GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on Friday 24 June 2016 in the **Subscription Rooms, George Street, Stroud GL5 1AE** commencing at **9.30 a.m.** with tea and coffee. **(PLEASE NOTE TIME AND VENUE FOR THIS MEETING)**

Professor Clair Chilvers
Chair

17 June 2016

AGENDA

				Approximate Timings
1.	Welcome and Apologies			09:30
2.	Declarations of Interest			
	WELL LED			
	Minutes of the Board and its Sub-Committees	(subject to ratification by the Board and its relevant sub-committees)		
3.	Minutes of the meeting held on 20 May 2016	**PAPER**	**To approve**	09:32
4.	Matters Arising	**PAPER**	**To note**	09:33
5.	Summary of the meeting of the Finance and Performance Committee to be held on 22 June 2016	**PAPER (To follow)** (Tony Foster)	**To note**	09:36
6.	Minutes of the meeting of the Finance and Performance Committee held on 18 May 2016	**PAPER** (Tony Foster)	**To note**	09:39
7.	Minutes of the meeting of the Audit Committee held on 17 May 2016	**PAPER** (Anne Marie Millar)	**To note**	09:40
8.	Minutes of the meeting of the Quality Committee held on 10 June 2016	**PAPER** (Gordon Mitchell)	**To note**	09:45
	Chief Executive's Report and Environmental Scan			
10.	June 2016	**PAPER** (Deborah Lee)	**To note**	09:45
	EFFECTIVE			
10.	Integrated Performance Framework Report	**PAPER** Helen Simpson)	**To endorse**	09:55
11.	Financial Performance Report	**PAPER** (Helen Simpson)	**To endorse**	10:10
12.	Emergency Pathway Report including Emergency Care Recovery Plan	**PAPER** (Eric Gatling)	**To endorse**	10:25
13.	Nurse and Midwifery Staffing	**PAPER** (Maggie Arnold)	**To approve**	10:40
14.	Trust Risk Register	**PAPER** (Helen Simpson)	**To approve**	10:45
15.	Education. Learning and Development Annual Plan 2016/17	**PAPER** (Dave Smith)	**To approve**	10:50
16.	Annual Re-validation of Senior Medical Staff	**PAPER** (Sean Elyan)	**To approve**	11:00
	RESPONSIVE			
17.	Annual Complaints Report 2015-16	**PAPER** (Maggie Arnold)	**To note**	11:10
	SAFE			

18.	Infection Control Annual Report	**PAPER** (Maggie Arnold)	**To note**	11:25
	FOR INFORMATION			
19.	Minutes of the meeting of the Council of Governors held on 18 May 2016	**PAPER** (Clair Chilvers)	**To note**	11:35
	Next Meeting			
20.	Items for the next meeting and Any Other Business	**DISCUSSION (All)**	**To Discuss**	11:40
	Staff Questions			
21.	A period of 10 minutes will be provided to respond to questions submitted by members of staff		**To Discuss**	11:45
	Public Questions			
22.	A period of 10 minutes will be provided for members of the public to ask questions submitted in accordance with the Board's procedure.		**Close**	11:55 12:05
	Break			

Date of the next meeting: The next meeting of the Main Board will take place at on **Friday 29 July 2016** in the **Gallery Room, Gloucestershire Royal Hospital** at 9.00 am. **(PLEASE NOTE VENUE FOR THIS MEETING)**

Public Bodies (Admissions to Meetings) Act 1960

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST BOARD HELD IN THE GALLERY ROOM, GLOUCESTERSHIRE ROYAL HOSPITAL ON FRIDAY 20 MAY 2016 AT 9.00 AM

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

PRESENT	Prof Clair Chilvers	Chair
	Mrs Helen Simpson	Acting Chief Executive/ Finance Director
	Dr Sally Pearson	Director of Clinical Strategy
	Dr Sean Elyan	Medical Director
	Mrs Maggie Arnold	Director of Nursing
	Mr Eric Gatling	Director of Service Delivery
	Mr Dave Smith	Director of Human Resources and Organisational Development
	Mr Tony Foster	Non-Executive Director
	Mr Clive Lewis	Non-Executive Director
	Ms Anne Marie Millar	Non-Executive Director
	Mrs Helen Munro	Non-Executive Director
	Mr Keith Norton	Non-Executive Director
APOLOGIES	Mr Gordon Mitchell	Senior Independent Director/ Vice Chair
IN ATTENDANCE	Mr Martin Wood	Trust Secretary
	Mrs Deborah Lee	Chief Executive Designate
	Mr Dhushy Mahendran	Chief of Service – Women and Children
PUBLIC/PRESS	Mr Martin Pittaway	Staff Governor
	Mr Alan Thomas	Lead Governor
	Dr Andrew Foo	Anaesthetic ITU Consultant Applicant
	Mr Matt Discombe	Citizen/ Echo
	Mr Craig Macfarlane	Head of Communications
	Ms Rebecca Wassell	Associate Director of Transformation

The Chair welcomed all to the meeting. In particular, she welcomed Mr Keith Norton who was attending his first meeting following his appointment as a Non-Executive Director. She welcomed Mrs Deborah Lee who was attending the meeting as Chief Executive Designate.

ACTION

142/16 DECLARATIONS OF INTEREST

Mr Keith Norton declared an interest in that he was Vice Chair of the Roses Theatre, Tewkesbury which received financial assistance from the Trust. This declaration was recorded in his register of interest declarations.

143/16 MINUTES OF THE MEETING HELD ON 29 APRIL 2016

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

144/16 MATTERS ARISING

041/16 Integrated Performance Framework Report: The Chair suggested that the Trust should aspire to improving the target for 90% of stroke patients spending 90% (from 80%) of their time on a Stroke Ward and asked for an indication of any barriers to achieving this

target. In response, the Director of Service Delivery supported this aspiration and said that he will undertake a detailed analysis of the data to see why this could not be achieved. The Director of Service Delivery reported that a root cause analysis is being undertaken to understand why the Trust is not achieving a 100% target and to identify actions to move towards this aspiration and that a timeframe for completion will be presented to the next meeting of the Board in May 2016. *This item appeared later in the Agenda. Completed.*

044/16 Nursing and Midwifery Staffing: The Chair enquired why only two of the first group of nine overseas-qualified nurses were successful in the International English Language Testing System (IELTS) examination. In response, the Nursing Director commented that the examination is challenging. The Director of Human Resources and Organisational Development added that the Trust is offering coaching in language skills to new recruits. He undertook to approach colleagues to see if they were experiencing similar test results. The Nursing Director said that she will take this up with the Nursing and Midwifery Council. The Director of Human Resources and Organisational Development reported that a straw poll had been undertaken of colleagues which indicated that their organisations are not experiencing the same recruitment issues largely because they are not recruiting on such an extensive basis. The Chair commented that the test papers are hard and questioned why it is necessary for the Nursing and Midwifery Council to sub-contract the tests. She invited the Director of Human Resources and Organisational Development and the Nursing Director to meet with her to discuss the position further. The Chair reported that she had spoken to the Director of Human Resources and Organisational Development and the Nursing Director and a response is awaited to a freedom of information request regarding the pass rate from those from different countries. *The Chair undertook to invite the Interim Assistant Nursing Director / Revalidation Lead to progress the Freedom of Information request. Ongoing.* **CC**

045/16 Cultural Change Programme: The Chair invited the Associate Director of Transformation to provide a further update to the Board in May 2016. *This item appeared later in the Agenda. Completed.*

077/16 Chief Executive's Report and Environmental Scan – Trust Risk Register: New Risk – Palliative Care team unable to provide the necessary responsive and comprehensive service due to staff shortages. The Chief of Service for Diagnostics and Specialities said that a business case is being prepared for submission to the next meeting of the Efficiency and Improvement Board for additional staff resources. He expressed confidence in being able to fill the posts if the business case is approved. The Chair invited the Chief of Service to provide an update for the May 2016 Board meeting. *The Acting Chief Executive/ Finance Director confirmed that funding has been approved. Completed.*

082/16 Financial Performance Report: In response to a question from the Chair, the Finance Director said that the revised report format will be introduced in May 2016. *The Acting Chief Executive said that this will be presented to the June Finance and Performance Committee and subsequently to the June 2016 Board meeting. Ongoing.*

083/16 Emergency Pathway Report: The Chair invited the Director of Service Delivery to revise the Emergency Pathway report to focus on

quality, safety and performance metrics to enable the Board to obtain assurance on all issues after prior consideration by both the Finance and Performance and the Quality Committees. The Director of Service Delivery said that this will be developed over the next couple of months. *Ongoing.*

122/16 7 Day Services Update: The Chair apologised that she had not yet written to the Chair of the Clinical Commissioning Group to place on record the Board's concern and to seek an explanation of the decision not to fund 7 Day Services in the current financial year. A draft letter was being prepared for the Chair to sign imminently. *Completed.*

048/16 2015 Staff Survey Results: The Director of Human Resources and Organisational Development confirmed that the 2015 Staff Survey Results Action Plan is to be presented at the Board Seminar in June 2016. *Completed as a Matter Arising.* [0904]

145/16 SUMMARY OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 18 MAY 2016

The Chair of the Committee, Mr Tony Foster, presented the summary of the meeting of the Finance and Performance Committee held on 18 May 2016. The Committee examined in detail the Integrated Performance Framework Report, the Financial Performance Report and the Emergency Pathway Report which appear later on the Board agenda. The Integrated Performance Framework Report is in a new format with a more forward looking arrangement with conclusions drawn from the data presented. The format of the Financial Performance Report and the Emergency Pathway Report are also to be revisited. With regard to the Financial Performance Report, the Trust's cash position has improved following the financial settlement agreed with the Clinical Commissioning Group. The data supporting the financial risk rating of 3 is to be provided shortly. Work on outstanding debt is continuing and is being reduced.

The Chair thanked Mr Foster for his report.

RESOLVED: That the summary minutes be noted. [0906]

146/16 MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 27 APRIL 2016

RESOLVED: That the minutes of the meeting of the Finance and Performance Committee held on 27 April 2016 be noted. [0906]

147/16 SUMMARY OF THE MEETING OF THE AUDIT COMMITTEE HELD ON 17 MAY 2016

The Chair of the Committee, Ms Anne Marie Millar, presented the summary of the meeting of the Audit Committee held on 17 May 2016. She referred to the final accounts where a general satisfactory opinion has to date been received from the External Auditors. A further discussion will take place when the final accounts are presented to the Board in minute number 158/16 below. A number of internal audit reports had been considered including one on SmartCare and the recommendations contained therein will be monitored in the recommendations tracker.

During the course of the discussion, the Chair referred to the internal audit report on the draft Estates and Procurement review which overall was classified as high risk and she sought the background to this classification. In response, Ms Millar said that the high risk classification was the way in which the Trust operated with regard to quantity surveyors and key recommendations had been made which are being implemented and will be monitored by the Committee.

The Chair thanked Ms Millar for her report.

RESOLVED: That the summary minutes be noted. [0909]

148/16 MINUTES OF THE MEETING OF THE SUSTAINABILITY COMMITTEE HELD ON 22 APRIL 2016

RESOLVED: That the minutes of the meeting of the Sustainability Committee held on 22 April 2016 be noted. [0909]

149/16 RETIREMENT OF THE CHAIR IN DECEMBER 2016

The Chair confirmed her intention to retire at the end of her second term of office in December 2016. A process will be underway shortly to seek a successor and she encouraged Board members to alert potential suitable candidates to the forthcoming recruitment process. [0910]

150/16 RECRUITMENT OF NEW CHAIR

The Director of Human Resources and Organisational Development updated the Board on the process to be followed to appoint a new Chair of the Trust to take office from 1 January 2017 when Prof Clair Chilvers's term of office will come to an end. The appointment of a Chair of the Trust is a matter for the Council of Governors and attached to the report was the paper presented to the Council of Governors on 18 May 2016 setting out in greater detail the process and timetable to be followed to enable a successful appointment to be made. Gatenby Sanderson have been appointed to lead the search and it is expected that the post will be advertised in early July 2016. The dates for the final selection process will need to be brought forward to the week previous to 3 and 4 October 2016 as set out in the papers. On the afternoon of the first date candidates will make a presentation to stakeholders. An open evening will be held to give potential candidates an opportunity to interact with the Board. The dates for the revised timetable will be circulated to the Board when determined. **DS/MW**

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

RESOLVED: That the process for appointing a new Chair of the Trust be noted. [0912]

151/16 ACTING CHIEF EXECUTIVE'S REPORT AND ENVIRONMENTAL SCAN

The Acting Chief Executive presented her report and highlighted the following:-

- **National:** The Acting Chief Executive invited the Director of Human Resources and Organisational Development to update

the Board on the outcome of the talks between the BMA and the Government over the Junior Doctors' contract. The BMA is to recommend to its members acceptance of the revised contract with the details being made available by the end of May 2016. A ballot will take place in June with the results being available in early July 2016. The proposal is for the contract to be introduced for F1 Doctors in October 2016 (from August 2016). The deadline for our Trust to appoint a guardian for safe working practices remains the same date of the end of June 2016. The financial implications of the revised contract will be considered when the details become available.

- **Regulators:** The NHS Improvement targets in relation to the caps in levels of agency spend and rates of pay are stretching and access to the Sustainability and Transformation funds available to local health economies could be dependent on achieving them in addition to other targets. Our Trust priority is to provide safe care to patients.
- **Our Trust:** Emergency Department attendances continue to remain high. There are encouraging signs in improved emergency department performance from the three workstreams which have been established.

  This years' Staff Award ceremony has been brought forward to 16 June 2016 to which the Board and Governors have been invited to attend.

  Our Radiographers and a team from ASPEN Medical came second in the BJN Awards for Oncology Nurse of the year for a booklet they helped to develop.

  Following a donation from FOCUS, our Radiotherapy Team based in the Oncology Unit at Cheltenham General Hospital is now treating patients in their new, dedicated high dose rate brachytherapy suite.

  The Medical Director referred to the two Radiology appointments made which is the first time for a while that such appointments have been made due to national shortages of radiologists which will help performance but staffing numbers remain below that required.

The Chair invited the Board to consider the items in the Trust Risk Register and the following comments were made:-

- M 1 – inability of the local health and social care system to manage demand within the current capacity leading to significant fluctuation of attendances in the emergency department – Mrs Munro asked if there is any movement to reduce the risk. In response, the Director of Service Delivery said that there has been no change in demand and admissions given that demand has increased compared to 2015 and on this basis it is considered that the risk rating score should remain unchanged. Our Trust is working with system colleagues to reduce the risk.
- M 1a – the clinical risk of delay in treating patients arriving at Accident and Emergency during periods of high demand or staff shortage – the Chief Executive (Designate) commented that the 15 minute standard is now the current safety metric. The Director of Service Delivery added that the position is tracked

daily with information now in the emergency pathway report and forming part of the weekly Non-Executive Director telephone calls.

- F 2 – failure to develop and implement in a timely fashion appropriate cost improvement programme projects and action plans to bring spend back to budgeted levels. Agency spend remains high and is impacted by both unfunded beds linked to high levels of demand and supply of substantive staff. The Director of Human Resources and Organisational Development said that this risk is being re-evaluated in relation to agency staff.
- HR 2b – a lack of trained nurses (permanent and bank/agency) due to insufficient training places, a higher than expected turnover and new restrictions on overseas (non-European) retention rules leading to a failure to match nursing recruitment requirements – the Director of Human Resources and Organisational Development said that this risk is to be rephrased to reflect that the highest number of staff groups and key vacancies for nurses are in Medicine Division.
- N 2276 – with the introduction of a new system of nurse revalidation there is a risk of poor compliance to the recommendations leading to large numbers of nurses losing their registration, causing a significant impact on staffing. The Nursing Director reported that this risk rating has been reduced and will be removed from the Trust Risk Register to the Lead Directors Risk Register and she will report to the next Safer Staffing Group.
- IT – 2246 – ageing and out of support network hardware, single internet circuit causing increased likelihood of hardware failures, decreasing likelihood and increase costs of finding replacement parts, reduction in resilience leading to loss of IT services in physical locations and systems, operational disruption, reduces efficiency of clinical delivery and patient through foot (using manual processes) backlog of data entry – the Chair asked for information about the timeframe to remove this from the Trust Risk Register. In response, the Director of Clinical Strategy said that work is underway to replace the equipment and it is anticipated that the risk will be mitigated by the end of July 2016. She undertook to pick up with the Director of Safety a clearer articulation of the risk and the mitigating actions. **SP**

The Chief Executive (Designate) observed that the risk in the Trust Risk Register is more of an issues log than a risk register.

The Chair thanked the Acting Chief Executive for her report.

RESOLVED: That the report be noted. [0926]

152/16 DRAFT QUALITY REPORT 2015/16

The Director of Clinical Strategy invited the Board to approve the Quality Report 2015/16 as recommended by the Quality Committee. The priorities for improving quality in 2016/17 were consistent with the operational plan. The external auditors, Grant Thornton, had confirmed that the Quality Report had been prepared in line with the national guidance. Subject to completed testing of performance indicators and finalising certain procedures the external auditors were proposing to

issue a qualified conclusion as the data to support the incomplete pathways did not cover the full year and a number of errors were identified from their testing of data underpinning the indicator. The indicators selected by Governors for review on the "Seek" element of the Dementia indicator resulted in a qualified 'opinion' as a result of errors identified during testing which understated the Trust's performance. An Action Plan has been developed by the Director of Service Delivery to address the issues raised in the incomplete pathways regarding errors in the clock start and stop times.

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

- The Chair referred to the qualified external auditors opinion on the 2014/15 Quality Report and enquired whether the reasons for the qualification were the same. In response, the Director of Service Delivery said that the issues in 2014/15 related to the non-admitted pathway. The introduction of SmartCare will provide a more precise recording and training will include enforcing the 18 week pathway rules.

(Mr Lewis joined the meeting)

- The Director of Clinical Strategy said that the external auditors' opinion on the Quality Report will be presented to the Council of Governors during the summer.
- The Chair expressed her appreciation to the Communications Team for the presentation of the Quality Report.

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

RESOLVED: That the Quality Report 2015/16 be approved. [0935]

153/16 INTEGRATED PERFORMANCE FRAMEWORK REPORT

The Director of Service Delivery presented the Integrated Performance Framework Report and of the key highlights on performance drew attention to the percentage of stroke patients spending time on a stroke ward exceeding the target of 80% at 84.6%. Of the areas of exception in performance he highlighted that emergency admissions continue to run at levels over the plan for the year 2015/16, ending at 7.5% over plan at the end of March 2016; a significant increase over the 6.9% reported in February 2016. The percentage of patients spending less than four hours in the emergency department was 85.4% compared to the target of 95%. This was an improvement on the 77.7% reported in March 2016. A recovery plan is in place with the support of NHS Improvement. The Trust did not meet the recovery trajectory for the 62 day cancer standard in March 2016 and is not expected in the action plan to do so until September 2016. The trajectory is under constant review due to ongoing capacity issues in Urology. An action plan for recovery is to be presented to the Trust Management Team in June 2016. Additional Consultants and a private provider to provide additional capacity are being used to improve performance. He expressed confidence that performance will improve after June 2016 to meet the national standard by September 2016. The previous issues with echocardiograms, planned endoscopy patients and ultrasound/ MRI scans had been addressed. The Medical Director added that demand issues are impacting on the cancer two week wait standard which has not been met.

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

- The Chair referred to the percentage of women seen by a midwife by 12 weeks which had not been met in April 2016 at 87.4% compared to the standard of 90%. The reason given was that this is likely due to the high level of new midwives resulting in an increased amount of errors being made when recording dates and wondered whether this is a training issue. In response, the Chief of Service for Women and Children said that he expected performance to improve as midwives became more familiar with the system.
- The Chair invited Board members to provide the Director of Service Delivery with suggestions to develop the new style of Integrated Performance Management Framework Report. **ALL**
- The Medical Director said that the mortality data need refining and should be treated cautiously.

(Ms Sue Barnett, Improvement Director, joined the meeting)

- The Director of Human Resources and Organisational Development said there is a focus reducing temporary staffing expenditure. **EG**
- Mrs Munro referred to the length of stay standard which had not been met and asked for the reasons why which the Director of Service Delivery undertook to provide in the next report. **Exec Team**
- The Chair invited the Executive Team to consider what performance aspirations could be achieved and to include them in the report.
- The Chair asked why VTE performance had not improved. In response the Director of Service Delivery said that the issue was in the Acute Care Unit at Gloucestershire Royal Hospital where there is a high turnover of patients; many spending less than half a day in the Unit. The form has been re-designed and additional training provided. The overnight period is a particular challenge.
- In response to a question from the Chair about the medically fit list, the Director of Service Delivery said that whilst the agreed maximum is 40 patients the current forecast of 55 patients is based on historical trends.
- The Director of Service Delivery said in response to a question from the Chief Executive Designate that the main driver for the poor cancer performance is the two week waits in Urology. The Medical Director added that there has been a substantial number of two week wait referrals amounting to approximately 20%.
- The Chief Executive Designate said that national details are to be made available shortly explaining how performance fits into the Sustainability and Transformation Programme funding.
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The Chair thanked the Director of Service Delivery for the report.

RESOLVED: That the Integrated Performance Framework Report be noted and the actions being taken to improve organisational performance be endorsed. [0954]

154/16 IMPROVING THE TARGET FOR PERCENTAGE OF STROKE PATIENTS SPENDING 90% OF TIME ON A STROKE WARD

The Director of Service Delivery presented the report on improving the target for the percentage of stroke patients spending 90% of time on a stroke ward. The national target is that at least 80% of patients with a stroke should spend 90% of their time in hospital on a designated stroke ward. Over 2015/16 our Trust has met and exceeded this standard on 10 out the 12 months, The standard was also achieved in April 2016. At the March 2016 Trust Board a question was asked about what could be done to achieve 100%.

There are 3 wards at Gloucestershire Royal Hospital that are stroke wards. However any stroke patient who is not on one of these wards is still under the care of a Consultant Stroke physician. In February 2016 there were 70 patients admitted with a stroke or suspected stroke and in March 2016 there were 73. So on average just over 2 patients a day, however the range can be as high as up to 7 patients in a day. The clinical pathway is that any patient arriving at the emergency department with a suspected stroke is transferred to a stroke ward as soon as possible and they should not go via the Acute Care Unit. A protected stroke bed is held every day to accommodate an emergency admission and when this has been used and there are no discharges planned then a patient is identified to step down and receive their remaining care on a general ward.

The three main reasons why patients spend less than 90% of their time on a stroke ward are lack of immediate capacity, delays in the capacity for step down care and late diagnosis of a stroke. To achieve the overall aim for every patient with a stroke or suspected stroke to spend all of their time on a stroke ward will require additional beds on the stroke wards, zero delays for step down care and earlier diagnosis. Our Trust will continue to work to achieve this aim.

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

RESOLVED: That the report be noted. [0959]

155/16 FINANCIAL PERFORMANCE REPORT

Due to the timing of the Final Accounts audit, the Finance Director presented the report containing a high level view of the actual financial position at April 2016 which showed an operating deficit of £0.5m representing an adverse variance of £1.5m from the planned position of a £1.0m surplus at April 2016 partly due to the phasing of the financial plan. Expenditure on temporary staff was £0.7m higher than the average of 2015/16. The Cirencester development is now underway and it is anticipated that activity will increase as the year progresses. The Cost Improvement Programme target is lower than 2015/16, but remains a challenge. The Finance Director anticipated the financial position to improve before the end of the first quarter.

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

- The Chair referred to the delay in the Cirencester development and asked why patients were not booked for the opening of the

facility. In response, the Director of Service Delivery said that there have been staff training issues with a new list for discussion. The plan was for a low level of activity in April 2016 and he envisaged that by June 2015 the facility will be operating at full capacity. It will then be rolled out to other Community Hospitals. Activity levels will be presented in future reports.

- The Chair referred to the financial implications of over performing on activity levels. In response, the Finance Director said that with the payment challenges in the system the time is now right for income to follow activity with payment by results. She expressed the view that our Trust should work to planned levels and not open extra capacity and that the Clinical Commissioning Group should actively manage demand in accordance with its plans. The Chief Executive Designate said there should be no risk share arrangements at year end and there are concerns if there are challenges around the quality of our data.
- Mr Foster asked for details of the cost of the industrial action by junior doctors and the plans to claw back those costs. In response, the Director of Service Delivery said that 1,250 elective cases were lost which should be recoverable over the year. Patients requiring a bed were cancelled rather than day cases.
- Mr Foster referred to the expenditure on agency nurses of £1,297m which was £780k above the average month which he considered to be alarming. The Director of Human Resources and Organisational Development said in response that this amount could represent when the bill was received. Use of Thornbury nurses has reduced by 25%. None of the agencies are operating within the NHS Improvement framework cap levels and agencies have not agreed to pay at NHS rates. The Director of Service Delivery added that the Finance and Performance Committee had considered agency spend in relation to vacancies, the increased agency use for 1:1 care and the weekly tracking of expenditure rather than monthly. The opening of escalation beds overnight requires agency staffing due to operational pressures. The Nursing Director added that mental health patients require 1:1 care and beds are opened at short notice due to capacity issues which require agency nurses. The overspend relates to usage. The Chief Executive Designate said that discussions need to take place to limit demand for temporary staff and proposals should be presented to the Board. The Medical Director undertook to share the work on locums filling gaps.
- In response to questions from Mr Lewis and Mr Foster, the Acting Chief Executive and Finance Director explained that due to the truncated report details of the creditor/debtor position will be presented to the Board in June 2016.

The Chair thanked the Acting Chief Executive and Finance Director for the report.

RESOLVED: That:-

1. The financial position of the Trust at the end of Month 1 of the 2016/17 financial year is an operational deficit of £0.5m be noted. This is an adverse variance to plan of £1.5m.

2. The Trust needs to improve its controls on the use of agency staff as this has already impacted the first month of 2016/17 be noted.
3. The position has been impacted due to the rescheduling of elective work resulting as part of the Trust plans in advance of the industrial action by junior doctors.
4. Actions to address the issues identified in this report will continue and progress will continue to be reported monthly to the Finance and Performance Committee and the Foundation Trust Board. [1018]

156/16 EMERGENCY PATHWAY REPORT

The Director of Service Delivery presented the Emergency Pathway report and highlighted the following:-

- The report was in the new format containing information on quality and the work of the three workstreams from which there are early indications of improved performance. There will now be a focus on developing workstreams 4, 5 and 6; admission avoidance, assessment and alternatives to beds. There will be a visit to the Oxford University Hospitals to learn from their nursing and residential home model.
- The 95% four hour target for Emergency Department performance was not successfully met in April 2016 with Trustwide performance reported as 85.38%. Whilst neither site achieved the 95% standard, there has been an upward improvement trend compared to the previous four months and particularly compared to March 2016 when performance was 77.7%
- Attendances and admittances are above plan and the Clinical Commissioning Group has been asked as a matter of urgency for their proposals to address this demand.
- The outcome from the NHS Improvement visit as part of its investigation is awaited.

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

- The Chair observed that the revised format report contains information on safety.
- The Chair reported on her attendance at the County Council's Health and Care Overview and Scrutiny Committee (HCOSC) earlier in the week of the Board meeting where the South West Ambulance Service presented its six monthly report. It was reported that our Trust was not able to supply information for time to assessment due to the absence of a reception system resulting in red risks. The HCOSC at its next meeting is to urgently address with Gloucestershire Care Services the unscheduled closures of Minor Injury Units which is impacting on both the ambulance service and our Trust. With regard to the first point, the Nursing Director reassured the Board that additional Emergency Nurse Practitioners (ENPs) are allocated to the Emergency Department at peak times to improve performance and ensure patient safety. The Medical Director said that the GP Out of Hours Service is sometimes cancelled at short notice impacting adversely on our Trust. Workstream three – reducing the length of stay for patients greater than 14 days is challenging to embed as business as usual.

- The Improvement Director commented on the improved performance in April 2016 which has been sustained so far into May 2016. There has been a discussion at the System Resilience Group about the multi-factors in addressing performance with an opportunity to refresh the system-wide plan. It is important to seek alternatives to treatment for long stay patients. She urged the Trust to continue with its work programme.

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

RESOLVED: That the report be noted and the actions being taken to improve performance be endorsed. [1031]

(Ms Sue Barnett, Improvement Director, left the meeting)

157/16 NURSE AND MIDWIFERY STAFFING

The Nursing Director presented the report updating the Board on the exception report made regarding compliance with the 'Hard Truths' – Safer Staffing Commitments for April 2016. In line with the set parameters for the safer staffing guidance there were no exceptions for April 2016. The Departments of Critical Care have a set shift cover. However, the two units 'flex' their staff on and off to help in times of low occupancy, and high occupancy. This explains why there are times when the staffing appears to be below the target, but actually reflects low patient occupancy. She drew attention to the notification from NHS Improvement of new information that is to be submitted within the safer board papers regarding Care Hours per Patient Day (CHPPD) from the June 2016 Board meeting. Work is underway as to how best to report these findings. These data may be used to determine staffing ratios. The results of the Keith Hurst bench mark exercise will be reported to the Board in June 2016. From April 2017 there will be a £1,000 per annum charge for each candidate employed from a non-EU country. The visas currently being used for Filipino nurses are for three years, and would therefore incur a total charge of £3,000 per candidate. It is not clear if staff employed before 1 April 2017 will be subject to the charge in their second or third years of employment etc. Our Trust is advertising separately specifically for candidates with the International English Language Testing System (IELTS) qualification.

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

- The Chair reported that the Chair of NHS Providers has asked for the outcome of our Freedom of Information request on the IELTS pass rate with a view to campaigning nationally for a change in the examination requirements.
- The Chair undertook to write to the County Members of Parliament expressing concern over the £1,000 per annum charge to be introduced for each candidate employed from a non-EU country. The Director of Human Resources and Organisational Development commented that the CHPPD may have more of an impact for our Trust than this charge. **CC**
- The Nursing Director said that our Trust is looking to develop its own nurses. The Chief Executive Designate said that a discussion needs to take place addressing the safety and quality aspects of the increasing permeant staff.

-

The Chair thanked the Nursing Director for the report.

RESOLVED: That the report be endorsed. [1045]

158/16 FINAL ACCOUNTS

The Acting Chief Executive and Finance Director presented the annual accounts for the year ended 31 March 2016. The accounts had been subject to External Audit. The accounts showed an operating surplus of £0.9m which was less that the planned surplus reflecting the financial and operational pressures faced by our Trust. The Audit Committee has received the analytical review of the accounts which she would forward to the Board. NHS Improvement has now announced the results of our Trust's arbitration submission involving Gloucestershire Care Services. This did not affect the outturn or the audit opinion, but the detail of the updated income position needed to be reflected in the accounts. The Board, therefore, would not be in a position to approve the final accounts and the Board were invited to delegate authority to the Chair, in consultation with the Chair of the Audit Committee, to approve the final accounts following any comments received from Board members. The updated final accounts together with the analytical review would be circulated to the Board. **HS**

The Chair thanked the Acting Chief Executive and Finance Director for the report.

RESOLVED: That authority be delegated to the Chair, in consultation with the Chair of the Audit Committee, to approve the final accounts following any comment s received from Board members. [1052]

159/16 CULTURAL CHANGE PROGRAMME UPDATE

(Ms Rebecca Wassell, Associate Director of Transformation joined the meeting for the presentation of this item)

The Associate Director of Transformation presented the report providing an update on the work of the Cultural Change Programme. Following a slow start to the delivery of the Programme, some good progress has now been made across many of the workstreams. The structure of the current programme is not readily interpreted across the wider organisation in terms of how it will improve the day-to-day working of our Trust. Whilst this can, in part, be enhanced by appropriate and regular communications, the programme also needs to be 'brought to life'. In this way staff can see how they are contributing to the success of our Trust's development and how we progress towards meeting our goal of Best Care for Everyone. The content of the individual work streams varies greatly in terms of depth and impact with much of the activity being transactional rather than real transformation. There is no clear alignment with Trust objectives and strategies. There is also no clear connection between activities within some of the work streams and the desired benefits. The programme is the 'culture change programme' yet the content of the programme points more towards whole Trust transformation, of which culture is a part – a culmination of the outputs of the various work streams activities. There are a number of Trust wide initiatives/brands, for example, Extraordinary Everyday and SAFER that are both well known amongst staff, but the connections between these, and the vision are

not well defined.
Each workstream sponsor reported on the main activities undertaken within their respective workstream.

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

- The Associate Director of Transformation said that the opportunity should now be taken to revise both the scope and structure of the programme to align more closely with our Trust's plans which was supported by the Chief Executive Designate.
- The Chair invited the Associate Director of Transformation to present a further update to the Board in July 2016. **RW (MW to note for Agenda)**

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

RESOLVED: That:-

1. Consideration be given to revising the scope of the programme from culture change to transformation, of which culture will be both a part, and a key output, rather than a fixed work stream.
2. The programme structure be revised to provide greater clarity on what the transformation and culture change will mean to everyone within the Trust. This should include narrative on what Best Care for Everyone will look like. [1052]

(Ms Rebecca Wassell, Associate Director of Transformation, left the meeting)

160/16 PATIENT HEALTH AND WELLBEING STRATEGY

The Director of Clinical Strategy presented the report inviting the Board to approve the Patient Health and Wellbeing Strategy. In early 2015 the Board approved the Trust's Health and Wellbeing Strategy as an overarching document setting out in broad terms our ambitions for our staff, our patients and the wider community with a more detailed document supporting each group. The Staff Health and Wellbeing Strategy was approved later in 2015 and our Patient Health and Wellbeing Strategy is the second of these supporting documents. The Five Year Forward View also highlighted the need for hard-hitting national action on obesity, smoking, alcohol and other major health risks. The County's Health and Wellbeing Strategy provides the more local context for our Strategy. The broad ambition of our Patient Health and Wellbeing Strategy is "every contact will count for promoting health and wellbeing". The strategy will be underpinned by a more detailed work programme which will be monitored by the Health and Wellbeing Committee.

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

- The Chair and Mr Foster acknowledged the good work of the Communications Team, in particular Kate Jeal, for the presentation of the Strategy.
- Mr Foster indicated that approximately 50% of our staff have been assessed to offer advice on smoking and obesity through two separate training modules and he wondered whether this could be combined. The Director of Clinical Strategy said that

generic training is provided and the greatest patient involvement is with HCAs who welcome that unique opportunity.

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

RESOLVED: That the Patient Health and Wellbeing Strategy be approved. [1131]

161/16 ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

Items for the next meeting: No additional items were identified for the next meeting.

Any other business:

Hope for Tomorrow: The Medical Director reported that "Hope for Tomorrow" has been awarded the Queen's Award for Enterprise in the Innovation Category. Our Trust played a key part in developing and piloting this system.

162/16 STAFF QUESTIONS

There were none.

The Director of Service Delivery reported that he was in a dialogue with Jonathan Ord, Consultant Urologist, following his question presented to the April 2016 Board meeting. [1133]

163/16 PUBLIC QUESTIONS

There were none. [1133]

164/16 DATE OF NEXT MEETING

The next **Public** meeting of the **Main Board** will take place at **9.30am** on **Friday 24 June 2016** in the **Subscription Rooms, George Street, Stroud**.

165/16 EXCLUSION OF THE PUBLIC

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

The meeting ended at 11.34am.

Chair
24 June 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JUNE 2016

MATTERS ARISING

CURRENT TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
June 2016	February 2016 Minute 044/16 Nursing and Midwifery Staffing	**CC/DS/MA**	The Chair enquired why only two of the first group of nine overseas-qualified nurses were successful in the International English Language Testing System (IELTS) examination. In response, the Nursing Director commented that the examination is challenging. The Director of Human Resources and Organisational Development added that the Trust is offering coaching in language skills to new recruits. He undertook to approach colleagues to see if they were experiencing similar test results. The Nursing Director said that she will take this up with the Nursing and Midwifery Council. The Director of Human Resources and Organisational Development reported that a straw poll had been undertaken of colleagues which indicated that their organisations are not experiencing the same recruitment issues largely because they are not recruiting on such an extensive basis. The Chair commented that the test papers are hard and questioned why it is necessary for the Nursing and Midwifery Council to sub-contract the tests. She invited the Director of Human Resources and Organisational Development and the Nursing Director to meet with her to discuss the position further. The Chair reported that she had spoken to the Director of Human Resources and Organisational Development and the Nursing Director and a response is awaited to a freedom of information request regarding the pass rate from those from different countries. The Chair undertook to invite the Interim Assistant Nursing Director / Revalidation Lead to progress the Freedom of Information request. *The request has been progressed and a response is awaited. Ongoing*
June 2016	March 2016 Minute 082/16 Financial Performance Report	**HS**	In response to a question from the Chair, the Finance Director said that the revised report format will be introduced in May 2016. The Acting Chief Executive said that this will be

			presented to the June Finance and Performance Committee and subsequently to the June 2016 Board meeting. *The revised format report was presented to the June 2016 meeting of the Finance and Performance Committee and appears later in the Agenda. Completed.*
June 2016	March 2016 Minute 083/16 Emergency Pathway Report	**EG**	The Chair invited the Director of Service Delivery to revise the Emergency Pathway report to focus on quality, safety and performance metrics to enable the Board to obtain assurance on all issues after prior consideration by both the Finance and Performance and the Quality Committees. The Director of Service Delivery said that this will be developed over the next couple of months. *This item appears later in the Agenda. Completed.*
June 2016	May 2016 Minute 150/16 Recruitment of New Chair	**DS/MW**	The dates for the revised recruitment timetable will be circulated to the Board when determined. *The revised timetable has been circulated to the Board. Completed.*
June 2016	May 2016 Minute 151/16 Acting Chief Executive's report and Environmental Scan - Trust Risk Register	**SP**	IT – 2246 – aging and out of support network hardware, single internet circuit causing increased likelihood of hardware failures, decreasing likelihood and increase costs of finding replacement parts, reduction in resilience leading to loss of IT services in physical locations and systems, operational disruption, reduces efficiency of clinical delivery and patient through foot (using manual processes) backlog of data entry – The Director of Clinical Strategy said that work is underway to replace the equipment and it is anticipated that the risk will be mitigated by the end of July 2016. She undertook to pick up with the Director of Safety a clearer articulation of the risk and the mitigating actions. *Ongoing.*
June 2016	May 2016 Minute 155/16 Integrated Performance Framework Report	**EG** **Exec Team**	Mrs Munro referred to the length of stay standard which had not been met and asked for the reasons why which the Director of Service Delivery undertook to provide in the next report. *Ongoing* The Chair invited the Executive Team to consider what performance aspirations could be achieved and to include them in the report. *Ongoing*

June 2016	May 2016 Minute 157/16 Nurse and Midwifery Staffing	**CC**	The Chair undertook to write to the County Members of Parliament expressing concern over the £1,000 per annum charge to be introduced for each candidate employed from a non-EU country. *Ongoing*
June 2016	May 2016 Minute 158/16 Final Accounts	**HS**	The updated final accounts together with the analytical review would be circulated to the Board. *These documents were circulated to the Board as part of seeking approval to the Final Accounts. Completed.*

FUTURE TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
July 2016	May 2016 Minute 159/16 Cultural Change Programme Update	**RW**	The Chair invited the Associate Director of Transformation to present a further update to the Board in July 2016. *Ongoing*

COMPLETED TARGETS

Target Date	Month/Minute/Item	Action with	Detail & Response
May 2016	February 2016 Minute 041/16 Integrated Performance Framework Report	**EG**	The Chair suggested that the Trust should aspire to improving the target for 90% of stroke patients spending 90% (from 80%) of their time on a Stroke Ward and asked for an indication of any barriers to achieving this target. In response, the Director of Service Delivery supported this aspiration and said that he will undertake a detailed analysis of the data to see why this could not be achieved. The Director of Service Delivery reported that a root cause analysis is being undertaken to understand why the Trust is not achieving a 100% target and to identify actions to move towards this aspiration and that a timeframe for completion will be presented to the next meeting of the Board in May 2016. *This item appeared later in the Agenda. Completed.*
May 2016	February 2016 Minute 045/16 Cultural Change Programme	**RW**	The Chair invited the Associate Director of Transformation to provide a further update to the Board in May 2016. *This item appeared later in the Agenda. Completed.*
May 2016	March 2016 Minute 077/16 Chief Executive's Report and Environmental Scan – Trust Risk Register	**FJ**	New Risk – Palliative Care team unable to provide the necessary responsive and comprehensive service due to staff shortages. The Chief of Service for Diagnostics and Specialities said that a business case is being prepared for submission to the

			next meeting of the Efficiency and Improvement Board for additional staff resources. He expressed confidence in being able to fill the posts if the business case is approved. The Chair invited the Chief of Service to provide an update for the May 2016 Board meeting. *The Acting Chief executive and Finance Director confirmed that funding has been approved. Completed.*
May 2016	May 2016 Minute 122/16 Seven Day Services Update	**CC**	The Chair apologised that she had not yet written to the Chair of the Clinical Commissioning Group to place on record the Board's concern and to seek an explanation of the decision not to fund 7 Day Services in the current financial year. A draft letter was being prepared for the Chair to sign imminently. *Completed.*
May 2016	May 2016 Minute 048/16 2015 Staff Survey Results	**DS**	The Director of Human Resources and Organisational Development confirmed that the 2015 Staff Survey Results Action Plan is to be presented at the Board Seminar in June 2016. *Completed as a Matter Arising*

ITEM 5

SUMMARY OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE TO BE HELD ON 22 JUNE 2016

PAPER (To follow)

Mr Tony Foster
Chair

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE TRUST FINANCE AND PERFORMANCE COMMITTEE HELD IN THE BOARDROOM, 1 COLLEGE LAWN, CHELTENHAM ON WEDNESDAY 18 MAY 2016 AT 10AM

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

PRESENT	Mr T Foster	Non-Executive Director (Chair)
	Mrs H Simpson	Acting Chief Executive/Finance Director
	Mr G Mitchell	Non-Executive Director
	Mr K Norton	Non-Executive Director
	Mr E Gatling	Director of Service Delivery
APOLOGIES	None	
IN ATTENDANCE	Mr M Wood	Trust Secretary

The Chair welcomed the members of the Committee to the meeting and in particular, he welcomed Mr Keith Norton to his first meeting of the Committee following his appointment as a Non-Executive Director.

ACTION

067/16 DECLARATIONS OF INTEREST

Mr Keith Norton declared an interest in his capacity as Vice Chair of the Roses Theatre, Cheltenham which received financial assistance from the Trust which is recorded in the register of interests.

068/16 MINUTES OF THE MEETING HELD ON 27 APRIL 2016

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

069/16 MATTERS ARISING

036/16 Integrated Performance Management Framework: The Finance Director undertook in response to a question from Mrs Bond to check the impact on performance on coding. The Finance Director said that the Clinical Commissioning Group has noted the improved quality of coding and the Trust is discussing the coding at source which is being challenged by the Clinical Commissioning Group. She added that there are benefits to the Trust from accurate coding which is not necessarily welcomed by the Clinical Commissioning Group. The year-end financial position agreed with the Clinical Commissioning Group has helped the Trust. *Completed.*

035/16 Financial Performance Report: Mr Foster asked how long it will take for the Trust to return to a normal cash position and what a good cash position might look like. Mr Foster observed that if the creditor position improved the working capital facility could be used to pay suppliers. The Chair invited the Finance Director to report to the Committee in May 2016 with a view of the action which the Trust should be working towards. *Details were circulated following the Committee's meeting. Completed.*

070/16 FINANCIAL PERFORMANCE REPORT

Due to the timing of the audit of the Trust Annual Accounts and Annual Planning and Contracting Processes for 2016/17, the Finance Director presented the report containing a high level view of the actual financial position for April 2016 The actual financial position at April 2016 showed an operating deficit of £0.5m representing an adverse variance of £1.5m from the planned position of a £1.0m surplus at April 2016 partly due to the phasing of the financial plan. There had been a loss of income due to the industrial action by junior doctors. Pay costs including agency costs had increased which is a particular cause for concern. The Executive Team had discussed this with the Chiefs of Service to address. NHS Improvement had asked why our Trust's expenditure on agency is so far adrift from plan.

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

- Mr Norton asked for information on the impact of the industrial action by junior doctors. In response, the Director of Service Delivery said Consultants had been reallocated from non clinical areas. Elective, outpatients and day case procedures had been cancelled and this was the first time that outpatient appointments had been cancelled. Appointments were not booked when the dates of the industrial action were known. Approximately 1% of our Trust's performance was lost as a result of the industrial action.
- The Finance Director said that the Cirencester development is now open and an opportunity for our Trust. The Chief of Service for the Surgery Division is looking at increasing activity as the year progresses. Approximately £2m per annum of activity will pass through the Cirencester development.
- The Chair expressed concern over the increase in nurse agency costs amounting to £700k for April 2016 given that from 1 April 2016 nurses from frameworks should be used. In response, the Director of Service Delivery said that no HCA's are being used from Thornbury. The use of nurses from Thornbury has dropped dramatically. The main issue for NHS Improvement is that no agencies have lowered their prices to comply with the framework. The long term aim is to reduce the bed base which will in turn reduce the demand for agency nurses. The Finance Director added that a continuation of an increasing trend in agency expenditure will impact on the Trust's ability to return a surplus. The Director of Service Delivery said that there needs to be an understanding of the nursing vacancies, the higher dependency of patients requiring 1:1 nursing supervision which often can only be achieved by using agency nurses and this needs to be looked at as part of the Cost Improvement Programme. The Chair invited the Finance Director to provide further detail at the next meeting of the Committee in June 2016. The use of agency nurses links to the Emergency Department pathway in providing alternative care, recruiting permanent staff, understanding why staff leave our Trust, reducing unit agency costs and having a right size organisation for the pay budget. There needs to be a discussion about closing beds which will impact on performance. Our Trust is to visit Oxford Hospital to learn more of their working arrangement with the third sector. The **HS**

Chair said that there was not a great level of confidence in being able to successfully redress agency costs.
- The Chair said that the report was silent on the NHS Improvement financial risk rating which he hoped remained at 3.
- The Acting Chief Executive/Finance Director said that the Director of Operational Finance is to revise the format of the financial Performance report.

The Chair thanked the Finance Director for the report.

RESOLVED: That:-

1. The Financial Position of the Trust at the end of month 1 of the 2016/17 financial year is an operational deficit of £0.5m be noted. This is an adverse variance to plan of £1.5m.
2. The Trust needs to improve its control on the use of agency staff and this has already impacted the first month of 2016/17 be noted.
3. The position has been impacted due to the rescheduling of elective work resulting as part of the Trust plans in advance of the industrial action by junior doctors.
4. Actions to address the issues identified in this report will continue and progress will continue to be reported monthly to the Finance and Performance Committee and the Foundation Trust Board.

071/16 INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK

The Finance Director presented the report summarising the key highlights and exceptions in Trust performance up to the end of April 2016 for the financial year 2016/17. She drew attention to each of the highlights and exceptions on performance as set out in the report.

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

- The Finance Director referred to the list of medically fit patients which during the week of the meeting was 90 patients compared to the system-wide plan of no more than 40 patients. This raised concerns on the reliance of the Clinical Commissioning Group to deliver the system-wide plan.
- The Director of Service Delivery drew attention to the revised format of the Integrated Performance Management Framework report which is subject to further refinement.
- The Director of Service Delivery drew attention to the cancer 2 week wait standard which has not been met commenting that the main issue is in Urology; however, the forecast is for a green rating. The main issues are again in Urology for our Trust not meeting the recovery trajectory for the 62 day cancer standard.
- The Director of Service Delivery drew attention to the number of patients waiting over 6 weeks for a key diagnostic test continuing and is predicted to not meet the target due to capacity issues in MRI and Neurophysiology. Action plans have been agreed with our clinical divisions to improve performance.
- Mr Norton referred to the data presented in the report which was helpful to the Committee but in his view did not provide sufficient assurance in areas such as safety and this should be

addressed in future reports.

- The Chair referred to the forecast position commenting that Divisions should take ownership of the improvement plans. The Director of Service Delivery added that Executive Reviews take place bi-monthly and as part of that work the 6 monthly forecast is determined. Mr Mitchell commented that the report gives the high level position but some form of "traffic light" symbol is required to draw attention to areas for the Committee's detailed consideration. He gave as an example that it is not readily identifiable from headlines that there are concerns about safety issues regarding the 15 and 60 minute standards in the Emergency Department. In response, the Director of Service Delivery said that safety indicators can be added to the "are we safe?" section of the report.
- The Chair referred to the number of clostridium difficile infections post 48 hours which was 1 for March 2015/16. In response, the Director of Service Delivery said that our Trust has successfully appealed 6 cases resulting in a re-adjustment of the figures.
- The Director of Service Delivery said that the major performance issues relate to the Emergency Department, the 62 day cancer standard and the 2 week wait cancer standard. Mr Norton suggested that this information should be included in the summary.
- The Finance Director said that the dementia-seek/assess performance needs to be revisited in the light of audit reports.

The Chair thanked the Finance Director for the report.

RESOLVED: That the Integrated Performance Framework Report be noted and the actions being taken to improve organisational performance be endorsed.

172/16 EMERGENCY PATHWAY REPORT

The Director of Service Delivery presented the report stating that the 95% 4 hour target for Emergency Department performance was not successfully met in April 2016, with Trustwide performance reported as 85.38%. Neither site achieved the 95% standard in April 2016. However, there has been an upward trend of improvement compared to the previous four months and particularly compared to March 2016 when performance was 77.7%. Safety and quality performance was included in the report to aid the discussion as to which Committee is responsible for those aspects. There has been an increase in attendances with the daily average number of Emergency Department attendances in May 2016 being 391. The number of patients on the medically fit list for one day and over has been at an average of 57 throughout April 2016 which remains above the system-wide plan of no more than 40 patients. Three further workstreams are being established to address the longer term issues.

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

Mr Norton referred to the daily average number of Emergency Department attendances and enquired as to the full year impact. In response, the Director of Service Delivery said that the Clinical Commissioning Group had agreed attendances of 330 per day as part

of QIPP and our Trust wishes the CCG to reduce attendances to this level for which our Trust receives payment.

- In response to a question from the Chair about admissions, the Director of Service Delivery said that the plan is for 110 admissions per day whereas in April 2016 the figure was 124 and in March 2016 123 impacting on length of stay requiring the opening of 2 additional wards staffed by agency staff with consequent costs.
- Mr Mitchell commented that following the NHS improvement investigation the Committee should focus on safety, changing things in our Trust's gift to influence the local health system and the three immediate priority workstreams. In the short term there has been a slight improvement but this should not underestimate the size and scale of the work required to achieve the 95% target. The report to the Committee should highlight those areas which should be considered in greater detail. The Director of Service Delivery observed that there are both finance and performance aspects and the issue of safety in the Emergency Department is also a matter for the Quality Committee. The Committee and the Quality Committee should consider their respective areas of responsibility in detail with an aggregated report presented to the Board. Further work is ongoing in this regard.
- The Director of Service Delivery referred to the letters dated 5 May and 17 May 2016 from NHS Improvement regarding operational plans and the accompanying trajectories. Further information on the trajectories was sought by 23 May 2016. With regard to the Emergency Department, our Trust is encouraged to leave our trajectory as it is so that patients benefit from improved services as soon as possible as the national modelling approach is less ambitious than our trajectory already submitted. The current Referral To Treatment (RTT) trajectory is considered broadly acceptable but our Trust has been asked to consider whether more ambition could be considered to move above the minimum standard of 92% from June 2016. The cancer and diagnostics trajectories were accepted by the south tripartite team. The Committee concluded that there should be no changes to the trajectories already submitted.
- The Director of Service Delivery said that the weekly telephone calls with Non Executive Directors are to continue and the Chair invited the Director of Service Delivery to include in the report those Non Executive Directors on each telephone call.

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

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

073/16 CASH POSITION UPDATE

Details of the cash position would be provided to the Committee by the end of the week of the meeting. The Acting Chief Executive/Finance Director said that the Director of Operational Finance is to take the lead on cash issues. **HS**

074/16 PREPARATION FOR THE JUNE MEETING

The Committee invited Chiefs of Service, Divisional Nursing Directors and Divisional Operations Directors to attend the meeting in June 2016 together with the Director of Estates and Facilities. This year a short presentation is required on the financial position, performance by exception and nurse and doctor staffing with the precise requirements being provided by the Finance Director and the Director of Service Delivery.

075/16 PROGRESS UPDATE ON CONTRACTING PROCESS

The Finance Director presented the report updating the Committee on the key points associated with the 2016/17 contracting process.
The Trust has concluded negotiations with the Clinical Commissioning Group. The overall contract value has been agreed however, the Clinical Commissioning Group continue to pursue commissioner QIPP schemes for inclusion in the Contract. Contract negotiations with Specialised Commissioners have been concluded on a full PBR basis which will be to the benefit of the Trust providing all activity is recorded on PAS. Arbitration with Gloucestershire Care Services is underway. It is likely that our Trust will give notice and market test a number of service provided by Gloucestershire Care Services which do not provide value for money.

During the course of the discussion, the Finance Director was invited to present to the July 2016 meeting of the Committee details of the outcome of the contract negotiations. **HS (MW to note for agenda)**

The Chair thanked the Finance Director for the report.

RESOLVED: That progress made in reaching agreement on the 2016/17 Contracts be noted.

076/16 NOTES OF THE EFFICIENCY AND SERVICE IMPROVEMENT BOARD MEETING HELD ON 11 MAY 2016

These minutes will be presented to the Committee in June 2016.

077/16 FINANCE AND PERFORMANCE COMMITTEE WORK PLAN

The Trust Secretary was invited to update the Workplan as follows:-

- July 2016 – Add temporary medical staffing
- September 2016 – transfer from July 2016 issues with the Clinical Commissioning Group Accounting Officer **MW**

078/16 WASH-UP SESSION TO ENHANCE THE TRANSPARENT FLOW OF ASSURANCE AND RISKS

This was considered as part of minute 079/16 below.

079/16 COMMITTEE REFLECTION

As part of the reflection, it was agreed that a presentation be made to the Committee in July 2016 on the Sustainability and Transformation Programme with input from the Director of Clinical Strategy. **HS/EG**

080/16 ANY OTHER BUSINESS

There were no further items of business.

081/16 DATE OF NEXT MEETING

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Finance and Performance Committee will be held on **Wednesday 22 June 2016** in the **Boardroom, 1 College Lawn, Cheltenham** commencing at **10am**.

Papers for the next meeting: Completed papers for the next meeting are to be logged with the Trust Secretary no later than 3pm on **Monday 13 June 2016**.

The meeting ended at 12.03pm.

Chair
22 June 2016

HOSPITALS NHS FOUNDATION TRUST GLOUCESTERSHIRE

MINUTES OF THE AUDIT COMMITTEE MEETING HELD ON 17 MAY 2016 AT 8.30AM IN THE BOARDROOM, NO 1 COLLEGE LAWN, CHELTENHAM

PRESENT

Mrs Anne Marie Millar	(AM)	Non - Executive Director Chair
Mr Tony Foster	(TF)	Non - Executive Director

IN ATTENDANCE (by invitation)

Mrs Helen Simpson (part)	(HS)	Finance Director & Acting CEO
Mr Alan Thomas	(AT)	Lead Governor
Mr Kevin Henderson	(KH)	Grant Thornton (GT), External Audit
Ms Dominique Lord	(DL)	Price Waterhouse Coopers (PWC), Internal Audit
Mr Andrew Seaton	(AS)	Director of Safety
Mrs Sarah Stansfield	(SS)	Director of Operational Finance
Mrs Alex Gent (part)	(AG)	Head of Shared Services
Mr Martin Wood	(MW)	Trust Secretary
Mr Sean Ceres	(SC)	Interim Director of Operational Finance
Ms Geraldine Daly	(GD)	Grant Thornton (GT), External Audit
Mrs Sarah Smith	(SS)	PA to Finance Director

APOLOGIES

Mrs Lynn Pamment	(LP)	Partner, Price Waterhouse Coopers (PWC), Internal Audit
Mr Lee Sheridan	(LS)	Head of Counter Fraud

ACTION

The Chair of the Audit Committee thanked Mr Clive Lewis and Mrs Helen Munro for their contribution to the Audit Committee.

037/16 DECLARATIONS OF INTEREST

None.

038/16 MINUTES OF MEETING HELD ON 8 MARCH 2016

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

039/16 MATTERS ARISING

022/16 COUNTER FRAUD PROGRESS REPORT - MATERIAL ISSUES FOR INCLUSION IN THE ANNUAL ACCOUNTS.

The Acting CEO updated that she had discussed the ongoing criminal investigation with the Chair of the Committee, PwC and GT and discussions had now been reflected in the Annual Governance Statement. ***Item Complete***

Attendees noted that recovery costs were now included in the Draft Annual Report. ***Item Complete***

025/16 NURSING ROSTERING

Mr Stephenson reported that PwC would be meeting with the Steering Committee and progress had been made although work was not yet complete. An update report will be presented at the next meeting of the Audit Committee.

The Acting CEO advised that the Interim CIP Director currently in post has a nursing background and had been selected to specifically help with rostering and agency cost.

030/16 EMERGENCY CARE PLAN, 4 HOUR WAITS AND MONITOR ACTION PLAN.

Mr Seaton advised that a root cause analysis had been presented to Monitor. ***Item Complete***

003/16 – INTERNAL AUDIT AGENCY NURSING

Mr Stephenson advised that the Trust had taken sufficient action to close the action. ***Item Complete***

RESOLVED: That the report be noted and revisited on the 6 September 2016.

040/16 ANNUAL ACCOUNTS FOR YEAR ENDED 31 MARCH 2016

The Acting CEO advised that the accounts had been prepared in accordance with accounting standards and were submitted on time and were now being presented to attendees for their view and comments. Attendees noted that there had been subsequent technical adjustments to the accounts which had been issued to attendees and the Trust were reporting a small surplus of £0.8k therefore the surplus remained unchanged.

Mr Ceres explained the reason for the late adjustment related to subsequent agreements on other contract and changes made by other organisations which were made in April and not shared or agreed with the Trust. Subsequently the Trusts position has changed; this resulted in a change of £1.4m agreed reduction in income offset by other changes. The changes did not have to be made as not material and at the time the accounts were published estimates were made which were reasonable. Mr Ceres explained that this has some benefits which the Trust has been able to utilise.

Attendees noted

- that there is some movement in Pay Expenditure resulting a pay increase moving from one year to the next.

- Impairments - attendees noted that there were technical adjustments made which related to the revaluation of Property, Plant and Equipment in 2015/16 which impacts financially and needs to be reported in the accounts.

The Acting CEO also update on robust negotiations with Commissioners which has resulted in a good settlement for the Trust.

ANALYTICAL REPORT

A number of areas were discussed by attendees

- Property Plant and Equipment (PPE) - the Chair commented on depreciation and Mr Ceres explained that this was of a result of the revaluation work agreed last year and this was a pre-planned expectation.
- Analysis of the operating income - a reduced income in catering was noted , the Acting CEO advised that this was due to the

closure of the Glass House Café as part of a planned refurbishment.
- Attendees noted the increase in premiums relating to increased clinical risk. Mr Ceres updated that the Trust was notified of the increase of £4m which has been calculated on a range of factors including historic claims; attendees noted that premiums had increased nationally.

ANNUAL GOVERNANCE STATEMENT

Attendees noted the updated statement .Key points of discussion were noted as

- Attendees discussed whether the statement should include a report on Committee work and the Trust Secretary agreed to consider for future statements. **MW**
- The Trust is in the higher third in terms of statistical reporting relating to reporting incidents. Mr Seaton advised that the Committee should be reassured that is due to the strong reporting cultural within the Trust.
- Financial Sustainability Risk Rating , the Acting CEO advised that the Trust is currently awaiting confirmation of the Trust's rating from NHS Improvement. The Acting CEO agreed to add the rating if received in time to meet deadlines for the Annual Report.
- Financial Resilience – removed from the report as it had been added in error.
- Internal Audit advised that there had been 4 high risk findings in the completed audit review. The Trust Secretary agreed to amend the Statement. **MW**
- The statement now includes a Counter Fraud update on an ongoing criminal investigation, attendees discussed the use of the word 'criminal' and Ms Daley commented that this was a statement of fact and not a misrepresentation. Attendees confirmed that the were content with the wording. The Finance Director also confirmed that the Communications team were aware and prepared for any media attention. (*post meeting legal action advice to remove word 'criminal' at this time.)*
- Attendees discussed where post balance sheet issues were picked up agreeing that this was not an issues for the governance statement, the Acting CEO agreed to ensure that the Board were updated .
- Board Governance Review - the Trust Secretary agreed to insert a paragraph on the review undertaken by RSM. **MW**
- The Trust Secretary agreed to reflect on whether the Governors should have sight of the Annual Report next year and to also consider whether a draft report should be presented to the Audit Committee. **MW**

LETTER OF REPRESENTATION

The Committee approved the letter of representation noting that it was still draft.

RESOLVED: That the reports be noted.

041/16 REPORTS FROM THE FINANCE DIRECTOR

LOSSES AND COMPENSATIONS

Attendees noted the ex gratia payments made and approved the write off of 517 invoices totalling £ 28,390.93. Attendees noted that invoices were at least two years old before considered for write off and Mr Ceres agreed to provide further financial analysis for future reports. **SC**

464 invoices related to prescription charges and Mrs Gent provided an update on the procurement of prescription machines in A&E which will be implemented this year and will help improve the level of invoices currently written off.

Mrs Alex Gent joined the meeting

SINGLE TENDER ACTION
Attendees noted the Single Tender Actions which have been signed off since the Audit Committee. Mrs Gent advised that a number of the waivers required specialist expertise or equipment that are only available from one source. When the Procurement team are now sourcing equipment they are now looking for a more open protocol.

RESOLVED: That the reports be noted.

Mrs Alex Gent left the meeting

042/16 EXTERNAL AUDIT UPDATE

AUDIT FINDINGS REPORT
Ms Daly presented the draft report, a final version will be issued to the Audit Committee and Main Board. Key points noted

- Grant Thornton reported that to date they had noted identified any adjustments affecting the Trust retained surplus position.
- Attendees agreed timescales for outstanding audit work. The Finance Director agreed to update the Chair of the Audit Committee on progress , attendees also agreed to a conference call of the Audit Committee to update on progress. **GT/SS/SC**
- The most significant outstanding issue is agreement of balances with Gloucestershire Care Services and the explanation of the variance. The Trust is not currently satisfied with GCS explanation and do not recognise the figures. GT will need to perform detailed testing on movement if required.
- Attendees noted the mismatches from the NHS agreement of balance exercise, the largest balance being with Gloucestershire Care Services, Mr Ceres updated that GCS had not taken part in the agreement of balancing exercise. Attendees agreed that these issues needed resolve urgently and the Acting CEO agreed to further discuss with the Chief Executive of GCS and update the Committee.
- Management response – depreciation by DTZ, the Trust has confirmed that it does not have a back log of maintenance and futures plans are place which the Main Board have sight of .
- Ms Daley advised that GT are required to report all misstatements.
- Attendees discussed the continuing use of agency noting that a cap had been set by NHS Innovation of 6% with a outturn of 8% for quarter 3.
- Attendees agreed that it would be preferable for a final version of the report to be presented to the Board at the meeting taking place on 20 May and the Acting CEO agreed to update the Chair of the Trust.

Other Risks were noted as :

- Employee remuneration accruals understated error not significant.
- Trade Creditors - creditors understated or not recorded in the correct period, error not significant.
- Intangible assets - GT had requested evidence to support

capitalisation and the breakdown of £500k non staff costs. Based on the work performed to address risks GT have concluded that the Trust has proper arrangements in all significant respects to ensure it delivered value for money in its use of resources.

REPORT OF THE QUALITY ACCOUNT
Grant Thornton confirmed that the Quality Report had been prepared in all material respects in line with requirements.

Incomplete pathways, GT reviewed the process used to collect data for this indicator there were a number of errors including four which related to clock starts dates , Mr Henderson highlighted that there was a need to ensure accuracy.

Work on the Quality report is still ongoing, subject to completion of testing Grant Thornton are proposing to issue a qualified conclusion on the Quality Report.

RESOLVED: That the reports be noted.

Mr Henderson , Ms Daley and Mrs Simpson left the meeting

043/16 INTERNAL AUDIT UPDATE

DRAFT ANNUAL REPORT AND HEAD OF INTERNAL AUDIT OPINION
There had been two reviews which had been high risk, these were Smartcare and Procurement. There was one further high risk reported in a medium risk reports which related to the induction of agency nurses. 30 of 44 recommendations had been fully implemented and there were a number of low risk reports.

PwC gave an opinion as follows 'Generally satisfactory with some improvements required 'this is the second highest opinion of four and is consistent with previous years.

INTERNAL AUDIT PLAN 2016/2017
Attendees noted the report including the use of contingency days which had been used for additional work, additional days would be required for any further work. The proposed plan was noted by attendees.

INTERNAL AUDIT CHARTER 2016/2017
Attendees noted the report which is produced annually to provide the framework for the conduct of the Internal Audit function in Gloucestershire Hospitals NHSFT.

CORE FINANCIAL SYSTEMS PHASE 3
The report summarised the continuous auditing and monitoring of core financial systems, there were a number of transactions and testing undertaken, attendees noted that there were very few recommendations which attendees were reassured by. Authorised Signatories is an area which was highlighted, although this still a risk it is one which is continually being reduced.

SMARTCARE
Mr Stephenson reported one high risk, two medium risk findings and three low risk findings overall the report was noted as high risk. There are a number of concerns relating to the project the highest risk within the report related to lack of formal stage-gate reviews. Attendees noted that the Director of Clinical Strategy had received the report and it would be

presented at the SmartCare Programme Board. Mr Stephenson agreed to meet with the SmartCare Programe Manager and the Director of Clinical Strategy to update on progress, Mr Stephenson agreed to provide a update at the next meeting of the Audit Committee. **PWC**

RECOMMENDATION TRACKER

Attendees agreed that the Tracker should be a rolling agenda item. Mr Stephenson agreed to confirm if items were high risk or beyond the dates for response and provide the correct version for circulation to the Audit Committee. **PWC**

DRAFT ESTATES PROCUREMENT REVIEW

The retrospective report has been prepared to assist in identifying areas of concern and suggested remediation actions. The report highlighted two high, one medium and one low risk, overall the report was noted as high risk. There were two high risk areas identified in the report which related to use of Quantity Surveyors in the tendering process which requires increased clarity and control and Insufficient evidence is maintained to establish how suppliers are selected for invitation to tender Mr Stephenson advised that formal acceptants of recommendations was still required . **AG/SS**

RESOLVED: That the reports be noted.

044/16 REVISED TERMS OF REFERENCE FOR THE AUDIT COMMITTEE

The Trust Secretary presented the revised Terms of Reference which Were updated to include the arrangements for reviewing shared services core financial reviews undertaken by Internal Audit with 2gether. The titles of attendees had also been updated. Mr Foster suggested that the Finance Director and Chief Executive should also be attendees of the Committee , the Trust Secretary agreed to discuss with the new Chief Executive when in post . **MW**

Discussion took place around whether members of the Committee could review the draft financial accounts informally ahead of GT. The Trust Secretary agreed to consider whether this should be a key role of the Committee to be added to the Terms of Reference. **MW**

RESOLVED: That the report be noted.

045/16 REPORTS OF THE HEAD OF COUNTER FRAUD

Mrs Alex Gent joined the meeting

ANNUAL REPORT

Attendee noted the key areas of activity undertaken between April 2015 and March 2016. Mrs Gent highlighted the summary of risk from the self-review assessment tool undertaken last year updating that this is currently under review and an update will be provided at the next meeting of the Committee.

ACTION PLAN

Attendees noted the Action Plan for 2016/17.

RESOLVED: That the report be considered.

046/16 REVIEW OF THE TRUST RISK REGISTER AND ASSURANCE FRAMEWORK

The Director of Safety presented the Trust Risk Register. He explained that a Datex web based system is being introduced for the recording of risks which will lead to changes in the way the information in the report is presented. It is proposed that risks with a score of 15 or 16 are monitored by an Executive Director or an appropriate Committee. When risks are elevated, such as with ED performance, to a sore of 20 a review is undertaken to explore the reasons for the elevation. A similar exercise is undertaken when risks with a score of 20 are elevated to 25. This process strengthens our response to risks. These proposals will be presented to Trust Management Team for approval.

RESOLVED: That the report be noted

AS left the meeting

047/16 TRANSITION PLANNING FOR EXTERNAL AUDITORS

The Chair asked for a timetable for formal meetings between the Trust and KPMG to be arranged. **SS**

Attendees noted that GT will make all their files available to KPMG when they become the Trusts external auditors in June.

RESOLVED: That the verbal discussion be noted.

048/16 REVIEW OF THE AUDIT SELF-ASSESSMENT CHECKLIST

The Chair presented the paper to attendees for comment. It was noted that Non-Executive Directors would need to have a discussion to ensure linkage between the Audit Committee and Quality Committee to provide assurance around clinical audit processes and management actions arising from clinical audits.

RESOLVED: That the report be noted.

049/16 REVISED AUDIT COMMITTEE WORKPLAN 2016

Attendees noted the updated workplan , agreeing two reports to be presented to the next meeting of the Committee :

- Smartcare
- Security Management

RESOLVED: That the report be noted

050/16 COMMITTEE REFLECTION & DEVELOPMENT

Attendees discussed the number of meetings per year with a view to increase the number of meetings from 5 to 6 and also consider the day on which the Committee meets.

Attendees was agreed that it would be useful for amended reports to have a version control added to the documents as well as amendments to be made using track changes so that changes are clearly visible to attendees.

Non-Executive attendance at the September meeting was discussed as Mr Foster is unable to attend. The Trust Secretary advised that alternative non-executive director will attend the meeting to ensure a quorum.

RESOLVED: That the verbal discussion be noted

051/16 ANY OTHER BUSINESS

None.

052/16 DATE OF THE NEXT MEETING

Tuesday 6 September , 8.30am in the Boardroom at 1 College Lawn

Pre meet for members only – 8.15am

THE MEETING ENDED AT 12 Noon

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CHAIR

MAIN BOARD – JUNE 2016
REPORT OF THE CHIEF EXECUTIVE

1. Introduction

1.1 After what seems like a long induction period, I am delighted to have finally taken up my appointment as Chief Executive. I consider it a huge privilege to have been afforded the opportunity to lead such a strong organisation and will do my utmost to continue the very good work that Dr Harsent and the Board have embarked upon.

1.2 I have had a tremendous welcome from Trust staff and partners, and I am looking forward to working with the Board and wider team to address the challenges ahead. I am especially grateful to Helen Simpson for her leadership and oversight in recent weeks and to the executive team for the support they have given her.

2. National

2.1 Following agreement between the government and the British Medical Association (BMA) over the Junior Doctors contract, detailed work is underway to implement the new arrangements including rotas. The BMA are currently running national roadshows for junior doctors to explain the proposed contract in advance of a referendum, set to take place in the second half of June and which will publish the referendum result on the 6th July.

3. Regional

3.1 West of England Academic Health Science Network (WEAHSN) – I am pleased to have accepted the seat on the WEAHSN Board as the representative of acute Trusts in the region. I attended my first meeting of the Board in early June and a detailed briefing note on the business discussed is has been circulated to colleagues. A summary of activities undertaken in quarter 1, is attached at Annex A for your information.

4. Regulators

4.1 NHS Improvement and the Faculty of Improvement are launching an intensive “year of improvement” support for NHS Trusts and Foundation Trusts. The aim is to build on the good work going on across the NHS, share good practice and learn from others.

4.2 The CQC have published their new strategy for 2016 to 2021. This sets out the CQC vision for a more targeted, responsive and collaborative approach to regulation. The introduction to their new strategy is attached at Annex B for your information.

4.3 Ofsted and the Care Quality Commission will be in our hospitals, week commencing 13th June, to assess how effectively we fulfil our responsibilities to children and young people with special educational needs and/or disabilities (SEND). They will be inspecting how well our hospitals, the council and our partners work together to identify, assess and support children and young people with SEND.

5. Our Trust

5.1 Attendance continues to remain high. In May there were 11,854 attendances. This compares to 10,632 attendances for the same period the previous year (May 2015). This is a continuing trend.

5.2 At the time of writing this report, the annual staff awards are due to take place at the Hatherley Manor Hotel. Our annual Staff Awards are a key part of the Trust's commitment to celebrating the success of individuals and teams, and recognising best practice across all sites, departments and job roles. We know that there are many staff who go the extra mile, have done something extraordinary, perhaps come up with innovative ideas or simply make our Trust a more welcoming, caring and friendly place to work and be cared for. This year's ceremony has been brought forward to Thursday 16th June and I'd like to take this opportunity congratulate colleagues who have been short-listed for awards and thank them for their commitment to the Trust.

5.3 Fairview Outpatient Department at Cheltenham General Hospital has been fully refurbished and is now open to patients. The improvement work is a new chapter for eye care services. This modern outpatient facility has been funded by the Trust and supported by Norvartis Pharmaceuticals UK Ltd and charitable funding from the Gloucestershire Eye Therapy Trust. Professor Chilvers will officially open this new facility in the autumn.

5.4 NHS England has set a requirement on all health and social care systems to develop Strategic Transformation Plans (STPs) by the end of June 2016. The STP will be the single system wide plan for us and our partner organisations to develop a shared vision for Gloucester which addresses the individual and collective challenges we face. The geographical footprint for our plans is Gloucestershire, though working with partners across our county borders will be crucial in some areas. The STP for Gloucestershire is being led by the Accountable Officer of the Clinical Commissioning Group supported by senior leaders and clinicians from across the health and social healthcare system.

5.5 Fundraising – I am delighted to report that fundraising for our hospitals is gathering pace with many events scheduled. There are too many examples to list but to highlight just some of the activities that have or are taking place:

Wednesday 8th June – Midsummers Night's Dream at Over Barn – over 100 people enjoyed a hilarious evening with Rain or Shine Theatre Company

June – group of parents doing a fundraising cycle ride from Winchcombe to Holland to raise money for Paediatrics in GRH following treatment to their son in the Unit

2nd October – Walk for Wards at Cirencester Park – hoping to improve on the £7,000+ we raised at our inaugural walk last October. So far we have sponsorship for refreshments and goody bags. Everyone welcome.

5.6 This month's learning from complaints/concerns include:

You Said	**We did**
Patient wanted to know whether there was a way of telling how long the wait for treatment in ED was going to be.	Reception staff encouraged to advise patients how long they can expect to wait, when they present. Information screens to be put in the department which will show current waiting times for triage and to see a doctor.
Patient unhappy about lack of bedding on paediatric ward.	Extra bedding has been sourced and ordered including more pillows.

5.7 The following consultant has been appointed:

Anaesthetics & Intensive Care Medicine - Andrew Foo

5.8 **Signing and Sealing**

261 GHNHSFT, Sola Properties Limited, Markey Student Property Limited - Deed of Covenant in relation to Lease of Formal House, Formal Place, Southgate Street, Gloucester GL1 1TX

Deborah Lee
Chief Executive Officer

June 2016

Report from West of England Academic Health Science Network Board, 13 June 2016

1. Purpose

This is the twelfth quarterly report for the Boards of the member organisations of the West of England Academic Health Science Network.

Board papers are posted on our website www.weahsn.net for information.

2. Highlights of our work in Quarter 1 2016/17

We have had the usual busy start to the year and highlights include:

- We have launched our Primary Care Patient Safety Collaborative – with 16 GP practices drawn from across the West of England. We will work together on patient safety culture, quality improvement, incident reporting and lessons learnt
- Our acute trusts joined by Taunton and Somerset NHS Trust are keen to work together with us to implement the forthcoming national programme on a structured approach to hospital mortality review and to share best practice. Dr Kevin Stewart of the Royal College of Physicians addressed our launch workshop.
- "Design Together, Live Better 2" – our innovation crowd sourcing programme is underway following a highly successful launch event in Swindon attended by 55 people.
- Our Diabetes Digital coach test bed is underway. Over the next two years we will recruit 12,000 people with diabetes in the West of England and encourage them to use a variety of digital self-management tools to support their self-care.
- We have 52 Improvement Coaches currently in training drawn from 20 of our member organisations. The aim is to develop staff who already have skills in improvement science so that they can coach colleagues and lead quality improvement at work. The Improvement Coach training is being supplemented by masterclasses. The first one "The Habits of an Improver" was given by Bill Lucas. Watch the film here http://www.weahsn.net/news/the-habits-of-an-improver/
- In partnership with Avon Primary Care Research Collaborative and the NIHR Collaboration for Leadership in Applied Health Research and Care (NIHR CLAHRC west) we have developed online evidence and evaluation toolkits http://www.weahsn.net/what-we-do/using-evidence-based-healthcare/evidence-and-evaluation-toolkits/ We are offering training session on using the toolkits in every CCG.
- We have formed an Emergency Department Safety Collaborative to support rollout of the ED safety checklist across the West of England. We also held a master class on 25 April which was attended by 22 delegates from Emergency Departments across the country.

- Improving Medicines Safety on discharge from hospital - three of our acute trusts are using a system called PharmaOutcomes to notify community pharmacists when a patients medication has been changed in hospital so that waste can be avoided. We will go on to introduce medicines reviews which may reduce re-admissions to hospital.

3. Sustainability and transformation plans

The AHSN has allocated Anna Burhouse, Natasha Swinscoe and Deborah Evans to work with the Chief Executive leaders of the Sustainability and Transformation Plans for Gloucestershire, BNSSG and BaNES, Swindon and Wiltshire respectively. We are working with the STPs to define our support offer to each of them.

4. Annual Report 2015/16

Our Annual Report is out! Read it here. http://www.weahsn.net/who-we-are/reports/annual-report-2015-16/ The Year in Numbers is attached to this report.

5. Stakeholder survey

The second annual AHSN stakeholder survey is due to be released late June / early July. Last year we had over 120 responses; the highest amongst AHSNs and the most positive responses. This reflects the very strong engagement we have with all CCGs, NHS Trusts and social enterprises across the West of England and the strength of our partnerships.

This year's results will count towards our "re-licencing" for the five years so we will be looking forward to a very a strong response and will contact stakeholders once the timetable is confirmed

6. West of England Local Clinical Research Network

We are working ever more closely with the NIHR West of England Local Clinical Research Network whose job is to increase the numbers of patients enrolled in research trials.

We have a joint "Join Dementia Research" project through which we have recruited 1,500 West of England residents to take part in dementia studies.

Deborah Evans,
Managing Director
June 2016

The year in numbers

1,606

1,606 clinical and non-clinical staff took part in patient safety, informatics and quality improvement events on key themes, including sepsis, falls prevention, medicines optimisation, early warning score, and emergency laparotomy.

£2.1 million

Our new Diabetes Digital Coach Test Bed is receiving £1.65 million in funding from the Department of Health, with further funding from our partner companies taking the project value over £2 million.

6

Working with Royal United Hospitals Bath, the Health Foundation and Sheffield Microcoaching Academy, we have trained six local clinicians and managers in improving patient flow across three care pathways.

26

26 different organisations are actively involved in our Safer Care Through Early Warning Scores programme.

20

Up to 20 primary care practices are joining our new Primary Care Collaborative.

40,000

Since its launch, OpenPrescribing.net has attracted 40,000 visitors.

116

116 healthcare professionals have benefitted from advanced skills-based training to enhance leadership, patient safety and flow, innovation and evaluation.

85%

In our stakeholder survey, 85% of our members believe we are effective at building a culture of partnership and collaboration.

52

52 primary care practices in Gloucestershire are taking part in phase two of Don't Wait to Anticoagulate.

4

Four new websites were launched to support NHS commissioners and clinicians: OpenPrescribing, Don't Wait to Anticoagulate, Evaluation and Evidence Works.

291

We have given advice to 291 companies wanting to work with the health sector, providing 154 business assists.

£9.5 million

To date, we have helped secure £9.5 million in funding for SMEs for the development of innovative healthcare solutions.

133

133 atrial fibrillation (AF) patients are now being anticoagulated as a result of phase one of Don't Wait to Anticoagulate, which worked with 11 primary care practices over four months. Modelling shows this saved between five and seven strokes and up to £163,205.

100+

More than 100 people participated in the Design Together, Live Better project to share their ideas for new healthcare innovations.

1,400

Join Dementia Research recruited 1,400 people across the West of England in its launch year.

137,315

To date, 137,315 patients have benefited from having their Connecting Care record viewed by clinicians.

29

29 of our initiatives have influenced and informed national thinking and guidance.

West of England Academic Health Science Network

Care Quality Commission

Shaping the future

CQC's strategy for 2016 to 2021

CQC is the independent regulator of health and adult social care in England.
We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Enter

OUR STRATEGY AT A GLANCE

Our ambition for the next five years is

A more targeted, responsive and collaborative approach to regulation, so more people get high-quality care.

We will achieve this by focusing on four priorities

1. **Encourage improvement, innovation and sustainability in care**
2. **Deliver an intelligence-driven approach to regulation**
3. **Promote a single shared view of quality**
4. **Improve our efficiency and effectiveness**

We will know we have succeeded when

- **People trust and use our expert, independent judgements about the quality of care.**
- **People have confidence that we will identify good and poor care and that we will take action where necessary so their rights are protected.**
- **Organisations that deliver care improve quality as a result of our regulation.**
- **Organisations are encouraged to use resources as efficiently as possible to deliver high-quality care.**

READ OUR STRATEGY

Foreword

David Behan
Chief Executive

Peter Wyman
Chair

We have radically changed our approach to regulating health and social care services over the last three years. Soon we will have completed inspections of all the services we rate, providing a powerful baseline understanding of the quality of care in England. We ask the same five questions of every service – Is it safe? Is it effective? Is it caring? Is it responsive? Is it well-led? – and publish our findings and ratings. We know that our work is leading to better care – providers tell us our reports help identify areas for improvement, and we regularly see improvements when we re-inspect.

Over the next five years the health and social care sector will need to adapt, and we do not underestimate the challenges that services face. Demand for care has increased as more people live for longer with complex care needs, and there is strong pressure on services to control costs. Success will mean delivering the right quality outcomes within the resources available.

We know providers are committed to addressing these challenges. Services are innovating, using technology and new ways of working to deliver care that is more person-centred. We will do all we can to encourage improvement, but we cannot do this alone. Providers, professionals, staff, commissioners, funders and other regulators need to work together, with people who use services, their families and carers, towards a shared vision of high-quality care.

Our strategy has been developed based on what thousands of people, providers, staff and partners have told us and what we have learned from more than 22,000 inspections. It sets out an ambitious vision for a more targeted, responsive and collaborative approach to regulation, so that more people get high-quality care.

As we move into this period of change, we will have fewer resources to deliver our purpose – so we need to use them as effectively as possible. We will always stay committed to our purpose, role and statutory objectives as we enter the next five years with energy, determination and passion.

Introduction

Health and social care regulation makes a real and practical difference to people's lives. There needs to be a strong, independent regulator that will always act on the side of people who use services. Our new strategy describes how we will build on what we have learned so we can continue to improve what we do. We will keep fulfilling our purpose to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve.

What we know

CQC's purpose and role remain of critical importance. Our assessments and inspections tell us that there is still significant variation in quality across different sectors and between services in each sector. In particular we are concerned about safety, which remains a serious challenge for those we have rated inadequate. Our assessments also tell us that effective leadership is very important to providing high-quality care – the overwhelming majority of good and outstanding services also feature good or outstanding leadership.

We are working in a challenging context. Demand for care has increased as more people live for longer with complex care needs. There is also strong pressure on services to control costs. To help meet these challenges, services are changing the way they organise and deliver care, and our approach needs to evolve too. We need to develop our monitoring to make best use of available information, especially from the public, who can be our eyes and ears in services. We must adapt to new models of care and work with others to support services to improve, particularly those with poor quality. We need to become more efficient in our operations, and reduce the process requirements we put on those we regulate.

Our ambition for the next five years

We are building a unique baseline of knowledge that provides critical insights into the quality of care people are receiving and we will soon complete inspections of all the services we rate. When we have finished, the answer is not simply to start again, but to use what we have learned – and what people tell us – to target our inspections where poor care, or a change in quality, is more likely.

We will focus on four priorities to deliver our ambition:

1 Encourage improvement, innovation and sustainability in care – we will work with others to support improvement, adapt our approach as new care models develop, and publish new ratings of NHS trusts' and foundation trusts' use of resources.

2 Deliver an intelligence-driven approach to regulation – we will use our information from the public and providers more effectively to target our resources where the risk to the quality of care provided is greatest and to check where quality is improving, and we will introduce a more proportionate approach to registration.

3 Promote a single shared view of quality – we will work with others to agree a consistent approach to defining and measuring quality, collecting information from providers, and delivering a single vision of high-quality care.

4 Improve our efficiency and effectiveness – we will work more efficiently, achieving savings each year, and improving how we work with the public and providers.

Our new strategy sets out an ambitious vision for a more targeted, responsive and collaborative approach to regulation, so more people get high-quality care.

We have produced an accompanying document, *What our strategy means for the health and adult social care services we regulate*, that describes how we will regulate and encourage improvement in each sector. As we work towards achieving our ambition we will develop the detail of our plans with people who use services and their carers, providers, staff and partners. We will also address the risks and opportunities for equality and human rights as outlined in our *Equality and human rights impact analysis*. We will consult, where appropriate, on changes to our inspection approach, and measure and report on whether we have achieved our ambition (see page 19).

What will stay the same

- Our purpose, role and operating model – inspections will continue to be central to our assessments of quality.
- Our work with the public to understand and focus on what matters to people.
- Our role in protecting and promoting equality and human rights, including for people being cared for under the Mental Health Act or the Mental Capacity Act Deprivation of Liberty Safeguards.

What will be different

We will develop our approach so that we:

- Put more of our resources into assessing the quality of care for services with poor ratings and those whose rating is likely to change, and less on those where care quality is good and likely to remain so.
- Better monitor changes in quality by bringing together what people who use services are telling us, knowledge from our inspections, and data from our partners.
- Make more use of unannounced inspections focused on the areas where our insight suggests risk is greatest or quality is improving – with ratings updated where we find changes.
- Have a more robust registration approach for higher-risk applications and a more streamlined approach for those that are low-risk.
- Focus more on the quality of care that specific population groups experience and how well care is coordinated across organisations.
- Learn alongside providers who offer new care models or use new technologies, to encourage innovation by flexibly and effectively registering and inspecting such new models.
- Develop a shared data set with partners, other regulators and commissioners, so providers are only asked for information about care quality once.
- Use online processes as the default to make interactions with providers and the public easy and efficient.
- Introduce new ratings of how well NHS trusts are using their resources to deliver high-quality care.

PRIORITY 1

Encourage improvement, innovation and sustainability in care

What we know

People's health and social care needs are increasing and changing, and there are limited resources to meet those needs. Some providers have found they cannot deliver services in the same way. Boundaries between hospital care, primary care, community care and adult social care services are blurring as providers look to new models and technology to efficiently deliver person-centred care.

There is a growing awareness that for care to be sustainable and meet people's needs, improvements have to be led by providers and commissioners, and planned across local areas with local communities. Across health and adult social care, local areas are developing plans, including through devolution, guided by the *Five Year Forward View*.

We expect to see some radical innovation and change, while some services will stay the same.

What we will do

We will continue to look for good care as well as poor care, and highlight examples of good practice and innovation, to enable learning and encourage improvement. We will do more to assess quality for population groups and how well care is coordinated across organisations, through our provider inspections and our thematic work. We will adapt our approach so we can effectively register and inspect providers who have new and innovative care models. With NHS Improvement, we will begin publishing ratings of how well NHS trusts and foundation trusts are using their resources to deliver high-quality care.

Learn how we will do it

How we will do it

When we register services, we will:

- Use a flexible approach that supports new ways of providing health and care, such as integrated care that cuts across organisational boundaries.
- Make sure that the person ultimately responsible for care can be held accountable for quality, for example registering a provider at a corporate level if it delivers care through subsidiary providers.

When we monitor quality, we will:

- Work more effectively to share information about how quality is changing locally, regionally and nationally. We will work with the Healthwatch network and other organisations that represent the public, with commissioners through our overview and scrutiny work, and with the Sustainability and Transformation Plan process.
- Use our information on a geographical basis to identify quality priorities and risks for local areas.
- Continue to use our market oversight function to monitor the financial health of difficult-to-replace adult social care providers.

When we inspect services, we will:

- Continue to encourage improvement by sharing what providers are doing well, and monitoring the impact our approach has on providers and staff, including incentives for improvement.
- Strengthen our assessment of how well providers work with others to share information and coordinate care.
- Assess how well providers deliver care for specific populations groups, for example whether end of life care is meeting the needs of different groups.
- Build our capability to inspect new models of care, such as care that is organised around conditions or population groups, or where hospitals, GP practices and care homes work together to deliver care.
- Make the most effective and efficient use of Experts by Experience to make sure we hear the views of people who use services and their families, and make clear how they have informed our judgements and ratings.

When we rate services, we will:

- Continue to publish ratings, incentivising providers to improve and recognising those who deliver high-quality care.
- Make our ratings available by area to inform planning and improvement.
- Work with NHS Improvement to publish ratings for NHS trusts and foundation trusts on how efficiently and effectively they use their resources.

When we need to enforce, we will:

- Inform and work closely with local organisations when we consider closing services, to ensure people can continue accessing their care.

When we use our independent voice, we will:

- Publish examples of good practice and innovative care to encourage improvement, for example through our *State of Care* report to Parliament.
- Continue producing national reports that support improvement by highlighting care quality for different population groups and pathways of care, such as *Right here, right now* our mental health crisis care review.
- Begin to publish estimates of the populations covered by good and outstanding care, to further encourage improvement.

PRIORITY 2

Deliver an intelligence-driven approach to regulation

What we know

We have powerful insights into the quality of health and social care and when we complete our comprehensive inspections we will be even clearer about the data that tells us most about quality. Technology has made it easier for people to leave instant feedback about services, and new tools to analyse data are constantly evolving. We are seeing this change across the health and care system, but there is more we can do to improve how we use and capture the views and experiences of people.

Inspections are critical to our work, as the factors affecting quality cannot be assessed from data alone. By bringing together information from people who use services and their carers, knowledge from our inspections, and data from our partners, we will be better equipped to monitor changes in quality.

What we will do

We will build a new insight model that monitors quality. We will inspect all new services, but then focus our follow-up inspections on areas where our insight suggests risk is greatest or quality is improving. We will update ratings where we find changes. By targeting our inspections, we will recognise improvement, and identify and act on poor care. We will make more use of unannounced inspections and focus on building a shared understanding of the local context and the quality of services between inspectors, providers and partners. When we register new services, we will look at risk levels and be flexible in our approach.

Learn how we will do it

How we will do it

When we register services, we will:

- Take a more robust approach for higher-risk applications and a more streamlined approach for those that are lower-risk, for example by considering the track record of a provider and who will be using the service.
- Strengthen the link with inspection by sharing information more effectively.
- Move all our interactions with providers online.

When we monitor quality, we will:

- Look at potential changes in quality by bringing together relevant information about a provider – our new insight model.
- Find new and better ways to encourage the public to tell us about their care and improve how we monitor, analyse and respond to their information.
- Use our insight model to make decisions about what action to take, such as responsive inspections triggered by information that highlights concerns or suggests quality has improved.
- Publish information about services so the public can access this between inspections.

When we inspect services, we will:

- Inspect all services that have not yet had a comprehensive inspection or who are newly registered with us.
- Continue to assess how well services meet the needs of those who may be more vulnerable due to their circumstances, including people being cared for under the Mental Health Act or the Mental Capacity Act Deprivation of Liberty Safeguards.
- Continue to inspect all services using a tailored approach driven by the data we gather and what people tell us.
- Change the frequency of re-inspections so that services rated good and outstanding are inspected less often than those that require improvement or are inadequate, for example moving to maximum intervals of five years for inspections of good and outstanding GP practices.
- Use the information we have about a service to focus our inspections on specific areas – such as maternity care – rather than the whole provider.
- Make more use of unannounced inspections in all sectors.
- Build an in-depth and shared understanding of the local context and the quality of services with inspectors, providers and partners.

When we rate services, we will:

- Update ratings on the basis of both comprehensive and focused inspections, for example we may inspect and rate a whole hospital or focus just on one or two core services.
- Publish ratings alongside shorter reports that make clear how we have come to our decisions.

When we need to enforce, we will:

- Continue to use the full range of our enforcement powers, such as restrictions or closure of services, fixed penalty notices or prosecution where we find poor care below the fundamental standards, to make sure people's rights are protected and those responsible are held to account.

PRIORITY 3

Promote a single shared view of quality

What we know

Care providers and other oversight bodies have welcomed the introduction of a clear way of assessing quality around the five key questions that we ask of every service: Is it safe? Is it effective? Is it caring? Is it responsive? Is it well-led? Some providers have aligned their governance processes around these questions. However, multiple definitions of care quality are still being used and we do not always make the best use of the information that services give us. As a result, providers are committing resources to meeting different information requests.

We know that regulation alone cannot improve quality, but requires the combined efforts of providers, professionals and staff, commissioners and funders, and regulatory bodies, all listening to the views of people who use services and their carers and working towards a single vision of high-quality care.

What we will do

We will work with our partners, providers and the public to agree a definition of quality and how this should be measured based on the five key questions. We will strengthen relationships with our partners to encourage improvement, and work towards a shared data set so that providers are only asked for information once. We will encourage providers to develop their own quality assurance based on the five key questions and to share this with us as part of an ongoing conversation about quality. We cannot achieve a single shared view of quality alone and we invite our partners to join us in delivering this ambition.

Learn how we will do it

How we will do it

When we register care services, we will:

- Improve the way we request information by using a consistent framework based around our five key questions.
- Work with newly registered services to embed the key questions at the heart of their understanding of high-quality care.

When we monitor care quality, we will:

- Work with providers and other system partners to make sure quality is measured transparently and consistently.
- Improve mechanisms for services to share information, including moving all transactions with them online.
- Develop systems for providers to make ongoing updates to information about their services – so we have an open flow of information in both directions.
- Expect providers to describe their own quality against our five key questions, including what has changed, their plans for improvement, and examples of good practice as part of annual reporting processes.
- Make use of relevant standards, such as National Institute for Health and Care Excellence (NICE) guidance, when defining what good quality care looks like.
- Share our monitoring data with partners to improve efficiency and reduce duplicate requests for information from services.

When we inspect services, we will:

- Build ongoing relationships between providers and CQC to have transparent conversations about care quality.
- Use information submitted by providers and from people who use services and their carers to inform what to inspect and where to inspect, but never use this alone to make a judgement about quality.
- Work with local partners to support services to improve after inspection, for example making sure the Healthwatch network is part of quality summits that follow inspections.

When we need to enforce, we will:

- Work closely with others to share information and align actions taken against services providing poor quality care.
- Make it clear how our enforcement against the fundamental standards relates to concerns under the five key questions.

When we use our independent voice, we will:

- Make sure that we put the five key questions at the heart of how we report quality issues.

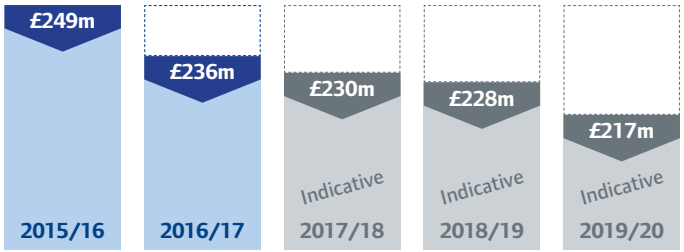
PRIORITY 4

Improve our efficiency and effectiveness

What we know

Our overall budget will reduce by £32 million by 2019/20, so we need to deliver our purpose with fewer resources. At the same time, the main source of our funding is switching from the Department of Health to fees paid by providers. We have a responsibility to use our resources as efficiently as possible, to make sure we deliver value for money for taxpayers and providers. The commitment of our staff has been critical to delivering our registration and inspection programme over the last three years and will continue to be fundamental to delivering our purpose, building on the foundations we have in place, and helping us to find innovative cost-saving measures.

CQC budget levels, 2015/16 to 2019/20



What we will do

We will work to keep our costs as low as possible as well as minimising the process requirements we have of providers. We will work more efficiently, delivering savings each year as identified in our business plans, to be a more effective regulator with a lower cost base by 2019/20. This means delivering a workforce strategy that ensures we have recruited, trained and retained the right level of skilled and expert staff. We will invest in our systems and in time-saving and online processes, so that we can improve how we work with the public and providers. We will continue to learn, share best practice, and

Learn how we will do it

collaborate with other regulators in the UK and internationally. And we will continue to regularly assess and report on our value for money to understand the impact of the changes we make on providers and partners.

How we will do it

We will develop our people by:

- Continuing to recruit the right people at the right time and developing the skills and knowledge of all employees through effective and tailored training programmes.
- Continuing to embed our values – excellence, caring, integrity, teamwork – to maintain and improve the culture we have worked hard to build.
- Promoting equality and celebrating diversity to get the best from our people and to ensure we are well-placed to identify equality issues when we monitor and inspect services.

We will ensure that we have the right systems and tools in place for our people and providers by:

- Building and improving quick and efficient systems for providers to submit information – such as our online provider portal.
- Improving the ways we make information available to the public, for example our website.
- Developing tools to support our regulatory activities and manage our resources – such as the national resource planning tool, which will improve how we schedule inspections.
- Supporting our people with the technology they need to work effectively and efficiently – for example by improving our IT infrastructure, our intranet and our flexible working.

We will save time and reduce bureaucracy by:

- Producing shorter, more consistent inspection reports more quickly.
- Removing and improving registration processes that are no longer required or are overly detailed.
- Continuing our work with partners to consider the impact of our regulation on business, including the Focus on Enforcement and Cutting Red Tape reviews for adult social care, the new Business Impact Target, and innovation and growth duties.

We will be more efficient by:

- Ensuring we are getting good value for money when we buy goods and services.
- Making the best use of the skills we have to deliver what we need.
- Ensuring we have robust financial management and reporting in place, with clear accountability and effective monitoring and escalation of risk.

What this strategy means for people who use services

We always act on the side of people who use services to make sure they get the right quality of care. Our strategy is clear that we will continue to work with the public to focus on what matters to people, to listen and act on people's views and experiences of care, and to protect people's rights, especially people in the most vulnerable circumstances. We will keep building public trust in our work and understanding of our role and purpose. And we will make sure people understand the quality of care they should expect and how to choose between local services. People will notice some changes as a result of this strategy, including:

- More information about the quality of services, that is easy for people to use and understand, and is up-to-date and available in-between inspections.
- Information from inspection that is accessible and available to the public more quickly after inspections.
- Better access to consistent and clear information about what quality care looks like – a single shared view of quality.
- Better use of information from the public to help us spot problems quickly, so we can prevent poor care and abuse happening to others in the future, and to celebrate improvements.
- Better customer service and online communications
- Close working with the Healthwatch network and our partners to hear about people's experience of care.
- More information in our reports on how well services deliver care for specific population groups, such as people with mental health needs in an acute hospital, and how new care models affect quality.
- New ratings of how well NHS trusts and foundation trusts are using their resources to deliver high-quality care.

We will renew and publish our Public Engagement Strategy towards the end of 2016.

Achieving our ambition together

We have set out a strategy for a more targeted, responsive and collaborative approach to regulation that ensures we continue to fulfil our purpose. We cannot do this alone and we will work closely with others to deliver our shared goal – that more people get high-quality care.

Our business plan each year will detail what we need to do to achieve our ambition over the five years of the strategy. For 2016/17, we will inspect, and where appropriate rate, all remaining services and locations at the same time as developing our approach. Changes to our inspections will come into effect from the start of 2017/18.

Over the course of the five years, we will improve our efficiency and effectiveness and develop new ways of working to adapt to the changes in the health and care sector.

We will work closely with the public, providers and our partners to develop our detailed plans for each sector we regulate, building on the approach set out in this strategy and the accompanying document, *What our strategy means for the health and adult social care services we regulate*. We will use a set of measures to check our progress and know when we have succeeded.

Working together

The **public and people who use services** have a crucial role to play in improving quality by sharing their experiences of care and speaking out when it needs to improve. We will:

- Co-produce our plans with people who use services, their carers and representative organisations.
- Work with the Healthwatch network, advocacy organisations and the voluntary and community sector to encourage people to share their experiences with us.

- Always speak to people who use services, their families and carers as part of our inspections.
- Make better use of people's experiences and views in our monitoring, inspections and ratings, including the expertise of Experts by Experience on our inspections.
- Build a culture that values public engagement throughout our work and equip our inspection teams to engage the public, and organisations that represent them, as part of our inspections and monitoring work.

Health and social care professionals and staff are the main drivers of innovation and improvement in the care that people receive. We will:

- Co-produce our approach with professionals and staff, and work with professional bodies.
- Involve professionals and staff in our inspections as specialist professional advisors.
- Always speak to staff as part of our inspections through focus groups and interviews.
- Draw directly on the expertise of our national professional advisors to inform our approach.
- Work closely with the National Freedom to Speak Up Guardian to support a culture of openness in the NHS, so that the concerns of staff are valued, encouraged, listened to and acted on.

Providers themselves must take responsibility for the quality of their services and drive continuous improvement and sustainable change. We will:

- Be responsive and make it as easy as possible for providers to work with us, for example through online systems.
- Co-produce our approach with providers, including through their trade associations and representative bodies.
- Reduce process requirements by streamlining data requests.
- Work together to encourage improvement at all levels, as well as holding services to account for the quality of care they deliver.

National regulators, oversight bodies and commissioners need to work to a single shared goal of high-quality care for people who use services. We will:

- Work through the National Quality Board and with leaders in the adult social care sector to agree and implement a single framework for defining and measuring quality.
- Contribute to the shared plans for delivering the *Five Year Forward View*.
- Continue to work with strategic partners, to ensure we are able to share information about risk quickly and effectively and work together efficiently.
- Work with NHS Improvement to develop a single view of success for NHS trusts and foundation trusts.

- Continue to work through the Future of Dental Regulation Programme Board to improve the system-wide approach to dental regulation.
- Build on the joint statement of intent with NHS England and the General Medical Council to improve how the system works with general practice by establishing a Future of General Practice Regulation Programme Board.
- Work with the Association of Directors of Adult Social Services and NHS England to find ways of creating greater consistency in how CQC, local authorities and clinical commissioning groups collect information from adult social care providers.
- Continue our current approach to joint inspections, such as the multi-agency work with HMI Prisons, HMI Constabulary, Ofsted and HMI Probation for children's services and in the criminal justice system, and look for opportunities to develop future joint inspection programmes.

Our measures for 2016 to 2021

In order to know whether we have achieved our ambition, we will need to measure how we are doing. We will keep these measures under review.

How we will measure whether we have achieved our ambition	
People trust and use our expert, independent judgements about the quality of care.	**Measure 1:** People reading our reports say they help them make choices.
	Measure 2: People tell us they trust that CQC is on the side of people who use services.
People have confidence that we will identify good and poor care and that we will take action where necessary so their rights are protected.	**Measure 1:** The number of newly registered services where a regulatory response is required.
	Measure 2: The range of ratings across all four rating categories (outstanding, good, requires improvement and inadequate).
	Measure 3: The number of services that are removed from the market where they fail to improve following enforcement action.
Organisations that deliver care improve quality as a result of our regulation.	**Measure 1:** The number of services that agree our standards, guidance and reports and inspections help them to improve.
	Measure 2: The number of services rated inadequate or requires improvement that improve on re-inspection.
Organisations are encouraged to use resources as efficiently as possible to deliver high-quality care.	**Measure 1:** (starting from 2017/18) The number of NHS trusts and foundation trusts that agree that the assessments and ratings we publish with NHS Improvement help them to improve the efficiency with which they use resources.
	Measure 2: (starting from 2017/18) The number of NHS trusts and foundation trusts rated inadequate or requires improvement for the efficiency with which they use resources that improve on re-inspection.

About CQC

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation.

Caring – treating everyone with dignity and respect.

Integrity – doing the right thing.

Teamwork – learning from each other to be the best we can.

Our statutory objectives

Our strategy is based on our main statutory objectives, which remain the guiding reason for doing what we do. These are: to protect and promote the health, safety and welfare of people who use health and social care services by encouraging improvement of those services; encouraging the provision of those services in a way that focuses on the needs and experiences of people who use those services; and encouraging the efficient and effective use of resources in the provision of those services.

How to contact us

Call us on **03000 616161**
Email us at **enquiries@cqc.org.uk**
Look at our website **www.cqc.org.uk**

Write to us at **Care Quality Commission**
Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA

Follow us on **Twitter @CareQualityComm**

Read more and download this report in other formats at **www.cqc.org.uk/ourstrategy**

Please contact us if you would like this report in another language or format.

CQC-318-1400-WL-052016

INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK

EXECUTIVE SUMMARY

TRUST BOARD – JUNE 2016

1.0 INTRODUCTION

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

2.0 PERFORMANCE AGAINST RECOVERY TRAJECTORIES

This month the Trust has met the four trajectories that it is required to meet in order to demonstrate improvement and to access the Strategic Transformation Fund.

3.0 KEY HIGHLIGHTS ON PERFORMANCE

3.1 ARE WE SAFE?

- The Trust is performing well in all of these indicators with the exception of the percentage of patients seen by a midwife by 12 weeks gestation which is 2.3% below plan. This is thought to be due to the high level of new midwives resulting in an increased amount of errors being made when recording dates and this is being addressed.

- There have been no post 48 hour cases of MRSA in May 2016; however, there was one case in April 2016 against a target of 0.

- Dementia case finding has achieved the 86% national target for April and May, at 86.5% and 87.3%, respectively.

3.2 ARE WE RESPONSIVE?

- The 95% 4 hour target for Emergency Department performance was not successfully met in May 2016, with Trust wide performance reported as 87.4%. Cheltenham achieved the 95% standard in May but Gloucester did not. There has been an upward trend of improvement compared to the previous four months and particularly compared to March 2016 when the performance was 77.7%. The Trust did meet the agreed improvement trajectory which was 85%.

- The Trust has met the 18 Week RTT standard in May and the Sustainability and Transformation plan overall at Trust level for incomplete pathways as it has done each month in 2015/16. This is despite GP referrals continuing to run at higher levels than last year, at 12.7% greater in April and 9.5% greater in May.

- In May the number of patients waiting over six weeks for a key diagnostic test continues to not achieve the 1% month end target, at 1.3%. This is due to capacity issues in MRI. Action plans have been agreed with our Clinical Divisions.

- The volume of planned / surveillance endoscopy patients waiting at month end continues to rise and not achieve the 1% waiting at month end. Volumes have risen from 308 patients in April to 340 patients in May.

- The Cancer two week wait standard has not been met in April. Actions plans are in place.

- The Trust did not meet the recovery trajectory for the 62 day cancer standard in April and is not expected, in the action plan, to do so until September. It did; however, meet the STP trajectory of 77.17%. The trajectory is under constant review due to ongoing capacity issues in Urology.

3.3 ARE WE EFFECTIVE?

- At 89.0%, the percentage of stroke patients spending time on a stroke ward exceeded the target of 80% in May.

- The number of delayed discharges (12) at month end achieved the target of 14 patients at the end of May. This is an improvement on the 24 delayed discharges waiting at the end of April. However, the number of medically fit patients (62) remaining in a hospital bed continues to run at high levels and above agreed system wide standards. This inability to discharge has impacted on our performance.

- The length of stay for general and acute elective inpatient spells has achieved the 3.4 days standard in April and May, at 3.0 days and 3.4 days, respectively.

- Throughout 2015/16 the Trust continually achieved the 99% standards for records submitted nationally with a valid GP code and with a valid NHS number.

3.4 ARE WE WELL LED?

- The percentage of staff who have completed their mandatory training has exceeded the Trust's target each month this financial year, at 91% for April and 92% for May 2016.

RECOMMENDATIONS

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

Author: **Eric Gatling, Director of Service Delivery & Chloe de Jong, Corporate Information Manager**

Presenting Director: **Helen Simpson, Deputy Chief Executive & Executive Director of Finance**

Date: **June 2016**

Gloucestershire Hospitals NHS
NHS Foundation Trust

PERFORMANCE MANAGEMENT FRAMEWORK

2016/17

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TRUST OVERVIEW

May 2016

ARE WE SAFE?

	Last 3 mths	Now	Next 3 mths	Management Priority	Forecast status
Infection	🔴	🟢	🟢	Minor	Stable
Mortality	🟢	🟢	🟢	Excellent	Stable
Safety	🟢	🟢	🟢	Moderate	Stable

ARE WE RESPONSIVE?

	Last 3 mths	Now	Next 3 mths	Management Priority	Forecast status
Emergency Department	🔴	🔴	🔴	Significant	At Risk
18 weeks	🟢	🟢	🟢	Minor	Stable
Cancer	🔴	🟡	🟡	Significant	At Risk

ARE WE EFFECTIVE?

	Last 3 mths	Now	Next 3 mths	Management Priority	Forecast status
Clinical Operation	🔴	🔴	🔴	Moderate	At Risk
Business Operation	🔴	🔴	🟡	Moderate	Improving

ARE WE WELL LED?

	Last 3 mths	Now	Next 3 mths	Management Priority	Forecast status
Finanical Health	🟢	🟢	🟢	On Track	Stable
Workforce Health	🟡	🟡	🟡	Moderate	At Risk

Management Priority Definition

Significant	Significant interventions are planned or in progress due to one or more factors: an externally-reported metric is off-track; multiple internal metrics are off-track; qualitative experiences are raising significant concerns
Moderate	Moderate interventions are planned or in progress due to one or more factors: an important internal metric is off-track; qualitative experiences are raising concerns; future projections are
Minor	Some interventions are planned or in progress: stretch targets are off-track; trends are adverse; qualitative experiences suggest performance may be at risk
On Track	All areas within this theme on track
Excellent	Amongst top performers nationally, with internal stretch targets consistently met

Forecast Status Definition

At Risk	Expected to worsen by next reporting period
Stable	Not expected to change significantly by next reporting period
Improving	Expected to improve by next reporting period

ASSESSMENT AGAINST THE NHS IMPROVEMENT RISK ASSESSMENT FRAMEWORK

	Target	2014/15 Q1	2014/15 Q2	2014/15 Q3	2014/15 Q4	2015/16 Q1	2015/16 Q2	2015/16 Q3	2015/16 Q4	Mar	Apr	May	Monitor Weighting	Estimated Current Position for Q1
18 WEEKS														
Incomplete pathways - % waited under 18 weeks	92%	92.2%	92.0%	92.3%	92.1%	93.2%	92.0%	92.0%	92.1%	92.0%	92.1%	92.0%	1.0	
ED														
% patients spending 4 hours or less in ED	95%	93.3%	94.3%	89.5%	82.7%	93.4%	88.7%	85.6%	78.5%	77.7%	85.4%	87.4%	1.0	1.0
CANCER														
Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) %	85%	88.1%	86.1%	78.4%	77.1%	73.9%	75.6%	79.5%	76.7%	76.7%	78.2%		1.0	1.0
Max wait 62 days from national screening programme to 1st treatment %	90%	91.4%	97.1%	92.4%	91.3%	97.3%	94.0%	95.6%	94.9%	100%	91.7%			
Max wait 31 days decision to treat to subsequent treatment : surgery %	94%	99.0%	100%	100%	98.8%	100%	100%	99.5%	99.5%	100%	98.1%		1.0	
Max wait 31 days decision to treat to subsequent treatment : drugs %	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			
Max wait 31 days decision to treat to subsequent treatment : Radiotherapy %	94%	100%	98.6%	99.8%	100%	100%	100%	100%	100%	100%	100%			
Max wait 31 days decision to treat to treatment %	96%	99.6%	99.8%	99.5%	100%	99.5%	99.7%	100%	99.8%	99.3%	98.6%		1.0	
Max 2 week wait for patients urgently referred by GP %	93%	90.5%	94.1%	94.3%	88.8%	91.5%	90.3%	92.4%	88.7%	85.2%	77.7%		1.0	1.0
Max 2 week wait for patients referred with non cancer breast symptoms %	93%	66.1%	93.6%	96.6%	94.9%	95.2%	91.8%	93.4%	95.3%	96.6%	94.6%			
INFECTION CONTROL														
Number of Clostridium Difficile (C-Diff) infections - post 48 hours	37/yr	9	6	8	13	8	10	10	13	1	5	3	1.0	1.0

PERFORMANCE MONITORING AGAINST THE SUSTAINABILITY AND TRANSFORMATION PLAN

2016/17

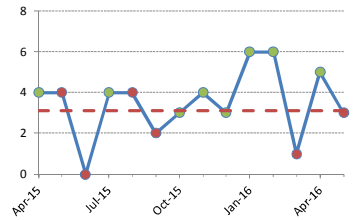
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
ED													
% patients spending 4 hours or less in ED	Trajectory	80.00%	85.00%	85.00%	87.00%	87.00%	91.90%	89.10%	91.20%	85.70%	85.10%	80.10%	89.60%
	Actual	85.44%	87.42%										
% patients spending 4 hours or less in ED (incl. Primary Care ED cases)	Trajectory	80.00%	85.00%	85.00%	87.00%	87.00%	91.90%	89.10%	91.20%	85.70%	85.10%	80.10%	89.60%
	Actual	85.70%	87.73%										
18 WEEKS													
Incomplete pathways - % waited under 18 weeks	Trajectory	92.02%	92.00%	92.01%	92.04%	92.04%	92.00%	92.00%	92.04%	92.01%	92.00%	92.00%	92.00%
	Actual	92.10%	92.01%										
DIAGNOSTICS													
15 key Diagnostic tests : % waiting over 6 weeks at month end	Trajectory	2.71%	2.16%	1.46%	0.99%	0.99%	0.99%	0.99%	0.94%	0.99%	0.98%	0.99%	0.99%
	Actual	5.1%	1.3%										
CANCER													
Cancer: Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) %	Trajectory	77.17%	80.37%	82.64%	82.91%	93.70%	85.31%	85.03%	85.19%	85.03%	85.00%	85.07%	85.62%
	Actual	78.2%											

TRUST PERFORMANCE & EXCEPTIONS (as at end May 2016)

ARE WE SAFE?

MEASURE	LAST 12 MTHS	ACTUAL Q1	Q2	Q3	Q4	Mar	Apr	May	FORECAST Jun	Jul	Aug	Sep	Oct	Nov	FoT	Standard	Target Set By	How often	Data Month
INFECTION																			
Number of Clostridium Difficile (C-Diff) infections - post 48 hours		8	10	10	13	1	5	3	2	0	2	3	3	3		37 cases/year	NHSI	M	May
Number of Methicillin-Resistant Staphylococcus Aureus (MRSA) infections - post 48 hours		0	0	2	1	0	1	0	0	0	0	0	0	0		0	GCCG	M	May
MORTALITY																			
Crude Mortality rates %		1.3%	1.0%	1.2%	1.4%	1.4%	1.3%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%		<2%	Trust	M	May
Summary Hospital-Level Mortality Indicator		109.9	109.7							1.1%			1.1%			≤1.1%	Trust	Q	Sep-15
HSMR (Analysis-relative risk-basket HSMR basket of 56-mortality in hospital) (rolling 12 months)		112.7	110.8	107.5														M	Feb
SMR (rolling 12 months)		111.6	110.3	108.0														M	Feb
SAFETY																			
Number of Never Events		0	1	1	0	0	0	0	0	0	0	0	0	0		0	GCCG	M	May
% women seen by midwife by 12 weeks		90.3%	90.0%	90.0%	89.6%	89.9%	85.8%	87.7%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%		>90%	GCCG	M	May
CQUINS																			
Acute Kidney Infection (AKI)		5%	19%	29%	50%	52%	56%		55.0%	55.0%	55.0%	55.0%	55.0%	55.0%		>90% by Q4	National	M	Apr
Sepsis Screening 2a		69%	83%	96%	90%	90%			90.0%	90.0%	90.0%	90.0%	90.0%	90.0%		>90% of eligibles	National	M	Mar
Sepsis Antibiotic Administration 2b			32%	43%	90%	90%			90.0%	90.0%	90.0%	90.0%	90.0%	90.0%		>90% of eligibles	National	M	Mar
Dementia - Seek/Assess		88.7%	89.3%	89.0%	86.9%	84.8%	86.5%	87.3%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%		Q1>86%; Q2>87%; Q3>88%; Q4>90%	National	M	May
Dementia - Investigate		100%	100%	100%	100%	100%	100%	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		Q1>86%; Q2>87%; Q3>88%; Q4>90%	National	M	May
Dementia - Refer		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		Q1>86%; Q2>87%; Q3>88%; Q4>90%	National	M	May
ED																			
% patients triaged in ED in 15 minutes			61.4%	57.9%	53.7%	53.2%	68.5%	78.9%								≥ 99%	Trust	M	May
% patients assessed by doctor in ED in 60 minutes			45.2%	44.7%	43.3%	41.1%	48.1%	47.2%								≥ 90%	Trust	M	May

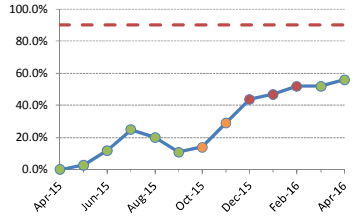
ARE WE SAFE?

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

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

Two of the three cases in May were unavoidable and will be appealed with the commissioners.

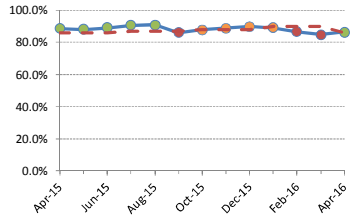
All cases have been revewed by root cause analysis to establish if cases are avoidable or unavoidable. All periods of increased incidence are investigated and ribotyped and action plans put in place. A summary of avoidable and unavoidable cases is discused monthly at the Infection Control Committee.

Acute Kidney Infection (AKI) Standard is >90% of 4 key items in discharge summaries Q4								Director of Safety

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

Project required creation of a new electronic recording process associated with the electronic discharge summary. Launched on July 1st with supporting briefings and education, through testing several changes have been made through the 2nd quarter. Forecast that results would steadily improve but in Sep/Oct there was a significant and unexpected fall. Further changes the results improved level to 44% in December. Negotiations are ongoing with the CCG to mediate any loss of income.

F2 Improvement Group supported by the academy and the clincal leads continue to evaluate & modify the systems in place. Actions include Peer teaching and demonstation of the system by the F2s of the infoflex system. Redesign of the infoflex system through user evaluation. Other actions include sharing results with Divisions and directly with consulants, SAS doctors and junior doctors. General awareness raising and screensavers. Target for the 4th quarter will be very difficult to achieve.

Dementia - Seek/Assess Standard is Q1>86%; Q2>87%; Q3>88%; Q4>90%								Director of Nursing

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

The target for Q4 was an average of 90%, this wasn't achived due to continued pressure on Juniors to report information on Rosterpro.

To improve the performance education activities are continuing as well as prompting of the Juniors.

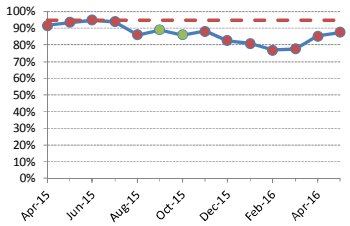
TRUST PERFORMANCE & EXCEPTIONS (as at end May 2016)

ARE WE RESPONSIVE?

MEASURE	LAST 12 MTHS	ACTUAL Q1	Q2	Q3	Q4	Mar	Apr	May	FORECAST Jun	Jul	Aug	Sep	Oct	Nov	FoT	Standard	Target Set By	How often	Data Month
ED																			
% patients spending 4 hours or less in ED		93.4%	88.7%	85.6%	78.5%	77.7%	85.4%	87.4%	85.0%	87.0%	87.0%	87.0%	90.0%	90.0%		≥ 95%	NHSI	M	May
Number of ambulance handovers delayed over 30 minutes		192	191	213	393	195	165	194	100	100	100	70	70	80		< previous year	GCCG	M	May
Number of ambulance handovers delayed over 60 minutes		13	21	28	33	12	3	0	7	7	7	10	10	10		< previous year	GCCG	M	May
18 WEEKS																			
Incomplete pathways - % waited under 18 weeks		93.2%	92.0%	92.0%	92.1%	92.0%	92.1%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%		≥ 92%	NHSI	M	Apr
15 key Diagnostic tests : % waiting over 6 weeks at month end		4.3%	5.1%	2.1%	4.0%	7.2%	5.1%	1.3%	1.5%	1.0%	1.0%	1.0%	1.0%	1.0%		<1% waiting at month end	GCCG	M	May
Planned/surveillance endoscopy patients - nos. waiting at month end with and without dates		400	341	142	225	225	308	340	200	200	250	200	200	150		< 1% waiting at month end	GCCG	M	May
CANCER																			
Max 2 week wait for patients urgently referred by GP %		91.5%	90.3%	92.4%	88.7%	85.2%	77.7%		93.0%	93.0%	93.0%	93.0%	93.0%	93.0%		≥ 93%	NHSI	M	Apr
Max 2 week wait for patients referred with non cancer breast symptoms %		95.2%	91.8%	93.4%	95.3%	96.6%	94.6%		95.0%	92.0%	92.0%	93.0%	93.0%	94.0%		≥ 93%	NHSI	M	Apr
Max wait 31 days decision to treat to treatment %		99.5%	99.7%	100%	99.8%	99.3%	98.6%		100%	100%	100%	100%	100%	100%		≥ 96%	NHSI	M	Apr
Max wait 31 days decision to treat to subsequent treatment : surgery %		100%	100%	99.5%	99.5%	100.0%	98.1%		100%	100%	100%	100%	100%	100%		≥ 94%	NHSI	M	Apr
Max wait 31 days decision to treat to subsequent treatment : drugs %		100%	100%	100%	100%	100.0%	100.0%		100%	100%	100%	100%	100%	100%		≥ 98%	NHSI	M	Apr
Max wait 31 days decision to treat to subsequent treatment : Radiotherapy %		100%	100%	100%	100%	100.0%	100.0%		100%	100%	100%	100%	100%	100%		≥ 94%	NHSI	M	Apr
Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) %		73.9%	75.6%	79.5%	76.7%	76.7%	78.2%		82.6%	83.0%	84.0%	85.0%	85.0%	85.0%		≥ 85%	NHSI	M	Apr
Max wait 62 days from national screening programme to 1st treatment %		97.3%	94.0%	95.6%	94.9%	100.0%	91.7%		92.0%	92.0%	92.0%	92.0%	92.0%	92.0%		≥ 90%	NHSI	M	Apr
Max wait 62 days from consultant upgrade to 1st treatment %		60.0%	92.9%	100%	100%	100.0%	- *		100%	100%	100%	100%	100%	100%		≥ 90%	NHSI	M	Apr

* Zero patients this month

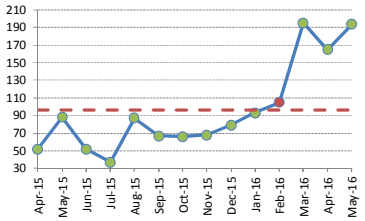
ARE WE RESPONSIVE?

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

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

Please refer to Emergency Pathway Report. Recovery plan in place.

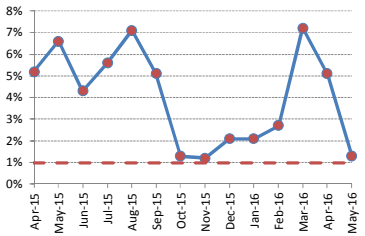
The trajectory for ED has been reviewed in conjunction with the NHSI sustainablity and transformation requirements. The trajectory for 2016/17 is: Q1 (85%); Q2 (87%), Q3 (90%) &; Q4 (90%)

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

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

Please refer to Emergency Pathway Report.

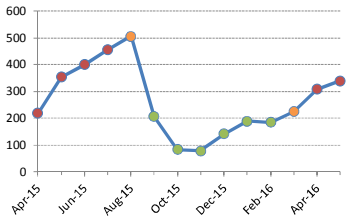
Also to note, South West Ambulance Service implemented a new computer aided dispatch system in April 2016. Joint work is ongoing between the Emergency Department and SWAST.

15 key Diagnostic tests : % waiting over 6 weeks at month end Standard is < 1% waiting at month end		🔴	🔴	🔴	🔴	🔴	🔴	Director of Service Delivery

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

109 patients of which MRI 54, Urodynamics 21, Echos 13, Flexi sigmoidoscopy 11, Cystoscopy 5, Colonoscopy 3, Audiology 1, Respiratory Physiology 1.

Recovery plans in place with Divisions to deliver the agreed trajectory.

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

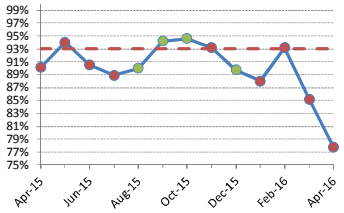
Commentary on what is driving the performance & what actions are being taken

Demand continues to increase, particularly for 2ww Endoscopy, which has impacted on capacity available.

Additional activity is being undertaken and discussions are underway with the surgeons to agree follow up protocols.

ARE WE RESPONSIVE?

MEASURE	QUARTERLY PROGRESS Q1	Q2	Q3	Q4	NOW	FOT	OWNER
Max 2 week wait for patients urgently referred by GP Standard is ≥93%							Director of Service Delivery



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

Referrals remain high. Urology contributed the largest number of breaches and agreement has been reached with an another provider to take routine referrals for urology from June, thereby freeing up capacity for increasing 2 week wait demand.

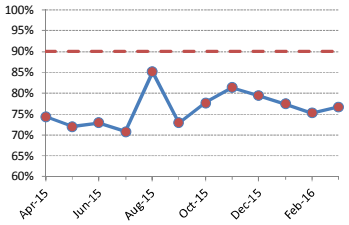
	April 16 (current)			Average treatments / month (rolling 12 months)
Target	Latest Position	Breaches	Treatments	
93%	77.7%	365	1639	1568

Acute leukaemia	100.0%	0	1	0
Brain / CNS	89.5%	2	19	20
Breast	96.6%	9	261	253
Gynaecological	84.1%	17	107	106
Haematological*	16.7%	5	6	7
Head & Neck	88.4%	22	190	162
Lower GI	84.2%	44	279	306
Lung	73.6%	14	53	48
Skin	90.3%	28	290	279
Testicular	20.0%	12	15	15
Upper GI	83.5%	33	200	184
Urological	17.9%	179	218	189

* Excludes acute leukaemia

Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers)
Standard is ≥85%

Director of Service Delivery



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

The position is in line with the Recovery Trajectory documented in the detailed cancer action plan prepared with help of Intensive Support Team. Progress to delivery of plan reviewed monthly at Cancer Services Managerment Group and Trust Management Team.

	April 16 (current)			Average treatments / month
Target	Latest Position	Breaches	Treatments	
85%	79.2%	33.5	161.0	148

Brain / CNS	100.0%	0.0	0.5	0
Breast	100.0%	0.0	25.5	25
Gynaecological	94.1%	0.5	8.5	10
Haematological*	33.3%	2.0	3.0	7
Head & Neck	52.9%	4.0	8.5	7
Lower GI	87.1%	2.0	15.5	17
Lung	71.4%	4.0	14.0	12
Other	55.6%	2.0	4.5	2
Sarcomas	100.0%	0.0	0.5	1
Skin	100.0%	0.0	29.0	28
Upper GI	90.6%	1.5	16.0	12
Urological	50.7%	17.5	35.5	27

* Excludes acute leukaemia
This position is the latest following the April submission and will be updated on the quarterly return

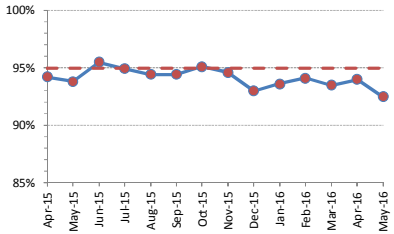
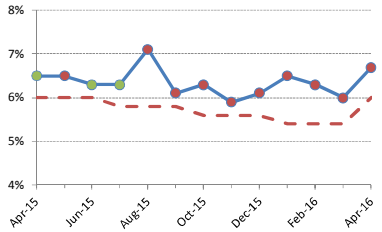
TRUST PERFORMANCE & EXCEPTIONS (as at end May 2016)

ARE WE EFFECTIVE?

MEASURE	LAST 12 MTHS	ACTUAL Q1	Q2	Q3	Q4	Mar	Apr	May	FORECAST Jun	Jul	Aug	Sep	Oct	Nov	FoT	Standard	Target Set By	How often	Data Month
CLINICAL OPERATION																			
% stroke patients spending 90% of time on stroke ward		80.4%	78.7%	91.4%	86.0%	84.0%	84.6%	89.0%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%		> 80%	GCCG	M	Apr
% of eligible patients with VTE risk assessment		94.5%	93.7%	93.3%	93.5%	93.5%	94.0%	92.5%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%		> 95%	GCCG	M	May
Emergency re-admissions within 30 days - elective & emergency		6.4%	6.4%	6.1%	6.4%	6.0%	6.7%		6.4%	6.4%	6.4%	6.4%	6.4%	6.4%		Q1<6%; Q2<5.8%; Q3<5.6%; Q4<5.4%	Trust	M	Apr
Number of Breaches of Mixed sex accommodation		0	0	17	30	19	12	0	0	0	0	0	2	0		0	GCCG	M	May
Number of delayed discharges at month end (DTOCs)		11	13	19	16	10	24	12	12	12	12	12	14	14		<14	Trust	M	May
No. of medically fit patients - over/day		46	47	41	60	61	71	62	55	55	55	55	55	55		≤ 40	Trust	M	May
Bed days occupied by medically fit patients		1,189	1,334	1,486	1,504	1,894	2,115	1,914	1,450	1,450	1,450	1,450	1,450	1,450		None	Trust	M	May
Patient Discharge Summaries sent to GP within 24 hours		87.7%	89.1%	88.6%	85.6%	88.0%	86.4%		88.5%	88.5%	88.5%	88.5%	88.5%	88.5%		≥85%	GCCG	M	Apr
BUSINESS OPERATION																			
Elective Patients cancelled on day of surgery for a non medical reason		1.1%	1.2%	1.3%	2.0%	1.6%	1.4%	1.7%								≤ 0.8%	Trust	M	May
Patients cancelled and not rebooked in 28 days		17	18	15	27	15	20	7								0%	GCCG	M	May
GP referrals year to date - within 2.5% of previous year		4.9%	4.4%	2.9%	3.7%	4.3%	12.7%	9.5%								range +2.5% to -2.5%	Trust	M	May
Elective spells year to date - within 2.5% of plan		-1.3%	5.1%	5.0%	7.3%	6.7%	*	*	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%		range ≥-1% to plan	Trust	M	Mar
Emergency Spells year to date - within 2.5% of plan		2.4%	4.0%	6.9%	7.1%	7.5%	*	*	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%		range ≤2.5% over plan	Trust	M	Mar
LOS for general and acute non elective spells		5.8	5.6	5.7	6.0	5.8	6.3	5.4	5.4	5.4	5.4	5.4	5.4	5.4		Q1 /Q2 <5.4days, Q3 /Q4 <5.8days	Trust	M	May
LOS for general and acute elective IP spells		3.6	3.6	3.6	3.6	3.7	3.0	3.4	3.4	3.4	3.4	3.4	3.5	3.6		≤ 3.4 days	Trust	M	May
OP attendance & procedures year to date - within 2.5% of plan		-0.5%	0.6%	0.6%		0.2%	*		0.2%	0.2%	0.2%	0.2%	0.2%	0.2%		range +2.5% to -2.5%	Trust	M	Mar
Records submitted nationally with valid GP code (%)		100%	100%	100%	99.9%	99.9%			100%	100%	100%	100%	100%	100%		≥ 99%	Trust	M	Mar
Records submitted nationally with valid NHS number (%)		99.8%	99.7%	99.7%	99.8%	99.8%			99.6%	99.6%	99.6%	99.6%	99.6%	99.6%		≥ 99%	Trust	M	Mar

* Plan to be finalised end of June 2016

ARE WE EFFECTIVE?

MEASURE		QUARTERLY PROGRESS Q1	Q2	Q3	Q4	NOW	FOT	OWNER
% of eligible patients with VTE risk assessment Standard is >95%								Trust Medical Director
Emergency re-admissions within 30 days - elective & emergency Standard is Q1<6%; Q2<5.8%; Q3<5.6%; Q4<5.4%								Trust Medical Director

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

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

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

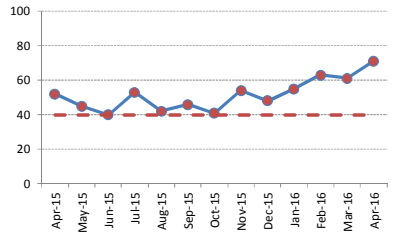
In addition the VTE committee will initiate a ward by ward review of performance and visit areas to identify improvement.

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

The emergency re-admission rate has been relatively constant this financial year.

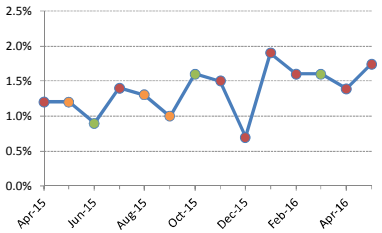
This is continuing to be reviewed by the Emergency Care board.

ARE WE EFFECTIVE?

MEASURE		QUARTERLY PROGRESS Q1	Q2	Q3	Q4	NOW	FOT	OWNER
No. of medically fit patients - over/day Standard is <40								Director of Service Delivery

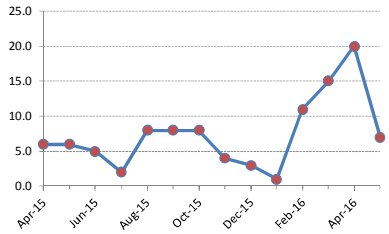
Commentary on what is driving the performance & what actions are being taken

Please refer to Emergency Care Report.

Elective Patients cancelled on day of surgery for a non medical reason Standard is <0.8%								Director of Service Delivery

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

The increase in the number of medically fit patients and level of emergency admissions inpacted on this measure. The Surgical Division focus has been adjusted to reduce the number of cancellations on the day with a process established to review all elective activity daily.

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

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

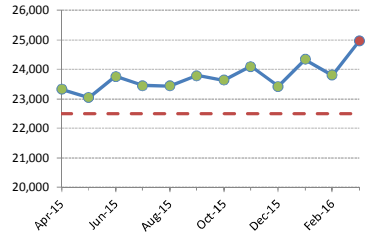
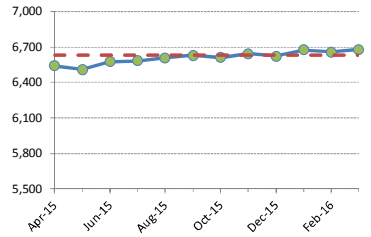
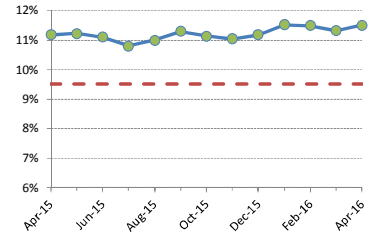
This is an improving position and performance managed daily, although some patients choose to wait longer than 28 days.

TRUST PERFORMANCE & EXCEPTIONS (as at end May 2016)

ARE WE WELL LED?

MEASURE	LAST 12 MTHS	ACTUAL Q1	Q2	Q3	Q4	Mar	Apr	May	FORECAST Jun	Jul	Aug	Sep	Oct	Nov	FoT	Standard	Target Set By	How often	Data Month
FINANCIAL HEALTH																			
NHSI Financial Risk Rating		3	3	3	3	3			3	3	3	3	3	3		Level 3	NHSI	M	Mar
Achieve planned Income & Expenditure position at year end		-£1.4m	-£1.6m	-£1.6m	-£1.6m	-£1.6m			£18.2m	£18.2m	£18.2m	£18.2m	£18.2m	£18.2m		Achieved or better at year end	NHSI	M	Mar
Total PayBill spend £M		£23.8m	£23.8m	£23.4m	£24.3m	£24.9m			£25m	£25m	£25m	£25m	£25m	£25m		Target + 0.5%	Trust	M	Mar
Total worked WTE		6,576	6,628	6,623	6,670	6,677			6,687	6,687	6,687	6,687	6,688	6,688		Target + 0.5%	Trust	M	Mar
WORKFORCE HEALTH																			
Annual sickness absence rate (%)		3.8%	3.8%	3.8%	3.8%	3.5%	3.5%		3.8%	3.7%	3.7%	3.7%	3.7%	3.7%		< 3.5	Trust	M	Apr
Turnover rate (FTE)		11.2%	11.3%	11.1%	11.7%	11.6%	11.6%		10.5%	10.5%	10.5%	10.5%	10.5%	10.5%		7.5-9.5%	Trust	M	Apr
Staff who have annual appraisal (%)		85%	83%	83%	83%	83%	84%	83%	86%	87%	87%	87%	87%	87%		> 90%	Trust	M	May
Staff having well structured appraisals in last 12 months (staff survey, on a 5 point scale)		38%	38%	38%	38%	3.0	3.0	3.0	3.1	3.1	3.1	3.1	3.1	3.1		> 3.8	Trust	A	May
Staff who completed mandatory training (%)		92%	92%	91%	91%	91%	91%	92%	90%	90%	90%	90%	90%	90%		> 90%	Trust	M	May
Staff Engagement indicator (measured by the annual staff survey on a 5 point scale)		3.66	3.66	3.66	3.69	3.71	3.71	3.71	3.8	3.8	3.8	3.8	3.8	3.8		> 3.8	Trust	A	May
Improve communication between senior managers & staff (staff survey) (%)		35%	35%	35%	34%	34%	34%	34%								> 38%	Trust	A	May

ARE WE WELL LED?

MEASURE		QUARTERLY PROGRESS Q1	Q2	Q3	Q4	NOW	FOT	OWNER
Total PayBill spend £M Standard is Target + 0.5%		🔴	🔴	🔴	🔴	🔴	🔴	Director of Finance
Total worked WTE Standard is Target + 0.5%		🟢	🔴	🟢	🔴	🔴	🔴	Director of Service Delivery
Turnover rate (FTE) Standard is Target 7.5% - 9.5%		🟡	🟡	🟡	🟡	🔴	🔴	Director of HR

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

The paybill remains an issue of high concern with a significant increase in April, despite the worked numbers being at their lowest level since August 2015. Increased scrutiny of non-clinical PTF's will take place at Directors Group with immediate effect and a short life 'agency taskforce' has been established to assist with agency spend reduction.

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

The worked FTE is lower than funded by 99 but higher than the NHSI Plan by 107 (1.6%). Contracted fte was 79.34 higher than in March 15. There are an additional 44.96 substantive Additional Clinical Staff & 20.47 Admin staff since March 15, these increases are offset by a reduction of 20.76 Estates & Ancillary & 18.92 Nursing staff. Temporary staff usage is 23.57 FTE higher than in March last year. Additional operational pressures in January saw the greater use of unfunded areas. The difference between the funded posts which have increased due business cases and the NHSI plan, which is constant, needs to reconciled.

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

It appears that turnover in Nursing has stabilised and work continues in Medical Division to effect reductions.

REPORT OF THE FINANCE DIRECTOR

FINANCIAL PERFORMANCE FOR THE PERIOD TO 31ST MAY 2016

1. Executive Summary

The position presented in this paper is a high level view of the position for Month 2.

The table below summarises the performance for the year to 31 May 2016 against key elements of the Trust's plan and financial duties.

	Month 2 YTD actual	Month 2 YTD plan	Variance	Full Year Plan
Delivering planned surplus	(£1.16m)	£2.36m	(£3.52m)	£5.3m

The Trust has submitted a revised plan trajectory to NHSI for approval to reflect the additional costs currently relating to operational pressures and the non-recurrent costs in Q 1 and Q2, relating to our A&E recovery workstreams. This maintains the agreed control total of £5.3m but alters the phasing, allowing for a deficit in the earlier months of the financial year.

Whilst this trajectory has not yet been approved by NHSI, current performance is shown against the restated plan in the table below:

	Month 2 YTD actual	Month 2 YTD revised plan	Variance	Full Year Plan
Delivering planned surplus	(£1.16m)	(£1.21m)	£0.05m	£5.3m

Key Issues:

- The financial position of the Trust at the end of M2 of the 2016/17 financial year is an operating deficit of £1.2m.

- This represents an adverse variance of £3.5m from the planned position of a £2.3m surplus for Month 2, largely due to the phasing of the financial plan. If the revised plan, as submitted to NHSI, were in place then the variance would have been reduced from an adverse position of £3.5m to a favourable position of £0.05m

- The above includes expenditure on temporary staff of £3.0m in the month which is also £0.5m higher than the average for 2015/16. This includes expenditure on bank staff. The figure has reduced slightly in the month with a small reduction in nursing agency being compensated for with an increase in medical agency.

- As a result of operational pressures which have continued throughout April and May continued upward pressure on pay expenditure continues to be a challenge, although the total pay bill has remained steady in May. A comparison of Month 2 to the previous financial year shows the in-month expenditure to be £1.5m higher than the 2015/16 average.

- The CIP target at £18.2m for the Trust is lower than 2015/16, but remains a challenge. This will be managed with strong governance and focus to ensure delivery.

- The Financial Sustainability Risk Rating based on M2 performance is 2. Providing that the overall planned position is delivered this will rise to 3 for the 2016/17 financial year.

2. Financial Position to 31st May 2016

The position at the end of Month 2 of the 2016/17 financial year is an operating deficit of £1.2m, which represents an adverse variance of £3.5m against plan. The position is summarised in the table below.

	YTD Actual £000's
SLA & Commissioning Income	72,772
PP, Overseas and RTA Income	795
Operating Income	10,932
Total Income	**84,499**
Pay	54,666
Non-Pay	27,358
Total Expenditure	**82,024**
EBITDA	**2,475**
EBITDA %age	**2.9%**
Depreciation	1,765
Public Dividend Capital Payable	1,241
Interest Receivable	-6
Interest Payable	637
Surplus/(Deficit)	**(1,162)**

A comparison of the overall expenditure run-rate in Month 2 to the average for 2015/16 shows a total increase of £1.5m (+3.9%) which is a slight improvement on the position in Month 1 (£1.8m compared to 2015/16 average). However this is significantly higher than where the Trust needs to be in order to deliver the plan.

Agency staffing expenditure continues to be a significant pressure on the overall pay expenditure position. As the Board is aware there is a national supply issue for trained nursing and medical staff in hard to recruit specialties. The Trust continues to work hard to mitigate this risk without impacting on the quality of care provided. This risk needs to be robustly managed over the course of the 2016/17 financial year whilst remaining mindful of our priority to provide safe services.

3. Income

The total Trust income for M2 is £42.1m, of which £36.0m is from commissioning contracts. There is a reduction of £0.8m in the month from commissioning income due to the emergency cap.

The majority of contractual income for 2016/17 has now been agreed and associated contracts signed. The table below shows the actual income values by month for 2016/17 by main Commissioners.

The plan for 2016/17 is, in the main, a PbR contact. If activity continues to increase, as was the case last financial year, this will be reflected in additional income though a significant proportion at marginal rate of 30%.. We are still awaiting the HRG level detail of the contracts from major commissioners and will further update the Board at Month 3.

CCG / Area Team Name	Month 1 Actuals £'000	Month 2 Actuals £'000
NHS Gloucestershire CCG	26,617	25,537
NHSE Specialised Commissioning	6,423	6,496
NHS South Worcestershire CCG	934	919
NHS Herefordshire CCG	370	340
Bath, Gloucestershire, Swindon and Wiltshire Area Team	340	344
Bath, Gloucestershire, Swindon and Wiltshire Area Team Dental	511	421
Other Commissioners	1,686	1,833
Trust Total	**36,882**	**35,890**

4. Expenditure

Breakdown of plans by division are being updated in accordance with contractual agreements now in place with Commissioners. This is to ensure that income and expenditure plans correlate with the activity and associated operational targets stipulated in contracts. This also includes the CIP requirements for each division.

The budget offers for 2016/17 has been reflected within the devolved budgets for month 2 in line with approved business cases and cost pressures.

The table below show the divisional expenditure performance against budget for Month 2.

	2016/17 Month 2 YTD Expenditure Budget £'000	2016/17 Month 2 YTD Expenditure Actual £'000	2016/17 Month 2 YTD Expenditure Variance £'000
PAY			Fav/(Adv)
Corporate Services	3,263	3,416	(153)
Estates and Facilities Division (EFD)	2,232	2,348	(116)
Diagnostics & Specialist	10,333	10,209	124
Medicine	10,696	12,699	(2,003)
Surgery	13,790	14,464	(674)
Women and Children	5,452	5,828	(376)
Total Pay	**45,765**	**48,963**	**(3,198)**
NON-PAY			
Corporate Services	5,734	5,845	(111)
Estates and Facilities Division (EFD)	3,246	3,304	(58)
Diagnostics & Specialist	5,513	6,698	(1,185)
Medicine	4,928	5,852	(924)
Surgery	4,557	5,369	(812)
Women and Children	415	667	(253)
Total Non Pay	**24,393**	**27,735**	**(3,342)**
Total Divisional Expenditure	**70,158**	**76,698**	**(6,540)**

There are significant overspends in clinical Divisions. Pay is over-committed in Medicine and Surgery, largely due to spending on agency staffing. Non-Pay is over-committed in all divisions, with over-spends in Diagnostics & Specialist, Medicine and Surgery.

A review of the divisional expenditure for Month 2 shows that the total expenditure run-rate is running at £1.6m higher than the monthly average for 2015/16 and breaks down as shown below.

	2015/16 Monthly Average £'000	2016/17 Month 2 £'000	Fav/(Adv) Movement to 2015/16 £'000	2016/17 Month 1 £'000	2016/17 Month 2 £'000	Fav/(Adv) Run-Rate Movement £'000
PAY						
Corporate Services	1,591	1,876	(285)	1,540	1,876	(336)
Estates and Facilities Division (EFD)	1,166	1,182	(16)	1,166	1,182	(16)
Diagnostics & Specialist	4,915	5,074	(159)	5,135	5,074	60
Medicine	5,848	6,254	(406)	6,445	6,254	191
Surgery	6,999	7,105	(106)	7,359	7,105	254
Women and Children	2,695	2,892	(196)	2,936	2,892	44
Total Pay	**23,214**	**24,383**	**(1,169)**	**24,581**	**24,383**	**198**
NON-PAY						
Corporate Services	2,313	3,255	(942)	2,590	3,255	(664)
Estates and Facilities Division (EFD)	1,571	1,605	(35)	1,699	1,605	94
Diagnostics & Specialist	3,268	3,027	241	3,670	3,027	643
Medicine	3,069	2,833	236	3,019	2,833	186
Surgery	2,952	2,895	58	2,475	2,895	(420)
Women and Children	337	322	15	345	322	23
Total Non Pay	**13,510**	**13,937**	**(426)**	**13,798**	**13,937**	**(139)**
Total Divisional Expenditure	**36,725**	**38,320**	**(1,595)**	**38,379**	**38,320**	**59**

The material movements are explained as follows:

Corporate Pay – There has been a transfer of ward clerk budgets and expenditure out of Divisions and into the corporate budgets at Month 2. This has increased both expenditure against prior year average and the run-rate.

Corporate Non-Pay – There has been a movement on SmartCare expenditure in M2 that accounts for the majority of the increase. This is matched by associated income that is not shown in the above table.

Surgery Non-Pay – The increase in the run-rate is due to MSE and contract services, but the M2 run-rate is in line with the average for last year.

Temporary Staffing

The table below shows a sub set of the pay expenditure above and shows the temporary staffing expenditure by staff group and expenditure type. Comparison of trends to previous year shows May expenditure at £0.5m higher than the 2015/16 average, but slightly lower than April expenditure.

Temporary Staffing Expenditure – Analysis by Staff Group	Expenditure 2015/16 Average £000's	Expenditure Month 1 £000's	Expenditure Month 2 £000's	Fav/(Adv) Movement to 2015/16 £000's
Medical Agency & Locum	787	631	823	(36)
Nursing Agency	598	1,294	959	(361)
Nursing Bank	552	722	641	(89)
Other Clinical staff	107	172	135	(28)
Non Clinical staff	372	307	405	(33)
Total	**2,416**	**3,125**	**2,963**	**(547)**

The Trust is required to report agency expenditure to NHSI on a monthly basis against the capped value for the 2016/17 financial year. This figure excludes bank and so is lower than the temporary staffing figure in the table above.

The agency expenditure as reported to NHSI for Month 1 was £2.099m against a total temporary staffing spend of £3.125m. The month 2 figure will be submitted at the end of the month to NHSI and reported to the board in next month's report.

The Board are closely scrutinising expenditure on agency staffing and the Executive Team have agreed actions to further control this spend.

Revised arrangements are being implemented in relation to those services provided by the Trust by Gloucestershire Care Services. This is to ensure that increased value for money is delivered within these contracts for the 2016/17 financial year.

5. Savings Plans

The CIP target for the Trust is £18.2m for 2016/17, which is £5.8m lower than the target for 2015/16. The target equates to 4.8% of expenditure. The split of this target by division is shown in the table below:

CIP PROGRAMME SUMMARY 2016/17	
Divisions	**2016/17 In Year Targets £'000**
Surgery	5,124
Medicine	4,474
W&C	1,514
D&S	4,406
EFD	1,616
Corporate	1,045
Total (£'000)	**18,179**

The plans for delivery of the CIP have now been reviewed by the CIP Director and the Director of Operational Finance in accordance with the principles agreed. Deep dive reviews have been undertaken with all divisions to ensure that plans are robust and deliverable.

The plan focuses on reducing expenditure. All income schemes have been reviewed and retained where appropriate.

6. Statement of Financial Position 2016/17

We are currently reviewing our systems, processes and reporting mechanisms in detail around payables, receivables and the Better Payment Practice Code. Due to this, current mid-month positions are is provided below. A more detailed report will be provided to Finance and Performance Committee followed by an update to the Board once this work is completed.

Payables

The Trust's aged Payables analysis as at 16th June 2016 is shown in the table below. The 'live' position is shown to ensure that the latest information available is provided.

	<30 days	31-60 days	61-90 days	91-120 day	120+ days	**Total**
Deposits	1	0	0	0	0	**1**
NHS creditors	36	494	442	914	1,209	**3,095**
Other Govts Depts Creditors	0	0	30	14	91	**135**
Local Authority Creditors	0	3	0	0	0	**3**
Territorial NHS Creditors	1	3	3	4	28	**39**
Non-NHS trade creditors	4,993	6,068	2,869	931	557	**15,418**
Total Creditors	**5,031**	**6,658**	**3,343**	**1,863**	**1,885**	**18,780**

The Trust has taken a number of measures to improve cashflow and support the reduction of aged payables around contracting arrangements, internal process and governance and use of the working capital facility.

Receivables

The Trust's aged debt analysis as at 16th June 2016 is shown in the table overleaf. The 'live' position is shown to ensure that the latest information available is provided. A number of

changes to processes and procedures have been implemented to reduce debt and ensure all organisations are following good practice guidance around payment of outstanding debt.

	<30 days	31-60 days	61-90 days	91-120 day	120+days	**Total**
English CCGs	35,450	2,087	8,936	(67)	(836)	**45,571**
Other English NHS	3,818	1,087	261	694	7,135	**12,995**
Other Territory NHS	208	170	258	113	374	**1,123**
Overseas Patients	46	22	35	22	353	**477**
Private Patients	212	54	26	19	346	**657**
Other Non-NHS	539	295	233	127	260	**1,453**
	40,274	**3,714**	**9,749**	**907**	**7,632**	**62,275**

Within 'English CCGs' the monthly invoices for contracts have been raised in month and account for the high balance in <30 days. There is a significant credit balance showing as over 120 days. This reflects a payment on account received from Gloucestershire CCG in advance of the year-end settlement. It will be allocated as part of this process and revised information will be available for M3.

Within 'Other English NHS', the single largest debtor in the 120+ days is Gloucestershire Care Services at a value of £6.2m. We have recently settled a dispute with GCS and we expect this balance to be cleared shortly.

Cash Balances

The Trust cash balance at the end of May 2016 stands at £5.1m. The position is shown in the table below.

Trust Cashflow Statement May-16	May £'000
Opening Bank Balance	6,929
Receipts	
Main CCG SLAs	34,598
All other NHS Organisations	8,418
Other Receipts	5,761
Total Receipts	48,777
Payments	
Payroll	(21,047)
Creditor(including capital)payments	(29,593)
Other Payments	0
Total Payments	(50,639)
Closing Bank Balance	**5,066**

Revised contractual measures have been put in place as part of the 2016/17 contracting round to help improve the cash position moving forward this financial year.

7. Recommendation

The Board are asked to note:

- The financial position of the Trust at the end of Month 2 of the 2016/17 financial year is an operational deficit of £1.2m. This is an adverse variance to plan of £3.5m, although a favourable variance of £0.05m against the proposed revised plan.

- The Trust needs to improve its controls on the use of agency staff as this has already impacted the early part of 2016/17. Although there is a small reduction in month 2, it is not material in impact.

- Actions to address the issues identified in this report will continue and progress will continue to be reported monthly to the Finance and Performance Committee and the Foundation Trust Board.

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

Presenting Director: **Helen Simpson, Executive Director of Finance**

Date: **June 2016**

EMERGENCY PATHWAY REPORT
MONTHLY PERFORMANCE REPORT: MAY 2016
FOR MAIN BOARD IN JUNE 2016

1. Executive Summary

Key Messages

- The 95% 4 hour target for Emergency Department performance was not successfully met in May 2016, with Trustwide performance reported as 87.4%. Cheltenham achieved the 95% standard in May but Gloucester did not. There has been an upward trend of improvement compared to the previous four months and particularly compared to March 2016 when the performance was 77.7%.

- The Trust did meet the agreed improvement trajectory which was 85%.

- The daily average number of Emergency Department attendances in May 2016 was 382 patients (11,854 for the month), compared to May 2015 (343 per day) and April 2016 (359 per day). The work of the GP in the Gloucestershire Royal Hospital Emergency Department and direct attendances to the Ambulatory Emergency Care units are not included in the 2016/17 attendances.

- The daily average number of admissions from the Emergency Department in May 2016 was 124 patients (3,849 for the month), which is an increase compared to May 2015 (111 per day) and April 2016 (110 per day).

- General and Acute average length of stay for non-elective admissions has reduced from 6.31 days in April 2016 to 5.36 days in May. The internal target for Q1 is 5.4 days.

- The number of patients on the medically fit list for one day and over has been at an average of 62 throughout May 2016. This remains above the system-wide plan of no more than 40 patients.

Key Risks

- Demand exceeding both the contractual plan and historical levels.

- The number of patients medically fit for discharge occupying an acute hospital bed.

- Despite recruiting additional consultants, gaps in Emergency Department doctors' rotas, especially at middle and junior grades, continue to remain a key risk to delivering Emergency Department performance.

- Enhanced performance is dependent on a number of countywide projects to streamline the urgent care system to manage Emergency Department demand, as well as improved discharge processes at the Trust. This involves close working with health and social care partners. Details of these projects are contained within this report.

Report Purpose

To report performance on the key performance indicators, key risks identified and the latest Emergency Care Board milestone plan. The report reflects data up to 31st May 2016.

The emergency pathway performance management metrics enables the Board to track where changes are delivering sustainable performance and identify where further focus and effort is needed.

Emergency Pathway Metrics

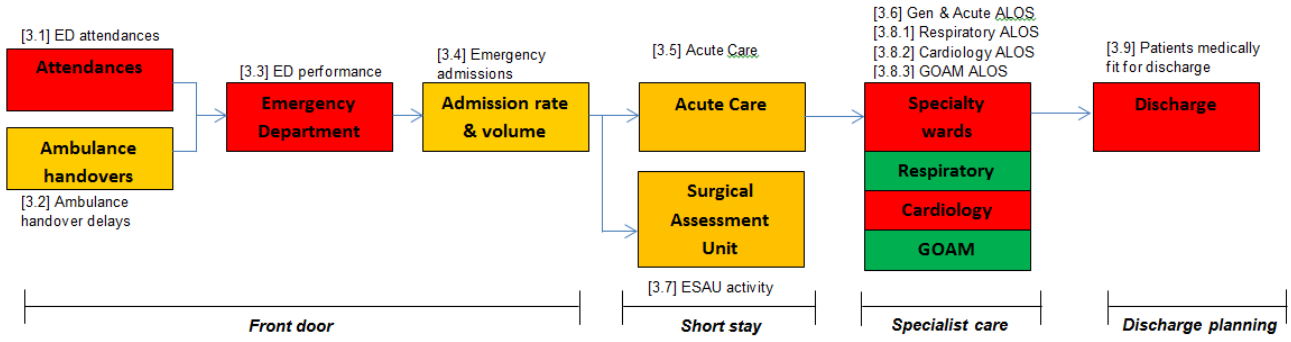
The diagram below shows the key processes within the emergency pathway.

Each process step is colour coded according to performance and sustainability, defined as:

- Blue - process in control, performance sustained > 3 months
- Green - process measure performance on target
- Amber - process measure performance moving in right direction but not achieving target
- Red - process measure performance off target.

The numbers in brackets refer to paragraph numbers that show the relevant process measure in more detail.

Figure 1 Emergency pathway key process measures:



An Emergency Care Action Plan to improve performance has been agreed with NHS Improvement and the Trust is focusing on three key areas:

1. Patient Flow
2. Emergency Department
3. Admission Avoidance

The Trust-appointed Improvement Director commenced in March 2016. She has worked with the Executive to identify three priority workstreams for immediate improvements, they are:

1. Emergency Department – with specific focus on the safety metrics for Time to Initial Assessment within 15 minutes and Time to Treatment within 60 minutes.
2. Site Management – to increase the presence of senior co-ordination of both hospitals 24/7, to ensure patients are in the right place, first time.
3. >=14 Day Length of Stay patients – to reduce the number of these patients who currently occupy 65% of total bed days across the Trust.

2.1 Safety & Quality

Narrative: The Director of Safety, Head of Patient Experience and Executive Directors are working to improve visibility of the quality of care being delivered, particularly when there are long waits, or the Emergency Departments are crowded. The first draft of the Safety & Quality report is included below, for consideration by the Board:

Measure	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Comments/themes and actions
SAFETY METRICS								
Number of Never Events	0	0	0	0	0	0	0	
Number of confirmed serious incidents	0	1	0	1	1	0	1	• **December** - Delay to act of confirmed severe sepsis – actions informs Sepsis /FAB60 project • **February** - Transfusion of blood intended for another patient – Reorganisation of blood fridge so emergency O neg blood separate from patient specific blood. Staff involved received further training • **March –** assessment and management of ventilated patient - actions include reinforcing pathways for patients with existing invasive ventilation requirements • **May –** failure to monitor a patient presenting with a chest infection

Top ten categories for incident reporting by staff in Emergency Department

Admission transfer – the increase in Jan – Feb 2016 relates to a staff member entering all occasions where there were capacity issues e.g. corridor patients on the reporting system. Alternative methods for monitoring of this have ow been identified

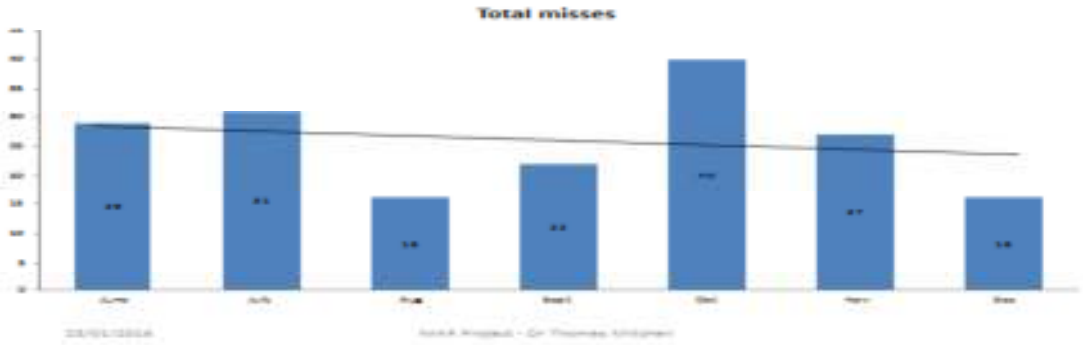
Abuse and violence – incidents include specific verbal, physical aggression involving patients/ 3rd parties or for disruptive patients/ 3rd parties ED staff have received conflict resolution /safe holding training and have access to the 2222 escalation security process

Care monitoring and review – monitoring of patients NEWS score supporting earlier intervention and informing the SAFER proforma project below

Diagnosis and assessment – includes occasions for missed fractures and other diagnoses helping to inform the missed abnormal radiology project see below

Communication – issues identified during handovers between staff in the department and with other specialties are being addressed through the projects listed below

	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Total
Admission/ transfer	8	15	8	6	25	9	45	22	36	98	88	36	9	9	**414**
Abuse and Violence	20	11	21	15	18	9	19	12	17	7	6	20	3	19	**197**
Care, Monitoring, Review	8	3	4	6	5	6	11	28	4	1	6	8	3	9	**102**
Diagnosis & Assessment	5	6	5	3	3	4	3	7	7	3	6	8	6	4	**70**
Communication	4	4	5	4	7	2	4	5	6	3	5	6	5	5	**65**
Medication Incident	7	7	5	8	4	3	5	4	3	1	2	3	2	3	**57**
Staffing / Beds / Systems (no individual patient involvement)	9	1	0	0	3	5	4	8	4	2	4	4	6	2	**52**
Treatment/ Procedure	5	3	4	2	2	1	2	3	1	2	2	4	5	0	**36**
Falls	2	2	2	2	2	4	2	3	1	3	0	3	0	2	**28**
Discharge & Transfer	1	0	1	3	0	2	2	2	4	1	2	5	1	0	**24**
Total	**69**	**52**	**55**	**49**	**69**	**45**	**97**	**94**	**83**	**121**	**121**	**97**	**40**	**53**	**992**

Current Improvement and Audit projects	
Patient Safety Checklist – part of the WEAHSN (Academy supported)	This has been piloted in CGH since March 2016, early review of completion has led to refinements to the proforma with the aim to implement in GRH in June.
• **Missed Abnormal Radiology (NHSLA funded)** **Actions have included** – Teaching and education sessions contributing to a decrease in missed fractures – Identification of new pathways involving T&O and radiology – Production of newsletter raising awareness of project and actions	
• **Improve Pain Management (CQC recommendation) (Academy supported)** **Actions planned include** – Increased staff training, – Increased usage of Patient Group Directives initiative for nursing staff to prescribe and administer a dose of analgesic prior to medical review – 'Patient Safety checklist' successfully rolled-out to GRH from 1st June 2016. Now in existence across both sites. Audit criteria to be determined.	Data to follow
Hourly board rounds in Emergency Departments in both hospitals Actions include - Consultants are completing hourly rounds in both departments to ensure awareness of senior clinicians of the sickest patients supporting escalation and prompt treatment / transfer - Audit criteria to be determined.	Data to follow
Morbidity and Mortality considerations	• **OOH referral to ED of a young patient who collapsed on premises. Diagnosed as a stroke** Learning: good observations and history taking established a list of problems to investigate further. Overnight CT - difficulties organising out of hours CT angio. Raising awareness that younger persons do have strokes • **Elderly patient admitted post fall. CT head and CXR performed. Admitted overnight and discharged the next day. Returned to ED next day. Lt sided effusion seen on Xray. Chest drain inserted.** Learning: Thorough exam showed chest injury, chest drain inserted. Age not seen as a barrier to care. All patients

	presenting with injury should be seen by ED team and images reviewed before handing care to a specialty team. Always use chest drain check list when inserting chest drains

Trust Risk Register

M1 - Inability of the local health and social care system to manage demand within the current capacity leading to significant fluctuation of attendances in ED
M1a - The clinical risk of delay in treating patients arriving at Accident and Emergency during periods of high demand or staff shortage
M1b - Lack of availability of key groups of staff to fill vacancies caused by insufficient training programmes and regional allocations resulting reduced ability to meet operational and clinical targets and standards.
M1c **-** The hospital is at full capacity with limited ability to accommodate surges in admissions with the consequence of an increasing LOS, increased use of temporary staffing and increased cancellations on the day of surgery due to outliers. This directly affects the Trust ability to respond to mass casualties in a major incident
C12 **-** Delayed discharge of patients who are on the medically fit list above the agreed 40 limit leading to detrimental effects on capacity and flow of patients through the hospital from ED to ward

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

PATIENT EXPERIENCE

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May- 16	
Family and Friends positive response rate	2.4	1.9	0.7	2.5	4.5	2.3	4.9	2 Health care assistants are championing F&FT. receptionist in Majors handing out cards on late shift. Raising the profile. Transfer from card to digital methodology planned to start in June.
Rate of Complaints	10	9	10	12	12	11	14	Delays in treatment
Number of Concerns	3	1	6	8	2	1	3	Delays in ED
Number of compliments	4	23	11	8	6	10	11	
"You said we did" lessons learnt	Patients have requested drinking water and a television., Both of these requests are being actioned							

National Quality Indicators

Aim: To consistently deliver national Emergency Department quality standards.

How: Emergency Department and length of stay initiatives defined in Emergency Care Board action plan.

Narrative: The key Quality Indicators of Total Time in Department and Time to Treatment were not met in May. However, there has been improvement over the last four months.

Measure	Target	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Unplanned reattendance rate	<5%	1.40%	1.60%	1.80%	1.60%	1.40%	1.30%	1.30%	1.50%	1.40%	1.60%	1.40%	1.30%	1.40%	1.70%	1.50%	1.30%	1.30%
Total time in department	95th % < 4hrs	06:26	07:25	05:49	05:03	04:36	04:00	04:26	06:01	05:35	06:05	05:38	06:25	06:53	07:37	07:37	06:25	05:45
Patients left without being seen	<5%	1.20%	2.00%	1.90%	1.20%	1.50%	1.60%	1.50%	2.40%	2.00%	2.20%	1.20%	1.70%	1.40%	1.80%	1.90%	1.70%	1.80%
Time to Treatment	Median = 60 mins	00:48	01:05	01:01	00:55	00:50	00:59	00:57	01:13	01:08	01:14	00:57	01:10	01:02	01:13	01:12	01:02	01:03

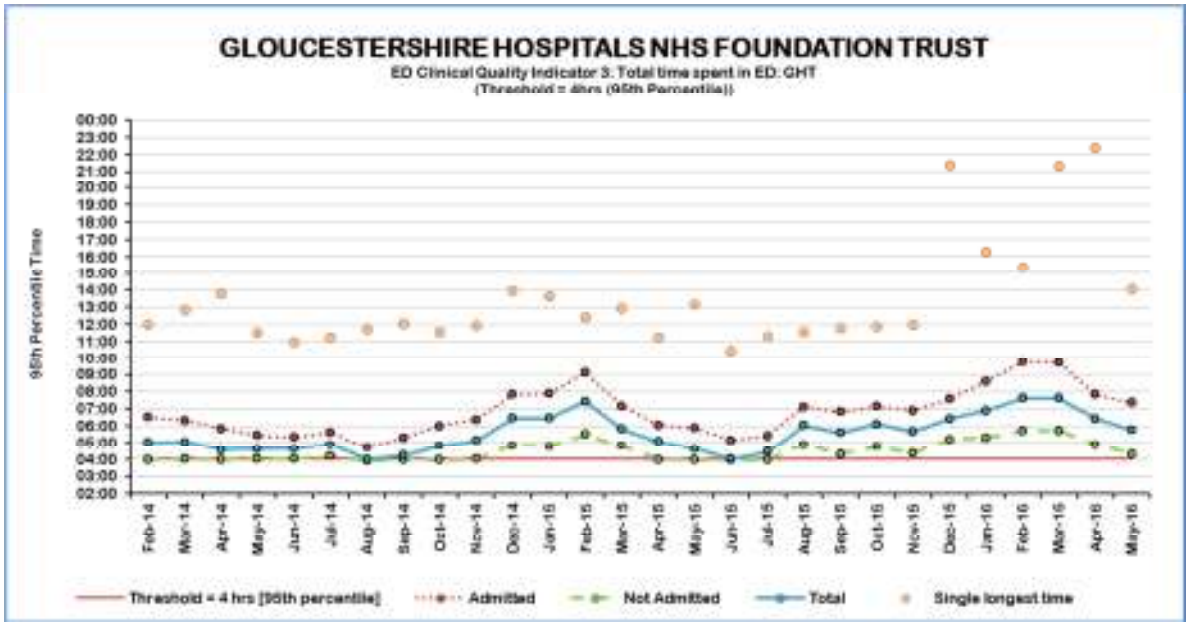
Time to Initial Assessment Compliance *(Standard: within 15 minutes of arrival)*:

	Number of....	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Trust Total	Total Patients	10007	10632	10895	10982	10600	10747	11079	10532	10844	10734	10603	11510	10777	11854
	Patients seen within 15 minutes	6572	7043	6912	6864	6646	6350	6406	6328	6072	6076	5441	6127	7381	9353
	Patients not seen within 15 minutes	3435	3589	3983	4118	3954	4397	4673	4204	4772	4658	5162	5383	3396	2501
	% Compliant	65.70%	66.20%	63.40%	62.50%	62.70%	59.10%	57.80%	60.10%	56.00%	56.60%	51.30%	53.20%	68.50%	78.90%

Source: Insight – Immediate Priority Dashboard (Monthly – 15 Minute Assessment)

To better understand the distribution of total time spent in the Emergency Department, activity has been plotted for admitted and non-admitted patients. This information is being used to improve awareness and target changes to process. The chart shows patients' time spent in the department reducing after the winter pressures (post February 2015) and with the actions being taken.

The 95th percentile time (for all patients) in May was 5 hours 45 minutes, compared to 4 hours 36 minutes the previous year. The single longest wait was identified as circa 14 hours. The longest wait in April-16 has been validated by the service and confirmed as a data quality error. The long-wait in March-16 was an out-of-county Mental Health patient requiring review by the Crisis team, who did not require admission to an acute hospital.



2.2 Immediate Priority Workstreams

The primary areas of focus for the Trust in the immediate term are the three priority areas identified by the Executive Team. These are detailed below, including the clinical outcome measures and how these workstreams link to our existing emergency care programme plan.

1. Emergency Department:

With specific focus on the safety metrics for Time to Initial Assessment within 15 minutes and Time to Treatment within 60 minutes. This includes a detailed demand and capacity review of all staff and streams of work to optimise resources.

Clinical Outcomes:

- Improvement in Time to Initial Assessment (15 mins) for 99% of patients;
- Improvement in Time to Treatment (60 mins);
- No one in the department for more than six hours (for anything);
- No patients waiting in the corridor.

Links to existing plan:

- There are actions relating to workforce (Emergency Care Practitioners and Middle Grade doctors) which aimed to assist in the achievement of the clinical outcomes identified.
- There are also links to the Emergency Department Internal Professional Standards.

Measures:

For All Patients	CGH				GRH				TRUST			
	Feb	Mar	Apr	May	Feb	Mar	Apr	May	Feb	Mar	Apr	May
Avg. Time to Initial Assessment (mins)	17	16	13	10	26	21	16	13	22	19	15	12
% Assessed within 15 mins	57.7%	61.7%	74.7%	83.8%	47.6%	48.4%	65.0%	76.2%	51.3%	53.2%	68.5%	78.9%
Avg. Time to Treatment (mins)	66	65	61	53	106	103	89	90	91	89	79	77
% Treated within 60 mins	53.9%	55.8%	59.8%	64.8%	33.3%	32.8%	41.6%	37.5%	40.9%	41.1%	48.1%	47.2%
Number >6hrs (avg. per day)	4	7	7	2	34	34	15	14	38	41	22	16
% waiting >6hrs	3.0%	5.2%	5.7%	1.3%	14.6%	14.3%	6.4%	5.8%	10.3%	11.0%	6.1%	4.2%
Patients in Corridor (avg. per day)	0*	0*	0	0	77	80	63	51	77	80	63	51

Note: Data for patients waiting in the corridor starting to be captured from June 2016.

2. Site Management:

To increase the presence of senior co-ordination of both hospitals 24/7, to ensure patients are in the right place, first time. An interim rota is being put in place with full implementation planned for June.

Clinical Outcomes:

- 12 hour daytime cover 07:30 – 22:00 7 days a week by a Senior Clinician, with evidence of outliers reduced;
- 12 hour night time cover 17:00 – 08:00 7 days a week by General Managers, with evidence from daily reports that managers come in to tackle issues in line with the Escalation Policy;
- Staff are aware of their role and function in the bed meetings and the information required;
- Have a Stroke, Cardiac and Fractured Neck of Femur bed available for next patient.

Links to existing plan:

- The action relating to additional Senior Nurse / Clinical Lead to work each Saturday and Sunday has a direct correlation to this workstream.
- The refinement of the bed meetings has also been an action identified on the existing plan and is now being prioritised as part of this workstream.

Measures:

For All Patients	CGH				GRH				TRUST			
	Feb	Mar	Apr	May	Feb	Mar	Apr	May	Feb	Mar	Apr	May
Number of Surgical Outliers Bed Days	526	317	295	338	122	71	71	125	648	388	366	463
Number of Medical Outliers Bed Days	512	919	703	180	1358	1537	1617	1572	1870	2456	2320	1752
Number of Medical Outliers (avg. per day)	18	30	23	6	47	50	54	49	65	79	77	57
Number of days in Black Escalation	0	0	2	0	15	12	5	9	15	12	7	9
Number of days in Red Escalation	7	8	8	6	5	16	13	12	12	16	12	12

Note: The data relating to Outliers is currently under validation.

3. >= 14 Day Length of Stay:

To reduce the number of these patients who currently occupy 65% of total bed days across the Trust to improve flow and reduce outliers.

Clinical Outcomes:

- Reduction in bed days occupied;
- Reduction in numbers on the >= 14 days Length of Stay by 20%;
- Standardise SAFER programme;
- Reduction in the use of Day Surgery Units for Inpatients.

Links to existing plan:

- The roll-out of the SAFER bundle has been a key area for action throughout 2015/16 and workstream 1 includes the 'R' of SAFER – a systematic review of patients with extended lengths of stay (>14 days) to identify the issues and actions required to facilitate discharge. This will be led by senior leaders within the Trust.

Measures:

For All Patients	CGH				GRH				TRUST			
	Feb	Mar	Apr	May	Feb	Mar	Apr	May	Feb	Mar	Apr	May
Number of >=14 days on list	69	64	65	59	153	147	133	116	222	211	198	176
Number of Bed Days Occupied by >=14 day patients (Average)	1821	1560	1596	1535	3949	4584	4184	3284	5770	6144	5779	4820
Total Bed Days Occupied (Average)	3089	2860	2882	2752	5867	6466	5985	5257	8956	9326	8867	8009
% of Bed Days Occupied by >=14 Los Patients	59.0%	54.5%	55.4%	55.8%	67.3%	70.9%	69.9%	62.5%	64.4%	65.9%	65.2%	60.1%
EDD Accuracy	29.9%	27.8%	29.2%	31.3%	19.4%	20.8%	25.6%	25.6%	23.5%	23.6%	26.9%	27.7%
Number of Discharges before 12pm (avg. per day)	30	29	32	29	44	41	47	41	74	70	78	70
% of Discharges before 12pm	18.1%	18.2%	19.4%	19.0%	21.6%	20.8%	23.3%	21.4%	20.1%	19.6%	21.5%	20.3%
Number of Weekend Discharges	355	420	439	436	884	844	1015	970	1239	1264	1454	1406
Number of Inpatients on DSU overnight	115	125	207	90	503	514	425	445	618	639	632	535
Number of Inpatients on DSU overnight (avg. per day)	4	4	7	3	17	17	14	14	21	21	21	17

Note: The data relating to Bed Allocation (ACU to ward) is currently under validation.

3.1 Emergency Department Attendances

Aim: To ensure Emergency Department attendances remain in line with 2016/17 plan.

How: Work with:-

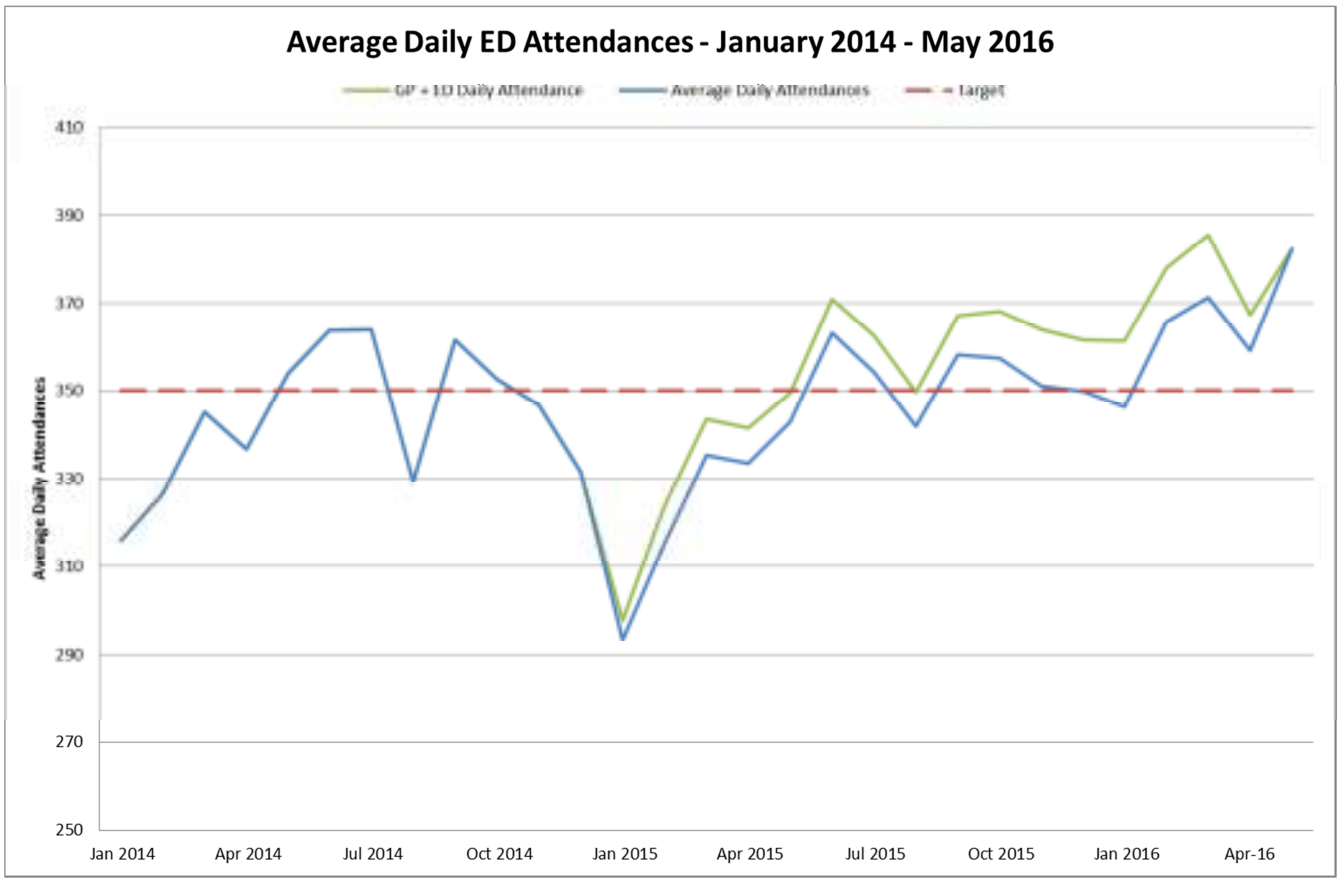
- South Western Ambulance Service NHS Foundation Trust (SWAST) to 'Smooth' emergency demand in the system;
- Integrated Discharge Team (IDT) within Emergency Department to increase direct admissions to community hospitals from Emergency Department;
- Develop the Older Person's Assessment and Liaison (OPAL) service;
- Maximise use of Minor Injury Units;
- Integrated Community Teams run by Gloucestershire Care Services NHS Trust

(All included in the Gloucestershire CCG Operational System Resilience Plan).

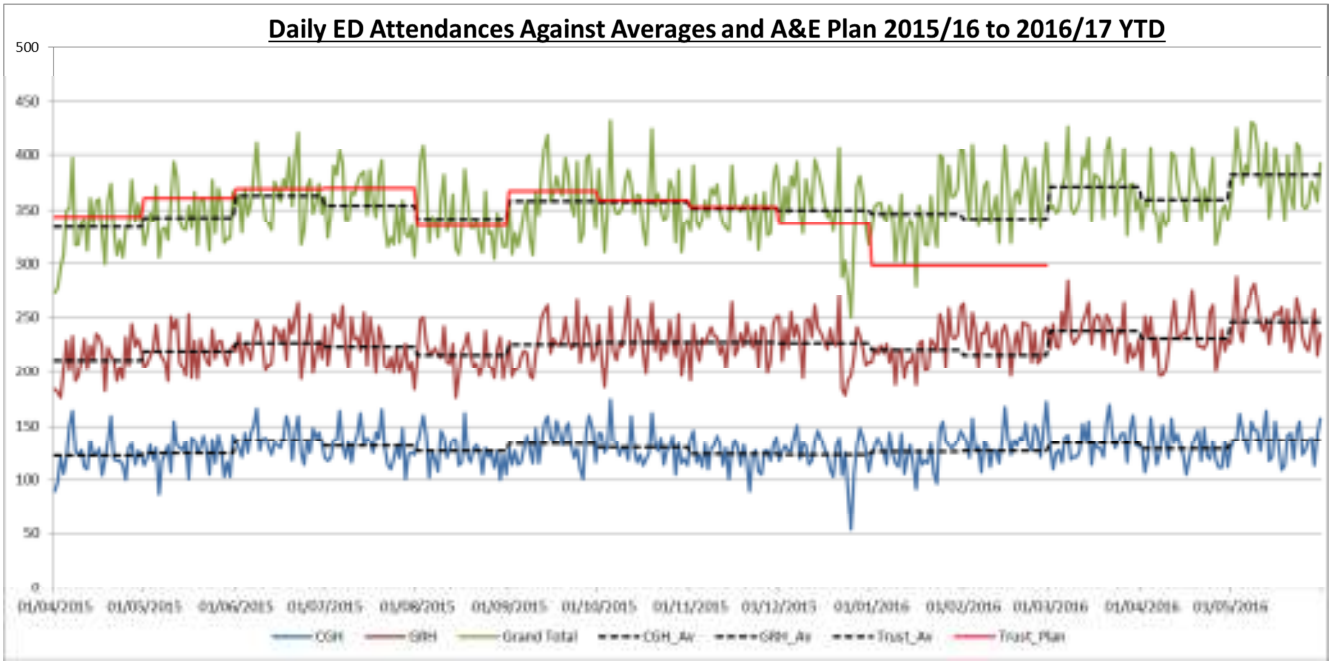
Narrative: There were 11,854 attendances in May 2016 (average of 382 per day) which is 23 per day higher than April 2016. This is higher than the 2016/17 plan of 358 per day pre-QIPP. Taking into account the level of planned attendances for 2016/17 this should be 330 a day.

Continued working with community partners is in place to manage alternative options for patients. This includes additional capacity at the Gloucester Health Access Centre and a Primary Care Practioner based in the Emergency Department of Gloucestershire Royal. Appropriate patients arriving at the Emergency Department are immediately repatriated to Primary Care. These patients are represented by the green line on the chart below, and are in addition to Emergency Department attendances.

Emergency Department Attendances Chart



Emergency Department Daily Attendances against Plan



Primary Care in Emergency Department

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

A Primary Care Practitioner (either a GP or an Advanced Nurse Practitioner) works alongside the Emergency Department Monday to Friday 10:00 to 22:00, with a Primary Care Receptionist streaming patients into the Out-of-Hours service at weekends.

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

Arrival Month	ED Attendances	4 Hour Breaches	Performance	GP in ED Cases	Adjusted Performance
Sep-15	10747	1187	88.96%	268	89.22%
Oct-15	11079	1538	86.12%	332	86.52%
Nov-15	10532	1252	88.11%	386	88.53%
Dec-15	10844	1882	82.64%	363	83.21%
Jan-16	10734	2130	80.16%	468	80.99%
Feb-16	10603	2499	76.43%	361	77.21%
Mar-16	11510	2559	77.77%	443	78.59%
Apr-16	10777	1576	85.38%	244	85.70%
May-16	11854	1491	87.42%	301	87.73%

Actions to be taken

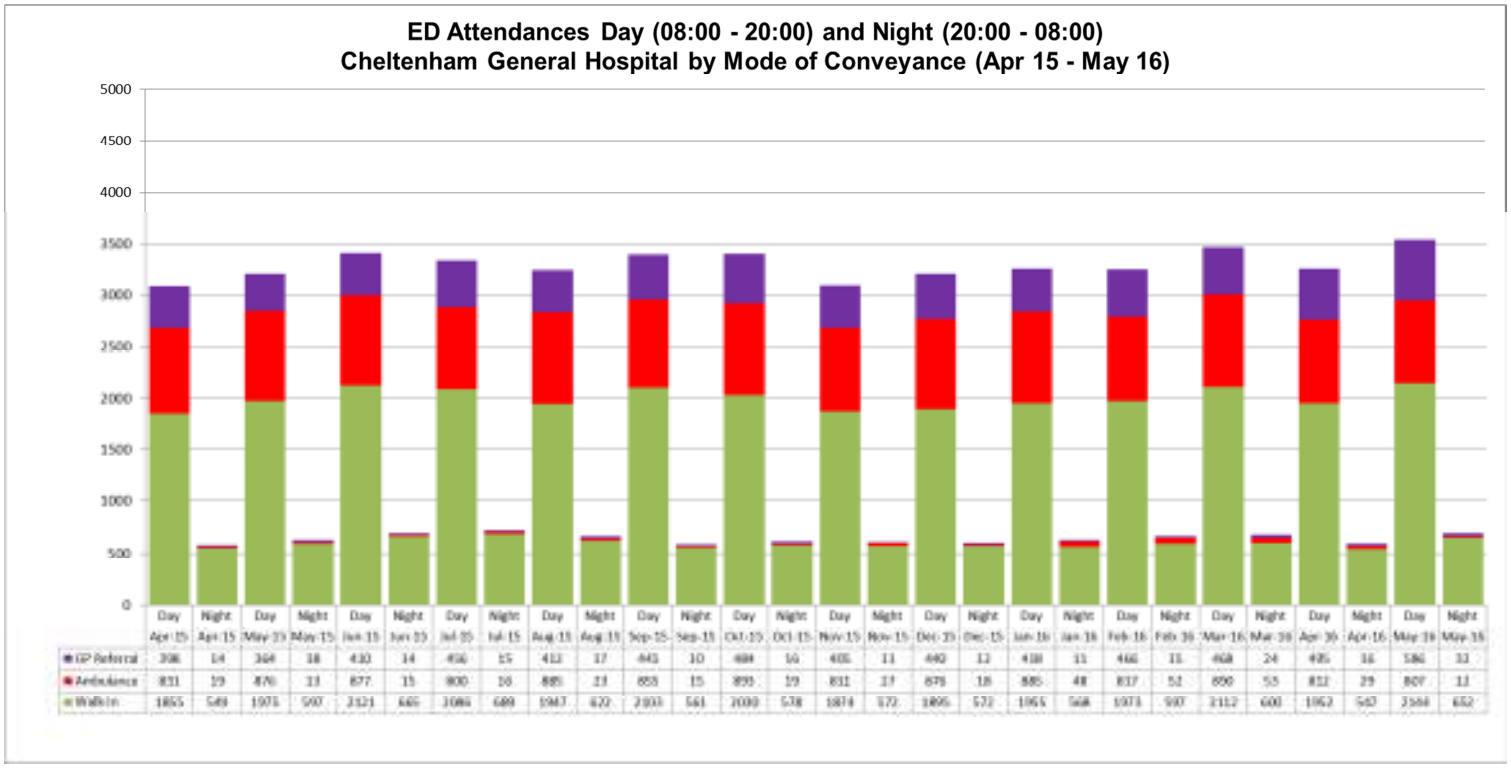
- Continue with Primary Care in Emergency Department pilot (now extended to July 2016) and managed by South West Ambulance Trust. The service is provided from a dedicated room near to Gloucestershire Royal Emergency Department reception.

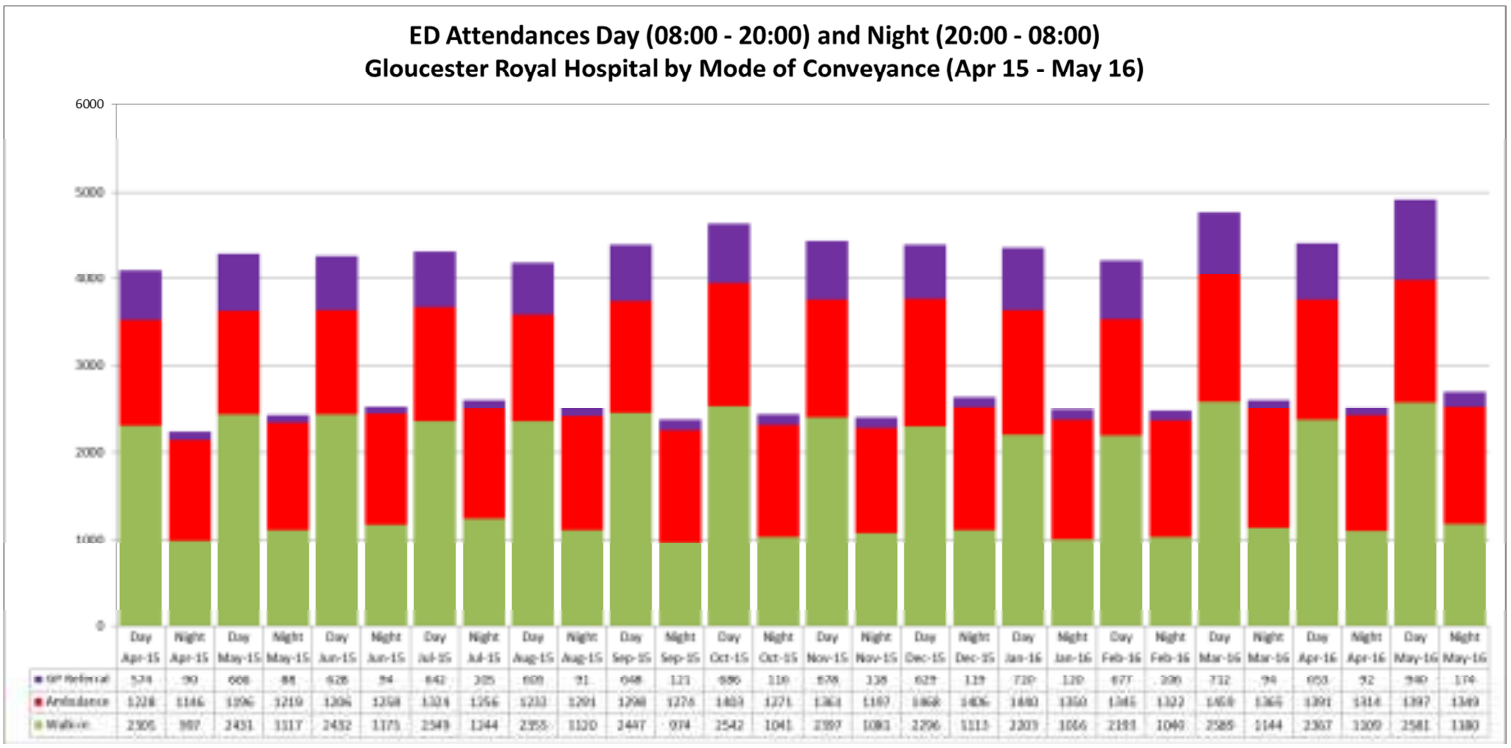
- Streamlining Urgent Care Programme: the 'Streaming' function and pathways have been revised, and a pilot that tested the role of a Clinical Navigator took place over two days w/c 12th October. This proved successful and Gloucestershire Clinical Commissioning Group has agreed to fund the post until the end of July 2016. The Clinical Navigator is now in post and a comprehensive Memorandum of Understanding has been agreed between the Trust and the Ambulance Service. To increase the numbers into Primary Care, the service will now accept some minor injury cases. This went live 29th February 2016.

- Continued use of the Ambulatory Emergency Care service on both sites. The Clinical Navigator is also able to refer suitable patients presenting to the Emergency Department directly into the Ambulatory Emergency Care service.

- System-wide performance management of Unscheduled Care QIPP schemes.

Emergency Department Attendances by Mode of Conveyance Charts





Narrative: In May 2016 there were 3,565 ambulance arrivals across both sites (average 115 per day). This is an increase of 7.9% on the same period last year, when there were 3,304 ambulance arrivals (average 107 per day).

Diverts Between Gloucestershire Royal Hospital & Cheltenham General Hospital

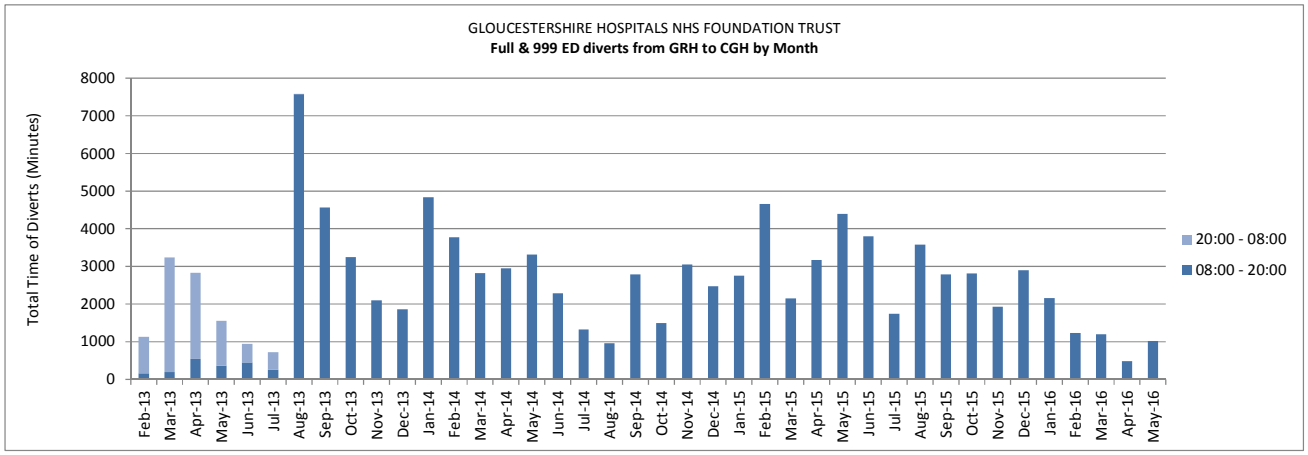
Aim: To reduce the number of across site diverts.

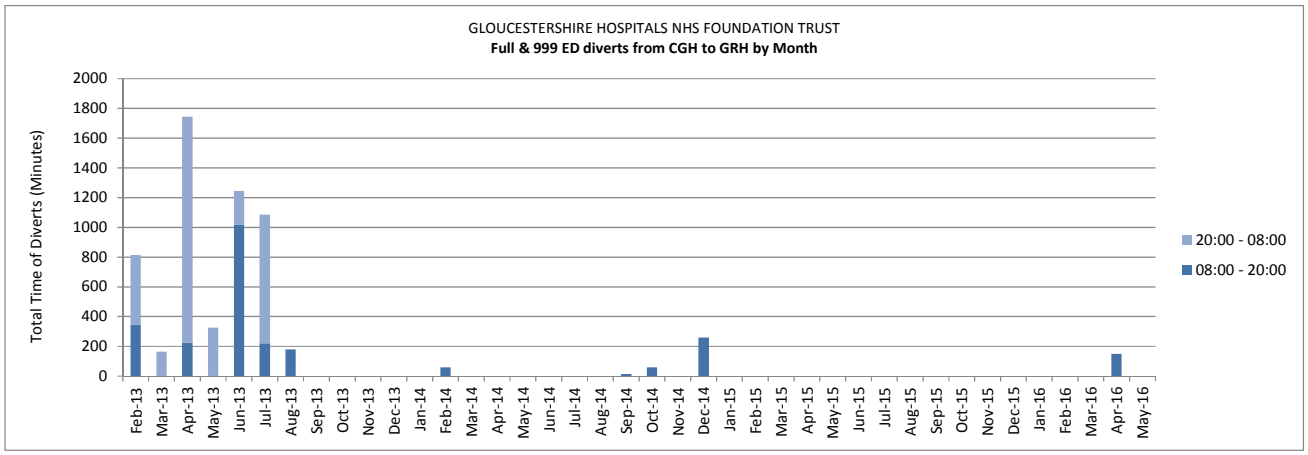
How: Enable flow within each site to ensure consistently available bed space for patients requiring admission.

Narrative: The Trust is actively working with Gloucestershire Clinical Commissioning Group, Gloucestershire Care Services and South Western Ambulance Trust to manage flow from 8 GP Practices into Cheltenham General as opposed to Gloucestershire Royal. This amounts to approximately one admission per day, or six patient bed days per day. Evidence suggests that there has been no significant change so far.

There were five occasions when a Full/999 divert took place in May 2016 compared to 6 in April.

The total duration of diverts increased from 10.5 hours in April to 17 hours in May. The average number of hours per divert in May was 3.4 compared to 1.8 hours last month.





3.2 Ambulance Handover Delays

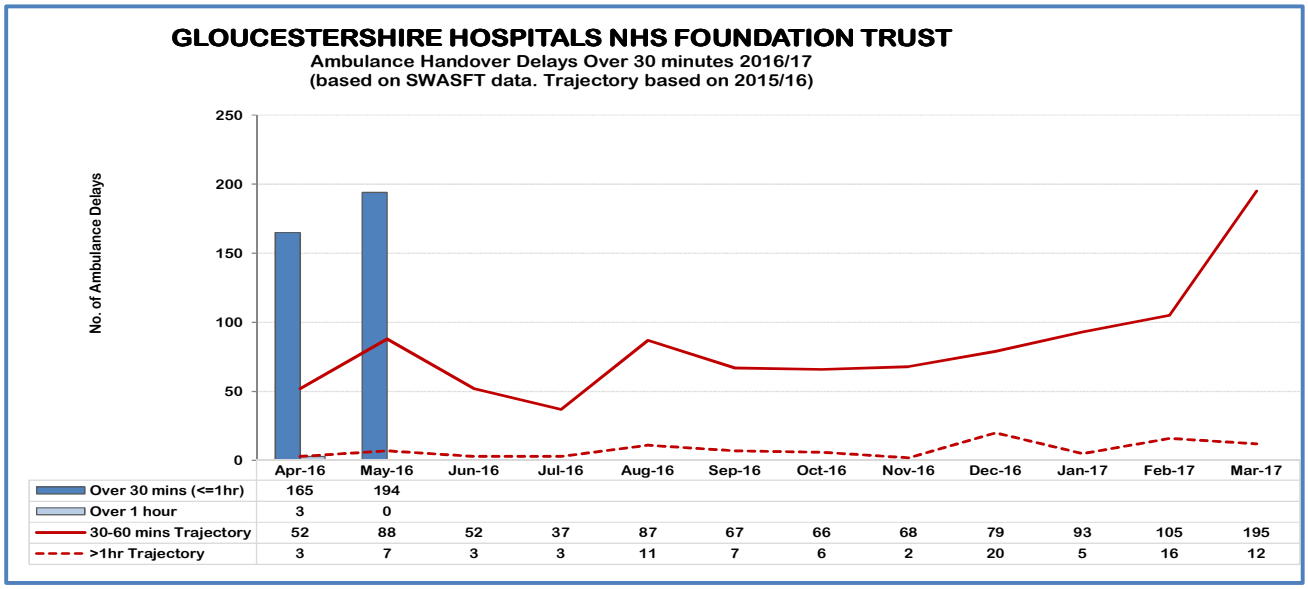
Aim: To reduce the number and time associated with ambulance handover delays.

How: Doctor and nurse rotas better aligned to demand, revised handover process, improved reporting, trialling new 'flow coordinator' post, implementing capacity and escalation action cards and use of Rapid Assessment and Treatment (RAT) model.

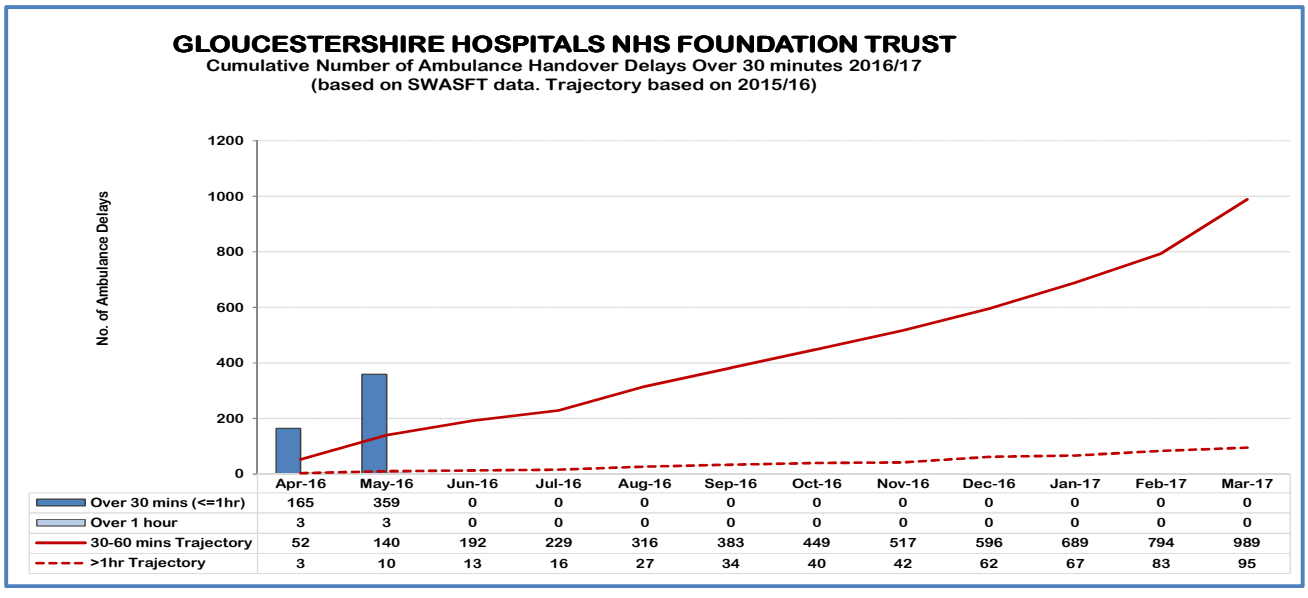
Narrative: There were 194 ambulance handover delays in May 2016; with no delays over an hour. This is an increase from last month when there were 168 delays (of which 3 were over an hour).

The level of ambulance handover delays is significantly higher than the same period last year; which forms the basis of the trajectory.

Note – The South West Ambulance Trust have recently introduced changes to their Computer Aided Dispatch (CAD) system that has resulted in a number of data validation issues in March. These are currently being worked through and will be resolved for future reports.



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Over 30 mins (<=1hr)	165	194										
Over 1 hour	3	0										
30-60 mins Trajectory	52	88	52	37	87	67	66	68	79	93	105	195
>1hr Trajectory	3	7	3	3	11	7	6	2	20	5	16	12



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Over 30 mins (<=1hr)	165	359	0	0	0	0	0	0	0	0	0	0
Over 1 hour	3	3	0	0	0	0	0	0	0	0	0	0
30-60 mins Trajectory	52	140	192	229	316	383	449	517	596	689	794	989
>1hr Trajectory	3	10	13	16	27	34	40	42	62	67	83	95

3.3 Emergency Department Performance

Aim: To consistently deliver the national 4 hour performance standard.

How: Emergency Department and length of stay initiatives defined in Emergency Care Board action plan.

Narrative: The table below shows Emergency Department performance against the national standard. A comprehensive weekly Emergency Department performance metrics pack is used to track performance and direct interventions. May 2016 data shows that Cheltenham General achieved the 95% standard, but Gloucester Royal did not. The overall Trust performance in May 2016 was 87.41%. This is an improvement on the previous 5 months but not as high as the same period last year.

3.3.1 Four Hour Standard

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
CGH actual	95.20%	95.79%	97.25%	96.21%	92.32%	94.91%	91.12%	92.43%	89.25%	87.34%	88.88%	87.85%
GRH actual	89.50%	92.27%	93.70%	92.41%	82.40%	85.61%	83.27%	85.86%	79.06%	76.08%	69.13%	72.09%
National std	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Trust actual	91.59%	93.54%	95.03%	93.82%	86.06%	89.06%	86.12%	88.17%	82.64%	80.16%	76.43%	77.77%

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
CGH actual	87.98%	95.94%										
GRH actual	83.93%	82.68%										
National std	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Trust actual	85.38%	87.41%										

Source: Insight, Unscheduled Care, Performance, EDP001. Summary of Performance (W, M, Q)

NHS England (Type 1) Emergency Department performance for Quarter 4 2015/16 have not yet been published. The Trust's performance for this period was 78.1% and 86.7% for 2015/16 as a whole.

Factors affecting performance included:

- Increased attendances out of hours;
- Delays in patient flow in the hospitals and across the system.

3.3.2 Breach Analysis

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

May 2016						
	Total Breached	**Breach due to Awaiting Assessment**	**Breach due to Awaiting Bed**	**Breach due to Undergoing Treatment**	**Breach due to ED Capacity**	**Others***
CGH	172	20	74	35	2	40
GRH	1320	445	381	126	153	215
Total	1492	465	455	161	155	256
%		31.17%	30.49%	10.79%	10.39%	17.16%

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

Source: Insight, Unscheduled Care, Breaches, EDB003. Breach Reasons by Month

3.4 Emergency Admissions

3.4.1 Emergency Admission Rate

Aim: To ensure the admission rate from the Emergency Department remains in control.

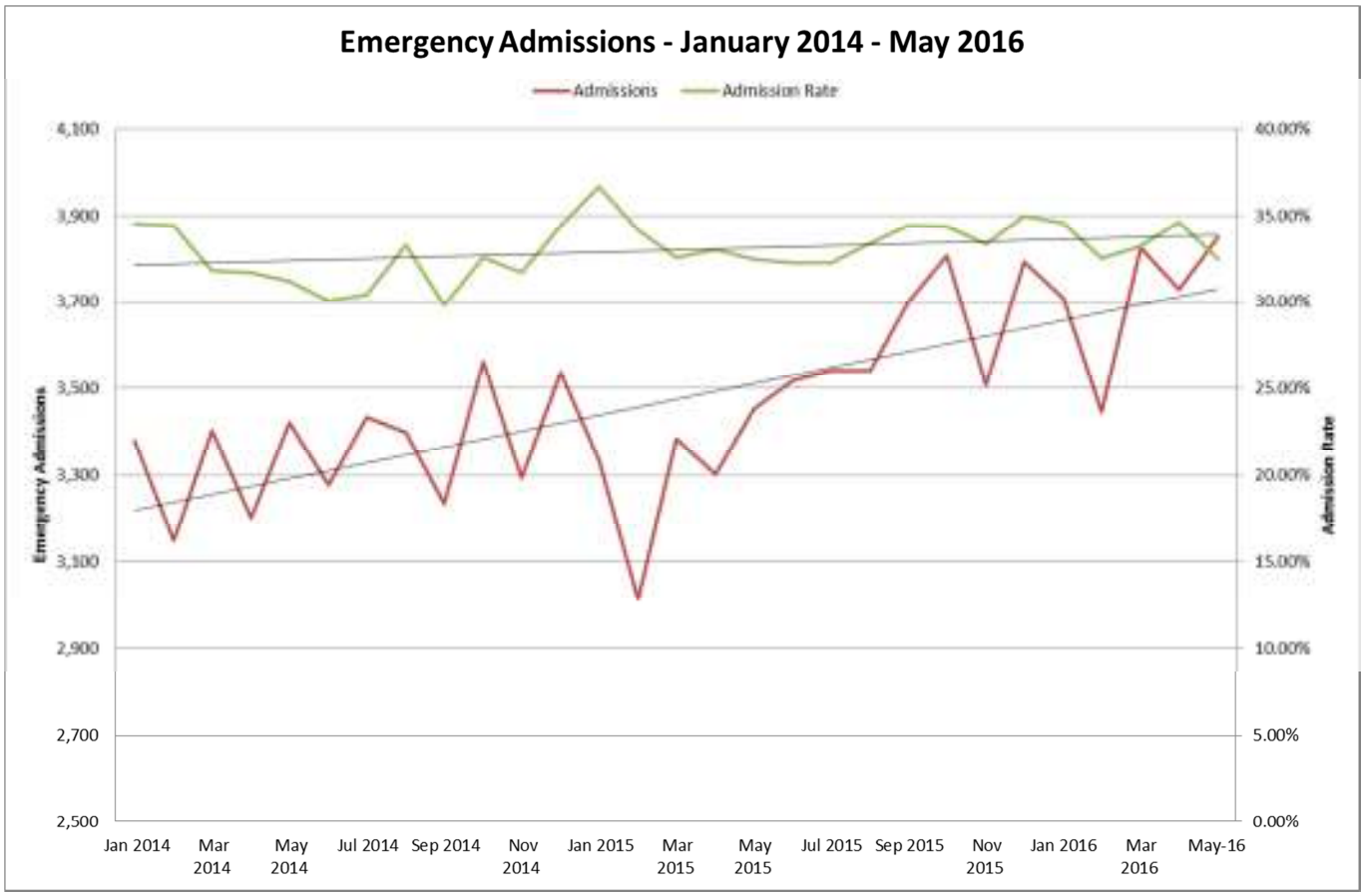
How: By avoiding admissions through alternatives as appropriate.

Narrative: The Emergency admission rate in May 2016 was 32.47% compared to April 2016, when the admission rate was 34.59%. In May 2016 there were 11,854 Emergency Department attendances and 3,849 patients were admitted (average 124 per day), compared to May 2015 when there were 10,632 attendances but 3,453 patients were admitted (average 111 per day).

Source: Insight, Unscheduled Care, Performance, EDP001. Summary of Performance (W, M, Q)

A review was recently undertaken with Gloucestershire Clinical Commissioning Group at the System Resilience meeting with regard to the increasing Emergency Admission Rate. The largest increases compared to 2014/15 have been for diseases of the respiratory system, circulatory system and genito-urinary system. A focus on the Gloucester City locality identified four key actions:

- Further work is required to understand the potential role of Older Person's Assessment & Liaison to reduce emergency admissions;
- Review of emergency admission rates Out-of-Hours and on weekends;
- Linking up Primary Care and Emergency Department activity data to understand the pressure points in both systems and how they impact each other;
- Consideration of a direct flow from General Practice telephony systems into a central service. This will enhance escalation intelligence.

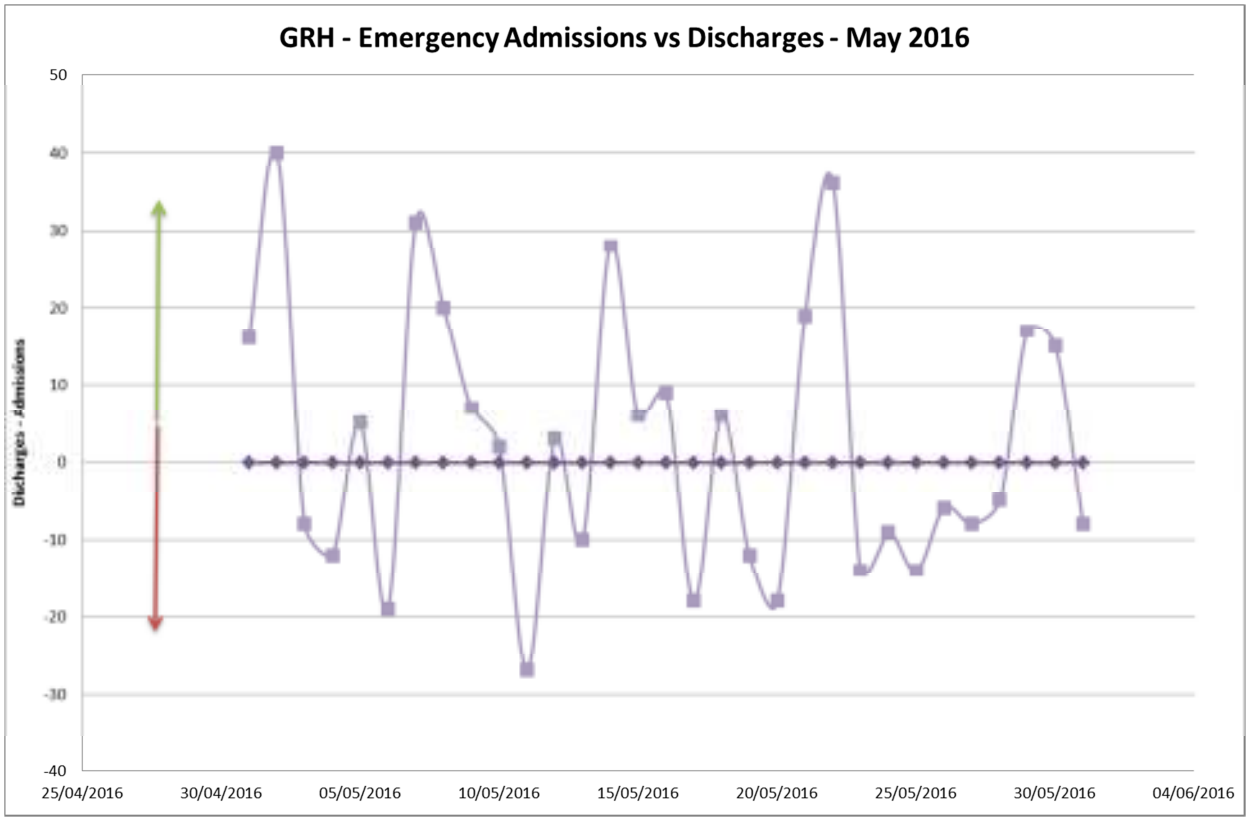


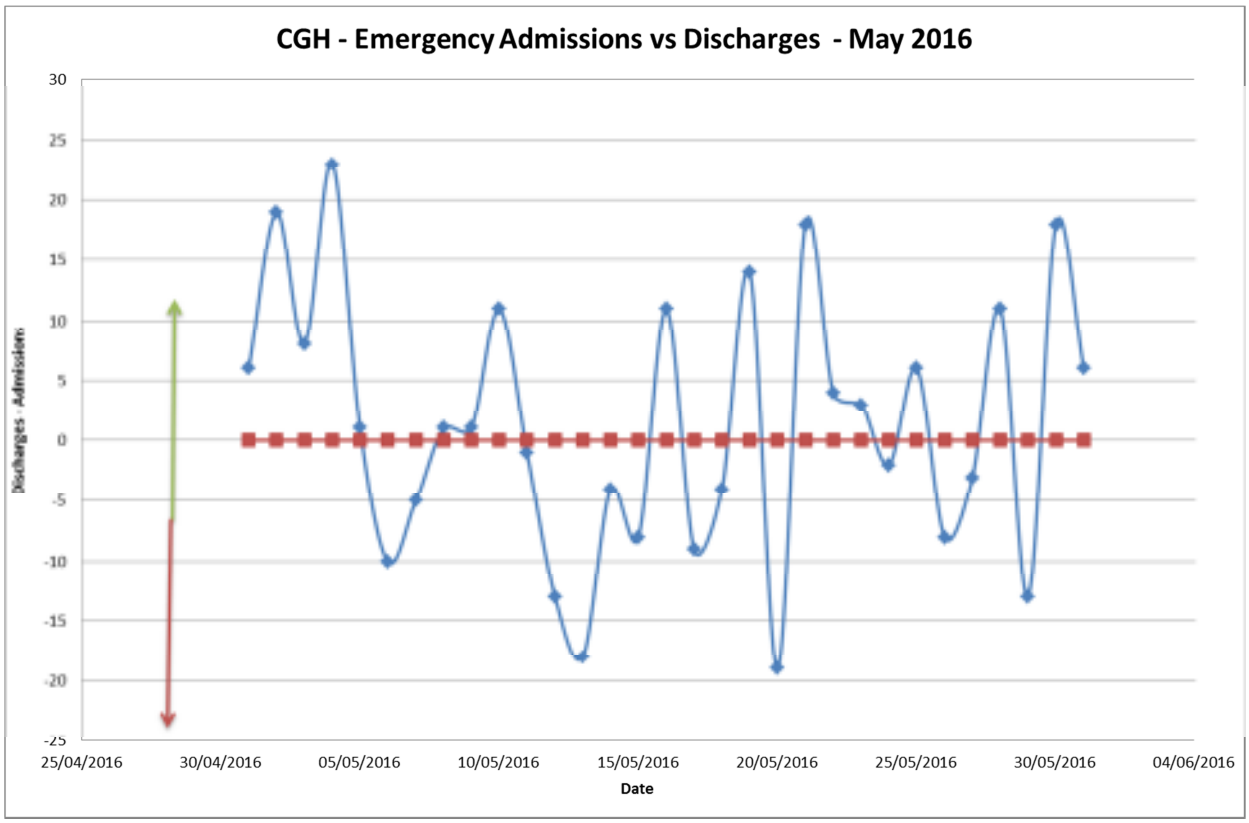
3.4.2 Admissions vs Discharges

Aim: To ensure the number of discharges on each site exceeds the number of admissions.

How: By ensuring the correct use of Estimated Dates of Discharge to meet the expected level of admissions each day.

Narrative: The following two graphs show the level of discharges on each site subtracted from the number of admissions.





3.5 Ambulatory Emergency Care Attendances

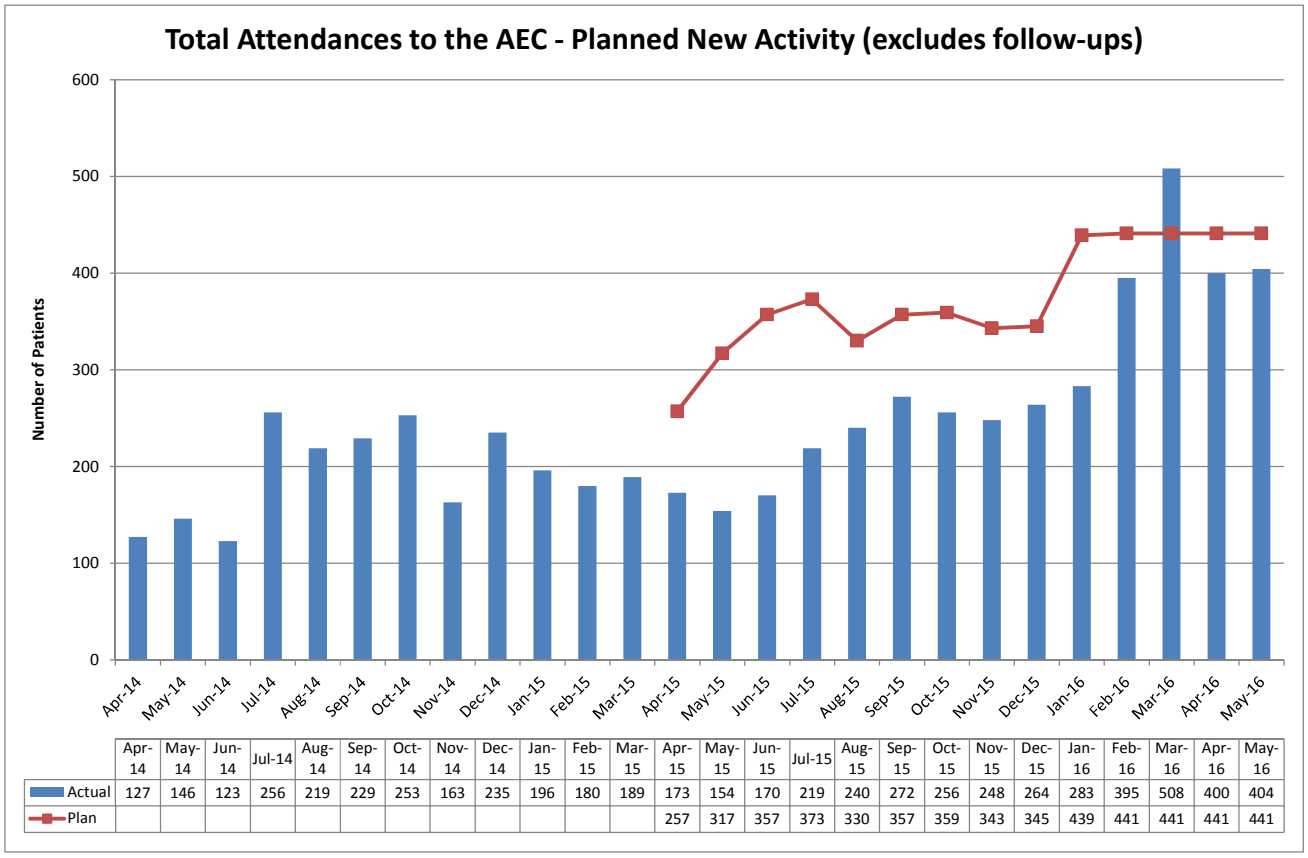
Aim: To increase the number of emergency patients managed on an ambulatory pathway.

How: Expand pathways and remodel ambulatory services.

Narrative: The Ambulatory Emergency Care service accepts patients either direct from the Emergency Department or via the Single Point of Clinical Access from GPs and South West Ambulance Trust.

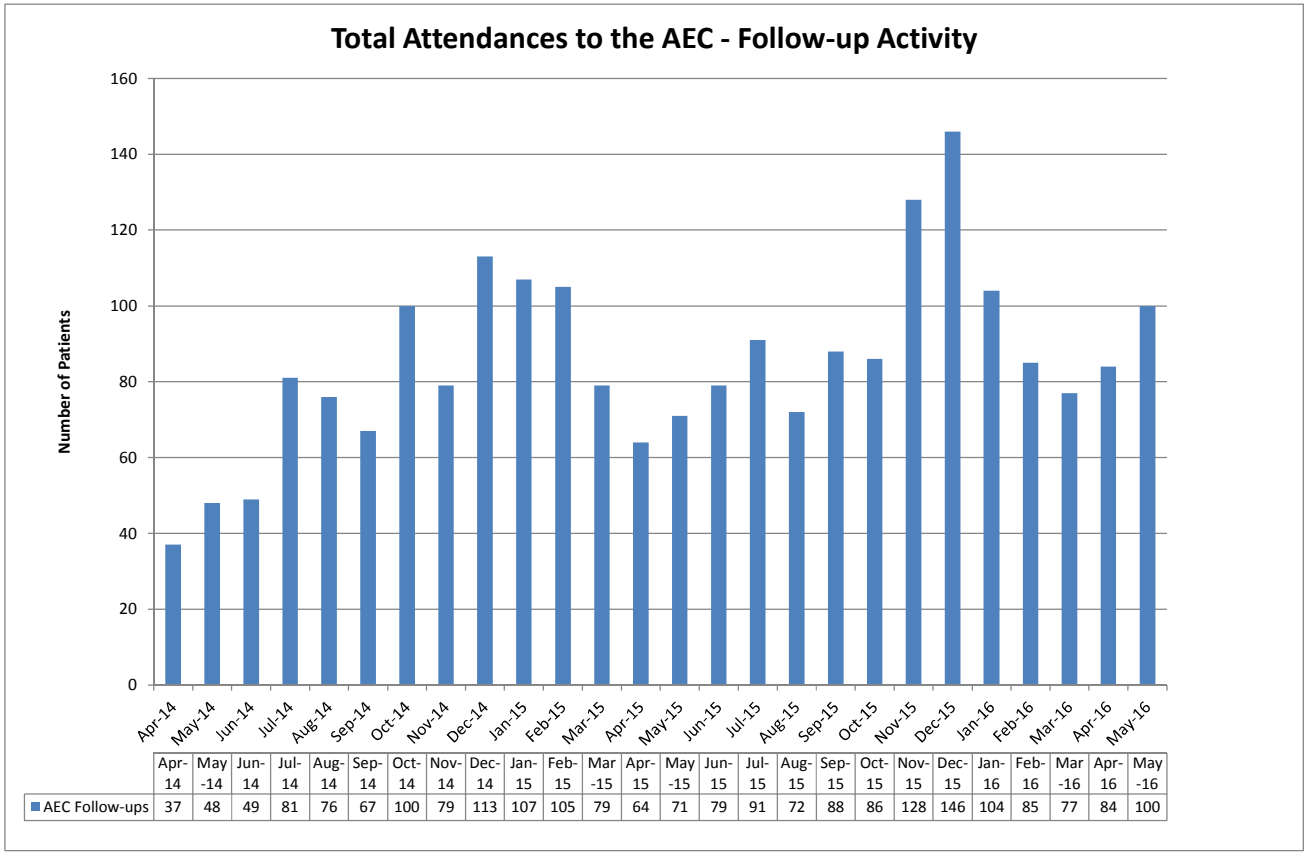
The chart below shows the actual number of new Ambulatory Emergency Care patients (excluding Follow ups) from April 2014. The daily average of new patients seen in May was 20.2 compared to 19.0 last month.

A service review was undertaken in November 2015, which identified a number of key actions to increase the number of new patients and as part of the Winter Plan, the Ambulatory Emergency Care service has increased its opening hours in order to capture the 'peaks' in Emergency Department attendances.



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Actual	127	146	123	256	219	229	253	163	235	196	180	189	173	154	170	219	240	272	256	248	264	283	395	508	400	404
Plan													257	317	357	373	330	357	359	343	345	439	441	441	441	441

In addition, the service has seen a number of follow-up attendances. Follow-up appointments are required in Ambulatory Emergency Care as they are used to avoid an unnecessary admission. The numbers from April 2014 are shown in the graph on the next page.



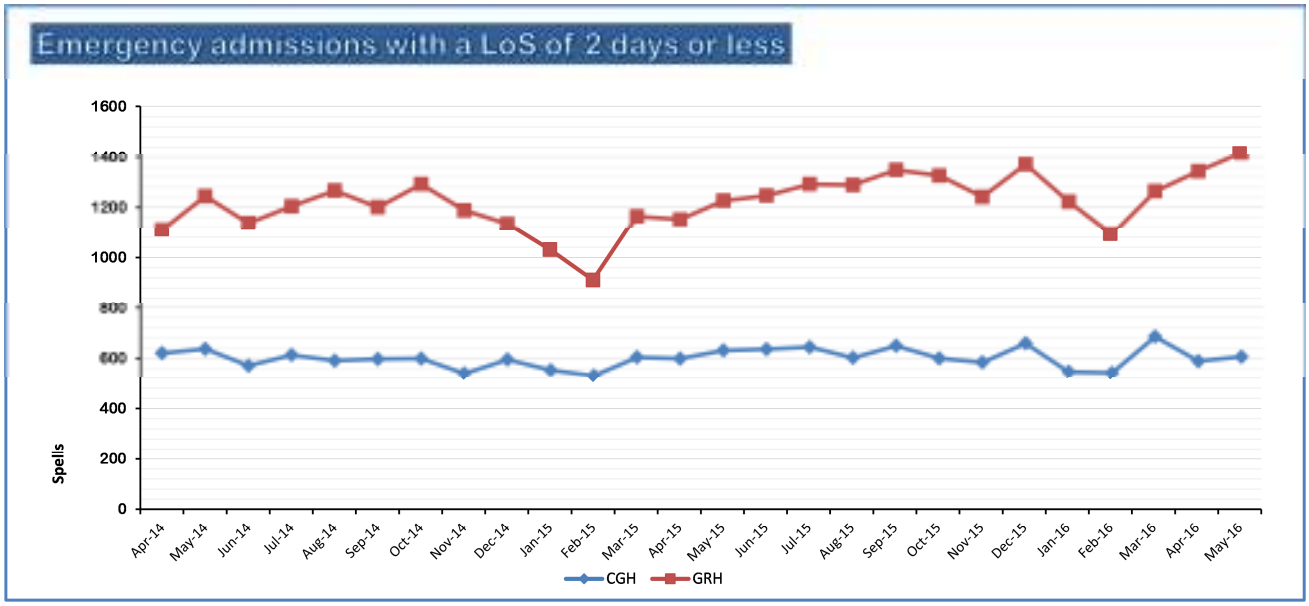
	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
AEC Follow-ups	37	48	49	81	76	67	100	79	113	107	105	79	64	71	79	91	72	88	86	128	146	104	85	77	84	100

3.5.1 Patients Discharged with a Length of Stay of 2 days or less, who were admitted as an Emergency

Aim: To increase the number of short stay discharges.

How: Expand number of acute care beds at Gloucestershire Royal to match demand, Acute Physicians to focus on Acute Care Units, fewer medical outliers and OPAL (Older Persons' Assessment and Liaison team).

Narratives May 2016 showed 2,023 patients with a length of stay of 2 days or less Trustwide (average 65.3 discharges per day); compared to April which showed 1,933 patients (average 64.4 discharges per day). The average per day for May 2015 was 60.0.



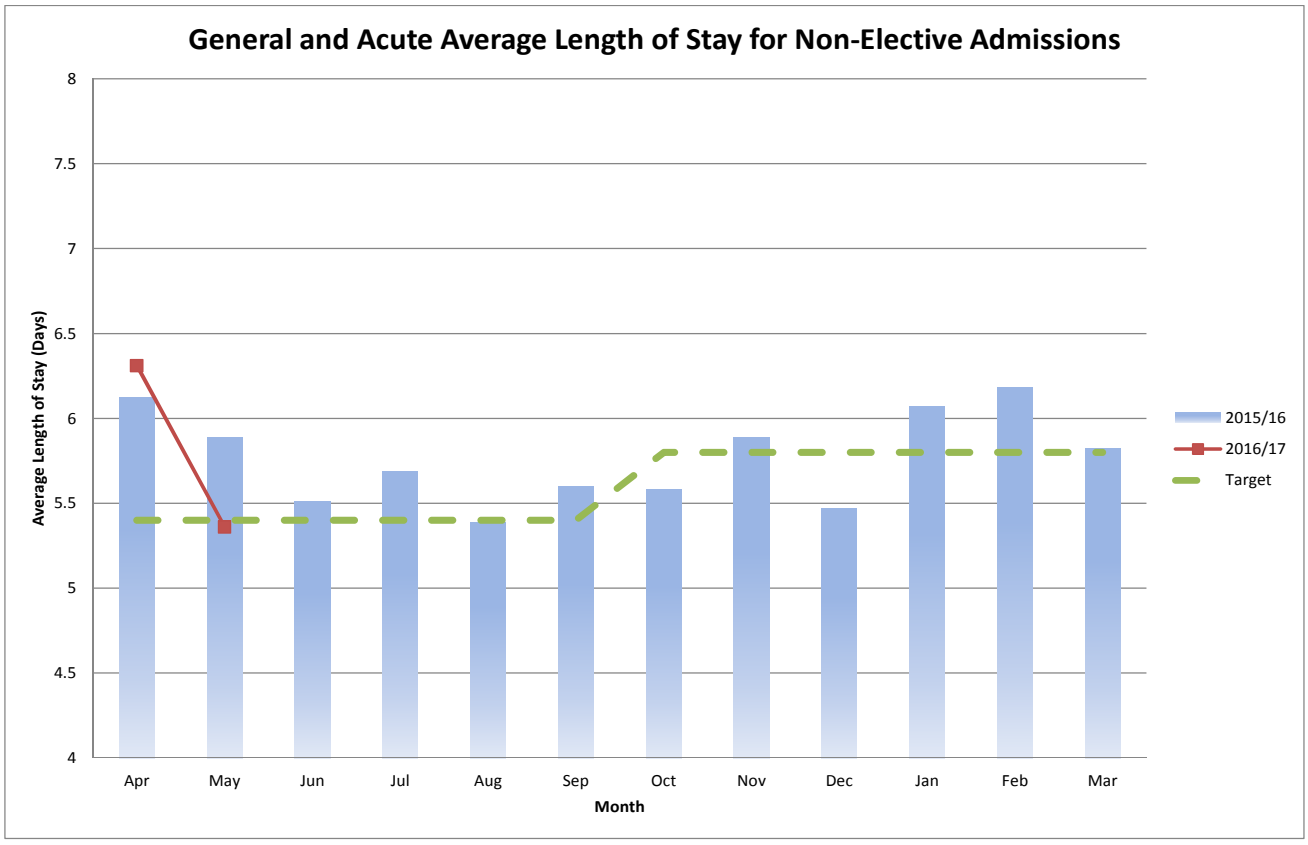
3.6 General & Acute Emergency Admissions Average Length of Stay

Aim: To reduce Trustwide general and acute emergency length of stay to less than 5.4 days in Quarter 1 of 2016/17.

How: Speciality driven action plans and continuation with: every patient reviewed every day; Estimated Discharge Date; ward level reports; discharge waiting areas; Blaylock tool and ticket home.

Narrative: The Trustwide quarterly targets will be reviewed throughout Quarter 1 2016/17. Divisions and Service Lines have been asked to develop internal action plans to bring down the Length of Stay in their area. May 2016 shows a reduction in the Average Length of Stay at 5.36 days compared to 6.31 days last month.

Renewed focus from March 2016 to ensure that all patients who have been in hospital 14 days or more (typically 200 patients), have a clear treatment and discharge plan.



A new approach to patient flow was launched on Monday 9 March 2015 with emphasis on the SAFER bundle:

S: Senior Review – all patients will have a Consultant Review before 10:00 followed by a Ward or Board Round;

A: All patients will have a Planned Discharge Date (that patients are made aware of), based on the medically suitable for discharge status, agreed by the clinical teams;

F: Flow of patients will commence at the earliest opportunity from assessment units (AMU & SAU) to inpatient wards. Receiving wards from assessment units will commence before 10:00 daily.

E: Early discharge – 50% of our patients will be discharged from base inpatient wards before midday. TTOs for planned discharges should be prescribed and with Pharmacy by 15:00 the day prior to discharge.

R: Review - a weekly systematic review of patients with extended lengths of stay (> 14 days) to identify the issues and actions required to facilitate discharge. This will be led by senior leaders within the Trust.

In order to embed these processes throughout the Trust, there is a CQUIN (Commissioning for Quality & Innovation) associated with the SAFER bundle this financial year.

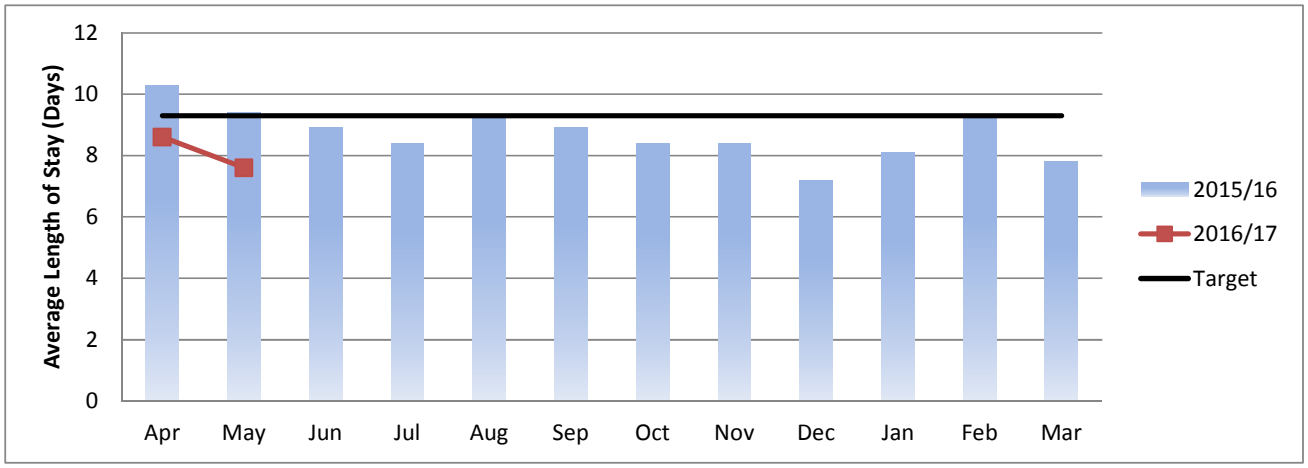
3.7 Average Length of Stay of Targeted Specialties

On continuation from last year Respiratory, Cardiology and General Old Age Medicine will be highlighted in this report. For Quarter 1 of 2016/17, the individual targets remain as per last year. The Specialty length of stay targets for this year will be reviewed throughout Quarter 1 2016/17. The reports below show Average Length of Stay in these three key specialties.

Respiratory, Cardiology and General Old Age Medicine have experienced their usual winter peak in presentations; the Division is working with the community to better manage this across the year.

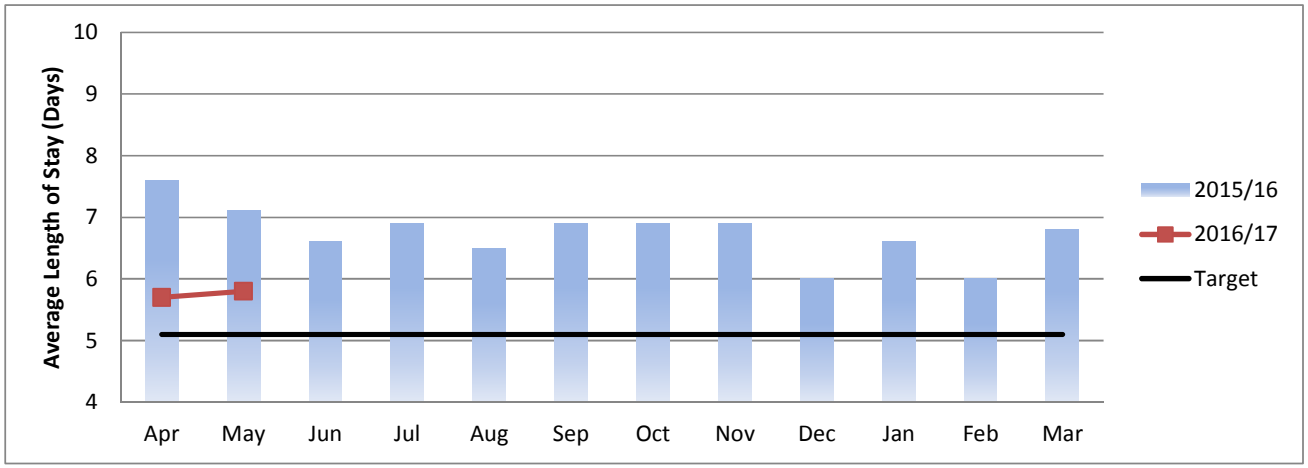
3.8.1 Respiratory Medicine - Average Length of Stay

Narrative: The internal target is currently set at 9.3 days for 2016/17. The Average Length of Stay decreased from last month to 7.6 days in May 2016 and remains within the target.



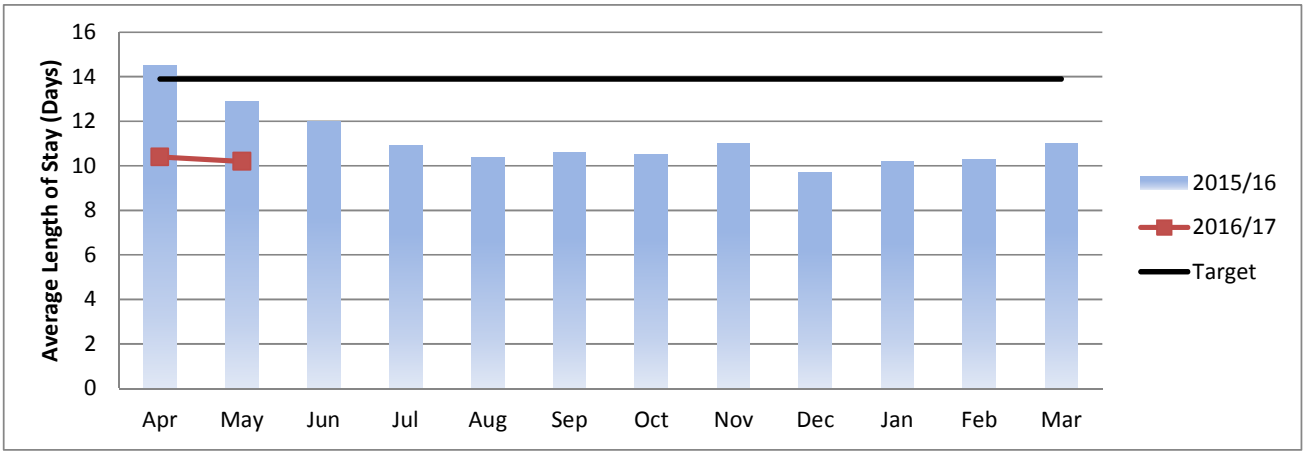
3.8.2 Cardiology - Average Length of Stay

Narrative: The internal target is currently set at 5.1 days for 2016/17. The Average Length of Stay for non-elective Cardiology discharges was 5.8 days in May 2016.



3.8.3 General Old Age Medicine (GOAM) – Average Length of Stay

Narrative: The internal target is currently set at 13.9 days for 2016/17. The General Old Age Medicine Average Length of Stay has remains static around 10 days and is well below target.



3.9 Average Number of Patients Medically Fit for Discharge

Aim: To reduce the number of medically fit patients occupying an acute bed by speeding up the process of discharging a patient to a suitable alternative within the community.

How: Focussing on a range of actions on safe and effective discharge processes. For the Trust and whole heath care system this is one of the key activities to manage.

Narrative: The number of people who are medically fit for discharge is managed daily with Gloucestershire Care Services NHS Trust and Gloucestershire Clinical Commissioning Group through a daily escalation call. Every bed day occupied longer than required to be in an acute hospital represents a cost of £200 per patient, per bed day.

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

The number of patients on the medically fit list for one day and over has been at an average of 62 throughout May 2016. This remains above the system-wide plan of no more than 40 patients. The method of reporting weekly Medically Fit numbers has changed from last month to align with CCG reporting so each financial week starts on a Friday. The table below shows the weekly averages, demonstrating improvement in the last week (including the first few days of June):

Week Commencing (Friday)	Fin. Week 2016	Average Per Day	Bed Days Lost
29/04/2016	Week 5	59	414
06/05/2016	Week 6	64	449
13/05/2016	Week 7	65	456
20/05/2016	Week 8	62	431
27/05/2016	Week 9	60	417

Source: InfoFlex and PAS (Integrated Discharge Team data)

The patients reported as medically fit are designated with a "Current Status" to show who is responsible for the next stage of the patient's discharge/transfer. The following are the three most frequently seen "Current Status" for medically fit patients:

- With Single Point of Clinical Access, waiting for community services;
- With Ward and Integrated Discharge Team to activate existing support;

- In Assessment with Adult Social Care.

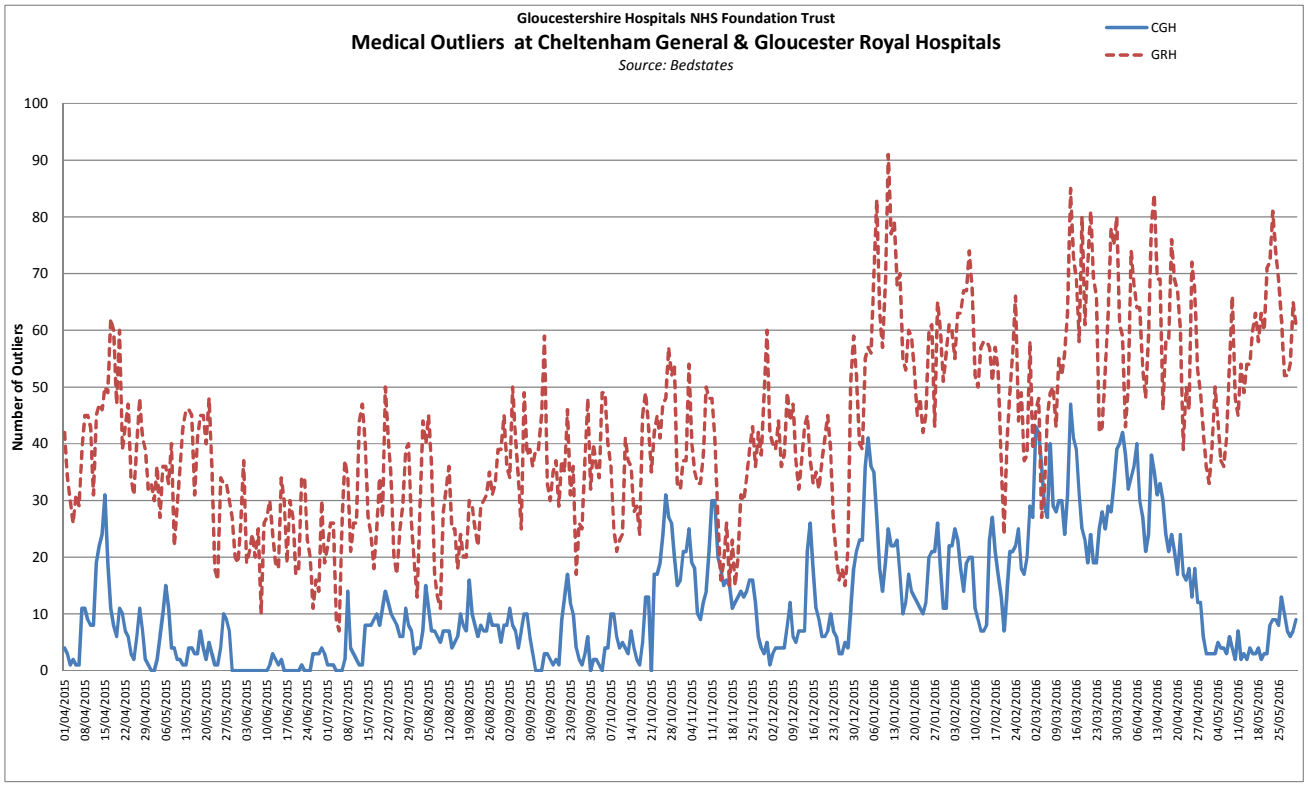
Currently, the Integrated Discharge Team manager is working to a 10 point plan of the most frequent reasons for delays across all systems both internal and external and to manage Medically Fit patients better in the future.
From September 2015, a weekly Senior Executive review of all Medically Fit patients takes place. This is being led by Mrs Arnold, Director of Nursing with her peers from across the system.

3.9.2 Medical Outliers

Aim: To reduce medical outliers to less than 10 across Trust so that patients are cared for on the right ward.

How: Expanded acute care beds at Gloucestershire Royal, Acute Physicians focused on front door, revised Acute Care Unit patient categorisation process, patient speciality allocation in Acute Care Units, initiatives as part of the length of stay project such as weekend discharge team and patient repatriation are focused on to reduce medical outliers.

Narrative: The daily average number of medical outliers was 49 at Gloucestershire Royal and 6 at Cheltenham General in May 2016; a reduction from 54 and 23 respectively last month.

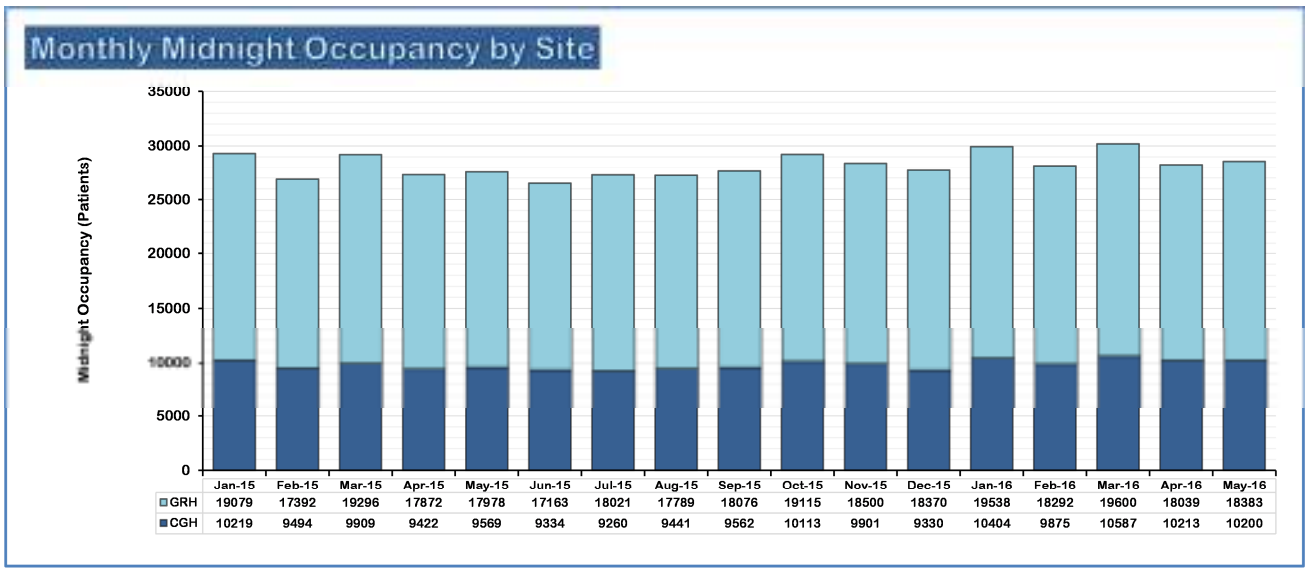


3.9.3 Midnight Bed Occupancy

Aim: To reduce the number of beds occupied and Trust percentage.

How: Every patient, every day, Estimated Date of Discharge, discharges, discharge waiting areas, Blaylock tool, ticket home, bed manager walk-downs.

Narrative: The daily average number of beds occupied in May 2016 was 922.0, compared to May 2015 (888.6 per day) and April 2016 (941.7 per day).



	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
GRH	19079	17392	19296	17872	17978	17163	18021	17789	18076	19115	18500	18370	19538	18292	19600	18039	18383
CGH	10219	9494	9909	9422	9569	9334	9260	9441	9562	10113	9901	9330	10404	9875	10587	10213	10200

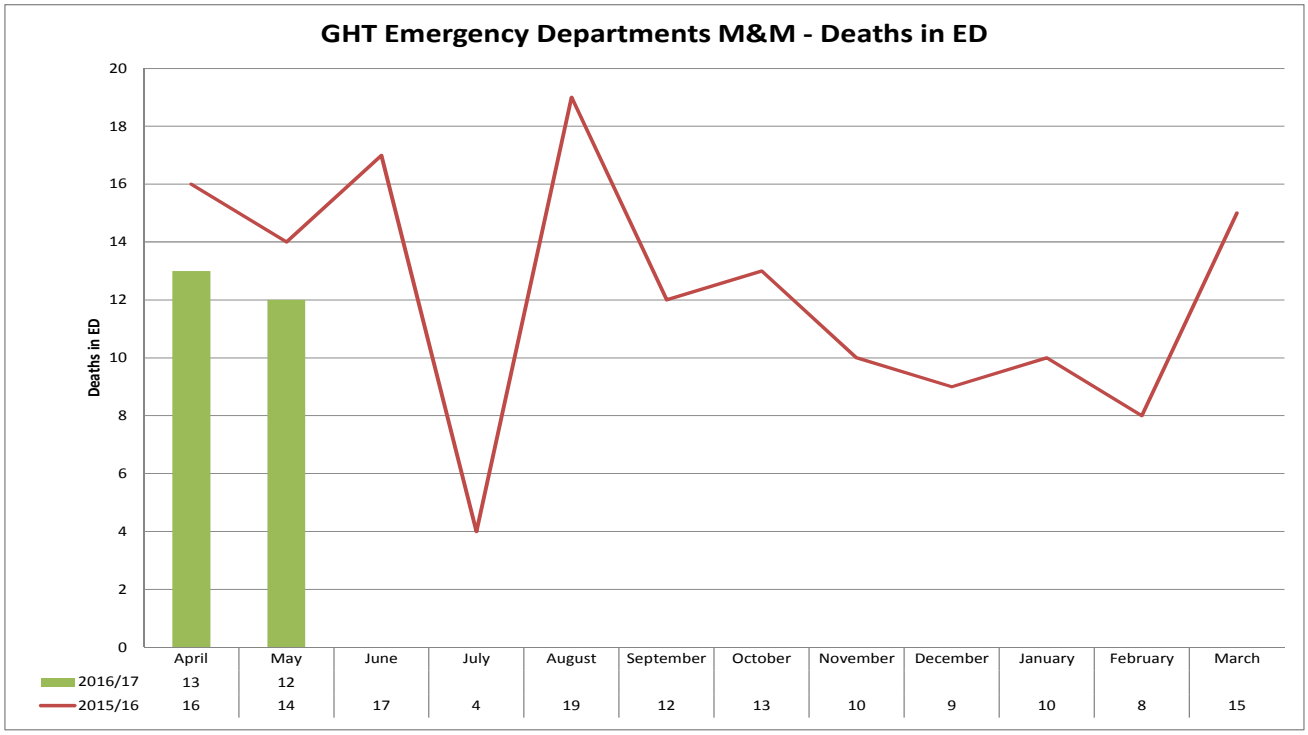
% Bed Occupancy (as at Thursday snapshot)

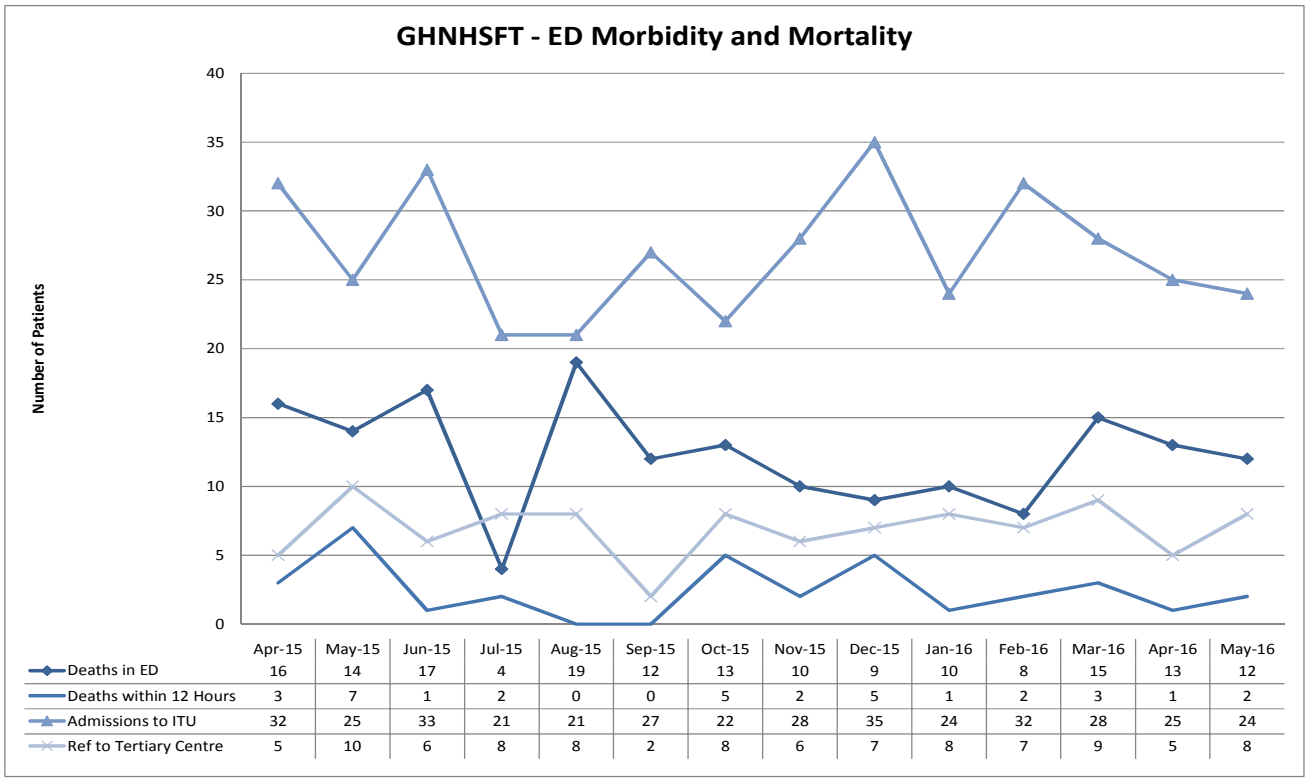
Week ending:	CGH	GRH	Total
08/05/2016	97.3%	95.9%	**96.5%**
15/05/2016	96.5%	98.3%	**97.6%**
22/05/2016	89.3%	97.6%	**94.3%**
29/05/2016	97.2%	97.0%	**97.1%**

3.10 ED Morbidity and Mortality

Aim: To review the Morbidity and Mortality trend.

Narrative: During May 2016 there were 12 deaths in the Emergency Department, which is lower than May last year (-2). There were 24 admissions to ITU and 8 referrals to tertiary centres. All of the deaths are reviewed in detail at the Service Line Morbidity and Mortality Reviews.





3.11 Medical Staffing

Aim: To ensure sufficient doctors are on duty in the Emergency Department and Acute Medicine.

Narrative: Whilst there has been success in recruiting Emergency Department Consultants, there remain gaps in middle grade rotas especially in Acute Medicine. This is one of the main contributors to Emergency Department breaches. Regular review of the rotas is underway an in the interim locums will continue to be employed to cover.

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

		Establishment (wte)	In Post May (wte)	Variance In Post vs. Establishment	Variance vs. in Post in April
Emergency Department	Consultants	17.70	19.51	+1.8	-0.9
	Trainee Doctors	34.49	32.30	-2.2	+0.20
Acute Medicine	Consultants	11.03	8.33	-2.70	0
	Trainee Doctors	83.29	67.60	-15.70	+1.2

As part of the 2015/16 contract negotiations, the Trust secured funding for three Emergency Department Consultants and 4.8 Emergency Nurse Practitioners for the Emergency Department. The full Emergency Department rota went live from 1st November 2015, providing consultant cover until midnight, seven days a week. Plans have been developed for alternative ways of covering the middle grade rota, which are currently under review by the Director of Service Delivery and the Medical Director.

Key Actions Going Forward

- To continue with the three immediate priority workstreams:

1. Emergency Department – with specific focus on the safety metrics for Time to Initial Assessment within 15 minutes and Time to Treatment within 60 minutes.
2. Site Management – to increase the presence of senior co-ordination of both hospitals 24/7, to ensure patients are in the right place, first time.
3. >=14 Day Length of Stay patients – to reduce the number of these patients who currently occupy 65% of total bed days across the Trust.

- To commence the three further workstreams and deliver the programme plan as attached Appendix 1.

Report Authors:

Andrew Seaton – Director of Safety

Heather Beer – Head of Patient Experience

Kim Hemming – Divisional Information Manager, Medicine

Jackie Miller – Senior Information Analyst

Lou Porter – Programme Manager

Presenting Executive:

Eric Gatling – Director of Service Delivery

EMERGENCY PATHWAY REPORT
APPENDIX 1 – EMERGENCY CARE IMPROVEMENT PLAN
FOR MAIN BOARD IN JUNE 2016

1. Background

The Board is sighted on the difficulties the Trust is experiencing in addressing the issues in the provision of emergency care for our patients. The performance of the Emergency Department (ED) standard has not been achieved for the last 5 years at an annual level, and has steadily declined over the last year with only one month, June 2015 achieving the required national standard and further deterioration form November 2015 onwards.

As a consequence, the Executive and Divisions have sought to reflect and identify the fundamental root causes of the issues in emergency care and provide solutions for the short and medium term, while simultaneously the System Resilience Group (SRG) is undergoing a similar process for the system.

In undertaking this work, the feedback from external reviews, NHS Improvement (NHSI), learning from visits to other systems and recognised best practice is a key plank on which the organisation is moving forward.

The three main issues the Trust will be addressing are:

- Ensuring patients in ED are assessed and treated in a timely way
- Improving the capacity and flow of beds across the Trust and externally
- Right sizing the physical capacity of the ED departments in relation to the activity moving through them.

2. Alternative approach

The Trust has sought to narrow its focus and concentrate on what will make the most significant difference to patient experience and outcome in the short and medium term. The key premise of this programme is to make into reality "**Best Care for Everyone"** underpinning any and every improvement.

The six main work streams with the Executive Leads are detailed in table 1 below:

Table 1:

Work stream Title	Executive Lead
Emergency Department	Director of Nursing & Midwifery
Site Management	Director of Service Delivery
SAFER Patient Flow Bundle	Medical Director
Clinical Patient Flow Model	Director of Clinical Strategy
Bed Distribution	Director of Service Delivery
Remove Delays to Discharge - External	Director of Nursing & Midwifery

A brief synopsis of each element is given below:

Emergency department

The essence of this programme of work is to ensure the department models the demand and capacity for ED using best practice guidance from NHSI, and to ultimately have the right staff, with the right skills at the right time to provide best care. This will be underpinned by training for the identified roles and responsibilities, ED safety checklist and the learning and solutions for issues arising from the breach analysis.

Site Management

Included here is the revision of Trust wide bed and escalation policies to ensure they are fit for purpose and consistently implemented. This will include revising the existing bronze, silver and gold on call arrangements and very clear policies in times of heightened escalation.

SAFER patient flow bundle

This will include recognised best practice for all patients and builds on the work already started to implement a set of simple rules for adult inpatient wards to improve patient flow and prevent unnecessary waiting for patients. This includes:

S – Senior Review Undertake a senior review before midday for all patients by a clinician able to make management and discharge decisions

A – All Patients will have an Expected Date of Discharge and Clinical Criteria for discharge

F- Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards

E – Early Discharge – an increasing number of patients will be discharged before midday

R – Review – A systematic Medical Discharge Team (MDT) review all patients with an extended Length of stay over 14 days

Clinical Model

This work stream has the objective of optimising the patient experience at the point at which a patient receives a first senior review either in ED or an assessment unit, advocating that the default position should be to treat patients in an ambulatory setting rather than as an inpatient admission. This will look at the solutions and requirements for this approach.

Bed Distribution

The objective of 'right sizing 'the Trust bed base to reflect the demand, operational practice and scope for improvement for emergency and elective care to ensure all patients that require a bed, whether for a planned procedure or as an emergency patient can be accommodated.

Remove Delays to Discharge

The Trust is experiencing a significant number of delays to other services which can result in patients spending time in hospital when an alternative, more appropriate setting may be more suitable for their care.

Underpinning these elements will be some corporate cross-cutting work streams that enable, support or provide assurance to front line patient care. These work streams and Executive leads are detailed in table 2 below:

Table 2:

Work Stream Title	Executive Lead
Information Reporting & Business Intelligence	Director of Finance

Personalised Care & Patient Experience	Director of Nursing & Midwifery
Communication & Engagement	Director of Service Delivery
Governance	Chief Executive
Safety	Medical Director

3. Governance and Resources

It should be noted that although the work streams are detailed separately, there are co-dependencies and potential risks which the Emergency Care Programme Board will have over sight and will ensure are addressed as part of the governance arrangements. We will align the objectives of the cultural change programme and the approach advocated by the Gloucestershire Hospitals Quality Improvement Academy (GHQIA) will be used in undertaking any change. However, it should be noted, that it is not the intention for this programme to be all encompassing and where elements of work are underway elsewhere they will be cross referenced and dependencies identified.

Discussions are underway to agree the most appropriate governance arrangements for the Programme, in the context of the developing arrangements for the wider governance of transformation programmes across the Trust that will ensure the programme stays on track and delivers the objectives. The reporting from front line to Board will be aligned in the timescales as detailed in the programme.

The detail scrutiny of the plan and holding the Executive to account will sit with the Finance and Performance Committee and a workshop with the lead Non-Executive Directors has already taken place.

The programme will be resourced using talent that exists within the organisation under a transformation team to ensure this work stream (one of several) is aligned to other key Trust objectives.

LAST UPDATE:	14.06.2016

BRAG STATUS				
Delivered	Not on Track to Deliver	Some Issues - Narrative Disclosure	On Track to Deliver	Action Closed

EXECUTIVE LEAD:	Director of Nursing & Midwifery **- Maggie Arnold**	Outcome Measures:	- ED 4hr Standard
WORKSTREAM 1:	**Emergency Department**	Process Measures:	- 15 Minute to Time to Initial Assessment - 60 Minute to Time to Treatment - Number of patients in the department >6hrs - Number of 12hr Trolley waits - Number of patients waiting in the corridor - ED Safety Checklist - Number of Diverts - Number of Ambulance Handover delays >30 minutes
		Balancing Measures:	- Volume of activity - Number of patients left before seen - Number of return attendances (within 7 days) - Number of ambulances - Numbers streamed to GP Pilot and AEC

REFERENCE NUMBER	SUB-REFERENCE NUMBER	SUMMARY OF ACTION	NHSI / CQC	SITE (only specify if not applicable to both sites)	EXECUTIVE OR DIVISIONAL TRI OWNER (if different from Executive Lead)	ACTION OWNER	START DATE	END DATE	BRAG STATUS	COMPLETED / CLOSED DATE	EVIDENCE OF ACTION COMPLETED	DEPENDANCY	EMBEDMENT DATE	EVIDENCE OF EMBEDMENT	COMMENTS
1.1		**Ensure staffing and skill mix are matched to the times of patients' presentations**													**Ref 3.3.30 from old plan subsumed into 1.1**
	1.1.1	**Model the demand and capacity for ED using best practice guidance from NHSI**													
	1.1.1.1	Undertake Consultant Demand & Capacity analysis			Chief of Service, Medicine	General Manager, Unscheduled Care	**01.04.2016**	**17.06.2016**							
	1.1.1.2	Undertake Nursing Demand & Capacity analysis			Director of Nursing, Medicine	Modern Matron, Unscheduled Care	**01.04.2016**	**17.06.2016**							
	1.1.1.3	Identify gaps and change rota if required, focussing on nights and weekends	**CQC**		Divisional Medicine TRI	Unscheduled Care Quad	**01.04.2016**	**17.06.2016**							Ref 3.3.2, 3.3.2.2a, 3.3.20 from old plan subsumed into 1.1.1.3
	1.1.1.4	Undertake peer review internally and externally	**CQC**		Medical Director & Director of Nursing & Midwifery	Chief of Service & Director of Nursing, Medicine	**01.04.2016**	**17.06.2016**							Ref 3.3.2.2 from old plan subsumed into 1.1.1.4
	1.1.1.5	Identify staffing options for any residual gaps			Medical Director & Director of Nursing & Midwifery	Chief of Service & Director of Nursing, Medicine	**16.05.2016**	**24.06.2016**							Ref 3.3.2.5 from old plan subsumed into 1.1.1.5
	1.1.1.6	Ensure ED roles and responsibilities are clearly understood			Divisional Medicine TRI	Unscheduled Care Quad	**16.05.2016**	**24.06.2016**							Ref 3.3.28 from old plan subsumed into 1.1.1.6
	1.1.1.7	Construct Business Case			Divisional Medicine TRI	Unscheduled Care Quad	**23.05.2016**	**15.07.2016**							
	1.1.1.8	Recruit to approved posts			Divisional Medicine TRI	Unscheduled Care Quad	**11.07.2016**	**30.11.2016**							
	1.1.2	**Ensure operational policies are in place and staff are appropriately trained**													
	1.1.2.1	Write handover protocol ED to Wards (Nursing)			Director of Nursing, Medicine	Modern Matron, Unscheduled Care	**13.06.2016**	**15.07.2016**							Ref 3.3.24 from old plan subsumed into 1.1.2.1
	1.1.2.2	Ensure operational policy for the EDs are fit for purpose			Divisional Medicine TRI	Unscheduled Care Quad	**13.06.2016**	**15.07.2016**							
	1.1.2.3	Conduct the flow co-ordinator training, using external expertise from NHSI			Director of Nursing, Medicine	Modern Matron, Unscheduled Care	**01.04.2016**	**16.06.2016**							Ref 3.3.32 from old plan subsumed into 1.1.2.3
	1.1.2.4	Ensure Divisional TRI and Service line Quad have (at least) Bronze QIA training on service improvement			Divisional Medicine TRI	Unscheduled Care Quad	**05.05.2016**	**31.07.2016**							
	1.1.2.5	Introduce the ED Safety Checklist for all patients in Majors and Resus, with the aim to achieve 95% compliance consistently			Specialty Director, Unscheduled Care	ED Consultant & Quality Lead	**01.04.2016**	**31.10.2016**				Workstream 8, Reference 8.2	30.04.2017		
	1.1.2.6	Sepsis CQUIN: 1. To screen patients for red-flag Sepsis 2. To deliver antibiotics within 1 hour of emergency admission			Specialty Director, Unscheduled Care	Trust Sepsis Lead (CC)	**01.04.2016**	**31.03.2017**							
	1.1.2.7	Train staff in operational policies, ED Checklist, and Trust escalation policy			Divisional Medicine TRI	Unscheduled Care Quad	**01.05.2016**	**30.09.2016**							
	1.1.2.8	Ensure Senior Medical staff are trained in Level 3 Safeguarding	**CQC**		Chief of Service, Medicine	Specialty Director, Unscheduled Care	**13.06.2016**	**31.07.2016**							Ref 3.3.8.2 from old plan subsumed into 1.1.2.8
	1.1.2.9	Ensure staff understand the ED Quality Indicators and embed best practice and improvement techniques to continually address any issues that may arise			Divisional Medicine TRI	Unscheduled Care Quad	**01.05.2016**	**30.09.2016**							

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BRAG STATUS				
Delivered	Not on Track to Deliver	Some Issues - Narrative Disclosure	On Track to Deliver	Action Closed

EXECUTIVE LEAD:	Director of Nursing & Midwifery - **Maggie Arnold**	Outcome Measures:	- ED 4hr Standard
WORKSTREAM 1:	**Emergency Department**	Process Measures:	- 15 Minute to Time to Initial Assessment - 60 Minute to Time to Treatment - Number of patients in the department >6hrs - Number of 12hr Trolley waits - Number of patients waiting in the corridor - ED Safety Checklist - Number of Diverts - Number of Ambulance Handover delays >30 minutes
		Balancing Measures:	- Volume of activity - Number of patients left before seen - Number of return attendances (within 7 days) - Number of ambulances - Numbers streamed to GP Pilot and AEC

REFERENCE NUMBER	SUB-REFERENCE NUMBER	SUMMARY OF ACTION	NHSI / CQC	SITE (only specify if not applicable to both sites)	EXECUTIVE OR DIVISIONAL TRI OWNER (if different from Executive Lead)	ACTION OWNER	START DATE	END DATE	BRAG STATUS	COMPLETED / CLOSED DATE	EVIDENCE OF ACTION COMPLETED	DEPENDANCY	EMBEDMENT DATE	EVIDENCE OF EMBEDMENT	COMMENTS
1.2		**Design and implement a robust and systematic process for reviewing >4hr wait breaches and implement solutions**													
	1.2.1	**Provide regular details for hospital-wide weekly review**													
	1.2.1.1	Undertake breach analysis on a daily basis to implement quick-wins within the department			Director of Service Delivery	General Manager, Unscheduled Care	**01.04.2016**	**30.06.2016**							Ref 3.3.14 from old plan subsumed into 1.2.1.1
	1.2.1.2	Implement detailed Root Cause Analysis on any patient >10hrs in the department			Director of Service Delivery	General Manager, Unscheduled Care	**24.05.2016**	**30.06.2016**							
	1.2.1.3	Validate the reporting process and develop RCA process for all breaches against the IPS criteria			Director of Service Delivery	General Manager, Unscheduled Care	**13.06.2016**	**31.07.2016**							Ref 3.3.25 from old plan subsumed into 1.2.1.3
	1.2.1.4	Undertake weekly reviews to learn and implement Trustwide solutions			Director of Service Delivery	Divisional TRIs	**05.04.2016**	**30.04.2016**					30.09.2016		Ref 3.3.14, 3.3.31 from old plan subsumed into 1.2.1.4
	1.2.1.5	Ensure the breach analysis process and learning integrates with departmental, service, divisional and Trust governance arrangements			Director of Service Delivery	Director of Safety	**30.06.2016**	**31.10.2016**							Ref 3.3.26 from old plan subsumed into 1.2.1.5
	1.2.1.6	Ensure Patient First is allocated with an appropriate 'ology' prior to patient transfer from ED			Chief of Service, Medicine	Specialty Director, Unscheduled Care	**13.06.2016**	**30.09.2016**							Action from old plan subsumed into 1.2.1.6
1.3		**Implement solutions to address ED capacity**													
	1.3.1	Increase Resus capacity for this winter		**GRH**	Director of Clinical Strategy	Associate Director Programme Management & Service Improvement	**01.04.2016**	**01.11.2016**							Ref 9.0.1 from old plan subsumed into 1.3.1
	1.3.2	Increase Majors capacity for this winter		**GRH**	Director of Clinical Strategy	Associate Director Programme Management & Service Improvement	**01.04.2016**	**01.11.2016**							Ref 9.0.1 from old plan subsumed into 1.3.2
	1.3.3	Increase Minors capacity for this winter		**GRH**		Modern Matron, Unscheduled Care	**01.04.2016**	**01.11.2016**							Ref 9.0.1 from old plan subsumed into 1.3.3
	1.3.4	Increase streaming of GP appropriate cases into the Primary Care pilot		**GRH**	Chief of Service, Medicine	Specialty Director, Unscheduled Care	**01.06.2016**	**31.08.2016**					30.11.2016		Ref 3.1.5 from old plan subsumed into 1.3.4
	1.3.5	Implement agreed SWASFT and GHFT process for improving ambulance handovers and data reconciliation	**CQC**		Director of Operations, Medicine	General Manager, Unscheduled Care	**01.04.2016**	**31.07.2016**							Ref 3.2.1 from old plan subsumed into 1.3.5

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EXECUTIVE LEAD:	Director of Service Delivery - **Eric Gatling**	Outcome Measures:	- Reduction in Outliers
WORKSTREAM 2:	**Site Management**	Process Measures:	- Reduction in Red and Black Escalation days
		Balancing Measures:	- Volume of Emergency Admissions

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2.1		**Ensure ED and Trustwide escalation policies are fit for purpose and implemented consistently**													
	2.1.1	**Review and rewrite ED escalation policy to ensure it is robust, delivers tangible results and is embedded in the organisation, with Action Cards, KPIs and close integration with Trustwide escalation plan.**	**NHSI**												**Ref 3.3.23 from old plan subsumed in 2.1.1**
	2.1.1.1	Draft for consideration			Chief of Service, Medicine	General Manager, Unscheduled Care	**01.05.2016**	**24.06.2016**							
	2.1.1.2	Policy agreed and implemented			Chief of Service, Medicine	General Manager, Unscheduled Care	**01.05.2016**	**30.06.2016**					01.09.2016	- Copy of the Policy and Escalation Cards in place - Tracking that the actions in the policy have been followed when in Red & Black escalation (held by CD)	
	2.1.2	**Review and rewrite Trust escalation policy to ensure it is robust, delivers tangible results and is embedded in the organisation, with Action Cards, KPIs and close integration with system-wide plan and individual Trust department plans.**													**Ref 3.3.4 from old plan subsumed in 2.1.2**
	2.1.2.1	Draft for consideration			Director of Service Delivery, Director of Nursing and Medical Director	General Manager, Service Delivery	**31.05.2016**	**17.06.2016**							
	2.1.2.2	Policy agreed and implemented			Director of Service Delivery, Director of Nursing and Medical Director	General Manager, Service Delivery	**01.06.2016**	**01.08.2016**					01.11.2016	- Copy of the Policy and Escalation Cards in place. - Tracking that the actions in the policy have been followed when in Red & Black escalation (held by SB)	
2.2		**Ensure roles and responsibilites of bronze, silver and gold are clarified, understood and implemented and trained.**													
	2.2.1	**Develop a Competency framework and role descriptions to ensure everyone is aware of their roles and responsibilities.**													
	2.2.1.1	Bronze				General Manager, Service Delivery	**01.04.2016**	**30.06.2016**					01.09.2016	- Competency Framework	
	2.2.1.2	Silver & Gold				Director of Operations Womens & Children's	**01.04.2016**	**30.06.2016**					01.09.2016	- Competency Framework	
	2.2.2	**Develop Operational Policy**													
	2.2.2.1	Consult on operational policy proposals and rota configuration				Director of Operations Womens & Children's	**01.06.2016**	**01.07.2016**							
	2.2.2.2	Review feedback from consultation, define outcome and determine way forward				Director of Operations Womens & Children's	**01.07.2016**	**15.07.2016**							
	2.2.2.3	Implement				Director of Operations Womens & Children's	**01.08.2016**	**31.08.2016**					01.11.2016	- The rotas - Metrics for Outliers and Red / Black Escalation Days.	Ref 3.14.3 from old plan subsumed into 2.2.2.5

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BRAG STATUS				
Delivered	Not on Track to Deliver	Some Issues - Narrative Disclosure	On Track to Deliver	Action Closed

EXECUTIVE LEAD:	Director of Service Delivery - **Eric Gatling**	Outcome Measures:	- Reduction in Outliers
WORKSTREAM 2:	**Site Management**	Process Measures:	- Reduction in Red and Black Escalation days
		Balancing Measures:	- Volume of Emergency Admissions

REFERENCE NUMBER	SUB-REFERENCE NUMBER	SUMMARY OF ACTION	NHSI / CQC	SITE (only specify if not applicable to both sites)	EXECUTIVE OR DIVISIONAL TRI OWNER (if different from Executive Lead)	ACTION OWNER	START DATE	END DATE	BRAG STATUS	COMPLETED / CLOSED DATE	EVIDENCE OF ACTION COMPLETED	DEPENDANCY	EMBEDMENT DATE	EVIDENCE OF EMBEDMENT	COMMENTS
	2.2.3	**Ensure there is a systematic training plan to enable bronze, silver and gold participants to perform their duties**													
	2.2.3.1	Hold training sessions for all partiicpants				Associate Director of Education & Development	**05.07.2016**	**01.09.2016**					01.12.2016	- Training Registers matched against the staff profiles. '- Correct escalation processes followed (evidenced by the tracking of actions undertaken in red / black escalation).	
	2.2.3.2	Ensure all new members of staff who participate in the rotas, undertake training as part of their induction process				Associate Director of Education & Development	**01.09.2015**	**01.10.2016**							
	2.2.3.3	Run regular update sessions for all post-holders				Associate Director of Education & Development	**01.09.2015**	**01.10.2016**						- Annual updates schedule	
2.3		**Ensure Site Meetings are structured, timely, action-focussed and fit-for-purpose**													
	2.3.1	Create structure to the daily meetings to ensure that any issues can be resolved in a timely manner				General Manager, Service Delivery	**19.04.2016**	**27.06.2016**					01.10.2016	- Agreed template - Standard agenda - Action points noted from the site meetings and completed on the Capacity Planner - Proof of attendance in accordance with the agreed template.	Ref 3.14.4 from old plan subsumed into 2.3.1
	2.3.2	Ensure bed states comprehensive oversight of the position of the Trust at any one time, for effective and safe management of patient care				General Manager, Service Delivery	**19.04.2016**	**20.06.2016**					01.09.2016	- Copies of the Capacity Planner circulated in accordance with the agreed timetable.	Ref 3.14.5 from old plan subsumed into 2.3.2
	2.3.3	Ensure repatriation policies are systematically applied				General Manager, Service Delivery	**19.04.2016**	**20.06.2016**							
	2.3.4	Extend opening hours of the temporary staffing office			Director of HR	Temporary Staffing Manager	**19.04.2016**	**30.09.2016**							

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BRAG STATUS				
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EXECUTIVE LEAD:	Medical Director **- Sean Elyan**	Outcome Measures:	- Reduction in the number of patients with a LoS of >14 days - Reduction in the number of bed days occupied by patients with a LoS of >14 days
WORKSTREAM 3:	**SAFER Patient Flow Bundle**	Process Measures:	- Number of patients discharged on their EDD - Increased number of weekend discharges vs. weekday - Increased number of patients using of the Discharge Waiting Area - 1/3 of discharges before midday - Increased percentage of transport booked the day before discharge - Reduction in average Length of Stay - Improved (reduced) hospital occupancy rate - Reduced number of outliers - Reduce number of cancelled elective operations
		Balancing Measures:	- Readmission rate - Number of 0-1 day Length of Stay patients

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3.1		**Ensure robust discharge planning is established throughout the Trust, based on the principles of SAFER discharge.**													**Ref 3.10.17 from old plan subsumed into 3.1**
	3.1.1	**Ensure there is visibility of all patients with a Length of Stay >14 days, on a daily basis, in order to reduce the number of patients and bed days.**													**Ref 7.0.2 from old plan subsumed into 3.1.1**
	3.1.1.1	Ensure regular reporting, by patient, ward, specialty and consultant, with trend data and identifiable targets			Specialty Director, GOAM, Stroke & Neurology	Information Analyst	**21.03.2016**	**01.04.2016**							
	3.1.1.2	Ensure Insight Report is printed and reviewed daily on each ward			Executive Director of Nursing	Ward Managers	**21.03.2016**	**31.07.2016**							
	3.1.1.3	Establish a weekly review meeting for all >14 day patients to instill ownership and accountability of their management plans			Divisional Nursing Director, Medicine	Divisional Nursing Directors	**26.04.2016**	**15.07.2016**							
	3.1.1.4	Ensure there are weekly ward dashboards, with details of key criteria and expectations of improvements identified, and achievements highlighted			Specialty Director, GOAM, Stroke & Neurology	Project Manager, Workstream 3	**07.04.2016**	**15.07.2016**							
	3.1.1.5	Systematically conduct Multi Accelerated Discharge Events (MADE)			Director of Nursing & Midwifery	Director of Nursing, Medicine	**01.06.2016**	**31.07.2016**							
	3.1.2	**Implement the SAFER Patient Flow bundle as described in best practice by ECIP, to reduce unnecessary waiting**													**Ref 3.8.6 from old plan subsumed into 3.1.2**
	3.1.2.1	Roll-out Discharge planning training to include revised SPCA form, discharge planning, communication form and discharge menu, and updating of PAS+ boards, to all wards			Specialty Director, GOAM, Stroke & Neurology	Divisional Nursing Directors	**19.05.2016**	**25.06.2016**							
	3.1.2.2	Update PAS+ boards to remove unnecessary fields and reflect current procedures			Specialty Director, GOAM, Stroke & Neurology	PAS+ Manager	**29.03.2016**	**04.04.2016**							
	3.1.2.3	Deliver structured and consistent board rounds across the Trust (timings, content) in line with best practice, ensuring senior review before midday			Specialty Director, GOAM, Stroke & Neurology	Specialty Directors	**01.06.2016**	**31.08.2016**							Ref 3.8.4 & 3.8.5 from old plan subsumed into 3.1.2.3
	3.1.2.4	Ensure all Estimated Dates of Discharge are provided by Consultants, based on clinical criteria			Specialty Director, GOAM, Stroke & Neurology	Specialty Directors	**01.06.2016**	**31.08.2016**							Ref 3.10.6 from old plan subsumed into 3.1.2.4
	3.1.2.5	Increase number of discharges before 10:00, including the use of the discharge lounge.			Director of Service Delivery	General Manager, Service Delivery	**01.04.2016**	**31.08.2016**					30.11.2016		Ref 3.10.2 from old plan subsumed into 3.1.2.5
	3.1.2.6	Ensure each ward pulls the first patient from the assessment unit, to arrive on the specialty ward before 10:00.			Chiefs of Service	Specialty Directors	**01.07.2016**	**30.11.2016**							
	3.1.2.7	Increase weekend discharges, including provision of 7-Day ward rounds for Gastroenterology & Cardiology			Chief of Service, Medicine	Director of Operations, Medicine	**01.06.2016**	**31.08.2016**							Ref 3.10.8, 3.10.9 from old plan subsumed into 3.1.2.7
	3.1.2.8	Ensure transport arrangements are confirmed in advance. Target increase percentage booked the day before. As per SAFER CQUIN			Divisional Nursing Directors	Matrons	**01.06.2016**	**31.08.2016**					30.11.2016		
	3.1.2.9	Ensure third-party contractors for transport services, meet the needs for patient discharge			Director of Service Delivery	General Manager, Service Delivery	**01.08.2016**	**30.09.2016**							
	3.1.2.10	Ensure TTOs are written up in advance or in real-time			Chiefs of Service	Specialty Directors	**01.06.2016**	**30.09.2016**					31.03.2017		

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EXECUTIVE LEAD:	Director of Clinical Strategy **- Sally Pearson**	Outcome Measures:	- Reduce mortality - Increase of % of patients seen within 4hrs in ED
WORKSTREAM 4:	**Clinical Patient Flow Model**	Process Measures:	- Reduce ED Attendances - Reduce Emergency Admissions - Increase attendances direct to AEC from SWASFT - Increase attendances to AEC from ED - Increase attendances to AEC from ACU - Reduce Length of Stay - Reduce standardised admission ratio
		Balancing Measures:	- Increase in readmission rates - Increased MIU attendances - Increased GP attendances - Increased complaints - Decrease in % of patients seen within 18 weeks - Increase in diagnostic tests

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4.1		**Stream GP and ED referrals direct to assessment areas for Medicine, Surgery, Paediatrics, Trauma and Frail Elderly**													
	4.1.1	Establish Programme Board & Project Team				Project Manager	**13.06.2016**	**01.07.2016**							
	4.1.2	**Identify clinical model for four emergency pathway presentations and map them for the following clinical areas**													
	4.1.2.1	Medicine			Consultant Respiratory Physician (AW)	Chief Registrar (ZJ)	**01.07.2016**	**20.07.2016**							Ref 3.1.3 from old plan subsumed into 4.1.2.1
	4.1.2.2	Increase Low Risk Chest Pain pathway into AEC			Chief of Service, Medicine	Specialty Director for Cardiology	**01.07.2016**	**20.07.2016**							
	4.1.2.3	Increase COPD pathway into AEC			Chief of Service, Medicine	Specialty Director for Respiratory	**01.07.2016**	**20.07.2016**							
	4.1.2.4	Increase streaming of GP Ambulatory Emergency Care referrals direct to the department			Chief of Service, Medicine	Specialty Director, Unscheduled Care	**01.07.2016**	**20.07.2016**							
	4.1.2.5	Increase streaming of SWASFT Ambulatory Emergency Care referrals direct to the department			Chief of Service, Medicine	Specialty Director, Unscheduled Care	**01.07.2016**	**20.07.2016**							
	4.1.2.6	Implement 1-hour TROP-T tests in ED, AEC and assessment units			Chief of Service, Medicine	Consultant Cardiologist (PS)	**01.06.2016**	**01.08.2016**							
	4.1.2.7	Surgical			Chief of Service, Surgery	Chief Registrar (ZJ)	**01.07.2016**	**10.08.2016**						- Clinical model description, SOP and Ward Dashboard	
	4.1.2.8	Implement Abdominal Pain pathway			Chief of Service, Surgery	Specialty Director for General Surgery	**01.07.2016**	**10.08.2016**							Ref 3.4.4.1 on old plan subsumed into Ref 4.1.2.8
	4.1.2.9	Increase streaming of GP Paediatric referrals direct to the Paediatric Assessment Unit			Chief of Service, Womens & Childrens	Chief Registrar (ZJ)	**01.07.2016**	**20.07.2016**							
	4.1.2.10	Trauma			Chief of Service, Surgery	Chief Registrar (ZJ)	**01.07.2016**	**10.08.2016**							
	4.1.2.11	Frail Elderly			GOAM Consultant (ID)	Chief Registrar (EB)	**01.07.2016**	**20.07.2016**							
	4.1.2.12	Ensure patients mental capacity is clearly documented in relation to *"Do not attempt CPR"* and *"unwell / potentially deteriorating"* on patient plan forms.	**CQC**			Chief Registrar (ZJ)	**01.07.2016**	**10.08.2016**							**10.06.16:** Comment from SP that this will be picked up in workstream 4 but will need to be in others if condition changes.
	4.1.2.13	Determine measurable Internal Professional Standards for each discipline				Chief Registrar (ZJ)	**01.07.2016**	**10.08.2016**							
	4.1.3	**Identify workflows / volumes and capacity requirements (physical and human) and location**										**Workstream 5 - Ref. 5.1.8 & Workstream 6 - Ref 6.1.1.4**			**Ref 3.3.2.3, 3.3.2.4 & 3.3.1.3 on old plan subsumed into 4.1.3**
	4.1.3.1	Medicine			Consultant Respiratory Physician (AW)	Chief Registrar (ZJ)	**20.07.2016**	**31.07.2016**							
	4.1.3.2	Surgical			Chief of Service, Surgery	Chief Registrar (ZJ)	**10.08.2016**	**31.08.2016**							
	4.1.3.3	Paediatrics			Chief of Service, Womens & Childrens	Chief Registrar (ZJ)	**20.07.2016**	**31.07.2016**							
	4.1.3.4	Trauma			Chief of Service, Surgery	Chief Registrar (ZJ)	**10.08.2016**	**31.08.2016**							
	4.1.3.5	Frail Elderly			GOAM Consultant (ID)	Chief Registrar (EB)	**20.07.2016**	**31.07.2016**							
	4.1.4	**Ensure workforce model, operational policies, rotas and training are aligned to requirements**													

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EXECUTIVE LEAD:	Director of Clinical Strategy - **Sally Pearson**	Outcome Measures:	- Reduce mortality - Increase of % of patients seen within 4hrs in ED
WORKSTREAM 4:	**Clinical Patient Flow Model**	Process Measures:	- Reduce ED Attendances - Reduce Emergency Admissions - Increase attendances direct to AEC from SWASFT - Increase attendances to AEC from ED - Increase attendances to AEC from ACU - Reduce Length of Stay - Reduce standardised admission ratio
		Balancing Measures:	- Increase in readmission rates - Increased MIU attendances - Increased GP attendances - Increased complaints - Decrease in % of patients seen within 18 weeks - Increase in diagnostic tests

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	4.1.4.1	Medicine			Consultant Respiratory Physician (AW)	Chief Registrar (ZJ)	**31.07.2016**	**31.08.2016**							
	4.1.4.2	Surgical			Chief of Service, Surgery	Chief Registrar (ZJ)	**31.08.2016**	**30.09.2016**							
	4.1.4.3	Paediatrics			Chief of Service, Womens & Childrens	Chief Registrar (ZJ)	**31.07.2016**	**31.08.2016**							
	4.1.4.4	Trauma			Chief of Service, Surgery	Chief Registrar (ZJ)	**31.08.2016**	**30.09.2016**							
	4.1.4.5	Frail Elderly			GOAM Consultant (ID)	Chief Registrar (EB)	**31.07.2016**	**31.08.2016**							
	4.1.5	**Communicate model, process and go-live date internally and externally**										**Outcome of 4.1.4 may identify need for changes to physical estate, or substantial service change, which will require re-profiling of implentation timetable.**			
	4.1.5.1	Medicine			Consultant Respiratory Physician (AW)	Head of Communications & Marketing	**31.08.2016**	**14.09.2016**							
	4.1.5.2	Surgical			Chief of Service, Surgery	Head of Communications & Marketing	**30.09.2016**	**14.10.2016**							
	4.1.5.3	Paediatrics			Chief of Service, Womens & Childrens	Head of Communications & Marketing	**31.08.2016**	**14.09.2016**							
	4.1.5.4	Trauma			Chief of Service, Surgery	Head of Communications & Marketing	**30.09.2016**	**14.10.2016**							
	4.1.5.5	Frail Elderly			GOAM Consultant (ID)	Head of Communications & Marketing	**31.08.2016**	**14.09.2016**							

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EXECUTIVE LEAD:	Director of Clinical Strategy - **Sally Pearson**	Outcome Measures:	- Reduce mortality - Increase of % of patients seen within 4hrs in ED
WORKSTREAM 4:	**Clinical Patient Flow Model**	Process Measures:	- Reduce ED Attendances - Reduce Emergency Admissions - Increase attendances direct to AEC from SWASFT - Increase attendances to AEC from ED - Increase attendances to AEC from ACU - Reduce Length of Stay - Reduce standardised admission ratio
		Balancing Measures:	- Increase in readmission rates - Increased MIU attendances - Increased GP attendances - Increased complaints - Decrease in % of patients seen within 18 weeks - Increase in diagnostic tests

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	4.1.6	**Implement soft-launch**										**Outcome of 4.1.4 may identify need for changes to physical estate, or substantial service change, which will require re-profiling of implentation timetable.**			**Ref 3.4.5, 3.4.5.1, 3.7.1 from old plan subsumed in 4.1.6**
	4.1.6.1	Medicine			Consultant Respiratory Physician (AW)	Chief Registrar (ZJ)	**14.09.2016**	**14.10.2016**							
	4.1.6.2	Surgical			Chief of Service, Surgery	Chief Registrar (ZJ)	**14.10.2016**	**14.11.2016**							
	4.1.6.3	Paediatrics			Chief of Service, Womens & Childrens	Chief Registrar (ZJ)	**14.09.2016**	**14.10.2016**							
	4.1.6.4	Trauma			Chief of Service, Surgery	Chief Registrar (ZJ)	**14.10.2016**	**14.11.2016**							
	4.1.6.5	Frail Elderly			GOAM Consultant (ID)	Chief Registrar (EB)	**14.09.2016**	**14.10.2016**							

LAST UPDATE:	14.06.2016

BRAG STATUS				
Delivered	Not on Track to Deliver	Some Issues - Narrative Disclosure	On Track to Deliver	Action Closed

EXECUTIVE LEAD:	Director of Service Delivery - **Eric Gatling**	Outcome Measures:	- Every patient is accommodated in the right place, for their clinical requirement
WORKSTREAM 5:	**Bed Distribution**	Process Measures:	- Reduction in Medical outliers - No cancellation of elective surgery - No unplanned escalation areas
		Balancing Measures:	- Volume of activity - Outpatient conversion rate / increase in referrals

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5.1		**Ensure bed capacity meets the contractural and actual patient demand, across elective and emergency care**													
	5.1.1	Model contract predicted activity into a bed requirement (activity X x existing LOS by HRG), to provide baseline scenario				Information Analyst	**01.06.2016**	**30.06.2016**							
	5.1.2	Scheduling - Electives: model electives from consultant timetables, whilst assuming 90% utilisation of Theatres			Chief of Service, Surgery	Information Analyst	**01.07.2016**	**31.07.2016**							
	5.1.3	Model emergency bed requirements based on current practise / demand (not contract)				Information Analyst	**01.07.2016**	**31.07.2016**							
	5.1.4	Operational Model - Develop an agree operating model for beds				Directors of Operations	**01.07.2016**	**31.07.2016**							
	5.1.5	Benchmark against national best practice and develop alternative scenarios				Information Analyst	**01.07.2016**	**31.07.2016**							
	5.1.6	Provide the correct bed allocation between sites / divisions / specialities to accommodate utilisation, demand and escalation on the recommended and agreed scenario				Information Analyst	**01.08.2016**	**31.08.2016**							Ref 9.0.2 on old plan subsumed into Ref 5.1.6
	5.1.7	Implement the Cardiology plan for Angiographies and PCIs, reducing Length of Stay		**GRH**	Chief of Service, Medicine	Director of Operations, Medicine	**01.05.2016**	**31.07.2016**							Ref 9.0.6 on old plan subsumed into Ref 5.1.7
	5.1.8	Identify phasing for implementation of bed allocation, including assessment units, Hyper Acute Support Unit (Stroke), medical and surgical capacity (cross-checking the outcome of workstream 4)	**NHSI (Stroke)**		Director of Operations, Medicine	General Manager, GOAM, Stroke & Neurology	**01.09.2016**	**30.09.2016**				Workstream 4 - Ref. 4.2.3 & Workstream 6 - Ref 6.1.1.4			Ref 3.10.10 on old plan subsumed into Ref 5.1.8
	5.1.9	Implement recommendations			Chiefs of Service	Directors of Operations	**01.10.2016**	**30.11.2016**							

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BRAG STATUS				
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EXECUTIVE LEAD:	Director of Nursing & Midwifery - **Maggie Arnold**	Outcome Measures:	- Reduction in Medically Fit for Discharge list - Increase number of same-day discharges from ED, ACU and Short-stay ward - Reduction in Length of Stay
WORKSTREAM 6:	**Removing Delays to Discharge**	Process Measures:	- Allocation of EDD by day 1 of admission - Reduction in red days for MFFD patients
		Balancing Measures:	- Volume of Emergency Admissions - Readmission Rate - Capacity in the Community - Quality of discharge (safety & experience)

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6.1		**External Delays (Assessment & Provision)**													
	6.1.1	**Enable safe, prompt and timely discharge, utilising intermediate care beds in nursing homes**										**Review in light of the SRG's evaluation of the Discharge to Assess model**			
	6.1.1.1	Establish project group				Head of Patient Experience		**24.06.2016**							
	6.1.1.2	Visit Oxford				Head of Patient Experience	**09.06.2016**	**09.06.2016**							
	6.1.1.3	Scope model for Gloucestershire				Head of Patient Experience		**30.06.2016**							
	6.1.1.4	Business Case agreed				Head of Patient Experience		**31.07.2016**				Workstream 4 - Ref. 4.2.3 & Workstream 5 - Ref 5.1.8			
	6.1.1.5	Contract Agreed				Head of Patient Experience		**30.09.2016**							
	6.1.1.6	Recruitment of Clinical team				Head of Patient Experience		**31.10.2016**							
	6.1.1.7	Implement				Head of Patient Experience	**07.11.2016**	**31.01.2017**							
	6.1.2	**Ensure robust processes for external repatriation**													
	6.1.2.1	Identify current blockages (transfers to Swindon for Vascular)			Chief of Service, Surgery	Director of Operations, Surgery	**01.07.2016**	**31.10.2016**							
	6.1.2.2	Review network agreements for Cardiac patients with Bristol and Oxford			Chief of Service, Medicine	Director of Operations, Medicine	**01.07.2016**	**31.10.2016**							
	6.1.2.3	Ensure patients requiring fast track discharge are highlighted and expedited in a timely fashion			Chiefs of Service, Diagnostics & Specialites	OHPCLI Service Line, General Manager	**01.07.2016**	**30.09.2016**							
	6.1.2.4	Identify solutions for Palliative Care support			Chiefs of Service, Diagnostics & Specialites	OHPCLI Service Line, General Manager	**01.07.2016**	**30.09.2016**							
6.2		**Internal Delays (Assessment & Provision)**													
	6.2.1	**Review provision of IDT to ensure in line with best practice**													**Ref 3.10.3, 7.0.4 & 3.10.4b from old plan subsumed into 6.2.1**
	6.2.1.1	Conduct gap analysis against the best practice guidance			Director of Service Delivery	IDT Managers	**01.06.2016**	**31.07.2016**							
	6.2.1.2	Use improvement methodology to identify the drivers for change and suggested solutions			Director of Service Delivery	Head of Patient Experience	**01.08.2016**	**30.09.2016**							
	6.2.1.3	Implement any changes identified, incorporating feedback from third parties (Healthwatch) and patients			Director of Service Delivery	Head of Patient Experience	**01.10.2016**	**31.03.2017**							Ref 3.10.15 from old plan subsumed into 6.2.1.3
	6.2.2	**Provision of Pharmacy & Therapy staff and equipment (for complex discharges)**													
	6.2.2.1	Identify constraints and solutions (e.g. availability of therapy assistants at weekends)			Chief of Service, Diagnostics & Specialties	Head of Therapies & Head of Pharmacy	**01.07.2016**	**31.08.2016**							Ref 3.10.11 from old plan subsumed into 6.2.2.1
	6.2.2.2	Implement 'quick-wins'			Chief of Service, Diagnostics & Specialties	Head of Therapies & Head of Pharmacy	**01.09.2016**	**31.10.2016**							

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BRAG STATUS				
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EXECUTIVE LEAD:	Deputy CEO & Executive Director of Finance - **Helen Simpson**	Outcome Measures:	
ENABLING WORKSTREAM 7:	**Information Reporting & Business Intelligence**	Process Measures:	
		Balancing Measures:	

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7.1		**To provide sufficient Business Intelligence to support the workstreams and change initiatives for the Emergency Care Programme**													
	7.1.1	**Ensure capacity in place within Business Intelligence team and staff appropriately trained**													
	7.1.1.1	Undertake review of existing structure identifying gaps and identifying staffing options				Head of Business Intelligence	**01.04.2016**	**30.04.2016**							
	7.1.1.2	Construct business case and present for approval				Head of Business Intelligence	**01.05.2016**	**30.06.2016**							
	7.1.1.3	Recruit to approve posts insuring Interim support to cover gaps whilst recruiting				Head of Business Intelligence	**01.07.2016**	**30.10.2016**							
	7.1.2	**Design and implement Business Intelligence for all workstreams as they evolve**													
	7.1.2.1	Identify the measures for each workstream, including tolerances, improvement requirement and definition of measurement				Head of Business Intelligence	**01.04.2016**	**15.07.2016**							
	7.1.2.2	Agree the format, construct and visualisation required (e.g. by Department, Ward, Consultant, etc) and trend				Head of Business Intelligence	**15.07.2016**	**30.09.2016**							
	7.1.2.3	Benchmark against best practice, where applicable, to identify scope for change				Head of Business Intelligence	**15.07.2016**	**30.09.2016**							
	7.1.2.4	Roll-out plans for workstream requirements systematically				Head of Business Intelligence	**15.07.2016**	**30.09.2016**							
	7.1.2.5	Ensure run-charts, SPC charts and adhoc requests can be fulfilled to embed change practices as schemes develop				Head of Business Intelligence	**13.06.2016**	**30.09.2016**							

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EXECUTIVE LEAD:	Director of Nursing & Midwifery **- Maggie Arnold**	**Outcome Measures:**	**- Increased response rate for FFT** **- Improved pain assessment and management scores in the next Patient Experience capture**
ENABLING WORKSTREAM 8:	**Personalised Care & Patient Experience**	**Process Measures:**	**- Increase the sample size of the FFT** **- ED Checklist pain scores identified and addressed**
		Balancing Measures:	**- Volume of activity** **- Compliance with the ED Safety Checklist**

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8.1		**Improve Friends & Family Test response rate in ED**													**Ref 8.0.1 on old plan subsumed into Ref 8.1**
	8.1.1	Provide additional support for existing card methodology to ED staff and patients				Head of Patient Experience	**01.02.2016**	**31.07.2016**			- Local target of 8% response rate met				Embedment not applicable as change in methodology to digital
	8.1.2	Change in FFT provider via Procurement process				Head of Patient Experience	**01.04.2016**	**01.06.2016**		01.06.2016	- New contract in situ				
	8.1.3	Implementation of digital methodology				Head of Patient Experience	**01.05.2016**	**31.07.2016**			- Reports from the provider will state methods used (e.g. SMS)	TrakCare	31.01.2017	- Achievement of locally determined target and it's sustainability	
	8.1.4	Establish trajectory to reach Trust locally-set target				Head of Patient Experience	**01.11.2016**	**31.12.2016**			- Trajectory	TrakCare	TBC	- Response rate meeting trajectory	
8.2		**Improve assessment and management of pain in ED**	**CQC**									Workstream 1, Reference 1.1.2.5			**Ref 8.0.2 on old plan subsumed into Ref 8.2**
	8.2.1	Monitor compliance of pain assessment and management		**CGH**	Director of Safety	Clinical Governance Lead for ED	**01.04.2016**	**31.10.2016**					30.04.2017		
	8.2.2	Monitor compliance of pain assessment and management		**GRH**	Director of Safety	Clinical Governance Lead for ED	**01.06.2016**	**31.10.2016**					30.04.2017		
	8.2.3	Quarterly monitoring to ECB			Director of Safety	Clinical Governance Lead for ED	**31.10.2016**	**30.04.2017**							

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EXECUTIVE LEAD:	Director of Service Delivery - **Eric Gatling**	Outcome Measures:	- Increase in staff survey scores on engagement - Increase in staff survey scores on ability to influence change
ENABLING WORKSTREAM 9:	**Communication & Engagement**	Process Measures:	- Number of 'hits' on the Outline link - Number of 'hits' on SAFER intranet page - Number of change projects iniatiated in the Emergency Care Programme
		Balancing Measures:	

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9.1		**Internal communication: Targeted staff communications and engagement to raise awareness of emergency care and the need to improve patient care**													
	9.1.1	Develop a visual identity aligned to our vision to deliver consistent messaging that is recognised across the organisation				Head of Communications	**01.03.2016**	**01.05.2016**			SAFER launched and all materials co-branded in line with this identity			SAFER being used as vehicle to communicate all messages	
	9.1.2	Launch a website portal to support learning, development & education and that is consistently branded with SAFER				Head of Communications & Head of Learning & Development	**01.03.2016**	**01.05.2016**			Website launched: safergloshospitals.co.uk			Website link being shared with clinical staff and as part of induction training	
	9.1.3	Launch website portal with staff: Poster, pop-up banner & staff meetings				Head of Communications & Head of Learning & Development	**01.03.2016**	**30.06.2016**			Poster and pop-up banner completed			Google analytics to monitor staff engagement	
	9.1.4	Develop & launch a dedicated intranet space that is informative and aligned to SAFER branding				Head of Communications	**01.03.2016**	**01.05.2016**			Dedicated intranet space launched			The section on the intranet will remain on the homepage indefinitely	
	9.1.5	Develop & launch a newsletter that is accessible and available to staff				Head of Communications	**18.04.2016**	**31.05.2016**			First edition distributed to staff electronically & hard copy			Further copies being planned. Hard copies will be distributed via posters	
	9.1.6	Develop a regular feature in Outline (staff newsletter)				Head of Communications	**01.04.2016**	**30.04.2016**			Two feature articles carried in Outline in April & May			Features regularly appearing in Outline	
	9.1.7	Refresh screensaver on a monthly basis				Head of Communications	**01.04.2016**	**30.04.2016**			Screensaver launched			Regular screensaver programme paused for SAFER messaging	
	9.1.8	Use Quarterly 100 Leaders' events as engagement opportunities and to celebrate success			Director of HR	Head of OD	**08.07.2016**	**08.07.2016**			Work session with senior leaders			Leaders empowered to communicate down the line	
9.2		**Operational communication: Work closely with staff at every opportunity to ensure messages are better understood and embedded for each workstream**													
	9.2.1	Workstream 2: Develop and implement a staff communication pack in support of the refreshed escalation policy				Head of Communications	**05.06.2016**	**31.10.2016**			New staff guidance launched			Staff training to embed new practice	
	9.2.2	Workstream 3: Develop and implement a staff 'Communication & Discharge Planning Folder'				Head of Communications	**13.05.2016**	**02.06.2016**			Discharge folder shared with teams in pilot wards				
9.3		**Forward planning: Embedding continuous quality imporvement through staff communication & engagement**													
	9.3.1	Divisional Board meetings: Cascade messaging through Executive representation at all Divsional Board meetings (x4)					**13.07.2016**	**30.11.2016**			Discharge folder shared with teams in pilot wards				
	9.3.2	Cross Divisional Engagement: Cascade messaging via staff engagement sessions					**10.09.2016**	**31.12.2016**							
	9.3.3	Production and distribution of SAFER newsletter that coincides with important milestones/programme developments					**13.06.2016**	**31.12.2016**			Discharge folder shared with teams in pilot wards				
	9.3.4	Develop and enhance the website portal safergloshospitals.co.uk as a mechanism for supporting and enabling continuous quality imrpvement					**01.07.2016**	**31.08.2016**			Discharge folder shared with teams in pilot wards				
	9.3.5	Ongoing corporate messaging across all channels to celebrate achievements, recognise good practice and update staff on progress. Methods to include: * Outline * This Week - global staff email * Intranet * Involve CEO staff breifing * Screensavers					**01.07.2016**	**31.12.2016**			Discharge folder shared with teams in pilot wards				
	9.3.6	Pilot new digital screens in ED. The screens will inform patients how long waits are in ED					**01.05.2016**	**01.07.2016**			Discharge folder shared with teams in pilot wards				

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BRAG STATUS				
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EXECUTIVE LEAD:	Chief Executive Officer **- Debbie Lee**	Outcome Measures:	- NHS Constiution standards achieved - Board assurance framework robust
ENABLING WORKSTREAM 10:	**Governance**	Process Measures:	- Key metrics from workstreams visible from ward to board
		Balancing Measures:	- Mortality - Volume of attendances and admissions - Standardised admission ratios - Finance

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10.1		**Establish robust governance arrangements from ward to board for the Emergency Care Programme**													
	10.1.1	Establish Governance structure for Emergency Care, including membership and Terms of Reference for a new ECB and operational meeting			Director of Service Delivery	Director of Service Delivery	**30.06.2016**	**31.07.2016**						- Governance Structure / Individual TORs	
	10.1.2	Review the Terms of Reference for Emergency Care Board, Quality Committee, Finance & Performance and Trust Management Team to align monitoring, reporting and escalation, from front line services to Board				Trust Secretary	**30.06.2016**	**31.10.2016**							
	10.1.3	Review external good practice for Governance assurance and refresh the Quality Framework				Director of Safety	**30.06.2016**	**31.12.2016**							
	10.1.4	Review the internal mechanisms for identifying, supporting and monitoring improvement programmes and develop a Trustwide implementation plan aligned to the Quality Framework and quality reporting				Director of Safety	**01.04.2016**	**31.03.2017**							
	10.1.5	Revise risk management process to create a standardised organisational Board response to risks rated red				Director of Safety	**16.05.2016**	**26.08.2016**							
	10.1.6	Revise Quality reports to create a programme of reporting linked to the current Quality Framework reflecting the Emergency Pathway and key indicators				Director of Safety	**16.04.2016**	**31.07.2016**							
	10.1.7	Establish a programme for the Quality Committee to review quality related risks throughout each year				Director of Safety	**16.05.2016**	**26.08.2016**							
	10.1.8	Implement systematic process for learning from incidents in Emergency Care.			Director of Service Delivery	Director of Safety	**01.04.2016**	**31.07.2016**							Ref 3.15.1 from old plan subsumed into 10.1.8
10.2		**Establish frameworks that support change management, and integration and transition to business as usual**													
	10.2.1	PMF for the Trust to be written, which will include the transition to Business as Usual			Director of Service Delivery	Director of Service Delivery	**12.05.2016**	**15.07.2016**							Ref 6.0.4 from old plan subsumed into 10.2.1

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EXECUTIVE LEAD:	Medical Director **- Sean Elyan**	Outcome Measures:	- Compliance with the IPS
ENABLING WORKSTREAM 11:	**Safety**	Process Measures:	- Time to first senior review - Diagnostic test and report turnaround time
		Balancing Measures:	- Staffing - Finance - Referral rates

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11.1		**Implement Internal Professional Standards for all specialties**													
	11.1.1	**Implement Internal Professional Standards for all specialties. Required to standardise and formalise documentation, including timeliness of assessments, diagnostics, decisions, treatment and should be shared and published, with clear links to the learning from the ED RCA process**	**NHSI**												**Ref 3.3.16 on old plan subsumed into 11.1.1**
	11.1.1.1	Medicine			Chief of Service, Medicine	Divisional Governance Lead	**01.06.2016**	**31.07.2016**							
	11.1.1.2	Surgical			Chief of Service, Surgery	Divisional Governance Lead	**15.06.2016**	**15.08.2016**							
	11.1.1.3	Women's & Childrens			Chief of Service, Womens & Childrens	Divisional Governance Lead	**30.06.2016**	**31.08.2016**							
	11.1.1.4	Diagnostics & Specialties			Chief of Service, Surgery	Divisional Governance Lead	**15.06.2016**	**15.08.2016**							
	11.1.2	**Ensure all IPS are measurable and set up the system to capture the metrics**													**Ref 3.3.16a on old plan subsumed into 11.1.2**
	11.1.2.1	Medicine			Chief of Service, Medicine	Divisional Information Lead	**01.08.2016**	**30.09.2016**							
	11.1.2.2	Surgical			Chief of Service, Surgery	Divisional Information Lead	**16.08.2016**	**15.10.2016**							
	11.1.2.3	Women's & Childrens			Chief of Service, Womens & Childrens	Divisional Information Lead	**01.09.2016**	**30.11.2016**							
	11.1.2.4	Diagnostics & Specialties			Chief of Service, Surgery	Divisional Information Lead	**16.08.2016**	**15.10.2016**							

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

NURSE AND MIDWIFERY STAFFING
JUNE 2016

1 Purpose

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

2 Background

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

3 Findings

3.1 There are no exceptions to report this month, however the divisional nursing directors have been asked to review and report in divisions on their data sets.

3.2 The Board is reminded that twice each year we are required to undertake the Keith Hurst bench mark exercise and report any changes to our Board. This exercise has now been completed and is attached in Annex A. As reported last month the benchmark has been updated to reflect the acuity of patients in acute hospitals resulting in some investment being required. Whilst it has been confirmed by the Finance Director that the money required has been identified our Trust needs to reflect on the impact of this on both the agency spend and recruitment i.e. allocating the money but not recruiting substantively will result in higher cost as more agency nurses will be required to fill the 'new' gaps. As the Director of Nursing & Midwifery I would therefore suggest that the current numbers are reported on as and when the posts are substantively recruited to. The numbers can be reported accurately. The Director of Nursing & Midwifery assures the Board she will maintain very close scrutiny of this and will continue to review and allocate agency staff with the divisional nursing directors as appropriate to maintain patient experience and safety whilst still pursuing all recruitment avenues.

3.3 Surgical Division

3.3.1 From a nursing metrics performance all areas scored green. Safer Staffing – all areas are green. Department of Critical Care (DCC) due to staff flexing can trigger, that staffing is below their usual staffing level. Harm free care - DCC at CGH and GRH triggered 87.5% and 88.9% respectively due to pressure ulcer development within the units. These patients remain challenging due to their underlying fragility, however both units are continuing to explore initiatives to reduce or eliminate pressure ulcers. Funding has been agreed for additional beds on Guiting, 2b, and Snowshill.

3.3.2 High use of bank and agency continues within unfunded bed areas. 40% of agency spend is to offset the vacancy position. Sickness levels for trained staff is higher than normal for the period; this is being reviewed with the modern matrons.

3.3.3 Pure vacancies – Band 5 = 41.07wte, which is a small increase over last month, Band 2 over recruited by 16.61wte due to overseas nurses awaiting PIN being placed in this cost centre. Total vacancies are actually 11.15wte. Usual trend analysis on exiting staff continues and does not show any trend. Recruitment continues in line with the Trust recruitment strategies.

3.4 **Medical Division**

3.4.1 The fill rate for below 90% on the acute care assessment unit C (ACUC) at Cheltenham General Hospital is related to staff sickness and vacancies. It should be noted that the data does not capture all actions undertaken to mitigate risk such as band 7 ward managers working clinically, part shifts worked by staff, and the flexible use of staff across the division, such as a staff member moving from another ward for a shift or part shift. The matrons risk assess their staffing position on a shift by shift basis to ensure safe staffing levels across the division. If staffing levels are considered to be compromised due to the acuity and dependency of patients, additional capacity being open, then escalation to the Divisional Nursing Director for authorisation of temporary staffing is undertaken.

3.4.2 A comprehensive programme of recruitment is ongoing to reduce the vacancy factor across the Medical Division. Sickness is managed as per Trust policy with support from the matrons and Human Resources as required.

3.4.3 Nursing Contact Time

The 3 areas for quality improvement identified from the Care Contact Audit was nursing handover, nursing documentation and medication rounds. At present the division is experiencing significantly high levels of vacancies across its core service lines e.g. general old age medicine, stroke and neurology. As highlighted above there is a comprehensive recruitment programme ongoing to address this situation. One impact of a high vacancy factor is the dependence on, and usage of, temporary staff. This results in lack of continuity and unpredictability of staff capability and knowledge of the organisational policies, procedures and standards. This has been noted on several wards with concerns being raised as to the standard and quality of patient handover, time taken by nursing staff to complete medication rounds and attendance of nurses on doctors ward rounds.

3.4.4 The Executive Director of Nursing & Midwifery and Divisional Nursing Director for Medicine have recently convened staff meetings with some of the wards that are reporting these concerns. Following the meetings an action plan for improvement has been produced which will look at the implementation of the productive handover and ward round. This will take time to implement as constrained by the current recruitment position. The Divisional Nursing Director and matrons for the Medical Division will take this work forward over the next 6 months. In the interim bedside handovers have been introduced across many of the aforementioned wards. This approach is considered best practice in regards to enhancing patient communication and engaging the patient in their ongoing care delivery.

3.5 **Women & Children's Division**

3.5.1 Within the Women and Children's Division to date safer staffing data has only been collected for in patient areas namely the Maternity Ward, Children's in Patients, SCBU and Stroud Maternity. Following the publication of new guidance consideration is now being given to the collection of data in areas providing intrapartum care; the Delivery Suite and Birth Units at Gloucester and Cheltenham. It is difficult to provide meaningful data as staffing levels in intrapartum areas need to fluctuate according to activity.

3.5.2 Currently based on the May data all areas of the Division are currently showing 100% compliance with safer staffing and harm free care with the exception of 2a which is showing 95.25% harm free care and total safer staffing levels of 93% and 98 % on day and night duty respectively. Harm recorded was associated with urinary Catheters and UTIs.

3.5.3 Continued use of the Gynaecology Day Surgery Unit as an inpatient bed base during escalation has resulted in the use of additional temporary staff to support the additional bed capacity. Shortfalls in the nursing rotas cannot always be filled despite the use of bank, and at times, agency. There is an increased risk associated with the use of temporary staff that are

unfamiliar with the area and the use of gynaecology nurses to care for patients from unfamiliar specialities. The Divisional Nursing Director is undertaking a full review of staffing on 2a.

3.5.4 As a result of a combination of a recent positive recruitment drive, a pilot to incentivise staff for bank work, a planned reduction in the bed base over the summer the staffing levels have improved in Children's Inpatients and is expected to continue to do so over the coming months. However activity and acuity of the patients in the area can be unpredictable and subject to rapid change therefore closure of the 5 beds, with the associated reduction in nurse staffing, will be closely monitored.

3.6 Diagnostic & Specialist Division

Both Lilleybrook and Rendcomb wards within the Oncology centre were green in relation to fill rates for both registered and unregistered staff. Harm free care was also measured at 100%. Operationally there are a small number of vacancies but this has not affected care delivery. Bank staff are utilised always in the first instance with minimal agency used and no non-framework agency nursing this month. There is a wider strategic plan around retention of specialist nurses in cancer care which is being developed by the centre.

4 Recruitment Update

4.1 UK Pipeline

- There are currently 12 experienced UK-based nurses in the recruitment pipeline due to commence employment in summer 2016.
- There are currently 9 live Band 5 registered nurse advertisements open, but interest continues to be low. There is a separate advertisement open for bank nurses.

4.2 Overseas-Qualified Nurses

- The majority of the candidates interviewed in March have commenced employment this month, with the remaining candidates due to start before the end of July.
- Further testing days were held on 01 June and 03 June, and of the 125 candidates invited to the testing, 29 candidates have passed the first stage of assessments and will undertake an interview at the end of the month.
- A separate advertisement specifically targeting candidates with the requisite IELTS examination result has been temporarily withdrawn from NHS Jobs, and will be refreshed and relaunched before the end of the month.

4.3 EU Recruitment

- The Trust attended recruitment events hosted by the British Council in Thessaloniki and Athens at the beginning of June. The events were well attended, partly due to the high unemployment levels in the country. A number of nursing candidates had UK experience and UK registration and are being pursued as a priority. The remaining candidates were looking for further information with a view to booking their IELTS examination during the summer.
- A second recruitment event is being hosted by the British Council in Greece for October 2016. The Trust will consider whether or not to attend based on the result of the June event before the booking deadline at the end of June.
- The Trust continues to interview and appoint nurses from across Europe, with regular Skype interview days being booked. The latest event resulted in a further four offers of employment being made.
- Last year it was agreed to support none EU nurses to access IELTS courses to enabled them to register onto the NMC register. This year the scheme is to be extended to EU as well as non EU nurses.

- As with last year Health Education England is offering £500 per candidate to register for the test and support travel and infrastructure costs. The funding can be used for both EU and non EU nurses who are in a permanent positions within the organisation.

4.4 **Philippines Recruitment**

- The impending immigration skills charge imposed by the Home Office on employers from April 2017 has reduced the attractiveness of recruiting in The Philippines. As such, the Recruitment Strategy Group has agreed to a third and final campaign in The Philippines for August/September 2016 with a view to offering as many candidates as possible a position, under the proviso that they join us before the increased fees are implemented in April 2017.

- November 2015 Campaign: The first three nurses from the November 2015 campaign arrived and commenced employment on 16 May 2016, and a further two nurses will be joining the Trust in mid-June.

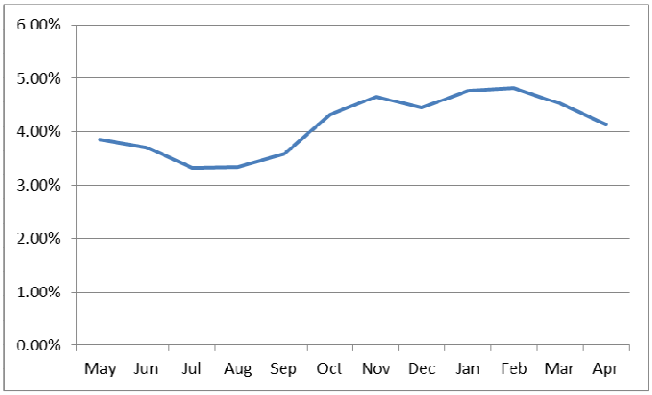
Status	**Numbers**
Commenced employment	3
Awaiting deployment	2
Passed IELTS and CBT exams, accepted by the NMC, waiting for visa application	2
Passed IELTS and CBT exams, waiting for NMC decision letter	9
Passed IELTS examination, waiting for CBT examination	5
Not passed the IELTS examination	98
Withdrawn (due to alternate offers or repeatedly failing the IELTS examination)	18
Total (minus withdrawn candidates)	**119**

- May 2016 Campaign: The Trust conducted interviews across one week in May 2016 and made a further 65 offers of employment to successful candidates for positions within our medical and surgical wards, and within our unscheduled care directorate. Further interviews are being conducted via Skype during June for specialist areas, and to date this has resulted in five offers being given to paediatric nurse candidates.

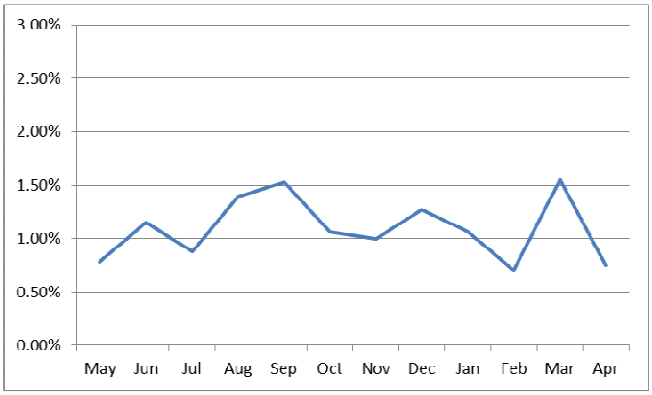
4.5 **Nursing Workforce Metrics**

Division	**Band 5 Vacancies**	**Sickness**		**Turnover**		**Maternity**	
		RGNs	**HCAs**	**RGNs**	**HCAs**	**RGNs**	**HCAs**
Diagnostic & Specialties	0	4.04%	5.20%	12.57%	13.16%	3.44%	1.38%
Medicine	103.62	3.89%	5.61%	18.71%	20.47%	3.31%	3.58%
Surgery	41.07	4.35%	4.24%	10.52%	20.07%	4.14%	2.21%
Women & Children	0	4.03%	3.47%	9.74%	10.62%	3.44%	4.90%

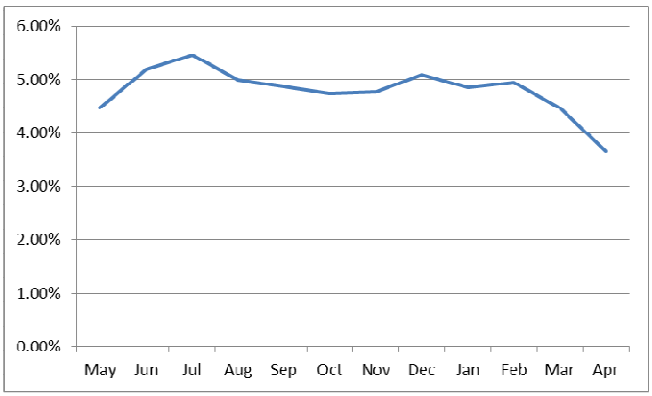
Data Note: 12 month rolling data



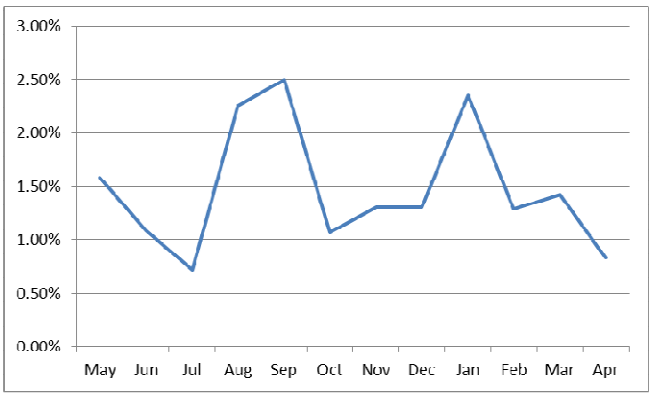
RGN: Sickness Absence by Month (May 15 – Apr 16)



RGN: Turnover by Month (May 15 – Apr 16)



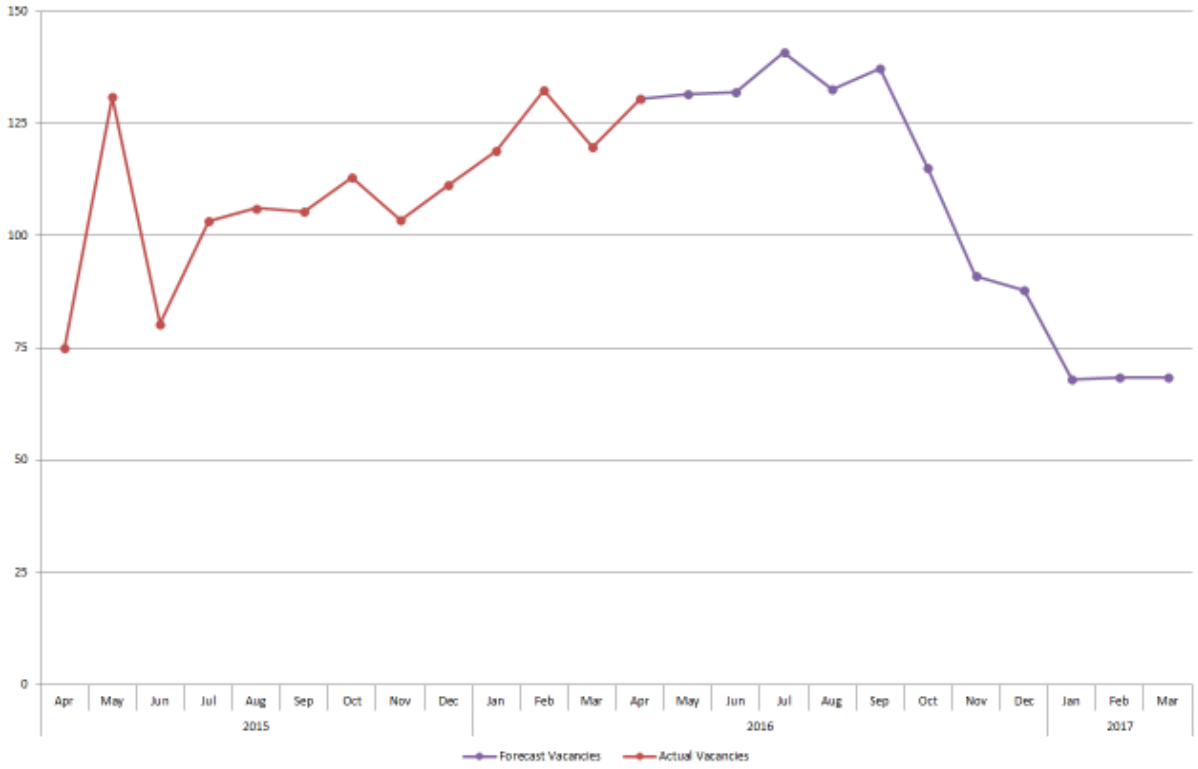
HCA: Sickness Absence by Month (May 15 – Apr 16)



HCA: Turnover by Month (May 15 – Apr 16)

4.6 Vacancy Forecast

The latest data (available only for April 2016) shows an increase in the vacancy rate to the second-highest rate in the last 12 months. The vacancy rate is expected to continue to rise in the coming months, due to the number of starters in the organisation not equalling the number of staff leaving. In addition to continued recruitment of registered nurses, the current focus is to recruit sufficient numbers of overseas-qualified nurses, healthcare assistants and apprentice healthcare assistants to ensure there are no additional vacancies on the wards, and to provide additional cover to wards with high staff nurse vacancy rates. At present, all four divisions are currently over-established at healthcare assistant level, in line with the current recruitment strategy.



5 Next Steps and Communication

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

6 Recommendations

The Board is asked to note this report for assurance that our Trust is delivering safe staffing levels and has plans to maintain and improve upon this position.

Authors:

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

Hurst Nursing Staffing Benchmarking Exercise - June 2016

MEDICINE (Speciality)												
Ward	**Hurst RGN**	**Hurst HCA**	**Total Est.**	**Funded RGN**	**Funded HCA**	**Total Est.**	**Diff. RGN**	**Diff.HCA**	**Recommendation**	**Cost RGN**	**Cost HCA**	**Total cost**
6a	21.3	15.9	37.2	21.41	16.37	37.78	0.11	0.47	Maintain	£ -	£ -	£ -
6b	18.6	13.9	32.5	17.97	12.43	30.4	-0.63	-1.47	Business case	£ 22,759.38	£ 34,383.30	£ 57,142.68
7a	26	12.3	38.3	20.96	17.19	38.15	-5.04	4.89	Skill mix review	£ -	£ -	£ -
7b	18.9	11.8	30.7	17.19	12.94	30.13	-1.71	1.14	Business case	£ 61,775.46	£ 26,664.60	£ 35,110.86
8a	23.35	16.45	39.8	21.35	16.37	37.72	-2	-0.08	Business case	£ 72,252.00	£ 1,871.20	£ 74,123.20
8b	22.5	10.8	33.3	20.91	14.83	35.74	-1.59	4.03	Skill mix review	£ -	£ -	£ -
Cardio GRH	35	17.5	52.5	38.34	12.8	51.14	3.34	-4.7	Skill mix review	£ -	£ -	£ -
Cardio CGH	19.2	9.6	28.8	25.58	2.87	28.45	6.38	-6.73	Maintain (covers CCU)	£ -	£ -	£ -
Avening	20.3	10.5	30.8	19.67	16.37	36.04	-0.63	5.87	Skill mix review	£ -	£ -	£ -
Hazelton	18.9	9.2	28.1	15.55	14.54	30.09	-3.35	5.34	Skill mix review	£ -	£ -	£ -
Knightsb'ge	13.5	9.1	22.6	12.12	9.06	21.18	-1.38	-0.04	Business case	£ 49,853.88	£ 935.60	£ 50,789.48
Totals	**237.55**	**137.05**	**374.6**	**231.05**	**145.77**	**376.82**	**-6.5**	**8.72**		**£ 206,640.72**	**£ 63,854.70**	**£ 270,495.42**

MEDICINE (GOAM)												
Ward	**Hurst RGN**	**Hurst HCA**	**Total Est.**	**Funded RGN**	**Funded HCA**	**Total Est.**	**Diff. RGN**	**Diff.HCA**	**Recommendation**	**Cost RGN**	**Cost HCA**	**Total cost**
4a	21.75	17.65	39.4	21.37	18.21	39.58	-0.38	0.56	Skill mix review	£ -	£ -	£ -
4b	17.9	17	34.9	20.1	17.57	37.67	2.2	0.57	Rebalance within Service	£ -	£ -	£ -
9b	18.51	17.7	36.21	21.23	19.17	40.4	2.72	1.47	Rebalance within Service	£ -	£ -	£ -
GW1	18.5	17.7	36.2	21.35	17.74	39.09	2.85	0.04	Rebalance within Service	£ -	£ -	£ -
Woodman'e	20.9	19.9	40.8	22.23	19.3	41.53	1.33	-0.6	Rebalance within Service	£ -	£ -	£ -
Ryeworth	23.85	17.35	41.2	21.81	20.49	42.3	-2.04	3.14	Rebalance within Service	£ -	£ -	£ -
Totals	**121.41**	**107.3**	**228.71**	**128.09**	**112.48**	**240.57**	**6.68**	**5.18**		**£ -**	**£ -**	**£ -**

MEDICINE (UNSCHEDULED CARE)												
Ward	**Hurst RGN**	**Hurst HCA**	**Total Est.**	**Funded RGN**	**Funded HCA**	**Total Est.**	**Diff. RGN**	**Diff.HCA**	**Recommendation**	**Cost RGN**	**Cost HCA**	**Total cost**
ACUA	32.8	13.4	46.2	28.66	11.89	40.55	-4.14	-1.51	Business case	£ 149,561.64	£ 35,318.90	£ 184,880.54
9a	11.7	8	19.7	13.42	9.04	22.46	1.72	1.04	Rebalance within Service	£ -	£ -	£ -
ACUC	31.5	14.2	45.7	27.42	11.43	38.85	-4.08	-2.77	Business case	£ 147,394.08	£ 64,790.30	£ 212,184.38
Totals	**76**	**35.6**	**111.6**	**69.5**	**32.36**	**101.86**	**-6.5**	**-3.24**		**£ 296,955.72**	**£ 100,109.20**	**£ 397,064.92**

SURGERY (GENERAL)												
Ward	**Hurst RGN**	**Hurst HCA**	**Total Est.**	**Funded RGN**	**Funded HCA**	**Total Est.**	**Diff. RGN**	**Diff.HCA**	**Recommendation**	**Cost RGN**	**Cost HCA**	**Total cost**
5a	19.3	10	29.3	18.33	11.65	29.98	-0.97	1.65	Rebalance within Service	£ -	£ -	£ -
5b	29.1	15.1	44.2	28.66	13.73	42.39	-0.44	-1.37	Rebalance within Service	£ -	£ -	£ -
Bibury	17.6	10.1	27.7	15.55	9.18	24.73	-2.05	-0.92	Business case	£ 74,058.30	£ 21,518.80	£ 95,577.10
Snowshill	16.2	7.2	23.4	15.4	6.3	21.7	-0.8	-0.9	Business case	£ 28,900.80	£ 21,051.00	£ 49,951.80
Guiting	30.5	11.1	41.6	26.26	12.91	39.17	-4.24	1.81	Business case (34 beds)	£ 153,174.24	£ 42,335.90	£ 110,838.34
Prescott	28.4	15.8	44.2	30.45	13.86	44.31	2.05	-1.94	Rebalance within Service	£ -	£ -	£ -
Totals	**141.1**	**69.3**	**210.4**	**134.65**	**67.63**	**202.28**	**-6.45**	**-1.67**		**£ 256,133.34**	**£ 84,905.70**	**£ 256,367.24**
SURGERY (T&O)												
Ward	**Hurst RGN**	**Hurst HCA**	**Total Est.**	**Funded RGN**	**Funded HCA**	**Total Est.**	**Diff. RGN**	**Diff.HCA**	**Recommendation**	**Cost RGN**	**Cost HCA**	**Total cost**
3a	17.5	12.7	30.2	22.11	13.29	35.4	4.61	0.59	Rebalance within Service	£ -	£ -	£ -
3b (35 beds)	30.8	17.3	48.1	23.41	13.79	37.2	-7.39	-3.51	Rebalance within Service (3	£ -	£ -	£ -
Alstone	19.3	12	31.3	19.58	9.59	29.17	0.28	-2.41	Rebalance within Service	£ -	£ -	£ -
Dixton	13.1	8.2	21.3	11.43	9.37	20.8	-1.67	1.17	Rebalance within Service	£ -	£ -	£ -
Totals	**80.7**	**50.2**	**130.9**	**76.53**	**46.04**	**122.57**	**-4.17**	**-4.16**		**£ -**	**£ -**	**£ -**
SURGERY (H&N)												
Ward	**Hurst RGN**	**Hurst HCA**	**Total Est.**	**Funded RGN**	**Funded HCA**	**Total Est.**	**Diff. RGN**	**Diff.HCA**	**Recommendation**	**Cost RGN**	**Cost HCA**	**Total cost**
2b (all beds)	21.9	5.9	27.8	18.91	4.44	23.35	-2.99	-1.46	Business case	£ 108,016.74	£ 34,149.40	£ 142,166.14
Totals	**21.9**	**5.9**	**27.8**	**18.91**	**4.44**	**23.35**	**-2.99**	**-1.46**		**£ 108,016.74**	**£ 34,149.40**	**£ 142,166.14**

D&S

Ward	Hurst RGN	Hurst HCA	Total Est.	Funded RGN	Funded HCA	Total Est.	Diff. RGN	Diff.HCA	Recommendation	Cost RGN	Cost HCA	Total cost
Lillybrook	25.5	6.2	31.7	22.45	10.12	32.57	-3.05	3.92	Rebalance within Service	£ -	£ -	£ -
Rencombe	20.1	10.1	30.2	22.36	10.03	23.07	2.26	-0.07	Rebalance within Service	£ -	£ -	£ -
Totals	**45.6**	**16.3**	**61.9**	**44.81**	**20.15**	**55.64**	**-0.79**	**3.85**		**£ -**	**£ -**	**£ -**

W&C (GYNAE)

Ward	Hurst RGN	Hurst HCA	Total Est.	Funded RGN	Funded HCA	Total Est.	Diff. RGN	Diff.HCA	Recommendation	Cost RGN	Cost HCA	Total cost
2a	19.2	7	26.2	19.17	6	25.17	-0.03	-1	Business case	£ -	£ 23,390.00	£ 23,390.00
Totals	**19.2**	**7**	**26.2**	**19.17**	**6**	**25.17**	**-0.03**	**-1**		**£ -**	**£ 23,390.00**	**£ 23,390.00**

2 £ 23,390.00

5 £ 36,126.00

Total RGN	Total HCA	Totsal cost
£ 867,746.52	**£ 306,409.00**	**£ 1,174,155.52**

Ref	Risk / Project Title	Lead for Risk / Project	Controls	Gaps in controls	Assurances / Monitoring	Review date	Consequence (current)	Likelihood (current)	Risk level (current)	Risk level (Target)
N17	Adolescents presenting with Self Harming Behaviours	Arnold, Maggie	1. The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients. 2. Relevant extra staff are brought in during admission periods to support the care and supervision of these patients. 3. CQC\commissioners have been made formally aware of the risk issues.	None	The Quality Committee will receive six monthly updates of the risk controls	29/07/2016	5	4	20	8 -12
S118	As a consequence of increased emergency activity (see M1) the Day care unit and other similar non inpatient areas with beds are opened overnight to house inpatients causing an increased patient safety risk, a reduced patient experience and a negative effect on Day surgery activity and efficiency	Gatling, Eric	Emergency Care Plan	None	1.Day to day bed management systems including community wide capacity tele-conferences and escalation procedures 2. Available bed capacity based on staff availability 3. Daily senior clinical manager meetings to manage safety, experience and activity whilst unit is open at night 4. Revision of risk assessments evaluating the change in function of the areas	08/07/2016	4	5	20	4 - 6
S100	As a consequence of rising demand the Trust continues to miss the 62day cancer standard leading to delayed treatment and increasing risk of intervention by Monitor	Gatling, Eric	1. Improve the access to Patient information on implications of missing appointments 2. Weekly meetings between AGM and MDT Coordinators to discuss pathway management and expedite patients as appropriate. 3. Performance Management at Cancer Management Board 4. Escalation procedure in place to avoid breaches 5. Performance trajectory report for each pathway	Patient choice Clinic capacity	Monitoring through Cancer Management Board 62 Day Recovery Plan	30/06/2016	4	5	20	4 - 6
F7	Delay in providing follow-up appointments in a number of specialities- Neurology, Cardiology Rhuematology and Ophthalmology	Gatling, Eric	Each specialty has a recovery plan in place		Performance manage the specialties through the OPB Establish individual specialty recovery plans	29/07/2016	4	4	16	8 -12
C12	Delayed discharge of patients who are on medically fit list above the agreed 35 limit	Gatling, Eric	Emergency Care plan	Internal tracking of patient pathway	Monitoring by ECB, F&P and Systems resilience group Reports - Emergency Pathway report	08/07/2016	4	5	20	8 -12
C11	Failure of timely transport arrangements provided by the Commissioner lead contract with ARRIVA	Gatling, Eric	Agreed recovery plan and monitoring	None	Weekly performance dashboard Regular contract performance meetings Sharing of individual patient stories	06/07/2016	3	5	15	4 - 6

F2	Workforce shortages resulting in excessive agency expenditure	Smith, David	1. Overseas recruitment plan 2. Pilot of extended Bank office hours 3. Temporary staffing short life work group 4. Bank incentive payments 5. GOAM RRP 6. Master vender for medical locums 7. Temporary staffing tool self assessment	People Committee to be created to provide monitoring and assurance	Establishing new People Committee and reporting to Trust Board	29/07/2016	4	5	20	8 -12
S127	Fractured neck of femur mortality rates above national average for GRH	Elyan, Sean	External review scheduled (end of June), MDT for Mortality instated.	None	MDT/M&M, external review, Detailed action plan based on internal and external review monitored by Div Surg Board and Quality Committee	31/07/2016	4	4	16	8 -12
HR2b	High level of nursing vacancies, particularly in Medicine.	Smith, David	1. Proactive nurse recruitment strategy 2. Nurse recruitment business case 3. Trained nurse and HCA recruitment facility	Medical vacancies are currently very high Establish People Committee reporting	PMF Executive lead Divisional reviews People Committee	30/06/2016	4	5	20	8 -12
DSp1347OHPCLI	Inability to maintain business continuity for the OPMAS computer systems	Jewell, Frank	Implementation of manual prescribing systems- resource issues Possiblity of external IT support for OPMAS if internal support not avaialble Programme for stable virtual server Back up server undertaken		Incidnets	28/10/2016	5	3	15	4 - 6
M1	Inablity of the local health and social care system to manage demand within the current capacity leading to a significant fluctuation of attendees in ED	Gatling, Eric	1. Emergency care Plan, 2. Systems Resilience Group and actions 3. Appointment of Improvement Director 4. Planned Care Plan, 5. STP plans.	Current gap between contracted activity, reduction anticipated as part of QIPP and actual activity.	1. Weekly Emergency Care Board 2. Weekly ED Quality report 3. Monthly Emergency Pathway report	07/07/2016	5	5	25	8 -12

DSp2288PALL	Inadequate staffing capacity to cover workload growth	Jewell, Frank	1)The band 7 hours have been covered by other team members doing additional hours and also acting up but this adds to the pressures on those individuals. 2)Consultant Locum cover being advertised 3)Issues escalated to Ops Director and Executives. IDT cover for Oncology/haematology requested from EG 4)Business case to increase staffing for palliative care 5)Identified this as a cost pressure 6)Glos Consultant spending time at CGH to support and supervise SpR. Reduced all non-clinical commitments and centralising how any such requests are managed to prioritise what can be done. 7)Other GHTNHSFT Consultant spending 50% of time on each site	None	Agenda item on board meetings Weekly e-mail updates by Pall care consultant Dr Emma Husbands	30/09/2016	4	4	16	4 - 6
M1b	Lack of Availability of key groups of staff	Elyan, Sean	1. Monitoring of Medical Locum spend at F&PC 2. Identification of new style medical posts (e.g Chief Registrar)by Medical Education Board. 3. Report to People Committee on progress of plan	1. People committee to be established	People Committee report F&P Locum costs	30/06/2016	4	5	20	8 -12
IT2246	Network Vulnerabilities leading to potentially significant breaks in business continuity	Pandor, Zack	1. Secondary links are in place offering reduced capacity. 2. There is a 10 day lead time for replacement components for the out of support and end of life hardware	None	Using SNMPC toolset is used to monitor network connection, in addition components are monitored manually during working hours. IM&T Committee	30/06/2016	4	4	16	4 - 6
C3	A sequence of Never Events leading to potential regulatory intervention and the potential effects on the reputation of the Trust	Elyan, Sean	1. Individual Never Events have policies\protocols in place supported by professional competence 2. Near miss Never Events and lessons learnt are reported and monitored at Patient safety Forum. 3. Individual Never Events are reported to the Board and receive a full RCA, action plan and are monitored by Safety & Experience Review Group 4. Standards related to Never Events are periodically reviewed to check compliance 5. Compliance to the WHO checklist in theatres is monitored by the Theatre team 6. Implementation of NatSSIPS programme underway	1. Up to date review of the National standard's related to Never Events 2. NatSSIPs to be fully implemented 3. Orthopaedic theatres FMEA to identify process weaknesses	1. Surgical Division Quality Report - WHO checklist 2. Monitoring of Near miss Never Events at PSF 3. SI Monthly report to TMT,QC & TB 4. SI Annual report and six monthly update 5. Safety & Experience Review Group monitoring SIs	06/07/2016	5	3	15	8 -12

M1a	The clinical risk of delay in treating patients arriving at ED during periods of high demand or staff shortage	Gatling, Eric	Stream 1 improvement programme in place to address internal safety processes 2. Emergency Care Plan Addressing three main areas of concern: a) demand b) staffing (medical and nursing) c) Beds and capacity 3. Delivery of relevant QIPP plan to reduce attendances	None	1. Weekly Emergency Care Board 2. Weekly safety monitoring report 3. Monthly Emergency Care Pathway report	07/07/2016	4	5	20	8 -12
M1c	The hospital is at full capacity with limited ability to accommodate surges in admissions	Gatling, Eric	1. Implement the LOS plan to reduce LOS as part of Emergency Care Plan. 2. Complete Capacity modelling exercise to identify further improvement. 3.Examine wider community alternatives to support capacity surges	None	1. Weekly Emergency Care board. 2. F&P monthly meetings 3. Monthly Emergency Pathway Report 4. PMF report 5. System Resilience Group	07/07/2016	5	5	25	8 -12

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD – JUNE 2016

EDUCATION, LEARNING AND DEVELOPMENT ANNUAL PLAN 2016-17

1. Aim

1.1 This paper provides a summary of the progress made against the annual Education, Learning and Development (ELD) work plan for 2015-16 and proposes the work plan for 2016-17 as the ongoing work required to deliver the three strategic aims for education in GHFT.

1.2 The strategic aims sit within the wider Workforce Strategy and are:

- To influence patient outcomes and experience positively as a result of our education and training.
- To position ourselves within the heart of a changing NHS landscape in order to influence future direction locally and nationally
- Become known and renowned for the quality of our education and development.

1.3 This year a summary from Leadership and Organisational development has been included in the paper and in future years, following the establishment of the Workforce Committee, the intention is to include a report from Medical Education.

1.4 The Board is asked to note the progress made against the annual work plan for 2015/16 and the proposed priorities for the coming year.

2. Background

2.1 Nationally, the landscape for healthcare education faces unprecedented changes: Working with the Departments of Health and Business and Industry, Health Education England (HEE) is implementing several changes that will impact on healthcare education from 2017. These are;

- The introduction of an Apprenticeship Levy from April 2017 and targets to increase the numbers of apprentices starting each year

- The establishment of a new role to sit between the Health Care Assistant and Registered Nurse – to be known as the Nursing Associate

- The removal of commissioned bursaries to support non-medical higher education programmes from September 2017, to be replaced by student loans.

More information on each of these, including consideration of what how they will impact GHFT is included in section 6 of the paper.

2.2 Closer to home, in 2015 our Chief Executive identified workforce challenges as being top of our priority list for the next few years and this remains the case in the coming year.

3 Summary

3.1 For the ELD service, Best Care for Everyone means providing the right ELD for the right people and at the right time in order to deliver the best care for our patients as well as to attract and retain our workforce.

3.2 An ELD workplan was put forward and approved by the Board in May 2015; the first half of this paper describes progress made against this, summarising both difficulties and highlights.

3.3 Going forward, our focus is to continually develop, design, deliver and evaluate high quality, responsive ELD activity to meet the strategic aims and workforce challenges. Our three priorities are to:-

- Enable and support workforce transformation: influencing and maximizing the opportunities presented by the healthcare education reforms and shaping new roles and career routes such as Apprenticeships and Nursing Associates.

- Ensure workforce sustainability and retention: developing new career pathways and providing "Best Care for Everyone" through our ELD offer from work experience placements and Corporate Induction to a wide range of education and development opportunities all designed to equip our staff to deliver best care.

- Maximise Business Opportunities and Efficiencies: supporting the local Sustainability Transformation Plan (STP) to forge new collaborations and multi-agency integration.

3.4 These are the proposed top three in-year priorities forming the basis of the ELD work plan and the ELD service objectives for 2016-17 (Annex A).

4 Progress Made Against the 2015-16 Strategic Aims Work Plan

4.1 2015-16 was a challenging year with unprecedented changes emerging in the national and local education landscape. It was nonetheless productive with successful outcomes and good progress made against the 17 in-year priorities. Please see key messages highlighted below and Annex B for more detail on the end of year RAG report.

4.2 Strategic Aim 1: Influence patient outcomes and experience positively as a result of our education and training

4.2.1 Questions one to nine in Annex B relate to supporting this strategic aim: Key messages to note from these are as follows:

4.2.2 ELD provision continued to grow in 2015/16 with the embedding of the Lecturer Practitioners providing training at the front end of patient care and both accredited and developmental CPD available in-house and with our partnership universities. Additional training was delivered this year to equip our staff in dealing with new priorities such as "specialing", (the observation of patients at risk of self-harm), safe-guarding children multi-agency workshops and safeguarding supervision workshops – all reflecting the growing complexity of the patient care we provide. This is in addition to our "must do" activity where we achieve an average of 92% compliance against our mandatory training, record numbers of eLearning completions and 24 induction courses for 1049 new employees.

4.2.3 Education has also played a key role in supporting our recruitment agenda in 2016 through our offers of work experience, apprenticeships, student placements and, crucially, in supporting our overseas nurses to become registered practitioners by supporting them through the rigorous language and skills testing required by the NMC.

4.3 Strategic Aim 2: Position ourselves within the heart of a changing NHS landscape in order to influence future direction locally and nationally

4.3.1 The in-year priorities under this aim relate to questions 10 to 12 from Annex B where we achieved a green rating in all three. To date, 2015-16 has seen the emergence and gradual development of both the national education reforms and the local Sustainability Transformation Plan (STP): Whilst we have contributed to these discussions nationally, regionally and locally, many of the discussions this year have been to plan how the changes will be implemented in 2017 and consequently, more detail on these is included in section 5 where the proposed future work plan is explained.

4.4 Strategic Aim 3: Become known and renowned for the quality of our education and development

4.4.1 The key challenge in achieving this aim is to improve the broader perception by all our staff in all staff groups as reflected in our staff survey scores.

4.4.2 It is difficult to make a direct comparison of our performance against the Key Finding relating to "Job-relevant training, learning and development (non-mandatory) due to changes in the staff survey questions but our score of 3.95 remains stubbornly lower than the average

of 4.03. As seen in the table below, the scores for nursing at 4.09 suggest the extensive work carried out this year to support them is being appreciated, but the lower scores for administrative and clerical staff and General Managers suggests the additional opportunities and information days for these groups have not resulted in the same improvements. More work will take place in 2016-17 to understand what the issues are and make further improvements going forward.

KF 13 - Job-relevant training, learning and development (TLD) (non-mandatory)

	GHFT 2015	Av Trusts 2015	GHFT 2014	Av Trusts 2015	GHT Nurses 2015	A&C 2015	Gen Mgrs 2015
KF 13	3.95	4.03	-	-	4.09	3.75	3.78

The breakdown of questions that make up the key finding are as shown in the table below where it would appear that although our compliance levels are good at 98% and our satisfaction scores are generally high at between 78 and 85%, these small margins suggest the perception of staff is still lower than the national average.

Questions in KF13:

Q		GHFT 2015	Av Trusts 2015	GHFT 2014	Av Trusts 2014
18a	% staff saying they have received *non-mandatory* T,L,D in the last12 months	74	72	*	*
18b	% staff saying their *non-mandatory* TLD helped them to do their job more effectively	81	83		
18c	% staff saying their *non-mandatory* TLD helped them to stay up-to-date with professional requirements	85	87		
18d	% staff saying their *non-mandatory* TLD helped them to deliver a better patient/service user experience	78	81		
19	% who had received mandatory training in the last 12 months	98	97		

The cells in green are those included in the KF

*= 2014 this also included mandatory training and therefore does not offer a comparison with 2015 scores.

4.4.3 More positively, the following are all offered as evidence that our work is recognised, renowned and valued in some areas:

- 100% compliance in the newly formatted Learning and Development Agreement with HEESW received in May 2016.
- 100% in the Library Quality Assurance Framework for the second year running.
- Nominations, highly commended and winners in several regional award events (listed in Annex C)
- 17 nominations for staff in education roles for our GHFT Staff awards and three finalists - winners to be announced at Hatherley Manor on 16th June.

4.4.4 The need to build strong networks with our educational and careers colleagues under the banner of "Extraordinary Everyday" remains key - both as a means to build our reputation as a good employer and to support the pipeline of our future workforce. Activity in 2015-16 included the following:

- The development of our Careers and School Ambassadors to a register of 79 staff members committing to visiting local schools, supporting careers events and our own AGM in October 2016.
- 239 work experience placements in 2015-16, an Emergency Department tour for 11 students, a midwifery workshop for 25 students and a Medical/Professional Careers experience event for 25 students.
- Participation at several school careers events including Sir Thomas Rich's and Dean Close and other County events such as the successful Grow Gloucestershire event where our stall was rated as one of the most popular by delegates.
- We will be hosting the next Career and Employability event for 60 local careers advisors on 14th June.

5 Strategic Education Priorities for 2016-17

5.1 As previously mentioned, the healthcare education landscape is facing unprecedented changes and many of these will impact on our trust. Consequently, an overview of apprenticeships, the Nursing Associate role and the move to student loans are included in this section as they are fundamental in how we plan for 2016-17 and beyond.

5.2 To support the achievement of our strategic education aims, the in-year priorities for 2016-17 reflect these national changes and are covered in the following three headings:

- Enable and support workforce transformation
- Ensure workforce sustainability and retention
- Maximize business opportunities and efficiencies

More detail on the work streams below these is included in Annex A.

5.3 Apprenticeships

5.3.1 The Government is committed to the creation of three million apprenticeships by 2020 advocating the economic benefits and high return on investment of employing apprenticeships. They also identify the specific benefits to the public sector as being a means to:

- build a talent pipeline of either new recruitment or to develop internal talent to fill critical skills gaps
- develop existing staff for those who wish to change roles, learn new skills or advance within an organisation
- enable social mobility and encourage talent from diverse backgrounds.

5.3.2 To help achieve the three million apprenticeships, all employers with a pay bill of more than £3 million will be required to pay an apprenticeship levy of 0.5% of their pay bill, the first payment likely to be taken at the end of May 2017. In the absence of further details as to exactly how the levy will be calculated, for GHFT on an assumed pay bill of approximately £300 million, 0.5% will equate to £1.5 million. This can subsequently be drawn back down via a digital vouchers system to support and fund the apprenticeship qualifications but it is unlikely employers will be able to use these funds to support staffing or infrastructure in the way existing funds from HEE do currently.

5.3.3 From April 2017, employers will be expected to meet a target of 2.3% apprenticeship starts per annum against their total headcount of staff. A target of 2.3% in GHFT is cc180 apprenticeship starts per annum, to include 16-19 year olds at educational level 2 and 3 and increasingly, existing employees on higher apprenticeships at levels 4 and 5 (equivalent to Foundation Degree and National Certificates/Diplomas).

5.4 Nursing Associate Role

5.4.1 In December 2015, the Government announced a plan to create a new nursing support role. The new role is expected to work alongside care assistants and registered nurses to deliver hands-on care, focusing on ensuring patients continue to get compassionate care. It is anticipated the role will be a higher apprenticeship involving day release for two years to study a level 5 Foundation Degree and will be a band 4 on completion of the qualification (although this will be subject to AfC evaluation). The aim is to enable both existing and newly recruited health care assistants to train at a more technically skilled level than current HCAs and either remain at that level or use this as a "step-on/step-off" role to progress further and complete the final two years of the nursing degree.

5.4.2 A public consultation for the role closed on 11th March 2016, the outcomes of which were published at the beginning of June and include an overall agreement to the role and to the title of Nursing Associate. The initial number to be recruited nationally in 2017 will only be 1000, but in readiness for larger numbers in future, the University of Gloucestershire

has made a commitment to develop a programme locally and GHFT will work closely with them.

5.5 Changes to the Bursary System for Healthcare Degrees

5.5.1 Recent publications from the Department of Health suggest the current system of financial support for nursing, midwifery and allied health professional (AHP) students is not considered to be sustainable. Currently, people studying for a degree in nursing, midwifery and the AHPs receive bursaries to cover tuition and living costs. These Bursaries are paid from general taxation and are not recoverable from the student after they graduate. The number of students trained can therefore be constrained by the Government's finances and there is no guarantee the graduate returns to work in the NHS.

5.5.2 In their document *Reforming healthcare education funding:– April 2016*, the Government propose that by reforming student finances for new nurses, midwives and AHP students from 1st August 2017, the following issues should be resolved:

- a more consistent set of training numbers each year, not subject to year on year variation caused by spending budget changes
- reduced exchequer costs with students funding their training through the standard student support system
- increased student numbers and more qualified staff available to work in the NHS
- reduced student attrition and greater commitment to work in the health system

5.5.3 The AHP professions included are Dietetics, Occupational Therapy, Physiotherapy, Podiatry, Speech and Language Therapy, Diagnostic Radiotherapy, Therapeutic Radiotherapy, Orthoptics, Orthotics/Prosthetics, Operating Department Practitioner, Dental Hygienist, and Dental Therapist.

5.5.4 How this should be implemented is currently out to consultation (closes 24th June), after which more information will be released. What is known currently is that this will be in place for students wishing to study these healthcare degrees starting from August 2017 and that more Universities (including the University of Gloucestershire) are preparing to develop and offer degree programmes once the "market" opens up and places are no longer restricted to the HEE commissioned numbers.

5.5.5 It is not yet known how these changes will affect the numbers, motivations and expectations of future students, nor how this will help or hinder the smaller professions currently facing recruitment shortages. Regional and local work groups have been established to plan for and mitigate these shortages and the anticipation is that these will gain momentum as the national picture evolves.

6. Leadership and Organisational Development

6.1 Progress made in 2015-16:

The focus of the service over 2015-16 has been as a fundamental support to the launch of our Trust vision, Best Care for Everyone, and the ongoing activity arising from the Leadership Systems Workstream. Some key highlights are outlined below.

6.1.1 **Leadership Behaviours:** Following consultation with our 100 Leaders Group we have refreshed our Leadership Behaviours to strengthen the connection with our values and to focus on how we lead Ourselves, Our Teams and Our Trust. These are now available on the intranet.

6.1.2 **Appraisal paperwork:** In conjunction with Life Long Learning we have simplified our appraisal paperwork with our leadership behaviours being a key feature of the revamped paperwork. The aim is to cascade the new appraisal paperwork to all staff, the view being that we all need to manage ourselves and our approach as we work with our colleagues and our patients.

6.1.3 **Leadership Welcome Day/Consultant Induction Day**; In order to improve the support that we provide to new managers and leaders within our organisation we have launched a Leadership Welcome Day. The session is interactive in nature, enables individuals to explore the qualities they bring to their leadership style and gives time for consideration of any challenges they may face; both personal and professional. Individuals are signposted to tools and support that can be accessed both internally and externally. Each participant leaves the session having completed the bronze level accreditation with our Trust Safety and Quality Improvement Academy.
A similar event has been developed to support our newly appointed Consultants.

6.1.4 **Recruitment Assessment Toolkit**
A recruitment assessment toolkit has been produced by the Workforce Resourcing Manager and L&OD Specialist to support managers in recruiting individuals with the right values, behaviours and skill set into management and leadership posts within our Trust.

6.1.5 **iManage**
Our first level people management programme has been adapted to align with our new leadership behaviours. iManage is a cohort programme with modules developing management practice with respect to Our Selves, Our Teams and our Trust. The programme launches this month.

6.2 Leadership and Organisational Development Priorities for 2016-17
6.2.1 The Leadership Systems Work stream activity will continue with two additional areas of focus:

6.2.2 **Competency Framework**
Work has begun on a Knowledge, Skills and Experience Framework for our clinical leadership model to align with our Leadership Behaviours Framework. This activity will be finalised, approved and launched. The aim is to inform talent management within our organisation and associated leadership development activity.

6.2.3 **Succession Planning and Talent Management**
Recognising the importance of ensuring that we are prepared for changes within our workforce, the aim is to design and implement robust succession planning processes at Service/Support Line, Division and Trust wide level. As part of this process the intention is to design and implement a talent retention and development programme to support the identification and development of talent across our organisation.

7. Reporting and Monitoring
7.1 As in previous years, a quarterly RAG report will be presented to the ELD Committee to monitor progress against the workstreams supporting the three priorities.

7.2 In the newly emerging GHFT Committee structure, the ELD Committee will become a sub-group of the Workforce Committee reporting to the Main Board. It is clear that the importance of education to all staff is increasing and the need to ensure robust and appropriate governance through this committee will be vital going forward.

8. Recommendations
8.1 The Board is asked to note progress against the 2015-16 work plan for Education, Learning and Development and the annual priorities for 2016-17 in support of the Workforce Strategy 2015-20.

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Contributor: Becky Wheeler, Head of Leadership and Organisational Development

Presenting Director:
Dave Smith, Director of Human Resources and Organisational Development

Date: June 2016

References:

Department of Health: Reforming healthcare education funding: creating a sustainable workforce – 04/2016
Reforms to funding and financial support for nursing, midwifery and AHP Bursary students (SR 2015) - Impact Assessment 07/04/2016
Department for Business, Innovation and Skills; Apprenticeships Levy – 08/2015
ApprenticeshipsGOV.UK
Department for Business, Innovation and Skills – 06/2015
Building Capacity to Care and Capability to Treat – HEE 06/2016
Raising the Bar - Shape of Caring, Lord Willis 11/2015

ANNEX A

Education, Learning & Development Annual Work Plan and Priorities 2016-17 to achieve the three strategic ELD aims of:

Strategic Aim 1: To influence patient outcomes and experience positively as a result of our education and teaching
Strategic Aim 2: To position ourselves within the heart of the changing NHS landscape in order to influence future direction locally and nationally
Strategic Aim 3: To become known and renowned for the quality of our education and development

No.	**Education, Learning and Development Priorities for 2016-17** (Work streams to deliver the ELD Aims of the People Strategy 2015-2020)
1	**Enable and support workforce transformation: (Supporting recruitment and future pipelines)**
	Specifically: • Contribute to, influence and subsequently maximize the opportunities presented by the healthcare education reforms • Develop high quality mentoring and support for our students to ensure they have a positive placement experience • Contribute to the development of the new Nursing Associates role, working with our HEI partners and clinical staff to ensure successful implementation • Develop new healthcare career routes through Apprenticeships for 16-19 year olds and increase the use of Higher Apprenticeships • Further develop our Extraordinary Everyday work experience opportunities, aligning with the University Technical College (UTC) as the project progresses
2	**Ensure workforce sustainability and retention:**
	Specifically: • Develop career pathways to attract and retain our newly qualified workforce • Work with HEESW and our local universities to provide ELD solutions to our workforce shortages such as those created through reductions in Junior Doctors • Review current provision of ELD in line with “Best Care for Everyone” to ensure they all offer the right education and development at the right time – and ensure high quality, compassionate, patient-centered and competent care
3	**Maximise Business Opportunities and Efficiencies:**
	Specifically: • Support the local Sustainability Transformation Plan (STP) • Forge new collaborations and multi-agency integration to enable the 5 year Forward View, developing new roles and shared education opportunities as opportunities arise

ANNEX C: Awards and Recognition

Health Education England South West STAR Awards 2016			
Intermediate Apprentice of the Year Inspirational Apprentice Inspiring Educator Inspiring Educator Advanced Apprentice of the Year Education and Innovation champion Apprentice of the Year	Jack Mills Alice Ward Michelle Bevan Lucy Mathieson Chevonne Smith Nick Oxlade Sarah Jayne Hooper	Former apprentice Lifelong Learning Former Portering Apprentice Learning and Development Lead Corporate Training Specialist Apprentice nursery assistant Simulation Lead Chedworth suite	Winner Finalist Finalist and Highly Commended Finalist and Commended Finalist Finalist Finalist
Gloucestershire Media Apprenticeship Awards 2016			
Outstanding Apprentice of The Year (Health, Education & Care (Private or Public Sector) and Outstanding Apprentice of The Year (Public Sector)	Gemma Hibberd Sam Brown apprentice	Apprentice HCA eLearning technologist	Shortlisted Finalist Shortlisted Finalist
Grow Gloucestershire Showcase Awards (Oct 15)			
Outstanding Support to a Young Person	Becki Clapton	Lifelong Learning administrator for Work Experience	Winner
GHNHSFT Staff Awards 2016			
Apprentice of the Year Learning & Development Support Support Services Leader	Sam Brown Farouk Mehta Mandy Newbould	Learning Technology Team Training Systems Team HR Systems and Smartcards Team	Winners announced on 16th June
National UK Apprentice Awards			
Apprentice of the Year	Sam Brown	Learning Technology Team	Awaiting outcomes July 2016

Annex B

	ANNEX B ELD Priorities and Workplan 2015-16 - RAG Status					
		Jul-15	Oct-15	Feb-16	May-16	
Item	**In Year Priority**	**RAG**	**RAG**	**RAG**	**FINAL**	
	Strategic Aim: To influence patient outcomes and experience positively as a result of our education and teaching.					
1	Continue to support staff retention and perception through increasing the number and quality of opportunities to learn and develop; This, both at the point of care and on dedicated programmes and ensuring all espouse consistent messages on our values of compassionate and patient-centred care.	G	G	G	G	Programmes and point of care work evaluate well in evaluations, including follow-ups from 1 to 1s and in groups post-programme completion. Staff survey results for nurses and HCAs in particular are above the national average.
2	Support our Nurse Recruitment work stream by providing ELD activity ranging from Pre-registration nurse recruitment events, corporate induction, adaptation courses and additional English or clinical skills tuition	G	G	G	G	Significant activity in 2015 to design and commence IELT training for overseas nurses plus additional induction and socialization workshops. Additional Mentor programmes and preceptorship run and an in-house FLAP programme established.
3	Develop the Advanced Practitioner roles and skills required to support the reduction in Junior Doctor availability from 2015	A	A	A	A	Education pathways established with UWE (funded by HEESW) but the intention is to enable more robust processes for the wider operational component of the project (ensuring clarity on the role and where they are needed). To be included in the Workforce Committee Agenda.
4	Maximise the opportunities to develop our bands 1-4 staff aligned to the Talent for Care Strategy and the Willis report recommendations for our HCAs (both published March 2015)	A	A	A	A	Small scale success, as HEESW funding was reduced and more to be done to release many of these staff groups for development. Other developmental events such as HCA forums and A&C events were well received. More apprenticeship opportunities to be developed in 2017 and the new Nursing Associate role will help this aim.

5	Continue to increase the involvement of patients and carers in the design, implementation and evaluation of education, learning and development	A	A	A	G	Patients involved at point of care/front-line training and discussions and where possible, included on workshops.
6	Implement the five-year plan to maximize the growth and provision of multi-professional simulation training across our Trust and ultimately as a centre of excellence with the facility to generate income	G	G	G	G	Good progress made year on year. Simulation now embedded in many programmes from work experience and carers events, to student sessions and through to an extensive programme of post-graduate CPD.
7	Develop robust selection processes that enable a Values Based Recruitment approach to assessing our future nurse workforce	A	G	G	G	Scenarios and VBR questions designed. This work is now embedded into the wider recruitment work.
8	Develop robust processes for using and analysing the data available as the basis for further developing our ELD offer (staff/patient/student surveys, exit interviews, compliments)	A	A	A	A	Inpatient survey and staff survey data discussed and used to shape priorities. Much closer links to Datix for themes to target and several sources of Patient Experience data built in to programmes.
9	Enable greater oversight and transparency of all spend and income associated with ELD activity in order to inform fair distribution and value for money	R	R	R	A	This has proven stubbornly difficult to achieve due to budget data available. Reports are requested for ELD Committee from Divisions but not all have been able to provide this.
	Strategic Aim 2: To position ourselves within the heart of the changing NHS landscape in order to influence future direction locally and nationally.					
10	Continue to contribute actively and productively to the strategic work plans for HEE and HESW and on specific work projects as appropriate	G	G	G	G	Very active role in contributing to meetings regionally (HEE and NHS Employers, West of England Membership Council) and locally as the STP develops.
11	Maximise the in-year funding opportunities presented through HESW and/or HEE bids to develop innovative education and development solutions	A	A	G	G	Reduced funding overall from HEESW for Bands 1-4 as apprenticeships change, but NMET and additional funds are strong to support in-year priorities such as the IELT and preceptorship.
12	Explore and enable greater partnerships with our educational colleagues for the continual improvement of the care we provide and our employment proposition	A	A	A	G	Stronger local networks both formal and informal and regular discussions take place as the changing education landscape takes shape.
	Strategic Aim 3: To become known and renowned for the quality of our education and development					

13	Ensure a minimum of 90% compliance in appraisals and continue to increase the staff survey score on staff having "well-structured" appraisals (to a 45%)	A	A	A	R	Changes to the survey scoring for this KF means it is not possible to compare 2014 scores to 2015. Appraisals compliance is at 83%
14	As part of the Extraordinary Everyday project, strengthen our links with local schools and other agencies with a view to increasing the number of work experience opportunities for local youngsters and thereby increase an interest in NHS careers for our future workforce	G	G	G	G	Good progress made please see main text
15	Ensure the quality of placement experienced by students when on placement in GHFT. (Includes nursing, medical, professional/scientific and AHPs	G	G	G	G	Increased numbers of Mentors and mentor training. As the education reform changes evolve, more work may be needed in 2017 to meet growing expectations.
16	Align the provision of our statutory and mandatory training to the regional and national streamlining projects and reduce the duplication of staff completing these unnecessarily when moving between Trusts; a) Core Skills Framework b) eLearning Induction for Junior Doctors (as supported by the Deanery)	G	A	A	A	Phase 2 to align GHFT StatMan training to Core Skills framework to be completed Sept 2016. A newly updated Doctors e Induction programme will be used for the July/August 2016 intake.
17	Increase the number of Higher Apprenticeship opportunities and the range of 16-18 apprenticeship roles across GHFT	A	A	A	A	Discussions continue: difficulties encountered relate to lack of finalised higher apprenticeship frameworks/standards by educational providers. Potential within IT, clinical strategy, communications. Need to establish pay structure

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD JUNE 2016

ANNUAL APPRAISAL/ REVALIDATION SENIOR MEDICAL STAFF

1 Purpose of Report

1.1 To provide an up to date review of the Appraisal and Revalidation processes for the Board.

2 Executive Summary

2.1 Revalidation began in December 2012, and the three year cycle has been completed with 394 doctors having been revalidated by the end of March 2016.

2.2 NHS England request quarterly reports and an end of year report. See Appendix 1 which is the end of year return requested by NHS England for the financial year of 2015.

3 Background

3.1 The Revalidation Operation Group meets quarterly to ensure that the Revalidation process is working and to discuss any problems. This group is made up of the Responsible Officer, Appraisal Lead, Medical Staffing Manager, Appraisal/Revalidation Officer and Revalidation Administrator.

3.2 The Responsible Officer (RO) along with the Medical Staffing Manager and Appraisal/Revalidation Officer, ensure that all paperwork required for Revalidation is in place. Once a decision has been made by the RO, the GMC are informed of the outcome, along with the doctor.

3.3 Documents relating to the appraisal and revalidation process have been updated to be compliant with current national guidance and have been added to the appraisal and revalidation site on the intranet.

3.4 The Appraisal Steering Group meet half yearly. Membership consists of the Appraisal Lead (Chair), Responsible Officer (Medical Director), LNC representative, 2 SAS Doctors and 2 Consultants. The present members are:- Dr Sean Elyan, RO, Dr Janet Ropner, Chair, Dr Steve Cooke LNC representative, Dr Nicol Vaidya, and Dr Caroline Harvey representing the SAS Doctors and Dr Nicola Williams, and Dr James DeCourcy representing the Consultants. The appraisal officer services these meetings. The Group reports to the Director of Medical Education, Quality Committee, LNC and Trust Board annually.

3.5 There are 38 appraisers, one appraiser has resigned and one is appraising reduced numbers. This gives an overall number of 37 appraisers doing the requisite number of appraisals.

3.6 A system has been put in place to capture the appraisals of those doctors who have their main employment within Gloucestershire Care Services along with those on honorary contracts.

4. Quality Assurance

4.1 Appraisees evaluate their appraisals and this feedback is sent to the Appraisers annually.

4.2 Appraisers are required to reflect on their performance. The number of appraisals they carry out, the number signed off within 28 days and the number of Support Groups they

attend are recorded. The Appraisers meet with the Appraisal Lead on a yearly basis to discuss their performance. See Appendix 2.

4.3 Quality Assurance of the appraisal summaries and Business Development Plans (PDP's) using a standard tool is carried out. This is performed by the Appraisal Lead and three volunteer Appraisers. Appraisals summaries and PDP's were also scored during the autumn appraiser support group. Once marked the overall score is forwarded to the appraiser for their education. We are having an independent verification visit from the team from NHS England 2016.

4.4 Reporting Form A: A new Form A has been developed which will replace the old Form A. It is anticipated that this will be piloted. This form will be completed by the Specialty Director or Chief of Service and will be reviewed at the appraisal by the appraiser.

4.5 Four Appraiser Support Groups take place each year. Appraisers are expected to attend two. This has ensured that all appraisers are up to date with current legislation and changes to the appraisal and revalidation process.

5 Clinical Governance

5.1 The appraisal process requires links to strong clinical governance processes. The Audit Department provide details of any audits for which senior medical staff have been nominated as lead. The Risk Department send a report to those who have been involved in a Serious Untoward Incident. A nil return is sent to all other Senior Medical Staff by the Appraisal Administrator. The Complaints Department continue to send reports to those involved in complaints.

6 Information Systems

6.1 The Patient and Colleague feedback process is administered through the appraisal administration team.

Appraisals themselves are recorded on the MAG (Medical Appraisal Guide) form. A new MAG form has been produced by NHS England. These should be completed and returned to the appraisal administration team within 28 days of the date of the appraisal.

7 Implications

The cost of managing revalidation and appraisal has previously been presented. No new additional costs have been identified. However as appraisers retire or leave the Trust, retaining the funding for appraisers to maintain an adequate cohort of appraisers is important.

8 Recommendation – To Note

The Board is asked to note the report for assurance that the Trust has a robust medical appraisal and revalidation system which is compliant with national requirements.

Author: **Janet Ropner Associate Medical Director**

Presenting Director: **Sean Elyan Medical Director**

Date **May 2016**

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2016 should be included. Where the answer is 'nil' please enter '0'. **See guidance notes on pages 16-18 for assistance completing this table**		1a	1b	2	3	
		Number of Prescribed Connections	Completed Appraisal (1a)	Completed Appraisal (1b)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	376	211	137	28	0	376
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	80	44	25	11	0	80
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	18	3	0	15	0	18
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	0	0	0	0	0	0
2.1.7	TOTAL (this cell will sum automatically 2.1.1 – 2.1.6).	474	258	162	54	0	474

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

TRUST BOARD JUNE 2016

ANNUAL COMPLAINTS REPORT 2015-2016

1. Introduction

The aim of this report is to provide information on the complaints and concerns reported to the Trust during 2015-16. The annual benchmarking report for written complaints received by NHS organisations is not published until end August 2016 so the information in this paper represents our internal performance.

2. Key points

- *961 written complaints received, 0.9/1000 total episodes of care. Increase of approximately 6% since 2014-15*
- *98% acknowledgement within national standard of 3 days*
- *76% response rate within local standard of 35 working days (target 95%)*
- *1804 concerns dealt with via our PALS department*
- *Main areas of focus within both complaints and concerns remain: clinical treatment; communication (verbal and written); and appointments (booking system, delays, cancellations)*
- *9621 compliments received and formally logged during the same period of time*

3. Complaints

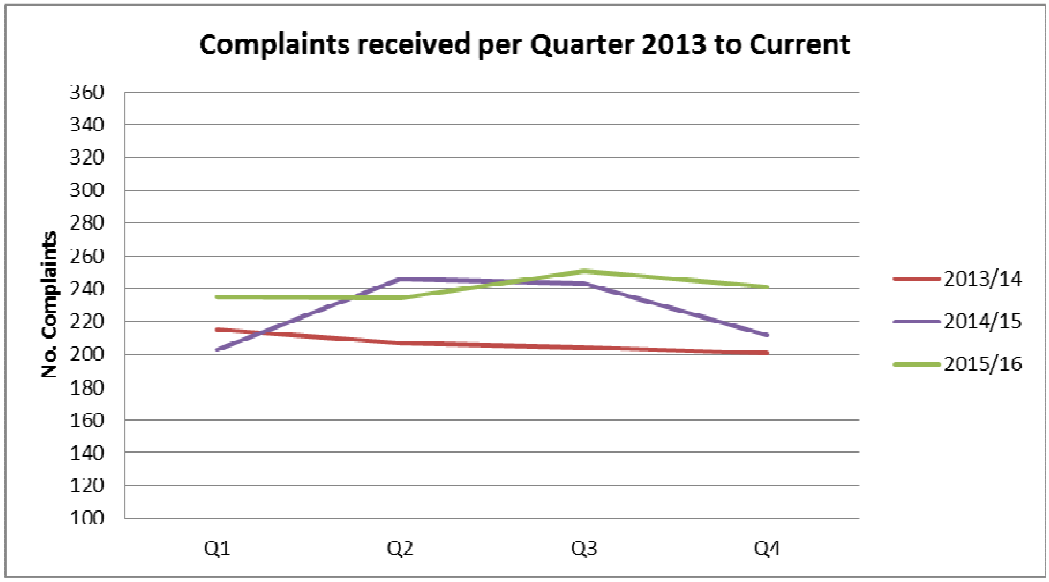
3.1 Number of Complaints Received

During 2015-16 the Trust received a total number of 961 complaints which equates to an average of approximately 18.5 complaints received per week. This is an increase of approximately 6.3% against the number of complaints received during 2014-15 (904). The increase in the overall number of complaints received cannot be attributed to a specific theme or issue.

This figure equates to 6.3 complaints per 1000 inpatient spells or 0.9 complaints per 1000 total episodes of care (includes all inpatients, outpatients, maternity and Emergency Department attendances).

The Trust received a total of 9621 compliments as notified by all hospital areas during 2015-16.

The graph below illustrates the total number of written complaints received over time since 2013-14.

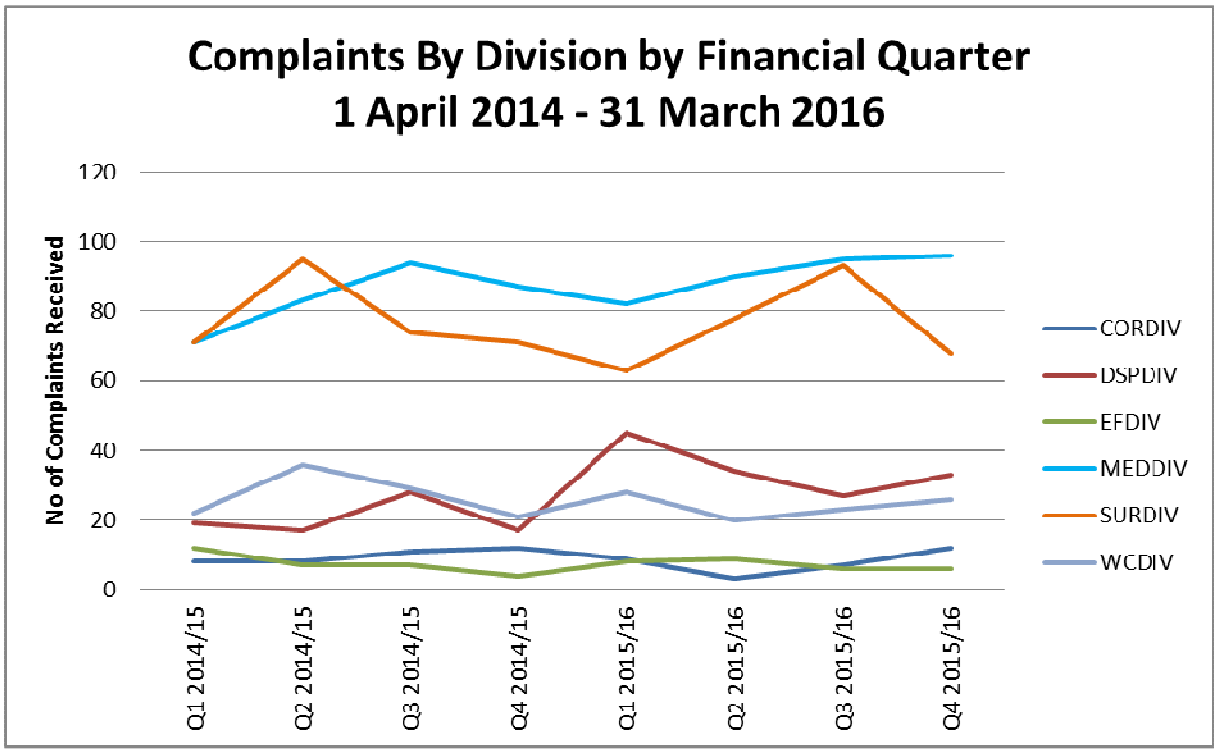


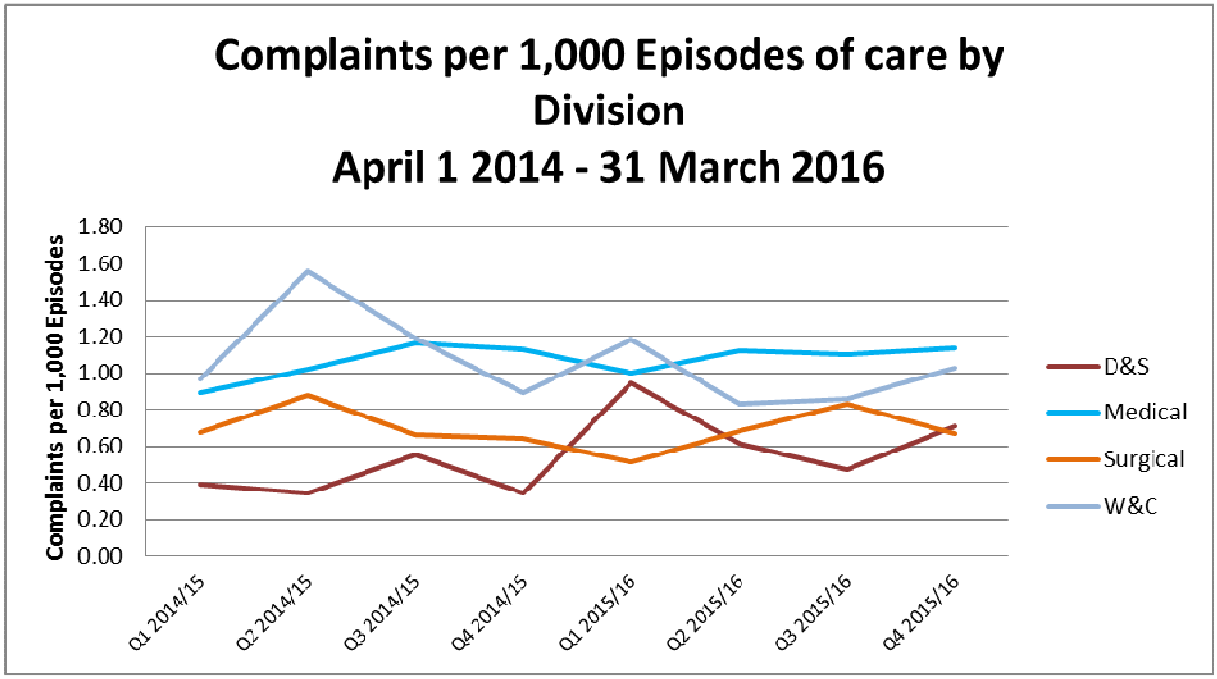
3.2 Upheld Complaints

Of the 961 complaints received in 2015-16, 848 were closed at 15 April 2016 of which 59% were upheld after investigation (19% were fully upheld and 40% were partly upheld) compared with 57% upheld either partly or fully in 2014-15.

3.3 Complaints reported by Division

The graphs below show the number and rate of complaints reported by Division since 1 April 2014.



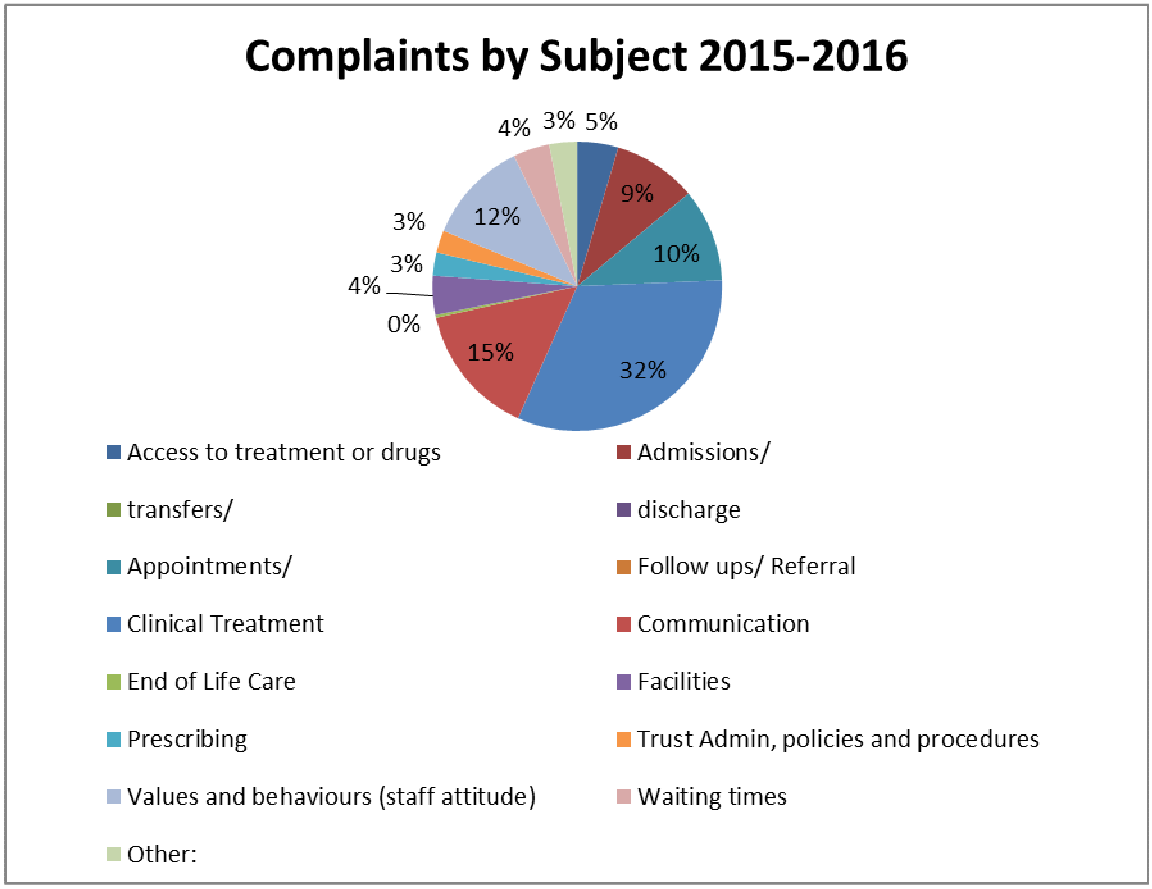


The table below shows written complaints received by main hospital service area and shows that the largest area for complaint numbers is outpatients which are to be expected given volume of patients seen within this service area. 2015/16 saw an increase in the complaints received relating to Outpatient areas – mainly focussed on cancellations and wait times which reflected the increased level of referrals and general demand experienced by the Trust. The number of complaints received that related to inpatient services reduced slightly from 2014/15.

	Number of complaints received 2015/16	% of total for 2015/16	Number of complaints received 2014/15
Total number complaints	**961**		**904**
In-patient	371	39%	394
Outpatient	459	48%	367
ED	116	12%	108
Maternity	15	1%	15

3.4 What do people complain about?

During 2015/16, we received complaints about the following issues:



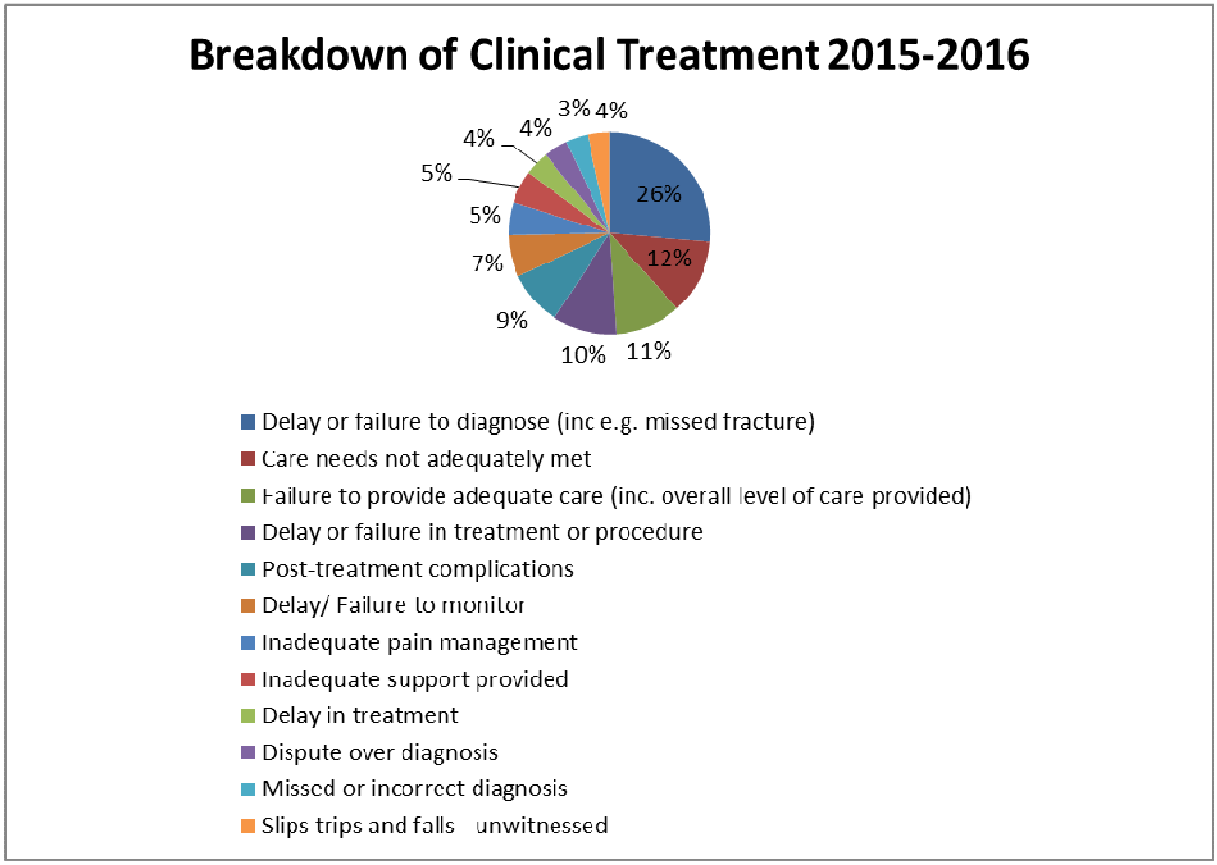
"Other" includes complaints relating to damage to personal property, commissioning, privacy, dignity and wellbeing, staff numbers and transport.

The nationally mandated categorisation of complaints changed in 2015/16 so comparison with previous years is difficult.

However, the main causes for complaint during 2015/16 were:

- *Clinical care and treatment -32%/311 complaints*
- *Communication (written or oral) – 15%*
- *Values and behaviour – 12%*
- *Appointments/follow ups/referrals – 10%*
- *Admissions/transfers/discharges – 9%*

A breakdown of the category for "all aspects of clinical care and treatment" is given below and shows that delay or failure to diagnose is the most frequent sub-cause for complaint followed by care needs not adequately met.



There were no complaints received about the Trust complaints process during 2015-16.

3.5 Complaint Acknowledgement and Response Times

There is a requirement under the current NHS Complaints regulation to respond within three working days to a written complaint with an acknowledgement letter. During 2015-16 this requirement was met in 98% of cases. 19 cases (2%) were acknowledged outside of this time; 15 were acknowledged within 4 days and 4 were acknowledged within 5 days.

Of the 961 complaints received during 2015-16, 848 have been closed at the time of writing this report. Our internal standard of written response within 35 working days in 95% of these cases was not met, performance for the year was 76%. This is a decrease against the previous year when 88% of cases were closed within 35 working days.

The table below displays cumulative response rate by Division during 2015-16.

Division	Q1	Q2	Q3	Q4
Corporate	78% (7/9)	83% (10/12)	79% (15/19)	84% (21/25)
D&S	71% (32/45)	92% (58/79)	61% (64/105)	73% (88/121)
E&F	63% (5/8)	82% 14/17)	83% (19/23)	85% (22/26)
Medicine	78% (64/82)	79% (136/172)	74% (195/262)	77% (238/311)
Surgery	79% (50/63)	74% (104/141)	76% (177/233)	79% (222/281)
W&C	68% (19/28)	67% (32/48)	66% (47/71)	67% (56/84)
Trust average	**75%**	**75%**	**73%**	**76%**

A number of significant factors contribute to the delay in responses including: increased demand upon the workforce; increased number of complaints received; the availability of health care records; the complexity of the cases requiring cross-divisional and dual process responses; implementation of the Duty of Candour requirements; increased clinical pressures on Divisional staff which affects the investigation response time plus the time for senior staff complaint response clearance.

Availability of medical care records remains a significant delaying factor, particularly for complex complaints which involved numbers of clinical staff. A request to the Trust Information Governance and Health Records Committee to permit copying of notes within a controlled process was unfortunately turned down. It is anticipated that going forward the advent of Trakcare will greatly assist with the complaint response rate but in the meantime the Complaints Manager is working closely with Divisions to review the process of investigation, response and authorisation.

3.6 Local Resolution Meetings

During 2015-16 a total of 23 local resolution meetings were held with complainants and Trust staff. The aim of local resolution meetings is to provide an opportunity for the complainant to explain what they are unhappy or unclear about and gives them and us the time to listen and discuss the complaint. They are an important and invaluable way of resolving issues and we offer face to face meetings where possible and where appropriate.

We have also developed and delivered specialist training for Trust staff chairing complaint local resolution meetings.

4. Parliamentary and Health Service Ombudsman Reviews (PHSO)

During 2015/16 the Trust was notified of 28 cases which had been referred by complainants to the PHSO for second stage resolution and which the PHSO has decided to investigate. This equates to approximately *3%* of the total number of complaints received. The PHSO do not inform the Trust of referrals that they decide do not meet their threshold and therefore are not formally investigated through their second stage resolution process.

It often takes significantly longer than a year for the Ombudsman to carry out an investigation and to make a decision as to whether a complaint should be upheld at second stage. For this reason, we look at their judgements over a longer period of time rather than purely within one calendar year. Of the 30 cases reported on by the PHSO in 2015/16, over half were not upheld following investigation. There were no specific themes or clinical areas identified within the PHSO cases that were upheld.

Since 2012 the PHSO has decided to investigate a total of 108 cases referred to them. Following their investigation, 62 (57%) cases were not upheld, eight cases were upheld and 23 cases partially upheld (a total of 29%). Three cases were withdrawn, one has been discontinued and we are still awaiting the outcome on the remaining 11 cases.

5. Referrals from SEAP (Support. Empower. Advocate. Promote)

SEAP act as an independent complaints, advocacy and advice service and in Gloucestershire, are hosted by Healthwatch Gloucestershire. They support complainants through the process of making a complaint which will include attending any local resolution meetings.

We received 17 referrals from SEAP during 2015-16. After investigation, 9 (53%) were not upheld, 6 were partly upheld and one was upheld. One response is outstanding. Complaints received related to a range of service areas including admission/discharge, clinical treatment, communication, medication issues and staff behaviour.

6. Concerns resolution

During 2015-16, our PALS team dealt with 1804 concerns of which the top three themes were as follows:

- Communication between Trust and patients/carers
- Appointments
- Access to treatment or drugs

All concerns are also reviewed by the Divisions and feed into the consideration of improvement. Actions resulting from addressing of concerns include many individual level actions but some broader actions. Of the cases initially managed by PALS as concerns, 74 cases subsequently became formal complaints.

During 2015/16 we have been able to resource regular opening of the PALS office at Cheltenham General Hospital and have been working closely with the wards to identify and resolve concerns promptly.

7. Learning from Complaints and Concerns

Learning from what our patients and carers tell us works well and what may need improving is a key component of enabling us to deliver our Trust strategic objective *"to improve the experience of our patient's year on year"*.

Lessons learnt are captured via a number of patient experience routes across the Trust including through concerns, complaints, Friends and Family Test, national and local surveys and dedicated projects such as the Stroke Experience-based Co-design and National Age UK "Listen and Learn" projects. With respect to concerns and complaints, quarterly reports are submitted to Patient Experience Strategic Group, Quality Committee and Board which contain lessons learnt. Specific examples of lessons learned are also reported within the monthly Chief Executive report to Trust Board and published within our monthly staff publication, Outline.

Monthly divisional-level reporting continues and information on lessons learned from complaints and other patient experience measures (for example Friends and Family Test) are displayed within the patient experience boards in ward areas.

The table below provides information of the top areas for complaint by Division plus examples of actions taken by the clinical areas in response.

Division	Top reasons for complaint/concern and actions taken/planned
Medicine	• ***Failure to provide adequate care.*** Actions taken have included: dedicated training for staff on caring for patients with dementia and learning disability; volunteer role developed to support mealtime and dementia care cognitive stimulation programme • **Communication with patients** Actions taken include: reiteration of "Kindness and Respect" standards to staff; communications skills training provided; revision of referral forms in Cardiology; revision of process for assessment of new Rheumatology referrals. • **Premature discharge/transfer of patients** Actions taken include: production of new web based discharge training

	programme “No longer than necessary”; joint days with care home association; actions within Trust ED/flow improvement programme.
Unscheduled Care	• **Missed fractures.** Improvement project developed as part of Trust Quality Improvement Academy. Actions include training of junior doctors/ENPs and development of review and recall system. • **Waiting times in department (to be seen and treated).** Integral part of Trust ED Improvement programme. • **Information as to anticipated wait times within department**. Digital information screens being trialled from June 2016 in both EDs
Surgery	• **Communication with patients** Actions include: revision of biopsy leaflet in Urology to make communication clearer (as part of Trust-wide Patient Information Review programme); revision of administrative procedures to contact patients in Head and Neck • **Appointment delay** Actions include revision of processes and resources within Audiology department around telephone access; provision of hearing aid repairs – agreement made with the Gloucestershire Deaf Association to provide drop in hearing aid repair clinics on the Trust’s behalf. • **Post treatment complications** Information about clear instructions on prophylactic fragmin included in junior doctors induction
Diagnostics & Specialties	• **Communication.** Additional training sessions provided for Divisional staff. New intermediate communication skills training developed and now available to staff. • **Information as to anticipated wait times within Outpatient clinic areas.** Pilot of digital information screens in Oncology due to begin July 2016**.**
Women & Children	• **Communication with patients and relatives.** Processes and standards for maternity triage and assessment being reviewed. Reinforcement of standards via divisional newsletters and briefings. • **Waiting times for frenulectomy.** Additional capacity provided.
Estates & Facilities	• **Car parking availability/cost.** Review of parking facilities for staff and patients currently in progress. • **Smoking outside hospital entrances**. Discussed at Trust Health and Wellbeing Committee • **Cleanliness.** Revision of cleaning schedules, audit and staff training.
Corporate	• **Delays in discharge caused by number factors including medication/transport.** Programme of work focussed on

	discharge processes including close relationship with patient transport providers. • **Multiple ward moves.** Introduction of clearer process to identify patients being moved frequently and site management processes revised. Part of ED/Flow Improvement programme. • **Communication.** Communication skills and customer service training continues. Trust Kindness and Respect Standards reinforced. • **Delays to appointments and appointment cancellations.** This has been adversely affected by demand within the Trust during the past months. Clinics affected in particular have been cardiology, ENT and Urology. Individual service areas are reviewing demand and capacity and additional capacity has been provided in some clinic areas.

8. Our Internal Complaints Management Processes

The Trust's inspection by the CQC in March 2015 included a review of our internal complaints management process as part of assessment of the "Responsiveness" domain. This review involved an interview with the Head of Patient Experience and a visit to the Complaints Department to interview complaints team members and to carry out a case note review of current and historical complaints. The inspection findings were positive about our internal process which was pleasing to note given the improvement work undergone by the team during 2013-14.

During the past year we have continued to review our current processes to ensure that it meets the evolving needs of both complainants and staff. Actions taken have included:

- Continued to work on actions linked to the Ombudsman vision *"My expectations for raising concerns"* published November 2014, the majority of which have now been completed. Progress on these actions is reported on a regular basis to the Patient Experience Strategic Group (which reports to Quality Committee)

- Carried out audits of complaint responses against guidance from the 'Plain English' campaign

- Datix Web Complaints system module for internal management of complaints information continues to be embedded throughout the Trust

- Development of complaint triage system so that all complaints are triaged on day of arrival to identify severity and any dual processes so that issues arising from complaints are dealt with in the most appropriate manner

- Implementation of a weekly review of Complaints in conjunction with Legal, Duty of Candour and Risk teams. The focus is improving quality and safety and minimising duplication of processes

- Development and facilitation of two workshops for Trust senior managers focusing on improving skills and confidence when chairing face to face local resolution complaint meetings.

- Revision of *"Complaints and feedback"* policy

- Revision of complaint acknowledgement letters which now include a summary of areas for investigation

- Guidance sheets and action cards for complainants, staff and meeting chairs have been produced and introduced relating to attending face to face local resolution complaint meetings.

Looking forward we plan to:

- Continue to embed Datix Web Complaints module across the organisation

- Further improve the quality of complaint investigation and response by continuing to implement the "lead investigator" model and revise our structure of investigation response and sign-off

- Respond to the outcomes of the complainants survey (see below)

- Ongoing alignment of processes with Legal, Risk and Duty of Candour teams to enable our requirements for Duty of Candour to be met

9. Patient Association: NHS Benchmarking Complainant Survey

During 2015 the Trust participated in the national pilot Patient Association: NHS Benchmarking Complainant Survey. This survey was sent out to *all* complainants ten weeks after the final response was sent to them and asked questions about their experience of the complaints process as measured against the Patient Association Standards. These standards and those reflected in the Ombudsman "my expectations" guidance are currently being used by NHS England to develop a way of assessing quality of complaint processes and early participation in the survey was felt to be advantageous in preparing our Trust for any further developmental need.

Over the participating period 637 surveys were posted, 230 were returned giving a response rate of 36%.

Our Trust scored positively in the following areas:

- *Made to feel comfortable by staff handling their complaint*
- *Found it easy to make a complaint*
- *Timescales were discussed at the beginning of the process*
- *Understood the explanation given in the response to their complaint*

Areas for improvement include:

- Strengthen explanation to the complainant about actions taken to prevent a reoccurrence of an issue
- Provide an explanation of how we will manage individuals including any HR processes when the complaint involves specific Trust staff members
- Provide future updates on any changes made as a result of complaint

10. Recommendations

The Board is asked to note the 2015-16 annual report on Complaints.

Author: Heather Beer, Head of Patient Experience

Date: June 2016

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MAIN BOARD/JUNE 2016

INFECTION PREVENTION AND CONTROL ANNUAL REORT

1 Progress of Infection Prevention and Control in 2015-2016

The Annual Report of the Director of Infection Prevention and Control (DIPC) provides information on the progress and achievements of the infection control objectives set for 2015/16 and outlines objectives for 2016/17.

2 Executive Summary

The last year has seen further progress for Gloucestershire Hospitals NHS FoundationTrust (GHNHSFT) with regard to infection prevention and control. We have built on the increasing recognition, within all levels of the organisation, that infection prevention and control is everyone's business. The Divisions continue to be involved in implementing infection prevention and control actions and taking ownership and responsibility of any issues, with the Trust Board continuing to receive monthly reports on the progress with infection prevention and control.

Maintaining low numbers of Clostridium difficile cases has remained a challenge and the final number of hospital-acquired cases was 41 against a trajectory of 37. 6 of these cases were deemed unavoidable due to their co morbidities and need for antibiotic therapy and have been successfully appealed with the Commissioners and agreed therefore the total number of avoidable Clostridium difficile cases was 35. Efforts have concentrated on ensuring high standards of environmental and near patient equipment cleaning and good antimicrobial prescribing.

Outbreaks of Norovirus have been much less despite high numbers circulating in the Gloucestershire community and GHNHSFT reported just 12 bay or ward closures.

Our Trust continued to work on the implementation of all current national initiatives to control healthcare associated infection. The 2015/16 infection control countywide work plan for the year was progressed. Outstanding areas will be incorporated into this year's infection control objectives and action plan.
Challenges for 2016/17 are to achieve zero healthcare acquired MRSA bacteraemias and C. difficile target of 37 cases.

3 Background

This report summarises the key issues and progress on infection prevention and control within the Trust, and places an emphasis on infection control issues and outcomes within the whole organisation rather than focusing on the activities undertaken by the Infection Control Team.

4 Recommendation

To endorse the 2015-16 annual Infection Prevention and Control report.

Authors: **Cheryl Haswell, Matron – Infection and Prevention and Control and Maggie Arnold, Director of Nursing and Director of Infection, Prevention and Control**

Presenting Director: **Maggie Arnold, Director of Nursing and Director of Infection, Prevention and Control**

Date 9.6.16

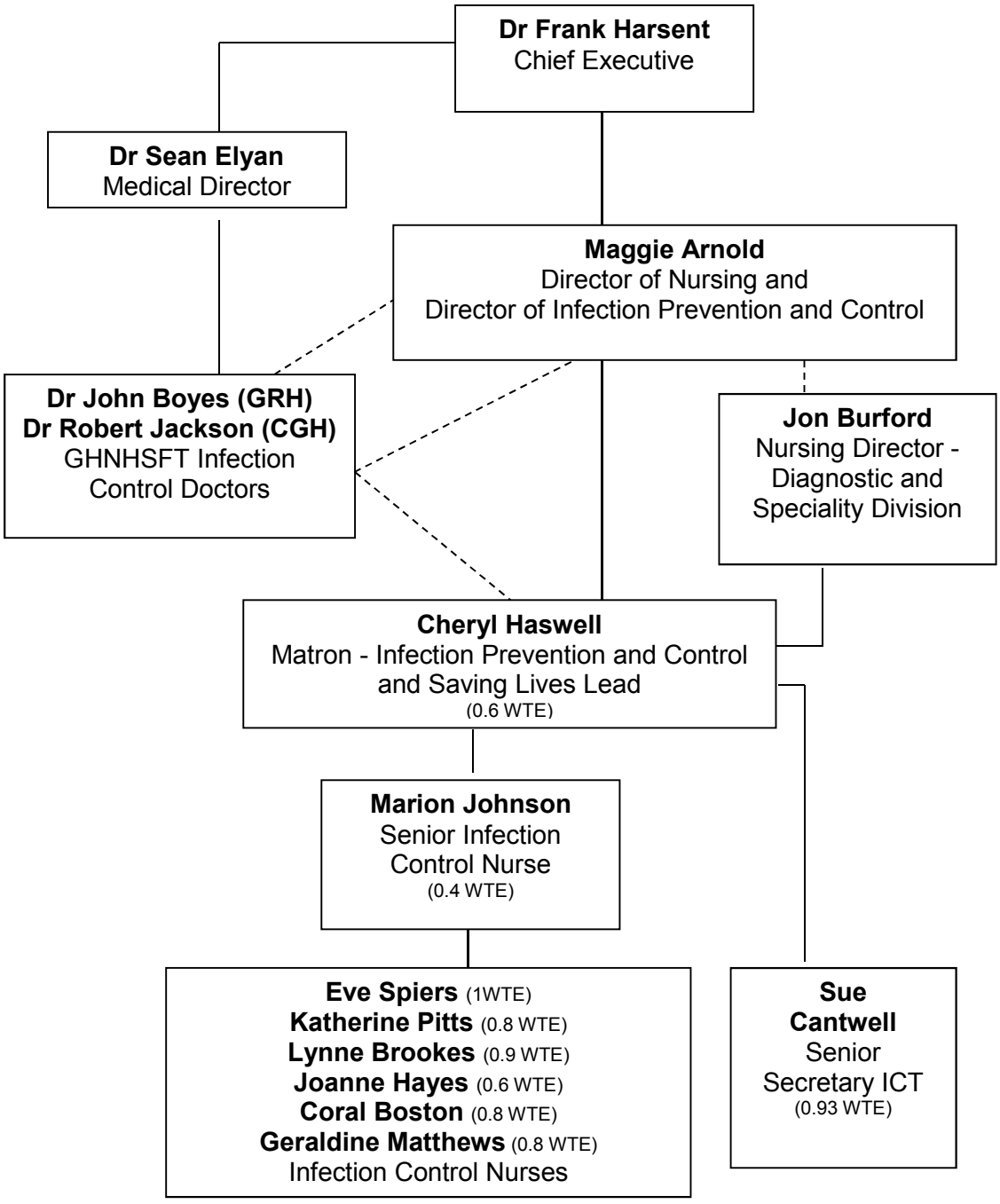
THE INFECTION PREVENTION AND CONTROL ANNUAL REPORT 2015-2016

1. Introduction

The Director of Infection Prevention and Control's (DIPC) annual report summarises the infection control activities from 1st April 2015 to 31st March 2016.

2. Overview

In 2015/16 Mrs Maggie Arnold continued in her role as DIPC and Nursing Director, and reported directly to the Chief Executive. Infection prevention and control lines of accountability within GHNHSFT is outlined below. On-call senior management and microbiology support is available for infection prevention and control emergencies arising out of hours.



Team membership at April 2016.

3. Description of infection control activities – Infection Prevention

3.1 Infection Control Service

The infection control nursing team and infection control doctors continued to contribute to delivering the infection control service. A close working relationship was maintained with the Microbiology Department, Pharmacy, Estates and Facilities, Risk Management, Communications Team, Occupational Health, Patient Experience, clinical and managerial staff within the Trust to maintain high standards and to promote a strong infection control culture within the organisation.

3.2 Infection Control Committee (ICC)

In 2015/2016 the Infection Control Committee (ICC) continued to meet monthly with a broad membership and an agenda that rotated from meeting to meeting. It included representation from the Trust Board. The Clinical Divisions provided assurance of their management and ownership of infection control to the committee by presenting their divisional action plans quarterly.

4. Microbiological support

The ICT continues to work closely with the Microbiology Department. The consultant medical microbiologists (CMMs) provide urgent infection control cover out of hours as part of the consultant microbiologists "on call" duties. The CMMs are currently providing on call cover out of hours on a 1 in 4 basis.

The Trust employs a team of 5 CMMs:-
Dr Alan Lees – Microbiology, Head of Department
Dr John Boyes- Infection Control Doctor, Gloucestershire Royal hospital
Dr Robert Jackson- Infection Control Doctor, Cheltenham General Hospital
Dr James Stone – Infection Control Doctor for Gloucestershire Care Services
Dr Philippa Moore –2gether, DIPC

The Microbiology Laboratory provides a wide repertoire of Microbiology Diagnostic tests and appropriately prioritises the accurate and timely investigation of samples of clinical and infection control importance.

5. Surveillance

Monthly surveillance reports continued to be produced by the infection control team detailing Meticillin Resistant *Staphylococcus aureus* (MRSA), Meticillin Sensitive S*taphylococcus aureus* (MSSA), *Escherichia coli* (E coli) bacteraemias and cases of *Clostridium difficile* infection. There is close monitoring of MRSA screening and identification of potential MRSA inpatient acquisitions and Carbapenemase Producing Enterobacteriaceae (CPE) screening for those patients identified as being at risk. The reports were circulated to each Division, Saving Lives Infection Control Link nurses, and members of ICC monthly.

All cases of MRSA bacteraemia infection and *Clostridium difficile* deaths which are recorded on part 1 of the death certificate were formally investigated. The findings and lessons learnt were presented at appropriate committees and shared with the Commissioners.

6. Mandatory Surveillance

6.1 *Clostridium difficile* Infection (CDI)

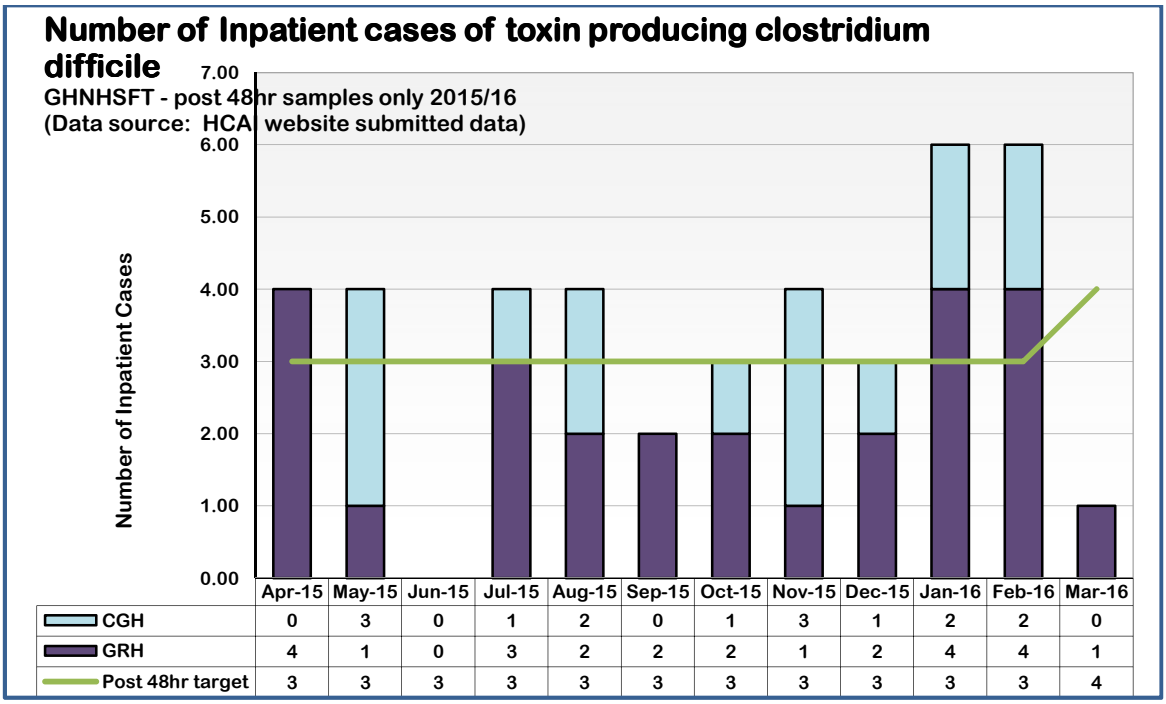
Mandatory surveillance data for CDI has been published on an annual basis by the Public Health England (PHE) on behalf of the Department of Health (DH) since 2004. All patients in the county 65 years and over who have unformed faeces samples (diarrhoea) submitted to the Microbiology Department are tested for toxigenic *Clostridium difficile*. *Clostridium difficile* testing is also performed on selected patients between the ages of 2-64 years following testing guidance from DH and PHE. All positive results are reported to (PHE) via the PHE Healthcare Associated Infection (HCAI) Data Capture System (DCS) so that a rate of infection can be calculated using

denominator data for GHNHSFT inpatients. This system was updated in November 2015.

A new case is defined as follows:
A patient is defined as having *Clostridium difficile* infection (CDI) if they have a faeces sample that has evidence of toxin-producing *Clostridium difficile* and the patient has diarrhoea (minimum of 3 loose stools, Bristol Stool Chart types 5-7) not attributable to any other cause, which required specific anti-*C.difficile* antibiotic treatment for the episode. Repeat positive results on the same patient within 28 days of the initial diagnosis are regarded as the same episode of infection.

There has been sustained year on year reduction in levels of CDI since 2006 within GHNHSFT. The agreed trajectory for CDI for 2015-16 was set at 37 trust-attributable episodes. The Trust did not achieve this target and reported 41 cases. However, 6 of the 41 cases were deemed to be unavoidable following root cause analysis and therefore not attributed to the Trust. These cases have been appealed with the Commissioners and agreed so the total number of avoidable cases of CDI was 35 cases which was under the annual target.

The graph below shows monthly post-48 hour (Trust attributable) reported CDI episodes for GHNHSFT (displayed also by hospital site) versus the trajectory.



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
CGH	0	3	0	1	2	0	1	3	1	2	2	0
GRH	4	1	0	3	2	2	2	1	2	4	4	1
Post 48hr target	3	3	3	3	3	3	3	3	3	3	3	4

Periods of Increased Incidence (PII) are identified from regular surveillance of *Clostridium difficile* infections within the Trust. When two cases or more of post 48 hour *Clostridium difficile* infection occurred within a 28-day period in a ward the PII of Clostridium *difficile* infection was investigated by the Infection Control Team and samples sent for ribotyping. Once all information is collated, including ribotyping, a multi-disciplinary team meeting may be called. Attendance at meetings was mandatory for relevant medical and nursing staff, pharmacy representatives, clinical risk and the Infection Control Team, including the Infection Control Doctor.

There has been a decrease in the total number of PIIs of CDI in 2015-16 to 6 which contrasts with 2014-15 when there were 7 PIIs. In 2015/16 the Infection Control Nurses continued to undertake a root cause analysis on every case of pre and post 48 hour CDI. When investigations identified the same ribotyping, action plans were implemented and ongoing surveillance was continued to monitor any further cases.

Selective referral of samples for ribotyping continues to assist in the management and investigation of suspected periods of increased incidence. All samples in March 2016 were ribotyped to provide a snapshot of ribotypes that are being seen countywide; this was funded by the Commissioners.

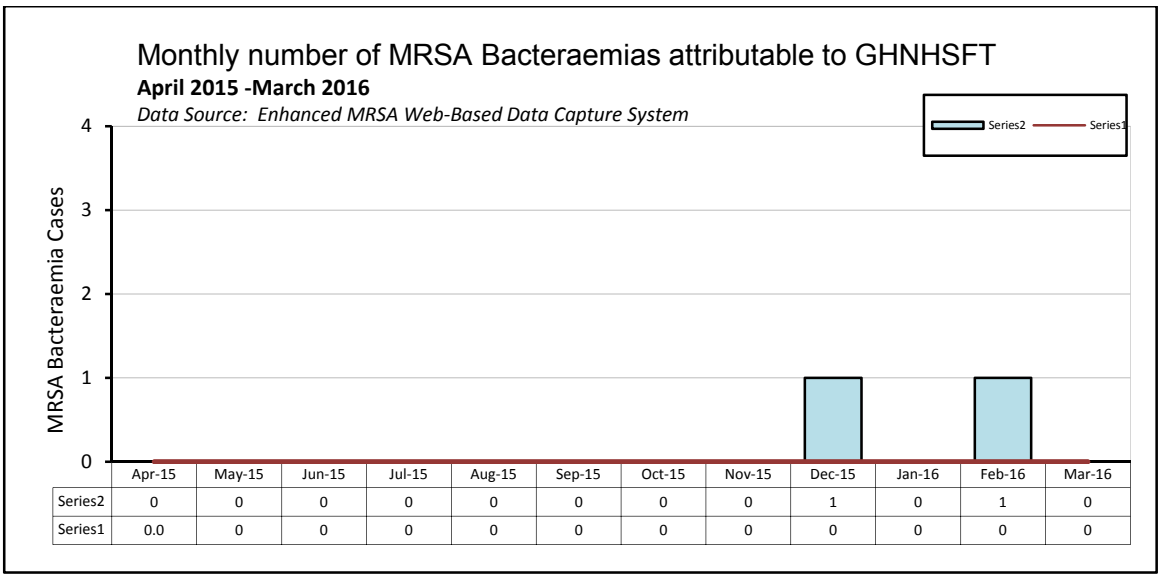
6.2 Meticillin Resistant *Staphylococcus aureus* (MRSA) Bacteraemia

NHS England published guidance on the reporting and monitoring arrangements, post infection review process for MRSA bloodstream infections, and made it a requirement in April 2014 to institute a rigorous Post Infection Review in all cases of MRSA bloodstream infection.

The outcome of the Post Infection Review assists in attributing responsibility for MRSA bloodstream infections. All cases reported are assigned either to an acute Trust, Clinical Commissioning Group or a Third party. This process relies on strong partnership working by all organisations involved in the patient's care pathway, to jointly identify and agree the possible causes of, or factors that contributed to, the patient's MRSA bloodstream infection. At the beginning of the 2014 financial year NHS England introduced a new category for the PIR assignment of MRSA bacteraemia cases, acknowledging the increasingly complex nature of the MRSA bacteraemia being reported. Assignment to a "third party" through the arbitration process can now be made for cases with a specimen date post April 2014. The "third party" option provides a category for patients who have been attributed to default providers or CCGs who may not have been involved in the patient's care or who can provide strong evidence following a PIR that there were no failings in patient care. In 2015/16 2 cases of MRSA bacteraemia were assigned as third party.

MRSA bacteraemias continued to be reported to the Public Health England (PHE) via the Healthcare Associated Infection (HCAI) Data Capture System (DCS) as part of Department of Health mandatory HCAI surveillance.

In 2015/16 in the whole healthcare community there has been a cumulative total of 12 MRSA bacteraemias, this is an increase of 2 compared to 2014-15. Of the 12 bacteraemias that occurred, two of these cases were a post-48 hour bacteraemia and therefore attributed to GHNHSFT. The annual target (objective) of MRSA bacteraemias for GHNHSFT was 0 (which was a national zero tolerance target) and unfortunately this was not achieved.



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Series2	0	0	0	0	0	0	0	0	1	0	1	0
Series1	0.0	0	0	0	0	0	0	0	0	0	0	0

All cases of MRSA bacteraemia were examined in detail by a rigorous root cause analysis and a timeline of interventions to establish the underlying predisposing factors to prevent future infections. Common themes in patients were significant underlying chronic disease, including Diabetes Mellitus, vascular insufficiency, urological conditions and intravenous drug use. Learning from the cases has highlighted the need for full MRSA screens on admission to include nose, groin any skin lesions or wounds such as pressure ulcers, leg ulcers, and urine from long-term catheters to accurately assess patient's MRSA carriage status.

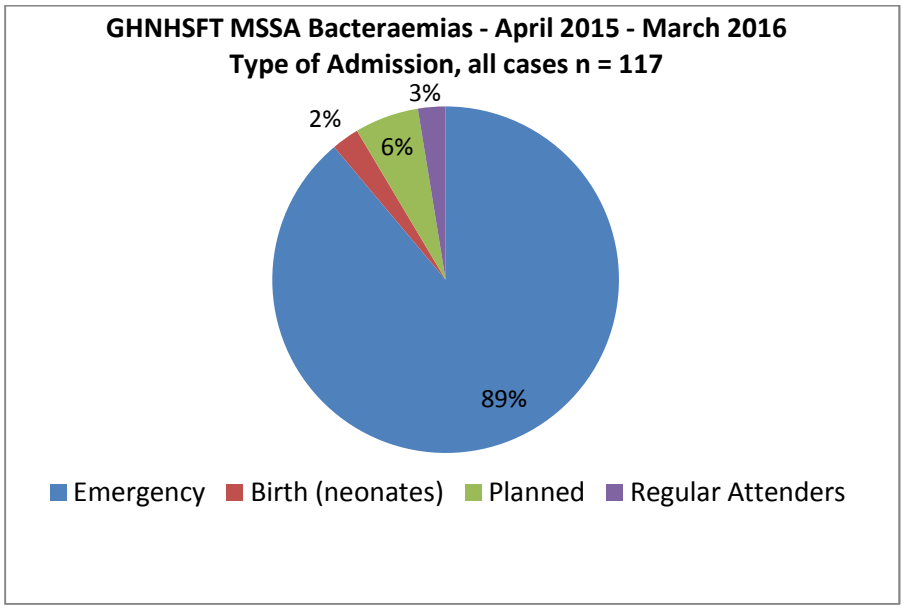
6.3 Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia

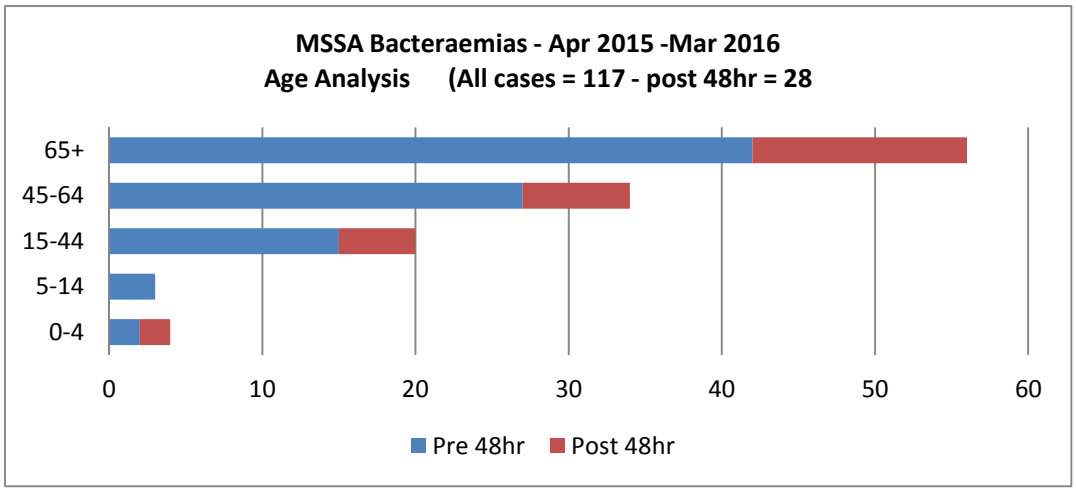
Since January 2011, all acute NHS Trusts have been mandated to report all Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemias to the DH via the HCAI data capture system as part of mandatory surveillance of HCAI. The current system entails the Microbiology Department recording these infections and manually entering the infection episodes onto Public Health England (PHE) HCAI Data Capture System. The episode data includes date sample taken and date of admission so an assessment of whether the infection is pre or post-48 hours of admission can be made (one definition of a healthcare-associated infection is one that occurs more than 48 hours after admission). There is no nationally set or locally agreed target for post-48 hour (trust attributable) MSSA bacteraemia. GHNHSFT is however keen to keep the numbers of these infections to an absolute minimum.

These episodes have been analysed locally to gain a better understanding of the epidemiology of this relatively common invasive bacterial infection.

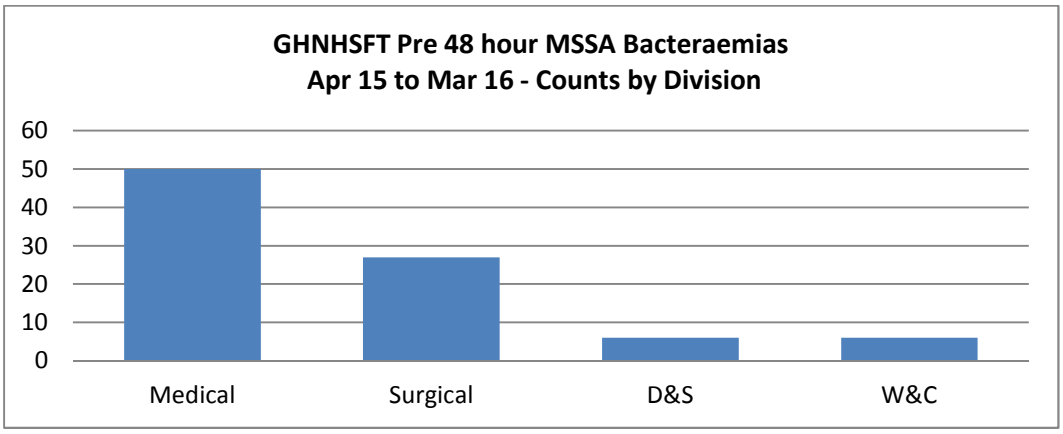
In the county there are approximately 10 MSSA bacteraemias per month. In the last 12 months of the surveillance there were 117 MSSA bacteraemias. 76% (89) of episodes were in patients in the first 48 hours of their admission. 24% (28) were post-48 hour episodes. The incidence of infection increased with increasing age but there were some (7) infections occurring in children with four of these occurring in children below the age of 5 years. Forty eight percent of all the MSSA bacteraemias occurred in the over 65s. The average age of patients with a MSSA bacteraemia was 59 years.

The type of admission of patient having MSSA bacteraemias in recorded in the pie chart below.

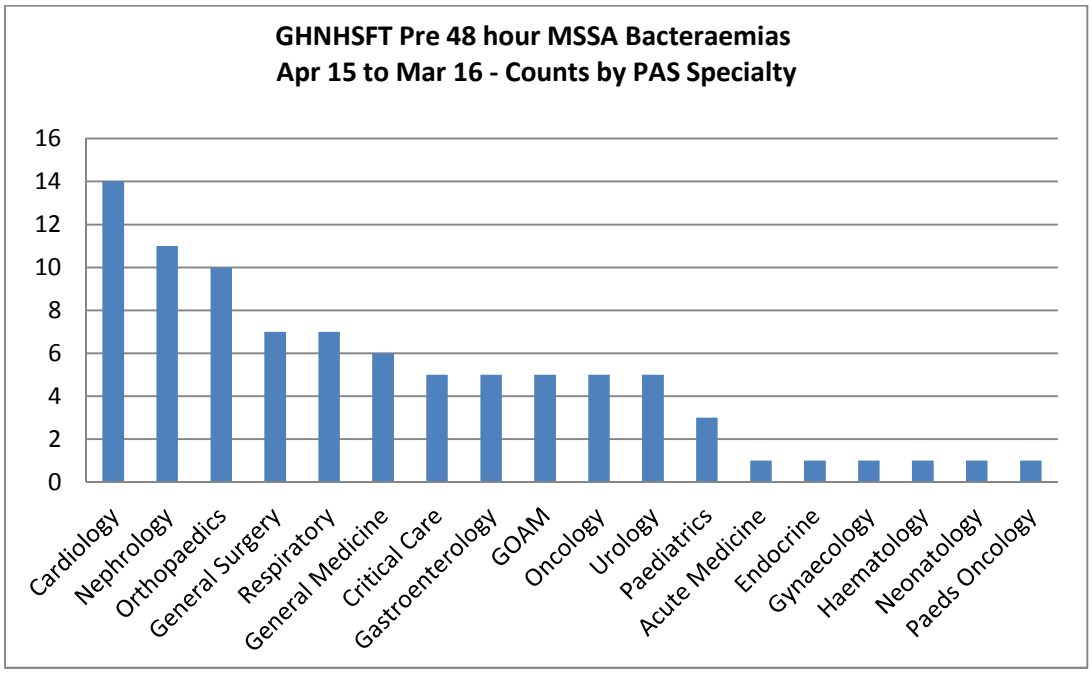


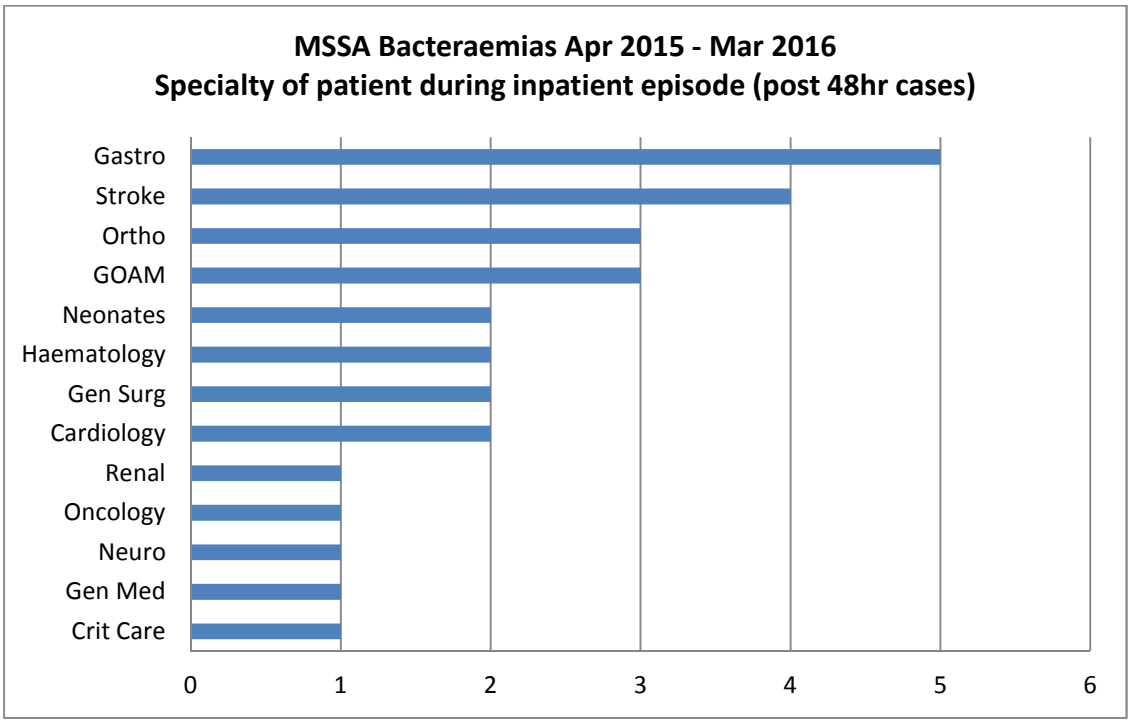


Between April 2015 and March 2016 the surveillance showed that more males (62%) than females were affected. Of the post-48 hour MSSA bacteraemias 61% of these occurred in males. Most of the infections occurred in patients managed within the Medical Division. MSSA bacteraemias by Division are shown below.



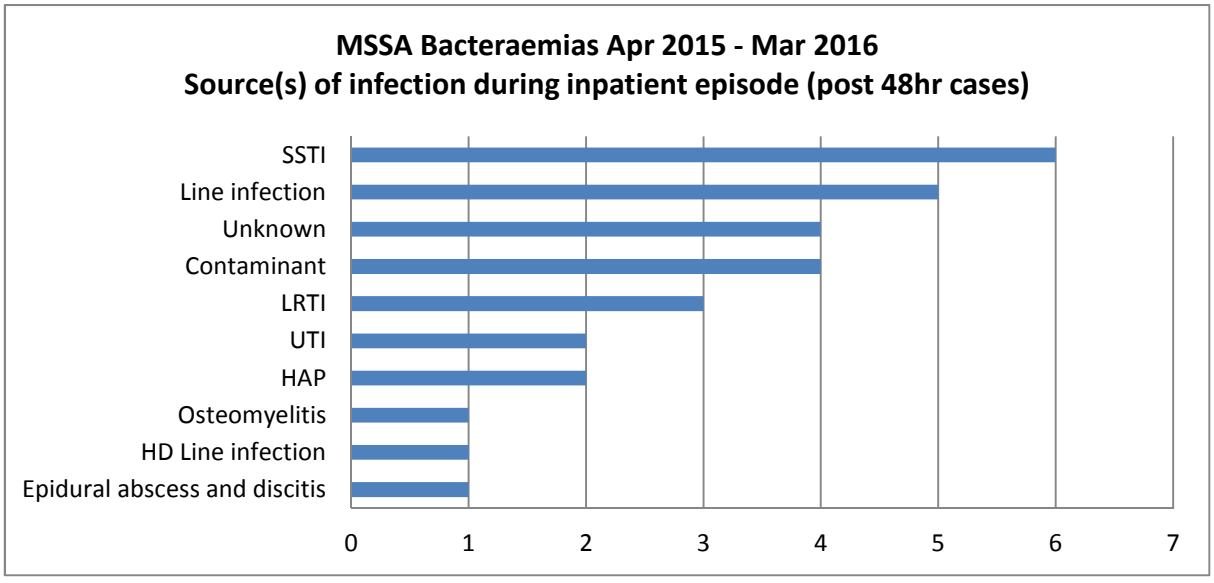
The specialty caring for the patients with episodes of pre-48 and post-48 hour MSSA bacteraemias is shown in the following two bar charts.





Analysis of the clinical risk factors for the post-48 hour MSSA bacteraemias has been performed. RCAs were completed and risk factor data compiled by the ICNs. Analysis of the risk factor data and production of graphs and charts has been performed by Nicola Adkins, Information Officer, in the Microbiology Department.

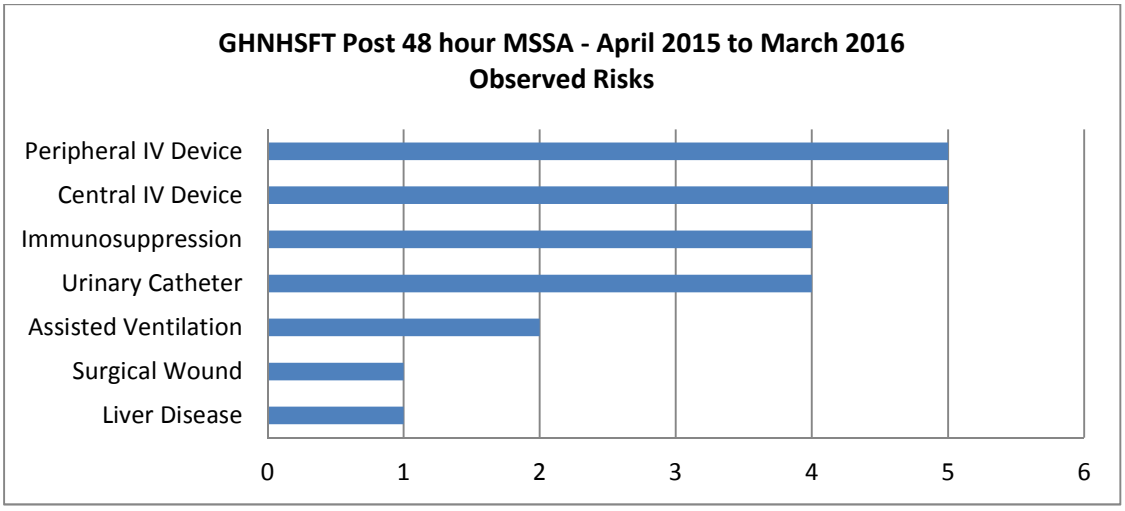
The sources of the post-48 hour MSSA bacteraemias were assessed by one of the consultant microbiologists (CMMs). Some patients' results reflected blood culture contamination (4 episodes) rather than genuine bacteraemia. For a small number of bacteraemias the source of infection was unclear, and for others there was more than one site (source) of infection present.



Risk factor information was available for 61% of all post-48 hour bacteraemia cases.

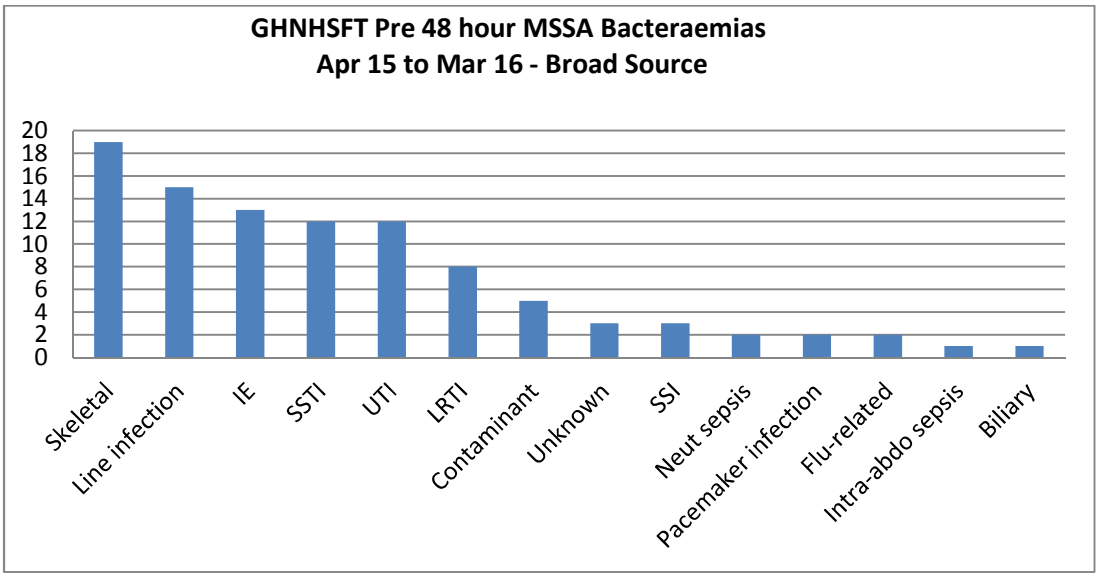
General risk factor information for episodes is presented in the graph over page which includes presence of invasive devices (not necessarily the source of the infection), procedures, and underlying predisposing conditions. Note that patients may have more than one risk factor. The four commonest risk factors for MSSA bacteraemia were peripheral and central intravascular devices, presence of a urinary catheter and being

immunosuppressed. Other factors included assisted ventilation, presence of a surgical wound and liver disease.

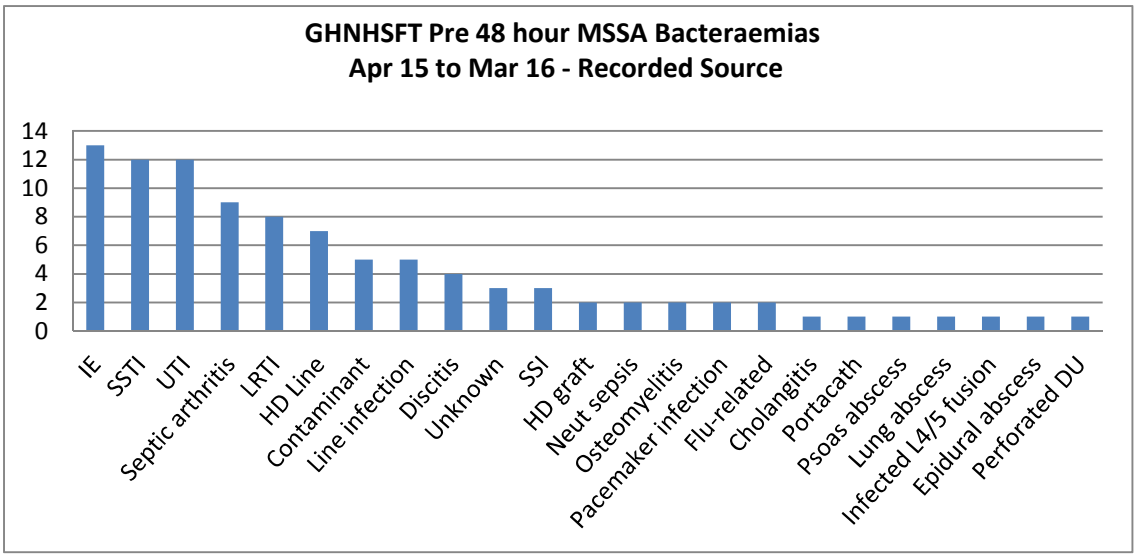


Detailed analysis of the sources of bacteraemias in pre-48 hour bacteraemia episodes revealed that a significant proportion may be healthcare associated and be related to use of invasive devices and clinical interventions.

Broad categories of sources of pre-48 hour bacteraemias are shown below.



More detailed sources are illustrated in the bar chart over page.



Sources likely to be HCAIs were line infections (many related to haemodialysis (HD)), and surgical site infections (SSI). The findings of the analysis of the pre-48 hour MSSA bacteraemias are interesting and warrant closer and continuous prospective surveillance of MSSA bacteraemias by the Trust.

The ICT were also surprised how many patients with MSSA bacteraemia had endocarditis (IE) and the frequency of association of many of the episodes with the patients being intravenous drug users (IVDUs).

6.4 *Escherichia coli (E. coli)* bacteraemia

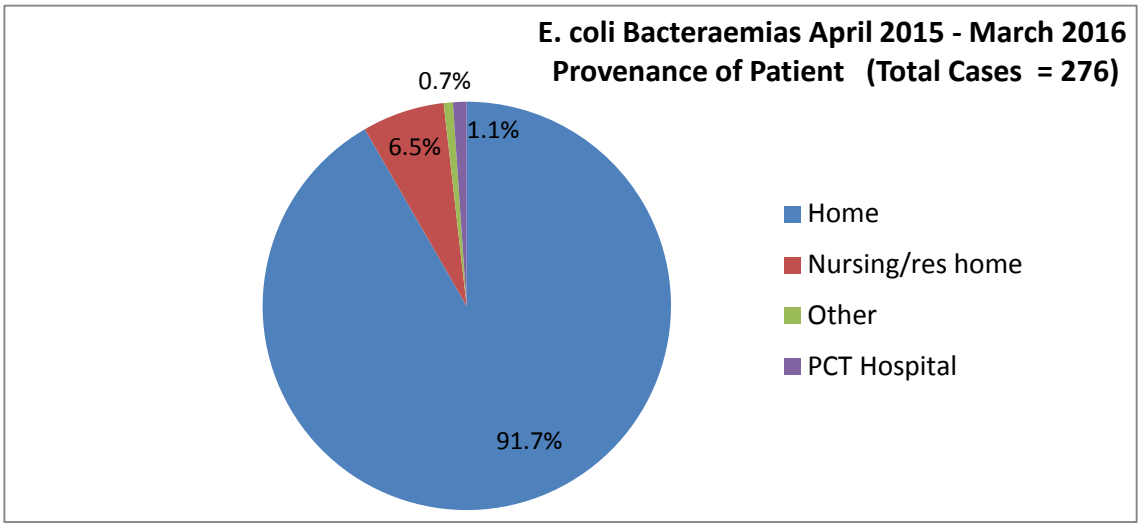
The DH has required Trusts to submit mandatory surveillance data on *E.coli* bloodstream infections since June 1st 2011. *E.coli* constitutes the commonest Gram-negative bacterium detected from clinical microbiology samples; in Gloucestershire there are on average 23 *E.coli* bacteraemias each month. Most *E.coli* bacteraemias are not a reflection of HCAI; most occur in patients due to underlying disease and are related to common infections such as urinary tract infection, intra-abdominal sepsis and biliary tract infection. Most of these infections commence in the community (but being detected when patients are admitted for investigation and treatment). A proportion of the *E.coli* bacteraemias are healthcare-associated and are related to recent previous hospitalisations and invasive interventions performed on patients, the most important of which is urinary catheterisation.

Arrangements have been put in place to ensure that this surveillance is undertaken in Gloucestershire. This surveillance is initially performed by the CMMs using proformas supplied for data collection by the PHE/DH Mandatory Surveillance Team, with manual data inputting by the Information Officer in the Microbiology Department onto the HCAI Data Capture System. The *E.coli* surveillance is resource intensive; the proformas require a significant amount of data fields to be completed (not all of which is readily available in the Microbiology Department) for each episode. Some of the data on *E.coli* bacteraemias is somewhat subjective (based on judgment rather than documented fact) and is affected by the reliability of the information supplied to the Microbiology Department by the clinical team. Interpretation of the presented data should take these limitations into consideration. The ICT assist in data collection for those *E.coli* bacteraemia cases occurring more than 48 hours after admission.

In 2015-16 there were 276 reported episodes of *E.coli* bacteraemia. This is a slight decrease compared to 2014-15 when 287 cases were reported.

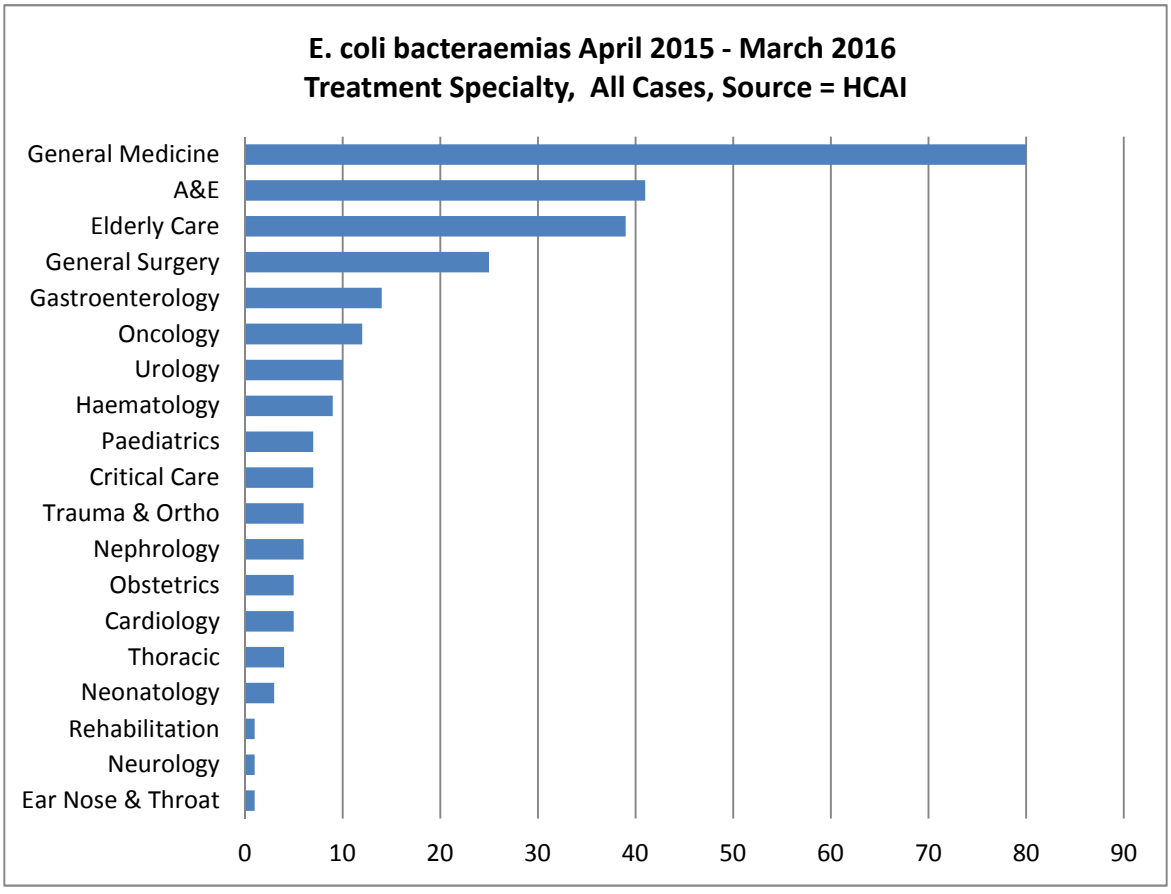
Patient Provenance for *E.coli* bacteraemias

In this context, provenance is where the patient was resident prior to the hospital episode when the *E.coli* bacteraemia was diagnosed.



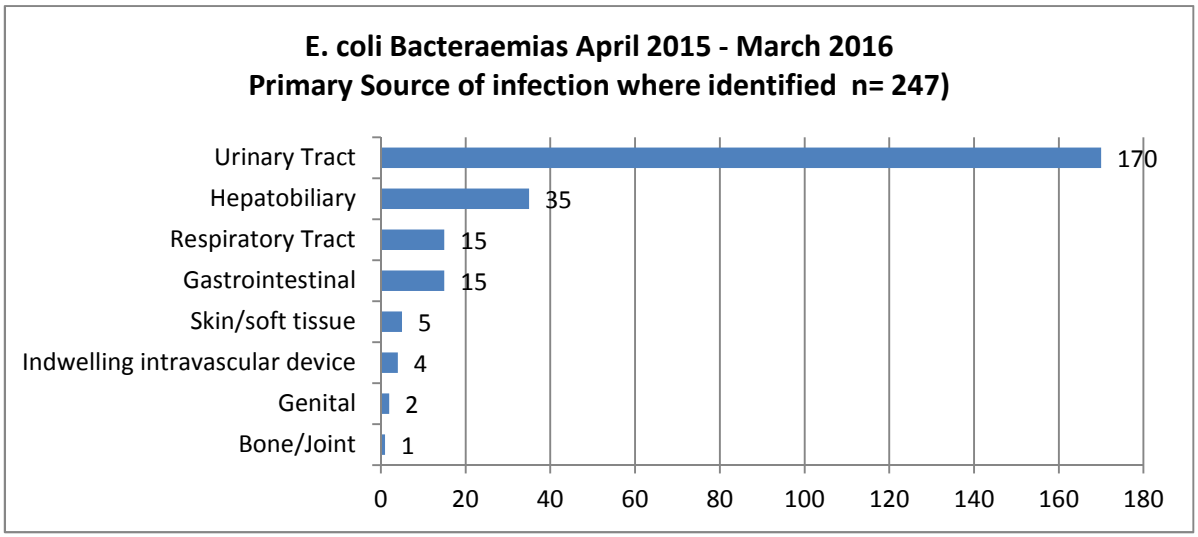
Specialty

The specialty looking after patients with *E.coli* bacteraemias at the time of the collection of the positive blood culture is shown in the Treatment Specialty bar chart below.



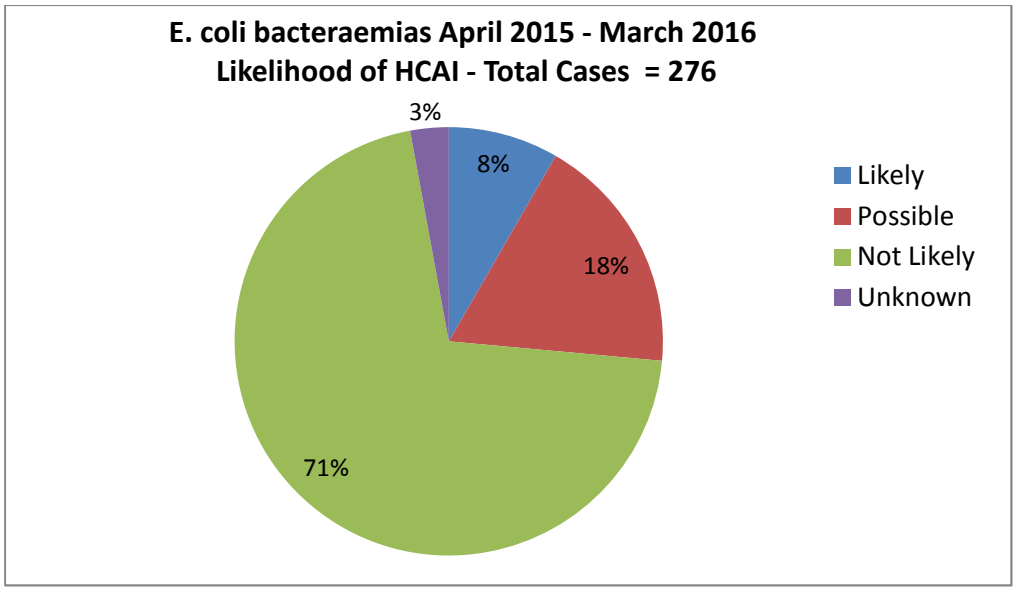
Source of the bacteraemia

In 29 episodes the source of the bacteraemia was unknown. Sixty nine percent of cases reported the urinary tract as the primary source of infection. Hepatobiliary, gastro-intestinal and respiratory tract infections accounted for the majority of the rest of the sources.

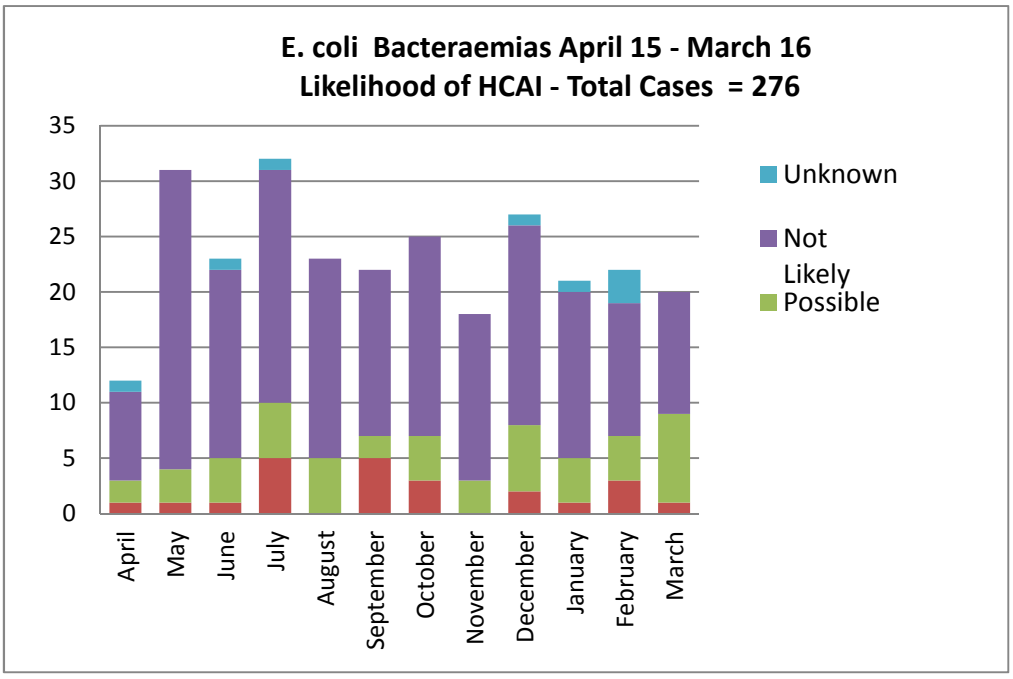


Healthcare-associated Bacteraemias

Twenty six percent of bacteraemias were assessed as being either probably (likely) or possibly healthcare associated.

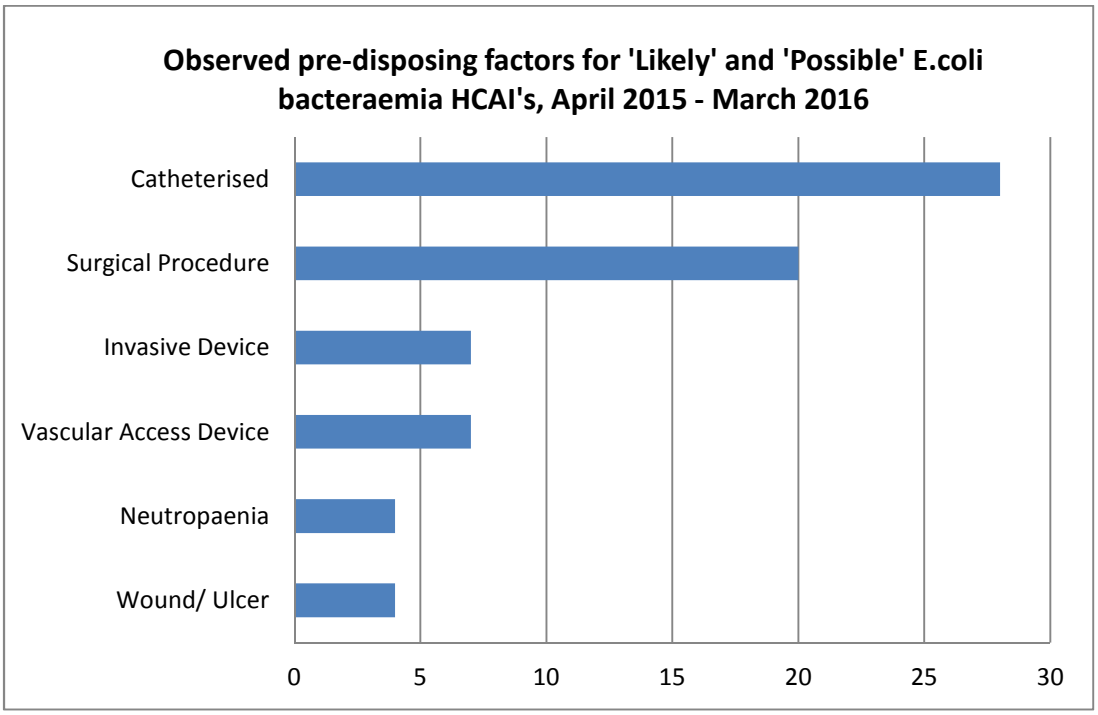


Seasonality and “likelihood” of bacteraemia being healthcare-associated.



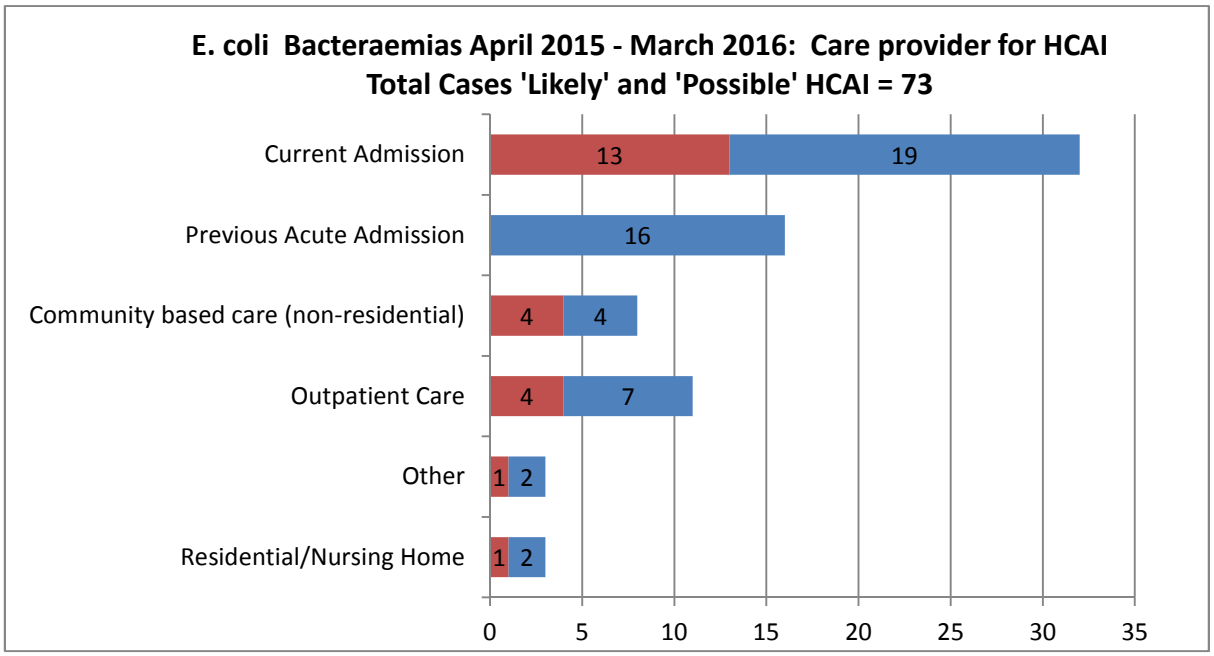
Risk factor analysis of the healthcare-associated infection episodes

The most common predisposing factors for likely and possible HCAI *E.coli* bacteraemias are shown below.



Of the 23 “likely” HCAIs, 19 cases were Urinary Tract Infections. Of these 19, ten patients had catheters including six with long term catheters (28 days or more).

Data was collected on the location where any healthcare had been given previously for those 73 episodes classed as probable (likely) and possible healthcare-associated.



7. Carbapenemase Producing Enterobacteriaceae (CPE)

Screening of patients for CPE was introduced in Gloucestershire in September 2014 to comply with a requirement to implement the national CPE toolkit for Acute Trusts This guidance was intended to assist in preventing any outbreaks and reducing the spread of these resistant organisms within health care settings.

The monthly surveillance report presented monthly data on CPE testing undertaken in GHNHSFT Microbiology for the laboratory catchment area in Gloucestershire. The total numbers of specimens (screens) sent specifically for screening for carriage of CPE is presented. The numbers of specimens that have grown Enterobacteriaceae that are suspected to be CPE on the basis of local testing are also presented (possible CPE). Any samples with possible CPE are sent to a reference lab for confirmation. The number of samples shown to have confirmed CPE (on the basis of reference laboratory results) is also presented.

CPE isolates can potentially be yielded from any diagnostic microbiology specimen (e.g. sputum, blood cultures, and urine) as well as from samples sent specifically for CPE screening. CPE screening samples are mainly rectal swabs and stool samples, but with a few other selected superficial ('manipulated') sites being investigated for carriage as clinically indicated. Most detections of CPE will reflect asymptomatic carriage, but these organisms do have the potential to cause clinical infections and when detected from sites other than CPE screening samples might be causing clinical infection.

Enterobacteriaceae are a large family of bacteria also known as coliforms. They include species such as *Escherichia coli*, *Klebsiella* spp. and *Enterobacter* spp. Carbapenems are very broad-spectrum antibiotics normally reserved for serious infections caused by drug-resistant Gram-negative bacteria (including Enterobacteriaceae). Carbapenems include meropenem, ertapenem, imipenem and doripenem. Carbapenemases are resistance enzymes produced by certain bacteria that destroy carbapenem antibiotics, conferring resistance. There are different types of carbapenemases, of which KPC, OXA-48, NDM and VIM enzymes are currently the most common.

GHNHSFT identifies how many CPE screens have been taken monthly within the healthcare community and identifies the location of any confirmed cases. This information was reported in the monthly surveillance report. CPE incidence is presented as numbers of "detections" rather than as a rate of infection (true incidence).

In 2015 /16 there was 4 confirmed cases of CPE the patients were identified as being at risk of CPE on admission, isolated and screened as per policy. A total of 383 samples have been tested for CPE from April 2015. This is an increase compared to 2014/15 when 235 samples were tested.

8. Surgical Site Surveillance (SSIS)

Data for the SSIS programme is compiled by the Practice Development and Educational Support Nurse for the Surgical Division.

Further progress has been made within the SSIS service in 2015-2016. Data was collected in the following specialities orthopaedics (trauma and elective), upper gastro intestinal surgery, colorectal, general/gastric surgery and breast categories. The gap in the SSIS programme is vascular surgery as urology does not exist for the purposes of the surveillance. To develop the service further to include vascular surgery funding is required. This will be revisited when the impact of TrackCare (the electronic record keeping system) is implemented which may release hours to extend surveillance further within the current establishment of the SISS team.

Throughout the year, the Trust has been assigned “high outlier” status on more than one occasion (hip and knee replacements and large bowel surgery) and “low outlier” once (cholecystectomies). The team provides discrete details of all SSIS to the Clinical Governance leads when identified as an outlier on a quarterly basis. A case note review was then performed for trend analysis.

The final member of the SSIS team attended SSIS training at PHE Colindale in 2015-16. Learning from the training suggests that the processes developed in GHNHSFT are robust and meet the requirements of PHE (and in some areas, surpass the required level).

9. Ward closures due to outbreaks of diarrhoea and vomiting

The *Combat Norovirus* campaign continued in 2015-16 to raise awareness amongst staff, patients, and visitors about Norovirus and promotion of hand washing using soap and water during outbreaks. This included a countywide conference for Gloucestershire’s Health Community staff to promote a countywide approach to “Keeping Well in Winter”.

From April 2015 - March 2016 there was a total of 12 ward or bay closures due to outbreaks of diarrhoea and vomiting, of which 3 had Norovirus identified as the causative organism. This a significant reduction compared to the 42 outbreaks reported in 2014-15.

There was a total of 80 bed days lost throughout the year due to the outbreaks with a total of 103 patients affected with symptoms and 10 staff reported sick with symptoms that were made known to the Infection Control Team.

During October 2015 to May 2016 the Infection Control Nurses provided a service to review outbreaks of diarrhoea and vomiting at weekends and bank holidays. Although this is a limited and remains an unfunded service it is recognised that the availability of an Infection Control Nurse at these times has been very beneficial and has contributed to managing the outbreaks and the operational pressures that occur as a result of ward closures.

Outbreak meetings are held as part of the escalation procedure for the management and communication of Norovirus outbreaks. Visiting was suspended only to the affected wards to assist in controlling the spread of diarrhoea and vomiting and this decision was reviewed daily. This information was communicated on the Trust website, local radio, local press, internal global emails, and social media and via an

automated telephone message via the main switchboard to provide details of ward closures.

10. Influenza

Influenza activity was been particularly high over the first few months of 2016. The predominant strain locally, in those requiring admission that are subsequently tested, appears to be Influenza A (H1N1). This is in keeping with figures produced from the DH showing similar high levels of this strain throughout the UK. The seasonal peak of Influenza A appeared to be in Week 10 of 2016 but regional figures would suggest that reportable cases are now on the decline. The peak of Influenza A cases this year has been approximately twice that of last year's Influenza A.

Regional Influenza B cases have been steadily increasing since week 8 of 2016 and continue to be seen increasing through mid-April.

Influenza outbreaks in the community, both nursing homes and education or nursery settings, have also been significantly higher than the previous year. This may be due to the known high attack rate and association with specific age groups of the H1N1 strain. Regionally Gloucestershire experienced the second highest numbers of cumulative influenza-like illness outbreaks in its care homes.

A total of 3368 flu vaccinations had been completed up to April 2016in GHNHSFT. Of these, 2799 were given to patient-facing staff, which represents 83% of the vaccinations given. Numbers are similar to previous years. It is recognised that some staff may also have received vaccinations from their General Practitioner and we have been unable to determine exact numbers. The Trust recognised the importance of vaccination and all senior staff encouraged their teams to have an annual flu vaccination.

In January 2016, the Infection Control Team and Oncology Department became aware of several patients who were experiencing flu like symptoms which had originally been felt to be associated with a complication of their underlying condition i.e. neutropenia. On testing, H1N1 Flu A was confirmed and following discussion between the two departments, immediate steps were taken to prevent further spread by isolating affected patients, contact tracing of patients exposed to positive flu cases and administration of prophylaxis flu medication if appropriate. Where isolation of suspected or confirmed cases was not possible individual bays were closed to admissions. The Infection Control Team and Oncology Bed Manager worked closely to facilitate isolation and bay reopening.

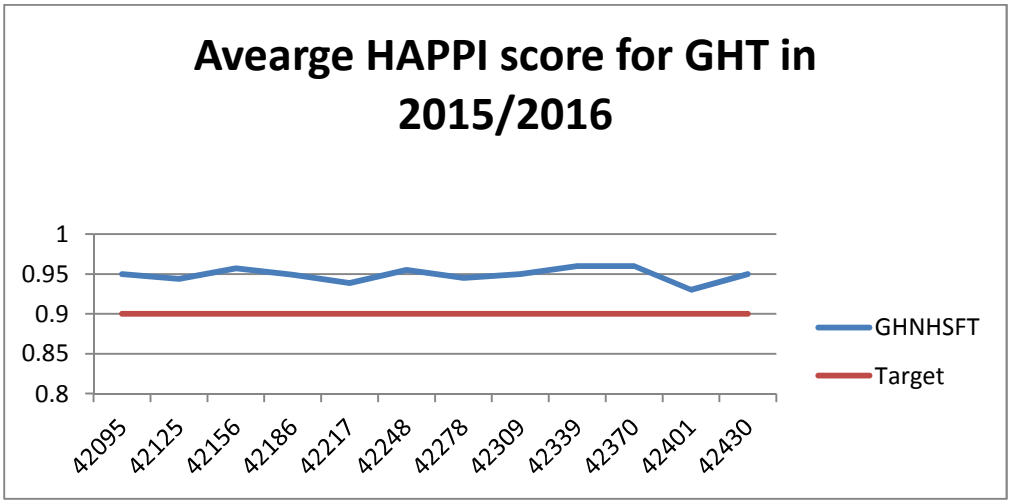
On appreciation of the scale of the Flu outbreak and consideration that for some patients, it was a as result of their hospital admission which suggested a hospital acquired infection, the Director for Infection Prevention and Control escalated its management to Serious Incident status. A report was produced and learning identified for the Trust for future outbreaks.

No patient died as a result of the flu infection and the Trust worked closely with PHE to effectively manage this outbreak.

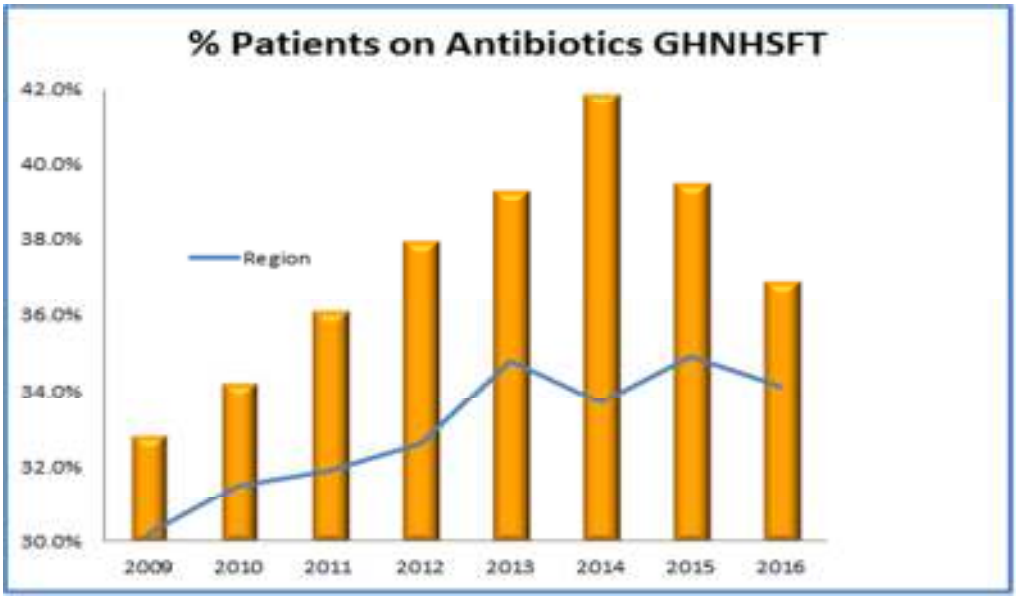
Trust issues brought on by these very high levels of Influenza include inability to appropriately isolate patients. This situation often leads to exposed patients being offered Influenza prophylaxis and in some cases treatment courses of antivirals. The high numbers have also heightened awareness of the appropriate respiratory Personal Protective Equipment and the need in some cases for fit-testing of respiratory FFP3 masks. The Trust has an ongoing legal requirement to put in place a robust training and fit-testing programme. In addition, there has been a new policy for Infection Control management of Respiratory Tract Infections, developed following publication of a new Public Health England guideline.

11. Antimicrobial Stewardship (AMS)

During 2015 -16 the high standard of antimicrobial prescribing, set by the previous year's Commissioning for Quality and Innovation (CQUIN), has continued with the average HAPPI score remaining above the target of 90% throughout. The HAPPI score consists of an assessment of the documentation on the patient drug chart of antimicrobial allergy, review/stop date and clinical indication for use together with the appropriate choice and route of administration of antibiotic.



Additionally, there has been a reduction in the percentage of patients on antibiotics seen in the most recent annual Antimicrobial Point Prevalence Audit.



In 2016 there will be a separate Annual Report to the Trust Board for Antimicrobial Stewardship.

12. Decontamination

12.1 In May 2015 Debbie Lewis joined as the General Manager for Trust Decontamination with Eric Gatling, Director of Service Delivery, as the Trust named Decontamination Lead at Board Level. Andrew Fifield (Estates) was the Trust's Authorised Person for Decontamination.

The Trust's Authorised Person for Decontamination [AP (D)], Andrew Fifield (Estates), left the trust in February 2015 to join Gloucester Care Services. However he remains the Trust's Authorised Person on a contractual two day a week basis (*see note below

re Trust Risk Register).The Trust's external AE (D) (Authorised Engineer for Decontamination) remains Mark Walker, Deconcidal Ltd.

12.2 Sterile Services Departments (SSD)

The scheduled surveillance and certification audit with SGS (an MHRA-appointed Notified Body) of the service was undertaken in January 2016. Accreditation to International Organization for Standardisation, (ISO) 13485:2012; ISO 9001:2008; and the relevant clauses of the Medical Devices Directive 93/42/EEC were successfully maintained. Just 1 minor non-conformance was received.

The AE (D) also raised concern that the Authorised Person (Decontamination) [AP (D)] is no longer directly employed by the acute Trust. The Department of Health Choice Framework for local Policy and Procedures, CFPP 01-01 implies that a Trust the size of Gloucester should employ an AP (D) directly. The current situation will be monitored in 2016. Furthermore, the AE (D) raised concern that Estates have lost the majority of the in-house Competent Person (Decontamination) [CP (D)] over the past 2 years and this will have a significant impact on the budget and service.

The lack of Decontamination-trained Estates staff has been raised as a risk on the Trust Risk Register and is being addressed.

A business case has been submitted to amalgamate the two Trust Sterile Service departments onto one site with the preferred option being the GRH site as it has the larger footprint of the two sites. Work is being completed to establish the feasibility of this project which is hoped to be completed in October 2016.

The service continues to monitor the incidence of holed sets. Holes jeopardise the sterility of reprocessed medical devices and thus represent a patient-safety risk and render the devices unusable. The service continues to observe a positive decline in the incidence in comparison with previous years, with the current rate at 0.17% of all items reprocessed by SSD. A tray wrap trial has been completed in 2016 and a new wrap will be utilized which is compliant to EN 868 and has stronger properties, this has also provided an opportunity to standardize sizes of wrap used.

12.3 Endoscopy – GRH

The fabric of the unit remains in good condition with staff well trained in the use of the automated leak test system for manual cleaning, in use of the Endoscopic Washers and Disinfectors, endoscope storage cabinets, and gas packing system. The chemicals used in the department are a mix of Serchem and Getinge. All Risk Assessments and COSHH Risk Assessments are up to date.

The unit has a formal Decontamination Training and Induction programme. Funding for specialist training courses is requested at the beginning of the financial year. Training continues to be active with decontamination team staff members attending the following:

- Decontamination Managers Course
- Annual ED Flow Manufacturer Training and Competency Assessments
- Olympus Keymed Course

T-Doc Track and Trace system is working well and has now been rolled out across the whole unit and adjustments made to ensure it meets service needs and audit requirements. Staff members have received training by the manufacturer and updates take place on a regular basis on request. Quarterly Track and Trace audits are carried out. A business case has been submitted a General Manager for funding from the Trust for T-Doc to be installed in areas outside of the Endoscopy Unit e.g. Outpatients, ENT and General Theatres so that the '3 hour rule' can be implemented.

There is currently no electronic method of identifying when a scope should not be used and relies on the user to interpret the paper printout from the EWD.

Weekly testing is carried out by Getinge. The Total Viable Counts (TVC) results continue to be within acceptable levels. Electronic laboratory reports are received weekly with the unit being informed of any exceptionally high counts by telephone and with advice on action needed.

All Decontamination policy action cards have been updated in 2016 and further action cards have been introduced for the more specialist scopes and C-MAC® blades that are used on the GRH site. All of the updated/new Action Cards are currently with the Policy Group and/or are awaiting approval from the Trust Decontamination Group.

The Annual Decontamination Audit was carried out by the Trust AE (D) on 25th January 2016. The following comments were made:

- The glare from the sun in the decontamination area may prevent staff from carrying out an adequate inspection of the scopes during manual cleaning. The need for an internal blind needs to be elevated.
- Ventilation needs to be tested to show it meets HTM 03-01 for Endoscopy
- Environment needs to be tested for chemical vapour as per COSHH Section 8

12.4 Endoscopy – CGH

Cheltenham Endoscopy unit is a purpose built facility that opened in 2009. It remains in good condition, decontamination audits are carried out annually by an external company (DeconCidal) and by the Trust's decontamination lead.

All staff complete the unit's decontamination training programme which has been recently reviewed and updated. The unit is proactive in ensuring staff access bi-annual study days held in the unit and also to relevant external courses for which a bid is placed with the trust for funding annually. Decontamination action cards are due to be reviewed and then will be forwarded to the trust decontamination group.
In-house training sessions comprise of the following

- Manufacturers of the automated endoscope reprocessors (Cantel Medical) carryout a comprehensive training session for new staff and up dates for competent staff.
- Endoscope manufacturers (Olympus) provide a training session that incorporates information relating to the care and maintenance of flexible endoscopes, including manual decontamination.
- Cairn Technologies: chemical spills training
- T-Doc track and trace, includes administration training for senior staff.
- Manufacturers of the drying cabinets carry out a comprehensive training session for new staff and updates for competent staff.
- Training in use of scope tech which includes leak testing.
- Training in the types of chemicals used and their actions in the decontamination process.
- Sypol Training (COSHH management system)
- Getinge one day course: Complete endoscope decontamination process EDP 32
- Getinge 3 day Decontamination Managers Course.

T-DOC Track and trace was installed in April 2016 in the CGH endoscopy unit. Prestbury Clinic and Kemerton Ward were installed in February 2016. General theatres are still outstanding. Until this system has been installed in general theatres the endoscopy unit is entering the relevant information onto the T-DOC system to ensuring traceability.

Since installation, many adjustments to the system have taken place to reflect/ensure correct data can be recorded and retrieved. Admin training for senior staff has taken place this ensures that should an audit need to take place there is always a trained person on shift that can facilitate this. At present weekly audits take place to ensure all the relevant information has been captured.

Weekly testing of TVC was undertaken by the Estates Department. TVC counts continue to be within acceptable limits. A reverse osmosis system was installed and issues with the system being unable to supply the machines with sufficient water, was further addressed by the Estates Department in March 2016 by purchasing and installing an additional unit and is now fully functional.

The following recommendations following Decontamination external audits carried out in Jan 2016 were made

- There is no AP (D) in post for the Acute Trust, the staff do have access to the previous post holder who has moved to the community hospitals, but his time is severely limited, and as such, the unit staff do not have readily available access to technical advice.
- Unit to remove remaining reusable endoscope accessory-heater probe. Heater probe now replaced with disposable equivalent.
- Conductivity testing: This has been addressed, corrective measures taken immediately.
- Delay in quarterly and annual reports being reviewed by an AP (D). This has being added to the risk register. Interim measures have been put in place by Sister Endoscopy.

The following was highlighted as needing to be addressed by the decontamination lead

- Designated staff to undertake administration training in the use of T-DOC. This was completed January /February 2016
- To remove the override facility on the T-DOC system. This facility was immediately removed.

12.6 Trust Medical Devices and Decontamination Group

The Trust Medical Devices and Decontamination Group has divided into two separate groups, the Decontamination Group continued to be is chaired by the Trust Decontamination Lead/ Director of Estates and Facilities. The Associate Director of Estates and the General Manager for Decontamination has raised concerns as to the effectiveness of the current format and group membership. The group incorporates two previously independent groups that were merged a few years ago; the Medical Devices Group, and the local Decontamination Group. It is felt that the membership and agendas of the group are too diverse leading to poor attendance and outcomes. A proposal is being constructed for the separation of the two groups and reinstatement of the Local Decontamination Group as an independent forum. The Terms of reference and attendance list have been amended and the group meets quarterly to discuss all aspects of Decontamination within the trust, any highlighted concerns are reported through the Infection Control Committee.

13. Risk Management

The Infection Control Committee receives an overview of all infection related incidents reported on the Trust electronic reporting system annually. All clinical divisions provide an update on Infection Prevention and Control for their areas on a quarterly basis providing details to key themes provided through incident reporting. They are supported by a quarterly review of Patient Experience feedback from the Complaints Department / Patient Advisory and Liaison Service (PALS).

The Trust's electronic reporting system has 'infection related' as a specific category for staff, a range of subcategories have been confirmed by the Infection Control Team

and have been reviewed in 2015 to reflect any changes in infection prevention and control focus for example CPE monitoring. In 2015-16, 455 incidents were reported in this category which included all *Clostridium difficile* infections, MRSA bacteraemias, periods of increased incidence, ward closure's and unable to isolate.

The incidents reported most frequently were *Clostridium difficile* infection pre and post 48 hour cases and included cases that were not toxin positive (93), handover did not include infection risk (16) no isolation facilities unable to cohort (36).

88 incidents were reported under the category of 'Domestic Services' relating to cleaning/ waste collection for April 2015 – March 2016. Domestic Services managers are notified of all incidents in this category on submission of the form for their review and investigation as well as feedback to the relevant area. The Infection Control Committee does not receive a report from the Estates and Facilities Division on Infection Prevention and Control within their remit apart from monitoring of cleanliness standards at each meeting as clinical divisions provide. This will be included in 2016.

13.1 Confirmed serious incidents

In 2015-16 serious incident status has been confirmed for 3 incidents relating to Infection Prevention and Control for the following

MRSA acquisition/ MRSA bacteraemia on the Vascular ward (Surgical division) at CGH.A period of increased incidence of MRSA acquisitions was identified on the vascular ward

Action taken - An action plan was developed by the ward and a deep clean undertaken. Hand hygiene audits were undertaken to test reliability of recent scores A spot-check audit of MRSA admission screening was undertaken and all samples typed and review of dressing or wounds undertaken. Ongoing monitoring through surveillance has continued

Flu outbreak in Oncology (Diagnostics and Specialties division) at Cheltenham General (reported as ward closure)

Action taken please see item 10

Possible contamination of cystoscope by body fluids (reported as equipment issues)

Action taken- the equipment was quarantined on detection of a rust colored deposit, the manufacturer was notified and an inspection of the equipment undertaken. All patients who had been exposed to this piece of equipment were identified and staff completed a case note review. A risk assessment of the exposure of the risk was undertaken by PHE and a lookback exercise was not required. An action plan was put in place which included a plan to implement track and trace system within Urology and the development of a procedural document for issuing and returning equipment cleaned by endoscopy.

14. Public and Patient Involvement

14.1 National Survey Programme 2015

The Trust participated in the National Inpatient Survey 2015 and the National Maternity Survey 2015 as required by the Care Quality Commission for all NHS Trusts in England. These results are benchmarked and compared against the range of results from all other trusts that take part in national surveys.

National Inpatient Survey 2015

1,204 inpatients who used the Trust during July 2015 received a postal questionnaire with a response rate of 50%. The Trust results were similar to 2014 results. The majority of our patients reported that:

The hospital room or ward was very / fairly clean 97% (97% 2014)
The toilets and bathrooms were very / fairly clean 94% (92% 2014)
Hand-wash gels were visible and available for patients and visitors to use 88% (92% 2014)

The reason for the reduction in the result relating to "hand-wash gels were visible and available for patients and visitors to use" is not understood. Alcohol hand foam is available in all clinical areas at the point of care, located at the foot of the bed on wards and on entry and exit to clinical areas which is in excess of the recommendation of the World Health Organisation. The PLACE audit and internal auditing also contradicts this result.

We are unable to make a comparison against other Trusts as the final national report has not yet been published but early indications are that we are about the same as other Trusts for:

- Cleanliness of hospital room or ward
- Cleanliness of toilets or bathrooms

Early indications show that we are performing worse than other Trusts for:

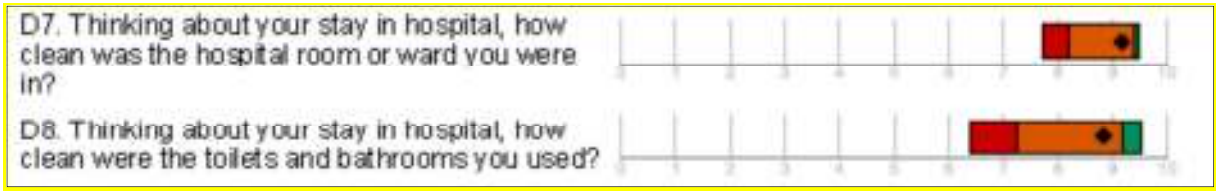
- Patient perception of availability of hand wash gels for patients and visitors to use

National Maternity Survey 2015

443 women who gave birth using the Trust's Maternity Services during February 2015 received a postal questionnaire with a response rate of 54%. Patients reported that:

- The hospital room or ward was very / fairly clean 99% (97% 2013)
- The toilets and bathrooms were very / fairly clean 98% (93% 2013)

Compared with all other trusts that took part in the survey in England our results are within the range of 'about the same' as most other trusts nationally.



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14.2 Complaints, Concerns, Comments, and Compliments

The Patient Experience Department recorded 20 concerns and 27 complaints, a total of 47 between April 2015 and March 2016. This is a slight increase in the overall number recorded during the previous financial year (2014/15) which was 45, but a decrease from 56 in the year preceding this (2013/14).

Of the 20 concerns recorded 16 were relating to GRH and 4 to CGH. Of the 24 complaints recorded 19 were relating to GRH and 8 to CGH.

Themes arising from Concerns and Complaints during this period were:

Environment-general cleanliness

There were 37 reports of wards and departments not being cleaned to an acceptable standard. This feedback relates to dirty toilets, floors, and general poor standards of cleanliness in clinical and public areas. 17 of these were concerns raised with PALS (Patient Advice and Liaison Service). All of these concerns were escalated immediately to domestic services.

Hand Hygiene

There continues to be a year on year reduction in the number of concerns and complaints relating to hand hygiene, 14 (2012/13) 8 (2013/14) 4 (2014/15) and 2 (2015/16). One of these was a concern relating to poor hand washing technique and the other a complaint relating to a broken hand gel dispenser.

Issues relating to Infection Control

We received 8 concerns and complaints relating to infection control issues. These were mainly concerned with concerns about clinical interventions and included

- Poor handwashing
- Doctor failed to wear gloves during investigations
- A patient with an infection was seen in clinic where patients have compromised immune systems
- An Intravenous Bionnector attached to a cannula was not taped
- Poor infection control when inserting cannula

15. Audits

15.1 In 2015-16 there has been no involvement with external audits of Infection Prevention and Control

15.2 Internal Audits

Patient Led Assessments of the Hospital Environment (PLACE)

The PLACE inspections for 2015 took place during March to May 2015 at Gloucestershire Royal, Cheltenham General, and Stroud Maternity sites. GRH was visited over two days, Stroud Maternity and CGH were visited on one day by inspection teams made up of patient representatives from Healthwatch, volunteers and staff. Specific training had been given to all the inspection teams. During the inspections, 21 wards, 16 departments were visited in addition to general internal and external areas.

In 2015 our hospitals achieved the cleanliness scores presented below

Cheltenham General Hospital	Stroud Maternity Hospital	Gloucestershire Royal Hospital
97.65%	93.90%	96.39%

Review of deaths associated with Clostridium difficile

A review was undertaken of the number of patients whose death was attributed to Clostridium *difficile* infection and cited on the death certificate from April 2015 to March 2016. Compared to 2014-15 when there were 12 deaths (7 post 48 hour and 5 pre 48 hour) the total number of patients whose death was attributed to *Clostridium difficile* infection remains the same. In 2015-16 there were 8 post 48 hour cases that were recorded as having death attributed to *Clostridium difficile* infection. Of the 8 cases, 4 had *Clostridium difficile* infection mentioned in part 1 of the death certificate. The number of post 48 hour deaths where the primary cause has been cited as *Clostridium difficile* infection remains the same as 2014-15.

15.3 *Planned audit programme for Infection Prevention and Control*

The planned audit programme for 2015-16 that was undertaken is detailed below

- *Saving Lives* programme's high impact interventions (HIIs) care bundles – undertaken monthly
- Hand hygiene-undertaken bi-monthly
- Environmental audits-Monthly programme
- MRSA screening compliance with policy
- MSSA bacteraemias Renal Medicine
- Aseptic non touch technique baseline audit (trustwide)
- Aseptic non touch technique, Oncology Unit
- Reliability hand hygiene audits undertaken by GoJo
- Surgical Skin preparation

16. Water Management

Legionella and *Pseudomonas aeruginosa* sampling throughout the year suggests both remain under control. Following the decision by Water Action Group to reduce the flushing of water outlets in line with national guidance (with the exception of augmented care wards) to date there has been no adverse effect with the water systems.

The legionella risk to patients and staff has been significantly mitigated by control measures put into place. However, the nature of these bacteria is such that it can still be introduced into the hospital water systems from the mains water supply. Continued and ongoing control measures and monitoring are required to maintain low levels of risk of hospital-acquired legionellosis.

Pseudomonas aeruginosa is an environmental organism which thrives in water and damp environments. It is an opportunistic pathogen usually not causing clinical infection in immunocompetent individuals except in certain circumstances. It is well recognised as a significant pathogen in the immunocompromised and is capable of causing infection in patients requiring augmented care (critical care, neonatology, units for patients requiring major organ support, and burns units).

All relevant water outlets in augmented care areas have continued to be sampled to assess for the presence of *Pseudomonas aeruginosa*. When the organism was detected in outlets, control measures were put into place to minimise the risk of the organism being transmitted to patients in these clinical areas through use of this water. The initial requirement for risk assessments and sampling augmented care units was achieved and the Trust has continued with an on-going sampling and monitoring regime

Replacing shower mixers in augmented care wards with mixers that can be thermally disinfected insitu, plus the addition of implementing the quarterly shower hose and head replacement scheme has shown significant drop in positive *Pseudomonas aeruginosa* samples from showers.

CGH water systems continue to be dosed with chlorine dioxide and the CGH water tanks were cleaned and chlorinated November 2015 and include sampling for Legionella, all tanks returned negative sample results.

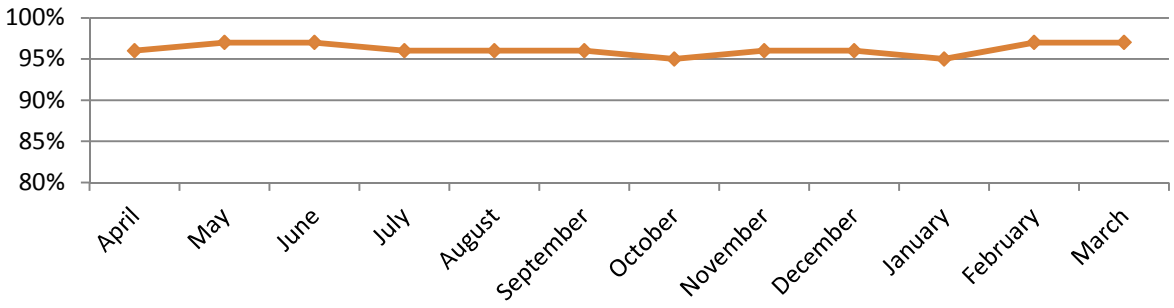
GRH water systems continue to be managed mainly by copper silver ionisation.

Time temperatures at sentinel outlets continue to remain within recommended targets in accordance with the HTM guidance.

17. Hand Hygiene

Hand hygiene audits continued to be undertaken bi-monthly by the hand hygiene Champions the results are reported to each Division and the Board. In 2015/16 The average overall trustwide hand hygiene compliance was 96%.

Trustwide hand hygiene compliance April 2015 – March 2016



As part of the service level agreement with the suppliers of the alcohol hand foam reliability audits were also undertaken by the company's Education Practitioner.

The Trust participated in a *Hand Hygiene Awareness Week* in May 2015. As part of the World Health Organisation's Global hand hygiene awareness day, 248 Staff and 48 members of the public were educated and updated on hand hygiene technique; this included the use of the "Glow boxes" and information stands at CGH and GRH. A competition was held for the best hand hygiene display in a clinical area and judged by Mrs Pat Eagles, a HealthWatch member with a special interest in Infection Prevention and Control. An Annual update for the *Clean Your Hands* champions was also held and focused on reliability of the auditing process.

A new hand hygiene leaflet for staff was approved in 2015 and includes information on how to care for hands. The patient hand hygiene leaflet was also refreshed and updated and is a core trust leaflet provided by the Patient Experience Department.

In 2015, following an identified problem with the functioning of automatic alcohol hand foam dispensers, all automatic dispensers were upgraded free of charge by the suppliers.

18. Infection Control Policies

The following policies were reviewed, developed and approved in 2015-16

- Water Management policy
- Meticillin-Resistant Staphylococcus aureus (MRSA)
- Cleaning and disinfection (Decontamination) in the clinical area
- Chickenpox and Shingles - Management and Control of Varicella Zoster Virus
- Gastroenteritis Outbreak Management
- Precautions in Acute Respiratory Infection
- Infection Control Policy
- Blood Culture Policy
- Viral Haemorrhagic Fever (VHF)

19. Environmental Cleaning

The Infection Control Committee continues to monitor cleanliness for the Trust as part of the compliance strategy. The development of a Hotel Services Manager role with responsibility for cleaning across the Trust improved the reporting of cleanliness ensuring systems and processes are being developed to improve services.

Improvements have been made in the monitoring of cleanliness standards (2007) in both acute hospitals. The Facilities Management service has implemented a new monitoring system although there have been some technical issues which are being addressed; the quality of the reports has improved. Regular audit processes are in

place for the Trust off site units. Stroud Maternity and Cinderford Renal Dialysis Unit are reported on a quarterly basis, from April 2016 Cirencester Theatre will be included in the reporting schedule.

CGH has seen a number of site changes and new works over the last year and the contractor has maintained standards during this busy time. Whilst changes were made to increase the level of cleaning in both the Emergency Department and ACUA at GRH, the activity in these areas remains high and access to cleaning has been challenging. A schedule of regular monitoring of both these areas is in place to monitor standards.

The Hotel Service Manager has met with the Infection Control Matron on a regular basis to discuss cleaning standards, strategy and walk about the hospital inspecting cleanliness standards. This senior level audit input has identified failure points and areas of good practice in the cleaning standards; this has been used by the domestic service teams to focus on training of staff.

As part of the GRH Domestic Management review a training role has been identified to improve competency and induction training for Domestic staff. There has been an increase in supervisors at the coalface able to engage with the domestic assistant teams and monitor service at a much closer level.

A review of the recruitment and selection process for the department with Human Resources to increase the cultural fit of recruits has proved successful. These measures, as a result at GRH have increased cleaning standards which reflect an overall improvement bringing the standards in line with the agreed risk category cleaning standard targets.

Facilities' Management have drafted a Trust Cleaning Strategy and a Trust Cleaning Operational Policy, working together with the local Infection Control Nursing team for advice, these documents will be presented to the Infection Control Committee for ratification in June 2016

Utilisation of the *Bioquell* proactive environmental decontamination Service has been challenging due to high bed occupancy rates of inpatients. The Trust uses a contracted service and has one dedicated engineer and two pieces of hydrogen peroxide vapour (HPV) equipment, which are capable of inactivating organisms that cause common infections, on each hospital site. Whilst the service is not usually scheduled for bank holidays, Bioquell engineers remain flexible to the Trust's requirements, should any emergency need arise. Weekend working is accounted for through a rolling pattern of one in four weekends, should there be increased activity, and the Proactive engineers are willing to meet requirements of the Trust.

In 2015-16 there have been a total of 733 deployments with a weekly average of 7 at GRH and 6 at CGH. A total of 954 bed decontaminations have taken place .Compared to 2014-15 there were 680 deployments with an average of 7 deployments at GRH and 5 CGH with 858 beds decontaminated.

20. Education and Training

The Infection Control Team continues to contribute to corporate induction and non-clinical mandatory training sessions run by the Training and Learning Department. In addition to this the Infection Control Doctors delivered induction sessions for new junior medical staff. Infection Control training remains a mandatory requirement.

Education and training in infection control combines a dual approach of e learning supported by ward-based education delivered by the Infection Control Nurses supported by the Saving Lives/ Infection Control Link Practitioners. The eLearning was reviewed and updated in March 2016 to included topics identified from incidents and recurring themes that require improvement.

The ICT also provide additional Infection Control training and education to a variety of other staff groups. Examples of specific events and training in 2015-16 included: The annual Saving Lives Study Day, held in October. The day included Influenza- Why flu vaccinations matter, Respiratory Infection Control Guidance-What you need to know, CPE Update What's new and how is CPE affecting us in Gloucestershire, Chicken Pox & Shingles, ANTT our baseline audit results, and implementing ANTT in Oncology and Hand hygiene-Product update. Workshops also included the launch of Urinary Catheter care policy and Countywide Urinary Catheter Passport, Hand hygiene action plan 2015, Improving sharps safety; Update on Norovirus toolkit. A member of staff shared their personal story of suffering from Clostridium *difficil*e and had developed a video for teaching purposes which has also been shared with the Trust Board.

Learning from incidents of infection in 2015-16 has resulted in additional face to face training sessions being delivered to band 2 nurses and focused on specimen taking (urine and stool samples), completion of stool charts, decontamination and use of personal protective equipment. The sessions held received good evaluation and will be included in future band 2 development programmes.

Training was also provided on the following:

- Hand Hygiene training
- Band 5 development courses for nurses
- Band 2 development course for nurses
- Induction programme for overseas recruitment nurses
- Volunteer updates
- Quarterly Infection Control Link Practitioner sessions
- Decontamination of equipment for clinical areas
- Use of Personal Protective Equipment including respiratory guidance
- Local updates following learning from incidents
- Aseptic Non Touch Technique (ANTT)
- Saving Lives care bundle auditing.
- Ebola PPE updates

Compliance with mandatory infection control training in 2015-16 by staff group is detailed below and shows the same overall compliance as 2014-15 of 91%

Division/ Staff Group	**2015-16**	**2014-15**
Grand Total	**91%**	**91%**
Corporate	89%	89%
Diagnostics & Specialty	94%	95%
Estates & Facilities	87%	84%
Medicine	90%	92%
Non-Division	76%	84%
Surgery	93%	93%
Women's & Children	93%	92%

21. Meeting objectives for Infection Prevention and Control during 2015-16

The progress of meeting objectives set in 2015/16 is detailed below

- To sustain and further develop a program to focus on promoting the ownership of infection prevention and control by all Trust employees - **complete and ongoing**
- Ongoing compliance with the Code of Practice on the Prevention and Control of Infection -Outcome 8 Care Quality Commission -**complete and ongoing**

- Meet reduction targets for *Clostridium difficile* Infection as determined by the DH and agreed with the Commissioners **target missed but objective carried forward – target met for avoidable infections.**
- Implement process for identifying and agreeing cases of CDI where there were no lapses in care (unavoidable cases) with the commissioners – these episodes can then be appealed against the target **complete and presented and approved to Countywide HCAI Group**
- Agree and implement revised system for identifying, investigating and reporting on HCAI-related incidents including ones categorised as serious- **complete**
- Review content and format of GHNHSFT Monthly HCAI surveillance Report – consider whether data could be presented in alternative user-friendly ways for internal (clinical teams) and external audiences **– carried forward to 2016**
- Commence utilisation of new requesting and reporting systems for HCAI – this will include the PHE Carbapenemase Producing Enterobacteriaceae Electronic Reporting System (ERS) and the anticipated revised HCAI Data Capture System **- complete**
- Expand and improve the usefulness of Surgical Site Infection Surveillance. Strengthen links between relevant Divisions and ICT to optimise the accuracy of the surveillance, and ensure it is fed back promptly to surgical teams – **priority areas for expansion in 2015-16 are breast surgery, colorectal surgery complete caesarean section vascular surgery to be reviewed for 2016**
- Continue to collaborate with Estates and Facilities and Clinical Strategy on all clinical service reconfigurations, refurbishments and new build projects **complete and ongoing**
- Maintain a planned and targeted audit programme **- complete**
- Deliver the annual Saving Lives / Infection Control study day -**complete**
- Implement any necessary changes identified following Infection Control Peer Review in 2015 –due to **complete June 2016**
- To improve patient experience by using patient stories and incidents as mode of learning for all infection control training- **complete**
- To update the Quality Committee and Trust board when appropriate- **complete and ongoing**
- To lead and / or influence community infection control practices by working closely with our partners as part of the Countywide Healthcare Associated Infection Strategy Group- **complete and ongoing**
- Review control and monitoring arrangements for HCAI aspects of Water Safety – this will include review and implementation of a revised Water Management Policy - **complete**
- Ensure local Viral Haemorrhagic Fever (VHF) Policy is up to date – compare locally developed Action Cards and educational materials with those being used nationally by PHE for training of staff in EDs - Maintain staff preparedness for the management of suspected Ebola and other causes of Viral Haemorrhagic Fever -**complete**
- Develop and implement a Trust Cleaning Strategy **April 2016 in draft**
- In collaboration with Gojo upgrade all automatic alcohol hand foam dispensers to latest model available- **complete**
- Implement trustwide the quality framework for Aseptic Non Touch Technique. **Complete post-implementation audit planned**
- Review Regional e learning training packages for Infection Prevention and Control that are to be introduced for use in GHNHSFT **- incomplete - updated local e learning is now in progress as an alternative**
- Introduce new rapid diagnostics (Malditof) into Microbiology Department to improve speed of diagnosis of infections and to improve antimicrobial stewardship **Incomplete -Business case not approved to be resubmitted in 2016**
- Implement improvements in the patient pathway in collaboration with the Health Community and Commissioners following the results of the *Clostridium difficile* relapse review to include a multidisciplinary review **incomplete**

Multidisciplinary review of all cases required – formation of CDI multi-disciplinary team (MDT) is required which should do weekly ward rounds

22. Improvement Plan 2016-17

- To sustain and further develop a program to focus on promoting the ownership of infection prevention and control by all Trust employees
- Ongoing compliance with the Code of Practice on the Prevention and Control of Infection -Outcome 8 Care Quality Commission
- To update the Quality Committee and Trust board when appropriate
- To reduce the number of avoidable cases of *Clostridium difficile*
- To reduce the number of periods of increased incidence of *Clostridium difficile* in the Medical Division
- To reduce the number of complaints and concerns relating to cleanliness
- To participate in the National Point Prevalence Survey 2016 and identify areas for improvement from findings
- To undertake a deep clean programme targeting clinical areas with increased incidence of infection
- Continue to collaborate with Estates and Facilities and Clinical Strategy on all clinical service reconfigurations, refurbishments and new build projects
- Implement the updated e learning programme for infection prevention and control which includes lessons learnt from incidents of infection
- Review and refresh the *Saving Lives* audit programme
- Audit compliance with compliance with Aseptic Non Touch Technique (ANTT)
- Expand and improve the usefulness of Surgical Site Infection Surveillance for vascular surgery and caesarean section
- Review and reduce the risk of the patients surgical pathway by implementation of the national *One Together* quality improvement project in the Surgical Division
- Deliver the annual *Saving Lives* / Infection Control study day
- Maintain a planned and targeted audit programme
- Evaluate the effect of influenza in 2015-16 to inform winter planning for 2016-17
- Audit compliance with Carbapenemase Producing Enterobacteriaceae screening
- Submit a business case to implement a Meticillin Sensitive *Staphylococcus aureus* (MSSA) screening and decolonisation programme for patient groups at high risk of infection
- Review content and format of GHNHSFT Monthly HCAI surveillance Report – consider whether data could be presented in alternative user-friendly ways for internal (clinical teams) and external audiences

Authors: Cheryl Haswell, Matron, Infection Prevention and Control
Maggie Arnold, Director of Infection Prevention and Control

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS HELD IN THE LECTURE HALL, REDWOOD EDUCATION CENTRE, GLOUCESTERSHIRE ROYAL HOSPITAL ON WEDNESDAY 18 MAY 2016 AT 5.30 PM

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

PRESENT	Mrs P Adams	Staff, AHPs
Governors/ Constituency	Mrs S Attwood	Staff, Nursing and Midwifery
	Dr David Beard	Public, Tewkesbury
	Mrs J Harley	Patient Governor
	Mrs C Johnson	Public, Forest of Dean
	Mrs A Lewis	Public, Tewkesbury
	Dr T Llewellyn	Staff, Medical and Dental
	Ms C McIndoe	Staff, Other/ Non-Clinical
	Mr J Marstrand	Public, Cheltenham
	Cllr B Oosthuysen	Appointed, Gloucestershire County Council
	Mr M Pittaway	Staff, Other/ Non-Clinical
	Mrs D Powell	Public, Gloucester
	Dr A Seymour	Appointed, Clinical Commissioning Group
	Ms F Storr	Public, Gloucester
	Mr A Thomas	Public, Cheltenham (Lead Governor)
Directors	Prof C Chilvers	Chair
	Mrs H Simpson	Acting Chief Executive/ Finance Director
	Mr E Gatling	Director of Service Delivery
	Dr S Pearson	Director of Clinical Strategy
	Mrs M Arnold	Nursing Director
	Mr D Smith	Director of Human Resources and Organisational Development
	Mr G Mitchell	Senior Independent Director/ Vice Chair
	Mr T Foster	Non-Executive Director
	Mr C Lewis	Non-Executive Director
	Ms A M Millar	Non-Executive Director
Public/ Press/ Observers	Mr C Macfarlane	Head of Communications
IN ATTENDANCE	Mr M Wood	Trust Secretary
APOLOGIES	Prof C Dunn	Public, Stroud
	Dr C Feehily	Appointed, Healthwatch
	Mrs J Hincks	Public, Costwold
	Dr P Jackson	Public, Forest of Dean
	Dr S Elyan	Medical Director
	Mrs H Munro	Non-Executive Director
	Mr K Norton	Non-Executive Director

The Chair welcomed members of the Council and thanked Governors for attending.

ACTION

029/16 DECLARATIONS OF INTEREST

There were none.

030/16 MINUTES OF THE MEETING HELD ON 24 FEBRUARY 2016

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

031/16 MATTERS ARISING

009/16 Quality Report 2015/16: With regard to mental health oversight, the Director of Clinical Strategy said that this will be a priority for next year and the issue is whether the Trust has the necessary information upon which to base a measure. The Council left it to the Director of Clinical Strategy to see if there is any measure which can be developed this year. *The Director of Clinical Strategy reported that this is ongoing and is influenced by the Sustainability and Transformation Programme in the development of mental health priorities which is owned by all organisations in the local health system. Completed for matters arising.*

The Lead Governor undertook to seek a majority view of Governors for the local indicator based on their first and second preferences and let the Director of Clinical Strategy know by 4 March 2016. *Based on the largest number of first choices Dementia: Find and Assess, Investigate and Refer was selected as the local indicator. Completed.*

010/16 Membership Strategy Update: Mrs Adams sought information on the approach to staff (who are also members unless they choose not to be) and member engagement wishing to ensure that there is no duplication and that there is a broader input from staff members. The Senior Patient Experience Manager said that she will ask the Head of Patient Experience to respond to the points raised. *The Head of Patient Experience has met Mrs Adams and the issues raised have been passed on to the Senior Independent Director and will be picked up as part of the work from the Governor effectiveness review. Completed.*

013/16 Chair/ Non-Executive Director Remuneration: The Chair said that it would be helpful if any changes were presented to the Council of Governors on 18 May 2016. To this end it was suggested that at the next available Governor meeting this matter be considered with the Director of Human Resources and Organisational Development who should be approached if any additional information was required for that discussion. *This item appears later in the Agenda. Completed.*

014/16 Update from Governors on Member Engagement: Prof Dunn undertook to re-send to the Trust Secretary for circulation to Governors the report prepared with Mrs Johnson of the meeting of the South West Governor Exchange Network held in November 2015. *The Trust Secretary says that this report has been circulated to Governors. Completed.*

Prof Dunn said that that section of the Salisbury Hospital's website is out of date and the Trust Secretary undertook to pursue this with the Secretary of the Network. *The Trust Secretary reports that this has been raised with the Salisbury Trust and he was invited to approach then again to see when this will be addressed. Ongoing.*

Prof Dunn invited the Trust Secretary to consider whether Council of Governor meeting papers could be made available electronically to Governors as he was now able to download the papers from the Trust's website. *Following discussions with Prof Dunn it was concluded that*

Governors be informed that the open Council of Governors papers are available on the Trust's website and can be downloaded if Governors so wish. Completed.

Ms Storr referred to the open evening held in February 2016 for prospective Non-Executive Directors and suggested that a similar event be held for prospective Governors in the elections later in the year. *This is being arranged for the forthcoming elections. Completed.*

Mrs Johnson said that the Forest of Dean Health Forum met the needs of the area and the Clinical Commissioning Group should be contacted to see if similar arrangements exist elsewhere in the County. The Trust Secretary was invited to contact Mrs Becky Parish at the Clinical Commissioning Group. *The Trust Secretary reports that Becky parish comments that the Forest Health Forum is not replicated elsewhere in the County. It used to be called The Bream Health Forum and has been going for about 30 years. There are specific, often time-limited, groups around the County that governors might want to get involved in, but the Forest one is totally unique. Completed as a matter arising.*

015/16 Governor Sub-Committee Reports: Quality Committee – 4 December 2015 and 15 January 2016: These reports were deferred to the next meeting in May 2016.*This item appears later in the Agenda. Completed.*

032/16 MINUTES OF THE MEETING OF THE GOVERNANCE AND NOMINATIONS COMMITTEE HELD ON 30 MARCH 2016

The Chair presented the minutes of the meeting of the Governance and Nominations Committee held on 30 March 2016.

Mr Thomas questioned the accuracy of minute 014/16 relating to the appointment of an additional Non-Executive Director and proposed amendments to the constitution and in the light of those comments the Chair said that the minutes will be presented to the next meeting of the Governance and Nominations Committee and that the report on the agenda in minute number 043/16 below regarding this topic be deferred for further consideration by the Governance and Nominations Committee.

033/16 REPORT OF THE ACTING CHIEF EXECUTIVE

The Acting Chief Executive presented her report and highlighted the following:-

- Clostridium difficile: The Nursing Director reported that our Trust had been successful in the six cases subject to appeal resulting in a total of 35 cases for 2015/16 which was below the annual target of 37.
- 18 weeks Referral to Treatment - Incomplete Pathways: This target was achieved in overall terms.
- Cancer: Difficulties remain with the 14 days to first appointment and the 62 days to treatment targets due to increased demand pressures in some specialities, particularly Urology where there is investment to improve performance.
- Emergency Department four hour wait: The target for Q4 and cumulatively for 2015/16 was not met. A recovery plan is in plan with support from NHS Improvement. Our Trust is working with

the health community to improve performance. The out of hours service is not always available and there is confusion over the opening times of Minor Injury Units which is not helping our Trust.

- Industrial Action by Junior Doctors: The Director of Human Resources and Organisational Development reported that on the afternoon of the Council meeting an announcement was made that an agreement to resolve the dispute had been reached involving ACAS. This was subject to a referendum by the junior doctors and if agreed will form the basis of a new contract. The detail of the agreement are awaited.
- SmartCare: Mr Foster gave a synopsis of the background leading to the postponement of implementation. In January 2016 difficulties came to light with the software impacting on the programme for training validation leading to the second postponement decision being taken in April 2016. A re-planning exercise has been undertaken with the "go-live" date for Phase 1 being September 2016 with Phase 1A some two months later. No date has been set for the implementation of Phase 2 which will be in 2017. The learning from the delay is a stronger change control process and greater discipline in the way in which the project is managed. There were minimal financial consequences to our Trust with the first postponement. The second postponement will have financial costs for our Trust with the continuation of the current HP support and the cost of backfilling staff posts. Discussions are taking place with Intersysyems on how these costs are to be met. The benefits realisation will start from Phase 2. Government funding for the programme is not affected by the postponement.

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

- Mrs Johnson asked what information could be given to the public in response to questions on the "go-live" date. In response, Mr Foster said a communication is to be sent to staff and through "Involve" announcing this date.
- Mr Marstrand referred to the difficulties which were known in January 2016 which seemed not to affect the confidence in meeting the May 2016 "go-live" date yet that date was again postponed. Mr Foster said in response that it was not appropriate to cause alarm with those difficulties as work was continuing to maintain the May 2016 "go-live" date but unfortunately this could not be achieved.
- The Lead Governor said that the benefits rationalisation should begin earlier in the implementation process and that the costs of the postponement picked up by InterSystems should have been communicated earlier. In response, Mr Foster said that the benefits rationalisation were always planned for Phase 2 implementation but acknowledged that there was a delay in this Phase going live which was not as great as the postponement of Phase 1 and 1A. The staff training is being re-arranged.

The Chair thanked the Acting Chief Executive for her report.

RESOLVED: That the report be noted.

034/16 Q4 PERFORMANCE

The Acting Chief Executive and Finance Director presented the report summarising the key highlights and exceptions in Trust performance up until the end of quarter four of the 2015/16 financial year. She drew attention to the area of exception on performance in relation to the Emergency Department four hour target. There is a focus on improving performance with the Improvement Director developing workstreams on particular areas. The improvement programme is gaining momentum but she said that it will take time to fully develop.

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

- Mrs Johnson noted that there are action plans in place to address the cancer two week wait standard which has not been met commenting that it is difficult to see how those action plans are making a difference. She expressed the hope that performance will improve. In response, the Acting Chief Executive and Finance Director said in response that the focus is in the short to medium term to make improvements quickly not just for the medium to long term. Discussions are taking place with the Clinical Commissioning Group over increasing demand which has to be planned for.
- Dr Llewelyn said that a more radical approach is required to address Emergency Department performance as existing plans are not stemming the increasing demand.
- The Lead Governor referred to the weekly telephone calls with the Non-Executive Directors and the Improvement Director discussing Emergency Department performance seeking assurance that all actions are being undertaken and enquired if there is an end to this process. In response, the Chair said that the telephone calls are useful to check what has happened. There is modest improvement in performance week on week which is in the right direction. Some plans will take longer to see the benefits. The end will be when the performance target has been met and there is no longer any NHS Improvement involvement. The end date is challenging as there are system wide issues requiring partner input particularly in reducing the medically fit list. She acknowledged that there are issues within our Trust to do to improve performance. The focus now is to concentrate on fewer areas to make a substantial difference and this is being set out in the workstreams.
- Mr Marstrand referred to the decision by Monitor in November 2015 to withdraw its detailed focus on Emergency Department on the basis that the plans in place would deliver improvements. This did not happen and it has taken time for our Trust to come out of winter. He wished to see triangulation of the evidence that performance is now moving in the right direction. The Chair said that there is now no distinction between winter and the rest of the year as our Trust saw its highest ever attendances during the week preceding the Council of Governors meeting. Our Trust is factoring in this as business as usual.
- Mr Mitchell referred to the three workstreams focusing on immediate priorities; Emergency Department, site management and reducing the number of patients in hospital greater than 14 days. The Non-Executive Director telephone calls are focusing on time to assessment in terms of 15 and 60 minutes and

patients in hospital greater than 14 days for which the number is reducing. The issue for our Trust is how to operate at levels of demand overall beyond planned levels. It is about meeting the complex needs of patients rather than just meeting the four hour target. The increased levels of demand have become the new norm and this requires discussion amongst all partners as to how this should be dealt with.

- Dr Llewellyn said that the focus from NHS Improvement is on the safety.

The Chair thanked the Acting Chief Executive and Finance Director for the report.

RESOLVED: That the report be noted.

035/16 GOVERNOR EFFECTIVENESS – REPORT OF THE WORKING GROUP

The Senior Independent Director/Vice Chair presented the report of the Task Group on Governor Effectiveness. He set out the background to the establishment of the Group from the recommendations of the Board Governance Review undertaken by RSM in relation to Governor effectiveness and the issues raised and considered. The highest priorities in terms of importance identified by the Group were developing effective engagement between Governors and constituents and developing and building effective relationships between Governors and Non-Executive Directors. The actions have been clustered into packages of work broadly prioritised and arranged to address four aims. For practical and capacity reasons the programme has been phased over the next two years. The next steps relate to the July Council of Governors meeting for Governors to consider their own objectives, a review of the constitution in two phases, consideration of further development of the Code of Conduct to include a disciplinary process for Governors, Staff Governor issues, developing Governor/Non-Executive Director relations, Council of Governor meetings, resourcing of the programme and supporting Governors in engagement and outside focus.

The Lead Governor supported the recommendations of the Task Group.

(Ms Anne Marie Millar joined the meeting)

During the course of the discussion Ms Storr urged that sufficient resources be made available to take forward this work which formed one of the recommendations of the Task Group.

The Chair thanked the Senior Independent Director/Vice Chair and Lead Governor for their report and for their work in taking forward the recommendations from the Board Governance review in relation to Governor Effectiveness.

RESOLVED: That:-

1. The report of the Task Group be approved.
2. The programme of development be approved.

036/16 QUALITY REPORT 2015/16

The Director of Clinical Strategy presented the Quality Report 2015/16 which had been prepared with input from Governors at the session on developing priorities in December 2015 and Governors serving on the Quality Committee. The External Auditors had now issued their statement which will be included in the Quality Report presented to the Board for approval on 20 May 2016. The opinion was qualified as in 2015 and the External Auditors will present their findings to the Council of Governors in July 2016. The reason for the qualification was that the indicator percentage of incomplete pathways within the 18 weeks for patients on incomplete pathways at the end of the reporting period did not meet the six dimensions of the data quality in two respects. She invited Governors to inform her of any minor textural amendments by the end of 20 May 2016.

During the course of the discussion, Mr Marstrand referred to the differing Emergency Department performance figures in the audited Quality Report and those in the Q4 Performance Report. The Acting Chief Executive and Finance Director undertook to look into this and respond to Mr Marstrand. **HS**

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

RESOLVED: That the report be noted.

037/16 OPERATIONAL PLAN 2016/17

The Director of Clinical Strategy presented the Operational Plan 2016/17 which had been submitted to NHS Improvement by the required deadline of 15 April 2016. This was the first opportunity which Governors had to see the complete document.

During the course of the discussion Mrs Adams referred to the workforce transformation on page 17 which set out the identification of opportunities to streamline administration as far as possible, and ensure that clinical time is not being spent unnecessarily on administrative tasks and how that related to workforce efficiency and the delivery of the Cost Improvement Programme on page 19 which included the reduction in temporary staffing expenditure in medical, nursing and other staff categories. In response, the Director of Human Resources and Organisational Development said that all departments had reviewed support staff in line with clinical requirements. The Carter Review will have a real impact on our Trust. He stressed that it is not about tackling administrative staff costs for the sake of it but about ensuring efficient service delivery with the right staff at the right grades which will include consideration of shared support services.

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

RESOLVED: That the report be noted.

(Mr Gordon Mitchell left the meeting and Mr Clive Lewis joined the meeting)

038/16 2015 STAFF SURVEY

The Director of Human Resources and Organisational Development made a presentation setting out the results of the 2015 staff survey covering response rates; rolling action plans; engagement; top 5/ Bottom

5; staff experience – Better/worse, divisions/Staff Groups, observations and top 3 issues which was circulated to Governors.

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

RESOLVED: That the presentation be noted.

(Ms Carol McIndoe left the meeting and Mr Eric Gatling, Director of Service Delivery joined the meeting)

039/16 GOVERNOR FOCUS CONFERENCE

The Lead Governor reported on his attendance at the NHS Providers Governor Focus Conference held in April 2016. Attendance had provided a good opportunity to meet Governors from other Trusts. There were four sessions at the Conference on the state of the NHS, the work of NHS Improvement, a particularly informative session on the CQC and the role of Governors in inspections with the publication of guidance on this topic and Governor engagement.

For the July Council of Governors meeting in addition to the planned taking forward the action plan of the Governor elements of the Board Governance Review he would like to explore Governors adopting a hospital ward, Governors serving on Board Committees and membership including the possibility of establishing a Governor Committee to consider membership issues including the membership strategy.

The Lead Governor commended the Governor courses organised by NHS Providers and the Trust Secretary was invited to recirculate the programme and Governors were encouraged to attend relevant courses. **MW**

The Chair thanked the Lead Governor for his presentation.

RESOLVED: That the presentation be noted.

040/16 CHAIR/ NED REMUNERATION

(Mr Tony Foster, Mr Clive Lewis and Ms Anne Marie Millar were not present for the discussion of this item. This item did not affect the current Chair as the proposal was to be effective from the start date of the new Chair of the Trust in January 2017.)

The Director of Human Resources and Organisational Development presented the report considered by the Governance and Nominations Committee containing in detail a comparison of the pay trajectories of other staff in the period of the NHS Providers Chair and Non-Executive Director Remuneration Survey 2015 and the Committee's recommendations for consideration by the Council of Governors.

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

RESOLVED: That

1. The salary of the Trust Chair be increased to £50k from appointment in January 2017 and the post should be advertised at this level.
2. The Vice Chair should have a minimum uplift of £2k to £3k per

annum starting September 2016.

3. The Audit Chair should not have an uplift at this stage but should be reviewed again next year.
4. The Non–Executive Director salary is slightly above the median and should remain unchanged at £13,200.

041/16 APPOINTMENT OF CHAIR OF THE TRUST

The Chair presented the report inviting the Council of Governors to approve the arrangements for the appointment of a new Chair of the Trust. Prof Clair Chilvers term of office as Chair of the Trust will come to an end on 31 December 2016. It is therefore necessary to make arrangements to recruit a successor from 1 January 2017. Following discussions between the Chair and Lead Governor, it is proposed that the recruitment process will be overseen by the Governance and Nominations Committee. The appointment of Chair of the Trust is a Council of Governors appointment. To enable an appointment to be made at interview it is recommend that authority be delegated to the interview panel to make an offer to the candidate as determined by the panel. This will be formally circulated by e-mail immediately afterwards inviting all Governors to approve the appointment.

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

- The Lead Governor clarified that the proposal for the 3 October was for a presentation in the afternoon by prospective candidates to stakeholder which included Governors.

- The Lead Governor said that the term of office for some of those Governors on the Interviewing Panel ceased on 1 October 2016 and there was a possibility that they may not be re-elected and available for the final interviews planned for 3 and 4 October 2016. (Post meeting note: The revised dates are 28 and 29 September 2016).

RESOLVED: That:-

1. The process for the appointment of a new Chair of the Trust be approved subject to a revised final interview date being determined;

2. Authority be delegated to the interview panel to make an offer to the candidate as determined by the panel which will be formally circulated by e-mail immediately afterwards inviting all Governors to approve the appointment.

042/16 APPOINTMENT OF NON-EXECUTIVE DIRECTORS

The Chair was pleased to formally inform the Council of Governors that in accordance with the authority delegated to it by the Council of Governors, the Interviewing Panel had appointed Mr Keith Norton (from 1 May 2016) and Ms Tracey Barber (from 1 September 2016) as Non-Executive Directors to replace Mrs Maria Bond and Mr Clive Lewis respectively.

RESOLVED: That these appointments be noted.

043/16 APPOINTMENT OF ADDITIONAL NON-EXECUTIVE DIRECTOR – PROPOSED AMENDMENT TO THE CONSTITUTION

This item was withdrawn for further consideration by the Governance and Nominations Committee.

044/16 GOVERNOR ELECTIONS 2016

The Trust Secretary presented the report informing the Council of Governors of the arrangements to fill Governor vacancies occurring in 2016. There are eight Public Governor and three Staff Governor vacancies and, with the exception of Ms Storr, existing Governors are eligible to seek re-election if they so wished. The term of office of the three appointed Governors also expired in 2016 and each existing Appointed Governor is eligible for re-appointment by their appointing body. The timetable for the elections was attached to the report. Arrangements are being made to appoint an election agent in accordance with the Trust's Constitution. It is proposed to hold an open evening at the beginning of July 2016 along similar lines to that for the appointment of Non-Executive Directors. The Chair will continue to write to constituency members inviting them to consider attending the open evening and standing for election. The Governance and Nominations Committee are to review the election pack.

During the course of the discussion in response to a question from Dr Beard, the Trust Secretary undertook to inform existing Governors of the date by which they had to submit their nomination papers should they wish to seek re-election and to include that date in the election timetable. **MW**

The Chair thanked the Trust Secretary for the report.

RESOLVED: That the process for the Governor elections in 2016 be approved subject to the above.

045/16 UPDATE FROM GOVERNORS ON MEMBER ENGAGEMENT

The Chair invited Governors to report on any member engagement activities which they had undertaken since the last meeting and the following were reported:-

- Mrs Adams said that as a Staff Governor she is encouraging staff to participate in the Friends and Family Test which the Chair acknowledged is a good idea for Staff Governors.
- Mrs Johnson said that the Forest Health Forum is trialling over the next three months a drop in session on the first Tuesday of the month to encourage greater engagement with the community.

The Chair thanked those Governors for the reports.

046/16 GOVERNOR ATTENDANCE AT COUNCIL MEETINGS

The Council received the details of Governor attendances at Council of Governor, Committee and Governor Development Sessions for the period April 2015 to March 2016.

047/16 GOVERNOR SUB-COMMITTEE REPORTS

Quality Committee – 4 December 2015, 15 January, 11 March and 15 April 2016: In the absence of the Chair of the Committee, Mrs Helen Munro, the Lead Governor said that Mrs Lewis, one of the Governors on the Quality Committee had circulated to Governors a note of the meeting held on 15 April 2016. Mrs Munro was invited to cover the meeting topics when she presented to the Committee in November 2016.

Health and Wellbeing Committee – 5 April 2016: The Chair of the Committee, Mr Tony Foster, reported on the main items discussed at the meeting of the Health and Wellbeing Committee held on 5 April 2016.

Audit Committee – 8 March and 17 May 2016: The Chair of the Committee, Ms Anne Marie Millar, reported on the main items discussed at the meeting of the Audit Committee held on 8 March and 17 May 2016.

Sustainability Committee – 22 April 2016: This Committee was now an Executive function.

Equality Committee – 14 March 2016: The Chair of the Committee, Mr Clive Lewis, reported on the main items discussed at the meeting of the Equality Committee held on 14 March 2016.

Patient Experience Strategic Group – 23 March 2016: The Chair as Chair of the Committee reported on the main items discussed at the meeting of the Patient Experience Strategic Group held on 23 March 2016. Mr Marstrand referred to the patient information leaflets produced by the Trust and the Trust Secretary was invited to provide Governors with the weblink containing that information. **MW**

048/16 GOVERNOR QUESTIONS

None received.

049/16 ANY OTHER BUSINESS

There were no further items of business.

050/16 DATE OF NEXT MEETING

The next meeting of the Council of Governors will be held in the Lecture Hall, Sandford Education Centre, Keynsham Road, Cheltenham on Wednesday 6 July 2016 commencing at 5.30pm.

051/16 PUBLIC BODIES (ADMISSION TO MEETINGS) ACT 1960

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

The meeting ended at 7.34pm.

Chair
6 July 2016

ITEM 20

ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

DISCUSSION

ITEM 21

STAFF QUESTIONS

Prof Clair Chilvers
Chair

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

PROCEDURE FOR PUBLIC QUESTIONS AT BOARD MEETINGS

The Trust welcomes feedback from members of the public. We are committed to delivering the best care and constantly looking at ways to improve the services we provide at out hospitals. There are a variety of ways in which you can give your feedback. These are:-

- As a patient or visitor to the hospital by completing a comment card which is available on wards and departments.
- By contacting the Patient and Liaison Service (PALS) who offer confidential, impartial help, advice or support to any aspect of a patient's care. The team aim to help resolve issues and concerns speedily by liaising with appropriate staff on your behalf. PALS can be contacted by phone on 0800 019 3282; by text on 07827 281 266; by e-mail pals@gloucestershirehospitals@glos.nhs.uk or by writing to the PALS Office, Gloucestershire Royal Hospital, Great Western Road, Gloucester GL1 3NN. Complaints can be made to the Complaints Team by phoning 0300 422 5777, by e-mail complaints.team@glos.nhs.uk of by writing to the Complaints Team at Gloucestershire Royal Hospital/at the above address.
- By asking a question at our Board meeting by following the procedure below. Board meetings are open to the public and are normally held on the last Friday of the month at Trust HQ, 1 College Lawn, Cheltenham. Meetings normally start at 9.00am

All feedback is taken seriously and is used to either praise staff for the excellent care or service they have provided or used to make improvements where needed.

Written questions for the Board Meeting

People who live or work in the county or are affected by the work of the Trust (including members of the Trust who live outside of the County) may ask the Chair of the Trust Board a question on any matter which is within the powers and duties of the Trust.

Ten minutes will be allocated at the end of the public section of each Board meeting for written questions from the public to be answered. Where it is not possible for all written questions to be dealt with within this timeframe a written response will be provided to the questioner and copied to all Board members within 7 working days of the meeting. In exceptional circumstances, the Chair may extend the time period for public questions.

Notice of questions

A question may only be asked if it has been submitted in writing to the Trust Secretary by 12.00 noon 3 clear working days before the date of the Board meeting. Each question must give the name and address of the questioner. If a question is being asked on behalf of an organization then the name of the organization must be stated. Written questions are to be submitted to the Trust Secretary, 1 College Lawn, Cheltenham, GL53 7AT or by e-mail to martin.wood@glos.nhs.uk No more than 3 written questions may be submitted by each questioner.

Procedure

At the Board meeting the questioner, if present, will be invited to read out the question. If absent, the Chair may read out the question. A written answer will be provided to a written question and will be given to the questioner and to members of the Trust Board before being read out at the meeting by the Chair. Copies of the questions and the responses will be recorded in the minutes.

Additional Questions

A questioner who has submitted a written question may, with the consent of the Chair, ask an additional oral question arising directly out of the original question or the reply.

An answer to an oral question will take the form of either:

- a direct oral answer; or
- if the information required is not easily available a written answer will be sent to the questioner and circulated to all members of the Trust Board.

Unless the Chair decides otherwise there will not be discussion on any public question.

Written questions may be rejected and oral questions need not be answered when the Chair considers that they:

- are not on any matter that is within the powers and duties of the Trust;
- are defamatory, frivolous or offensive;
- are substantially the same as a question that has been put to a meeting of the Trust Board and been answered in the past six months; or
- would require the disclosure of confidential or exempt information.

For further information, please contact Martin Wood, Trust Secretary on 0300 422 2932 by e-mail martin.wood@glos.nhs.uk