute medicine and subspecialty rosters, labour substitution with nurses and other posts | £ 80 | £ 24 | £ 13 | £ 4 | Review completed and action plan developed and implemented | 1,2,3,4,5,7,8 | 1,2,3,6 | 01/11/2016 | 31/12/2016 | Assumptions:<br>1% reduction assumed in the current baseline for locum expenditure | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Med08 | Procure and implement the use of a workload measurement tool *- Same as Job planning (Med01)* | £ - | £ - | £ - | £ - | Tool procured | 4,7 | 2,3 | 01/10/2016 | 31/12/2016 | | | |
| | | | Med09 | In relation to Junior medical staff a review of work programmes is required to see if better cover could be provided by rostering or increasing establishment with clinical fellows or alternative roles | £ - | £ - | £ - | £ - | Review completed and action plan developed and implemented | 1,2,3,4,5,7,8 | 1,2,3,4,5 | 01/01/2017 | 30/09/2017 | | | |
| | | | Med10 | Enhance and enforce controls around study and annual leave booking | £ 397 | £ 397 | £ - | £ - | Policies and controls in place, savings quantified | 1,3,4,5,6,7 | 1,2,3 | 01/10/2016 | 30/11/2016 | Assumptions:<br>5% reduction assumed in the current baseline for locum expenditure | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Med11 | Rigorously implement consequences of non-compliance | £ - | £ - | £ - | £ - | Evidence of disciplinary actions taken. | 1,2,3,4,5,6,7 | 1,2,3 | 01/12/2016 | 31/03/2016 | | | |
| | | | Med12 | Review all locum appointments | £ - | £ - | £ - | £ - | Review complete | 1,3,5,7,8 | 1,2 | 01/10/2016 | 31/10/2016 | | | |
| | | | Med13 | Agree and implement exit strategies for long term medical locums (cf Med11) | £ 80 | £ 80 | £ 33 | £ 33 | No of locums and expenditure decrease | 1,2,3,5 | 1,2 | 01/10/2016 | 31/10/2016 | Assumptions:<br>1% reduction assumed in the current baseline for locum expenditure | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Med14 | Medical representation on Taskforce | £ - | £ - | £ - | £ - | Representative identified | | 2,3 | 01/08/2016 | 31/08/2016 | | | |
| | | | Med15 | All clinical staff need to be on rostering, to match workload with staffing demand (post system change) | £ - | £ - | £ - | £ - | Decrease agency hours and spend | 1,3,4,5,7,8 | 1,2,3,5 | 01/04/2017 | 30/09/2017 | | | |
| | | | Med16 | Review of Locum job plans to ensure 10 DCCs | £ - | £ - | £ - | £ - | Decrease agency hours and spend | 1,3 | 1,3 | 01/10/2016 | 30/11/2016 | | | |
| | | | Med17 | Replace hard to fill medical posts with alternative roles e.g. ANPs | £ 80 | £ 32 | £ 20 | £ 8 | Plan agreed and savings quantified | 1,3,5,7 | 1,2,4,5 | 01/04/2017 | 30/06/2017 | Assumptions: 1% reduction in associated spend | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | N |
| | | | Med18 | Increase the number of Surgical Assistants | £ - | £ - | £ - | £ - | Job Description agreed, savings quantified | 1,3,5,7 | 1,2,4,5 | 01/01/2017 | 31/03/2017 | | | |
| | | | Med19 | Reduce Weekend and Bank Holiday sickness levels | | | | | | | | | | | | |

| Deliverable | Owning workstream | Full Year Task Value savings £k | | Tasks | Full Year Gross Impact £k | Full Year Net Impact £k | Part Year Gross Impact £k | Part Year Net Saving £k | Outcomes | KPI Measure(s) | Objective | Start date | End date | Costing Assumption | Measurement | Defined Measurement Criteria Y-Yes, C-Measurable in combination with other tasks, N-Not Measurable |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Workstreams | | | | | | | | | | | | | | | | |
| Workforce | Workforce | £2,461 | WF01 | Trust to provide workforce plan for 2016/17 and 2017/18 - *but this is BAU?!?!* | £ - | £ - | £ - | £ - | Plan provided | 5,6,7,8 | 3 | 01/12/2016 | 31/03/2017 | | | |
| | | | WF02 | Development of band 3/4 posts as part of the reduction in temporary and agency staffing costs, around theatres / endoscopy and procedure based areas | £ - | £ - | £ - | £ - | Increase in band 3/4 posts in specified areas, with decreased temporary staffing spend | 1,3,4,5,8 | 1,2,4,5 | 01/01/2017 | 31/03/2017 | | | |
| | | | WF03 | Focus on Overseas Recruitment | £ 1,390 | £ 417 | £ - | £ - | Plan agreed | 1,3,4,5,7,8 | 1,2,3,5 | | ONGOING | Assumptions:<br>A 10% reduction in current spend on nursing vacancies and 10% on current locum spend | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | WF04 | Ensure all substantive and Bank recruitment offers made are taken up | £ - | £ - | £ - | £ - | Improved recruitment conversion rates | 1,3,4,5,7,8 | 1,2,3,5 | 01/10/2016 | ONGOING | | | |
| | | | WF05 | Collate outcomes from Exit interviews to understand root cause issues with turnover, and provide to Nursing management to address | £ - | £ - | £ - | £ - | Reduce staff turnover/churn | 1,3,5,7 | 1,2,3,5 | | ONGOING | | | |
| | | | WF06 | Reduce the time from recruitment to appointment | £ - | £ - | £ - | £ - | | 1,3,45 | 1,2,3,4 | 01/10/2016 | ONGOING | | | |
| | | | WF07 | Develop a Trustwide reward system | £ 1,000 | £ 90 | £ 250 | £ 23 | Identify exceptions not addressed by Reward Strategy Group | 1,3,5 | 1,2,5 | 01/11/2016 | 31/12/2016 | Cost estimate provided to finance - not validated | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | N |
| | | | WF08 | Implement starter interviews, to identify issues in recruitment to be addressed | £ - | £ - | £ - | £ - | Improve staff retention rates | 1,3,5,7 | 1,3,5 | 01/10/2016 | 31/10/2016 | | | |
| | | | WF09 | Implement starter +3 month interviews, to identify issues in retention to be addressed (expectation vs reality) | £ - | £ - | £ - | £ - | Improve staff retention rates | 1,3,5,7 | 1,2,3,5 | 01/10/2016 | 30/11/2016 | | | |
| | | | WF10 | Continue with current enhancement payments for permanent trained staff | £ - | £ - | £ - | £ - | Directive given | 1,3,4,5,7,8 | 1,2,5 | 01/07/2016 | 31/07/2016 | | | |
| | | | WF11 | Develop and Agree a Temporary Staffing Policy | £ - | £ - | £ - | £ - | Policy ratified | 1,3,4,8 | 1,2,3 | 01/07/2016 | 30/09/2016 | | | |
| | | | WF12 | Cease the use of non-framework agencies for all staff groups | £ 71 | £ 71 | £ 24 | £ 24 | Directive communicated | 1,2,8 | 1,2,3 | 31/03/2016 | ONGOING | Estimate only | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | N |
| | | | WF13 | Enhanced controls in the decision making process that determines need for expensive agency (nurse and medical) resource. | £ - | £ - | £ - | £ - | Re-publish relevant policy and procedure, and education of managers to comply. | 1,2,3,8 | 1,2,3 | 01/11/2016 | 30/11/2016 | | | |
| | | | WF14 | Agree review of vacant posts which have been advertised but not recruited to more than twice in a fixed period, and no backfill available, to establish alternatives. If not needed, de-establish | £ - | £ - | £ - | £ - | Increased substantive recruitment with alternative roles.<br>Number of posts disestablished | 5 | 1,2,4 | 01/11/2016 | 30/11/2016 | | | |
| | | | WF15 | Implement focus groups for nursing for different stages of career | £ - | £ - | £ - | £ - | Focus groups set up | 5 | 1,2,5 | 01/10/2016 | 30/11/2016 | | | |
| Temporary staffing Office | Workforce | £206 | TS01 | Review and agree bank rates to encourage more staff to enrol | £ 93 | £ 28 | £ 39 | £ 12 | Revised bank rates agreed and implemented | 1,3,4,8 | 1,2,5 | 01/11/2016 | 31/12/2016 | Assumptions:<br>1% reduction in all nursing agency spend | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | TS02 | Increase the usage of medical and other staff groups Bank | £ 113 | £ 34 | £ 47 | £ 14 | Plan and implementation completed | 1,3,4,8 | 1,2,5 | 01/11/2016 | 31/11/2016 | Assumptions:<br>1% reduction in all locum and other category spend | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | TS03 | Automatic registration on bank for all clinical staff groups | £ - | £ - | £ - | £ - | Implemented as part of recruitment process | 1,3,8 | 1,2,3 | 01/10/20156 | 31/10/2016 | | | |
| | | | TS04 | Increase Opening Hours of Bank Service | £ - | £ - | £ - | £ - | Hours extended | 1,3,8 | 1,2,5 | 01/01/2016 | 31/01/2016 | | | |
| | | | TS05 | Ensure policies and controls are in place for booking of Locum staff | £ - | £ - | £ - | £ - | Policies and controls in place | 1,3,4,5,6,7,8 | 1,2,3 | 01/010/2016 | 31/10/2016 | | | |
| Procurement / Payroll | Workforce | £704 | PP01 | Recruit Procurement specialist to focus on Temporary Staffing | £ - | £ - | £ - | £ - | Post filled | 1,2 | 1,4 | 01/07/2016 | 30/09/2016 | | | |
| | | | PP02 | Agree Liaison Upgrade following review with procurement | £ - | £ - | £ - | £ - | Liaison Upgrade purchased | 1,2 | 1,3 | 01/01/2017 | 31/01/2017 | | | |
| | | | PP03 | Review and agree potential savings for a Locum unit price reduction | £ 282 | £ 282 | £ 47 | £ 47 | Potential agreed | 1,2 | 1,3 | 01/11/2016 | 30/11/2016 | 5% reduction in overall locum spend | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | PP04 | Negotiate and agree reduced unit price reductions and trajectories with 5% decreases until cap achieved for Locum | £ - | £ - | £ - | £ - | Unit price reductions evidenced on Liaison | 1,2 | 1,3 | 01/11/2016 | 31/03/2017 | | | |
| | | | PP05 | Review and agree potential savings for a Nurse unit price reduction | £ 422 | £ 422 | £ 70 | £ 70 | Potential agreed | 1,2 | 1,3 | 01/10/2016 | 31/12/2016 | 5% price reduction in nursing spend | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | PP06 | Negotiate and agree reduced unit price reductions and trajectories with 5% decreases until cap achieved for Nursing | £ - | £ - | £ - | £ - | Unit price reductions evidenced on Liaison | 1,2 | 1,3 | 01/11/2016 | 31/03/2017 | | | |
| | | | PP07 | Implement Rosterpro additional pay run | £ - | £ - | £ - | £ - | Decrease agency hours required and spend | 1,3,4,8 | 2,5 | 01/09/2016 | 31/10/2016 | | | |
| | | | PP08 | Procure a new e-rostering to replace Rosterpro and to support medical rostering, with expert support included in the package | £ - | £ - | £ - | £ - | New e-rostering system procured | 1,3,4,7 | 1,2,3 | 01/09/2016 | 31/12/2016 | | | |
| | | | OR01 | Operational control centre where e-rostering staff and bank and agency staff booking come together | £ - | £ - | £ - | £ - | Decrease agency hours and spend | 1,3,4,8 | 1,2,3 | 01/11/2016 | 31/01/2017 | | | |

| Deliverable | Owning workstream | Full Year Task Value savings £k | | Tasks | Full Year Gross Impact £k | Full Year Net Impact £k | Part Year Gross Impact £k | Part Year Net Saving £k | Outcomes | KPI Measure(s) | Objective | Start date | End date | Costing Assumption | Measurement | Defined Measurement Criteria Y-Yes, C-Measurable in combination with other tasks, N-Not Measurable |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Operations / Reconfiguration | Operations & Performance | £2,029 | OR02 | Realignment and centralisation of services across sites | £ - | £ - | £ - | £ - | Plan agreed; tracking of appropriate benefits of the Reconfiguration Programme | 1,3,4,5,6,7 | 1,2,5 | 01/04/2017 | 31/03/2018 | | | |
| | | | OR03 | De-escalate any additional ward capacity open, as an exception to normal escalation policy | £ 724 | £ 724 | £ - | £ - | Directive communicated | 1,3 | 1,2,5 | 01/11/2016 | 31/11/2016 | 10% reduction in nursing agency spend due to vacancies, sickness and additional beds | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings. The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | OR04 | Agree the closure of DSU beds on both sites for activity not related to core business | £ 290 | £ 290 | £ - | £ - | Directive communicated | 1,3 | 1,2,5 | 01/11/2016 | 31/11/2016 | Actual spend on DSU | This can be monitored by reduction in costs charged to DSU | Y |
| | | | OR05 | Review all management interims and implement strategies for exit or employment | £ 190 | £ 190 | £ 63 | £ 63 | No of interims and expenditure decrease | 1,2,3,5 | 1,3,5 | 01/09/2016 | 31/10/2016 | 10% reduction in agency spend on management/infrastructure agency spend | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings. The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | Y |
| | | | OR06 | Review all fixed term contracts in place for greater than 2 years and implement strategies for exit or employment | £ - | £ - | £ - | £ - | No of interims and expenditure decrease | 1,2,3,5 | 1,3,5 | 01/10/2016 | 30/11/2016 | | | |
| | | | OR07 | Introduce weekly meetings to review ward cover and rota gaps | £ - | £ - | £ - | £ - | Meetings set up | 1,3,4,7,8 | 1,2,3,5 | 01/07/2016 | 30/07/2016 | | | |
| | | | OR08 | Ensure all breaks and hours claimed are accounted for in Timesheets appropriately for Bank, Agency and Locum | £ 825 | £ 825 | £ 275 | £ 275 | Reduction in Expenditure of £1.6m PYE or £3.3m FYE | 1,3 | 1,3 | 01/09/2016 | 31/10/2016 | Cost provided by agency taskforce - presentation - risk assessed down to 25% of FYE provided value | The analysis used to inform this figure is not produced by the Trust therefore ongoing monitoring has not yet been agreed | N |
| | | | OR09 | All clinical staff need to be on rostering to match workload with staffing demand (post system change, c.f. PP08) | £ - | £ - | £ - | £ - | Decrease agency hours and spend | 1,3,4,7 | 1,2,3,5 | 01/04/2017 | 30/06/2017 | | | |
| | | | OR10 | Stronger enforcement of flexible working, sickness absence policies | £ - | £ - | £ - | £ - | Policy communicated; performance management of non-compliance. | 1,3,4,5,6,7 | 1,2,3,5 | | ONGOING | | | |
| Performance and Information trajectories | Operations and Performance | Enabler | PI01 | Develop Divisional trajectories in accordance with the agency ceiling | | | | | Trajectories agreed | 1,3,4,5,7 | 1 | 01/08/2016 | 31/08/2016 | | | |
| | | | PI02 | Develop individual ward / departmental trajectories | | | | | Trajectories agreed | 1,3,4,5,7 | 1 | 01/08/2016 | 31/08/2016 | | | |
| | | | PI03 | Develop dashboards for monitoring trajectories | | | | | Dashboard Developed | 1,3,4,5,7 | 1 | 01/08/2016 | 31/08/2016 | | | |
| | | | PI04 | Introduce a common dataset of core information on agency staff including run rate expenditure | | | | | Common Dataset developed | 1,3,4,5,7 | 1,3 | 01/11/2016 | 31/12/2016 | | | |
| Communication | Programme Director | Enabler | Com01 | Improved communication via Agency Programme Board | | | | | Agency Programme set up | 4,5,6,7,8 | 3 | 01/06/2016 | 30/06/2016 | | | |
| | | | Com02 | Agree a clear set of principles around communications and how they are distributed | | | | | Principles agreed and in place | 4,5,6,7,8 | 3,5 | 01/09/2016 | 30/09/2016 | | | |
| | | | Com03 | Establish protocol, guidance and communications for the appropriate approach to locums to convert to substantive | | | | | Action in place | 4,5,6,7,9 | 3,5 | 01/10/2016 | 31/10/2016 | | | |
| | | | | Total FYE | £ 7,645 | £ 4,787 | £ 1,350 | £ 866 | | | | | | | | |

Updated by Paula Perks
Cost Improvement Manager
12/09/2016

| | Self-certification checklist<br>Please discuss this in your board meeting | Yes - please specify steps taken | No. We will put this in place - please list actions |
|---|---|---|---|
| | **Governance and accountability** | | |
| **1** | Our trust chief executive has a strong grip on agency spending and the support of the agency executive lead, the nursing director, medical director, finance director and HR director in reducing agency spending. | Agency Programme Board has been rapidly mobilised, with Agency Executive (Director of HR & OD) chairing and Exec workstream leads. Programme Board reports to Workforce Committee chaired by a Non-Executive Director (October minutes: *http://www.gloshospitals.nhs.uk/SharePoint2/Board%20Papers/2016/October%202016/Item%209%20-%20October%20Workforce%20Committee%20Minutes.pdf* , and focus on Agency spend is enshrined in the Workforce Strategy (newly published) and the Trust's Agency Programme. CEO comms to all staff in recent weeks has focused strongly on reducing agency spend in line with financial turnaround. | |
| **2** | Reducing nursing agency spending is formally included as an objective for the nursing director and reducing medical agency spending is formally included as an objective for the medical director. | The Medical Director is the lead for the Medical Workstream of the Agency Programme Board and responsible for delivering reduced spending in this area. Likewise, The Nursing Director is the lead for the Nursing Workstream of the Agency Programme Board, and responsible for delivering reduced spending in this area. | |
| **3** | The agency executive lead, the medical director and nursing director meet at least monthly to discuss harmonising workforce management and agency procurement processes to reduce agency spending. | Agency Programme Board meets weekly. Chaired by Director of HR & OD as agency Executive lead, and with Medical Director and Nursing Director leading two critical workstreams as per item 2 above. | |
| **4** | We are not engaging in any workarounds to the agency rules. | | Due to market forces we are having to Break Glass and engage in workaround activities on a weekly basis to ensure safe patient care, as reported in weekly NHSI returns. However the Agency Programme's workstreams, notably Procurement/Payroll, are striving to address unit cost reductions and improved compliance from suppliers and key actions include the appointment of a dedicated Procurement Specialist who will lead renegotiations with agencies.<br><br>(Programme Plan ref. PP03, PP04, PP05, PP06) |
| | **Clear process for approving agency use** | | |

| | | | |
|---|---|---|---|
| **5** | We know what our biggest challenges are and receive regular (eg monthly) data on:<br>- which divisions/service lines spend most on agency staff or engage with the most agency staff<br>- who our highest cost and longest serving agency individuals are<br>- what the biggest causes of agency spend are (eg vacancy, sickness) and how this differs across service lines. | Finance and activity data on agency usage is available. We know that our highest use of agency staff across our clinical divisions is in Medicine for both Nursing and Medical. Within this our highest useage of clinical shifts for Nursing is within our General and Old Age Medical wards at 22.6% followed by Emergency Department at 6%. For Doctors, there is a clear bias towards Emergency Department at 42% and Acute Medicine at 14.4% These are fuelled by vacancy issues. Whilst in other divisions vacancies remain the prime factor, there are instances of long term sickness amongst medical staff which have required extensive backfill. We have compiled information on highest cost and longest serving agency individuals for central returns and are actively seeking to address these individual cases. | We continue to develop our data and are seeking to develop a weekly 'run rate' of agency expenditure which will enable us to address issues in real time |
| **Clear process for approving agency use** | | | |
| **6** | The trust has a centralised agency staff booking team for booking all agency staff. Individual service lines and administrators are not booking agency staff. | Bank and Locum Service Team has been in place for some years, including working via a Master Vendor contract for Medical Locums.<br><br>In the meantime, out of hours there is some engagement by service lines with agencies as necessary. Expanded central service will minimise this from January 2017.<br><br>(Programme Plan ref. TS04) | Current service is only funded Mon-Fri 08.45-16.30, however will be expanding to M-F 07.30-19.30 plus weekend and Bank Holidays (anticipated 08.00-16.00) from January 2017, subject to outcomes of staff consultation and recruitment to fill rota. In conjunction with this, we are also planning to co-locate the Temporary Staffing Team with the Site Management team (subject to the availability of appropriate space) to enable a greater sense of connection. |
| **7** | There is a standard agency staff request process that is well understood by all staff. This process requires requestors and approvers to certify that they have considered all alternatives to using agency staff. | In place and business-as-usual as per Temporary Staffing Policy (revised October 2016). Enforcement is a focus for the Agency Programme.<br><br>(Programme Plan ref. TS05, OR10) | |
| **8** | There is a clearly defined approvals process with only senior staff approving agency staff requests. The nursing and medical directors personally approve the most expensive clinical shifts. | In place and business-as-usual as per Temporary Staffing Policy (revised October 2016).<br><br>(Programme Plan ref. Med01, Med11, Nur01, Nur10, Nur13, WF13, ) | |
| **Actions to reducing demand for agency staffing** | | | |
| **9** | There are tough plans in place for tackling unacceptable spending; eg exceptional over-reliance on agency staffing services radiology, very high spending on on-call staff. | As per Agency Programme plan, which includes actions and activities for improved diligence of putting substantive staff on high-value on-call shifts to avoid paying more expensive agency workers for less productivity.<br><br>(Programme Plan ref. Nur13, Med10, Med11) | A Radiology Strategy has been considered by the Executive team and the Chief of Service is developing specific proposals to deal with workforce issues which have required expensive internal/external solutions. These include changing the skill mix to upskill Radiographers |

| | | | |
|---|---|---|---|
| **10** | There is a functional staff bank for all clinical staff and endeavour to promote bank working and bank fill through weekly payment, auto-enrolment, simplifying bank shift alerts and request process. | In place and business-as-usual, including: auto-enrolment; leavers interviews to include retention on Bank; recent introduction of additional mid-month pay run for substantive staff's Bank shifts; planned removal of paper Bank timesheets to reduce bureaucracy, internal promotion and communication of Bank working opportunities and improvements to raise profile.<br><br>(Programme Plan ref. TS01, TS02, TS03) | There is currently no Bank for clinical staff other than Nursing and Medical (eg AHP, HSS etc); this is an area for development. Work is ongoing to improve both capacity and utilisation of the Nursing and Locum banks. |
| **11** | All service lines do rostering at least 6 weeks in advance on a rolling basis for all staff. The majority of service lines and staff groups are supported by eRostering. | | eRostering system is RosterPro Central. The Trust is looking to progress to a replacement system in 2017 to include rostering of other staff groups; this is part of the Agency Programme plan (PP08).<br><br>While in place and business-as-usual for many areas, there remain a number of areas who are not compliant with 6 weeks in advance rostering. Some compliance improvements are needed regarding 6-week proximity, and this is part of the Agency Programme Board action plan (to increase to 80% of rostering complete 6 weeks in advance).<br><br>(Programme Plan ref. Nur07, Nur08) |
| **12** | There is a clear process for filling vacancies with a time to recruit (from when post is needed to when it is filled) of less than 21 days. | Central recruitment Team process is very lean; however time to recruit (from need to fill) is dependent factors external to the team, notably recruiting managers shortlisting and setting interview and start dates, candidate responses and notice periods, etc. Ongoing review of internal processes is on the Agency Programme plan.<br><br>NB weekly Vacancy Control Panel being instigated from 18/11/2016.<br><br>(Programme Plan ref. WF04, WF06, ) | A time to recruit of less than 21 days is unrealistic in the context of standard NHS notice periods, albeit nurse recruitment is not linked to vacancies as in recognition of the challenges, we are constantly recruiting. |

| | | | |
|---|---|---|---|
| **13** | The board and executives adequately support staff members in designing innovative solutions to workforce challenges, including redesigning roles to better sustain services and recruiting differently. | The Trust, including the new Vacancy Control Panel process, actively encourages innovative solutions to workforce needs; further, in early 2015 the Sustainable Clinical Services initiative attempted to promote innovative thinking around future services. Overall, the Trust actively and openly encourages such alternatives (eg Nursing Associate role, which will be implemented during 2017). The Recruitment Strategy Group continually explores new and innovative approaches to recruitment, including overseas recruitment activity as well as UK-based recruting through a range of different routes and sources. The Radiology Strategy (referred to in 9 above)<br><br>(Programme Plan ref. WF01, WF02, WF14, Nur03, Nur06, Nur16, Nur17, Med02, Med04, Med06, Med07, Med09, Med12, Med13, Med16, Med17, Med18, PP01, OR01, OR05, OR06) | The Sustainable Workforce Group (newly formed) will take the lead in identifying and developing opportunities for creative solutions to workforce problems. |
| **14** | The board takes an active involvement in workforce planning and is confident that planning is clinically led, conducted in teams and based on solid data on demand and commissioning intentions. | The Board takes an active involvement in Workforce issues, notably in the recent instigation of the Workforce Commiittee (reports directly to Board) that has a number of key groups reporting through it (e.g. Recruitment Strategy, Reward Strategy, Agency Programme. Workforce data is readily available to all Service Lines and Divisions, and is provided to inform workforce planning as part of the overall business planning cycle. This has developed over the last two years from being a separate planning document to being a key, integrated element of Service Line Plans. HRBPs take the lead on supporting clinical areas with the development and implementation of their own bespoke workforce plans, whilst Trust-wide plans are articulated in the planning documents and workforce strategy.<br><br>(Programme Plan ref. PI01, PI02, PI03, PI04, Med02 Med04 | The timings of the planning and commissioning process are not always conducive to the development of workforce plans which are truly informed by service plans. This is an area for development in the future. |
| **Working with your local health economy** | | | |

| | | | |
|---|---|---|---|
| **15** | The board and executives have a good understanding of which service lines are fragile and currently being sustained by agency staffing. | Finance Committee have regularly requested the Directors of HR&OD, the Medical Director and the Nursing Director for Medical Division (area of highest spend and utilisation) to attend and update on progress. Information is available and discussed in the Agency Programme Board relating to areas of high temporary staffing use and spend, but given the Trust-wide remit of this group the focus is usually top level and not detailed in terms of the position of individual service lines. Data around temporary staffing use and spend is widely available at Divisional level; this is accessible by the whole organisation as part of our staff engagement agenda and to stimulate good ideas from the front line about how we can control and reduce our usage.<br><br>(Programme Plan ref. Com01, Com02, Com03) | Reporting at a more granular level on Locum use is now available through the Tableau tool (staffflow data); our aim is to work towards producing something similar internally for Nursing staff. |
| **16** | The trust has regular (eg monthly) executive-level conversations with neighbouring trusts to tackle agency spend together. | We have taken part in a series of meetings with colleagues from Bristol, Bath and Weston with a view to agreeing a consolidated approach. We have also held discussions with Derby to learn from their innovative practices in recruiting and retaining acute middle grades. Our Nursing Director for Medicine has also visited her counterpart at Epsom and St.Helier | Future activities include a meeting with Great Western to discuss their agency controls process and dialogue/visit with Royal, Devon and Exeter who are performing well in comparison to colleagues in the region |

| | |
|---|---|
| **Signed by** | [Date] |
| **Trust Chair:** | [Signature] |
| **Trust Chief Executive:** | [Signature] |

*Please submit signed and completed checklist to the agency inbox (NHSI.agencyrules@nhs.net) by 30 November 2016*

# GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

## MAIN BOARD – NOVEMBER 2016

| Report Title |
|---|
| PREPARATIONS FOR WINTER 2016/17 – AN UPDATE |
| **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 update the Board following the paper at the October Trust Board on the actions that 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.

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Bed capacity and staffing levels are the biggest risks to the delivery of the plan. Therefore this paper focuses mainly on the actions to address this issue.

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

This issue will remain under review for the winter period.

**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)** |
| 23 November 2016 | | | | | |

**MAIN BOARD – NOVEMBER 2016**
**PREPARATIONS FOR WINTER 2016/17 – UPDATE PAPER**

## 1. AIM

1.1 This paper follows on from the briefing paper presented to the Trust Quality and Performance Committee and the Trust Board both held in October 2016

1.2 The preparations for winter are an iterative process both within the Trust and across the Health and Social care system and therefore this paper aims to update the Board members on the very latest position following a number of meetings over the last four weeks.

1.3 The Gloucestershire system wide plan is in the final stages of development and sign off. The intention is to circulate this final plan to the Trust Board when it is available.

## 2. UPDATE ON KEY ACTIONS

2.1 At the October 2016 meetings the Board was briefed on the plans and key risks were identified. Detailed below is the latest position.

## 3. BED CAPACITY

3.1 The Trust bed modelling work indicated that at an ideal occupancy of 85% for elective cases and 90% for emergency, the Trust will have, before any mitigating actions a peak bed deficit of 91 beds at Gloucestershire Royal Hospital in February 2017 and a peak bed deficit of 26 beds at Cheltenham General Hospital in March 2017.

3.2 Therefore there are a range of actions planned to mitigate this risk with bed capacity. This section details the new and key actions for this coming winter and these are over and above previously reported actions. All of these actions aim to address the bed capacity shortfall by either, avoiding an admission, improving patient flow within the hospital or accelerating discharge. The anticipated outcome of these actions is now being modelled into the bed model.

## 4. INTERNAL ACTIONS

4.1 Implementation of red and green days to identify and take action to address any non-value adding waits in the inpatient pathway (known as red days). This is a nationally led initiative and recommended by NHS Improvement. The roll out plan by ward is already 66% complete across both hospitals and full implementation will be in place by 5 December 2016.

4.2 Rapid access to senior decision makers via a hot phone for General Practitioners and Emergency Department doctors to offer a clinical opinion and provide if possible an alternative to an admission. This was also a national recommendation from NHS Improvement. To date hot phones have been introduced in cardiology and emergency medicine. Plans are well underway with respiratory, elderly care, general surgery and gastroenterology to implement over the next two months.

4.3 Opening ambulatory care at weekends at Gloucestershire Royal Hospital. The service currently works an extended day service Monday to Friday on both sites preventing admissions. The Medical Division have agreed that the biggest benefit will be weekend working rather than extra evening hours. So the focus is on recruiting staff to open weekends and cover more pathways. A new location has been identified nearer to the Emergency Department and this will be trialled over the winter period. The aim is to increase the numbers of admissions avoided from the

current 15% to 25%. A date to start the weekend opening is under negotiation with the staff.

4.4 Changes to the integrated discharge team by separating into two teams, one team focussed on front door admission avoidance and being run by Gloucestershire Care Services working alongside rapid response and community teams. The second team with a dedicated operational lead (who is a social worker) will be focussed on ward discharges and will be run by Gloucestershire Hospitals. This change took effect from 1 November 2016 and aims to reduce the number on the medically fit list and the time that a patient is delayed.

4.5 Starting 1st December 2016 the Ward Discharge Team will provide 'wrap around' support for all wards across the Trust. The wards have been grouped into hubs that mirror the existing therapy hubs. As such the new Onward Care Hubs will work closely with therapy, ward staff and social work colleagues to achieve a risk positive attitude to timely discharges. In order to achieve this, the team will spend 90% of their working day directly on the wards assisting them with all areas of the discharge process. This will include supporting ward staff with restarting care packages ready for the patient's estimated date of discharge, completing forms, accessing Community Hospitals, Discharge to Assess, Community Reablement beds and ensuring good social work support.

4.6 Three Multi Agency Discharge Events are planned for w/c 12 December 2016, w/c 9 January 2017 and w/c 20 February 2017. These clinically led events will build on the SAFER initiative and Red/Green days that have already been rolled out across the Trust. We will also adopt the University Hospitals Bristol NHS Foundation Trust "Breaking the Cycle" approach to using a level 1-3 framework command and control structure and introducing a Ward Liaison worker and aim to improve patient flows and release capacity during the period of increased pressure on services during winter. The anticipated outcome of the December event is to create capacity ahead of Christmas, the January week is to enable the recommencement of elective surgery and the February week is to manage anticipated pressures related to school half term holidays and the associated impact on staffing levels. During each day the focus will be on solving problems that stop us meeting the SAFER bundle using the Red and Green methodology and escalating them when they cannot be solved within a set timeframe.

4.7 Three ward moves are planned to take place at Gloucestershire Royal Hospital w/c 17 December 2016, the intention is improve the location for patients in gynaecology, fracture neck of femur, care of the elderly and acute medicine. This will overall increase the number of beds for medicine by six beds and reduce the numbers of outliers and thereby reduce length of stay.

4.8 Extension to pharmacy service on the weekend: Pharmacy services are reviewing the pilot that started in November 2016 for an extended opening service over the weekends for the Pharmacy Dispensaries. The on-call pharmacist will remain on site until 4pm, on both Saturday and Sundays, to undertake any additional discharge medication as required.

## 5. EXTERNAL ACTIONS

5.1 The impact of the range of existing QIPP schemes that when fully delivered should achieve a reduction of approximately 14 emergency admissions per day.

5.2 The intention is to retain the current 50 discharge to assess beds over the winter period. This is funded through the existing Gloucestershire system resilience funding.

5.3 The impact of Urgent Care Reset Plan should release approximately a further 11 beds per day. Although the details of this and the date are not yet agreed.

5.4 Eight additional beds in Gloucestershire Care Services to open during December to January.

5.5 To use all the available existing reablement beds currently in the wider health and social care system. This could free up a further 30 plus beds.

## 6. CHRISTMAS AND NEW YEAR PERIOD

6.1 Each division and corporate services are finalising a directory of services for the holiday season that will form part of the local and Gloucestershire plans for Christmas & New Year. Within the Trust the services will be reconfigured in line with demand as plans in previous year with the following high level changes:

- Electives: The elective activity through main theatres has already been planned at a lower level to enable elective surgery beds to be used for emergency cases whilst more surgery takes place through the Day Surgery Unit. This has been built into the trajectory for the recovery of the 18 week referral to treatment performance.
- Plans are also being finalised for the surgeons to use the unfilled endoscopy sessions over the holiday period. This equates to 12 lists.
- Divisions are exploring the opportunity for elective activity being undertaken by alternative providers during times of anticipated increased demand, however, last winter lists were transferred to other providers with limited success. Further work is required to finalise the caseload for outsourcing in order to ensure robust governance and operational arrangements.
- Surgical beds will be reallocated to medicine and during this time additional surgical outpatients and minor procedures will be undertaken.

## 7. FLU VACCINATION

7.1 The aim is to vaccinate more than 4,000 staff. As at 14 November the number vaccinated was 2,948 and the following table shows the take up by staff group. Continued effort is in place to achieve this aim.

| | ***Baseline 2016*** | | | ***Grand Total*** | ***% Take Up*** |
|---|---|---|---|---|---|
| ***P Type of Worker*** | **Sep** | **Oct** | **Nov** | | |
| ***NHS - Health Care Assistants & other Unqualified Support Staff*** | 2065 | 1000 | 135 | 1135 | 55% |
| ***NHS - Medical staff*** | 851 | 315 | 107 | 422 | 50% |
| ***NHS - Qualified Nursing, Midwifery and Health Visiting staff*** | 2293 | 718 | 179 | 897 | 39% |
| ***NHS - Scientific, therapeutic and technical staff Physio*** | 927 | 410 | 83 | 493 | 53% |
| ***TOTALS*** | 6136 | | 504 | 2948 | 48% |

## 8. RECOMMENDATION

8.1 The Board is asked to:

- Approve this report.
- Endorse the actions being taken.

**GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST**
**PUBLIC BOARD MEETING FRIDAY 25th NOVEMBER 2016**
**Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at 9.00 a.m

| Report Title |
|---|
| **ANNUAL REPORT ON THE TRUST'S EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ARRANGEMENTS** |
| **Sponsor and Author(s)** |
| Sally Pearson; Director of Clinical Strategy<br>Rachel Minett; Emergency Planning and Resilience Manager |

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

**Executive Summary**

Purpose
To provide assurance to the Board on the Trust's level of compliance with the national core standards for Emergency Preparedness Resilience and Response (EPRR).

Key issues to note
The Trust has demonstrated a substantial level of compliance against the national EPRR standards. This has been externally validated by Gloucestershire CCG and NHSE. This represents an improvement on the position last year.
Work in year has provided a more robust framework for the management and oversight of our response, including training and learning from incidents and exercises
Development of our Lockdown Plans have been commended

Conclusions
The Trust is substantially compliant with national core standards for EPRR, and arrangements are being formalised. A small non-recurring investment is required to maintain this status.

Implications and Future Action Required
The action plan will be monitored through the Emergency Planning, Resilience and Responsiveness Group, to ensure that we continue to be compliant with the standards throughout the year.
A further report for assurance will be provided to the Board in November 2017
With the change in Executive portfolios, during the year, responsibility for Emergency Planning will transfer to the Chief Operating Officer.

**Recommendations**

The Board is asked to accept this report as assurance of the Trust's compliance with EPRR standards

**Impact Upon Strategic Objectives**

No specific impact although failure to meet the national EPRR standards would impact on the operational resilience of the trust during an emergency

**Impact Upon Corporate Risks**

No specific risk identified

**Regulatory and/or Legal Implications**

None

**GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST**
**PUBLIC BOARD MEETING FRIDAY 25th NOVEMBER 2016**
**Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** commencing at 9.00 a.m

| **Equality & Patient Impact** | | | | | | | |
|---|---|---|---|---|---|---|---|
| No specific patient group is affected by the issues addressed in this report | | | | | | | |
| **Resource Implications** | | | | | | | |
| Finance | | **x** | Information Management & Technology | | | | |
| Human Resources | | **x** | Buildings | | | | |
| Allocation of £5k non recurringly from an existing allocation requested | | | | | | | |
| **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)** |
| | | | | | Emergency Planning and Resilience Group (EPRG) |

# EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE

## 1 Aim

To provide the Board with an update on the emergency preparedness activity since the last report (November 2016) and the position against the NHS Emergency Preparedness Resilience and Response (EPRR) core standards.

## 2 Background

Each year the Trust Emergency Preparedness Resilience and Response (EPRR) is reviewed through the NHS England assurance process. http://www.england.nhs.uk/ourwork/eprr/. The process is an evidence based internal self-assessment against nationally defined standards. This assessment is then reviewed by the relevant Clinical Commissioning Group (in our case Gloucestershire) and the local area team of NHS England.

The structure of this report follows the main headings of the National Standards.

## 3 Governance

3.1 Appendix 1 sets out our self-assessment against the national EPRR Standards. It is based on the position in August 2016. The national standards are detailed in the left hand column, followed by our assessment of the level of the evidence we have in place to demonstrate compliance. Green indicates evidence in place, amber, partial evidence and red, no evidence. The right hand column details the actions in place to improve compliance where required. At present NHSE have given a rating of substantial compliance for the standards overall, this is an improvement from last year. We are likely to remain amber for: fuel shortage plans and mutual aid standard due to need to work with other agencies and awaiting new national guidance. Appendix 2 sets out our improvement plan.

3.2 Of note is we have made considerable headway on Lockdown training and preparation as was demonstrated with our Lockdown incident. Our Local Security Management Systems (LSMS) has been asked to provide support to other organisations based on our preparations.

3.3 The Emergency Planning and Resilience Group (EPRG) meetings have structured agendas to address the main headings of the national standards. The governance for action cards and plans has been reviewed to give clarity to the process and the responsibilities of departments and divisions.

## 4 Maintenance of plans

4.1 A rolling timetable for reviewing plans is now in place, plans are reviewed annually unless otherwise stated or in line with incorporating lessons learned from exercises and incidents or changes in national guidance. This year we have:

4.2

- Written the BCM plan – this will undergo further review following EPM completion of BCM training.
- Major Incident plan reviewed, no significant changes.
- Reviewed The Pandemic Flu plan. This now dovetails with our Infection Control plans and the Local Resilience Forum (LRF) plans.
- Updated the Adverse Weather Plan
- Updated the CBRN (Chemical Biological Radiation Nuclear) decontamination plan.
- Rewritten the Human Resources Business Continuity policy
- Reviewed and combined Mass casualties P3 (walking wounded) with Mass Prophylaxis plan using the same pathway.
- Updated the Heatwave plan.

## 5 Command Control and Communication

5.1 The Local Health Resilience Partnership tests the incident notification cascade, through Exercise Bugle. This has now reduced to six monthly from monthly.

5.2 The new operational Silver structure whilst increasing the operational support through increased numbers on the rota has caused challenges in providing Incident and Command and Control training to these staff, due to operational pressures. Bespoke training is now being rolled out.

5.3 The current switch board alerting system is now limited by the existing technology. This is due to be addressed with the Next Generation Telecommunications plan which it is hoped we will be signing up to in February, an interim on the old system texting function will be used, is now in the proses of being rolled out.

## 6 Training, Exercising and Incident Reviews

6.1 An EPRR training matrix has been introduced and mandatory elements will be added to individual's learning trees from January following the standard training system. Compliance with training will be monitored through the divisions and the EPRG.

6.2 This year the Emergency Planning Manager successfully completed the Business Continuity Institute CBCI course and with this knowledge will over the next few months introduce more robust processes, to systematically address BCM across the trust.

6.3 One of the Trusts LSMS has applied to do the Emergency Planning Diploma which if accepted will aid the delivery of the Trusts Emergency Preparedness Resilience and Response.

6.4 Exercises this year have included:

- Lockdown exercise
- Exercise Beatle - This was a joint health response incident teleconference exercise
- Exercise Bugle - This is a monthly health community incident cascade test
- Ex Eagle. This is an exercise to test the setting up of the Incident Control room
- Chemical Biological Radiation and Nuclear (CBRN) and Hazardous Materials (Hazmat) team training
- Mass Casualty P3 (walking wounded/self-presenters)
- Mass Prophylaxis – The rapid mass distribution of countermeasures such as anti-viral or antibiotics.
- SWAST Ambulance emergency department major incident notification exercise Connecting
- Exercise Parnassus – rapid response catchment exercise. A localized extreme rain incident similar to Boss Castle (we have 3 risk areas in Gloucestershire) multiagency exercise.
- Exercise Opus – mass casualties with mass fatalities, multiagency exercise.
- Exercise Sunflower – flu pandemic multiagency exercise.

The learning from all exercises is reported to the EPRG using a standard template report. Learning points are reflected in the regular reviews of our plans or added to the action plan for the EPRG.

Going forward we are looking a more formal approach for selecting and training staff to support incidents. Requests for these staff will be made up as far as possible and appropriate proportionality from across divisions.

6.5 There are debriefs following all declared incidents. The findings are reported to the EPRG using a standard debriefing and report template that meets national guidance. Key themes, need for ongoing training, need for local ownership to local plans and action cards.

## 7 Resources

Last year the Board agreed to a non-recurring allocation of £25k to replace the CBRN specialist suits. Subsequent to this the Government agreed nationally to replace these suits. The Trust still needs to maintain all other decontamination and emergency response kit. The requirements will be driven by the recommendations of the audit of CBRN kit performed by SWAST. It is recommended that £5k of the £25k identified for 2016/17 is carried forward to 2017/18 to meet these requirements.

## 8. Recommendation

The Board is asked to accept this report as assurance of the Trust's compliance with EPRR standards

**Author:** **Rachel Minett Emergency Planning Manager**
**Presenting Director:** **Sally Pearson Director of Clinical Strategy**

## NHS England Core Standards for Emergency preparedness, resilience and response

**v4.0**

The EPRR Core Standards spreadsheet has 7 tabs:

**Introduction** - this tab,. outlining the content of the other 6 tabs and version control history

**EPRR Core Standards tab -** with core standards nos 1 - 37 (green tab)

**Business Continuity tab:-** with deep dive questions to support the review of business continutiy planning for EPRR Assurance 2016-17 (blue tab) with a focus on organisational fuel use and supply.

**HAZMAT/ CBRN core standards tab**: with core standards nos 38- 51. Please note this is designed as a stand alone tab (purple tab)

**HAZMAT/ CBRN equipment checklist:** designed to support acute and NHS ambulance service providers in core standard 43 (lilac tab)

**MTFA Core Standard (NHS Ambulance Services only):** designed to gain assurance against the MTFA service specification for ambulance service providers only (orange tab)

**HART Core Standards (NHS Ambulance Services only):** designed to gain assurance against the HART service specification for ambulance service providers only (yellow tab).

This document is V4.0. The following changes have been made :

- Inclusion of Business Continuity questions to support the 'deep dive' for EPRR Assurance 2016-17, replacing the Pandemic Influenza tab
- Inclusion of the HART service specification for ambulance service providers and the reference to this in the EPRR Core Standards
- Inclusion of the MTFA service specification for ambulance service providers and the reference to this in the EPRR Core Standards
- Updated the requirements for primary care to more accurately reflect where they sit in the health economy
- update the requirement for acute service providers to have Chemical Exposure Assessment Kits (ChEAKs) (via PHE) to reflect that not all acute service providers have been issued these by PHE and to clarify the expectations for acute service providers in relation to supporting PHE in the collection of samples

| | Core standard | Clarifying information | Self assessment RAG<br><br>Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months.<br><br>Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. |
|---|---|---|---|
| **Governance** | | | |
| 1 | Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management) | | |
| 2 | Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response. | Lessons identified from your organisation and other partner organisations.<br>NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect:<br>- the undertaking of risk assessments and any changes in that risk assessment(s)<br>- lessons identified from exercises, emergencies and business continuity incidents<br>- restructuring and changes in the organisations | |
| 3 | Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response. | Arrangements are put in place for emergency preparedness, resilience and response which:<br>• Have a change control process and version control<br>• Take account of changing business objectives and processes<br>• Take account of any changes in the organisations functions and/ or organisational and structural and staff changes<br>• Take account of change in key suppliers and contractual arrangements<br>• Take account of any updates to risk assessment(s)<br>• Have a review schedule<br>• Use consistent unambiguous terminology,<br>• Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; | |
| 4 | The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the | After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) .<br>Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment | |
| **Duty to assess risk** | | | |
| 5 | Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver it's functions. | Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for:<br>• severe weather (including snow, heatwave, prolonged periods of cold weather and flooding);<br>• staff absence (including industrial action); | |
| 6 | There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers. | • the working environment, buildings and equipment (including denial of access);<br>• fuel shortages;<br>• surges and escalation of activity;<br>• IT and communications;<br>• utilities failure;<br>• response a major incident / mass casualty event<br>• supply chain failure; and | |
| 7 | There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners. | Other relevant parties could include COMAH site partners, PHE etc. | We do not have any COMAH sites in our area. |
| **Duty to maintain plans – emergency plans and business continuity plans** | | | |
| 8 | Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity.<br><br>Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive): | Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan)) | |
| | | corporate and service level Business Continuity (aligned to current nationally recognised BC standards) | |
| | | HAZMAT/ CBRN - see separate checklist on tab overleaf | |
| | | Severe Weather (heatwave, flooding, snow and cold weather) | |
| | | Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions) | |
| | | Mass Countermeasures (eg mass prophylaxis, or mass vaccination) | |
| | | Mass Casualties | |
| | | Fuel Disruption | |
| | | Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical | |

| | Core standard | Clarifying information | Self assessment RAG<br><br>Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months.<br><br>Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. |
|---|---|---|---|
| | | Infectious Disease Outbreak | |
| | | Evacuation | |
| | | Lockdown | |
| | | Utilities, IT and Telecommunications Failure | |
| | | Excess Deaths/ Mass Fatalities | |
| | | having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme) - see HART core standard tab | NA |
| | | firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab | NA |
| 9 | Ensure that plans are prepared in line with current guidance and good practice which includes: | • Aim of the plan, including links with plans of other responders<br>• Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions<br>• Trigger for activation of the plan, including alert and standby procedures<br>• Activation procedures<br>• Identification, roles and actions (including action cards) of incident response team<br>• Identification, roles and actions (including action cards) of support staff including communications<br>• Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed<br>• Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents | |
| 10 | Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources | Enable an identified person to determine whether an emergency has occurred<br>- Specify the procedure that person should adopt in making the decision<br>- Specify who should be consulted before making the decision<br>- Specify who should be informed once the decision has been made (including clinical staff) | |
| 11 | Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical. | Decide:<br>- Which activities and functions are critical<br>- What is an acceptable level of service in the event of different types of emergency for all your services<br>- Identifying in your risk assessments in what way emergencies and business continuity incidents threaten | |
| 12 | Arrangements explain how VIP and/or high profile patients will be managed. | This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management | |
| 13 | Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and | | |
| 14 | Arrangements include a debrief process so as to identify learning and inform future arrangements | Explain the de-briefing process (hot, local and multi-agency, cold)at the end of an incident. | |
| **Command and Control (C2)** | | | |
| 15 | Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to | Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel | |
| 16 | Those on-call must meet identified competencies and key knowledge and skills for staff. | NHS England publised competencies are based upon National Occupation Standards . | |
| 17 | Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the | This should be proportionate to the size and scope of the organisation. | |
| 18 | Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident. | | http://intranet/en/Your-Division/Corporate-Services/Emergency-Planning/<br><br>Electronic and hard logs are available. Loggests are trained /refresher once a year. Loggest call out information is available in the control rooms. |
| 19 | Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident | | |
| 20 | Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these | Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials | |

| | Core standard | Clarifying information | Self assessment RAG<br><br>Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months.<br><br>Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. |
|---|---|---|---|
| 21 | Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements; | Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident | |
| **Duty to communicate with the public** | | | |
| 22 | Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents. | Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about:<br>- Any immediate actions to be taken by responders<br>- Actions the public can take<br>- How further information can be obtained<br>- The end of an emergency and the return to normal arrangements<br>Communications arrangements/ protocols:<br>- have regard to managing the media (including both on and off site implications)<br>- include the process of communication with internal staff<br>- consider what should be published on intranet/internet sites<br>- have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations. | |

| | Core standard | Clarifying information | Self assessment RAG<br><br>Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months.<br><br>Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. |
|---|---|---|---|
| 23 | Arrangements ensure the ability to communicate internally and externally during communication equipment failures | | |
| **Information Sharing – mandatory requirements** | | | |
| 24 | Arrangements contain information sharing protocols to ensure appropriate communication with partners. | These must take into account and inclue DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supercedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance. | |
| **Co-operation** | | | |
| 25 | Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate) | | |
| 26 | Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA | | |
| 27 | Arrangements include how mutual aid agreements will be requested, co-ordinated and r | NB: mutual aid agreements are wider than staff and should include equipment, services and supplies. | |
| 28 | Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas. | | |
| 29 | Arrangements outline the procedure for responding to incidents which affect two or more regions. | | |
| 30 | Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties | Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc | |
| | Plans define how links will be made between NHS England, the Department of Health and PHE, Including how information relating to national emergencies will be co- | | |
| 1 | Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months | | |
| 2 | Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level | | |
| **Training And Exercising** | | | |
| 34 | Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents | • Staff are clear about their roles in a plan<br>• Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type.<br>• Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate<br>• Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective | |
| 35 | Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work. | • Exercises consider the need to validate plans and capabilities<br>• Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties.<br>• Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years.<br>• If possible, these exercises should involve relevant interested parties.<br>• Lessons identified must be acted on as part of continuous improvement.<br>• Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing | |
| 36 | Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises | | |
| 37 | Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or | | |

| | Core standard | Clarifying information | Acute healthcare providers | Evidence of assurance | Self assessment RAG<br><br>Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months.<br><br>Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months.<br><br>Green = fully compliant with core standard. | Action to be taken | Lead | Timescale |
|---|---|---|---|---|---|---|---|---|
| **2015 Deep Dive** | | | | | | | | |
| DD1 | Organisation has undertaken a Business Impact Assesment | • The organisation has undertaken a risk based Business Impact Assessment of services it delivers, taking into account the resouces required against staffing, premises, information and information systems, supplies and suppliers<br>• The organisation has identified interdependencies within its own services and with other NHS organisations and 3rd party providers | Y | • updated Business Imact Assessment<br>• corporate risk register | Identified risks are on divisional risk registers, corporate risk registers and the EPRG risk register.<br>Evidence from local plans. | On going work for all areas to review BCM plans.<br>On going work with new arrangements with suppliers | **EPM** | |
| DD2 | Organisation has explicitly identified its Critical Functions and set Minimum Tolerable Periods of disruption for these | • The organisation has identified their Critical Functions through the Business Impact Assessment.<br>• Maximum Tolerable Periods of Disruption have been set for all organisational functions - including the Critical Functions | Y | • Business Continuity plan explicitly details the Critical Functions<br>• Business Continuity plan explicitly outlines all organisations functions and the maximum tolerable period of disruption | Evidence in BCM plan<br>Evidence Identified critical functions and template for use adaptable to situation. Local BCM plans state MTPs | | | |
| DD3 | There is a plan in place for the organisation to follow to maintain critical functions and restore other functions following a disruptive event. | • The organisation has an up to date plan which has been approved by its Board/Governing Body that will support staff to maintain critical functions and restore lost functions<br>• The plan outlines roles and responsibilities for key staff and includes how a disruptive event will be communicated both internally and externally | Y | • an organisation wide Business Continuity plan that has been updated in the last 12 months and agreed the Board/Governing Body | Evidence from the BCM plan booked for sign off at September board. Email booking confirmation. | | | |
| DD4 | Within the plan there are arrangements in place to manage a shortage of road fuel and heating fuel | • The plan details arrangements in place to maintain critical functions during disruption to fuel. These arrangements include both road fuel and were applicable heating fuel. | Y | • detail within the plan that explicitly makes reference to shortage of fuel and its impact of the business. | GHT heating fuel main supply is gas, oil is the contingency with 4 days supply for our generators. | LRF plan exercise August. Separate GHT Fuel | | |
| DD5 | The Accountable Emergency Officers has ensured that their organisation, any providers they commission and any sub-contractors have robust business continuity planning arrangements in place which are aligned to ISO 22301 or subsequent guidance which may supersede this . | EPRR Framework 2015 requirement, page 17 | Y | | Evidence in BCM plan and EDF plan | | | |
| DD6 | Review of Critical Services Fuel Requirement Data Collection Programme (F1:F18) | Please complete the data collection below - this data set does not count towards the RAG score for the organisations. Please provide any additional information in the "Other comments" free text box. | Y | • NHS Ambulance Trusts have already provided this information in a national collection in May 2016. | N/A | | | |

**Fuel Demand Summary**

**When providing information on the fuel requirements for both business as usual and to operate a critical service please ensure the supply and demand balances whereby:**

**Total Daily fuel use (F1) = own bunkered fuel use (F5) + any 3rd party bunkered fuel use (F6) + any forecourt fuel use (F9)**

| | Section 1: Business as Usual Demand | Petrol | |
|---|---|---|---|
| F1 | How much fuel do you use daily when providing a business as usual service? (litres) | #### | 12390L for staff cars - Heating is via gas. |

| | Section 2: Bunkered Fuel | Petrol | |
|---|---|---|---|
| F2 | Do you hold bunkered fuel (Yes/No)<br>If no go to F6 | No | **1) What happens if I have mutual aid agreements with another Critical Service provider to utilise their bunkered stock, do I need to record the bunkered stock or will they?**<br>DECC is requesting that the supplier records the bunkered stock holdings and the user records the demand. As the user of these bunkered fuels in this instance, please record the use of these stocks under the section referring to access to third party bunkered stock. |
| F3 | What is the total bunkered fuel capacity? (litres) | | **2) Should we assume that in the build up to an emergency our bunkered stocks would be full, as we would be prioritising deliveries and therefore the days' stock held calculations should be based on full capacity and not average daily stock holdings?**<br>The prioritisation of supply will be dependent on the facts of any fuel shortage scenario, and will be a decision taken at the time. Data provided in the template should provide DECC with a sufficient evidence base to make decisions based on capacity and BAU bunkered stocks. Therefore please fill out the template as requested, providing notes where you think that estimates are required, or where you have had to average data in order to fit the template. |
| F4 | On average, what volume of bunkered fuel do you hold? (litres) | | |
| F5 | Do you use your own bunkered fuel when providing a business as usual service?<br>If no go to F6 | | |
| F6 | Do you access a 3rd party or another service's bunkered fuel when providing a business as usual service?<br>If no go to F8 | no | **3) Our choice of bunkered fuel supplier varies depending on supply cost or availability. Who do I record as the primary supplier?**<br>Please provide the supplier you get most of your fuel from, but also note that this varies and provide details of the other suppliers and |
| F7 | If you have answered "Yes" to F6 or have bilateral supply agreements to operate a business as usual service, please provide a description of any agreement(s), amount of supply and companies / organisations | | |

| | Section 3: Petrol Stations / Forecourts | Petrol | |
|---|---|---|---|
| F8 | Do you use forecourts to operate a business as usual service? (Yes/No) | Yes | GHT has services split across two sites, Cheltenham General Hospital and Gloucestershire Royal Hospital. GHT planning assumptions used are numbers taken from parking permit figures i.e. staff with parking permit live over 1.5miles: Weekend staffing for minimum staffing /critical function + minimum other key staff needed on weekdays and for avarage busiest day of the week.<br>Due to the huge variation staff travel in from we are using the assumption of staff using 30L per week working 5 days. The assumption also includes same site working , reduction in number of shifts, some staff being put in local accommodation, maximising car sharing, Use of our normal stagecoach 99 shuttle buss that runs between sites. |
| | If no go to F10 | | |
| F9 | What is the average daily forecourt fuel use to operate a business as usual service? (litres) | #### | Busiest day of the week 2065 staff across site, planning assumption of using 6L per day total 12390L<br>Quietest day of the week i.e. as for weekend/ BHD/minimal staffing/critical functions 613 across site total 3678L |

**Critical Service Operation Only**

Please refer to question 4 of the guidance notes for further information on how to identify the fuel requirements of a critical service.
During an emergency it is expected that organisations will not be operating as normal and will only be delivering those essential services that are Critical.
Low fuel consumption alternatives should also be explored as part of the Critical Service identification process. For example, if there is the possibility that a Critical Service activity can be carried out remotely, and therefore does not require the use of
The below section refers to the fuel requirements to deliver a Critical Service only.

| | Section 4: Critical Service Demand | Petrol | |
|---|---|---|---|
| F10 | How much fuel would you use daily if you were providing a critical service? (litres) | | Quietest day of the week i.e. as for weekend/ BHD/minimal staffing/critical functions 613 across site total 3678L |

| | Section 5: Critical Service Bunkered Fuel | Petrol | |
|---|---|---|---|
| F11 | Do you have access to either your own or 3rd party bunkered fuel if you were providing a critical service (either from general access or mutual supply agreements)? (Yes/No)<br>If no go to F14 | No | |
| F12 | What volume of your own bunkered fuel would you use daily if you were providing a critical service? (litres) | | |
| F13 | What volume of 3rd party or another service bunkered fuel (either from general access or mutual supply agreements) would you use daily if you were providing a critical service? (litres) | | |
| F14 | If you have answered "Yes" to F13 or have bilateral supply agreements to operate a critical service, please provide a description of any agreement(s), amount of supply and companies / organisations involved.<br>If no go to F15 | | |

| | Section 6: Critical Service Petrol Stations / Forecourts | Petrol | |
|---|---|---|---|
| F15 | Will you need access to Designated Filling Stations (DFS) if you were providing a critical service? (Yes/No)<br>If no go to F17 | Yes | |
| F16 | What volume of fuel would you use daily from Designated Filling Stations (DFS) if you were providing a critical service? (litres) | #### | 3678L |

## Critical Service Operation Only

F17 To ensure that there are adequate Designated Filling Stations* (DFS) to meet the demands of all critical users , please detail in the table below the number of vehicles required to operate a critical service
A Designated Filling Station (DFS) is a retail filling station with the purpose of only supplying road fuel for critical use only. The DFS list will be compiled to provide sites giving a good geographic coverage of the UK to meet the predicted regional demand

| Vehicles | Number of Vehicles required to operate a critical service | |
|---|---|---|
| | Petrol | Diesel |
| With NHS Logo 613 | 306 | 306 |
| Without NHS Logo | | |
| Private vehicles | | |
| Total 613 | | |

F18 If you have answered "Yes" to question 2 (Do you hold bunkered fuel?) please detail which company primarily supplies your bunkered fuel and where known which local or regional supply depot or terminal does the fuel gets delivered from. Please

| Who primarliy supplies your bunkered fuel?<br>Please Select from drop down list: | If other or mult |
|---|---|
| | |
| | |

| Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards<br>(NB this is designed as a stand alone sheet) | | | Self assessment RAG<br>Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months.<br>Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 |
|---|---|---|---|
| Q | **Core standard** | **Clarifying information** | |
| | **Preparedness** | | |
| 38 | There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex) | Arrangements include:<br>• command and control interfaces<br>• tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus)<br>• pre-determined decontamination locations and access to facilities<br>• management and decontamination processes for contaminated patients and fatalities in line with the latest guidance<br>• communications planning for public and other agencies<br>• interoperability with other relevant agencies<br>• access to national reserves / Pods<br>• plan to maintain a cordon / access control<br>• emergency / contingency arrangements for staff contamination<br>• plans for the management of hazardous waste | |
| 39 | Staff are able to access the organisation HAZMAT/ CBRN management plans. | Decontamination trained staff can access the plan | |
| 40 | HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation. | • Documented systems of work<br>• List of required competencies<br>• Impact assessment of CBRN decontamination on other key facilities<br>• Arrangements for the management of hazardous waste | |
| 41 | Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7. | | |
| 42 | Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is | • For example PHE, emergency services. | |
| | **Decontamination Equipment** | | |
| 43 | There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. | • Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab<br>• Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) | |
| 44 | The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or | There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017 | |

| Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards<br>(NB this is designed as a stand alone sheet) | | | Self assessment RAG<br>Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months.<br>Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 |
|---|---|---|---|
| Q | **Core standard** | **Clarifying information** | |
| 45 | There are routine checks carried out on the decontamination equipment including:<br>A) Suits<br>B) Tents<br>C) Pump | There is a named role responsible for ensuring these checks take place | |
| 46 | There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for:<br>A) Suits<br>B) Tents<br>C) Pump<br>D) RAM GENE (radiation monitor)<br>E) Other equipment | | as above |
| 47 | There are effective disposal arrangements in place for PPE no longer required. | (NHS England published guidance (May 2014) or subsequent later guidance when applicable) | |
| | **Training** | | |
| 48 | The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training | | |
| 49 | Internal training is based upon current good practice and uses material that has been supplied as appropriate. | • Documented training programme<br>• Primary Care HAZMAT/ CBRN guidance<br>• Lead identified for training<br>• Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually).<br>• A range of staff roles are trained in  decontamination techniques<br>• Include HAZMAT/ CBRN command and control training<br>• Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a | |
| 50 | The organisation has sufficient number of trained decontamination trainers to fully support it's staff HAZMAT/ CBRN training programme. | | |

| Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards<br>(NB this is designed as a stand alone sheet) | | | Self assessment RAG<br>Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months.<br>Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 |
|---|---|---|---|
| Q | **Core standard** | **Clarifying information** | |
| 51 | Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant. | • Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/<br>• Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: | |

**HAZMAT CBRN equipment list - for use by Acute and Ambulance service providers in relation to Core Standard 43.**

| No | Equipment | Equipment model/ generation/ details etc. | Self assessment RAG<br>Red = Not in place and not in the EPRR work plan to be in place within the next 12 months.<br>Amber = Not in place and in the EPRR work plan to be in place within the next 12 months.<br>Green = In place. |
|---|---|---|---|
| | **EITHER: Inflatable mobile structure** | | |
| E1 | Inflatable frame | Standard | |
| E1.1 | Liner | One spare per site | |
| E1.2 | Air inflator pump | Two per site | |
| E1.3 | Repair kit | | |
| E1.2 | Tethering equipment | | |
| | **OR: Rigid/ cantilever structure** | | |
| E2 | Tent shell | | NA |
| | **OR: Built structure** | | |
| E3 | Decontamination unit or room | | NA |
| | **AND:** | | |
| E4 | Lights (or way of illuminating decontamination area if dark) | Free standing and some outside lighting maintained by medical engineering /estates | |
| E5 | Shower heads | Standard + spare | |
| E6 | Hose connectors and shower heads | Standards + spare | |
| E7 | Flooring appropriate to tent in use (with decontamination basin if needed) | Issues with tents | |
| E8 | Waste water pump and pipe | Spare per site maintained by medical engineering | |
| E9 | Waste water bladder | Standard issue | |
| | **PPE for chemical, and biological incidents** | | |
| E10 | The organisation (acute and ambulance providers only) has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required. (NHS England published guidance (May 2014) or subsequent later guidance when applicable). | All upgraded in February | 24 persite + 48 |
| E11 | Providers to ensure that they hold enough training suits in order to facilitate their local training programme | | |
| | **Ancillary** | | |
| E12 | A facility to provide privacy and dignity to patients | Modesty tents | |
| E13 | Buckets, sponges, cloths and blue roll | All part of self presenter kits | |
| E14 | Decontamination liquid (COSHH compliant) | Standard washing up liquid | |
| E15 | Entry control board (including clock) | | |
| E16 | A means to prevent contamination of the water supply | Fluorescein dye | |
| E17 | Poly boom (if required by local Fire and Rescue Service) | | NA |
| E18 | Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes) | We have disposable tyvec suits, | we have made up ones not the fire service ones |
| E19 | Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs) | We have disposable tyvec suits, | we have made up ones not the fire service ones |
| E20 | Waste bins | Avaliable from ED | |
| | Disposable gloves | | |
| E21 | Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe | In entry control box and form ED | |
| E22 | FFP3 masks | Use ED suply to aviod loss from gong out of date | |
| E23 | Cordon tape | | |
| E24 | Loud Hailer | | |
| E25 | Signage | Picture format of process | |
| E26 | Tabbards identifying members of the decontamination team | Looking to replace with labeld versions | |
| E27 | Chemical Exposure Assessment Kits (ChEAKs) (via PHE): should an acute service provider be required to support PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, PHE will contact the acute service provider to agree appropriate arrangements. A Standard Operating Procedure will be issued at the time to explain what is expected from the acute service provider staff. Acute service providers need to be in a position to provide this support. | | as requierd via PHE |
| | Radiation | | |
| E28 | RAM GENE monitors (x 2 per Emergency Department and/or HART team) | | |
| E29 | Hooded paper suits | Chemical standard | |
| E30 | Goggles | In sort box and avaliable from ED | |
| E31 | FFP3 Masks - for HART personnel only | | |
| E32 | Overshoes & Gloves | Have avaliablel and wellingtons | |

**EPRR Improvement Plan: Gloucestershire Hospitals NHS Foundation Trust**
**Version: Version 2 October 11 2016**

Gloucestershire Hospitals NHS Foundation Trust has been required to assess itself against the NHS core standards for Emergency Preparedness, Resilience and Response (EPRR) as part of the annual EPRR assurance process for 2016/2017. This improvement plan is the result of this self-assessment exercise and sets out the required actions that will ensure full compliance with the core standards.

This is a live document and it will be updated as actions are completed.

| Core standard | Current self-assessed level of compliance (RAG rating) | Remaining actions required to be fully compliant | Planned date for actions to be completed | Lead name | Further comments |
|---|---|---|---|---|---|
| **8 Duty to maintain risk** Fuel Disruption | | LRF/LHRP GHT plans will be revised following national planning guidance available in the Autumn. | March 2017 dependent on reviewed national guidance release | EPM | Informed at August LRHP meeting that national planning guidance is being reviewed and will be available in the Autumn therefor waiting for this to further update LRF/ LHRP and GHT Fuel plan accordingly |
| **16 Command and control** Those on-call must meet identified competencies and key knowledge and skills for staff | | 24 hour on call arrangements/rotas are in place. On call competencies identified based on the NOS. On call training has been revised, and being rolled out from July, to update, refresh staff and for new staff. | On going | EPM | Training being rolled out and will be ongoing. |
| **27 Cooperation** Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained. | | Mutual aid arrangements not defined across local health system. Further agreements with HR need to be in place to agree liabilities. Looking at Devon and Cornwall's model with the LHRP. NHSE asked for clarification and guidance. | ? March 2017 | NHSE | HR BCM plan reflects the agreement between organisations. |

| | | | | | |
|---|---|---|---|---|---|
| **37 Training and exercising** Preparedness ensures all incident commanders (on call directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation. | | Will be rolled out with new training, this now includes IIEM silver for Directors. This will be recorded on learning tree and reviewed at appraisal. | Rolling training program | EPM | Realistically maintaining compliance will be difficult due to staff turnover. However, an ongoing training program starting with all incident commanders is ongoing action cards are in place. The contingency is to call on a peer/EPM with the skills/training. |
| **50 CBRN preparedness** The organisation has sufficient number of trained decontamination trainers to fully support its' staff HAZMAT/ CBRN training programme. | | CBRN trainers increased from 2 to 4. Training is via SWAST annually - training booked for 16/08/16. | End August 2016 | EPM | Number of CBRN trainers have gone up to 4 + a radiation expert. |
| **51** Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant. | | Ongoing ED training - difficulty maintaining staff training due to ED pressures and staff turnover. | Ongoing training | EPM | Realistically maintaining compliance will be difficult due to staff turnover. However an ongoing training program starting with all ED staff induction is in place as are action cards. |
| | | | | | |

# Gloucestershire Hospitals NHS Foundation Trust - Agency Action Plan

| Update | | 05/10/2016 |
|---|---|---|

| | | |
|---|---|---|
| FYE Total Plan Value £k | | £ 7,645 |
| PYE Total Plan Value £k | | £ 1,350 |

**Objectives**

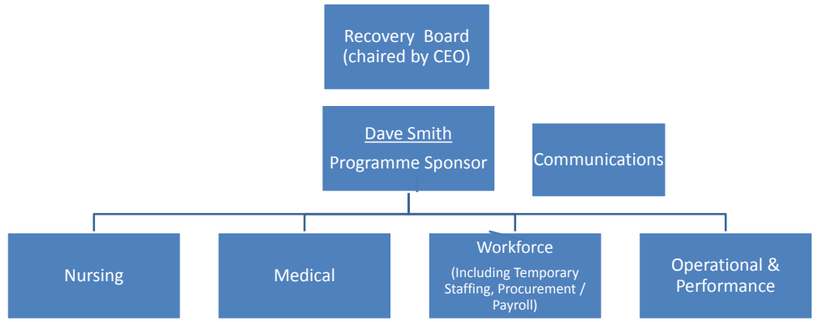
Ob1/ Deliver the Agency Financial Ceiling in accordance with agreed trajectories £16m cap
Ob2/ Maintain and improve Best Care For Everyone
Ob3/ Enhance the Trust's Process and Controls
Ob4/ Development of new roles
Ob5/ Recruitment and Retention

**Key Performance Indicators (KPIs)**

KPI1/ Financial - Agency spend & forecast each month against trajectories
KPI2/ Financial - Agency rates and commission monthly improvement (unit price reductions)
KPI3/ Activity - Decrease in Agency & Locum hours used
KPI4/ Rostering - Achieve 80% fill rates 6 weeks before roster commences
KPI5/ Staffing - Decrease in vacancy rate and turnover through increased substantive proportion
KPI6/ Staffing - Decrease in sickness absence rates (with no increase in other absence types)
KPI7/ Staffing - Annual leave levels consistent across year
KPI8/ Staffing - Increase in bank usage as proportion of total non-substantive resource

**Agency Task Force Programme Governance Structure**

Executive Sponsor & Programme Board Chair : (To be confirmed)
Programme Manager : To be agreed
Programme Board report to be confirmed




Workstreams to deliver Tasks on plan and to provide Exception reports to the Programme Board

| Deliverable | Owning workstream | Full Year Task Value savings £k | | Tasks | Full Year Gross Impact £k | Full Year Net Impact £k | Part Year Gross Impact £k | Part Year Net Saving £k | Outcomes | KPI Measure(s) | Objective | Start date | End date | Costing Assumption | Measurement | Defined Measurement Criteria Y-Yes, C-Measurable in combination with other tasks, N-Not Measurable |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Nursing & AHPs | Nursing | £1,013 | Nur01 | Reduce the number of ad-hoc and out of hours bookings | £ 101 | £ 30 | £ 34 | £ 10 | Number of ad-hoc and out of hours booking reduced | 1,3,8 | 1,2,3 | 01/10/2016 | 30/11/2016 | Assumptions:<br>Agency booked for covering staff sickness has been used as the driver for ad-hoc and out of hours bookings<br>A 10% reduction in current spend has been assumed | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Nur02 | Develop minimum staffing levels based on a risk assessment on acuity | £ - | £ - | £ - | £ - | Numbers agreed and savings to be quantified (if any) | 1,3,4,5 | 1,2,3 | 01/07/2016 | 31/07/2016 | | | |
| | | | Nur03 | Realign HCA over establishment, and improve mobility of staff between specialties | £ - | £ - | £ - | £ - | Plan agreed and implemented; baseline of HCA levels across Divisions | 1,3,4,5,6,7 | 1,2,3 | 01/10/2016 | 30/11/2016 | | | |
| | | | Nur04 | Review bookings of staff for specialling patients | £ 60 | £ 60 | £ 20 | £ 20 | Review completed, and action plan agreed; update to policy/process/procedures, and publish/enforce | 1,3,4,8 | 1,2,3 | 01/10/2016 | 30/11/2016 | Assumptions:<br>Agency booked for specialling has been used as the driver<br>A 5% reduction in current spend has been assumed | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Nur05 | Review of Nursing contact time / hours | £ - | £ - | £ - | £ - | Contact time reviewed and saving to be quantified | 1,4,5,6,7 | 1,2,3 | 01/12/2016 | 31/12/2016 | | | |
| | | | Nur06 | Refresh 'Back to Nursing' courses | £ - | £ - | £ - | £ - | Course reviewed and promoted | 1,3,4,5,6,8 | 1,2,3,5 | 01/10/2016 | 31/12/2016 | | | |
| | | | Nur07 | Improve fill rates for rosters for nurses to 80% 6 weeks before roster commences, by reviewing and actioning the Rosterpro data analysis | £ 149 | £ 45 | £ 50 | £ 15 | Decrease in agency hours & spend required | 1,3,4,7 | 1,2,3 | 01/10/2016 | 30/11/2016 | Assumptions:<br>Agency booked for covering unfilled vacancies has been used as the driver<br>A 2.5% reduction in current spend has been assumed | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Nur08 | Ensure all nursing rosters match demand requirements and a process is agreed to ensure these are updated as required | £ 149 | £ 45 | £ 50 | £ 15 | Decrease agency hours and spend | 1,3,4,7 | 1,2,3 | 01/09/2016 | 31/10/2016 | Assumptions:<br>Agency booked for covering unfilled vacancies has been used as the driver<br>A 2.5% reduction in current spend has been assumed | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Nur09 | All clinical staff need to be on rostering, to match workload with staffing demand (post system change) | £ - | £ - | £ - | £ - | Decrease agency hours and spend | 1,3,4,5,7 | 1,2,3 | 01/04/2017 | 30/06/2016 | | | |
| | | | Nur10 | Agree escalation and levels of approval | £ 36 | £ 36 | | | Escalation policy agreed | 3,4,8 | 2,3 | 01/07/206 | 31/07/2016 | Assumptions:<br>Agency booked for additional beds opened, internal incident extra capacity and patient acuity has been used as the driver<br>A 5% reduction in current spend has been assumed | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Nur11 | Develop a process for ward level / service level management of caps | £ - | £ - | £ - | £ - | Process developed | 1,3,8 | 2,3 | 01/08/2016 | 31/08/2016 | | | |
| | | | Nur12 | No booking of Agency HCAs (exceptions for specialling) | £ 269 | £ 237 | £ 112 | £ 99 | Directive communicated | 1,3,7,8 | 1,2,3 | 01/09/2016 | 30/09/2016 | Assumptions:<br>£100k reduction in current spend for specialling cover<br>£100k reduction in current spend for vacancy cover<br>£69 reduction in current spend for sickness cover | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Nur13 | Cease all use of Thornbury not approved by executive director | £ 250 | £ 250 | £ 104 | £ 104 | Directive communicated | 1,3,7,8 | 1,2,3 | 01/10/2016 | 31/10/2016 | Assumptions:<br>Current Thornbury spend assessed and assumed 3 in all 4 requests will still be authorised | This can be measured by the reduction in use of a single supplier | Y |
| | | | Nur14 | Peer Review with Chief Nurse at Epsom & St Helier | £ - | £ - | £ - | £ - | Agree further actions and Implement | 1,3,5,8 | 1,2,3,4,5 | 01/10/2016 | 31/01/2017 | | | |


Updated by Paula Perks
Cost Improvement Manager
12/09/2016

| Deliverable | Owning workstream | Full Year Task Value savings £k | | Tasks | Full Year Gross Impact £k | Full Year Net Impact £k | Part Year Gross Impact £k | Part Year Net Saving £k | Outcomes | KPI Measure(s) | Objective | Start date | End date | Costing Assumption | Measurement | Defined Measurement Criteria Y-Yes, C-Measurable in combination with other tasks, N-Not Measurable |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Nur15 | Review of AHP contact time / hours | £ - | £ - | £ - | £ - | Revised contact hours agreed & Decrease in Agency spend to be quantified | 1,3,5,7,8 | 1,2,3,5 | 01/10/2016 | 31/12/2016 | | | |
| | | | Nur16 | Introduce ward housekeeper roles | £ - | £ - | £ - | £ - | Job Description agreed, savings to be quantified | 1,3,5,7 | 1,2,4,5 | | ONGOING | | | |
| | | | Nur17 | Development of Ward Pharmacy prescribers | £ - | £ - | £ - | £ - | Job Description agreed, savings to be quantified | 1,3,5,7 | 1,2,4,5 | | ONGOING | | | |
| | | | Nur18 | Development of nursing administration role to increase contact time - If pt information in Trak, must be real time. | £ - | £ - | £ - | £ - | Job Description agreed, savings to be quantified | 1,3,5,7 | 1,2,4,5 | 01/01/2017 | 31/03/2017 | | | |
| | | | Nur19 | Ref WF05 - reduce nursing turnover | | | | | | | | | | | | |
| | | | Nur20 | Reduce Weekend and Bank Holiday sickness levels | | | | | | | | | | | | |
| Medical | Medical | £1,233 | Med01 | Reduce the number of ad-hoc and out of hours bookings | | | | | Number of ad-hoc and out of hours booking reduced | 1,3,8 | 1,2,3 | 01/10/2016 | 30/11/2016 | | | |
| | | | Med02 | Job Planning review and rigour - Implementation of electronic task allocation for medical staff, to understand and align staffing to need and reform working practice. | £ 397 | £ 119 | £ 66 | £ 20 | Tool implemented, savings quantified and action plan agreed | 1,3,4,5,7 | 1,2,3,5 | 01/04/2017 | 30/06/2017 | Assumptions:<br>5% reduction assumed in the current baseline for locum expenditure | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Med03 | Ensure the Deaneries notify the Trust of fill rates at least 4 months ahead and agree resource transfer to Trusts to fund vacant slots upfront | £ - | £ - | £ - | £ - | Confirmation process is in place and managed | 1,3,4,5,7,8 | 1,2,3,5 | 01/09/2016 | 31/10/2016 | | | |
| | | | Med04 | 1. Agree and Implement Top 10 ideas to encourage Drs to move from agency to permanent contracts.<br>2. *A process and procedure to get this right is required to ensure avoidance of introduction fee.* | £ 199 | £ 60 | £ 33 | £ 10 | Top 10 Ideas agreed and communicated. Process and procedure produced and communicated. | 1,3,4,5,7 | 1,2,3,5 | 01/10/2016 | 30/11/2016 | Assumptions:<br>2.5% reduction assumed in the current baseline for locum expenditure | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Med05 | WLI Saturday through Job Planning to look like a regular working day | £ - | £ - | £ - | £ - | Savings Quantified and implementation plan agreed<br>Appropriate review of consultant contract required. | 1,3,4,5,7 | 1,2,3,5 | 01/02/2017 | 30/06/2017 | | | |
| | | | Med06 | Group job planning move to 1.5 PAs to increase DCC (applied only to consultants not recently employed under new T&Cs) | £ - | £ - | £ - | £ - | Job Planning Policy and Process updated to include, savings to be quantified | 1,3,4,5,7 | 1,2,3,5 | 01/01/2017 | 31/03/2017 | | | |
| | | | Med07 | Review of Hospital at night to consider medical staff workload, with pooling of acute medicine and subspecialty rosters, labour substitution with nurses and other posts | £ 80 | £ 24 | £ 13 | £ 4 | Review completed and action plan developed and implemented | 1,2,3,4,5,7,8 | 1,2,3,6 | 01/11/2016 | 31/12/2016 | Assumptions:<br>1% reduction assumed in the current baseline for locum expenditure | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Med08 | Procure and implement the use of a workload measurement tool *- Same as Job planning (Med01)* | £ - | £ - | £ - | £ - | Tool procured | 4,7 | 2,3 | 01/10/2016 | 31/12/2016 | | | |
| | | | Med09 | In relation to Junior medical staff a review of work programmes is required to see if better cover could be provided by rostering or increasing establishment with clinical fellows or alternative roles | £ - | £ - | £ - | £ - | Review completed and action plan developed and implemented | 1,2,3,4,5,7,8 | 1,2,3,4,5 | 01/01/2017 | 30/09/2017 | | | |
| | | | Med10 | Enhance and enforce controls around study and annual leave booking | £ 397 | £ 397 | £ - | £ - | Policies and controls in place, savings quantified | 1,3,4,5,6,7 | 1,2,3 | 01/10/2016 | 30/11/2016 | Assumptions:<br>5% reduction assumed in the current baseline for locum expenditure | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Med11 | Rigorously implement consequences of non-compliance | £ - | £ - | £ - | £ - | Evidence of disciplinary actions taken. | 1,2,3,4,5,6,7 | 1,2,3 | 01/12/2016 | 31/03/2016 | | | |
| | | | Med12 | Review all locum appointments | £ - | £ - | £ - | £ - | Review complete | 1,3,5,7,8 | 1,2 | 01/10/2016 | 31/10/2016 | | | |
| | | | Med13 | Agree and implement exit strategies for long term medical locums (cf Med11) | £ 80 | £ 80 | £ 33 | £ 33 | No of locums and expenditure decrease | 1,2,3,5 | 1,2 | 01/10/2016 | 31/10/2016 | Assumptions:<br>1% reduction assumed in the current baseline for locum expenditure | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | Med14 | Medical representation on Taskforce | £ - | £ - | £ - | £ - | Representative identified | | 2,3 | 01/08/2016 | 31/08/2016 | | | |
| | | | Med15 | All clinical staff need to be on rostering, to match workload with staffing demand (post system change) | £ - | £ - | £ - | £ - | Decrease agency hours and spend | 1,3,4,5,7,8 | 1,2,3,5 | 01/04/2017 | 30/09/2017 | | | |
| | | | Med16 | Review of Locum job plans to ensure 10 DCCs | £ - | £ - | £ - | £ - | Decrease agency hours and spend | 1,3 | 1,3 | 01/10/2016 | 30/11/2016 | | | |
| | | | Med17 | Replace hard to fill medical posts with alternative roles e.g. ANPs | £ 80 | £ 32 | £ 20 | £ 8 | Plan agreed and savings quantified | 1,3,5,7 | 1,2,4,5 | 01/04/2017 | 30/06/2017 | Assumptions: 1% reduction in associated spend | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | N |
| | | | Med18 | Increase the number of Surgical Assistants | £ - | £ - | £ - | £ - | Job Description agreed, savings quantified | 1,3,5,7 | 1,2,4,5 | 01/01/2017 | 31/03/2017 | | | |
| | | | Med19 | Reduce Weekend and Bank Holiday sickness levels | | | | | | | | | | | | |

| Deliverable | Owning workstream | Full Year Task Value savings £k | | Tasks | Full Year Gross Impact £k | Full Year Net Impact £k | Part Year Gross Impact £k | Part Year Net Saving £k | Outcomes | KPI Measure(s) | Objective | Start date | End date | Costing Assumption | Measurement | Defined Measurement Criteria Y-Yes, C-Measurable in combination with other tasks, N-Not Measurable |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Workstreams | | | | | | | | | | | | | | | | |
| Workforce | Workforce | £2,461 | WF01 | Trust to provide workforce plan for 2016/17 and 2017/18 - *but this is BAU?!?!* | £ - | £ - | £ - | £ - | Plan provided | 5,6,7,8 | 3 | 01/12/2016 | 31/03/2017 | | | |
| | | | WF02 | Development of band 3/4 posts as part of the reduction in temporary and agency staffing costs, around theatres / endoscopy and procedure based areas | £ - | £ - | £ - | £ - | Increase in band 3/4 posts in specified areas, with decreased temporary staffing spend | 1,3,4,5,8 | 1,2,4,5 | 01/01/2017 | 31/03/2017 | | | |
| | | | WF03 | Focus on Overseas Recruitment | £ 1,390 | £ 417 | £ - | £ - | Plan agreed | 1,3,4,5,7,8 | 1,2,3,5 | | ONGOING | Assumptions:<br>A 10% reduction in current spend on nursing vacancies and 10% on current locum spend | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | WF04 | Ensure all substantive and Bank recruitment offers made are taken up | £ - | £ - | £ - | £ - | Improved recruitment conversion rates | 1,3,4,5,7,8 | 1,2,3,5 | 01/10/2016 | ONGOING | | | |
| | | | WF05 | Collate outcomes from Exit interviews to understand root cause issues with turnover, and provide to Nursing management to address | £ - | £ - | £ - | £ - | Reduce staff turnover/churn | 1,3,5,7 | 1,2,3,5 | | ONGOING | | | |
| | | | WF06 | Reduce the time from recruitment to appointment | £ - | £ - | £ - | £ - | | 1,3,45 | 1,2,3,4 | 01/10/2016 | ONGOING | | | |
| | | | WF07 | Develop a Trustwide reward system | £ 1,000 | £ 90 | £ 250 | £ 23 | Identify exceptions not addressed by Reward Strategy Group | 1,3,5 | 1,2,5 | 01/11/2016 | 31/12/2016 | Cost estimate provided to finance - not validated | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | N |
| | | | WF08 | Implement starter interviews, to identify issues in recruitment to be addressed | £ - | £ - | £ - | £ - | Improve staff retention rates | 1,3,5,7 | 1,3,5 | 01/10/2016 | 31/10/2016 | | | |
| | | | WF09 | Implement starter +3 month interviews, to identify issues in retention to be addressed (expectation vs reality) | £ - | £ - | £ - | £ - | Improve staff retention rates | 1,3,5,7 | 1,2,3,5 | 01/10/2016 | 30/11/2016 | | | |
| | | | WF10 | Continue with current enhancement payments for permanent trained staff | £ - | £ - | £ - | £ - | Directive given | 1,3,4,5,7,8 | 1,2,5 | 01/07/2016 | 31/07/2016 | | | |
| | | | WF11 | Develop and Agree a Temporary Staffing Policy | £ - | £ - | £ - | £ - | Policy ratified | 1,3,4,8 | 1,2,3 | 01/07/2016 | 30/09/2016 | | | |
| | | | WF12 | Cease the use of non-framework agencies for all staff groups | £ 71 | £ 71 | £ 24 | £ 24 | Directive communicated | 1,2,8 | 1,2,3 | 31/03/2016 | ONGOING | Estimate only | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | N |
| | | | WF13 | Enhanced controls in the decision making process that determines need for expensive agency (nurse and medical) resource. | £ - | £ - | £ - | £ - | Re-publish relevant policy and procedure, and education of managers to comply. | 1,2,3,8 | 1,2,3 | 01/11/2016 | 30/11/2016 | | | |
| | | | WF14 | Agree review of vacant posts which have been advertised but not recruited to more than twice in a fixed period, and no backfill available, to establish alternatives. If not needed, de-establish | £ - | £ - | £ - | £ - | Increased substantive recruitment with alternative roles.<br>Number of posts disestablished | 5 | 1,2,4 | 01/11/2016 | 30/11/2016 | | | |
| | | | WF15 | Implement focus groups for nursing for different stages of career | £ - | £ - | £ - | £ - | Focus groups set up | 5 | 1,2,5 | 01/10/2016 | 30/11/2016 | | | |
| Temporary staffing Office | Workforce | £206 | TS01 | Review and agree bank rates to encourage more staff to enrol | £ 93 | £ 28 | £ 39 | £ 12 | Revised bank rates agreed and implemented | 1,3,4,8 | 1,2,5 | 01/11/2016 | 31/12/2016 | Assumptions:<br>1% reduction in all nursing agency spend | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | TS02 | Increase the usage of medical and other staff groups Bank | £ 113 | £ 34 | £ 47 | £ 14 | Plan and implementation completed | 1,3,4,8 | 1,2,5 | 01/11/2016 | 31/11/2016 | Assumptions:<br>1% reduction in all locum and other category spend | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | TS03 | Automatic registration on bank for all clinical staff groups | £ - | £ - | £ - | £ - | Implemented as part of recruitment process | 1,3,8 | 1,2,3 | 01/10/20156 | 31/10/2016 | | | |
| | | | TS04 | Increase Opening Hours of Bank Service | £ - | £ - | £ - | £ - | Hours extended | 1,3,8 | 1,2,5 | 01/01/2016 | 31/01/2016 | | | |
| | | | TS05 | Ensure policies and controls are in place for booking of Locum staff | £ - | £ - | £ - | £ - | Policies and controls in place | 1,3,4,5,6,7,8 | 1,2,3 | 01/010/2016 | 31/10/2016 | | | |
| Procurement / Payroll | Workforce | £704 | PP01 | Recruit Procurement specialist to focus on Temporary Staffing | £ - | £ - | £ - | £ - | Post filled | 1,2 | 1,4 | 01/07/2016 | 30/09/2016 | | | |
| | | | PP02 | Agree Liaison Upgrade following review with procurement | £ - | £ - | £ - | £ - | Liaison Upgrade purchased | 1,2 | 1,3 | 01/01/2017 | 31/01/2017 | | | |
| | | | PP03 | Review and agree potential savings for a Locum unit price reduction | £ 282 | £ 282 | £ 47 | £ 47 | Potential agreed | 1,2 | 1,3 | 01/11/2016 | 30/11/2016 | 5% reduction in overall locum spend | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | PP04 | Negotiate and agree reduced unit price reductions and trajectories with 5% decreases until cap achieved for Locum | £ - | £ - | £ - | £ - | Unit price reductions evidenced on Liaison | 1,2 | 1,3 | 01/11/2016 | 31/03/2017 | | | |
| | | | PP05 | Review and agree potential savings for a Nurse unit price reduction | £ 422 | £ 422 | £ 70 | £ 70 | Potential agreed | 1,2 | 1,3 | 01/10/2016 | 31/12/2016 | 5% price reduction in nursing spend | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings.<br>The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | PP06 | Negotiate and agree reduced unit price reductions and trajectories with 5% decreases until cap achieved for Nursing | £ - | £ - | £ - | £ - | Unit price reductions evidenced on Liaison | 1,2 | 1,3 | 01/11/2016 | 31/03/2017 | | | |
| | | | PP07 | Implement Rosterpro additional pay run | £ - | £ - | £ - | £ - | Decrease agency hours required and spend | 1,3,4,8 | 2,5 | 01/09/2016 | 31/10/2016 | | | |
| | | | PP08 | Procure a new e-rostering to replace Rosterpro and to support medical rostering, with expert support included in the package | £ - | £ - | £ - | £ - | New e-rostering system procured | 1,3,4,7 | 1,2,3 | 01/09/2016 | 31/12/2016 | | | |
| | | | OR01 | Operational control centre where e-rostering staff and bank and agency staff booking come together | £ - | £ - | £ - | £ - | Decrease agency hours and spend | 1,3,4,8 | 1,2,3 | 01/11/2016 | 31/01/2017 | | | |

| Deliverable | Owning workstream | Full Year Task Value savings £k | | Tasks | Full Year Gross Impact £k | Full Year Net Impact £k | Part Year Gross Impact £k | Part Year Net Saving £k | Outcomes | KPI Measure(s) | Objective | Start date | End date | Costing Assumption | Measurement | Defined Measurement Criteria Y-Yes, C-Measurable in combination with other tasks, N-Not Measurable |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Operations / Reconfiguration | Operations & Performance | £2,029 | OR02 | Realignment and centralisation of services across sites | £ - | £ - | £ - | £ - | Plan agreed; tracking of appropriate benefits of the Reconfiguration Programme | 1,3,4,5,6,7 | 1,2,5 | 01/04/2017 | 31/03/2018 | | | |
| | | | OR03 | De-escalate any additional ward capacity open, as an exception to normal escalation policy | £ 724 | £ 724 | £ - | £ - | Directive communicated | 1,3 | 1,2,5 | 01/11/2016 | 31/11/2016 | 10% reduction in nursing agency spend due to vacancies, sickness and additional beds | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings. The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | C |
| | | | OR04 | Agree the closure of DSU beds on both sites for activity not related to core business | £ 290 | £ 290 | £ - | £ - | Directive communicated | 1,3 | 1,2,5 | 01/11/2016 | 31/11/2016 | Actual spend on DSU | This can be monitored by reduction in costs charged to DSU | Y |
| | | | OR05 | Review all management interims and implement strategies for exit or employment | £ 190 | £ 190 | £ 63 | £ 63 | No of interims and expenditure decrease | 1,2,3,5 | 1,3,5 | 01/09/2016 | 31/10/2016 | 10% reduction in agency spend on management/infrastructure agency spend | The costing assumes reduction in a category of spend. This category is also assumed as the driver for a number of the other costings. The overall reduction in spend in this category can be measured, but there is currently no way of attributing the reduction to the specific actions in this plan | Y |
| | | | OR06 | Review all fixed term contracts in place for greater than 2 years and implement strategies for exit or employment | £ - | £ - | £ - | £ - | No of interims and expenditure decrease | 1,2,3,5 | 1,3,5 | 01/10/2016 | 30/11/2016 | | | |
| | | | OR07 | Introduce weekly meetings to review ward cover and rota gaps | £ - | £ - | £ - | £ - | Meetings set up | 1,3,4,7,8 | 1,2,3,5 | 01/07/2016 | 30/07/2016 | | | |
| | | | OR08 | Ensure all breaks and hours claimed are accounted for in Timesheets appropriately for Bank, Agency and Locum | £ 825 | £ 825 | £ 275 | £ 275 | Reduction in Expenditure of £1.6m PYE or £3.3m FYE | 1,3 | 1,3 | 01/09/2016 | 31/10/2016 | Cost provided by agency taskforce - presentation - risk assessed down to 25% of FYE provided value | The analysis used to inform this figure is not produced by the Trust therefore ongoing monitoring has not yet been agreed | N |
| | | | OR09 | All clinical staff need to be on rostering to match workload with staffing demand (post system change, c.f. PP08) | £ - | £ - | £ - | £ - | Decrease agency hours and spend | 1,3,4,7 | 1,2,3,5 | 01/04/2017 | 30/06/2017 | | | |
| | | | OR10 | Stronger enforcement of flexible working, sickness absence policies | £ - | £ - | £ - | £ - | Policy communicated; performance management of non-compliance. | 1,3,4,5,6,7 | 1,2,3,5 | | ONGOING | | | |
| Performance and Information trajectories | Operations and Performance | Enabler | PI01 | Develop Divisional trajectories in accordance with the agency ceiling | | | | | Trajectories agreed | 1,3,4,5,7 | 1 | 01/08/2016 | 31/08/2016 | | | |
| | | | PI02 | Develop individual ward / departmental trajectories | | | | | Trajectories agreed | 1,3,4,5,7 | 1 | 01/08/2016 | 31/08/2016 | | | |
| | | | PI03 | Develop dashboards for monitoring trajectories | | | | | Dashboard Developed | 1,3,4,5,7 | 1 | 01/08/2016 | 31/08/2016 | | | |
| | | | PI04 | Introduce a common dataset of core information on agency staff including run rate expenditure | | | | | Common Dataset developed | 1,3,4,5,7 | 1,3 | 01/11/2016 | 31/12/2016 | | | |
| Communication | Programme Director | Enabler | Com01 | Improved communication via Agency Programme Board | | | | | Agency Programme set up | 4,5,6,7,8 | 3 | 01/06/2016 | 30/06/2016 | | | |
| | | | Com02 | Agree a clear set of principles around communications and how they are distributed | | | | | Principles agreed and in place | 4,5,6,7,8 | 3,5 | 01/09/2016 | 30/09/2016 | | | |
| | | | Com03 | Establish protocol, guidance and communications for the appropriate approach to locums to convert to substantive | | | | | Action in place | 4,5,6,7,9 | 3,5 | 01/10/2016 | 31/10/2016 | | | |
| | | | | Total FYE | £ 7,645 | £ 4,787 | £ 1,350 | £ 866 | | | | | | | | |

Updated by Paula Perks
Cost Improvement Manager
12/09/2016

# GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

## MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD IN THE LECTURE HALL, SANDFORD EDUCATION CENTRE, KEYNSHAM ROAD, CHELTENHAM ON WEDNESDAY 2 NOVEMBER 2016 AT 5.30PM

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

**PRESENT**

| | | |
|---|---|---|
| Governors/ Constituency | Mrs S Attwood | Staff, Nursing and Midwifery |
| | Mrs G Awege-Elkingtone | Public, Forest of Dean |
| | Mr G Cave | Public, Tewkesbury |
| | Mr G Coughlin | Public, Gloucester City |
| | Mrs A Davies | Public, Cotswold |
| | Prof Chris Dunn | Public, Stroud |
| | Mrs P Eagle | Public, Stroud |
| | Dr C Feehily | Appointed, Health Watch |
| | Mrs J Hincks | Public, Cotswold |
| | Dr P Jackson | Public, Forest of Dean |
| | Dr T Llewellyn | Staff, Medical and Dental |
| | Mr J Marstrand | Public, Cheltenham |
| | Cllr B Oosthuysen | Appointed, Gloucestershire County Council |
| | Mr M Pittaway | Staff, Other/Non-Clinical |
| | Mr R Randles | Staff, Nursing and Midwifery |
| | Mr A Thomas | Public, Cheltenham (Lead Governor) |
| Directors | Prof C Chilvers | Chair |
| | Ms D Lee | Chief Executive |
| | Dr S Elyan | Medical Director |
| | Mr T Foster | Non-Executive Director |
| | Mrs H Munro | Non-Executive Director |
| | Mr Keith Norton | Non-Executive Director |
| **IN ATTENDANCE** | Mr M Wood | Trust Secretary |
| **APOLOGIES** | Mr C Greaves | Appointed, Clinical Commissioning Group |
| | Mrs J Harley | Patient Governor |
| | Ms C McIndoe | Staff, Other/Non-Clinical |
| | Mrs M Arnold | Nursing Director |
| | Mrs E Gatling | Director of Service Delivery |
| | Mr S Diggles | Interim Finance Director |
| | Dr S Pearson | Director of Clinical Strategy |
| | Mr D Smith | Director of Human Resources and Organisational Development |
| | Ms T Barber | Non-Executive Director |
| **PRESS/PUBLIC** | Mr P Lachecki | Chair of the Trust/Council of Governors Designate |
| | Mr J Aitkinson | Public |

*The Chair welcomed members of the Council and thanked Governors for attending. She welcome those new Governors who were attending their first meeting following the Annual General Meeting. She also welcome Mr Peter Lachecki who was observing the meeting before taking on the role of Chair of the Trust/Council of Governors on 7 November 2016. The Chair said that this would be the last meeting which Mr Martin Pittaway would be attending before taking up employment with another organisation later during the month. She thanked him for his*

*faithful contribution to the Council.*

**035/16 DECLARATIONS OF INTEREST**

There were none.

**036/16 MINUTES OF THE MEETING HELD ON 3 AUGUST 2016**

**RESOLVED**:- That the minutes of the meeting held on 3 August 2016 were agreed as a correct record and signed by the Chair.

**037/16 MATTERS ARISING**

**079/16 MINUTES OF THE MEETING OF THE GOVERNANCE AND NOMINATIONS COMMITTEE HELD ON 22 JUNE 2015:**
The Lead Governor said that it will be necessary for an informal meeting of the Council of Governors to be held to consider the programme of development from the Governor Effectiveness sections of the Board Governance Review and it was suggested that this meeting take place on Wednesday 21 September 2016 at 5:30pm. He undertook to liaise with the Chair to identify topics for discussion. *This meeting was held on 19 September 2016. Completed.*

**080/16 REPORT OF THE CHIEF EXECUTIVE:**
The Lead Governor asked which Committee/Non-Executive Director had oversight in this area to which he could submit further questions. In response, Mr Mitchell undertook to receive those questions and address the issues raised. *The Chief Executive undertook to pursue this matter. Ongoing.* **DL**

**081/16 Q1 PERFORMANCE:**
The Lead Governor asked how assured the Non-Executive Directors are in the effectiveness of mandatory training. In response, the Chair said that this will picked up by the Workforce Committee. *The Chair said that the new Chair of the Workforce Committee, Ms T Barber, is aware of this issue and once considered by the Workforce Committee, will be reported back to the Council. Ongoing.*

**083/16 REPORT OF THE CHAIR OF THE HEALTH AND WELLBEING COMMITTEE:**
Mrs Lewis asked on behalf of Ms Storr why spiritual welfare which was considered to be important, had not been considered. In response, the Chair said that the Lead Chaplin is a member of the Patient Experience Strategic Group and she will discuss with the new Chair of the Health and Wellbeing Committee where this is best placed to be discussed. *Mrs Munro reported that this matter will be picked up by the Health & Wellbeing Forum. Completed as a matter arising.*

Dr Jackson observed that staff sickness records are poor and that there needs to visibility of the outcome of those measures to reduce staff sickness. In response, the Chair said that the Board sees that information and she will consider where a deep dive into that area best fits. *The Director of Human Resources and Organisational Development said that our sickness rate is 3.79% which is lower than the national rate of 4.35%. Mr Marstrand observed that the length of sickness absence could impact on the figures. Ongoing.*

**084/16 PROPOSED REVISIONS TO THE CONSTITUTION:**

Mrs Powell added that membership should relate to areas where services are provided by our Trust and sought a definition of where those services are currently provided. In response, the Chair said that the arrangements for the public constituency member will provide flexibility and that current services are provided in Herefordshire, Worcestershire and Swindon (including Wiltshire). The list of geographical areas will be maintained by the Trust Secretary and updated should there be any changes in the geographical areas out of county where services are provided. *The Trust Secretary reported that the list is being maintained and there have been no changes to date. Completed as a Matter Arising.*

**085/16 UPDATE FROM GOVERNORS ON MEMBER ENGAGEMENT:**

Mr Marstrand referred to a letter regarding the elections which a constituent in the Forest of Dean had received and the Trust Secretary undertook to discuss that letter with him. *The Trust Secretary undertook to speak to Mr Marstrand. Ongoing.*

**086/16 SUB-COMMITTEE REPORTS – PATIENT EXPERIENCE STRATEGIC GROUP:**

The Chair undertook to consider with the Trust Secretary the Lead Governor's request that the minutes of the Committee are made available to Governors. *The Trust secretary reported that the Group's minutes are now available on the Governors restricted area of our website. Completed.*

**ELECTION OF LEAD GOVERNOR AND GOVERNORS TO SERVE ON THE GOVERNANCE AND NOMINATIONS COMMITTEE:**

The Trust Secretary reported that the election process for the Lead Governor and Governors to serve on the Governance and Nominations Committee will now be undertaken. *Ongoing.*

**038/16 ANNUAL AUDIT LETTER**

*(Geraldine Daly, Engagement Lead, and Kevin Henderson, Manager, from Grant Thornton attended the meeting for the presentation of this item.)*

The Chief Executive thanked the representatives from Grant Thornton for attending the meeting to present the Annual Audit Letter. Given our Trust's financial position, she said that since signing off the 2015/16 accounts, which were considered to be an accurate reflection of the financial position of our Trust at the time, concerns have been raised about the underlying financial position of our Trust. Details of all the issues identified as part of the audit of the 2015/16 accounts, have been recorded in the Audit Findings Report as well as the Annual Audit Letter. Our Trust is undertaking a Financial Governance Review as well as a baselining review to understand the current financial position. Grant Thornton is required to present the Annual Audit Letter to the Council of Governors and this was not an opportunity for other issues to be raised.

The Engagement Lead from Grant Thornton presented the Annual

Audit Letter. Grant Thornton had issued an unqualified opinion on the Trust's financial statements and an unqualified value for money conclusion. Grant Thornton had concluded that the Quality Report was prepared in line with the regulations and guidance. However, Grant Thornton qualified their limited assurance report as they had identified errors when undertaking their testing of the Referral to Treatment incomplete pathways indicator. This was reflected in their separate report on the Quality Report.

The Engagement Lead stressed the importance of their Audit Findings Report which was presented to the Trust's Audit Committee on 17 May 2016 and discussed subsequent changes with the Director of Finance and the Chair of the Audit Committee from then until 27 May 2016 when a final Audit Findings Report was issued prior to the issuing of Grant Thornton's opinion.

The Engagement Lead then highlighted the main sections of the report.

The Lead Governor echoed the comments of the Chief Executive regarding the basis for the presentation of the report.

The Chair thanked the Engagement Lead for the report.

**RESOLVED**:- That the Annual Audit Letter for the year ended 31 March 2016 be noted.

**039/16 REPORT OF THE CHIEF EXECUTIVE AND OCTOBER BOARD UPDATE**

The Chief Executive presented her report. She focussed on the current context and the announcement by NHS Improvement that our Trust has been put into financial special measures. Our Trust has been placed in financial special measures not because of any longstanding financial deficit but because our current financial position is at a significant variance to the plan submitted to NHS Improvement. Our Trust has commissioned jointly with NHS Improvement a Financial Governance Review to understand why this situation happened, how long it has been going on and who was involved and how. The Terms of Reference for the Financial Governance Review which seeks to answer these questions has been made publically available. There needs to be an understanding of why external safety nets failed to help identify this situation. The Financial Governance Review commenced on 31 October 2016 and will involve Governors. The Chief Executive will work with the Lead Governor to provide an opportunity to comment on the review both in a personal context and providing a collective Governor view. Our Trust has been determined in breach of its licence and is not undertaking its role to the standard required. This, whilst disappointing, is inevitable given that our Trust has been placed in financial special measures demonstrating the seriousness of the position. Our Trust is one of eight Trusts nationally placed in financial special measures with the other seven being in financial special measures due to longstanding financial deficits. The Chief Executive expressed confidence that the position can be turned round and her challenge is to come out of financial special measures quicker than any other organisation. She acknowledged the anger from staff governors who were telling the Board of issues and they did not listen. She wished to return to good engagement and was open to ideas to help.

She stressed that the quality and safety of patients will be maintained and good financial management and high quality patient care go hand in hand. KPMG is assisting with the system and processes to come out of financial special measures to get back "into the pack" and into financial recovery. She estimated that the financial turnaround will take approximately six months with another eighteen months before financial recovery is achieved.

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

- Dr Feehily expressed her appreciation to the Chief Executive for her openness and coherent way in which the situation is being handled. She asked how our Trust is treating the scale of the issue. In response, the Chief Executive explained that our Trust is using "best endeavours" to understand the underlying financial position which is not currently fully known. The work being undertaken by KPMG to understand the baselining position and on the Cost Improvement Programme, is designed to accelerate recovery and build a more robust recovery plan. Early indications are that our Trust will be forecasting a deficit of £23M which is unlikely to grow materially, but further work is nonetheless continuing.
- Dr Feehily asked when a developed model of care as part of the Gloucestershire Sustainability and Transformation Programme will be the subject of public consultation. In response, the Chief Executive said that the Plan is to be published on 11 November 2016. It will describe a vision for service standards with a discussion taking place during January to March 2017. At the end of May 2017, the Plan will be subject to public consultation. A formal consultation will take place between May and August 2017.
- Mrs Lewis asked the Chief Executive for the outcome of the Summit of Partners held on 20 October 2016 held to bring about a step change in the system response to the ongoing delays in the discharge of patients. The Chief Executive said in response that the current system is to discharge patients into community hospitals and then to their place of residence. Our Trust wishes to see patients placed in their residence as the first place of discharge and when it is not safe to do so, to be discharged to community hospitals. There are one hundred community beds for discharge which is insufficient. Support needs to be provided to those patients who return to their place of residence. The Chief Executive stressed that all partner organisations are in complete alignment with this process and the outcome of the summit was that all partners have agreed to make this system work. Mr Randles commented that sessions have been held with discharge nurses so as to understand the process better.
- Prof Dunn said that a more structured way should be introduced for patients awaiting surgery rather than all attend at a given time, for example 8.00am, and have to wait until 2.00pm to be seen. In response, the Chief Executive said that some patients should be invited to attend at the start with the rest being staggered and she needed to understand the reasons why teams work in the way that they do. Mrs Davies echoed the point raised by Prof Dunn.

- The Lead Governor asked for an update on the SmartCare Programme. The Chief Executive said that the programme is to go live on 2 December 2016 and there are no red indicators. There is a level of confidence that SmartCare can be introduced on this date which has not been seen before. Peer feedback from Bristol has been received. If the 2 December 2016 go live date is missed, the next opportunity to fit in with InterSystems programme, will not be until March 2017. The Chief Executive stressed that the training processes have been reviewed and modified and is at amber status pending increased training attendance. This will not impact on the go live date.

The Chair thanked the Chief Executive for her report.

**RESOLVED**:- That the report be noted.

**040/16 ANNUAL OPERTIONAL AND FINANCIAL RECOVERY PLAN 2017-19**

The Chief Executive gave a presentation on the external requirements for the preparation of an Operational Plan and a Financial Recovery Plan for the period 2017 to 2019. The proposal is that our Trust's Recovery Plan is our Operational Plan which will be driven through our Transforming Care for Everyone Programme to maximise our opportunities to reduce costs through improvements in quality. The Recovery Plan was required to be submitted to NHS Improvement on 1 December 2016 with the Plan being presented to the Board on 25 November 2016. It is proposed that the Plan is presented to Governors after approval by the Board and prior to submission and Monday 28 November 2016 was a suitable occasion. The Lead Governor was invited to consider how this would best fit with Governors. The presentation would be circulated to Governors. **AT/MW**

The Medical Director added that good quality care and sound financial management go hand in hand and that the quality of patient care would not be affected.

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

- Mrs Powell said that there were issues with the Central Booking Office in that she had not received an electronic communication about her appointment which she said had led to a deterioration in her health. In response, the Chief Executive apologised for this situation and explained that a central booking model had been created. However, this was not providing all the benefits of the previous arrangements and the model will be revisited. The issuing of letters had been outsourced.
- In response to questions from Mrs Lewis about nursing staff numbers, the Chief Executive said that the recruitment of nurses is progressing well but there are issues when nurses are trained in Bristol and Worcester and tend to seek employment in those areas, making it difficult for our Trust to recruit from a training establishment. The aim is to establish a college in our County for the recruitment of nurses. The same process will apply for associate nurses although there are only 1000 places nationally with our Trust requiring 400 per year. Gloucester

University is to be a local training provider.

The Chair thanked the Chief Executive for the presentation.

**RESOLVED**:- That the presentation be noted.

**041/16 SUSTAINABILITY AND TRANSFORMATION PLAN (STP) UPDATE**

The update was provided as part of the Chief Executive's report in minute number 039/16 above.

**042/16 GOVERNOR REPRESENTATION ON BOARD COMMITTEES**

The Chair presented the report setting out the role and mandate of Governors on Board Committees. Our Trust was at the forefront of the practice of inviting Governors to attend Board Committees; however, since the original innovation, limited development of the role has happened and Governors' "added value" to the traditional Committee structure is now uncertain to both Governors and the Board. The key objectives of Governor involvement in Board Committees is to enable Governors to fulfil their statutory role of holding Non-Executive Directors 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 Board Committee topic. The document was intended to guide Governors, and other Board Committee members, to ensure that Governors are enabled to maximise their contribution to Board Committee business. It is recognised that all Governors will benefit from tailored training and development to fulfil their role. The Board had agreed that one Governor be invited to attend all Board Committees in a non-voting capacity. The membership of the committees is to be determined by the new Chair of the Trust in consultation with the Lead Governor and Trust Secretary. **PL/AT/MW**

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

- The Lead Governor recognised that it was for the Board to determine its own Committee structure. However, he sought clarity on the Governor role and questioned the number of Governors to be invited to serve on Board Committees. The Chair said that the Board Committee structure will be circulated to all Governors. The Chief Executive explained that Governor attendance at Board Committees is to take on a broader remit to enable Governors to fulfil their statutory duty of holding Non-Executives to account and this could be achieved through Committee attendance. Details of the actual engagement need to be determined to enable the Committees themselves to fulfil their role. The Chief Executive explained that attendance is to observe and to raise with Non-Executive Directors concerns and to feedback to Governors if they are undertaking their scrutiny, challenge and assurance functions. Details of the issues considered by a Committee are not a role for Governors. Concerns have been raised about the effectiveness of Governors and a process needs to be put in place for Governors to ensure that Non-Executive Directors are fulfilling **MW**

their statutory duty.

- The Chair suggested that a Governor Development Session be used as a timely extension to that provided on their role of holding Non-Executive Directors to account. The Chief Executive added that all Governors needed to be equipped with the skills to undertake their role.
- Mrs Davies suggested that the proposal for one Governor representative on each Board Committee was too restrictive in that what would be the position if that attendee was ill and unable to attend. She suggested that a deputy be appointed who could also attend to provide continuity. This was supported by Mr Marstrand. The Chief Executive said that she was open to suggestions regarding Governor attendances so long as it did not affect the business of the Board committees.
- Given that attendees need to be identified soon with Board committee meetings taking place later in the month, the Lead Governor was invited to seek preferences. **AT**

**RESOLVED**:- That the role and mandate of Governors on Board Committees as set out in the report be noted.

## 043/16 UPDATE FROM GOVERNORS ON MEMBER ENGAGEMENT

The Chair invited Governors to report on any member engagement activities which they had undertaken and the following were reported:-

- Dr Jackson reported on his attendance at the Forest of Dean Health Forum on 1 November 2016 where there had been a good discussion on a presentation by Gloucestershire Care Services on the Sustainability and Transformation Programme.
- Mrs Powell and Prof Dunn reported that they had taken the opportunity at the Annual Members' Meeting on 1 October 2016 to meet members. Mr Marstrand said that he had taken the opportunity at the Annual Members' Meeting to talk to Mr Ben King which was linked to an Aorta Aneurism Seminar held in the Sandford Education Centre. He had also attended a Deep Space Workshop in Charlton Kings.

The Chair said that the arrangements for Governors to engage with members needed to be developed further. Ms Barber, Non-Executive Director, has offered to help with member engagement. The Chair said that this is a difficult area to develop as it is not undertaken well nationally. Mrs Attwood commented that staff governor engagement with their members needs to be developed as there is currently no such forum.

## 044/16 SUB-COMMITTEE REPORTS

The Chair said that the arrangements for Board Committee reports presented to the Council of Governors needed further development. The current arrangements for the Non-Executive Chair or another Non-Executive member of the Committee to provide the report was as an alternative to Governor feedback to give Governors an opportunity to hold Non-Executive Directors to account. The minutes of Board Committee meetings were included in the Board papers which were made available to Governors.

The Chief Executive said that given that there will be Governor representation on Board Committees, it may be appropriate that those representatives provide the report.

**Quality Committee – 2 September 2016:**

The Chair reported that the Committee received an informative presentation from the Diagnostics and Specialties Division on the work being undertaken. Mr Ben King and Dr David Gabbott made an informative presentation demonstrating the work undertaken by the deteriorating Patient and Resuscitation Committee. Dr Preetham Boddana made a presentation on acute kidney infection performance demonstrating that the work being undertaken was better than previously thought.

**Quality and Performance Committee – 26 October 2016:**

Mr Norton, as Chair of the Committee, reported that the Winter Plan 2016/17 had been considered and a final version will be presented to the next meeting of the Committee in November 2016. Key measures on the Performance Management Framework were not showing improvement and further work is required. There is no assurance that services can be maintained when the focus moves from one service area where improvements have been made to another to be developed.

Mr Thomas, Lead Governor, supported the Chair's comments that it is important not to lose sight of service improvements across all services.

**Finance Committee – 28 September and 26 October 2016:**

Mr Foster, as Chair of the Committee, said that September 2016 was the first time that the Finance Committee had met with the performance issues being considered by the Quality and Performance Committee. A detailed financial report was considered. On 26 October 2016, the Committee had received further detailed financial information with divisional data. The forecast to the financial year end was presented. The Committee considered an update on the Deloitte financial reporting review recommendations noting that of the thirty-four recommendations, five recommendations have not started (a reduction from eight in the previous month); eleven recommendations are in progress (twenty-one from the previous month) and eighteen actions have been completed (five from the previous month). The Committee at its next meeting is to consider the baselining and cost improvement work currently being undertaken by KPMG, and agency spend. Progress has been made in the payments to suppliers but our Trust is not currently back on contract terms.

**Health and Wellbeing Committee – 4 October 2016:**

Mrs Helen Munro said that this was the first Committee that she had attended as Chair. The Committee had received a presentation on the focus of alcohol and reducing harm from alcohol. There is frustration that this service is only available during office hours when alcohol related attendances peaked between 5.00pm to 5.00am and particularly from Friday evening to Monday morning. Smoking shelters

on hospital sites had been considered and the Committee had concluded that they be not re-introduced. Other options to encourage people not to smoke are being considered. The entrance to the Tower Block at Gloucestershire Royal Hospital is a particular area of concern. The Committee is also looking at the wider health system to address issues such as obesity.

Mr Marstrand asked whether the Stop Smoking Service provided by Gloucestershire County Council has ceased. In response, the Chief Executive undertook to provide an update to Mr Marstrand. **DL**

The Lead Governor said that he had also raised with the Trust issues regarding the Alcohol Liaison Service and he accepted that a response will be provided in due course.

**Workforce Committee – 14 October 2016:**

Mr Keith Norton, as Chair of the Committee, reported that the Committee had recommended approval of the Workforce strategy which was considered good enough for now. The three priorities for the forthcoming year are workforce supply and retention, costs including financial management of those costs and engagement.

**Patient Experience Strategic Group – 27 September 2016:**

The Chair said that the arrangements for this Group are being reviewed. A new digital methodology for the Friends and Family Test was launched in July 2016 which negates the need for Emergency Department staff to hand patients a card to complete on discharge. This has resulted in a substantial increase in the response rate for September 2016 at 26% Trust-wide.

**Governor Questions:**

The following questions have been received from Governors:-

Jenny Hincks

"I have been informed that the carers passport has been altered and that the carers do not know have the 'discounted food' into the restaurants (staff rates) if this is true can I ask why. The passports were introduced to allow carers help while caring for their loved one in the hospital and as well as help with parking costs food was discounted."

Response

The Chief Executive said that the arrangements applicable to staff would also apply to carers.

Julius Marstrand

1. Approximately how many operations does the hospital normally have to cancel during the course of a year, either due to not having sufficient resources (doctors/nurses/other specialists/theatres etc.) available to carry out the operations, or due to not having enough acute beds for patients to recover

from operations due to the delayed discharge of MFFD patients, or for any other similar reasons?
2. How many operations are typically carried out per week and what proportion of these are likely to have to be cancelled in the event of a five day Junior Doctors strike?

Response

1. In a year we cancelled circa 2,600 cases
2. On average 1,150 cases are carried out per week and during the junior doctors strike equivalent to 100 cases per week were cancelled.

Julius Marstrand

May I formally ask how the Trust's own Five Year Plan fits within the framework of the STP, or whether this is likely to change anyway in light of the STP, or the Financial Special Measures?

Response

The Chief Executive said that the STP is a two year plan which should reflect our priorities.

Alan Thomas

Governors welcome sight of the recent Press Release relating to a long-standing complaint recently settled for a sum of £1.1m. The statement included the phrase 'important lessons have been learned from the case'. Media statements often contain such phraseology, but governors would like to know precisely what lessons have been learned, and how NEDs are assured that such lessons have actually been learnt, to ensure that the risk of a similar incident, or set of circumstances, arising again is reduced.

Response

The incident that this claim relates to was some 7 years ago and thus not subject to our current process for lessons learnt. The case has been a complex one to conclude legally, but one of the issues with this case was the delay in doing a CT scan. The lesson learnt would be that as a consequence of this and other incidents in the past, and also in line with subsequent clinical guidance and best practice, we now provide a more comprehensive service which allows clinicians to request radiology tests (in this case a CT scan) at any time of the day.

The process for NEDS to be made aware of lessons learnt is via 2 routes:-

1. The Serious Incident (SI) report in the confidential section of Board each month, which lists new incidents
2. All SIs are reported into the Quality Committee monthly, together with progress, lessons and outcomes. Quality Committee is chaired by a NED and also has Governor representation.

**045/16 ANY OTHER BUSINESS**

There were no further items of business.

**046/16 DATE OF NEXT MEETING**

The next meeting of the Council of Governors will be held in the Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital on Wednesday 7 December 2016 commencing at 5.30pm.

**047/16 PROF CLAIR CHILVERS – CHAIR OF THE TRUST AND COUNCIL OF GOVERNORS**

Mr Alan Thomas, the Lead Governor, said that this would be the last meeting which Professor Clair Chilvers would be attending as Chair of the Trust and Chair of the Council of Governors. On behalf of Governors, he thanked her for her work for the Trust and made a presentation which was applauded.

Mrs Jenny Hincks, on behalf of the Governors, thanked Clair for her dedication and valued contribution to our Trust. It has become a stronger organisation with Clair as Chair. Another of her legacies was the setting up of the NHS/Cathedral Choir which Jenny had seen perform on several occasions. On a personal note, Clair had helped Jenny perform her duties as a Governor and had been willing to give guidance and advice when needed for which Jenny thanked her.

Governors were sorry to see Clair leave and they wished her all the best for the future and hoped that she enjoyed a well-deserved retirement. This was applauded by Governors.

In response, Clair said that she would miss all Governors. She had enjoyed the challenges of working with Governors. She thanked Alan Thomas, the Lead Governor, for his support. There was now an opportunity for Governors to be as effective as they can be in fulfilling their role. This was applauded by Governors.

**048/16 PUBLIC BODIES (ADMISSION TO MEETINGS ACT) 1960**

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

The meeting ended at 7.30pm.

**Chair**

**7 December 2016**

# ITEM 17

# ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

# DISCUSSION

# ITEM 18

# STAFF QUESTIONS

**Peter Lachecki**
Chair

# ITEM 19

# PUBLIC QUESTIONS

**(Procedure attached)**

**Peter Lachecki**
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, Alexandra House, Cheltenham General Hospital, Sandford Road, Cheltenham, GL53 7AN 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