GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on **Friday 26th May 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

19th May 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 10th May 2017	**PAPER**	**To approve**	09:32
4.	Matters Arising	**PAPER**	**To note**	09:35
5.	Annual Accounts 2016/17	**PAPER** (Sarah Stansfield)	**To approve**	09:40
6.	Quality Report	**PAPER** (Sally Pearson)	**To approve**	10:00
7.	Items for the Next Meeting and Any Other Business	**DISCUSSION** (All)	**To Note**	10:20

	Governor Questions		
8.	Governors Questions – A period of 10 minutes will be permitted for Governors to ask questions	**To Discuss**	10:25
	Staff Questions		
9.	A period of 10 minutes will be provided to respond to questions submitted by members of staff	**To Discuss**	10:35
	Public Questions		
10.	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**	10:45 10:55

Date of the next meeting: The next meeting of the Main Board will take place at on **Wednesday 7th June 2017** in the **Subscription Rooms, George Street, Stroud** at **9.00 am. PLEASE NOTE VENUE FOR THIS MEETING.**

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

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
	Arshiya Khan, 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 WEDNESDAY 10 MAY 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
	Maggie Arnold	Director of Nursing
	Natasha Swinscoe	Interim Chief Operating Officer
	Dave Smith	Director of Human Resources and Organisational Development
	Sarah Stansfield	Acting Director of Finance
	Tracey Barber	Non-Executive Director
	Dr Claire Feehily	Non-Executive Director
	Tony Foster	Non-Executive Director
	Rob Graves	Non-Executive Director
	Keith Norton	Non-Executive Director
APOLOGIES	Dr Sally Pearson	Director of Clinical Strategy
IN ATTENDANCE	Martin Wood	Trust Secretary
PUBLIC/PRESS	Craig Macfarlane	Head of Communications
	One Governor, three members of the public and two members of staff.	

The Chair welcomed Governors, the public and staff to the meeting.

101/17 PATIENT STORY **ACTIONS**

(Lucy Mathieson and Suzie Cro, Head of Patient Experience, attended the meeting for the presentation of this item)

Lucy Mathieson presented her patient story on her experience in contacting the Out of Hours service and her attendance at the Emergency Department. She described her care in the Emergency Department as impeccable despite waiting on a trolley in the corridor – she felt safe, well cared for and there was a dedicated nurse. She was transferred to the Ambulatory Care Unit for a short period of time and on to another ward where she was not greeted by the Ward Manager. Her experience on that ward was far from satisfactory. She expressed concerns about the ward environment, staff attitude and culture, communication and responsiveness and noted that she had not received a discharge summary.

Lucy subsequently visited a friend in hospital where there was a poignant contrast to the care provided to them when compared to her stay. Nothing was too much trouble for staff, with no sense of patients being a nuisance. Lucy described this as the best care

ever. The ward culture was incredible with a very caring attitude. She noted this to be an oncology ward.

The Head of Patient Experience said that she has visited the ward and organised a quality review and patient experience review of both wards. The two wards would "buddy" each other with the aim of driving improvement.

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

(Mr Graves joined the meeting)

- The Chief Executive asked why it took a patient to inform us of the issues as she was aware we had many different means of detecting such shortcomings ourselves including Matron walkabouts and cleanliness audits. In response the Nursing Director said that the hygiene issues had already been picked up with the Infection Control Team and through the Patient Lead Assessments of the Care Environment (PLACE) audits which were undertaken recently. Environment issues were raised on the audits by patients and the Nursing Director immediately contacted Estates and Facilities Division to remedy. However, she stated that Lucy's experience was of great concern and she has asked that the matron and Divisional Nursing Director do a "deep dive" into the issues raised through Lucy's experience.
- The Medical Director apologised for the absence of hand gel at the end of Lucy's bed which was inexcusable and he is working with the Nursing Director and all doctors to raise this when the containers are empty. He emphasised that it is as much doctors responsibility to support a positive patient experience as it is nurses and therapists.
- The Director of Human Resources and Organisational Development said that there should be a video of a ward round to demonstrate what good looks like.
- Dr Feehily asked for a sense of how many other patients had not received discharge summaries and whether this raised safety issues. In response the Chief Executive said that there are TrackCare challenges to electronic summary production and currently around 70% of summaries are sent electronically but all patients should leave with a printed summary to give to their GP. She asked the Medical Director to investigate Lucy's experience. **SE**
- In response to questions from Ms Barber and Mr Foster about learning for the Board, the Chief Executive said that an update would be presented to the Board, three months following the story so the Board were aware of the steps taken to improve future patient experience. **SC (MW to note for workplan)**
- Mr Norton sought further information on the time taken to escalate hygiene issues. In response, the Nursing Director said that the Infection Control Committee escalated the issues on the day that they became aware. There were trends that the area was not meeting standards. She apologised for the poor standard of the toilets.

- Lucy offered to work with SC on the action plan.

The Chair thanked Lucy for her patient story. [09:30]

102/17 DECLARATIONS OF INTEREST

There were none.

103/17 MINUTES OF THE MEETING HELD ON 12 APRIL 2017

RESOLVED: That the minutes of the meeting held on 12 April 2017 were agreed as a correct record and signed by the Chair.

Mr Graves referred to the Performance Management Framework and the inclusion of leading indicators and underlying trends. The Chief Executive responded saying that this has been captured and will form a suite of early warning indicators in the developing report.

The Chief Executive said that the Quality and Performance Committee should be informed of the evidence for supporting the decision to close the TrackCare tracker.

NS/AK
(MW to note for Agenda)

104/17 MATTERS ARISING

072/17 MINUTES OF THE MEETING OF THE QUALITY AND PERFORMANCE COMMITTEE HELD ON 22 FEBRUARY 2017

The minutes of the meeting of the Quality and Performance Committee held on 22 February 2017 be deferred to the next meeting. *These minutes appeared later in the Agenda. Completed.*

073/17 FINANCIAL PERFORMANCE REPORT – CAPITAL INVESTMENT PROGRAMME 2017/18

The Acting Finance Director said that the plan is to conclude the asset audit by mid-summer 2017 and then RAG the assets to determine how best to use the Medical Equipment Fund monies. It is proposed to pre plan for 50% of the monies with 50% being for ad hoc assets. It was agreed that the Audit and Assurance Committee should receive an update following the audit. *This has been included in the work plan for the Audit and Assurance Committee. Completed as a Matter Arising.*

078/17 SAFETY ALERT – NASOGASTRIC TUBE REPLACEMENT – ASSURANCE REPORT

The audit will be undertaken in August 2017 with the results being presented to the Senior Nursing Committee and the Quality and Performance Committee. *This has been included in the work plan for the Quality and Performance Committee. Completed as a Matter Arising.* [09:35]

105/17 CHIEF EXECUTIVE'S REPORT

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

- The Emergency Care Improvement Support Team (ECIST) visited our Trust earlier in the week to provide fresh ideas for our Emergency Department improvement efforts. Their report, when received, will be shared with staff.
- TrackCare remains a challenge and the executive is considering engaging third party support to accelerate the scale and pace of recovery.
- Mathew Swindells, National Director of Commissioning had visited our health and care system, following an invitation, as part of our collective efforts to promote the positive things going on in Gloucestershire.
- Board members were invited to make their pledge as part of Gloucestershire County Council's One You Pledge campaign which will be published once made.
- The Chief Executive thanked, Maggie Arnold, Nursing Director, who had announced her retirement from September 2017 for her outstanding contribution to the NHS and our Trust
- Publication of the CQC report is now likely to be June 2017.
- Publication of the key findings of the independent Financial Governance Review Report is impacted by the Purdah period and will not take place before the General Election.

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

- Dr Feehily asked whether there are any messages for the Board and Assurance Committees following the ECIST visit. The Chief Executive said in response that whilst the written report is awaited no new issues had been identified which the Trust is not already aware. They re-affirmed our focus on leadership and culture alongside those more transactional areas which will give the greatest operational improvement. The report will be presented to the Emergency Care Programme Board when received.
- The Director of Human Resources and Organisational Development said that he has met Dr Feehily and the Head of Patient Experience and the Raising Concerns Group is to be reconstituted. There remains the issue on how the Board is best sighted on this topic and a similar reporting arrangement may be required to that for the Guardian of Safe Working Hours.
- The Director of Human Resources and Organisational Development referred to the various national campaigns taking place during the week of the Board meeting and on subsequent occasions and it is important for the organisation to take a view on those which it will take promote and engage with. DL asked the Head of Communications to create a campaign planner to aid with oversight and prioritisation.
- The Chair referred to the visit by Mathew Swindells and

- asked DL for a view on his perspective that our Trust is holding back partner organisations form progressing the Accountable Care System model (ACS). The Chief Executive said that our partners appear to have a positive view of the leadership of the Trust and the efforts being made to address the concerns in respect of finance and performance and in her experience she found them nothing other than supportive. Rob Graves asked whether Board to Board meetings would be beneficial to reinforce partnership working. The Chief Executive said that the Gloucestershire Strategic Forum is the oversight Board for the STP which brings together the five CEOs and Chairs but she stated that thought was being given to how to involve wider Board members in the agenda. The Chair commented that whilst he was no adverse to Board to Board meetings, there needed to be clarity of purpose and desired outcomes.

The Chair thanked the Chief Executive for her report.

RESOLVED: That the report be noted. [09:56]

106/17 QUALITY AND PERFORMANCE REPORT

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 March 2017 for the financial year 2016/17. The key points to note were that 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 77.86% in March (83% in April) which remained below the trajectory. The 15 minute triage standard continues to improve and in March was 80.2% and further work is underway to achieve the 95% standard. The main focus is on improving the 60 minute to assessment standard. Performance against the Patient Safety Checklist remains low and is a cause for concern. This is also a focus for improvement. Unvalidated 31 day cancer performance has improved in March. Unvalidated 62 days cancer performance improved slightly in March but deteriorated for Quarter four. The Trust is on target to meet the standard in July 2017. The provisional date for recommencing the submitting of Referral To Treatment data is June 2017 based on the data for May 2017. The Trust reported four 52 week breaches in March 2017 with 11 in April and a similar number expected in May 2017 when the expectation was nil in May 2017. The Chief Executive said that the Quality and Performance Committee should understand the reasons for the poor performance and poor forecasting.

NS/AK
(MW to note for Agenda)

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

- Mr Norton referred to our Trust not meeting any of the four national waiting trajectories and asked if there was any

impact on patient safety. In response, the Chief Executive said that there is currently no evidence of patient harm and harm reviews continue to be undertaken for all patients with excessive delays but poor patient experience associated with excessive waiting is a significant issue. Ms Barber asked if patient communication is as good as it can be when the performance standards are not being met. In response the Chief Executive said that there was scope to improve our communication with patients both in respect of letters and verbal communication and this was being addressed through the Outpatient Improvement Group. Dr Feehily asked how patient experience could be more visible at the Board. In response, the Chief Executive said that the Patient Experience Report is presented quarterly to the Quality and Performance Committee and assurance and any issues are presented in the Committee Chair's report to Board.

- Dr Feehily referred to the 52 week breaches and asked if there was a sudden response when the 52 week timeframe is reached. In response the Chief Executive said that the 52 week breaches trigger is a national reporting requirement and patient focus starts on referral and escalation starts at 35 weeks however, ongoing clinical oversight of all patients waiting over 18 week may result in a patient's care being expedited if appropriate. The most common cause of 52 week breaches was when patients were waiting for a procedure which very few surgeons are able to carry out. Dr Feehily asked how the Patient Safety Checklist mitigates against poor patient experience. The Interim Chief Operating Officer said that the check list prompts staff to undertake a range of activities including offering patients refreshment for example. It is good practice for the checklist to be undertaken on an hourly basis and progress is being made for the checklist to be embedded in Departments. Use of the checklist in the Emergency Department has seen an improvement in recent months. The Chief Executive asked that the 15 minutes to triage and the Patient Safety Checklist be added to the Performance Framework report. **NS/AK**
- In response to a question from Mr Foster about the term "arrears" in the report, the Chief Executive said that this pertained to data that, due to the validation process, did not appear in the reporting period but in arrears and was not related to issues with Trakcare though there were still gaps in reporting which were. The Chair said that it will be useful for the Quality and Performance Committee to be sighted on the programme to recommence reporting with an understanding of the enablers to hit the required performance standards. **NS/AK**
- The Chair referred to the commentary on Acute Kidney Infection (AKI) that trainees on both sites are being stretched and we have to look at smarter ways of working to improve patient safety and how we respond to primary care. The Medical Director agreed to review the commentary as he did not believe this was the factor driving

the deterioration in performance.

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 fully understand the current levels of poor performance and have action plans to improve this position.

TRUST RISK REGISTER

The Chief Executive presented the Trust Risk Register (TRR) providing oversight of the key risks within the Trust and assurance that the Executive Team is actively controlling and pro-actively mitigating risks so far as is possible. The changes since the last report related to DSP2401 which had been de-escalated and removed from the TRR to Divisional monitoring due to partial mitigation following the recruitment of additional dietitians. DSO2404haem has been reviewed and re-worded to reflect a quality of service risk and added to the TRR. F1339 and F2511 are new financial risks and have been added to the TRR. The Trust Leadership Team is to review the TRR in June 2017 and a greater time period for discussion at the June Board meeting will be required as it is expected a number of risks will be added in period for the request to review all safety risks rated 12+

MW

In response to a question from Ms Barber about learning from one panning period to another, the Chief Executive gave as an example the learning and successes from the last year's Winter Plan had just been taken forward into the Easter Plan and then to the May Bank Holiday Plan.

The Chair thanked the Chief Executive for the report.

RESOLVED: That the report be noted as assurance that the Executive is actively controlling and pro-actively mitigating risks so far as is possible and that the changes to the Trust Risk Register be approved.

REPORT OF THE CHAIR OF THE QUALITY AND PERFORMANCE COMMITTEE ON THE MEETING HELD ON 27 APRIL 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 27 April 2017. The Chair and the Director of Clinical Strategy are taking stock of the items presented to the Committee and the timings for agenda items. There is to be a focus on Divisional input. The presentation of the Safer Staffing report was discussed and it was agreed that in future that report be presented only to the Quality and Performance Committee with exception reporting to the Board through the Committee's report to the Board. Ms Barber added that workforce issues from the report should be presented to the Workforce

Committee.

The Chair thanked Dr Feehily for her 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.

MINUTES OF THE MEETINGS OF THE QUALITY AND PERFORMANCE COMMITTEE HELD ON 22 FEBRUARY AND 30 MARCH 2017:

RESOLVED: That the minutes of the meetings of the Quality and Performance Committee held on 22 February and 30 March 2017 be noted. [10:35]

107/17 FINANCIAL PERFORMANCE REPORT

REPORT OF THE ACTING FINANCE DIRECTOR:

The Acting Finance Director presented the report providing an overview of the financial performance of our Trust as at the end of the 2016/17 financial year. All figures were subject to finalisation as part of the annual accounts process and audit. It provided the three primary financial statements for information. 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 the 2016/17 financial year is an operational deficit of £17.968M which represents a favourable variance to the forecast position of £32k. Positively, this out turn is the same as the original Financial Recovery Plan forecast produced at month seven. It does however, represent an adverse variance to the original NHS Improvement plan of £36.2M. There has been a very significant reduction in debtors as a result of the investment in, and actions of, the Credit Control Team. There has also been a reduction in the number of outstanding creditors beyond payment terms largely achieved through distressed funding and borrowing. Individual discussions are held in those small number of instances where payment terms are not being met and this is mainly for non-financial issues.. The capital expenditure cash flow of £15.2m reflects the cash payments in year and the charge to the 2016/17 capital programme is £11.7m.

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

- The Chair asked whether there remained any issues with paying for goods and services. In response, the Acting Finance Director confirmed that there are no such issues. Where genuine issues arise they are not cash related.
- The Chair expressed his appreciation to the Acting Finance Director and her team for the outstanding activity undertaken to achieve this year-end financial position. The Acting Finance Director added that it was a credit to whole organisation in reducing expenditure.

- Mr Graves added that a working group of the Audit and Assurance Committee on 8 May 2017 looked in detail at the draft accounts which was an informative session and followed the correct process.

The Chair thanked the Interim Finance Director for the report.

RESOLVED: That:-

- The unaudited financial position of the Trust at the end of the 2016/17 financial year is an operational deficit of £17.968m be noted. This is a favourable variance to forecast of £32k.
- Against the original NHSI Plan, the adverse variance is £36.2m.

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REPORT OF THE CHAIR OF THE FINANCE COMMITTEE ON THE MEETING HELD ON 26 APRIL 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 26 April 2017. The year-end position was an operational deficit of £17.968m against a target of £18m. The only issue related to stock movement around drugs. There were no further liabilities. The budget for 2017/18 had been prepared with strong staff engagement this year, hopefully leading to greater ownership and management of the budgets. The Cost Improvement Programme had delivered £10.4m against a plan of £13m. An additional £2m is to be added to the 2017/18 Programme. Assurance had been sought as to whether the 2017/18 Programme could be achieved as the 2016/17 Programme was not. The assurance provided was that each component of the Programme is RAG rated so there is clarity in respect of risk, CIP schemes had been more robustly scoped than in previous years, and the monitoring approach is more thorough than previously. Additionally, given the biggest risk was not in the delivery domain, additional operational management resource was being invested to support CIP delivery.

Mr Foster said that the Audit and Assurance Committee on 8 May 2017 had reviewed the draft accounts for 2016/17 and had received an explanation of the prior year adjustments, going concern and impairment.

The Chair thanked Mr Norton for his 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.

MINUTES OF THE MEETINGS OF THE FINANCE COMMITTEE HELD ON 29 MARCH AND 26 APRIL 2017:

RESOLVED: That the minutes of the meetings of the Finance Committee held on 29 March and 26 April 2017 be noted. [10:50]

108/17 2017/18 FINANCIAL RECOVERY PLAN AND BUDGET UPDATE

The Acting Finance Director presented the report providing an update on the development of the Financial Recovery Plan and seeking approval for the 2017/18 budget position.

The Financial Recovery Plan and Operational Plan for 2017/18, previously presented to the Board detailed a deficit position of £14.7m. Subsequent work had now been done resulting in the identification of further (unavoidable) cost pressures of approximately £3m which had increased the Cost Improvement Programme target to £34.7m (from £31.7m) to avoid further deterioration of the plan. There remains a risk to delivery of approximately £5m and identification of this residual CIP is a priority however, it was noted that this level of unidentified CIP, going into the financial year was not unusual and the phasing of delivery would demonstrate this delivery in the latter half of the year. As a result the FRP had been maintained at the previous position (£14.6m due to "rounding" impacts). The budget has been prepared in line with that position and based on seasonal plans with a greater deficit in quarter 1 than in the remaining quarters. The budget is supported by working capital and capital borrowing of £27.6m which provides deficit support and funding for capital spend in excess of internally generated funds. The Trust is looking at different ways of minimising capital spend such as leasing of equipment. No Sustainability and Transformation Funding has been accounted for in the budget as the control total has not been agreed and is unlikely to be unless a revised total is offered. SS advised that if the Trust cannot agree a control total that the position would likely be further impacted by exposure to contractual fines and penalties and the £14.6m did not take this into account pending resolution of discussions ongoing. There is a significant risk with the loss on income from the issues surrounding TrackCare and discussions are underway with the Commissioners to mitigate this risk through block contract arrangements.

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

- In response to a question from Mr Graves, the Director of Finance said that c80% of the Cost Improvement Programme is recurrent and this information will be included in subsequent reports. The Chief Executive noted the positive nature of this and its contrast to previous years.
- Mr Graves referred to the back end loading of the Cost Improvement Programme asking whether this is a unique position and how easily it could be monitored as it is imperative that the Cost Improvement Programme target is met. In response the Acting Finance Director said that this position is being adopted in other Trusts. In month twelve there is one item of £2.5m relating to a rates scheme initiative and there remains a risk to that scheme. However, the focus for the whole year would be to continue to identify new CIP to offset any emerging in year risks and support deliver of the two year breakeven plan.

- The Chair asked for a sense of working in the Project Management Office to drive forward the Cost Improvement Programme. The Acting Finance Director said in response that the team is in early stages of development with interviews for a Director taking place later in the week. The Team is however now embedding a range of practices to provide support, monitoring and holding to account.
- The Medical Director referred to the £1.7m cash balance which was lower than the operating balance. The acting finance director explained that this was due to the difference between final outturn and the plan submission (relating to 31st march 2016)
- The Chief Executive said that the fines and penalties for not agreeing a Control Total may impact on the budget but she was hopeful that, if levied, local commissioners may reinvest them in the Trust to support delivery of the FRP.

The Chair thanked the Acting Finance Director for the report.

RESOLVED: That the Financial Recovery Plan be set at £14.6m deficit and the budget for 2017/18 as set out for the Board, be approved and issued to budget holders without delay. [11:07]

109/17 WORKFORCE REPORT

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 twelve of the 2016/17 financial year. It provided information on the continuing overspend on pay (including agency) costs, movements in headcount. The key issues to note were that total pay expenditure remained relatively constant between months eleven and twelve. The reasonable conclusion is that the proactive steps being taken to control and reduce pay spend are having a positive effect. Nursing agency expenditure increased significantly between months eleven and twelve partly as a consequence of an adjustment in month eleven which artificially depressed pay spend. Other factors affecting the spend increase included ED vacancy cover, the opening of the new unscheduled care ward (4A), where there were high levels of staff sickness, and pressures within General and Old Age Medicine (GOAM) services. Other factors were the payment of invoices for interim IT staff in month 12 for work in month ten. The number of interim staff in Corporate Services is reducing but less so in IT due to vacancy levels and ongoing requirements in respect of TrakCare.

The Chief Executive Officer enquired why there was a cost pressure relating to the Tower Block ward moves given the significant work done to re-pattern nursing staff to ensure no cost pressure materialised. Nursing Director explained the background to the moves in wards 2A, 4A and 9A which provided a better patient experience and did not result in an increase in nursing

spend. The Chief Executive Officer thanked the Nursing Director but sought future further explanation on the origins of the very significant cost pressure set out in the paper in light of her comments. **MA**

The Director of Human Resources and Organisational Development explained the new national requirement to meet a medical locum spend target of £1.157m in 2017/18 which equates to a monthly reduction of £575k; this is £120k lower than we are currently achieving. There is considerable work to be undertaken to deliver this target. Locums are seeking additional payments to offset tax and National Insurance liabilities arising from the introduction of IR35. The Trust is working hard to convert medical locums to permanent positions but there is no financial incentive for locums to do so. Rota management is crucial to ensure that locums are only used when needed, given their cost.

The Medical Director added that more innovative ways of working and recruiting need to be found to reduce locum spend further and this was a huge focus for him and the Chiefs of Service. The current focus is on the largest areas of spend involving the smallest number of staff. He gave as an example where one locum had been replaced by two nurses. He said that a challenging reduction target will drive the look at innovative ways of working.

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

RESOLVED: That the report be noted.

REPORT OF THE CHAIR OF THE WORKFORCE COMMITTEE ON THE MEETING HELD ON 6 APRIL 2017:

The Chair of the Committee, Ms Tracey Barber, reported on the business conducted at the meeting of the Workforce Committee held on 6 April 2017. She was pleased that the core members of the Sustainable Workforce Group had now met and that the full group will meet with operational staff to further support engagement. The Director of Human Resources and Organisational Development is reviewing the Workforce Strategy to form the objectives for the short, medium and long term. The format of the Workforce report is to be developed to focus on workforce issues in addition to the financial workforce aspects. The Committee has requested a review of the effectiveness of the Vacancy Control Panel (VCP) and further work is being undertaken to outline the purpose of the VCP, key findings to date and what broader strategic issues and implications it has brought to light. The Committee received details of the actions put in place, following receipt of a letter from the CQC regarding the Fit and Proper Persons Test. Ongoing monitoring will be undertaken by the Quality & Performance Committee which has oversight of the CQC Action Plan. Ms Barber invited the Trust Secretary to list the acronyms in future reports. **MW**

The Chair thanked Ms Barber for her 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.

MINUTES OF THE MEETING OF THE WORKFORCE COMMITTEE HELD ON 6 APRIL 2017:

RESOLVED: That the minutes of the meeting of the Workforce Committee held on 6 April 2017 be noted. [11:30]

(The Board adjourned from 11:30am to 11:45am)

110/17 NURSE AND MIDWIFERY STAFFING REPORT

The Nursing Director presented the report providing assurance to the Board in respect of nurse staffing levels for April 2017 against the Compliance Framework *Hard Truths – Safer Staffing Commitments*. She drew attention to the fact that the data is a snapshot based on the first Tuesday of every month. The report did not raise any significant concerns in respect of staffing levels and the risk of low staffing impacting on care quality and safety. Thirteen Nurse Associates started with our Trust this week which will be a benefit to us. Discussions are taking place with the residual cohort of overseas nurses, for them to fulfil HCA roles should they not be successful in obtaining Nurse and Midwifery (NMC) registration in the immediate future and HCA recruitment had been slowed to enable these supernumerary staff to be absorbed. The nursing metrics breakdown by ward now included infection control in the reasons for trigger where relevant. There will be a review of the indicator which will be included in reports from July 2017.

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

- The CEO enquired if the Model Hospital comparators were to be included in the data in the future. In response the Nursing Director said that the Model Hospital data is considered by the Senior Nursing Committee but the Model does not provide benchmarking data and thus remained of limited use currently.
- The Chair invited the Nursing Director to give her perspective on the likely long term interest in the nursing profession. The Nursing Director commented that in her view the profession is likely to become more “hands on” to allow other roles to be developed in supporting doctors such as the Associate Nurse Professional working at night. There is a change in attitude and support needs to be provided to younger nurses to enable then to perform the work of more experienced nurses. The Nursing Director has been speaking to student nurses who have indicated that that will stay with our Trust and if the current 85 student nurses stayed then this would have a significant benefit for us. Worcester University has invited our Trust to take a greater number of student nurses next intake which we

hope to do subject to securing placement supervisors for them.

- The Chair said that from his attendance at a recent Heath Education England Chair's meeting he had received complimentary comments about our working with local universities.

The Chair thanked the Nursing Director for the report.

RESOLVED: That the report be noted as a source of assurance that staffing levels across our Trust are supporting the delivery of safe care. [11:53]

111/17 SMARTCARE PROGRESS REPORT

In the absence of the Director of Clinical Strategy, the Chief Executive presented the report to provide assurance from the SmartCare Programme Board on progress within the continued operation of TrackCare and planned implementation of phases 1.5 and 2. The focus is on the timeframe for the launch of subsequent phases. The Programme Board will consider when this is the right time. The earliest that InterSystems will be able to launch Phase 1.5 will be September/October due to existing commitments. Significant issues are ongoing with Phase 1 mobilisation and resolution of these are being pursued with InterSystems. We will be seeking third party assurance that we have learnt the lessons from the introduction of Phase 1 before subsequent Phases are launched. Internal Audit were already involved in this work.

In response to a question, the CEO said it was acknowledged that the pace and scale of operational recovery was not commensurate with the requirements of the Trust. Notably, that both patient and staff experience continues to be materially impacted by the deployment. The executive were currently exploring external support for stabilisation and recovery.

The Chair thanked the Chief Executive for the report.

RESOLVED: That the report be noted as a source of assurance that the programme planning for subsequent phases of TrackCare deployment is robust. [11:56]

112/17 OUR GOALS AND OBJECTIVES FOR 2017 -19

The Chief Executive presented the report seeking endorsement for the Trust's renewed goals and objectives for the next two years. She acknowledged the efforts of the Director of Clinical Strategy in developing this piece of work. There have been may changes since the original plan was published in 2014 leading to a review by the Board and the proposed goals and objectives reflected the aspirations of the Board within the context of our existing mission and vision of *Best Care For Everyone*. The goals and objectives once approved will be mapped and developed to the relevant Committee where possible with oversight in Board Seminars.

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

- The objective supporting health promotion alongside treatment referred to staff not patients and the CEO said this would be amended and the staff objective would remain but be aligned to the workforce goal. **SP**
- The Chair expressed his appreciation to Mr Graves and Mr Norton for their input into the preparation of the goals and objectives.
- The CEO said that as a reflection of the "top down" development of the goals, we should consider a brief period of staff engagement to ensure staff were supportive of the direction and priorities proposed. The Chief Executive said that she would include the goals and objectives in her blog and invited the Medical and Nursing Directors to present them to the Local Medical Committee and Senior Nursing Committee respectively. **DL/SE/MA**
- Mr Graves said that the goals and objectives are ambitious which he considered to be achievable. Mr Norton added that they are expressed clearly and simple in language for the patient to understand.

The Chair thanked the Chief Executive for the report.

RESOLVED: That the goals and strategic objectives be endorsed subject to the above additions. [12:07]

113/17 END OF LIFE CARE STRATEGY AND CHARTER

(Dr Emma Husbands, Consultant in Palliative Medicine, attended the meeting for the presentation of this item)

The Medical Director introduced the report by reading a patient letter which exemplified excellent End of Life Care and the impact it has on patients and their families. He congratulated Dr Husbands in taking this work forward but acknowledged End of Life Care was everyone's business.

Emma Husbands, Consultant in Palliative Medicine explained that the End of Life Charter was developed following the introduction of the County End of Life Strategy to break down barriers and to encourage discussion about end of life issues. The Strategy provides a comprehensive and co-ordinated approach to the development of End of Life Services for patients and families across the County.

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

- Mr Graves referred to the introduction of the Charter and the references to patients and staff which he thought could be expressed differently, He would meet the Consultant in Palliative Medicine to discuss. **RG/EH**
- Ms Barber said that the development of the Strategy and

Charter was a huge piece of work prepared in a short timeframe and she acknowledged the work of the Dr Husbands and her team in achieving this. She stressed that End of Life Care is for all staff and not just for the End of Life Team.

- The Chair invited the Consultant in Palliative Medicine to liaise with the Head of Communications to communicate the launch of the Charter. **EH/CM**
- In response to a question from the Chair the Medical Director said that the Charter objectives will be tested by the End of Life Care Group.

The Chair thanked the Medical Director for the report.

RESOLVED: That the Trust's End of Life Strategy and Patient Charter be endorsed. [12:20]

114/17 GOVERNOR QUESTIONS

Mrs Anne Davies offered the following comments on the meeting:

- She felt that there was discrimination for being elderly from the patient story. She expressed surprise that the patient was moved to an internal ward.
- She thanked the Nursing Director for arranging and accompanying Governors on the recent hospital visits.
- The list of acronyms had been made available to Governors but had yet to appear on the website. This would be addressed by the Trust Secretary and Head of Communications **MW/CM**
- She drew attention to death doulas which performed a role similar to Macmillan nurse.
- She asked for assurance that the recent attempted suicide by a patient would not be repeated. The Chief Executive explained that the patient's intentions were not known, that this incident was classified as a Serious Untoward Incident and as such would be fully investigated in accordance with those processes and any missed opportunities and lessons learned would be acted upon to reduce the likelihood and/or impact of a similar incident occurring in the future.[12:25]

115/17 STAFF QUESTIONS

There were none. [12:25]

116/17 PUBLIC QUESTIONS

The question and response from Mr Bren McInerney was set out in the paper. The issues and subsequent questions raised are being addressed by the Head of Patient Experience and she will work with Mr McInerney to resolve and any outstanding concerns should be referred to the Board. [13:27]

SC117/17 ANY OTHER BUSINESS:

Emergency Department: Mr Norton commented that on the earlier discussion noting disappointment that there was no "silver bullet" and it all comes down to leadership, culture and communication.

Diversity and Inclusion Week: The Director of Human Resources and Organisational Development said that next week is NHS Diversity week, and to mark this we are hosting four listening events to focus exclusively on hearing about and learning from the experiences of staff in relation to a legally protected characteristic. In particular we are keen that BAME (Black, Asian and Minority Ethnic) staff and staff with a disability come along. This is because we know from the 2016 NHS staff survey that, unfortunately, they report a worse experience in certain areas compared to other staff groups.

Natasha Swinscoe, Interim Chief Operating Officer: The Chair said that this was the last meeting which Natasha would be attending as Interim Chief Operating Office before returning to her substantive role. He said that she had joined our Trust at a difficult time and had made a huge effort and commitment to move forward and provide a platform for improvements. He thanked Natasha for her substantial contribution to the work of our Trust and wished her well for the future.

Natasha said that she had enjoyed her time with our Trust and will keep us up to date with developments in the Academic Health Science Network which might be beneficial to us.

ITEMS FOR THE NEXT MEETING:

The Quality report was identified as an item for the next meeting.

118/17 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at **9am** on **Friday 26 May 2017** in the **Lecture Hall, Sandford Education Centre, Keynsham Road, Cheltenham.**

119/17 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 12.30 pm

Chair
26 May 2017

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – 26 MAY 2017

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
June 2017	May 2017 101/17 Patient Story	**SE**	Dr Feehily asked for a sense of how many other patients had not received discharge summaries and whether this raised safety issues. In response the Chief Executive said that there are TrackCare challenges to electronic summary production and currently around 70% of summaries are sent electronically but all patients should leave with a printed summary to give to their GP. She asked the Medical Director to investigate Lucy's experience. *Ongoing*
May 2017	May 2017 103/17 Minutes of the Meeting of the Trust Leadership Team held on 12 April 2017	**NS/AK**	The Chief Executive said that the Quality and Performance Committee should be informed of the evidence for supporting the decision to close the TrakCare tracker. *This has been included in the Committee's workplan.*
May 2017	May 2017 106/17 Quality and performance report - Report of the interim chief operating officer:	**NS/AK**	The Trust reported four 52 week breaches in March 2017 with 11 in April and a similar number expected in May 2017 when the expectation was nil in May 2017. The Chief Executive said that the Quality and Performance Committee should understand the reasons for the poor performance and poor forecasting. *Ongoing.*
June 2017	May 2017 106/17 Quality and performance report - Report of the Interim Chief Operating Officer	**NS/AK**	The Chief Executive said that 15 minutes to triage and the Patient Safety Checklist be added to the Performance Framework Dashboard. *This has been included in the report. Completed.*
June 2017	May 2017 106/17 Quality and performance report - Report of the interim chief operating officer	**NS/AK**	In response to a question from Mr Foster about the term "arrears" in the report, the Chief Executive said that this pertained to data that, due to the validation process, did not appear in the reporting period but in arrears and was not related to issues with Trakcare though there were still gaps in reporting which were. The Chair said that it will be useful for the Quality and Performance Committee to be sighted on the programme to recommence

			reporting with an understanding of the enablers to hit the required performance standards. *Ongoing.*
June 2017	May 2017 106/17 Quality and performance report - Trust Risk Register	**MW**	The Trust Leadership Team is to review the TRR in June 2017 and a greater time period for discussion at the June Board meeting will be required as it is expected a number of risks will be added in period for the request to review all safety risks rated 12+*This will be incorporated in Agenda planning. Completed as a Matter Arising.*
June 2017	May 2017 109/17 Workforce Report	**MA**	The Chief Executive Officer enquired why there was a cost pressure relating to the Tower Block ward moves given the significant work done to re-pattern nursing staff to ensure no cost pressure materialised. Nursing Director explained the background to the moves in wards 2A, 4A and 9A which provided a better patient experience and did not result in an increase in nursing spend. The Chief Executive Officer thanked the Nursing Director but sought future further explanation on the origins of the very significant cost pressure set out in the paper in light of her comments. *Ongoing.*
June 2017	May 2017 109/17 Report of the Chair of the Workforce Committee on the Meeting Held On 6 April 2017	**MW**	Ms Barber invited the Trust Secretary to list the acronyms in future reports. *This will be undertaken for future reports. Completed as a Matter Arising.*
June 2017	May 2017 112/17 Our Goals And Objectives For 2017 -19	**SP**	The objective supporting health promotion alongside treatment referred to staff not patients and the CEO said this would be amended and the staff objective would remain but be aligned to the workforce goal. *Completed.*
June 2017	May 2017 112/17 Our Goals And Objectives For 2017 -19	**DL/SE/MA**	The CEO said that as a reflection of the “top down” development of the goals, we should consider a brief period of staff engagement to ensure staff were supportive of the direction and priorities proposed. The Chief Executive said that she would include the goals and objectives in her blog and invited the Medical and Nursing Directors to present them to the Local Medical Committee and Senior Nursing Committee respectively. *Ongoing.*

June 2017	May 2017 113/17 End Of Life Care Strategy And Charter	**RG/EH**	Mr Graves referred to the introduction of the Charter and the references to patients and staff which he thought could be expressed differently, He would meet the Consultant in Palliative Medicine to discuss. *Ongoing.*
June 2017	May 2017 113/17 End Of Life Care Strategy And Charter	**EH/CM**	The Chair invited the Consultant in Palliative Medicine to liaise with the Head of Communications to communicate the launch of the Charter.
June 2017	114/17 Governor Questions	**MW/CM**	The list of acronyms had been made available to Governors but had yet to appear on the website. This would be addressed by the Trust Secretary and Head of Communications. *This has been included on the Trust website. Completed.*

FUTURE TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
August 2017	May 2017 101/17 Patient Story	**SC**	In response to questions from Ms Barber and Mr Foster about learning for the Board, the Chief Executive said that a quarterly review after the patient story will be presented to the Board. *Ongoing.*

COMPLETED TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
May 2017	April 2017 072/17 Minutes of the meeting of the Quality and Performance Committee held on 22 February 2017	**MW**	The minutes of the meetings of the Quality and Performance Committee held on 22 February 2017 be deferred to the next meeting. *These minutes appear later in the Agenda. Completed.*
May 2017	April 2017 073/17 Financial Performance Report – Capital Investment Programme 2017/18	**MA** **SS**	The Nursing Director was invited to submit to the Quality and Performance Committee the allocation of the Environmental Fund. *This has been included in the Workplan for the Quality and Performance Committee. Completed as a Matter Arising.* The Acting Finance Director said that the plan is to conclude the asset audit by mind-summer 2017 and then RAG the assets to determine how best to use the Medical Equipment Fund monies. It is proposed to pre plan for 50% of the monies with 50% being for ad hoc assets. It was agreed that the Audit and Assurance Committee

			should receive an update following the audit. *This has been included in the Workplan for the Audit and Assurance Committee. Completed as a Matter Arising.*
May 2017	April 2017 078/17 Safety Alert – Nasogastric Tube replacement – Assurance Report	**SE/AS**	The audit will be undertaken in August 2017 with the results being presented to the Senior Nursing Committee and the Quality and Performance Committee. *This has been included in the Workplan for the Quality and Performance Committee. Completed as a Matter Arising.*

Gloucestershire Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2017

Foreword to the accounts

Gloucestershire Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2017, have been prepared by Gloucestershire Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed …………………………………………….

Name	**Sarah Stansfield**
Job title	**Acting Director of Finance**
Date	**31 May 2017**

Consolidated Statement of Comprehensive Income

	Note	2016/17		2015/16 Restated	
		Trust	Group	Trust	Group
		£000	£000	£000	£000
Operating income from patient care activities	3	439,869	439,869	425,918	425,918
Other operating income	3	66,315	67,551	64,352	65,262
Total operating income from continuing operations		**506,184**	**507,420**	**490,270**	**491,180**
Operating expenses	5, 7	(528,679)	(529,885)	(480,968)	(482,534)
Operating surplus/(deficit) from continuing operations		**(22,495)**	**(22,465)**	**9,301**	**8,645**
Finance income	10	36	98	32	211
Finance expenses	11	(4,430)	(4,430)	(4,195)	(4,195)
PDC dividends payable		(6,457)	(6,457)	(7,447)	(7,447)
Net finance costs		**(10,851)**	**(10,789)**	**(11,610)**	**(11,431)**
Gains on disposal of non-current assets	12	1,077	1,077	-	-
Movement in the fair value of investment property and other investments	18	-	95	-	(112)
Deficit for the year from continuing operations		**(32,269)**	**(32,082)**	**(2,309)**	**(2,898)**
Deficit for the year		**(32,269)**	**(32,082)**	**(2,309)**	**(2,898)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	6	3,867	3,867	-	-
Revaluations	17	-	-	717	717
Other reserve movements		-	-	(90)	(90)
Total comprehensive expense for the period		**(28,402)**	**(28,215)**	**(1,682)**	**(2,271)**
Deficit for the period attributable to:					
the Foundation Trust		(32,269)	(32,082)	(2,309)	(2,898)
Total comprehensive expense for the period attributable to:					
the Foundation Trust		(28,402)	(28,215)	(1,682)	(2,271)

The operational deficit for 2016/17, excluding the impact of impairments, was -£17,968k, as detailed in Note 2 on page 15

Statements of Financial Position

	Note	31 March 2017 Trust £000	31 March 2017 Group £000	31 March 2016 Restated Trust £000	31 March 2016 Restated Group £000
Non-current assets					
Intangible assets	14	7,393	7,393	3,584	3,584
Property, plant and equipment	15, 16	296,272	296,272	308,601	308,601
Other investments	18	-	1,969	-	1,974
Trade and other receivables	21	4,668	4,668	4,505	4,505
Total non-current assets		**308,333**	**310,302**	**316,690**	**318,664**
Current assets					
Inventories	20	7,400	7,400	8,036	8,036
Trade and other receivables	21	17,697	17,760	26,424	26,580
Cash and cash equivalents	22	7,974	8,220	3,950	4,148
Total current assets		**33,071**	**33,380**	**38,410**	**38,764**
Current liabilities					
Trade and other payables	23	(44,355)	(44,425)	(59,526)	(59,833)
Other liabilities	24	(2,089)	(2,089)	(623)	(623)
Borrowings	25	(5,356)	(5,356)	(5,283)	(5,283)
Provisions	27	(182)	(182)	(186)	(186)
Total current liabilities		**(51,982)**	**(52,052)**	**(65,618)**	**(65,925)**
Total assets less current liabilities		**289,422**	**291,630**	**289,482**	**291,503**
Non-current liabilities					
Other liabilities	24	(7,612)	(7,612)	(7,987)	(7,987)
Borrowings	25	(83,126)	(83,126)	(54,537)	(54,537)
Provisions	27	(1,524)	(1,524)	(1,396)	(1,396)
Total non-current liabilities		**(92,262)**	**(92,262)**	**(63,920)**	**(63,920)**
Total assets employed		**197,160**	**199,368**	**225,562**	**227,583**
Financed by					
Public dividend capital		166,519	166,519	166,519	166,519
Revaluation reserve		70,292	70,292	67,334	67,334
Other reserves		209	209	209	209
Income and expenditure reserve		(39,860)	(39,860)	(8,500)	(8,500)
Charitable fund reserves	19	-	2,208	-	2,021
Total taxpayers' and others' equity		**197,160**	**199,368**	**225,562**	**227,583**

The notes on pages 8 to 42 form part of these accounts.

The annual accounts were approved by the Board of Directors on 26th May 2017 and signed on behalf of the Trust by:

Name	Sarah Stansfield
Position	Acting Director of Finance
Date	**31 May 2017**

Statement of Changes in Equity for the year ended 31 March 2017

Trust & Group	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	NHS charitable funds reserves	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**166,519**	**67,334**	**209**	**(8,500)**	**2,021**	**227,583**
Surplus/(deficit) for the year	-	-	-	(32,269)	187	**(32,082)**
Impairments	-	3,867	-	-	-	**3,867**
Transfer to retained earnings on disposal of assets	-	(909)	-	909	-	**-**
Taxpayers' and others' equity at 31 March 2017	**166,519**	**70,292**	**209**	**(39,860)**	**2,208**	**199,368**

Statement of Changes in Equity for the year ended 31 March 2016 Restated

Trust & Group	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	NHS charitable funds reserves	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2015 - brought forward	**165,519**	**66,617**	**209**	**(6,140)**	**2,649**	**228,854**
Prior period adjustment	-	-	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2015 - restated	**165,519**	**66,617**	**209**	**(6,140)**	**2,649**	**228,854**
Surplus/(deficit) for the year	-	-	-	(2,309)	(589)	**(2,898)**
Revaluations	-	717	-	-	-	**717**
Public dividend capital received	1,000	-	-	-	-	**1,000**
Other reserve movements	-	-	-	(51)	(39)	**(90)**
Taxpayers' and others' equity at 31 March 2016	**166,519**	**67,334**	**209**	**(8,500)**	**2,021**	**227,583**

Information on reserves

NHS charitable funds reserves
This balance represents the ring-fenced funds held by the NHS charitable funds consolidated within these accounts. These reserves are classified as restricted or unrestricted.

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Available-for-sale investment reserve
This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

Other reserves
On the original setting up of the Trust in 2003 there was an error made in in the granting of the initial PDC to cover the total value of the net assets of the new organisation. The adjustment was credited to other reserves. This reserve will remain with the Trust until the Trust is dissolved.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

Statement of Cash Flows

	Note	31 March 2017 Trust £000	31 March 2017 Group £000	31 March 2016 Restated Trust £000	31 March 2016 Restated Group £000
Cash flows from operating activities					
Operating surplus/(deficit)		(22,495)	(22,465)	9,301	8,645
Non-cash income and expense:					
Depreciation and amortisation	5.1	9,946	9,946	9,847	9,847
Net impairments and reversals of impairments	6	14,301	14,301	(3,795)	(3,795)
Income recognised in respect of capital donations	3	(658)	(658)	(659)	(659)
Non-cash movements in on-SoFP pension liability		-	-	-	-
(Increase)/decrease in receivables and other assets		8,819	8,889	(5,202)	(5,367)
(Increase)/decrease in inventories		636	636	3	3
Increase/(decrease) in payables and other liabilities		(11,975)	(12,045)	11,738	11,695
Increase/(decrease) in provisions		124	124	(106)	(106)
NHS charitable funds - net movements in working capital, non-cash transactions and non-operating cash flows		-	18	-	512
Net cash generated from/(used in) operating activities		**(1,302)**	**(1,254)**	**21,127**	**20,776**
Cash flows from investing activities					
Interest received	10	36	36	32	32
Purchase of intangible assets	14	(3,809)	(3,809)	(2,990)	(2,990)
Purchase of property, plant, equipment		(10,515)	(10,515)	(8,745)	(8,745)
Sales of property, plant, equipment		2,790	2,790	-	-
Net cash generated from/(used in) investing activities		**(11,498)**	**(11,498)**	**(11,703)**	**(11,187)**
Cash flows from financing activities					
Public dividend capital received		-	-	1,000	1,000
Movement on loans from the Department of Health		30,786	30,786	(2,635)	(2,635)
Capital element of finance lease rental payments		(2,222)	(2,222)	(2,803)	(2,803)
Capital element of PFI, LIFT and other service concession payments		(742)	(742)	(371)	(371)
Interest paid on finance lease liabilities		(277)	(277)	(345)	(345)
Interest paid on PFI, LIFT and other service concession obligations		(2,093)	(2,093)	(2,273)	(2,273)
Other interest paid		(1,902)	(1,902)	(1,561)	(1,561)
PDC dividend paid		(6,726)	(6,726)	(7,148)	(7,148)
Net cash generated from/(used in) financing activities		**16,824**	**16,824**	**(16,136)**	**(16,136)**
Increase/(decrease) in cash and cash equivalents		**4,024**	**4,072**	**(6,712)**	**(6,548)**
Cash and cash equivalents at 1 April		**3,950**	**4,148**	**10,662**	**10,695**
Cash and cash equivalents at 31 March	22	**7,974**	**8,220**	**3,950**	**4,148**

Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation
NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Going concern

The accounting rules (IAS 1) require management to assess, as part of the accounts preparation process, the NHS Foundation Trust's ability to continue as a going concern. The financial statements have been prepared on a going concern basis as we do not either intend to apply to the Secretary of State for the dissolution of the NHS Foundation Trust without the transfer of the services to another entity, or consider that this course of action will be necessary.

We are also required to disclose material uncertainties in respect of events or conditions that cast doubt upon the going concern ability of the NHS Foundation Trust and these are disclosed below.

The Trust incurred an operating deficit in the year of £17,968k (see Note 2) and is forecasting a further significant operating deficit in 2017/18. The Trust's operating and cash flow forecasts have identified the need for continued additional financial support to enable it to meet debts as they fall due over the foreseeable future, which is defined as a period of 12 months from the date these accounts are signed.

Recovery plans were put in place in the year to enable the continuity of services and distress funding was received in the short term to ensure that liabilities could be met and services provided. The Trust presented its financial recovery plan to NHS Improvement in the year which indicated a deficit for 2016/17 and 2017/18 and consequent significant cash funding requirements to enable the Trust to meet its liabilities and to continue the provision of services. At the point of finalising these financial statements we note the following:

1. The forecast for 2016/17, as submitted to NHS Improvement within the Trust's Financial Recovery Plan, was achieved; and
2 The Trust still requires significant external cash funding. Applications for funding will continue, the total level of funding required and to be received is as yet uncertain. To date the Trust has received distress funding of £33.4m to 31 March 17 from the Department of Health.

Having considered the material uncertainties and the Trust's financial recovery plans and the likelihood of securing additional financial funding to support the financial operations, the directors have determined that it remains appropriate to prepare these accounts on a going concern basis. The accounts do not include any adjustments that would result in Gloucestershire Hospitals NHS Foundation Trust not being able to continue as a going concern.

Note 1.1 Consolidation

The NHS Foundation Trust is the corporate Trustee to Gloucestershire Hospitals Charitable Fund. The Foundation Trust has assessed its relationship to the Charitable Fund and determined it to be a subsidiary because the Foundation Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the Charitable Fund and has the ability to affect those returns and other benefits through its power over the fund.

The Charitable Fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on FRS102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

• recognise and measure them in accordance with the Foundation Trust's accounting policies; and
• eliminate intra-group transactions, balances, gains and losses.

Joint operations
The Trust participates in a pooled Budget arrangement under S31 of the Health act 1999 for the provision of equipment loaned to the community e.g. walking frames. This arrangement constitutes a jointly controlled operation in accordance with IAS 31. Where the balances are material the Trust has recognised its share of assets, liabilities, income and expenditure in its accounts.

Note 1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services.
Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.3 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Accounting valuation
A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Note 1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.5 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes;
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
• it is expected to be used for more than one financial year; and
• the cost of the item can be measured reliably.
• individually have a cost of at least £5,000: or form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependendent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or form part of the initial setting-up costs of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing to the location and condition necessary for it to be capable of operating in the manner intended by management.

Non Current assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs, such as installation, directly attributable to bringing them into working condition. The carrying values of non current assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. The costs arising from financing the construction of the fixed asset are not capitalised but are charged to the income and expenditure account in the year to which they relate.

A formal revaluation is required every 5 years with an interim formal valuation in the third year of each cycle. A full valuation was undertaken in 2014-15. A desk top valuation, measured on a Modern Equivalent Asset (MEA) basis, was undertaken by the Trust's Independent Valuer as at 31.03.2017.

The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value. The Market Value valuation is on the assumption that the property is sold following the cessation of the existing operations consistent with the Department of Health guidelines.

Assets in the course of construction are valued at cost and are valued by professional valuers as part of the Trust's valuation exercise when they are brought into use.

PFI assets are valued net of VAT.

Operational equipment is valued at current value except where these are considered to be of short useful life or low value. If this is the case a depreciated replacement cost basis is used as a proxy. Equipment surplus to requirements is valued at net recoverable amount.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the DH GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Assets under construction
Assets under construction are measured at cost of construction as at 31 March. Assets are reclassified to the appropriate category when they are brought into use.

De-recognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, government grant and other grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions
PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment at their fair value, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Useful Economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life (Years)	**Max life (Years)**
Land is assumed to have an infinite life		
Buildings, excluding dwellings	37	90
Dwellings	37	90
Plant & machinery	5	15
Transport equipment	7	7
Information technology	3	5
Furniture & fittings	10	10

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the FT expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.6 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:
• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the Trust intends to complete the asset and sell or use it
• the Trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
• the Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful economic life of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life (Years)	Max life (Years)
Intangible assets - internally generated		
Development expenditure	1	8

TrakCare Asset implementation

During 2014/15 the Trust procured a clinical information system "TrakCare". The Trust began the implementation process in 2014-15, which is expected to be completed during 2018-19. The system will be run through a managed service agreement and accounted for through the Statement of Comprehensive Income.

During the implementation phase a significant number of staff will be utilised to ensure there is appropriate knowledge within the organisation to effectively operate the system. These will be defined roles with defined benefits arising from them. The Trust is capitalising the costs arising from the implementation due to the future economic benefits that will be derived from the system. The basis for this treatment is under IAS 38 Intangible Assets (Research and Development).

The Trust proposes to commence amortising the asset following go-live of phase 2.

Note 1.7 Revenue government and other grants

Government grants are grants from government bodies other than income from commissioners or NHS Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Note 1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The Trust's inventories comprise mainly of drugs held in the Pharmacy and medical and surgical equipment (MSE) principally held in operating theatres and surgical departments. The pharmacy stock is subject to an integrated stock system which accounts for the stock held at average cost basis. MSE is held in a variety of locations and is accounted for on a first in first out basis.

Note 1.9 Trade Receivables

Trade receivables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method, which usually equates to invoice total, less provision for impairment. A provision for impairment of trade receivables is estimated when there is objective evidence the Trust will not be able to collect the debt.

Note 1.10 Trade Payables

Trade payables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest rate which usually equates to invoice value.

Note 1.11 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised as “fair value through income and expenditure”, as loans and receivables, and financial liabilities are classified as other financial liabilities.
Financial liabilities are classified as “fair value through income and expenditure” or as “other financial liabilities”.

Financial assets and financial liabilities at “fair value through income and expenditure”
Financial assets and financial liabilities at “fair value through income and expenditure” are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not “closely-related” to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise of: current investments, cash and cash equivalents, NHS receivables, accrued income and “other receivables”.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Financial liabilities
All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at “fair value through income and expenditure” are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced.

The impairment loss to be recognised through the bad debt provision is determined based on a percentage of debt outstanding for private patients and the Compensation Recovery Unit. For NHS outstanding debt an assessment is made based on the ongoing discussions with Trust commissioners. Bad debts are written off at a point where all possible recovery action has failed.

Note 1.12 Leases

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.13 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 27.2 but is not recognised in the NHS Foundation Trust's accounts.

Non-clinical risk pooling
The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any “excesses” payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 28 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 28, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax
Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Corporation tax
Gloucestershire Hospitals NHS Foundation Trust is a Health Service Body under the definition of section 519A Income and Corporation Taxes Act (ICTA) 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this Act. There is a power for HM Treasury to dis-apply the exemption in relation to specified activities of a Foundation Trust (section 519A (93) to (8) ICTA 1988). The Trust is not within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, as the profits derived from these activities do not exceed £50,000 per annum

Note 1.18 Foreign exchange
The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:
• monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.19 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.20 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Transfers of functions [to / from] [other NHS bodies / local government bodies]
The Trust had no transfer of functions in or out during 2016-17

Note 1.22 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2016/17.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted
● IFRS 9 Financial Instruments
● IFRS 15 Revenue from Contracts with Customers
● IFRS 16
● IFRIC 22 Foreign Currency Transactions and Advance Consideration

Note 1.24 Critical accounting estimates and judgements
The following are the critical judgements apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.
a) Plant and equipment is valued at depreciated replacement cost, the valuation being assessed by the Trust's Independent Valuer who values those assets with a written down value of greater than £100k. This process also includes those equipment items currently leased.
b) the Trust leases a number of equipment assets and the Trust has assessed the risks and rewards of ownership in categorising these leases as either operating or finance leases.
c) The Trust is required to review property, plant and equipment for impairment in between formal valuations by a suitably qualified valuer. Management make judgements about the condition of assets and review their estimated lives taking account of the professional advice of the Trust's Independent Valuer. The judgement of residual life is based on the assumption that the buildings and services would be subject of a future robust maintenance regime.

Note 1.25 Key sources of estimation uncertainty
The following are the key assumptions concerning the future and any key sources of estimation uncertainty at the end of the reporting period that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

a) the cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements as an accrual. As the calculation involves a large number of staff, sampling techniques are used to collate the results for the entire Trust.

b) for partially completed spells an estimate is made of the income accruing to the Trust from patients in hospital on 31 March 17 awaiting discharge or part way through their treatment (partially completed spells or PCS). This technique uses an average figure based on accrued monthly income received over the first three quarters of the year.

c) The useful economic life of each category of fixed asset is assessed when acquired by the Trust. A degree of estimation is occasionally used in assessing the useful economic lives of assets.

Note 2 Operating Segments

The financial information presented to the Trust Board by the Director of Finance regarding the performance of the Trust is based on the whole Trust as one entity (i.e. it is not split over operating segments). The Trust's internal management structure is based on operating divisions i.e. Surgery, Medicine, Diagnostics and Specialties, Women and Children, Estates and Facilities and Corporate Services. The Divisional boards are provided with financial information specific to their operational areas.

Accordingly, for segmental reporting the Trust considers the presentation to inform the Board representative of the business of healthcare as its sole segment.

Operating Division		**2016/17**			**2015/16 Restated**	
	Trust	**Hosted Services**	**Total**	**Trust**	**Hosted Services**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Diagnostics & Specialities	105,013	-	105,013	97,927	-	97,927
Medicine	116,613	-	116,613	106,704	-	106,704
Surgery	121,855	-	121,855	119,081	-	119,081
Women & Children	39,028	-	39,028	36,290	-	36,290
Estates & Facilities	34,504	-	34,504	32,749	-	32,749
Corporate Services	40,251	28,177	68,428	33,764	27,039	60,803
Trustwide	19,311	-	19,311	21,362	-	21,362
Capital financing	21,135	-	21,135	21,492	-	21,492
Total Expenditure	497,709	28,177	525,887	469,369	27,039	496,408
Total Income	479,741	28,177	507,918	463,266	27,039	490,305
Deficit	**(17,968)**	**-**	**(17,968)**	**(6,104)**	**-**	**(6,104)**

2015/16 & 2016/17 Hosted Services relate to GP and Public Health Trainee Schemes.

Reconciliation of Statement of Comprehensive Income (SOCI)

	2016/17	**2015/16 Restated**
	£000	**£000**
Statement of Comprehensive Income	(32,269)	(2,309)
Net impairments	14,301	-3,795
Deficit	**(17,968)**	**(6,104)**

Note 3 Operating income

Note 3.1 Income from activities (by nature)

	2016/17		2015/16 Restated	
	Trust	**Group**	**Trust**	**Group**
	£000	**£000**	**£000**	**£000**
Income from Activities				
Elective income	76,438	76,438	77,657	77,657
Non elective income	97,025	97,025	93,210	93,210
Outpatient income	68,511	68,511	69,645	69,645
A & E income	16,332	16,332	15,478	15,478
Other NHS clinical income	175,916	175,916	164,324	164,324
Private patient income	2,933	2,933	3,340	3,340
Other clinical income	2,714	2,714	2,264	2,264
Total income from activities	**439,869**	**439,869**	**425,918**	**425,918**
Other Operating Income				
Research and development	2,189	2,189	2,661	2,661
Education and training	12,897	12,897	12,587	12,587
Receipt of capital grants and donations	658	658	659	659
Non-patient care services to other bodies	10,536	10,536	10,659	10,659
Sustainability and Transformation Fund income	3,225	3,225	-	-
Income in respect of staff costs where accounted on gross basis	30,125	30,125	29,574	29,574
Incoming resources received by NHS charitable funds	-	1,236	-	910
Other income*****	6,685	6,685	8,212	8,212
Total other operating income	**66,315**	**67,551**	**64,352**	**65,262**
Of which:				
Related to continuing operations	66,315	67,551	64,352	65,262
Related to discontinued operations	-	-	-	-
	506,184	**507,420**	**490,270**	**491,180**

****** Analysis of Other Operating Income: Other**

	2016/17	2015/16 Restated
	Total	**Total**
	£000	**£000**
Car parking **	933	946
Crèche services	852	851
Catering	1,196	914
Other	3,704	5,501
Total	**6,685**	**8,212**

Note 3.2 Income from patient care activities (by source)

	2016/17		2015/16 Restated	
Income from patient care activities received from:	**Trust**	**Group**	**Trust**	**Group**
	£000	**£000**	**£000**	**£000**
CCGs and NHS England	429,366	429,366	415,328	415,328
Other NHS foundation trusts	8	8	247	247
NHS trusts	302	302	-	-
NHS other	4,546	4,546	4,649	4,649
Non-NHS: private patients	2,933	2,933	3,340	3,340
Non-NHS: overseas patients (chargeable to patient)	359	359	408	408
NHS injury scheme (was RTA)	1,309	1,309	790	790
Non NHS: other	1,046	1,046	1,156	1,156
Additional income for delivery of healthcare services	-	-	-	-
Total income from activities	**439,869**	**439,869**	**425,918**	**425,918**
Of which:				
Related to continuing operations	439,869	439,869	425,918	425,918
Related to discontinued operations	-	-	-	-

** with effect from 1 April 2010 the operation of the Trusts car parks was taken over by an external car parking provider. All revenues and expenses (see note 3.1) formerly derived by the Trust are now accounted for by the external operator. The income for car parks relates to commission paid by the provider to the Trust when certain income levels are met.

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	2016/17		2015/16 Restated	
	Trust	**Group**	**Trust**	**Group**
	£000	**£000**	**£000**	**£000**
Income recognised this year	359	359	408	408
Cash payments received in-year	207	207	202	202
Amounts added to provision for impairment of receivables	-	-	272	272
Amounts written off in-year	245	245	122	122

The £245k written-off in-year relates entirely to prior year debt provided for as part of 2015/16 restated accounts.

Note 4 Other operating income

Under the terms of its provider license, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2016/17		2015/16 Restated	
	Trust	**Group**	**Trust**	**Group**
	£000	**£000**	**£000**	**£000**
Income from services designated (or grandfathered) as commissioner requested services	429,366	429,366	415,328	415,328
Income from services not designated as commissioner requested services	-	-	-	-
Total	**429,366**	**429,366**	**415,328**	**415,328**

Note 4.1 Profits and losses on disposal of property, plant and equipment

The Trust disposed of 1 & 2 College Lawn (Trust HQ, office accommodation) during the financial year. The profit on disposal was £1,077k.

Note 5.1 Operating expenses

	2016/17		2015/16 Restated	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Services from NHS foundation trusts	1,531	1,531	1,510	1,510
Services from NHS trusts	7,606	7,606	8,640	8,640
Services from CCGs and NHS England	85	85	-	-
Services from other NHS bodies	512	512	39	39
Purchase of healthcare from non NHS bodies	285	285	330	330
Employee expenses - executive directors	1,540	1,540	1,244	1,244
Remuneration of non-executive directors	136	136	140	140
Employee expenses - staff	328,134	328,338	309,919	309,963
Supplies and services - clinical	48,174	48,174	46,556	46,556
Supplies and services - general	9,456	9,456	9,003	9,003
Establishment	4,396	4,396	4,249	4,249
Transport	1,085	1,085	1,028	1,028
Premises	21,131	21,131	19,370	19,370
Increase/(decrease) in provision for impairment of receivables	8	8	1,119	1,119
Change in provisions discount rate(s)	(2)	(2)	1	1
Drug costs	58,272	58,272	53,911	53,911
Rentals under operating leases	592	592	511	511
Depreciation on property, plant and equipment	9,946	9,946	9,847	9,847
Net impairments	14,301	14,301	(3,795)	(3,795)
Audit fees payable to the external auditor				
audit services- statutory audit	58	61	66	70
other auditor remuneration (external auditor only)	1,465	1,465	6	6
Clinical negligence	15,559	15,559	12,949	12,949
Legal fees	123	123	126	126
Consultancy costs	1,998	1,998	1,493	1,493
Internal audit costs	77	77	66	66
Training, courses and conferences	1,346	1,346	1,382	1,382
Patient travel	6	6	7	7
Car parking & security	255	255	276	276
Redundancy	-	-	30	30
Hospitality	15	15	14	14
Insurance	418	418	377	377
Losses, ex gratia & special payments	21	21	15	15
Other resources expended by NHS charitable funds	-	999	-	1,518
Other	150	150	539	539
Total	**528,679**	**529,885**	**480,968**	**482,534**

Of which:

All income and expenditure relates to continuing operations

Trust expenditure in 2016/17, excluding the impact of impairments, was £514,378k. For 2015/16, the comparable expenditure figure was £484,763k.

Note 5.2 Other auditor remuneration

	2016/17		2015/16	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Other auditor remuneration paid to the external auditor:				
1. Audit of accounts of any associate of the trust	-	-	-	-
2. Audit-related assurance services	9	9	6	6
3. Taxation compliance services	-	-	-	-
4. All taxation advisory services not falling within item 3 above	122	122	-	-
5. Internal audit services	-	-	-	-
6. All assurance services not falling within items 1 to 5	-	-	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-	-	-
8. Other non-audit services not falling within items 2 to 7 above	1,334	1,334	-	-
Total	**1,465**	**1,465**	**6**	**6**

The £1,334k of other auditor remuneration relates to advisory work in the following areas:
Turnaround support, CIP development and financial position normalisation.
All work was procured in line with Public Contract Regulations and was authorised as part of the NHS Improvement process for approving consultancy expenditure.

Note 5.3 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £2m (2015/16: £2m).

Note 6 Impairment of assets

	2016/17		2015/16	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Net impairments charged to operating deficit resulting from:				
Changes in market price	14,301	14,301	2,133	2,133
Other	-	-	(5,928)	(5,928)
Total net impairments charged to operating deficit	**14,301**	**14,301**	**(3,795)**	**(3,795)**
Impairments charged to the revaluation reserve	(3,867)	(3,867)	-	-
Total net impairments	**10,434**	**10,434**	**(3,795)**	**(3,795)**

The impairment charge to the operating surplus/deficit arises from the revaluation of the buildings on the balance sheet under the modern equivalent asset basis

Note 7 Employee benefits

	2016/17		2015/16 Restated	
	Trust	**Group**	**Trust**	**Group**
	£000	**£000**	**£000**	**£000**
Salaries and wages	**253,513**	**253,513**	245,853	245,853
Social security costs	**23,270**	**23,270**	17,701	17,701
Employer's contributions to NHS pensions	**31,099**	**31,099**	30,243	30,243
Temporary staff (including agency)	**21,792**	**21,792**	17,396	17,396
NHS charitable funds staff	**-**	**204**	-	44
Total gross staff costs	**329,674**	**329,878**	**311,193**	**311,237**
Recoveries in respect of seconded staff	**-**	**-**	-	-
Total staff costs	**329,674**	**329,878**	**311,193**	**311,237**

Note 7.1 Retirements due to ill-health

During 2016/17 there were 7 early retirements from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2016). The estimated additional pension liabilities of these ill-health retirements is £344k (£215k in 2015/16).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this ‘employer cost cap’ assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 9 Operating leases

Note 9.1 Gloucestershire Hospitals NHS Foundation Trust as a lessor

The Trust does not receive any operating lease income.

The Trust has a number of short term (tenable with 1 years notice by either side) "leases" whereby other NHS organisations within Gloucestershire use rooms or facilities. The charge incorporates facilities management together with other recharges to facilitate the use of the accommodation. Accordingly there is no rent as such to be able to split out of the total cost. The income such is therefore recorded above within other operational income.

Note 9.2 Gloucestershire Hospitals NHS Foundation Trust as a lessee

The Trust provides staff (subject to meeting certain criteria) with a lease vehicle, which is available for both personal and business duties. This is based on the NHS lease scheme. Vehicles are initially leased on a fully maintained basis for 3 years with an option to extend to a fourth year.

The Trust occupies a former Victorian Warehouse converted to office accommodation which houses the County's Finance and Procurement Shared Services. This lease is due to expire in September 2018.

	2016/17		2015/16	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Operating lease expense				
Minimum lease payments	592	592	511	511
Total	**592**	**592**	**511**	**511**

	31 March 2017		31 March 2016	
	Trust	Group	Trust	Group
Future minimum lease payments due:	£000	£000	£000	£000
- not later than one year;	397	397	470	470
- later than one year and not later than five years;	195	195	164	164
- later than five years.	-	-	-	-
Total	**592**	**592**	**634**	**634**
Future minimum sublease payments to be received	-	-	-	-

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2016/17		2015/16	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Interest on bank accounts	36	36	32	32
Investment income on NHS charitable funds financial assets	-	62	-	179
Other	-	-	-	-
Total	**36**	**98**	**32**	**211**

Note 11 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2016/17		2015/16	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Interest expense:				
Loans from the Department of Health	2,048	2,048	1,570	1,570
Commercial loans	12	12	-	-
Finance leases	277	277	345	345
Main finance costs on PFI and LIFT schemes obligations	1,362	1,362	1,421	1,421
Contingent finance costs on PFI and LIFT scheme obligations	731	731	851	851
Total interest expense	**4,430**	**4,430**	**4,187**	**4,187**
Other finance costs	-	-	8	8
Total	**4,430**	**4,430**	**4,195**	**4,195**

Note 12 Gains on disposal/derecognition of non-current assets

	2016/17		2015/16	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Profit on disposal of non-current assets	1,077	1,077	-	-
Net profit on disposal of non-current assets	**1,077**	**1,077**	**-**	**-**

The Trust disposed of 1 & 2 College Lawn, which was office accommodation, during the financial year. The profit on disposal was £1,077k.

Note 13 Foundation trust income statement and statement of comprehensive income

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The Group’s deficit for the period was £32,082k (2015/16: £2,898k deficit, restated). The Trust's total comprehensive income/(expense) for the period was -£28,215k (2015/16: -£2,271k).

Note 14.1 Intangible assets - 2016/17

Trust & Group	Development expenditure	Total
	£000	£000
Valuation/gross cost at 1 April 2016 - brought forward	**3,584**	**3,584**
Additions	3,809	**3,809**
Gross cost at 31 March 2017	**7,393**	**7,393**
Net book value at 31 March 2017	**7,393**	**7,393**
Net book value at 1 April 2016	**3,584**	**3,584**

Note 14.2 Intangible assets - 2015/16

Trust & Group	Development expenditure	Total
	£000	£000
Valuation/gross cost at 1 April 2015 - as previously stated	**594**	**594**
Gross cost at 1 April 2015 - restated	**594**	**594**
Additions	2,990	**2,990**
Valuation/gross cost at 31 March 2016	**3,584**	**3,584**
Net book value at 31 March 2016	**3,584**	**3,584**
Net book value at 1 April 2015	**594**	**594**

Note 15.1 Property, plant and equipment - 2016/17

Trust & Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016 - brought forward	**34,776**	**236,394**	**7,972**	**1,949**	**71,058**	**576**	**29,539**	**336**	**382,599**
Additions	-	3,944	-	633	3,222	-	1,965	-	**9,764**
Impairments	-	(36,480)	(232)	-	-	-	-	-	**(36,712)**
Reversals of impairments	-	26,278	-	-	-	-	-	-	**26,278**
Reclassifications	-	329	-	(329)	(194)	187	-	7	**(0)**
Disposals / derecognition	(510)	(1,203)	-	-	-	-	-	-	**(1,713)**
Valuation/gross cost at 31 March 2017	**34,266**	**229,262**	**7,740**	**2,253**	**74,086**	**763**	**31,504**	**343**	**380,216**
Accumulated depreciation at 1 April 2016 - brought forward	**-**	**(0)**	**0**	**-**	**49,969**	**571**	**23,125**	**333**	**73,998**
Provided during the year	-	3,874	153	-	4,155	28	1,726	10	**9,946**
Impairments	-	2,600	-	-	-	-	-	-	**2,600**
Reversals of impairments	-	(2,600)	-	-	-	-	-	-	**(2,600)**
Accumulated depreciation at 31 March 2017	**-**	**3,874**	**153**	**-**	**54,124**	**599**	**24,851**	**343**	**83,944**
Net book value at 31 March 2017	**34,266**	**225,388**	**7,587**	**2,253**	**19,962**	**164**	**6,653**	**-**	**296,272**
Net book value at 1 April 2016	**34,776**	**236,394**	**7,972**	**1,949**	**21,089**	**5**	**6,414**	**3**	**308,601**

Note 15.2 Property, plant and equipment - 2015/16

Trust & Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015	**33,654**	**238,249**	**10,695**	**2,666**	**65,327**	**576**	**25,950**	**336**	**377,452**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation/gross cost at 1 April 2015 - restated	**33,654**	**238,249**	**10,695**	**2,666**	**65,327**	**576**	**25,950**	**336**	**377,452**
Additions - purchased/ leased/ grants/ donations	-	4,477	-	1,541	5,731	-	3,589	-	**15,338**
Reclassifications	-	2,258	-	(2,258)	-	-	-	-	**-**
Revaluations	1,122	(8,590)	(2,723)	-	-	-	-	-	**(10,191)**
Valuation/gross cost at 31 March 2016	**34,776**	**236,394**	**7,972**	**1,949**	**71,058**	**576**	**29,539**	**336**	**382,599**
Accumulated depreciation at 1 April 2015	**(45)**	**10,172**	**720**	**-**	**45,424**	**536**	**21,721**	**326**	**78,854**
Accumulated depreciation at 1 April 2015	**(45)**	**10,172**	**720**	**-**	**45,424**	**536**	**21,721**	**326**	**78,854**
Provided during the year	-	3,637	219	-	4,545	35	1,404	7	**9,847**
Impairments	-	2,133	-	-	-	-	-	-	**2,133**
Reversals of impairments	-	(5,928)	-	-	-	-	-	-	**(5,928)**
Revaluations	45	(10,014)	(939)	-	-	-	-	-	**(10,908)**
Accumulated depreciation at 31 March 2016	**-**	**(0)**	**0**	**-**	**49,969**	**571**	**23,125**	**333**	**73,998**
Net book value at 31 March 2016	**34,776**	**236,394**	**7,972**	**1,949**	**21,089**	**5**	**6,414**	**3**	**308,601**
Net book value at 1 April 2015	**33,699**	**228,077**	**9,975**	**2,666**	**19,903**	**40**	**4,229**	**10**	**298,598**

Note 15.3 Property, plant and equipment financing - 2016/17

Trust & Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned	31,651	171,677	(0)	2,253	11,572	164	6,653	-	**223,969**
Finance leased	2,615	8,006	7,587	-	5,810	-	-	-	**24,018**
On-SoFP PFI contracts and other service concession arrangements	-	43,259	-	-	-	-	-	-	**43,259**
Donated	-	2,446	-	-	2,580	-	-	-	**5,026**
NBV total at 31 March 2017	**34,266**	**225,388**	**7,587**	**2,253**	**19,962**	**164**	**6,653**	**-**	**296,272**

Note 15.4 Property, plant and equipment financing - 2015/16

Trust & Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2016									
Owned	32,161	194,605	(0)	1,949	11,267	5	6,414	3	**246,403**
Finance leased	2,615	8,929	7,972	-	7,260	-	-	-	**26,776**
On-SoFP PFI contracts and other service concession arrangements	-	30,503	-	-	-	-	-	-	**30,503**
Donated	-	2,357	-	-	2,562	-	-	-	**4,919**
NBV total at 31 March 2016	**34,776**	**236,394**	**7,972**	**1,949**	**21,089**	**5**	**6,414**	**3**	**308,601**

Disclosure

Included within the land (£2,615k) and dwelling (£7,819k) above at 31 March 2017 relate to a number of properties formerly in the ownership of Gloucestershire Royal NHS Trust and the East Gloucestershire NHS Trust (which now form the Gloucestershire Hospitals NHS Foundation Trust) sold to a registered Housing Association in April 2000 and June 2004 respectively. These units were for residential accommodation mainly to NHS staff and families. The registered Housing Association is now responsible for this provision with the Trust having nomination rights. Both separate agreements contain a 99 year lease with a Trust only option to break at 30 years and every 5 years, which if exercised will enable the Trust to take back the freehold of the land and buildings with vacant possession at no cost. They have been valued by the independent professional advisor on a fair value basis.

Plant and machinery includes a number of "finance leases" included as part of the IFRS requirements which relate to high cost medical equipment which the Trust will use for the whole primary lease period which is consistent with its perceived asset life. At the balance sheet date the value of these leases equates to £5,810k. This equipment is for Radiology equipment, linear accelerators and ultrasound machines . At the Statement of Financial Position date the Trust has entered into 3 new finance leases agreements, the equipment was made available during the year. The minimum payments under the lease total £700k payable over 7 or 5 years.

Included within building is the PFI scheme consisting of a Diagnostic & Treatment centre, therapy services, a new accident and emergency department and 75 inpatient bed spaces. The scheme was handed over in April 2002 and runs for 31 years and 10 months from that date. The initial scheme cost including all fees was £38m. The value at the Statement of Financial Position date is £43.3m.

With the exception of plant and machinery the above values have been determined by the the Trust's Independent Valuer, revaluation of the Trust estate to DRC values consistent with Department of Health guidance.

The residential accommodation properties above have been valued at market value, which have been valued under current value as above.

In April 2011 a new Multi Storey Car Park became operational. This facility has been constructed by a third party on land owned by the Trust and leased to the Third party for a period of 30 years.

During that period the car park will be used for car parking by staff and visitors at Gloucestershire Royal Hospital. The third party operator will receive all income and be responsible for all out goings with the Trust receiving income when a certain level of receipts are achieved. The value of its construction was £8.7m, which was brought onto the balance sheet at 31 March 2012 as a leased asset offset by deferred income.

In August 2014 the new Hereford Radiotherapy Centre became operational. This facility has been constructed on land owned by a third party This has previously been classified as a asset under construction and in 2014-15 was reclassified as a long term debtor to be amortised over a period of 25 years.

Note 16 Donations of property, plant and equipment

Additions - donated relate to assets either purchased wholly or items partially funded by the Trust's own charitable funds. The Charitable Funds are administered by the Trust's Main Board as Corporate Trustees. Funds are registered with the Charity Commissioners registration charity number 1051606. Additionally from time to time an external charity working closely with the Trust may provide funding directly for a capital project.

Note 17 Revaluations of property, plant and equipment

The value and remaining useful asset lives of land and building assets are estimated by the Trust's Independent Valuer. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property.

A desk top modern equivalent asset valuation exercise was undertaken during 2016/17 in line with national guidance on revaluation cycles. At the valuation date of 31 March 2017, land and buildings have suffered an overall impairment loss, i.e. a reduction in value totalling £14,301k.

The appropriate assets have been written down to their recoverable amount within the Statement of Financial Position, with the loss charged to the revaluation reserve to the extent there was a balance remaining and thereafter to expenditure as an impairment of property, plant and equipment.

Note 18 Other investments

	2016/17		2015/16	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Carrying value at 1 April	-	**1,974**	-	**2,423**
Movement in fair value	-	95	-	(112)
Disposals	-	(100)	-	(337)
Carrying value at 31 March	-	**1,969**	-	**1,974**

Note 19 Analysis of charitable fund reserves

	31 March 2017	31 March 2016
	£000	£000
Unrestricted funds:		
Unrestricted income funds	1,780	1,688
Other reserves	426	331
Restricted funds:		
Restricted income funds	2	2
	2,208	**2,021**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 20 Inventories

	2016/17		2015/16	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Drugs	2,672	2,672	3,403	3,403
Consumables	4,277	4,277	4,186	4,186
Energy	450	450	446	446
Total inventories	**7,400**	**7,400**	**8,036**	**8,036**

Inventories recognised in expenses for the year were £106,467k (2015/16: £68,406k). Write-down of inventories recognised as expenses for the year were £0k (2015/16: £0k).

Note 21.1 Trade receivables and other receivables

	31 March 2017		31 March 2016 Restated	
	Trust	**Group**	**Trust**	**Group**
	£000	**£000**	**£000**	**£000**
Current				
Trade receivables due from NHS bodies	7,895	7,895	22,239	22,239
Provision for impaired receivables	(1,617)	(1,617)	(2,205)	(2,205)
Prepayments (non-PFI)	1,952	1,952	1,208	1,208
Accrued income	6,209	6,209	1,977	1,977
PDC dividend receivable	207	207	-	-
VAT receivable	592	592	703	703
Other receivables	2,459	2,459	2,502	2,620
Trade and other receivables held by NHS charitable funds	-	63	-	38
Total current trade and other receivables	**17,697**	**17,760**	**26,424**	**26,580**
Non-current				
Other receivables	4,668	4,668	4,505	4,505
Total non-current trade and other receivables	**4,668**	**4,668**	**4,505**	**4,505**

Other receivables 2016/17, £4,668k consists of Residential accommodation (£700k), Hereford Radiotherapy Centre £3,635k and Road Traffic Accident income £1,733k

Other receivables 2015/16, £4,505k consists of Residential accommodation (£743k), Hereford Radiotherapy Centre £3,856k and Road Traffic Accident income £1,392k

Note 21.2 Provision for impairment of receivables

	2016/17		2015/16 Restated	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
At 1 April as previously stated	**2,205**	**2,205**	**1,199**	**1,199**
Prior period adjustments	-	-	-	-
At 1 April - restated	**2,205**	**2,205**	**1,199**	**1,199**
Increase in provision	125	125	1,351	1,351
Amounts utilised	(596)	(596)	(113)	(113)
Unused amounts reversed	(117)	(117)	(232)	(232)
At 31 March	**1,617**	**1,617**	**2,205**	**2,205**

Note 21.3 Analysis of financial assets

Trust & Group	**31 March 2017**	**31 March 2016 Restated**
	Trade and other receivables	**Trade and other receivables**
Ageing of impaired financial assets	**£000**	**£000**
0 - 30 days	-	-
30-60 Days	-	-
60-90 days	-	-
90- 180 days	-	-
Over 180 days	1,617	2,205
Total	**1,617**	**2,205**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	975	1,181
30-60 Days	310	302
60-90 days	79	97
90- 180 days	120	98
Over 180 days	163	-
Total	**1,647**	**1,678**

The above analysis of financial assets excludes NHS debt.

Note 22 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2016/17		2015/16	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
At 1 April	**3,950**	**4,148**	**10,662**	**10,695**
Prior period adjustments	-	-	-	-
At 1 April (restated)	**3,950**	**4,148**	**10,662**	**10,695**
Net change in year	4,024	4,072	(6,712)	(6,547)
At 31 March	**7,974**	**8,220**	**3,950**	**4,148**
Broken down into:				
Cash at commercial banks and in hand	9	9	13	13
Cash with the Government Banking Service	7,965	8,211	3,937	4,135
Total cash and cash equivalents as in SoFP	**7,974**	**8,220**	**3,950**	**4,148**
Total cash and cash equivalents as in SoCF	**7,974**	**8,220**	**3,950**	**4,148**

Note 22.1 Third party assets held by the NHS Foundation Trust

Gloucestershire Hospitals NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Foundation Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

Note 23 Trade and other payables

	31 March 2017		31 March 2016 Restated	
	Trust	**Group**	**Trust**	**Group**
	£000	**£000**	**£000**	**£000**
Current				
NHS trade payables	5,077	5,077	9,577	9,577
Capital payables	1,723	1,723	3,696	3,696
Social security costs	6,594	6,594	5,818	5,818
Other payables	9,847	9,847	20,072	20,072
Accruals	21,114	21,114	20,301	20,301
PDC dividend payable	-	-	62	62
Trade and other payables held by NHS charitable funds	-	70	-	307
Total current trade and other payables	**44,355**	**44,425**	**59,526**	**59,833**

Note 24 Other liabilities

	31 March 2017		31 March 2016 Restated	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Current				
Deferred grants income	2,089	2,089	623	623
Total other current liabilities	**2,089**	**2,089**	**623**	**623**
Non-current				
Other deferred income	7,612	7,612	7,987	7,987
Total other non-current liabilities	**7,612**	**7,612**	**7,987**	**7,987**

Note 25 Borrowings

	31 March 2017		31 March 2016	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Current				
Loans from the Department of Health	2,635	2,635	2,635	2,635
Obligations under finance leases	2,046	2,046	2,129	2,129
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	675	675	519	519
Total current borrowings	**5,356**	**5,356**	**5,283**	**5,283**
Non-current				
Loans from the Department of Health	59,966	59,966	29,179	29,179
Obligations under finance leases	4,525	4,525	6,049	6,049
Obligations under PFI, LIFT or other service concession contracts	18,635	18,635	19,309	19,309
Total non-current borrowings	**83,126**	**83,126**	**54,537**	**54,537**

Note 26 Finance leases

Trust as a lessor
Future lease receipts due under finance lease agreements where Gloucestershire Hospitals NHS Foundation Trust is the lessor:

The Trust did not have any finance lease agreement as a lessor.

Trust as a lessee
Obligations under finance leases where Gloucestershire Hospitals NHS Foundation Trust is the lessee.

	31 March 2017		31 March 2016	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Gross lease liabilities	**7,217**	**7,217**	**9,034**	**9,034**
of which liabilities are due:				
- not later than one year;	2,260	2,260	2,400	2,400
- later than one year and not later than five years;	4,121	4,121	5,618	5,618
- later than five years.	836	836	1,016	1,016
Finance charges allocated to future periods	(646)	(646)	(857)	(857)
Net lease liabilities	**6,571**	**6,571**	**8,177**	**8,177**
of which payable:				
- not later than one year;	2,046	2,046	2,129	2,129
- later than one year and not later than five years;	3,789	3,789	5,158	5,158
- later than five years.	736	736	891	891

Note 27.1 Provisions for liabilities and charges analysis

Trust & Group	Pensions - early departure costs	Other legal claims	Total
	£000	£000	£000
At 1 April 2016	**1,483**	**99**	**1,582**
Change in the discount rate	(2)	-	**(2)**
Arising during the year	218	48	**266**
Utilised during the year	(88)	-	**(88)**
Reversed unused	-	(52)	**(52)**
At 31 March 2017	**1,611**	**95**	**1,706**
Expected timing of cash flows:			
- not later than one year;	87	95	**182**
- later than one year and not later than five years;	348	-	**348**
- later than five years.	1,176	-	**1,176**
Total	**1,611**	**95**	**1,706**

Note 27.2 Clinical negligence liabilities

At 31 March 2017, £185,143k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Gloucestershire Hospitals NHS Foundation Trust (31 March 2016: £155,041k).

Note 28 Contingent assets and liabilities

	31 March 2017		31 March 2016	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Value of contingent liabilities				
Other	(587)	(587)	(790)	(790)
Gross value of contingent liabilities	**(587)**	**(587)**	**(790)**	**(790)**
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	**(587)**	**(587)**	**(790)**	**(790)**
Net value of contingent assets				

The contingent liability arises from an assessment of the impact of the Bear Scotland ruling relating to whether overtime needs to be included in holiday pay calculations.

The Trust has assessed the impact as a contingent liability given that payment is not considered probable. The base contingent liability has been valued at £500k, with an additional £87k relating to Early Retirement Injury Benefit. The reduction from the prior year is all attributable to a reassessment of the Early Retirement Injury Benefit.

Note 29 Contractual capital commitments

	31 March 2017		31 March 2016	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Property, plant and equipment	1,983	1,983	1,800	1,800
Intangible assets	1,400	1,400	2,700	2,700
Total	**3,383**	**3,383**	**4,500**	**4,500**

Note 30 Defined benefit pension schemes

The Trust's past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Note 31 On-SoFP PFI, LIFT or other service concession arrangements

Note 31.1 Imputed finance lease obligations

The trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2017		31 March 2016	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Gross PFI, LIFT or other service concession liabilities	**33,877**	**33,877**	**35,759**	**35,759**
Of which liabilities are due				
- not later than one year;	1,998	1,998	1,882	1,882
- later than one year and not later than five years;	6,808	6,808	6,981	6,981
- later than five years.	25,071	25,071	26,896	26,896
Finance charges allocated to future periods	(14,567)	(14,567)	(15,931)	(15,931)
Net PFI, LIFT or other service concession arrangement obligation	**19,310**	**19,310**	**19,828**	**19,828**
- not later than one year;	675	675	519	519
- later than one year and not later than five years;	1,822	1,822	1,866	1,866
- later than five years.	16,813	16,813	17,443	17,443

Note 31.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

The trust's total future obligations under these on-SoFP schemes are as follows:

	31 March 2017		31 March 2016	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	102,982	102,982	107,816	107,816
Of which liabilities are due				
- not later than one year;	4,955	4,955	4,834	4,834
- later than one year and not later than five years;	21,089	21,089	20,575	20,575
- later than five years.	76,938	76,938	82,407	82,407

Note 31.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's payments in 2016/17:

	31 March 2017		31 March 2016	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
Unitary payment payable to service concession operator	**5,201**	**5,201**	**5,146**	**5,146**
Consisting of:				
- Interest charge	1,362	1,362	1,421	1,421
- Repayment of finance lease liability	519	519	976	976
- Service element and other charges to operating expenditure	1,847	1,847	1,522	1,522
- Capital lifecycle maintenance	742	742	-	-
- Revenue lifecycle maintenance	-	-	376	376
- Contingent rent	731	731	851	851
- Addition to lifecycle prepayment	-	-	-	-
Total amount paid to service concession operator	**5,201**	**5,201**	**5,146**	**5,146**

Note 32 Off-SoFP PFI, LIFT and other service concession arrangements

The Trust has no Off-SoFP PFI Scheme

Note 33 Financial instruments

Note 33.1 Financial risk management

A financial instrument is a contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

IFRS 7, Financial Instruments Disclosure and Presentation, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities.

Credit Risk

Because of the continuing service provider relationship that the NHS Foundation Trust has with local Clinical Commissioning Groups and NHS England and the way those bodies are financed, the NHS Foundation Trust is not exposed to the degree of credit risk faced by many other business entities. The Trust has invoices for services and facilities provided to NHS organisations which are currently being queried by the other parties, notably NHS bodies, within Gloucestershire and Welsh NHS bodies .These are subject to a provision for impaired receivables as set out in note 21.1. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies.

Market Risk

This is the risk that the fair value or cash flows of a financial instrument will fluctuate because of changes in market prices. This includes currency risk (foreign exchange rates) and interest rate risk.

The NHS Foundation Trust has limited powers to borrow or invest surplus funds. Cash is held on deposit with a number of safe harbour institutions which are deemed to have significantly low risk and high liquidity.

100% of the Foundation Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Gloucestershire Hospitals NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk. The Trusts PFI scheme unitary payments are linked to RPI.

Liquidity risk

This is the risk that the NHS Foundation Trust will encounter difficulties meeting obligations associated with financial liabilities.

The NHS Foundation Trust's net operating costs are incurred under annual service agreements with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Foundation Trust also largely finances its capital expenditure from funds made available from Government under an agreed limit. Gloucestershire Hospitals NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

Note 33.2 Financial assets

Trust & Group	Loans and receivables	Assets at fair value through the I&E	Total
	£000	£000	£000
Assets as per SoFP as at 31 March 2017			
Trade and other receivables excluding non financial assets	22,158	-	**22,158**
Cash and cash equivalents at bank and in hand	7,974	-	**7,974**
Financial assets held in NHS charitable funds	246	1,969	**2,215**
Total at 31 March 2017	**30,378**	**1,969**	**32,347**

Trust & Group	Loans and receivables	Assets at fair value through the I&E	Total
	£000	£000	£000
Assets as per SoFP as at 31 March 2016			
Trade and other receivables excluding non financial assets	32,438	-	**32,438**
Cash and cash equivalents at bank and in hand	3,950	-	**3,950**
Financial assets held in NHS charitable funds	198	1,974	**2,172**
Total at 31 March 2016 Restated	**36,586**	**1,974**	**38,560**

Note 33.3 Financial liabilities

Trust & Group	Other financial liabilities	Total
	£000	£000
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	62,601	**62,601**
Obligations under finance leases	6,571	**6,571**
Obligations under PFI, LIFT and other service concession contracts	19,310	**19,310**
Trade and other payables excluding non financial liabilities	44,425	**44,425**
Total at 31 March 2017	**132,907**	**132,907**

Trust & Group	Other financial liabilities	Total
	£000	£000
Liabilities as per SoFP as at 31 March 2016		
Borrowings excluding finance lease and PFI liabilities	31,814	**31,814**
Obligations under finance leases	8,177	**8,177**
Obligations under PFI, LIFT and other service concession contracts	19,828	**19,828**
Trade and other payables excluding non financial liabilities	47,287	**47,287**
Total at 31 March 2016 Restated	**107,106**	**107,106**

Note 33.4 Maturity of financial liabilities

	31 March 2017		31 March 2016	
	Trust	Group	Trust	Group
	£000	£000	£000	£000
In one year or less	49,781	49,781	52,569	52,569
In more than one year but not more than two years	4,369	4,369	5,283	5,283
In more than two years but not more than five years	43,844	43,844	12,281	12,281
In more than five years	34,913	34,913	36,973	36,973
Total	**132,907**	**132,907**	**107,106**	**107,106**

Note 34 Losses and special payments

Trust & Group	2016/17 Total number of cases Number	2016/17 Total value of cases £000	2015/16 Total number of cases Number	2015/16 Total value of cases £000
Losses				
Bad debts and claims abandoned	2,190	596	1,258	157
Total losses	**2,190**	**596**	**1,258**	**157**
Special payments				
Ex-gratia payments	47	16	30	7
Total special payments	**47**	**16**	**30**	**7**
Total losses and special payments	**2,237**	**612**	**1,288**	**164**
Compensation payments received				

In addition to the £596k of bad debts and claims abandoned a further £310k relating to a prior year charge to NHS South Worcestershire CCG was reversed during the year. This had been assessed separately in the 2015/16 final accounts position.

Note 35 Transfers by absorption

The Trust had no transfers by absorption

Note 36 Prior period adjustments

In response to declining cash reserves over recent years and a material worsening of the financial position for 2016/17 the Trust has undertaken an in-depth review of the 2015/16 accounts position. This has been supported by external independent reports.

Following this review the Trust has identified a number of errors which materially impact the overall view of the financial position presented in the prior year accounts, i.e. to 31 March 2016 as a result of oversights and misinterpretations of facts in their production.

The Board has reviewed these errors individually and in aggregate and, in accordance with International Accounting Standard 8 Presentation of Financial Information have proposed a prior year adjustment (PPA) to correct the errors, resulting in a net impact on the reported surplus for the year ended 31 March 2016 of £6,981k. This adjustment has been discussed with and understood by NHS Improvement as the Trust Regulator.

The PPA includes a reduction in reported revenue of £2,793k and increase in costs of £4,188k for the year ending 31 March 2016 arising from a number of issues which are summarised below:

- Settlement agreements on income, agreed at time of accounts preparation, not being accounted for in full
- Impacts of decisions reached through binding mediation not being accounted for in full
- A number of known liabilities not being accounted for
- Income and expenditure for specific projects that had not been appropriately accounted for across financial years
- Oversights around provisioning, with particular reference to bad debt

	2015/16 Reported £000	PPA Adjustment £000	Impairments Adjustment £000	2015/16 Restated £000
SOCI				
Total Operating Income	498,990	(2,793)	(5,927)	490,270
Operating Expenses	(482,708)	(4,188)	5,927	(480,969)
Total	**16,282**	**(6,981)**	**-**	**9,301**
SOFP				
Total Current Assets	42,597	(4,187)		38,410
Total Current Liabilities	(62,824)	(2,794)		(65,618)
		(6,981)		
I&E Reserve	(1,519)	(6,981)		(8,500)

An additional adjustment to the prior year has been made to recognize impairment reversals of £5.9m in expenditure rather than income. This has no overall net effect on the Trust's deficit position. This was due to an an amendment in the Group Accounting Manual.

Note 37 Events after the reporting date

The Trust has no events after the reporting period

Note 38 Related parties

Gloucestershire Hospitals NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the period, none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Gloucestershire Hospitals NHS Foundation Trust.

The Department of Health is regarded as a related party. During the period, Gloucestershire Hospitals NHS Foundation Trust, including in carrying out its role of host to the Gloucestershire Finance, Procurement and Estates Shared Services, has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

NHS Gloucestershire CCG
NHS Wyre Forest CCG
NHS Redditch & Bromsgrove CCG
NHS South Worcestershire CCG
NHS Herefordshire CCG
NHS Wiltshire CCG
NHS Swindon CCG
NHS South Warwickshire CCG
NHS Oxfordshire CCG
NHS England
Wye Valley NHS Trust
The Welsh Assembly (as part of NHS Wales which includes a number of commissioners)
2 gether NHS Foundation Trust
Gloucester City Council
Cheltenham Borough Council
NHS Litigation Authority
NHS Logistics Authority
NHS Blood and Transplant Service
NHS Pensions Agency

The Foundation Trust has also received revenue and capital payments from its charitable fund. The

	Receivables		Payables	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Value of balances with related parties				
- Department of Health	213	63	-	62
- Other NHS bodies	11,940	23,445	16,028	8,814
Total	**12,153**	**23,508**	**16,028**	**8,876**

	Income		Expenditure	
	2016/17 £000	2015/16 £000	2016/17 £000	2015/16 £000
Value of balances with related parties				
- Department of Health	45	202	3	-
- Other NHS bodies	495,094	475,502	88,523	26,015
Total	**495,139**	**475,704**	**88,526**	**26,015**

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – 26 MAY 2017

Report Title
DRAFT QUALITY ACCOUNT 2016/17
Sponsor and Author(s)
Author: Alison Warren, Deputy Head of Communications Presenting Director: Sally Pearson, Director of Clinical Strategy
Executive Summary

Purpose

The purpose of this paper is to present to the Board the Quality and Performance the Quality Account 2016/17 prior to its submission to the NHSE and NHSI by the end of May.

Key issues to note

The Quality Account is the annual report about the quality of care within NHs organisations and is intended to increase public accountability and drive improvements in care. It sets out progress against the priorities for 2016/17, and our priorities for 2017/18.

Priorities or the coming year were identified by reviewing:

- our own performance data
- progress within the priorities for 2016/17
- national priorities
- issues raised with us throughout the year by key stakeholders both within and outside our organisation, including our Council of Governors, Gloucestershire Clinical Commissioning Group, Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC) and HealthWatch Gloucestershire,

An initial list of priorities for 2017/18 derived from these sources and national guidance was reviewed by our Board on 25 November 2016 and by our Council of Governors 28 November 2016 and then shared with Gloucestershire Clinical Commissioning Group, Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC) and Healthwatch Gloucestershire during December to allow them to identify any further priorities that they would want us to consider.

The format of the document is prescribed and includes statements on the account from Gloucestershire CCG, Gloucestershire Health and Care Overview and Scrutiny Committee, Gloucestershire Healthwatch

As in previous years NHS foundation trust auditors are required to review the content of the quality account against the requirements set out in the NHS foundation trust Annual Reporting Manual and provide a signed limited assurance report (which is included in the quality account) and provide a report to the NHS foundation trust's council of governors and board of directors (the Governors' Report) of their findings and recommendations for improvements.

To date they have not identified any concerns with the content or format of the report, although our inability to report our referral to treatment performance for a portion of the year will limit the assurance they can provide

Conclusions

The 2017/18 Quality Account, complies with the national requirements and can be submitted to NHSE

and NHSI

Implications and Future Action Required

The Quality Account will be submitted to NHSE and NHSI by 31 May and published on our website and the NHS Choices website.
The Quality Account will form the Quality section of our Annual Report
Progress against the priorities for 2017/18 will be monitored by the Quality and Performance Committee
The External Auditor's report on the outcome of the external assurance of the Quality Account will be presented to the Council of Governors on 13th September 2017.

Recommendations

The Board is recommended to endorse the Quality Account for submission to NHSE and NHSI

Impact Upon Strategic Objectives

Progress with the priorities in the Quality Account will help us to achieve our strategic objectives in the domain of "Our Patients"

Impact Upon Corporate Risks

None

Regulatory and/or Legal Implications

The publication of a Quality Account is a regulatory requirement

Equality & Patient Impact

None

Resource Implications

Finance		Information Management & Technology	
Human Resources		Buildings	
None			

Action/Decision Required

For Decision		For Assurance		For Approval	X	For Information	

Date the paper was presented to previous Committees

Quality & Performance Committee	Finance Committee	Audit Committee	Remuneration & Nomination Committee	Senior Leadership Team	Other (specify)
27/04/2017					

Outcome of discussion when presented to previous Committees

Final draft endorsed for circulation to stakeholders for them to provide their statements.

NHS
Gloucestershire Hospitals
NHS Foundation Trust
Quality
Account
2016/17
www.gloshospitals.nhs.uk
BEST CARE FOR EVERYONE

What is a quality account?

A Quality Account is an annual report about the quality of services provided by an NHS healthcare organisation.

Quality Accounts aim to increase public accountability and drive quality improvements in the NHS. Our Quality Account looks back on how well we have done in the past year at achieving our goals.

It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

Glossary Symbol
This symbol ℹ indicates a term's inclusion in the glossary on p79.

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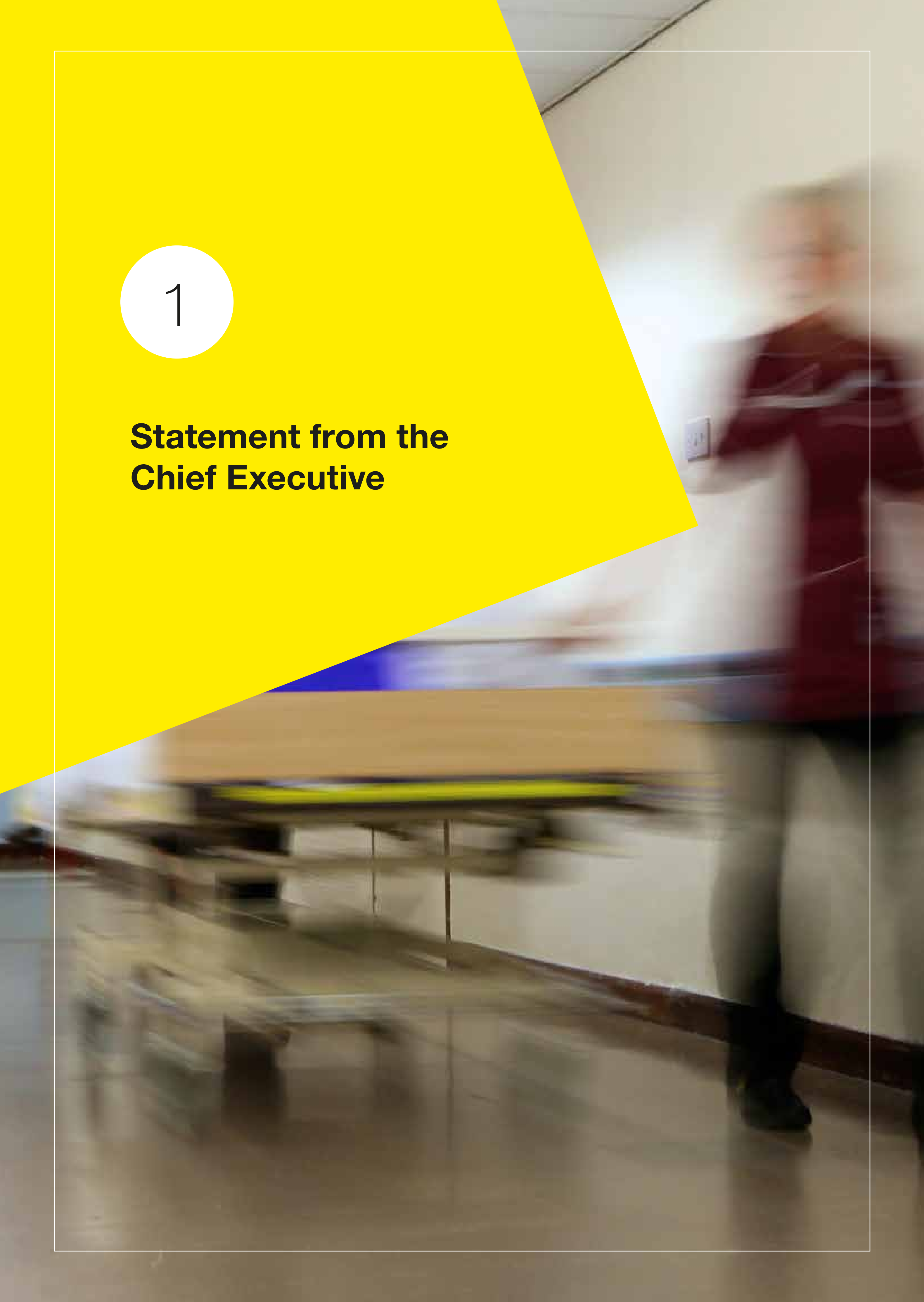

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Statement from the Chief Executive

Welcome to the Quality Account for 2016/17.

I am delighted to introduce this year's Quality Account for Gloucestershire Hospitals NHS Foundation Trust. Since joining the Trust in June last year, I have been struck by the number of tremendous examples where our staff are leading the way in delivering high quality care and receiving acclaim, both locally and nationally, for the things that we are doing here in Gloucestershire.

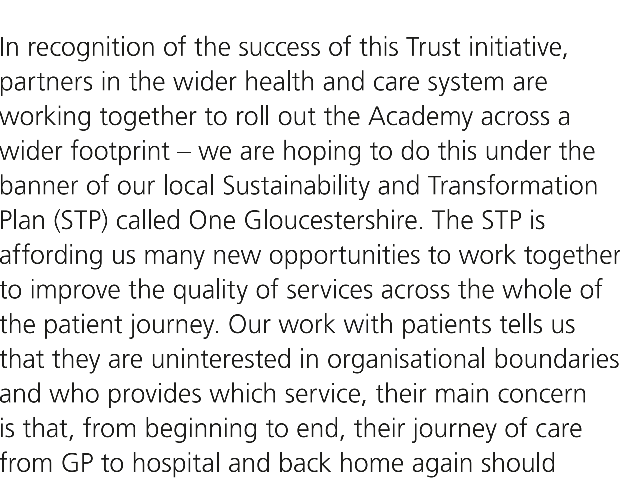
The Quality Account is our opportunity to reflect on and celebrate the things we have achieved in the last year and to look ahead and set out our quality priorities for the future.

2016/17 was a challenging year for the Trust following announcements in September 2016 that our financial position was significantly worse than had been previously understood. However, to our staff's credit they have continued to improve the quality of care for all of our patients and to use innovation and transformation as a means of addressing our financial challenges whilst maintaining or improving the quality of care we are able to offer to our patients.

We also launched our new patient administration system, TrakCare, in December 2016, designed to modernise the way we manage clinical information supporting improvements in care delivery. Four months on it is clear that we underestimated the impact it would have, and continues to have, on our services. We are working hard to address the operational issues that have arisen since we went live and to ensure that, until such time as the issues are resolved and benefits realised, we limit the impact on our patients' experience, particularly in outpatient care where the impact is being felt most acutely.

My personal focus since arriving in the Trust some eight months ago has been to create an environment and a culture where staff can flourish and deliver our vision of Best Care For Everyone. This requires a culture where we are willing to listen to staff about the things that constrain them from delivering high quality care, a culture where staff are supported to innovate and improve their own services and a culture where we are willing to embrace, as golden opportunities, the things that (on occasions) go wrong so that we can learn and improve care for the future.

One of the means through which we are striving to support staff to play their part of quality improvement is the Gloucestershire Safety & Quality Improvement Academy (GSQIA). More than 500 staff have now undertaken the first level of training which equips them with the basic knowledge and tools to undertake small scale quality improvement at the ward or department level. I too am the proud owner of a Bronze Award having joined staff and other Board members in a training session!



In recognition of the success of this Trust initiative, partners in the wider health and care system are working together to roll out the Academy across a wider footprint – we are hoping to do this under the banner of our local Sustainability and Transformation Plan (STP) called One Gloucestershire. The STP is affording us many new opportunities to work together to improve the quality of services across the whole of the patient journey. Our work with patients tells us that they are uninterested in organisational boundaries and who provides which service, their main concern is that, from beginning to end, their journey of care from GP to hospital and back home again should feel joined up and of consistently high quality.

One of the most important measures of how we are doing when it comes to quality of care is what patients tell us about their experience of our services and our staff. One of the ways that I keep in touch with the day to day reality of what it feels like to be a patient in one of our hospitals, is to ensure that I review each and every patient complaint that the Trust receives. Thankfully alongside this I also have the pleasure of reviewing the many, many compliments we also get which far outweighs complaints. When we get it very right for patients there are typically two common characteristics.

Firstly, patients feeling like they have been treated as an individual, viewed by staff as a partner in their care with services tailored to their specific needs and preferences and always delivered with kindness and compassion. The second trait is truly excellent communication. Poor communication is the biggest issue raised in complaints about care, rarely the technical care or the outcome, but how patients and their families were listened to and communicated with. Supporting staff to deliver compassionate, individualised care will remain one of the Trust's highest

priorities for the coming year. I shall be keeping a close eye on the post bag, hoping to see improvements in this area and I am delighted to welcome Suzie Cro, our recently appointed Head of Patient Experience, to support our endeavours in this regard.

One highlight of 2016/17 was a recent visit by the Care Quality Commission. In January 2017, the CQC re-inspected the Trust following their visit in 2015. As ever, staff were amazing in ensuring that we were prepared and ready to greet the 30+ inspectors that toured our services over a busy four-day period. Many were eager to share their examples of great care and quality improvement with inspectors and I, for one, was very proud of how we embraced the inspection and the insights it will afford us to improve care further. We have yet to receive the final inspection report but early feedback reflects many positive examples of where we have improved the quality of care for patients. I am hopeful that some of those areas rated as Requiring Improvement in 2015 will be officially recognised as good and maybe even outstanding!

There are numerous quality improvement highlights in the year gone by, but a couple that stand out for me are the progress we have made to improve outcomes for patients who experience a hip fracture and the care for those patients who are approaching the end of their life. A year ago, patients in Gloucester were likely to experience a poorer outcome, following in hip fracture, than in many other neighbouring hospitals. The Trust's response to this was to embrace quality improvement and become part of a national programme to improve outcomes for this group of patients – nine months into the programme, patients cared for in Gloucestershire Royal Hospital can now expect to achieve significantly improved outcomes, better than the national average, as a result of the initiative and this includes a tremendous 29% improvement in survival following hip fracture.

With the same focus on learning and quality improvement, following feedback from the CQC in 2015, staff involved in delivering end of life care to patients and their families have worked tirelessly to improve services both within and outside of the hospital to support patients to have a "good death" and whenever it is their wish, to die at home. Of particular note is the extent to which we have embraced this across all services and diagnoses, not just in respect of the care for those dying from cancer.

Looking ahead, section 2.1.2 of the report sets out our priorities for the coming year. A number of these build upon last year's priorities where they remain relevant or where we didn't achieve the quality goals that we set ourselves, and I am confident that with this clarity and focus on the things that matter most, we will see the quality of our services improve even further in the coming year.

I do hope you enjoy reading more about the things that our staff have achieved in the last year and hearing more about our priorities for the coming year to ensure our vision of Best Care for Everyone becomes a reality.

And finally, the formal bit – I can confirm that to the best of my knowledge, the information included in this report has been subject to all appropriate scrutiny and validation checks and as such represent a true picture of the Trust's activities and achievements in respect of quality.

Deborah Lee,
Chief Executive Officer

2

Our priorities and statements of assurance

Helping us improve the quality of care

Each year our Quality Committee agrees a set of priorities which help us improve the quality of care we provide for our patients.

These priorities are identified because they are important to our regulators and/or commissioners or are decided following discussions with our Council of Governors, the Gloucestershire Health and Care Overview and Scrutiny Committee (HCOSC) and Healthwatch Gloucestershire. We also meet at regular intervals throughout the year with Healthwatch Gloucestershire to maintain a continuing dialogue and ensure any issues raised can be addressed in our improvement plans.

The following section is divided into four parts:

- How well have we done in 2016/17: looks at what our priorities were during 2016/17 and whether we achieved the goals we set ourselves. Where performance was below what was expected we explain what went wrong and what we are doing to improve
- What are our priorities for 2017/18: explains why these priorities have been identified and how we intend to meet our targets in the year ahead
- Statements of assurance from the Board
- Reporting against core indicators.

The later sections of the report provide an overview of the range of services we offer and give some context to the data we share in section three.

The Quality & Performance Committee is responsible for monitoring the progress of the organisation against our quality improvement priorities. The Committee meets eight times a year and reviews a series of measures which give us a picture of how well we are doing.

The Quality & Performance Committee is a sub-committee of the Board and has clinical and managerial representation from across our Trust. It includes non-executive directors, executive directors, governors, representation from Gloucestershire Clinical Commissioning Group and is currently chaired by Dr Claire Feehily, Non-Executive Director. From April - December 2016 the committee was chaired by Helen Munro and from January - February 2017 by Keith Norton, both Non-Executive Directors.

Our priorities

Our priorities for improving quality

The table opposite provides an overview of our priorities for 2016/17. This table gives you an at-a-glance view of the work undertaken in the past year and which of our stakeholder groups identified the priorities for improvement.

In 2016/17 our priorities were aligned with the dimensions of quality we are measured against by the Care Quality Commission: Safe, Effective, Caring, Responsive and Well-led.

Progress against the priorities identified was measured by agreed metrics and monitored by the Quality & Performance Committee throughout the year.

Priorities for improving quality in 2016/17

Priorities	Incomplete from last year	National priority for 2016/17	Issue for commissioners / CQUIN	Issue for HCCOSC	Issue from Healthwatch	Issue identified internally inc. governors
1. Safe						
Reducing the likelihood of fractures being missed in our emergency departments	✓					
To implement the National Safety Standards for Invasive Procedures		✓				
To ensure patients with overwhelming infection receive antibiotics within an hour	✓	✓				
Improving the management of patients with Acute Kidney Injury (AKI)	✓	✓	✓			
2. Effective						
Reducing the number of lower limb amputations in people with diabetes	✓		✓			
Improving the management of patients requiring emergency abdominal surgery	✓	✓	✓			✓
To ensure people are prescribed antibiotics in accordance with local formularies		✓	✓			
To improve the management of patients with fractured neck of femur	✓		✓			✓
3. Caring						
Living with and beyond cancer	✓	✓	✓			
Improving End of Life care				✓		✓
4. Responsive						
To improve the care of emergency patients through the implementation of the SAFER programme	✓	✓	✓	✓	✓	✓
Improving discharge	✓		✓	✓	✓	✓
Improving care for people who use our services and have dementia and delirium		✓		✓		✓
Learning from users	✓			✓	✓	✓
Improving the experience for children and their families as they move from paediatric to adult services	✓		✓	✓		✓
5. Well-led						
To ensure all staff in leadership roles are trained in service improvement methodology				✓		✓

How well have we done in 2016/17?

Safe

Reducing the likelihood of fractures being missed in our Emergency Departments (A&E)

Studies show that a failure to detect a fracture on an x-ray is the most common diagnostic error made in Emergency Departments (A&E). Ordering the correct x-ray or ultrasound scan, then detecting an abnormality on the image takes skill and experience. This is why all diagnostic images (or scans) are reviewed by a specialist, either a radiologist or radiographer, so that a fracture that has been missed by staff in A&E can be identified on review.

An undiagnosed fracture can cause significant distress to the patient and could have potentially serious consequences.

During 2016/17 we have made good progress in reducing the number of fractures missed, including those considered to be 'major' misses (those that require an operation or manipulation), as illustrated in Fig 1. And we have also made good progress in reducing the time it takes to review and identify and missed fracture (see Fig 2).

In the year ahead we hope that the introduction of electronic ordering of radiology, reporting and recording of actions will improve our performance further. These processes will be introduced as part of Phase 1.5 of our Electronic Health Record ℹ, TrakCare. You can read more about this on p49.

Fig. 1: Number of missed fractures

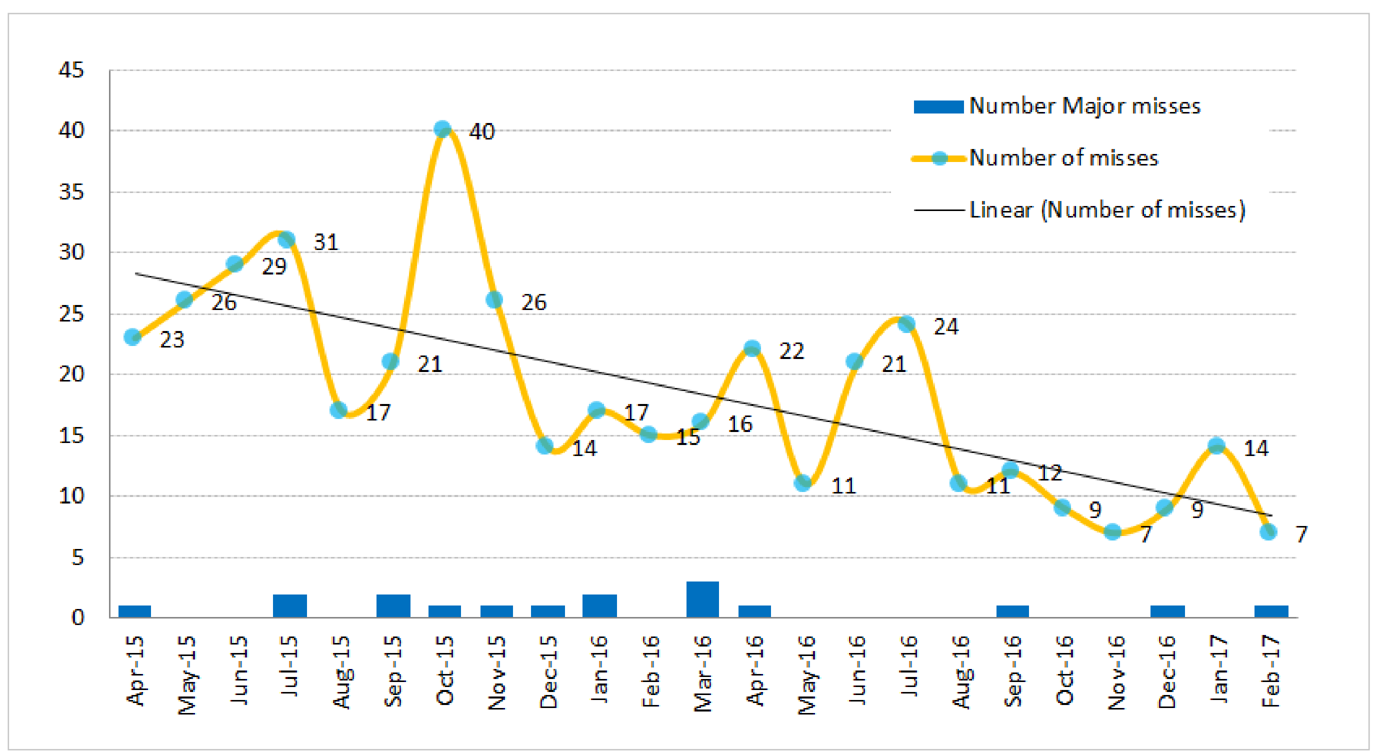
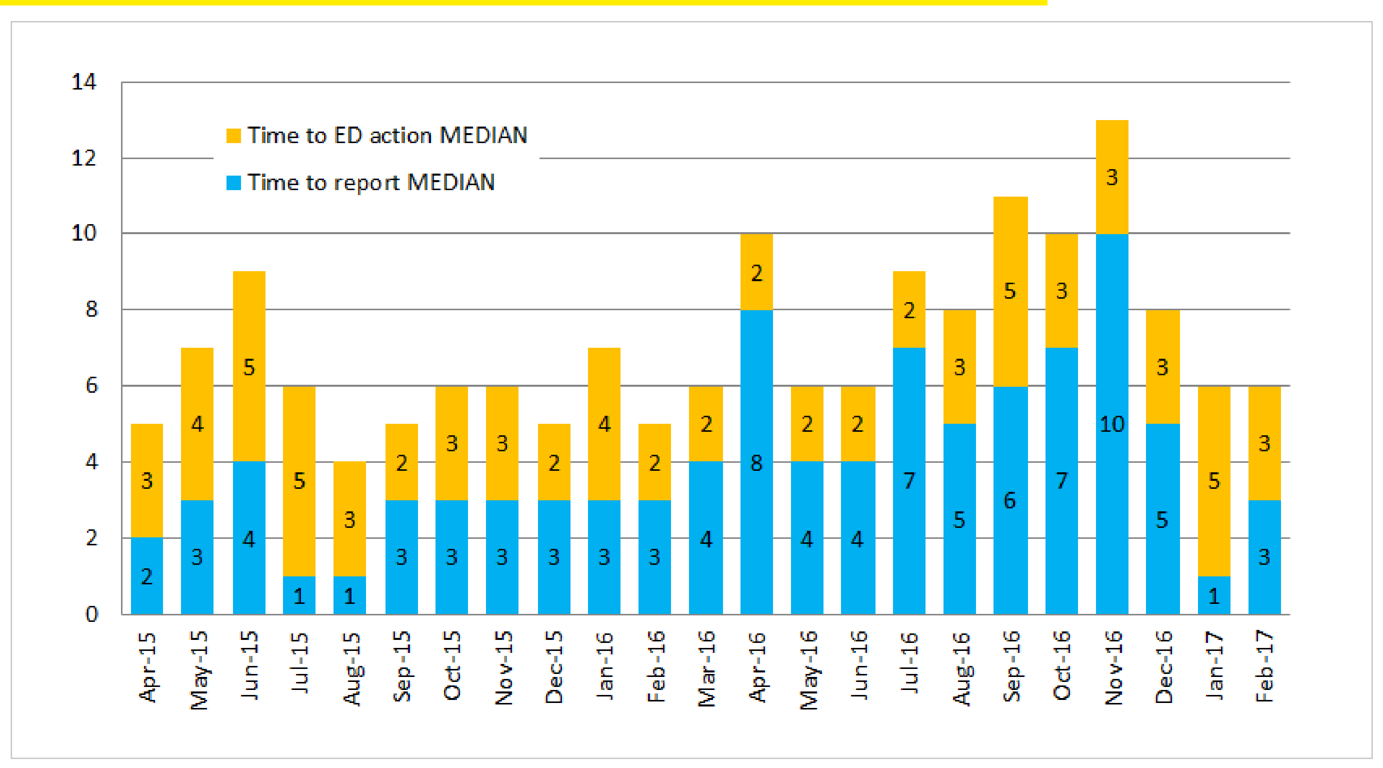


Fig. 2: Time taken to identify a fracture that has been missed in A&E



To implement the national safety standards for invasive procedures

In September 2015 a set of national safety standards were published in NHS England to help hospitals provide safer surgical care for patients. The National Safety Standards for Invasive Procedures (NatSSIPs) aim to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events (errors that should never happen) could occur.

These new standards set out broad principles of safe practice and advise healthcare professionals on how they can implement best practice, such as through a series of standardised safety checks and education and training. The standards also support NHS providers to work with staff and develop and maintain their own, more detailed, local standards and encourage the sharing of best practice between organisations.

Our targets in 2016/17 were to deliver the following by September 2016:

- Agree director (or equivalent) with lead responsibility for ensuring all relevant staff are aware of the NatSSIPs and are supported in developing local checklist
- Identify all procedures undertaken across clinical settings in our organisation that the NatSSIPs are applicable to
- For these identified clinical procedures, develop and test our processes based on the relevant NatSSIPs using local insight, including from patients and the public, together with the resources, networks and collaborative opportunities highlighted in the Alert
- Commence implementation of procedures and practice compliant with local processes within cycles of continuous improvement including consideration of teamwork and training, human factors and cultural aspects of compliance
- Share best practice with NHS England.

In order to deliver the above, we held a series of collaborative events with clinicians, inviting external speakers, to discuss implementation of NatSSIPs. We established a newsletter, issued monthly to staff representatives from each of the Divisions, which provided updates on the progress made and actions agreed following these collaborative events.

We delivered all goals by the target date of September 2016 and we have designed a generic checklist for individual procedures. We are now applying this learning to the outpatient setting, working to create a checklist for clinics who perform a range of invasive procedures.

To ensure that patients with overwhelming infection receive antibiotics within an hour

Every year in the UK there are 150,000 cases of sepsis, resulting in 44,000 deaths, more than bowel, breast and colon cancer combined. Sepsis is a life-threatening condition that arises when the body's own response to an infection injures its own tissues and organs. Sepsis can lead to shock, multiple organ failure and death, especially if not recognised early and treated quickly. Each month our hospitals' Emergency Department (A&E) treats between 40 and 50 patients with sepsis.

In 2016/17, as in the previous year, the CQUIN has two main objectives:

- Part A: patients who meet the clinical criteria for sepsis should be screened for sepsis using the local tool
- Part B: those who present with red flag sepsis, severe sepsis or septic shock, must receive antibiotics within an hour. These patients should also receive a review after three days of antibiotics.

These two objectives apply to both children and adults arriving at our hospitals via the Emergency Departments (A&Es) or other direct emergency admission routes such as via maternity or oncology. They also apply to patients who have already been admitted to a ward and then develop sepsis.

This year our performance against Part A has again been strong, with 95% of patients who meet the criteria for sepsis being consistently screened (See Fig 3). This practice has been successfully embedded in our clinical practice for a few years now, and we are confident that this standard will be maintained in the year ahead. Additionally, sepsis patients admitted via the oncology emergency pathway are also consistently receiving their antibiotics within an hour.

Oncology emergency pathway still working really well for those patients. The most challenging area for us this year has been achieving Part B in the Emergency Department (A&E) (See Fig 4). We know that once they have been screened for sepsis, patients receive their antibiotics quickly. However, due to the high level of activity in the departments there has often been a delay in administering these drugs within one hour of attendance at A&E.

Once screening has been carried out we know patients receive antibiotics quickly. Our main focus has been on making that process work earlier in the pathway. To help address this issue, this year we introduced an ED checklist, a list of key tasks and/or assessments to be carried out or repeated at hourly intervals after a patients' arrival at A&E. This includes sepsis screening within the first hour of arrival.

Fig. 3: Percentage of patients screened for sepsis

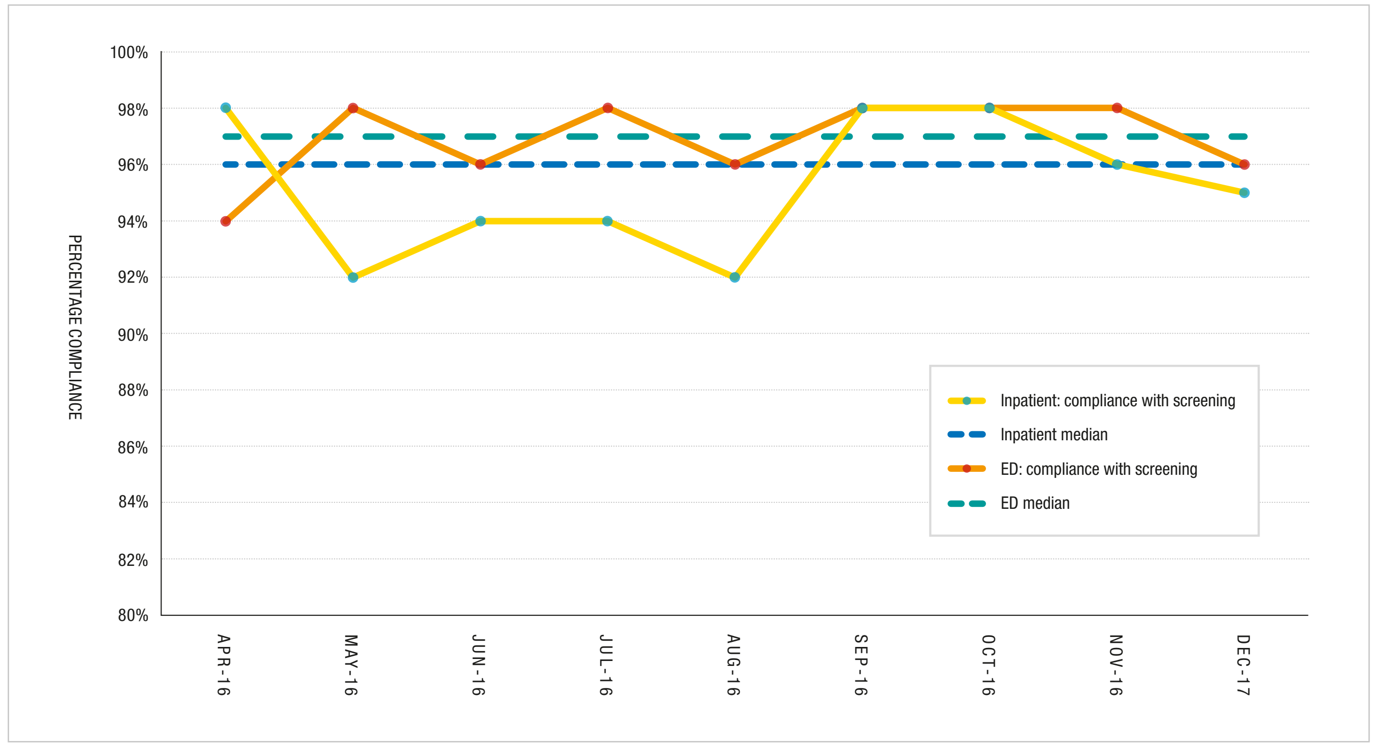
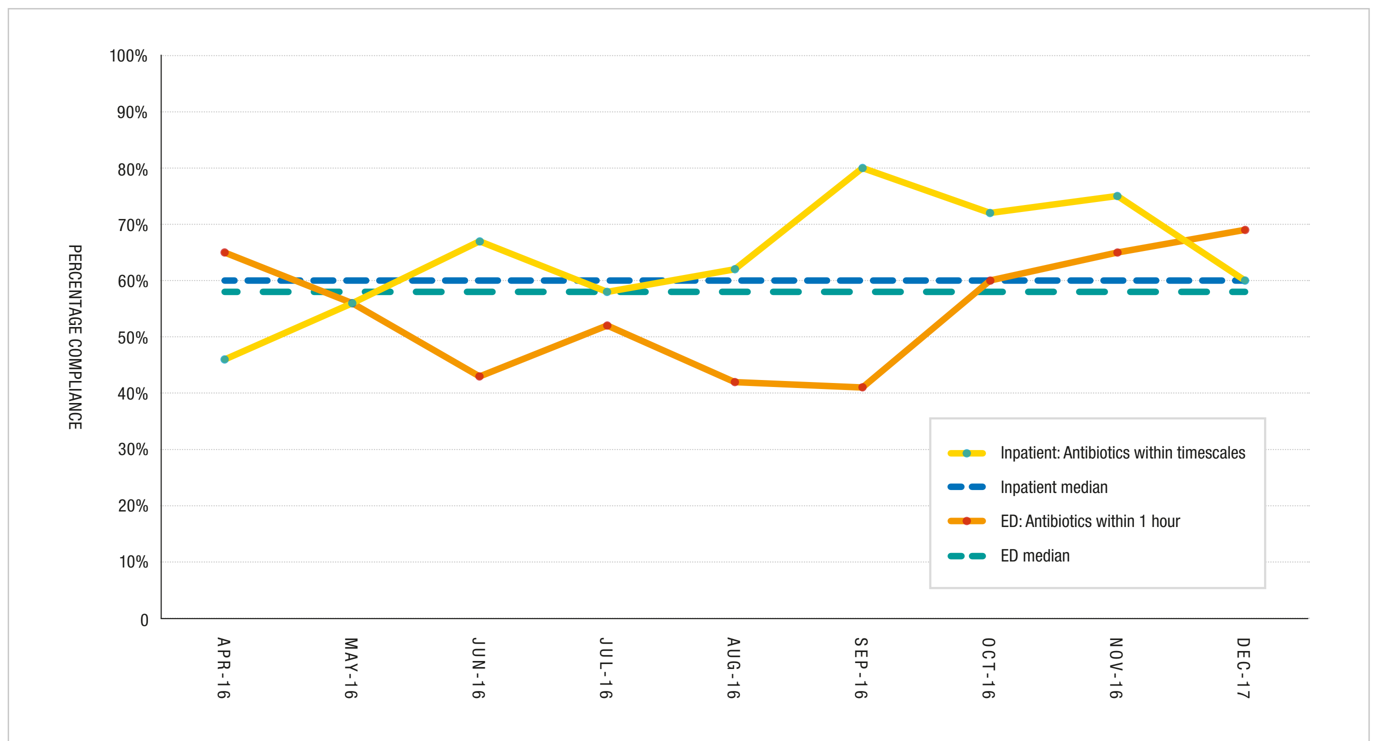


Fig. 4: Percentage of sepsis patients receiving antibiotics within an hour



To improve the management of patients with Acute Kidney Injury

Acute Kidney Injury (AKI) is a sudden loss of kidney function and is strongly linked to high mortality rates and an increased length of stay for patients. In a hospital there are a number of reasons why a patient may develop an AKI, for example through infection or as a result of dehydration.

Improving the management of patients with AKI was a local CQUIN for us in 2016/17. Our goals were to ensure that every patient who sustained an AKI during their stay in hospital must have a discharge letter for their GP that contains the following information:

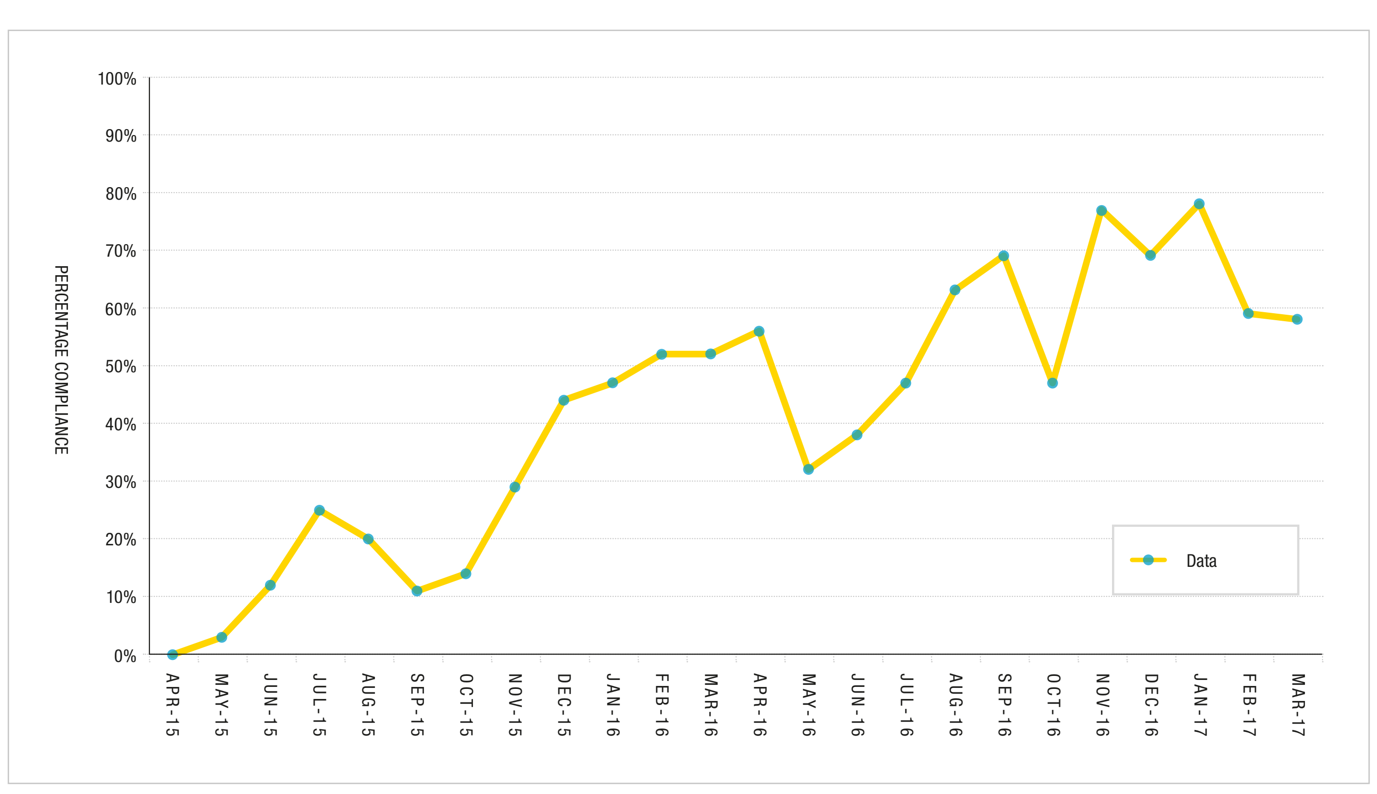
- What stage the AKI has been diagnosed
- Whether their medication has been reviewed and if so, what the outcome was
- What blood tests will be required once they have been discharged
- How frequently they will require these blood tests.

Our performance against these targets during 2016/17 has improved over the year, the result of several key actions. This includes the following:

- Relaunch of our Ned the Nephron, a highly visible sticker which is fixed to a patients' medical chart to indicate that their medication review must be included in the discharge summary
- Signing up to the national 'Think Kidneys' public health campaign
- A focus on teaching junior doctors at induction
- Pharmacy started to provide AKI flags on their system to prompt medication teams preparing for a patient's discharge.

You can see how we've performed against our goals in Fig 5.

Fig. 5: AKI Discharge Summary Results: Overall Compliance



How well have we done in 2016/17?

Effective

Reducing the number of lower limb amputations in people with diabetes

Diabetes can lead to a number of complications including heart disease, kidney disease, retinopathy (eye problems), problems with peripheral circulation (peripheral vascular disease) and neuropathy (a nerve disorder). Peripheral vascular disease and neuropathy can lead to the development of ulcers in the feet which, because of reduced blood flow, heal poorly and can lead to surgical amputations.

To help reduce the number of patients with diabetes requiring an amputation and to achieve our CQUIN goals, we took the following actions in 2016/17:

- A foot check sticker was introduced to six pilot wards across our hospitals (three at GRH and three at CGH). This is part of a long-term project to spread foot checks across the entire Trust so that when any patient with diabetes is admitted to our hospitals, they have their feet checked. The aim of the check is to see if they have any active foot problems that need addressing, but also to assess if they are at risk of developing foot ulceration during their in-patient stay and prevent the development of new foot problems
- We applied for funding from NHS England to develop an in-patient Foot Protection Team and a decision is expected in March 2017
- A monthly Root Cause Analysis of a sub-set of patients with diabetes who have undergone amputations, identified areas of concern and has led to improved team working between those that look after patients with diabetic foot disease. It has provided impetus for the development of a care pathway agreed by all those involved with diabetic footcare
- The introduction of an e-referral for diabetic foot patients has provided an easy and accessible way for this group of patients to be referred into the diabetes service, whether they are an in-patient or have been seen in the Emergency Department (A&E).

In 2017/18, the aim is that a Multidisciplinary Diabetic Foot Clinic will have been established on at least one of our hospital sites.

Improving the management of patients requiring emergency abdominal surgery

The National Emergency Laparotomy Audit (NELA) is part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP), overseen by the Healthcare Quality Improvement Partnership (HQIP).

NELA looks at structure, process and risk-adjusted outcome measures for the quality of care received by patients undergoing emergency laparotomy.

NELA was commissioned following evidence of a high incidence of death, with a reported mortality rate of up to 15% and a wide variation in the provision of care and mortality, for patients undergoing emergency laparotomy in hospitals across England and Wales.

The aim of the audit is to improve the quality of care for patients undergoing emergency laparotomy through the provision of high quality comparative data from all providers of this procedure.

NELA is currently in its third year. In Year 1 an organisational audit was undertaken, with individual patient data collection in Years 2 and 3. All patients over the age of 18 years, having a general surgical emergency laparotomy in all NHS hospitals in England and Wales are enrolled on a prospective basis.

All patients undergoing emergency laparotomy surgery have a NELA data collection proforma completed in advance and this information is then entered onto the NELA data base.

We have also joined the Emergency Laparotomy Collaborative which has been set up to encourage collaboration and share knowledge of quality improvement to reduce mortality of emergency abdominal surgery.

Our NELA targets for patients undergoing emergency laparotomy during 2016/17 were:

- for 90% of patients to be operated on by a consultant surgeon or senior staff who are capable of managing these cases
- for 80% of patients to be anaesthetised by a consultant anaesthetist or senior staff who are capable of managing these cases
- for 90% of patients to have a pre-operative lactate blood test to help the diagnosis of sepsis
- to carry out multi-disciplinary mortality and morbidity reviews four times a year
- for 90% of patients to have access to critical care after surgery.

The measures below are produced in a quarterly report and the results are presented at regular joint meetings with the surgeons and anaesthetists, along with a review of all patients who have died following emergency laparotomy.

The NELA project is bringing improvements in the care of patients undergoing emergency laparotomy in our hospitals and has improved mortality in this high risk group of patients.

You can see how we performed against the NELA targets in Figs 6–9.

Fig. 6: Consultant or Post CCT delivered surgery

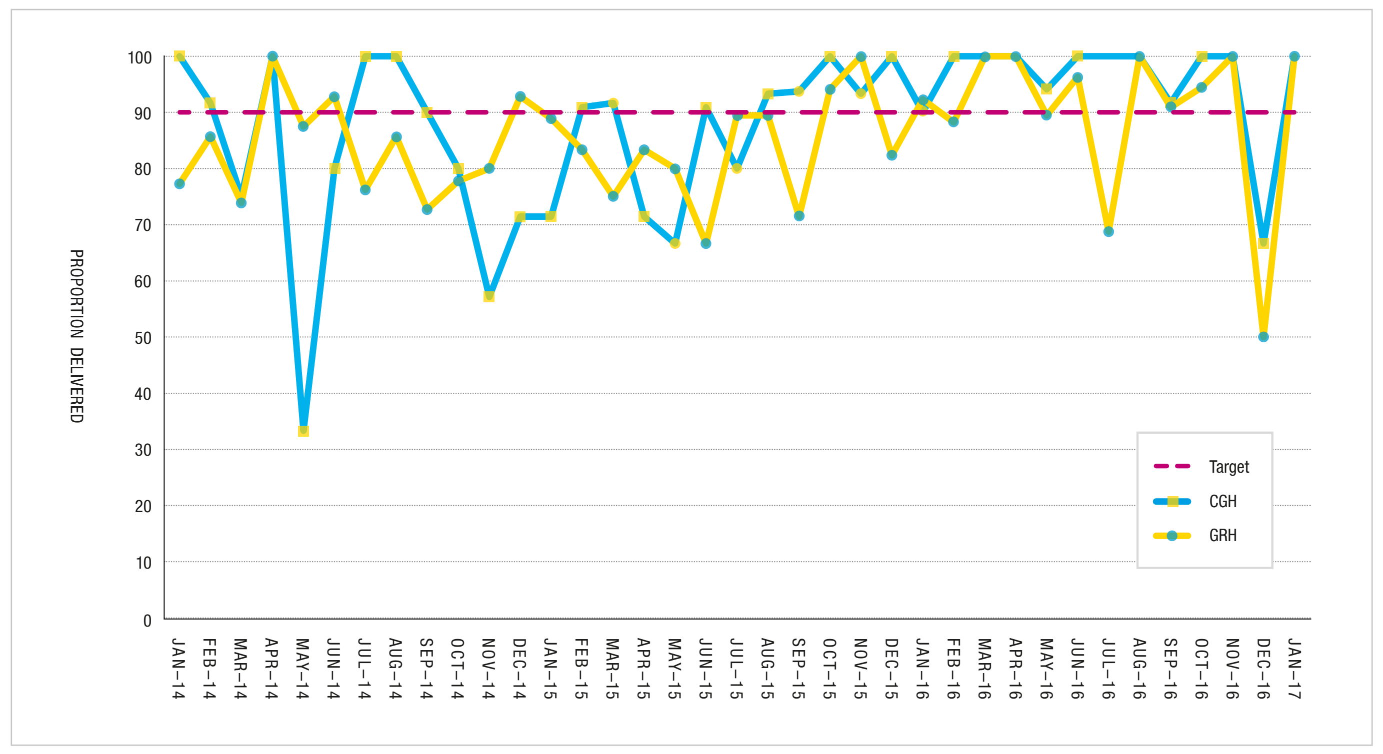


Fig. 7: Consultant or Post CCT Delivered Anaesthesia

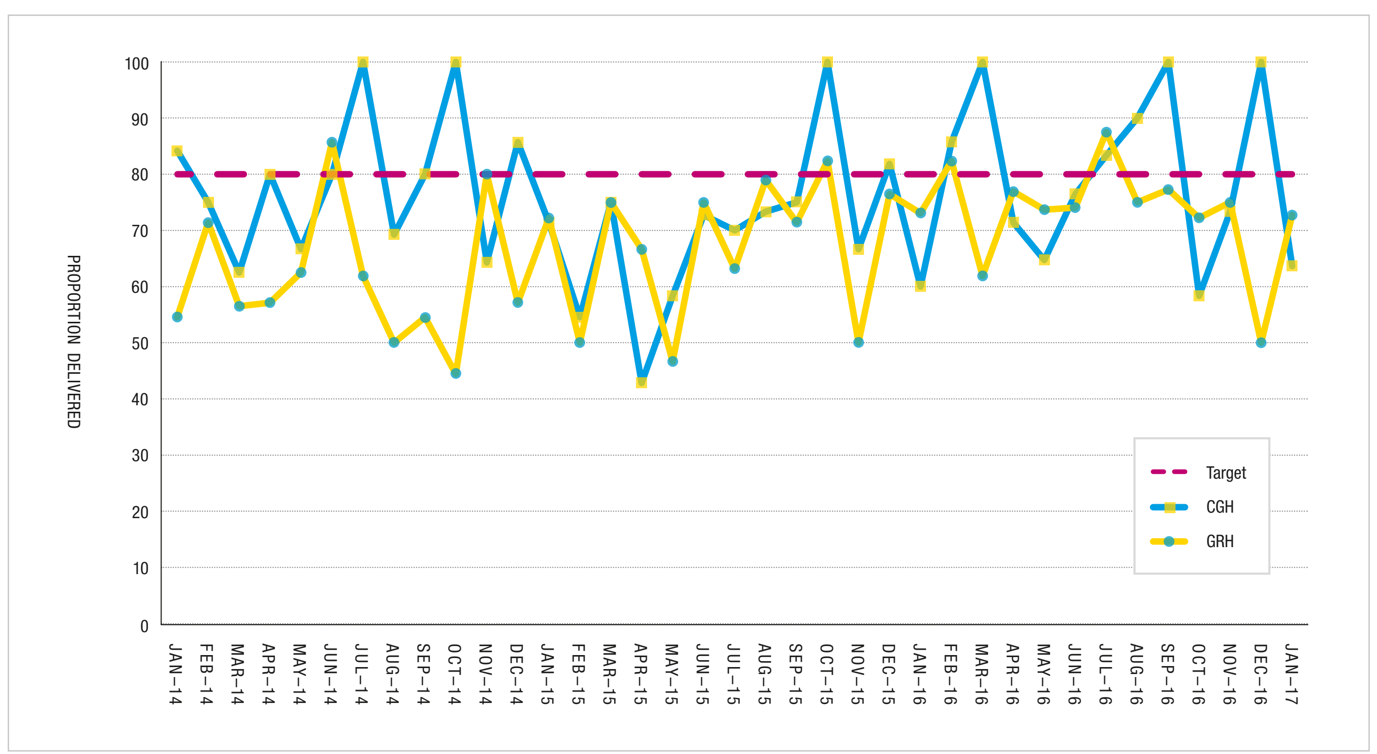


Fig. 8: Pre-op blood lactate

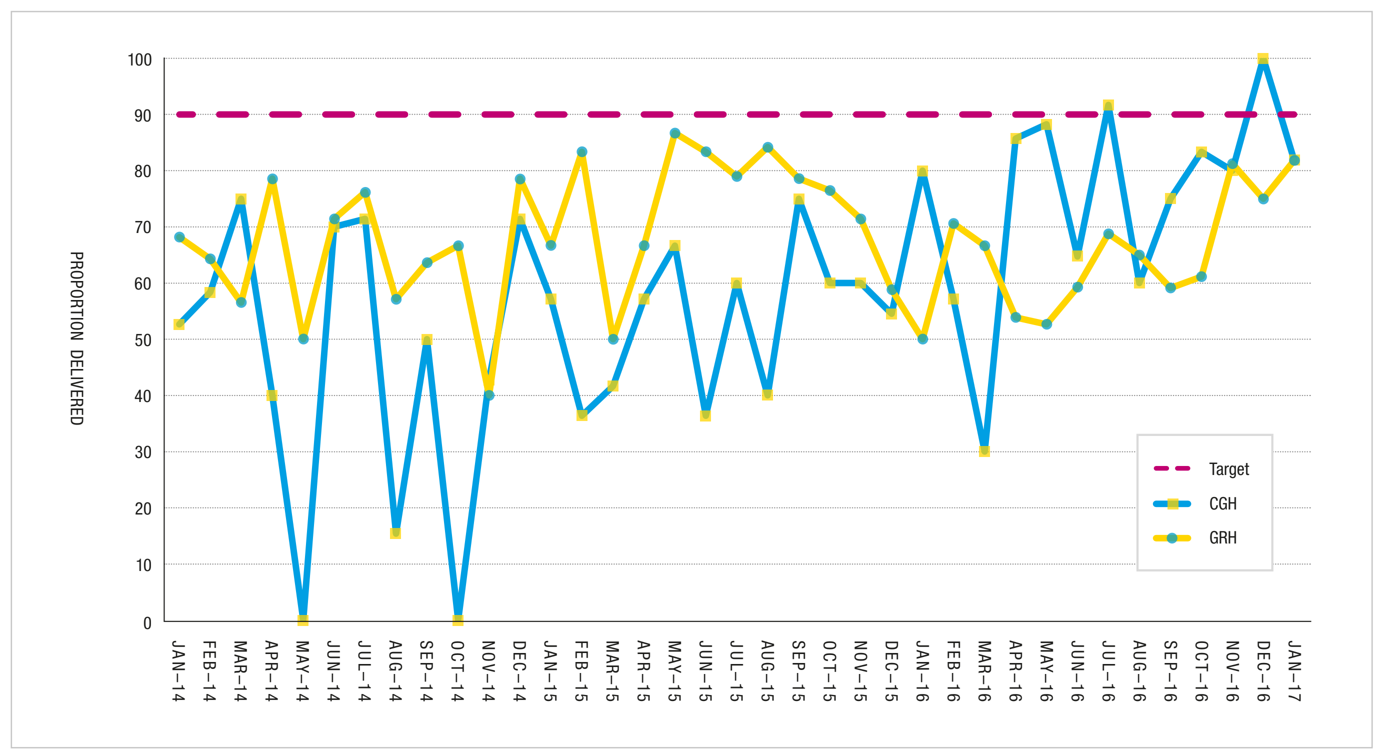
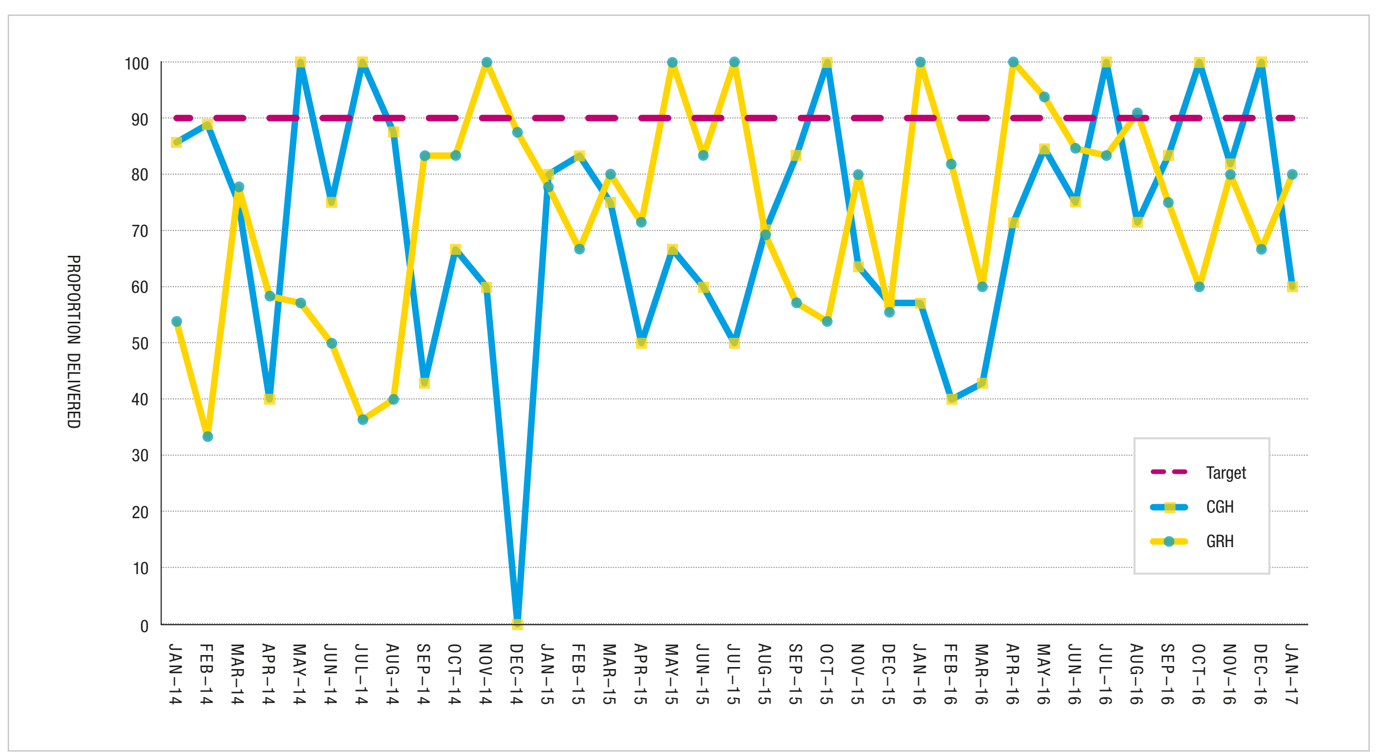


Fig. 9: Critical Care Access ≥5% Mortality



To ensure that patients are prescribed antibiotics in accordance with local formularies

The World Health Organisation recently published a priority list of antibiotic resistant bacteria for which new antibiotics are urgently required. An increasing number of patients in Gloucestershire are acquiring infections due to these antibiotic resistant bacteria and providing effective treatment for these patients is becoming increasingly challenging.

Effective Infection Prevention and Control (IPC) interventions are essential to reduce the spread of these antibiotic resistant bacteria.

We know that antibiotic resistance is linked to antibiotic usage and it is therefore vital that we use the antibiotics that are currently available as wisely as possible. This is the basis for Antimicrobial Stewardship (AMS) which is defined by the National Institute for Health and Care Excellence (NICE) as 'an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness'.

Given these challenges the resources required for effective AMS and IPC services which comply with national standards, such as those issued by NICE, will need to be kept under careful review within our local health economy.

The document "Antimicrobial Stewardship: "Start Smart, – Then Focus" updated in 2015 remains the best practice guidance for secondary healthcare settings in England. This toolkit highlights the importance of prescriber compliance with local antimicrobial prescribing guidelines. Our local antibiotic guidelines are produced and reviewed by the Antimicrobial Stewardship Team working with other health professionals.

A number of measures are in place to ensure that people are prescribed antibiotics in accordance with our local guidelines. An annual Point Prevalence Study (PPS) is performed across our Trust for all in-patients. In addition, the monthly HAPPI (Hospital Antibiotic Prudent Prescribing Indicators) data and results for this are distributed to prescribers on a monthly basis. This data includes measures of appropriate documentation and use of antibiotics compared to our local guidelines. PPS results for 2016 demonstrated 95.1% guideline compliance with a regional average of 86.8%. PPS for 2016 also showed a further decrease (a good thing), for the second year, in the percentage of patients prescribed antibiotics on the day of data collection. Further audits undertaken during the year have included those looking at the appropriateness of antibiotics given for surgical prophylaxis and another looking at the appropriateness of piperacillin/tazobactam use in the emergency departments.

During 2016/17 the Antimicrobial Stewardship Team have been working with others to further review and develop our local antibiotic guidelines and to promote and monitor compliance with these through education, training and audit activities. This includes ongoing work to promote appropriate and effective management of sepsis. Antimicrobial resistance has been introduced as a national indicator in the Commissioning for Quality and Innovation (CQUIN) scheme for 2016/17; the goal is a reduction in antibiotic consumption and encouraging focus on antimicrobial stewardship including antibiotic review within 72 hours. We are working on various strategies to reach these targets. Although the CQUIN data is not yet complete our Trust has achieved the Quarter 3 target milestone for empiric review of antibiotic prescriptions within 72 hours.

The ongoing development and implementation of e-Prescribing as part of our TrakCare project will be important in allowing improved monitoring and feedback of antibiotic prescribing data in the future.

To improve the management of patients with fractured neck of femur

The femur (thigh bone) is one of the largest and strongest bones in the body. A fractured neck of femur is when the top part of this bone is broken. This type of fracture normally requires surgery to repair.

The National Hip Fracture Database alerted us to a higher than expected mortality rate in patients with hip fractures. In addition, patients with a fractured neck of femur were not receiving their operations as quickly as they should have. For these reasons, during 2016/17 the hip fracture service improvement programme in our Trust has been a top priority for us. We have increased the number of hip fracture beds to 26 in GRH with a focus on the site management department ℹ to get the patient to the 'right place, first time'. Early admission to the specialist hip fracture ward has allowed early access to pressure relieving equipment, access to specialist nursing and addressing early nutritional needs of our patients.

To further improve the standard of care we provide, we have joined a national quality improvement programme (QIP) to improve hip fracture care called 'Scaling Up for Safety: Hip Fractures', a programme supported by the Health Foundation ℹ.

The "Scaling Up team" is a multi-disciplinary team from our hospitals with representatives of all aspects in the hip fracture patient care pathway including nurses, doctors, surgeons, anaesthetists, therapists, and specialist orthogeriatic physicians.

All these activities have enabled us to make significant progress in improving care for patients with a hip fracture in 2016/17.

We have improved multiple aspects of patient care including:

- 90% of our patients receiving early pain relief in A&E through the administration of nerve blocks ℹ (National average 39.9%).
- We have managed to operate on our hip fracture patients within 36 hours, 81% of the time (national average 75.3%). We are now monitoring this on a real terms basis, and in January 2017 we have reached 96.8%.
- We have standardised our anaesthetic practice to provide the safest possible anaesthetic with minimal sedating (opoid) analgesia used. We have increased the number of anaesthetics given in combination with a nerve block from 2% of spinal and 6.9% of general anaesthetics in Dec 2014, to 74.3% for spinal and 95.1% for general anaesthesia. (See Fig 10–11).
- We have produced a number of care bundles ℹ that are aimed at standardising care. The peri-operative ℹ care bundle is aimed at reducing the rate of AKI, through pump fluid administration, early blood transfusion and adequate patient warming. The nurse developed 'Return to Ward' care bundle, aimed at standardising the nursing approach to post-operative care through regular monitoring and assessment, has been introduced and compliance is at 99%
- We have managed to mobilise our patients on the day of surgery 84% of the time (Increased from 73.6% in 2015; national average 2016, 70.6%). Increased resource into our therapy team has allowed for a seven day service with additional therapists at weekends
- Our pressure ulcer incidents have remained low at 1.3% (1.6% in 2015), well below the national average of 4% (see Fig 14–15). This has been achieved through all our patients getting access to pressure-alleviating equipment. The ward environment has also been improved with close attention paid to making sure it is 'dementia friendly'
- The ongoing monitoring of patient experience gives us real time feedback and allows us to adapt the quality of the care we provide. The latest figures for 2017 show that the 65% of our patients and families are likely or highly likely to recommend the ward to family or a friend. Our latest month average score is 9.1 out of 10. Some of the recent projects that have contributed to our positive patient feedback are our daily exercise class, our breakfast club, aimed at getting patients caring for themselves and practicing for their home environment and our 'come dine with me' policy where we encourage relatives to visit to eat with their relatives in a separate ward seating area
- New to our Trust for 2017, aimed at improving the nutritional state of patients and their ability to recover from injury, is the ward nutritional nurse. This role is crucial for providing additional supplemental nutrition and having the time to meet all the nutritional needs of our patients. Our Trust length of stay has reduced to 15.7 days which is below the national average of 19.3 days.

The re-design of the patient pathway and the engagement from all staff team members has enabled us to make significant progress in providing a safe quality care for our hip fracture patients. We expect our hip fracture mortality to be well within national limits for 2016 and our patient experience is rated as good.

Fig. 10: Percentage of general anaesthetics given with a nerve block at GRH

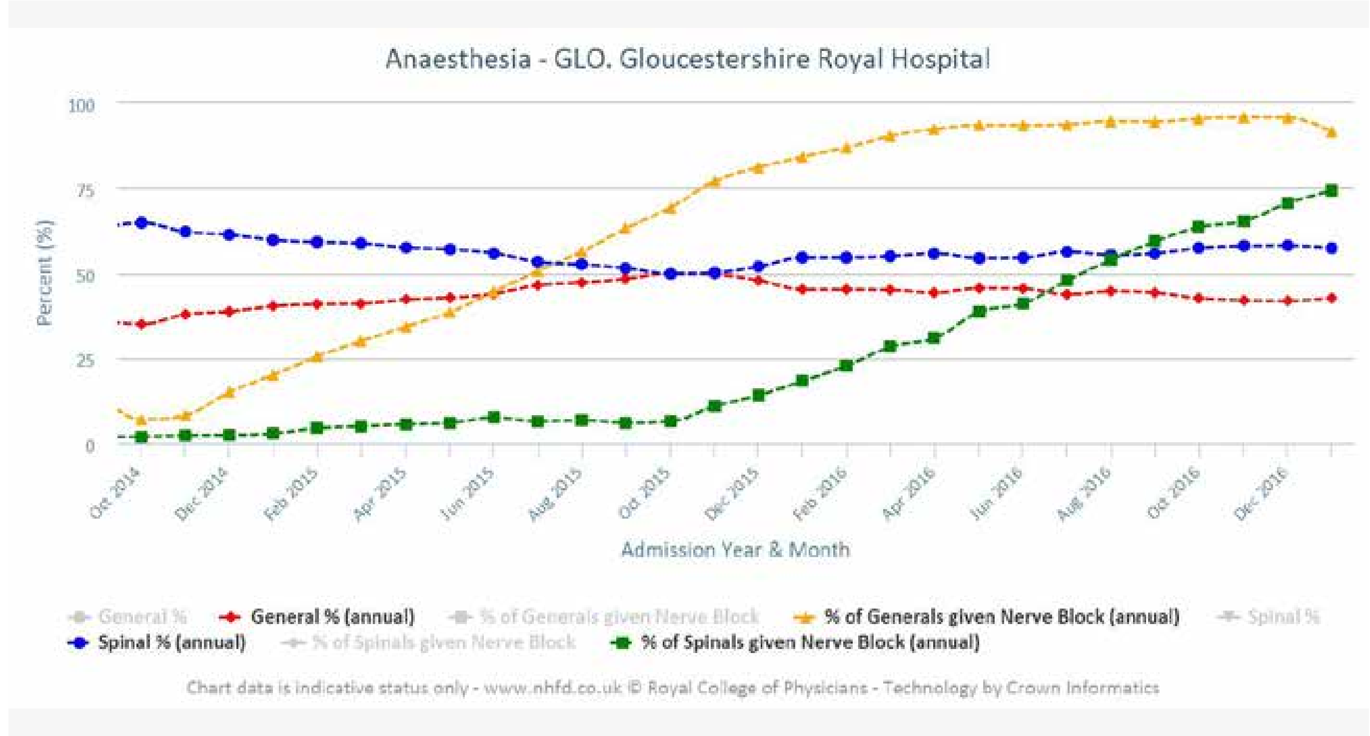


Fig. 11: Percentage of general anaesthetics given with a nerve block at CGH

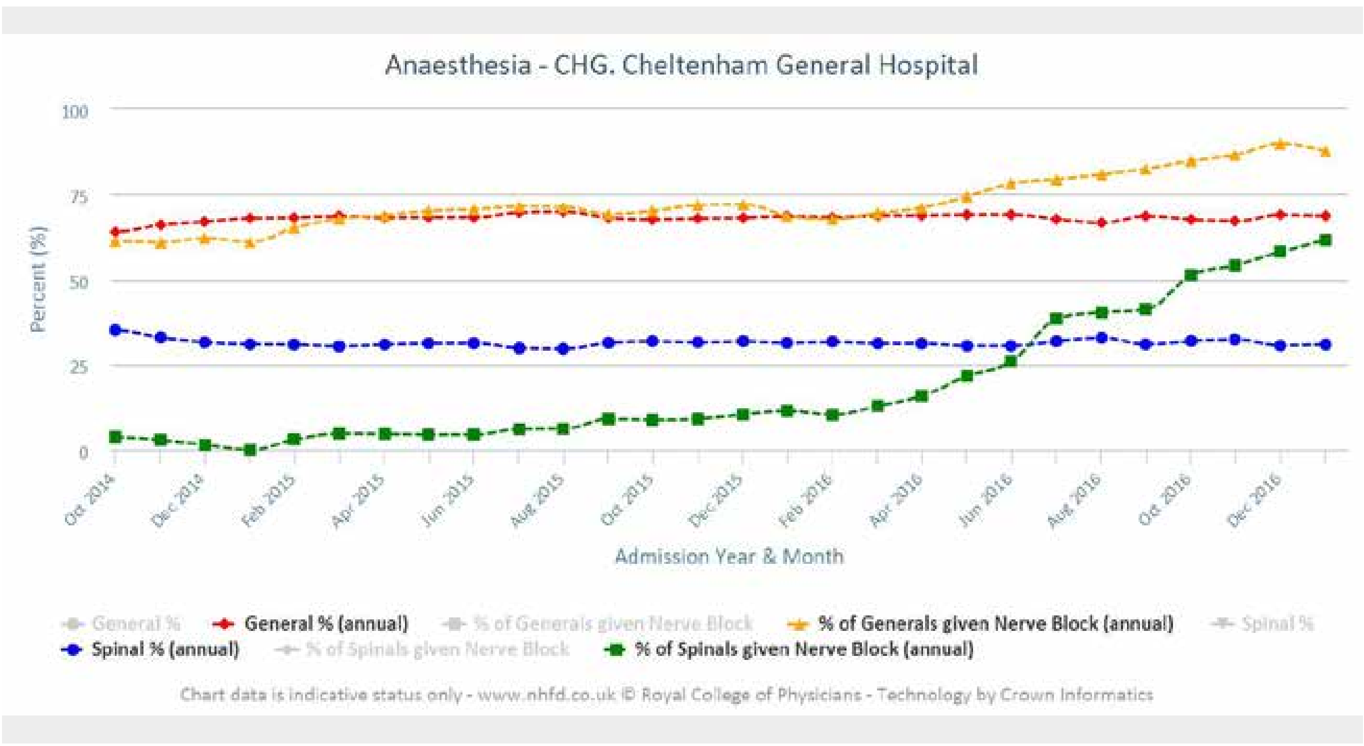


Fig. 12: Percentage of patients meeting Best Practice Treatment criteria at GRH

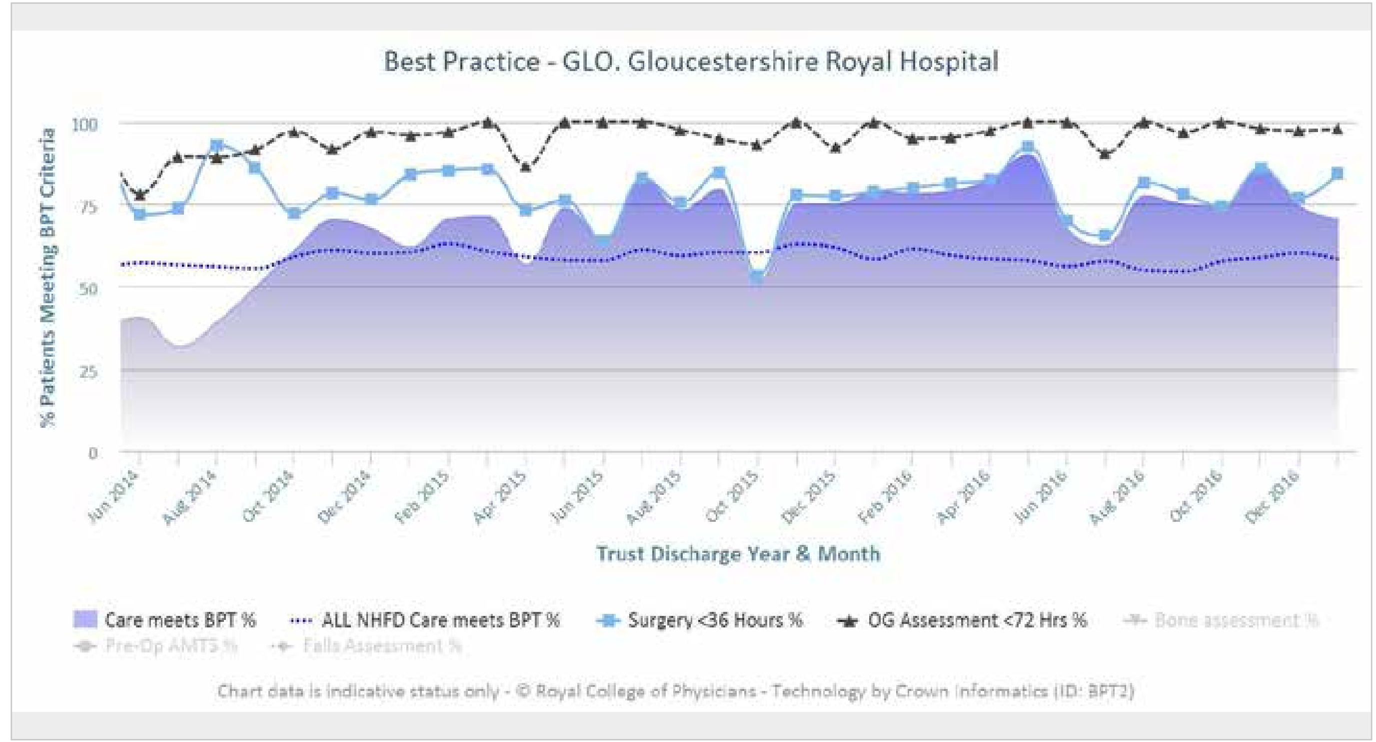


Fig. 13: Percentage of patients meeting Best Practice Treatment criteria at CGH

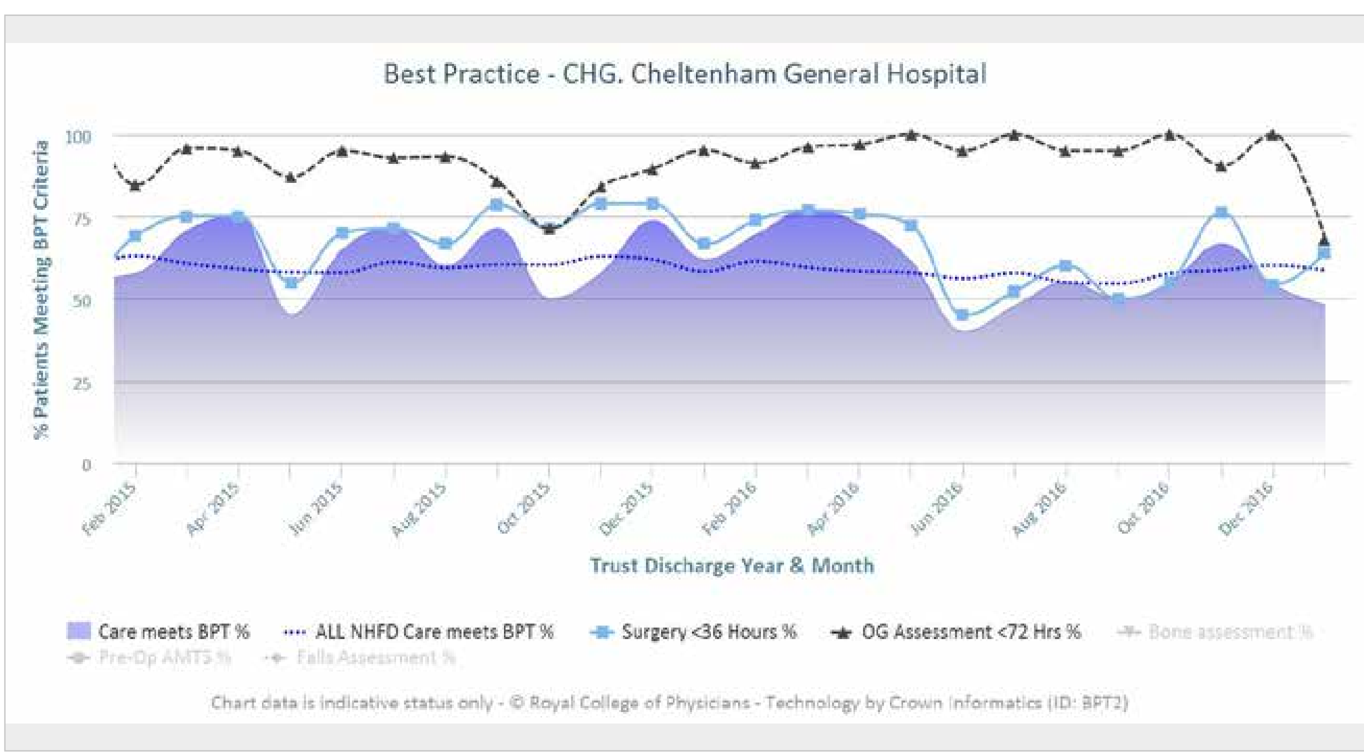


Fig. 14: Percentage of pressure ulcers vs national average, at GRH

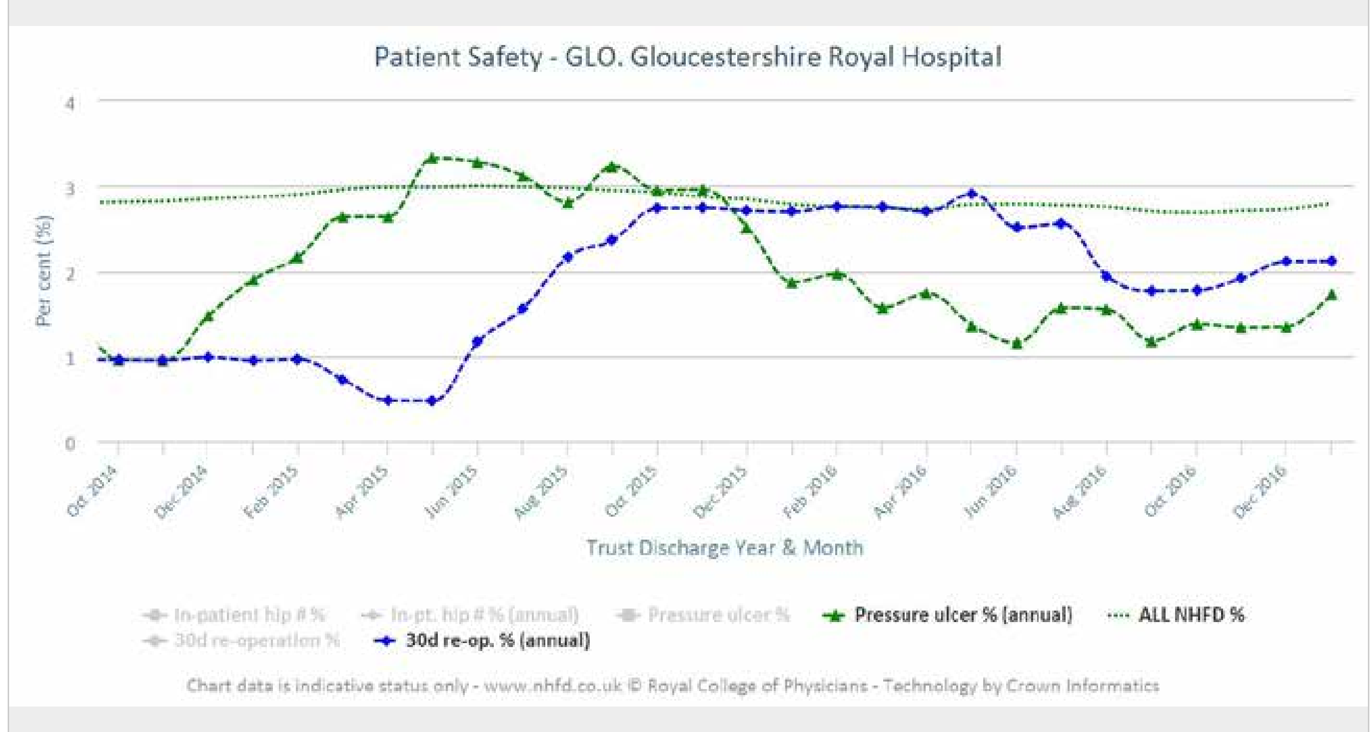
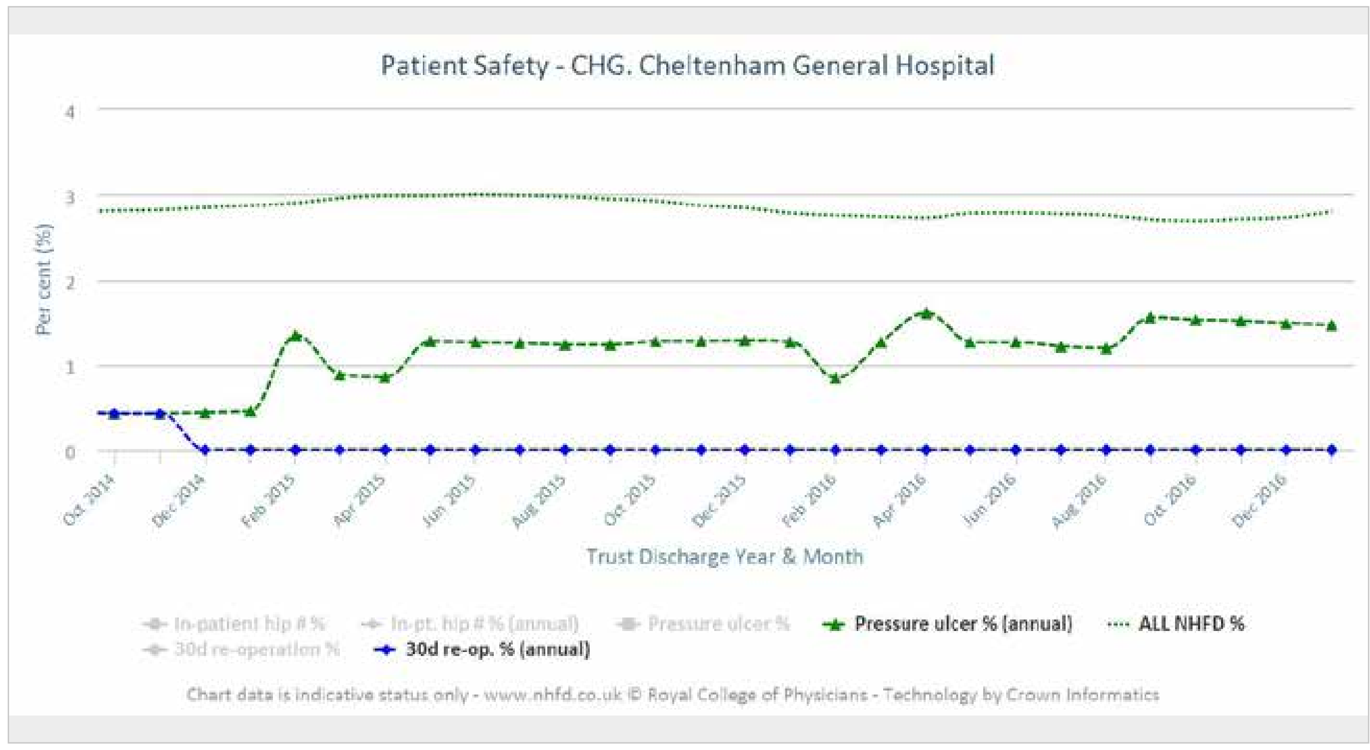


Fig. 15: Percentage of pressure ulcers vs national average, at CGH



How well have we done in 2016/17?

Caring

Living with and beyond cancer

Around 1.8million people in England are currently living with a diagnosis of cancer. This number is increasing by more than three percent a year with an estimated total number of over three million by 2030. As the population ages and the incidence of cancer rises, there is a greater need to transform cancer services in Gloucestershire. Every year more 3,400 more people in Gloucestershire receive a cancer diagnosis and there are an estimated 18,000 cancer 'survivors' in the county. Research shows that the impact of cancer doesn't end when the treatment does. The long-term consequences of cancer and its treatment include chronic fatigue, sexual difficulties, mental health problems, as well as having an impact on social and family relationships.

The national cancer strategy, Achieving World Class Cancer Outcomes: A Strategy for England 2015-2020, included a number of key recommendations to improve the quality of life after cancer treatment, including: –

- ensuring people are supported and have their needs met, including the late effects of disease or treatment
- commissioning of services to incorporate the Cancer Recovery Package across all sites, and to implement risk-stratified follow up for breast cancer and two other types of cancer by 2020
- improving integration across primary, secondary and social care.

In Gloucestershire we launched a countywide Living With & Beyond Cancer programme, alongside Macmillan, Gloucestershire Care Services and Gloucestershire Clinical Commissioning Group. The programme consisted of a two-year CQUIN ℹ to be implemented in breast, prostate and colorectal cancer services:

- Holistic Needs Assessment (HNA): to enable patient and clinician to address wider health and wellbeing issues to promote recovery
- Treatment Summaries: to enable patients to self-manage their own condition and to communicate relevant clinical information to the patient's GP
- Risk Stratified Pathways: to identify appropriate patients for a new supported self-management pathway opposed to a 'one-size fits all' model.

In 2016/17 the Living With & Beyond Cancer programme CQUIN ℹ targets were:

- 90% of all cancer patients treated in breast, prostate and colorectal services to be offered an HNA
- 25% of all patients will be offered a Treatment Summary following completion of treatment and 95% of all patients are risk stratified and placed on a suitable pathway.

These targets have proved challenging to achieve for a number of reasons. In particular, our staff have struggled to take on the additional workload at a time of increased operational pressure. However the cancer services management team and the Living With & Beyond Cancer programme team

are committed to achieving these targets during 2017/18. Currently, HNAs are being offered to 20% of our colorectal, breast and prostate cancer patients, with over 400 HNA assessments taking place and over 200 care plans generated.

In January 2017 we recruited four Macmillan Support Workers who will help boost the capacity of the clinical teams and support them in carrying out HNAs. Additionally an electronic solution for the HNAs, due to go live in May 2017, will help teams offer them on a more systematic basis. The programme team are also engaging the clinicians in oncology to roll out HNAs being offered during a patient's cancer treatment, this will ensure all patients are being offered an HNA irrespective of their treatment pathway.

A lot of work has been done this year to redesign pathways and engage with Consultants and Oncologists in order to test the Treatment Summaries, which are now embedded in the cancer clinical system. The programme team looks forward to the Treatment Summaries going live in early 2017/18. The team remains committed to working collaboratively with our partner organisations to deliver the vision set out by the Cancer Taskforce that all cancer patients are offered elements of the Recovery Package by 2020.

To improve end of life care

As a Trust we are committed to achieving the best possible standards of care for patients approaching the end of their life.

During 2016/17 we made great progress working with partner organisations on a number of projects at both a county-wide and Trust level. These include:

- Development of a county-wide End of Life Care Strategy. This has been published and can be viewed online at www.gloucestershire.gov.uk
- County-wide paperwork review – universal documents which enable advance care planning discussions, co-ordinated and individualised care in the last days of life and structured best interest decision making where people are unable to make decisions about their own care
- Development of information sharing between organisations
- Listening to our user’s feedback using the co-design approach to address issues such as access to medications out of hours
- Ultimately we pulled out of the Point of Care Foundation project, mentioned in last year's Quality Account, as the patient shadowing approach did not fit our agreed projects which focussed on optimising discharge planning. The project continued through our own Quality Academy and resulted in a simple tool which guides processes to ensure a safe and thorough discharge for a patient who is dying and wishes to do so out of hospital
- In September 2016, we established an End Of Life Care quality group for the Trust. This team monitors care and shares learning and good practice across the Trust.

How well have we done in 2016/17?

Responsive

To improve the care of emergency patients through the implementation of the SAFER programme

The term 'patient flow' refers to the way our patients move through to discharge. We want to design efficient services which allow patients to move quickly through the Emergency Department (A&E) to a ward where the staff are specially trained to deal with their particular condition or illness, before discharging them – either to their own home or to another appropriate care provider.

Good patient flow allows us to provide safe, effective care and gives patients the best possible experience of our services. Conversely, research has linked poor patient flow with increased mortality, an increased risk of adverse incidents and poor financial performance.

Improving the way our patients move through our hospital from admission to discharge has been a strong and continuing priority for the Trust during 2016/17.

The SAFER flow bundle is a set of actions which, when combined, should improve the flow of patients through our hospitals and prevent unnecessary waits. These actions formed our CQUIN goals this year:

- **S**enior Review: effectiveness of board round processes – all medical wards now hold a morning board round providing a senior medical review for all patients. Surgical patients are seen by the consultants on the ward prior to surgery early in the morning
- **A**ll patients to have an Expected Date for Discharge (EDD): improve accuracy for EDDs – through the Red2Green initiative, all patients should have their EDD reviewed daily to improve accuracy. An EDD policy has been drafted to support this
- **F**low: timely flow from the assessment units to inpatient wards through the use of internal professional standards – work is still required to deliver this element of the SAFER workstream and sits within the plan for 2017/18 (see p50).
- **E**arly Discharge: pre-planning and booking of transport to support early discharges. There is more work to do here in partnership with Arriva who provide our patient transport services.
- **R**eview: Reduction in length of stay supported by positive risk taking strategies – Sessions were run where staff watched a video on positive risk taking. Through our Breaking the Cycle events (see more on this below) it has become apparent that further work on this is required. The Onward Care Team Manager is also delivering some training on the wards on subject areas relating to timely discharge that were highlighted for further education.

Another initiative aimed at improving the flow of patients is the 7 day services programme which aims to provide consistent high quality care for patients every day of the week. This includes the availability of consultant care and key diagnostic services. Following on from our success in introducing 7-day services in our respiratory department in 2015/16, this year we rolled out 7 day working to the gastroenterology specialty.

In October 2016, we launched a 7-day endoscopy service covering weekends and bank holidays at both of our hospital sites. Within the first four months, 190 procedures were carried out at weekends.

This year, our Trust prioritised reducing the number of patients with a 14 day or more Length of Stay in our hospitals. This has developed into an initiative called 'Red2Green Days' from October 2016.

Our Red2Green initiative focusses on highlighting and removing any delays for patients in our hospitals, as well as ensuring that all patients are in the right place of care for their needs. This aligns with our 'right care, right time, right place' aim, and our priority to remove any unnecessary delays to a patient's stay, including delays within the discharge process.

We have also been working with colleagues at Gloucestershire Clinical Commissioning Group (CCG), Gloucestershire Care Services (GCS), Gloucestershire County Council (GCC) and, 2gether NHS Foundation Trust, through a number of Breaking the Cycle Together events. These aim to help us remove blocks and barriers to discharge in real time, improving patient flow throughout the hospitals. Working together in this way has allowed shared learning to take place and has highlighted areas where we can make improvements, but we are yet to see a significant improvement in any of the measures.

Although not specifically related to the SAFER CQUIN goals, the graphs on p32–33 are used as key indicators of our performance against our priority to improve the flow of patients throughout our hospitals.

Fig. 16: Average number of medically fit patients per day

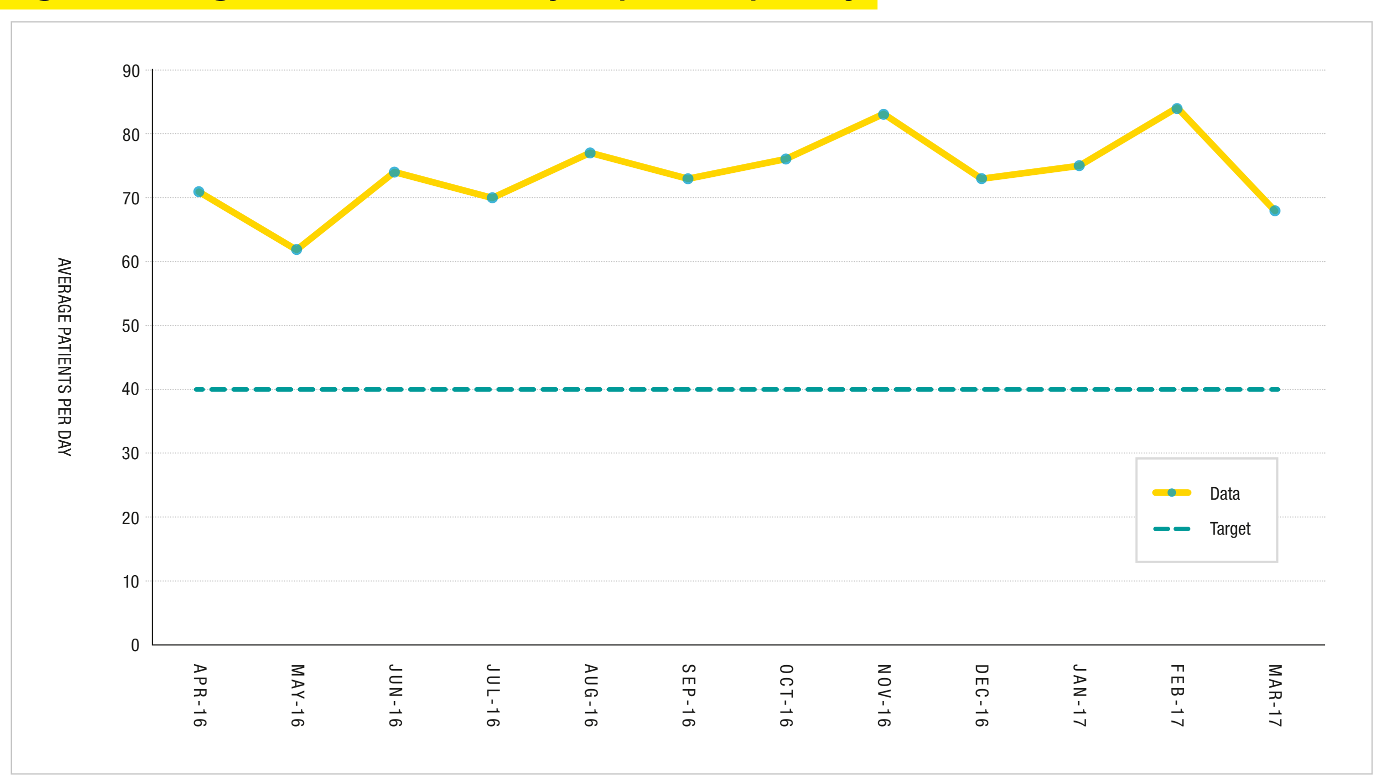


Fig. 18: Percentage of patients spending 4 hours or less in ED

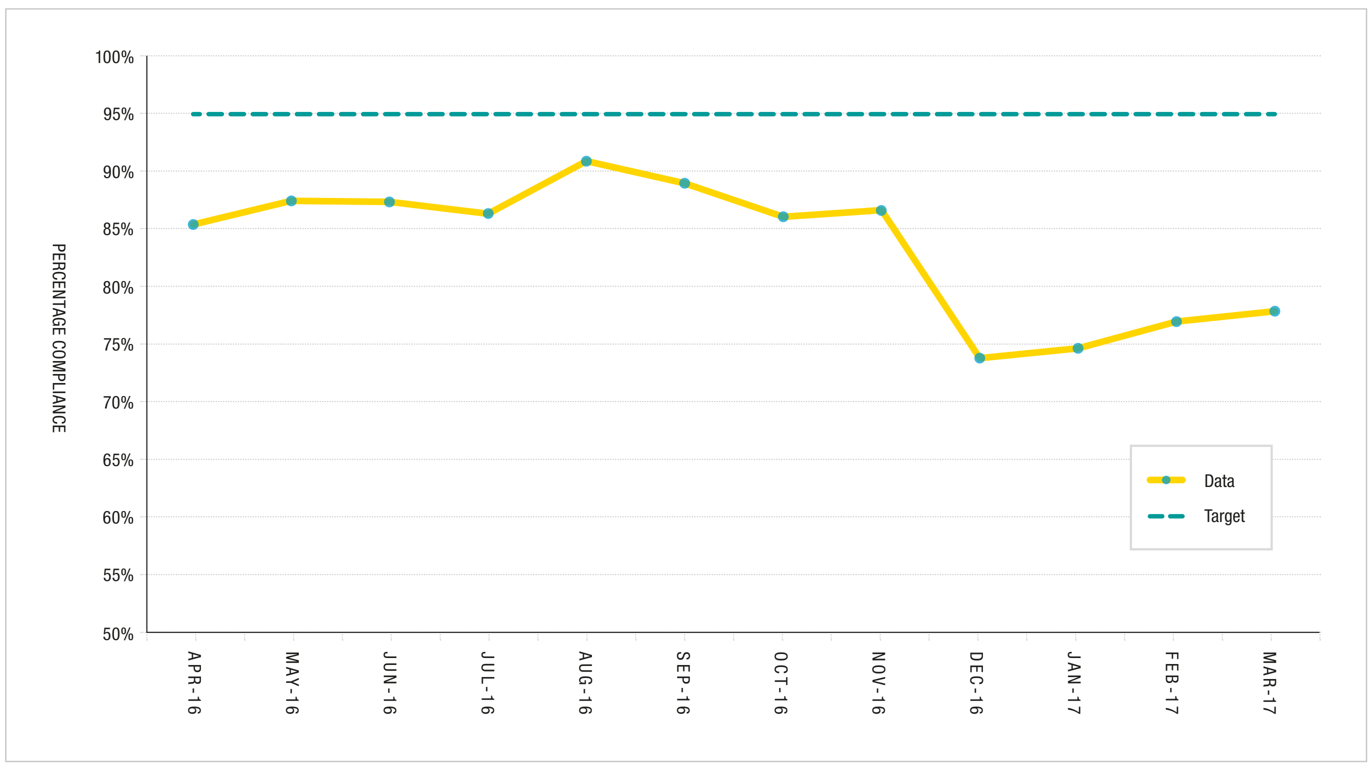
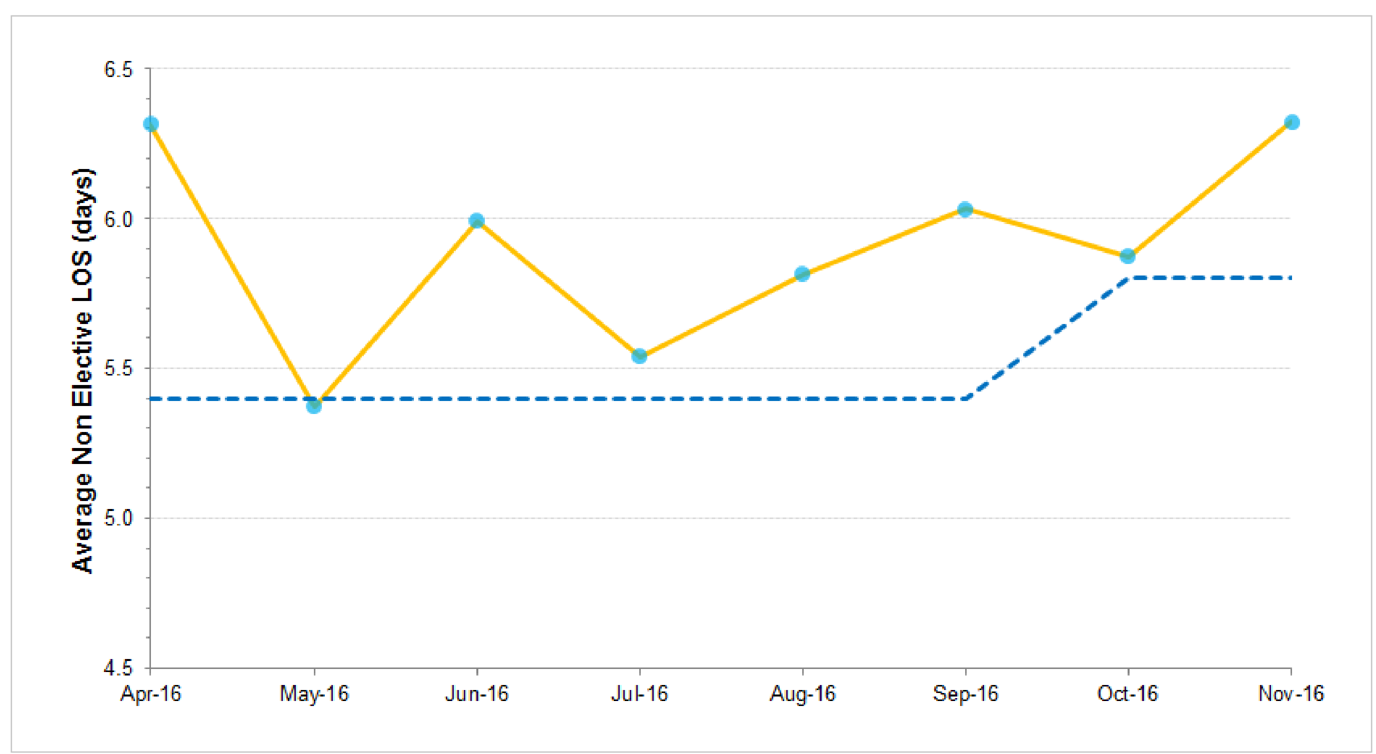


Fig. 19: Average length of stay for non elective patients (days)



To improve the discharge process

A priority for our Emergency Care Programme Board during 2016/17 was to improve the discharge process. Three areas in particular were identified for immediate improvement; these were largely incorporated in the SAFER CQUIN, 15/16 and 16/17 (see p30).

During 2015/16 through the SAFER CQUIN we started to embed SAFER principles in our hospitals and the milestones were fully achieved that year. Working in partnership with Gloucestershire Clinical Commissioning Group we identified learning from the first year of the SAFER CQUIN and agreed where additional focus was required for 16/17. This will also have a positive impact on the four hour performance. Other benefits include:

- Patients will benefit from improved care coordination ensuring they receive their care in a timely manner in the right environment
- Patients will benefit from a well planned, timely discharge
- Staff will benefit from being able to provide patients with the specialist care for their needs
- Staff will have all the information they need to ensure care is delivered appropriately
- Staff will be able to deliver real time, accurate information to the Site Management Team and ensure the Ward Information System is up to date
- The Trust will benefit from improved patient flow throughout the organisation
- The Trust will benefit from having meaningful information to enable capacity and demand to be managed

In 2016/17 we expanded our focus on improving the discharge process to include 'Critical Care-Timely discharge'. We know that patients who have a delay in their planned discharge from critical care to a lower level (eg other inpatient wards or social care) are more likely to experience a night time discharge or an expedited discharge to accommodate another patient. Such poorly executed discharges frequently lead to a negative patient experience characterised by unnecessary risks. Delays in discharge result in high occupancy rates which reduce efficiency and responsiveness of the service, lead to increased costs for our commissioners due to the unnecessary bed day costs and critical care capacity being unavailable to other patients who require admission.

The aim was to reduce delayed discharges from Adult Critical Care (ACC) to ward level care by improving bed management in ward based care, therefore removing delays and improving flow.

The national standard is that all discharges should be made within 4 hours of a clinical decision to discharge being taken within daytime hours. This target is not being met nationally and in 2015/16 there was a CQUIN to support reducing delays under 24 hours which we fully achieved.

The 16/17 CQUIN aims to continue work to remove delays of more than 24 hours and support removal of delays of more than 4 hours. Up to Q3 we have met the targets of compliance for 24hr discharges and 4 hour discharges.

In March 2017 Healthwatch Gloucestershire published a review of a report of the experience of patients being discharged from our care which they conducted in 2015. We welcome the input of Healthwatch Gloucestershire and the feedback of patients and will be reviewing the recommendations made to make improvements to the way we discharge patients in the year ahead.

Improving care for people who use our services and have dementia and delirium

It is estimated there are around 850,000 people living with dementia in the UK, with numbers set to rise to over one million by 2025. Around 225,000 people will develop dementia this year alone – that's one every three minutes. In our hospitals, one in four patients may experience cognitive impairment (problems with memory and processing thoughts) and around 180 patients a month with a diagnosis of dementia are discharged every month.

During 2016/17 we have delivered a series of initiatives to help us improve the care we provide for people with dementia who use our services, as well as their families and carers:

- Delirium trigger tool: Following a successful pilot testing a tool which guides clinicians on early recognition of symptoms of delirium, we are now developing this further in the form of a Trust clinical assessment sticker. The sticker will help ensure standardised care at the right time. The assessment tool is now used in our Emergency Departments. We also have a page on Delirium on our staff intranet to support this assessment
- Ward based training within targeted clinical teams continues and our delirium e-learning package will be further improved during 2017

- In 2017 the work of our dementia working group expanded to support our healthcare partners to implement a seamless pathway for people living with dementia across Gloucestershire. A programme of patient and family/carer quality and safety improvements has now started. This work aims to avoid unnecessary hospital admissions, improve the care experience, improve communications and improve discharge planning
- In line with national best practice, we continue to support early diagnosis of dementia by assessing patients aged 75 years and over who are admitted via the emergency care pathway to identify early signs of possible dementia. This ensures assessment of care needs, information sharing with the patient's GP and appropriate referral depending on their care needs
- Our estates team have been working to develop an environmental dementia-friendly toolkit. This will provide guidance on what a dementia-friendly environment looks like in our hospitals to help inform future developments. Work is in progress at this time to extend the implementation of dementia-friendly ward signage to a further number of key wards during 2017
- Our Trust Dementia Care Strategy ''What Does Good Dementia Care Look Like In Our Trust'' was launched in January 2017. This was developed in light of feedback from carers of patients with dementia and has four key themes, communication, person centred care, care environment and staff training. We continue to provide a programme of face to face dementia training, including dedicated training with our Emergency Department (A&E) and Acute Care Unit teams.
- Throughout 2016 and 2017 our Patient Experience Team and staff from our Dementia Steering Group have been supporting local Memory Cafes led by Gloucestershire Alzheimer's Society. The cafes are an opportunity to share information, to seek feedback on experience and to learn from people within Gloucestershire who are living with dementia
- In January 2017 we introduced Patient Diaries. The aim of the diary is to promote communication between patient, family/carers and care team by sharing information on wellbeing or activity relating to our patients who are experiencing cognitive impairment
- Our Dementia Champions continue to promote best practice care for our patients who are living with dementia
- Cognitive stimulation activity and wellbeing sessions continue within our General and Old Age Medicine Wards, and a review of this activity is planned for spring 2017.

CASE STUDY

We have introduced twiddle mitts in our hospitals in 2016/17. Twiddle mitts are basic knitted hand muffs with items such as large buttons or knitted flowers attached, which a patient can 'twiddle' in their hands. They are known to have a calming effect on a patient who has dementia, allowing them to focus on the item rather than responding to distractions.

Dr Tanya de Weymarn, Emergency Department Consultant and the ED frailty lead, worked to introduce them in our hospitals as part of the Gloucestershire Elderly Emergency Care (GEEC) Project. She has found the mitts an invaluable resource for patients.

She said: "Staff are regularly telling me that patients have been calmed by using twiddle mitts. As the patients are less likely to be distressed, they are less likely to harm themselves by trying to climb out of bed (with the risk of falling) or by pulling at clinical equipment such as drips. This in turn has meant that staff can spend time fulfilling other care requirements in ED. Its not just the patients that have benefited from the twiddle mitts. Staff have enjoyed knitting and crocheting the mitts and doing something different that can make a patient's stay less stressful. A patient holding a twiddle mitt is immediately identifiable as potentially needing extra help and assistance (in addition to the butterfly symbol in the notes which is used for patients with cognitive impairment). The whole project has increased awareness of cognitive impairment and dementia as well as raising a smile with staff."

The twiddle mitt project wouldn't have been possible without the input of volunteers who both knit and support their use in our A&Es.

Learning from users

Our patients experience our services first hand; they have a unique, highly relevant perspective on what works and what doesn't. Their input into designing services can therefore be invaluable.

Seeing services from the patient's point of view opens up real opportunities for improvement that may not have been considered before.

In 2016/17 we continued to build on the findings from a project we started during 2015/16 with Age UK which involved actively listening and learning from older, frail, elderly patients on our wards. We know that understanding how a person has lived their life before they became a patient will help our staff see beyond their immediate needs and incorporate the patient's goals and aspirations into healthcare decisions we make. In 2015/16 we worked with volunteers on Wards 4a, 4b, 6a (at GRH) and Ryeworth (at CGH) to spend time with patients, listening to their feedback on their experiences in our hospitals.

This year we have been sharing the learning with other wards and departments. We are also taking part in a new project called Understanding the Patient Experience led by Oxford University. We are one of six Trusts throughout the country who will look at how ward staff use patient experience data to make changes and this will continue throughout most of 2017.

We have been working with young people, their families and clinical teams looking at the transition from Paediatric to Adult Services. A shadowing methodology has been adopted as part of this work which also forms part of a CQUIN. The project is part of our Quality Improvement Academy.

We have also introduced an automated system of collecting Friends & Family Test data this year, enabling us to listen to feedback given via the Voice Messaging Service. This new service also allows ward staff to read and/or listen to patients comments on an almost real-time basis.

CASE STUDY

This year we introduced a new child-friendly way of encouraging younger patients to leave feedback in our hospitals.

The Monkey Wellbeing 'Pants and Tops' scheme is a national initiative aimed at increasing the amount of comments received. If their comments are regarded as positive, they write their message on paper t-shirts (tops) and if they have a negative review they write them on paper pants. The comments are then displayed on a 'washing line' on the ward.

Improving the experience for children and their families as they move from paediatric to adult services

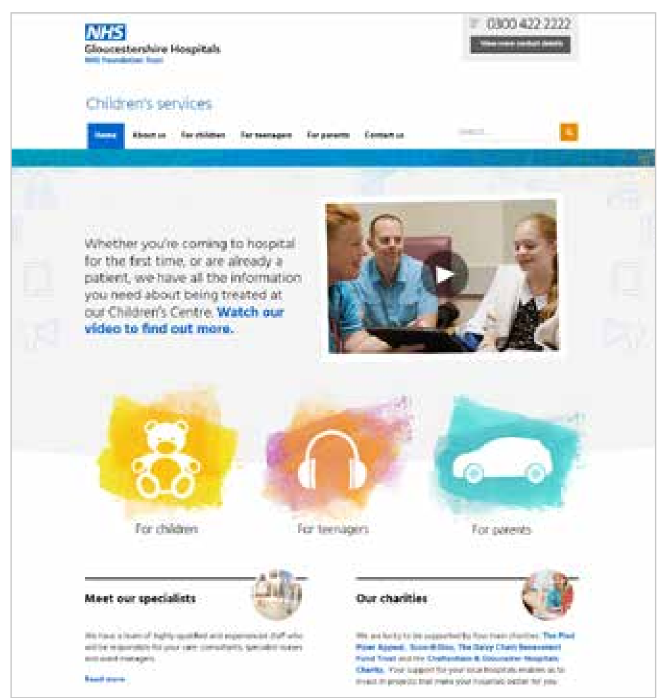
Moving from children's to adult services can be a difficult time for our younger patients, who will be leaving a team of doctors and nurses that they may have received care from for many years. It is important that they 'transition' from one service to another smoothly, to make this journey as easy as possible for the patient and their family or carer.

Following a pilot study we undertook in 2015/16 in the epilepsy speciality using a pathway called Ready, Steady, Go and Hello ℹ, the transition pathway has been rolled out in more specialities during 2016/17 including diabetes, renal and rheumatology.

We have developed a web page on our children's services mini-site to support children on this pathway, to ensure that the transition resources are available to young people with long-term conditions as identified within the specialities and their families and or carers.

We have also developed a transition e-learning module ℹ for staff and have raised awareness of the transition pathway by holding workshops at all of the Nursing Strategy events held during 2016/17.

Our Patient Experience team has also been working with young people by 'shadowing' them in clinics throughout the different phases of the transition pathway to provide valuable feedback so that we can continually improve the patient experience and the services we provide for young people with long term conditions.



How well have we done in 2016/17?

Well led

To ensure that all staff in leadership roles are trained in service improvement methodology

The Gloucestershire Safety & Quality Improvement Academy (GSQIA) was established in June 2015. From October 2015 the Academy started the delivery of two Quality Improvement (QI) programmes:

- A Bronze level: Introduction to QI. This provides an overview of QI methodology
- A Silver level: QI in Action. This is a seven-month programme to support staff working on a QI initiative.

The Quality Improvement training was part of a wider objective to contribute to the development of a culture of continuous improvement within our Trust, where staff at all levels have the confidence to highlight areas for improvement and then have the skills, knowledge and support to be able to introduce those changes. Our Quality Improvement Programme is about being the best we can be. It's about taking the things that we know can be better and making a lasting improvement.

Our objective for 2016/17 was to train every new Consultant, senior doctor or leader on induction at Bronze level, introducing them to quality improvement and encouraging them to think of ways they can use the methodologies to introduce improvements in their own specialties. We also aimed to train all new Band 5 nurses in their transition training.

During 2016 the Academy delivered the Bronze – Introduction to Quality Improvement – training during two scheduled Consultant Welcome days, training 18 new consultants. The Academy also delivered the Bronze level training to 63 new Leaders over the course of six Leadership Inductions and to 61 new Band 5 nurses during two transition programmes.

In addition to these programmes the Academy also trained 35 new F1 Doctors and 19 staff undertaking the iManage programme, during 2016. This has taken the total number of Bronze level Improvers trained by the Academy since its introduction to 544 at the end of 2016.

CASE STUDY

In order to increase the safety of the sleep apnoea service with no additional resources, Beverley Gray, Head of the Respiratory, Sleep and GI Physiology Service, worked with partners to improve the patient pathway and, as a result, reduce the waiting times. The outcome was a radical redesign of the pathway in co-ordination with Gloucestershire Clinical Commissioning Group (CCG) and one that should, on full implementation, significantly improve the patient experience.

Beverley said: "The bronze and silver award taught us key learning and assessment tools such as driver diagrams, PDSA cycles and SPC charts. These enabled us to measure the position the service was in at the start of the project and after each step change. We were also given invaluable tools to help with the process of mapping the patient pathway, enhancing the work we had undertaken prior to the training.

"Our project grew from an internal pathway project to being the basis of the CCG Sustainability and Transformational Plan. The ongoing update sessions at regular intervals also ensured we maintained focus on the project and provided a nice little insight with a few suggestions from the team about the direction we were going with the project.

"As a department we have always had a culture of reassessment for improvement but haven't necessarily used tools to support or review these changes. The lessons learned from GSQIA will help us not only with this project but other objective changes made within our services going forward into the future.

"We would both thoroughly recommend anyone who has an interest in improving the quality or safety of their service to undertake the bronze and silver awards through GSQIA."

Beverley Gray and William Sims

Read more at www.gloshospitals.nhs.uk/gsqia

2.1.2

What are our priorities for 2017/18?

Our priorities for improving quality

The table overleaf provides an overview of our priorities for 2017/18. This table gives you an at-a-glance view of the work undertaken in the past year and which of our stakeholder groups identified the priorities for improvement.

In 2017/18 our priorities will once again be aligned with the dimensions of quality we are measured against by the Care Quality Commission: Safe, Effective, Caring, Responsive and Well-led. More detail about each of these priorities can be seen in the following pages.

Progress against the priorities identified will be measured by agreed metrics and monitored by the Quality & Performance Committee throughout the year.

Priorities for improving quality in 2017/18

Priorities	Incomplete from last year	National priority for 2016/17	Issue for commissioners / CQUIN	Issue for HCCOSC	Issue from Healthwatch	Issue identified internally inc. governors
1. Safe						
Reducing the impact of serious infections	✓	✓	✓			
2. Effective						
Delivering high quality urgent and emergency care		✓	✓	✓	✓	✓
The effective use of complex devices		✓	✓			
Improving the use of medicines	✓	✓	✓			
Preventing ill health		✓	✓			✓
3. Caring						
Time to care		✓		✓	✓	✓
4. Responsive						
Proactive and safe discharge	✓	✓	✓	✓	✓	✓
5. Well-led						
Harnessing the benefits of technology	✓	✓				✓

What are our priorities for 2017/18?

Safe

Reducing the impact of serious infections

Timely identification and treatment of patients with sepsis in emergency departments and acute settings

In 2017/18, as in the previous year, the CQUIN has two main objectives:

- Part A: patients who meet the clinical criteria for sepsis should be screened
- Part B: those who present with red flag sepsis, severe sepsis or septic shock, must receive antibiotics within an hour. These patients should also receive a review after three days of antibiotics.

Following our inspection by the Care Quality Commission in January 2017, we developed an action plan to address concerns regarding the safety of patients in our Emergency Departments (A&E). This included actions to ensure compliance with our CQUIN ℹ goals for sepsis in the year ahead. We intend to do the following:

- Signposting to support staff and encourage them to Think Sepsis at the point of entry to A&E
- Ensure the sepsis protocol and documentation is available at triage
- Support the project through our Gloucestershire Safety & Quality Improvement Academy.

Assessment of clinical antibiotic review between 24 and 72 hours of patients with sepsis and reduction in antibiotic consumption per 1,000 admissions

This CQUIN ℹ project aims to ensure appropriate treatment of life-threatening infections, while at the same time reducing the chance of the development of strains of bacteria that are resistant to antibiotics.

There will be a continuation of last year's project of antibiotic usage data being reviewed. Overall consumption, together with carbapenem, and piperacillin-tazobactam antibiotics ℹ usage will be audited with a view to reduce 'antibiotic consumption per 1,000 admissions'.

An assessment of the quality of the clinical antibiotic review will be carried out between 24 and 72 hours of the start of therapy, for patients with sepsis and who are still inpatients at 72 hours. Building on the achievements of 2016/17, microbiologists and specialist pharmacists from the Antimicrobial Stewardship Committee will oversee these audits and assess whether the narrowest spectrum antibiotic treatment from our local guidelines is prescribed for the defined period. This audit data will be reported to Public Health England via an online submission portal.

What are our priorities for 2017/18?

Effective

Delivering high quality urgent and emergency care

To ensure our local response to the National Urgent and Emergency Care Review includes the development of models of care that ensure patients are treated with the very best expertise and facilities in order to maximise their chances of survival and a good recovery

The Gloucestershire Sustainability & Transformation Plan highlighted the need for the way we respond to people requiring emergency and urgent care to be reviewed right across the system, from GP to hospital services.

For our part we want to look at new models of care that will allow us to triage patients within 15 minutes and to ensure they have been reviewed by a senior clinical team within 60 minutes.

We will work with our clinical teams to identify a range of options which we will want to discuss with members of the public before deciding how to proceed.

Progress to delivering specialist input within 14 hours, daily Consultant review every day, timely diagnostics and interventions (four key standards in national programme by 2018)

There is a national drive to ensure consistent care seven days a week. Following initial guidance in 2013, 10 standards of care have been developed by NHS England that we must achieve by 2020. Four of these standards regarding initial Consultant input, regular Consultant review, access to diagnostics and access to interventions have been prioritised and we must achieve them by 2018.

We see these standards, in our Trust, as central to ensuring the delivery of high quality care. We have done considerable work to date; initially piloting a seven day approach in respiratory medicine and subsequently supporting the investment in additional staff and reorganisation of work patterns to deliver the appropriate performance against the standards. Good progress has been made across the four key standards and we are monitoring these in line with other trusts through national audits (most recently in March 2017).

The effective use of complex devices

To ensure that the selection of internal cardiac devices remains consistent with the commissioning policy, service specification and relevant NICE guidance

Complex implantable cardiac devices are Implantable Cardioverter Defibrillators (ICD) and Cardiac Resynchronisation Therapy (CRT) devices.

In the right patient, complex devices can reduce the risk of sudden death, improve quality of life and improve the prognosis in patients with heart disease. Clinical decision making around device selection varies between units and this variance may impact on clinical outcomes as well as the overall cost of the complex devices.

The staffing of cardiology departments involved in implanting complex cardiac devices also varies across England which impacts on the effectiveness of decision making, results in variation of device programming and outpatient follow-up arrangements as well as on-call cover for related emergencies.

This CQUIN scheme, which we will be working to deliver during 2017/18, seeks to promote:

- Enhancement and maintenance of local governance systems to ensure compliance with national policies and specifications
- Development of sub-regional network policies to encourage best practice when determining device choice including minimum standards for patient consent to ensure the best device is selected for that patient
- To improve timely access for all patients who need referral for consideration of complex device implantation
- To ensure that referral pathways and robust decision making processes are developed for complex and clinically unusual cases.

Improving the use of medicines

To optimise the use of medicines commissioned by specialised services

Optimising the use and management of medicines provides a further opportunity for the NHS to improve patient outcomes, pathways and experience, whilst reducing expenditure, unwarranted variation and wastage. One example of reducing wastage is for patients to bring in their medication with them when attending hospital. This means a duplicate supply isn't dispensed for them whilst in hospital, saving the NHS and the health community of Gloucestershire, money. It also enables us to determine what medication the patient is actually taking and how, which is crucial in ensuring successful treatment and care.

Over many years specialist pharmacists working with senior medical and nursing colleagues have produced protocols and guidelines to improve medicine use, changing selection and processes. Pharmacists with prescribing qualifications have also been embedded in certain clinical areas, leading to local, regional and national awards being won in relation to developing the workforce and improving patient safety.

Working nationally, we are building on previous successes to enable faster adoption of best value medicines including the new biosimilar biologic medicines. Once our new Electronic Health Record, TrakCare, is fully rolled out and embedded into practice, improvements in data quality and outcome registries will further help reduce clinical variation and waste, improving productivity and performance related to medicines.

To introduce standardised doses of anticancer therapies

The treatment of cancer via chemotherapy is the single biggest service within NHS England's specialised commissioning spends. It is estimated that NHS England spends approximately £1.5 billion on the routine commissioning of chemotherapy, with medicine costing 80% of this. With the elderly population increasing and advancement in chemotherapy treatments, this cost is increasing by approximately 8% per year.

Traditionally, chemotherapy doses have been unique to individual patients based on a dose per kg of body weight. Such specific dosing has been demonstrated not to provide additional clinical or patient benefit and significantly increases time and costs of preparation and costs of drug wastage.

Standardising chemotherapy doses across certain weight bands provides many advantages. It allows chemotherapy to be prepared in advance; it simplifies the process reducing risk and it reducing waiting times for patients. Batch production within the Pharmacy Aseptic Manufacturing Unit (PAMU) can occur, which minimises waste. Similarly if a patient is

unwell on the day and can't receive chemotherapy, that product can be kept for the next patient.

Working nationally, we are now aligning our dose bands to have a standardised approach across England which we hope will further eliminate waste through a consistent approach to patient care.

Preventing ill health

Improvement of health and wellbeing of NHS staff: 5% improvement in two of the three annual staff survey questions on health and wellbeing, musculo-skeletal issues and stress

Our priority to 'prevent ill health' reflect the CQUINS agreed with our commissioners as part of our contract for the coming year but accurately reflect the importance to our Trust of health and wellbeing. These will be managed within the Staff Health and Wellbeing Group which in turn reports to the Trust Workforce Committee, a full sub-committee of the Board.

The first of the measurements, all of which are taken from the annual staff survey, focuses on the percentage of staff who believe that our organisation takes positive action on health and wellbeing. This requires an improvement of 5% over a two year period of the number of staff responding 'yes, definitely' with the baseline being set against the results of the 2015 staff survey. Currently, 29% of staff respond in this way (no movement from last year) with 15% responding, 'yes, to some extent'. As part of our Trust Staff Health and Wellbeing Strategy, we have said that key to improving the health of our staff is involving them in the solutions. Therefore we will be surveying them on both the issues that impact their health and the interventions they would like us to make and the responses will feed our action plan.

The second of the measurements relates to improving (reducing) the percentage of staff who in the last 12 months have experienced musculoskeletal problems as a result of work-related activities. We have improved our performance by 1% over the last year which means that we have a further 4% improvement to make this year, with a minimum target of 82% of staff reporting that they have not reported such problems. The Trust Health and Safety Risk Manager is leading this project and is adopting a 'Quality Improvement' approach to this issue and is seeking to develop a process to effect systematic improvements. As back and musculoskeletal issues constitute one of the main reasons for employee absence across our trust, this systematic approach is much welcomed.

The third element relates to effecting a reduction in the percentage of staff who say that they have felt unwell in the last 12 months as a result of work-related stress. Again, in terms of a baseline, we have achieved a 1% modest improvement in performance over the last year (leaving a further 4% improvement to find in the coming year) moving the percentage from 34% to 33%. This is 2% below the national average, however it is recognised that an improvement of 1% is fragile and that the current figure locally and nationally is unacceptable. We intend to adopt the same systematic approach in identifying higher risk areas or staff groups and will also build on existing activities which include;

- annual stress risk assessments for both clinical and non-clinical areas
- team intervention activities facilitated by the Leadership and Organisational Development team
- well received resilience training sessions facilitated by our Staff Support service
- individual counselling sessions provided by our Staff Support service.

Improving the health and wellbeing of our staff will not be restricted to these identified priorities and we recognise that there are other factors at play such as improving the physical working conditions for staff, the opportunities for both physical and social activities and crucially, the opportunity to have their voice heard through a variety of engagement mechanisms. All of these will contribute to improving the health and wellbeing of our staff and in turn, the health and wellbeing of our patients.

Healthy food for staff, visitors and patients including changes to food and drink provision with a focus on reducing sugars on sale in drinks

As part of the response to the Francis report and other key documents, the Department of Health recently published The Hospital Food Standards Panel's report on standards for food and drink in NHS hospitals (Department of Health August 2014). This report aims to improve food and drink across the NHS so that everyone who eats there has a healthier food experience and that everyone involved in its production is properly valued. The report identified five food standards required of hospitals which are captured within our strategy.

In June 2014, Public Health England (PHE) published 'Sugar reduction: Responding to the challenge'. This set out what PHE would do to review the evidence across a broad range of areas and identify those where action is most likely to be effective in reducing sugar intakes. Sugar Reduction: The evidence for action

In November 2016 details were announced by NHS England on action to cut obesity and reduce the sales and consumption of sugary drinks sold in hospitals.

A Staff Health and Wellbeing CQUIN has been introduced with specific healthier food choices The healthier food choice scheme includes incentives that end price promotions on high fat, salt, saturates and sugar foods, that stop advertising of unhealthy foods on NHS premises and that end the sale of unhealthy foods at checkouts, while ensuring healthier meals are available out of hours.

The Trust will be working with the onsite shops in both Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH) to implement the changes required in the CQUIN. Our in-house retail services are working towards implementing the CQUIN, and supporting the delivery of the Trust Food and Nutrition Strategy.

Improving the uptake of flu vaccinations for front line clinical staff

We face significant challenges around maintaining our workforce during times of increased sickness, so it's vital to reduce the impact of flu to protect patient care.

Our Flu Vaccination Programme 2016/17 was focussed on using NHS Employers' campaign messaging to encourage our staff to take up the vaccine and using NHS England's campaign materials to encourage our patients to get their flu jabs in the community.

Working Well provided a programme of drop-in sessions to enable our staff to access vaccination clinics at both sites and we had a team of trained volunteer peer vaccinators supporting the programme by vaccinating colleagues in their wards and departments.

58% of our patient-facing staff (3,549) took the opportunity to get their jab at our hospitals or at their GP surgery. Additionally, 232 staff in non-patient facing roles took the opportunity to protect themselves by getting vaccinated against flu.

However, as part of its Healthy Workplaces effort, the CQUIN for 2017/18, we will have financial incentives to improve the health and wellbeing of our staff and we will be expected to increase staff flu vaccination rates to nearer 75 per cent in the coming year. To enable this to happen, we will be reviewing our organisational approach to better encourage front-line staff to take up the flu vaccination.

What are our priorities for 2017/18?

Caring

Time to care

To ensure safe staffing levels and implement the new approach to measuring Care Hours Per Patient Day

Care Hours Per Patient Day (CHPPD) is a new tool, introduced by NHS Improvement in 2016, which will allow hospitals to identify how they can change and flex their staffing levels to improve productivity and the quality of care for patients.

From May 2016, all hospital trusts began reporting monthly CHPPD data to NHS Improvement. CHPPD is calculated by adding the hours of registered nurses and the hours of healthcare assistants and dividing the total by every 24 hours of inpatient admissions. CHPPD is reported as a total and split by registered nurses and healthcare assistants to provide a complete picture of care and skill mix. Over time, it is expected that hospitals will be able to compare their data with other comparable wards and specialties nationally, to help ensure their wards are staffed to support the delivery of high quality care.

To prevent falls and pressure ulcers

Pressure ulcers are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure and develop over a short period of time. Pressure ulcers tend to affect people with health conditions that make it difficult to move, especially those confined to a bed or sitting for long periods of time. For some patients, pressure ulcers require basic nursing care. For others they can be serious and lead to life-threatening complications, such as blood poisoning or gangrene.

We have four Tissue Viability (TV) ℹ nurses in our hospitals who all work to achieve our goal of preventing the development of pressure ulcers. We ensure as a service to educate staff that all patients are assessed within six hours of admission, using a risk assessment tool called the Waterlow Score.

Early detection of skin changes is vital in the prevention of pressure ulcers. The areas we focus on as a team to educate staff are the following:

- Skin Care Guidelines and good skin care
- Moisture Lesions verses Pressure ulcers
- Grading of pressure ulcers
- Correct equipment for at risk patients
- SSKIN Bundle for all patients with a Waterlow score 10 and above. This is a document that highlights the areas for nursing staff to focus on and follow regarding prevention of pressure ulcers.
- We have Tissue Viability link meeting for qualified and Health care assistant staff. The training for HCA is new as they are an important part of the ward team who need to identify and report skin changes.

We will be running an educational event for staff in November the day is called Stop Pressure Ulcer day. It's a yearly event and focuses on prevention

and treatment of pressure ulcers. This year we are doing an outside event, it will allow us to highlight and update staff on the importance for this area. We have in past years had stands up in the hospital that reaches out to the public and staff.

As a TV team we introduced trust wide a product called Kerra Pro, an aid to help with the prevention of pressure ulcers. This was launched this year and each ward area has had training on the product. We continue to educate staff on identifying the difference between a Moisture Lesion and a pressure ulcer. We provide posters with photographic pictures to help with this.

We look out at and evaluate advanced wound therapies and products in the treatment of pressure ulcers. A new therapy which we have and will be using is Veraflo which irrigates wound/pressure ulcers and this hopefully cleans the wound bed and speeds up the healing process.

We continue to audit yearly on mattresses and cushions used in the trust, to ensure the equipment is safe and fit for purpose. We also check to see the equipment used is of suitable for the risk of the patient developing pressure ulcers. We target any hot spot areas which need education or support.

We are a dedicated TV team and are always looking at improving on knowledge for staff and providing excellent patient care with TV.

To improve end of life care

Maintaining the momentum of our progress so far is a priority for the coming years. Our Trust Board are supportive of our aim to ensure that End Of Life Care (EOLC) is always on the agenda.

Following the development of a countywide EOLC strategy, we have distilled the core objectives into a Trust-focussed EOLC strategy. We are planning to launch this in early 2017 with the aim of creating pride in the provision of end of life care across our services. We recognise the need to individualise practice within different departments but also to engage every staff group in recognising that EOLC is truly everybody's business and that even the catering department can play their part, as well as those providing hands-on care.

We are committed to ensuring that all staff undertake some training in EOLC. Additional role-specific training will also be important, but EOLC really does affect everyone and so it is essential training for all.

We are also formalising the role of our end of life champions. These are members of staff who are passionate about leading improvements in end of life care.

We are committed to addressing the need for a wider societal change around EOLC discussions, advance care planning and 'starting the conversation'. This will include our staff and patients, helping to breakdown some of the myths that surround EOLC. Public and staff events will form a key part of the EOLC work programme. Further information will be available shortly on our website: www.gloshospitals.nhs.uk

What are our priorities for 2017/18?

Responsive

Proactive and safe discharge

Supporting proactive and safe discharge using the Emergency Care Data Set and increasing the proportion of patients admitted via non-elective routes, being discharged from acute hospitals to their usual place of residence within seven days

We are committed to improving the time patients spend in our hospitals and to reducing any unnecessary delays. To ensure proactive and safe discharge we are implementing SAFER and Red to Green initiatives (read more on p30).

From April 2017, we will be working with four wards at GRH ℹ, setting them up as exemplar wards delivering SAFER and Red to Green, before rolling it out to another eight wards in May 2017.

In addition, in 2016 we reconfigured our Integrated Discharge Team to provide a closer fit with the needs of the individual wards. We continue to work with other partner agencies to manage and reduce the number of medically fit for discharge patients and delayed transfers of care. In February 2017 we set up a therapies-led ward for the medically fit for discharge patients. The aim is to reduce the length of stay for these patients and a better experience, by providing rapid and concentrated physiotherapy while they await discharge.

Delayed discharge has a serious impact across health and care, reducing the ability of emergency departments to respond to people's needs, and increasing costs to local health economies. This is a two-year CQUIN that aims to improve discharges for patients across all wards.

The CQUIN ℹ in 2017/18 aims to improve patient care and experience, improve patient flow, and reduce the number of patients whose discharge is delayed, including the costs associated.

There are three parts to this CQUIN:

- Mapping existing discharge pathways and roll out new pathways
- Demonstrate that credible planning is in place to make the required preparations (e.g. by upgrading IT systems and training staff) so that the Emergency Care Data Set (ECDS) ℹ can be collected and returned from 1st October 2017
- Increasing the proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% points from baseline (Q3 and Q4 2016/17).The rationale for this is that inappropriate, early discharge carries risks to patients and therefore providers and commissioners should carefully monitor readmission rate.

What are our priorities for 2017/18?

Well led

Harnessing the benefits of technology

To develop the use of our clinical information system to support the ordering of tests and the communication of results

As an organisation, our vision for the future of healthcare technology is one where our information systems are innovative, safe, accessible and reliable, helping us improve care and reduce costs.

As part of our long term strategy to deliver this vision, in December 2016 we went live with Phase 1 of our new Electronic Health Record (EHR), TrakCare. Phase 1 included the replacement of ageing clinical systems in the Emergency Department, Maternity and Theatres.

Phase 1.5 will be launching during 2016/17 and builds on the EHR further to deliver electronic ordering of tests and samples from radiology, pharmacy and pathology.

Once fully implemented, TrakCare will ensure we have an EHR that:

- is kept constantly up to date and available to key staff involved in each patient's care
- improves patient safety, for example, by highlighting special needs, allergies and past medication doses
- supports clinicians in taking decisions on treatment, with prompts to take action or carry out tests, for example
- speeds up the ordering and turnaround of tests, such as blood and tissue analysis
- puts an end to the difficulties posed by missing notes
- reduces medication errors
- means patients shouldn't need to repeat the same information to different staff
- reduces or eliminates the use of paper.

Following the implementation of Phase 1 we experienced a number of operational issues. The impact on the organisation, as a consquence of the issues experienced after Phase 1 go live can be categorised broadly as:

- **System design:** there were a number of processes which weren't working as required. We have been working with InterSystems, who built TrakCare, to resolve these issues.
- **Training and operational readiness:** although we had developed a range of e-learning modules in advance of go live, we were unable to share a test version of the system, for staff to use. As a consequence, while we were operationally ready for go live, many members of staff 'on the ground' felt unprepared for the significant change to working practices which followed.
- **Reporting:** after go live, we were unable to fulfil our reporting requirements, as although reports were able to be produced by TrakCare, they did

not appear as expected. We had been unable to test this element of the system ahead of go live.

- **Data quality:** we underestimated the impact that a move to a new way of working would have on those inputting info into the new system. During go live we were temporarily collecting data on paper. This meant that for a period until the data was inputted into TrakCare, our systems were missing key data.

We have taken a number of actions to restore operational performance since go live, including:

- We recognised that we needed to establish a better connection between the project team delivering TrakCare and the operational side of our business. We quickly appointed an operational lead and set up an Operational Impact Board.
- We have been looking at the way we have configured access to the system, making more user friendly and easier for our staff to use
- We have conducted a thorough review of all clinics in TrakCare and are re-building any that have been configured incorrectly
- We have worked to input data captured on paper during the first few weeks after go live
- We keep staff informed about the progress made to resolve the issues experienced in a weekly global message

Most importantly, we have taken steps to ensure there has been no harm to patients:

- We have encouraged staff to ensure that any issues or risks connected to TrakCare are logged in Datix, our online incident reporting tool. A group of clinicians review these and investigate as required. If we do find an issue, we ensure this is raised within the project team weekly meetings and is managed accordingly in partnership with InterSystems.
- We hold monthly safety meetings where all patient safety risks associated with TrakCare are reviewed, addressed and any future learning identified.

We are committed to learning lessons from this experience so we are prepared for future deployments. We have conducted a formal review and identified key learning points. In particular we are committed to ensuring that staff groups who will be impacted by a technical deployment are fully engaged and prepared for the changes.

To increase the use of the national e-referral system to allow patients to choose appointment times that suit them by publishing all of our first outpatient appointment slots available on NHS e-Referral Service (eRS)

The NHS e-Referral Service (eRS) is a secure and free NHS appointment booking service.

If you're referred to a hospital or clinic for your first outpatient appointment, the NHS e-Referral Service lets you book the appointment at a hospital or clinic of your choice, on a date and time that suits you. This is a more efficient process for patients and for us as we know the right appointment has been booked.

To establish Advice & Guidance services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care

We have already established an Advice & Guidance (A&G) service for GPs in dermatology, endocrinology, Ear Nose & Throat, haematology, nephrology, neurology, paediatrics and rheumatology, and we are looking to expand this service further into more specialties in 2017/18. The Advice & Guidance service allows GPs to gain input from a specialist consultant without the need to refer their patient to an outpatient clinic. GPs can use the Electronic Referral Service (ERS) to ask for advice and/or guidance from one of our consultants. GPs use ERS to send an electronic message direct to one of our acute specialties. Over 85% of all queries receive a response within two working days. This also helps us to manage demand for new outpatient appointments whilst simultaneously allowing GPs to provide care closer to patients' home by continuing to manage them within primary care.

NHS England recognises the value of A&G services and have made funding available over the next two years to help providers establish and expand their provision. A maximum of £695k is available this year to providers who can meet all the necessary CQUIN milestones, including providing A&G for services that total at least 35% of all outpatient referrals. Our Outpatient Board will oversee the expansion of the A&G service, ensuring that we select services that will maximise the benefit to patients and will help these specialties establish the mechanisms and processes to ensure GPs and their patients receive a robust and timely service.

Learning to improve

To participate in and learn from the results of national audits, and reviews of our services

Our Trust participates in a number of National Clinical Audits, on a compulsory and voluntary basis. Participation in these audits provides an invaluable insight into the quality of care being provided based on nationally agreed standards and allows us to benchmark our performance with other trusts.

Results of National Audits are used by clinicians to help identify any possible quality improvements, the implementation of which allows us to improve the quality of our services and achieve better patient outcomes.

Liaison with the Gloucestershire Safety and Quality Improvement Academy over the coming year will provide structure to these quality improvement projects, with the hope that this will result in improvements being sustained in the long term.

To respond to patient feedback and surveys on discharge

The Patient Experience Improvement Team will work with our divisions and the Gloucestershire Safety and Quality Improvement Academy (GSQIA) to respond to patient feedback and surveys on discharge. The discharge improvement programmes will be part of the aim to develop a continuous improvement culture within this organisation. The approach that will be used will be a simple one which will be asking staff about "what works well," "what needs improving" and "what are the barriers to a quality discharge?"

Supported by the Patient Experience Improvement Team, our departments and wards will be encouraged to work on projects they believe are important to their patients.

To build the capacity and capability of our staff to improve services through our Quality Academy

The Gloucestershire Safety & Quality Improvement Academy has trained over 600 staff to the Bronze level of understanding QI methodology. All new consultants, managers and band 5 nurses receive this training automatically. Over 50 members of staff have delivered quality improvement programmes as part of the silver training. This has been in preparation for developing a continuous improvement structure that is locally owned and embedded, supported by a quality improvement expert (Gold) who can coordinate and coach on improvement at a specialty or department level.

In 2017/18 we will build on our success to date and identify up to 10 specialties to test and refine a new framework over four workshops (What, How, Plan & Feedback) throughout the year to begin the development programme and systematically work through the practical implications and assumptions of the model. We already have four potential volunteers who are very eager to be involved.

In parallel and in conjunction with the Leadership team, we will train and develop 10-15 quality coaches from across the specialties who will coordinate the quality programme in the specialties.

The second stage will be to roll out the programme across the Trust, dependent on the evaluation and success of the initial programme.

To really transform and embed this approach it will take several years of systematic testing, development and spread, the output will be to improve clinical engagement and embed quality improvement providing staff with the tools and environment to lead and own the quality agenda in their service.

Statements of assurance

The following section includes response to a nationally defined set of statements which will be common across all Quality Reports. These statements serve to offer assurance that our organisation is:

- performing to essential standards, such as securing Care Quality Commission registration
- measuring our clinical processes and performance, for example through participation in national audits
- involved in national projects and initiatives aimed at improving quality such as recruitment to clinical trials.

Information on the review of services

The purpose of this statement is to ensure we have considered quality of care across all our services. The information reviewed by our Quality & Performance Committee is from all clinical areas. Information at individual service level is considered within our divisional structure and any issues escalated to the Quality & Performance Committee.

During 2016/17 Gloucestershire Hospitals NHS Foundation Trust provided and/ or subcontracted 41 NHS services.

The Trust has reviewed the data available to us on the quality of care in all of these NHS services. The income generated by the NHS services reviewed in 2016/17 represents 100% of the total income generated from the provision of the NHS services by Gloucestershire Hospitals NHS Foundation Trust for 2016/17.

Information on participation in clinical audit

The purpose of this statement is to demonstrate that we monitor quality in an ongoing, systematic manner.

From 1 April 2016 to 31 March 2017, 39 national clinical audits and six national confidential enquiries covered NHS services that Gloucestershire Hospitals NHS Foundation Trust provides.

During that period Gloucestershire Hospitals NHS Foundation Trust participated, or is currently participating in 39 (100%) of national clinical audits and 6 (100%) national confidential enquiry of the national clinical audits and national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquires in which Gloucestershire Hospitals NHS Foundation Trust participated, and for which data collection was completed during 1 April 2016 – 31 March 2017 are listed in Fig 20, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry or a straight percentage of cases submitted

Review and action of results from reports of national clinical audits/confidential enquiries 2016/2017 are summarised in Fig 20.

Clinical Audit has been an integral part of the Trust's CQUIN programme over 2016/2017 providing evidence information for Sepsis and Acute Kidney Injury. The collection of Safety Thermometer data continued

Trustwide during 2016/17 (monitoring of data related to harms due to falls, pressure ulcers and urinary tract infections with catheters in situ). In addition the Medicines Safety thermometer has been set up and collects monthly data looking at allergy status, medication omissions and identifying harms from high risk medications. Clinical audit has also provided information for other national projects e.g. The Saving Lives campaign, which is used to identify areas of improvement and action as necessary.

Over 100 local clinical audits were undertaken in 2016/2017 and this has resulted in various improvement and education programmes including:

- Work within the medical team at CGH improved clerking times for medical patients by an overall average of 25% and by 35% during peak times (18:00-20:00)
- Improved education has been successful in reducing unclear diagnoses and missed comorbidities in paediatric discharge summaries by > 50% in 3 months. Further work will be undertaken to spread this learning

This high level of participation demonstrates that quality is taken seriously by our organisation and that participation is a requirement for clinical teams and individual clinicians as a means of monitoring and improving their practice.

Participation in clinical research

The inclusion of this statement demonstrates the link between our participation in research and our drive to continuously improve the quality of services.

The number of patients receiving NHS services provided or subcontracted by Gloucestershire Hospitals NHS Foundation Trust in 2016/17, which were recruited during that period to participate in research approved by an NHS Research Ethics Committee, and included on the National Institute for Health Research (NIHR) Portfolio was 3,044. This is a significant increase over 2015/16's total of 1,133 and the Clinical Research Network West of England stretch-target of 1,200 for GHNHSFT.

Much of this increase can be attributed to 7 studies that have each recruited over 100 participants (one study accounts for nearly 1,000 participants) and we need to be mindful of this as those high-recruiting studies close and the local portfolio changes. We will need to carefully consider new studies, and the increasing financial pressure on the Delivery Team, if recruitment levels are to be maintained in 2017/18.

Annual Plans are being submitted to the Clinical Research Network West of England (CRN WoE) and include a prediction of recruitment of 855 participants in 2017/18. However, this is based on current open studies and is likely to change over the year as new studies are approved and old ones close. As such, it is very difficult to accurately predict a target for the coming year. No formal target for 17/18 has yet been set with the Network.

To 13th March 2017, Gloucestershire Hospitals NHS Foundation Trust acted as host to 65 new studies approved since 1st April 2016, a slight drop on 2016/17. Of these studies 35 were adopted to the NIHR Portfolio.

In total the Trust was recruiting to 110 Portfolio Studies over the 12 month period, which is slightly more than the previous year (102).

There was a wide range of clinical staff participating in research approved by an NHS Research Ethics Committee during 2016/17. These staff participated in research covering the majority of medical specialties across all four divisions in Gloucestershire Hospitals NHS Foundation Trust.

Duty of Candour

For many years our Trust has delivered the 'being open' standards recommended for patients who have suffered avoidable serious harm or death. These standards require us to inform the patient or family of the event and provide an explanation and apology for what went wrong.

Depending on the family's wishes, this can take the form of meetings, letters and/or sharing the serious incident report. The Duty of Candour is new legislation that came into force at the end of October 2015 that extends the definition from 'serious harm and death' to include 'moderate harm.'

Arrangements within our divisions for investigating incidents which have (or have the potential to have caused moderate harm varied.

The Safety Department works to ensure that all reported patient safety incidents that trigger the Duty of Candour are managed in accordance with statutory and contractual requirements. In October 2016 the team appointed to a new Duty of Candour Co-ordinator post. The co-ordinator now screens all moderate and harm incidents through our Datix reporting system with the Divisional Risk Managers.

Trust staff report around 20-30 moderate harm incidents per week. It is necessary for each incident to be reviewed and consideration given to a) whether this has been correctly reported and b) whether on initial review it is considered that the patient has or may (in the future) suffer moderate harm or above. Of those 20-30 incidents, it is estimated that 2-3 cases per week fulfil the criteria for Duty of Candour.

During October 1st 2016 – Nov 30th 2016;

- 23 incidents triggered the Duty of Candour criteria and were followed through the new process
- 4 were scoped and not deemed a Duty of Candour incident after further investigation
- 7 incidents are still currently being scoped and require further information to ascertain the actual level of harm caused.

Figure 20: Participation in National Audits

Audit title	Did the Trust Participate?	Number of case submitted / number required	Was the report reviewed?	Actions taken as a result of audit / use of the database
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	50% entered via NICOR web portal. 70% required for minimum data standard	Data included in the Annual National Audit Report from NICOR February 2017.	Action to increase data input, achieve the minimum standard. Look to achieve the Best Practice Tariff
Adult Asthma	Yes	20	Currently being reviewed by lead clinician, will be shared at local educational meeting	Initial review suggests care received is not reflected by documentation present in casenotes. Plan for development of an asthma discharge bundle: management plan, inhaler review, triggers , smoking cessation etc.
Asthma (paediatric and adult) care in emergency departments	Yes	CGH 30 GRH 70	Local review of submitted data by lead clinician, awaiting National report for Trust comparison.	Quality Improvement Project (QIP) for asthma care in ED underway
Bowel Cancer (NBOCAP)		2016 report: 403 reported (447 cases identified HES data) 90% Case ascertainment	Time-lag between national Audit reports, but all patients discussed at local MDT	Outcomes of patents having a major resection: 90 day mortality, 30 day unplanned readmission and 2 year mortality found to be within national limits. Individual cases discussed at MDT.
Cardiac Rhythm Management (CRM)	Yes	633 procedures – Full submission	National Audit Report Yearly from NICOR Report February 2017	Overall 99.8% recorded for data completeness. 26/27 96.3% primary implants found to meet 'Primary Prevention NICE ICD implant indications' (National average 63.9%)
Case Mix Programme (CMP)	Yes	100% of patients admitted to critical care areas	Yes at individual unit M&M meetings and lessons shared between units at cross county quarterly meetings.	The reports provide information on mortality rates, length of stay, etc and provide the Trust with an indication of our performance relation to other ICUs. Where trends are identified then these allow us to make recommendations about changes to practice. Standards are reviewed against those proposed as quality indicators by the Intensive Care Society
Child Health Clinical Outcome Review Programme Chronic Neurodisability Young People's Mental Health	Yes	Case identification data provided to NCEPOD and clinical questionnaires returned.	Reports for both of these studies will be available later in the year.	Await NCEPOD reports for completion of action plans and dissemination of learning points.
Coronary Angioplasty/ National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Full submission of nationally mandated dataset	Data is included in the annually produced National Audit report from NICO Data for last complete calendar year show departmental performance is above expected for case mix using current risk model	Data collected both for national audit and to generate operator specific outcome reports. These are publicly available via BCIS or NICOR
Diabetes (Paediatric) (NPDA)	In progress – data submission for 16/17 June 2017	For 2015/16 Whole clinic cohort – 267 children and young people with diabetes	2015/16 report reviewed and discussed 9th March	Quality Improvement projects planned for areas found to be below national average - Foot examination, urine screening for albuminuria, blood pressure measurement and encouraging patients to attend structured education sessions.
Elective Surgery (National PROMs Programme)	Yes	August to November 2016 for the return of the pre-operative Q1. Rates are as follows: Hernia: 29.5% Hip: 47.3% Knee: 60% V Veins: 41.8%	Provisional figures only – finalised Aug 2017	Currently forms are handed out on day of surgery in the SAS units. Best practice from NHS Digital suggests that the Q1 should be handed out at pre-assessment. Preliminary discussions have been had with the Band 7 for these areas to look into the possibility of doing this to see if it will improve participation rates. Looking at the data on a monthly basis, there seems to be no trend as such, and the rates vary wildly within all the categories.
Endocrine and Thyroid National Audit	Yes	2015 no. reported 2016 all cases by surgeon. Total: Thyroid: 65 Parathyroid: 18	Reviewed at BAETS meeting annually	No actions to report

Audit title	Did the Trust Participate?	Number of case submitted / number required	Was the report reviewed?	Actions taken as a result of audit / use of the database
Falls and Fragility Fractures Audit programme (FFFAP) Fracture Liaison Service Database Falls National Hip Fracture Database	Yes	100% required CGH: 275 / 100% GRH: 520 / 100%	2015 report published in Sept 2016. Extensive review – data discussed every 2 months at T&O board and MDT (using up to date data extracted from online tool). Full 2016 report due to be published Sept 2017.	From 2015 data Trust found to be under-performing in terms of 30 day mortality. Extensive work undertaken – reconfiguration of services and set up of 2 monthly MDT for hip fracture. GHNHSFT involved in Nationwide Quality Improvement Programme. Latest data shows Trust is no longer an outlier and is in the top quartile for best practice (care received).
Head and Neck Cancer Audit	Yes	Old DAHNO and new HANA data sets uploaded	Last National report published in Sept 2015 for 2013/14 data. Cases discussed locally at MDT	Local discussion and learning from cases via MDT. Learning points from reports disseminated through service.
Inflammatory Bowel Disease (IBD) programme UK IBD Registry		Registry software unavailable locally for this years data collection (however, same data locally collated)	Discussed at specialty meeting	Previously unable to upload data, but webtool now available for use going forwards.
Major Trauma Audit	Yes	528	Report reviewed jointly at ED and T&O morbidity and mortality meeting	Data Completeness is now 99%, an increase from 26% originally. The Data Accreditation is now 96.7%, the highest it has been on record. We received praise and recognition for this across the network. The hospital network statistics have been improved; this has improved national trauma statistics for the trust. The data now corresponds more accurately with real practice. Therefore key areas for improvement have been identified and action plans generated. M&M cases discussed at the Trauma Committee meeting and the suggestions for improvement fed back to the team. New trauma call criteria, calls put out Discussed at the ED meeting and highlighting the importance of the documentation. Discussed at the meetings and with each individual person the target for CT. When things are highlighted to the Trauma Lead, the cases are discussed with Radiology lead
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRACE-UK)	Yes	Data entered for all maternal deaths and still births	All maternal deaths and stillbirths reviewed at Governance meetings.	No specific actions but learning points disseminated throughout the service
Medical and Surgical Clinical Outcome Review Programme Acute Pancreatitis Physical & mental health care of mental health patients in acute hospitals Non-invasive ventilation	Case identification data provided to NCEPOD and clinical and organisational questionnaires returned.			Leads identified for each study report, including completion of NCEPOD self-assessment checklist. Regular review through Patient Safety Forum.
National Audit of Dementia	Yes	GRH 48 + 5 reliability forms CGH 30 + 5 Reliability forms	Awaiting report, but data also collected locally for review	Actions to support a positive care experience for patients with Dementia (carers and family): → The care environment (development of Trust Dementia Friendly environment Toolkit) → Staff training (development of Dementia Care Training and Education Strategy, targeted training in specific care teams for delirium) → Person centred care (promotion of the patient / carer held ''This is Me'' document) → Communication (including programme to enhance the experience of discharge). → Trustwide Dementia Care Champions to promote best practice within their care teams to support our patients and Carers.
National Cardiac Arrest Audit (NCAA)	Yes	To date 2016/17 = 149 Cardiac Arrests submitted that met the scope of the Audit	Reports are received quarterly and discussed within the Deteriorating Patient and Resuscitation Committee Meetings	Results presented at the Patient Safety Forum, Trust and national results presented within Mandatory training and Trust Induction, the Trust is benchmarked nationally. The last full year data shows both CGH and GRH sites are above the national average with respect to Return of Spontaneous Circulation and Survival to Discharge after a Cardiac Arrest.

Audit title	Did the Trust Participate?	Number of case submitted / number required	Was the report reviewed?	Actions taken as a result of audit / use of the database
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	No data collection in 2016	Continuous data collection from Jan 1 to web portal		No previous data collection. Successful set up of web portal and continuous data collection
National Comparative Audit of Blood Transfusion programme Use of blood in Haematology	Yes	12 Inpatients 16 day case patients	Reviewed by the Hospital Transfusion Team	Trust found to be compliant with National Standards
Audit of Patient Blood Management in Scheduled Surgery	Yes – data collection until mid January 2017	11 patients.	Final report and findings are due later this year, but no exact date has been given. When available the final report will be reviewed by the HTC.	Awaiting final report and HTC review
National Diabetes Audit – Adults National Footcare Audit National Inpatient Audit National Pregnancy in Diabetes Audit National Diabetes Transition National Core	Yes	Adults audit – 2621 patients +/ – insulin pump submitted August 2016 Submission via the hospital PAS system, with data being connected to care processes and lab results recorded by GPs	Reports reviewed by teams post publication and disseminated	National Core diabetes audit - Submission via the hospital PAS system pre-Trakcare, data later connected to care processes and lab results recorded by GPs, very crude data for secondary care. Actions for diabetes transition audit also linked to transition CQuIN and implementation of 'Ready, steady, Go, Hello' for young adults transitioning from child to adult services. As a result of the national IP audit a project is underway to review inpatients with diabetes to find themes and issues affecting them to help inform the service – for example quality improvement project to reduce delays to patients receiving insulin
National Emergency Laparotomy Audit (NELA)	Yes	Continual submission of emergency laparotomy patients	Monthly review at Trust NELA group meetings	Trust is part of the Emergency Laparotomy Collaborative. NELA is a Trust Priority for 2016/17 with targets to reach 80-90% compliance with specific indicators (Patients to be operated and anaesthetised by a consultant or senior staff who are capable of managing these cases, patients to have a pre-operative lactate blood test to help the diagnosis of sepsis, patients at >5% risk to have access to critical care after surgery)
National Heart Failure Audit	Yes	50% of cases entered Data is entered via NICOR web portal 70% required for minimum standard	National Heart Failure Audit Annual Report from NICOR Published March 2017	Plan to increase data input and achieve the minimum standard and to look at achieving the Best Practice Tariff
National Joint Registry (NJR) Knee replacement Hip replacement	Yes	Hip: GRH 418, CGH 412 Knee: GRH 286 (inc uni-compartmental) CGH 441	All reports in the public domain. Discussion at departmental meetings. Completed 1st annual audit report (copy enclosed) covering 14-15 and currently working on 15-16 report. This identifies cases not submitted to NJR and addresses inaccuracies	1. Recent visit by GIRFT lead (Prof Briggs) who highlighted areas for improvement eg ring-fencing beds in orthopaedics for arthroplasty work 2. Further visit by Prof Briggs April 2017 to discuss further 3. Annual audit noted that in particular rev knees were not being picked up for NJR and this has hopefully been addressed by cross checking NJR form input and discussion with surgeons 4. Importance of compliance and involvement with NJR is clear – likely in future tariff will be paid on cases registered in NJR 5. In the future it will be mandatory to use NJR annual figures as part of appraisal 6. GHNHSFT consultant now on the NJR Regional Clinical Committee which helps our Trust understand and keep ahead of developments in NJR
National Lung Cancer Audit (NLCA)	Yes	353	Will be discussed in 2017 AGM. TBA	This year the NLCA identified approx 10% additional lung cancer cases from datasets additional to COSD. This has had the effect of reducing some of our figures, eg %discussed at MDT. I have pulled patient level data from NCRAS and interrogated this. It shows that the new 'non-COSD' cases were generally frail elderly patients admitted acutely who died within a few days of presentation and therefore did not go through MDT. Very few of these patients had tissue confirmation of lung cancer and around 25% of them probably did not have lung cancer. These results have been fed back to NLCA.

Audit title	Did the Trust Participate?	Number of case submitted / number required	Was the report reviewed?	Actions taken as a result of audit / use of the database
National Ophthalmology Audit Adult Cataract surgery	Yes	Prospective collection of all cataract surgery	1st NOD annual audit published April 2016 with historical data to test audit methodology and assess data quality	Ensure risk indicator data are recorded so that risk adjustment can be accurately applied. Prospective data entry underway through medisoft. Regular review of local surgical outcomes.
National Prostate Cancer Audit	Yes	All prostate cancers: 544 in 2015, similar number expected awaiting confirmation	Reviewed departmentally – incomplete data entry noted	Time commitment for audit remains high. Recruitment of support workers as part of the 'Living with and beyond cancer' project work.
National Vascular Registry	Yes	Carotid endarterectomy 64 (HES estimate 76) AAA repair 70 (HES estimate 74) AAA emergency repair 29	Report reviewed at speciality meetings	No reported actions
Neonatal Intensive and Special Care (NNAP)	Yes	The NNAP uses the mandatory database, 'Badger' to access all records needed per question. 674 completed episodes of care included in 2016 report (2015 data)	Reviewed at Paediatric governance meetings	Central line sepsis bundle developed and implemented (Sep 16) the use of which is being audited. Care bundles and teaching packages have been developed in relation to temperature including monthly teaching at midwifery training events. In order to ensure accuracy of 'Badger' uploads these cases are being signed off by a consultant.
Nephrectomy audit	Yes	288 (92% of NES predicted)	Results presented at departmental meeting, March 2017	Complication rates of procedures with Clavien Dino III found to be higher than the national average. Plan for review of these procedures (lead assigned).
Oesophago-gastric Cancer (NAOGC)	Yes	Clinical cohort	Time-lag between national Audit reports, but all patients discussed at local MDT	Review of previous report found Trust to be within National ranges
Paediatric Pneumonia	Yes	105 cases submitted	Data entry completed 30th April 2017. Local data available for export currently under review by lead clinician	Initial review of data suggests no concerns regarding results, for further review and dissemination to colleagues.
Percutaneous Nephrolithotomy (PCNL)	Yes	27	Results presented at departmental meeting, April 2017	Following review and dissemination of results no issues identified.
Radical Prostatectomy Audit	Yes	108	Presented with local data 16 Oct	Complication rate above national average (7.3%) but not consistent with locally kept data. Data being reviewed, for presentation Feb 17 at local audit meeting
Renal Replacement Therapy (Renal Registry)	Yes	All renal dialysis and transplant patients registered Haemodialysis: 211 Peritoneal dialysis: 43 Transplant: 175	18th Annual report findings reviewed in audit meeting. Good practice and areas for improvement identified – results are within funnel plot tolerance for all measured outcomes.	Ensure better data completion for PD patients Watch trend in epo prescription at upper end of therapeutic range; may be room for cost savings
Rheumatoid and Early Inflammatory Arthritis	Yes	15	Report published July 2016 (2015/16 data)	Ongoing action to recruit to the audit to ensure accurate representation of Trust results and completeness of data sets. Ongoing actions to attain NCE Quality Standard (QS33): referral, assessment, education, disease control, rapid access and annual review
Sentinel Stroke National Audit programme (SSNAP)	Yes	All patients admitted with stroke or TIA entered – Approximately 900 every year	There are quarterly reports and an overall organisational report that are reviewed at the monthly departmental meetings of the stroke service as and when the reports are available.	1. Consolidation of service. 2. Business case in progress 3. Ward swallow training complete 4. Fact finding mission to University Hospital, Stoke on Trent to find out how they have improved their SSNAP results planned for February 2017 5. Other ongoing actions for individual domains.
Severe Sepsis and Septic Shock – care in emergency departments	Yes	GRH 45 CGH 45	Local results available following submission and presented at ED audit meeting	Ongoing work related to severe sepsis in ED which is combined with the National CQuIN (this will continue through 17/18 and 18/19). Development of sepsis screening tool and trial of pre-made antibiotics for use with severe sepsis patients.
UK Cystic Fibrosis Registry Paediatric Adult	Yes	42 cases (full cohort)	Local results and results based on Bristol area 'hub' available from CP registry and regularly monitored and reviewed.	No actions required from last year's data as key areas found to be at or above National figures. However, there is a concern that due to local pressures relating to availability of dieticians and physiotherapy within paediatrics this will impact next year's data

Information on the use of Commissioning for Quality & Innovation (CQUIN) framework

The agreed national, local and specialised CQUIN schemes, the rationale behind them and the associated payments for 2016/17 can be seen in Figure 21 on p62.

The level of the Trust's income in 2016/17 which was conditional upon the quality and innovation goals, was £8.5m out of a total planned eligible income of £38.6m (2015/16: £7,883,560 out of a total planned eligible income of £291,637,168). In line with national rules this represented about 2.5% of income for national and local CQUINs and 2.0% for specialised commissioning.

Q1 and Q2 performances across the board were generally good securing £3,088,555 from a possible £3,470,850 across all commissioners. Two CQUINs missed their targets during this period, Transition from Child to Adult services were required to resubmit evidence to achieve Q1 and Q2 (Q1 confirmed as achieved) and some elements of SAFER were not achieved. In December the Trust and GCCG agreed a year end contract settlement [£305m] the consequence being there is no further financial risk for GCCG commissioned CQUINs, but we continue to deliver and report. A settlement was also reached in March with Worcestershire CCG (£11m) meaning no Q4 financial risk for all National and Local CQUINS.

Qualitatively, the CQUINs likely to not achieve their milestones (no further financial impact) by Q4 are: AKI – results for October dropped to 47% (Quarter target – 65-69.9%) which will make Q3 targets challenging; Diabetic Foot is on target to achieve Q3 but likely to fail Q4 due to not rolling out foot checks to all wards; SAFER continues to be challenging and not expected to achieve all the milestones.

In contrast to previous years we have agreed two year contracts with our commissioners to include 17/18 and 18/19; these include for the first time contractually agreed two year CQUINs. The scheme has shifted focus from local CQUIN indicators to prioritising STP engagement and delivery of financial balance across local health economies. Therefore there are no local schemes in this period, six nationally mandated CQUINs (GCCG and Associates – £4,220,122 (1.5%) – awaiting Worcester CCG values), four specialised schemes (£1,379.360) and one from the Armed Forces branch of NHSE (£8,558). As in previous years goals are linked to the improvements required through the NHS Outcomes Framework, NHS Operating Framework 2016/17 and delivering the Forward View 2016/17-2020/21. There are key areas of change for 17/19:

- 1.5% will be assigned to deliver against mandated National CQUIN indicators
- No local CQUIN variations
- 0.5% of National CQUIN will be subject to provider engagement and commitment to STP process (principals specified in contract)
- 0.5% of National CQUIN will be subject to a risk reserve, which is subject to the system delivering its control total in line with national guidance.
- Specialised CQUIN is offered at 2.0% of eligible contract value.

Figure 21: 2016/17 CQUIN goals

Goal No.	Measure	Description	Weighting as % of contract value	Potential value of goal £000	Quality domain
National CQUIN goals (including specialised element)					
1	Sepsis/Paediatric Sepsis	To screen all appropriate patients and to rapidly initiate intravenous antibiotics within 1 hour or presentation for those in septic shock, Red Flag sepsis or suspected severe sepsis.	0.25%	733,187	Safe
2	Antimicrobial resistance	Reduce antibiotic consumption and encouraging focus on antimicrobial stewardship and ensuring antibiotic review within 72 hours	0.25%	733,187	Safe
3	Acute Kidney Injury	AKI diagnosis and treatment in hospital and the plan of care after discharge, improving information to GPs and also positively impact on readmission rates	0.1%	293,275	Safe
Local CQUIN goals					
5	Transition: Planned processes for the transition from child to adult services	To improve the planned process of young people 16-25 transitioning from young peoples services to adult services. Provide an individualised transition plan, using a structured approach for all young adults.	0.4%	1,173,099	Responsive
6	Medicines Safety Thermometer	Medicines safety	0.1%	293,275	Safe
7	Diabetic Foot: Reduction in the number/rate of lower limb amputations through the deployment of a Multi-Disciplinary Team Approach	Year 2 of this CQUIN is to improve diabetic foot care with the aim of detecting foot ulcers earlier and then onward referral to a formalised diabetic foot team for treatment and to prevent unnecessary complications.	0.4%	1,173,099	Responsive
8	Cancer Survivorship	Year 2 of this CQUIN supporting people Living with and Beyond Cancer. Involves the development, implementation and sustainable embedding of new pathways for Colorectal, Breast and Prostate cancer.	0.5%	1,466,374	Responsive
9	SAFER flow bundle	A combined set of actions to improve patient flow and prevent patients waiting unnecessarily. Patient journey from hospital admission to discharge is improved by adopting the five principals of SAFER: S-Senior review, A-All patients to have a EDD, F-Flow from assessment units, E – Early discharge, R-Review daily long stay patients (>14 days)	0.5%	1,466,374	Responsive
Specialised CQUIN goals					
11	Dose Banding of Adult Intravenous Systemic Anticancer Therapy (SACT)	Standardisation chemotherapy doses of SACT through nationally consistent approach to dose banding in order to increase safety, efficiency and to support the parity of care across all NHS providers of SACT in England	0.33%	409,758	Effective
12	Adult Critical Care (ACC) timely discharge	To reduce delayed discharges from ACC to ward level care by improving bed management, thus removing delays and improving flow. This supports the national standard that all discharges should be made within 4 hours of decision being taken to discharge within daytime hours.	0.33%	409,758	Responsive
13	Spinal Surgery Networks, data, Multi-Disciplinary Teams (MDT)	Establish regional spinal surgery networks, data flows and MDT for surgery patients with aim to promote better management of spinal surgery by creating and supporting a regional network of a hub centre and partner providers that will ensure data is collected to enable evaluation of practice effectiveness and that elective surgery only takes place following MDT review.	0.33%	409,758	Effective
14	Armed Forces Health	Review and revision of Provider Waiting List/Access Policy to ensure the principals of the Armed Forces Covenant as set out in the in the NHS Constitution and NHS contract are appropriately reflected ensuring no disadvantage to the Defence Medical Service population.	TBC	7,471	Responsive

Figure 22: 2017/18 CQUIN goals

Goal No.	Measure	Description	Weighting as % of contract value	Potential value of goal £000	Quality domain
National CQUIN goals					
1	Improving staff health and well-being	Improving the support available to NHS staff to help promote their health and well-being in order for them to remain healthy and well	0.250%	703,354	Effective
2	Reducing the impact of serious infections (antimicrobial resistance and sepsis)	Timely identification and treatment for sepsis in emergency departments and acute inpatient settings and a reduction of clinically inappropriate antibiotic prescription and consumption	0.250%	703,354	Safe
5	Advice and guidance	To improve GP access to consultant advice prior to referring patients in secondary care	0.250%	703,354	Responsive
6	Improving services for people with mental health needs who present to A&E	Ensuring that people presenting at A&E with mental health needs have these needs met more effectively through an improved, integrated service, reducing their future attendance at A&E	0.250%	703,354	Safe
7	E-referrals	All providers to publish ALL their services and make their First Outpatient Appointment slots available on NHS e-Referral Service (eRS) by 31 March 2018	0.250%	703,354	Responsive
8	Supporting safe and proactive discharge	Enabling patients to get back to their usual place of residence in a timely and safe way	0.250%	703,354	Safe
Specialised CQUIN goals					
9	Medicines optimisation	This CQUIN scheme aims to support the procedural and cultural changes required fully to optimise use of medicines commissioned by specialised services	0.750%	517,260	Effective
10	Nationally standardised dose banding for adult intravenous anticancer therapy (SACT)	Implementation of nationally standardised doses of SACT using the dose-banding principles and dosage tables published by NHS England	0.750%	517,260	Effective
11	Complex device optimisation (ICDs)	This scheme seeks to ensure that device selection for patients remains consistent with the commissioning policy, service specification, and relevant NICE guidance and that contractual requirement are in place for providers while new national procurement and supply chain arrangements are embedded	0.250%	172,420	Effective
12	Spinal surgery networks	To establish and operate regional spinal surgery networks, data flow and MDT for surgery patients. To promote the better management of spinal surgery by creating and supporting a regional network of a hub centre and providers	0.250%	172,420	Effective
13	Armed Forces health	Embedding Armed Forces covenant	N/A	8,558	Responsive

Information Governance (IG)

The Trust's Information Governance Toolkit score for 2016/17 has been published as 77%, and is graded green.

The Information Governance Toolkit is available on the Health and Social Care information Centre (HSCIC) website (igt.hscic.gov.uk). The information quality and records management attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation.

The effectiveness and capacity of these systems is routinely monitored by our Trust's Information Governance and Health Records Committee. A performance summary is presented to our Trust Board annually.

Information governance incidents including any data breaches classified using HSCIC guidance at level 1 or level 2 in severity are reviewed and investigated throughout the year and reported internally through the Trust's Information Governance and Health Records Committee. In addition any level 2 severity incidents are reported to the Information Commissioner's Office in accordance with HSCIC reporting guidelines.

Summary of Serious Incident Requiring Investigations involving personal data as reported to the Information Commissioner's office in 2016–17 (Level 2)

Date of incident (month)	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
June 2016	Lost or stolen paperwork	Ward nursing handover sheet found in a public place by a member of the public	31	Patients contacted where possible either whilst still on the ward or by telephone call and letter
February 2017	Lost or stolen paperwork	Ward nursing handover sheet found in a public place by a member of staff	12	Patients not contacted, as information had been contained within the Trust
March 2017	Lost in transit	Envelope of post lost in transit in a pathology van on route to a GP surgery, believed to include pathology results, Outpatient Clinic and Emergency Department discharge letters.	Not known	Surgery notified
Further action on information risk	GHNHSFT will continue to monitor and assess its information risks, in light of the incidents above. The processes and controls within the teams involved have been reviewed in order to identify and address any weakness and ensure the improvement of systems where required. Extensive communication to trust staff specifically highlighting the need to ensure safe keeping of handover sheets has been introduced as a regular reminder. Additional controls have been implemented including tighter controls on each ward in terms of who can print them and how they are distributed. Additional reminders of correct procedure to ensure safe transit of confidential post have also been introduced.			

Summary of other personal data related incidents internally reported 2016–17 (Level 1) as per HSCIC guidance

Category	Breach Type	Total
B	Disclosed in Error	23

Quality of data

Good quality data underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made. The patient NHS number is the key identifier for patient records. Accurate recording of the patient's General Medical Practice Code is essential to enable the transfer of clinical information about a patient from a Trust to the patient's GP.

During 2016/17, Gloucestershire Hospitals NHS Foundation Trust has taken the following actions to improve data quality (DQ):

- all existing reports have been reviewed and revised
- routine DQ reports are automated and routinely available to all staff on the Trust intranet via the Business Intelligence portal 'inSight'
- we asked our internal auditors to audit the data contributing to our performance indicators.
- the Trust continues to work with an external partner to advise the Trust on optimising the recording of clinical information and the capture of clinical coding data.

Gloucestershire Hospitals NHS Foundation Trust has submitted records during 2016/17 to the Secondary Users Service (SUS) for inclusion in the Hospital Episode Statistics.

In data published for the period April 2016 to March 2017 (based on April 2017), the percentage of records which included a valid patient NHS number was:

- 99.8% for admitted patient care (national average: 99.3%)
- 99.9% for outpatient care (national average: 99.5%)
- 98.8% for accident and emergency care (national average: 96.9%)

The percentage of published data which included the patient's valid GP practice code was:

- 100% for admitted patient care (national average: 99.9%)
- 99.5% for outpatient care (national average: 99.8%)
- 99.3% for accident and emergency care (national average: 99.5%)

A comprehensive suite of data quality reports covering the Trust's main operational system (Trakcare) is available and acted upon. These are run on a daily, weekly and monthly basis and are now available through the Trust's Business Intelligence system, inSight. These include areas such as:-

- outpatients including attendances, outcomes, invalid procedures
- inpatients including missing data such as NHS numbers, theatre episodes
- critical care including missing data, invalid Healthcare Resource Groups.

Clinical coding error rate

GHNHSFT commissioned an Information Governance Audit to be completed for 2016/17 by a Clinical Classifications Service Approved Clinical Coding Auditor and Trainer.

The error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary diagnosis 95.50%
- Secondary diagnosis 93.77%
- Primary procedure 92.49%
- Secondary procedure 94.54%

A sample of 200 Finished Consultant Episodes (FECs) were audited: 75 were selected for Audit of Orthopaedic disorders and procedures (HRG Sub-chapter HA,HB,HC,HD,HR); 75 selected for audit of Urology disorder and procedures (HRG Sub-chapter LA & LB Urology procedures and disorders) and 50 selected for Audit for mixed specialities. All data was from quarter 1 in financial year 2016.

All figures exceed the recommended 90% accuracy for primary diagnoses and procedures and 80% accuracy for secondary diagnoses and procedures required for Information Governance purposes at Level 2. This is a good result and an improves on previous years.

GHNHSFT will be taking the following actions to improve data quality:

- All errors uncovered during the course of the audit fed back to the coding team and any areas of training covered.
- Individual coder audits will be carried out on a monthly basis, with ten spells each coder each month being examined. This will serve

to highlight potential training issues/areas of concern and will inform whether individual coders need to be audited more frequently.

- The department is striving to increase awareness around the importance of accurate coded data throughout the organisation. This is being achieved through meetings with clinicians, divisional leads, General Managers and Assistant General Managers.
- The Coding Manager is working with Patient Records, Ward Clerks and clinical staff to ensure patient case notes reach the coding department in a timely manner and that appropriate information and documentation is incorporated.
- A Trainee Coding Auditor has been recruited and is assisting the Clinical Coding Manager with the audit process to ensure individual coder audits are undertaken along with speciality audits as requested by divisions and the Clinical Coding Manager. This will ensure that any training errors and areas of concern are addressed at the time of coding, or within 10 working days of the coding being entered onto the Trusts Trak system by the coder.
- Protected time to be given to coders at 30 minutes per day to update the classifications with new standards implemented. This will also be covered to some extent during the weekly team meetings, which everyone attends, when any changes come in.

Staff Survey key indicators

In the 2016 Staff Survey, we reported the following results:

- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 month (KF26): 25%
- Percentage of staff believing that our Trust provides equal opportunities for career progression or promotion (KF21): 88%.

Sign up to safety

Our Trust has signed up to the principles of the Sign Up To Safety campaign ambitions of halving avoidable harm over the next three years and as a consequence, saving lives.

Each year we review and consult on our current safety priorities and develop key targets. These objectives, developed in consultation with our partners at the Clinical Commissioning Group and Healthwatch, are incorporated in the Trust Performance Management Framework and the Quality Dashboard for continuous monitoring.

We are committed to delivering year on year improvements in safety. We do this by working with patients and our dedicated front line teams to report and learn from incidents, by reviewing and learning from national audits and guidance (such as NICE) and by learning from staff and patients experiences. Members of our Trust Board visit more than 100 departments and wards every year to emphasise the importance of safety and patient experience and carry out both day and night visits to listen to talk about good quality patient care, allowing time for staff to raise their concerns.

The Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England.

From April 2010, all NHS trusts have been legally obligated to register with the CQC. Registration is the licence to operate and to be registered, providers must, by law, demonstrate compliance with the regulatory requirements of the CQC (Registration) Regulations 2009.

From April 2015 all providers had to meet the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) is registered with the CQC without conditions. This means that our Trust has continued to demonstrate compliance with the regulations.

The Care Quality Commission visited us during March 2015 as part of their new inspection regime. We were also visited in January 2017 but at the time of writing, we are awaiting the formal publication of their findings. The new inspections ask five key questions:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

This results take the form of a rating for each hospital – inadequate, requires improvement, good or outstanding.

The outcome of the 2015 visit is set out in the tables opposite and in our action plan overleaf. In addition to identifying 'must do' areas for improvement the CQC also identified a number of 'should do's' which are also being addressed by the relevant services.

From April 1 2015, all trusts are expected to publish the results of their CQC inspection as part of the new regulations on their website and display their rating prominently on hospitals sites.

The CQC has not taken enforcement action against Gloucestershire Hospitals NHS Foundation Trust during 2016/17. Gloucestershire Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Care Quality Commission ratings following inspection in 2015

CQC ratings for Gloucestershire Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

CQC ratings for Cheltenham General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Medical care	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

CQC ratings for Stroud Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

CQC ratings for our overall trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement

Figure 23: Areas for improvement from CQC inspection in 2015

CQC area	"Must do" area for improvement	Status
Safe	Develop clear protocols with regard to the care of patients queuing in the corridors in the emergency departments. This should include risk assessment and the identification of safe levels of staffing and competence of staff deployed to undertake this care.	Complete: September 2015
	Ensure the premises for the medical day unit are suitable to protect patients' privacy, dignity and safety.	Complete: September 2015
	Take immediate steps to address infection control risks in the ambulatory emergency care unit.	Complete: September 2015
	Continue to take steps to ensure there are sufficient numbers of suitably qualified, skilled and experienced consultants and middle grade doctors to provide senior medical presence in the emergency departments 24 hours a day, seven days a week, and to reduce reliance on locum medical staff.	Complete: monitored via the Trust risk register and Board reporting process. September 2015
	Ensure that systems to safeguard children from abuse are strengthened and children's safeguarding assessments are consistently carried out. There must be a process to ensure all appropriate child safeguarding referrals are made.	Complete: September 2015
	→ 1. Ensure patients' mental capacity is clearly documented in relation to 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) and 'unwell/ potentially deteriorating patient plan' (UP) forms.	Action recommended for closure with an agreed implementation plan for all actions.
	→ 2. Improvements in record keeping must include documented explanations of the reasoning for decisions to withhold resuscitation,	Results of audits to be presented to the Quality Committee in May.
	→ 3. Documented discussions with patients and their next of kin, or reasons why decisions to withhold resuscitation were not discussed.	NB Delayed because of agreement of wording with CQC
	Ensure that where emergency equipment in the form of resuscitation trolleys is not available, the decision to not supply it is based on a thorough risk assessment.	Complete: September 2015
	Ensure that where emergency equipment is available, this should be ready to use at all times.	Complete: September 2015
	Ensure that systems are in place to ensure that all medication available is in date and therefore safe to use.	Complete September 2015
	Review communication methods within maternity services to ensure that sensitive and confidential information is appropriately stored and handled, whilst being available to all appropriate staff providing care for the patient concerned.	Complete: Notice board function changed, September 2015
	Take steps to strengthen the audit process in the emergency department to provide assurance that best (evidence-based) practice is consistently followed and actions continually improve patient outcomes.	Closed action - monitor future audits through the Divisional Quality Committee. September 2015
	Ensure that appropriate written consent is obtained prior to procedures being carried out in the outpatient department.	Recommended for closure audit shows 82% compliance, further monitoring through Divisional Quality report
	Ensure an effective system is in place on the medical wards to detect and control the spread of healthcare-associated infection	Complete: September 2015
	Ensure that all patients (men and women) are able to access the full range of tests in the urology outpatient department	Complete: September 2015.
Effective	Ensure minutes are kept of mortality and morbidity meetings in medicine so that care is assessed and monitored appropriately, lessons learnt and actions taken and recorded.	Recommended for closure. New framework developed and agreed, future monitoring through Divisional Quality report.
	Ensure that patients' records across the hospitals are stored securely to prevent unauthorised access.	Recommended for closure with future regular communication about safe storage.
	Take steps to strengthen the audit process in the emergency department to provide assurance that best (evidence-based) practice is consistently followed and actions continually improve patient outcomes.	Complete: monitor future audits through the Divisional Quality Committee. September 2015
	Ensure minutes are kept of mortality and morbidity meetings in medicine so that care is assessed and monitored appropriately, lessons learnt and actions taken and recorded.	Recommended for closure. New framework developed and agreed, future monitoring through Divisional Quality report.

CQC area	"Must do" area for improvement	Status
Responsive	Improve its performance in relation to the time that patients spend in the emergency department to ensure that patients are assessed and treated within appropriate timescales.	Complete: monitored via the Trust risk register and Board reporting process. September 2015
	Continue to reduce ambulance handover delays and take steps to ensure that patients arriving at the emergency departments by ambulance do not have to queue in the corridor because there is no capacity to accommodate them in clinical areas.	Complete: monitored via the Trust risk register and Board reporting process. September 2015
	Work with healthcare partners to ensure that patients with mental health needs who attend the emergency departments out of hours receive prompt and effective support from appropriately trained mental health practitioners.	Complete: September 2015
	Ensure that patients in the emergency departments have an assessment of their pain and prompt pain relief administered when necessary.	Complete: action monitor progress through Divisional Quality Report. September 2015
	Ensure that appropriate written consent is obtained prior to procedures being carried out in the outpatient department.	Recommended for closure audit shows 82% compliance, further monitoring through Divisional Quality report
	Ensure that all patients (men and women) are able to access the full range of tests in the urology outpatient department.	Complete: September 2015

Reporting against core priorities

A review of our quality performance

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the trust by the Health and Social Care Information Centre (HSCIC), now known as NHS Digital.

NHS England produces guidance each year for the Quality Account outlining which performance indicators should be published in the annual document.

You can see our performance against these mandated indicators in Figure 24 on p72.

Figure 24: Reporting against core indicators

Indicator (required by NHS England)	Year	GHNHSFT	National average	Highest trust figure	Lowest trust figure	Explanation of why GHNHSFT considers that the data from the HSCIC are as described	Actions GHNHSFT intends to take to improve the indicator and quality of services
(a) SHMI for the trust for the reporting period; and	**2014/15**	1.092	1.000	1.210	0.670	*Data period: Oct15 - Sep16. Published Mar-17	The Trust's figures are higher than expected compared with other trusts. We run a Trust Mortality Review Group, chaired by the Medical Director, which reviews this indicator and other more granular parameters in relation to mortality. We also use the Dr Foster Intelligence System to monitor mortality indicators
	2015/16	1.132	1.000	1.178	0.678		
	2016/17*	1.156	1.000	1.164	0.690		
(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	**2014/15**	21.3%	25.7%	50.9%	0.0%	*Data period: Oct15 - Sep16. Published Mar-17 This indicator cannot be calculated locally as it uses the same national dataset as SHMI which includes ONS data on post-hospital deaths. A proxy using in-hospital data only can be calculated but this is not currently routinely reported.	The most recent figures place the Trust 13% lower than the national average. This is being monitored by the Trust Mortality Review Group and the Dr Foster Intelligence System.
	2015/16	20.9%	28.5%	54.6%	0.6%		
	2016/17*	16.8%	29.7%	56.3%	0.4%		
Number of patient safety incidents / number which resulted in severe harm or death	**2014/15**	9,758 / 64	8,809 / 43	24,804 / 193	2,116 / 4	The way the data has been recorded changed from 2015/16 hence the large increase in numbers nationally since 2014/15. Previously we were in the 'Large Acute' sector and we used the 'Large Acute' total as the national average. In 2015/16 the Trusts are divided into new categories, we are in Acute (Non-Specialist) which houses more Trusts than the previous year's 'Large Acute' category. *Data period: Apr16 - Sep16. Published Mar-17	Results are within the expected range compared with other trusts. The Trust will continue to encourage reporting of patient safety incidents and carry out root cause analysis investigations for significant patient safety incidents.
	2015/16	11,517 / 40	9,465 / 39	23,990 / 60	3,510 / 26		
	2016/17*	6,932 / 22	4,955 / 19	1,485 / 3	13,485 / 40		
Rate per 1,000 bed days of patient safety incidents / rate per 1,000 bed days resulting in severe harm or death	**2014/15***	30.04 / 0.2	35.77 / 0.18	73.46 / 0.82	18.6 / 0.35	From 2014/15 the rate is calculated per 1,000 beddays instead of per 100 admissions, and the figures are drawn from all non-specialist acute trusts. *Data period: Apr16 - Sep16. Published Mar-17	Figures are within the expected range compared with other trusts. The Trust will continue to encourage reporting of patient safety incidents and carry out root cause analysis investigations for significant patient safety incidents
	2015/16	35.04 / 0.12	38.35 / 0.16	75.25 / 0.13	19.87 / 0.30		
	2016/17	41.82 / 0.13	39.89 / 0.15	71.81 / 0.60	21.15 / 0.06		
Rate of C diff (per 100,000 bed days) among patients aged over two	**2014/15**	11.4	15.0	62.6	0.0	Following the implementation of a new Patient Administration System in December 2016, the Trust was unable to assure the data quality of information extracted from the system to support: → Referral to Treatment times → 6 week → Dementia assessment and referral → Safer staffing → Monthly activity return	Figures are within the expected range compared with other trusts. The Trust will continue to monitor C diff on a monthly basis.
	2015/16	12.5	14.9	66.0	0.0		
	2016/17	N/A	N/A	N/A	N/A		
Percentage of patients risk assessed for VTE	**2014/15**	93.3%	96.1%	100.0%	88.6%	*Data period: Apr16 – Dec16. Published Mar-17 Source: NHS England VTE Risk Assessment Statistical Work Area. National dataset compiled from monthly local data submissions. National indicator values may differ slightly from locally calculated values due to small variations in assumptions for denominator. *April 2015 to December 2015	
	2015/16	93.5%	95.8%	100.0%	79.9%		
	2016/17*	93.5%	95.6%	100.0%	78.7%		

Indicator (required by NHS England)	Year	GHNHSFT	National average	Highest trust figure	Lowest trust figure	Explanation of why GHNHSFT considers that the data from the HSCIC are as described	Actions GHNHSFT intends to take to improve the indicator and quality of services
The percentage of patients aged 0–15 readmitted to hospital within 28 days of being discharged	**2011/12**	9.88%	10.26%	14.94%	6.40%	Published Mar-14. No further data as at 07/03/2017 The data on the HSCIC has not been updated beyond 2011/12. This indicator is no longer reported locally. The preferred national and local indicator is now readmissions within 30 days which is broadly consistent with this indicator.	
	2012/13	N/A	N/A	N/A	N/A		
	2013/14	N/A	N/A	N/A	N/A		
	2014/15	N/A	N/A	N/A	N/A		
	2015/16	N/A	N/A	N/A	N/A		
	2016/17	N/A	N/A	N/A	N/A		
Readmissions within 28 days: age 16 or over	**2011/12**	10.52%	11.45%	13.80%	9.34%	Published Mar-14. No further data as at 07/03/2017 No national data has been published since 2011/12. This indicator is no longer reported locally. The preferred national and local indicator is now readmissions within 30 days which is broadly consistent with this indicator.	
	2012/13	N/A	N/A	N/A	N/A		
	2013/14	N/A	N/A	N/A	N/A		
	2014/15	N/A	N/A	N/A	N/A		
	2015/16	N/A	N/A	N/A	N/A		
	2016/17	N/A	N/A	N/A	N/A		
Responsiveness to inpatients' personal needs	**2014/15**	66.5%	68.9%	86.1%	59.1%	Published Aug-16. Next data release Aug-17 Data is taken from the Health & Social Care Information Centre NHS Outcomes Framework website under the section 'Ensuring Patients Have a Positive Experience of Care.' This indicator is based on five questions from the national inpatient survey.	
	2015/16	67.6%	69.6%	86.2%	58.9%		
	2016/17	N/A	N/A	N/A	N/A		
Friends & Family Test Q12d (If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation)	**2014**	61.9%	65.2%	92.8%	38.2%	*From 2015 onwards the numbering has changed from Q12d to Q21d in the Staff Survey. This is calculated by calendar year instead of financial year. Data is taken from the National Staff Surveys 2014, 2015 & 2016 which is administered and analysed by a third party. We have use the cluster of acute trusts for benchmarking the England average, high and low values. From 2015 onwards the numbering has changed from Q12d to Q21d in the Staff Survey. This is calculated by calendar year instead of financial year.	See pxx to find out more about our performance in relation to learning from the experiences of our users.
	2015*	69.0%	65.0%	85.4%	46.0%		
	2016	64.0%	70.0%	84.8%	48.9%		

Patient Reported Outcome Measures (PROMS)

Patient Reported Outcome Measures (PROMs) collect information on the effectiveness as perceived by the patients themselves of the NHS care they have received. Since April 2009, patients undergoing four different types of elective surgery – hip replacement, knee replacement, groin hernia repair, varicose vein surgery – have been invited to complete lifestyle questionnaires before and after their operations. Their responses are converted into scores and when taken with other clinical information, they allow the effectiveness of treatments to be assessed and hospital providers to be compared.

Two well-established general health and lifestyle surveys are used – EQ-5D & EQ-VAS (EuroQol five-dimensional descriptive health questionnaire and visual analogue scale) – alongside condition-specific questionnaires – Aberdeen Varicose Vein Questionnaire, Oxford Hip Scores and Oxford Knee Scores – each of which pose questions relating to the individual experience of the patient with the condition. Patients complete these surveys and questionnaires before and after their operations and the difference in their scores are used as a measure of the improvement resulting from their operation being carried out.

The figures we have reported in Figure 21 are the percentage of patients reporting an improvement in their health and well-being after their procedure as measured by each of the questionnaires. The figure for the Trust is shown against the England average improvement rate for comparison.

Fig. 25: April 2014 – March 2015

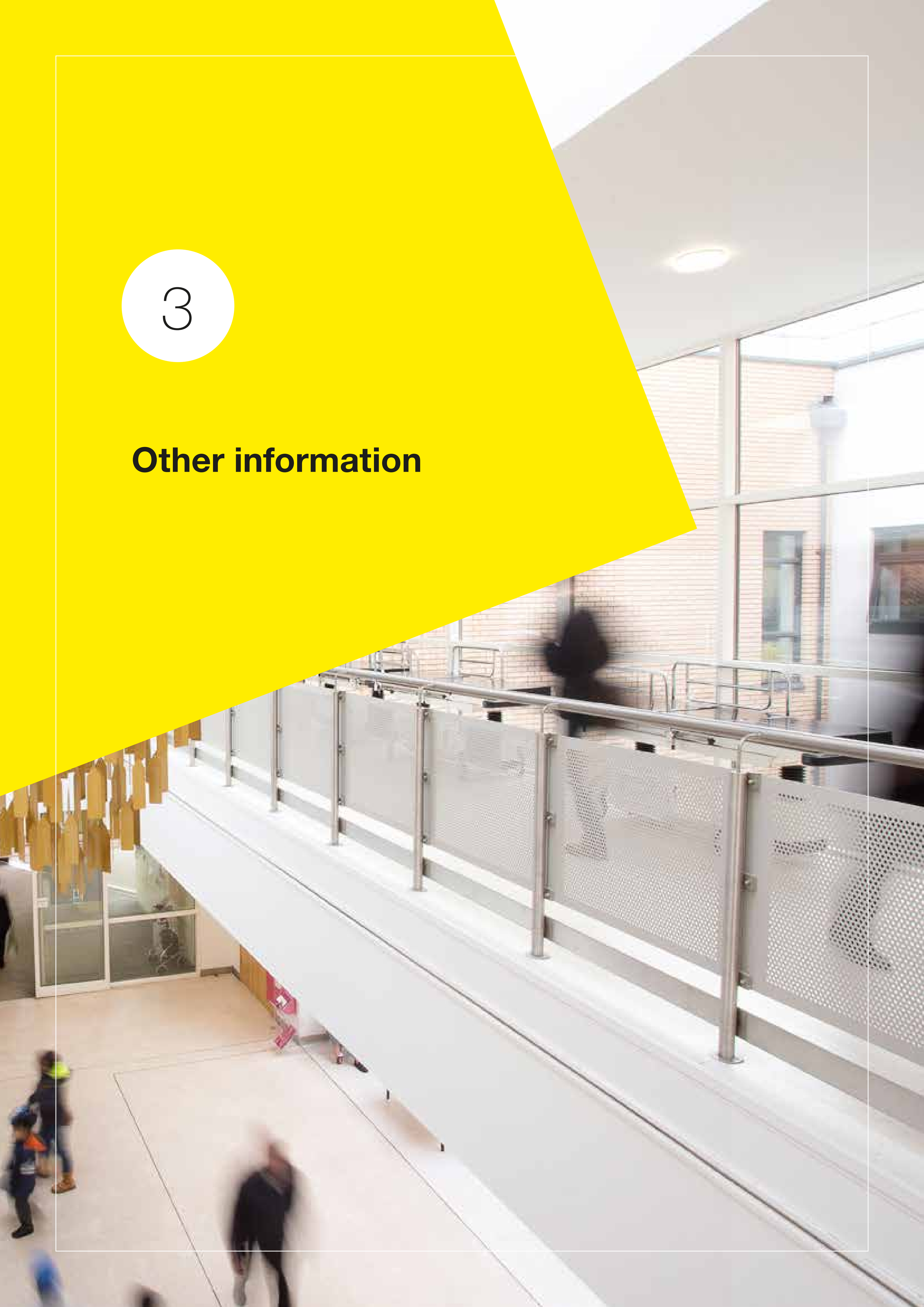
	EQ-5D		EQ VAS		Condition-specific Measure	
Procedure	**Trust %**	**England %**	**Trust %**	**England %**	**Trust %**	**England %**
Groin	52.0	50.7	42.3	38.1		
Hip	87.3	89.5	64.0	66.0	96.9	97.3
Knee	80.8	81.0	50.8	55.6	95.0	93.8
Varicose Veins	68.9	52.0	48.0	39.2	91.7	82.5

April 2015 – March 2016 (Provisional. Published Feb-17)

	EQ-5D		EQ VAS		Condition-specific Measure	
Procedure	**Trust %**	**England %**	**Trust %**	**England %**	**Trust %**	**England %**
Groin	50.8	50.9	37.9	37.7		
Hip	89.2	89.6	63.8	66.5	97.0	97.5
Knee	80.9	81.6	54.8	56.3	97.2	94.1
Varicose Veins	50.0	52.6	31.4	40.3	87.5	82.6

April 2016 – December 2016 (Provisional. Published May-17)

	EQ-5D		EQ VAS		Condition-specific Measure	
Procedure	**Trust %**	**England %**	**Trust %**	**England %**	**Trust %**	**England %**
Groin	53.8	51.7	64.3	39.9		
Hip	76.7	90.4	51.6	68.2	97.2	97.5
Knee	90.6	82.4	55.2	60.1	100.0	94.5
Varicose Veins	50.0	51.5	0.0	41.7	100.0	82.9



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Other information

Other information on the quality of our services

The following section presents more information relating to the quality of the services we provide.

In Figure 26 on p77 there are a number of performance indicators which we have chosen to publish which are all reported to our Quality & Performance Committee.

The majority of these have been reported in previous Quality Account documents. These measures have been chosen because we believe the data from which they are sourced is reliable and they represent the key indicators of safety, clinical effectiveness and patient experience within our organisation.

Figure 26: Other indicators we've chosen to report

Indicators	2015/16	2016/17	National target for 16/17
Safety			
Clostridium difficile year on year reduction: post 48 hours	41	42	37 (local target)
MRSA bacteraemia at less than half the 2003/4 level: post 48 hours	3	3	0
MSSA	117	105	N/A
Rate of Inpatient Falls per 1000 bed days	7.1	5.9*	N/A
Rate of Medication Incidents per 1000 bed days	3.2	3.4*	N/A
Never events	2	2	0
Number of RIDDOR	37	24	N/A
Rate of Staff Falls per 1000 head count	1.7	1.1	N/A
Rate of Incidents arising from Clinical sharps per 1000 staff	2.5	1.9	N/A
Rate of physically violent and aggressive incidents occurring per 1000 staff	3	3	N/A
Global Trigger Tool per 1000 bed days	39.7	31/1000*	N/A
NHS Safety Thermometer – percentage receiving harm free care	93.13%	92.3	N/A
Risk assessment for patients with Venous Thromboembolism (VTE)	94.2%	93.5%*	95%
Crude mortality rate	1.2%	1.2%*	N/A
Effectiveness			
Dementia 1a: Case Finding – 90% of eligible patients aged 75 years and over, as emergency admissions, asked the case finding question	87.8%	88.5%*	90%
Dementia 1b: Clinical Assessment – 90% of eligible patients aged 75 years and over, as emergency admissions will receive clinical assessment of their reported memory loss	100%	100%*	90%
Dementia 1c: Referral for Management – 90% of eligible patients aged 75 years and over, as emergency admissions, who score positively on the Abbreviated Mental Test (a test used to assess dementia), and where concerns over memory function remain will be referred onwards	100%	100%*	90%
% patients spending 4 hours or less in ED	86.7%	83.7%	95%
Number of ambulance handovers delayed over 30 minutes	1086	1884	N/A
Number of ambulance handovers delayed over 60 minutes	95	26	N/A
Emergency readmissions within 30 days – elective & emergency	6.4%	6.6%*	N/A
Research Accruals	1133	3048	1200
Performance in initiating research	88.9%	66.7%	80%
Performance in delivering research	44.4%	27.3%	80%
Percentage stroke patients spending 90% of time on stroke ward	84.3%	85.6%	80%
Percentage women seen by midwife by 12 weeks	90.1%	91.7%*	90% (local target)

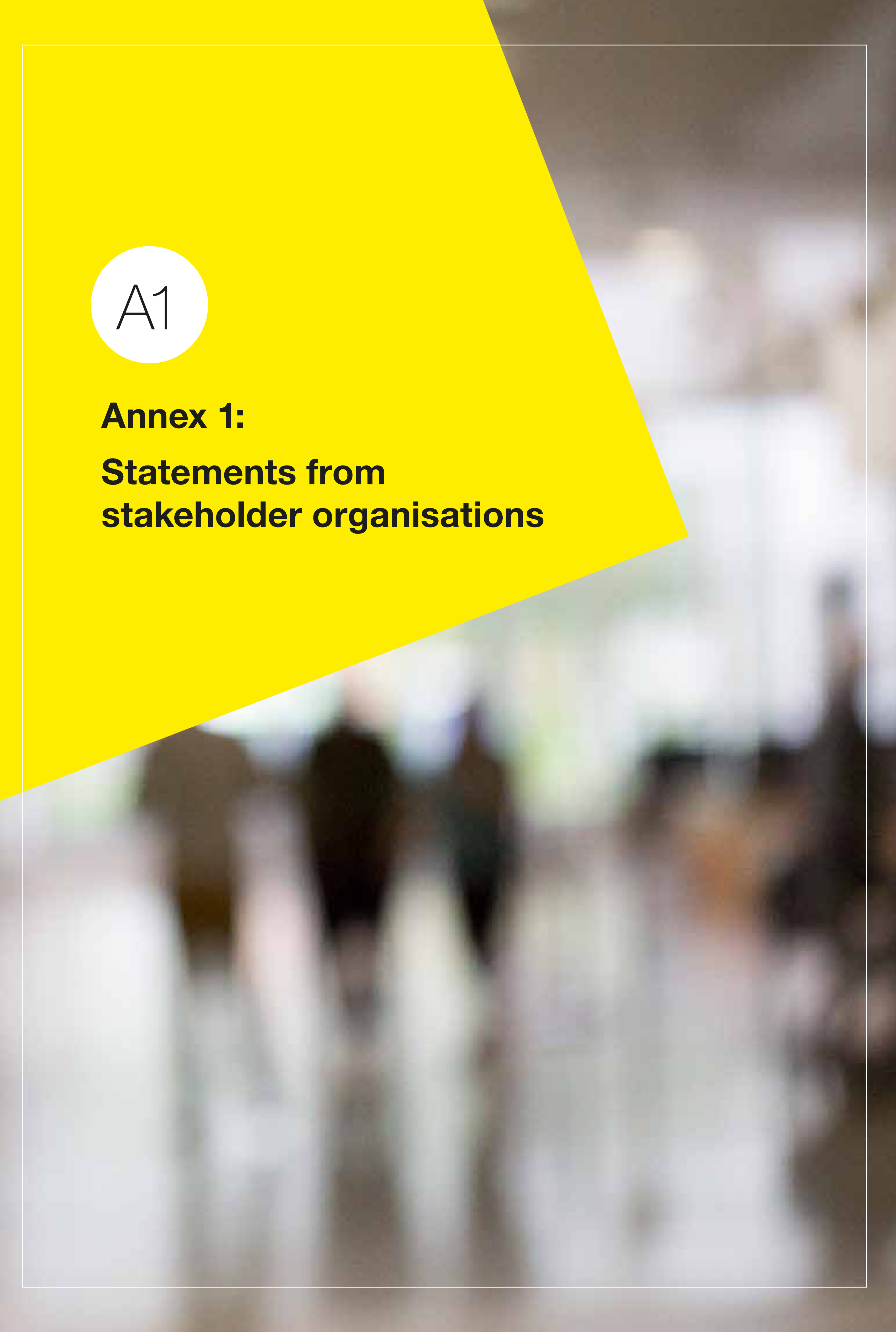
Indicators	2015/16	2016/17	National target for 16/17
Patient Experience			
Number of written complaints	961	915	N/A
Rate of written complaints per 1000 inpatient spells	6.3	4.86*	N/A
Number of comments on NHS Choices: Positive / Negative	106 / 39	121 / 52	N/A
Number of comments Patient Opinion: Positive / Negative	112 / 29	52 / 56	N/A
Max 2 week wait for patients urgently referred by GP	90.8%	89.2%	93%
Max 2 week wait for patients referred with non cancer breast symptoms	93.8%	93.2%	93%
Max wait 31 days decision to treat to treatment	99.8%	96.8%	96%
Max wait 31 days decision to treat to subsequent treatment: surgery	99.7%	94.7%	94%
Max wait 31 days decision to treat to subsequent treatment: drugs	100%	100%	98%
Max wait 31 days decision to treat to subsequent treatment: Radiotherapy	100%	99.3%	94%
Max wait 62 days from urgent GP referral to 1st treatment (exl. rare cancers)	76.4%	74.9%	85%
Max wait 62 days from national screening programme to 1st treatment	95.4%	92.5%	90%
18 week maximum wait from point of referral to treatment (admitted patients adjusted)	86.5%	77.6%*	N/A
18 week maximum wait from point of referral to treatment (non-admitted patients unadjusted)	92.8%	87.1%*	N/A
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways	92.1%	78.9%*	92%

* April 2016 – November 2016. Following the implementation of a new Patient Administration System in December 2016, the Trust was unable to assure the data quality of information extracted from the system to support:

→ Referral to Treatment times
→ 6 week
→ Dementia assessment and referral
→ Safer staffing
→ Monthly activity return

** April 2016 – January 2017

*** April 2016 – February 2017



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Annex 1:

Statements from stakeholder organisations

Statement from NHS Gloucestershire Clinical Commissioning Group

NHS Gloucestershire Clinical Commissioning Group (CCG) welcomes the opportunity to provide comments on the Quality Report prepared by Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) for 2016/17 in line with NHS Improvement guidance 'Detailed requirements for quality reports for foundation trusts 2016/17 published February 2017.

The past year has continued to present major challenges across both Health and Social care in Gloucestershire and we are pleased that GHNHSFT have worked jointly with partner organisations, including the CCG during 2016/17 to deliver a system wide approach to maintain, further develop and improve the quality of commissioned services and outcomes for service users and carers. We wish to acknowledge the Trust's contribution and commitment to the development of the Sustainability and Transformation Plan for Gloucestershire (STP).

Following the comprehensive CQC inspection during 2015, where the overall outcome was rated as 'requires improvement', the CCG has continued to work with the Trust to monitor the implementation of the CQC action plan developed to address areas identified for further improvement. We note the progress in closing down these actions and recognise the focus and commitment of management and staff in addressing the necessary quality improvements. The Trust was re-inspected in January 2017 and the outcome of this inspection has not yet been published. The CCG will continue to work with the Trust to address any areas identified during the recent inspection throughout 2017/18.

The 2016/17 Quality Report is easy to read and understandable given that it has to be considered by a range of stakeholders with varying levels of understanding. The report clearly identifies how the Trust performed against the agreed quality priorities for improvement for 2016/17 and also outlines their priorities for improvement in 2017/18.

The CCG endorses the quality priorities included in the report whilst acknowledging the very difficult financial and partnership challenges GHNHSFT have to address in the future, particularly in the implementation and delivery of the Gloucestershire STP. We are pleased to note progress and achievement against these quality priorities, and will continue to work with the Trust where targets have not been met. The CCG will be looking to the Trust to have a specific focus on quality improvement in relation to the urgent care pathway and the experience of the patient using these services.

The CCG would like to commend the Trust on quality improvements in relation to the progress in reducing mortality for patients with fractured hips. The multi-disciplinary approach to this has been effective and thorough. The quality improvements in End of life care are also be to be commended. There continues to be a concern regarding the higher than expected mortality rate in the Trust and look forward to the Trust continuing to implement their mortality strategy during this coming year.

The CCG notes the comments regarding the introduction of the new electronic health record, Trakcare. The Trust acknowledges the operational issues encountered due to the implementation of this system and the CCG recognise the work being undertaken to address these. However, the CCG would have liked to see more information on what these issues are and the actions taken to mitigate the subsequent communication problems that have arisen, for both patients and other health care professionals. The flow of information from the Trust has been severely disrupted and this has potentially led to a reduction in the quality of care for patients.

The CCG would also like to acknowledge the work undertaken in relation to safe discharge, and is pleased to note that this remains a priority for 2017/18. It is recognised that there could be quality improvements in this area as indicated in the Healthwatch Gloucestershire report of the experience of patients being discharged from care. The CCG welcomes the information that the Trust will be acting on this feedback.

The CCG recognises the content provided on patient experience, however, this report lacks the level of information expected in respect of patient engagement and feedback, particularly in relation the urgent care pathway. We would welcome more focus in this area during the next year.

The CCG would like to congratulate the Trust for their outstanding work regarding the very effective Safety and Quality Improvement Academy and the quality improvement initiatives delivered to date. This approach is endorsed by the CCG and welcomes the strengthening of a culture of continuous quality improvement.

GHNHSFT need to be in a strong position to manage both present and future challenges. The

CCG will continue work with the Trust to deliver acute services that provide best value whilst having a clear focus on providing high quality, safe and effective care for the people of Gloucestershire.

Gloucestershire CCG confirms that to the best of our knowledge we consider that the 2016/17 Quality Report contains accurate information in relation to the quality of services provided by GHNHSFT. During 2017/18 the CCG will work with GHNHSFT, all stakeholders including the people of Gloucestershire, to further develop ways of receiving the most comprehensive reassurance we can regarding the quality of the acute hospital services provided to the residents of Gloucestershire and beyond.

Dr Marion Andrews-Evans
Executive Nurse & Quality Lead
NHS Gloucestershire CCG

Statement from Healthwatch Gloucestershire (HWG)

Healthwatch Gloucestershire welcomes the opportunity to comment on Gloucestershire Hospitals NHS Foundation Trust's quality account for 2016/17. Healthwatch Gloucestershire exists to promote the voice of patients and the wider public with respect to health and social care services.

As of April 1st 2017 Healthwatch Gloucestershire came under new management and are therefore we unable to comment on the previous year's activity as it relates to work carried out under the previous Healthwatch Gloucestershire contract. However, we look forward to developing relationships with the Trust over the coming year and working with them to ensure the patient voice is heard.

We welcome the Chief Executive's declaration in the opening statement that one of the most important measures of how the Trust is doing in terms of quality of care is listening to patients about their experience of using the services provided by the Trust. In addition, we are pleased to see that patients are involved in the setting of priorities via the Trust's interaction with Healthwatch Gloucestershire.

We acknowledge the progress that had been made in improving care for patients with a hip fracture. In particular, we are pleased to see that the Trust has a system of real-time feedback monitoring in place to assess patient experience and that this is being actively used to adapt the quality of care that is provided. We hope to see a maintenance of this progress and would be interested to hear more about the nature of the feedback given by patients.

Improving the discharge process remained a priority for the Trust last year and we are pleased to see that proactive and safe discharge is a priority for the coming year. It is good to see that patient care and experience forms part of the 2017/18 CQUIN for the Trust and that patient experience is being considered in plans for future improvements to the process.

A great deal of work has been carried out to improve care for those who have dementia and delirium and it is good to see that patients, their relatives and unpaid carers have played a significant role in this work.

We have concerns about the rising proportion of patients spending more than 4 hours in the Emergency Department. However, we note that delivering high quality urgent and emergency care is a priority for the coming year and we welcome this. We look forward to working with the Trust, commissioners and NHS Improvement to ensure that patients' experiences of emergency care, are taken into account and used to improve the quality of services in the future.

The Trust have prioritised end of life care and this is to be commended. Their plan to run public events around end of life care is a positive move and Healthwatch Gloucestershire would be happy to work with the Trust to promote these events.

The health and wellbeing of staff is imperative for the safe and high quality delivery of care to patients. Therefore, it is positive to note that 'prevention of ill health' of staff is a priority for the coming year.

We see that there have been some operational problems following the introduction of the new electronic health record (TRAKCARE). As this has the potential to impact on the experience of patients, we are pleased to see that there are plans to review the system so that learning can take place.

Responding to patient feedback and surveys on discharge is a priority for the coming year. This is part of an aim to develop a continuous improvement culture across The Trust. As an organization that exists to ensure that the patient voice is heard and acted on, Healthwatch Gloucestershire welcome this priority.

Healthwatch Gloucestershire look forward to developing the relationship with The Trust over the coming year and working with them to ensure that the experiences of patients, their families and unpaid carers are heard and taken seriously.

Dr Sara Nelson
Head of Research & Insight
Evolving Communities CIC

Statement from Gloucestershire Health and Care Overview and Scrutiny Committee

On behalf of the Health and Care Overview and Scrutiny Committee I welcome the opportunity to comment on the Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) Quality Account 2016/17.

This year has been even more challenging than usual for the Trust with the identification of the significant financial deficit. However, the committee welcomed the swift response by the Chief Executive, and looks forward to receiving the findings of the finance governance review and debating these with the Chair and Chief Executive of the Trust.

Having said this, the potential for there to be a negative impact on services as a result of the financial deficit remains a concern. The committee has discussed its concerns with the Trust and recognises that the current funding structure in the NHS, with funding following the patient, does not present an incentive for the Trust to stop providing services; and it has, of course, been commissioned by the Gloucestershire Clinical Commissioning Group to do so.

The committee also recognises that the Trust will be looking for opportunities to do things differently/ better; and that this is in line with the direction of travel of the Gloucestershire Sustainability and Transformation Plan. However, whilst understanding the situation this does not mean that the committee does not still have concerns and will be giving due consideration to any proposals that come through the STP, and maintain its close watch on the Trusts' performance against its targets.

The committee is pleased to note that work to improve the position with regard to delayed transfers of care remains a priority for the Trust. The committee is aware that as this is an issue that cuts across health and social care, that improving performance is not just reliant on the Trust, but across the wider health and social partnership.

This issue is one that the committee will want to look at in more detail in the new council, and members look forward to working with the Trust and partner organisations, including the county council, on this matter.

The committee's concerns regarding performance against targets relating to the 62 day GP referral cancer target, 2 week cancer waits, RTT and 4 hour A&E wait remain. However, members are aware that the Trust is working with the Gloucestershire Clinical Commissioning Group to redress this situation. The committee is also aware that the 4 hour A&E target reflects the national position.

On behalf of the committee I would like to thank Deborah Lee, Chief Executive, for her willingness to engage with the committee during what has been a very challenging first year in post.

Cllr Iain Dobie
Chairman Health and Care Scrutiny Committee

Independent Auditor's Limited Assurance Report to the Council of Governors of Gloucestershire Hospitals NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Gloucestershire Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Gloucestershire Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed requirements for quality reports for foundation trusts 2016/17 ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Requirements for external assurance for quality reports for foundation trusts 2016/17.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2016 to May 2017;
- papers relating to quality reported to the board over the period April 2016 to May 2017;
- feedback from commissioners, dated [DD] May 2017;
- feedback from governors, dated [DD] May 2017;
- feedback from local Healthwatch organisations, dated [DD] May 2017;
- feedback from Overview and Scrutiny Committee, dated [DD] May 2017;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the [latest] national patient survey, dated [DD MMMM] 2017;
- the [latest] national staff survey, dated [DD MMMM] 2017;
- Care Quality Commission Inspection, dated [DD MMMM YYYY];
- the 2016/17 Head of Internal Audit's annual opinion over the trust's control environment, dated [DD] May 2017; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatement or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been

prepared solely for the Council of Governors of Gloucestershire Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Gloucestershire Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement.

The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Gloucestershire Hospitals NHS Foundation Trust.

Basis for disclaimer

As set out in the Statement on Quality from the Chief Executive of the Foundation Trust on pages 5 to 6 of the Trust's Quality Report, the Trust has concerns with accuracy of data arising from the implementation of a new Patient Administration System in December 2016, as a result the Trust did not report on the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways for the full year.

As a result of these issues, we have concluded that we are unable to test sufficiently the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period indicator for the year ended 31 March 2017.

Disclaimer / Adverse / Qualified conclusion (TBC)

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for disclaimer' section above, nothing have come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the remaining indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in

accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

Jonathan Brown
KPMG LLP
Chartered Accountants
66 Queen Square,
Bristol, BS1 4BE

[##] May 2017

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Annex 2:

Statement of directors' responsibilities

Statement of directors' responsibilities for the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality account.

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 and supporting guidance;
- the content of the Quality Account is not inconsistent with internal and external sources of information including:
- board minutes and papers for the period April 2016 to May 2017
- papers relating to quality reported to the board over the period April 2016 to May 2017
- feedback from commissioners dated 15/05/17
- feedback from governors dated 22/02/17
- feedback from local Healthwatch organisations dated 12/05/17
- feedback from Overview and Scrutiny Committee dated 28/04/2017
- the trust's complaints report to be published, under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, in June 2016
- the national patient survey 08/06/2016
- the national staff survey 7 March 2017
- the Head of Internal Audit's annual opinion over the trust's control environment dated xxx
- the Quality Account presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Account.

The directors confirm to the best of their knowledge and belief they have complied with all of the above requirements in preparing the Quality Account, with the exception of the statement relating to data quality. The data underpining the measure of performance reported in the Quality Account, up to the end of November, is robust and reliable and conforms to specified data quality standards and prescribed definitions and has been subject to appropriate scrutiny and review. Following the implementation of a new Patient Administration System in December 2016, the Trust was unable to assure the data quality of information extracted from the system to support:

- Referral to Treatment times
- 6 week diagnostic test access
- Dementia assessment and referral
- Safer staffing
- Monthly activity return

A suspension of reporting was agreed with NHS Improvement as the regulator and a recovery plan is in place. Key elements of the action plan address:

- Changes to the system
- Addressing backlogs of data
- Improving data quality
- Re-estabilising reporting.

By order of the Board,

Deborah Lee
Chief Executive

Peter Lachecki
Chair

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Glossary

Care bundle: A care bundle is a set of clinical interventions that, when used together, significantly improve patient care.

Care Quality Commission (CQC): the independent regulator of health and social care in England

CGH: Cheltenham General Hospital

Chemotherapy: This is a cancer treatment which uses medication to kill cancer cells.

Clinical Commissioning Group: In 2013, our commissioners became the Gloucestershire Clinical Commissioning Group. Commissioning is the process of assessing the needs of a local population and putting in place services to meet those needs. Commissioners are those who do this and who agree service level agreements with service providers for a range of services.

Clinical outcomes: These are broadly agreed, measurable changes in health or quality of life that result from the care received.

CQUIN: This stands for the Commissioning for Quality and Innovation payment framework. The motivation behind CQUINs is to reward excellent performance by linking a proportion of providers' income to the achievement of local quality improvement goals.

Electronic Health Record (EHR): this is a digital version of a patient's health record. A health record in our hospital will contain all clinical information about a patient's care, including x-rays, treatments received or ongoing, allergies, medications, long-term conditions, test results, personal data such as name and date of birth and admission and discharge notes.

Emergency Care Data Set: this is a new collection of data which will help us understand how and why people access urgent and emergency care over the winter to help improve planning and reduce pressure.

Emergency Department: Otherwise known as A&E

Emergency laparotomy this is a surgical operation that is used for people with severe abdominal pain to find the cause of the problem and in many cases, to treat it.

GRH: Gloucestershire Royal Hospital

Health Foundation: this is an independent charity committed to bringing about better health and healthcare for people in the UK.

Healthy Workplaces: This is a toolkit which aims to support NHS organisations to improve staff health and wellbeing.

Healthwatch Gloucestershire: Healthwatch was established in April 2013 and is the consumer champion of health and social care in England, giving children, young people and adults a powerful voice

HCOSC: Gloucestershire Health and Care Overview and Scrutiny Committee. This is a body which scrutinises the decisions of local health organisations

Infection prevention and control interventions: These are steps taken by our infection prevention and control team to prevent the spread of infection.

Length of Stay (LOS): This is the amount of time that a patient stays in a hospital bed from the point of admission to the time they are discharged.

Nerve blocks These are used to treat and manage pain and work by interrupting the pain signals sent to your brain.

Oncology: This is a branch of medicine which deals with the prevention, diagnosis and treatment of cancer. A medical professional who pracitices oncology is an oncologist.

Pathway: This is the route that a patient will take from their first contact with an NHS member of staff, such as a GP, through referral to hospital, to the completion of their treatment.

Peri-operative: This generally refers to the three phases of surgery - preoperative, intraoperative and postoperative. The goal of perioperative care is to provide better conditions for patients before, during and after their operation.

Public Health England: This is an executive agency of the Department of Health. Its formation in 2013 came as a result of the reorganisation of the NHS in England as outlined in the Health and Social Care Act (2012).

Site management: This is a team of staff who manage the bed availability across our hospitals.

Tissue viability: This is a clinical specialty that considers all aspects of skin and soft tissue wounds, including surgical wounds, pressure ulcers and all forms of leg ulceration.

World Health Organisation: This is a specialised agency of the United Nations that is concerned with international public health.

ITEM 7

ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

DISCUSSION

ITEM 8

GOVERNOR QUESTIONS

Peter Lachecki
Chair

ITEM 9

STAFF QUESTIONS

Peter Lachecki
Chair

ITEM 10

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