GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on Wednesday 12 April 2017 in the **Lecture Hall, Sandford Education Centre, Keynsham Road, Cheltenham** commencing at 9.00 a.m. with tea and coffee from 8.45 a.m. **(PLEASE NOTE DATE AND VENUE FOR THIS MEETING)**

Peter Lachecki
Chair

5 April 2017

AGENDA

				Approximate Timings
	Patient Story			09:00
1.	Welcome and Apologies			09:30
2.	Declarations of Interest			
	Minutes of the Board	(subject to ratification by the Board and its relevant sub-committees)		
3.	Minutes of the meeting held on 24 February 2017	**PAPER**	**To approve**	09:32
4.	Matters Arising	**PAPER**	**To note**	09:35
	Chief Executive's Report and Environmental Scan			
5.	April 2017	**PAPER** (Deborah Lee)	**To note**	09:40
6.	Quality and Performance Report:			
	• Update Report of the Interim Chief Operating Officer	**VERBAL** (Natasha Swinscoe)	**For Assurance**	09:50
	• Trust Risk Register	**PAPER** (Deborah Lee)		
	• Report of the Chair of the Quality and Performance Committee on the meeting held on 29 March 2017	**PAPER** (Rob Graves)		
	• Minutes of the meeting of the Quality and Performance Committee meeting held on 22 February 2017	**PAPER** (Claire Feehily)		
7.	Financial Performance Report:			10:35
	• Capital Investment Programme 2017/18	**PAPER** (Sarah Stansfield)	**For Approval**	
	• Report of the Acting Finance Director	**PAPER** (Sarah Stansfield)	**For Assurance**	
	• Report of the Chair of the Finance Committee on the meeting held on 30 March 2017	**PAPER** (Keith Norton)		
	• Minutes of the meeting of the Finance Committee held on 23 February 2017	**PAPER** (Keith Norton)		
8.	Audit and Assurance Committee			10:50
	• Report of the Chair of the Audit and Assurance Committee on the meeting held on 10 March 2017	**PAPER** (Rob Graves)	**For Assurance**	

	• Minutes of the meeting held on 10 March 2017	**PAPER** (Rob Graves)	**To note**	
	Break			**11.00 - 11.10**
9.	Workforce Report			
	• Report of the Director of Human Resources and Organisations Development	**PAPER** (Dave Smith)	**For Assurance**	11:10
	• Report of the Chair of the Workforce Committee on the meeting held on 6 April 2017	**PAPER (To follow)** (Tracey Barber)		
	• Minutes of the meetings of the Workforce Committee held on 3 March 2017	**PAPER** (Keith Norton)		
10.	Nurse and Midwifery Staffing Report	**PAPER** (Maggie Arnold)	**For Assurance**	11:30
11.	SmartCare Progress Report	**PAPER** (Sally Pearson)	**For Assurance**	11:40
12.	Staff Survey	**PAPER** (Dave Smith)	**For Assurance**	12:00
13.	Safety Alert – Nasogastric Tube Misplacement – Assurance report	**PAPER** (Sean Elyan)	**For Assurance**	12:15
14.	Approach to Transformation	**PAPER** (Sally Pearson)	**To endorse**	12:20
15.	Innovation Governance Toolkit Standards	**PAPER** (Sally Pearson)	**To endorse**	12:35
16.	Safe Working Hours for Doctors and Dentists in Training	**PAPER** (Sean Elyan)	**For Assurance**	12:40
17.	Items for the Next Meeting and Any Other Business	**DISCUSSION** (All)	**To Note**	12:50
	Governor Questions			
18.	Governors Questions – A period of 10 minutes will be permitted for Governors to ask questions		**To Discuss**	12:55
	Staff Questions			
19.	A period of 10 minutes will be provided to respond to questions submitted by members of staff		**To Discuss**	13:05
	Public Questions			
20.	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**	13:15 13:25
	Luncheon			**13.25 – 13.55**

Date of the next meeting: The next meeting of the Main Board will take place at on **Wednesday 10 May 2017** in the **Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital** at **9.00 am.**

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."

Board Members

Peter Lachecki, Chair

Non-Executive Directors	**Executive Directors**
Tracey Barber	Deborah Lee, Chief Executive
Dr Claire Feehily	Maggie Arnold, Nursing Director
Tony Foster	Sarah Stansfield, Acting Finance Director
Rob Graves	Dr Sean Elyan, Medical Director
Keith Norton	Dr Sally Pearson, Director of Clinical Strategy
Vacancy	Dave Smith, Director of Human Resources and Organisational Development
	Natasha Swinscoe, Interim Chief Operating Officer

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST BOARD HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL ON FRIDAY 24 FEBRUARY 2017 AT 9AM

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

PRESENT	Peter Lachecki	Chair
	Deborah Lee	Chief Executive
	Dr Sean Elyan	Medical Director
	Dr Sally Pearson	Director of Clinical Strategy
	Natasha Swinscoe	Interim Chief Operating Officer
	Dave Smith	Director of Human Resources and Organisational Development
	Stuart Diggles	Interim Director of Finance
	Tracey Barber	Non-Executive Director
	Dr Claire Feehily	Non-Executive Director
	Tony Foster	Non-Executive Director
	Rob Graves	Non-Executive Director
	Rhona Macdonald	Non-Executive Director
	Keith Norton	Non-Executive Director
APOLOGIES	Maggie Arnold	Director of Nursing
IN ATTENDANCE	Martin Wood	Trust Secretary
	Paul Garrett	Deputy Nursing Director
	Mr Vinay Takwale	Chief of Service – Surgery
PUBLIC/PRESS	Craig MacFarlane	Head of Communications
	Suzie Cro	Head of Patient Experience
	Louise Courtier	Corporate Governance Administrator
	Two Governors, Two members of the public and a representative from the press.	

The Chair welcomed Governors, the public and representatives of the press to the meeting. He formally welcomed Dr Claire Feehily and Mr Rob Graves to their first Board meeting following their appointment as Non-Executive Directors from 1 February 2017. He was delighted to secure their services, both having financial qualifications and experience as Non-Executive Directors, and having worked extensively in the Gloucestershire health economy.

033/17 PATIENT STORY **ACTIONS**

Suzie Cro, Head of Patient Experience, presented her story involving the South West Ambulance Service and our Trust. There were numerous positive examples of the care she received including the compassion shown to her by staff. Alongside this were some opportunities for learning particularly in relation to information sharing and involving patients in decisions about their care. Of particular note it was apparent that not all staff were aware of the patients' rights to see their medical record. This is being taken forward as an action point from this experience.

The Chair thanked Suzie for her patient story. [09:25]

034/17 DECLARATIONS OF INTEREST

There were none.

035/17 MINUTES OF THE MEETING HELD ON 31 JANUARY 2017

RESOLVED: That the minutes of the meeting held on 31 January 2017 were agreed as a correct record and signed by the Chair subject to minor amendments form the Director of Clinical Strategy on the SmartCare Progress Report (Minute 013.17).

036/17 MATTERS ARISING

013/17 SMARTCARE PROGRESS REPORT:

The Chair invited the Director of Clinical Strategy to consider how the Board could have sight of the operation of TrakCare. *It was the preference of the Board that all members should have sight of TrakCare and the Director of Clinical Strategy undertook to liaise with the Trust Secretary for this to be incorporated into a Board Seminar. This has been included in the Workplan. Completed.*

008/17 AUDIT AND ASSURANCE COMMITTEE - 18 JANUARY 2017

Dr Feehily asked for information on the process for sharing internal audit reports. The Chief Executive said that each internal audit report now has an Executive sponsor and she undertook to discuss a process with the Chair of the Audit and Assurance Committee to ensure that appropriate Board Committees were sighted on relevant audits once they had been received by the A&AC.. [09:31] **DL/RG**

037/17 CHIEF EXECUTIVE'S REPORT AND ENVIRONMENTAL SCAN

The Chief Executive apologised for the absence of a written report and updated the Board on the following:-

CQC Inspection: Verbal feedback had been received together with two follow up letters. The CQC had acknowledged that there had been significant improvement in the safety and governance of our Emergency Department at Gloucester though they expressed concerns about the care of patients at very busy times. The CQC also commented on improvements in safeguarding arrangements and notably end of life care. . Inspectors reported mixed levels of staff engagement across the two hospitals and within specific staff groups. The Director of Human Resources and Organisational Development has arranged additional listening events to hear directly the issues raised. The CQC had noticed a positive change in culture from staff at all levels on both sites since the previous inspection.

Financial Special Measures: The Chief Executive together with our

Chair and Interim Finance Director had meet NHS Improvement on 22 February 2017 in London as part of a programme of review meetings. The progress made this year had been well acknowledged. Our planned year end outturn position is a deficit of £18m and break even in financial year 2018/19 (FY19). The planned deficit of £14.7m in FY18 remains to be agreed with NHS Improvement. A financial control total remains to be agreed and will attract Sustainability and Transformation Funding if agreed.

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

- Dr Feehily asked how leaders will be held to account with a change in the direction of travel. The Chief Executive said in response that the culture is about empowering, engagement and quality improvement methodology. The Medical Director added that there is a tendency amongst staff to focus on the negatives which they should be empowered to correct. Lesley Morrison is taking forward the things which staff are proud of.
- The Chair congratulated the Chief Executive, Interim Finance Director, the Director of Operational Finance and their teams for the work on the preparation of the Financial Recovery Plan and the acknowledgment of this from NHS Improvement which is a terrific achievement
- The Medical Director acknowledged the work of Dr Emma Husbands, Alison Doyle and the Quality Improvement Academy in developing and implementing the End of Life Pathway across our Trust. Mr Graves added that individual success brings success to our organisation. The Chief Executive added that it is about nurturing leadership and an embryonic development strategy will be presented to the Board Seminar in March 2017
-

The Chief Executive noted that there are currently three Staff Governor vacancies which is a mechanism for staff to become involved. Following publication of the vacancies and the role of governors, twelve expressions of interest had been received.

DS
(MW to note for Agenda)

The Chair thanked the Chief Executive for her report.

RESOLVED: That the report be noted. [09:58]

038/17 QUALITY AND PERFORMANCE REPORT

REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE ON THE MEETING HELD ON 22 FEBRUARY 2017:

The Chair of the Committee, Dr Claire Feehily, presented the report describing the business conducted at the meeting of the Quality and Performance Committee held on 22 February 2017. She expressed her appreciation to Mr Norton, the previous Chair, and to the Trust secretary for their support. She drew attention to issues with the Referral to Treatment (RTT) data and the measures being taken to ensure safety whilst patients await treatment. Diagnostics and

Specialities had presented with emerging risks of staff recruitment especially in pharmacy where pharmacists are being recruited to the community where different conditions of service apply. The Radiology imaging backlog has reduced to 5,000 and is now considered low risk. The implications of changes in midwifery staffing for 1 April 2017 are understood. The Performance Management Framework Report was considered. A theme emerging in a number of reports were the various impacts of TrackCare. Emergency Department 4 hour target, particularly during surges in demand, remains of considerable concern and it was noted that weekly CEO escalation meetings have been instigated. There are changes to the pathway being implemented in the short term, particularly to address safety measures such as 15 minute triage. It is pleasing that our Trust is responding to the CQC inspection with the development of an action plan in advance of the final report. On mortality further detailed data is to be presented to get a better grip on performance.

The Chair thanked Dr Feehily for the report.

RESOLVED: That the report indicating the Non-Executive Director challenges made and the assurance received for residual concerns and/or gaps in assurance be noted.

REPORT OF THE INTERIM CHIEF OPERATING OFFICER:

The Interim Chief Operating Officer presented the report summarising the key highlights and exceptions in Trust performance up until the end of January 2017 for the financial year 2016/17. The key issues to note were that in January 2017 our Trust did not meet any of the four national waiting trajectories for A&E 4 Hour Wait, 62 Day Cancer Standard, 18 Week Referral to Treatment (RTT) Standard or 6 Week Diagnostic Waits. A & E performance has continued to be of particular concern in January. Our Trust has welcomed the offer of support from the national Emergency Care Intensive Support Team with a focus on support to the Emergency Department and acute areas. They are to undertake a 12 hour diagnostic on 6 March 2017. It has been challenging to repatriate the surgical wards swung to medicine to support winter pressures which has impacted on our ability to re-start elective operating in some specialities. Our Trust is expected to return to achieving both the two week wait for cancer referrals and the 62 day cancer standards during the quarter - two week waits in February and 62 days is April. 31 days performance has deteriorated in November and December 2016. Concerns regarding Referral to Treatment (RTT) data quality following migration to TrackCare have resulted in a decision to cease reporting until the quality of data can be assured. Our Trust has appointed an RTT specialist for three months to resolve this issue and a team of data entry staff are inputting the referrals backlogs after which point our Trust should be able to re-commence reporting. The specialist is to undertake capacity and demand analysis which will be presented to the Quality and Performance Committee in May 2017. There are regular meetings with NHS Improvement, NHS England and the Clinical Commissioning Group to track and report progress to recover the reporting and delivery position. Our Trust reported seven 52

breaches in January and these patients will all be booked in February 2017.

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

- Ms Barber enquired how staff is to be managed with the introduction of the Emergency Care Support Team to main the focus. In response, the Interim Chief Operating Officer said that there is listening to the team as to what needs to change and that an overarching view is prepared
- Mr Norton said that our Trust has previously used emergency departments "experts" but performance has not improved to meet the 4 hour standard and he asked what would be different on this occasion. The Interim Operating Officer said in response that the process will be embedded by delivery and leadership. A permanent appointment is being made to the post of Director of Operations. The Chief Executive added that there is a change in leadership to provide ownership in the Tri with weekly escalation meetings which she and the Interim Chief Operating Office are attending. Responding to Mr Graves the Interim Operating Officer said that delivering changes in performance will lead to improvements. The Emergency Care Programme has oversight of performance and reports to the Quality and Performance Committee
- The Interim Chief Operating Officer said that she would liaise with Ms Barber ways to triangulate the reported number of breaches to manage patient care. The Medical Director added that there has been an increase in the number of complaints relating to outpatient appointments as a result of TrackCare introduction (excluding the Emergency Department). There is clinical oversight to ensure that there is no patient harm. There is a Standing Operating Procedure in place to provide grip when breeches occur. There had been seven harm reviews and he has either written or met those patients. He expressed confidence that the necessary systems are in place
- Ms Macdonald asked if there were early warning signs that 31 day performance would deteriorate.. The Chief Executive explained that our internal auditors, Price Waterhouse Coopers, had undertaken an audit of 31 day performance which had revealed some reporting errors and the deterioration was a reflection of correcting these errors. There is a weekly focus on the reported data and performance is improving.
- On 62 day and 52 weeks the Medical Director said that there is zero tolerance and actions are being taken before breaches occur and harm reviews conducted on every long waiting patient on these two pathways.
- The Interim Chief Operating Officer said that the endoscopy backlog needs to be addressed to ensure JAG accreditation is achieved
- In response to a comment from the Chief Executive, the Deputy Nursing Director said that a root cause analysis has been undertaken of the C. Difficile cases and no trends have

been identified

The Chair thanked the Interim Chief Operating Officer for the report.

RESOLVED: That the Integrated Performance Framework report be noted as assurance that the Executive Team and Divisions are appropriately focussed on improving current poor levels of performance.

TRUST RISK REGISTER

The Chief Executive presented the Trust Risk Register stating that safety risks with a score of 12 and above are now included in the Register. Remaining risks with a score of 15 and above are included in the Register. Those risks with a score of 12 and above are considered by the relevant Board Committee. Patient experience in the Emergency Department in periods of surge is not included in the Trust Risk Register as controls and mitigation actions are enacted. In response to a question from Dr Feehily about more regular reporting of patient experience, the Chief Executive said that this will now be included in the monthly Performance Management Framework Report.

The Chair thanked the Chief Executive for the report.

RESOLVED: That the report be noted.

MINUTES OF THE MEETING OF THE QUALITY AND PERFORMANCE COMMITTEE HELD ON 27 JANUARY 2017:

RESOLVED: That the minutes of the meetings of the Quality and Performance Committee held on 27 January 2017 be noted. [10:19]

039/17 FINANCIAL PERFORMANCE REPORT

REPORT OF THE CHAIR OF THE FINANCE COMMITTEE ON THE MEETING HELD ON 23 FEBRUARY 2017:

The Chair of the Committee, Mr Keith Norton, presented the report describing the business conducted at the meeting of the Finance Committee held on 23 February 2017. He drew attention to the year to date deficit of £17.8m which is the fourth consecutive month that the financial recovery plan trajectory has been met. Of the 34 recommendations in the Deloitte Financial Reporting Review 30 are complete and 18 of those are now viewed as business as usual. On workforce, medical agency spend has reduced and the pay bill has reduced between Months nine and ten and is the lowest level this financial year. The Financial Recovery Plan is to break even at the end of financial year 19. The Cost Improvement Programme target for 2017/18 is £31.7m of which £25.3m currently has a level of maturity and development. The Capital Programme has been reduced (reduced??) due to cash constraints however it is intended to use lease arrangements to replace critical equipment. A clear process has been agreed and understood by Divisions for budget setting in 2017/18.

The Chair thanked Mr Norton for the report.

RESOLVED: That the report indicating the Non-Executive Director challenges made and the assurance received for residual concerns and/or gaps in assurance be noted.

REPORT OF THE INTERIM FINANCE DIRECTOR:

The Interim Finance Director presented the report providing an overview of the financial performance of our Trust as at the end of month ten of the 2016/17 financial year. It provided the three primary financial statements along with analysis of the variances and movements against the forecast position, including an analysis of movement in the forecast outturn. It also provided a summary of the variance against the planned position to NHS Improvement. The key issues to note were that the financial position of our Trust at the end of month ten of the 2016/17 financial year is an operational deficit of £17.8M which is basically in line with forecast. It also represented an adverse variance to the original NHS Improvement Plan of £31.0M. The operational deficit is £900k ahead of forecast due to timing issues with the agreement of contracts with both the Gloucestershire Clinical Commissioning Group and Specialised Commissioners. There is a favourable variance to forecast of £909k of which £800k relates to excess levels of activity. £0.5m of the variance is driven by a SmartCare adjustment. Financial Recovery Plan savings were forecast to be £0.9m included as a bottom line adjustment to forecast. Actual delivery of savings is within pay, non-pay and income to a value of £1.3m at Month ten. The significant improvement in the forecast position for the final quarter reflects the schemes included as part of the Financial Recovery Plan with a further increase in Month 12 to reflect the profit on the sale of College Lawn. This has the overall impact of making Month 12 a surplus month.

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

- In response to a question from Dr Feehily regarding TrackCare, the Chief Executive said that the Board needs greater assurance on the impact of Trakcare on activity, income and operational impact and that each Board Committee needs greater oversight of their respective activities within TrackCare
- The Chair sought and received confirmation that the budget setting approach will be different for the forthcoming financial year with ownership built from the bottom upwards with greater staff engagement

The Chair thanked the Interim Finance Director for the report.

RESOLVED: That:-

- The financial position of our Trust at the end of month ten of the 2016/17 financial year is an operational deficit of £17.8M which is an adverse variance to the forecast of £0.9m be noted

- The adverse variance against the NHS Improvement Plan is £31.0M
- The focus on performance reporting is now against the forecast position and achievement of the £18.0M recovery target
- The NHS Improvement Plan and the planning process that created it is not as robust as would be expected. The plan lacks granular supporting detail and as such comparisons are not necessarily to be relied upon in isolation for decision making or performance management purposes. Our Trust's internal budget does not reconcile, either by cost category or phasing, to the NHS Improvement Plan. The figures presented in the report as "plan" reflected the figures as submitted to NHS Improvement unless explicitly stated otherwise
- Our Trust is forecasting an income and expenditure deficit of £18.0M against a planned surplus of £18.2M, representing a £36.2M adverse variance to the NHS Improvement Plan. This forecast has moved to reflect the Financial Recovery Plan since the prior month

MINUTES OF THE MEETING OF THE FINANCE COMMITTEE HELD ON 25 JANUARY 2017:

RESOLVED: That the minutes of the meetings of the Finance Committee held on 25 January 2017 be noted. [10:52]

040/17 AUDIT AND ASSURANCE COMMITTEE – 18 JANUARY 2017

RESOLVED: That the minutes of the meeting of the Audit and Assurance Committee held on 18 January 2017 be noted. [10:53]

(The Board adjourned from 10:53am to 11:07am)

041/17 WORKFORCE REPORT

REPORT OF THE CHAIR OF THE WORKFORCE COMMITTEE ON THE MEETING HELD ON 3 FEBRUARY 2017:

The Chair of the Committee, Ms Tracey Barber, presented the report describing the business conducted at the meeting of the Workforce Committee held on 3 February 2017. The Committee was established with short-term key performance indicators and in March 2017 a longer term approach will be considered along with the Workforce Strategy. There are improvements in agency spend, nursing recruitment and retention and sickness absence which is below the national average. The Committee is clear around the sickness data and that there is under reporting by doctors.

She invited the Medical Director to explain the increase in medical spend between months 5 and 6 and the background to subsequent reductions. The Medical Director explained that there were a number of issues which came together at the same time resulting in the increase in medical spend in these months. There was a step increase of between £300k and £400k between August and

December 2016 resulting in agency spend carried forward.

Medicine and Surgery Divisions caused by backfilling surgical locum positions and multiple medical vacancies. The medical vacancies were largely as a result of the establishment of the Outlier Team which provided increased quality of care but put pressure on consultant and junior doctors requiring support. New "R3" doctors were created to address ward pressures identified by the Deanery resulting in increased locum spend. Enhanced controls are now in place. The Vacancy Control Panel is converting to substantive posts and there is Divisional scrutiny and confidence leading to the decrease in agency spend between October 2016 and January 2017 of £300k. The Medical Director stressed that savings are not being made to impact adversely on patient care. The Director of Human Resources and Organisational Development said that the Workforce Group is planning for middle grade rotas and the Chief of Service for Surgery Division is looking at innovative ways of filling gaps. There may be opportunities to spend for longer term savings.

The Chair thanked Ms Barber for the report.

RESOLVED: That the report indicating the Non-Executive Director challenges made and the assurance received for residual concerns and/or gaps in assurance be noted.

REPORT OF THE DIRECTOR OF HUMAN RESOURCES AND ORGANISATOINAL DEVELOPMENT:

The Director of Human Resources and Organisational Development presented the report providing an overview of the workforce performance as at the end of month ten of the 2016/17 financial year. It provided information on the continuing overspend on pay (including agency) costs, movements in headcount as well as further information on two of the key drivers of spend, turnover and sickness. Of the key issues to note it was pleasing to see a reduction in the overall pay bill between months nine and ten of £0.47M, building on the previous month's reduction of £0.41M with the pay bill at its lowest level this financial year. Agency expenditure continues to reduce overall and is now at its lowest level since June 2016. Equal focus is being applied between agency expenditure and pay expenditure generally and engagement with staff representatives on key initiatives with the support of the Chief Executive. Nursing vacancies are now 106 whole time equivalents, the lowest level for the whole of 2016/17.

The Director of Human Resources and Organisational Development said that there is increased Divisional grip and ownership on pay expenditure. Staff paid is lower that funded full-time equivalents. The Vacancy Control Panel is having a positive impact with some submissions adjusted for a better way of working.

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

- Mr Foster said that greater data is now available and action

being taken to reduce the medical agency pay bill with the conversion where possible of locums to substantive posts and this approach needs to be sustained
- In response to a question from the Chief Executive, the Director of Human Resources and Organisational Development said that there are plans to reduce expensive headcount so as not to impact on staff working extra shifts
- The Chair said the process is in hand of determining those elements of the report which should be presented to the Finance and Workforce Committees

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

RESOLVED: That the contents of the report be noted and the actions being taken be endorsed.

MINUTES OF THE MEETINGS OF THE WORKFORCE COMMITTEE HELD ON 6 JANUARY AND 3 FEBRUARY 2017:

RESOLVED: That the minutes of the meetings of the Workforce Committee held on 6 January and 3 February 2017 be noted. [11:25]

042/17 NURSE AND MIDWIFERY STAFFING REPORT

The Deputy Nursing Director presented the report providing assurance to the Board in respect of nurse staffing levels for January 2017 against the Compliance Framework "Hard Truths" – Safer Staffing Commitments. He highlighted that 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. Interviews for the new Associate Nurse student places are scheduled for the next two weeks and our Trust's allocation in 13. The Nurse and Midwifery Council (NMC) will register the individuals. This is a good way of addressing the shortfall in nurses. Our Trust continues to recruit nurses from the locality. Our Trust is providing intensive training for those nurses undertaking the International English Language Testing System (ILETS). Sickness absence is at 4.5% with a process to address on a compassionate basis. The action plan following the meeting with Professor Mark Radford, Director of Nursing at NHS Improvement is largely completed and is being monitored. The NHS Improvement "Model Hospital" database has been accessed providing high level comparators showing our Trust favourably with regard to staffing costs, but providing the opportunity for further comparisons and refinement as the database develops. A quarterly report on the "Model Hospital "will be presented quarterly to the Board. The Care Hours per Patient Day compares data at ward level in the UK.

MA/PG
(MW to note for Agenda)

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

- The Chief Executive enquired whether the introduction of the Care Hours per Patient Day would provide flexibility to

appoint staff to different roles. In response the Deputy Nursing Director said that this is possible but will be challenging in the way it is undertaken

- The Chief Executive asked that the data for Medicine Division needs to be complete for the next report. **MA/PG**
- The Chief Executive asked how the correlation between harm and staffing levels was undertaken,In response the Deputy Nursing Director said that pressure ulcers etc are included in the Safety Thermometer and a root cause analysis is undertaken which looks at whether staffing levels have contributed to any harm. He acknowledged that further work is required in this areas and he is taking forward learning from a recent nursing summit and will approach North East Hertfordshire Trust on their approach
- The Medical Director said that the red scores in the cleanliness data in Medicine Division need to be investigated **MA/PG**
- The Chair asked if the "Model Hospital" will provide greater comparisons for intelligent learning. The Deputy Nursing Director said in response that it can be undertaken as the data develops as the Model is being used throughout England

The Chair thanked the Deputy Nursing Director for the report.

RESOLVED: That the report be noted as a source of assurance that staffing levels across our Trust are delivering safe care. [11:48]

043/17 OPERATIONAL PLAN 2017 - 19

The Director of Clinical Strategy presented the publically accessible version of our Trust's Operational Plan 2017 – 19 prior to uploading to the publications session of our website. The Operational Plan was submitted to NHS Improvement in December 2-16 reflecting our Transforming Care for Everyone programme as our means of moving towards our vision of Best Care for Everyone. There is a requirement to publish a publically accessible version of the Plan by the end of February 2017. The content of the Plan presented to the Board was unchanged from that submitted to NHS Improvement but was presented in the style of our corporate documentation.

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

- The Interim Finance Director said that there is a possibility that the financial information may change following a further review of our Financial Recovery Plan by NHS Improvement and the Director of Clinical Strategy undertook include this in the Plan and reference on our website. The 2017/18 projected deficit to be consistent with the Financial Recovery Plan
- Ms Barber commented on the power of the visual graphics to aid public understanding
- In response to a question from the Chair the Director of Clinical Strategy said that copies of the Plan in braille are available on request. The new web platform will provide

opportunities for Trust documents to be more readily accessible and she would consider this approach with the 2gether Trust to identify a suitable document to pilot **SP**

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

RESOLVED: That, subject to the above amendments, the Operational Plan 2017 -19 is an endorsed for publication on our Trust's website. [11:54]

044/17 SMARTCARE PROGRESS REPORT

The Director of Clinical Strategy presented the report providing assurance from the SmartCare Programme Board on progress towards the stable operation of TrakCare post phase one go-live and planned implementation of phase 1.5. Since the preparation of the report there had been a further meeting of the Programme Board where the following issues had been discussed. There is a technical issue with the supplier where a contractual delay period has been agreed before our Trust commences payment for the system. The treatment of Consumer Price Index is not included in the Business Case and will require a revision to purchase orders, the funding for which will be met from the Treasury allocation. Further work is being undertaken on report presentation as part of transformation to provide an emphasis on assurance on the impact of the system. The system is not sufficiently robust to provide reporting information for inclusion in the Performance Management Framework report and the Executive Team is looking at this based on the risk register and assigning it to the assurance process. The introduction of Phase 1.5 has been delayed and there are delays on the availability of the supplier due to changes in the timetable. From an operational perspective there are lessons to be learnt and the work of Price Waterhouse Coopers will assist in that work. The corporate centre influenced the operational model and the plan in the business case will be reviewed to develop future phases in an operational environment.

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

- The Chief Executive said that the Board needs to have assurance, before the launch of V1.5, that the issues which arose with the launch of the first version will not reoccur and that we have learnt from the mistakes made.
- Mr Norton asked the Director of Clinical Strategy for her personal view on whether it was the right product and poorly implemented or the wrong product. In response, the Director of Clinical Strategy said that it is the best product for our setting and there has been considerable learning to be taken on board for future planning. The Medical Director added as a user of the system that unequivocally it is the right system. The workflow looks different but that is not a fault of the system. There is leaning from the Chemotherapy Model before the introduction of Phase 1.5
- Mr Graves asked if a survey of day to day users of the

system has been undertaken. In response the Director of Clinical Strategy said that in broad terms experiences of the system are being collected in the clinical environment by working alongside users. There is the development of champions to assist uses and provide feedback on experiences. There is a focus on risks to patient safety and concerns are raised through Datix and reviewed by the Clinical Safety Group

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

RESOLVED: That the report be noted as a source of assurance that the programme to identify issues within the respective operational and support areas to achieve satisfactory recovery for Phase 1 and planning for subsequent phases is robust. [12:19]

045/17 APPOINTMENT OF ADDITIONAL NON-EXECUTIVE DIRECTOR

The Chair presented the report inviting the Board to review the appointment of one additional Non-Executive Director exclusively to be from the University of Gloucestershire. The Board had agreed to the appointment of an additional Non-Executive Director making a total of seven Non-Executive Directors giving a clear majority on the Board rather than the Chair exercising any casting vote. This fully fulfilled the NHS Improvement Code of Governance requirement in that the Board of Directors should comprise a majority of Non-Executive Directors. At the time the Board agreed that this appointment should be from the University of Gloucestershire. The Council of Governors approved this proposal in July 2016.

Whilst supportive of working relationships with stakeholder organisations, it is considered that there might be occasions when a conflict of interest might arise if one particular stakeholder from a group of stakeholders, in this case from the University of Gloucestershire, were to be appointed as a Non-Executive Director. Consideration should be given to the appointment of a Non-Executive Director from an organisation such as health and social care, a person with a mental health background or a young person.
The Council of Governors considered this matter on 22 February 2017 and agreed to the proposal.

The recruitment process is underway for the appointment of Non-Executive Director "6" with a clinical background. To assist with succession planning it was proposed to recruit to the additional vacancy later in the year.

RESOLVED: That the additional Non-Executive Director should not necessarily be from the University of Gloucestershire and that consideration be given to the type of organisation for this appointment in conjunction with the Council of Governors. [12:22]

046/17 GOVERNOR QUESTIONS

Mrs Davies suggested that a glossary of abbreviations/acronyms be prepared to help understanding of the Board papers. The Chair **MW**

agreed that the feasibility of such a glossary will be reviewed

The Lead Governor commended the Board for the manner in which it now conducts the majority of its business in the public part of the meeting. He referred to the discussions around leadership observing that he considered "followership" as an equally important skill. He also referred to the SmartCare Progress Report and the discussion around the training provided and questioned the evaluation particularly around e-learning and its effectiveness in six months' time. The Director of Clinical Strategy said that a high level evaluation of the training provided had been undertaken which had concluded that it was not sufficient in terms of the amount and design in that the design centred around roles and not staff groups such as nurses. The training is being changed to focus on roles and e-learning will be an important component of that training. The leadership will review the skills and competencies in the use of TrackCare after a period of operation. [12:29]

047/17 STAFF QUESTIONS

There were none. [12:29]

048/17 PUBLIC QUESTIONS

There were none. [12:29]

049/17 ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

ANY OTHER BUSINESS:

No further items of business were identified.

ITEMS FOR THE NEXT MEETING:

No further items were identified for the next meeting.

050/17 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at **9am** on **Wednesday 12 April 2017** in the **Lecture Hall, Sandford Education Centre, Keynsham Road, Cheltenham**

051/17 EXCLUSION OF THE PUBLIC

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

The meeting ended at 12:30pm.

Chair
12 April 2017

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – APRIL 2017

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
April 2017	February 2017 008/17 Audit and Assurance Committee – 18 January 2017	**DL/RG**	Dr Feehily asked for information on the process for sharing internal audit report. The Chief Executive said that each internal audit report now has an Executive sponsor and she undertook to discuss a process with the Chair of the Audit and Assurance Committee to ensure that there was no duplication by the Audit and Assurance Committee and the relevant service Committee. *Ongoing.*
April 2017	February 2017 042/17 Nurse and Midwifery Staffing Report	**MA/PG** **MA/PG**	The Chief Executive asked that the data for Medicine Division needs to be complete for the next report. *Ongoing.* The Chief Executive asked how the correlation between harm and staffing levels was undertaken. In response the Deputy Nursing Director said that pressure ulcers etc are included in the Safety Thermometer and a root cause analysis is undertaken which looks at whether staffing levels have contributed to any harm. He acknowledged that further work is required in this areas and he is taking forward learning from a recent nursing summit and will approach North East Hertfordshire Trust on their approach. *Ongoing.*
April 2017	February 2017 043/17 Operational Plan 2017 -19	**SP**	In response to a question from the Chair the Director of Clinical Strategy said that copies of the Plan in braille are available on request. The new web platform will provide opportunities for Trust documents to be more readily accessible and she would consider this approach with the 2gether Trust to identify a suitable document to pilot. *Ongoing.*
April 2017	February 2017 046/17 Governor Questions	**MW**	Mrs Davies suggested that a glossary of abbreviations/acronyms be prepared to help understanding of the Board papers. The Chair agreed that the feasibility of such a glossary will be reviewed. *Governors have been provided with the link to a Jargon Buster document on the GovernWell*

			Section of NHS Providers website which helps in explaining some of the acronyms which they come across in their role. Completed.

FUTURE TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
May 2017	February 2017 042/17 Nurse and Midwifery Staffing Report	**MA/PG**	A report on the "Model Hospital "will be presented quarterly to the Board. *Ongoing.*

COMPLETED TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
January 2017	Smartcare Progress Report	**SP**	The Chair invited the Director of Clinical Strategy to consider how the Board could have sight of the operation of TrakCare. *It was the preference of the Board that all members should have sight of TrakCare and the Director of Clinical Strategy undertook to liaise with the Trust Secretary for this to be incorporated into a Board Seminar. This has been included in the Workplan.*

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – APRIL 2017

REPORT OF THE CHIEF EXECUTIVE

1. Current Context

1.1 Despite us moving on from the traditional winter months, operational pressures remain. An easing of ambulance activity in early March resulted in significant improvements in A & E performance including achieving the 95% standard for the first time in many months; this is of particular relevance to our performance improvement plans given this improvement was not seen over the Christmas and New year period when operational activity was reduced and flow greatly improved. However, performance remains very volatile with very poor performance regularly appearing on Monday and Tuesday of each week. National support for A & E recovery is being mobilised with Trust's being asked to review their own local models against a national exemplar site and this work is in hand.

1.2 Delivery of the national performance targets for access to services which includes A&E, 6 week diagnostic waiting times and outpatient referral to treatment times remain a very significant concern. Actions to expedite recovery are described more fully in the Board Performance Report. Cancer two week waiting times have been achieved for two consecutive months and are expected to continue to be met going forward and 31 day and 62 day performance are expected to be achieved from July onwards.

1.3 Finally, the impacts of the new Patient Administration System (PAS) TrakCare continue to be felt. With the aim of expediting recovery and providing greater assurance to the Board, through its committees, the Chief Executive has revised the oversight and governance arrangements. These revisions are set out fully in this month's SmartCare Programme Board report but will include an Operational Recovery Group and a CEO led Recovery Oversight Board.

2. National

2.1 This month the Chancellor of the Exchequer set out his budget for the forthcoming year. There were two announcements of note, for health services, within his budget. The first was the announcement of £350m of capital to support the transformation plans of local Sustainability and Transformation Plan (STP), this is alongside a further £100m to support introduction of the A & E model of care described above. The Trust has already submitted a bid for £69m of capital to support its own strategic capital plans and is now awaiting confirmation of whether its bid has been prioritised against the capital available and has also submitted a second bid against the targeted A & E capital funds.

2.2 In addition the Chancellor announced £1bn of non-recurrent revenue to support local authorities to address some of the challenges facing social services and impacting on NHS services. Gloucestershire County Council (GCC) expects to receive in the order of an additional £20m over the next three years with c£10m expected in 2017/18. Very positively GCC colleagues have invited all STP partners to contribute to the development and agreement of plans for how this money will be spent. The Chief Executives of NHS England and NHS Improvement have set out their own expectations for the impact of the funding on health services which are described in the attached letter but in summary they are expecting a reduction of 2-3,000 delayed transfers of care within health settings and a consequent improvement of c10% in A & E 4 hour performance – given this Trust's current performance these expectations are very, very challenging.

2.3 On the 31st March NHS England published their document *Next Steps on the Five Year Forward View.* Whilst the initial direction set out in 2016 remains unchanged, this most recent publication has been clearer on the key priorities over the next two years. The four priorities set were

2.4 Delivering financial balance across the NHS
2.5 Improving cancer and mental health services
2.6 Improving 4 Hour Performance
2.7 Improving access to GP and primary care services

These restating of priorities received significant media coverage in response to the apparent de-prioritisation of the 18 week referral to treatment (RTT) target. A summary of the report can be requested from the Trust secretariat or accessed via the NHS Providers website https://www.nhsproviders.org/news-blogs/news/nhs-providers-comments-on-the-nhs-five-year-forward-view-delivery-plan. For our Trust RTT remains a very high priority and will be prioritised alongside the national "must-do" priorities not least as many of the underlying issues to address A & E, cancer and financial performance are the same issues that have resulted in a decline of RTT performance.

2.4 Positively for this Trust, a second wave of *Modernising Radiotherapy* capital has been announced and the Trust has been invited to bid. This capital can be used to replace aging radiotherapy equipment such as linear accelerators (the machines that deliver radiotherapy to patients with cancer) and other cancer related equipment. Although we were unsuccessful on the first round, I am hopeful that we will succeed this time around and I am pleased that we have the full support of Alex Chalk MP to progress this initiative.

3 Our System

3.1 Partners have continued to work together on the Gloucestershire STP - *One Gloucestershire – Transforming Care, Transforming Communities* with the focus now moving to implementation and delivery. A key component of the plan is how we deliver urgent and emergency care in the future, through a model much less reliant on acute and hospital based care.

3.2 The vision and emerging models of care for the future have been presented to a number of forums as part of the pre-consultation engagement work and this included a presentation to a meeting of our own Governors, the Health and Care Overview and Scrutiny Committee (HCOSC) and a number of other community groups. The Board and Governors will be briefed more fully on the options emerging that will be consulted on later in the year. Not unusually, there are significant assurance "gateways" that the system plan must proceed through; these are overseen by NHS England and STP partners are actively engaged with NHSE to plan the next steps. The first of these assurance gateways takes place in April 2017.

3.3 In June Gloucestershire County Council will be launching the One You Pledge campaign and the Trust has agreed to become a partner within the "healthy workplace" element of this important initiative. The aim is to encourage our staff to make a pledge around one of five areas and maintain this pledge for four weeks – the areas are exercise, smoking, eating, drinking and stress. Our own Staff Health & Wellbeing Board has been asked to think of creative ways in which we can encourage and support uptake amongst staff in the Trust.

3.4 Nationally there is increasing interest in looking at different ways of organising health systems and their constituent parts to achieve more integrated care, at lower cost and with improved outcomes for patients and their families. Two models being explored are Accountable Care Organisations (ACO) and Accountable Care Systems (ACS). The STP Delivery Board has expressed an interest in understanding more about the risks and benefits of these approaches for Gloucestershire and a first discussion on the issue will take place at the forthcoming Gloucestershire Strategic Forum.

3.5 The anticipated bidding round for University Technical Colleges (UTC) that was scheduled for October 2016 did not go ahead. We understand that this was due to the change in leadership and resulting policy review at the Department for Education. We have continued to develop our proposal in anticipation of the publication of revised dates. We now understand that the next bidding round will be for UTCs, Free Schools and any other types of new schools and we have been told that any announcement on this will take place after Easter 2017, although no specific timeline has been given. We have also been informed that the Department for Education (DfE) will be writing to us imminently to provide details of a contact who will work with us to develop our submission. This is a very positive step as it means that we can engage with DfE prior to submission to address any concerns. This has not happened in previous rounds. We have been asked to consider opportunities for a 11-19 (years of age) offer and will assess this with the DfE once contact has been made. We are currently working towards an application this summer with an announcement expected in autumn 2017 however this is dependent upon the DfE.

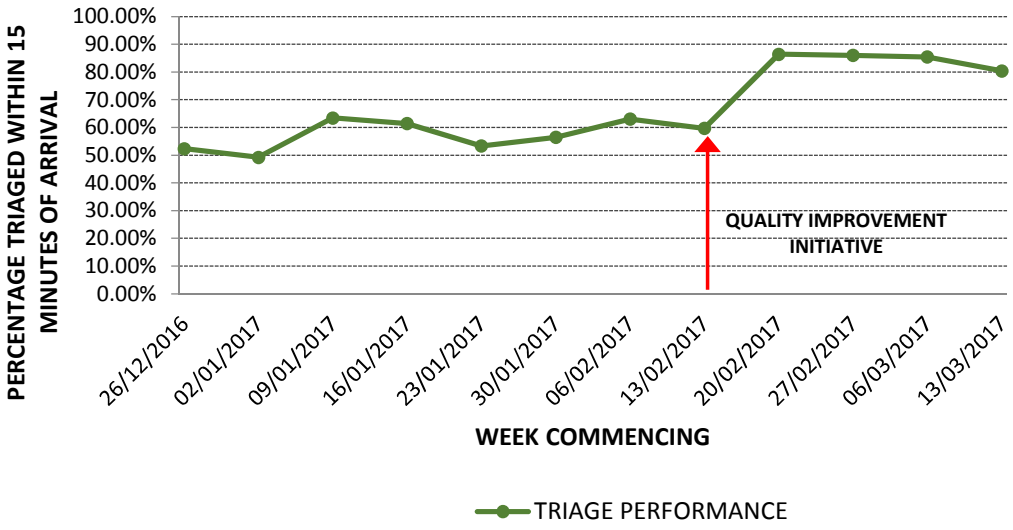
4. Our Trust

4.1 The past month has seen the continuation of a very significant focus on developing the Trust's financial recovery plan and importantly moving from identification of savings opportunities to developing and implementing plans. The support from KPMG has now ended and the Trust is building its own in house expertise and Programme Management Office (PMO). There is still a significant gap in the amount of cost improvement plans (CIP) already well developed and the total CIP required to deliver the Financial Recovery Plan and the focus on identifying new CIP is a significant part of the work being led by the PMO, under the direction of the Finance Director. The Trust has its third formal Financial Special Measures Progress Review Meeting (PRM) on the 4th April when the Chair, Chief Executive and Director of Finance will represent the Board. The main focus of the meeting will be to reach agreement on the Control Total for 2017/18. The Trust is still working to develop a plan which supports a £14.7m deficit position by March 2018 but this is becoming increasingly challenging to maintain.

4.2 I am pleased to announce that the Trust has made a successful appointment to the substantive Director of Finance role and announcements are pending due to the offer being subject to NHS Improvement and ministerial approval. However, the Trust's own Remuneration Committee has approved the appointment and subject to the caveat above, the candidate is expected to start in mid-June. In the interim Sarah Stansfield, currently Director of Operational Finance will act into the role of Director of Finance and Stuart Diggles will be retained to provide financial turnaround support until the substantive appointee is in post.

4.3 Following the recent Care Quality Commission (CQC) inspection, work continues to address the opportunities for improvement identified by the inspectors. Of particular note is the work, led by front line staff, to improve the proportion of patients attending our Gloucester Emergency Department who are triaged (assessed for priority) within 15 minutes of arrival. This is a key marker of safety within any department and is particularly crucial at times of peak activity. Inspectors observed performance in the range of 40% to 80% during their visit and following the improvement initiative performance has been regularly sustained above 80%. Disappointingly, the draft CQC report is now expected later than originally signalled with receipt expected on the 24th April and planned publication for 23rd May 2017.

GLOUCESTERSHIRE ROYAL HOSPITAL TRIAGE PERFORMANCE (LAST 12 WEEKS)



4.4 The Trust's staff continue to excel and many of their efforts have been recognised this month. Ian Ingledew was awarded Oncology Nurse of the Year in the prestigious Nursing Times Awards, in a field of very strong competition. Reflecting the interest in the Trust and its staff, news of this award had reached more than 21,000 people within three days of the announcement via Trust social media. Staff working in maternity services were also recognised for their excellence and innovation and were just one of three teams in England awarded £50,000 to develop an initiative to improving parental experience of maternity services.

4.5 Reflecting the importance of recognising and celebrating success, planning has commenced for this year's Staff Awards Ceremony which will take place in September. In light of the financial challenges facing the Trust, our organisers have got "creative" in seeking sponsorship to offset the costs of the event this year. We have never needed this sort of boost for staff, as much as we do currently and I am delighted therefore that the event will continue this year.

4.6 The Clinical Senate continues to develop our thinking in respect of the future configuration of services across our two sites. A number of options are emerging that will improve the quality of care we are able to offer to patients requiring urgent and emergency care whilst supporting the developing of "centres of excellence" for those patients requiring planned or more specialist care. Next steps are to evaluate the feasibility of the options looking at factors such as deliverability, cost and patient benefit. Once complete a case will be presented to the Trust Board in May 2017 who will agree which options to take forward for wider consultation in the summer.

4.7 Following an improvement initiative under the auspice of the Emergency Care Programme Board, the Trust has now transitioned Gallery Wing Ward into a reablement ward targeted at those patients who are medically stable for discharge but whose discharge is delayed. The philosophy of the ward is to ensure the continued reablement of patients whilst they are delayed to ensure that they do not deteriorate whilst awaiting discharge. With this goal in mind, the ward is therapy led and managed by the Division of Diagnostic and Specialities rather than Medicine Division as it was previously. I enjoyed a very positive visit just a week after the ward opened and met staff and patients who were all very positive about the changes. In the first week, the team had discharged 38 patients, with 32 of those patients having a revised (typically less dependent) discharge pathway than originally planned with a number of patients going home who were previously expected to go into a community hospital bed.

4.8 Finally, we are in the final stages of the independent Financial Governance Review. The draft report is undergoing factual accuracy checking with key contributors with a view to the Board receiving the report at its May 2017 and meeting with publication of the findings and recommendations shortly afterwards.

Deborah Lee
Chief Executive Officer

April 2017

All NHS Provider Trust Chief Executives
All CCG Accountable Officers
All CCG Clinical Leaders
Copy to Local Authority Chief Executives

Gateway Reference: 06600

9th March 2017

Dear colleague,

Action to get A&E performance back on track

We are writing to thank you and your staff for your work over what has been a highly pressurised winter, and - following the Chancellor's Budget statement yesterday - to let you know about the action now needed to turnaround A&E performance in 2017. Further detail will be provided in the NHS Delivery Plan being published in three weeks' time.

Throughout this winter, there have been three consistent themes relating to urgent and emergency care: difficulties in discharging inpatients when they are ready to go home; rising demand at A&E departments, with the fragmented nature of out-of-hospital services unable to offer patients adequate alternatives; and complex oversight arrangements between trusts, CCGs and councils.

To avoid a repeat next winter of this past winter, we need to make concrete changes on all three fronts.

Freeing up hospital bed capacity

First, we know that difficulties with discharging emergency inpatients has reduced the effective availability of beds in which to care for both emergency patients presenting in A&E, as well as patients needing planned surgery. It is therefore vital that, together with our partners in local government, we ensure that the extra £1 billion the Chancellor has made available for social care is in part used to free-up in the region of 2000-3000 acute hospital beds. We would ask that you immediately now engage with the senior leadership of your local adult social care departments to discuss how those patients stuck in hospital needing home care or care home places can access those services.

It is also, however, indisputable that there are places which have still not adopted best practice to enable appropriate flow, including better and more timely hand-offs between A&E clinicians and acute physicians, discharge to assess, 'trusted assessor' arrangements, streamlined continuing healthcare processes, and seven day discharge capabilities. You now need to ensure these happen everywhere, and well before October 2017.

Managing A&E demand

Some estimates suggest that between 1.5 and 3 million people who come to A&E each year could have their needs addressed in other parts of the urgent care system. They turn to A&E because they are unclear about the alternatives or are unable to access them.

You therefore now need to:

- Ensure every hospital implements a comprehensive front-door streaming model by October 2017, so that A&E departments are free to care for the most urgent patients. Yesterday's Budget has made available an extra £100 million of capital to be deployed in the next six months to support this. Proposals will need agreement with the Department of Health and we will be letting you know proposed allocations of this within the next six weeks.
- Strengthen support to your Care Homes so as to ensure that they have direct access to clinical advice, including where appropriate on-site assessment. We are making available £30 million to support universal roll-out of this model via 111, in order to reduce the risk of care home residents being admitted to hospital.
- Implement the recommendations of the Ambulance Response Programme by October 2017, freeing up capacity for the service to increase their use of Hear & Treat and See & Treat, thereby conveying patients to hospital only when this is clinically necessary.
- Proceed with the standardisation of Walk-In-Centres, Minor Injury Units and Urgent Care Centres, so that the current confusing array of options is replaced with a single type of centre which offers patients a consistent, high quality service.
- Roll out evening and weekend GP appointments, to 50% of the public by March 2018 and 100% by March 2019.
- Increase the number of 111 calls receiving clinical assessment by a third by March 2018, so that only patients who genuinely need to attend A&E, or use the ambulance service, are advised to do this.

Aligned national support and oversight

Given the national importance of improving NHS urgent and emergency care performance, we intend to simplify the focus of the 30% performance element of the Sustainability and Transformation Fund (STF) for 2017/18, so that it will focus on A&E rather than requiring providers to focus on multiple objectives. For individual trusts it will be linked to effective implementation of the actions set out above as well as achieving performance before or in September that is above 90%, sustaining this, and returning to 95% by March 2018.

In order to ensure complete alignment between NHS England and NHS Improvement in supporting and overseeing urgent implementation of the above actions, we have appointed Pauline Philip as the single national leader accountable to us jointly.

Furthermore, from 1st April we are nominating a single, named Regional Director drawn from NHSI and NHSE to support this implementation work and hold accountable both CCGs and trusts through their local STP's A&E Delivery Boards. Each RD will therefore act with the delegated authority of both NHSI and NHSE in respect of urgent and emergency care.

Thank you for your ongoing leadership on this critical part of what the NHS does for the people of this country.

Yours sincerely

Simon Stevens
CEO, NHS England

Jim Mackey
CEO, NHS Improvement

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST FINANCE COMMITTEE HELD IN THE BOARD ROOM, ALEXANDRA HOUSE, CHELTENHAM GENERAL HOSPITAL ON THURSDAY 23RD FEBRUARY 2017 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		
Stuart Diggles	SD	Interim Director of Finance
Sean Elyan	SE	Medical Director
Dr Claire Feehily	CF	Non-Executive Director
Tony Foster	TF	Non-Executive Director
Deborah Lee	DL	Chief Executive
Keith Norton **(Chair)**	KN	Non-Executive Director
Dave Smith	DS	Director of Human Resources and Organisational Development
Sarah Stansfield	SS	Director of Operational Finance
Natasha Swinscoe	NS	Interim Chief Operating Officer
GOVERNOR REPRESENTATIVE		
Alan Thomas	AT	Lead Governor
APOLOGIES		
Peter Lachecki	PL	Chair of the Trust
IN ATTENDANCE		
Louise Courtier	LC	Corporate Governance Administrator
Neil Jackson	NJ	Director Of Estates & Facilities
Martin Wood	MW	Trust Secretary

The Chair welcomed all to the meeting. In particular, he welcomed Dr Clair Feehily who was attending as a observer prior to taking up her appointment on 1 February 2017.

017/17 DECLARATIONS OF INTEREST **ACTION**

There were none.

018/17 MINUTES OF THE MEETING HELD ON 25th JANUARY 2017

Agreed

019/17 MATTERS ARISING

020/16 FINANCIAL PERFORMANCE REPORT

The Director of Operational Finance has reported to provide an overview of the financial performance of our Trust as at the end of Month 10 of the 2016/17 financial year. It provides the three primary financial statements along with detailed analysis of the variances and movements against the forecast position, including an analysis of movement in the forecast outturn. It also provides a summary of the variance against the planned position to NHS Improvement.

The key points to note were the financial position of our Trust at the end of Month 10 of the 2016/17 financial year is an operational deficit of £17.8m. This is a favourable variance to the forecast position of £0.9m. It also represents an adverse variance to the original NHSI plan of 31.0m. 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 £18.0m against a planned surplus of £18.2, representing a £36.2m adverse variance to the NHSI plan. A negative available cash balance of £2.1m based on borrowing received to date.

The Director of Operational Finance has advised that it is not possible to predict what will be in the unexpected box however he can't see anything obvious that will knock us off plan in month 12.

The stock count is due to be done at the end of the financial year.

Interim Director of Finance has advised he is encouraging staff to report issues sooner so they can be resolved straight away to avoid surprises further down the line.

It has been agreed that the Divisional Leads need to be taking more ownership.

It has been highlighted that this has been a very good month all considered.

ACTION: 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.

RESOLVED: The financial position for M10 shows a favourable variance to forecast of £0.9m, with a significant adverse variance to plan of £31.0m (inclusive of the STF funding for Q1 of the financial year). The forecast assumes no further STF funding is received in 2016/17 and a final forecast outturn of a deficit of £18.0m which represents an adverse variance to planned NHS Improvement control total of £36.2m.

021/17 DELOITTE FINANCIAL REPORTING REVIEW RECOMMENDATIONS

The Finance Director presented the report to update the Finance Committee on the progress to date against the 34 recommendations which resulted from the Deloitte Review: Financial Reporting – Enhancing Transparency dated 17 August 2016.

The key points to note were a further amount of activity in relation to the recommendations has been completed in the last month. The summary

of progress is:

- 0 recommendations not started (1 last month)
- 4 recommendations are in progress (4 last month)
- 30 actions completed (29 last month)

Of the 30 actions completed, 18 can be viewed as now being incorporated as business as usual (BAU).

The first item still in progress relates to payments in relation to GP trainees, the initial meeting held went well with clear understanding of our position, further meeting to be arranged. 2 items in progress relate to the Hereford Radiotherapy Unit, following review last month external legal review has been requested. The final item in progress relates to asset and estate valuation under MEAV-AS which is subject to an external valuation, this valuation work has been awarded following the tender process, valuation work is underway, initial view expected late February 2017.

ACTION: To continue to deliver against these recommendations still requires support from resource which is also required to support other initiatives. External costs for legal advice and valuations will be incurred.

This report is to be circulated to the Council Of Governors. **MW**

RESOLVED: Good progress has continued to be made against the recommendations, especially in relation to those that are stated as being in progress but for which initial pieces of work are completed.

022/17 WORKFORCE UPDATE

The Director of Human Resources and Organisational Development presented the report to provide an overview of the workforce performance of our Trust as at the end of Month 10 of the 2016/17 financial year. It provides information on the continuing overspend on pay (including agency) costs, movements in headcount as well as further information on two of the key drivers of spend, turnover and sickness.

The key points to note were that it is pleasing to see a reduction in the overall paybill between M9 and M10 of £0.47m, building on the previous month's reduction of £0.41m. The paybill is at its lowest level this Financial Year. Agency spend continues to reduce overall and is now at its lowest level since June 2016. Equal focus is being applied between agency expenditure and pay expenditure generally and engagement with staff representatives on key initiatives continues with the support of the CEO. We continue to make inroads into qualified nursing vacancies which are now at 106 WTE, the lowest level for the whole of 2016/2017. The Committee is provided with 4 appendices, 2 of which reflect reporting into the Turnaround Implementation Board and which set out in greater detail the work being undertaken to reduce overall pay expenditure and reduce agency spend, and 2 of which provide more detailed analysis of the relationship between vacancies and agency spend in the Nursing and Medical workforce.

It has been asked if this can be sustained without impact to safety and patient care. The Medical Director has reassured by advising that they are replacing expensive agency staff with more experienced bank staff. Therefore money is being saved and there is a better quality of care for the patients. This will be monitored carefully to ensure patient safety and wellbeing is being put first every time. In the event that the only option is to hire the expensive agency staff then this will be done.

January's figures are much better than expected and the Director of Human Resources and Organisational Development is confident that the VCP is working well to reduce agency spend.

ACTION: The focus on reducing agency use and reducing vacancy levels appears to be having a positive impact and must be maintained and increased. Work to leverage off the experience and operational structures of other organisations in controlling both agency and general pay expenditure is ongoing.

RESOLVED: It is pleasing to see that the increased control regarding pay spend is delivering a sustained reduction in this area. The increased scrutiny of agency use and spend appears to be having an impact with a reduction in the overall spend in this area. This has been largely attributable to the increase in substantive nursing numbers, and we need to ensure that similar traction is developed within the medical and corporate areas in reducing spend.

023/17 REGULATORY REVIEW UPDATE & FINANCIAL RECOVERY PLAN

The Interim Director of Finance has presented the report to update the Finance Committee on our Trusts position under Financial Special Measures (FSM).

The key points to note were this was presented to NHSI on 22 February 2017 by the Chairman, CEO and Interim DoF by using the summary meeting report. This document provides an update on the current status of the FRP and on progress since the prior NHSI FSM meeting in December. The table below is repeated from prior month to show the change to deficit presented.

Deficit £M	**2016/17**	**2017/18**	**2018/19**
FRP submitted 29/11/16	(18.7)	(16.7)	(4.0)
FRP Update	(18.0)	(14.7)	0.0
Improvement	0.7	2.0	4.0

Tim Briggs, Professor of Orthopaedic surgery is to assist our Trust in the delivery of the FRP.

ACTION: To respond to actions following the meeting with NHSI on 22 February 2017.

RESOLVED: Progress under FSM continues to be made; the FRP Update has been submitted to NHSI and reviewed.

024/17 COST IMPROVEMENT PROGRAMME UPDATE

The Interim Finance Director presented the report to provide an overview of the CIP performance for 2016/17 and planning for 2017/18.

The key points to note were the CIP performance at the end of Month 10 is a saving of £5.3m. This is an adverse variance to the FRP plan of £1.4m YTD. This adverse variance has not impacted on the total Trust forecast outturn and as such is an issue of information capture rather than under-delivery. Our Trust continues to work on development of new schemes to bridge the current shortfall in the programme Continuation of the PID QIA process with the Medical and Nurse Director. CIP target for 2017/18 is £31.7m of which £24m currently has a level of maturity and development.

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

RESOLVED: The CIP position for M10 shows an adverse variance to the FRP plan of £1.4m YTD. This adverse variance has not impacted on the total Trust forecast outturn and as such is an issue of information capture rather than under-delivery.

025/17 CAPITAL PROGRAMME UPDATE

The Director of Estates and Facilities presented the report to provide the Finance Committee with an overview of the capital programme progress to date and year end forecast position.

The key points to note were the lengthy programme prioritisation process has led to delayed implementation. Over the longer term delayed spending is creating a growing backlog for buildings and equipment. This is leading to an increased risk of failure from both infrastructure and equipment, increasing the risk of service interruption. Reduction of the in-year programme will increase pressure on the 2017-18 capital budget for works rolling forward into the new year. Expenditure on TrakCare and other IM&T investment now forms more than 40% of the programme; this increased level of investment is likely to continue for up to two more years. Access has continued to be a challenge to enabling improvement works, however good progress on environmental improvement has been made during the lead up to the CQC visit. The 2017-18 capital plan is in the final stages of clarification and is due to be presented to the March Finance Committee.

It has been confirmed that additional funding will be confirm at the end of March / April's meeting.

ACTION: Capital Programme is unlikely to increase in value for some time, therefore prioritisation to maintain a safe environment over service development will be necessary without additional funding being made available or alternative funding models being implemented. Increased IM&T investment will continue to be required over the next 2 years, however this should start to deliver revenue efficiencies once the phase

1.5 of TrakCare is implemented. Our Trust has also been asked to provide further information on the Strategic Transformation Programme (STP) proposal for service reconfiguration. We await news as to the success of the bid for major capital investment.

RESOLVED: The 2016-17 capital programme is in progress. Flexibility is now reducing to adjust the programme . However the Target outturn of approx. £12.6m will not be exceeded. This has been achieved in part by delaying items until 2017/18 thereby increasing 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.

026/17 BUDGET SETTING PRINCIPALS APPROACH & PROGRESS 2017/ 18

The Director of Operational Finance presented the report to provide the Committee with an outline of the budgeting framework and principles to be applied as part of the 2017/18 budget setting and planning cycle, an outline of the responsibilities of budget managers regarding budget setting and management and an update on progress to date.

The key points to note were In developing the approach and principles being applied to the budgeting process particular attention has been paid to ensuring that the significant historic shortcomings in budgeting are not repeated. The approach draws upon experience and good practice that has been used in other organisations. A detailed set of planning assumptions have been applied to the plan as submitted to NHSI. These appropriately reflect consideration of national guidelines and a view of local pressures and circumstances. They are also consistent with the principles outlined throughout this paper.

ACTION: Budget proposals will be reviewed in detail with Finance Business Partners to ensure consistency and identify areas for further confirmation/challenge with Divisional teams. This process will be completed in March so that budget proposals can be submitted for Executive Review prior to presentation to Finance Committee in March.

RESOLVED: The Committee is asked to note the approach being taken for budget setting for 2017/18, principles being applied, involvement of Divisional management in the process and progress to date.

027/17 FINANCE DEPARTMENT – PROPOSED RESTRUCTURE

The Director of Operational Finance Director presented the report providing an outline to the proposal to restructure our Trust's internal finance function to provide a high quality, robust support service to the Trust.

The key point to note were that the changes proposed aim to:

- Cover the contracting portfolio transferring from clinical strategy to finance on 1st April 2017
- Strengthen senior accountability across the functional areas
- Strengthen financial governance

ACTION: The structure will need to go out for 30 days of consultation (suggested early March 2017). Implementation will then proceed in line with the Trust's Organisational Change policy.

RESOLVED: The proposed structure strengthens management arrangements within the finance function and provides significantly improved support for the Trust.

028/17 FINANCE RISK REGISTER

This report was not yet available to view. This item will remain on the agenda as a reoccurring item and is to be reported to the Committee within the next few months.

029/17 FINANCE COMMITTEE WORK PLAN

The capital programme will be split between Quality & Performance Committee & Finance Committee. This is to be discussed between the chairs. **CF / KN**

030/17 MATTERS TO BE ESCALTED TO THE BOARD

None to note.

031/17 COMMITTEE REFLECTION

- CIP – Methodology. SOP to be brought forward.
- TrackCare – Assume the report to be available from the 1st of April to ensure this is earning money again.

032/17 PAPERS TO BE CIRCULATED TO GOVERNORS

Deloitte Financial Reporting Review Recommendations **MW**

034/17 ANY OTHER BUSINESS

None to note.

035/17 DATE OF THE NEXT MEETING

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Finance Committee will be held on **Wednesday 29th March 2017** in the **Board Room, Alexandra House, Cheltenham General Hospital at 9AM.**
Papers for the next meeting:

Completed papers for the next meeting are to be logged with the Trust Secretary no later than 3pm on **Monday 20th March 2017**.

Chair
29th March 2017

MAIN BOARD – APRIL 2017

Report Title
Performance Management Framework
Sponsor and Author(s)
Natasha Swinscoe, Chief Operating Officer
Executive Summary

Purpose

This report summarises the key highlights and exceptions in Trust performance up until the end of February 2017 for the financial year 2016/17.

Key issues to note

- This month the Trust has not met any of the four national waiting trajectories for A&E 4 hour wait, 62 day cancer standard, 18 week referral to treatment (RTT) standard or 6 week diagnostic wait. The Trust has met the 2 week wait standard.
- A&E 4 hour performance was 77% in February. The Trust welcomed the Emergency Care Intensive Support Team on 6th and 7th March and is now working through their initial follow up report. ECIST have offered to continue to support the Trust for 1-2 days per month.
- The Trust met the 2 week wait cancer target in February achieving 94.7% against the target of 93%. Unvalidated 31 days performance has also improved in February.
- In respect of RTT, concerns regarding data quality, following the migration to TrakCare, resulted in a decision to cease RTT reporting until the quality of data can be assured. Work to resolve this issue is still underway. The Trust appointed an RTT specialist who commenced work in late February. A team of data entry staff are inputting the referral backlogs, after which point the Trust should be able to commence reporting. Regular fortnightly oversight meetings continue with Gloucestershire CCG, NHSI and NHSE to monitor recovery.
- The Trust did not meet the diagnostics target in February, mainly driven by underperformance in echocardiology with 47 breaches.
- The Trust reported seven 52 week breaches in February. These patients were all treated in March.

Conclusions

Significant focus continues in order to improve performance against the national standards. Clinical oversight of patients awaiting care continues to ensure that no patients come to harm due to delays in their treatment.

Implications and Future Action Required

Delivery of agreed action plans is critical to restore performance back to the minimum expected standards.

Recommendations
The Trust Board is requested to receive the Integrated Performance Framework Report as assurance that the executive team and Divisions are appropriately focussed on improving current poor levels of performance.
Impact Upon Strategic Objectives
Current performance jeopardises delivery of the Trust's strategic objective to improve the quality of care for our patients

Impact Upon Corporate Risks
Continued poor performance in delivery of the four national waiting time standards ensures the Trust remains under scrutiny by local commissioners and regulators
Regulatory and/or Legal Implications
The Trust remains under regulatory intervention for the A&E 4-hour standard.
Equality & Patient Impact
Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	
No change.			

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

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

Gloucestershire Hospitals NHS
NHS Foundation Trust

PERFORMANCE MANAGEMENT FRAMEWORK

2016/17

THIS PAGE IS LEFT INTENTIONALLY BLANK

ASSESSMENT AGAINST THE NHS IMPROVEMENT RISK ASSESSMENT FRAMEWORK

		2014/15				2015/16				2016/17													
	Target	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	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%	90.7%	*	92.1%	92.0%	92.0%	90.9%	90.9%	90.2%	89.9%	87.0%	*	*	*	1.0
ED																								
% patients spending 4 hours or less in ED	95%	93.3%	94.3%	89.5%	82.7%	93.4%	89.7%	85.6%	78.5%	86.7%	88.5%	82.3%	85.4%	87.4%	87.1%	86.3%	90.9%	88.9%	86.38%	86.62%	73.86%	74.69%	77.00%	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%	76.9%	78.2%	77.4%	81.2%	73.6%	79.0%	76.8%	72.9%	72.9%	72.0%	62.7%	69.3%	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%	96.0%	91.7%	84.6%	95.0%	100%	89.9%	100%	86%	97.0%	100.0%	82.8%	92.3%	
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%	90.7%	98.1%	100%	100%	98.1%	100%	100%	100%	89.4%	83.7%	84.2%	97.0%	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%	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%	98.3%	99.5%	100%	100%	100%	100%	100%	98.3%	100%	100%	95.0%	98.4%	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%	94.9%	98.6%	99.6%	99.0%	99.2%	99.7%	98.8%	98.8%	93.8%	94.1%	90.1%	93.9%	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%	91.7%	77.7%	86.5%	90.3%	89.9%	86.2%	88.6%	89.0%	93.5%	92.6%	85.1%	94.7%	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%	92.0%	94.6%	94.3%	90.5%	91.2%	93.4%	96.4%	95.7%	92.5%	88.3%	89.4%	95.0%	
INFECTION CONTROL																								
Number of Clostridium Difficile (C-Diff) infections - post 48 hours	37/yr	9	6	8	13	8	10	10	13	10	10	7	5	3	2	5	1	4	1	4	2	7	0	0.0

In month position, therefore figure not validated

* Due to the implementation of a new EPR system we are currently unable to report on this data

PERFORMANCE MONITORING AGAINST THE SUSTAINABILITY AND TRANSFORMATION PLAN

2016/17

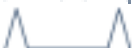
		Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4
ED																	
% patients spending 4 hours or less in ED	Trajectory	80.00%	85.00%	85.00%	83.50%	87.00%	87.00%	91.90%	88.50%	89.10%	91.20%	85.70%	88.70%	85.10%	80.10%	89.60%	85.19%
	Actual	85.38%	87.41%	87.06%	86.90%	86.00%	90.66%	88.94%	88.48%	86.04%	86.62%	73.86%	82.30%	74.69%	77.00%		
% 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%	87.07%	74.57%	82.81%	75.40%	77.60%		
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%	89.90%	86.96%	*	*	*	*		
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%	0.90%	*	*	1.18%	1.79%		
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%	72.9%	79.2%	72.0%	76.9%	62.7%	69.3%		
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%	76.8%	71.3%	72.9%	79.2%	72.0%	76.9%	62.7%	69.3%		

In month position, therefore figure not validated.

* Due to the implementation of a new EPR system we are currently unable to report on this data

TRUST PERFORMANCE & EXCEPTIONS (as at end February 2017)

SAFETY

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q3	Q4	2016/17 Q1	Q2	Q3	Dec	Jan	Feb	FORECAST Mar	Apr	May	Jun	Jul	Aug	FoT	Standard	Target Set By	How often	Data Month
INFECTION																				
Number of Clostridium Difficile (C-Diff) infections - post 48 hours		10	13	10	10	7	2	7	0	3	TBC	TBC	TBC	TBC	TBC		37 cases/year	NHSI	M	Feb
Number of Methicillin-Resistant Staphylococcus Aureus (MRSA) infections - post 48 hours		2	1	1	0	0	0	1	0	0	TBC	TBC	TBC	TBC	TBC		0	GCCG	M	Feb
MORTALITY																				
Crude Mortality rates %		1.2%	1.4%	1.2%	1.1%	*	*	*	*	1.2%	TBC	TBC	TBC	TBC	TBC		<2%	Trust	M	Nov
Summary Hospital-Level Mortality Indicator		110.7	113.2	112.4	arrears	arrears	arrears	arrears	arrears	TBC	TBC	TBC	TBC	TBC	TBC		≤1.1%	Trust	Q	Jun
HSMR (Analysis-relative risk-basket HSMR basket of 56-mortality in hospital) (rolling 12 months)		107.5	106.8	108.0	111.8	arrears	arrears	arrears	arrears	TBC	TBC	TBC	TBC	TBC	TBC		Confidence interval	Dr Foster	M	Nov
SMR (rolling 12 months)		108.0	110.2	112.3	118.2	arrears	arrears	arrears	arrears	TBC	TBC	TBC	TBC	TBC	TBC		Confidence interval	Dr Foster	M	Nov
SAFETY																				
Number of Never Events		1	0	0	1	1	0	0	0	0	TBC	TBC	TBC	TBC	TBC		0	GCCG	M	Feb
% women seen by midwife by 12 weeks		90.0%	89.6%	87.2%	92.3%	*	*	*	*	90.0%	TBC	TBC	TBC	TBC	TBC		>90%	GCCG	M	Nov
CQUINS																				
Acute Kidney Infection (AKI)		29%	50%	42%	60%	64%	69%	78%	59%	55.0%	TBC	TBC	TBC	TBC	TBC		>90% by Q4	National	M	Jan
Sepsis Screening 2a		96%	92%	96%	97%	97%	96%	94%	arrears	90%	TBC	TBC	TBC	TBC	TBC		>90% of eligibles	National	M	Dec
Sepsis Antibiotic Administration 2b		43%	49%	55%	45%	64%	69%	arrears	arrears	90%	TBC	TBC	TBC	TBC	TBC		>90% of eligibles	National	M	Dec
Dementia - Seek/Assess		88.8%	86.3%	88.1%	88.3%	*	*	*	*	90%	TBC	TBC	TBC	TBC	TBC		Q1>86%; Q2>87%; Q3>88%; Q4>90%	National	M	Nov
Dementia - Investigate		100%	100%	100%	100%	*	*	*	*	100%	TBC	TBC	TBC	TBC	TBC		Q1>86%; Q2>87%; Q3>88%; Q4>90%	National	M	Nov
Dementia - Refer		100%	100%	100%	100%	*	*	*	*	100%	TBC	TBC	TBC	TBC	TBC		Q1>86%; Q2>87%; Q3>88%; Q4>90%	National	M	Nov
ED																				
% patients triaged in ED in 15 minutes		57.9%	53.7%	75.3%	78.6%	*	*	*	*	TBC	TBC	TBC	TBC	TBC	TBC		≥ 99%	Trust	M	Nov
% patients assessed by doctor in ED in 60 minutes		44.7%	43.3%	47.1%	46.0%	*	*	*	*	TBC	TBC	TBC	TBC	TBC	TBC		≥ 90%	Trust	M	Nov

* Due to the implementation of a new EPR system we are currently unable to report on this data

In month position, therefore figure not validated.

TRUST PERFORMANCE & EXCEPTIONS (as at end February 2017)

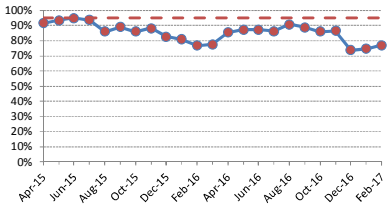
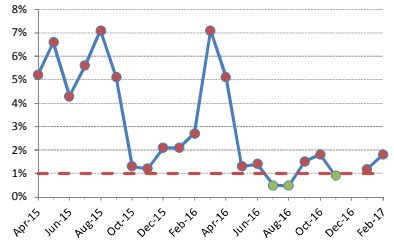
RESPONSIVE

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q3	Q4	2016/17 Q1	Q2	Q3	Dec	Jan	Feb	FORECAST Mar	Apr	May	Jun	Jul	Aug	FoT	Standard	Target Set By	How often	Data Month
ED																				
% patients spending 4 hours or less in ED		85.6%	78.5%	86.9%	88.5%	82.4%	73.9%	74.7%	77.0%	89.6%	TBC	TBC	TBC	TBC	TBC		≥ 95%	NHSI	M	Feb
Number of ambulance handovers delayed over 30 minutes		241	428	517	541	*	*	*	*	90	TBC	TBC	TBC	TBC	TBC		< previous year	GCCG	M	Nov
Number of ambulance handovers delayed over 60 minutes		28	33	3 **	1	*	*	*	*	9	TBC	TBC	TBC	TBC	TBC		< previous year	GCCG	M	Nov
18 WEEKS																				
Incomplete pathways - % waited under 18 weeks		92.2%	92.0%	92.0%	90.7%	*	*	*	*	92.0%	TBC	TBC	TBC	TBC	TBC		≥ 92%	NHSI	M	Nov
15 key Diagnostic tests : % waiting over 6 weeks at month end		1.5%	4.0%	2.6%	0.8%	*	*	1.18%	1.79%	1.0%	TBC	TBC	TBC	TBC	TBC		<1% waiting at month end	GCCG	M	Feb
Planned/surveillance endoscopy patients - nos. waiting at month end with and without dates		142	225	441	405	*	*	*	*	100	TBC	TBC	TBC	TBC	TBC		< 1% waiting at month end	GCCG	M	Nov
CANCER																				
Max 2 week wait for patients urgently referred by GP %		92.4%	88.7%	84.9%	88.2%	91.7%	92.6%	85.1%	94.7%	92.0%	TBC	TBC	TBC	TBC	TBC		≥ 93%	NHSI	M	Jan
Max 2 week wait for patients referred with non cancer breast symptoms %		93.4%	95.3%	93.1%	93.7%	92.0%	88.3%	89.4%	95.0%	94.0%	TBC	TBC	TBC	TBC	TBC		≥ 93%	NHSI	M	Jan
Max wait 31 days decision to treat to treatment %		100%	99.8%	99.1%	99.2%	94.9%	94.1%	90.1%	93.9%	100%	TBC	TBC	TBC	TBC	TBC		≥ 96%	NHSI	M	Jan
Max wait 31 days decision to treat to subsequent treatment : surgery %		99.5%	99.5%	99.4%	99.4%	90.7%	83.7%	84.2%	97.0%	100%	TBC	TBC	TBC	TBC	TBC		≥ 94%	NHSI	M	Jan
Max wait 31 days decision to treat to subsequent treatment : drugs %		100%	100%	100%	100%	100%	100%	100%	100%	100%	TBC	TBC	TBC	TBC	TBC		≥ 98%	NHSI	M	Jan
Max wait 31 days decision to treat to subsequent treatment : Radiotherapy %		100%	100%	100%	99.5%	99.5%	95.0%	98.4%	100%	100%	TBC	TBC	TBC	TBC	TBC		≥ 94%	NHSI	M	Jan
Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) %		79.5%	76.7%	79.0%	76.9%	76.9%	72.0%	62.7%	69.3%	85.0%	TBC	TBC	TBC	TBC	TBC		≥ 85%	NHSI	M	Jan
Max wait 62 days from national screening programme to 1st treatment %		95.6%	94.9%	90.6%	96.0%	96.0%	100.0%	82.8%	92.3%	92.0%	TBC	TBC	TBC	TBC	TBC		≥ 90%	NHSI	M	Jan
Max wait 62 days from consultant upgrade to 1st treatment %		100%	100%	100%	71.4%	71.4%	-	100.0%	-	100%	TBC	TBC	TBC	TBC	TBC		≥ 90%	NHSI	M	Jan

* Due to the implementation of a new EPR system we are currently unable to report on this data

In month position, therefore figure not validated.

RESPONSIVE

MEASURE		QUARTERLY PROGRESS Q4	Q1	Q2	Q3	NOW	FOT	OWNER
% patients spending 4 hours or less in ED Standard is ≥95%								Chief Operating Officer
15 key Diagnostic tests : % waiting over 6 weeks at month end Standard is < 1%								Chief Operating Officer

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

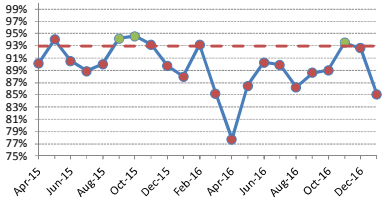
Please refer to Emergency Pathway Report. Recovery plan in place to improve performance in line with the agreed trajectory.

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

112 patients, of which: 47 cardiology, 40 audiology, 12 gastroscopy, 10 colonoscopy, 2 sleep studies, 1 urodynamics.

RESPONSIVE

MEASURE	QUARTERLY PROGRESS						OWNER
	Q4	Q1	Q2	Q3	NOW	FOT	
Max 2 week wait for patients urgently referred by GP							Chief Operating Officer
Standard is ≥93%							



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

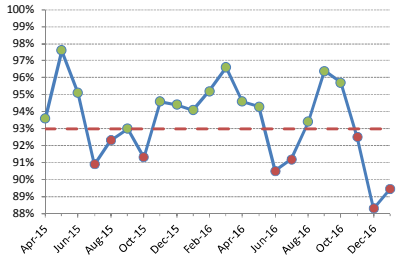
January 2017's performance now validated as 85.0%. The under-performance against this standard and the trajectory of 93% is primarily due to Trakcare operational issues following implementation on the 3rd December 2016. There were 210 breaches in January - predominantly in the first two weeks due to difficulties in flexing OP clinic capacity to meet demand due to the lack of visibility of vacant clinic slots; which was also compounded with the cancer tracking system Infoflex going down for a week. These issues have now been addressed and all patients are now being offered an appointment within 2 weeks and delivery of the standard is being met from February 2017.

The Trust had developed an action plan and a trajectory to recover the 2WW performance by 31st October 2016, which had been shared with Gloucestershire CCG, NHS England and NHS Improvement and it had been approved. This has since been updated to achieve and sustain 2WW performance by February 2017, this was received by Quality and Performance in December 2016.

		November 2016			December 2016			Q3 2016/17	January 2017			February 2017			Average first seen / month (rolling 12 months)
	Target	Latest Position	Breaches	Date First Seen	Latest Position	Breaches	Date First Seen		Latest Position	Breaches	Date First Seen	Latest Position	Breaches	Date First Seen	
	93%	93.4%	119	1829	92.5%	116	1550	91.6%	85.0%	210	1401	94.7%	70	1321	1647
Brain / CNS		90.0%	3	30	95.8%	1	24	93.5%	73.3%	4	15	94.1%	1	17	22
Breast		96.7%	8	246	93.0%	18	258	95.4%	93.6%	18	283	97.7%	6	262	258
Gynaecological		97.4%	4	159	100.0%	0	102	98.4%	98.7%	1	79	98.2%	2	113	121
Haematological*		100.0%	0	16	100.0%	0	17	92.0%	100.0%	0	9	87.5%	1	8	13
Head & Neck		94.6%	10	188	95.2%	8	168	93.6%	98.6%	1	73	98.6%	1	72	161
Lower GI		96.5%	11	315	94.1%	16	275	94.5%	73.8%	59	226	93.6%	11	174	299
Lung		98.0%	1	51	95.7%	2	47	97.7%	97.5%	1	41	92.0%	4	50	46
Skin		93.8%	24	390	96.3%	9	249	93.2%	87.8%	30	246	100.0%	0	228	323
Testicular		88.2%	2	17	92.3%	1	13	80.7%	83.3%	4	24	93.3%	1	15	17
Upper GI		86.1%	30	217	84.8%	33	218	84.0%	81.2%	34	181	85.7%	25	175	187
Urological		87.0%	26	200	84.3%	28	179	81.5%	74.1%	58	224	91.3%	18	207	199

* Excludes acute leukaemia

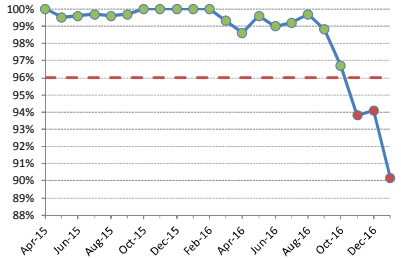
RESPONSIVE

MEASURE		QUARTERLY PROGRESS Q4	Q1	Q2	Q3	NOW	FOT	OWNER
Max 2 week wait for patients referred with non cancer breast symptoms Standard is ≥93%								Chief Operating Officer

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

January's final position was 89.4% against a target of 93%. There were 19 breaches, 10 of which were due to patient choice. The remaining 9 breaches were due to clinic capacity due to the Trakcare operational issues described above. These issues continued into the first half of January, but they have now been resolved and the standard is now being met.

Max 31 days decision to treat to treatment
Standard is ≥96%



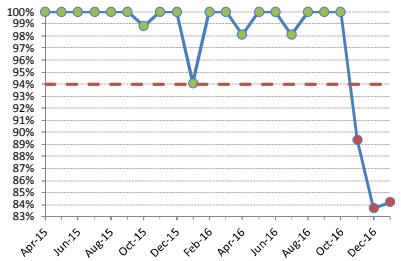
Chief Operating Officer

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

There were 29 breaches in January, giving a performance of 90.3% (against a target of 96%). 25 of these breaches were due to elective capacity, mainly in urology.

Actions are included in the wider Cancer Waiting Times recovery plan, but specifically in Urology:
- Additional consultant capacity is now in place and will start to have an impact
- The service is moving to generic pre-assessment – although this has been delayed
- The Urology admissions team is now in post and having a positive impact
- The pooling of theatre lists has begun and is ongoing

Max wait 31 days decision to treat to subsequent treatment : surgery %
Standard is ≥94%



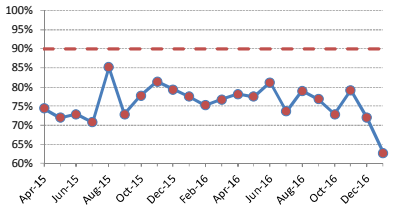
Chief Operating Officer

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

The performance for January was 84.2% against a target of 94%, due to surgical capacity. 27 of the 29 breaches above were surgical. Please see Max 31 days decision to treat for actions.

RESPONSIVE

MEASURE	QUARTERLY PROGRESS Q4	Q1	Q2	Q3	NOW	FOT	OWNER
Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) % Standard is ≥90%	🔴	🔴	🔴	🔴	🔴	🔴	Chief Operating Officer



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

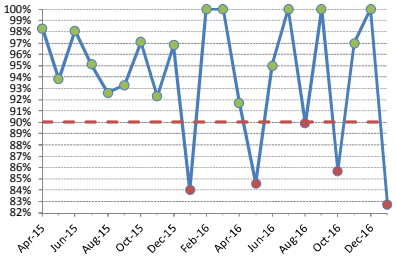
January's validated position is 63.3%, against a standard of 85% and against a trajectory of 80.5%. There were 9 fewer treatments than projected (147.5 as opposed to 156.5) and 23.5 more breaches than projected (54 as opposed to 30.5). Many of these breaches were the result of backlog clearance, particularly in Urology. The number of patients >62 days as at 10/3/17 is at its lowest since the revised recovery commenced at 175 (286 2/1/17) and 42 patients >104 days (70 2/1/17).

The Trust had developed an action plan and a trajectory to recover the 62 day performance by 31st January 2017. This plan has been revised in light of the Trakcare operational issues and delays in implementing multi-assessment and diagnostic clinics in Urology. The trajectory now shows recovery from April 2017. This plan has been shared with Gloucestershire CCG, NHS England and NHS Improvement and it has been approved. All Trakcare operational issues are being addressed, but remains a risk to recovery as well as the delivery of the full urology recovery to plan to timescale.

		November 2016			December 2016			Q3 2016/17	January 2017			February 2017			Average treatments / month
	Target	Latest Position	Breaches	Treatments	Latest Position	Breaches	Treatments		Latest Position	Breaches	Treatments	Latest Position	Breaches	Treatments	
	85%	81.1%	36	191	73.2%	40	147.5	75.9%	63.3%	54	147.5	68.9%	42	133.5	158
Breast		100.0%	0	23.5	95.0%	1	20	98.3%	100.0%	0	24.5	100.0%	0	23	24
Gynaecological		87.5%	1	8	61.5%	5	13	69.8%	64.7%	3	8.5	62.5%	3	8	11
Haematological*		46.6%	8	15	100.0%	0	8	61.9%	50.0%	5	10	35.7%	4.5	7	9
Head & Neck		88.8%	1	9	66.6%	1	3	75.0%	50.0%	1	2	60.0%	3	7.5	6
Lower GI		89.3%	2.5	23.5	76.1%	5	21	85.0%	62.5%	7.5	20	76.0%	3	12.5	17
Lung		83.8%	2.5	15.5	76.6%	3.5	15	74.4%	76.0%	3	12.5	65.6%	5.5	16	13
Other		50.0%	1.5	3	0.0%	1	1	58.3%	0.0%	2	2	0.0%	0.5	0.5	2
Sarcomas		100.0%	0	1		0	0	100.0%		0	0		0	0	1
Skin		100.0%	0	39	100.0%	0	22	98.8%	94.4%	1	18	94.4%	1	18	30
Upper GI		100.0%	0	13	70.8%	3.5	12	86.9%	68.0%	4	12.5	88.8%	1.5	13.5	13
Urological		51.8%	19.5	40.5	40.0%	19.5	32.5	44.4%	26.6%	27.5	37.5	29.0%	19.5	27.5	32

* Excludes acute leukaemia

Max wait 62 days from national screening programme to 1st treatment % Standard is ≥90%	🟢	🟢	🟢	🟢	🔴	🟢	Chief Operating Officer



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

January's performance is 82.8% against a target of 90% (29 patients treated and 5 breaches). 2 of the breaches were due to elective capacity (1x breast and 1x colorectal). 2 of the breaches were due to complex diagnostic pathways and 1 was due to patient choice. Performance for February is currently above target.

TRUST PERFORMANCE & EXCEPTIONS (as at end February 2017)

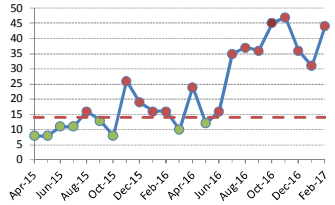
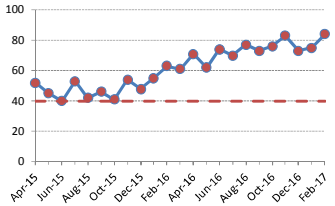
EFFECTIVE

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q3	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3	Dec	Jan	Feb	FORECAST Mar	Apr	May	Jun	Jul	Aug	FoT	Standard	Target Set By	How often	Data Month
CLINICAL OPERATION																				
% stroke patients spending 90% of time on stroke ward		91.4%	86.0%	85.1%	90.0%	88.6%	84.3%	83.6%	arrears	82.0%	TBC	TBC	TBC	TBC	TBC		> 80%	GCCG	M	Jan
% of eligible patients with VTE risk assessment		94.2%	93.7%	93.6%	93.7%	*	*	*	*	93.0%	TBC	TBC	TBC	TBC	TBC		> 95%	GCCG	M	Nov
Emergency re-admissions within 30 days - following an elective or emergency spell		6.1%	6.4%	6.7%	6.5%	*	*	*	arrears	6.4%	TBC	TBC	TBC	TBC	TBC		Q1<6%; Q2<5.8%; Q3<5.6%; Q4<5.4%	Trust	M	Oct
Number of Breaches of Mixed sex accommodation		17	30	19	9	5	0	3	0	0	TBC	TBC	TBC	TBC	TBC		0	GCCG	M	Feb
Number of delayed discharges at month end (DTOCs)		19	10	16	36	36	36	31	44	16	TBC	TBC	TBC	TBC	TBC		<14	Trust	M	Feb
No. of medically fit patients - over/day		48	60	69	73	73	73	75	84	40	TBC	TBC	TBC	TBC	TBC		≤ 40	Trust	M	Feb
Bed days occupied by medically fit patients		1,457	1,791	2,086	2,252	2,376	2,271	2,330	2,342	1,450	TBC	TBC	TBC	TBC	TBC		None	Trust	M	Feb
Patient Discharge Summaries sent to GP within 24 hours		88.6%	85.6%	85.7%	88.3%	*	*	*	arrears	88.5%	TBC	TBC	TBC	TBC	TBC		≥85%	GCCG	M	Nov
BUSINESS OPERATION																				
Elective Patients cancelled on day of surgery for a non medical reason		1.3%	2.0%	1.6%	1.6%	*	*	*	*	TBC	TBC	TBC	TBC	TBC	TBC		≤ 0.8%	Trust	M	Nov
Patients cancelled and not rebooked in 28 days		15	27	35	10	*	*	*	*	TBC	TBC	TBC	TBC	TBC	TBC		0	GCCG	M	Nov
GP referrals year to date - within 2.5% of previous year		2.9%	3.7%	7.9%	5.1%	*	*	*	*	TBC	TBC	TBC	TBC	TBC	TBC		range +2.5% to -2.5%	Trust	M	Nov
Elective spells year to date - within 2.5% of plan		5.0%	7.3%	4.9%	1.6%	*	*	*	*	1.0%	TBC	TBC	TBC	TBC	TBC		range ≥-1% to plan	Trust	M	Nov
Emergency Spells year to date - within 2.5% of plan		6.9%	7.1%	7.7%	3.8%	*	*	*	*	1.0%	TBC	TBC	TBC	TBC	TBC		range ≤2.5% over plan	Trust	M	Nov
LOS for general and acute non elective spells		5.7	6.0	5.9	5.8	*	*	*	*	5.4	TBC	TBC	TBC	TBC	TBC		Q1 /Q2 <5.4days, Q3 /Q4 <5.8days	Trust	M	Nov
LOS for general and acute elective IP spells		3.6	3.6	3.3	3.7	*	*	*	*	3.6	TBC	TBC	TBC	TBC	TBC		≤ 3.4 days	Trust	M	Nov
OP attendance & procedures year to date - within 2.5% of plan		0.6%		0.5%	-1.5%	*	*	*	*	0.2%	TBC	TBC	TBC	TBC	TBC		range +2.5% to -2.5%	Trust	M	Nov
Records submitted nationally with valid GP code (%)		100%	99.9%	99.9%	100%	arrears	100%	arrears	arrears	100%	TBC	TBC	TBC	TBC	TBC		≥ 99%	Trust	M	Dec
Records submitted nationally with valid NHS number (%)		99.7%	99.8%	99.8%	99.8%	arrears	99.8%	arrears	arrears	99.6%	TBC	TBC	TBC	TBC	TBC		≥ 99%	Trust	M	Dec

* Due to the implementation of a new EPR system we are currently unable to report on this data

In month position, therefore figure not validated.

EFFECTIVE

MEASURE		QUARTERLY PROGRESS Q4	Q1	Q2	Q3	NOW	FOT	OWNER
Number of delayed discharges at month end (DTOCs) **Standard is <14**								Chief Operating Officer
No. of medically fit patients - over/day **Standard is <40**								Chief Operating Officer

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

Please refer to Emergency Care Report.

There were 1,886 beddays lost due to Delayed Transfers of Care in February 2017. Following the high numbers in February the March numbers are much improved and continue to come down each day.

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

Please refer to Emergency Care Report.

The main issue driving the medically fit is access to domiciliary care. Alternative options are being explored with the CCG primarily around pathway 1 for Discharge to Assess. In addition the new medically fit ward is operational now which will be a pull model for the community services.

There were 2,342 beddays lost due to medically fit patients in February 2017.

TRUST PERFORMANCE & EXCEPTIONS (as at end February 2017)

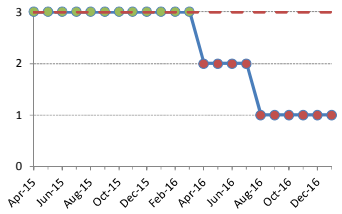
WELL LED

MEASURE	LAST 12 MTHS	ACTUAL 2015/16 Q3	Q4	2016/17 Q1	Q2	Q3	Dec	Jan	Feb	FORECAST Mar	Apr	May	Jun	Jul	Aug	FoT	Standard	Target Set By	How often	Data Month
FINANCIAL HEALTH																				
NHSI Financial Risk Rating (YTD)		3	3	2	1	1	1	1	arrears	TBC	TBC	TBC	TBC	TBC	TBC		Level 3	NHSI	M	Jan
Achieve planned Income & Expenditure position at year end		-£1.6m	-£1.6m	£18.2m	-£23.8	-£18.0	-£18.0	-£18.0	arrears	TBC	TBC	TBC	TBC	TBC	TBC		Achieved or better at year end	NHSI	M	Jan
Total PayBill Spend (£K)		£78.0m	£78.7m	£82.1m	£83.1m	£83.3m	£27.45m	£26.99m	arrears	TBC	TBC	TBC	TBC	TBC	TBC		Target + 0.5%	Trust	M	Jan
Total worked WTE		7,098	7,153	7,121	7,299	7,200	7,200	7,238	arrears	TBC	TBC	TBC	TBC	TBC	TBC		Target + 0.5%	Trust	M	Jan
WORKFORCE HEALTH																				
Annual sickness absence rate (%)		3.8%	3.8%	3.8%	3.8%	3.9%	3.9%	3.9%	3.9%	3.8	TBC	TBC	TBC	TBC	TBC		green < 3.6% red >4%	Trust	M	Jan
Turnover rate (FTE)		11.1%	11.7%	11.6%	11.5%	11.7%	11.7%	11.8%	11.9%	11.7	TBC	TBC	TBC	TBC	TBC		7.5-9.5%	Trust	M	Jan
Staff who have annual appraisal (%)		83%	83%	83%	80%	80%	80%	80%	82%	85.0	TBC	TBC	TBC	TBC	TBC		green >89% red < 80%	Trust	M	Feb
Staff having well structured appraisals in last 12 months (staff survey, on a 5 point scale)		38%	38%	3.0	3.0	3.0	3.0	3.0	3.0	3.1	TBC	TBC	TBC	TBC	TBC		> 3.8	Trust	A	Feb
Staff who completed mandatory training (%)		91%	91%	92%	92%	90%	89%	89%	89%	91.0	TBC	TBC	TBC	TBC	TBC		> 90%	Trust	M	Feb
Staff Engagement indicator (measured by the annual staff survey on a 5 point scale)		3.66	3.69	3.71	3.71	3.71	3.71	3.71	3.71	3.8	TBC	TBC	TBC	TBC	TBC		> 3.8	Trust	A	Feb
Improve communication between senior managers & staff (staff survey) (%)		35%	34%	34%	34%	34%	34%	34%	34%	34.0	TBC	TBC	TBC	TBC	TBC		> 38%	Trust	A	Feb

* Due to the implementation of a new EPR system we are currently unable to report on this data

In month position, therefore figure not validated.

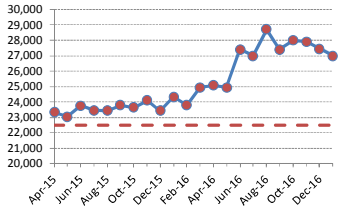
WELL LED

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

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

Please refer to the Trust Finance report for a full explanation of the drivers of the Trust financial performance.

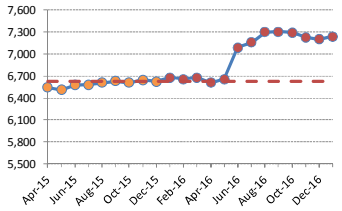
February data not yet available.

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

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

The Trust total PayBill for January is £27.0m. This is a reduction of £500k on the previous month.

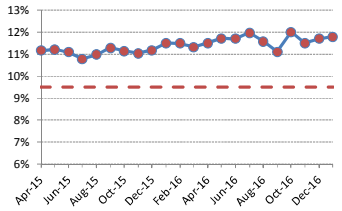
February data not yet available.

Total worked WTE Standard is Target + 0.5%								Chief Operating Officer

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

The Worked WTEs reflects the Trust Total which includes Hosted GP Services and Shared Services. This is consistent with reporting within the NHS Improvement plan and total reported pay bill in table above.

February data not yet available.

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

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

Within Nursing a target of 10 FTE leavers per month has been set for 2017/18, which represents an improvement in retention of 15.18%. The HR & Workforce teams are working hard to ensure that staff reasons for leaving are understood, and where possible, addressed.
In addition, efforts are being made to enhance our employment offering to improve retention levels, particularly through focusing on flexibility and career development.

Report Title
TRUST RISK REGISTER
Sponsor and Author(s)
Sponsor Ms Deborah Lee - Chief Executive
Executive Summary

Purpose

The purpose of this report is to present the Trust Risk Register (TRR) to the Board so they can be assured that the Executive has oversight of all significant risks within the organisation which have the potential to affect patient safety, care quality, workforce, finance, business, reputation or statutory matters and that there is evidence that these risks are being actively controlled wherever possible and that actions to mitigate or eliminate the risk are also being taken.

Key issues to note

- The revised process which requires all Trust Risks to be accepted onto the TRR through the Trust Leadership Team is now bedding in.
- There are a remaining 23 risks which are rated 15 or above within Divisional Risk Registers that TLT still needs to review for consideration of entry to the RTT. Chiefs of Service are required to complete this work by the end of April to enable sign off at May TLT. Corporate review of these risks indicates very few will remain rated at 15 or above.
- The Quality & Performance Committee has accepted the recommendation from the Trust Leadership Team that safety risks of 12 will also be included on the Trust Risk Register reflecting the Board's risk appetite i.e. least tolerance for safety risks. There are presently 55 safety risks on Divisional registers, however it is expected that a significant proportion of these will be de-escalated following executive review and reassessment.
- Three additional risks have been added to the Trust Risk Register since the last reporting period these are:

M2473 Risk of poor patient experience in Gloucestershire Royal Hospital Emergency Department, during times of peak activity.

DSP2401 Risk that patients requiring insertion of a gastrostomy tube (device to aid the delivery of nutrition direct to the gut) receive poor quality care due delays in receiving timely and comprehensive dietetic support.

This creates a total of 7 current risks (appendix 1)

Conclusions

The 7 risks on the Trust Risk Register have active controls to mitigate the impact or likelihood of occurrence, alongside actions aimed at significantly reducing or ideally, eliminating the risk.

Implications and Future Action Required

To continue the development of the risk management process and specifically conclude the review of outstanding Divisional risks 15+ and all safety risks of 12.

Recommendations
To receive this report as assurance that the Trust's major risks are being activity controlled and plans

are in place to reduce the likelihood of occurrence or impact.
Impact Upon Strategic Objectives
The report identifies risks which impact on delivery of the Trust's strategic objectives
Impact Upon Corporate Risks
The report presents the major corporate risks
Regulatory and/or Legal Implications
None
Equality & Patient Impact
The report describes some patient groups that are more likely to be affected by the risks described than others though this is by virtue of clinical need.

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)**
				5th April 2017	Risk Management Group

Trust Risk Register March 2017

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Commitee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
S1851	Surgical Services Division	Quality	Chief Operating Officer	Quality & Performance Committee	A risk that patients receive poor quality care as a consequence of demand for beds exceeding the beds available which could include cancelled operations, being cared for on a non-specialty ward or being cared for in an escalation area	1. Extended site management - Silver rota 2. Escalation policy and procedures for use of extra beds 3. Risk assessments evaluating the change in function of the areas.	Inadequate	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Major	Delivery of Winter plan Easter Bank Holiday Plan	06/04/2017
F1609	Corporate Division, Diagnostics and Specialties Division, Estate and Facilities, Medical Division, Surgical Services Division, Women's and Children's	Quality	Director of Nursing	Quality & Performance Committee	Risk of poor continuity of care and overall reduced care quality arising from high use of agency staff in some service areas.	1. Overseas recruitment programme 2. Pilot of extended Bank office hours 3. Agency Taskforce 4. Bank incentive payments and weekly pay for bank staff 5. General and Old Age Medicine Recruitment and Retention Premium 6. Master vendor for medical locums 7. Temporary staffing tool self assessment	Adequate	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Major	Monitoring at Workforce Committee Establish Quality Impact Assessment for project	06/04/2017
DSP2401diet	Diagnostics and Specialties Division, Medical Division, Surgical Services Division	Quality	Director of Nursing	Divisional Board	The patient quality risk as a result of insufficient dietetic capacity to provide timely assessment, advice and interventions specifically for patients with PEGs.	prioritise in line with department guidance. Staff are working additional hours in an attempt to meet demand review of skillmix	Inadequate	Major (4)	Likely - Weekly (4)	16	15 - 25 Major	Business case	21/04/2017

Trust Risk Register March 2017

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Commitee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
WF2335	Corporate Division, Diagnostics and Specialties Division, Estate and Facilities, Medical Division, Surgical Services Division, Women's and Children's	Finance	Director of HR & OD	Workforce Committee	The risk of excessively high agency spend in both clinical and non-clinical professions due to high vacancy levels.	1. Agency Programme Board receiving detailed plans from nursing, medical, workforce and operations working groups. 2.Increase challenge to agency requests via VCP 3. Convert locum\agency posts to substantive 4. Promote higher utilisation of internal nurse and medical bank.	Inadequate	Major (4)	Almost certain - Daily (5)	20	15 - 25 Catastrophic	Establish Workforce Committee Complete PIDs for each programme Reconfiguring Structures	06/04/2017
S1748	Surgical Services Division, Women's and Children's	Statutory	Chief Operating Officer	Quality & Performance Committee	The risk of failing national access standards including RTT and Cancer	1. Weekly meetings between AGM and MDT Coordinators to discuss pathway management and expedite patients as appropriate. 3. Performance Management at Cancer Management Board 4. Escalation procedure in place to avoid breaches 5. Performance trajectory report for each pathway	Inadequate	Major (4)	Almost certain - Daily (5)	20	15 - 25 Catastrophic	Re establish Planned care board Interim action plan to recover position	04/04/2017

Trust Risk Register March 2017

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Commitee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
M2473	Medical Division	Quality	Director of Nursing	Quality & Performance Committee	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	Identified corridor nurse at GRH for all shifts; ED escalation policy in place to ensure timely escalation internally; Cubicle kept empty to allow patients to have ECG / investigations (GRH); Pre-emptive transfer policy patient safety checklist up to 12 hours Monitoring Privacy & Dignity by Senior nurses	Inadequate	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Major	CQC action plan for ED	28/04/2017

Trust Risk Register March 2017

Ref	Division	Highest Scoring Domain	Execute Lead title	Title of Assurance / Monitoring Commitee	Inherent Risk	Controls in place	Adequacy	Consequence	Likelihood	Score	Current	Action / Mitigation	Review date
S2045	Surgical Services Division	Safety	Medical Director	Quality & Performance Committee	The risk of poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal	Prioritisation of patients in ED Early pain relief Admission proforma Volumetric pump fluid administration Anaesthetic standardisation Post op care bundle – Haemocus in recovery and consideration for DCC Return to ward care bundle Ward move to improve patient environment and aid therapy Supplemental Patient nutrition with employment of nutrition assistant Increased medical cover at weekends OG consultant review at weekends Increased therapy services at weekends Senior DCC nurses on secondment to hip fracture ward for education and skill mix improvement Review of all deaths	Adequate	Major (4)	Likely - Weekly (4)	16	15 - 25 Major	Deliver the agreed action fractured neck of femur action plan	28/04/2017

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD MEETING – 12 APRIL 2017
LECTURE HALL, SANDFORD EDUCATION CENTRE

Report Title
Capital Investment Programme for 2017-18
Sponsor and Author(s)
Stuart Diggles – Director of Finance (Sponsor) Neil Jackson – Director of Estates and Facilities Sean Ceres – Interim Head of Strategic Financial Planning
Executive Summary

Purpose

The purpose of this report is seek approval from the Board for the proposed 2017/18 capital investment programme. The programme has been considered by both the Finance Committee and the Trust Leadership Team (TLT) and recommended for approval by both.

Key issues to note

- The capital programme includes investment against the following priorities
    - Ongoing and committed schemes from 2016/17
    - The highest Health & Safety priorities
    - Essential backlog maintenance
    - Essential equipment replacement
    - Capital requirements to support approved revenue business cases
- A number of equipment replacements items fall outside the capital programme but alternative lease or managed service arrangements are being investigated to enable further asset replacement of some significant items.
- The capital programme schedule for 2017-18 is attached in Appendix A. the programme has been updated with the latest available programme information. The current internally funded schemes totalling £14.66m is aligned to a depreciation fund for 2017/18 of £12.70m resulting in a funding gap of £1.96m. Options to close this gap are included within the paper and whilst the proposed routes are not yet finalised, the risk of not closing the gap is considered to be low.
- There are a further £18.04m of externally funded schemes with funds coming from a variety of sources including Department of Health and lease arrangements.
- Schemes that are able to demonstrate a payback in the medium term (10 years) may be funded by further borrowing. Currently the utilisation of depreciation funding for additional assets is reducing the investment in existing asset maintenance and renewal. This is the purpose of deprecation funding, therefore wherever practicable the funding of additional assets should support effective payback on investment.

Conclusions

The attached programme balances available funding across the themes to address the highest risk issues. The risk of service interruption will continue given the age of the estate and many equipment assets, however, the highest risk items are address by the programme.

Furthermore, all bids which have not secured funding have been risk assessed and there are

no residual high risks that have not secured funding.

Implications and Future Action Required

Following Board approval the programme will be mobilised through procurement and other routes, in line with the cash and capital phasing set out in the operational plan.

Monitoring of spend against this plan will be undertake by the Finance Committee.

Capital Plan Summary

Internal Funded	
Total of H&S Related Major Schemes	1,020.0
Total of H&S projects	1,525.0
Total of Environmental Works	250.0
Total of Estates Unallocated Allowances	140.0
Non H&S Estates schemes Total	100.0
Committed Schemes Total	869.0
Service Reconfiguration Total	1,500.0
Major Equipment Replacement Total	1,547.0
IT	7,234.0
Contingency	475.0
Internal Funded Total	**14,660.0**
External funding - DH Loans and/or 3rd Party Lease	
A1695 - Sustainability/Energy Infrastructure Initiatives	200.0
A1755 - CGH Apollo Theatre AHU and theatre refurbishment	1,900.0
Strategic Site Redevelopment	12,540.0
Autoclaves	900.0
Radiology equipment	2,500.0
External Funded Total	**18,040.0**
Total	**32,700.0**

Recommendations

The Board is asked to approve the capital programme for 2017/18 noting the current funding gap of £1.96m which the Trust Leadership Team is confident can be eliminated.

Impact Upon Risk – known or new

The programme is prioritised on the basis of addressing highest risk issues identified in Trust and divisional risk registers.

Equality & Patient Impact

Each business case within the programme will review impacts and any mitigation actions.

Resource Implications

Finance	**X**	Information Management & Technology	X
Human Resources		Buildings	**X**

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**	**Trust Leadership Team**	**Other (specify)**
	29th March 2017			5th April 2017	

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – APRIL 2017

REPORT ON CAPITAL INVESTMENT PROGRAMME FOR 2017/18

Introduction

The capital planning process for 2017/18 has been undertaken on a risk prioritisation basis on the following themes:-

- Ongoing and committed schemes (such as Smartcare) from 2016/17
- Priority Health & Safety schemes
- Essential backlog maintenance
- Essential equipment replacement (via the Medical Equipment Fund)
- Capital requirements from approved business cases.

The timeline followed for completing the capital allocation for 2017-18 is set out below, much of the prioritisation has been undertaken in the previous year as part of the ongoing backlog and equipment replacement programme planning.

Actions	Completion Date
Identify any outstanding priorities for 2017/18 at Capital Control Group	20/01/2017
Prioritise schemes within funding available	20/01/2017
Confirm revenue consequences of programme	24/01/2017
Reflect any changes from second review of proposed revenue budgets	08/02/2017
Review of proposed business cases requiring capital.	22/02/2017
Present proposed capital programme to TLT	15/03/2017
Final business case review to align revenue and capital investment and final validation of business cases	17/03/2017
Present proposed capital programme to Finance Committee	29/03/2017
Present proposed capital programme to Trust Board	12/04/2017

The level of funding provision for each theme is established on the basis of historical spend with Health & Safety risks taking highest priority, then significant risk of failure, before schemes that support guaranteed savings or additional income. Existing contractual commitments are also prioritised to ensure delivery of existing contact liabilities.

Capital Plan
The capital programme schedule for 2017-18 is attached in Appendix A. the programme has been updated with the latest available programme information. The current internally funded schemes has now increased and totals £14.66m this is aligned to a depreciation fund for 2017/18 of £12.70m resulting in a funding gap of £1.96m.

The funding gap is due to the following movements in the plan.

Winter ED reconfiguration	£1,000k – new addition to plan
Business cases	£1,000k – previously in funded
Equipment enabling works costs	£1,027k – previously in funded, funding routes not available
Contingency within the programme	£ 475k – new addition to plan

This has been offset in part by planned slippage in the office hubs programme, a reduction in year of (£1,500k) Contractual commitment to this value will be made in year with expenditure in 2018/19.

Potential options to close the funding gap include:-

- Establishing a call off lease for MEF items (this would effectively move a number of business case items back into funded capital)
- Leasing of Radiology Treatment Planning System
- Further borrowing or lease for Smartcare equipment
- Lease arrangement for telephony equipment

Finally, schemes that are able to demonstrate a payback in the medium term (10 years) may be funded by further borrowing. Currently the utilisation of depreciation funding for additional assets is reducing the investment in existing asset maintenance and renewal. This is the purpose of deprecation funding, therefore wherever practicable the funding of additional assets should support effective payback on investment.

The above and further options to be discussed at Finance Committee.

Theatre refurbishment is assumed within external funding as this is more appropriate for external funding. This will clearly require a supportable business case. Appendix B details capital calls from business cases updating on the status of each request. Several schemes will take more than one year or will be delivered as a rolling programme. Risk mitigation actions for unapproved schemes will be confirmed by the relevant division.

The business case capital commitment for MEF in 17/18 is £558k, including the first year of the items below. The following items are to be funded over a period of 4 years on a rolling programme basis.

SU021	Audiology Hardware replacement	203,690
SU035	Upgrade/replacement of OCT Cirrus 4000 machines	274,560
SU036	Upgrade of HFA machines	366,000

A sum of £200k has also been identified for planned replacement of Beds and Corporate Nursing equipment within the MEF programme.

A £475k contingency has been created for in year adjustments to the programme.

Internal Funded	
Total of H&S Related Major Schemes	1,020.0
Total of H&S projects	1,525.0
Total of Environmental Works	250.0
Total of Estates Unallocated Allowances	140.0
Non H&S Estates schemes Total	100.0
Committed Schemes Total	869.0
Service Reconfiguration Total	1,500.0
Major Equipment Replacement Total	1,547.0
IT	7,234.0
Contingency	475.0
Internal Funded Total	**14,660.0**
External funding - DH Loans and/or 3rd Party Lease	
A1731 - GRH ED Expansion (SUrC)	0.0
A1695 - Sustainability/Energy Infrastructure Initiatives	200.0
A1755 - CGH Apollo Theatre AHU and theatre refurbishment	1,900.0
Strategic Site redevelopment	12,540.0
AutoClaves	900.0
Radiology Equipment	2,500.0
External Funded Total	18,040.0
Total	**32,700.0**

Priority Health & Safety schemes
Priority Health & Safety schemes have been established from existing incident and risk management to ensure risk mitigations continue to be implemented along with taking high priority items from Estates & Facilities risk register (extract of register Appendix D). This process prioritises Health & Safety and statutory compliance.

Essential backlog maintenance
Essential backlog maintenance is the prioritised item from the backlog maintenance programme as identified within the divisional risk register. The essential items are those at most significant risk of failure, however interruption to service is still likely given the extensive backlog position. Alternative funding approaches for major equipment replacement are being pursued to enable further equipment replacement to be undertaken. This reduces further the risk of business interruption.

Essential equipment replacement (via the Medical Equipment Fund) (Appendix C)
For lower cost (less than £200K) essential equipment, replacement is prioritised within the Medical Equipment Fund (MEF). The MEF Group is a sub-group to Capital Control Group.

The prioritisation of the MEF programme is currently based upon a replacement on failure approach. In order to ensure risk are being managed effectively a full asset review will be undertaken in 2017-18 to enable the development of a risk assessed backlog register. This will ensure significant risks are identified and mitigated as far as reasonably practicable. The process will also ensure funding is prioritised effectively and will support a steady movement from replace on failure to a planned replacement programme. The operation risks of any items not approved by MEF is held by the relevant division.

Capital requirements from approved business cases
In October 2016 all divisions were asked to submit business proposals for consideration by the Trust Leadership Team (TLT) as a part of the accelerated 2017/18 planning cycle. 138 cases were received, assessed and sifted in relation to the following criteria:-

- Level of risk – based on Trust risk methodology. Only very high intolerable risk schemes progressed. Ophthalmology server space was approved and referred for funding from the IM&T allocation.
- Income is greater than investment
- Savings are greater than the investment
- Funded by grant – e.g. Macmillan
- Investment required to deliver contract growth
- Identified for referral to Capital Control Group
- Not to progress and excluded (applied to 76 schemes)

In addition to the ophthalmology scheme a further 12 proposals were identified as 'capital' focussed and for further review by the capital control group.

Current schedule of business cases requesting capital investment and the status of those requests is summarised in Appendix B. A total of 29 requests including charitable funded, MEF and IMT schemes are being supported.

These schemes were presented using the Trust template that included a high impact and risk assessment.

A full review of the overall programme and the individual business cases was undertaken at the Capital Control Group on the 20 January 2017 the status of the business cases following this are detailed in Appendix B.

An additional review of remaining known risks was undertaken to inform the retain risks schedule for unapproved schemes risks copy attached (appendix E)

Next Steps

The programme will be initiated with funding allocation within the MEF programme and retained contingency managed to focus on highest priority issues.

A review of assets to enable MEF to identify and maintain oversight of the medical equipment backlog is underway, this will focus on identifying risk priorities and ensure future funds are prioritised on the basis of a more robust evidence base.

Appendix A

	Proposed Capital Plan 17/18 to 2021/22	**Original 17/18**	**Adjs**	**Adjs**	**Revised 17/18**	**18/19**	**19/20**	**20/21**	**21/22**
	Scheme	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Internal Funding	A1708 - GRH Tower Block Roof (Phase 2 16/17)	0.0			0.0	650.0	400.0		
Internal Funding	???? - Hazleton Essential repairs	400.0			400.0	0.0			
Internal Funding	???? - GRH kitchen void floor structural work	170.0			170.0	0.0			
Internal Funding	???? - GRH theatre block roof	450.0			450.0	0.0			
Internal Funding	A1721 - Main Kitchen Cook Freeze Facility/Receiving Unit	0.0			0.0	750.0	750.0		
Internal Funding	**Total of H&S Related Major Schemes**	**1,020.0**	**0.0**	**0.0**	**1,020.0**	**1,400.0**	**1,150.0**	**0.0**	**0.0**
Internal Funding									
Internal Funding	**- Estates H&S related projects**								
Internal Funding	A1764 - Site-wide Lift Improvement Programme/Repairs	200.0			200.0	200.0	200.0	200.0	200.0
Internal Funding	A1763 - Site-wide Ward Flooring,slips,trips & falls.	75.0			75.0	75.0	75.0	75.0	75.0
Internal Funding	A1619 - Site-wide Medical Gas Safety and Resilience	30.0			30.0	50.0	50.0	50.0	50.0
Internal Funding	A1748 - Site-wide Road/Safety/Resurfacing Improvement Programme	30.0			30.0	30.0	30.0	30.0	30.0
Internal Funding	A1628 - Sanitary/Re-Engineering Improvement tanks,taps,water hygiene	100.0			100.0	100.0	100.0	100.0	100.0
Internal Funding	A1618 - Site Wide Electrical Resilience Works	100.0			100.0	100.0	100.0	100.0	100.0
Internal Funding	A1747 - Site Wide Theatre Ventilation Compliance Works	150.0			150.0	150.0	150.0	150.0	150.0
Internal Funding	A1630 - Site Wide Asbestos Works	50.0			50.0	50.0	50.0	50.0	50.0
Internal Funding	A1631 - Site Wide Fire Safety Works	100.0			100.0	100.0	100.0	100.0	100.0
Internal Funding	xxxx - Backlog Maintenance upgrades/replacement of plant & equipment	200.0			200.0	300.0	300.0	300.0	300.0
Internal Funding	A1683 - Site-wide Access Control	100.0			100.0	20.0	20.0	20.0	20.0
Internal Funding	A1689 - Site-wide Nurse Call Improvement Programme	40.0			40.0	40.0	40.0	40.0	40.0
Internal Funding	A1674 - CGH/GRH Climate Control Adaption/Heating Systems	200.0			200.0	200.0	200.0	200.0	200.0
Internal Funding	A1757 - Site-wide Roof Improvement Programme/Repairs	100.0			100.0	100.0	100.0	100.0	100.0
Internal Funding	A1702 - Site-wide BMS Improvement Upgrades	50.0			50.0	50.0	50.0	50.0	50.0
Internal Funding	**Total of H&S projects**	**1,525.0**	**0.0**	**0.0**	**1,525.0**	**1,565.0**	**1,565.0**	**1,565.0**	**1,565.0**
Internal Funding									
Internal Funding	**- Environmental works**								
Internal Funding	A1690 - GRH Ward/Dept Environmental Improvements	200.0	-100.0		100.0	200.0	200.0	200.0	200.0
Internal Funding	A1691 - CGH Ward/Dept Environmental Improvements	200.0	-100.0		100.0	200.0	200.0	200.0	200.0
Internal Funding	A1675 - Catering General Equipment (including ward dishwashers)	50.0			50.0	50.0	50.0	50.0	50.0
Internal Funding	**Total of Environmental Works**	**450.0**	**-200.0**	**0.0**	**250.0**	**450.0**	**450.0**	**450.0**	**450.0**
Internal Funding									
Internal Funding	**- Estates Unallocated Allowances**								
Internal Funding	A1765 - Support Service (Porters/Linen/Domestics) General Equipment	20.0			20.0	20.0	20.0	20.0	20.0
Internal Funding	A1767 - Medical Engineering General Equipment	20.0			20.0	20.0	20.0	20.0	20.0
Internal Funding	A1703 - Site-wide CCTV Improvement Programme	40.0			40.0	100.0			
Internal Funding	??? - Relocation Projects	100.0	-50.0		50.0	50.0	100.0	100.0	100.0
Internal Funding	A1642 - Site-wide Wayfinding	10.0			10.0	5.0	10.0	10.0	10.0
Internal Funding	**Total of Estates Unallocated Allowances**	**190.0**	**-50.0**	**0.0**	**140.0**	**195.0**	**150.0**	**150.0**	**150.0**
Internal Funding									
Internal Funding	**- Non H&S Estates Schemes**								
Internal Funding	A1695 - Sustainability/Energy Infrastructure Initiatives	200.0	-200.0		0.0	200.0	200.0	200.0	200.0
Internal Funding	- Energy Performance Contract	0.0			0.0				
Internal Funding	A1766 - Catering/Retail Improvements (to generate revenue income)	20.0			20.0	20.0	20.0	20.0	20.0
Internal Funding	A1752 - Estates General Equipment (Backtrac/PDS's)	20.0			20.0	20.0	20.0	20.0	20.0
Internal Funding	A1017 - Feasibility and legal services	60.0			60.0	30.0	100.0	100.0	100.0
Internal Funding	**Non H&S Estates schemes Total**	**300.0**	**-200.0**	**0.0**	**100.0**	**270.0**	**340.0**	**340.0**	**340.0**
Internal Funding									
Internal Funding	**- Committed Schemes**								
Internal Funding	A1634 - Reconfiguration Works to enable asset disposals	50.0	-50.0		0.0	0.0		300.0	
Internal Funding	A1601 - ESS Re-capitalisation	510.0			510.0	510.0	510.0	510.0	510.0
Internal Funding	A1557 - GRH Tower Block lifts (lift 5&6) - Priority 1	0.0			0.0	0.0			
Internal Funding	A1609 - Hereford Radiotherapy	0.0			0.0	0.0			
Internal Funding	A1644 - CGH GT1/2 Theatre	0.0			0.0	0.0			
Internal Funding	A1762 - Fairview Reconfigurations for Ophthalmology Service (construction only)	21.0	-21.0		0.0	0.0			
Internal Funding	A1756 - CGH Oncology Block Roof Repair	0.0			0.0	0.0			
Internal Funding	- Victoria Warehouse Dilapidations (lease expires 09/2017)	200.0	-200.0		0.0				
Internal Funding	A1649 - CGH Radiopharmacy	0.0			0.0	0.0			
Internal Funding	A1776 - Radiology Room 8	0.0			0.0				
Internal Funding	A1684 - GRH Replacement CT Infrastructure costs	0.0			0.0	0.0			
Internal Funding	D3149 - RFID	0.0	359.0		359.0	359.0			
Internal Funding	**Committed Schemes Total**	**781.0**	**88.0**	**0.0**	**869.0**	**869.0**	**510.0**	**810.0**	**510.0**
Internal Funding									
Internal Funding	**- Service Reconfiguration Schemes**								
Internal Funding	Accommodation Hubs	2,000.0		-1,500.0	500.0	1,500.0	2,000.0	2,000.0	
Internal Funding	General Theatre refurbishment				0.0	1,500.0	1,500.0	1,500.0	1,500.0
Internal Funding	- Cotswold Dialysis Unit - Water Treatment Plant	0.0			0.0				
Internal Funding	- Severn Dialysis Unit - Extension / Reconfiguration				0.0		500.0	15.0	
Internal Funding	- GRH Demolition of Orchard Centre	0.0			0.0	0.0	300.0		
Internal Funding	2017/18 winter plan reconfiguration			1,000.0	1,000.0				
Internal Funding	Divisional business cases - now allocated to other areas (see Appendix B)	1,000.0	-313.8	-686.3	0.0	500.0	500.0	500.0	500.0
Internal Funding	Tower Block Ward Improvements				0.0		3,000.0	3,000.0	3,000.0
Internal Funding	Estates Cyclical Infrastructure Improvements				0.0		3,500.0	3,500.0	3,500.0
Internal Funding	Hazleton Ward improvements				0.0	1,500.0			
Internal Funding	**Service Reconfiguration Total**	**3,000.0**	**-313.8**	**-1,186.3**	**1,500.0**	**5,000.0**	**11,300.0**	**10,515.0**	**8,500.0**
Internal Funding									
Internal Funding	**Major Equipment Replacement**								
Internal Funding	- Linac	450.0			450.0				
Internal Funding	- MRI - GRH Infrastructure	577.0			577.0				
Internal Funding	- Radiotherapy Treatment Planning System and Diamond Plan checking system	200.0			200.0				
Internal Funding	- Infrastructure cost for the planning system	20.0			20.0				
Internal Funding	- Radiotherapy management system hardware replacement	200.0			200.0				
Internal Funding	- HL7 Server replacement	50.0			50.0				
Internal Funding	- Variseed planning system replacement	50.0			50.0				
Internal Funding	**Major Equipment Replacement Total**	**1,547.0**	**0.0**	**0.0**	**1,547.0**	**0.0**	**0.0**	**0.0**	**0.0**
Internal Funding									
Internal Funding	**IT**	**3,008.0**	**-532.0**	**100.0**	**2,576.0**	**2,000.0**	**2,000.0**	**2,000.0**	**2,000.0**
Internal Funding	**SmartCare**	**1,400.0**	**-100.0**		**1,300.0**				
Internal Funding	**MEF**	**1,800.0**		**558.0**	**2,358.0**	**2,300.0**	**2,300.0**	**2,300.0**	**2,300.0**
	JUYI		**1,000.0**		**1,000.0**				
	Contingency			**475.0**	**475.0**				
	Total	**15,021.0**	**-307.8**	**-53.3**	**14,660.0**	**14,049.0**	**19,765.0**	**18,130.0**	**15,815.0**

	Scheme	17/18 £000	Adjs £000	Adjs £000	17/18 £000	18/19 £000	19/20 £000	20/21 £000	21/22 £000
	External funding - DH Loans and/or 3rd Party Lease								
Loan funding	A1731 - GRH ED Expansion (SUrC)	3,000.0	-3,000.0		0.0	0.0			
Loan funding	A1695 - Sustainability/Energy Infrastructure Initiatives		200.0		200.0				
Loan funding	A1755 - CGH Apollo Theatre AHU and theatre refurbishment	1,900.0			1,900.0	75.0			
PDC	Strategic Site redevelopment	12,540.0			12,540.0	20,000.0	18,476.0	18,477.0	
Loan funding	AutoClaves		900.0		900.0				
Finance Lease	**Radiology Equipment**	**2,500.0**			2,500.0	**2,600.0**	**1,500.0**		
		19,940.0	**-1,900.0**	**0.0**	**18,040.0**	**22,675.0**	**19,976.0**	**18,477.0**	**0.0**
					32,700.0				
	- Interventional Fluoroscopy Rooms - CGH Equipment	500.0			500.0	600.0			
	- Interventional Fluoroscopy Rooms - CGH Works	500.0			500.0	500.0			
	- CT - GRH Equipment				0.0	1,050.0	1,050.0		
	- CT - GRH Works				0.0	450.0	450.0		
	- CT - CGH Equipment	1,100.0			1,100.0				
	- CT - CGH Works	400.0			400.0				
	- Digital Mammography Rooms				0.0				
	MRI - GRH Infrastructure				0.0				
	Linac				0.0				
		2,500.0			**2,500.0**	**2,600.0**	**1,500.0**		

Capital Plan Summary	17/18 £000's
Internally Funded:	
Health & Safety Projects	2,545.0
Environmental Works	250.0
Estates Unallocated Allowances	140.0
Non Health & Safety Projects	100.0
Committed Schemes	869.0
Service Reconfiguration	1,500.0
Major Equipment Replacement	1,547.0
IM&T	2,576.0
SmartCare	1,300.0
MEF	2,358.0
JUYI	1,000.0
	14,185.0
Externally funded	
Accommodation Hubs	1,900.0
Strategic Site redevelopment	12,540.0
AutoClaves	900.0
Radiology Equipment	2,500.0
Other	200.0
	18,040.0
Surplus/(Deficit)	**32,225**

18/19 £000's
2,965.0
450.0
195.0
270.0
869.0
5,000.0
0.0
2,000.0
0.0
2,300.0
0.0
14,049.0
75.0
20,000.0
0.0
2,600.0
0.0
22,675.0
36,724

Cap (Multiple Items)

Appendix B

Bus case category	Division	Decision / Status	Ref	What	Sum of Total Capital investment £	Revised Capital investment £	CCG Status
Demand	Women & Children	Growth Fund	WC004	Increase in neonatal cots	34,000	34,000	Bid to go to MEF
Demand Total					34,000	34,000	
Capital	Women & Children	Proceed	WC001	Purchase of 6 Transcutaneous Bilirubinometers	36,977	36,977	funded via MEF
Capital	Medicine	Not approved	M006	Severn Dialysis Unit Extension	356,402	356,402	
Capital	Medicine	Refer to CCG	M014	Use of Propofol (Endoscopic Sedation)	45,537	45,537	Bid to go to MEF
Capital	Medicine	Refer to CCG	M015	Endoscopy Management System (EMS)	74,340	74,340	Bid to go to MEF
Capital	Medicine	Refer to CCG	M026	Respiratory Ultrasound machine	18,000	18,000	Bid to go to MEF
Capital	Diagnostics & Specialities	Proceed	DS014	Clinic room management tool	40,000	40,000	IM&T Funding
Capital	Diagnostics & Specialities	Not approved	DS007	Radiotherapy E-referral & Consent (Casper A)	62,500	62,500	
Capital	Diagnostics & Specialities	Not approved	DS016	Interventional Radiology Replacement and Expansion	2,850,000	2,850,000	
Capital	Estates & Facilities	Proceed	EF001	Office Hubs	2,000,000	2,000,000	Part of overall Capital plan, funding to be confirmed
Capital	Estates & Facilities	Refer to CCG	EF007	Energy Savings - Salix	500,000	500,000	Not required
Capital	Estates & Facilities	Refer to CCG	EF008	GRH Kitchen Void	100,000	100,000	Included in Capital plan
Capital	Estates & Facilities	Refer to CCG	EF009	Hazelton Ward	400,000	400,000	Included in Capital plan
Capital	Estates & Facilities	Refer to CCG	EF011	Tower Block LV Switch	45,000	45,000	Included in Capital plan
Capital	Estates & Facilities	Refer to CCG	EF012	Tower Block Roof	900,000	900,000	Deferred to 18/19
Capital	Surgery	Proceed	SU015	Simplan Pro 3D Surgical Implant Planning Software	7,265	7,265	IM&T Funding
Capital	Surgery	Proceed	SU033	Ophthalmology Server Space	127,280	127,280	IM&T Funding
Capital	Surgery	Refer to CCG	SU021	Audiology Hardware replacement	203,690	203,690	Needs approval then bid to MEF on a rolling replacement basis
Capital	Surgery	Hold	SU022	AuditBase Server replacement	15,000	15,000	Needs approval then bid for IM&T Funding
Capital	Surgery	Refer to CCG	CP001	PSA Tracker for remote monitoring prostate cancer patients	47,560	47,560	Funded via grant
Capital	Surgery	Not approved	SU017	Ward Reconfiguration (FNOF mortality / quality)	674,594	674,594	Rejected
Capital	Surgery	Refer to CCG	SU028	Nasendoscope replacement	60,000	60,000	Bid to go to MEF
Capital	Surgery	Refer to CCG	SU034	Air flow in Treatment rooms on Fairview OPD	50,000	50,000	Hold pending justification of bid
Capital	Surgery	Refer to CCG	SU035	Upgrade/replacment of OCT Cirrus 4000 machines	274,560	274,560	Bid to go to MEF on a rolling replacement basis
Capital	Surgery	Refer to CCG	SU036	Upgrade of HFA machines	366,000	366,000	Bid to go to MEF on a rolling replacement basis
Capital	Surgery	Refer to CCG	SU039	Pentacam to support corneal service developments and replace Orbscan	34,254	34,254	Bid to go to MEF
Capital	Surgery	Refer to CCG	SU048	Stock Control System	626,257	626,257	Rejected - covered within Theatres MES proposal
Capital	Surgery	Refer to CCG	SU049	Replacement washer/disinfectors and Autoclaves for Sterile Services	1,104,342	900,000	Part of overall Capital plan, funding to be confirmed
Capital	Surgery	Refer to CCG	SU050	Provision of Emergency Power supply for Theatres	57,200	57,200	Bid to go to MEF
Capital	W&C	Proceed	CP003	Ward Moves GRH	51,242	51,242	Completed
Capital	IT	Proceed	CP004	Website intranet access	40,000	68,500	IM&T Funding
Capital Total					11,168,000	10,992,158	
Development	Diagnostics & Specialities	Proceed	DS012	e-Health Needs Assessment (eHNA) Project	12,066	12,066	IM&T Funding
Development	Diagnostics & Specialities	Not approved	DS003	High Dose Brachytherapy	178,000	178,000	
Development	Surgery	Hold	SU040	Evesham Business Case	67,200	67,200	Hold pending justification of bid
Development	Surgery	Hold	SU042	Radioactive iodine seed localisation of impalpable breast cancers	20,000	20,000	Hold pending justification of bid
Development Total					277,266	277,266	
Parked	Surgery	Parked	SU037	Replacement of HRT machines to support glaucoma services	274,560	274,560	subject to wider review
Retired Total					274,560	274,560	
Grand Total					11,753,826	11,577,984	

MEF	1,204,558	This reduces to £558k for 17/18 due to rolling programmes
IT	255,111	£100k included, remainder covered by IT spend slippage
Main Cap Budget	4,345,000	
Not funded	5,022,313	
Hold	152,200	
completed/grant/not required	598,802	
Total	11,577,984	

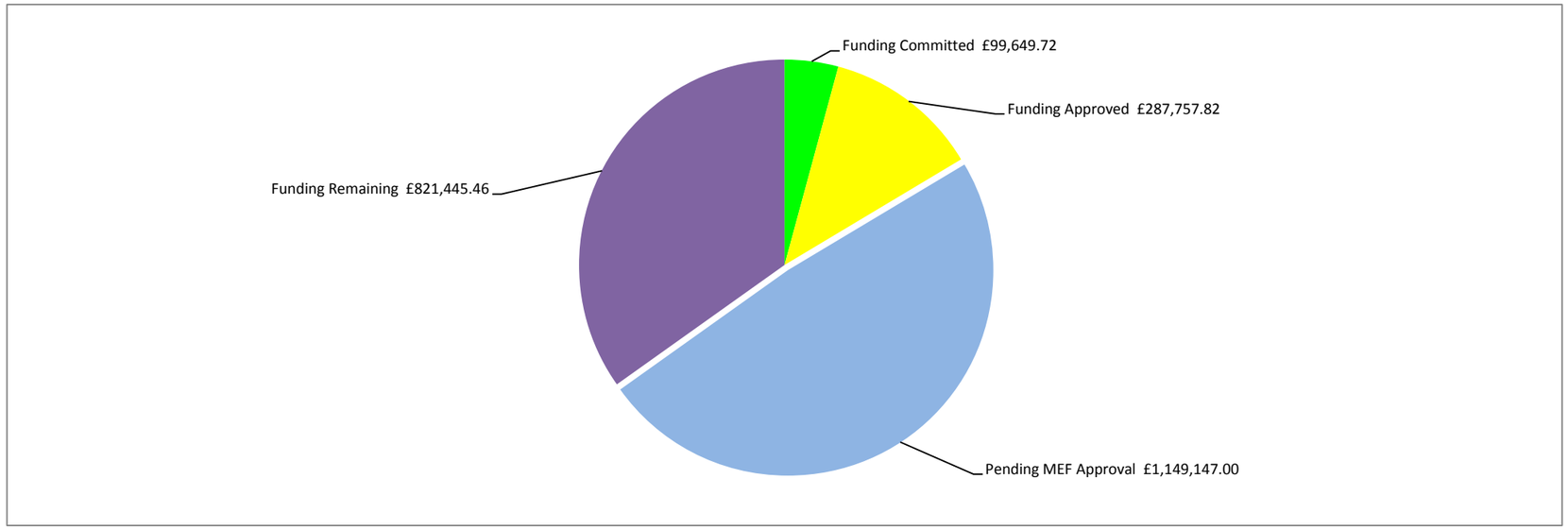
Medical Equipment Fund (MEF)

Appendix C

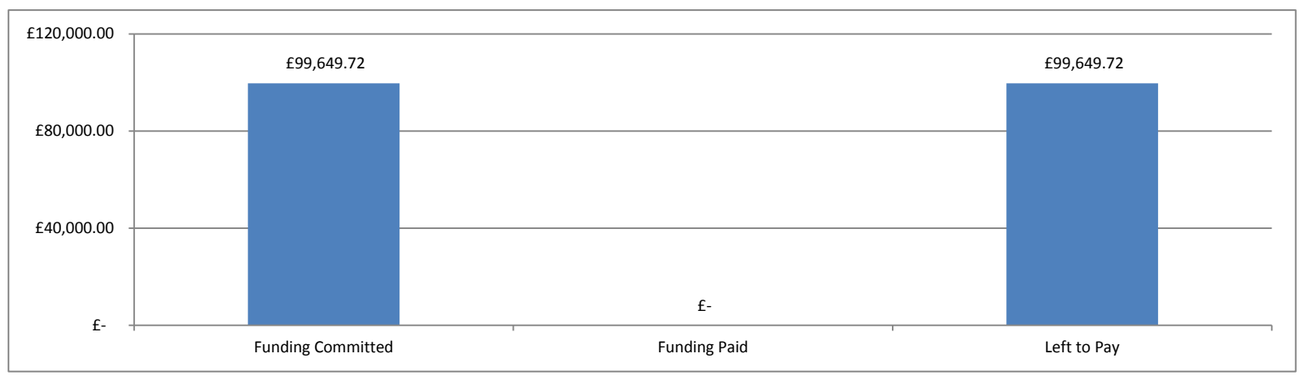
Funding Pot	£ 2,358,000.00		**Capital**	£ 99,649.72	
Funding Committed	£ 99,649.72		**Corporate**	£ -	
Funding Approved	£ 287,757.82		**Total**	£ 99,649.72	
Pending MEF Approval	£ 1,149,147.00	Including approved business cases £558k			
Funding Remaining	£ 821,445.46	to include £200k priotised for Corporate Nursing Items			

Leasing Capital Cost	0
Leasing Order Costs	0

Charitable	£ -



Funding Committed	£	99,649.72
Funding Paid	£	-
Left to Pay	£	99,649.72



MEF Requests received 17/18

MEF Ref	Item	Division / Dept	Dept Lead	Value (ex VAT)	Value (inc VAT)	MEF Approved date	Funding Route requested	Funding route agreed	Funding Route Given with Analysis Code	Date Code received	Comments
Completed											
N/A	Ophth Microscope	Surgery	Jackie Sills			N/A	N/A	N/A	Capital	N/A	Transferred from 15/16 list
MEF-064-Aug16	24 48 Hr BP Monitors (Novacor)	Medicine	Justine Willoughby			14/09/2016	Capital	Capital			Moved from 16/17 as per Sean Ceres
Approved											
MEF-001-Jun16	CO2 Laser	Surgery	Beryl Woodall			19/10/2016	Capital	Lease			Moved from 16/17 as per Sean Ceres
MEF-036-Aug16	Replacement DEXA Scanner (Vertec)	D&S	Frank Jewell			21/12/2016	Capital	Capital			
MEF-037-Aug16	Vascular Lab Ultrasound (Philips IU22 or Alternative)	Surgery	Cathryn Biston				Capital	Capital			Moved from 16/17 as per Sean Ceres
MEF-039-Aug16	Cordless Gamma Probe for Breast Theatres (Wake Medical)	Surgery	Cathryn Biston			14/09/2016	Charitable	Charitable			Amended to 2 (1 CGH 1 GRH)
MEF-065-Aug16	ECG Machine MAC 5500HDS (GE)	Medicine	Justine Willoughby				Capital	Capital	D3206	16/09/2016	Moved from 16/17 as per Sean Ceres
MEF-073-Oct16 pt2	Oral Surgery at Cirencester Hospital - Operating Lights	Surgery	Cathryn Biston			19/10/2016	Capital	Capital	D3220	24/10/2016	Moved from 16/17 as per Sean Ceres (Left over of the £48000)
MEF-077-Nov16	KV Superficial Mobile Therapy Unit	D&S	P Latimer			14/12/2016	Charitable	Charitable			
MEF-083-Jan17	Bilirubinometers (Draegar)	W&C	Hilary Lucas			18/01/2016	Charitable	Charitable			
MEF-085-Jan17	Diathermy Units and APC Unit (ERBE Medical)	Medicine	Jayne Hancock			22/02/2017	Capital	Capital			Moved from 16/17 as per Sean Ceres
MEF-090-Feb17	Digital Reminiscence Therapy Software System (My Dementia Improvement Network)	Medicine	Sue McShane			22/02/2017	Charitable	Charitable			
MEF-095-Mar17	Pendulum Camera Head (Storz)	Surgery	Cathryn Biston			07/03/2017	Capital	Capital			
MEF-097-Mar17	Stepper BK Ultrasound	Surgery	Hugh Gilbert			07/03/2017	Capital	Capital			
Deferred to 18/19 Sheet											
Pending											
MEF-042-Aug16	Ultrasonic Machine Cleaner CSSD Application	Surgery	Cathryn Biston	£35,580	£42,696						
MEF-091-Feb17	Replacement Stereo Biopsy Mamograph (MIS)	D&S	Caroline Dobson	£136,000.00	£163,200	Deferred 12 months 23/02/2017					
MEF-081-Jan17	Colonoscopy (Olympus Medical) for Cirencester	Medicine	Carol Quance	£40,200.00	£48,240	Deferred to March MEF more info needed					
MEF-087-Feb17	Vivid E95 2D and 3D Echo Machines & TOE Probe (GE Healthcare)	Surgery	Cathryn Biston	£114,845.00	£137,814	Deferred to March MEF more info needed					
MEF-088-Feb17	C-MAC	Medicine (Unscheduled Care)	Jane Birch	£10,138.80	£12,167	Deferred to March MEF more info needed					
MEF-092-Feb17	Telecam Camera Head Replacement (Storz)	Surgery	Judith Muir	£6,941.70	£8,330	Deferred to March MEF more info needed					
MEF-093-Feb17	Bladder Scanner (Bard)	Surgery	Louise Wiggins	£6,500.00	£7,800	Deferred to March MEF more info needed					
MEF-094-Mar17	Nasendoscopes (Pentax-Olympus-Storz) ENT	Surgery	Judith Muir	£72,000.00	£86,400						
MEF-096-Mar17	Cell Salvage (Sorin) Theatres	Surgery	Cathryn Biston	£9,500.00	£11,400						
MEF-098-Mar17	Cold Room (Mitchells)	D&S			£0						
MEF-099-Mar17	DS20-000 Dose 1 Electronmeter (Oncology Systems Ltd)	D&S		£8,310.00	£9,972						
MEF-100-Mar17	BeamChecker Plus (Oncology Imaging Systems)	D&S		£7,085.00	£8,502						
MEF-101-Mar17	ISORAD Diode European Detector Pod (Imaging Equipment Ltd)	D&S		£14,170.00	£17,004						
MEF-102-Mar17	Replacement Gynae HDR Applicator (Eletka)	D&S		£19,200.00	£23,040						
MEF-103-Mar17	Phototherapy Unit x 2 (HC Life)	D&S	K Tomasino	£3,600.00	£4,320						
MEF-104-Mar17	Fabians Evolution (Inspiration HealthCare)	D&S	K Tomasino	£8,552.00	£10,262						
					£591,147.00						

Capital Funded

Mef Ref	Item	Division / Dept	Proc Lead	Dept Lead	Value Approved (Inc vat)	Pre-req form	CC - 95999 AC - 9812 Analysis code	Supplier	Order number	Order Date	Order Value (Inc VAT)	Copy of PO to Supply Chain if Applic	Del. Date	Inv No.	Date Paid	Comments / Status
N/A	Ophth Microscope	Surgery	Ashley	Jackie Sills		16/198	D3223	Leica	GSS630683	05/12/2016	£ 93,650.92	N/A				Evaluations are complete Leica has been awarded transferred from 15/16 as per Sean Ceres
MEF-036-Aug16	Replacement DEXA Scanner (Vertec)	D&S	CSAS	Linda	£90,000.00	Yes	TBA	Emailled Frank for a Spec								To work on but not ordered/delivered/invoiced until Apr 2017
MEF-037-Aug16	Vascular Lab Ultrasound (Philips IU22 or Alternative)	Surgical	CS/AS	Cathryn Biston	£80,000.00	Yes Please									Moved to 17/18 as per Sean Ceres	FJ confirmed this was a straight forward replacement as existing machine is not fit for purpose.
MEF-064-Aug16	24 48 Hr BP Monitors (Novacor)	Medicine	CS/AS	Justine Willoughby		16/115	D3205	Novacor	GSS626377	07/11/2016	£5,998.80	N/A				Transferred from 16/17 as per Sean Ceres
MEF-065-Aug16	ECG Machine MAC 5500HDS (GE)	Medicine	CS/AS	Justine Willoughby	£7,944.00	16/116 med eng	D3206								Moved to 17/18 as per Sean Ceres	Division currently borrowing Nuclear Medicine's machine. SE queried whether Nuclear Medicine needs such a high spec machine and whether their machine could be moved across permanently and a lower (cheaper) spec machine ordered for Nuclear Medicine. Action: FJ to investigate cost and possibility of exchanging equipment with Nuclear Medicine. SB confirmed machine is obsolete. Finance has issued a code. Agreed to approve and order.
MEF-073-Oct16	Operating Lights - Oral Surgery at Ciren Hosp	Surgical	AS	Sara Morissey	£12,565.20	No	D3220		Getting Brandon in as lowest bidder							Transferred from 16/17 as per Sean Ceres - Original Funding was £48K, however this was to buy Power Tools as well (see 16/17 sheet)
MEF-085-Jan17	Diathermy Units and APC Unit (ERBE Medical)	Medicine	AS	Jayne Hancock	£58,293.62	Yes	D3229		Contract is with Covidien, Covidien to talk to Jayne to get requirements						Approved & Order x1 x2 Approved DEC 2017	1 now and 2 deferred. The one now is with APC - get ordered, take the value from the total and transfer rest to 17/18 SB provided the following via email "The ERBE diathermy's (CHD-9335/9334/9745) are all presently operational but the company had declared them obsolete 31-12-16 and parts cannot be guaranteed. All three purchased in June 2005". MS confirmed parts are no longer available and equipment is required long term. It was agreed one unit can be purchased now and two units purchased at the end of December 2017
MEF-095-Mar17	Pendulum Camera Head (Storz)	Surgery	AS	Cathryn Biston	£17,955.00	16/271 pending	D3235		RE670060			£19,687.50		-		
MEF-097-Mar17	Stepper BK Ultrasound	Surgery	AS	Hugh Gilbert	£21,000.00	Pending Pre-req	D3236		Emailled Hugh/Jon Ord to put req on			TBA				
					£287,757.82					**Total**	**£99,649.72**					

Charitable Funded

C/F Ref	Item	Division / Dept	Proc Lead	Dept Lead	Value Approved (inc vat)	Pre-req form	Budget	Supplier	Order number	Order Date	Order Value (Inc VAT)	Copy of PO to Supply Chain if Applic	Del. Date	Inv No.	Date Paid	Comments / Status
MEF-039-Aug16	Cordless Gamma Probe for Breast Theatres (Wake Medical)	Surgery	CS/AS	Cathryn Biston	£42,912.00	Ask dave when we know what we are ordering		Due back on the 24th February						When we know supplier and model advise Kate Green	Do not order until Funding raised	Confirmed charitable funding via League of Friends. Not on Supply Chain - KG has confirmed this is Charitably funded, however it is for 2 systems. KG will get this minuted at the next MEF meeting in Feb.
MEF-077-Nov16	KV Superficial Mobile Therapy Unit	D&S	CS/AS	Penny Latimer	£195,600.00	Yes Please	Focus 11041	Priliminary spec come through Claire currently going through 23/02/2017								KG advised the application was proposed to be funded by a legacy. The business case has been approved at the required levels. SB confirmed the new unit is to replace the existing one which will be decommissioned and therefore old equipment has no value. Update post meeting – KG confirmed maintenance is included and following the Charitable Funds Committee meeting on 16 December, funding may be from Focus or Hope for Tomorrow. KG to update LeR once source is confirmed. Application does not need to return to MEF. GLOF 11041 FOCUS FUND KG confirmed a legacy donation from Focus will be funding the full amount of this application. Agreed to proceed with order.
MEF-083-Jan17	Bilirubinometers (Draegar)	W&C	CS/AS	Dawn Morrall	£117,783.93	Yes Please		Draeger are the only bidder, organising a trial 24/02/2017							Approved & Order	will be charitably funded by a special fundraising program – contact to get spec is Dawn Morrall. DM advised equipment is needed to check on jaundiced babies in the community setting. It has been calculated as a starting point that 18 are required and a specification has been written. KG confirmed costs will be covered by fundraising and application will be submitted to Charitable Funds Committee. FJ suggested DM should investigate machines with remote transmitting properties to enable data to be immediately uploaded to TrakCare. Application agreed in principle, items will be ordered on a call off contract basis, potentially over a 2 year period, as funding is made available from Charitable Funds. Action: SB to check there are no maintenance issues. Action: DM to investigate remote transmitting capabilities B provided an update via email; "The Draeger Bilirubinometers require an annual calibration. Each unit must be returned to Draeger for this procedure. Draeger has quoted an annual cost of £185.00 per unit." KG advised that this cost could be included in the fundraising appeal. It was agreed the original business case requesting 6 machines is superseded by this MEF application. KG confirmed that the specification includes remote transmitting.
MEF-090-Feb17	Digital Reminiscence Therapy Software System (My Dementia Improvement Network)	Medicine	CS	Sue McShane	£7,795.00	No		Received quote and information, sent to IT to see if they need any involvement 09/03/17								
				Total	**£364,090.93**					**Total**	**£0.00**					

Corporate

Budget	£0.00	Over/Under	£0.00
Committed	£0.00		
Projected	£0.00		

Mef Ref	Item	Proc Lead	Dept Lead	Value Approved (inc vat)	Pre-req form	CC - 95999 AC - 9812 Analysis code	Supplier	Order number	Order Date	Order Value (Inc VAT)	Del. Date	Inv No.	Date Paid	Comments / Status
				£0.00						£0.00				

Lease

Item	Division / Dept	CC - 11993 AC - 7023 Analysis code	Proc Lead	Dept Lead	Pre-req form	Funding Approved	Lease Company	Equipment Supplier	Equipment	Order number	Order Date	Capital Value (Inc VAT)	Order Value (Inc VAT)	Comments / Status	Del. Date	Delivery Sign Off	Acceptance Sign Off	Entered onto Contract Database
MEF-001-Jun16 - CO2 Laser	Surgery		Lee	Beryl Woodall	Yes	£181,794.00						Moved to 17/18 as per Sean Ceres Approved for 2017/18	Trial arranged for January 2017	OK to Lease equipment is being rented at a cost of £3,500 + VAT per day and has been rented 3-4 times so far. However, this has resulted in a 62 day breach as the machine was not available. Following a long discussion about the viability of owning, renting or leasing the equipment, it was agreed the equipment is necessary and LeR would work with the suppliers to agree the best lease terms. CP confirmed that although the full value of the lease will be applied to revenue it will be spread across the year. CB updated that the machine currently in use is free of charge to the Trust. Application to be moved from the 2016/17 MEF budget to 2017/18. Application will be brought back to MEF in April 2017 as a priority case.				
					Total	**£181,794.00**						**£0.00**	**£ -**					

Lease Amount	£ -
Capital amount of Lease	£ -
Difference	£ -

	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Capital Committed	£ 99,649.72	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Capital Committed Total	£ 99,649.72	£ 99,649.72	£ 99,649.72	£ 99,649.72	£ 99,649.72	£ 99,649.72	£ 99,649.72	£ 99,649.72	£ 99,649.72	£ 99,649.72	£ 99,649.72
Capital Paid	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Capital Paid Total	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Capital Left to Pay		£ 99,649.72	£ 99,649.72	£ 99,649.72	£ 99,649.72	£ 99,649.72	£ 99,649.72	£ 99,649.72	£ 99,649.72	£ 99,649.72	£ 99,649.72
Charitable Committed	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Char Committed Total	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Charitable Paid	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Char Paid Total	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Charitable Left to Pay		£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Leasing Committed	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -
Leasing Committed Total	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -

Mar figures are the value of orders placed prior to the 1st April 2017

Feb-18	Mar-18
£ -	£ -
£ 99,649.72	£ 99,649.72
£ -	£ -
£ -	£ -
£ 99,649.72	£ 99,649.72
£ -	£ -
£ -	£ -
£ -	£ -
£ -	£ -
£ -	£ -
£ -	£ -
£ -	£ -

07/04/2017

EFD Risk Register

Appendix D

Datix ID	RA number / Irregular Maintenance Ref	Site	RA	Date Opened	Category	Domain	Title	Description	Initial Risk Rating	Current Controls (Assurance SV)	Further Actions Required	Costs (Current)	Funding Source (Backlog / Capital/ Revenue)	Year (Backlog / Capital/ Revenue)	Speciality	Risk Lead	Executive Lead	Review date	Lapse (months)	Status	Number of Open Risks	Consequence (current)	Likelihood (current)	Rating (current)
2474	EFD14	Trust Wide	YES	06/03/2017	INFRASTRUCTURE	SAFETY	Risk of failure of EFD assets and infrastructure leading to moderate / major harm to patients	Risks include: • Moderate / major harm to patients due to failure of Trust infrastructure assets, especially in critical areas such as Theatres and DCC • Loss of reputation to the Trust due to service interruption and unwanted media attention • Breach of relevant H & S Legislation • Breach of Best Practice guidance – HTMs • Cancellation / delay to lists, loss of activity • Harm to patients due to interruption of operations in the event of an incident	15	PPMS in place and carried out on a regular basis on all EFD assets / infrastructure, AE audits carried out on an annual basis which identify areas for improvement surrounding specific HTM assets / infrastructure – action plans are written as a result of these audits and monitored to ensure compliance, All incidents of infrastructure failure are reported on the DATIX Web Incident Reporting system and action plans written and completed as required. These incidents are monitored on a regular basis and discussed at relevant H & S and speciality group meetings, Estates Helpdesk (backtraq) is in place and being used for reporting any faults that may arise due to infrastructure failure which are fixed by internal maintenance staff – reactive maintenance regime, Specific risk assessments have been written by relevant Estates Officers and managers identifying the risks associated with failure of specific assets, Projects in place to identify priority areas for improvement, Back log maintenance programme in place to carry out routine maintenance to EFD assets, Capital Programme in place allocating funding to areas most significantly affected, Condition monitoring in place with external contractors, Service contracts are in place with external companies, Critical services are provided on an N+1 basis providing resilience / redundancy implying that any one asset can fail or be under maintenance and service provision will be still be maintained	Condition survey to be carried out on all Trust assets, Priority system for replacement to be put into place and delivered, Cyclical maintenance and upgrade to be provided through capital projects	47,000,000	CAPITAL	2017 / 2018	ESTATES	JACKSON	DEBORAH LEE	07/06/2017	2	OPEN	1	5	3	15
2073	E31	GRH	YES	01/05/2015	AHU	SAFETY	The risk of not carrying out Backlog Maintenance and Inspection/Verification Rectification Work to Specialised Air Handling Units - To include Theatres 3 GRH (E71), Theatre 4 GRH (E70), Theatre 5 GRH) (E69), Theatre 6 GRH (E68), Theatre 7 GRH (E67), Containment Level 3 Room, GRH (E49)	Ventilation Inspection carried out and recommendations highlighted in the report. As yet a scheme / programme of works has not been put into place to address these rectifications and as a result there is a serious potential for failure. Potential for: Infections to patient Staff exposure to Anaesthetic gases. Potential breach of H & S at Work Act 1974 S3 leading to possible enforcement action Trust Reputation – adverse publicity due to media attention Trust Income due to potential loss of theatre activity	16	Annual Verification identifies issues, Condition reports. Servicing of AGSS systems. Previous Notification to Theatres. I.C. Risk. Annual Verifications and sample testing will continue. 5, 6, 8 - 1, 11-14 all revivified and rebalanced where required Sept 16. All verification reports on Share Point. All verification works are on-going and in date	Programme of work/schemes to address the problems/risks. Monitoring of staff (as above). Trust commitment at high level to enter a partnership that addresses the problem. High level Trust input required to recognise and put into place a programme and plan of action	300,000	CAPITAL	2016 / 2017	ESTATES	MATTHEWS	NATAHSA SWINSCOE	23/04/2017	1	OPEN	1	4	3	12
2074	E30	CGH	YES	01/05/2015	AHU	SAFETY	Risk of failure of specialised Air Handling Units and Split Air Conditioning Systems due to condition of them - To include Orthopaedic Recovery, CGH (no risk assessment - Backtraq ref. 300), Apollo Theatre AHU CGH (E34), Rendcombe Ward Side Rooms CGH (Backtraq ref. 306), Gamma Camera (Backtraq ref. 301)	Staff exposure to Anaesthetic gases. Potential breach of H & S at Work Act 1974 S3 leading to possible enforcement action Trust Reputation – adverse publicity due to media attention Trust Income due to potential loss of theatre activity Risk of excessive high temperatures to personnel, excessive high temperatures/ humidity to medical equipment, Disruption to patient services & business continuity	16	Monitoring & responding to existing services as opportunity arises. All reverification complete so far as is reasonably practical by Dec 2016. Replacement schedule is included on Capital programme as cyclical programme.	Full survey & Capital investment required for replacement of services.	725,000	CAPITAL	2016 / 2017	ESTATES	HATTON	NATAHSA SWINSCOE	23/04/2017	1	OPEN	1	4	3	12
1785	C6	GRH	YES	08/04/2013	FLOOR	SAFETY	Risk of Slips, Trips and Falls in Receiving and Distribution Catering Area - Damage to Flooring in receiving and Distribution Catering Area (Stores) leading to possible harm to staff	The concrete base was of the wrong grade causing the surface to leech, the flooring surface has failed to adhere to the concrete due to the surface underneath being unsound. Potential injury to pedestrians within the Catering stores area including Catering Staff, Contractors and Delivery personnel leading to harm to staff from slips / trips and falls. All staff are aware of the state of the flooring and take care accordingly. No recent incidents have been reported	9	Patch repairs in order to reduce risk, however these will be temporary in lifespan and will fail eventually as the construction of the floor in general is not suitable for the application. Slips, trips and falls risk assessment being reviewed 3 August 2016	Provide a safe environment Ref: GHNHST plan to reduce trips and falls and patient and staff safety, Estates to get quotes from Contractors for repair to the Catering flooring, Temporarily ensure that the area is as safe as possible prior to repair work being carried out eg. signage, and ensure that the risk is communicated to all staff. To be addressed once whole Catering work area layout has been agreed	25,000	CAPITAL	2017 / 2018	CATERING	ALDER	NEIL JACKSON	31/01/2018	10	MANAGED	1	3	4	12
1571	E75 211	GRH	YES	15/07/2011	CALORIFIER	SAFETY	Risk of Failure of Tower Block Heating Calorifiers leading to total failure of heating services to the Tower Block	Failing dated heating calorifiers which could result in total failure of heating services to the main tower block and associated patient services. Hot water and heating compromised resulting in inadequate ward temperatures and a possible increase in waterborne bacteria counts owing to fluctuating temperatures with the hot water system. One heating calorifier has failed already. Second Calorifier has now failed.	12	Increase PPMs and reactive repairs to maintain equipment prior to replacement. Non-essential heating services to non-clinical areas bypassed or re-routed to maintain best possible supply to clinical areas. Regular sampling and testing. Consultant appointed to design an upgrade scheme	Capital investment to replace modulated heating Calorifiers. All four Calorifiers to be replaced with heat plate exchangers which will be more efficient	200,000	CAPITAL	2016 / 2017	ESTATES	ROWE	NEIL JACKSON	22/02/2017	-1	OPEN	1	4	3	12
1569	E74 85	GRH	YES	15/07/2011	ELECTRICAL PANEL	SAFETY	Risk of power failure and electrical shock due to a panel Failure in the Tower Block (10th and 11th Floor)leading to harm to both staff and patients	There is a high risk of total power failure and electrical shock form dated LV control panels and switchgear leading to risk of electrical shock	16	Permit to work, trained and qualified staff only to work on panels. RAMS for all works. Electrical Safety Group has been established to monitor progress and action	Capital investment to replace current HV control panels. It is recommended to replace the current control panels with new Sauter compatible panels	100,000	CEF	2016 / 2017	ESTATES	WEIR	NEIL JACKSON	23/03/2017	-1	OPEN	1	4	3	12
2250	E57	GRH	YES	27/11/2015	EXTERNAL BUILDING FABRIC	SAFETY	The risk of harm to patients staff and visitors from debris falling from height from the Tower Block roof and façade. The risk of water ingress into the roof structure leading to structural deterioration and damage to equipment.	Due to age and deteriorating condition of the external façade of the Tower Block there is a risk of debris / cladding falling from height: 1) High winds, water ingress and general deterioration of the Tower Block Roof Mansard materials including roof felt and boards have a strong possibility of falling from the roof to ground level. 2) Spalling of loose masonry or cladding panels to the external elevations of the Tower Block Due to the design of the mansards not all elevations have access. The loss of water protection is also having an impact on the wood board materials	20	Quotes being obtained for temporary repair of felting. Removing loose materials where possible and monitoring the areas. Securing as a temporary measure loose cable trays. Monitoring areas and assisting with local remedial repairs as a reactive measure. Window cleaning has been stopped due to condition of the Tower Block. All staff are aware of the Trust Incident Reporting system and 5757 number to call in the event of an incident Capital Programme 2016 / 2017. Steel work has been completed. Cladding to be carried out and condition survey undertaken. Loose concrete removed Dec 2016	**Temporary solution:** Securing the mansards materials and making them wind proof, Removal of loose cladding materials from façade. **Permanent solution:** Replacement of roof cladding to Tower Block, Repair of external façade Undertake a structural survey of both the internal and external elevations of the Tower Block to identify the condition of the cladding panels and their fixings Making the mansards waterproof	1,000,000	CAPITAL	2016 / 2017	ESTATES	JACKSON	NEIL JACKSON	24/04/2017	1	OPEN	1	5	2	10
2218	EFD8	CGH	YES	23/09/2015	FIRE ALARM	SAFETY	Risk of failure of Unsupported Zytron Fire Alarm Installation within Sandford Education system, CGH leading to potential major harm to all users of the Education Centre	Potential risks include: • Fire alarm fails leading to no automatic detection status within the premises • Possible Improvement Notice issued by Fire Service. • Loss of reputation, adverse publicity and loss of public confidence that we are operating a safe site • System failure may lead to loss of property in part or in full with severe financial consequenc • System failure may lead to loss of property in part or in full with severe service provision and environmental consequence	9	System is being maintained with support. On Capital Programme 2016 / 2017. Quotes have been received for replacement of fire alarm system and emergency lighting	Life expectancy of equipment has generated action to replace current system. Needs to be replaced by the end of 2016	40,000	CAPITAL	2016 / 2017	FIRE	ROWE	NEIL JACKSON	27/02/2017	-1	OPEN	1	5	2	10
2033	326 EF21	GRH	YES	03/03/2015	FLOOR	QUALITY	Risk of further damage to supporting concrete beams in the kitchen void (Amalgamated with RAC4) leading to potential closure of the Kitchens due to structural damage	Potential risks include: • The integrity of the whole of the floor is compromised • Bacteria collecting in the undercroft which could affect the food being produced • Pests, both ground and airborne will be drawn to the area as a result of food waste which can leak through the flooring • Water collects in the undercroft which increases the risk of legionella bacteria and pseudomonas bacteria proliferating • There is a large gas pipe situated under the beams and this could potentially be damaged • Risk of further deterioration to supporting concrete beams • Structure damage due to evidence of supporting beams fatigue / deterioration	12	Specialist survey carried out; Monitor area / risk assessed, support props (Acrow Props) installed. Quarterly deep clean of undercroft takes place; DATIX Incident reporting; Business case as been written for this (November 2016). It has been tendered but contractors have not been appointed to carry out the work - Design underway Feb 2017	To install a grid of steel beams under the precast concrete beams to provide additional support, and to undertake full concrete repairs to all areas of cracking and spalling concrete, including preventative 'active' rust treatment to all areas of rusting reinforcement and the application of a surface protection coating	100,000	CAPITAL	2016 / 2017	ESTATES	RUSSELL	NEIL JACKSON	25/04/2017	1	OPEN	1	5	2	10
2304	E63	GRH	YES	09/03/2016	ROOF LEAK	SAFETY	Risk of moderate harm to all users of buildings due Roof Leaks - to include Orchard Centre GRH, (E51), Estates Workshop GRH (E18), Theatre Plant Room GRH (E44), Wotton Lodge (E58)	There are a number of buildings Trust Wide which have leaking roofs. These are currently on the EFD Risk Register and these are The Orchard Centre, Theatre Block, and the Estates Building, Sandford Education Centre, CGH The roofs throughout the who site are generally in a bad state of repair Risks include: • Slips, trips and falls causing moderate injury, especially to vulnerable persons • Loss of Trust reputation due to unwanted media attention • Possible financial loss due to compensation claims and potential fines • Potential loss of Trust activity. This will result in cancelled operations • Ceilings collapsing • Deteriation of building to a point where it becomes unusable.	9	Short term patch repairs are made as required, Buckets are used to collect rainwater temporarily, All leaks are reported to the Estates helpdesk when then occur, Wet floor signs are in place and water cleared up by staff as required. Theatre block Roof Design and specification to be returned at the end of September 2016 - spec has been returned, tender submitted and contractors appointed Orchard Centre Roof to be addressed as part of the relocation project from Wotton Lodge Wotton Lodge Roof - decision to be made as to whether to make temporary repairs Estates Workshop - no change to risk assessment	Long term repairs to roofs needed	1,190,000	CAPITAL	2016 / 2017	ESTATES	ROWE	NEIL JACKSON	23/03/2017	-1	OPEN	1	3	3	9
1563	294	Trust Wide	NO	15/07/2011	BMS	SAFETY	Risk of failure of Trustwide BMS network leading to potential harm to all hospital users	Potential loss of electronic control of systems throughout hospital (Obsolete equipment and software no longer supported or available). Risks include breach of relevant H & S legislation leading to improvement action; potential loss of reputation to the Trust due to failure of system; financial loss to the Trust	15	Potential to be included through the GRH Capital and Energy Fund project (CEF) but this not until 2017. Estates business case required if escalation needed. Currently there is service contract in place with Sauter. No incidents have been reported.	Upgrade and improvement program for GRH BMS systems. Awaiting External Contract	180,000	CAPITAL	2017 / 2018	ESTATES	HEAYSMAN	NEIL JACKSON	26/09/2017	6	MANAGED	1	3	3	9
2289	S10	CGH	YES	12/02/2016	CCTV	SAFETY	Increase in risk of personal safety due to lack of financing for upgrade CCTV system at Cheltenham General Hospital	Increase in risk of personal safety as cameras are not monitored. Risk of breaches of Data Protection Act 1998, and other relevant legislation. If inspected by the ICO for CCTV the system could be deemed not fit for purpose and leave Trust open for prosecution / fine	12	The current CCTV system is currently part the way through an upgrade and is waiting for the agreed funding to be released. 20% of the existing CCTV cameras are either not recording images or recording images that are not fit for purpose. Continue to monitor incident reports and where required Continue to review policies and risk assessments to ensure the security of the area	Next phase of CCTV upgrade to be started as a matter of urgency - Submit business case. Continue to review Police requests for Urgent CCTV images LSMS's will attend out of hours. Maintain risk assessment annually. Monitor CCTV signage, repair or place old / broken signs	25,000	CAPITAL	2016 / 2017	SECURITY	SPEKE	NEIL JACKSON	30/03/2017	0	OPEN	1	3	3	9
2215	E47	CGH	YES	23/09/2015	ROOF LEAK	SAFETY	The risk of ceilings collapsing, water ingress into light fittings, bacterial growth in carpets and deterioration of the building to the point where it becomes unstable due to Leaking roof of Sandford Education Centre, CGH	At the moment the roof is leaking. Potential risks include: • Ceilings collapsing • Water ingress into light fittings • Bacterial growth in carpets • Deteriation of building to a point where it becomes unusable. • Loss of reputation to the Trust due to unwanted media attention should an incident occur • Financial loss to the Trust due to compensation claims from third parties • Potential breach of relevant Health and Safety legislation leading to improvement / enforcement action	12	Risk Assessment completed, All staff are aware of the incident reporting procedure to follow in the event of an incident, Vegetation has been removed from the roof which has relieved the issue somewhat. The situation is only an issue when it rains. Cooperation in place between Estates staff and SEC staff to manage the situation. Ceiling tiles changed as necessary and buckets used to catch rainwater - jobs reported to 6800 as necessary and guttering cleaned out	Replace the concrete roofing material and foam membrane to ensure plants can't grow and to make the roof safe, Possibility of temporary drain trays to catch the water, Carpets to be cleaned on a regular basis, Quote to be obtained for the replacement of the roof	50,000	CAPITAL	2017 / 2018	ESTATES	HATTON	NEIL JACKSON	26/09/2017	6	MANAGED	1	3	3	9
2303	E62	GRH	YES	02/03/2016	DRAINS	QUALITY	Risk of harm to all hospital users and the Trust due to cross-contamination and drainage collapse due to the state of the drains (sewage) - to include Tower Block Walkway (E50)	The drains at GRH are in a bad state of repair. The pipe work is ageing and risks at the moment include: • Blockages which could potentially lead to flooding internally and externally • Drainage collapse • Risks to health due to potential exposure to sewage • Slips, trips and falls There have been 134 reports of blocked drains, or sinks draining slowly on the BackTraq system at both sites from 1 January 2015 to 25 September 2015.	9	Equipment being sourced to clean drains internally thus reducing cost of external contractors. PPE is provided for maintenance staff when unblocking drains, All faults are reported to the Estates helpdesk for rectification . Work to start on cleaning and repairing on 5th December 2016	All drains and associated pipework to be repaired / replaced. Survey to be carried out on condition of all the drains at GRH to identify priority areas.	50,000	CAPITAL	2016 / 2017	ESTATES	ROWE	NEIL JACKSON	23/04/2017	1	OPEN	1	3	3	9
2283	AEG6	GRH	YES	11/11/2015	PATHWAYS / HIGWAYS	SAFETY	Risk of slips / trips / falls and minor to moderate harm to both patients and staff due to condition of the pathways and highways at GRH	The Pathways and Highways Spending Restrictions and the lack of an identifiable resource to commit to the challenge of addressing issues has also been a contributory factor. Staff, visitors and patients could be moderately harmed due to slips, trips and falls on uneven surfaces – possibly RIDDOR reportable. Potential breach of the Health and Safety at Work etc Act 1974 Sections 2 and 3 leading to possible improvement / enforcement action, Damage to vehicles and financial loss due to repair of the vehicle	9	Warning signs, road spray areas of danger, Trends being monitored on the DATIX Web incident reporting module – see incident numbers above, Survey has been carried out and quotes received of £11, 000 to carry out repairs needed, Patch repairs carried out as required. Audits carried out by Facilities Officer in conjunction with Estates Department. Responsibility for audits to be passed to Grounds and gardens instead of Estates. Location of pot holes has been determined and repairs need to be carried out. Capital Programme 2016 / 2017 - funding allocated and work being quoted for and sourced	Repairs by external contractor to be carried	25,000	CAPITAL	2016 / 2017	AEG	SMITH	NEIL JACKSON	30/03/2017	0	OPEN	1	3	3	9
2369	AEG7	CGH	YES	03/02/2016	PATHWAYS / HIGWAYS	SAFETY	Risk of slips / trips / falls and minor to moderate harm to both patients and staff due to condition of the pathways and highways at CGH	Potential risks include: • Slips, trips and falls leading to moderate injury and RIDDOR reportable incidents • Breach of relevant H & S information leading to potential improvement notice being served on the Trust • Financial loss to the Trust from legal fees and compensation claims • See DATIX Web for incident reports	9	Warning signs, road spray areas of danger, Trends being monitored on the DATIX Web incident reporting module – see incident numbers above, Survey has been carried out and quotes received of £11, 000 to carry out repairs needed, Patch repairs carried out as required, Audits carried out by Facilities Officer in conjunction with Estates Department. Responsibility for audits to be passed to Grounds and gardens instead of Estates. Location of pot holes has been determined and repairs need to be carried out. Capital Programme 2016 / 2017 - funding allocated and work being quoted for and sourced	Repairs by external contractor to be carried	25,000	CAPITAL	2016 / 2017	AEG	SMITH	NEIL JACKSON	30/03/2017	0	OPEN	1	3	3	9

2088	334 E38	GRH	YES	06/05/2015	BOILER	SAFETY	Risk of loss of heating due to age of failure of the boilers in both Wotton Lodge (E38) and Severn Dialysis (E37)	Potential Loss of Heating and Hot Water in the Building as a result of Ageing and Non Energy Efficient Strebel Boiler. Strebel Boiler has been Installed for over 25yrs. Potentially expensive to maintain, High carbon footprint and High Energy Cost. This will potentially affect the Dialysis patients using this facility as well as the staff	12	Presently Estate has a PPM contract in place for the existing boiler. We have been advised to look at replacing it due to ageing and lack of genuine spare parts in case of a major failure. Project suspended.	Replacement with a Modern and Energy Efficient Boiler that will cope with modern demand and less expensive to maintain. Need to determine whether boiler replacement will form part of the CHP works	40,000	CAPITAL	2017 / 2018	ESTATES	OLAYIWOLA	NEIL JACKSON	23/03/2017	-1	OPEN	1	3	3	9
1767	296 53	GRH	YES	31/12/2012	CCTV	SAFETY	Increase in risk of personal safety due to lack of financing for upgrade CCTV system at Cheltenham General Hospital	Inadequate and aging equipment. Inadequate CCTV suite facilities. Inadequate management system. (Please see attached risk Assessment). Loss of security and production, safety of patients, visitors and staff members. CCTV system is out of date and constantly breaking down	16	All CCTVs and management system to be reviewed. Works being scoped. Link with Billfinger as they need to do this as well.	Old CCTV to be replaced as necessary.	25,000	CAPITAL	2016 / 2017	SECURITY	SAUNDERS	NEIL JACKSON	30/03/2017	0	OPEN	1	3	3	9
2348	E66	GRH	YES	13/06/2016	ELECTRICAL DISTRIBUTION BOARD	SAFETY	Risk of failure of Electrical coil / contactors on Ward 7a leading to complete electrical failure causing minor / moderate harm to patients	7a had loss electrical power - defective coil supplying the non-essential distribution board was found to be the cause - failure of electrical coil and loss of electrical supply. Potential risk includes: • Complete electrical failure to non-essential distribution boards resulting with possible ward closure • Business Interruption • Unwanted media attention and loss of reputation • Breach of relevant H & S legislation	9	Alterations to the electrical wiring were completed and undertaken within the switch panel to enable the non-essential distribution to be re-supplied from the essential bus-bar. Risk Assessed. It will cost £18, 000 to replace all coils within the Tower Block	Survey of all electrical switch panels on the Tower Block to ensure that this doesn't happen again. Rewire of all distribution boards. Source funding to replace aged coils and contactors throughout the Tower Block supplying individual non-essential distribution boards on the wards.	18,000	CAPITAL	2016 / 2017	ESTATES	WEIR	NEIL JACKSON	23/03/2017	-1	OPEN	1	4	2	8
1906	E8	GRH	YES	04/04/2014	LV	SAFETY	Risk of failure of LV Circuit breaker supplying the Tower Block leading to loss of power for a considerable period	Loss of Power for considerable period if the old Circuit Breaker Fails to operate when required in the event of a Main Power failure to site where by the Emergency Generator at ECA needs to be used. Risk of: Trust could be harmed due to adverse publicity and unwanted media attention in the event of a complaint being received or in the event of an incident; Potential breach of relevant H & S legislation leading to possible improvement / enforcement action; Potential financial loss to the Trust in compensation claims or fines	12	Switching embargo placed on the panel for routine testing. Business case has been written for replacement (November 2016)	Replace panel or provide switch until panel is replaced	300,000	CAPITAL	2017 / 2018	ESTATES	HEAYSMAN	NEIL JACKSON	23/03/2017	-1	OPEN	1	4	2	8
1968	E11	CGH	YES	19/12/2014	EXTERNAL BUILDING FABRIC	SAFETY	Risk of harm or injury from loose, blown or spalled render and masonry to the external elevations of Hazleton Ward/Centre Block (amalgamated with E35 due to being the same risk) Risk of structural failure due it internal dilapidation of Hazelton Ward Ceiling	Potential Risks include: • Structural failure of roof • moderate harm / injury to patients / visitors / staff / members of the public due to falling concrete • disruption to hospital services • loss of Trust reputation • loss of revenue • failure to comply with relevant legislation Structure of floor is collapsing generating uneven surface and splits to flooring material leading to slips, trips and falls Possible breach of relevant H & S Legislation	20	'Snapshot' visual survey undertaken from ground level to establish the scope of the loose, blown or spalled render and masonry to the external elevations of the building. Any dangerous material to be removed, and Harris fencing has been put up to isolate persons from the area. Area being monitored. Funds allocated within 15/16 capital programme. Guy Russell will lead on works delivery programme. Ward is currently not in use by patients aned is used as a storage area. Area is now vacant and there is no access to unauthorised persons.	To undertake a comprehensive structural survey of the external elevations of Centre Block to identify all areas requiring repair or replacement and to undertake those works	270,000	CAPITAL	2016 / 2017	ESTATES	RUSSELL	NEIL JACKSON	25/04/2017	1	OPEN	1	4	2	8
2378	E76	GRH	YES	27/07/2016	ELECTRICAL CIRCUIT	SAFETY	The risks associated with existing aluminium cables supplying electrical circuits throughout the Tower block basement due to deterioration	The aluminium conductors have started to fail due to age and cause circuits to trip resulting with interruption to circuits until rectified. The cable insulation of individually cores are deteriorating resulting with high insulation readings. Risk of fire to property and assets, Health and safety issue due to breach of relevant Health and Safety Legislation. Failure of electrical circuits, Evidence of heat build-up deteriorating aluminium cable	16	Electrical contractor to provide quote for complete rewire of aluminium cables. Checked every five yearly under the five yearly installation check.	Carry out rewire. Repalce aluminium cable for FP fire resistant cabling. In the electrical condition report of July 2016 it is was recommended the aluminium cabling supplying all circuits should be replaced. Funding for heat mapping required	40,000	CAPITAL	2017 / 2018	ESTATES	WEIR	NEIL JACKSON	26/09/2017	6	FUNDING	1	4	2	8
2144	E40	GRH	YES	03/06/2015	HWS VALVES	SAFETY	Risk of not being able to isolate HWS supplies to the Tower Block wards and departments under an emergency or essential /maintenance work. This could seriously affect the activity of the Trust	Any "burst" or similar requiring maintenance isolation is unlikely. It has also resulted in planned insurance inspections cannot be undertaken and water re-engineering work is incomplete.	12	Notify Estates Staff that valves do not hold and not to rely on them. 50% complete. Underway 31 Jan 2017	Replacement of HWS flow and return valves wards and departments within the Tower Block - 50% complete	30,000	CAPITAL	2016 / 2017	ESTATES	ROWE	NEIL JACKSON	25/04/2017	1	OPEN	1	4	2	8
2034	298 E7	GRH	YES	03/03/2015	SOIL PIPE	SAFETY	Risk of flooding of the bed store in the basement of the Tower Block GRH due to the condition of the main horizontal soil and vent stack supplying the Tower block A wards leading to possible harm to patients because the water may need to be turned off for emergency repair	Potential of: flooding of the bed store and restricting use of toilets, sluice hoppers and macerators etc (any equipment connected to the soil pipe) throughout the Tower Block A wards	12	Pipe Work is patched up as required. Pressure jetting of soil pipe work to remove the blockage. Temporary fibre glass liner mould has been installed external to the damaged soil pipe.	LONG TERM: replace all the cast iron soil piping in this area - To include all branch offs connected to the main horizontal pipe run. Survey of the area to be carried out.	50,000	CAPITAL	2017 / 2018	ESTATES	ROWE	NEIL JACKSON	26/09/2017	6	MANAGED	1	4	2	8
1939		CGH	NO	01/08/2014	CALORIFIER	QUALITY	Risk of Failure of Calorifiers - to include Day Surgery 2A #2 CGH (302), Centre Block Heating Calorifiers #2, CGH (303), Pathology calorifiers #2, CGH (304)	Dated and non efficient calorifiers - high maintenance costs. Efficiency savings to be made	9	All calorifiers are working currently. PPMS carried out	Replace with efficient heat plate exchangers. Calculations to be carried out on energy saving and centralising / rationalisation	150,000	CAPITAL	2017 / 2018	ESTATES	SPILLER	NEIL JACKSON	26/09/2017	6	FUNDING	1	4	2	8
2379	E79 348	GRH	YES	05/08/2016	HV TRANSFORMER	SAFETY	Risk of failure of individual transformers due to overloading due to uncertainty of site wide electrical capacity for future projects leading to harm to patients - Site wide HV transformer	Minimal available electrical capacity was highlighted following the recent installation of the mobile cardiac unit positioned at London Road entrance supplied from one of the transformers at Mortuary sub-station. Additional electrical equipment added on to existing electrical infrastructure could possibly cause overload/overheat of transformer. Resulting with little/no resilience if transformer failed. Capital talking about the feasibility of an additional mobile MRI scanner to be located on an already strained electrical network. Potential Risks include: • Risk of fire hazard / health and safety issue • Failure of individually transformers due to overloading	9	Periodically monitoring and recording loadings as and when informed of Capital projects. Risk Assessed	Source funding to employ electrical consultant to complete an in-depth loading survey of the site wide electrical network	10,000	CAPITAL	2017 / 2018	ESTATES	WEIR	NEIL JACKSON	26/09/2017	6	FUNDING	1	4	2	8
1551	E78 347	GRH	YES	14/07/2011	BUSBARS	STATUTORY	Risk of Complete electrical failure to North and South essential and non-essential supplies throughout tower block due failure of Tower Block electrical bus-bars	Tower Block BusBArs outdated and vulnerable and at risk of failure. Estates have no record of maintenace on the infrastructure of the tower block bus-bars ever being carried out. Risk of fire, electrical failure of bus bars / health and safety issue Failure of electrical circuits	12	Risk Assessed	Employ specialist electrical company to test and inspect bus-bars and obtain loading. Source funding to employ specialist contactor to complete condition report and carry out maintenance on all bus-bars.	12,000	CAPITAL	2016 / 2017	ESTATES	WEIR	NEIL JACKSON	23/03/2017	-1	OPEN	1	4	2	8
2217	E46	CGH	YES	23/09/2015	CEILING	SAFETY	Risk of collapse of the suspended ceilings of all corridors within College Road Wing due to failure of clips leading to potential harm to all users of the corridors	At the moment much of the ceiling is being held together by cable ties. Risks include: • Potential breach of the H & S at Work etc. Act 1974 Section 2 and 3 (employees and persons other than employees) • Loss of reputation to the Trust due to unwanted media attention due to the state of the ceilings and possible injury to both staff and patients • Financial loss to the Trust due to compensation claims and fines • Moderate / major injury to all users of the hospital including vulnerable persons	12	Raised awareness of EFD concerns. Attempting to add to Backlog Maintenance procedure. Works underway - to be completed June 2017	Complete suspended ceiling replacement, re-fixing of suspended services & re-evaluation of fire alarm detection	50,000	CAPITAL	2016 / 2017	ESTATES	HENDERSON	NEIL JACKSON	23/03/2017	-1	OPEN	1	4	2	8
2368	E2	Trust Wide	YES	04/10/2012	LEGIONELLA	SAFETY	Risk of Legionella Bacteria proliferating in hot and cold water systems - (to include 350 Swan Neck taps (Risk Assessment E33 GRH and Backlog Maintenance Notification 305 CGH). Shower (Backlog maintenance notification 307 CGH), E17 Lagging of all CWS Tanks	Risk to the Trust due to a possible breach of the Health and Safety at Work etc Act leading to enforcement action Risk of inhalation of airborne water particles leading to Legionnaires Disease – risk to staff, patients, members of the public, contractors, visitors Risk of outbreak of Legionnaires' Disease leading to adverse publicity to the Trust Financial harm to the Trust through legal fees and compensation claims should an outbreak of Legionnaires' disease occur • WS2437: 31 Aug 2016: Legionella bacteria discovered in water outlets in ward 9a, Tower Block, GRH	20	Policies and Procedures are in place detailing the controls in place to minimise the risk of proliferation of legionella bacteria, Water in the cold water system is kept below 20°C and hot water system above 55°C time temperature records are conducted on a weekly basis, All outlets – including taps, showers and toilets are flushed for at two to three minutes twice a week. On closed wards all outlets are flushed through for three minutes twice a week in line with PN04-17, Water systems are treated using Copper Silver Ionisation and Chlorine Dioxide to prevent the growth of legionella bacteria, Monthly testing / sampling of the water for Legionella bacteria is carried out – including ensuring that test equipment is annually calibrated. Swan neck taps have been replaced on ward 9a	330 Swan Neck taps to be replaced with shorter neck taps to eliminate risk of legionella growth (Risk Assessment E33 GRH and Backlog Maintenance Notification 305 CGH). CGH, Lagging of all CWS Tanks with at least 50mm mineral fibre material with aluminium foil finish. Inspection and re-lagging of all Tanked and mains water downstream pipework, GRH (E17 Risk Assessment). Dead Legs in TB basement, GRH to be removed. Audit forms of tap flushing carried out by the Domestics to be regularly monitored by the Domestic Department so that all records are kept up to date	280,000	CAPITAL	2016 / 2017	EFD	JACKSON	MAGGIE ARNOLD	22/02/2017	-1	OPEN	1	4	2	8
2018	316 E12	GRH	YES	26/02/2015	ELECTRICAL DISTRIBUTION BOARD	SAFETY	Risk of failure of Electrical Distribution board main isolators leading to loss of power to critical services	Complete failure of outdated electrical distribution board – main isolator on distribution board: Potential Risks include: • Loss of power to critical services • Damage to infrastructural cabling, Health and safety and fire issues • Risk of electric shock	16	5 year program contracted for electrical condition reports. Issuing HTM 06-02/06-03: Certificate of authorisation for live working PTW prior to any work on non-compliant distribution boards. Service Contract in place, regular PPMS carried out and distribution boards being upgraded as part of a rolling programme	Review site wide and upgrade to trust specification - Full metered Schneider Acti 9. Path Lab distribution board upgrade to be completed by Dec 2016. Programme to be established for remaining non-compliant IPX2 boards. Electrical distribution board upgrade for all areas. Replace individual circuits with recommended circuit protection device. Monitor electrical condition reports. Continue issuing PTW and ensure PPE is worn	100,000	CAPITAL	2017 / 2018	ESTATES	WEIR	NEIL JACKSON	26/09/2017	6	FUNDING	1	4	2	8
2349	E65	GRH	YES	13/06/2016	MEDICAL GAS	SAFETY	Risk of harm to patients and infrastructure failure due to failure to carry out Remedial work To 2013 Medical Gases Audit	Risks include: Patient/Trust Image - System Failure Staff/Contractor/Patient Trust Image - Hazard associated with non-compliant systems and equipment Patient - Serious injury/potential loss of life Non-compliance with HTM02-01 (Best Practice) - Insufficient/competent A.P. Cover Potential Breach of relevant H & S legislation leading to improvement / enforcement action Trust Reputation – adverse publicity due to media attention Trust Income due to potential loss of theatre activity	12	Action plan to undertake recommendations completed, Risk Assessment completed. 50 % of action plan completed	Funding and Resource to be made available to undertake a scheme to complete Action Plan. Controls in place locally. AE to undertake site audit.	100,000	CAPITAL	2016 / 2017	ESTATES	MATTHEWS	NEIL JACKSON	23/03/2017	-1	OPEN	1	4	2	8
2184	339 E42	GRH	YES	23/07/2015	ELECTRICAL SWITCHGEAR	SAFETY	Risk of complete failure of electrical switchgear resulting with department shutdown and loss of body storage due to non-compliant electrical switchgear in Redwood House main electrical incomer upgrade	Power failure resulting in department shutdown and loss of use to training rooms and restaurant - Old obsolete non compliant switchgear. Following a recent electrical shutdown to the building it was found that the mains electrical incomer isolator was non-operational. Resulting with isolation of the electrical supplies to the switchgear being isolated further down the electrical network. Departments affected by electrical shutdown: Redwood House, Redwood House Restaurant, Clinical Academy, Clinical Projects (IT Portacabin. Complete failure of electrical switchgear resulting with potential department shutdown and loss of body storage Breach of relevant H & S Legislation leading to possible improvement action Loss of reputation to the Trust due to unwanted media attention Financial loss to the Trust due to fines and compensation claims	9	Can be isolated further down electrical distribution network within Redwood House / Risk Assessed	Electrical switchgear upgrade - Replace existing main incomer isolator	3,000	BACKLOG	2016 / 2017	ESTATES	WEIR	NEIL JACKSON	23/03/2017	-1	OPEN	1	3	2	6
2282	E56 342	GRH	YES	03/02/2016	CEILING	SAFETY	Risk of harm to patients and staff due to collapse of Tower block ward 8a metal ceiling leading to minor / moderate harm	Potential risk of metal ceiling collapsing when interfering (removing or refitting) metal ceiling tiles which is an health and safety issue. Potential risks include: • Ceiling tiles falling and causing minor / moderate injury to any persons in the vicinity	12	Dynamic risk assessment carried out prior to interfering with ceiling, Contractor attended site and carried out repair to ceiling section, Replacement ceiling obtained	Replace metal ceiling grid for modern suspended ceiling and textured ceiling tiles. Make DLO and Contractors aware of risk prior to works commencing	128,000	CAPITAL	2017 / 2018	ESTATES	WEIR	NEIL JACKSON	26/09/2017	6	MANAGED	1	3	2	6
1933	308	CGH	NO	01/08/2014	CONDENSATE RECEIVER	STATUTORY	Risk of failure of condensate Receiver - to include College Road Wing (308), Theatre Block (309) leading to loss of heating and	Risk of failure. Dilapidated equipment passed optimum efficiency risk of failure leading to lengthy service delays and loss of heating Loss of reputation to the Trust	6	Increased PPMs. Standby pump operational if failure is at a particular point	Condition survey to be carried out to determine single point of failure prior to replacing with efficient equipment.	30,000	CAPITAL	2018-2019	ESTATES	SPILLER	NEIL JACKSON	23/03/2017	-1	OPEN	1	2	3	6
1556		GRH	NO	14/07/2011	EXPANSION CISTERN	SAFETY	Risk of failure of outdated Tower Heating Expansion Cistern leading to loss of heating and moderate harm to patients	Heating feed system requires capital investment to replace outdated equipment.		Increased maintenance activity	Heating feed system requires capital investment to replace outdated equipment.	12,000	CAPITAL	2017 / 2018	ESTATES	ROWE	NEIL JACKSON	26/09/2017	6	MANAGED	1	2	3	6
2082	325 E20	GRH	YES	06/05/2015	LV	SAFETY	Risk of loss of power due to no LV generator connection at the following substations (LV generator connection from sub stations; ECB, Orchard Centre, Mortuary and Redwood House)leading to potential harm to patients	Interruption to electrical supplies to wards / departments due to no permanent connected LV cables from generator connection box to LV switchgear - risk of down time of electrical supplies to wards / departments interrupted	16	Risk assessed. HV ring main. Two transformers in place Ability to cross feed from one transformer to another in the event of failure – but requires load shedding therefore ability in place to maintain critical services. Mortuary is potentially able to tap into the Tower Block if necessary	Install permanent LV cables from generator box to LV switchgear. Supplier to provide appropriate equipment to be able to tap into main?	30,000	CAPITAL	2017 / 2018	ESTATES	WEIR	NEIL JACKSON	26/09/2017	6	MANAGED	1	4	1	4
1574		GRH	NO	15/07/2011	LIGHTING	QUALITY	Risk of lighting failure due to non-compliance of existing IT Lighting Circuit	Lighting circuit non compliant require update. Risk is failure of lighting.		Backlog maintenance. When any refurbishment takes place then the lighting circuitry is reviewed and upgraded as necessary which also saves cost	Non-compliant lighting requires update - updated as areas are refurbished	10,000	BACKLOG	2018-2019	ESTATES	WEIR	NEIL JACKSON	26/09/2017	6	MANAGED	1	1	2	4
												5,723,000									74			

Unapproved schemes risks management

APPENDIX E

Division	Business case category	Capital Investment £	Capital type	Ref	Date of orginal bid	Title	Description	Current Status	Risk Domain	Risk Impact	Current Controls (Assurance)	Further Actions Required	Assuring Committee / Monitoring	Monitoring / Assurance Actions	Comments	Risk Lead	Executive Lead	Consequence (current)	Likelihood (current)	Rating (current)
Medicine	Capital	356,402	Building/Engineering	M006	01/01/2017	Severn Dialysis Unit Extension	Extension to existing dialysis unit on GRH site	Differed pending next annual business case round	Business	loss of growth opportunity	Monitoring market response for competition	Business case updated for whole service strategy ahead of 2018-19 business case round	Operational Directors Group	Status Updates to DG		Roger Blake	Natasha Swinscoe	2	3	6
Diagnostics and Specialities	Capital	62,500	MEF	DS007	01/01/2017	Radiotherapy E-referral & Consent (Casper A)	picked up on TRACK 2.0 Oncology build	Not Approved	Quality	Service interruption, loss of data	Service has special controls place to prevent system disruption		Operational Directors Group	Status Updates to DG		Tracy Iles	Natasha Swinscoe	4	3	12
Diagnostics and Specialities	Capital	2,850,000	Major Equipment	DS016	01/01/2017	Interventional Radiology Replacement and Expansion	bid to modernise and develop the service offer	Not Approved	Business	Loss of opportunity	Monitoring market response for competition	Develop business case for 2018-19 business case round	Operational Directors Group	Status Updates to DG		Tracy Iles	Natasha Swinscoe	2	4	8
Surgery	Capital	203,690	IT	SU021	01/01/2017	Audiology Hardware replacement	Equipment beyond service support life	Bid next year on rolling replacement basis	Business	Service interruption	In year bid to MEF in case of individual plant failure	Develop business case for 2018-19 business case round	Operational Directors Group	Status Updates to DG		Beryl Woodall	Natasha Swinscoe	4	3	12
Surgery	Capital	15,000	MEF	SU022	01/01/2017	AuditBase Server replacement	Captures activity- only available source at the current time	Differed pending next annual business case round	Quality	Service interruption, loss of data	Service is putting special controls place to prevent system disruption	IT to advise on hosting service on different server	Operational Directors Group	Status Updates to DG		Beryl Woodall	Natasha Swinscoe	4	3	12
Diagnostics and Specialities	Development	178,000	MEF	DS003	01/01/2017	High Dose Brachytherapy	Possible investment to develop income	Not Approved	Business	Loss of growth opportunity	Monitoring market response for competition	Develop business case for 2018-19 business case round	Operational Directors Group	Status Updates to DG		Tracy Iles	Natasha Swinscoe	2	4	8
Surgery	Development	67,200	MEF	SU040	01/01/2017	Evesham Business Case	Business development	Cancelled	Business	non					Development limited to Tewksbury and Cheltenham without need for capital					0
Surgery	Development	20,000	MEF	SU042	01/01/2017	Radioactive iodine seed localisation of impalpable breast cancers	Business development	On Hold	Business	Loss of growth opportunity	Monitoring market response for competition	Develop business case for 2018-19 business case round	Operational Directors Group	Status Updates to DG		Beryl Woodall	Natasha Swinscoe	2	4	8
Surgery	On Hold	274,560	MEF	SU037	01/01/2017	Replacement of HRT machines to support glaucoma services		Differed pending next annual business case round	Business	MEF to review planned individual replacement as rolling programme.	In year bid to MEF in case of individual plant failure	Review the basis of rolling programme	Operational Directors Group	Status Updates to DG		Beryl Woodall	Natasha Swinscoe	3	4	12
Diagnostics and Specialities	On Hold	TBC	MEF		01/01/2017	Cold room for phlebotomy risk of failure	Recently cold room has failed as has local refrigeration replacement scheme being prepared	Bid next year on rolling replacement basis	Business	Service interruption, loss of samples	Arrangements for interim hire of unit in case of failure	Potential to purchase local fridges as mitigation to be taken to MEF	Operational Directors Group	Status Updates to DG		Alison Eades	Natasha Swinscoe	3	4	12
Surgery	On Hold	60,000	Building/Engineering		01/01/2017	Fairview ventilation upgrade	Consideration for final ventilation solution following refurbishment of Fairview	On Hold	Health and Safety	Link between ventilation and infection rates not confirmed as yet	Infection rates being monitored	clinical case to be submitted to next CCG	Operational Directors Group	Status Updates to DG		Beryl Woodall	Natasha Swinscoe	2	3	6
																				0

Divisions	Business case category	Capital Type	Domain
Women and Children	Demand	MEF	Patient Safe
Medicine	Capital	Major Equipment	Health and
Diagnostics and Specialities	Development	Building/Engineering	Quality
Estates and Facilities	On Hold	Grant	Workforce
Surgery		IT	Statutory
IT			Reputation
Corporate			Business
			Environmer

	Risk grading		Current Status
ety	1	Negligible	On Hold
Safety	2	Minor	Differed pending next annual business case round
	3	Moderate	Cancelled
	4	Major	Included in another project
	5	Catastroph	Superseded
al			Bid next year on rolling replacement basis
			Approved Grant funded
ntal			Not Approved

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
PUBLIC BOARD MEETING WEDNESDAY 12 APRIL 2017

Report Title
Financial Performance Report - Period to 28th February 2017
Sponsor and Author(s)
Author: Sarah Stansfield, Acting Director of Finance Sponsoring Director: Sarah Stansfield, Acting Director of Finance
Executive Summary

Purpose

This report provides an overview of the financial performance of the Trust as at the end of Month 11 of the 2016/17 financial year. It provides the three primary financial statements along with analysis of the variances and movements against the forecast position, including an analysis of movement in the forecast outturn. It also provides a summary of the variance against the planned position to NHS Improvement.

Key issues to note

- The financial position of the Trust at the end of Month 11 of the 2016/17 financial year is an operational deficit of £20.1m. This is an adverse variance to forecast prepared at Month 10 of £0.7m.
- Against the forecast developed as part of the original FRP at Month 7 the variance is favourable of £0.1m and the Trust is on track to deliver the revised FY17 plan of £18m deficit.
- Against the original NHSI Plan the adverse variance is £34.2m.
- 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 £18.0m against a planned surplus of £18.2, representing a £36.2m adverse variance to the NHSI plan.

Conclusions

The financial position for M11 shows an adverse variance to forecast of £0.7m, with a significant adverse variance to plan of £34.2m (inclusive of the STF funding for Q1 of the financial year).

The forecast assumes no further STF funding is received in 2016/17 and a final forecast outturn of a deficit of £18.0m which represents an adverse variance to planned NHS Improvement control total of £36.2m.

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

Financial Performance Report
Period to 28th February 2017

Introduction and Overview

In order to reflect the focus on delivery of the required outturn as per the Financial Recovery Plan this report is now written in such a way as to provide an overview of the financial performance of the Trust, **against forecast**, as at the end of Month 11 of the 2016/17 financial year.

The Trust has delivered a year-to-date deficit position of £20.1m (including the Q1 STF funding of £3.2m). This represents an adverse variance to forecast of £688k for the year-to-date. The Month 11 position against the NHSI Plan is shown in detail on pages 10 to 14. The Month 11 position against the original NHSI forecast created at Month 7 is shown on page 9.

Statement of Comprehensive Income

Month 11 Financial Position	M11 F'cast £000's	M11 Actual £000's	YTD Variance £000's
SLA & Commissioning Income	395,922	395,248	(674)
PP, Overseas and RTA Income	4,583	4,644	61
Operating Income	58,122	58,126	4
Total Income	**458,627**	**458,018**	**(609)**
Pay	303,000	302,759	241
Non-Pay	159,766	158,907	859
FRP Savings	(1,529)	0	(1,529)
Total Expenditure	**461,237**	**461,666**	**(429)**
EBITDA	**(2,610)**	**(3,649)**	**(1,039)**
EBITDA %age	**(0.6%)**	**(0.8%)**	**(0.2%)**
Non-Operating Costs	19,996	19,645	351
Surplus/(Deficit)	**(22,606)**	**(23,294)**	**(688)**
STF Funding	3,225	3,225	0
Surplus/(Deficit) (inc. SFT)	**(19,381)**	**(20,069)**	**(688)**

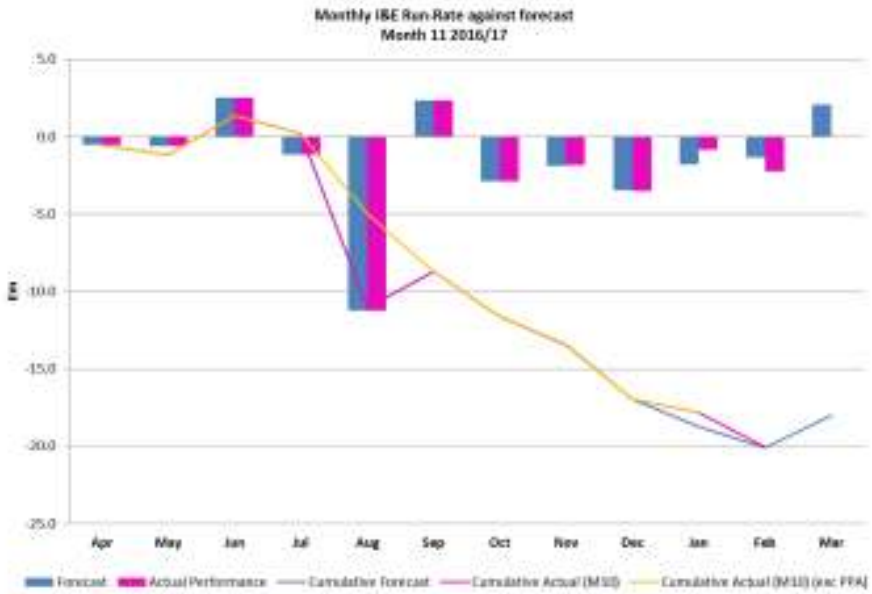
The table summarises (at a high level) the Trust position for Month 11 of the 2016/17 financial year against the forecast prepared last month.

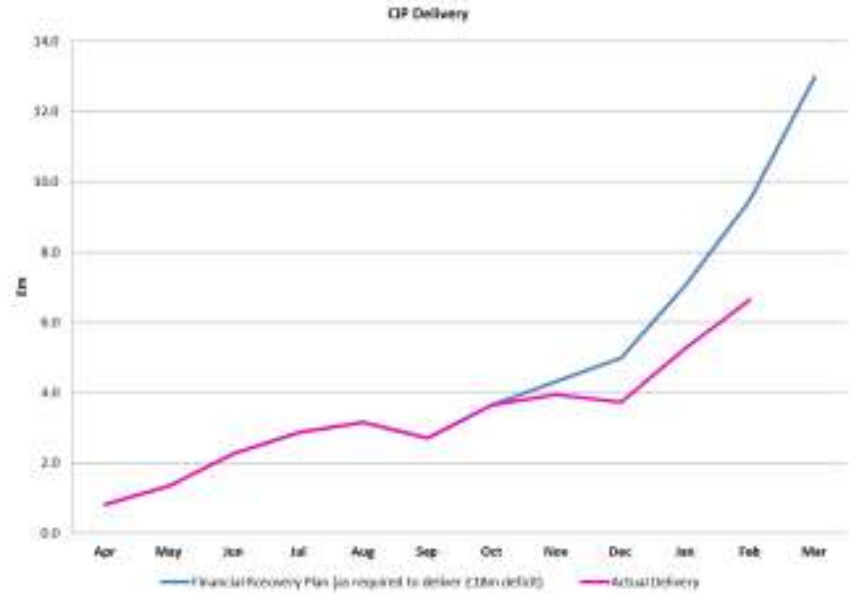
The year-to-date deficit of £23.3m has been mitigated by receipt of Q1 STF funding of £3.2m.

FRP savings not already assimilated into pay and non-pay lines were forecast to be £1.5m, included as a bottom line adjustment to forecast. Actual delivery of savings within pay, non-pay and income come to a value of £1.7m at M11.

The adverse position against forecast is largely due to depressed income recovery in Month 11. This is due to a combination of issues with TrakCare backlog input, data quality issues and reductions in activity due to operational pressures during February.

At A Glance – Month 11 Forecast





Gloucestershire Hospitals NHS
NHS Foundation Trust

The chart shows the forecast outturn position of £18.0m (based on the M7 number plus subsequent improvements) against the actual position year to date.

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

The significant improvement in the forecast position for the final quarter reflects the schemes included as part of the financial recovery plan, with a further increase in Month 12 to reflect the profit on sale for College Lawn and a number of CIPs coming through in the final month. This has the overall impact of making Month 12 a surplus month.

CIP delivery shows a cumulative achievement for the year-to-date of £6.6m against a forecast requirement of £9.5m, an adverse variance of £2.9m.

The M12 forecast figure includes the assumed profit on disposal of College Lawn.

This adverse variance has not impacted on the total Trust forecast outturn and as such is an issue of information capture rather than under-delivery. The re-assessment of pre-FRP savings schemes is not fully complete and needs to be captured.

Detailed income and expenditure vs forecast

Gloucestershire Hospitals NHS
NHS Foundation Trust

Month 11 Financial Position	M11 F'cast £000's	M11 Actual £000's	YTD Variance £000's
SLA & Commissioning Income			
Elective (inc. Daycase)	69,905	69,534	(371)
Non-elective/Emergency	90,484	88,789	(1,695)
Outpatients	70,292	69,895	(398)
Accident & Emergency	15,105	14,996	(108)
Excluded Drugs	48,627	49,012	385
CQUIN	7,899	7,920	21
Other (Includes risk adjustment)	93,609	95,102	1,492
Sub-Total	**395,922**	**395,248**	**(674)**
PP, Overseas and RTA Income	4,583	4,644	61
Operating Income	58,122	58,126	4
Total Income	**458,627**	**458,018**	**(609)**
Pay	303,000	302,759	241
Non-Pay			
Drugs	52,068	52,395	(327)
Clinical Supplies	38,672	38,349	323
Other Non-Pay	69,026	68,163	863
FRP Savings	(1,529)	0	(1,529)
Total Expenditure	**461,237**	**461,666**	**(429)**
EBITDA	**(2,610)**	**(3,649)**	**(1,039)**
EBITDA %age	**-0.6%**	**-0.8%**	**-0.2%**
Depreciation	9,624	9,605	19
Public Dividend Capital Payable	6,336	6,106	230
Interest Receivable	(32)	(33)	1
Interest Payable	4,069	3,968	101
Surplus/(Deficit)	**(22,606)**	**(23,294)**	**(688)**
STF Funding	3,225	3,225	0
Surplus/(Deficit) (inc. SFT)	**(19,381)**	**(20,069)**	**(688)**

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 £0.6m under-recovery. During M11 there have been a number of impacts on commissioning income that have impacted on the position. Trakcare backlogs and other associated data quality issues have seen income reduce during the month. Actual activity for February is also below forecast levels due to the significant operational pressures that continue to be experienced.

Operating Income – includes education, training and research flows and other income (which includes staff recharges for CITS, Shared services etc.). This is in line with forecast for M11.

Pay – expenditure is showing a favourable variance of £0.2m against forecast levels. Capitalisation of £0.3m of salaries for business intelligence related to the Trakcare implementation has offset increased pay enhancement costs in the month which relate to higher levels of bank holidays etc. in December and January.

Non-Pay – Other non-pay shows a significant favourable variance for the year-to-date, this is largely driven by the delivery of CIP.

FRP Savings – FRP savings in total are £1.7m at M11. These are reflected in the run rates for the relevant categories of income and expenditure in the main body of the table as commented above.

Cost Improvement Programme

Gloucestershire Hospitals NHS
NHS Foundation Trust

CIP Analysis	Annualised Post-FRP Plan £000s	FOT £000s	FOT Variance £000s	YTD Actual Month 11 £000s
Medicine	175	191	16	112
Surgery	156	196	40	135
D&S	76	86	10	48
W&C	78	34	(44)	10
EFD	47	87	40	75
Over-arching schemes	2,708	2,292	(417)	1,337
Sale of College Lawn	1,000	1,048	48	0
Unidentified	1,508	0	(1,508)	0
Total CIP	**5,748**	**3,934**	**(1,814)**	**1,717**

The target of £5.7m is made up of the following:

- £4.0m of CIP
- £1.0m of profit on asset sale
- £0.7m of stretch target to improve the forecast outturn deficit from £18.7m to £18.0m.

Delivery against this programme for the year-to-date is £1.7m, with an associated forecast outturn of £3.9m. This represents a adverse variance of £0.1m as at Month 11.

The key variances of forecast outturn against plan are:

- Theatres – The £100k under -performance is mainly on utilisation.
- Unidentified schemes- £1.5m

The year-to-date negative variance has not impacted on the total Trust forecast outturn of £18.0m as it reflects early delivery of some of the savings and as such is an issue of data capture and profiling.

Ongoing Actions:

- Discussions ongoing with relevant Directors around the corporate schemes in their areas
- Performance review meetings with each division to agree recovery and mitigation schemes
- Implementation of existing and new schemes developed as part of the Financial Recovery Plan
- Re-assessment to be undertaken to ensure full capture and reporting of pre-FRP CIP

CIP Review Work:

- KPMG have now concluded their work with the Trust and the work of the FRP CIP programme is now being managed by the Trust PMO to ensure continuity and ongoing delivery of identified schemes.

Balance Sheet(1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2016 £000	Balance as at M11 £000	B/S movements from 31st March 2016 £000
Non-Current Assests			
Intangible Assets	3,585	3,585	0
Property, Plant and Equipment	308,601	307,634	(967)
Trade and Other Receivables	4,505	4,544	39
Total Non-Current Assets	**316,691**	**315,763**	**(928)**
Current Assets			
Inventories	8,036	7,876	(160)
Trade and Other Receivables	30,611	21,143	(9,468)
Cash and Cash Equivalents	3,950	11,404	7,454
Total Current Assets	**42,597**	**40,423**	**(2,174)**
Current Liabilities			
Trade and Other Payables	(63,726)	(52,119)	11,607
Other Liabilities	(497)	(274)	223
Borrowings	(5,283)	(5,283)	0
Provisions	(186)	(182)	4
Total Current Liabilities	**(69,692)**	**(57,858)**	**11,834**
Net Current Assets	**(27,095)**	**(17,435)**	**9,660**
Non-Current Liabilities			
Other Liabilities	(7,987)	(7,368)	619
Borrowings	(54,538)	(84,211)	(29,673)
Provisions	(1,396)	(1,351)	45
Total Non-Current Liabilities	**(63,921)**	**(92,930)**	**(29,009)**
Total Assets Employed	**225,675**	**205,398**	**(20,277)**
Financed by Taxpayers Equity			
Public Dividend Capital	166,519	166,519	0
Reserves	67,543	67,543	0
Retained Earnings	(8,387)	(28,664)	(20,277)
Total Taxpayers' Equity	**225,675**	**205,398**	**(20,277)**

The table shows the M11 balance sheet and the variance between movements from the 2015/16 closing balance sheet, supporting narrative is on the following page.

Balance Sheet (2)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Commentary below reflects the Month 11 balance sheet position against the prior year outturn

Note: The opening balance sheet has been restated for the prior period adjustment 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 reduction in non-current assets which reflects depreciation charges in excess of capital additions for the year-to-date.

Current Assets

- Inventories remain broadly in line with the year-end. The 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.
- Receivables balances are now £9.5m below their closing March 16 level.
- 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 following receipt of distress funding.

	Financial Year 2016/17		Current Month February	
	Number	£'000	Number	£'000
Total Bills Paid Within period	128,819	232,980	6,891	9,951
Total Bill paid within Target	73,750	138,641	6,105	7,623
Percentage of Bills paid within target	57%	60%	89%	77%

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

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

Non-Current Liabilities

- Borrowings show a significant increase due to 'distress funding' arrangements.

- **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	Nov-16 £000s	Dec-16 £000s	Jan-16 £000s	Feb-17 £000s	YTD - M11 £000s
Surplus (Deficit) from Operations	**401**	**308**	**3,441**	**(151)**	**(10,222)**	**2,967**	**(1,952)**	**(1,357)**	**(2,362)**	**136**	**(1,522)**	**(10,313)**
Adjust for non-cash items:												
Depreciation	882	883	882	881	882	882	882	811	873	873	873	9,604
Impairments within operating result	0	0	0	0	0	0	0	0	0	0	0	0
Gain/loss on asset disposal	0	0	0	0	0	0	0	0	0	0	0	0
Provisions	0	0	0	0	0	0	0	0	0	0	0	0
Other operating non-cash	(58)	(1,276)	1,011	(425)	648	554	(593)	(828)	459	(802)	(204)	(1,514)
Operating Cash flows before working capital	**1,225**	**(85)**	**5,334**	**305**	**(8,692)**	**4,403**	**(1,663)**	**(1,374)**	**(1,030)**	**207**	**(853)**	**(2,223)**
Working capital movements:												
(Inc.)/dec. in inventories	(198)	(13)	1,882	(1,880)	(539)	1,619	(993)	(5)	28	(144)	377	134
(Inc.)/dec. in current assets	(6,042)	4,983	(9,375)	5,321	6,857	5,994	(5,590)	3,424	2,809	(3,066)	4,091	9,406
(Inc.)/dec. in current provisions	0	0	(4)	0	0	0	0	0	0	0	0	(4)
(Inc.)/dec. in trade and other payables	5,104	(5,795)	3,983	(611)	6,768	(20,068)	(2,815)	703	(5,269)	546	3,878	(13,576)
(Inc.)/dec. in other financial liabilities	3,000	(2,853)	0	127	0	5	(27)	(22)	0	(12)	0	218
Net cash in/(out) from wokring capital	**1,864**	**(3,678)**	**(3,514)**	**2,957**	**13,086**	**(12,450)**	**(9,425)**	**4,100**	**(2,432)**	**(2,676)**	**8,346**	**(3,822)**
Capital investment:												
Capital expenditure	(678)	(550)	(726)	(657)	(639)	(506)	(1,285)	(532)	(1,000)	(1,108)	(940)	(8,621)
Capital receipts	0	0	0	0	0	0	0	0	0	0	0	0
Net cash in/(out) from investment	**(678)**	**(550)**	**(726)**	**(657)**	**(639)**	**(506)**	**(1,285)**	**(532)**	**(1,000)**	**(1,108)**	**(940)**	**(8,621)**
Funding and debt:												
PDC Received	0	0	0	0	0	0	0	0	0	0	0	0
Interest Received	0	0	4	3	3	2	2	3	3	3	3	26
DH loans - received	0	0	0	0	0	19,900	6,700	5,318	0	1,503	0	33,421
DH loans - repaid	0	0	0	0	0	(2,061)	0	0	0	0	0	(2,061)
Other loans	0	4,000	0	0	(4,000)		0	0	0	0	0	0
Finance lease capital	(256)	(256)	(256)	(256)	(256)	(256)	(256)	(256)	(256)	(256)	(256)	(2,816)
PFI/LIFT etc capital	(235)	(235)	(235)	(235)	(235)	(235)	(235)	(235)	(235)	(235)	(235)	(2,585)
PDC Dividend paid	0	0	0	0	0	(3,864)	0	0	0	0	0	(3,864)
Other	0	0	0	0	0	0	0	0	0	0	0	0
Net cash in/(out) from financing	**(491)**	**3,509**	**(487)**	**(488)**	**(4,488)**	**13,486**	**6,211**	**4,830**	**(489)**	**1,015**	**(488)**	**22,120**
Net cash in/(out)	**1,920**	**(804)**	**607**	**2,117**	**(733)**	**4,933**	**(6,162)**	**7,024**	**(4,951)**	**(2,562)**	**6,065**	**7,454**
Cash at Bank - Opening	**3,950**	**5,870**	**5,066**	**5,673**	**7,790**	**7,057**	**11,991**	**5,829**	**12,853**	**7,902**	**5,340**	**3,950**
Closing	**5,870**	**5,066**	**5,673**	**7,790**	**7,057**	**11,991**	**5,829**	**12,853**	**7,902**	**5,340**	**11,404**	**11,404**

The cashflow for the first eleven 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 decreased in month.

Trade Payables – decreased in February.

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 – Full Year

Gloucestershire Hospitals NHS
NHS Foundation Trust

Forecast Outturn - against prior month forecast	M10 Forecast Outturn* £000's	M11 Forecast Outturn** £000's	Movement Fav/(Adv) £000's	
SLA & Commissioning Income	434,509	433,648	(861)	
PP, Overseas and RTA Income	5,347	5,010	(337)	
Operating Income	62,697	63,612	915	
Total Income	**502,553**	**502,271**	**(282)**	
Pay	330,483	330,512	(29)	
Non-Pay	175,410	174,876	533	
Total Expenditure	**505,893**	**505,388**	**504**	
EBITDA	**(3,340)**	**(3,117)**	**223**	
EBITDA %age	(0.7%)	(0.6%)	0.0%	
Non-Operating Expenditure	21,991	21,599	392	
Surplus/(Deficit)	**(25,331)**	**(24,717)**	**614**	
STF Funding	3,225	3,225	0	
Surplus/(Deficit) (inc. STF)	**(22,106)**	**(21,492)**	**614**	
Sale of College Lawn	1,048	1,048	0	Profit on disposal
FRP Savings	2,728	2,283	(445)	Reduced requirement reflects delivery of £1.7m included in pay & non-pay above
Savings to meet additional pressures	330	161	(169)	Reduced due to overall position
Surplus/(Deficit) (inc. STF)	**(18,000)**	**(18,000)**	**0**	

*** Reflects the full-year forecast outturn produced as part of Month 10 reporting**
**** Reflects the re-forecast outturn position produced alongside Month 11**

The table shows the revised full year forecast for Month 11 against full year forecast produced at Month 10.

The forecast outturn for the 2016/17 financial year as at Month 11 is a deficit of £18.0m (no movement from Month 10).

The forecast now reflects forecast over performance agreed with commissioners, improvements in pay and non-pay due to delivery of FRP savings requirements and the further delivery of the balance of the FRP savings requirement.

Gloucestershire Hospitals NHS
NHS Foundation Trust

Financial Performance Against FRP (based on M7 forecast)
Period to 28th February 2017

Introduction and Overview

The analysis in this section of the report provides an overview of the Trust's financial performance against the trajectory initially developed at Month 7 as part of the Financial Recovery Plan (FRP) for information. The Trust produces a 'live' forecast on a monthly basis so the view is as current as practical and this is the analysis on which this report largely focuses.

The Trust has delivered a year-to-date deficit position of £20.1m (including the Q1 STF funding of £3.2m). This represents a favourable variance to the original M11 FRP forecast (produced at M7) of £54k for the year-to-date.

Statement of Comprehensive Income

Month 11 Financial Position	M11 F'cast £000's	M11 Actual £000's	YTD Variance £000's
SLA & Commissioning Income	394,457	395,248	791
PP, Overseas and RTA Income	4,518	4,644	126
Operating Income	61,655	58,126	(3,530)
Total Income	**460,630**	**458,018**	**(2,613)**
Pay	304,823	302,759	2,065
Non-Pay	161,754	158,907	2,847
FRP Savings	(3,017)	0	(3,017)
Total Expenditure	**463,560**	**461,666**	**1,894**
EBITDA	**(2,930)**	**(3,649)**	**(718)**
EBITDA %age	**(0.6%)**	**(0.8%)**	**(0.2%)**
Non-Operating Costs	20,417	19,645	772
Surplus/(Deficit)	**(23,348)**	**(23,294)**	**54**
STF Funding	3,225	3,225	0
Surplus/(Deficit) (inc. SFT)	**(20,123)**	**(20,069)**	**54**

The table summarises (at a high level) the Trust position for Month 11 of the 2016/17 financial year against the forecast prepared to support the original FRP at M7.

The year-to-date deficit of £23.3m has been mitigated by receipt of Q1 STF funding of £3.2m.

There are some significant variances on operating income and non-pay which reflect movements between these categories for SmartCare related transactions. Non-operating expenditure shows a favourable variance due to the reforecasting of both depreciation and PDC (offset by an increase in interest charges) that have taken place since the Month 7 forecast was prepared.

FRP savings not already assimilated into pay and non-pay lines were forecast to be £3.0m, included as a bottom line adjustment to forecast. Actual delivery of savings are within pay, non-pay and income come to a value of £1.7m at M11.

Gloucestershire Hospitals NHS
NHS Foundation Trust

Financial Performance Against NHSI Plan
Period to 28th February 2017

Performance Against NHSI Plan

At the end of Month 11 of the 2016/17 financial year the Trust has delivered a year-to-date deficit position of £20.1m (including the Q1 STF funding of £3.2m). This represents an adverse variance to plan of £34.2m as at the year-to-date.

Statement of Comprehensive Income

Month 11 Financial Position	YTD Plan £000's	YTD Actual £000's	YTD Variance £000's
SLA & Commissioning Income	394,473	395,248	775
PP, Overseas and RTA Income	5,235	4,644	(591)
Operating Income	57,223	58,126	903
Total Income	**456,931**	**458,018**	**1,087**
Pay	291,227	302,759	(11,532)
Non-Pay	137,764	158,907	(21,143)
Total Expenditure	**428,991**	**461,666**	**(32,675)**
EBITDA	**27,940**	**(3,649)**	**(31,588)**
EBITDA %age	**6.1%**	**-0.8%**	**-6.9%**
Non-Operating Costs	23,509	19,645	3,864
Surplus/(Deficit)	**4,430**	**(23,294)**	**(27,724)**
STF Funding	9,675	3,225	(6,450)
Surplus/(Deficit) (inc. SFT)	**14,105**	**(20,069)**	**(34,174)**

The table summarises (at a high level) the Trust position for Month 11 of the 2016/17 financial year against the plan as submitted to NHSI in June.

The year-to-date deficit of £21.0m has been mitigated by receipt of Q1 STF funding of £3.2m.

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.

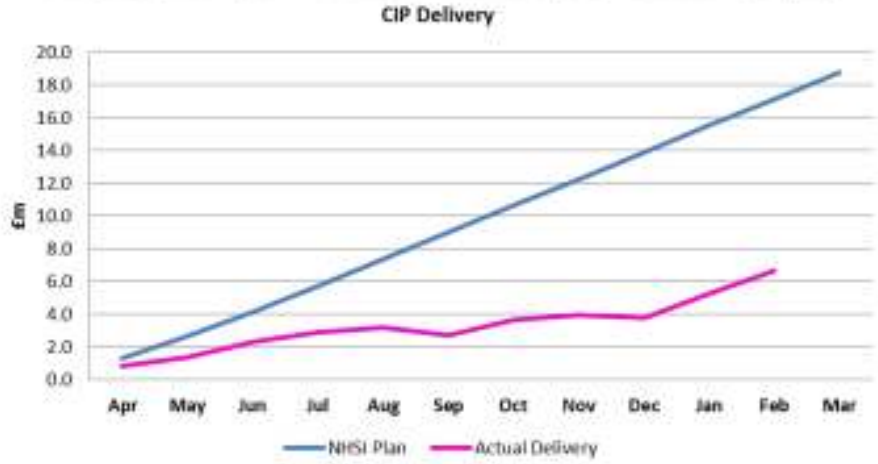
At A Glance – Month 11

Gloucestershire Hospitals NHS
NHS Foundation Trust

The I&E cumulative deficit as at Month 11 is £20.1m against an NHSI plan surplus of £14.1m – an adverse variance of £34.2m.

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

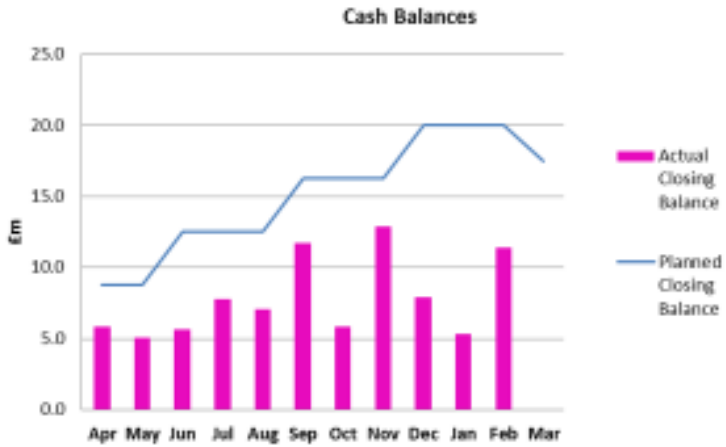
The drivers of this position are explained in more detail in the income and expenditure sections of this report.



CIP delivery shows a cumulative achievement for the year-to-date of £6.6m against an NHSI plan of £17.2m – an adverse variance of £10.6m.

At A Glance – Month 11

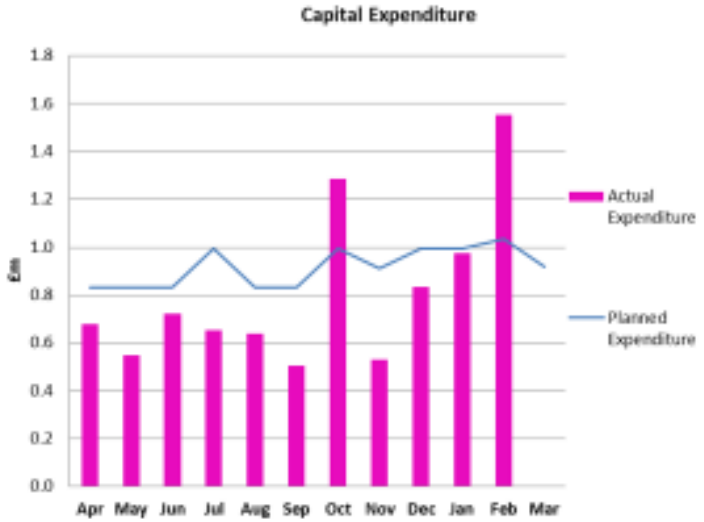
Gloucestershire Hospitals NHS
NHS Foundation Trust



The cash balance as at 31st January was £11.4m against an NHSI planned balance of £20.0m for the month – an adverse variance of £8.6m.

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.
- November includes further drawdown of £5.3m of distress funding
- Further distress funding of £1.5m was drawn down in January



Capital spend in month 11 was £1.6m against an NHSI plan of £1.0m.

This brings the cumulative spend for the YTD to £8.9m against a total plan of £10.1m – an adverse variance of £1.2m.

Capital spend 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	10.1	8.9	(1.2)

Balance Sheet(1)

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Financial Position	NHSI Plan as at M11 £000	Balance as at M11 £000	Variance - M11 Plan vs Actual £000
Non-Current Assests			
Intangible Assets	0	3,585	3,585
Property, Plant and Equipment	290,938	307,634	16,696
Trade and Other Receivables	7,138	4,544	(2,594)
Total Non-Current Assets	**298,076**	**315,763**	**17,687**
Current Assets			
Inventories	7,150	7,876	726
Trade and Other Receivables	37,220	21,143	(16,077)
Cash and Cash Equivalents	19,989	11,404	(8,585)
Total Current Assets	**64,359**	**40,423**	**(23,936)**
Current Liabilities			
Trade and Other Payables	(46,837)	(52,119)	(5,282)
Other Liabilities	0	(274)	(274)
Borrowings	(3,203)	(5,283)	(2,080)
Provisions	(1,292)	(182)	1,110
Total Current Liabilities	**(51,332)**	**(57,858)**	**(6,526)**
Net Current Assets	**13,027**	**(17,435)**	**(30,462)**
Non-Current Liabilities			
Other Liabilities	(8,270)	(7,368)	902
Borrowings	(58,553)	(84,211)	(25,658)
Provisions	(816)	(1,351)	(535)
Total Non-Current Liabilities	**(67,639)**	**(92,930)**	**(25,291)**
Total Assets Employed	**243,464**	**205,398**	**(38,066)**
Financed by Taxpayers Equity			
Public Dividend Capital	165,519	166,519	1,000
Reserves	66,827	67,543	716
Retained Earnings	11,118	(28,664)	(39,782)
Total Taxpayers' Equity	**243,464**	**205,398**	**(38,066)**

The table shows the M11 balance sheet and associated variance to the plan as submitted to NHSI.

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.

NHSI Single Oversight Framework

Gloucestershire Hospitals NHS
NHS Foundation Trust

Capital Service Cover Metric	(0.08)
Rating	4
Liquidity Metric	(18.38)
Rating	4
I&E Margin Metric	(4.58%)
Rating	4
I&E Variance from Plan Metric	(7.61%)
Rating	4
Agency Metric	79.79%
Rating	4
Use of Resources rating	4

The Single Oversight Framework (SOF) has been developed by NHSI and replaces Monitor's Risk Assessment Framework and TDA's Accountability Framework. It applies to both NHS trusts and NHS foundation trusts. The SOF works within the continuing statutory duties and powers of Monitor with respect to NHS foundation trusts and of TDA with respect to NHS trusts. The framework came into force on 1st October 2016.

The performance reported here reflects that for M11 against the new framework.

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Board is asked to note:

- The financial position of the Trust at the end of Month 11 of the 2016/17 financial year is an operational deficit of £20.1m. This is an adverse variance to forecast of £0.7m.
- Against the forecast developed as part of the original FRP at Month 7 the variance is favourable of £0.1m.
- Against NHSI Plan the adverse variance is £34.2m.
- The focus of performance reporting is now against the forecast position and achievement of the £18.0m deficit recovery target.
- 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 £18.0m against a planned surplus of £18.2, representing a £36.2m adverse variance to the NHSI plan. This forecast has moved to reflect the Financial Recovery Plan since the prior month.

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

Presenting Director: **Sarah Stansfield, Acting Director of Finance**

Date: **March 2017**

Report to the Board of Directors meeting - Wednesday 12 April 2017

From Audit & Assurance Chair – Robert Graves, Non-Executive Director

This report describes the business conducted at the Audit and Assurance Committee held Friday 10 March 2017, 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
Counter Fraud Report	The Head of Counter Fraud provided an update on progress against the action plan, current investigations and awareness training.	The request for a summary analysis of investigations was re-iterated with an additional request for benchmarking. The approach to awareness training for long-serving employees was questioned.	Gap in assurance – action to address agreed	A report on activity will be prepared for the next meeting. The Workforce Committee will be asked to progress ensuring awareness training is incorporated in the mandatory training.
Internal Audit	The Internal Audit review covered progress against current plan, the draft plan for 17/18, the provisional 16/17 opinion, reports covering information governance and centralised booking and the recommendations tracker.	The scope and content of the 17/18 plan was questioned in the light of a need for flexibility. The approach to achieving cross committee links was discussed. The importance of a single source for core documents was raised.	Evidence presented to demonstrate delivery of 16/17 plan and basis for determining 17/18 priorities presented i.e. risk based.	The plan will be further refined to incorporate latest assessed needs and any audit requirements arising from the Financial Governance Review and include links to relevant committees by topic.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
				The Committee will be briefed at its next meeting on the oversight approach that is employed to ensure a single source for documents.
External Audit	The External Auditor provided a technical update and progress report in relation to the 16/17 audit.	The auditors were asked if the information and communication flow between the finance team and the audit teams is working well. The approach to assessing non –working inventory was questioned.	Evidence that work is proceeding well with good, timely communication between teams.	The approach to assessing non-working inventory needs to be addressed.
Trust Risk Register	The new format risk register was presented.	Members asked how to gain a greater understanding of the process that leads to this summary.	Gap in assurance to be addressed through action described.	The Risk Management Group will report to the committee twice a year on the risk assessment process.
Finance Director Report	The report addressed losses & compensations, single tender actions, accounting policies and the 16/17 year end report.	Lack of supporting detail and evidence challenged.	Gap in assurance to be addressed through action described.	A cumulative summary of losses and compensations in future reports was requested.

MINUTES OF THE AUDIT AND ASSURANCE COMMITTEE MEETING HELD ON FRIDAY 10 MARCH 2017 AT 8.45AM 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

Mr Tony Foster	(TF)	Non-Executive Director
Mr Robert Graves	(RG)	Non-Executive Director (Chair)
Ms Rhona Macdonald	(RM)	Non-Executive Director

IN ATTENDANCE (by invitation)

Mr Rob Andrews	(RA)	KPMG Manager
Mr Jonathan Brown	(JB)	KPMG Engagement Lead
Professor Chris Dunn	(CD)	Governor
Mr Stuart Diggles	(SD)	Interim Finance Director
Ms Deborah Lee	(DL)	Chief Executive
Ms Dominque Lord	(DL)	Price Waterhouse Coopers (PWC), Internal Audit
Mr Peter Lachecki	(PL)	Chair
Mrs Lynn Pamment	(LP)	Partner, Price Waterhouse Coopers (PWC), Internal Audit
Mrs Sarah Stansfield	(SS)	Director of Operational Finance
Mrs Sarah Smith	(SS)	PA to Finance Director
Mr Lee Sheridan	(LS)	Head of Counter Fraud
Mr Andrew Seaton	(AS)	Director of Safety

APOLOGIES

Mr Jonathan Sawyer	(JS)	Price Waterhouse Coopers (PWC), Internal Audit
Mr Martin Wood	(MW)	Trust Secretary

ACTION

Mr Graves shared his expectations on how the Committee should conduct its business. Specifically the meeting and discussion should be challenging, comprehensive, concise, conclusive and courteous. He advised the group that in the pre-meet there was discussion about the purpose and frequency of the pre-meetings. While a private meeting between members and auditors is good practice and should occur at least once annually it is not necessary ahead of every Audit and Assurance Committee meeting. This conclusion was reached on the understanding that the auditors or members can request a private meeting at any time if the need arises.

A working session on the Trust Accounts has been arranged to review the accounts in detail on May 8th. Mr Graves advised that as Chair of the Audit and Assurance Committee he considers this an important duty and of considerable assistance in gaining a greater understanding of the accounts.

026/17 DECLARATIONS OF INTEREST

None.

027/17 MINUTES OF MEETING HELD ON 18th JANUARY 2017

An amendment was agreed to the Quality Accounts Assurance paragraph to reflect that Quality Indicators are mandated.

RESOLVED: The minutes of the meeting held on the 18th January 2017

were agreed as a correct record.

028/17 MATTERS ARISING

009/17 Counter Fraud Report - update on investigations to form an annex to the regular report

Mr Sheridan sought further advice on how the report should be produced to meet the requirements of the Committee and ensure that there is visibility of counter fraud cases.

Action: Mr Sheridan agreed to further discuss the Committee's requirements with the Chair of the Committee. **LS**

006/17 INTERNAL AUDIT

Attendees discussed how the Committee were assured that auditor's reports were received by relevant Committees.

Action: Mrs Pamment agreed to include within the final 17/18 plan a supplementary column to identify the responsible Committee for each Audit report.

All other actions were completed or agenda items for the meeting.

RESOLVED: That the report be noted and revisited on the 23 May 2017.

017/17 REPORT FROM THE HEAD OF COUNTER FRAUD

Progress on the Action Plan was noted, all activity is currently progressing and it is anticipated that all actions will be complete by year end.

Since April Counter Fraud has delivered 44 awareness presentations to Nursing and Domestic Staff noting that Counter Fraud is commissioned to undertake 10 awareness sessions. Further discussion took place around the proportion of staff covered by the awareness sessions and how long-serving staff are captured. The recommendation from the Committee is that the scope of mandatory training is extended to include a 10 minute awareness presentation which would need to be considered by the Workforce Committee.

Action: Mr Wood to take the Committee's recommendation to extend mandatory training to include Counter Fraud awareness to the Workforce Committee. **MW**

Mr Sheridan advised that a third substantive Local Counter Fraud Specialist had now been appointed.

Mr Sheridan provided a verbal update on the ongoing criminal investigation involving a former member of staff, Counter Fraud are currently awaiting guidance as to when the case will be heard at Bristol Crown Courts. Attendees also received an update on further cases including 2 incidences where pharmacy forms had been wrongly presented to Pharmacy. The individuals involved are no longer employed by the Trust. Joint work with Pharmacy has been undertaken to tighten procedures.

Action: Mr Sheridan agreed to produce an analysis of activity over the past two years and look at how best to incorporate benchmarking data. **LS**

RESOLVED: That the report be noted.

Mr Lee Sheridan left the meeting at 9.15am.

018/17 INTERNAL AUDIT

INTERNAL AUDIT PROGRESS REPORT AND DRAFT ANNUAL REPORT

A numbers of reports have been issued in draft and will be presented at the May meeting, Mrs Pamment advised that the consequence of revisiting the plan mid-year was that the timetable is weighted more heavily to the end of the year than originally intended and delays do not relate to timing of responses. It is expected that plan for 2017/18 and coming year will be better phased with the aim to ensure the plan is right first time.

Attendees noted the progress against plan and the detailed status of reviews conducted since the last Committee. Further discussion took place around Information Security and whether the scope included an element of cyber security or whether it was an area that required a more comprehensive look to provide a complete picture of assurance in this area .

Action: The Committee requested that a Trust expert in Cyber activity jointly present with Internal Audit to provide assurance around exposures, risks, business continuity and ability to get back on track. **PWC/AS**

Indicative Annual Plan rating

The opinion was noted as 'Significant Improvement required', this is the third out of four possible opinions that Internal Audit can issue. Mrs Pamment advised that this was partially due to the number of critical and high risk recommendations. Mr Diggles commented that this was expected and to achieve value for money from auditors the work is aimed at high risk areas. Attendees agreed that this gave a sense of recognition of where the Trust is and what needs to be achieved to improve the rating also noting that work was in train which should improve the opinion for next year although still very challenging. The Committee agreed that progress towards improvement will need to be closely monitored.

DRAFT INTERNAL AUDIT PLAN17/18

Attendees noted the draft plan which is currently being discussed with trust management. Some areas must be included based on their required frequency while other areas will be included based on risk.

The executive team have collectively reviewed the draft and the attendees discussed whether Chairs of Trust Committees should have the same opportunity.

Ms Lee raised the flexibility within the plan noting that there is currently a 10 day allowance for contingencies. The aim is to prioritise work based on risk and importance. It was also acknowledged that output from the forthcoming governance review may influence the focus and prioritisation of activity with resulting changes to the plan.

Action: Mrs Pamment agreed to include responsible Committees as well as the Executive Sponsor in the plan schedules. **LP**

A final version of the Audit Plan will be presented at the May meeting of the Committee.

INFORMATION GOVERNANCE

The final report has been issued with a low risk classification. Mrs Pamment explained that the scope of the work was limited to review of evidence to comply with the standards within the Information Governance Toolkit which the Trust are required to submit and was not a review of comprehensive Information Governance .There were two low risk finding

and one medium risk which related to out of date evidence.

Further discussion took place around how the Trust ensures that there is a single source for core documents. Ms Lee explained that the Risk Management Committee have responsibility for document management and there is now a new level of oversight

Action: Mr Seaton agreed to provide an example of how the Trust has oversight of the single source for core documents to provide further assurance to the Committee members.

AS

CENTRALISED BOOKING OFFICE OUTPATIENT CLINICS
The final report has been issued with a high risk classification with one high risk and two medium risk findings which relate to lack of Policy and Procedures documentation and poor communication between the Booking office and Clinical Leads. Areas of good practice were also noted.

Prof Dunn asked whether it felt that patient input would be beneficial. Ms Lee explained that the remit of the audit was not to include input from patients as there are mechanisms already in place for the Trust to receive patients' input. Attendees noted that the Planned Care Programme has oversight of outpatients and is reported through to the Quality and Performance Committee.

RECOMMENDATIONS TRACKER
Attendees noted that there had been significant effort to reduce the number of overdue reports and that there was now better traction in the follow-up process although further improvements can be made.

RESOLVED: That the reports be noted.

Ms Lee joined the meeting at 10.00am

Mrs Pamment left the meeting at 10.15am

019/17 EXTERNAL AUDIT

PROGRESS REPORTS AND TECHNICAL UPDATE
Attendees noted areas of work undertaken since the last Committee meeting which were noted as

- External Audit had met with Counter Fraud to gain an update on ongoing cases.
- External had met with Mr Diggles and Mrs Stansfield to discuss progress of the audit and year end approach.
- External Audit had liaised with the Trust over its approach to the quality accounts audit.
- External Audit had set up the audit for the Technology Strategy Board Grant Claim.

A technical updated was received and the following points noted :

- The 2017 Pulse Survey, External Audit advised that the Trust would be briefed on relevant areas.
- Off Payroll working in the Public Sector (IR35) – the Trust will need to ensure that they are complainant with new regulations.

EXTERNAL AUDIT INTERIM FINDINGS
Attendees noted the summary of findings

- Reviews were undertaking of the control environment in five key areas

1. Budget Monitoring
2. Cash
3. Income
4. Payroll
5. Journals

- Testing identified a control finding regarding authorisations. Mrs Stansfield reassured the Committee that adequate processes were in place with mitigating controls.
- Quality Account quality indicators - the Governor indicator had not yet been agreed.
- Discussion to place around stock take procedures and auditors initial view compared to other Foundations Trust is that the organisation is not overstocked. Mr Diggles updated on the new stock managements system for Theatres. Mr Graves asked what the procedures were for identifying slow moving and obsolete/out of date stock. The Committee were advised that this is well controlled for Pharmacy stock which accounts c. 75% of inventory. No information was available in respect of these procedures for other categories of stock
- CIP – recommendation closed based on the Trust focus of CIP.
- Trakcare annual impairments review of capitalised costs in accordance with accounting policy. Mrs Stansfield advised that the value is likely to increase towards the end of the financial year; whilst significant phases have yet to be implemented the Trust will not write down costs.

RESOLVED: That the report be noted.

Mr Lachecki left the meeting at 10.45am

020/17 REVIEW OF THE TRUST RISK REGISTER

Attendees noted the refined risk register which reflects improvement work undertaken and now includes a clear description of risks that are being managed. .

Further discussion took place around whether the risk register provided sufficient assurance to the Committee, Mr Graves commented that the information was so high level that he did not get a sense of the risk. The Committee agreed the need to have greater assurance that the risk management system is working and felt it was important to receive input from all committees. Ms Lee suggested that the Risk Management Group provides a report of risk processes twice yearly to provide assurance to the Committee.

Action: Mr Seaton agreed to provide a report on the risk management process for the May meeting of the Committee. **AS**

RESOLVED: That the reports be noted.

Ms Lee left the meeting at 11.00am

021/17 REPORTS FROM THE INTERIM FINANCE DIRECTOR

LOSSES AND COMPENSATIONS

Mr Diggles presented the paper which reported ex gratia payments made to the value of £664 and written off invoices totalling £820,321.63. The total losses and write offs amounted to £820,985.63. These had been transacted as agreed in the January Audit and Assurance Committee meeting.

Action: Mr Graves requested that the appendix which details the losses and write-offs becomes a cumulative summary from each meeting showing all transactions to date in the financial year. **SD**

SINGLES TENDER ACTION

The report detailed the single tender actions which have been signed and requiring disclosure since the Audit Committee held on 18 January 2017. Mr Diggles advised that there were a low number of waivers and they are processed through a robust Procurement process.

ACCOUNTING POLICIES

The report outlined the changes to the Trust accounting policy within the 2015/16 published accounts. These formed three categories

- Guidance changes – NHSI publish the annual accounts template that contains a standard set of accounting policies to adopt.
- Intentional changes - changes made to reflect any changes in accounting policy that the Trust has adopted.
- Omissions - an unintentional change that was the result of omission.

Attendees noted:

- The Trust will need agree a narrative to explain fully the prior year adjustment for the Trust Accounts which will need to be agreed by the Director Finance, Chief Executive and Audit and Assurance Committee.

Action: Mr Diggles and Mrs Stanfield agreed to progress the narrative to provide a full explanation of the prior year adjustments. **SD/SS**

RESOLVED: That the reports be noted.

022/17 AUDIT AND ASSURANCE COMMITTEE WORKPLAN 2017

Attendees noted the Committee's work plan. Discussion took place around how best to keep the Non-Executive Directors informed, recognising that there are alternatives (e.g. email, Board seminar briefings).

RESOLVED: That the reports be noted.

023/17 COMMITTEE REFLECTION & DEVELOPMENT

Attendees discussed items discussed at the Committee that need to be considered by another Committee.

Action: To include a standing agenda item for items to pass to other Committees. **SS**

024/17 ANY OTHER BUSINESS

None.

RESOLVED: That the report be completed

025/17 DATE OF THE NEXT MEETING

Tuesday 23 May 2017 8.45 am in the Boardroom at Alexandra House.

Pre meet for members only – 8.30am

_____

CHAIR

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST WORKFORCE COMMITTEE HELD IN THE BOARD ROOM, ALEXANDRA HOUSE, CHELTENHAM GENERAL HOSPITAL ON FRIDAY 3RD MARCH 2017 AT 2PM

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

PRESENT

Rob Graves	RG	Non-Executive Director
Craig McFarlane	CM	Head of Communications
Keith Norton (Chair for the Meeting)	KN	Non-Executive Director
Eve Russell	ER	Associate Director of HR
Dave Smith	DS	Director of Human Resources and Organisation Development
Sarah Stansfield	SS	Director of Operational Finance

GOVERNOR

Geoff Cave	GC	Public Governor
Rob Randles	RR	Staff Governor

APOLOGIES

Maggie Arnold	MA	Nursing Director
Tracey Barber	TB	Non-Executive Director (Chair)
Dr Sean Elyan	SE	Medical Director

IN ATTENDANCE

Louise Courtier	LC	Corporate Governance Administrator
Abby Hopewell	AH	Head of Leadership & Organisational Development
Peter Lachecki	PL	Trust Chair
Martin Wood	MW	Trust Secretary

030/17 DECLARATIONS OF INTEREST

There were none.

031/17 MINUTES OF THE MEETING HELD ON 3rd FEBRUARY 2017

RESOLVED: That the minutes of the meeting held on 3rd February 2017 were agreed as a correct record and signed by the Chair subject to Mr Peter Lachecki being added to the list of those present.

032/17 MATTERS ARISING

JANUARY 2017 – 04/17 WORKFORCE DASHBOARD & FTE TRACKER INCLUDING VERBAL UPDATE FROM AGENCY PROGRAMME BOARD

To reinforce Trust policy for reporting sickness. The Nursing Director stressed that sickness polices are being followed. *Completed as a Matter Arising.*

JANUARY 2017 – 05/17 RESOURCE REVIEW

This group is still in the early stages of development. TB still to arrange a meeting with John Lewis once they are in Cheltenham. *This is being taken forward by the Chair. Completed as a Matter Arising.*

FEBRUARY 2017 - 018/17 WORKFORCE DASHBOARD

The Director of Human Resources and Organisational Development sought clarification from the Committee on the future focus for the report. In response, the Chair said that the focus for the first three months of the next financial year should be on agency spend moving to cost, supply and engagement towards the end of the financial year. Any further suggestions from Committee members should be submitted to the Director of Human Resources and Organisational Development. *This will be included in the reports for the first three months of the next financial year. Completed as a Matter Arising.*

FEBRUARY 2017 - 020/17 NURSING RECRUITMENT AND AGENCY SPEND

The Chair referred to the advantages as to why our Trust was chosen as an employer which is used in the recruitment process but not in the retention process and she invited the Associate Director of Human Resources to explore whether this approach could be adopted for staff retention. *This item appeared later in the Agenda. Completed.*

FEBRUARY 2017 - 026/17 MATTERS TO BE ESCALATED TO THE BOARD

The Committee invited the Nursing Director to consider whether there are any risks associated with the quality metrics. *Ongoing.*

MW to follow this up with MA. **MW**

ONGOING

It has been suggested by the group that a colour coding system for the matters arising section is looked into. This is to make It more clear what's outstanding, ongoing and complete. **MW / LC**

033/17 MEDICAL LOCUM SPEND

The Director of Human Resources and Organisational Development presented the report providing an overview of our Trust Medical Agency Spend describing reasons for the step-change in medical agency spend over the period July to August 2016. Secondly it described actions underway to reduce medical agency spend.

Thirdly it described the downward trajectory position relevant to medical agency spend.

It was noted that parental leave and long-term sickness absence are two impacting reasons into the need to provide temporary medical cover. Internal Trust policy arrangements allow for the covering of absent colleagues in these circumstances. However, despite the goodwill and commitment amongst our substantive medical workforce, internal cover is not always possible. Reliance in such circumstance may default to temporary medical agency workers.

It was also noted that medical agency utilisation increased significantly between Period 4 [July] and Period 5 [August], an increase of 11.4 WTE. The increase in agency hire relevant to this period predominantly falls to Acute Medicine [7.6 WTE], General and Old Age Medicine [2.8 WTE], the hosted South West GP contract [Hosted Services L8] [4.0 WTE] and Trauma and Orthopaedics [4.7 WTE], whilst other areas, for example, Nephrology and Respiratory experienced a marked reduction over the same period.

PL said that the statement 'Reasons for increased utilisation across the spectrum of acute medicine, general and old age medicine and trauma and orthopaedics include: unsustainability of the medical rota, given the inability to recruit into vacancies, with the consequence of agency hire to cover the on-call rotas; limited oversight of the medical rota generally' is very broad. He asked if this was ongoing and being addressed. DS has advised there are different systems for the creation of the different medical rotas. A universal solution is being considered not just for medical rotas but for nursing and AHP's as well to give greater visibility of our workforce. A business case is being put together however may cause a significant in year cost pressure and therefore is not guaranteed to be implemented.

RG has asked that it would be helpful to have a variance analysis. SS has advised this may be difficult to bullet point this as the key point overlap. KN supports improvements.

It has been highlighted that there has been improvement in medical agency spend now the attention has been given and there is more control now.

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

RESOLVED: That the report be noted.

032/17 NURSING RETENTION FOCUS GROUPS

The Associate Director of HR presented the report on Nursing Retention for information.

The aim of the focus groups were to determine what factors keep Nursing & Midwifery staff working for GHNHSFT and what

influences them to stay in post / in the organisation or leave.

This will also be presented at the Recruitment Strategy Group and Senior Nursing and Midwifery Committee (SNMC).

KN has advised that this is been taking seriously by Workforce Committee.

The Chair thanked the Associate Director of HR for the report.

RESOLVED: That the report be noted.

033/17 VACANCY CONTROL PANEL (VCP) REVIEW

The Associate Director of Human Resources presented the report on Vacancy Control Panel Review. The purpose is to review the activity and effectiveness of the Vacancy Control Panel (VCP), following a request in the February meeting of the Workforce Committee.

It has been reported that there has been lots of activity and is reducing the pay spend. The approval percentage is very high however this does not imply a lack of control but good control by the Divisions.

ER has advised that a more detailed breakdown of this data is available via the VCP tracker which is maintained on the VCP SharePoint site.

It is recommended that this remains in place and to report back in April's meeting. **MW** (to note for agenda)

The Chair thanked the Associate Director of HR for the report.

RESOLVED: That the report be noted.

034/17 WORKFORCE REPORT

The Associate Director of Human Resources presented the report providing an overview of the workforce performance of the Trust as at the end of Month 10 of the 2016/17 financial year. It provides information on the continuing overspend on pay (including agency) costs, movements in headcount as well as further information on two of the key drivers of spend, turnover and sickness.

The key points to note were a reduction in the overall paybill between M9 and M10 of £0.47m, building on the previous month's reduction of £0.41m. The paybill is at its lowest level this Financial Year. Agency spend continues to reduce overall and is now at its lowest level since June 2016. Equal focus is being applied between agency expenditure and pay expenditure generally and engagement with staff representatives on key initiatives continues with the support of the CEO. We continue to make inroads into qualified nursing vacancies which are now at 106 WTE, the lowest level for the whole of 2016/2017.

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

- This report has already been seen at Finance Committee and the Main Board meeting and Quality Impact Assessment has been highlighted
- Patient safety is a priority 'Best Care For everyone'. This was reassuring from the Board
- RG has asked for further information on cost drivers and other measurements. It has been suggested he meet with DS and ER for a more detailed discussion. **DS/ER/RG**
- The long term sickness record to be brought back to the next meeting. MW to add as an agenda item **MW / LC**

ACTION: The focus on reducing agency use and reducing vacancy levels appears to be having a positive impact and must be maintained and increased. Work to leverage off the experience and operational structures of other organisations in controlling both agency and general pay expenditure is ongoing.

The Chair thanked the Associate Director of HR for the report.

RESOLVED: the increased control regarding pay spend is delivering a sustained reduction in this area. The increased scrutiny of agency use and spend appears to be having an impact with a reduction in the overall spend in this area. This has been largely attributable to the increase in substantive nursing numbers, and we need to ensure that similar traction is developed within the medical and corporate areas in reducing spend.

035/17 PRESENTATION FROM EACH WORKSTREAM

- **Recruitment Strategy**

The Associate Director of Human Resources presented the report on Recruitment Strategy Group to provide a brief paper to set out for the Workforce Committee's approval proposed targets for both Nursing vacancies and Nursing leavers for 2017/2018. These targets have been discussed and agreed by the Trust's Recruitment Strategy Group (RSG) and they come to Workforce Committee with RSG's endorsement.

It was noted that the average vacancy rate for Band 5 Registered Nurses during 2016 was 12.44%, with a range between 15.51% and 9.96%. An ambitious target of **11.00%** is proposed for 2017, which represents an improvement on last year's vacancies of 11.58%. To achieve the 11% target, two sub-targets have been set for Medicine and Surgery of 18.11% and 7.08% respectively. These figures also represent an 11.58% improvement on 2016's vacancy rate. It has been assumed for these purposes that the establishment will remain static for 2017; however, it is known that the establishment will fluctuate over the course of the year.

It was also noted that in 2016, an average of 11.79 WTE Band 5

Registered Nurses left the organisation each month, with a range between 22.71 WTE and 6.36 WTE. A target of **10.00 WTE leavers per month** is proposed for 2017, which represents an improvement on retention of 15.18%. Although the number of leavers does fluctuate much more than the vacancy rate, the spikes in staff leaving our Trust as per normal seasonal variations are expected in March, December and July/August.

- Ideas of staffing levels for the coming years for nursing is known via the workforce planning process
- Nursing associate role not yet fully scoped but is in development
- Feedback provided from the group has highlighted that forecasting needs to be clearer and demographic information needs to be considered.
- KN has highlighted the importance of the feedback process

- **Sustainable Workforce Group**

The Associate Director of Human Resources advised this group is still in the early stages of development. Objectives are being set however are a work in progress. This can be looked at again in coming months.

- **Agency Programme Board**

- The Director of Human Resources and Organisational Development has advised this is on track with reductions in spend achieved
- Grip and control being exercised in Medicine and Nursing
- The early signs show the trajectory is in the right place.
- There are plans to reduce agency cost further for next year however the Trust will need to up the pace for next year to ensure grip

- **Reward Strategy**

  - There has been a further increase in bank usage however the expected proposal from Medicine was not received.
  - An assessment of the effectiveness of the bank office is being considered
  - KN has advised maybe a more creative approach to the reward system would be useful. DS has advised that a more strategic approach is required, recognising the current constraints of AfC. Staff value development and career progression
  - Self-service payroll system to be introduced in attempts to remove paper payslips. This has been highlighted as having the potential to assist with a more creative approach to publicising elements of Total reward.

- **Education Learning & Development**

  - Progress is being made on apprenticeships with plans to double the numbers. This will be highlighted in the Workforce plan. It has been highlighted that apprenticeships

are good to get people into the NHS bring people into real jobs with education. The committee was keen to ensure this was more about creating valuable long term roles and good working experience than about saving money

- There are 13 Nursing Associates to be introduced soon as part of a small national pilot. There are a total of 32 across the county

- **Staff Engagement**

- Staff Survey results from 2016 now in
- Staff have been encourage to provide feedback on travel and parking, this has been one of the most successful engagement events ever
- Data will be presented to TLT with recommendations and proposals and it is recognised that this will be challenging
- A & C engagement has also provided good feedback

- **Health & Well Being**

- A new chair for this meeting is to be decided by the end of the month from Staff Side
- There has been excellent work in developing resilience training for staff
- The focus for the following year will be on the CQUINs for improving performance against musculoskeletal, stress and flu vaccinations.

- **Equality & Diversity**

- The Director of Human Resources and Organisational Development referred to Mr Dhushy Mahendran, Chief of Service for Women and Children's Division, taking over as Chair of this Group to take forward equality and diversity. As previously agreed he will be invited to attend a meeting of the Committee to provide an update on the work of the group. **MW / LC**
- Focus will be on improving the employment experience of BME and disabled staff and increasing employment opportunities for learning disabilities.

- **Terms of Reference**

This will be added to the next agenda for discussion.

036/17 WORKFORCE STRATEGY COMMUNICATIONS PLAN UPDATE

The Head of Communications presented the report to update the Committee on progress achieved to date in engaging and communicating with staff following the launch of the Workforce Strategy.

The key points to note were the Workforce Strategy (2016/17) triangulates key work programmes in/on track (business as normal) as part of the wider corporate communication agenda. The approach

and progress (to date) of communications & engagement as a key enabler in achieving the strategic objectives of the Workforce Strategy and wider corporate goals. Internal communication mechanisms are not as effective as they could be. Staff engagement is challenging particularly among key groups. Good progress against the Workforce Strategy has been achieved in some areas (recruitment, staff health & wellbeing, agency work etc.) while momentum is at an early stage in other areas (reward strategy & sustainable workforce).

- It was noted that the website and business case are close to completion for TLT and to go live in April
- The intranet is to be made available outside the Trust which will be of benefit to the Governors

The Chair thanked the Head of Communications for an informative report.

RESOLVED: Good progress to date. Key metrics (overall pay, run rate & staff survey results) are encouraging. Internal communication mechanisms and levels of staff engagement need to be improved.

037/17 STAFF SURVEY

The Director of Human Resources and Organisational Development has provided a verbal update to the Committee. Nothing much has changed since last year, which is disappointing in the context of results nationally, however in the context of changes within the Trust in the last year is reflective of reality.

038/17 ITEMS FROM THE BOARD OR OTHER COMMITTEES

None to note.

039/17 ITEMS TO HIGHLIGHT TO OTHER COMMITTEES

None to note.

040/17 MATTERS / RISKS TO BE ESCALATED TO THE BOARD

- CQC letter regarding fit and proper person testing. CQC have raised issues concerning compliance particularly about criminal record checks for Board members. An action plan has been sent to CQC and will be overseen by this committee. These actions are to be completed by 31st March 2017

041/17 PAPERS FOR CIRCULATION TO THE GOVERNORS

None to note.

042/17 QUESTIONS TO OURSELVES

1) Are we clear this month where we should be focusing on as

a business?

The Committee noted that there is clarity of focus on the objectives.

2) Are we clear what our successes are?

DS has highlighted the reduction in agency costs, engagement activities, improved recruitment, retention, communications and VCP.

3) Impact of discussions on recovery plan?

SS has highlighted this is positive on all fronts.

043/17 ANY OTHER BUSINESS

- DS has advised that a paper on the staff survey results will be brought back to this Committee before presenting at the next Board meeting — **DS** **(LC to note for Agenda)**
- PL has asked for a new agenda item 'Comments or questions to the group' to be added to the next agenda — **MW / LC**

042/17 DATE OF NEXT MEETING

The next meeting of the Gloucestershire Hospitals Foundation Trust Workforce Committee will be held on **Thursday 6th April 2017** at **2pm** in the **Board Room, Alexandra House, Cheltenham General Hospital.**

Papers for the next meeting: Completed papers for the next meeting are to be logged with the Trust Secretary no later than 3pm on **Tuesday 28th March 2017.**

The meeting ended at 16:00pm.

Chair
6th April 2017

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – 12th APRIL 2017

Report Title
Workforce Report - Period to 28th February 2017
Sponsor and Author(s)
Authors: Eve Russell, Associate Director Workforce Sarah Stansfield, Director of Operational Finance Sponsoring Director: David Smith, Director of Human Resources and Organisational Development.
Executive Summary

Purpose

This report provides an overview of the workforce performance of the Trust as at the end of Month 11 of the 2016/17 financial year. It provides information on the pay spend, progress on agency expenditure control and movements in headcount.

Key issues to note

- It was disappointing to see an increase in the overall paybill between M10 and M11 of £0.45m. This had broken the trend of month on month reductions witnessed over the previous 4 months, returning the pay spend to the level of December 2016, still the second lowest level of this financial year
- The reason for the increase is found in the unusually high number of bank holidays at the end of December/early January which is paid for in the February pay run. The excess this year was caused by Xmas and New Year falling at a weekend, necessitating in additional bank holidays at premium time being created
- It is expected that this trend will reverse in March and pay spend will return to January levels
- Agency expenditure remained level with the prior month with nursing expenditure stabilising and an increase in medical locums being balanced with a reduction in non-clinical agency
- Whilst nursing appears to have shown a decrease, this is primarily due to an accounting adjustment and further analysis is required to understand the increase in medical locum expenditure
- We continue to make inroads into qualified nursing vacancies which are now at 106 WTE, the lowest level for the whole of 2016/2017 however we need to continue the focus on employee retention at a time of challenged supply
- We are seeing some reductions in sickness levels as we exit the Winter period and it is particularly pleasing to see the disciplined approach taken in Medicine division to both short and long term absence

Conclusions

It is very pleasing to see that the reductions in agency spend gained over the last few months have been maintained and this is reflective of both the grip applied by the work stream leads and by divisional colleagues. The focus on medical locums must continue and in particular to

both understand and address the reasons for the in-month increase. Creative recruitment solutions are being considered in certain specialties which may help reduce reliance on agencies, particularly in acute medicine.

Implications and Future Action Required

The focus on reducing agency use and reducing vacancy levels appears to be having a positive impact and must be maintained and increased. In particular, planning for staffing over Easter needs to reflect the potential for additional spend with each work stream lead identifying their plans now. In terms of the overall paybill, the phasing of the pay budget to reflect the potential spikes caused by bank holidays may need to be considered.

Recommendations
The Board is asked to note the report.
Impact Upon Strategic Objectives
A failure to improve the financial position will lead to increased scrutiny over investment decision making.
Impact Upon Corporate Risks
Significant impact on deliverability of the financial plan for 2016/17 and 2017/18.
Regulatory and/or Legal Implications
A failure to control all elements of the paybill will impact the Financial Recovery Plan and may lead to increased regulatory activity by NHS Improvement around the financial position of the Trust.
Equality & Patient Impact
It is essential that any steps taken to curb pay expenditure are impact assessed to ensure that quality and safety of patient services are assured.

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)**

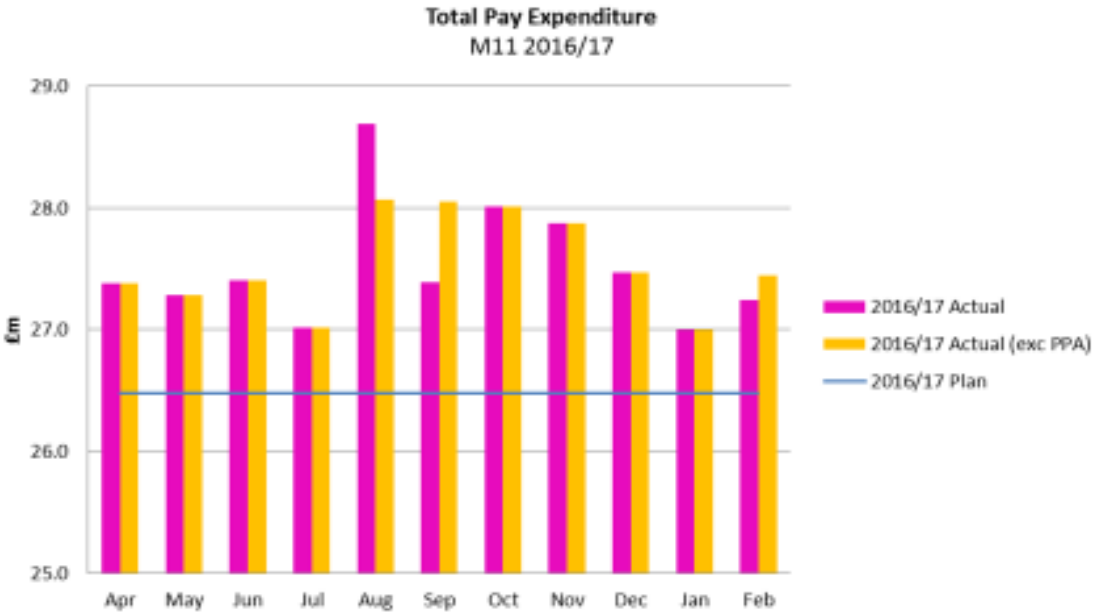
Gloucestershire Hospitals NHS
NHS Foundation Trust

Workforce Report
Period to 28th February 2017

Introduction and Overview

The purpose of this presentation is to provide an overview for the Finance Committee of our current position in terms of Workforce expenditure and other relevant Performance Indicators. It will include a breakdown of current pay along with a description of actions being taken to address any concerns.

Pay Expenditure



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.

Pay expenditure reflects the total expenditure across the Trust, including bank and agency. It includes all hosted and shared services.

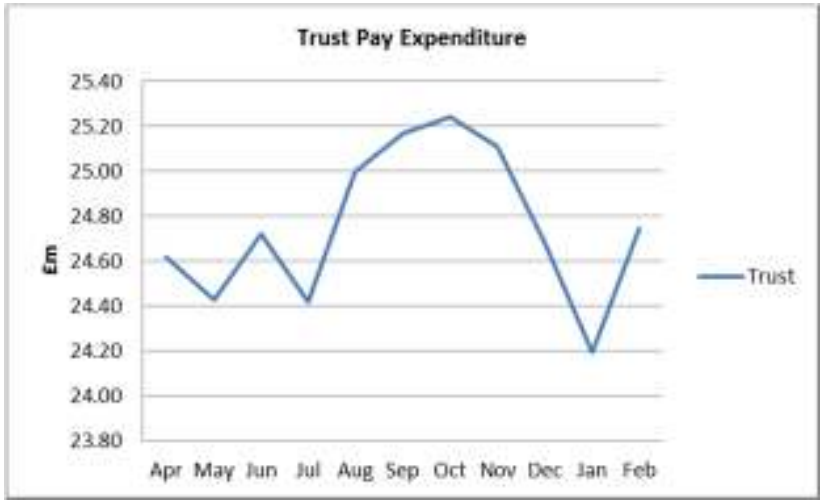
Whilst total pay expenditure had reduced every month between October 2016 and January 2017, February sees an increase. However, this is largely due to the high proportion of pay enhancements which naturally fall within January (Bank Holidays and weekends), which significantly distort the picture. This is an annual occurrence, and therefore in general terms, it is reasonable to conclude that the proactive steps being taken to control and reduce pay spend are still having a positive impact.

During M11 Finance processed a prior period adjustment to nursing agency. This had a value of £0.2m and removed this value from current year spend. As such the underlying pay position is £0.2m higher than the actual reported. Please refer to the Finance report for more detail.

Pay Expenditure – detailed analysis

Gloucestershire Hospitals NHS
NHS Foundation Trust

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Movement M8-M9	Movement M9-M10	Movement M10-M11
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
2016/17 Actual	**27.38**	**27.28**	**27.41**	**27.02**	**28.69**	**27.39**	**28.01**	**27.87**	**27.47**	**27.00**	**27.24**			
2016/17 Actual (exc PPA)	**27.38**	**27.28**	**27.41**	**27.02**	**28.07**	**28.05**	**28.01**	**27.87**	**27.47**	**27.00**	**27.45**	**(0.41)**	**(0.47)**	**0.45**
Medicine	6.44	6.25	6.31	6.35	6.87	6.56	6.58	6.35	6.40	6.10	6.44	0.05	(0.30)	0.34
Surgery	7.36	7.10	7.21	7.16	7.29	7.29	7.54	7.35	7.16	7.08	7.43	(0.18)	(0.09)	0.36
Women and Children	2.94	2.89	2.90	2.82	2.89	2.98	2.96	2.94	2.89	2.84	2.79	(0.05)	(0.06)	(0.05)
Corporate Services	1.65	1.81	1.71	1.81	1.68	1.78	1.83	2.14	1.85	1.87	1.58	(0.29)	0.02	(0.30)
Diagnostics & Specialist	5.10	5.04	5.20	5.06	5.15	5.17	5.12	5.04	5.09	5.08	5.15	0.05	(0.01)	0.07
Estates and Facilities	1.17	1.18	1.18	1.15	1.18	1.18	1.15	1.15	1.19	1.11	1.13	0.04	(0.08)	0.02
Hosted Services - GP	2.27	2.30	2.22	2.21	2.51	2.37	2.30	2.26	2.30	2.37	2.29	0.04	0.07	(0.08)
Other (inc. Trustwide & SS)	0.46	0.69	0.68	0.45	0.49	0.72	0.52	0.64	0.57	0.55	0.63	(0.07)	(0.02)	0.08
Trust	**24.62**	**24.43**	**24.72**	**24.42**	**25.00**	**25.17**	**25.24**	**25.11**	**24.68**	**24.20**	**24.75**	**(0.44)**	**(0.48)**	**0.55**
Hosted	**2.77**	**2.85**	**2.69**	**2.60**	**3.07**	**2.88**	**2.76**	**2.76**	**2.79**	**2.80**	**2.70**	**0.03**	**0.01**	**(0.10)**
Total	**27.38**	**27.28**	**27.41**	**27.02**	**28.07**	**28.05**	**28.01**	**27.87**	**27.47**	**27.00**	**27.45**	**(0.41)**	**(0.47)**	**0.45**



We continue to see a positive change, month on month, in total pay expenditure within W&C and Corporate Divisions. In month 11 there was an increase in overall expenditure of £0.45m, primarily in Medicine and Surgery, however this can be attributed in significant part to the pay enhancements issue as previously stated. It is pleasing to see D&S Division continuing to operate within their budget

We would expect to see pay expenditure stabilise in March, following the very low spend in January, and the unrepresentatively high spend in February.

Pay expenditure by Division

Pay Analysis Divisional	Budget £000's	Substantive £000's	Bank £000's	Agency £000's	Total £000's	Variance £000's
Surgery	75,849	74,243	2,269	3,461	79,973	(4,124)
Medicine	59,166	54,671	3,480	12,521	70,673	(11,506)
D&S	57,038	54,886	657	672	56,215	823
W&C	30,057	29,659	936	1,259	31,854	(1,797)
EFD	12,129	11,942	771	65	12,778	(649)
Corporate*	47,839	48,084	1,067	2,115	51,266	(3,427)
Total Pay	**282,077**	**273,485**	**9,180**	**20,093**	**302,759**	**(20,681)**

* Includes Trustwide and hosted services

NB: The budget figures reflect those on the financial ledger and do not reconcile, either by cost category or phasing, to the NHSI plan.

Pay expenditure reflects the total expenditure across the Trust. It includes all hosted and shared services.

In addition to the efforts being made to reduce Agency expenditure, work continues in relation to control and reduction of non-agency pay costs. This project now includes 8 work streams, all of which are overseen by the Executive Director of HR and OD:

1. Executive Authorisation of non-clinical overtime
2. Review of HR Policies and extension of Salary Sacrifice opportunities
3. Review of annual leave accrual
4. Review of RRP
5. Nursery income generation
6. Change of notice periods for Band 5 staff (increase to 8 weeks)
7. Increase in number of apprenticeships
8. Recruitment income generation

.

Staff in Post

Staff in post reflects contracted FTE data.

Detailed analysis of the substantive staffing levels reveal that since 31 October 2016 there has been a decline of 49 WTE in the total staff numbers. This has been fairly evenly spread across the workforce, which is positive in some cases, but a cause of concern in others insofar as we still experience vacancies across some key clinical staff groups. We continue to recruit into key shortage areas (eg Nursing, Medical) in efforts to reduce our agency expenditure and ensure we are staffing our clinical areas at the appropriate levels and with the right staff.

The establishment for Band 5 Registered Nurses/Midwives continues to decrease, and is now 14.50 WTE less than August 2016.

Due to the reduced establishment, and an increased number of staff in post, the vacancy rate for Band 5 nurses has fallen to 106.64 WTE.

The nurse vacancy forecast predicts that the vacancy level will remain below 120 WTE during 2017, as opposed to the 160+ WTE vacancy levels experienced in 2016. This should support a continued reduction in Nurse agency spend.

A Vacancy Control Panel (VCP) chaired by the Executive Director of HR and OD sits each week and scrutinises every request for recruitment with the exception of Band 5 nurses.

The high "paid" figure in the table below relates to the enhancement issue as previously referenced albeit is significantly higher than December when the pay bill came in at the same poundage.

Division - Establishment - Month 11	Funded WTEs	Contracted WTEs	Worked WTEs	Paid WTEs	Funded less contracted WTEs
Surgery	1,815	1,760	1,804	1,945	56
Medicine	1,508	1,351	1,503	1,633	157
D&S	1,647	1,565	1,558	1,596	82
W&C	705	707	702	792	(2)
EFD	497	474	511	571	22
Corporate*	1,159	1,206	1,161	1,172	(47)
Total WTEs	**7,331**	**7,063**	**7,239**	**7,709**	**268**

* Includes Trustwide and hosted services

The table shows the current M10 FTE data against the establishment

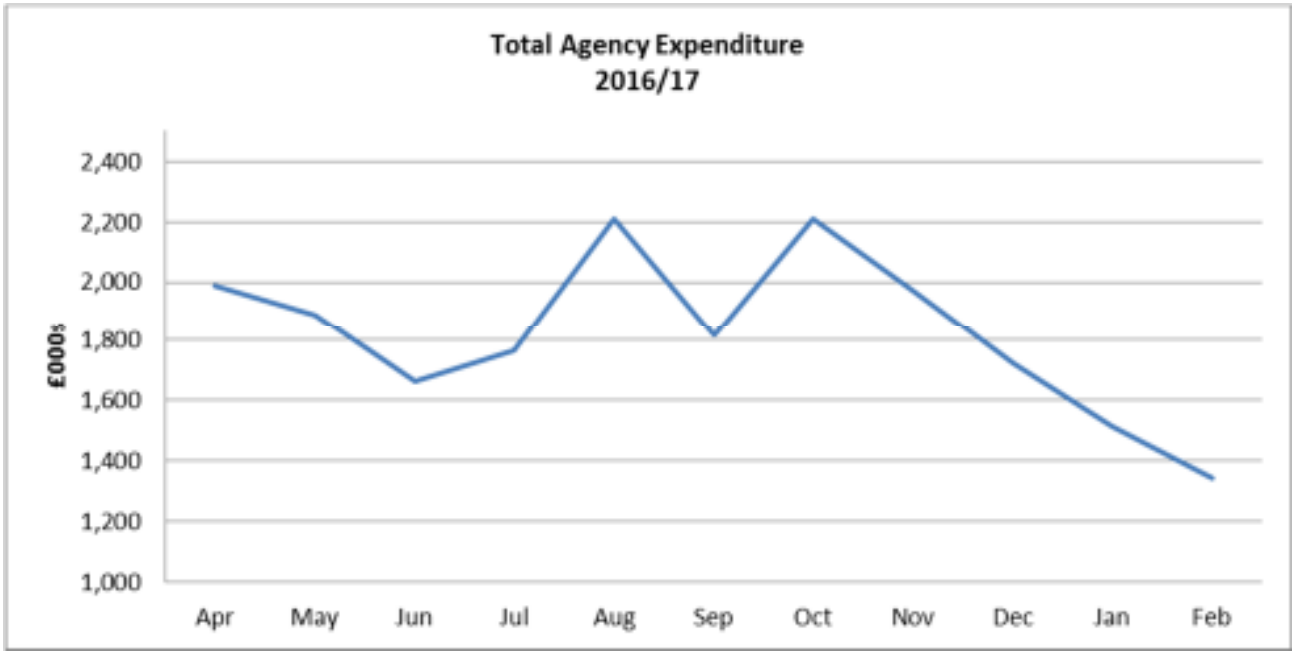
Definitions:

- **Funded**– the FTE value held within the financial ledger to reflect budgeted establishment
- **Contracted WTE** – reflects the number of contracted substantive WTE
- **Worked WTE** – reflects WTEs worked within the month, includes bank and agency
- **Paid WTE** – reflects WTEs paid within the month (includes premiums, unscoial hours payments etc. – converted to WTE)

Agency Spend

The focus on reducing Agency Spend continues through the Agency Programme Board (chaired by the Executive Director of HR and OD), through which a comprehensive programme of actions designed to reduce agency spend is being tracked and managed. It is extremely pleasing to see that progress continues; agency spend in Month 11 was at the lowest level so far this year (although noting the adjustment made by Finance (detail below) the true position is one of spend consistent with January (Month 10) levels.

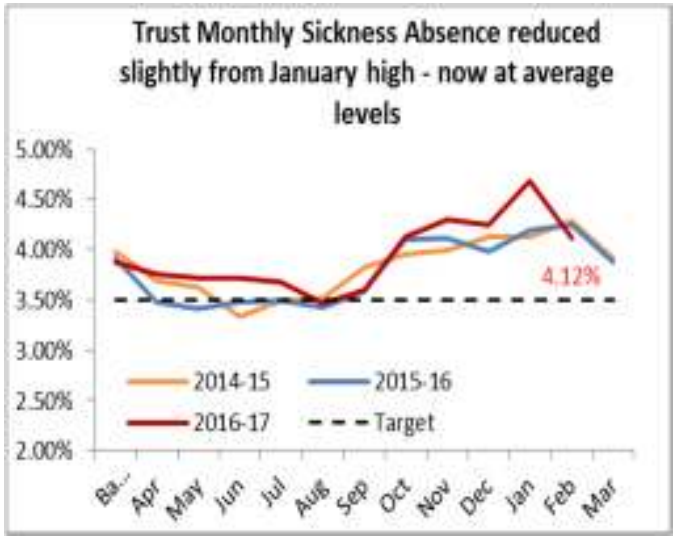
Agency Spend by Staff Group											
	Apr £000s	May £000s	Jun £000s	Jul £000s	Aug £000s	Sep £000s	Oct £000s	Nov £000s	Dec £000s	Jan £000s	Feb £000s
Medical	420	552	509	487	873	835	937	704	803	602	703
Nursing	1,294	959	755	1,012	1,052	650	968	628	616	626	422
Other	274	380	399	265	285	331	303	639	303	288	219
Total	**1,988**	**1,891**	**1,663**	**1,764**	**2,211**	**1,816**	**2,209**	**1,971**	**1,721**	**1,516**	**1,345**



During M11 Finance processed a prior period adjustment to nursing agency. This had a value of £0.2m and removed this value from current year spend. As such the underlying pay position is £0.2m higher than the actual reported. Further analysis is also being done to understand the increase in medical locum expenditure in month

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Monthly Sickness Absence

Description	Current Performance			Trend	Comments
Sickness Absence is measured as percentage of available Full Time Equivalents (FTEs) absent against available FTE. The Trust target Is 3.5% with the red threshold 0.5% above this figure. Target is set annually by HR Director	12 months to Feb 17 (Annual)	**Actual**	**KPI**		Annual sickness absence of 3.94% still remains lower than the national average for Large Acute Trusts (4.34% to Nov 16). Long term (over 28 days) sickness accounts for approximately half of absence taken (50.3%). The estimated cost of annual sickness absence (lost hours, not replacement) is £7,216,862. **Sickness absence is prone to late recording, therefore the latest month's figure is liable to revision upwards in the following month's report**.
		% Abs	**% Abs**		
	Trust Total	3.94%	3.50%		
	Corporate	3.94%	3.50%		
	Diagnostics & Specialty	3.72%	3.50%		
	Estates & Facilities	4.53%	3.50%		
	Medicine	3.68%	3.50%		
	Surgery	3.97%	3.50%		
	Womens & Children	4.38%	3.50%		
	Add Prof Scientific and Technic	3.24%	3.50%		
	Additional Clinical Services	5.05%	3.50%		
	Administrative and Clerical	4.05%	3.50%		
	Allied Health Professionals	2.81%	3.50%		
	Estates and Ancillary	4.34%	3.50%		
	Healthcare Scientists	3.55%	3.50%		
	Medical and Dental	1.92%	3.50%		
	Nursing and Midwifery Registered	4.25%	3.50%		

Gloucestershire Hospitals NHS
NHS Foundation Trust

Trust Annual Turnover

Description	Current Performance			Trend	Comments
Turnover is measured using the total leavers (heads) as a percentage of the average headcount for the reporting period. The Trust target is 9.5% with the red threshold above 10.5% and below 6%. This is set annually by HR Director	12 months to Feb 17 (Annual)	**Actual**	**KPI**		Turnover remains high. Staff Nurse turnover remains at less than 15% This continues the improvement from the beginning of the year when Medicine Staff nursing was over 23% - it is now 15.17%. Corporate Turnover is high in a number of areas, particularly Finance, Information, Procurement and 7 day Ward Clerk services.**Turnover is prone to late recording, therefore the latest month's figure is liable to revision upwards in the following month's report.**
		% TO	**% TO**		
	Trust Total	12.48%	9.50%		
	Corporate	17.25%	9.50%		
	Diagnostics & Specialty	10.27%	9.50%		
	Estates & Facilities	9.46%	9.50%		
	Medicine	14.86%	9.50%		
	Surgery	12.40%	9.50%		
	Womens & Children	11.39%	9.50%		
	Add Prof Scientific and Technic	6.77%	9.50%		
	Additional Clinical Services	15.32%	9.50%		
	Administrative and Clerical	13.92%	9.50%		
	Allied Health Professionals	13.99%	9.50%		
	Estates and Ancillary	8.13%	9.50%		
	Healthcare Scientists	16.47%	9.50%		
	Medical and Dental	6.85%	9.50%		
	Nursing and Midwifery Registered	11.81%	9.50%		
	Staff Nurses	14.45%	9.50%		

Recommendations

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Committee are asked to :

- NOTE the contents of this paper and APPROVE the actions being taken

Author: **Sarah Stansfield, Director of Operational Finance; Eve Russell, Associate Director of HR**

Presenting Director: **David Smith , Director of Human Resources and Organisational Development**

Date: **March 2017**

Gloucestershire Hospitals NHS
NHS Foundation Trust

Appendices

- Agency Programme TIB Update
- Pay Grip TIB Update

Agency

Accountable Person: Dave Smith, HR&OD Director
Date Completed: 14.03.2017
For TIB on: 21.03.2017

Gloucestershire Hospitals NHS
NHS Foundation Trust

This template is owned by the CIP PMO – please do not make any unauthorised changes without prior consent. Return to: CIP@glos.nhs.uk

2016/17 Summary						2017/18 Summary		
Pre-FRP Target (£k)	Actual (£k)	Forecast Outturn (£k)	FRP Target (£k)	Actual (£k)	Forecast Outturn (£k)	FRP Target (£k)	Actual (£k)	Forecast Outturn (£k)
3,000	560	560	565	136	565	2,584	TBD	2,584

2016/17 – Scheme Detail:

Previous Reporting Period *(bring forward what you reported at last TIB):*

Maturity Level:	1	2	3	4	5	Total
No. of Schemes					4	4
Value (£k)					565	565

This Reporting Period:

Maturity Level:	1	2	3	4	5	Total
No. of Schemes					4	4
Value (£k)					565	565

- An additional £359k is reported on Nursing Agency saving within the Medicine Division

2017/18 – Scheme Detail:

Previous Reporting Period *(bring forward what you reported at last TIB):*

Maturity Level:	1	2	3	4	5	Total
No. of Schemes				1	4	5
Value (£k)				532	2,052	2,584

This Reporting Period:

Maturity Level:	1	2	3	4	5	Total
No. of Schemes				1	4	5
Value (£k)				532	2,052	2,584

- Operations Agency (£532k) now has a material risk of non-delivery in FY1718 due to potential inability to close escalation capacity. We have met all 5 specialties and no plans are yet in place to deliver agency savings through length of stay. We are seeking alternative plans to deliver Operational agency savings

Delivered since previous TIB:

- Recruitment KPIs and vacancy targets approved via Workforce Committee and Reward Strategy Group (achievement of KPIs dependent on full implementation of NHS Jobs 2,)
- IR35 Trust position statement submitted to Director's Group; required comms (internal and external) being produced
- Locum spot shift requisition process reinstated
- Presentations of medical bank software suppliers held and being invited for second round to progress procurement process
- Nursing: - Ongoing process of Thursday 2pm conference call to look at weekend staffing, chaired by ND on call
  - progress of work with performance report from Rosterpro (hours worked/owed) as many hours owed are technical (leavers still on system etc.)
  - review of specialing arrangements (W&C work with commissioners)
  - authorisation process in place for all agency and flow chart developed and to be distributed
  - W&C: Meeting with Divisional Nursing Director, Matron & Band 7 nurses re roster management, all rosters being reviewed one week in advance, daily "huddle" with bands 7 or rep from all areas to ensure effective communication and facilitate flexible deployment
  - Surgery: KPI of roster fill-rate and non-compliant wards discussed at the Surgical Modern Matrons Meeting

Plan for next period (including recovery actions for any 'slippage'):

- New NHS Jobs 2 functionalities for recruiting managers to be presented at 100 leaders
- IR35 Trust position statement to be issued to all Agencies
- Locum conversions to substantive to be progressed. Detailed information on long term locum staff, agency fees etc. to be used by in conversion discussions with Divisions.
- Discussions regarding management interims to formulate exit strategies to be finished
- Procurement process of Medical bank software solution to be progressed
- Nursing – review recent pilot of 1 month intensive English language testing for IELTS as did not improve the situation, W&C focus on developing HCA to undertake specialing role
- Formulate alternative Operational schemes to deliver agency savings in FY1718

Key Risks & Issues to Delivery:

Risk or Issue	Score	Mitigation	Owner
Operational pressures, including use of unfunded/escalation areas necessitating need for temp staff	12 (4x3)	Strong authorisation process and concerted action on reviewing bed base (including Length of Stay Programme)	TS
Highly likely that first new (full-time) recruit into Temporary Staffing Office will not stay, presenting further delay to go-live of expanded hours/service.	12 (3x4)	DC to check whether original VCP authorisation for post still stands. 2nd new starter joined Monday 20th. Apprentice candidates short-listed, interviews scheduled. Replacement for Joan McIntosh approved at VCP 17/02	DS

Workforce (Pay Grip)

Accountable Person: Dave Smith, HR&OD Director
Date Completed: 14.03.2017
For TIB on: 21.03.2017

Gloucestershire Hospitals NHS
NHS Foundation Trust

This template is owned by the CIP PMO – please do not make any unauthorised changes without prior consent. Return to: CIP@glos.nhs.uk

2016/17 Summary						2017/18 Summary		
Pre-FRP Target (£k)	Actual (£k)	Forecast Outturn (£k)	FRP Target (£k)	Actual (£k)	Forecast Outturn (£k)	FRP Target (£k)	Actual (£k)	Forecast Outturn (£k)
0	0	0	614	10	500	1,780	TBD	1,522

2016/17 – Scheme Detail:

Previous Reporting Period *(bring forward what you reported at last TIB):*

Maturity Level:	1	2	3	4	5	Total
No. of Schemes				8		8
Value (£k)				584		584

This Reporting Period:

Maturity Level:	1	2	3	4	5	Total
No. of Schemes				8		8
Value (£k)				584		584

- Work is ongoing with Val Doyle and Sarah Stansfield to track the savings from schemes (annual leave sale/purchase, HR income generation, non-clinical overtime)

2017/18 Scheme Detail:

Previous Reporting Period *(bring forward what you reported at last TIB):*

Maturity Level:	1	2	3	4	5	Total
No. of Schemes	1			8		9
Value (£k)	314			1,208		1,522

This Reporting Period:

Maturity Level:	1	2	3	4	5	Total
No. of Schemes	1			8		9
Value (£k)	314			1,208		1,522

- Alternative schemes are being worked up to close the gap, including Admin and Clerical substantive reduction of 1% £314k – although we are using iView to determine whether this scheme should be focussed on Admin and Clerical, and/or other staff groups

Delivered since previous TIB:

- Initial iView analysis completed and areas identified to look into to reduce pay spend
- Detailed Pay Spend analysis to be followed up with HRBPs to analyse areas of opportunity to reduce substantive pay costs over and above basic salary and next steps discussed
- Change in notice period from 4-8 weeks agreed with Staff Side – consultation commenced
- New ideas to close FRP gap are being worked up

Plan for next period (including recovery actions for any 'slippage'):

- Outcome of detailed Pay spend analysis to be progressed with Divisions
- DoF to confirm approach to leave accrual change with auditors
- Develop new ideas and progress to level 4
- Non-clinical overtime Exec authorisation to be discussed with DoF

Key Risks & Issues to Delivery:

Risk or Issue	Score	Mitigation	Owner
Retention issues – given pending changes to HR policies, there is risk that it is harder to recruit to and replace key roles	6	Promote benefits of employment at GHT. Monitor staff turnover, absentee rate and recruitment patterns	DS
Compliance with notice period policy	4	Establish controls to ensure compliance	DS
Slippage in timing of notice period changes and HR policy changes	9	Development of alternative schemes to close any gaps	DS

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

PUBLIC BOARD MEETING WEDNESDAY 12 APRIL 2017
Lecture Hall, Sandford Education Centre commencing at 9.00 a.m

Report Title
NURSE AND MIDWIFERY STAFFING **April 2017**
Sponsor and Author(s)
Maggie Arnold – Executive Director of Nursing and Midwifery Adam Kirton – Head of Recruitment
Executive Summary
Purpose The purpose of this report is to provide assurance to the Trust Board in respect of nurse staffing levels for March 2017, 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 report comment in detail where staffing hours are either lower than the centile set by NHS England, or over, and the rationale behind these findings. • There continues to be close scrutiny of agency spend and recruitment and reports are submitted to TIB as required. • The divisional nursing directors have analysed their department's data and have individually responded for the purpose of this report. Conclusions, implications and Next Steps • Continue with proactive recruitment. • Continue to manage agency spend • To welcome Nurse Associates
Recommendations
The Board is asked to receive this report as a source of assurance that staffing levels across the Trust are supporting the delivery of 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					

NURSE AND MIDWIFERY STAFFING
March 2017

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 February 2017.

2 Background

Over the past two years 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/ Divisional Safer Staffing Reports

3.1 Surgical Division

Nursing Metrics Focus
From a nursing metrics performance, all areas were GREEN, except ward 2A ward, who were AMBER due to medication errors and cleanliness. The Modern Matron for the ward has discussed this with the ward sister, and an action plan is in place.

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

Alstone	HCA 144%	Over established with 2 overseas nurses awaiting registration
DCC Trust wide	(C)HCA 70.5% (G) HCA 58%	Due to 'flexing off' of staff during low patient occupancy
2a	RGN 126% HCA 157%	In transition with new ward, and supporting staffing with additional RGN and HCA. Patient dependency review in place and will be considered against Hurst for April. Staffing will be adjusted thereafter.

Care Hours per Nursed Day Focus
We have now been provided access to the 'Model Hospital' database, as a comparison tool, as supplied by NHS Improvement. Data is not aggregated at ward level yet as this is "under development". It is anticipated that future development will allow speciality ward comparisons.

Harm free Care Focus
We have continued to develop an understanding of where we feature in comparison to other organisations. It should be noted there is no overarching 'national' RAG rating for HARM FREE and NEW HARMS therefore our Clinical Audit department have attempted to look at the national mean and develop a RAG scoring suggestion against that. For this month, the RAG for each harm category follows.

National Median

	Nat. Median			
Harm free	93.75%	95%+	93-94.9%	<93%
New harm free	97.62%	98%+	97%	<97%

	Nat. Median	≤ Nat. median = green	>Nat. median to Nat. median +50% = amber	>Nat median +50% = red
Pressure ulcers (new)	0.99%	≤0.99%	0.99-1.49%	>1.49%
Falls with harm	0.69%	≤0.69%	0.69-1.04%	>1.04%
Catheter and UTI	0.80%	≤0.80%	0.80-1.20%	>1.20%
New VTEs	0.40%	≤0.40%	0.4-0.6%	>0.6%

Surgery

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Harm free	94.4%	96.0%	95.6%	91.8%	89.6%	91.5%	92.6%	93.4%	92.3%	93.6%	94.2%	91.7%	90.9%	94.9%	91.0%	93.2%	89.4%
New harm free	97.6%	98.9%	98.4%	95.3%	96.5%	96.1%	98.5%	98.2%	97.4%	98.5%	98.2%	95.5%	95.1%	97.5%	95.3%	97.3%	95.1%
Pressure ulcers - new	1.59%	0.74%	0.40%	1.95%	1.54%	1.55%	0.37%	1.10%	1.48%	0.75%	1.08%	1.52%	0.75%	0.73%	0.39%	0.68%	2.12%
Falls with harm	0.00%	0.00%	0.00%	1.56%	0.39%	0.78%	1.11%	0.37%	0.74%	0.00%	0.36%	1.89%	1.51%	0.36%	1.96%	1.35%	1.41%
Catheter and UTI	2.78%	1.47%	1.59%	2.73%	1.93%	1.55%	1.48%	3.66%	1.11%	1.87%	1.81%	2.27%	3.02%	1.46%	1.96%	0.68%	2.12%
New VTEs	0.40%	0.37%	0.40%	0.39%	0.39%	0.39%	0.00%	0.37%	0.74%	0.37%	0.36%	0.38%	0.75%	0.00%	1.18%	0.34%	0.35%

Ward	***Harm free care***	***Reason for Trigger***	***Correlation with safer staffing concerns***
Bibury	95%	1 UTI secondary to catheter	No
DCC	88.9%	1 community inherited DVT	No and inherited
Snowshill	92%	1 UTI secondary to catheter	No
3a	94%	1 new Grade 2 Pressure Ulcer	No
3b	84%	4 patient falls with moderate harm	No
5a	95.4%	1 old grade 2 pressure ulcer	No and inherited
5b	87.8%	2 new grade 2 pressure ulcer. 1 UTI secondary to catheter.	No

Finance and Vacancy Focus

The Agency spend rose in month (Month 10), to £75.2k (£54.3k in month 9) (£1,805m to date), and has risen against the trajectory set but both the Trust and NHS I. The main cause of Agency spending, as before, was and increase incidence of ongoing staffing for the use of unfunded areas, such as Day Surgery units, Surgical HDU and Recovery, due to Black escalation, and at relatively short notice. Bank spend is at £158.4k, (£1,662m YTD) which is a fall over last month, and again is used mostly to support vacancies within the RGN line.

Sickness levels, is above the Trust set average, (RGN 4.78%/HCA 5.27%) and is similar to last month, and will continue to be worked upon. Turnover is below the national average (RGN 11.82%/HCA 16.29%)

The bottom line nursing staffing funded vacancy position within the division has reduced again on last month, and is now showing an over-establishment of 7.78 fte 'pure' bottom line vacancies. To explain this the band 2/3 lines are still over established with mainly overseas nurses, awaiting NMC registration, and additionally for this month, newly qualifying nurses (11 fte), which increases the over establishment by 33.56 fte (22.35 fte last month). This level will see a level fall again on receipt of NMC PIN's during April, and then moving into band 5 vacancies. Pure Band 5 vacancies are 33.82 fte, and again have reduced over last month (36.39 fte), and, dependant on new leavers, should reduce further when the 11 fte newly qualified nurses move into the band 5 lines on PIN receipt. The remaining vacancies are a relatively small number of band 6 and 7 posts. Ongoing recruitment exercises are, however, still in place, including active participation in the Mid-March recruitment event.

3.2 Medical Division

3.2.1 Introduction and Overview

The Nursing Metrics are a set of 'outcome' measures that consider aspects of patient care. Using in collaboration with other datasets, they help understanding on the overall performance of ward areas, and suggest areas of corrective action.

Safer Staffing Focus

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

Cardiac – CGH	Night - Registered Nurse 75%	Cardiac always runs with 3 trained this is their agreed establishment however the data reports it against 4 nurses hence 75%
Ryeworth Ward	Night - Care Staff 130.65%	On night duty an extra HCA has been utilised from numbers to support specials
Woodmancote Ward	Day - Care Staff 130.80%	Increase in care staff to support specials within numbers High volume of specials in Jan / Feb
	Night - Registered Nurse 123.81%	Increase in registered nurse for area at night: permission Divisional nursing Director
	Night - Care Staff 129.76%	Increase in care staff for area at night : permission Divisional nursing Director
4A	Day - Care Staff 136.43%	Ward 4a has 18.00WTE band 5 vacancies and to offset this they are using significant bank band 2 healthcare assistants to reduce risk, improve safety and ensure positive patient experience.
	Night - Registered Nurse 123.81%	Permission for Nursing Director to over establish by 1WTE band 5 at night, they will revert to funded establishment now that bay has swung from 4a to 4b.
4B	Day - Registered Nurse 78.57%	
	Day - Care Staff 76.79%	High volume of specials Jan / Feb
	Night - Care Staff 75%	High volume of specials Jan / Feb
6A	Day - Registered Nurse 78.57%	Ward has 4.42WTE band 5 vacancies, although we continue to actively recruit to mitigate risk, ensure safety and maintain quality we are adjusting the skill mix where possible as ward is over recruited by 3.90WTE band 3 and 1.57WTE band 2
8A	Night - Care Staff 137.5%	There significant numbers of complex neurological patients including head injuries who

		have required 1:1 nursing on a daily basis, this has been managed during the day but been particularly challenging at night to ensure they do not come to harm themselves or harm others.
9B	Day - Care Staff 129.52%	High volume of specials Jan / Feb
	Night - Care Staff 139.29%	High volume of specials Jan / Feb
ED - GRH		There are significant staffing vacancies which are filled with bank or agency but staff skills are limited with this approach but mitigate the risk to a degree. RAG rated red for staffing, HH and complaints
ACUA		Due to increased acuity of patients the unit is showing as RAG rated RED for complaints and orange for falls, medication errors and HH.
ED - CGH		There are significant staffing vacancies which are filled with bank or agency but staff skills are limited with this approach but mitigate the risk to a degree. RAG rated red for staffing, EWS action and pressure ulcers.

Care Hours per Nursed Day Focus

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

Harm free Care Focus

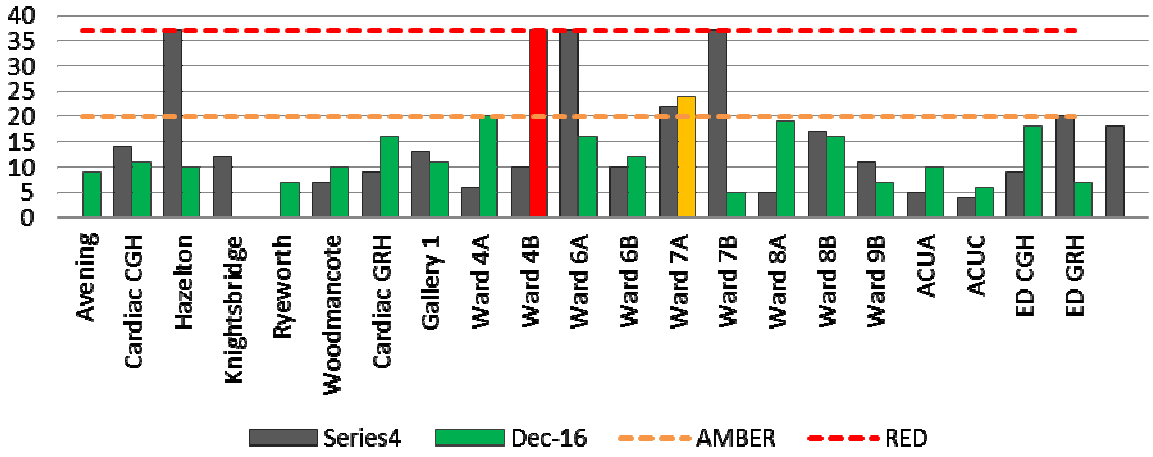
A full quarter report will be available for end quarter 4 on national comparisons. Of the 24 Medical wards and departments 17 scored 100%, 4 scored below 100% for Harm Free Care and the remaining 3 locations are non – reporting. Importantly, it should be remembered that the national reporting includes 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. Trigger reasons follow:

Ward	Harm Free Care (%)	Reason for trigger	Correlation with Safer Staffing
Cardiology - GRH	95.55%	1 new VTE (35 Patients)	No
		1 old pressure ulcer (35 patients)	
6A	92.86%	1 old pressure ulcer (28 patients)	No
		5 catheters (28 patients)	
6B	95.24%	1 new UTI (no catheter) 3 catheters	No
		(23 patients)	
		1 VTE assessment not completed (23 patients)	No
		4 old pressure ulcers (23 patients)	
8B	92.59%	1 fall	No
		4 catheters (25 patients)	

2. Medical Division

Nursing Metrics Focus

FIGURE 1 - NURSING METRICS FEBRUARY 2017 Vs JANUARY 2017



WARD 4B RAG RATED RED AUTOMATICALLY DUE TO LACK OF DATA

January 2017

February 2017

Review by Senior Sister and Lead Nurse of all Action Plans generated for Red and Amber Indicators

Review by DND, Senior Sister and Lead Nurse of all Action Plans generated for Red and Amber Indicators

Planned visit to area by DND and Lead Nurse to meet Senior Sister

TABLE 1 – NURSING METRICS BREAKDOWN BY WARD FEBRUARY 2017

Feb-17	WARD																				
	Avening	Cardiac CGH	Hazelton	Knightsbridge	Ryeworth	Woodmancote	Cardiac GRH	Gallery 1	Ward 4A	Ward 4B	Ward 6A	Ward 6B	Ward 7A	Ward 7B	Ward 8A	Ward 8B	Ward 9B	ACUA	ACUC	ED CGH	ED GRH	TOTAL
EWS score	0	0	0	0	0	0	0	0	5	N/D	0	0	3	0	3	0	0	0	0	0	0	11
EWS Action	0	0	0	0	0	0	0	0	5	N/D	0	0	5	0	5	0	0	0	0	5	0	20
MRSA Bacteraemia	0	0	0	0	0	0	0	0	0	N/D	0	0	0	0	0	0	0	0	0	0	0	0
C Diff	0	1	0	0	3	0	0	0	0	N/D	0	0	0	0	0	0	0	0	0	0	0	4
Falls	3	7	2	0	0	3	2	4	0	N/D	10	3	3	3	3	3	3	2	3	0	0	54
Pressure Ulcers	N/D	1	0	0	0	5	0	0	0	N/D	0	4	4	0	4	5	0	0	0	5	0	28
Staffing RN	0	0	0	0	0	0	4	4	4	N/D	2	2	0	0	0	4	0	0	0	4	0	24
Staffing HCA	0	0	0	0	0	0	4	1	1	N/D	1	0	0	0	0	2	N/D	0	0	0	0	9
Written Complaints	0	1	0	0	0	N/D	1	1	1	N/D	1	1	2	0	0	0	0	2	1	0	2	13
Medications Error	4	1	4	0	0	0	2	0	2	N/D	0	0	2	0	2	0	2	2	0	0	0	21
SUI	0	0	0	0	0	0	0	0	0	N/D	0	0	0	0	0	0	0	0	0	0	0	0
Hand Hygiene	0	0	2	0	2	0	0	0	N/D	N/D	0	0	3	0	0	0	0	2	0	2	3	14
Cleanliness	2	0	2	N/D	2	2	3	1	2	N/D	2	2	2	2	2	2	2	2	2	2	2	36
TOTAL	9	11	10	0	7	10	16	11	20	37	16	12	24	5	19	16	7	10	6	18	7	234

- 4B was the only location this month to have late data submitted. The Matron will discuss with the ward manager as part of their formal 1:1s.
- Cleanliness remains an on-going priority for the medical wards; the overall score has increased to 36 in February compared with 27 in January 2017.
- Hand hygiene remains a key focus for the medical wards. 6 wards are RAG rated as red, with 15 wards RAG rated as green. This is real improvement from January.
- EWS- Score, of the 21 areas 1 did not submit data of the remaining 20 areas 3 RAG rated as red and 17 RAG rated as green. Targeted work is ongoing throughout the division to ensure that all RGNs undertake the e-learning deteriorating patient module which has now been made mandatory within the division.
- Medication Errors has increasing significantly from the January position of 10 errors compared 21 errors in February 2017, maintaining the RAG rating to red. Wards are encouraged to participate in the pharmacy MDT huddle which aims to provide staff with accelerated learning opportunities.
- The overall pressure ulcer score has increased to 28 in February compared to 17 in January with 6 wards red.
- Falls have increased from 37 in January to 54 in February 2017 across the division.
- There has been a decrease in written complaints being received from 16 in January to 13 in February

Finance and Vacancy Focus

In February 2017 the (provisional) spend on agency was £379.9k in the month. There have been transfers between the divisions with wards 2a/4a/9a. The funding for these wards has not yet been finalised so an accurate vacancy figure is not currently available. However if the assumption is that the Medical Division will lose funding of 62.04wte and gain funding of 34.80wte then the bottom line Nursing staffing vacancies will be 97.87wte (9.73%). This includes bank funding of 45.35wte. The vacancy is split 90.90wte qualified staff vacancies offset by an over establishment of 38.38wte unqualified staff.

3.3 Diagnostics and Specialties Division

3.3.1 Nursing Metrics Focus

From a nursing metrics performance, both Lilleybrook and Rendcomb Wards were GREEN.

3.3.2 Safer Staffing Focus

The following wards are;

Lilleybrook	RGN 105.13% HCA 96.43%	GREEN
Rendcomb	RGN 102.18% HCA 100.4%	GREEN

3.3.3 Care Hours per Nursed Day Focus

We have now been provided access to the 'Model Hospital' database, as a comparison tool, as supplied by NHS Improvement. Data is not aggregated at ward level yet as this is "under development". It is anticipated that future development will allow speciality ward comparisons.

3.3.4 Harm free Care Focus

We have continued to develop an understanding of where we feature in comparison to other organisations. It should be noted there is no overarching 'national' RAG rating for HARM FREE and NEW HARMS therefore our Clinical Audit department have attempted to look at the national mean and develop a RAG scoring suggestion against that.

Diagnostic and Specialty

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Harm free	97.4%	93.7%	97.5%	97.3%	100.0%	97.5%	95.1%	91.1%	90.0%	91.4%	92.5%	97.4%	89.7%	100.0%	90.9%	96.8%	96.8%
New harm free	97.4%	92.3%	97.5%	100.0%	100.0%	100.0%	97.6%	100.0%	95.0%	100.0%	97.5%	97.4%	92.3%	100.0%	93.2%	100.0%	100.0%
Pressure ulcers - new	0.00%	7.69%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.50%	0.00%	2.50%	2.63%	5.13%	0.00%	2.27%	0.00%	6.45%
Falls with harm	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.50%	0.00%	0.00%	0.00%	0.00%	0.00%	2.27%	0.00%	0.00%
Catheter and UTI	2.63%	2.56%	0.00%	2.70%	0.00%	0.00%	2.44%	6.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
New VTEs	0.00%	0.00%	2.50%	0.00%	0.00%	0.00%	2.44%	0.00%	0.00%	0.00%	0.00%	0.00%	2.56%	0.00%	2.27%	0.00%	0.00%

Divisional Narrative

The safety thermometer did not trigger any new harms for January and matches the safer staffing data as Green. However, there has been two pressure sores reported

on Lilleybrook which are being investigated. This is being reviewed locally with the ward sister and Matron from the datix entries.

3.3.5 Finance and Vacancy Focus

The nursing Agency spend in January 17 fell again and is currently year to date at £25k. The use of Agency in D&S is minimal as both Oncology Wards have a high retention level and nursing vacancies are low. During January only one shift of 6 hours was used on Lilleybrook Ward. Bank spend for January 16 is £30K which is a rise from the previous month and year to date is £183K, bank is mostly used to cover over running clinics and day case activity which has overrun due to the Trust being in black escalation and non-inpatient areas being opened.

Sickness levels remain unchanged for RGN are below the Trust target at 2.03% and above the Trust target for HCA's at 3.81%. Turnover for RGN and HCA is below national average for this month. Where pockets of increased absence are evident our HR business partners are meeting and working on target plans with the individual managers.

The bottom line nursing staffing funded vacancy position within the division is 6 WTE. Recruitment is in progress.

3.4 Women and Children's Division

3.4.1 Care Hours per Nursed Day Focus

This data is collected for Stroud Maternity and Maternity In Patients , Gynaecology (9a) , Childrens In Patients and Neonatal Unit.. All areas reporting this data have care staff within the acceptable range ie >80% and 120%

3.4.2 Intrapartum Maternity Care

As stated in last month's report in line with the recommendations with in Care HPPD in Maternity consideration has been given to how we monitor the collection of staffing data in areas providing intrapartum care namely the Delivery Suite and the Birth units at Gloucester and Cheltenham. However, the complexities have made it difficult to provide meaningful data in this same format as for other ward areas, as staffing levels in intrapartum areas need to fluctuate frequently according to activity. As a result it has been decided to present 1:1 care data for intrapartum care areas as this is collected on all women in all intrapartum care settings and provides a more accurate evaluation of staffing in these areas as it describes the number of women who have 1:1 care in labour. Unfortunately since the implementation of track care this data has not been available electronically butt the following data has been obtained by a manually sample

Gloucestershire Royal Delivery Suite	No data
Gloucestershire Royal	99%
Aveta Birth Centre CGH	100%
Stroud. Birth Centre	100%

The midwife to birth ratio is currently approximately 1:29-30 across the Trusts acute and community based service, which would be green on the speciality obstetric Dashboard. Staffing and activity are usually analysed together. The Dashboard is under normal circumstances monitored monthly by the division alongside the aggregated outcomes from across the service, and outcome measures are bench marked with the South West Maternity dash board. However since implementation of Track no data has been available for monitoring so this figure is an estimate only.

3.4.3 **Harm free Care Focus**

No areas within the Division who collect the Classical Safety Thermometer data (namely Gynaecology and Neonatal services) 'triggered' red on the Safer Staffing return.

3.4.4 **Future Developments**

Maternity inpatients areas have moved to the Maternity Specific safety thermometer and paediatrics moved to collect data using the paediatric thermometer, but no meaningful data is available at present.

To support this staffing data a midwifery led care dashboard is being developed in conjunction with a set of "Red Flag events" as described NICE NG 4 Safe midwifery staffing for maternity settings. This dashboard is under development. In addition, the birth rate plus acuity tool is currently used to monitor staffing on the high risk Delivery suite and alongside birth unit at Gloucester royal. The tool in its current format is not intended for use in other free standing birth units. The tool records staffing versus activity every 4 hours during the day and every two hours at night.

Neonatal services are reviewing how data captured on Badger might be used to report on staffing and acuity of babies in the unit.

3.4.5 **Finance and Vacancy Focus Agency and Bank Use**

In Month 10 the Division worked 7.81 WTE nurses less than the funded establishment. This includes Bank use of 13.71 WTE and Agency use of 4.59 WTE. Of the 7.81 WTE working less than funded, 17.84 WTE are qualified staff (mainly Band 6 and above) offset by 10.03 WTE over establishment for unqualified staff (Band 3's).

The Divisional Agency spend reduced to £42k in Month 10 from £63k in Month 9 (£901k year to date). The main cause of Agency spending is the Paediatric Ward (£486k to date) and Ward 2a/9a (£326k to date). The Agency staffing for this unfunded area has reduced significantly in Month 10 following the move to Ward 9a from Ward 2a. The Division expect minimal agency use in this area going forward, in month 10 it was £ 1k .Paediatric Ward agency spend is mainly coded as vacancy or sickness cover, although vacancies are now minimal . It also includes £121k RMN agency spend of which £61k has been recharged to our Commissioner. Work is being done to develop HCA to take on this role where appropriate

In addition it is pleasing to see an associated reduction in the Divisional Bank spend which is £45k in Month 10 reduced from £90k in Month 9 (£818k YTD).

4. **Nursing Workforce Metrics - Recruitment Update**

4.1 **UK/EU Recruitment**

- There are currently 25.52 WTE experienced UK-based Band 5 nurses in the recruitment pipeline, with start dates currently to be confirmed.
- A total of 23.89 WTE Newly Qualified Nurses joined the Trust in the winter 2016/17 cohort. A further 3.60 WTE are expected to join in the coming weeks.
- The Trust held a successful Open Day for Newly Qualified Nurses and ODPs on 16 February 2017, which resulted in over 125 applications for summer 2017 start dates. A further Open Day is planned for 21 June 2017 for candidates looking to commence employment in winter 2017/18.

- From 125 applications for Newly Qualified Nurse / ODP positions, a total of 110 candidates have been shortlisted for interview on Saturday 25 March 2017. It is anticipated that representatives from all clinical areas will attend to interview.
- Thirteen Trainee Nursing Associates have been recruited with an anticipated start date of 24 April 2017.
- There are currently 26 advertisements live on NHS Jobs for Registered Nurses / Midwives.
    - 16 x Substantive Band 5 Registered Nurses
    - 1 x Bank Band 5 Registered Nurses
    - 1 x Bank Band 6 Registered Mental Health Nurses
    - 4 x Band 6 Specialist Registered Nurses
    - 1 x Band 7 Specialist Registered Nurse
    - 1 x Band 7 Senior Sister / Charge Nurse (Endoscopy Unit at Cheltenham General)
    - 2 x Band 8a Lead Nurse / Modern Matron (Trauma & Orthopaedics and Unscheduled Care at Gloucestershire Royal

4.2 **Non-EU Recruitment**

- Nine nurses were deployed to the Trust during w/c 13 March 2017, with a further six candidates due to be deployed before the end of March (subject to final pre-employment checks being completed).
- The Trust has received a full refund for the £500 'down-payment' made for the November 2015 and May 2016 candidates that have not yet completed their IELTS, as it is acknowledged by our overseas recruitment partner that it is unlikely that these candidates will ever secure the requisite IELTS scores. The vacancy forecast has been amended accordingly.
- The Home Office has released further guidance about the introduction of the Immigration Skills Levy that will apply for all non-EU recruitment where a work permit is required.
    - The additional charges will be implemented on 06 April 2017 to all candidates that do not currently have a Certificate of Sponsorship (therefore, the 15 candidates being deployed this month will not be impacted by the charge).
    - This levy will increase the cost per hire by £3,000 per candidate.
    - Recruitment Strategy Group has agreed to implement a revised 'tie in' period of three years for candidates that require the Immigration Skills Levy to be paid. Candidates voluntarily resigning from the Trust (except in certain circumstances) will be required to repay their recruitment costs.

Commenced employment	Passed the OSCE – Working as Band 5 Staff Nurse	11	1	0
	Failed the OSCE twice – Returning to the Philippines	1	0	0
	Not yet taken the OSCE – Working as Band 3	1	0	0
	Subtotal (commenced employment)	**13**	**1**	**0**
Passed IELTS examination	CBT passed – Visa issued – Awaiting deployment	6	2	1
	CBT passed – Awaiting visa application	5	3	0
	CBT passed – Awaiting NMC Decision Letter	5	4	8
	Awaiting CBT examination	3	4	7
	Subtotal (passed IELTS examination)	**19**	**13**	**16**
Not passed IELTS examination	Awaiting examination	39	63	145
	Application currently on hold	20	3	2
	Subtotal (not passed IELTS examination)	**59**	**66**	**147**

4.3 **Nursing Workforce Metrics**

4.3.1 Vacancy Metrics

The over-establishment of Band 2 Healthcare Assistants has been reduced over the past month (reduced by 14.79 WTE to 19.88 WTE), whilst the over-establishment of Band 3 Unregistered Nursing Staff has increased further to 59.41 WTE due to the recruitment of nurses from the Philippines and the recruitment of Newly Qualified Nurses. It is expected that this over-establishment will decrease next month as a number of these individuals have now gained registration. The Band 5 over-establishment in Women & Children is predominantly due to midwifery recruitment, and these staff will progress to Band 6 soon. The over-establishments in Medicine and Surgery at Band 6 and Band 7 (Surgery only) have been agreed to help sustain the number of registered nurses in these areas. The over-establishments in Diagnostics & Specialties at Bands 4, 5, and 7+ are unaccounted for. The ward reconfiguration on Wards 2a, 4a and 9a has been completed and is reflected within the data. The ward reconfiguration of Gallery Wing Ward 1 is not within the dataset, and this is expected to impact figures in Medicine positively, and have little impact on Diagnostics & Specialties.

	Diagnostics & Specialties		**Medicine**		**Surgery**		**Women & Children**	
	WTE	**%**	**WTE**	**%**	**WTE**	**%**	**WTE**	**%**
Apprentice HCA	6.00	60.00%	8.00	44.44%	5.20	23.64%	1.00	20%
Band 2	0.53	1.04%	-16.87	over	-14.89	over	-3.44	over
Band 3	-1.00	over	-32.84	over	-7.46	over	-2.97	over
Band 4	1.03	21.64%	4.06	23.33%	-0.91	over	0.70	7.30%
Band 5	-4.45	over	89.59	19.21%	36.29	6.69%	-14.79	over
Band 6	2.71	6.50%	-5.02	over	-6.07	over	12.09	5.09%
Bands 7+	-3.74	over	1.60	2.40%	-2.86	over	5.66	7.63%

Data Note: Data for this table is from 31 Dec 2016. Women & Children data include Midwives. over = over-established

4.3.2 Staffing Metrics

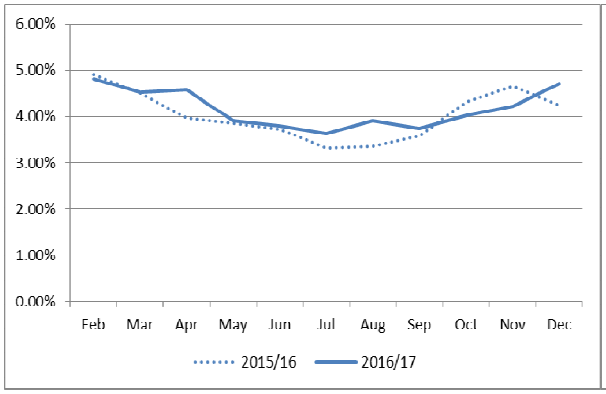
	Diagnostics & Specialties		**Medicine**		**Surgery**		**Women & Children**	
	WTE	**%**	**WTE**	**%**	**WTE**	**%**	**WTE**	**%**
Apprentice HCA	7.00	70.00%	9.00	50.00%	6.00	27.27%	1.00	20.00%
Band 2	1.42	2.78%	1.58	0.58%	-21.10	over	-1.78	over
Band 3	-1.00	over	-36.84	over	-12.46	over	-9.11	over
Band 4	-2.44	over	4.26	24.48%	-0.91	over	0.70	7.30%
Band 5	-4.75	over	103.42	22.18%	33.82	6.20%	-6.96	over
Band 6	2.74	6.57%	-6.17	over	-7.47	over	8.05	3.48%
Bands 7+	-3.94	over	2.60	3.90%	-5.66	over	8.06	10.30%

Data Note: Data for this table is from 31 Jan 2017. Women & Children data include Midwives. over = over-established

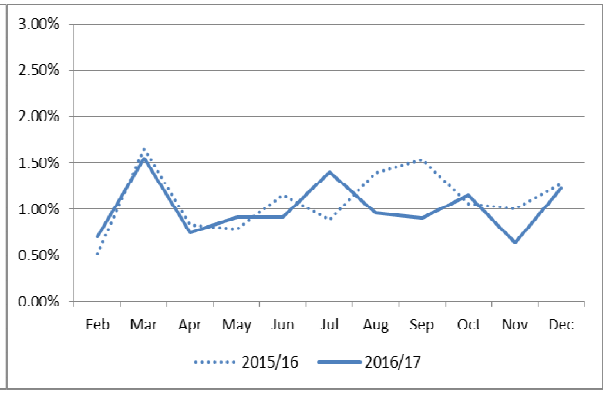
4.3.3 Staffing Metrics

Division	Sickness		Turnover		Parental Leave	
	RGNs	HCAs	RGNs	HCAs	RGNs	HCAs
Diagnostic & Specialties	4.46%	4.11%	8.99%	16.22%	4.38%	2.13%
Medicine	3.67%	4.90%	13.40%	21.76%	4.04%	3.00%
Surgery	4.26%	4.43%	11.82%	16.29%	4.05%	2.96%
Women & Children	4.74%	4.04%	10.66%	13.27%	4.05%	1.77%
Trustwide	**4.25%**	**4.59%**	**11.85%**	**18.01%**	**4.01%**	**3.04%**

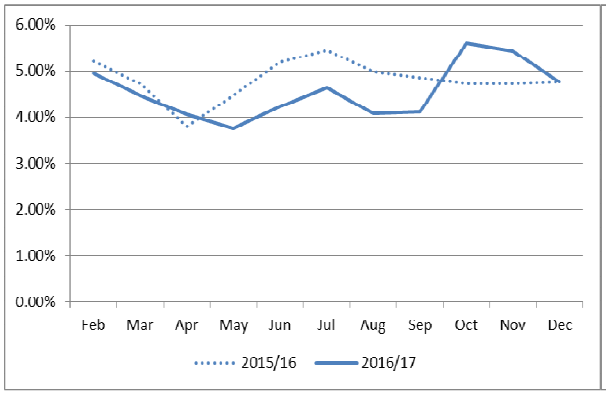
Data Note: 12 month rolling data. Trustwide data includes Corporate Services.



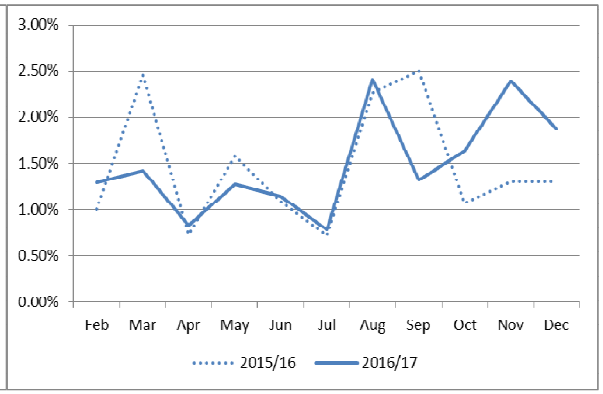
RGN: Sickness Absence by Month (Feb 15 – Jan 17)



RGN: Turnover by Month (Feb 15 – Jan 17)



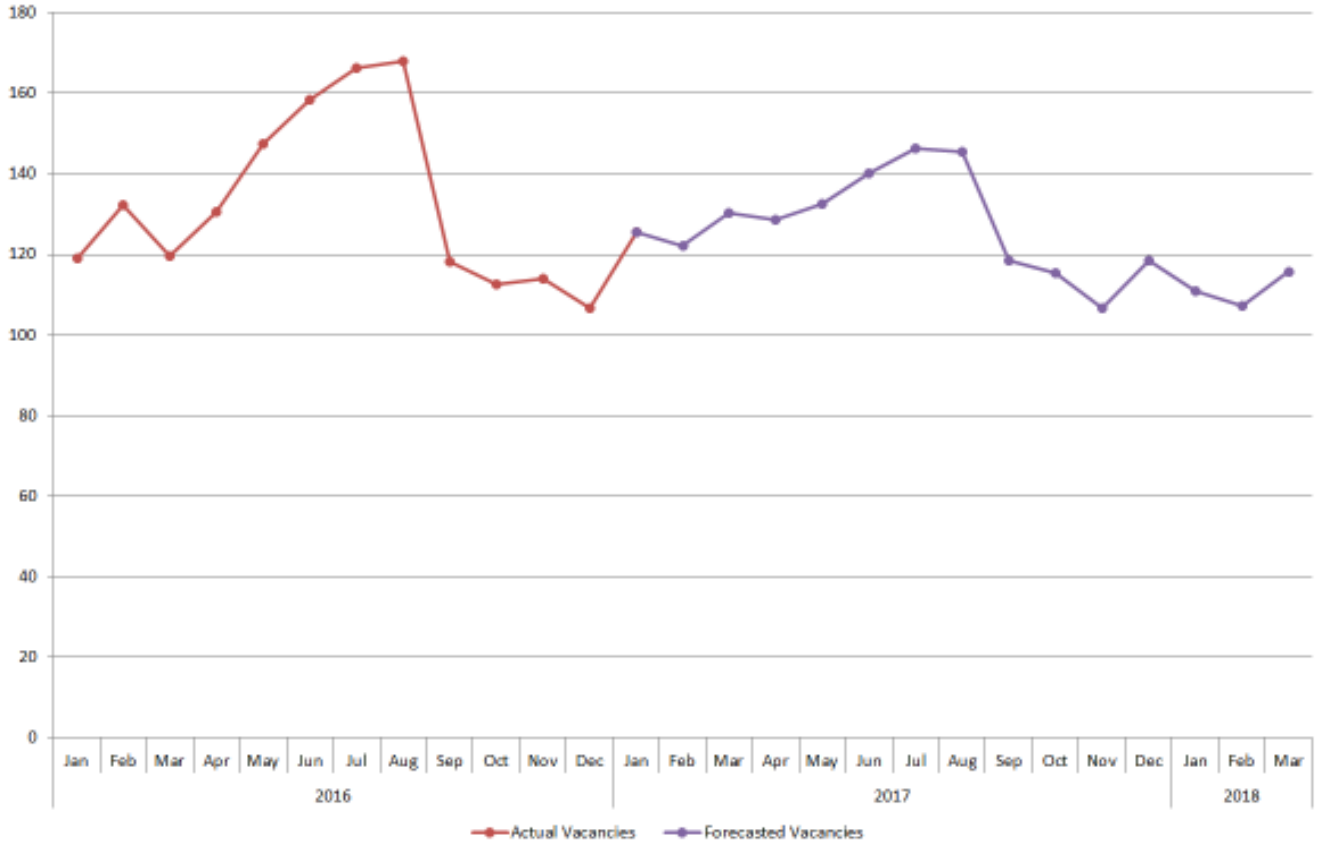
HCA: Sickness Absence by Month (Feb 15 – Jan 17)



HCA: Turnover by Month (Feb 15 – Jan 17)

4.3.4 **Vacancy Forecast**

- Following four months of establishment decrease by 14.50 WTE, the establishment for Band 5 Registered Nurses/Midwives has increased by 9.23 WTE, which has impacted the vacancy position considerably.
- Due to the increased establishment, and a reduction of the number of staff in post, the vacancy rate has increased by 1.89 WTE to 125.53 WTE.
- The current vacancy rate of Band 5 Registered Nurses/Midwives is 10.34%, the highest it has been since August 2016.


180
160
140
120
100
80
60
40
20
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2016
2017
2018
Actual Vacancies
Forecasted Vacancies

5 Revalidation

Revalidation is still doing well in our Trust as was proven when the CQC came to visit in January and a question was asked by the CQC about how much support Registrants had when it came to Revalidation in our Trust- All who were in the room knew about the Revalidation team and the workshops as well as the support on offer to staff. Wendy Collins the Revalidation Lead was also at the drop in session and she was able to introduce herself and update the CQC on any other questions they had.

So far this year we have had 112 people revalidate in January and February. Nobody has been called to be verified by the NMC so far.

Workshops are still well attended and 1-1 sessions proving very popular especially as we can accommodate them in their own work place if necessary as some people find it hard to get away from a ward or department.

6 Nurse Associates

The Nursing Associate role is a highly trained support role to help Registered Nurses deliver effective, safe and responsive care. Nursing Associates in the future will also play a key part in the multi-disciplinary workforce needed to respond to the future needs of public and patients. The role will enable linear and lateral career progression across the care and nursing workforce.

The 13 GHT Trainee Nursing Associates (recruited internally from existing healthcare support worker roles) will begin on their 2 year programme with University of Gloucestershire on 24th April 2017. This is a 'fast follower Trainee Nursing Associate pilot' being delivered by the University to healthcare partners (GHT, CCG, GCS and 2gether) with Health Education England governance, guidance, national curriculum framework and financial support.

Over the duration of the programme the Trainee Nursing Associates are GHT employees, they will attend 45 days at University and have placement experience in 'hospital', 'close to home' and 'at home' settings. Through a blended learning approach Trainee Nursing Associates will achieve required learning outcomes to graduate with a Level 5 Nursing Associate Foundation Degree.

The Trainee Nursing Associate Job Description has been nationally agreed and set at band 3, the Nursing Associate Job Description and requirements for registration with the NMC are currently being determined. It is expected the role will be set at band 4. The programme will also enable the Nursing Associate to access the final 12-18 months (to be confirmed) of the undergraduate BSc Nursing Degree.

7 Next Steps and Communication

- To upload report to NHS choices
- To share with NHSi leads as requested
- To continue to monitor agency use
- To continue to proactively recruit and work with our academic colleagues to ensure improved student numbers
- Welcome our new Nurse Associate Trainees who will commence training --

8 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**
Part Author:	**Adam Kirton Head of Recruitment**
March 2017	

Maternity Services Midwifery and Nursing Staffing Report April 2015 – March 2016

Author: Dawn Morrall, Assistant Director of Midwifery & Nursing

Date: April 2016

Reviewed by: Maternity Clinical Governance Committee: October 2016

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) Maternity Staffing Annual Report April 2015 – March 2016

Introduction

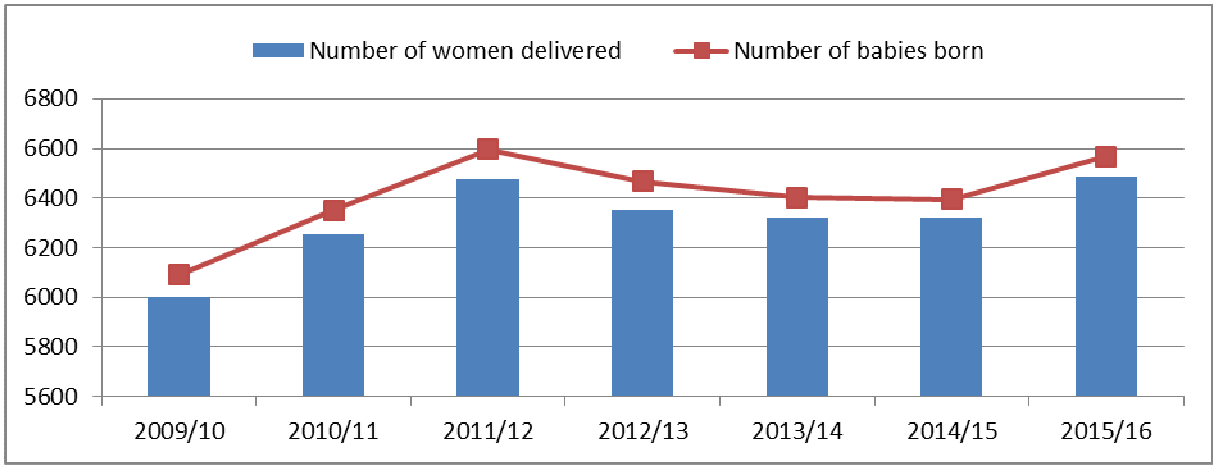
This report provides assurance of the GHNHSFT maternity staffing levels from 1st April 2015 – 31st March 2016. The midwifery, nursing and support staff staffing levels have been reviewed against the recommendations of National Institute of Clinical Excellence (NICE) (2015) Safe Midwifery Staffing for Maternity Services.

Background

The Maternity Services at Gloucestershire Hospitals NHS Foundation Trust has experienced a slight predicted rise in birth activity in 2015/16 (see graph).

The total number of bookings conducted by the Community Midwifery Team from April 2015 to March 2016 was 6718.

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Number of women delivered	6001	6254	6478	6352	6320	6320	6484
Number of babies born	6090	6352	6597	6468	6403	6396	6569
Avg number women delivering per day	16	17	18	17	17	17	18



Annual Review of Midwifery, Nursing and Support Staffing levels

The total midwifery establishment at the end of March 2016 222.51wte (includes all management/SOM time and Midwifery Management and Specialist posts) and the MCA/HCA establishment was 50.63wte

The ratio of Midwife to Birth has been calculated to include the number of midwives employed to provide direct clinical care to women and does not include Midwifery management, clinical governance, risk management, practice development, Midwifery supervision and specialist posts as recommended by Birthrate Plus (2016)). Birthrate Plus is the only recognised maternity specific workforce planning tool which has been endorsed by NICE (2016), The Kings Fund (2012) and the Royal Colleges (2007). The current nationally recommended midwife to birth ratio is 1:29.5 (NICE 2015). The GHNHSFT ratio has been calculated to include a percentage of specialist midwifery posts as agreed by the Divisional Triumverate (2013). This was agreed following a review and benchmarking exercise with a number of similar sized Trusts. This provides a total 204.7 wte midwives to calculate the Midwife:Birth ratio for GHNHSFT.

Using the calculation above the Midwife:Birth ratio for 2015/16 was 1:31 using an establishment figure of 204.7. The Midwife:Birth ratio is monitored monthly on the **maternity dashboard (Appendix 1**). The dashboard includes a Midwife:Birth ratio calculated using the establishment figure and the actual establishment figure which takes account of maternity leave, sickness absence and bank used within the month.

The **Maternity Staffing Policy (See Appendix 2)** describes midwifery and nursing staffing for the maternity service. Midwifery and nursing staffing for direct clinical care is distributed across the following clinical areas (NB this does not include

allocated management/SOM time which is in addition to establishment for direct clinical care): -

Midwifery Staffing Establishment		
Clinical Area	***Staffing***	***Funded***
Delivery Suite	Team Leaders	11.84
(31622)	Band 5/6	43.97
		55.81
Ward	Team Leaders	1.00
(32022)	Band 5/6	41.16
		42.16
Birth Unit GRH	Team Leaders	1.00
(31922)	Band 5/6	16.48
		17.48
Birth Centre CGH	Team Leaders	1.00
(40641)	Band 5/6	10.30
		11.30
Triage	Team Leaders	1.00
(26222)	Band 5/6	4.88
		5.88
ANC	Team Leaders	1.00
(31822)	Band 5/6	6.98
		7.98
West Hub	Team Leaders	2.50
(31722)	Band 5/6	9.03
		11.53
East Hub	Team Leaders	3.00
(47941)	Band 5/6	13.83
		16.83
MPT	Team Leaders	1.70
(31322)	Band 5/6	11.16
		10.66
Stroud Maternity Hospital	Team Leaders	1.00
(32023)	Band 5/6	5.22
		6.22
South Hub	Team Leaders	2.00
(47911)	Band 5/6	15.21
		17.21
Forest Community	Team Leaders	1.00

(47908)	Band 5/6	9.14
		10.14
Temporary Contracts	(Mat leave)	
TOTAL		**213.2wte**

MCA Staffing Establishment	
Clinical Area	***Funded Staffing (Band 2)***
Delivery Suite	13.18
Ward	13.39
Birth Unit GRH	5.36
Birth Centre CGH	4.75
Triage	1.6
ANC	6.18
Stroud Birth Unit	5.74
Community	0.43
TOTAL	**50.63**

Midwifery staffing levels in all areas are supported by MCA's. GHNHSFT does not use agency midwifery staff as all vacant posts are actively recruited to including proactive recruitment to the midwifery bank.

Staffing levels on Delivery Suite

In addition to the Midwifery and Maternity Care Assistant (MCA) staffing on the delivery suite, a dedicated theatre team which includes a midwife, ODA and scrub practitioner, provide support for elective and emergency caesarean sections. Midwifery staffing levels on delivery suite include 2 band 7 midwives; one supernumerary coordinator and one to support 'fresh eyes' on all shifts **(see roles & responsibilities of Band 7 Delivery suite – Appendix 3).**

Staffing Levels on the Birth Units

There is a core senior band 6 co-ordinator identified on each Birth Centre off duty whose role is to ensure that good communication with the Delivery Suite Coordinator to ensure that all intrapartum areas are providing 1:1 care to all women in established labour..

Capacity and Staffing

Monthly monitoring of bookings provides information on future periods of higher than average predicted activity (**see appendix 4**) and the Maternity Service has a robust Escalation Policy in order to maintain safe staffing levels **Maternity Service Escalation policy ((hyperlink) (appendix 5).**

In addition the following action has also been implemented throughout the year to ensure staffing levels in all areas remains appropriate and safe.

- Consistent and robust monitoring and management of long and short term sickness
- Deployment of staff by Midwifery Manager/Coordinator where unpredictable shortfalls in staffing occur.
- Live database of midwifery and nursing staff to anticipate shortfalls due to vacancy or maternity leave and recruit staff proactively and in a timely manner.
- Proactive management of duty rosters to ensure appropriate allocation of annual leave and study leave to avoid shortfalls throughout the year.
- Review of skill mix to ensure appropriate use of support staff and MCA's.
- Recruitment over establishment to address shortfalls in midwifery establishment due to high levels of maternity leave.
- Staff offered increased hours when vacancies occur as well as proactive recruitment.
- Use of texting system to text midwives within a group when bank shifts available via Delivery Suite.
- Support of Midwifery Managers and Specialist Midwives to address unpredicted shortfalls or short term (hours) peaks in activity to expedite discharges ie. to perform Examination of the Newborn.
- Support of Supervisors of Midwives out of hours to provide advice and a 'fresh eyes' overview of the service at time of high activity.

Workforce developments & Business planning throughout 2015/16

- Staffing in midwifery was reviewed against the recommendations identified in the NICE guidance - Safer Midwifery Staffing for Maternity Services (2015). A business case was developed which identified 11.29wte additional midwives were required to increase the midwife to birth ratio to the recommended 1:29.5 (calculated using 2014/15 births). Funding was agreed with a plan to increase the increased midwifery staffing in three separate phases. Phase one and two were implemented in November 2015 and February 2016 with a further phase planned for May 2016. The number of wte midwifery staff involved in direct clinical care will increase to 210.61wte improving the midwife to birth ratio from 1:31 to 1:30 (taking account of the 4% increase in births during 2015/16). The additional staffing has supported an increase in staffing on the alongside midwifery birth unit in Gloucester, the maternity triage and community midwifery. Recruitment to these additional funded posts is ongoing. An action plan was developed to ensure that all recommendations are implemented over 2016/17.
- Midwives in the SWAST Ambulance hub – Midwives in the Ambulance Hub is a project funded by the GCCG to provide a dedicated telephone line for women using the maternity service. The project involves partnership working between midwifery services, SWAST and the GCCG. Women telephoning the Hub are triaged by experienced midwives with the aim of reducing the number of admissions, ensuring that the right women are seen in the right place by the right professional and standing down emergency ambulances where appropriate. The project will be evaluated against the project aims in October 2016.

- Midwifery Partnership Teams (MPT) – The MPT is a pilot project to address the needs of vulnerable women in Gloucester inner city and an area of Cheltenham. Both areas are amongst the 10% most deprived areas of Gloucestershire. The project was adapted from a Midwifery Group Practice (MGP) pilot project which commenced in November 2010. The MPT project was successful in gaining further funding from the Gloucestershire CCG for the year 2015/16. 2.2wte midwives were funded by the GCCG to support an enhanced level of intensive midwifery care and partnership working across Children's Centre's. The MPT is subject to ongoing monitoring and a review and evaluation has been commenced to inform future models of midwifery care to support vulnerable women in Gloucestershire.
- The Midwifery Management Team is a Divisional Director of Midwifery & Nursing, an Assistant Director of Midwifery & Lead for Midwifery Led Care (births in a midwifery led facility or at home are a third (30%) of the total number of births in Gloucestershire), and two midwifery matron posts, one for Community, screening and safeguarding and one for Complex inpatient care. **(See attached Structure** – **Appendix 5**). A Mental Health Specialist Midwife post is planned to support the increasing number of women with mental health problems within the maternity services and to support the increase in workload of the Midwifery Management and Vulnerable Women's Team.
- A review of maternity services against the recommendations of Better Births – National Maternity Review (2016) is planned for 2016/17 to explore the development of community hubs and integration of community midwives and birth unit staff

Review and monitoring of Staffing levels 2015/16

The midwifery and nursing staffing establishment in all clinical areas is shown above.

Actions arising from ongoing monitoring and audit of staffing levels

- Midwifery staffing reviewed in light of new NICE guidance (2015) Safer Midwifery Staffing for Maternity Services and action plan developed (**See Appendix 7).**
- Midwife to Birth ratio (both establishment and actual) monitored through the GHNHSFT Maternity dashboard is reported to Maternity Governance Committee and Divisional Board via the Women's Health Team meeting and is escalated to Trust Quality Committee with exception reporting to Trust Management Team (TMT) by the Chief of Service/Director of Midwifery & Nursing.
- Trends of incidents and Adverse Clinical Incident (ACI) reporting relating to staffing shortfalls/high activity are monitored via the Maternity Risk Forum and are escalated to the Maternity Clinical Governance Committee.
- Ongoing review of community caseloads to ensure equity, consistency and compliance with the nationally recommended caseload for Community Midwives of 98 per wte (Cited West Midlands Perinatal Institute 2011).

- Proactive management and monitoring of sickness in Maternity to reduce the sickness within the service. Sickness policy flow chart was implemented and widely circulated and implementation monitored.

Monitoring of contingency plans to address staffing short falls for increased workload and sickness

The Assistant Director of Midwifery has weekly management meeting with Midwifery Managers covering all clinical areas where staffing levels across the service are reviewed and any shortfalls or expected peaks in activity are proactively managed. The Divisional HR Manager and Divisional Finance Manager attend the Management meetings on a monthly basis to review and discuss workforce issues, including sickness, maternity leave and use of bank staff.

Staff are deployed throughout the service as required based on clinical need. This may be to Delivery Suite or the Birth Units to ensure provision of 1:1 care in established labour or to the Maternity Wards to expedite discharge of mothers and babies to release bed capacity to ensure admissions and transfers can be accepted (See Escalation Policy for high levels of staffing shortfall or peaks in activity). All midwives are expected to participate in rotation/Keeping in Touch (KIT) days to other areas and this is monitored by the Leads and management team.

One to One Midwifery Care Audit

Ongoing audit of one to one midwifery care is in place and allows ongoing monitoring of the one to one care in established labour (**See Appendix 7).**

APPENDICES

1. Maternity dashboard
2. Maternity Staffing Policy
3. Roles & responsibilities of Band 7 on Delivery Suite.
4. Expected Births data
5. Maternity Escalation Policy
6. Midwifery Structure
7. NICE (2015) Safer Midwifery Staffing for Maternity Services - Action Plan
8. One-to-one care in labour audit

Dawn Morrall

Assistant Director of Midwifery – June 2016

Birthrate Plus (2016) Birthrate Plus , cited on Birthrate Plus website.

NHS England (2016) Better Births - National Maternity Services Review NHSE: London

NICE (2015) ***Safe Midwifery Staffing for Maternity Services*****, NICE*: London***

RCOG (2007) ***Safer Childbirth – Minimum Standards for the Delivery of care in Labour,*** **RCOG:London**

The Kings Fund (2012) Improving Safety in Maternity Units, The Kings Fund website

West Midlands Perinatal Institute (2011) ***Perinatal Mortality, Social Deprivation and Community Midwifery 2008-9*****. West Midlands Perinatal Institute for Maternal Health.**

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – APRIL 2017

Report Title
SMARTCARE PROGRESS REPORT
Sponsor and Author(s)
Sponsor: Dr Sally Pearson Author: Dr Sally Pearson
Executive Summary

Purpose

To provide assurance to the Board, from the Smartcare Programme Board, on progress within the continued operation of TrakCare and planned implementation of Phases 1.5 and 2.

Key issues to note

- The governance arrangements for the programme have been reviewed. A proposed revised governance approach is included in the papers, along with proposed terms of reference for the Smartcare Programme Board and the Trakcare Operational Board (appendix 1)
- As part of these governance arrangements the Board will, in the future, receive 2 reports
  - Technical progress report (appendix 2)
  - Operational impact report
- The Operational Impact Report has not yet been considered by the Quality and Performance Committee and is not included in the papers for this cycle.
- The programme (as detailed in the Technical Progress Report) is set at AMBER status pending confirmation of proposed deployment dates.
- Service Management and performance is being managed in line with contractual requirements.
- Lessons learned from the planned update failure of the MR5.1 software release has resulted in a revised and robust testing methodology to be employed by InterSystems prior to release to the live environment – confirmed by the subsequent successful update.
- Phase 1.5 planning, taking into account lessons learned from Phase 1, has established a proposed timeframe for implementation of the Phase 1.5 components.
- Progress with preparatory activity in relation to Phases 1.5 and 2 are progressing with established Trust ownership and engagement.
- Training continues to be positively supported through the Champions and Q&A sessions with proposals for extending the operational effectiveness of training development being made.
- The introduction of the Clinical Systems Safety Group is assuring appropriate risk management with specific regard to clinical safety.
- Programme financial forecasting is in progress against the revised implementation timescale

Conclusions

Trakcare is in full Phase 1 operation across the Trust but with significant operational issues that will be reported through the Quality and Performance Committee.
Activity required to meet the proposed planned implementation of Phase 1.5 is being undertaken. Timelines presented are recognised as being achievable based upon currently planned software delivery and resourcing, but will need to be influenced by measures of operational readiness, informed by the outcome of the review of implementation of phase 1 and progress against the Operational Recovery Plan

Implications and Future Action Required

A further programme board report `and an operational impact report will be presented to the next Board meeting

Recommendations

The Board is asked to:

- Endorse the revised governance arrangements
- note the programme report as a source of assurance that the programme continues to progress

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 APRIL 2017

REVISED GOVERNANCE ARRANGEMENTS FOR SMARTCARE

1. Purpose

To secure Board approval for revised governance arrangements to provide assurance on:

- The performance of the contract with Intersystems
- The state of readiness for further deployments of functionality within Trakcare
- Recovery of operational impacts following deployment of phase 1 of Trakcare

2. Background

The Smartcare Programme Board was established in 2010 to oversee the procurement of an enterprise wide electronic health record, as part of NHS England's South Local Clinical Systems Acute programme. Given the scale of the programme the Programme Board has reported directly to the Board, covering all aspects of the programme.

The review of the deployment of phase 1 Trakcare, has led to the analysis that the Programme Board was well positioned to assess the readiness for a technical deployment of the system, but less well equipped to assess the operational readiness to accept the system without impacting on the delivery of the service

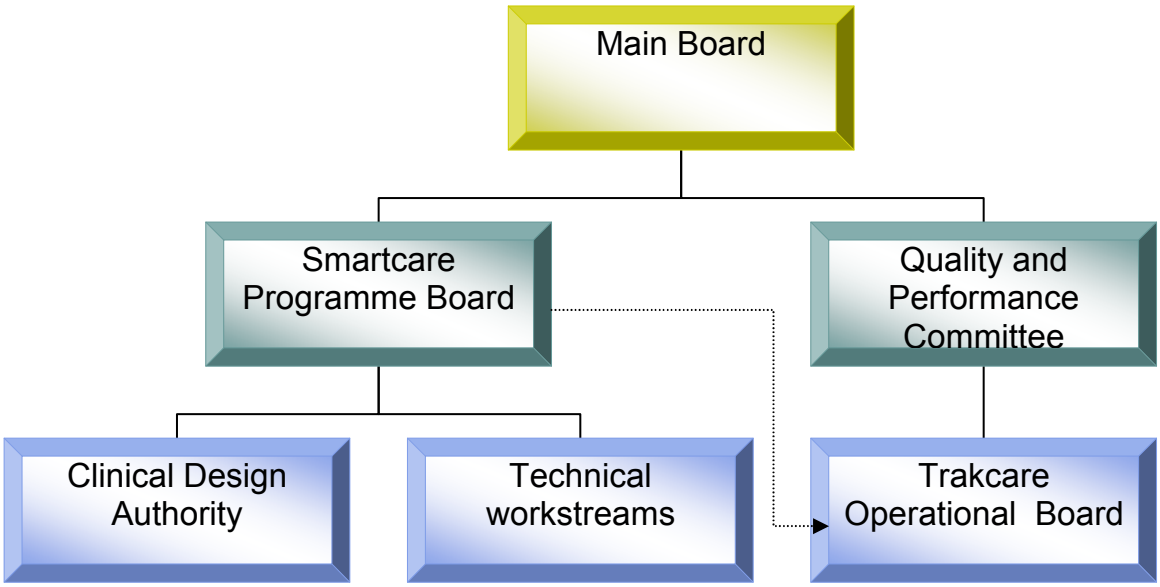
This has led to a review of the governance arrangements and the proposals set out below

3. Proposed Arrangements

The Smartcare Programme Board will continue with a revised membership and terms of reference that reflect the responsibility to oversee the contractual relationship with the supplier and the progress to develop the technical solutions to support deployments of further functionality of the system. Terms of reference for the Board are attached at annex1. The Director of Clinical Strategy will chair the Programme Board as the Senior Responsible Officer for the programme. The Board will report to the Main Board monthly

The Chief Operating Officer will chair the Trakcare Operational Board. Terms of Reference for this group are attached at annex 2. This Board will have oversight of the operational recovery plan following the deployment of phase 1 of Trakcare. It will also provide the operational sign off of readiness for all subsequent deployments. The Board will provide monthly reports to the Quality and Performance Committee with a summary to the Board.

The revised governance structure is shown in the diagram below.



In addition to this formal reporting structure, operationally there will be a fortnightly Trakcare Recovery Oversight Group to ensure adequate progress against the issues identified. Membership of this meeting includes:

- Chief Executive (Chair)
- Director of Clinical Strategy (SRO for Trakcare)
- Chief Operating Officer (Lead for operational recovery)
- Finance Director (lead for financial recovery)

4. Recommendation

The Board is asked to endorse the revised governance arrangements for Trakcare

Author: **Dr Sally Pearson**

Presenting Director: **Dr Sally Pearson**

Date: April 2017

GLOUCESTERSHIRE HOSPITALS NHS TRUST

SMARTCARE PROGRAMME BOARD

TERMS OF REFERENCE

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

The Board is the principal body governing the technical Programme of implementation for TrakCare and its subsequent development as the Integrated Clinical information System for Gloucestershire Hospitals NHS Foundation Trust. The Board is responsible to the Trust Leadership Team and Main Board for the following main functions:

1. To provide overall direction for the programme.

2. To agree the strategic scope and timing of the planned implementation of the SmartCare deliverables and for control and delivery of the programme.

3. To provide assurance for the programme by providing governance and control to assure delivery, for example by the receipt of progress reports form structures within the programme and by addressing and managing risks and issues that have been escalated.

4. To hold to account all internal (workstreams) and external parties (InterSystems and named third-parties) in respect of the delivery of the phased implementation for TrakCare.

5. To hold the principal communication interface with the supplier, InterSystems, in terms of deployment for the planned phased implementation according to the contract, and for the technical provision of new functionality, both of business and clinical nature.

6. To work in conjunction with the Operational Impact Board in respect of assuring the operational readiness of functional use of TrakCare including provision of training and respective business engagement leading to live deployment.

Membership & Responsibilities

Chair
Senior Responsible Officer

Vice Chair
Chief Clinical Information Officer

Members
- Non-Executive Director
- SmartCare Programme Manager
- TrakCare Operational Lead
- Finance representative
- Specialty Director - Pathology
- Divisional Director of Operations – D&S
- Associate Director of Business Intelligence
- IT lead
- SmartCare Technical Architect
- Head of Leadership and Organisational Development
- Radiology lead
- Senior Pharmacist Patient Services
- Training lead
- Communications lead
- InterSystems Programme Manager
- InterSystems Project Manager (Phase 1.5/2)
- InterSystems Project Manager (Phase 1.5 Labs)

Officers
SmartCare team administration support

7. To provide monthly assurance reports to the Quality and Performance Committee.

Quorum
The Committee shall be quorate when the following are present:

- Chair or vice chair
- 3 GHT leads
- Representation from SmartCare Programme Team
- Representation from InterSystems

Frequency of Meetings
Monthly

Reporting Line
Main Board
Trust Leadership Team

Sub-Committees
Clinical Design Authority
Programme workstreams

Submission/Availability of Minutes
Minutes circulated to membership
Monthly reports to TLT and Main Board

Review
April 2018

GLOUCESTERSHIRE HOSPITALS NHS TRUST

TRAKCARE OPERATIONAL BOARD

TERMS OF REFERENCE

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

The Committee is responsible to the Quality and Performance Committee and the Trust Leadership Team for the following main functions:

1. To have oversight of the operational recovery plan following the deployment of phase 1 of Trakcare.

2. To provide operational sign off of readiness for all subsequent deployments. provide assurance

3. To determine the measures of operational readiness to be included in the Authority To Proceed sign off processes for future deployments of Trakcare

4. To provide assurance to the SmartCare Board of achievement of these measures to support future go-live decisions

5. To escalate to the SmartCare Programme Board any technical aspects of Trakcare that are impacting on operational performance or safety

6. To provide monthly assurance reports to the Quality and Performance Committee

Membership & Responsibilities

Chair
Chief Operating Officer

Vice Chair
Trakcare Operational Lead

Members
- SmartCare Programme Manager
- Chief Clinical Information Officer
- Associate Director Business Intelligence
- Trakcare lead for each clinical division
- Service Agreements Manager

Officers
PA for Director of Clinical Strategy

Quorum
The Committee shall be quorate when the following are present:
- Chair or Vice Chair
- Representation from 3 of 4 divisions
- Representation from SmartCare Programme Team

Frequency of Meetings
Weekly

Reporting Line
Quality and Performance Committee
SmartCare Programme Board

Sub-Committees
None

Submission/Availability of Minutes
Minutes circulated to membership
Monthly reports to TLT and Q&PC

PROGRESS REPORT SmartCare			
Date completed:	23/03/17	**Version**	1.0
Project Sponsor:	**Dr Sally Pearson**	**TRUST RAG Status**	**AMBER**
Project Manager:	Gareth Evans		

SmartCare Progress Report – March 2017

Executive Summary & Programme Status

An overall RAG status of **AMBER** as deployment dates for subsequent phases are still to be confirmed
This report identifies performance and progress in the following Phases:

- Phase 1
- Phase 1.5
- Phase 2

Phase 1

Contract performance

Contract performance is measured against the Service Levels as defined in Schedule 2.2 of the contract with InterSystems. The schedule defines the SLA performance criteria for system availability and SLA measurement against logged issues. The performance criteria determine a total number of Service Points (TSP) against SLA failure and are then translated into Service Credits against the Service Charge for that monthly period.

The calculation used is: Service Credit(£) = Service Charge(£) x (TSP/2000)

InterSystems provide a monthly Service Report that identifies the number of Service Points against each criteria.

Reporting is based upon:

Service Desk Response Time
Incident Resolution Time (Live, Train & Test systems)
System Performance (Live, Train & Test systems)
Service Downtime (Live, Train & Test systems)

The Trust requirement for providing agreed levels of 1st and 2nd line support services to TrakCare has developed over the three months since go-live. For December and January the application of 1st and 2nd line support was not to the standard expected as per the contract arrangement and as such, calls being made to the InterSystems support service (TRC) were not being raised appropriately in respect of Priority or information content. A review was held with InterSystems and on-site meetings have been held with the InterSystems Support Application Specialist to identify and set-up appropriate mechanisms. The Trust now has 1st line being provided via the CITS support desk and 2nd line via the PAS and Clinical Systems teams with the Programme Team providing escalation capability. This has had a positive effect on the calls being raised with InterSystems in terms of type and priority with improved information. Ongoing analysis of the calls is to be undertaken with InterSystems to ensure that appropriate triage is being applied prior to logging.

TRC Incident reporting Summary

Incidents

Incidents Opened YTD:	268
Incidents Closed YTD:	231
Incident Closure(%):	86

Open Incidents:	110
Incidents Closed Same Day(%):	471
Incidents Updated Since Last Login:	0
Incidents Pending:	0

An incident was incurred on 14th March whereby journal files used in the TrakCare application required a system restart to be made to resolve a performance issue. This was carried out overnight on 14th/15th march and incurred 1-hour of downtime.

The February service report issued has identified Total Service Points (TSP) of 280 for February. This translates to a total of £8,133.30 in Service Credits to be applied at the end of the quarter pending any additional credits in March. The report for March which will include downtime elements will be received in April.

System Deliverables

The contract identifies the detail of deliverables within the System against the respective phases of implementation. The Phase 1 deliverables have been provided with exceptions as agreed in respect of Theatres Stock Control and Pharmacy. One area of non-delivery is in respect of the 'shadow' server on which to run analytics queries so as not to impact on Live system performance. This has been escalated to InterSystems management to expedite as the use of analytics on Live data is essential to ensuring satisfactory levels of business monitoring directly from TrakCare.

Contract Payment schedule and any variance from plan

The contract is built around a financial model that includes Milestone Payments against phased delivery and Service Charges for Live operational functionality.

The milestone payments are to be revised in terms of timing in conjunction with the revised implementation plan. A table of milestone payments including CPI application to Service Charges against the revised plan will be issued with the April report.

The implementation milestone payments have a fixed total cost that applies to the full elapsed period of implementation irrespective of any impact of delay. The Service Charges are monthly totals that are set against specific phased implementation of functionality tied in with the components of each phase.

Indexation (CPI)

During the final stages of contract negotiation and signature, it was agreed by all three Trusts in the collaborative procurement that indexation (CPI) would be applied as per the InterSystems final bid during the contracted period. This was agreed to be set at prevailing CPI value at contract anniversary for operational service charges for years 2-4 and then capped at 1.5% or if CPI is 3% or greater, a reduction of 0.5% to be applied.

The impact of CPI has been applied for 2017. Prior to application of CPI, the monthly service charges for Phase 1 were £57,350 per month. CPI of 1.0129% has been applied. Service charges are now £58,095 per month from January 2017.

The application of CPI was not included in the central funding provided as per the original Memorandum Of Agreement with Department of Health. Discussion was taken up with the SLCS team when the agreement was made to include CPI in 2015 and the recommendation was made that the Trusts apply for a CCN against the original MOA at the time that CPI was introduced.

We have included the detail of CPI application in the current quarterly report to SLCS and will be following up on the raising of a CCN with the SLCS team.

Maintenance

TrakCare is subject to system maintenance schedules applicable to both the software and the infrastructure. Whilst every effort is made to ensure that maintenance does not incur downtime for users, it is inevitable that some will be required dependent upon the type of maintenance necessary.

The contract provides for planned maintenance downtime of 40 minutes per month or an aggregated 2-hours per quarter (Service Period). Downtime outside of this period is either by agreement (applicable to major updates or phased go-live periods) or is considered unplanned and will therefore incur service credits.

At a meeting held on 14th March, InterSystems agreed to publish a schedule of pre-planned maintenance activity and to determine if downtime was required. Discussion was also held in respect of timing of downtime so as to cause minimal impact on the operational services.

The monthly service report covers downtime periods experienced for the preceding month including any Service Credits to be applied.

Update releases

In March a scheduled Maintenance Release of TrakCare – MR5.1 was due to be implemented on 9th March. The release includes a large number of fixes and functional addition for Phases 1 and 1.5 including key reporting requirements and was identified as requiring a period of downtime of 1.5 hours plus Trust testing. The implementation of MR5.1 failed and resulted in a total amount of downtime of 3.5 hours before the system was restored to its previous state.

A root cause analysis of the update failure was undertaken and five TrakCare Maternity questionnaire updates were identified as the cause. The issue was that the questionnaires existed in an earlier form in the Live system and had data recorded against them. This prevented the update from continuing in each case. Whilst a resolution to each case is available, the time required was not sufficient to complete prior to operational access being required.

A revision of the pre-update testing process has been implemented immediately in order to identify similar issues in a copy of the Live system with no user impact such that any required resolution(s) may be performed prior to the planned implementation taking place.

The re-schedule implementation of the MR5.1 update was carried out on 22nd March successfully and within the 1.5 hours identified as being required.

Further Maintenance Releases will be required in the progression toward Phase 1.5 go-live. The schedule referred to in the Maintenance section will include planned MR release timeframes and associated downtime.

Phase 1.5

Preparation and planning

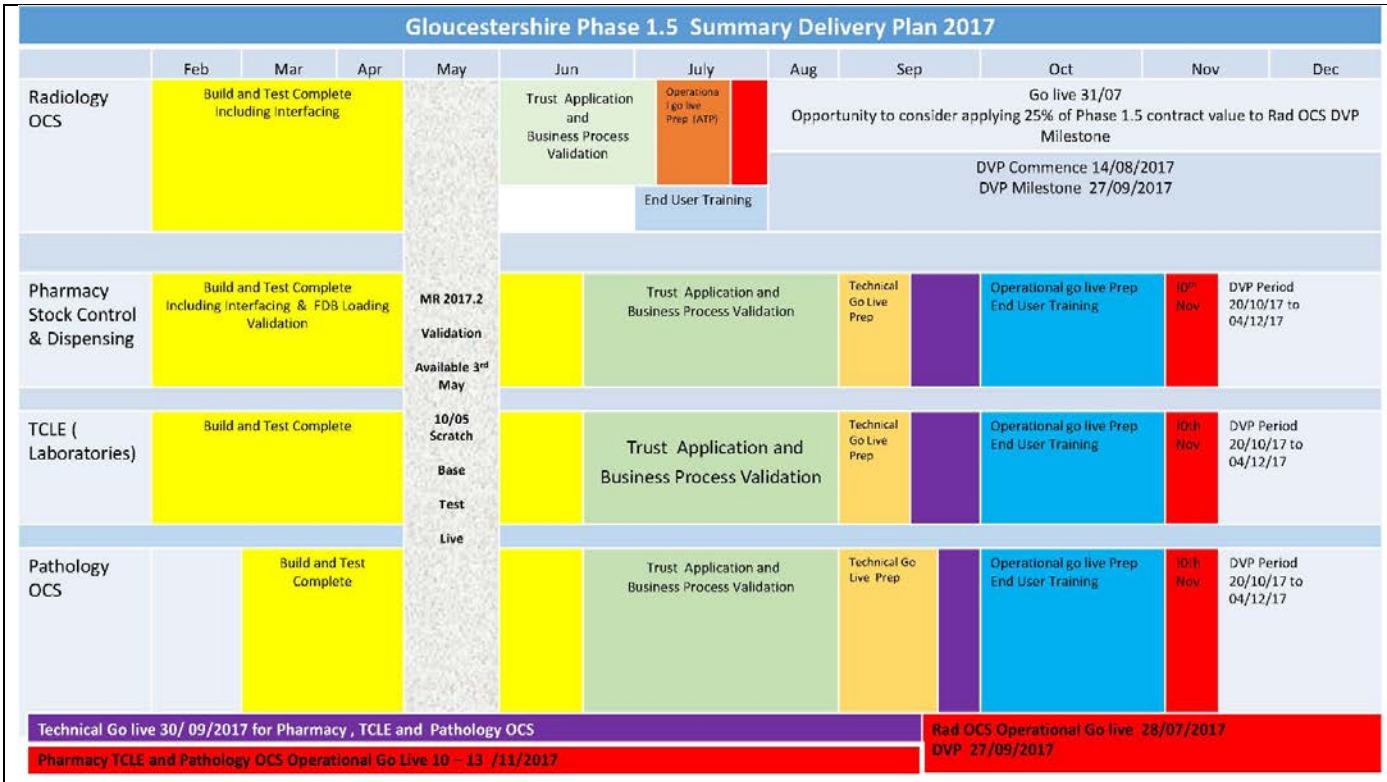
Progress has continued within the planning and implementation of Order Communications, Pharmacy and Pathology as preparation for Phase 1.5.

Overall Phase 1.5 Planning

Phase 1.5 consists of four distinct components in respect of go-live planning:

- Radiology Order Comms
- Pharmacy Stock Control and Dispensing
- Pathology Order Comms
- Pathology (TrakCare Lab Enterprise)

A joint planning exercise has been undertaken with InterSystems and the timeline given below has been presented to the Programme Board.



In summary, the plan proposes a go-live date for Radiology Order Comms by the end of July 2017 with the remaining elements in a combined go-live in November 2017. This is the timeline for technical delivery of the system. The Programme Board and The Operational Impact Group will need to overlay on this plan the assessment of operational readiness, taking into account the lessons learnt from the deployment of phase 1.

Risks to Planned Phase 1.5 Timeline

The planned timeline is primarily dependent upon resource availability and software deliverables in order to meet the requirements for each stage.

Major risk is the delivery of Pathology software updates in line with the planned implementation. As TrakCare Labs Enterprise (TCLE) is still a new development for InterSystems, we have suffered from delayed functional implementation prior to now and this has to be considered a risk going forward. Regular reporting and meetings held with the TCLE team including Sydney based development will help to add assurance on delivery timescales.

The delay in update to MR5.1 is also typical of an issue that can cause subsequent delay to the build of Phase 1.5. Any delay can cause a disparity between versions in Build and Live such that planned build and configuration updates may be delayed until the systems are in synch. This is mitigated by the revised and more robust testing procedures now implemented prior to implementation of MR updates.

Current estimation of required resources within each of the Phase 1.5 elements is appropriate for completing the activities defined. Engagement within the respective areas – Radiology, Pharmacy and Pathology has been established and will include representation at Programme Board level.

Pharmacy has had reduced levels of InterSystems support since Phase 1 go-live. This has predominantly been due to concentration on Northern Devon proposed go-live in April but has been raised with the InterSystems team as needing to improve in order to ensure that the current planned timelines are met.

Phase 1.5 Plan Tracking

In order to maintain a more accurate assessment of key milestone and activity progress, the Programme Team will use a planning tracker approach similar to that used by InterSystems for the Labs implementation and with the ability to move from planning to Authority To Proceed (ATP) at each respective stage.

The Planning Tracker tool will be issued for review in the next report. The format will be as per the example below for each Phase element.

Phase 1.5 Progress Tracker

Gloucestershire Hospitals NHS Foundation Trust

ID	Area/ Workstream	Item Description	Date to complete	Project Dependency	Status	Mitigating/management actions required to complete	Programme Owner/ Lead	Target date for mitigation
P1.5-ROC-01	Radiology Order Comms	Initial planning meeting completed and key workstream resources identified.	20/03/2017	Project Management	Complete		Jane Benfield	
P1.5-ROC-02	Radiology Order Comms	Initial meeting of Questionnaire Sub-group	21/03/2017	Project Management	Complete		Jane Benfield	
P1.5-ROC-03	Radiology Order Comms	Clinical demonstration of TrakCare Order Comms with Active Clinical Notes. Required to enable confirmation of Radiology and Pathology question definition.	03/04/2017	Build / Config	On schedule	DB to complete build of demo in Scratch. Note: no interface available in Scratch. Advanced demo to be built after progress to Base environment for 1.5.	David Bowen (ISC)	

Phase 1.5 Lessons Learned Application

Rachel Minett as Emergency planning officer has led a Formal Review / Lessons Learned process with support from PWC as our Internal Auditors. The formal feedback report will be issued by PWC and reviewed by the Programme Board at the April meeting. It is anticipated that the key recommendations will relate to:

- Improving Engagement
- Business change management
- Cutover plans
- Embedding learning

For all components, the implementation will include provision of a technically live system for end-user access in order that operational use may be assessed for full understanding of revised end-to-end processes and any related change activity for Standard Operation Procedures identified. In addition, this approach will provide a confirmation of adequate levels of training being delivered and any identified issues can be resolved prior to operational go-live.

Use of the technically live system will be built into the ATP process to ensure that the operational areas have an acceptable level of confidence in the new functionality prior before authority to proceed is taken forward.

For each component phase, a period of approximately 6-weeks is planned for technically live access.

Additional and improved testing will also extend to InterSystems preparatory activity prior to implementation of updates in Live. As determined in the MR5.1 update process, a revised MR/Patch test process using a copy of the current Live system will be undertaken at two stages – 1-week prior to MR/patch implementation and 1-day prior to ensure no new configuration activity has impacted the delivery.

Order Communications Update

In order to ensure appropriate Trust ownership and engagement within the Order Communications element of Phase 1.5, a substantive member of the Programme Team has taken the lead role. Jane Benfield as the existing inpatient lead has taken the Order Comms role has initiated the involvement of key Radiology and Pathology staff in the combined project scope.

The first meetings of the revised group have been held. The group will formulate the processes for both Radiology and Pathology focussed Order Communications and include clinical involvement as determined by the group. A series of weekly sessions for this group has been defined.

The group is planning detailed activity within the implementation and has commenced the preparation for build and configuration to meet the planned timescales.

Pharmacy Update

The provision of Maintenance Release – MR5.1 is required as a pre-requisite to detailed configuration for Pharmacy. There is a two-week delay on this progress due to the re-scheduling of the update. Manual build of the drug database with items not included in the formulary provided by FDB is under way. Training and testing material is being produced although pending full configuration of the Pharmacy solution to check functionality and screen layouts.

With the InterSystems concentration of supporting the forthcoming go-live of Northern Devon, it has affected the amount of InterSystems resource and development allocation. This has been escalated to the InterSystems Project Team and is expected to resolved.

Trust Pharmacy resources have been extended with the appointment of a full-time Pharmacist to oversee the medication safety aspects of TrakCare prescribing both in Phases 1.5 and 2.

Pathology Update

The Pathology build and configuration has continued in accordance with the InterSystems planning tracker although the delayed update to Maintenance Release MR5.1 is required in order to progress due to additional developments required to meet the project scope being contained within the update. This is not regarded as causing any delay to the planned implementation.

Whilst progress on the build is pending, pathology have continued to develop test scripts prepare for initial testing of interfaces between analysers and TrakCare. Additional planned work is continuing on the external interfaces with systems such as Sunquest ICE required to enable continued GP reporting of results post go-live.

Data migration activity is continuing with Transfusion Medicine and data quality checks in progress for Chemistry and Cytology.

Pathology validation planning is continuing. Validation scripts for General Pathology, Specimen Reception, Microbiology, Chemistry, Haematology, Immunology and Cytology are complete with Histology, Phlebotomy and Transfusion Medicine in progress. Validation plans are to be completed as part of this process.

PHASE 2

The current outline planned timeline for Phase 2 is scheduled to complete initial deployment by March 2018.

Detailed planning for Phase 2 is to commence in April so that defined deliverables are able to be determined for the component parts of Phase 2.

The need for progressing the potential replacement of Opmas is a key requirement for Phase 2 with a need to deliver as soon as safely possible. The Programme has therefore engaged with the Oncology and Haematology departments to prepare for the introduction of Oncology in TrakCare.

An InterSystems demonstration was delivered to the Trust Oncology Team (30 staff in attendance) The outcome was positive as it demonstrated that TrakCare does meet the Trust requirements and has encouraged engagement.

Detailed delivery planning is now under way with Trust assigned Project Leads. Rachel Woodcock is taking the workstream lead/Business Analyst role for the Programme team with Rebecca Frewin (Haematology) as clinical lead. The Oncology team has identified a set of resources required for the project and is progressing VCP applications in this respect.

A progress Tracker element will be delivered for this workstream.

Training

Training is continuing to provide face-to-face and Champion sessions with good engagement from the Trust. Q&A sessions are proving very helpful to staff attending.

Training is now run wholly within the PAS training team. Two members of the existing team are due to move to new

posts in the TrakCare support structure by the end of March. Recruitment is in progress to replace. The risk to the resourcing of Training until replacements are brought up to speed with TrakCare has been mitigated with the planned use of the transferred staff.

A proposal to extend the remit of TrakCare training into the Operational areas was submitted to the Programme Board. The proposal is to take a minimum of 4 existing staff members (up to Band 4) who have demonstrated an interest in TrakCare and its evolution to be trained as trainers. The staff would be seconded to the Programme for the duration of Phase 1.5 in order to attain the level of knowledge required for both Phase 1 and phase 1.5. They would provide face-to-face and Champion training during this period through to one month post go-live. On return to their respective divisions, they would be able to provide key support and educational roles thereby easing the load on the TrakCare support teams in PAS/Clinical Systems.

This proposal is to move forward to VCP.

Programme Resourcing

The Programme resource structure is being reviewed to better embed ownership of the programme across the organisation

It is intended to place defined functional resources within the appropriate Trust line management structures and for those resources to be assigned to the SmartCare Programme. Ideally the resources will be substantive but this is not possible in the short-term.

The Programme has had a reliance on contract resources for delivery of implementation, testing and training. The functional roles need to be subsumed into ongoing operational support of TrakCare and to enable development to incorporate associated projects within the Trust.

Movement of current resources to positions with BI and Programme Management are taking place in April.

The use of contract resources will be limited to those necessary to complete the implementation tasks or to enable sufficient knowledge transfer to Trust resources over the Phase 1.5 implementation.

The Programme has seen a reduction in contractor use with the contract training staff having completed their assignments. The revision of the PAS training team will look to take on those aspects of training that were contractor based and extend training activity into the Learning & Development and Clinical Skills base within the Trust.

The move of functional support to substantive resources is likely to expose gaps within the current workforce in terms of availability and capability. The programme will identify those gaps and report through the Programme Board including development of mitigation for the roles.

Finance

A revised forecast of programme resource requirements for the re-planned implementation of Phases 1.5 and 2 has been provided to finance. A re-scoping of the budget is necessary to ensure that continued progress is able to be met.

The Programme has been reporting on a monthly basis to finance but the recent departure of the finance assistant with SmartCare as a defined activity has presented a break in reporting.

The use of the budget requires a full review on appropriate allocation of funding to backfill and essential resourcing.

The re-scoping will identify a revised budgetary forecast and with the review on allocated use of funding plus the allocation of a dedicated finance assistant will enable a run-rate to be reported on a monthly basis.

Programme Risks

The Programme continues to monitor Issues and Risks through the reporting structure used by the Support Team as well as the Operational Leads review meetings supported by the divisional and Core Issues logs.

Any incidents where TrakCare may have contributed are reported using the existing Datix system, and the potential link to TrakCare identified. Incidents are investigated in the usual way and anywhere TrakCare has been shown to have contributed are referred to the Clinical Systems Safety Group (which reports to the Patient Safety Group) to determine the action required to prevent further incidents. Risks are also recorded on Datix with a categorisation of TrakCare (TCnnnn) as appropriate. To date there is no evidence of harm as a consequence of any of the reported risks or issues. All TrakCare related incidents are reviewed by Dr Paul Downie.

Next Planned activities

Report of Post Go-Live Lessons Learned with PWC

Continuation of Phase 1 recovery action plan activity with Operational Leads

Phase 1.5 preparation and development as per proposed plan.

Programme Team activities to be identified in line with agreed planning of post Phase 1 actions and future phase development.

Status against communications plan

Continuation of communications with all stakeholders regarding TrakCare – both from Programme and Operational perspectives via weekly global update.

Modification to be made to distribution of TrakCare notices to include all Community based sites and external stakeholders.

Progress
(against project plan / project brief)

Tasks/Milestones completed

Task	Start	Finish/ % comp.	Comments
Detailed implementation Plan		31/03/15	Version 1.0 Completed for payment milestone confirmation.
Project Initiation Document		29/04/15	Version 1.0 Completed for payment milestone confirmation.
Phase 1 Operational Assessment Stage Complete		31/05/15	Milestone Achievement Certificate Issued.
Phase 1.5 Operational Assessment Complete		30/09/15	Milestone Achievement Certificate Issued.
Phase 1 Build Milestone		17/07/16	Milestone Achievement Certificate to be Issued from Programme Board 07/11/16.
Phase 1 ATP Complete (Technical Live)		25/10/16	Milestone Achievement Certificate to be Issued from Programme Board 07/11/16 on basis of Technically LIVE system being available and supported.
Revised Milestone Plan pending InterSystems CCN		Dec 16	CCN has been completed and signed off.
Phase 1 ATP Complete (Operationally Live)		5 Dec 16	System Live
Phase 1 Deployment Verification Complete		6 Mar 17	Completed

Milestones approaching			
Milestone	**Due**	**Activity to progress**	

Risks
(where score on risk log requires escalation to Programme Board)

NOTE: All risks under review in line with Issue Management

Title & Description	Impact	Resolution
Level of clinical engagement is key to the successful implementation of agreed strategy and solution.	10	Monitored and actioned by clear prioritization by collaborative and Trust Boards. Datix Risk 2006
Scale of operational change may require additional and possible external resource to be identified to progress in parallel with implementation.	8	To be revised in line with identified Issues and remedial action plans. Datix Risk 2069
Lack of power/network in areas not covered by generators leading to lack of access to TrakCare.	12	Risk to be assessed with input from Estates. Datix Risk 2320
Lack of Trust resource assigned to project configuration/validation for Pathology. Original level of resource agreed is not being provided.	12	In progress with Phase 1.5 planning in Pathology. Datix Risk 2362

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – 12th APRIL 2017

Report Title
Staff Survey Results 2016
Sponsor and Author(s)
Authors: Carole Preston, Leadership Development Specialist, Abby Hopewell, Head of Leadership and OD Sponsoring Director: David Smith, Director of Human Resources and Organisational Development.
Executive Summary

Purpose

This report provides an overview of the results from the 2016 annual staff survey details the engagement steps to identify the priorities and to develop both the corporate and local action plans to make progress against those priorities. As such the report is presented as a source of assurance to the Board that the Executive has considered and is responding the recent results.

Key issues to note

- The response rate of 50% reflects us continuing to feature in the top 20% of trusts in England for survey completion numbers.

- It was disappointing to see that there had been no increase in the employee engagement score in this year, following 5 years of 'steady' improvements.

- The majority of scores remained consistent with the prior year. As a Trust we compare favourably with others in terms of;

    1. Percentage of staff working extra hours
    2. Percentage of staff feeling unwell due to work related stress
    3. Percentage of staff believing the organisation provides equal opportunities for career progression or promotion.
    4. Staff reporting most recent experience of violence
    5. Staff reporting most recent experience of harassment, bullying or abuse

- Conversely we compare less favourably with regards to;

    1. Effective use of patient/service user feedback
    2. Staff confidence and security in reporting unsafe clinical practice
    3. Staff satisfaction with the quality of work and care they are able to deliver.
    4. Staff attending work in last 3 months despite feeling unwell
    5. Staff confidence and security in reporting unsafe clinical practice

- A series of engagement presentations to share the data at divisional and staff group level are ongoing with a view to identifying the priority issues for the coming year at both corporate and divisional level. Dependent upon survey responses by department, results at a more granular level are also being shared to facilitate the development of local action plans.

Conclusions

Our staff have experienced significant challenges during the last 12 months; some of these reflect the operational pressures affecting the whole of the NHS others reflect issues specific to our Trust such as the unexpected deterioration in the Trust's financial position. It is likely that the

survey responses reflect some of these issues. However, and importantly, this difficult year must not be seen as an explanation or excuse for results that are both disappointing and not in line with our ambitions as an employer of choice for staff. It is equally important that the responses themselves are not seen as a the "whole story" but are used as the basis for ongoing dialogue and engagement with staff in order that we can effectively determine what really matters to them and to respond most effectively.

Finally, responses within Divisions and across staff groups differs and our response must be sufficiently granular to target specific issues, in particular areas and amongst individual staff groups.

Implications and Future Action Required

In particular it will be to key to talk to staff as to how we can ensure that we make more effective use of patient/service user feedback as well as increasing their confidence and security in reporting unsafe clinical practice. The engagement sessions will also assess staff perspectives on the action plan from last year and early feedback suggests that the engagement work surrounding the travel to work plans has been positive but now needs to come to a come to a conclusion. The consolidated corporate plan for 2017 will be presented to the Trust Leadership Team in June along with the divisional plans, following this period of engagement and assurance of progress will be provided to the workforce committee on a periodic basis.

Recommendations
The Board is asked to receive the report as assurance that the Executive Team has considered the recent staff survey results and has plans in place to further analysis the findings and develop specific and Trust-wide actions to address key findings.
Impact Upon Strategic Objectives
Employee engagement is key to delivering every aspect of the Trust strategic objectives
Impact Upon Corporate Risks
Reduced engagement levels could lead to workforce supply issues
Regulatory and/or Legal Implications
N/A
Equality & Patient Impact
It is essential that all staff are able to effectively contribute to the trust through development and opportunities. Workforce supply issues have consequences for patient care and cost.

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)**

MAIN BOARD – APRIL 2017

2016 STAFF SURVEY RESULTS

1. Aim

To present to the Trust Board the key findings from the 2016 staff survey results and to outline the process by which results will be shared with staff and proposed next steps for how and when actions will be taken. The report is a source of assurance to the Board that the executive has considered the survey results and is taking action to address the key findings.

2. Background

Between October and December 2016, the national NHS staff survey was undertaken, inviting staff to share their experiences of working in Gloucestershire Hospitals Foundation Trust (GHFT). As in previous years, the Board opted to undertake a full census of all staff across the Trust. This is in recognition of the fundamental link between employee engagement and patient experience and the Trust's desire to give the opportunity for everyone in our workforce to have their say. The response rate in the 2016 survey unfortunately dropped to 50% in comparison to 51% last year, however the number of staff taking part in the survey increased from 3702 in 2015 to 3777 in 2016. We remain in the highest 20% of response rates for acute trusts in England.

3. Context - 2015 Staff Survey Results

3.1 Before looking at the results from the current survey, it is important to provide some context from the previous year. The bottom five ranking scores for our Trust in 2015 are outlined below.

- ***The quality of non-mandatory training, learning or development***
- ***The effective use of patient and service user feedback***
- ***Staff satisfaction with the quality of work and patient care they are able to deliver***
- *Staff motivation at work*
- ***The percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell***

Four of these areas remain in the bottom five in 2016 (highlighted in bold). Staff motivation at work has moved out of the bottom five although there is no discernible difference between the 2015 and 2016 scores.

3.2 As a response to the 2015 staff survey results, and in addition to the rolling action plans owned locally by the Divisions, four Trust-wide priorities were agreed which we have been working on for the last 12 months:

- *To engage with staff about the challenges of travel to work and associated parking issues*
- *To improve the environment and get better and quicker at fixing things*
- *To reduce some of the bureaucracy around work initiatives*
- *To be more open and transparent*

An update report was submitted to the Board in January 2017 to highlight our progress with these areas of work.

4. 2016 Staff Survey Results

4.1 The results of the staff survey are received in two ways. The Trust's survey provider (Quality Health) provides 'raw data' scores for every single question, providing a comparison with the average score for other Trusts as well as progress compared to the previous year. Scores are broken down into 5 main areas – *Your Job, Your Personal Development, Your Managers, Your Organisation, and Your Health, Wellbeing and Safety at work*.

The main **published** report sees the findings of the questionnaires summarised by the national survey centre Picker Europe, on behalf of the Department of Health, presented in the form of 32 Key Findings (KF). This year the Key Findings are presented under nine themes listed below (not the four NHS Constitution pledges which have been used in previous years):

- Appraisals and support for development
- Equality & diversity
- Errors & incidents
- Health & wellbeing
- Job satisfaction
- Managers
- Patient care & experience
- Violence, harassment and bullying
- Working patterns

4.2 There are some inconsistencies between the presentations of the scores given by Quality Health compared to Picker, given their distinct categorisation of themes. In terms of Quality Health's 'raw data' the Trusts scores are classified as 'about the same year on year' for all 87 individual questions. Within the Picker consolidated findings - where the questions are compressed into 32 Key Findings – 3/32 are statistically significant changes and all related to staff experience the remaining 20 are not statistically significant but are worthy of note; 12 show small improvements,10 show no change and 7 show a deterioration from the 2015 results.

5. Key Findings in the GHFT 2016 Survey

5.1 As mentioned in previous reports, the experiences of staff working in GHFT as presented in the survey results are set in the context of ongoing challenges – both local and national. For the purposes of this report, findings are presented below as follows:

- Staff Engagement Score
- Top and Bottom Ranking Scores
- Improvements and deteriorations since 2015

5.2 Additionally, analysis by Division and staff group is also available and is summarised in the appendices and will be critical to ensuring targeted and nuanced responses to the findings.

5.3 Staff Engagement Score

The overall indicator of staff engagement is calculated by Picker using the questions that make up KF1, KF4 and KF7. These relate to the following aspects of staff engagement:
KF1 – Staff recommending the Trust as a place to work or receive treatment
KF4 – Staff motivation at work
KF7 – Staff ability to contribute towards improvement at work

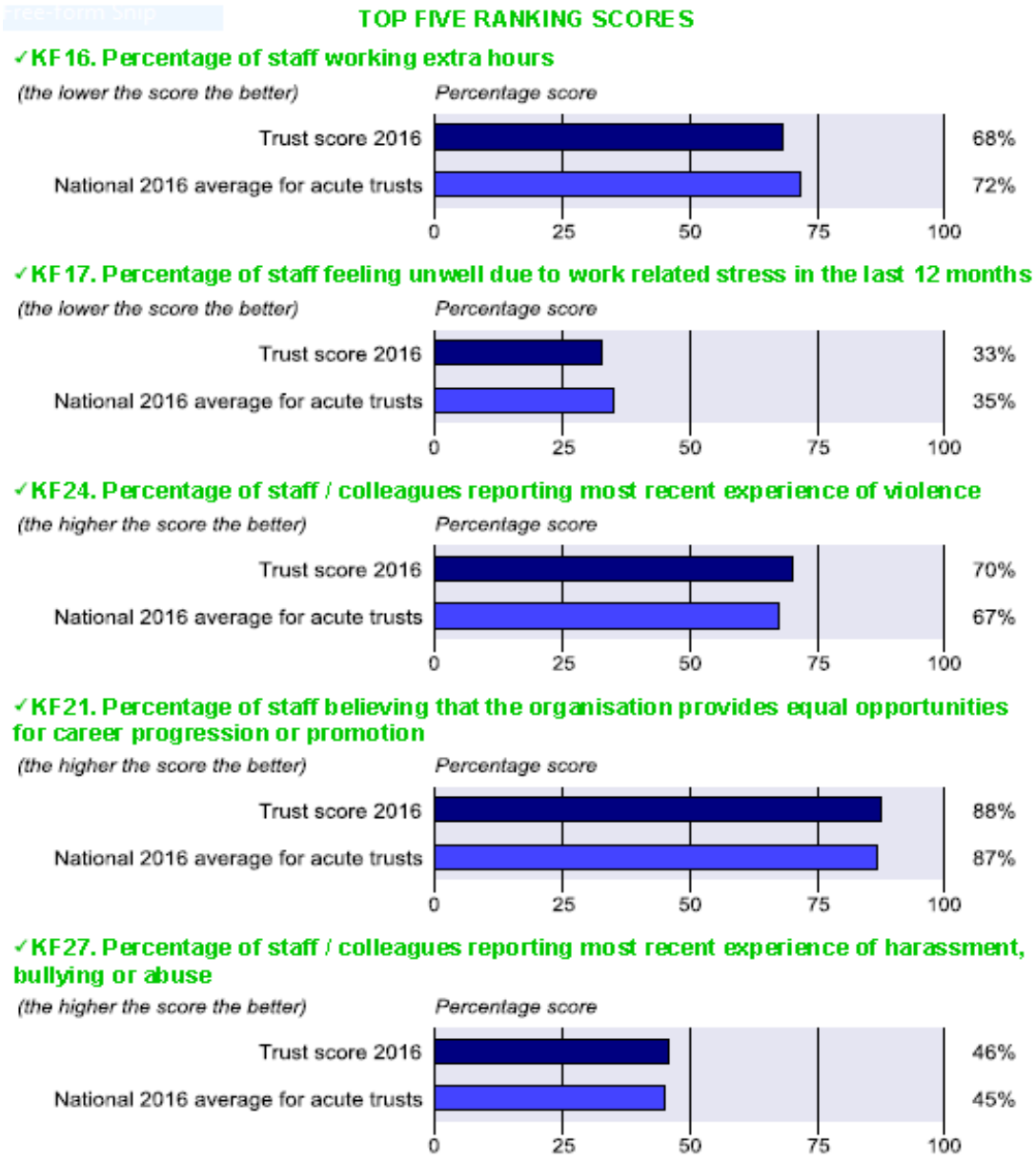
The table below shows the progress made by our Trust in terms of employee engagement over the last 5 years. This year our overall staff engagement score has remained stagnant against an average engagement score of **3.81** for acute trusts.

Staff Engagement	2012	2013	2014	2015	2016
Overall Staff Engagement	3.50	3.59	3.66	3.71	3.71
Staff ability to contribute towards improvements at work	64%	65%	66%	67%	67%
Staff recommendation of the Trust as a place to work or receive treatment	3.27	3.43	3.58	3.62	3.64
Staff motivation at work	3.70	3.77	3.77	3.86	3.85

5.4 Top and Bottom Ranking Scores

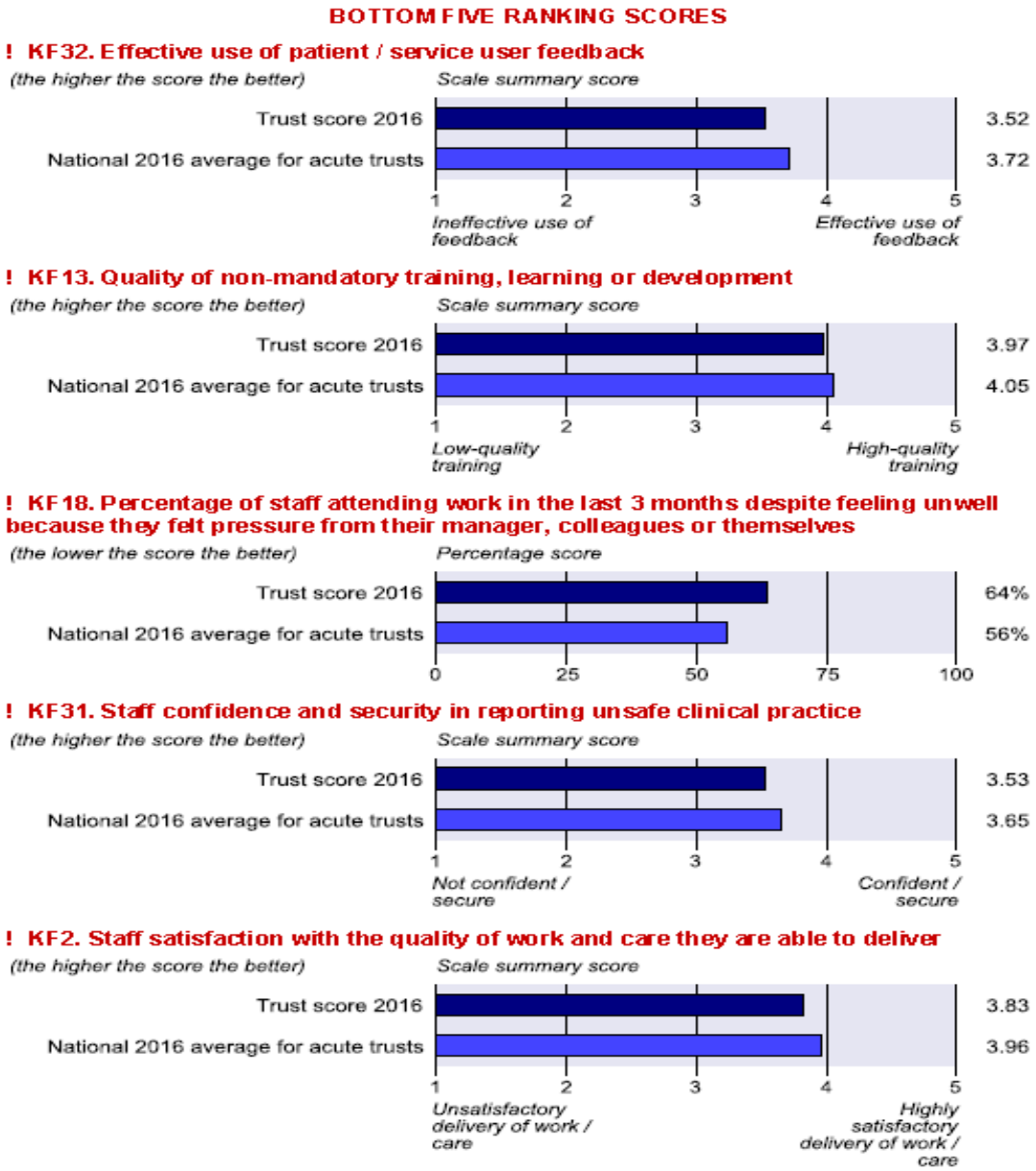
5.4.1 Top Five Ranking Scores

This highlights the five key areas in which the Trust compares **most favourably** with other acute trusts in England.



5.4.2 Bottom Ranking Scores

These are the five Key Findings for which GHFT compares **least favourably** with other acute trusts in England.

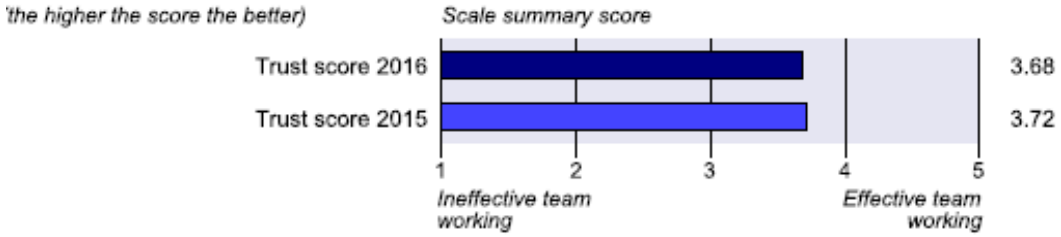


5.5 Improvements and deteriorations since 2015

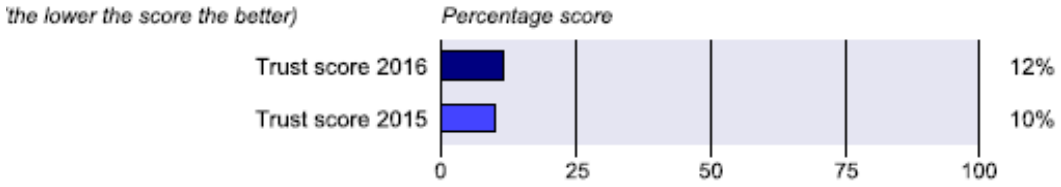
The vast majority of the 2016 staff survey results present a picture of little movement in scores compared to 2015. Whilst there have been minor changes in both positive and negative directions there are only few areas where we have observed a statistically significant shift. Of these, all of them relate to deterioration in staff experience; there were no areas where we saw a statistically significant improvement, unfortunately.

WHERE STAFF EXPERIENCE HAS DETERIORATED

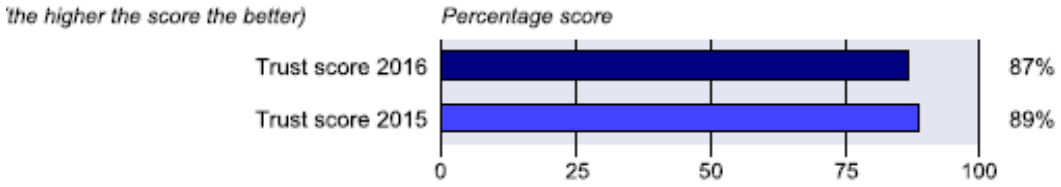
KF9. Effective team working



KF20. Percentage of staff experiencing discrimination at work in the last 12 months



KF11. Percentage of staff appraised in last 12 months



6. Conclusions and next steps

6.1 Looking at the results as a whole, it is reasonable to say that scores have been largely static with only very small movements since last year. In line with recommendations made by our survey provider, Quality Health, options include:

- Consider what we can do to better support staff who say they cannot manage conflicting demands on their time.
- Look at how we act on patient/service user feedback, and how we publicise our listening to/action following this.

6.2 The staff survey results provide a checkpoint to progress and before presenting a consolidated action plan to the Board, these results are now being shared with a range of key stakeholders during March and April to obtain perspectives, including:

- Divisional Boards
- Divisional Engagement groups
- Engagement Steering Group
- Trust Leadership Team
- 100 Leaders
- Employee Representatives (JSCC/LNC)
- Senior Staff Groups (e.g. Senior Nurse Committee))
- Council of Governors
- Health and Safety Committee
- Involve/open staff sessions

It is important for staff groups and divisions to analyse and localise these results, where applicable, forming appropriate action plans based on the themes/priorities identified. Some of the engagement referred to above has already taken place and it was pleasing to see at the recent 100 Leaders event that many managers were requesting more granular data relevant to their own areas.

Groups are asked to report back on actions and progress at regular intervals at Divisional Boards, Professional staff representative groups and the Engagement Steering Group.

6.3 Formulation, sign-off and implementation of action plans are as follows:

- **Divisions –** both departmental and divisional priorities and action plans are formulated at local level, in conjunction with divisional engagement groups. Divisional Boards to sign off action plans. Action plans shared with Engagement Steering Group and Board

- **Staff Groups** – priorities and action plans formulated for professional staff groups which cover/work across more than one division. Staff Group committees to sign off action plans. Action plans shared with Engagement Steering Group and Board **Trust-wide** – existing four priorities reviewed with all stakeholders to sense-check and agree whether these should all remain, be replaced or added to. Trust Board to sign-off and agree priorities for 2017/18. . Early feedback was taken from attendees at the 100 Leaders on this very issue. There was a general consensus that the challenges on travel and parking needed to progress to a conclusion. Recognition was given to the scale and scope of what was felt to be a genuine attempt to engage, with cautionary observations that the solutions will not be simple. What was clear was from the group was their disappointment on the scores pertaining to acting on patient feedback and belief that this should be incorporated into action planning going forward

7. Recommendations

- The Board is asked to **receive** the results from the 2016 staff survey
- The Board will be invited to endorse the Trust-wide staff engagement priorities for 2017/18 at the May 2017 Trust Board
- The Board is asked to note that the staff engagement action plans from each Division and staff group will be presented to the Trust Leadership Team in June 2017 Trust and the Board's Workforce Committee will receive periodic progress reports.

Authors: Carole Preston, Abby Hopewell and David Smith

Presenting Director: David Smith, HR and OD Director, March 2017

Table 6.2: Key Findings for different staff groups

	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
Appraisals & support for development								
KF11. % appraised in last 12 mths	90	81	87	92	80	80	91	90
KF12. Quality of appraisals	2.74	3.11	2.89	3.19	2.94	2.61	2.63	3.24
KF13. Quality of non-mandatory training, learning or development	4.05	4.02	3.73	4.03	3.84	3.84	3.95	4.11
Equality & diversity								
* *KF20. % experiencing discrimination at work in last 12 mths*	12	17	7	9	17	9	11	13
KF21. % believing the organisation provides equal opportunities for career progression / promotion	95	86	87	93	72	91	93	88
Errors & incidents								
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	45	31	12	36	27	33	45	43
KF29. % reporting errors, near misses or incidents witnessed in last mth	95	80	88	92	77	84	93	94
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.73	3.67	3.58	3.68	3.52	3.53	3.50	3.71
KF31. Staff confidence and security in reporting unsafe clinical practice	3.46	3.53	3.48	3.60	3.40	3.42	3.45	3.61
Health and wellbeing								
* *KF17. % feeling unwell due to work related stress in last 12 mths*	31	32	33	35	31	38	26	34
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	60	69	61	69	53	64	53	68
KF19. Org and mgmt interest in and action on health and wellbeing	3.56	3.59	3.66	3.65	3.43	3.43	3.19	3.59
Working patterns								
KF15. % satisfied with the opportunities for flexible working patterns	46	48	56	52	45	34	35	52
* *KF16. % working extra hours*	79	53	55	80	49	81	90	81
Number of respondents	147	663	934	287	215	154	314	1063

Please note that the staff groups classification was provided by Gloucestershire Hospitals NHS Foundation Trust

Table 6.2: Key Findings for different staff groups (cont)

	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
Job satisfaction								
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.62	3.69	3.67	3.63	3.62	3.43	3.57	3.62
KF4. Staff motivation at work	3.78	3.83	3.71	3.85	3.77	3.63	3.91	4.02
KF7. % able to contribute towards improvements at work	77	56	66	75	55	66	68	74
KF8. Staff satisfaction with level of responsibility and involvement	3.90	3.80	3.81	3.86	3.68	3.81	4.01	4.02
KF9. Effective team working	3.64	3.62	3.64	3.89	3.24	3.64	3.72	3.79
KF14. Staff satisfaction with resourcing and support	3.27	3.34	3.37	3.12	3.25	3.01	3.10	3.21
Managers								
KF5. Recognition and value of staff by managers and the organisation	3.36	3.43	3.47	3.41	3.23	3.21	3.31	3.48
KF6. % reporting good communication between senior management and staff	22	33	27	38	25	27	26	32
KF10. Support from immediate managers	3.62	3.68	3.78	3.72	3.32	3.52	3.48	3.80
Patient care & experience								
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.83	4.08	3.91	3.62	4.03	3.65	3.57	3.74
KF3. % agreeing that their role makes a difference to patients / service users	96	90	80	94	80	92	94	92
KF32. Effective use of patient / service user feedback	3.36	3.54	3.55	3.49	3.54	3.44	3.32	3.58
Violence, harassment & bullying								
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	7	29	2	14	14	2	15	30
* *KF23. % experiencing physical violence from staff in last 12 mths*	1	4	1	1	8	1	1	2
KF24. % reporting most recent experience of violence	-	65	68	45	77	-	47	78
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	22	34	16	36	16	16	36	41
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	17	26	24	19	25	24	23	29
KF27. % reporting most recent experience of harassment, bullying or abuse	40	50	44	44	64	44	29	46
Overall staff engagement	3.72	3.67	3.68	3.75	3.58	3.57	3.70	3.81
Number of respondents	147	663	934	287	215	154	314	1063

Please note that the staff groups classification was provided by Gloucestershire Hospitals NHS Foundation Trust

Table 6.3: Key Findings for different directorates

	Corporate Division	Diagnostics & Specialty Division	Estates & Facilities Division	Medicine Division	Non-Division	Surgery Division	Womens & Children Division
Appraisals & support for development							
KF11. % appraised in last 12 mths	87	90	82	82	91	87	90
KF12. Quality of appraisals	3.00	2.97	2.79	3.22	-	3.00	2.99
KF13. Quality of non-mandatory training, learning or development	3.83	3.97	3.83	3.99	-	4.03	4.03
Equality & diversity							
* *KF20. % experiencing discrimination at work in last 12 mths*	9	9	16	17	-	13	7
KF21. % believing the organisation provides equal opportunities for career progression / promotion	86	90	72	88	-	87	92
Errors & incidents							
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	13	29	29	43	-	33	40
KF29. % reporting errors, near misses or incidents witnessed in last mth	85	89	81	91	-	90	95
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.61	3.66	3.50	3.62	-	3.64	3.73
KF31. Staff confidence and security in reporting unsafe clinical practice	3.52	3.51	3.36	3.56	-	3.52	3.66
Health and wellbeing							
* *KF17. % feeling unwell due to work related stress in last 12 mths*	34	31	34	34	36	33	36
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	60	64	59	64	-	65	71
KF19. Org and mgmt interest in and action on health and wellbeing	3.71	3.60	3.44	3.52	4.14	3.51	3.53
Working patterns							
KF15. % satisfied with the opportunities for flexible working patterns	63	45	44	48	-	49	51
* *KF16. % working extra hours*	57	70	50	74	73	71	77
Number of respondents	480	1102	253	666	11	919	346

Please note that the directorates classification was provided by Gloucestershire Hospitals NHS Foundation Trust

Table 6.3: Key Findings for different directorates (cont)

	Corporate Division	Diagnostics & Specialty Division	Estates & Facilities Division	Medicine Division	Non-Division	Surgery Division	Womens & Children Division
Job satisfaction							
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.66	3.64	3.58	3.57	-	3.61	3.78
KF4. Staff motivation at work	3.72	3.79	3.75	3.95	4.06	3.89	3.97
KF7. % able to contribute towards improvements at work	73	67	56	68	-	67	67
KF8. Staff satisfaction with level of responsibility and involvement	3.85	3.85	3.67	3.97	-	3.91	3.94
KF9. Effective team working	3.78	3.72	3.26	3.72	-	3.70	3.63
KF14. Staff satisfaction with resourcing and support	3.38	3.25	3.18	3.16	-	3.30	3.21
Managers							
KF5. Recognition and value of staff by managers and the organisation	3.54	3.40	3.21	3.43	-	3.41	3.46
KF6. % reporting good communication between senior management and staff	31	31	27	29	18	30	34
KF10. Support from immediate managers	3.86	3.67	3.33	3.73	-	3.69	3.74
Patient care & experience							
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.79	3.81	4.01	3.74	-	3.88	3.80
KF3. % agreeing that their role makes a difference to patients / service users	81	90	80	92	-	91	90
KF32. Effective use of patient / service user feedback	3.62	3.46	3.56	3.59	-	3.48	3.55
Violence, harassment & bullying							
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	4	9	13	41	0	25	7
* *KF23. % experiencing physical violence from staff in last 12 mths*	1	1	8	4	0	3	1
KF24. % reporting most recent experience of violence	93	51	78	74	-	68	81
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	9	25	15	47	-	34	34
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	26	21	28	26	-	27	28
KF27. % reporting most recent experience of harassment, bullying or abuse	49	42	62	49	-	42	40
Overall staff engagement	3.72	3.70	3.58	3.74	-	3.70	3.81
Number of respondents	480	1102	253	666	11	919	346

Please note that the directorates classification was provided by Gloucestershire Hospitals NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
TRUST BOARD 12th APRIL 2017
Sandford Education Centre, CGH commencing at 9.00 a.m

Report Title
Nasogastric tube misplacement: continuing risk of death and severe harm Assurance Report
Sponsor and Author(s)
Director of Safety - Andrew Seaton
Executive Summary
Purpose To provide assurance of the extra controls in place to prevent Nasogastic tube related Never Events following the issuing of a stage 2 Patient Safety Alert. Key issues to note The Trust just prior to the alert being issued a completed a significant amount of improvement work following two Nasogastric Never Events. The Trusts processes have been reviewed in detail and further minor adjustments have been made (Appendix 2). This report once presented to a Public Trust Board will allow closure (12th April 2017) Conclusions Extra controls were put in place following the two previous Never Events which have prevented further incidents; this was done just prior to the alert being issued. Further refinements have been made following this review and any remaining actions are identified within the action plan which will be monitored at the Patient Safety Forum. As a result although it remains possible for further incidents, we have improved the resilience in the system and reduced the risk of future nasogastric tube related never events. Implications and Future Action Required Continuous monitoring of clinical audits at Patient Safety Forum
Recommendations
To recommend closure of the alert.
Impact Upon Strategic Objectives
To continue to improve the quality of care we deliver to our patients and reduce variation
Impact Upon Corporate Risks
None
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)**

MAIN BOARD – APRIL 2017

NASOGASTRIC TUBE MISPLACEMENT: CONTINUING RISK OF DEATH AND SEVERE HARM ASSURANCE REPORT

1. Introduction

On the 22 July 2016 a new stage 2 Patient Safety Alert was issued for Nasogastric tube misplacement: continuing risk of death and severe harm (Appendix 1). The alert needs to be closed following presentation to a Public Board meeting by the 21st April 2017.

2. Background

Use of misplaced nasogastric and orogastric tubes was first recognised as a patient safety issue by the National Patient Safety Agency (NPSA) in 2005 and three further alerts were issued by the NPSA and NHS England between 2011 and 2013. Introducing fluids or medication into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube is a Never Event. Never Events are considered 'wholly preventable where guidance or safety recommendations that provide strong systemic protective barrier are available at a national level, and should have been implemented by all healthcare providers.

Between September 2011 and March 2016, 95 incidents were reported to the National Reporting and Learning System (NRLS) and/or the Strategic Executive Information System (StEIS) where fluids or medication were introduced into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube. While this should be considered in the context of over 3 million nasogastric or orogastric tubes being used in the NHS in that period, 7 of these incidents show that risks to patient safety persist. Checking tube placement before use via pH testing of aspirate and, when necessary, x-ray imaging, is essential in preventing harm.

Within the Trust just prior to the alert being issued a significant amount of improvement had occurred as a consequence of two Nasogastric Never Events. The action plan mirrored the alert and assurance was reported to the Quality Committee as part of the normal monitoring and closure of action plans, following advice from NHSE it was suggested that to fully satisfy the alert that a separate report was required for Trust Board. This report will satisfy the final part of the alert to allow closure.

3. Action Required and Response

The following sections identify the actions and response to alert standards, a fuller response is attached (Appendix 2).

Alert Statement	Action Taken	**Current position**
Identify a named executive director who will take responsibility for the delivery of the actions required in this alert.	Maggie Arnold - Director of Nursing	Complete
Using the resources supplied with this alert, undertake a centrally coordinated assessment of whether your organisation has robust systems for supporting staff to	This assessment has been completed (Appendix 2)	Complete

deliver safety-critical requirements for initial nasogastric and orogastric tube placement checks.		
If the assessment identifies any concerns, use the resources supplied with this alert to develop and implement an action plan to ensure all safety-critical requirements are met.	1. Standardise the x-ray reporting form across Radiography and CCU and Paediatrics. 2. Revise the education approach in Paediatrics 3. Establish Annual Audits of practice.	30th April 2017 Completed August 2017
Share this assessment and agree any related action plan within relevant commissioner assurance meetings.	The original action plan from the Never Events was shared with the CCG. The CCG will be at the Quality & Performance Sub – Board Committee.	Complete
Share the key findings of this assessment and the main actions that have been taken in the form of a public board paper	The report will be shared at the Quality & Performance meeting on the 30th March and Trust Board on the 12 April 2017	Q&PC – Complete
As reported		

4. Conclusion

Extra controls were put in place following the two previous Never Events which have prevented further incidents; this was done just prior to the alert being issued. Further refinements have been made following this review and any remaining actions are identified within the action plan which will be monitored at the Patient Safety Forum. As a result although it remains possible for further incidents, we have improved the resilience in the system and reduced the risk of future nasogastric tube related never events.

Author: Andrew Seaton, Director of Safety

Date: March 2017

NHS Improvement

Patient Safety Alert

Nasogastric tube misplacement: continuing risk of death and severe harm

22 July 2016

Alert reference number:	NHS/PSA/RE/2016/006
Alert stage:	Two - Resources

Use of misplaced nasogastric and orogastric tubes[1] was first recognised as a patient safety issue by the National Patient Safety Agency (NPSA) in 2005[2] and three further alerts were issued by the NPSA and NHS England between 2011 and 2013.[3-5] Introducing fluids or medication into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube is a Never Event. Never Events are considered 'wholly preventable where guidance or safety recommendations that provide strong systemic protective barrier are available at a national level, and should have been implemented by all healthcare providers.'[6]

Between September 2011 and March 2016, 95 incidents were reported to the National Reporting and Learning System (NRLS) and/or the Strategic Executive Information System (StEIS) where fluids or medication were introduced into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube. While this should be considered in the context of over 3 million nasogastric or orogastric tubes being used in the NHS in that period,[7] these incidents show that risks to patient safety persist. Checking tube placement before use via pH testing of aspirate and, when necessary, x-ray imaging, is essential in preventing harm.

Examination of these incident reports by NHS Improvement clinical reviewers shows that misinterpretation of x-rays by medical staff who did not appear to have received the competency-based training required by the 2011 NPSA alert is the most common error type. Other error types involve nursing staff and pH tests, unapproved tube placement checking methods, and communication failures resulting in tubes not being checked. The reports included 32 incidents where the patient subsequently died, although given many patients were critically ill before the tube was introduced, it is not always clear whether the death was directly related to the misplaced tube.

Review of local investigations into these incidents suggests problems with organisational processes for implementing previous alerts. This Patient Safety Alert is therefore directed **at trust boards** (or their equivalent in other providers of NHS funded care) and the processes that support clinical governance. It is NOT directed at frontline staff. Some of the implementation issues identified were:

- problems with systems to ensure staff who were checking tube placement had received competency-based training
- problems with ensuring bedside documentation formats include all safety-critical checks
- problems maintaining safe supplies of equipment, particularly radio-opaque tubes and CE-marked pH test strips.

The resource set that accompanies this alert provides a range of support for trust boards (or their equivalents) to assess whether previous nasogastric tube guidance has been implemented and embedded within their organisations improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes. It includes briefings to help non-executives and governors to understand the issues, summaries of safety-critical requirements of past alerts, self-assessment/assurance checklists, and learning from reported incidents.

Actions

Who: All organisations where nasogastric or orogastric tubes are used for patients receiving NHS-funded care

When: To commence as soon as possible and to be completed by 21 April 2017

1. Identify a named executive director* who will take responsibility for the delivery of the actions required in this alert.
2. Using the resources supplied with this alert, undertake a centrally co-ordinated assessment of whether your organisation has robust systems for supporting staff to deliver safety-critical requirements for initial nasogastric and orogastric tube placement checks.
3. If the assessment identifies any concerns, use the resources supplied with this alert to develop and implement an action plan to ensure all safety-critical requirements are met.
4. Share this assessment and agree any related action plan within relevant commissioner assurance meetings.
5. Share the key findings of this assessment and the main actions that have been taken in the form of a public board paper.**

* For organisations that are not trusts/foundation trusts and do not have executive directors, a role with equivalent senior responsibility should be identified.

**For organisations without a board, an equivalent publically available alternative to a board paper should be identified eg a report on a public-facing website.

See page 2 for references

Alert reference number:	NHS/PSA/RE/2016/006
Alert stage:	Two - Resources

Resources

Patient safety incident reporting

For detail of dates and search strategy within the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (StEIS) see page x of the supporting *initial placement checks for nasogastric and orogastric tubes resource set* on the NHS Improvement website improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes

References

1. Hanna G, Phillips, L, Priest O & Zhifang N (201) Improving the safety of nasogastric feeding tube insertion A report for the NHS Patient Safety Research Portfolio July 2010 www.birmingham.ac.uk/Documents/college-mds/haps/projects/cfhep/psrp/finalreports/PS048ImprovingthesafetyofnasogastricfeedingtubeinsertionREVISEDHannaetal.pdf
2. National Patient Safety Agency - Reducing the harm caused by misplaced nasogastric feeding tubes 2005 www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59794&p=4
3. National Patient Safety Agency Patient Safety Alert: Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants 2011 www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=129640
4. National Patient Safety Agency Rapid Response Report: Harm from flushing of nasogastric tubes before confirmation of placement 2012 www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=133441
5. NHS England Patient Safety Alert: Stage 1 - Placement devices for nasogastric tube placement DO NOT replace initial placement checks 2013 www.england.nhs.uk/wp-content/uploads/2013/12/psa-ng-tube.pdf
6. NHS England Never Events Policy and Framework 2015 www.england.nhs.uk/patientsafety/never-events/
7. Page 9 of the supporting *initial placement checks for nasogastric and orogastric tubes resouirce set* on the NHS Improvement website improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes

Stakeholder engagement

- Medical Specialities Patient Safety Expert Group
- Children and Young People's Patient Safety Expert Group
- Surgical Services Patient Safety Expert Group
- Patient Safety Steering Group

For details of the membership of the NHS Improvement patient safety expert groups and steering group see www.england.nhs.uk/ourwork/patientsafety/patient-safety-groups/

NHS Improvement

Patient Safety Alert

Nasogastric tube misplacement: continuing risk of death and severe harm

22 July 2016

Alert reference number:	NHS/PSA/RE/2016/006
Alert stage:	Two - Resources

Use of misplaced nasogastric and orogastric tubes[1] was first recognised as a patient safety issue by the National Patient Safety Agency (NPSA) in 2005[2] and three further alerts were issued by the NPSA and NHS England between 2011 and 2013.[3-5] Introducing fluids or medication into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube is a Never Event. Never Events are considered 'wholly preventable where guidance or safety recommendations that provide strong systemic protective barrier are available at a national level, and should have been implemented by all healthcare providers.'[6]

Between September 2011 and March 2016, 95 incidents were reported to the National Reporting and Learning System (NRLS) and/or the Strategic Executive Information System (StEIS) where fluids or medication were introduced into the respiratory tract or pleura via a misplaced nasogastric or orogastric tube. While this should be considered in the context of over 3 million nasogastric or orogastric tubes being used in the NHS in that period,[7] these incidents show that risks to patient safety persist. Checking tube placement before use via pH testing of aspirate and, when necessary, x-ray imaging, is essential in preventing harm.

Examination of these incident reports by NHS Improvement clinical reviewers shows that misinterpretation of x-rays by medical staff who did not appear to have received the competency-based training required by the 2011 NPSA alert is the most common error type. Other error types involve nursing staff and pH tests, unapproved tube placement checking methods, and communication failures resulting in tubes not being checked. The reports included 32 incidents where the patient subsequently died, although given many patients were critically ill before the tube was introduced, it is not always clear whether the death was directly related to the misplaced tube.

Review of local investigations into these incidents suggests problems with organisational processes for implementing previous alerts. This Patient Safety Alert is therefore directed **at trust boards** (or their equivalent in other providers of NHS funded care) and the processes that support clinical governance. It is NOT directed at frontline staff. Some of the implementation issues identified were:

- problems with systems to ensure staff who were checking tube placement had received competency-based training
- problems with ensuring bedside documentation formats include all safety-critical checks
- problems maintaining safe supplies of equipment, particularly radio-opaque tubes and CE-marked pH test strips.

The resource set that accompanies this alert provides a range of support for trust boards (or their equivalents) to assess whether previous nasogastric tube guidance has been implemented and embedded within their organisations improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes. It includes briefings to help non-executives and governors to understand the issues, summaries of safety-critical requirements of past alerts, self-assessment/assurance checklists, and learning from reported incidents.

Actions

Who: All organisations where nasogastric or orogastric tubes are used for patients receiving NHS-funded care

When: To commence as soon as possible and to be completed by 21 April 2017

1. Identify a named executive director* who will take responsibility for the delivery of the actions required in this alert.
2. Using the resources supplied with this alert, undertake a centrally co-ordinated assessment of whether your organisation has robust systems for supporting staff to deliver safety-critical requirements for initial nasogastric and orogastric tube placement checks.
3. If the assessment identifies any concerns, use the resources supplied with this alert to develop and implement an action plan to ensure all safety-critical requirements are met.
4. Share this assessment and agree any related action plan within relevant commissioner assurance meetings.
5. Share the key findings of this assessment and the main actions that have been taken in the form of a public board paper.**

* For organisations that are not trusts/foundation trusts and do not have executive directors, a role with equivalent senior responsibility should be identified.

**For organisations without a board, an equivalent publically available alternative to a board paper should be identified eg a report on a public-facing website.

See page 2 for references

Alert reference number:	NHS/PSA/RE/2016/006
Alert stage:	Two - Resources

Resources

Patient safety incident reporting

For detail of dates and search strategy within the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (StEIS) see page x of the supporting *initial placement checks for nasogastric and orogastric tubes resource set* on the NHS Improvement website improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes

References

1. Hanna G, Phillips, L, Priest O & Zhifang N (201) Improving the safety of nasogastric feeding tube insertion A report for the NHS Patient Safety Research Portfolio July 2010 www.birmingham.ac.uk/Documents/college-mds/haps/projects/cfhep/psrp/finalreports/PS048ImprovingthesafetyofnasogastricfeedingtubeinsertionREVISEDHannaetal.pdf
2. National Patient Safety Agency - Reducing the harm caused by misplaced nasogastric feeding tubes 2005 www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59794&p=4
3. National Patient Safety Agency Patient Safety Alert: Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants 2011 www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=129640
4. National Patient Safety Agency Rapid Response Report: Harm from flushing of nasogastric tubes before confirmation of placement 2012 www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=133441
5. NHS England Patient Safety Alert: Stage 1 - Placement devices for nasogastric tube placement DO NOT replace initial placement checks 2013 www.england.nhs.uk/wp-content/uploads/2013/12/psa-ng-tube.pdf
6. NHS England Never Events Policy and Framework 2015 www.england.nhs.uk/patientsafety/never-events/
7. Page 9 of the supporting *initial placement checks for nasogastric and orogastric tubes resouirce set* on the NHS Improvement website improvement.nhs.uk/resources/resource-set-initial-placement-checks-nasogastric-and-orogastric-tubes

Stakeholder engagement

- Medical Specialities Patient Safety Expert Group
- Children and Young People's Patient Safety Expert Group
- Surgical Services Patient Safety Expert Group
- Patient Safety Steering Group

For details of the membership of the NHS Improvement patient safety expert groups and steering group see www.england.nhs.uk/ourwork/patientsafety/patient-safety-groups/

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – APRIL 2017

Report Title
APPROACH TO TRANSFORMATION – PROPOSAL
Sponsor and Author(s)
Author: Ian Quinnell - Associate Director for Service Improvement Presenting Director: Dr Sally Pearson – Executive Director for Clinical Strategy
Executive Summary
Purpose At a Board Seminar on 20th July 2016, it was agreed that in order to deliver the Trusts vision of 'Best Care for Everyone' a Transformation Programme would be established to ensure that the appropriate governance, process and resource be assigned to ensure an organisational 'step change' through large, complex changes. The Transformation Programme will provide the necessary structure and draw upon expertise and resources to deliver the required pace and scale of change across GHFT and the wider system to address a number of challenges and deliver against its strategic objectives This proposal outlines the approach that will be taken to establish a Transformation Programme. Key issues to note None Conclusions • To establish a Transformation Board • To establish a Transformation Programme to support the delivery of the Trusts immediate priorities • To establish the 'core' transformation team • To implement the programme reporting framework and emerging transformation model Implications and Future Action Required For The Trust Leadership Team to receive regular progress reports from the Transformation Board. For issues to be escalated to the Main Board as appropriate
Recommendations
The Board is asked to endorse this approach to enable the establishment of the Transformation Board and subsequent governance, structure and programmes of work.
Impact Upon Risk – known or new
n/a
Equality & Patient Impact
n/a

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

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

Date the paper was presented to previous Committees		
Divisional Board	**Trust Leadership Team Sub-group**	**Other (Specify)**
Outcome of discussion when presented to previous Committees		

Approach to Transformation – Proposal
Main Baord April 2017

1. Introduction

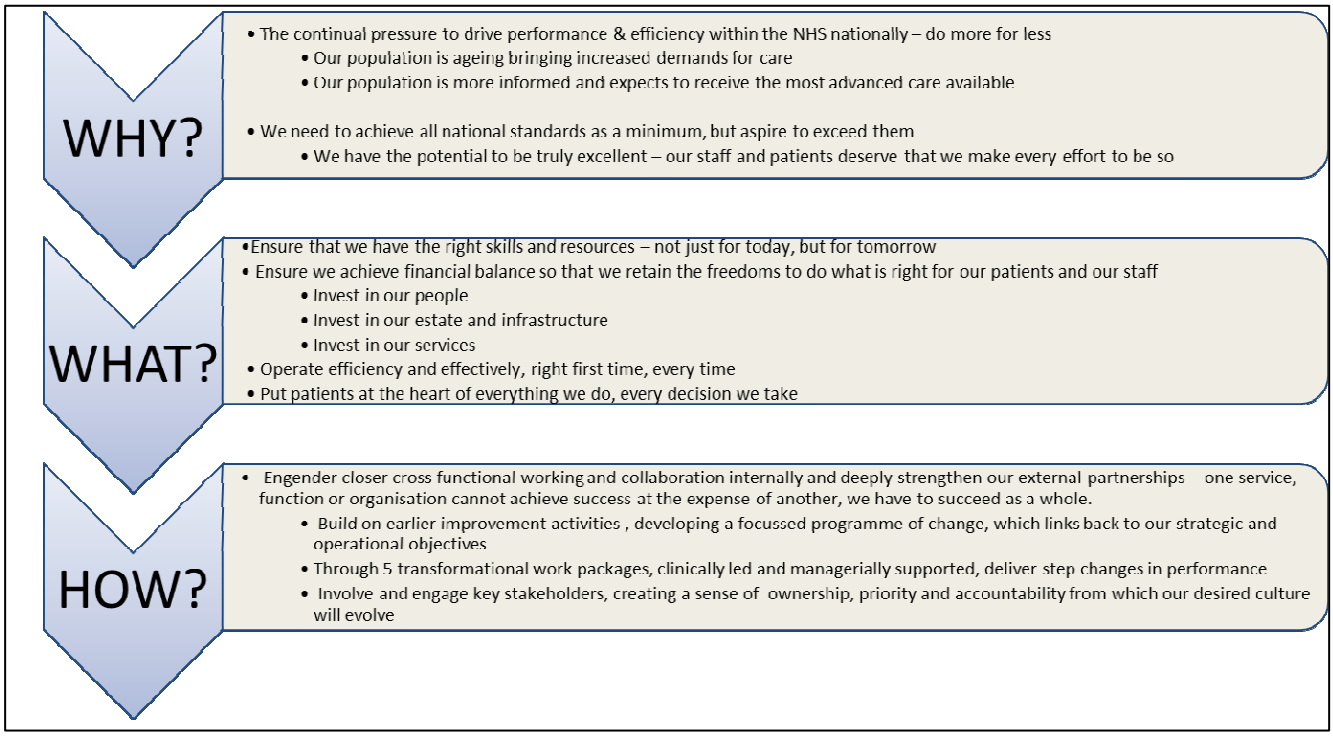
At a Board Seminar on 20th July 2016, it was agreed that in order to deliver the Trusts vision of 'Best Care for Everyone' a Transformation Programme (Appendix 1) would be established to ensure that the appropriate governance, process and resource be assigned to ensure an organisational 'step change' through large, complex changes.

The Transformation Programme will provide the necessary structure and draw upon expertise and resources to deliver the required pace and scale of change across GHFT and the wider system to address a number of challenges and deliver against its strategic objectives

Under the heading 'Transforming Care for Everyone', it was been agreed at the Board Seminar that the Trust would –

- *Create a unifying programme of change*
- *deliver against the Six "pillars" of transformational activity, delivering step changes in performance*
- *To be clinically led and managerially supported*
- *That the programme will enable the desired organisational culture to evolve*

The following slide taken from the Board Seminar presentation summarises the why, what and how the Transformation programme will support the delivery of the required 'step change' -

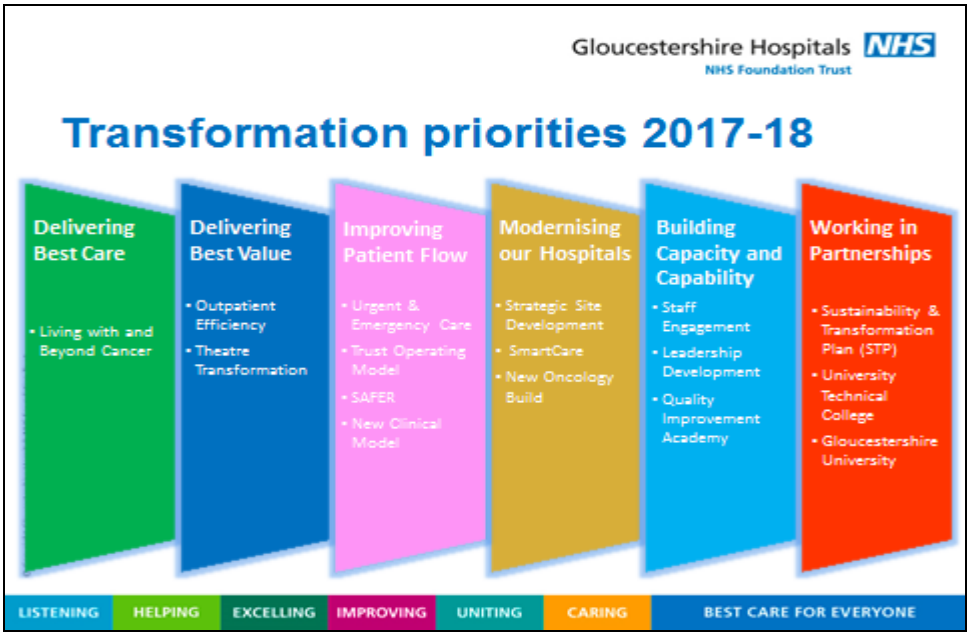


To enable the initial planning of the Transformation team, six pillars were presented to the Main Board seminar for consideration to reflect the areas of focus and priority. These include –

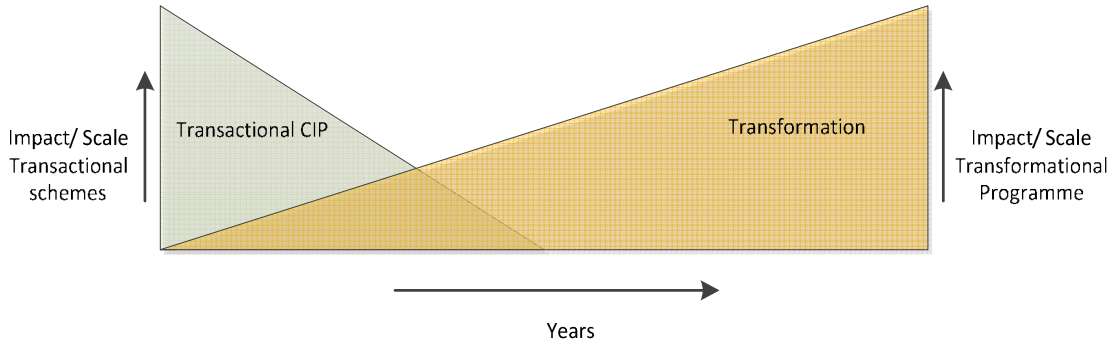
In order to deliver the necessary change across these six pillars, a Transformation Board (Terms of reference – Appendix 2) will be established as part of the new committee framework which will report to Trust Leadership Team and be responsible for the following -

- *To lead, direct and coordinate the delivery of the Transforming Care Programme, in order that it achieves its goals as agreed with the Trust Leadership Team.*
- *To lead the development of an improvement culture, ensuring teams are supported to identify and deliver opportunities for small and large scale change*
- *Lead and direct the overall delivery of Transforming Care and ensure each of the six transformation themes identified addresses the key issues and challenges facing the Trust.*
- *Ensure an appropriate scope of work is developed and mobilised to achieve the aims and goals of the six themes, including appropriate measures of success and the implementation of corrective actions where appropriate*

A number of existing programmes can already be mapped to these six pillars which include:



It is important to note the close relationship that will exist between the Transformation and Cost Improvement programmes in the context of the six pillars. The primary focus for the Trust at present is the delivery of its Financial Recovery Plan of which 'service transformation' (Appendix 3) is one of its work streams. However, over the coming years once the transactional CIP schemes have been realised and further opportunities become limited, the scale and impact of transformational schemes will need to increase as savings targets will become more difficult to realise.



2. Approach

Resource
In order to establish a Transformation Programme and the necessary structure and governance to deliver the required levels of change, it is proposed that a 'Core' Transformation team is created which pulls together the necessary change and improvement expertise from across the Organisation.

This core team will exist (virtually) and be aligned to the priorities set by the Transformation Board and consist of:

- Project & Programme Management (Programme Management & Service Improvement team)
- Informatics & Modelling – Information
- Service Improvement accountant – Finance
- Improvement Advisors – Quality Improvement Academy (QIA)
- HR Advisor – Human Resources

The Core team will also be supplemented as required on specific programmes/projects by those who have undertaken:

- IHI accreditation
- Silver Quality Academy awards
- Nye Bevan (NHS Leadership Academy)
- Chief Registrars
- Secondments & Talent Bank (individuals seeking career development & new opportunities within a transformational change initiatives)

Adopting similar principles to those applied to the Emergency Care Programme, it is proposed that for each 'pillar' a series of programmes & work streams will be established and contain a governance structure that consists of a :

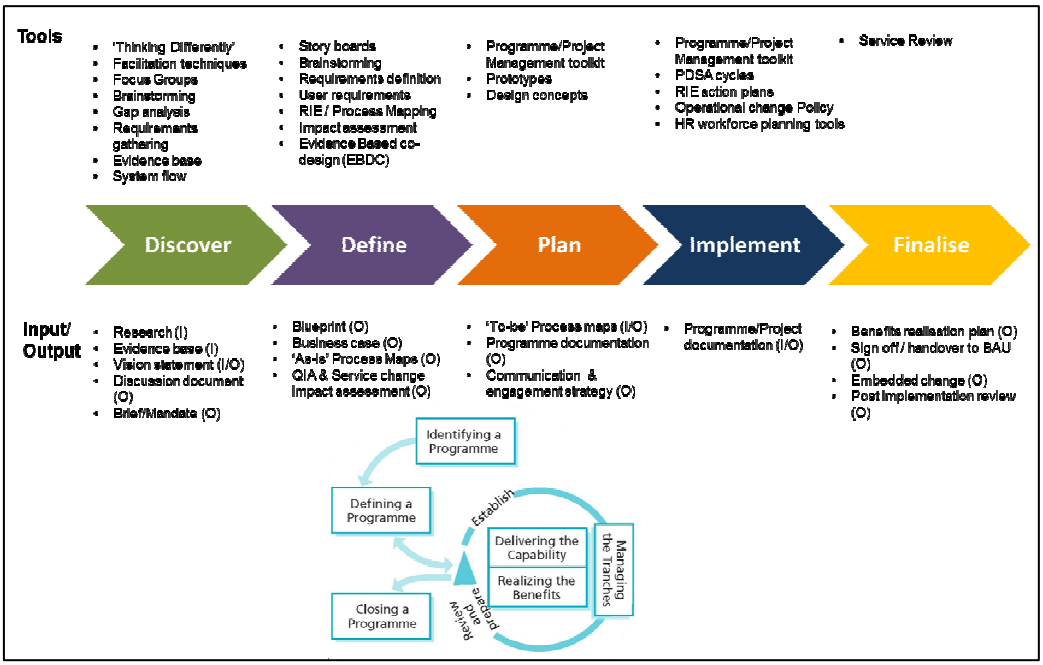
- Executive Sponsor
- Clinical Lead
- Operational Lead
- Project/Programme Manager

In the short term, resource required to support the Transformation Programme from these identified areas will need to be negotiated and agreed locally as required. However in the longer term, the aspiration of the Programme is to seek a resource budget to support a number of secondments to the core team and enable the backfill of clinical and operational leads who may be assigned to activities.

Transformation Model
This structure will require the necessary project and programme management principles being adopted along with a governance structure that provides the necessary support and rigour to ensure delivery and to report into the Transformation Board as required.

In order to adopt a common approach to the design, delivery and implementation of Transformation programmes across the Trust as well as providing the necessary assurances, a developing model is proposed. This draws upon existing standards and approaches utilised across the Trust such as :

- Project Management Toolkit (adopting principles from Prince2 & Managing Successful Programmes (MSP))
- Quality Improvement Academy (QIA)
- Evidence Based Co-Design
- Process Mapping & Rapid Improvement Event (RIE) guidance
- Organisational Change
- Business Planning



In adopting a programme approach outlined above (design, define, plan…), this enables a staged 'gateway' review to be introduced into all programmes to provide the necessary review and assurance of delivery to the Transformation Board. These reviews will provide an assessment of progress and a check of readiness of the next phase of activity before further commitment of resources and funding is agreed.

3. Timescales

The implementation of this approach –

	Activity	Milestone date
1	Agreed model and structure of the Transformation team	April 2017
2	Transformation Board Established	April 2017
3	'Core' Transformation team established	May 2017
4	Reporting and Programme framework implemented	May 2017
5	Agreement as to the Programmes immediate priorities for delivery as a result of the annual and strategic planning cycle	June 2017
6	Commence systematic review of all Trust change initiatives to understand current condition and what is needed	June 2017

4. Recommendation

The Board is asked to endorse this approach to enable the establishment of the Transformation Board and subsequent governance, structure and programmes of work.

Author: Ian Quinnell - Associate Director for Service Improvement

Presenting Director: Dr Sally Pearson – Executive Director for Clinical Strategy

Gloucestershire Hospitals NHS
NHS Foundation Trust

Best Care For Everyone – realising our vision in Gloucestershire Hospitals

Deborah Lee, Chief Executive

Gloucestershire Hospitals NHS
NHS Foundation Trust

Objectives

By the end of the session you will have

- ✓ Understood, accepted and be confident to communicate the case for renewing our approach to transformation
- ✓ Endorsed (and amended) the vision of what *Best Care For Everyone* will look like, if we succeed
- ✓ Understood how we are defining transformation – both what it is and what it isn't
- ✓ Confirmed support for the scope of the 5 themes
- ✓ Endorsed the culture that will characterise the organisation, when our vision has become a reality
- ✓ Made your **personal** commitment to the programme through a personal pledge, which can be measured

Gloucestershire Hospitals NHS
NHS Foundation Trust

The Case for Change

- We are not consistently achieving national - both quality (CQC) and access (NHSI)
- Demographic challenges and patient expectation will require us to “do more for less”
- We have realised many of the “quick wins” through transactional change
- The current pace and scale of change we are achieving, will leave us standing still at best but more likely see us fall behind our peers
- We have the potential to be truly excellent – our staff and patients deserve that we make every effort to be so
- Financial balance will ensure we retain the freedoms to do what is right for our patients and our staff
- Hope is not a plan!!

“What if we don’t change at all ...
and something magical just happens?”

Gloucestershire Hospitals NHS
NHS Foundation Trust

Our Vision – Best Care For Everyone

Where are we now?

- High awareness and recognition of *Best Care For Everyone*
- However, no agreed description of what will it look like for patients and for staff
- No route map to get us there – the current transformation programme is floundering and unlikely to deliver the pace or scale of change required
- The challenge isn't receding
- A new Chief Executive is a window of opportunity to reassess our approach to delivering our vision

Gloucestershire Hospitals NHS
NHS Foundation Trust

Transformation

Definition:

verb: to change in form, appearance or structure

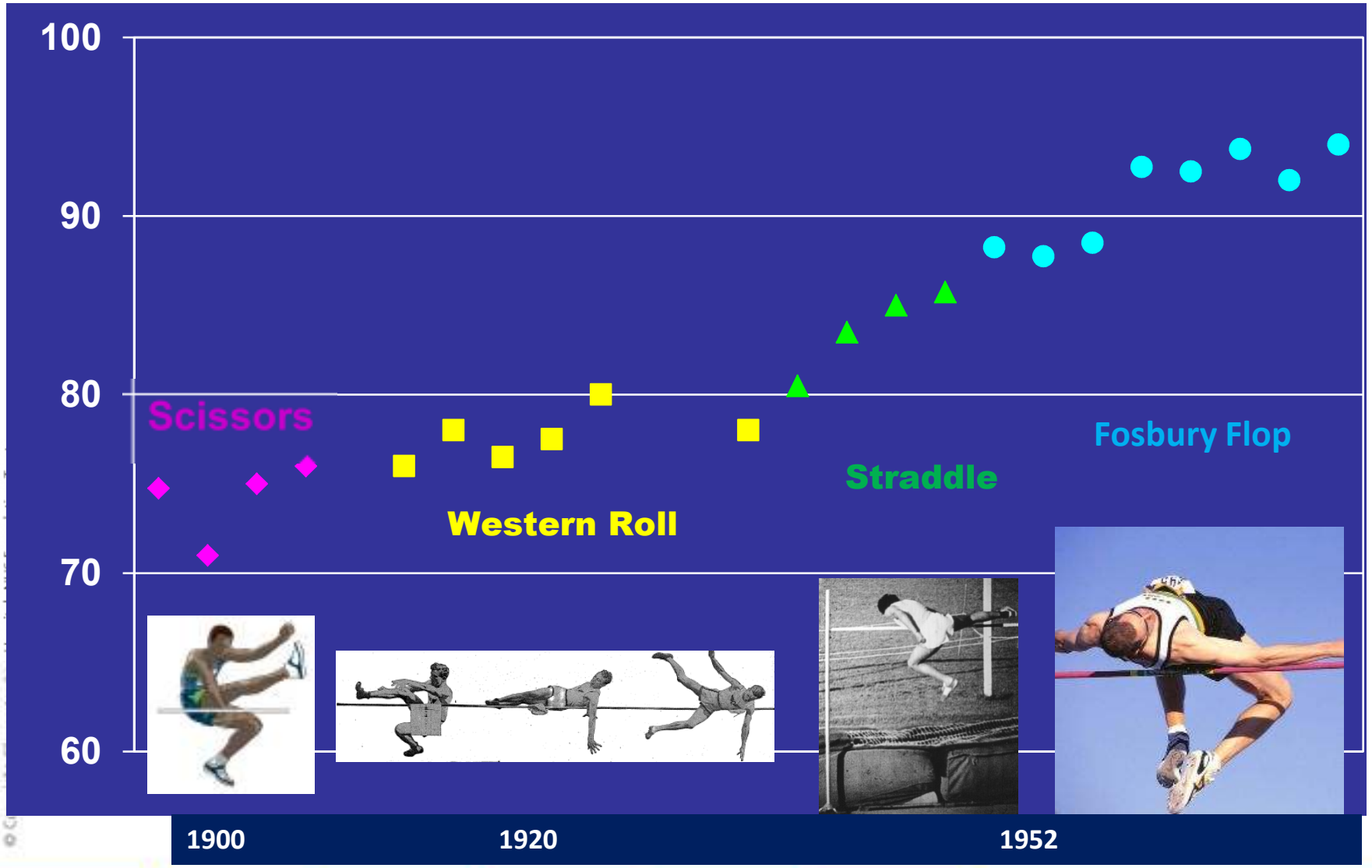
origin: Middle English 1300-1350, *transformen;* Latin: *transformare* to change in shape

A working definition:

Transformation describes change which is:

- **Complex** (across organisation boundaries and different aspects of the organisation's design)
- **Large scale** (can include many implementations of a simple, small change project)
- Achieves a **step change** (in e.g. results, performance, behaviour)
- Moves an organisation towards its **vision**

Be bold – from transaction to transformation



Gloucestershire Hospitals NHS
NHS Foundation Trust

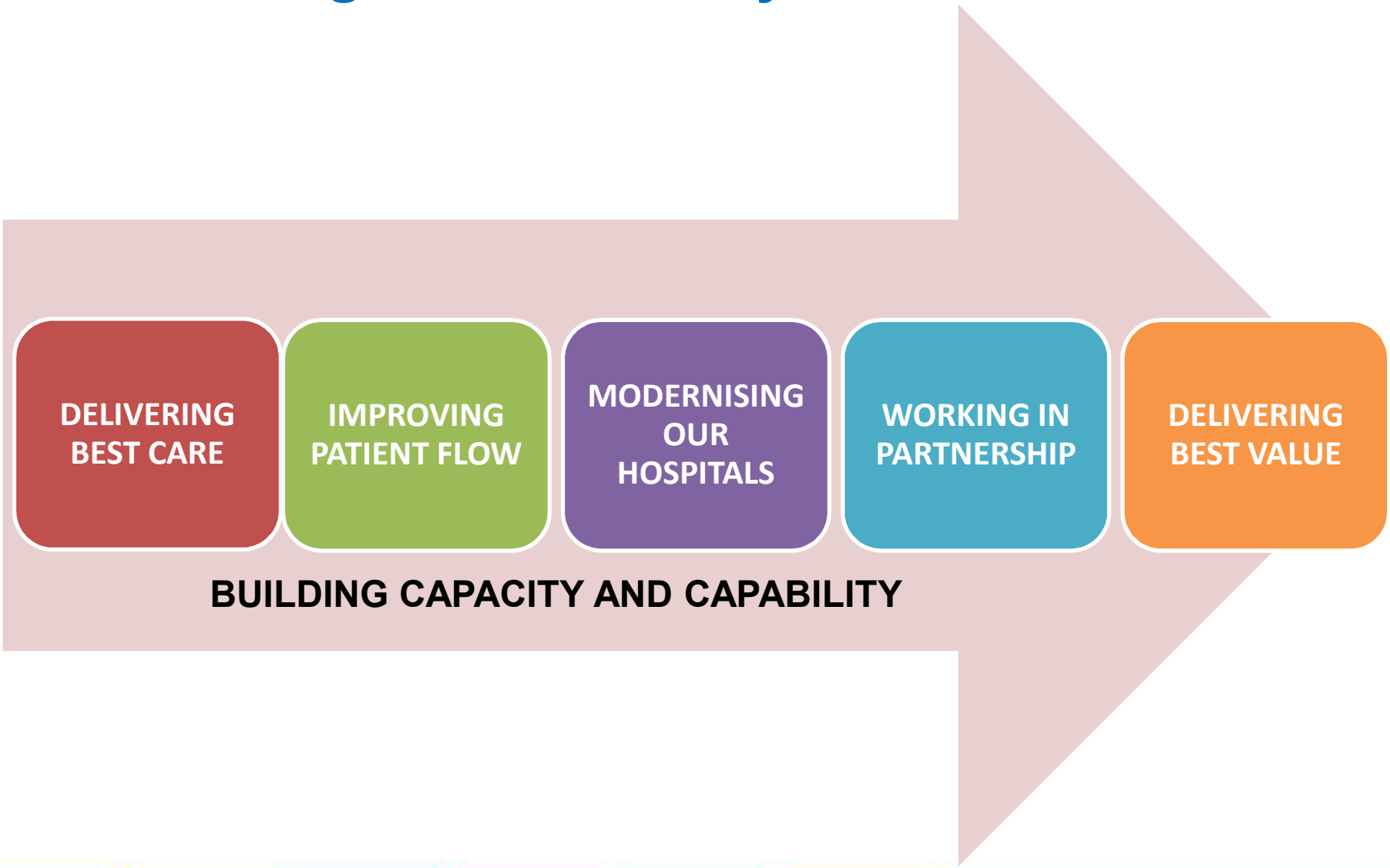
Transforming Care For Everyone

- The means through which we will deliver *Best Care For Everyone* – patients and staff
- A unifying programme of change, recognised across the Trust
- Five themes of transformational activity, delivering step changes in performance
- Clinically led, managerially supported
- The programme from which our desired culture will evolve

- **Not** business as usual or continuous improvement – both of are important and will remain

Gloucestershire Hospitals NHS
NHS Foundation Trust

Transforming Care For Everyone



LISTENING HELPING EXCELLING IMPROVING UNITING CARING BEST CARE FOR EVERYONE

Gloucestershire Hospitals NHS
NHS Foundation Trust

Transformation Priorities for 2016 - 17

DELIVERING BEST CARE

7-day services

Living with and beyond cancer

IMPROVING PATIENT FLOW

Emergency care

Trust operating model

MODERNISING OUR HOSPITALS

Strategic site development

SmartCare

WORKING IN PARTNERSHIP

Sustainability and transformation plan

University Technical College

University of Gloucestershire

DELIVERING BEST VALUE

Outpatient efficiency

Theatre transformation

BUILDING CAPACITY AND CAPABILITY

Staff engagement; Leadership development; Quality Academy

LISTENING | HELPING | EXCELLING | IMPROVING | UNITING | CARING | BEST CARE FOR EVERYONE

Gloucestershire Hospitals NHS
NHS Foundation Trust

Characteristics of our vision

Our patients are kept safe and benefit from excellent care	• Reduction in incidents which result in moderate or major harm alongside an open reporting culture, where we demonstrably learn from mistakes • The working environment supports staff to deliver efficient care pathways • Fewer deaths than expected based on an appropriate measure of mortality
Our patients recommend us as a place to be cared for	•The number of complaints about the quality of care is declining, despite it becoming easier for patients and family members to voice concerns •Patients trust us and have confidence in the safety and quality of the care we deliver •We can demonstrate our rapid adoption of good research and innovation to deliver best in class, modern care pathways
Our staff feel valued and are engaged	•Staff tell us they feel trusted and respected for their professional expertise •Staff report that "it is easier to get things done around here" and they feel involved in decisions that affect them •We are known and renowned for the quality of our education and development
It's a place that people want to work	• We have staff that are good enough to leave, but happy enough to stay •Staff are informed, communication is open and honest and staff are encouraged and supported to raise concerns and ideas, knowing they will be heard and acted upon •GHNHSFT is the healthcare employer of choice in the South West of England
We are pioneering and innovative	•Developments pioneered in our hospital are being adopted throughout the NHS •Increasing numbers of patients are able to access clinical trials •We operate within a culture of continual improvement that is a part of everyone's role
We are viewed positively by our partners	• Our partners value the contribution we make to the health community and their priorities • Effective leadership across all levels of our organisation, provide a seamless service to the patient and a collaborative approach to integrated health services for Gloucestershire

Gloucestershire Hospitals NHS
NHS Foundation Trust

What does our vision mean to you?

TRANSFORMATION BOARD
TERMS OF REFERENCE

Policy	√
Review of Policy	√
Review of Trust Area of Activity	√
Operations	**X**
Resource Management	**X**

The Transformation Board is responsible to the Trust Leadership Team for the following main functions:

- To lead, direct and coordinate the delivery of the Transforming Care Programme, in order that it achieves its goals as agreed with the Trust Leadership Team and The Main Board.

- To lead the development of an improvement culture, ensuring teams are supported to identify and deliver opportunities for small and large scale change

This will be achieved by:

1. Lead and direct the overall delivery of Transforming Care and ensure each of the six transformation themes identified addresses the key issues and challenges facing the Trust. These include –
    - Improving patient flow
    - Modernising our hospital
    - Working in partnership
    - Delivering best value
    - Delivering best care
    - Building capability and capacity

2. Ensure an appropriate programme(s) of work are developed and mobilised to achieve the aims and goals of the six themes, including appropriate measures of success and the implementation of corrective actions where appropriate

Membership & Responsibilities

Chair: Executive Director – Clinical Strategy

Vice Chair: tbc

Members:
Chief Operating Officer
Nominated Chief of Service
Nominated Divisional Operations Director
Nominated Non-Executive Director
Associate Director – Programme Management
Programme Management Team members (as required)

Invitees:
Work Stream Leads /Executive Directors who are not members may be invited to attend on an as need basis.

Officer: Programme Manager

Quorum: The Chair or Vice Chair and two other Members

Frequency of Meetings: Monthly

Reporting Line: Trust Leadership Team

Sub-Committees: Each Work Stream

Submission/Availability of Minutes:

3. Oversee the delivery and successful completion of programmes which support the delivery of Transforming Care, and the successful running of the supporting programme management team.	Minutes will be submitted to the next available Trust Leadership Team
4. To allocate the Trusts Programme Management resources to the Transformation board priorities	

FINANCIAL RECOVERY PROGRAMME – TRANSFORMATION WORKSTREAM

Service Transformation

Area	Cross Divisional
SRO	Dr Sally Pearson
Divisions	All

Context

- The Trust has 6 pillars underpinning the transformation programme; improving patient flow, modernising our hospital, working in partnership, delivering best value, delivering best care, building capability and capacity
- The following transformation schemes will enable the delivery of opportunities within the themes of our recovery plan. Some of the schemes have also been identified as STP priorities.
- Reconfiguration of services and sites will be required to deliver the transformation and will need capital developments.

Plans

FY18

- Radiology strategy
- Redesign of the MSK pathway*
- Redesign of the respiratory pathway^
- Diagnostics review*

FY19

- Introducing a new model of urgent care^
- Enhanced elective care offer
- Redesign of the circulatory pathway*
- Redesign of pathways for the management of chronic pain*
- Initiate site and service reconfiguration/development
- Capital development

^ Identified as STP priority

Actions and milestones

1. Evidence based model of urgent care available for engagement December 2016
2. Options for implementation of model for urgent care available for consultation May 2017
3. Business case for implementation of new model of urgent care September 2017
4. Integrated respiratory team in place May 2017
5. Redesigned pathway for hip, knee, shoulder and lower spine in place September 2017

£m	In year	FY18	FY19
Income	Accelerated implementation of schemes in FY18 and benefits to be realised in FY19		
Pay			
Non Pay			
Net			
Stretch			

Risks	Mitigation
Model depends on agreement with partner organisations	Early engagement and regular discussions
Expected benefits are not delivered at required pace	Detailed actions plans and benefits quantification in the next two months for delivery commencement in FY18

Resources required - Staff impact

- Resource to develop business cases
- Resource to support development of plans, activity modelling and quantification of benefits in the next two months and develop linkages with recovery plans.

MAIN BOARD – APRIL 2017
SANDFORD EDUCATION CENTRE

Report Title
INFORMATION GOVERNANCE TOOLKIT STANDARDS **FINAL ASSESSMENT**
Sponsor and Author(s)
Sponsor and presenting Director; Dr Sally Pearson: Director of Clinical Strategy Author; Thelma Turner Information Governance Lead
Executive Summary
Purpose The purpose of this report is to inform members of the Board of the final scores for our Trust's 2016/17 Information Governance (IG) Toolkit assessment. Key issues to note The IG Toolkit is an online system which allows organisations to assess themselves or be assessed against Information Governance policies and standards. It also allows members of the public to view participating organisations' IG Toolkit assessments The NHS Operating Framework requires trusts to achieve level 2 in the IG Toolkit. Level 2 is equivalent to substantial compliance. Our assessment shows us to be at level 2 with an overall rate of compliance of 77%. External assurance of this position has been provided by the Internal Audit of the evidence uploaded to demonstrate compliance with a sample of standards. Conclusions The Board should accept this report as assurance of the organisation's compliance with the required standards for Information Governance Implications and Future Action Required Progress against the audit action plan and action plans arising from any new requirements in version 15 the 2017 / 2018 toolkit will be monitored and reviewed by members of the Information Governance and Health Records Committee and the Director accountable for each standard. The 2017/18 Information Governance Report will be submitted to the Audit and Assurance Committee
Recommendations
It is recommended that the Board; 1 Endorse the final IGT assessment. 2 Give delegated authority to Dr Sally Pearson, Director of Clinical Strategy, in her capacity as Senior Information Risk Owner (SIRO) to give final approval to the improvement plans resulting from the assessment and audit 3 Accept the Information Governance Assurance Statement.

Impact Upon Strategic Objectives
Robust Information Governance arrangements support the delivery of safe care which respects the privacy and dignity of individuals, and the confidentiality of our staff.
Impact Upon Corporate Risks
The IG Toolkit requirements are related to the ISO27001 standard which defines a systematic approach to the management of information security risks.
Regulatory and/or Legal Implications
The NHS Operating Framework requires trusts to achieve level 2 in the IG Toolkit. Level 2 is equivalent to substantial compliance.
Equality & Patient Impact

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)**
					IGHR Committee
Outcome of discussion when presented to previous Committees					
Endorsed					

MAIN BOARD – APRIL 2017

INFORMATION GOVERNANCE TOOLKIT STANDARDS

FINAL ASSESSMENT

1.0 Aims

1.1 The purpose of this report is to inform members of the Board of the final scores for our Trust's 2016/17 Information Governance (IG) Toolkit assessment.

1.2 The final scores are published on the NHS Digital IG Toolkit website and following publication the scores are in the public domain.

1.3 The Board is therefore asked to endorse the formal submission and publication. Approval to proceed with submission was gained by the IG lead from the SIRO prior to the 31.03.2017 deadline.

2.0 Background

2.1 Version 14 of the Information Governance Toolkit (IGT) was released on 27/05/2016. There have been only minor changes, as the National Data Guardian is reviewing Data Security Standards the IG Toolkit has been rolled over from Version 13 to Version 14.

2.2 Each standard has to be rated on a scale of 0 to 3, with Level 0 and 1 representing non-compliance, Level 2 satisfactory and level 3 representing full compliance.

2.3 The NHS Operating Framework requires trusts to achieve level 2 in the IG Toolkit. Level 2 is equivalent to substantial compliance.

2.4 The IG Toolkit requirements are related to the ISO27001 standard which defines a systematic approach to the management of information security risks.

2.5 NHS Improvement does not formally consider our Trust's performance against the Information Governance toolkit, but instead considers this to be a contractual matter for our commissioners and, by extension, NHS Digital and the Information Commissioner.

2.6 Our Trust's submission is available to the Care Quality Commission (CQC). The IG Toolkit score is fed into CQC Quality and Risk Profiles and Key lines of enquiry:

S1: What is the track record on safety?

S3: Are there reliable systems, processes and practices in place to keep people safe and safeguarded from abuse?

Specifically: 11. Are people's individual care records written and managed in a way that keeps people safe? (This includes ensuring people's records are accurate, complete, legible, up to date and stored securely).

S4: How are risks to people who use services assessed, and their safety monitored and maintained?

Specifically: 6. How do arrangements for handovers and shift changes ensure people are safe?

E2 How are people's care and treatment outcomes monitored and how do they

compare with other services?

E5 Do staff have all the information they need to deliver effective care and treatment to people who use services?

C1 Are people treated with kindness, dignity, respect and compassion while they receive care and treatment?

Specifically: 7. Do staff respect confidentiality at all times?

W2 Does the governance framework ensure that responsibilities are clear and that quality, performance and risks are understood and managed?

3.0 Performance Overview

3.1 Each standard is led by a member of the Trust's Information Governance and Health Records Specialist Group. In addition, each standard is attributed to an executive director for monitoring and accountability.

3.2 The Information Governance and Health Records Committee oversees Information Governance strategy. The committee's approach this year has been to maintain last year's attainment levels seeking improvement compliance from level 2 to level 3 where possible.

3.3 Looking forward to 2017 /2018 and version 15 of the IG Toolkit; A significant re working of the IG toolkit is expected in preparation for adopting the General Data Protection Regulation (GDPR) in May 2018. SmartCare will also begin to enable future IG improvements by delivering enhanced security and audit functionality as well as further challenges; as the Trust continues the transition from paper based records and processes to further roll out of clinical functionality in a phased EPR implementation.

3.4 A summary of the results for each standard is available to members of the Committee in Appendix 1.

3.5 Appendix 2 provides a comparison based on last year's published scores with other Southwest acute trusts and local NHS bodies.

3.6 Our Trust's final score is 77% green.

4.0 Recommendation

It is recommended that the Board:

4.1 Endorses the final IGT assessment described under item 3 and detailed in Appendix 1.

4.2 Gives delegated authority to Dr Sally Pearson, Director of Clinical Strategy, in her capacity as Senior Information Risk Owner (SIRO) to give final approval to the improvement plans resulting from the assessment and audit which will be overseen within the terms of reference of the Trust's Information Governance and Health Records Committee and reported to the Board through the Audit and Assurance Committee.

4.3 Accepts the Information Governance Assurance Statement. This is required by all organisations submitting an IGT assessment and happens at the point of publication. The full statement can be viewed in Appendix 3.

5.0 Monitoring and Review

5.1 Performance has been reviewed by the Trust's internal auditors in January 2017. Their findings have been reflected in this year's submission and will be incorporated, where applicable, in next year's action plans. The audit action plan is detailed in Appendix 4

5.2 Progress against the audit action plan and action plans arising from any new requirements in version 15 the 2017 / 2018 toolkit will be monitored and reviewed by members of the Information Governance and Health Records Committee and the Director accountable for each standard.

Author:

Thelma Turner

Lead for Information Governance

Presenting Director:

Dr Sally Pearson

Director of Clinical Strategy

March 2017

Appendix 1

Information Governance Toolkit Version 14 – Final Assessment Report

April 2017

Version 14 No.	Description	Position at end Mar 2016	Target for end Mar 2017	Position at the end of March 2017	Lead	Director
Information Governance Management						
14-101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	3	3	3	Thelma Turner	Sally Pearson
14-105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	2	2	2	Thelma Turner	Sally Pearson
14-110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	2	2	2	Angela Cox	Stuart Diggles

14-111	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	2	2	2	Emma Mudie	Dave Smith
14-112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	3	3	3	Julie Connell	Dave Smith
Confidentiality and Data Protection Assurance						
14-200	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	2	2	2	Caroline Pennels and Thelma Turner	Sean Elyan
14-201	Staff are provided with clear guidance on keeping personal information secure and on respecting the confidentiality of service users The organisation ensures that arrangements are in place to support and promote information sharing for coordinated and integrated care, and staff are provided with clear guidance on sharing information for care in an effective, secure and safe manner	2	2	2	Thelma Turner	Sally Pearson
14-202	Consent is appropriately sought before personal information is used in ways that do not directly contribute to the delivery of care services and objections to the disclosure of confidential personal information are appropriately respected Confidential personal information is only shared and used in a lawful manner and objections to the disclosure or use of this information are appropriately respected	2	2	2	Lynne McEwan and Caroline Pennels	Sean Elyan

14-203	Individuals are informed about the proposed uses of their personal information Patients, service users and the public understand how personal information is used and shared for both direct and non-direct care, and are fully informed of their rights in relation to such use	2	2	2	Suzie Cro	Sally Pearson
14-205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	2	2	2	Caroline Pennels	Sean Elyan
14-206	There are appropriate confidentiality audit procedures to monitor access to confidential personal information Staff access to confidential personal information is monitored and audited. Where care records are held electronically, audit trail details about access to a record can be made available to the individual concerned on request	2	2	2	Debbie Windle Thelma Turner	Sally Pearson
14-207	Where required, protocols governing the routine sharing of personal information have been agreed with other organisations	2	2	2	Thelma Turner Caroline Pennels	Sally Pearson
14-209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	3	3	3	Caroline Pennels	Sean Elyan

14-210	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation, information quality and confidentiality and data protection requirements	2	2	2	Rob Holmes	Sally Pearson
Information Security Assurance						
14-300	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	3	3	3	Thelma Turner	Sally Pearson
14-301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	2	2	2	Thelma Turner	Sally Pearson
14-302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	2	3	3	Thelma Turner	Sally Pearson
14-303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	2	2	2	Mandy Newbould	Dave Smith
14-304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	2	2	2	Mandy Newbould	Dave Smith
14-305	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	2	2	2	Rob Holmes Debbie Windle	Dave Smith
14-307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy	2	2	2	Thelma Turner	Sally Pearson

	and information risk management strategy					
14-308	All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	2	2	2	Thelma Turner	Sally Pearson
14-309	Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	2	2	2	Thelma Turner	Sally Pearson
14-310	Procedures are in place to prevent information processing being interrupted or disrupted through equipment failure, environmental hazard or human error	2	2	3	Rob Holmes	Sally Pearson
14-311	Information Assets with computer components are capable of the rapid detection, isolation and removal of malicious code and unauthorised mobile code	3	3	3	Rob Holmes	Sally Pearson
14-313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	2	2	2	Rob Holmes	Sally Pearson
14-314	Policy and procedures ensure that mobile computing and teleworking are secure	2	2	2	Rob Holmes	Sally Pearson
14-323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	2	2	2	Thelma Turner	Sally Pearson
14-324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	2	2	2	Thelma Turner Elaine McWhinnie	Sally Pearson
Clinical Information Assurance						
14-400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	2	3	3	Thelma Turner	Sally Pearson

14-401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	2	2	2	Debbie Windle	Stuart Diggles
14-402	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	3	3	3	Debbie Windle Elaine McWhinnie	Stuart Diggles
14-404	A multi-professional audit of clinical records across all specialties has been undertaken	2	3	2	Alex Purcell Thelma Turner	Natasha Swinscoe
14-406	Procedures are in place for monitoring the availability of paper health/care records and tracing missing records	2	2	2	Thelma Turner	Natasha Swinscoe
Secondary Use Assurance						
14-501	National data definitions, standards, values and validation programmes are incorporated within key systems and local documentation is updated as standards develop	2	2	2	Elaine McWhinnie	Stuart Diggles
14-502	External data quality reports are used for monitoring and improving data quality	3	3	3	Elaine McWhinnie	Stuart Diggles

14-504	Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained	3	3	3	Elaine McWhinnie	Stuart Diggles
14-505	A robust programme of internal and external data quality/clinical coding audit in line with the requirements of the Audit Commission and NHS Connecting for Health is in place	2	2	2	Elaine McWhinnie	Stuart Diggles
14-506	A documented procedure and a regular audit cycle for accuracy checks on service user data is in place	3	3	3	Elaine McWhinnie	Stuart Diggles
14-507	The Completeness and Validity check for data has been completed and passed	3	3	3	Elaine McWhinnie	Stuart Diggles
14-508	Clinical/care staff are involved in validating information derived from the recording of clinical/care activity	2	2	2	Elaine McWhinnie	Stuart Diggles
14-510	Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national standards	3	2	2	Elaine McWhinnie	Stuart Diggles
Corporate Information Assurance						
14-601	Documented and implemented procedures are in place for the effective management of corporate records	2	2	2	Caroline Pennels (Anna)	Sally Pearson
14-603	Documented and publicly available procedures are in place to ensure compliance with the Freedom of Information Act 2000	3	3	3	Caroline Pennels	Andrew Seaton
14-604	As part of the information lifecycle management strategy, an audit of corporate records has been undertaken	2	2	2	Caroline Pennels (Anna)	Sally Pearson

Total Percentage Score	**75%**	**77%**	**77%**

Appendix 2

Information Governance Toolkit Version 13 (2015 – 16)

Southwest Acute Trusts and Gloucestershire Final Score Comparison

This section is provided to enable members of the Board to compare our Trust's performance with similar organisations in the Southwest and with other NHS bodies in Gloucestershire. The table makes use of last year's published scores which are now in the public domain.

The red (unsatisfactory) and green (satisfactory) ratings are based on the IG Toolkit requirement for all relevant standards to be graded at level 2 or higher.

Information Governance Toolkit Version 13 (previous year) – Southwest Acute Trust Final Scores

This information is publicly available at www.igt.hscic.nhs.uk

NACS Code	Organisation	2015	2016
	South West Acute	**v12**	**v13**
RD1	Royal United Hospital Bath NHS Trust	89%	88%
RVJ	North Bristol NHS Trust	67%	Not Published
RA9	South Devon Healthcare NHS Foundation Trust	90%	84%
RBA	Taunton And Somerset NHS Foundation Trust	88%	90%
RA7	University Hospitals Bristol NHS Foundation Trust	66%	72%
RA4	Yeovil District Hospital NHS Foundation Trust	81%	79%
RBD	Dorset County Hospitals NHS Foundation Trust	89%	92%
RNZ	Salisbury NHS Foundation Trust	85%	81%
RN3	Great Western Hospitals NHS Foundation Trust	77%	77%
RTE	**Gloucestershire Hospitals NHS Foundation Trust**	**77%**	**75%**
RK9	Plymouth Hospitals NHS Trust	75%	74%
RDZ	The Royal Bournemouth And Christchurch Hospitals NHS Foundation Trust	37%	67%
REF	Royal Cornwall Hospitals NHS Trust	73%	72%
RA3	Weston Area Health NHS Trust	73%	74%
RH8	Royal Devon And Exeter NHS Foundation Trust	75%	74%
RBZ	Northern Devon Healthcare NHS Trust	68%	78%
RD3	Poole Hospitals NHS Trust	73%	84%
	Organisation achieved level 2 or higher in all applicable standards		
	Organisation with one or more standards at level 1 or lower – i.e. not IGT compliant		

Information Governance Toolkit Version 12 (previous year) – Gloucestershire Organisations Final Scores

This information is publicly available at www.igt.hscic.nhs.uk

NACS Code	Organisation	2015	2016
	Gloucestershire		
RTQ	2gether NHS Foundation Trust	84%	84%
RTE	**Gloucestershire Hospitals NHS Foundation Trust**	**77%**	**75%**
V118	Gloucestershire County Council	79%	
0AE	Central Southern Commissioning Support Unit	77%	
0DF	NHS South, Central and West Commissioning Support Unit		81%
R1J	Gloucestershire Care Services NHS Trust	74%	55%
11M	NHS Gloucestershire CCG	68%	67%
12A	NHS South Gloucestershire CCG	74%	77%
AAH	Tetbury Hospital Trust Limited	66%	66%
	Organisation achieved level 2 or higher in all applicable standards		
	Organisation with one or more standards at level 1 or lower – i.e. not IGT compliant		

Information Governance Assurance Statement

Version 4, 10/06/2014

1. All organisations that have either direct or indirect access to HSCIC services[1], including N3, must complete an annual Information Governance Toolkit Assessment and agree to the following additional terms and conditions. Where the Information Governance Toolkit requirements are not met to an appropriate standard (minimum level 2), an action plan for making the necessary improvements must be agreed with the HSCIC External Information Governance team or with an alternative body designated by the Department of Health (e.g. a commissioning organisation).
2. All organisations providing indirect access[2] to HSCIC services for other organisations (approved N3 link recipients), are required to provide the Department of Health, on request, with details of all organisations that have been permitted access, the business justification and the controls applied, and must maintain a local log of organisations to which they have allowed access to N3. This log should be reviewed regularly by the organisation and unnecessary access rights removed. The Department of Health or an alternative body designated by the Department of Health may request sight of these logs in order to facilitate or aid audit or investigations.
3. The approved N3 link recipient is responsible for their compliance with IG policies and procedures and may request authorisation by the Department of Health to monitor and enforce the compliance and conduct of subsidiary connected organisations and suppliers to ensure that all key information governance requirements are met.
4. The use of HSCIC Services should be conducted to support NHS business activities that contribute to the care of patients. Usage of individual services must be conducted inline with those individual services requirements and acceptable use policies. The use of HSCIC provided infrastructure or services for unauthorised advertising or other non-healthcare related activity is expressly forbidden.
5. All threats or security events affecting or potentially affecting the security of HSCIC provided infrastructure or services must be immediately reported via the HSCIC incident reporting arrangements or via local security incident procedures where applicable.
6. All infrastructure and connections to other systems and networks which are not covered by an approved Information Governance Toolkit Assessment and agreement to this IG Assurance Statement must be segregated or isolated from IGT covered infrastructure and connections such that IGT covered infrastructure and connections, or HSCIC Services are not put at risk. A Logical Connection Architecture diagram must be maintained by network managers in accordance with HSCIC guidance and must be provided for Department of Health review on request.
7. Organisations with access to HSCIC Services shall ensure that they meet the requirements of the Department of Health policy on person identifiable data

[1] HSCIC Services include the N3 network and other applications or services provided by HSCIC, e.g. the NHS Spine Service, NHSmail, Choose and Book (and in future the NHS e-Referral Service).
[2] Access to the N3 network or HSCIC Services via another organisation or gateway

leaving England, or being viewed from overseas. A copy of the Information Governance Offshore Support Requirements applicable to those accessing HSCIC Services is available on request or can be downloaded from http://systems.hscic.gov.uk/infogov/igsoc/links/index_html. The agreement of the Department to this limited support or exceptionally to more extensive processing must be explicitly obtained.

8. Where another network is connected to N3, only services that have been previously considered and approved by the Department of Health as appropriate for that network are permissible. Requests for new or changed services must be provided to the Department for consideration.
9. Organisations may not create or establish any onward connections to the N3 Network or HSCIC provided services from systems and networks which are not covered by an approved Information Governance Toolkit Assessment and agreement to this IG Assurance Statement.
10. The approved organisation shall allow the Department of Health, or its representatives, to carry out ad-hoc on-site audits, and to review any/all evidence that supports the Information Governance Toolkit Assessment, as necessary to confirm compliance with these terms and conditions and with the standards set out in the Information Governance Toolkit.

Information Governance Assurance Statement

I confirm that I have read, understood and agree to comply with the additional terms and conditions that apply to organisations that have access to HSCIC services and acknowledge that failure to maintain compliance may result in the withdrawal of HSCIC services.

Extract from PWC Internal Audit Report 2016/2017 Information Governance - Summary of Findings & Actions

	Finding	Rating	Agreed Action	Action Owner	Executive Owner	Target Date
1	***Toolkit Evidence Issues***	Medium	We will review all evidence uploaded to the Toolkit to ensure that they are up-to-date and available. The review will involve: ensuring clear review dates are included on documentation that relates to a previous year but is not due for review, and removing evidence items relating to previous periods which are no longer relevant. The review will also involve replacing Intranet links with directly uploaded documents to the Toolkit.	IGHR Committee	Sally Pearson	30/09/17
2	***Requirement 14-111 Evidence Issues***	Low	The evidence for both Level 1c (Code of Confidentiality) and Level 2a(Disciplinary Policy) will be up-to-date copies, which will be directly uploaded to the Toolkit.	IGHR Committee	Sally Pearson	31/03/17
3	***Requirement 14-504 Evidence Issue***	Low	The evidence for Level 2c(Trust summary showing information on a month on month basis regarding trends and variations) will be an up-to-date copy, which will be directly uploaded to the Toolkit.	IGHR Committee	Sally Pearson	31/03/17

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – APRIL 2017

Report Title
Quarterly Report on Safe Working Hours for Doctors and Dentists in Training.
Sponsor and Author(s)
Dr Sean Elyan, Medical Director Dr Russell Peek, Guardian of Safe Working Hours
Executive Summary

Purpose

New terms and conditions of service (TCS) for junior doctors were introduced in August 2016. Under these TCS, the Trust provides an exception reporting process to allow junior doctors to report working hours or educational opportunities that vary from those set out in their work schedule. The Guardian of Safe Working Hours has oversight of exception reporting and assures the board of compliance with safe working hours limits. The guardian reports at quarterly to The trust Board.

Key issues to note

- This paper summarises 133 exception reports generated since December 2016. These exception reports highlight particular problems with working hours in the department of neurology.

- The current system introduces administrative delay into the process of exception management. This makes it difficult to provide robust assurance on safe working hours. The risk will increase as more doctors move onto the new terms and conditions and the requirement for data handling increases. However, by the end of April the Trust will have established a computer based system to assist in the management of these growing numbers though further administrative support is required and is being sourced through the medical staffing team.

Implications and Future Action Required

- One department needs to review work schedules to ensure they accurately reflect the expected pattern of work. The Director of Medical Education and Guardian are due to meet representatives from the service to explore the issues and provide support in seeking solutions.
- The Allocate module for junior doctor exception reporting is being set up with a view to go line in May 2017
- Administrative support to the Guardian is being established.

Recommendations
The Board is invited to receive this report as assurance that the Trust is compliant with the requirement for oversight of junior doctor working practices and that plans are in place to address areas of concern, notably the working practices of doctors in training within the neurology service.
Impact Upon Strategic Objectives
Our Services: To improve the health and wellbeing of our staff, patients and the wider community – need to ensure work schedules promote safe working hours. Our Staff: To redesign our workforce – need to ensure that work schedules are used to promote efficient workforce planning.

Our Business: Harnessing the benefits of information technology – potential to reduce administration costs through using an exception reporting tool that is fit for purpose.
Impact Upon Corporate Risks
Supports the Trust's efforts to control and manage the risk of staff working excessive hours
Regulatory and/or Legal Implications
The 2016 Junior Doctor Terms and Conditions of Service set out requirements for work scheduling and exception reporting.
Equality & Patient Impact
Significant staff fatigue is a hazard to patients and to staff and the Guardian's activity are targeted are reducing the risk of this impact

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)**
Outcome of discussion when presented to previous Committees					

MAIN BOARD

Quarterly Report on Safe Working Hours for Doctors and Dentists in Training.

Executive summary

This paper summarises 105 new exception reports and progress with 28 outstanding exceptions from the last quarterly report in January.

Exception reports confirm ongoing problems with junior doctor working hours in one department. Cumulative exceptions will result in a fine to the department for breach of hours regulations. A trainee work schedule review has been carried out. The department has suggested some adjustment to working expectations in response to the issues identified. The Director of Medical Education and Guardian are due to meet with representatives from the department soon to support them in finding long term solutions.

The current exception reporting system is labour intensive, introducing delays in resolution of exceptions. It is difficult to give timely assurance of safe working hours. The risk will increase as more doctors move onto the new terms and conditions and the requirement for data handling increases. In May 2017, the Trust will be in a position to introduce a software system to support this and work is underway to identify additional administrative support for this function and the Guardian.

Introduction

New terms and conditions of service (TCS) for junior doctors were introduced in August 2016. Under these TCS, the trust provides an exception reporting process to allow junior doctors to report working hours or educational opportunities that vary from those set out in their work schedule. The guardian of safe working hours oversees exception reporting and assures the board of compliance with safe working hours limits. The guardian reports at least quarterly to the trust board.

Foundation year 1 (F1) doctors and some year 2 (F2) doctors moved to the new TCS in December 2016. There is a rolling schedule for trainees in other programmes to move over to the new TCS in 2017. Most trainees will be on the 2016 TCS after August 2017.

Doctors in training may raise an exception report whenever working hours breach those set out in their personalised work schedule. An exception report is initially reviewed and addressed by the educational supervisor or nominated deputy. If appropriate, time off in lieu or payment for extra hours worked is agreed. In certain circumstances, a fine may be levied for exceeding safe working limits (see appendix for links to rota rules and reporting pathways).

The structure of this report follows guidance provided by NHS Employers.

High level data

Number of doctors / dentists in training (total):	390
Number of doctors / dentists in training on 2016 TCS (to date):	76
Amount of time available in job plan for guardian:	To be confirmed
Admin support:	none
Amount of job-planned time for educational supervisors: (first/additional trainees)	0.25/0.125 PAs.

Exception reports (with regard to working hours)

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions Closed	No. exceptions outstanding
General Surgery	7	15	17	5
Upper GI surgery	0	14	14	0
General/old age Medicine	1	2	3	0
Stroke	3	5	8	0
Neurology	13	51	50	14
Cardiology	2	0	2	0
Respiratory	2	2	4	0
Endocrinology	0	4	4	0
Oncology	0	4	4	0
Paediatrics	0	6	0	6
Sexual Health	0	1	1	0
Emergency Department	0	1	1	0
Total	28	105	108	25

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	24	86	91	19
F2	3	11	14	0
CT1-2 / ST1-2	1	2	3	0
ST3-8	0	6	0	6
Total	28	105	108	25

Exception reports by division				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Surgery	7	29	31	5
Medicine	21	69	76	14
Women and Children	0	6	0	6
Diagnostic / specialties	0	1	1	0
Total	28	105	108	25

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	*	*	*	19
F2	*	*	*	0
CT1-2 / ST1-2	*	*	*	0
ST3-8	*	*	*	6
Total	*	*	*	25

*Current reporting tool is not sensitive enough to identify response time

Work schedule reviews
1 trainee has undergone a work schedule review after a pattern of repeat exception reporting.

Locum bookings
The quarterly guardian report will ordinarily include details of locum bookings during the period under consideration. This information was not available to the guardian at the time of compiling this report. Future reports should include locum work undertaken by doctors employed by Gloucestershire Hospitals NHS Foundation Trust and by external agency staff.

Vacancies

Junior Doctor Vacancies by department (January 2017)					
Department	F1	F2	ST 1-2	ST 3-8	Additional training and trust grade vacancies
Emergency Dept			1		1 trust doctor vacancy
Anaesthetics					6 gaps at trust doctor and specialty grade level
ENT					1 trust doctor vacancy
General Medicine	1		1.5	5	23 trust doctor vacancies
General Surgery					2 trust doctor vacancies
Haematology					
Histopathology			1		
Obs & Gynae	1			1	
Oncology			2		
Ophthalmology					1 trust doctor vacancy
Oral & Max Fax			1		
Trauma & Ortho					3 trust doctor vacancies
Paediatrics			1	2	
Primary Care					
Psychiatry					
Sexual Health					
Total	2		7.5	8	37

Fines
One fine will be due after review of working hours over a rota cycle (junior doctors rotate placements on April 5th). This will be for breach of the 48-hour average working week rule.

Fines by department		
Department	Number of fines levied	Value of fines levied
Neurology	1 due at completion of rota cycle	To be confirmed
Total		

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter

Qualitative information
The IT department has produced a local exception reporting system. Junior doctors have reported difficulty accessing the system to make reports. The system does not automatically notify educational supervisors, the Guardian or Director of Medical Education when a report is made. The system requires administrative support to pass reports to the appropriate

supervisor and follow up to confirm when reports have been managed and closed. It does not automatically identify potential safety breaches or collate exception report data for management and oversight.

Educational and clinical supervisors are becoming more experienced with exception reporting and there has been improvement in reviewing and closing exception reports.

A Junior Doctors Forum meets quarterly to scrutinise the work of the guardian and advise on the distribution of any monies accrued through fines. I have sought broader representation for junior doctors on the forum by inviting doctors to nominate themselves to join the forum. 4 trainees have expressed an interest in representing peers working in their clinical areas.

In some departments, the work schedule is not representative of the usual expected hours of work.

Issues arising
64 of 133 (48%) exception reports arise from a single department. The work schedule has been reviewed, but problems with excessive working hours remain. The Guardian and DME are due to meet with representatives of the department in April to discuss the pattern of exceptions and support the team in finding solutions. Trainees are in contact with the guardian and aware of support available if issues cannot be resolved quickly.

58 exceptions have been resolved by arranging time off in lieu of additional hours worked. 50 exceptions have been resolved by payment for additional hours.

The current exception reporting system does not allow rapid identification or analysis of reporting patterns. There is a risk of delayed recognition of unsafe working hours.

Actions taken to resolve issues
Training sessions have been arranged for doctors moving to the new terms and conditions, including how to use the exception reporting system. Drop in sessions were arranged for educational and clinical supervisors to prepare them for managing exception reports. We plan to repeat these sessions as more doctors move over to the new TCS and if a new exception reporting tool is introduced.

The Allocate software system will be available for exception reporting from May 2017. In discussions with other guardians, it is clear that there are some functionality issues with this system (and the alternatives). However, it does automate the process of notifying supervisors of exception reports and recording resolution. It also provides a dashboard feature for guardians and Directors of Medical Education to overview exception reports.

Summary
There have been 133 exception reports made since trainees moved onto the new TCS in December. Nearly half of all reports arise from one department, where working patterns differ significantly from published work schedules. The number of exception reports remains within the range reported by other guardians nationwide.

Effective execution of the Guardian function requires an exception reporting tool that is fit for purpose and adequately supported within the administrative function of the Medical Staffing Team.

Author: **Dr Russell Peek, Guardian of Safe Working Hours**

Presenting Director: **Dr Sean Elyan**

Date 29/03/2017

Appendices

Link to rota rules factsheet:
http://www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/Factsheet%20on%20rota%20rules%20August%202016%20v2.pdf

Link to exception reporting flow chart (safe working hours):
http://www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/Safe%20working%20flow%20chart.pdf

ITEM 17

ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

DISCUSSION

ITEM 18

GOVERNOR QUESTIONS

Peter Lachecki
Chair

ITEM 19

STAFF QUESTIONS

Peter Lachecki
Chair

ITEM 20

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 and alternate between the Sandford Education Centre in Cheltenham and the Redwood Education Centre at Gloucestershire Royal Hospital. 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