# GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Main Board will be held on Friday 26 February 2016 in Board Room, 1 College Lawn, Cheltenham commencing at 9.00 a.m**.** with tea and coffee.

Professor Clair Chilvers
Chair

19 February 2016

AGENDA

| | | | | Approximate Timings |
|---|---|---|---|---|
| **1.** | Welcome and Apologies | | | 09:00 |
| **2.** | Declarations of Interest | | | |
| | **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 29 January 2016 | **PAPER** | **To approve** | 09:02 |
| **4.** | Matters Arising | **PAPER** | **To note** | 09:03 |
| **5.** | Summary of the meeting of the Finance and Performance Committee to be held on 24 February 2016 | **PAPER (To follow)** (Mr Gordon Mitchell) | **To note** | 09:07 |
| **6.** | Minutes of the meeting of the Finance and Performance Committee held on 27 January 2016 | **PAPER** (Mr Gordon Mitchell) | **To note** | 09:11 |
| **7.** | Minutes of the meeting of the Audit Committee held on 22 January 2016 | **PAPER** (Ms Anne Marie Millar) | **To note** | 09:13 |
| | **Chief Executive's Report and Environmental Scan** | | | |
| **8.** | February 2016 | **PAPER** (Dr Frank Harsent) | **To note** | 09:15 |
| | **Governance and Operations** | | | |
| **9.** | Integrated Performance Framework Report | **PAPER** (Mrs Helen Simpson) | **To endorse** | 09:25 |
| **10.** | Financial Performance Report | **PAPER** (Mrs Helen Simpson) | **To endorse** | 09:40 |
| **11.** | Emergency Pathway Report | **PAPER** (Mr Eric Gatling) | **To endorse** | 09:55 |
| **12.** | Nursing and Midwifery Staffing | **PAPER** (Mrs Maggie Arnold) | **To approve** | 10:05 |
| **13.** | Cultural Change Programme Update | **PAPER** (Ms Rebecca Wassell) | **To note** | 10:10 |
| **14.** | Legal Services Report | **PAPER** (Mr Andrew Seaton) | **To note** | 10:40 |
| **15.** | Combined Assurance Framework and Trust Risk Register | **PAPER** (Mr Andrew Seaton) | **To approve** | 10:50 |
| **16.** | 2015 Staff Survey Results | **PAPER** (Mr Dave Smith) | **To note** | 11:00 |
| **17.** | Appointment of an Additional Non-Executive Director - Proposed Amendment to the Constitution | **PAPER** (Mr Martin Wood) | **To approve** | 11:30 |
| | **Next Meeting** | | | |
| **18.** | Items for the next meeting and Any Other Business | **DISCUSSION (All)** | **To Discuss** | 11:35 |

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| | **Staff Questions** | | |
| **19.** | A period of 10 minutes will be provided to respond to questions submitted by members of staff. | **To Discuss** | 11:40 |
| | **Public Questions** | | |
| **20.** | A period of 10 minutes will be provided for members of the public to ask questions submitted in accordance with the Board's procedure. | **Close** | 11:50<br>12:00 |
| | **Break** | | |

**Date of the next meeting:** The next meeting of the Main Board will take place at on **THURSDAY 24 MARCH 2016** in the Board Room. 1 College Lawn, Cheltenham **at 9.00am. (PLEASE NOTE DATE OF 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 29 JANUARY 2016 AT 9 AM

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

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| **PRESENT** | Prof Clair Chilvers | Chair |
| | Mrs Helen Simpson | Finance Director and Deputy Chief Executive |
| | 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 Gordon Mitchell | Senior Independent Director/ Vice Chair |
| | Mrs Maria Bond | Non-Executive Director |
| | 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 |
| **APOLOGIES** | Dr Frank Harsent | Chief Executive |
| **IN ATTENDANCE** | Mr Martin Wood | Trust Secretary |
| | Mr Bob Pearce | Deputy Director of Service Delivery |
| | Mr Andrew Seaton | Director of Safety |
| | Mr Dhushy Mahendran | Chief of Service – Women and Children's |
| **PUBLIC/PRESS** | Dr Emily Davies | Locum Consultant |
| | Mrs Chris Vout | PA to the Nursing Director |
| | Mr Matt Discombe | Citizen |
| | Mr Craig Macfarlane | Head of Communications |
| | Ms Carol McIndoe | Staff Governor |

*The Chair welcomed all to the meeting.*

**ACTION**

### 001/16 DECLARATIONS OF INTEREST

There were none.

### 002/16 MINUTES OF THE MEETING HELD ON 18 DECEMBER 2015

**RESOLVED:** That the minutes of the meeting held on 18 December 2015 were agreed as a correct record and signed by the Chair.

### 003/16 MATTERS ARISING

**376/15 Integrated Performance Framework Report:** The Chair invited the Medical Director and the Director of Service Delivery to look at other staff undertaking VTE assessments provided there is a consistent approach. *The Medical Director reported that performance dips when there are day cases in the hospitals which should not be. The Director of Service Delivery added that there is an expansion of day cases in line with the action plan and these*

*cases do not require an assessment. The data are being revisited. Ongoing.*

The Chair said that the situation regarding the availability of community beds should be raised with the Gloucestershire Strategic Forum. *The Chair reported that this will be raised formally at the next meeting of the Forum, with the issue being continually raised at every opportunity. Ongoing.*

**377/15 Financial Performance Report:** The Director of Clinical Strategy asked for details of the creditor payment position which the Finance Director undertook to provide to the Board. *The Finance Director reported* that on the morning of the Board meeting the Clinical Commissioning Group had made an additional cash payment with a further payment the following week which will help improve the Trust's creditor position. The Director of Clinical Strategy commented that the matter arising related to the creditor payment position which was available for the December 2015 Board meeting. Completed.[0904]

**004/16 SUMMARY OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 27 JANUARY 2016**

The Chair of the Committee, Mr Gordon Mitchell, presented the summary of the minutes of the meeting of the Finance and Performance Committee held on 27 January 2016. He reported on those matters considered by the Committee which were not included on the agenda as separate items. Firstly, there was a discussion about the Trust's cash position where monies remain outstanding from other NHS organisations, some of which are in dispute. These monies should be paid more quickly. The Committee were aware of instances, albeit anecdotally, where the Trust, for different reasons, is not paying suppliers in line with contractual terms. Secondly, the Committee received a report from the Director of Human Resources and Organisational Development on pay expenditure. There is further work to be done to improve recruitment and retention throughout the organisation. There is a focus on work in General and Old Age Medicine in Medicine Division which will be presented to the Committee in April 2016.There is more within the Trust's remit to reduce expenditure on Thornbury nurses by doing things differently and the Trust is to look at how Royal United Hospitals, Bath have reduced Thornbury spend. Thirdly, the Committee considered the national initiatives to address the funding gap.

The Director of Service Delivery added that the Committee considered cancelled operations with a more detailed report on theatre efficiency being presented to the February 2016 meeting of the Committee.

The Chair thanked Mr Mitchell for his report.

**RESOLVED:** That the summary minutes be noted. [0910]

**005/16 MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 16 DECEMBER 2015**

**RESOLVED:** That the minutes of the meeting of the Finance and Performance Committee held on 16 December 2015 be noted.

[0910]

**006/16 MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING COMMITTEE HELD ON 5 JANUARY 2016**

The Chair of the Committee, Mr Tony Foster, presented the minutes of the meeting of the Health and Wellbeing Committee held on 5 January 2016. He drew attention to the presentation on obesity acknowledging that there is more to learn about obesity where there is no instant solution. The Trust's Health and Wellbeing Strategy is being developed. The Committee consider making every contact with the Trust count to improve healthier lifestyles.

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

- The Chair referred to the number of apologies recorded at the meeting and invited the Committee to consider whether deputies should attend when the appointed representative was unable to do so. **AF**
- The Chair welcomed the strong interest expressed by a 5th year medical student to undertake a public health or health and wellbeing related project during a four week placement with the Trust.
- In response to a comment from the Chair of the Committee about the absence of progress of the "No Smoking" signage, the Director of Finance said that funding for the signage will be considered by the Director of Estates and Facilities as part of the Division's budget.
- The Director of Clinical Strategy commented that there is a good pathway for obese children who are admitted but the system response is not well defined. Trust staff contribute to the county-wide group to prevent obesity. The Chair invited the Director of Clinical Strategy to take forward developing a system response to obesity. **SP**

The Chair thanked Mr Foster for his report.

**RESOLVED:** That the minutes be noted. [0915]

**007/16 SUMMARY AND MINUTES OF THE MEETING OF THE QUALITY COMMITTEE HELD ON 15 JANUARY 2016**

The Chair of the Committee, Mrs Helen Munro, presented the summary and minutes of the meeting of the Quality Committee held on 15 January 2016. The Committee received an informative presentation on experience based co-design in stroke services which is an experience based approach to enable staff and patients to work together to co-design services by gathering experiences of patients and staff through a number of means. A presentation on stroke and TIA services highlighted the time taken to determine business cases. The Divisional attendance was from Estates and Facilities where future reports are to contain more data on performance management including domestics. The quality priorities for 2016/17 were endorsed.

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

- Ms Millar asked for information on the planned service improvements in the catering service. The Nursing Director said that a project has been established with volunteers to be trained to feed patients excluding stroke patients. Volunteers are being recruited for this role. The issue of the availability of ward dining rooms for General and Old Age Medicine patients is being considered to enable them to eat together.
- The Director of Clinical Strategy said that it is proposed to include in the draft Operational Plan 2016/17 the three Trust wide quality programmes of our SAFER Programme, seven day services and SmartCare. The draft Plan is to be submitted to Monitor by 8 February 2016 and will be shared with the Board. **SP/MW**

The Chair thanked Mrs Munro for her report.

**RESOLVED:** That the summary and minutes be noted. [0921]

**008/16 SUMMARY AND MINUTES OF THE MEETING OF THE SUSTAINABILITY COMMITTEE HELD ON 18 JANUARY 2016**

The Chair of the Committee, Mrs Maria Bond, presented the summary and minutes of the meeting of the Sustainability Committee held on 18 January 2016. She highlighted that this was the first Board Committee meeting to be held by video conferencing between the two sites. This had been successful and it is planned to hold future meetings by this method. Mrs Attwood thought that this method could be used for nurse meetings. The Committee received a presentation on SmartCare where sustainability was not a priority when the business case was being considered. Nonetheless sustainability benefits have subsequently been identified. There is enthusiasm within the Sustainability Team where a list of projects to pursue has been compiled. The Director of Estates and Facilities is making arrangements to ensure that Vital Energi present their reports on the carbon energy project and that savings are being achieved.

During the course of the discussion, the Medical Director said that clinical teams use the video conferencing facility and he wished to ensure that there are no clashes acknowledging that clinical use is programmed. The Chair said that the use of the video conferencing facility is worth pursuing. The Director of Human Resources and Organisational Development said that video conferencing and tele conferencing (which is not used to its maximum extent in the Trust) can help to improve attendance in the discussion. The Chair invited Board Committee Chairs to consider the use of video and teleconferencing for their meetings. **Committee Chairs**

The Chair thanked Mrs Bond for her report.

**RESOLVED:** That the summary and minutes be noted. [0931]

**009/16 SUMMARY OF THE MEETING OF THE AUDIT COMMITTEE HELD ON 22 JANUARY 2016**

The Chair of the Committee, Ms Anne Marie Millar, presented the summary of the meeting of the Audit Committee held on 22 January 2016. She drew attention to the draft terms of reference for the Shared Services Audit Committee which are planned to for 2016/17.

The tender for the appointment of external auditors is progressing with presentations being made on the afternoon of the Board meeting. Further discussion is to take place at the March 2016 meeting on the key financial indicators. There is an improvement plan for clinical coding with proposals to invest in the clinical coding workforce.

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

- In response to a question from the Chair, the Finance Director said that the internal audit reports are as expected with action plans and a robust action tracker in place which is followed through by the internal auditors and considered at each meeting of the Committee. With regard to the external audit reports, Grant Thornton had confirmed that the Trust's Financial Sustainability Rating is 3.
- The Medical Director said that there is a critical link between coding and mortality which he and the Finance Director need to consider with the involvement of the Mortality Committee.
- Mr Mitchell explained that it is not straight forward to get increased income from the Clinical Commissioning Group with improved clinical coding.

The Chair thanked Ms Millar for her report.

**RESOLVED:** That the summary be noted. [0937]

**010/16 CHIEF EXECUTIVE'S REPORT AND ENVIRONMENTAL SCAN**

The Finance Director and Deputy Chief Executive presented the Chief Executive's report and highlighted the following:-

- **Our Trust:** The recent Christmas holiday period saw very high demand for emergency admissions and during the week of the Board meeting there were high levels of attendances. The Clinical Commissioning Group is working with GPs in ED and plans are in place to deal with the workload.
- The Chair asked for progress on the West of England Academic Health Science Network becoming a Genomics centre. In response, the Director of Clinical Strategy said that NHS England approval to the centre was anticipated before the end of the current financial year. There are contract implications for the Trust as University Hospitals Bristol, North Bristol and Gloucestershire were planned for a September 2016 start. James Bristol is part of the Centre. She anticipated that a report would be presented to the Quality Committee in September 2016 when the clinical pathway has been completed.

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

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

- M1c – The hospital is at full capacity with limited ability to accommodate surges in admissions with the consequence of an increasing length of stay, 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 –amend

impact score to 5 (from 4) - 4x5 =20
- C3 - Risk arising from the sequence of Never Events leading to potential regulatory intervention and the potential effects on the reputation of the Trust - agreed to amend to 3x5=15 (from 2x4=8)

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

**RESOLVED:** That the report be noted. [0944]

**011/16 INTEGRATED PERFORMANCE FRAMEWORK REPORT**

The Finance Director presented the Integrated Performance Framework Report and drew attention to the key highlights on performance where despite rising referrals the Trust continues to meet the 18 Week Referral To Treatment (RTT) standard at Trust level for incomplete pathways as it has done each month this financial year. Again, despite rising referrals, the Trust has met the 14 day cancer target for patients urgently referred by their GP in November and for patients referred urgently with non-cancer breast symptoms. Based on reduced activity in December the 14 day cancer standard is predicted just to be missed for the quarter for urgent GP referrals and will be achieved for patients urgently referred with non-cancer breast symptoms. The Trust continues to meet the 31 day cancer targets, having achieved the standard in each month of this year. The Trust exceeded the recovery plan for the 62 day cancer standard in December 2015. The percentage of stroke patients spending 90% of their time on a stroke ward at over 81% continues to exceed the 80% target.

Of the areas of exception on performance she drew attention to emergency admissions which continue to increase. The number of delayed discharges at month end and the number of medically fit patients remaining in a hospital bed continue to run at high levels and above agreed system wide standards. There were eight breaches of the mixed sex accommodation standard in December 2015. This related to high numbers of patients attending ED. There was one patient reportable MRSA incident in December 2015. In November 2015, there was a pre 48 hour case of MRSA bacteraemia which was found to be a contaminant under the PIR process and this case is automatically allocated to the Trust. There was one Never Event in December. The percentage of eligible patients with VTE risk assessment continues to fall but remains above the target. There is an action plan to address this.

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

- The Nursing Director said that the pre 48 hour case of MRSA arose through a member of staff taking blood. There was no impact on the patient. Staff have ben retrained. The reportable MRSA incident occurred in Oncology at Cheltenham General Hospital.
- Mr Lewis asked for the background to the increase in cancelled operations. In response, the Director of Service Delivery said that in December 2015 less elective activity was undertaken and 2% of operations were cancelled which was less than in December 2014. The situation had been

challenging and the balance was to cancel on the day, give two or three days' notice of cancellation or to leave as late as possible in that it might go ahead. Due to the Christmas period and the national guidance about the availability of beds immediately before the Christmas period elective activity in January 2016 has been underbooked.

- Mrs Munro questioned the impact of the Christmas period on planned endoscopy patients which was red risk rated. The Director of Service Delivery, in response, said that the Christmas period should not impact on performance but some patients did not wish to accept an appointment during this period.
- The Chair asked why Acute Kidney Infection (AKI) performance was red risk rated for December 2015. In response, the Director of Safety explained that new standards had been introduced and there was no electronic system in place to capture the data for the changes in April 2015. An information system was trialled from July 2015 but had not been successful. The necessary changes have now been made to the system but was insufficient to meet the target for Quarter 3 at 44%, 1% below the target. Given these circumstances the Trust is negotiating with the Clinical Commissioning Group to obtain financial recompense through the CQINN. TrackCare will help with the recording. AKI was more prevalent in the community and further information is being given to GPs to assist them. Junior doctors are receiving training through the Academy which will improve performance. The Medical Director echoed the comments of the Director of Safety saying that it is important that Primary Care are aware of AKI and that the profile is raised. Primary Care is outside of the recording mechanism. There is no evidence that there has been any internal management deterioration in dealing with AKI.

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. [0955]

**012/16 FINANCIAL PERFORMANCE REPORT**

The Finance Director presented the Financial Performance Report stating that the financial position of the Trust at the end of December 2015 is a surplus of £0.5m on income and expenditure which is £0.2m lower than the position reported in November 2015. Although operational pressures continue temporary staffing expenditure is £0.8m lower than the expenditure in November 2015. The Trust needs to continue to improve its controls on the use of agency staff, discretionary expenditure and accelerate the delivery of the Cost Improvement Programme to bring the overall position back into line with plan as soon as possible. The Monitor Risk Assessment under the new framework shows a Financial Sustainability Risk Rating of 3. The surplus of £0.5m on the income and expenditure position represents an adverse variance of £1.6m from the planned position of £2.1m surplus of income over expenditure at the end of December 2015. The cash position has improved to £5.8m at the end of December 2015. New measures are in place to improve the position

over the coming months. The impact of the emergency cap cumulative to December 2015 was £981k. Monitor has requested all Foundation Trusts to ensure that they are undertaking all measures to reduce expenditure in the current financial year. The Finance Director assured the Board that all the areas referred to by Monitor had been undertaken. There are, however, risks for the next financial year and more work needs to be done. The budget process for the next financial year is underway. There is a concentrated focus for the remainder of the current financial year to achieve the surplus.

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

- The Chair asked for details of the discussions with Gloucestershire Care Services (GCS) around the charging arrangements to the Trust which is impacting on the non-pay position. In response, the Finance Director said that the discussions are around checking the volume and price for work undertaken in community hospitals. An offer by GCS for a year end position is being considered.
- The Finance Director said that there are further opportunities to improve the Cost Improvement Programme during the current financial year.
- Mr Lewis asked for the background to the outstanding debt from other English Clinical Commissioning Groups and other non-English NHS organisations where the debt greater that 120 days totalled approximately £5m. In response, the Finance Director said that said that there are local issues to address particularly regarding specialised commissioners but she expressed confidence that they can be resolved. Some of the outstanding debt is disputed but the bulk related to timing issues. Pharmacy is issuing invoices more promptly to assist in receiving early payment. Mr Lewis also asked if there is a member of the Finance Team with sole responsibility for debt collection. The Finance Director said that the Head of Financial Reporting is responsible for the co-ordination of debt collection with staff in Shared Services. She expressed confidence that resources are in place to deal with debt collection.

The Chair thanked the Finance Director for the report.

**RESOLVED:** That:-

1. The financial position of the Trust at the end of month 9 of a surplus of £0.5m on income and expenditure be noted. This is £0.2m less than the position reported at Month 8.
2. The £0.5m surplus represents an adverse variance of £1.6m from the planned position of £2.1m surplus of income over expenditure at the end of December 2015 be noted.
3. The Trust needs to continue to improve its controls on the use of agency staff, discretionary expenditure and accelerate the delivery of its Cost Improvement Programme to bring the overall position back in to line with plan as soon as possible.
4. The new Monitor risk assessment framework shows a Financial Sustainability Risk Rating of 3.
5. Actions to address the issues identified in this report will continue in 2015/16 and progress will continue to be reported

monthly to the Finance and Performance Committee and the Foundation Trust Board. [1004]

**013/16 EMERGENCY PATHWAY REPORT**

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

- The 95% four hour target for Emergency Department performance was not successfully met in December 2015 with Trustwide performance reported as 82.6%.
- The issues to performance are the number of attendances and admissions compared to the same period in 2014 and the increase in ambulance handover delays.
- Those patients seen by GPs In the Emergency Department and the Ambulatory Care Unit are not included in the Trust's performance indicating a higher than reported level of demand.
- The number of patients on the medically fit list has been at an average of 51 throughout December 2015. This is three patients less than November 2015, but remains above the system-wide plan of no more than 40 patients.
- In December 2015 there was one trolley wait in the Emergency Department greater than 12 hours due to an exceptional clinical condition.
- In December 2015 there was a clear directive from NHS England, Monitor and the Trust Development Authority for 20% of hospital beds to be available on Christmas Eve. This the Trust achieved however on 28 December 2015 bed occupancy was at capacity. During the first week of January 2016 little surgery work was undertaken as a result of demand during the Christmas period.
- The risks are staffing levels at the "front door" resulting in increased expenditure on locum doctors and the impact on patient flow and onward patient care.
- The key actions are to support joint working with the Monitor Operational Support Team and work with the Clinical Commissioning Group, Gloucestershire Care Services and Gloucestershire County Council on the system-wide actions on the work of the recently-established Focus Group, revisiting single point of access, Intensive Discharge Team and increased escalation to ensure safe care for patients.

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

- The Chair invited the Director of Service Delivery to include in future reports details of peaks in the Emergency Department which cause significant difficulties for the Trust. **EG**
- In response to a question from the Chair about the situation in other Trusts, the Director of Service Delivery said that he is planning to visit Dudley Hospital to see how they have improved Emergency Department performance following the publication of an article in the Health Service Journal. The Deputy Director of Service Delivery added that Dudley is a one site operation where there is better integration amongst partners.
- Mr Mitchell expressed concern that at a high level the Trust's

Emergency Department performance did not compare favourably other Trusts. In response, the Director of Service Delivery said that a dialogue continues with Monitor and the Improvement Team with weekly performance reviews. The Trust's position in relation to other Trusts will become secondary with improved performance within the Trust. Comparable performance information is no longer publicly available.

- The Chair said that there is a telephone call arranged with Monitor for the end of February 2016 with Mr Foster and she hoped that performance will improve by then for a better patient experience. The Director of Service Delivery added that the Monitor Improvement Team is helping the Trust to improve performance. The Deputy Director of Service Delivery said that the Focus Group is to tighten up process between partner organisations and improve length of stay across the whole pathway and to provide pace for improvements.
- Mr Lewis referred to the increase in ambulance handover delays in December 2015 compared with July 2015. In response, the Director of Service Delivery said that there were two days in December 2015 with significant demand pressures which contributed to the delays impacting on patient flow and the lack of beds. Additional nurses were provided in the Emergency Department. He undertook to provide Mr Lewis with details of the impact of the fines and penalties on 30 and 60 days imposed by the South West Ambulance Service. The Nursing Director reassured the Board from her recent working at night that patients were not waiting in ambulances, but were waiting in the Emergency Department with qualified nurses. In one two hour period there were 30 patients on trolleys and "minors" and there was not the physical space to put patients. Patients were handed from the Ambulance Service to nurses in the hospital, triaged, provided with pain relief and resuscitation if needed. During that week there was only one complaint which related to the workload of the nurses. The Director of Service Delivery said that on occasions there is insufficient space in the Emergency Department and the workload of the Ambulance Service has increased by 39% compared to last year. The Medical Director said that GP admissions are booked with the Ambulance Service between 3.00 and 7.00pm, but due to the pressures on that Service are not picked up until the evening placing operational pressures on the Trust. The Chair said that she will invite the Chief Executive to speak to the Chief Executive of the Ambulance Service to discuss this issue. The Director of Safety added that the Academic Health Science Network had undertaken a piece of work with the Emergency Department in North Bristol to provide a checklist to mitigate risk, (however does not address patient flow) during very busy periods which can be used within the Trust. **EG** **CC** **EG**

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. [1026]

**014/16 NURSING 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 December 2015. In line with the set parameters for the safer staffing guidance there were no outlying exceptions for December 2015. Both Departments of Critical Care "flex" their staff during periods of low patient numbers so "trigger" falsely in that their staffing against their expected levels remain appropriate. The Nursing Director drew attention to recruitment update for UK, EU, Philippines and and for overseas-qualified nurses. Details of maternity leave will be included in the next report. The Nursing Director stressed that the opening of additional capacity has increased the requirement for additional nurses. There is also an increase in patients requiring 1:1 nursing. Agency staff are required for delayed discharge patients.

The Director of Human Resources and Organisational Development added that the Trust is not in line with other Trusts in the surrounding areas with approximately 29% non-compliance with the nursing framework costs. He was satisfied that the Trust is taking the correct measures to reduce nurse agency costs. He said that the Trust will need to determine a point at which agency staff are not used. The Trust recruitment and retention premiums are beginning to take effect. The Divisional Nursing Director for Medicine is undertaking a piece of work to understand retention issues in General and Old Age Medicine (GOAM) wards in the Division. There is further pressure from Monitor to reduce nursing agency expenditure. Thornbury are not helping in the process and their continued use places further pressure on the Trust. The Director of Human Resources and Organisational Director will work with the Nursing Director to determine a date when agency nurses will not be used. The use of HCAs will be considered. There are less training places available and agency working allows greater flexibility in working arrangements which the Trust needs to understand. Bank work offers staff the opportunity for flexible working arrangements. The Nursing Director stressed that the Trust needs to be able to offer greater flexibility in working arrangements for nurses.

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

- Mr Foster suggested that the Trust together with surrounding Trusts should agree a date by which they all will not use Thornbury nurses. The Nursing Director commented that Thornbury employs Trust nurses in the private sector and care homes and the Trust needs the capacity to be able to achieve this which she acknowledged had been undertaken in the past. The Trust also had the bear in mind its good CQC rating which other Trusts had not achieved by ceasing the use of Thornbury nurses.
- Mr Foster drew attention to the reduction in actual nursing vacancies in November 2015. The Nursing Director commented that this was due in part to the increased nursing investment. The Chair invited Mr Foster, the Nursing Director and the Director of Human Resources and Organisational Development to discuss the staff retention information. **MA/DS**
- The Nursing Director reported that the Nursing Establishment

Benchmarking against the Keith Hurst Database will be presented to the next Board meeting.

The Chair thanked the Nursing Director for the report.

**RESOLVED:** That the report be endorsed. [1044]

**015/16 BOARD STATEMENTS**

The Finance Director presented the report advising that the Trust is required to confirm the following Board statements:-

- *For Finance that:* The Board anticipates that the Trust will continue to maintain a financial sustainability risk rating of 3 for the financial year 2015/16.
- *For Governance that:* The Board is satisfied that plans in place are sufficient to ensure: on-going compliance with all existing targets as set out in the compliance framework and a commitment to comply with all known targets going forwards.
- *Otherwise:* The Board confirms that there are no matters arising in the quarter requiring an exception report to Monitor which have not already been reported.

The report set out the issues that the Board must consider in making these declarations.

The Chair thanked the Finance Director for the report.

**RESOLVED:** that:-

1. The Board expects that the Trust will continue to maintain a Financial Sustainability Risk Rating of 3 for the 2015/16 financial year however this is not without a significant challenge that will require ongoing rigour across the Trust's activities, particularly regarding the delivery of its Cost Improvement Programme

2. An exception report is made to Monitor on the A&E 4 hour standard and Cancer 62 day standard. The Trust will continue working with Monitor and partners across the health system to design and deliver performance improvement plans and improve performance on these targets in the remainder of the 2015/16 financial year and moving in to 2016/17.

3. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all other existing targets as set out in the compliance framework and a commitment to comply with all known targets going forward. [1045]

**016/16 RISK MANAGEMENT FRAMEWORK**

The Director of Safety presented the report seeking approval to the updated Risk Management Framework. The Risk Management Framework which is based on Health and Safety guidance 65 describes the Trust's approach to safety management. There is a legal requirement for the Trust to develop and formulise a Board-led Health and Safety Management Strategy so as to demonstrate that it is an organisation that is committed to continuingly improving safety

through ‘leadership, planning, delivering, reviewing and monitoring performance’. He referred to the ROSPA Gold Award to the Trust.

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

- Mrs Bond referred to the work undertaken by the Director of Safety during the last couple of years to deliver a cultural change within the Trust with robust action plans.
- In response to a question from Mr Lewis regarding training, the Director of Safety said that the Health and Safety Committee expects Divisions to report on staff training undertaken in risk management.

The Chair thanked the Director of Safety for the report.

**RESOLVED:** That the updated Risk Management Framework be approved. [1048]

**017/16 SEVEN DAY SERVICES UPDATE**

The Deputy Director of Service Delivery presented the report on the seven day services project update commenting on the pilot in respiratory, the whole Trust Plan and County-wide activity. The pilot in respiratory continues to be the focus for the transformation of delivery and the service has introduced a new model of working in Cheltenham General Hospital with the employment of the locum consultant. The Service has also changed its way of working in Cheltenham where the two wards now start the day with a Board Round using the format devised by Dr Kate Hellier as part of her Board Round project. The Gloucestershire Respiratory Team continues to explore integrated working with Gloucestershire Care Services. Twenty two wards now have weekend ward clerks. A Ward Clerk Manager starter earlier in the week of the Board meeting with an early task to provide training to book more timely appointments. The improvement of Board Rounds has been combined with Dr Hellier’s work and the rollout of the National SAFER programme. SAFER weeks have been held each month since October 2015 and provide a focus for improvement. The County-wide Steering Group met in January 2016 and reinforced the Trust’s approach to deliver against the four National Priority Standards.

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

- Mr Lewis asked if there were any contractual issues in the provision of seven day services particularly for ward clerks. In response, the Director of Human Resources and Organisational Development said that working hours have not been extended but ward clerks are employed to meet operational need. Weekend working forms part of the consultant and junior doctor contract and there is a willingness to work at weekends which already happen. This puts the Trust in a good position in advance of the national contract where negotiations remain ongoing.

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

**RESOLVED:** That the update on progress towards the introduction of seven day services into the Trust be noted. [1053]

**018/16 ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS**

**Items for the next meeting:** The Director of Human Resources and Organisational Development reported that the results of the 2015 Staff Survey will be reported to the next meeting.

**Any other business: Industrial action by junior doctors on 10 February 2016:** The Chair sought information on the industrial action planned by junior doctors for 10 February 2016. In response, the Director of Human Resources and Organisational Development reported that little information has been announced regarding the intentions for the strike. The Medical Director added that the Trust is planning for an all-out strike. [1056]

*(The Nursing Director left the meeting)*

*The meeting adjourned at 10.56 am to consider a patient story and reconvened at 11.42 am)*

**019/16 STAFF QUESTIONS**

The staff questions received from Pam Adams and Duncan Stevenson together with the answers given are attached as appendix 1 to these minutes. [1152]

**020/16 PUBLIC QUESTIONS**

The public question received from Mr Bren McInerney together with the answer given is attached as appendix 2 to these minutes. [1154]

**021/16 DATE OF NEXT MEETING**

The next **public** meeting of the **Main Board** will take place at **9am** on **Friday 26 February 2016** in the **Boardroom, Trust Headquarters, Cheltenham**.

**022/16 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 11.53 am.

**Chair**
**26 February 2016**

**APPENDIX 1**

**MAIN BOARD – JANUARY 2016**

| STAFF QUESTIONS | | | |
|---|---|---|---|
| Question Number | Questioner | Question | Response |
| 1. | Pam Adams | "I am aware of the issues with "no smoking" from both Sally Pearson and the Health and Wellbeing side. I think we have previously approached the local authority to send out a stronger public message. I think there may be an issue in that there was a recent request to charitable funds committee to provide new signage which had to be turned down due to lack of funds." | The Director of Finance said that funding for the signage will be considered by the Director of Estates and Facilities as part of the Estate's Division's budget. It is not appropriate to be financed from Charitable Funds.<br><br>*(Finance Director)* |
| | Duncan Stevenson | "1 With the recent success of the COP21 climate change summit in Paris, would the board consider committing our Trust to becoming carbon neutral by 2050 or earlier?" | The Trust is committed to meeting the legally binding carbon reduction targets set by the Climate Change Act 2008 i.e. to reduce carbon emissions by 34% by 2020 and by 80% by 2050 (based on the 1990 baseline). Becoming carbon neutral by 2050 or earlier would be an even greater challenge and one that the Trust may struggle on especially with regard to our indirect carbon emissions. Procurement is 65% of the NHS England carbon footprint (NHS SDU: NHS England Carbon Emissions: Carbon Footprinting Report published 2012) with much of this from pharmaceuticals and medical instruments. In the future it might be possible for the Trust to consider the aim to become carbon neutral in its estates but without the full commitment and changes from global suppliers it will be very difficult to become neutral without funding carbon offsets.<br><br>*(Finance Director)* |
| | | "2 Considering the effect | The Trust is reviewing all the vehicles |

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| | | diesel engines have on public health with emissions of Nitrogen and Sulphur Oxides etc., would the board consider replacing any and all diesel vehicles that our Trust owns or leases with low emissions vehicles?" | that it owns or leases – this includes the number of vehicles as well as the type. Low carbon options will be considered when vehicles need replacing and for shorter journeys electric or hybrid vehicles may be suitable but will obviously depend on service need. The Trust is investigating the possibility of providing charging points on our sites and this would facilitate the more widespread use of electric vehicles. The lease car policy is currently under review and there is a recommendation that Trust staff are limited in their choice of lease car to one that falls into vehicle tax Band A, B or C i.e. no more that 120g/km of CO2 emission. This suggestion is subject to agreement from Directors Group.<br><br>*(Finance Director)* |

**APPENDIX 2**

**MAIN BOARD – JANUARY 2016**

1. Mr Bren McInerney

**Question: "**I would like to formally record an open question at the January 2016 Gloucestershire Hospitals NHS Foundation Trust Board meeting. The open questions is for a response to the recently published book (December 2015) by James Titcombe, titled Joshua's Story. I don't wish to be prescriptive about what the response is, or should include, I would simply welcome a response to the content of this book.

It isn't just the sadness of a family fighting the system at a time they should otherwise be experiencing great joy, it is the ability to be totally honest when mistakes have been made."

**Response:** Joshua's Story reflects some of the distressing chain of events that began with serious failures of clinical care in the maternity unit at Furness General Hospital, part of what became the University Hospitals of Morecambe Bay NHS Foundation Trust. The result was avoidable harm to mothers and babies, including tragic and unnecessary deaths. What followed was a pattern of failure to recognise the nature and severity of the problem, with, in some cases, denial that any problem existed, and a series of missed opportunities to intervene that involved almost every level of the NHS.

As a Trust we are committed to open and transparent communication with our patients and partners. We believe this approach, however difficult, brings true accountability and creates a learning culture within our organisation.
We have for some time presented real patient and staff stories to the Trust Board and other key meetings to connect the reality of our hospital to our leaders and this includes situations where we may have caused harm or distress. Our Board visit wards and departments on a regular basis to discuss safety and patient experience issues.
To facilitate openness we invite our Commissioners and Governors to key Quality meetings so they can see the information and hear the discussion and responses to questions and in addition we share our key risks at every public Trust Board meeting.
With particular reference to cases where there has been harm caused (serious incidents) we have always followed the NHS "Being Open" guidance and we are currently introducing the "Duty of Candour" requirements to inform patients and their families about the findings of investigation. We will always offer to meet with patients and families to discuss with them the findings of any investigation and to give them an opportunity to ask questions in an open and honest forum. The Trust internal serious incident investigation reports are frequently shared with the Coroner and introduced as evidence into her inquiry. In fact in the past 6 months we have proactively shared reports with the Coroner that have identified new concerns and led to further inquiries.
For complaints and concerns we hold frequent face to face local resolution meetings which provide a route for transparent discussion and we have also recently developed specialised training for trust staff who chair local resolution meetings so that they are equipped with the necessary skills to run these important meetings that can be complex and difficult for both complainants and staff.

*(Director of Safety and Head of Patient Experience)*

## GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

### MAIN BOARD – FEBRUARY 2016

### MATTERS ARISING

**CURRENT TARGETS**

| Target Date | Month/Minute/Item | Action with | Detail & Response |
|---|---|---|---|
| February 2016 | December 2015 Minute 376/15 Integrated Performance Framework Report | **SE/EG** | The Chair invited the Medical Director and the Director of Service Delivery to look at other staff undertaking VTE assessments provided there is a consistent approach. *The Medical Director reported that performance dips when there are day cases in the hospitals which should not be. The Director of Service Delivery added that there is an expansion of day cases in line with the action plan and these cases do not require an assessment. The data are being revisited. Ongoing.* |
| | | **CC** | The Chair said that the situation regarding the availability of community beds should be raised with the Gloucestershire Strategic Forum. *The Chair reported that this will be raised formally at the next meeting of the Forum, with the issue being continually raised at every opportunity. Ongoing.* |
| February 2016 | January 2016 Minute 006/16 Minutes of the meeting of the Health and Wellbeing Committee held on 5 January 2016 | **AF** | The Chair referred to the number of apologies recorded at the meeting and invited the Committee to consider whether deputies should attend when the appointed representative was unable to do so. *Ongoing.* |
| | | **SP** | The Director of Clinical Strategy commented that there is a good pathway for obese children who are admitted but the system response is not well defined. Trust staff contribute to the county-wide group to prevent obesity. The Chair invited the Director of Clinical Strategy to take forward developing a system response to obesity. *Ongoing.* |
| February 2016 | January 2016 Minute 007/16 Summary and Minutes of the meeting of the Quality Committee held on 15 January 2016 | **SP/MW** | The draft Operational Plan is to be submitted to Monitor by 8 February 2016 and will be shared with the Board. *The Trust secretary reports that the draft Plan was circulated to the Board on 10 February 2016. Completed.* |
| February 2016 | January 2016 Minute 008/16 Summary and Minutes of the | **Committee Chairs** | The Chair invited Board Committee Chairs to consider the use of video and teleconferencing for their meetings. *The Trust secretary reports that* |

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| | meeting of the Sustainability Committee held on 18 January 2016 | | *Committee Chairs and those servicing Board Committees have been invited to put this as an item on the next Committee meeting. Completed as a matter arising.* |
| February 2016 | January 2016 Minute 013/16 Emergency Pathway Report | **EG** | The Chair invited the Director of Service Delivery to include in future reports details of peaks in the Emergency Department which cause significant difficulties for the Trust. *This is included in the report which appears later in the Agenda. Completed.* |
| | | **EG** | The Director of Service Delivery undertook to provide Mr Lewis with details of the impact of the fines and penalties on 30 and 60 days imposed by the South West Ambulance Service. *Ongoing.* |
| | | **CC** | The Chair said that she will invite the Chief Executive to speak to the Chief Executive of the Ambulance Service to discuss the issue where GP admissions are booked with the Ambulance Service between 3.00 and 7.00pm, but due to the pressures on that Service are not picked up until the evening placing operational pressures on the Trust. *Ongoing.* |
| | | **EG** | The Director of Safety said that the Academic Health Science Network had undertaken a piece of work with the Emergency Department in North Bristol to provide a checklist to mitigate risk, (but does not address patient flow) during very busy periods which can be used within the Trust. *Ongoing.* |
| February 2016 | January 2016 Minute 014/16 Nursing and Midwifery Staffing | **MA/DS** | The Chair invited Mr Foster, the Nursing Director and the Director of Human Resources and Organisational Development to discuss the staff retention information. *Ongoing.* |

## FUTURE TARGETS

There are none.

## COMPLETED TARGETS

| Target Date | Month/Minute/Item | Action with | Detail & Response |
|---|---|---|---|
| January 2016 | December 2015 Minute 377/15 Financial Performance Report | **HS** | The Director of Clinical Strategy asked for details of the creditor payment position which the Finance Director undertook to provide to the Board. *The Finance Director reported* that on the morning of the Board meeting the Clinical Commissioning Group had |

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|---|---|---|---|
| | | | made an additional cash payment with a further payment the following week which will help improve the Trust's creditor position. The Director of Clinical Strategy commented that the matter arising related to the creditor payment position which was available for the December 2015 Board meeting. *Completed.* |

# ITEM 5

# SUMMARY OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE TO BE HELD ON 24 FEBRUARY 2016

## PAPER (To follow)

**Mr Gordon Mitchell**
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 27 JANUARY 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 G Mitchell | Non-Executive Director (Chair) |
| | Mrs H Simpson | Finance Director and Deputy Chief Executive |
| | Mrs M Bond | Non-Executive Director |
| | Mr T Foster | Non-Executive Director |
| | Mr E Gatling | Director of Service Delivery |
| **APOLOGIES** | Dr F Harsent | Chief Executive |
| **IN ATTENDANCE** | Mr M Wood | Trust Secretary |

*The Chair welcomed the members of the Committee to the meeting.*

**ACTION**

**001/16 DECLARATIONS OF INTEREST**

There were none.

**002/16 MINUTES OF THE FINANCE AND PERFORMANCE COMMITTEE HELD ON 16 DECEMBER 2015**

**RESOLVED:** That the minutes of the Finance and Performance Committee held on 16 December 2015 were agreed as a correct record and signed by the Chair.

**003/16 MATTERS ARISING**

There were none.

**004/16 FINANCIAL PERFORMANCE REPORT**

The Finance Director presented the Financial Performance Report stating that the financial position of the Trust at the end of December 2015 is a surplus of £0.5m on income and expenditure which is £0.2m lower than the position reported in November 2015. Although operational pressures continue temporary staffing expenditure is £0.8m lower than the expenditure in November 2015. The Trust needs to continue to improve its controls on the use of agency staff, discretionary expenditure and accelerate the delivery of the Cost Improvement Programme to bring the overall position back into line with plan as soon as possible. The Monitor Risk Assessment under the new framework shows a Financial Sustainability Risk Rating of 3. The surplus of £0.5m on the income and expenditure position represents an adverse variance of £1.6m from the planned position of £2.1m surplus of income over expenditure at the end of December 2015. The cash position has improved to £5.8m at the end of December 2015. The creditor position has deteriorated with the Gloucestershire Clinical Commissioning Group (CCG) withholding payments. The CCG is asking for very detailed information on the work done by the Trust for the determination of any financial penalties where there is approximately £5m of monies in dispute. The level of

penalties has been agreed in principle but the CCG are still withholding the cash which is greater than the areas which they are questioning. If a working capital facility is taken out then the Finance Director said that the costs will be passed on to the CCG. New measures are in place to improve the position over the coming months. The impact of the emergency cap cumulative to December 2015 was £981k. Monitor has instructed all Foundation Trusts to ensure that they are undertaking all measures to reduce expenditure in the current financial year. The Finance Director assured the Committee that all the areas referred to by Monitor had been undertaken. There are, however, risks for the next financial year and more work needs to be done. The budget process for the next financial year is underway. There is a concentrated focus for the remainder of the current financial year to achieve the surplus.

The increased use of agency doctors has also contributed to a reduction in the surplus. There was a loss of income during the Christmas and New Year period due also to the additional empty beds. There are plans to increase elective activity in January 2016 to improve the income position.

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

- The Finance Director said that Rosterpro is gradually beginning to have an impact on the use of agency staff. However, there is a significant number of patients requiring 1:1 nursing care. The Trust is working to identify the areas of specific agency spend relating to those cases.
- Mr Foster sought information on those organisations which comprised the “other English NHS” debtors. In response, the Finance Director said that the majority were specialised commissions, especially for cancer services, and Welsh Health Boards. The Welsh Assembly has been approached to ensure that payments are made more quickly.

*(Mr Gatling left the meeting)*

- Mr Foster asked for the terms of the debtors greater than 120 days. The Finance Director said in response that the majority of commissioner debtors do not pay until the detail has been resolved.
- Mr Foster said that from his recent Executive walkabout he had been informed that the Trust had not paid invoices for flu testing kit in Pharmacy. The consequence is that this work will be done elsewhere. Similar issues of non-payment of invoices had been raised at the Sustainability Committee. He was alarmed that the impact of non-payment of invoices can have on patient safety. The Finance Director said that those organisations repeatedly chasing payment are receiving monies; however they are not always organisations where payments are due for payment. Three members of staff in Shared Services are taking calls from supplies regarding non-payment of invoices. This position is reflected across the NHS. Some organisations are now insisting on payment in advance. The position could be resolved by Commissioners making payments sooner. Mr Foster expressed in his view two serious concerns regarding the non-payment of creditors. Firstly, that it **HS**

is morally and commercially wrong to withhold payments and secondly, it can have a serious impact on patient safety. He asked how much is required by the Trust to make payments in line with contract terms and that this information should be presented to the February 2016 Board meeting. He considered this to be a dangerous practice which should cease. The Finance Director said that some suppliers are acting unreasonably. Negotiations are taking place with suppliers which is a national issue. She did not accept that it was a dangerous issue and the Finance Team and Shared services are working extremely hard to resolve.

- Mrs Bond commented that the Trust has created the problem leading to a loss of reputation. There is support for taking a robust stance with the CCG to secure prompt payment.

*(Mr Gatling returned to the meeting)*

- The Director of Service Delivery commented that Commissions are reluctant to pay the Trust for work undertaken above the contract even though they continue to send work to the Trust.
- The Chair asked for information on the negotiations with the CCG about the year-end financial position. In response, the Finance Director said that negotiations are continuing over an amount of £7m which is disputed. The CCG have the money to pay. The Director of Service Delivery added that GP referrals are greater than planned which the Trust is not in a position to control.

The Finance Director presented the Forecast Outturn based on the financial position as at the end of December 2015. Overall the forecast likely position is a surplus of £2.2m which represents an adverse variance from the original Monitor plan of £1.8m. The greatest area of concern is in Medicine Division.

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

- The Chair asked for information on the year end position. The Finance Director said that she has assumed that the Trust will receive approximately £2m of the additional £7m which is disputed with the CCG.
- Mrs Bond sought an assurance that the Trust can make and argue a robust case with the CCG. The Finance Director gave assurance that the assumptions will materialise. The Director of Service Delivery added that the CCG is challenging the Trust's coding arrangements particularly around co-morbidities. This is a subjective challenge which may deteriorate as the coding will become more precise with the introduction of SmartCare with a corresponding adverse impact on reference cost and hospitality mortality data.
- The Finance Director said that negotiations continue with Gloucestershire Care Services particularly around the prices charged for theatre use in community hospitals and speech and language facilities. The Trust has a good case to go to arbitration if necessary although this should be resolved between Finance Directors.
- In response to a question from the Chair, the Finance Director could not guarantee that the year-end surplus position will be

greater than £2.2m as there are significant risks that continue to be managed and every effort is being made to remain in surplus. There is a strong focus for the remainder of the financial year to deliver further the Cost Improvement programme particularly with cross-cutting schemes. There is potential for savings in Surgery Division where there is a high use of non-pay items.

The Chair thanked the Finance Director for the report.

**RESOLVED:** That:-

1. The financial position of the Trust at the end of month 9 of a surplus of £0.5m on income and expenditure be noted. This is £0.2m less than the position reported at Month 8.
2. The £0.5m surplus represents an adverse variance of £1.6m from the planned position of £2.1m surplus of income over expenditure at the end of December 2015 be noted.
3. The Trust needs to continue to improve its controls to manage risks on the use of agency staff, discretionary expenditure and accelerate the delivery of its Cost Improvement Programme to bring the overall position back in to line with plan as soon as possible.
4. The new Monitor risk assessment framework shows a Financial Sustainability Risk Rating of 3.
5. Actions to address the issues identified in this report will continue in 2015/16 and progress will continue to be reported monthly to the Finance and Performance Committee and the Foundation Trust Board.

**005/16 INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK**

The Finance Director presented the Integrated Performance Framework Report and drew attention to the key highlights on performance where despite rising referrals the Trust continues to meet the 18 Week Referral To Treatment (RTT) standard at Trust level for incomplete pathways as it has done each month this financial year. Again, despite rising referrals, the Trust has met the 14 day cancer target for patients urgently referred by their GP in November and for patients referred urgently with non-cancer breast symptoms. Based on reduced activity in December the 14 day cancer standard is predicted just to be missed for the quarter for urgent GP referrals and will be achieved for patients urgently referred with non-cancer breast symptoms. The Trust continues to meet the 31 day cancer targets, having achieved the standard in each month of this year. The Trust exceeded the recovery plan for the 62 day cancer standard in December 2015. The percentage of stroke patients spending 90% of their time on a stroke ward at over 81% continues to exceed the 80% target. Cancelled operations performance has improved.

The key issues are GP referrals which are running at higher levels than last year and were 2.9% over last year at the end of December 2015. There is little evidence that the demand management schemes are having an impact. Emergency department admissions continue to increase and at the end of December 2015 were 6.9% over plan. Whilst the number of ambulance handovers delayed over 30 and 60 minutes continues to run below the total for last year, there are surges which cause difficulties for the Trust. Partner co-operation is not

always readily available. There was one patient reportable MRSA patient in December 2015. In November 2015 there was a pre 48 hour case of MRSA bacteraemina. In December 2015 there was one Never Event. The percentage of eligible patients with VTE risk assessment continues to fall but remains above the trajectory.

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

- The Chair asked for the background to the 62 day cancer standard exceeding the recovery plan in December 2015. In response, the Director of Service Delivery said that the support of the Intensive Support Team has helped where there has been a steady improvement in performance over the last three months. Since October 2015 there had been an increase of approximately 100 urology patients.
- In response to a question from Mrs Bond, the Director of Service Delivery undertook to updated the Board at the February 2016 meeting on the reasons for the Acute Kidney Infection CQIN being red risk-rated. **EG**

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.

**006/16 EMERGENCY PATHWAY REPORT**

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

- The 95% four hour target for Emergency Department performance was not successfully met in December 2015 with Trustwide performance reported as 82.6%.
- The issues to performance are the number of attendances and admissions compared to the same period in 2014 and the increase in ambulance handover delays.
- In December 2015 there was one trolley wait in the Emergency Department greater than 12 hours due to an exceptional clinical condition.
- In December 2015 there was a clear directive from NHS England, Monitor and the Trust Development Authority for 20% of hospital beds to be available on Christmas Eve. This the Trust achieved however on 28 December 2015 bed occupancy was at capacity. During the first week of January 2016 little surgery work was undertaken as a result of demand during the Christmas period.
- The key actions are to support joint working with the Monitor Operational Support Team and work with the Clinical Commissioning Group, Gloucestershire Care Services and Gloucestershire County Council on the system-wide actions on the work of the recently-established Focus Group, revisiting single point of access, Intensive Discharge Team and increased escalation to ensure safe care for patients. The Monitor Team are visiting the Trust on the day of the Committee meeting. There is increased escalation to partner organisations. The period from January to March 2016 will be challenging. The Clinical Commissioning Group is to spend an

additional £2m on nursing homes beds for the community.

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

- Mrs Bond said that patients with minor injuries are attending ED when they should be attending the Rapid Response Team. The Director of Service Delivery said in response that locum doctors were unaware of the facility especially during the Christmas and New Year period.
- Mr Mitchell said the Emergency Department performance remains red risk rated and with the Monitor Support Team asked when it is anticipated that the trajectory will be reached. The Director of Service Delivery said that a robust action plan is in place and the Trust is speaking to Monitor on a weekly basis. The health system is committed to achieving performance at over 90% but he was not able to give a timeframe.

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

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

**007/16 BOARD STATEMENTS**

The Finance Director presented the report advising that the Trust is required to confirm the following Board statements:-

- *For Finance that:* The Board anticipates that the Trust will continue to maintain a financial sustainability risk rating of 3 for the financial year 2015/16.
- *For Governance that:* The Board is satisfied that plans in place are sufficient to ensure: on-going compliance with all existing targets as set out in the compliance framework and a commitment to comply with all known targets going forwards.
- *Otherwise:* The Board confirms that there are no matters arising in the quarter requiring an exception report to Monitor which have not already been reported.

The report set out the issues that the Board must consider in making these declarations.

The Chair thanked the Finance Director for the report.

**RESOLVED TO RECOMMEND:** that:-

1. The Board expects that the Trust will continue to maintain a Financial Sustainability Risk Rating of 3 for the 2015/16 financial year however this is not without a significant challenge that will require ongoing rigour across the Trust's activities, particularly regarding the delivery of its Cost Improvement Programme

2. An exception report is made to Monitor on the A&E 4 hour standard and Cancer 62 day standard. The Trust will continue working with Monitor and partners across the health system to design and deliver performance improvement plans and improve performance on these targets in the remainder of the 2015/16 financial year and

moving in to 2016/17.

3. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all other existing targets as set out in the compliance framework and a commitment to comply with all known targets going forward.

## 008/16 UPDATE ON PAY EXPENDITURE

*(Mr Dave Smith, Director of Human Resources and Organisational Development attended the meeting for the discussion of this item)*

The Director of Human Resources and Organisational Development presented the report updating the Committee on the Trust's overall position in terms of nurse recruitment and temporary staffing expenditure following the paper presented to the Committee in May 2015. He focused on nursing supply, retention and reducing agency spend. With regard to nursing supply, he stressed that the Trust is doing all that it can to increase the supply of nurses including recruiting newly-qualified nurses, UK-based overseas qualified nurses, Philippines and Greece and UK based experience nurse recruitment. Due to staff turnover the number of permanent nurses was not increasing dramatically. Secondly, Medicine Division Band 5 nurse turnover is 25%. The Divisional Nursing Director is personally undertaking exist interviews with all staff to ascertain the reasons for leaving particularly on the General and Old Age Medicine (GOAM) wards. New starters are receiving a questionnaire of their experience with the Trust after three month which is repeated at nine months. The recruitment and retention premiums are beginning to have an impact although the "golden hello" is seen as an issue amongst staff. Thirdly, further work is required to reduce agency costs.

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

- The Chair said that the concern is the cost of agency spend and the ability of the Trust to control it. He sought assurance that the Divisional Nursing Directors are challenging requests for agency staff. He referred to the introduction of the Monitor agency cap from 1 February 2016 and the Trust's ability to comply. Some frameworks remain above the Monitor rates and some are not supplying staff. He acknowledged that the Trust should always act in the interests of patient safety. The Director of Human Resources and Organisational Development said that the Trust will need to determine a date in the near future when the Trust will cease to use the most expensive Thornbury agency nurses.
- Mr Foster said that all Trusts should join together and determine that they will cease to use Thornbury agency nurses. The Director of Service Delivery said that the Trust no longer uses Thornbury HCAs. Some framework agencies are not able to supply certain nurse specialities thereby making it necessary to use Thornbury nurses. Bath Hospital have removed the need for agency nurses.
- In response to a question from Mrs Bond about the inability to recruit and retain nurses to GOAM wards, the Director of Human Recourses and Organisational Development explained that there is a case for employing Band 2 nurses in GOAM wards to assist Band 5 nurses. Some staff start in GOAM wards and then move to other wards within the Trust thereby

creating vacancies.

- Mrs Bond asked for information on the flexible working arrangements offered by the Trust. In response, the Director of Huma Resources and Organisational Development said that there are 30 shifts available on the nursing roster and approximately five are used on the wards. The majority of nurses work part-time and Ward Managers are encouraged to offer flexibility in the working arrangements either on a shift pattern or staff can choose the shifts they wish to work. There is a perception that staff are not, for example, able to work permanent nights or three long days if that is suitable to them which needs to be removed. School term time contracts are offered.
- The Chair said that the Committee should consider in April 2016 the work currently being undertaken by the Divisional Nursing Director for Medicine to determine what can be done differently to recruit and retain staff. The Trust should learn from the work undertaken in Bath. **DS/SM (MW to note for Agenda)**

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

**RESOLVED:** That the actions set out in the report be endorsed.

**009/16 CANCELLED OPERATIONS UPDATE**

The Director of Service Delivery presented the report providing an update on cancelled operations since the report presented to the Committee in May 2015 and covered the 2015/16 financial year. With the exception of December 2015, cancellations have not achieved the 0.8% target for any month in 2015/16. However, overall the cancellation rate has improved from the previous year. In September, October and November 2015 there was an increase in cancellations as a consequence of having no beds. Actions are being taken to improve performance. Cancellations on the day of surgery remain a risk during times of increased pressure in emergency activity. All efforts are being made to mitigate cancellations.

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

- In response to a question from Mr Foster, the Director of Service Delivery said that the Theatre Efficiency Group is looking to improve theatre utilisation to between 78% and 80% during the next quarter and then to 82%. The Theatre Team are supportive of this approach and wish to undertake the work.
- Mrs Bond said that there should be no cancellations due to the lack of equipment and list overruns should be challenged. Mr Foster suggested that the whole system of theatre efficiency should be considered and it was agreed that this should be at the next meeting in February 2016. The Director of Service Delivery commented that there could be a reduction in the number of theatres required if the whole process became before more efficient. **EG (MW to note for Agenda)**
- Mrs Bond said that consideration needs to be given when performance will become green risk rated.

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

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

**010/16 DEBTORS UPDATE**

The Finance Director presented the report providing an update on the debtors position of the Trust for December 2015. The discussion of debtors took place in minute no 004/16 above.

The Chair thanked the Finance Director for the report.

**RESOLVED:** That the level of outstanding debt and the additional actions being taken to reduce it be noted.

**011/16 CAPITAL PROGRAMME UPDATE**

The Finance Director presented the report providing an update on the Capital Programme as at December 2015. The capital expenditure at December 2015 is 9% behind plan. Information Management and Technology schemes are currently over plan, but it is anticipated that expenditure will be in line with plan at year end. Work has started to agree the capital budget for 2016/17 with the amount available for capital expenditure mainly driven by the surplus which the Trust makes and the level of depreciation charged within income and expenditure. The proposed capital budget for 2016/17 is £10.7m excluding charitable funding expected to be approximately £250K.

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

- Mr Foster referred to the proposed capital programme for 2016/17 which was lower than the current programme and asked about the impact on schemes proceeding. The Finance Director said that the wi-fi installation for SmartCare has been undertaken in the current financial year which was non-recurring. It was understood that the amount available for 2016/17 would be lower. Mrs Bond added that there are risks in not undertaking projects particularly around the Trust's estate referring to the issues in Hazleton Ward which arose as a result of lack of maintenance investment.
- The Director of Service Delivery said that the Medical Equipment Capital Fund is looking at bids for capital equipment to ensure that there is an order of priority.

The Chair thanked the Finance Director for the report.

**RESOLVED:** That the current position of the Capital Programme and the additional work outline in relation to finalising the 2015/16 and planning for 2016/17 be noted.

**012/16 PROGRESS UPDATE ON 2015/16 CONTRACTING PROCESS**

The Finance Director presented the report updating the Committee on progress to the 2015/2016 Contracting Process stating that the Trust continues to negotiate with the Clinical Commissioning Group and specialist services on the additional costs resulting from the volume and premium cost of agency nurses to help meet demand.

Negotiations also continue on the lack of progress of effective demand management schemes.

The Finance Director referred to a recent conversation with Monitor on the 2015/16 financial position where there is a requirement to further reduce expenditure. The Trust is working well on the areas identified by Monitor but there is a greater need to focus on reducing agency expenditure. She then drew attention to the Monitor Sustainability and Transformational funding offer for 2016/17 which was to be considered by the Board later in the week. The Committee considered the offer noting that all the information in the offer was not currently available. On balance the Committee were of the view that the offer should be accepted and that would form part of the Board discussion. The Chair thanked the Finance Director for the report.

**RESOLVED:** That progress made in managing the 2015/2016 contracts and that negotiations have commenced in relation to 2016/17 be noted.

**013/16 NOTES OF THE EFFICIENCY AND SERVICE IMPROVEMENT BOARD MEETING HELD ON 13 JANUARY 2016**

The Finance Director presented the notes of the meeting of the Efficiency and Service Improvement Board held on 13 January 2016.

The Chair thanked the Finance Director for the notes.

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

**014/16 FINANCE AND PERFORMANCE COMMITTEE WORK PLAN**

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

February 2016 – Add Theatre Efficiencies and Cost Improvement Update

April 2016 – Add Pay and Staff Retention Update

May 2016 – Delete Cancelled Operations

**015/16 ANY OTHER BUSINESS**

There were no further items of business.

**016/16 DATE OF NEXT MEETING**

The next meeting of the Gloucestershire Hospitals NHS Foundation Trust Finance and Performance Committee will be held on **Wednesday 24 February 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 15 February 2016**.

The meeting closed at 12.18 pm

**Chair**
**24 February 2016**

# MINUTES OF THE AUDIT COMMITTEE MEETING HELD ON 22 JANUARY 2016 AT 2.15PM IN THE BOARDROOM, NO 1 COLLEGE LAWN, CHELTENHAM

**Present:**

| | | |
|---|---|---|
| Mrs Anne Marie Millar | (AM) | Non-Executive Director Chair |
| Mrs Helen Munro | (HM) | Non-Executive Director |
| Mr Clive Lewis | (CL) | Non-Executive Director |

**In attendance (by invitation):**

| | | |
|---|---|---|
| Mrs Helen Simpson | (HS) | Finance Director & Deputy CEO |
| Mr David Bacon | (DB) | Interim Deputy Director of Finance |
| Mr Alan Thomas | (AT) | Lead Governor |
| Mr John Golding | (JG) | Partner, Grant Thornton (GT), External Audit *(except for Items 005/16 and 016/16)* |
| Mr Kevin Henderson | (KH) | Grant Thornton (GT), External Audit *(except for Items 005/16 and 016/16)* |
| Mr Peter Stephenson (part) | (PS) | Price Waterhouse Coopers (PWC), Internal Audit *(except for Item 017/16)* |
| Mr Sam Elwell (part) | (SE) | Price Waterhouse Coopers (PWC), Internal Audit *(except for item 017/16)* |
| Mr Andrew Seaton | (AS) | Director of Safety |
| Mr Lee Sheridan (part) | (LS) | Local Counter Fraud Specialist *(representing Mrs Cheung for Item 006/16)* |
| Mrs Alex Gent (part) | (AG) | Interim Head of Shared Services *(Items 004/16 and 005/16 only)* |
| Mr Philip Hopwood (part) | (PH) | Interim Head of Shared Services *(Item 008/16 only)* |
| Mr Martin Wood | (MW) | Trust Secretary |
| Mrs Caroline Hounsell | (CH) | Interim Administrator |

**Apologies:**

| | | |
|---|---|---|
| Mrs Sallie Cheung | (SC) | Head of Counter Fraud Services |
| Mrs Lynn Pamment | (LP) | Partner, Price Waterhouse Coopers (PWC), Internal Audit |

**ACTION**

## 001/16 DECLARATIONS OF INTEREST

GT representatives were requested to leave the meeting when Agenda Item 6 External Audit Tender Process was due to be discussed – SE, LP and KH left the meeting for these items.

GT agreed to leave the meeting whilst Item 15 Review of External Audit Performance was discussed and PWC agreed to leave whilst Item 16 Review of Internal Audit Performance was discussed.

## 002/16 MINUTES OF MEETING HELD ON 10 NOVEMBER 2015

**RESOLVED:** That the minutes of the meeting held on 10 November 2015 were agreed as a correct record and signed by the Chair, subject to Mr Thomas being added to the list of apologies.

**003/16 MATTERS ARISING**

**46/15 Secondary Employment** - HS has discussed with Dr Mike Seely. Noted as complete.

**46/15 Future Benefits Report** – SE advised final report is still in draft and will update at next Audit Committee meeting 08/03/16. **SE**

**47/16 Deep Dive Review of Register Key Risks & Clinical Coding** – on agenda Items 12 & 13, complete.

**53/15 Theatre Utilisation** – Item 11 withdrawn as not a matter for the Committee. However, the Committee expected that it will be an area addressed in the consultant job planning report. **SE**

**54/15 Losses & Compensations Staff Education** – DB reported a second Border Agency visit was being arranged. The Chair advised it was important to demonstrate continued commitment to staff education - item noted and complete.

**54/15 Losses & Compensations Staff Overpayments** – HS advised work had been carried out around payroll and that the process has been tightened. DB added that the Finance Business Partners were reinforcing the need for budget holders to do the relevant paperwork in a timely manner. AG updated that the current process was to be changed from a manual paperwork system to an automated one, which should speed up the process – item noted as completed, as well as be updated on PWCS tracker report to March Committee

**55/15 External Audit 15/16 Audit Plan** – Item 8 on agenda – completed.

**56/15 Internal Audit Recommendations Tracker Patient Properties** – SE advised that following a review of last year, there are 3 recommendations still outstanding and these were being actioned – item noted as completed. **DB**

**56/15 Internal Audit Recommendations Tracker** – DB confirmed all 2015/16 recommendations are reflected on the tracker – Item 9 on agenda – completed.

**PWC**

**56/15 Internal Audit Agency Nursing** – DB advised the Trust was continuing to implement a number of initiatives around agency nursing and requested internal audit update the report before item is closed.

**58/15 Counter Fraud** – Item 10 on agenda – completed.

**59/15 Review of Trust Risk Register & Assurance Framework Cash Flow** – HS advised that the continued use of agencies, in particularly Thornbury who expect payment within 2 weeks and whose staff will leave if not paid, puts extra pressure on cash flow, adding that if agency use was reduced the cost would come down by approximately £1.0m. HS confirmed that in the event of the Trust's cash reserve dropping to £3.8m contingency arragements would come into play – completed. **AG**

**62/15 Shared Services Operational Activity** – AG to update at next meeting 08/03/16.

**62/15 Shared Services Board Agreement** – DB advised that in May 2015 the Board agreed, in principle, to a Shared Services Audit Committee. (Extract from May

Main Board Minutes - Item "151/15 SUMMARY OF THE MEETING OF THE AUDIT COMMITTEE HELD ON 19 MAY 2015 Shared Services Audit Committee: the establishment of a Shared Services Audit Committee with the 2gether Trust has been agreed. This will be a sub-committee of the Audit Committee and, subject to the agreement of the 2gether Trust, will be presented to the Board for approval.") – complete as a matter arising.

**004/16 REVIEW OF AUDIT COMMITTEE TERMS OF REFERENCE**

All agreed there are no issues with the current Audit Committee Terms of Reference; however the Chair noted that once the Share Services Audit Committee Terms of Reference are agreed then the Audit Committee's Terms of Reference should be updated to reflect this. **HS**

**DRAFT TERMS OF REFERENCE FOR SHARED SERVICES COMMITTEE**

AG summarised that following the required agreement in principle from the Trust Board, the Shared Services Committee would form a subcommittee of the Audit Committee. It was agreed the Shared Service Committee should start from 1st April 2016 and meetings would take place 3 times a year. It was noted that the Terms of Reference should include details of the following, in a recognisable format, agreed by both Trusts; **AG**

- Membership & Responsibilities
- Chair (it was agreed the Chair should be rotated on a yearly basis between the Trust and 2gether)
- Vice Chair
- Members
- Attendees
- Office
- Quorum (it was agreed there should be one NED and one Finance Director from each Trust, without which the meetings will not take place)

It was agreed the annual reports for the Audit Committee would include those of the Shared Services Committee.

HS, with involvement from MW, to share Terms of Reference with their counterparts in the 2gether Trust and update at the next Audit Committee on 08/03/16. **MW**

**RESOLVED:** That the report be noted

**005/16 EXTERNAL AUDIT RECRUITMENT UPDATE**

*As previously agreed JG and KH left the meeting for this item.* AG summarised stating that three tender submissions had been received, with presentations due on Friday afternoon (29/01/16). AG is requesting feedback from the suppliers who had decided not to tender.

**RESOLVED:** That the report be noted

*JG and KH return to the meeting.*

*LS entered the room for the following item.*

**006/16 COUNTER FRAUD PROGRESS REPORT**

It was agreed to move this item to earlier in the agenda. LS gave Mrs Cheung's apologies and as this would have been Mrs Cheung's last meeting, the Committee members wished to express their gratitude to Mrs Cheung for all her excellent hard work leading the Counter Fraud Service

LS summarised the report asking for feedback on the attachment piece, wishing to ensure it captures everything the Committee requested at the previous meeting. The Chair requested more detail on the Department's successes and achievements, including details of any fraud that had been avoided. LS advised that the April 2016 report will contain this level of detail.

The Chair asked if there had been any progress in stopping the 'health tourist'. LS advised the Trust was one of the best in the Country at managing this issue as it has longstanding relationships with Overseas Departments and communication was ongoing.

CL asked for clarification around why there seems to be a disproportionate amount of fraud linked to hospital staff. LS advised there are always peaks and troughs throughout the year and that due to the Department working hard to raise awareness among the staff this has probably led to an increase in referrals.

The Chair thanked LS for the report.

**RESOLVED:** That the report be noted

*LS left the meeting.*

**007/16 REPORTS FROM THE FINANCE DIRECTOR**

**Losses & Compensations**
DB highlighted that the majority of payments related to prescription charges. HM observed that the overseas visitors charges was been managed better. DB advised this was due to a combination of work carried out by the Trust and the Border Agency. However, sometimes an overseas patient is admitted due to a genuine emergency which makes it difficult to claim monies back. DB advised that one patient was stopped at Border Control and following some negotiation a cheque for £12,000 was obtained in payment of the Trust's invoices.

DB advised CL that some invoices are up to 2 years old and that the Trust use an overseas debt collection agency called CCI Legal to assist. Although CCI Legal charges a fee for their services, each case is reviewed to ensure it is worth pursuing and the fee is paid by the patient as part of the final invoice.

**RESOLVED:** That - 1. The ex gratia payments made be noted
2. The write off of 207 invoices totalling £19,727 be approved

**Single Tender Action**
AG summarised the report, answering HS's query that the increase in the number of actions is due to the renewal of SmartCare's contractors. This is to ensure the continuity of the project.

The Chair noted that the Estates requirement for a short term CSSD Service

Contract was perhaps due to the Trust's bad planning. The Chair suggested this should be reviewed so the reasons for the delays were better understood and would therefore not be repeated

**RESOLVED**: That the report be noted

**008/16 CLINICAL CODING UPDATE**

PH gave a brief presentation on the background and operation of coding at the Trust *(copy to be circulated with minutes)*.

CL thanked PH and asked whether coding was ever outsourced. PH advised that he was unaware of any Trust contracting out and this may be due to patient confidentiality.

*CL left the room.*

HM asked for clarification on how the figure of £2.6m savings was calculated. PH answered by giving an example of a knee replacement, which in the past would be coded as a full replacement but omitted the additional code for a patella button (something that is used on every replacement operation). Once clinicians were aware they needed to add this extra detail then the coders can record it and this generated an additional income of £500 per patient.

AT raised the subject of co-morbidities and that this was an area of focus for Dr Foster Intelligence. PH advised there is currently a data collection issue which the Trust is working on and that he will share the information once it is in a reportable format.

*CL returns to the meeting.*

JG asked how engaged the clinicians are in this process and PH advised there is a need to educate and that this involves getting the clinicians early in their training to embed the process.

HM suggested that the presentation should be made to the Quality Committee to link in with a presentation made at the last Committee meeting about the recording of co-morbidities.

**MW to note for Quality Committee Workplan**

The Chair thanked PH for the presentation, adding that coding is critical to maximise income and ensure accurate recording of outcomes. The Chair asked how the Committee were going to be kept up to date regarding the recruitment issues mentioned in the presentation. PH advised that the success of the recruitment and retention of the workforce would be measured indirectly in 6, 12 and 18 months' time by an increase in productivity, less pressure on the coders themselves and consistently achieving billing deadlines.

**RESOLVED:** That the report be noted

*PH left the meeting.*

**009/16 INTERNAL AUDIT**

**2015/16 Internal Audit Progress Report** – copy circulated at time of meeting. SE gave an overview of the report highlighting that Ref 15 SmartCare was agreed

yesterday and that discussions with Mr Vinay Takwale (Chief of Service for Surgery) Ref 11 Consultant Job Planning would begin soon.

The Chair asked for confirmation that SE was happy PWC are in line with the projected timeline and SE confirmed PWC are on schedule.

SE confirmed there were no other changes to report.

**RESOLVED:** That the report be noted

**2015/16 Performance Monitoring** – SE highlighted 3 key areas flagged as Medium Risk as 'The Decision to Treat (DTT) gap', 'Supporting Documentation for cases referred by other Trusts – Operating effectiveness' and 'Vacant slot reports'. The Chair noted the report as useful feedback. HS agreed the reports were very useful and following the recent significant increase in demand on services are keen for PWC to look at wider community services.

**RESOLVED:** That the report be noted and recommendations added to the tracker.

**Shared Services Internal Audit 2015/16 Phase 2** – SE highlighted page 2 of the report, noting that the issue of signatories is reducing but there is a recurrent issue of control reconciliations not been prepared and reviewed within the 20 working day target. HS added that the Trust take this seriously and, following a number of recent actions taken against one member of staff, should continue to improve. SE also highlighted that a significant proportion of credit notes had been raised and approved by one individual. DB added that this has been addressed and the process changed.

The Chair noted that corrective actions have been taken.

**RESOLVED:** That the report be noted

**2015/16 Completion of Business Cases** – SE noted that since the report was completed the Trust had undergone a change of structure for approval of business cases. HM added that it was unclear how long the process takes and asked what the lead time is for feedback to the Divisions/individuals submitting the business case.

HS advised that the process for business cases was quicker and simpler since the Business Development Group was disbanded and cases now go through Peer Review and are then determined at Efficiency & Service Improvement Board. . HS added that due to the current financial constraints, and the requirement for approval of all cases at ESIB, the process will be quicker, however, we cannot always match expectations unless a business case is approved.

HM reiterated that individuals/Divisions need to know when a decision will be received once a business case has been submitted.

The Chair requested DB/HS address the issues identified. **HS**

**Decision:** That the report be noted

**2015/16 Business Cases – Post Implementation** – SE highlighted the areas where action by the Trust is required. All members accepted the findings of the report, with HS adding that it was very helpful.

**RESOLVED:** That the report be noted

**2015/16 Business Continuity Follow Up** – SE advised that Countywide IT had implemented all the findings contained within the report and this item can be closed.

**RESOLVED:** That the report be noted

**2015/16 IT Stock Control** – SE advised that the audit had been carried out at the request of Counter Fraud. There is now a weekly reconciliation in place which means that the reporting 3 missing computer drives have since been returned.

**RESOLVED:** That the report be noted

**Risk Assessment and Internal Audit Plan 2016/17 DRAFT** – due to time constraints the Chair requested this report is deferred to the next Audit Committee meeting. SE requested that the Committee members read the report and feedback in March.

**RESOLVED**: That the report be deferred to 8 March 2016 Audit Committee meeting

**Recommendations Tracker –** current report noted and discussion deferred to March.

**RESOLVED:** That the report be noted and revisited on the 8 March 2016

*SE and PS leave the meeting.*

**010/16 EXTERNAL AUDIT**

**2015/16 Progress Report and emerging issues & developments** – KH noted from the Charitable fund accounts (2014/15) comment on page 7 that these have now been signed off. DB updated that a formal submission to the Charity Commission had also been completed.

KH advised that changes in accounting standards relating to asset disposal would not have an impact on the Trust.

HS advised there are changes in assets that have been scheduled and GT need to consider how this impacts on the Trust.

The Chair noted that according to the reports the Trust was progressing well. HS added that she and the Chief Executive are meeting with the CCG to formally request greater transparency on a number of items, including medically fit patients.

**RESOLVED:** That the report be noted

**Key Financial Indicators 2015** – KH advised that the original report included every Foundation Trust; however, at the request of HS, the report was narrowed to include only Acute Trusts. KH noted that this report was a benchmarking exercise. DB and HS disagree with some of the methodology of the calculations within the reporting. The Chair advised JG/HS to discuss the report in further detail and report back to the March Committee with an agreed position. The Chair added that this item should be high on the agenda to ensure adequate time for discussion. **JG/HS**

**RESOLVED**: That the report be deferred to March meeting

**2015/16 The Audit Plan for GHNHSFT** – JG highlighted the recent reduction in Grant Thornton's fees of £5,000. JG noted that all findings will be published in the Audit Findings Report once a number of risk assessments have been completed.

**RESOLVED:** That the report be noted

**2015/16 The Audit Plan for Charitable Fund** – Due to time constraints the report was not discussed but had been pre-circulated so was duly noted.

**RESOLVED:** That the report be noted

**011/16 REVIEW OF TRUST RISK REGISTER & ASSURANCE FRAMEWORK**

AS updated that this item had been debated at both TMT and the Board, with any changes being noted in Appendix 2. AS advised the next report would be more in-depth. The Chair asked if there were any questions from the Committee members, to which there were none, adding that she felt there was not enough time left to give this item the attention it required. Item to be listed nearer the start of the next agenda.

**RESOLVED:** That the report be noted

**012/16 AUDIT COMMITTEE WORKPLAN 2016**

In terms of planning, the Chair advised the next two meetings will be key. HS advised the 'seminar' listed for 8 March referred to a discussion on asset disposal and the impact on the Trust.

**RESOLVED:** That the report be noted

**013/16 REVIEW OF THE AUDIT COMMITTEE – PROPOSED SELF-ASSESSMENT CHECKLIST**

The Chair agreed the checklist should be determined and completed outside of the meeting. **HS/AM HM/CL**

**014/16 ANY OTHER BUSINESS**

None

**015/16 COMMITTEE REFLECTION & DEVELOPMENT**

HM suggested future agendas should be prioritised better so important items are not rushed. The Chair agreed, suggesting timings should be added. CL also agreed, adding that the inclusion of an 'end time' on the agenda was beneficial.

*The Chair thanked KH and JG and they left the meeting.*

**016/16 REVIEW OF EXTERNAL AUDIT PERFORMANCE**

The Committee reviewed the performance of the External Auditors.

*CL left the meeting.*

*The Chair thanked PS and SE who leave the meeting.*

**017/16 REVIEW OF INTERNAL AUDIT PERFORMANCE**

The Committee reviewed the performance of the Internal Auditors.

**018/16 DATE OF THE NEXT MEETING**

Tuesday 8 March 2016, 0900 am in the Boardroom, No 1 College Lawn, Cheltenham

THE MEETING ENDED AT 4.28PM

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**CHAIR**
**8 March 2016**

# GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

## MAIN BOARD – FEBRUARY 2016

## REPORT OF THE CHIEF EXECUTIVE

### 1. National

1.1 The negotiations of the new Junior Doctors contract have broken down and the Secretary of State has said that he will impose the new contract. Our Trust has yet to receive details of what the new arrangement will be.

1.2 NHS England have published "The Mental Health Five Year Forward View". It lists a range of recommendations which have been accepted by NHS England who plan to invest an additional £1 billion by 2020/21 in mental health services. NHS Providers summary is at Annex A.

### 2. Regional

2.1 The West of England Academic Health Service Network has voted not to continue to be a company limited by guarantee. The Network will be hosted by the Royal United Hospital NHS Foundation Trust as from 1 April 2016.

### 3. Regulators

3.1 NHS Improvement (Monitor's new name) has issued a document "Implementing The Forward View: Supporting Providers to Declare". It outlines expectations for the next 3 – 4 years. Copies of the summary document have been given to the Board and Council of Governors.

### 4. Our Trust

4.1 Pressure on emergency services remained high during January and into February.

4.2 Arrangements for the strike by junior doctors on 10th February were effective.

4.3 SmartCare continues to move forward to Phase 1 go live in May. Currently we are working through a possible problem in Pharmacy Stock Control but in patient areas the focus is on planning staff training from next month.

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

| You Said | We did |
|---|---|
| There are no drop in clinics for patients who need hearing aid repairs quickly | We have agreed that Gloucestershire Deaf Association will now be providing simple frontline drop in hearing aid repair clinics on behalf of the Trust around the county |
| It is very difficult to hear what the staff are saying over the general noise on the ward | We will make better use of the new listening devices |
| Carers need more information did not know about special arrangement for parking etc. | We realise the importance of keeping carers informed so we will look to adopt a carers notice board where possible and ensure that there are sufficient carers leaflets. |

4.5 The Risk Register is contained within the Assurance Framework discussed later on the agenda.

**Dr Frank Harsent**
**Chief Executive**

February 2016

on the day BRIEFING

the association of foundation trusts and trusts NHS providers

# THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH

**This briefing provides an overview of today's publication of *The Five Year Forward View for Mental Health*, the report from the independent Mental Health Taskforce to the NHS in England, led by Paul Farmer, Chief Executive, Mind. The briefing includes a chapter-based summary, NHS Providers view and our media statement.**

## OVERVIEW

The report provides a comprehensive account of the challenges facing the provision of mental healthcare in the NHS and sets out a ten-year strategy for change based on the key themes that emerged during the Taskforce's engagement work: prevention, access, integration, quality and a positive experience of care. There are 58 recommendations designed to:

- align the priorities and activities of six NHS arm's length bodies to achieve parity of esteem between mental and physical health for children, young people, adults and older people
- solicit wider involvement across other national and local agencies to improve the social care, housing and employment offer for people with mental health problems
- focus on tackling mental health inequalities at local and national level experienced by people living in poverty, who are unemployed and who are already marginalised.

The Executive summary is followed by thematic chapters containing the context and basis for the 58 recommendations. Annexes contain recommended principles for payment approaches for mental health set out the full recommendations organised by each national body responsible for delivery.

### Priority actions for the NHS by 2020/21

- A 7-day NHS providing the right care, at right time, at right quality including crisis care seven days a week, out of area placements reduced and eliminated as quickly as possible, liaison psychiatry, treatment times for first episode psychosis within two weeks of referral, expanding community based services for those with severe mental health problems, reducing suicide by 10 percent.
- Integrated mental and physical health approach including expanding access to perinatal mental health, meeting the physical health needs of people living with severe mental health problems and increasing access to psychological therapies
- Promoting good mental health and preventing poor mental health, including expanding access for more children and young people to access high-quality mental health care when they need it, supporting more people to find or stay in work with access to psychological therapies, a focus on creating mental healthy communities including housing and support for those in the criminal justice system, and finally building a better future with research and a data revolution.

For brevity this summary gives a high-level overview of main points in each of the thematic chapters and highlights the key recommendations that will involve or impact on members, or will influence how funding moves through the system to the frontline.

## Ch.1: Getting foundations right: commissioning for prevention and quality care

This chapter explores system level factors that are preventing service users and their families from having timely access to high quality, person-centred, integrated mental health services.

- The system now: the Taskforce found a two-fold difference in apparent per-capita spend on mental health by CCGs across England, high fragmentation of services due to split commissioning, and rising pressures due to local authority cutes to social care and residential housing.
  - The DWP's Work Programme has helped fewer than one in ten people with mental ill-health into work.
  - Achieving integrated population-based commissioning that incorporates specialised secondary services is critical for improving outcomes.

- The system in the future: a vision for how commissioning will function by 2021including:
  - locally developed Mental Health Prevention Plans that blend healthcare, social care and user-led support and encompass public mental health, the wider social determinants of mental health such as housing, stigma and negative attitudes and integrated physical and mental healthcare
  - commissioning that is informed by robust data, reflects a clear understanding of local population mental health needs and which is based on evidence-based analysis of proven prevention and intervention strategies, with freedom to work across health and social care locally
  - expansion of provider-led commissioning of specialised services into perinatal and CAMHS inpatient services, including through the new models of care program.

- The delivery plan by 2020/21: Priority actions to delivery the vision for commissioning include:
  - Health and Wellbeing Board plans to promote good mental health, prevent problems and improve services, based on local data, supported by local Mental Health Champions
  - co-production with clinicians and experts by experience, based on the 4PI framework developed by the National Survivor and User Network
  - rapid progress in transformation of services for children and young people
  - clearer national expectations of and support for local commissioners, greater flexibility in use of financial levers and full accountability for commissioners for outcomes.
  - supporting more people into work, improving access to supported housing and tackling fractured commissioning in adult services, including across secure services and the criminal justice system.

Recommendations 1 to 12 set out proposals for a national Prevention Concordat and local suicide prevention plans to incentivise greater joint-working amongst key partners at local level; funding for integrated services for people with co-morbid drug and/or alcohol and mental ill-health; dedicated resourcing and support for employment support services for service users; collaborative commissioning for specialised services; improved supported housing offer for vulnerable people with mental-ill health; and establishing local mental health champions for local communities.

| Key recommendations impacting on providers |
| --- |
| 5. By 2020/21, NHS England and the Joint Unit for Work and Health should ensure that up to 29,000 more people per year living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems (see Chapter Two) and doubling the reach of Individual Placement and Support (IPS). The Department of Work and Pensions should also invest to ensure that qualified |

employment advisers are fully integrated into expanded psychological therapies services.

8. NHS England should work with NHS Improvement to run pilots to develop evidence based approaches to co-production in commissioning by April 2018.

9. NHS England should ensure that by April 2017 population-based budgets are in place which give CCGs or other local partners the opportunity to collaboratively commission the majority of specialised services across the life course. In 2016/17, NHS England should also trial new models through a vanguard programme that allow secondary providers of these services to manage care budgets for tertiary (specialised) mental health services to improve outcomes and reduce out of area placements.

## Ch.2: Good quality care for all seven days a week

This chapter sets out the Taskforce's view of the current barriers to timely access to effective, good quality, evidence-based mental health pathways with clear waiting times. Key issues include:

- under-developed capacity and models of support in primary healthcare
- no comprehensive set of standards for care quality in mental health, underpinned by robust outcomes data
- excessive waiting times for crisis and specialist secondary care, rising thresholds for access and resulting increases in acuity of need, rising costs of care and poorer outcomes from treatment and recovery
- intense pressures on adult mental health services, as found by the Independent Commission on acute adult inpatient care , resulting in unmanageably high bed occupancy rates and out of area placements
- too little availability of comprehensive liaison mental health services including for older people
- lack of recovery-focused care and suitable step-down services, including integrated care for co-morbidities
- equality challenges as evidenced by disproportionately high BME representation in secure settings
- poorly integrated physical and mental healthcare services.

To address these problems, the Taskforce recommendations 13 to 24 include:

- nation-wide roll-out of comprehensive clinical standards referral to treatment and recovery, including maximum waiting times for NICE-recommended care, based on the ambitions set out in Achieving Better Access to Mental Health Services by 2020/21 and the Five Year Forward View, in accordance with a proposed phased roll-out timetable
- waiting times should be informed by clinical evidence and should be for effective care in line with NICE recommendations
- all services should routinely collect and publish outcomes data.

### Key recommendations impacting on providers

17. By 2020/21, NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission. For adults, NHS England should invest to expand Crisis Resolution and Home Treatment Teams (CRHTTs); for children and young people, an equivalent model of care should be developed within this expansion programme.

18. By 2020/21, NHS England should invest to ensure that no acute hospital is without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals are meeting the 'core 24' service standard as a minimum.

21. NHS England should ensure that people being supported in specialist older-age acute physical health services have access to liaison mental health teams – including expertise in the psychiatry of older adults – as part of their package of care, incentivised through the introduction of a new national Commissioning for Quality and Innovation (CQUIN) framework or alternative incentive payments, and embedded through the Vanguard programmes.

22. In 2016, NHS England and relevant partners should set out how they will ensure that standards are introduced for acute mental health care, with the expectation that care is provided in the least restrictive way and as close to home as possible. These plans should include specific actions to substantially reduce Mental Health Act detentions and ensure that the practice of sending people out of area for acute inpatient care as a result of local acute bed pressures is eliminated entirely by no later than 2020/21. Plans should also include specific action to substantially reduce Mental Health Act detentions and targeted work should be undertaken to reduce the current significant overrepresentation of BAME and any other disadvantaged groups within detention rates. Plans for introduction of standards should form part of a full response to the Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, by no later than end 2016/17.

## Ch. 3: Innovation and research to drive change now and in the future

The Taskforce argues that national bodies should stimulate innovation at local level, building on progress already made through initiatives such as the Crisis Care Concordat, to incentivise the transformation to improve the quality and productivity of services. Alongside the recommended development of quality standards for mental health, the Taskforce's recommendations 25 to 31 propose measures to help deliver:

- greater innovation in new models of care including through the current PACS, MCP and UEC Vanguards
- expanding access to digital services and strengthened mental health research
- a system-wide approach to quality improvement.

| Key recommendations impacting on providers |
|---|

25. The MCP, PACS, UEC Vanguards and the Integrated Personalised Commissioning programme should be supported to ensure that the inclusion of payment for routine integrated care adequately reflects the mental health needs of people with long-term physical health conditions. Vanguard sites should also provide greater access to personal budgets for people of all ages, including children and young people who have multiple and complex needs, to provide more choice and control over how and when they access different services.

30. NHS England and NHS Improvement should encourage providers to ensure that 'navigators' are available to people who need specialist care from diagnosis onwards to guide them through options for their care and ensure they receive appropriate support. They should work with HEE to develop and evaluate this model.

31. NHS England should work with CCGs, local authorities and other partners to develop and trial a new model of acute inpatient care for young adults aged 16–25 in 2016, working with vanguard sites.

## Ch.4: Strengthening the workforce

The Taskforce identified multiple pressures on the current mental health workforce due to:

- rising vacancies especially in community mental health teams, the significant growth in referral rates for secondary services particularly in CAMHS, and morale pressures due to work pressures and, for NHS staff more broadly, inadequate training to respond effectively and compassionately to people in mental health crisis

- NHS mental health staff are exhibiting high rates of stress and half of psychological professionals are reporting they experience depression, but the quality and availability of staff wellbeing and occupational health support for mental health professionals is highly variable across employers
- while the profile of mental health care is growing and there is recent evidence of some increased interest in mental health as a profession, Public Health England's 'public mental health leadership and workforce development framework' should be expanded.

Recommendations 32 to 38 are therefore designed to improve the planning and coordination of a national mental health workforce strategy; expand staff wellbeing and occupational health programs; build basic mental healthcare skills for all frontline health and justice system staff especially primary care; and expand service user and carer involvement to ensure personal preferences are more effectively encompassed and understood within care planning.

| Key recommendations impacting on providers |
| --- |
| 34. NHS England should introduce a CQUIN or alternative incentive payment relating to NHS staff health and wellbeing under the NHS Standard Contract by 2017. |
| 35. NHS England should develop and introduce measures of staff awareness and confidence in dealing with mental health into annual NHS staff surveys across all settings. |
| 37. The Department of Health should continue to support the expansion of programmes that train people to qualify as social workers and contribute to ensuring the workforce is ready to provide high quality social work services in mental health. This should include expanding 'Think Ahead' to provide at least an additional 300 places. |

## Ch.5: A transparency and data revolution

In focusing on data and transparency, the Taskforce examines the current state of data (a "black hole of data"), highlights the need for a transparency revolution and sets out considerations for putting in place data plans. The starting point is that consistent, reliable data lags other areas of health, and often good information is not co-ordinated or analysed usefully. Issues covered include:

- The Mental Health Services Data Set only began operating on 01 February 2016 and reporting capability has not been tested. Prior to that reporting was sporadic. Changes to the dataset can take more than a year and the data is not helpfully grouped;
- Financial reporting is not consistently available in mental health. Provider data is linked to clusters, the reference costs are variable and clusters do not align with NICE recommended care so obscure the funding picture. CCGs report mental health finances under one heading only, not by condition.
- A lack of appropriate data sharing and linked data sets is hampering a holistic appropriate to planning and delivering care.
- To tackle these issues the report proposes, amongst other things:
  - The National Information Board to lead on collecting the right kind of mental health data at the right time, starting with a stock take of data to ensure it is meaningful and aligned with national priorities.
  - Routine data collection for everyone receiving care, with national datasets including information on diagnosis, interventions and outcomes linked to other datasets. This data should be accurate, relevant and timely.
  - Public Health England leading to make the National Mental Health Intelligence Network the trusted national repository
  - New funding to develop HSCIC data collection

- Work to link data across public agencies

Recommendations 39 to 46 focus on the detail needed for delivery of the data revolution, in particular focusing on robust data on the commissioning of mental health services.

| Key recommendations impacting on providers |
|---|
| 40. The Department of Health should develop national metrics to support improvements in children and young people's mental health outcomes, drawing on data sources from across the whole system, including NHS, public health, local authority children's services and education, to report with proposals by 2017. |
| 42. NHS England and the HSCIC should work to identify unnecessary data collection requirements, and then engage with NHS Improvement to prioritise persistent non-compliance in data collection and submission to the MHSDS, and take regulatory action where necessary. |
| 45. The Department of Health and HSCIC should advocate the adoption of data-rich Summary Care Records that include vital mental health information, where individuals consent for information to be shared, by 2016/17. |

## Ch.6: Incentives, levers and payments

The report identifies an uneven playing field in mental health, with the need to both reverse years of under-investment in mental health services and the need to reform the way in which services are paid. Therefore to create a level playing field, Recommendations 47 to 50 seek to deliver:

- moving away from using block contracts
- implementing the two new payment models for adult care – either year of care/episode of care or capitation-based payments
- incentivising better integration between physical and mental health through payment systems with adjustment to account for inequalities, and physical health providers reimbursed for meeting mental health needs (which will require coding changes)
- incentivising swift access, high quality care and good outcomes, using broader
- robust support for commissioners and providers from both NHS England and NHS Improvement to introduce new payment approaches.
- use of levers such as the standard contract, CQUINs, quality premiums, sanctions and regulations to encourage good performance
- funding formulae reviewed to ensure they support parity between mental and physical health
- reporting by CCGs on how their spending is related to need, access and outcomes for mental health.

| Key recommendations impacting on providers |
|---|
| 47. NHS England and NHS Improvement should together lead on costing, developing and introducing a revised payment system by 2017/18 to drive the whole system to improve outcomes that are of value to people with mental health problems and encourage local health economies to take action in line with the aims of this strategy. This approach should be put in place for children and young people's services as soon as possible. |
| 48. NHS England should disaggregate the inequalities adjustment from the baseline funding allocation for CCGs and primary care, making the value of this adjustment more visible and requiring areas to publicly report on how they are addressing unmet mental health need and inequalities in access and outcomes. |

49. ACRA should review NHS funding allocation formulas, including the inequalities adjustment, to ensure it supports parity between physical and mental health in 2016/17. They should also be reviewed to ensure they correctly estimate the prevalence and incidence of conditions across the mental health spectrum. Membership of ACRA should be revisited with the specific goal of ensuring that mental health expertise is adequately represented across the disciplines involved, e.g. clinical, academic, policy and providers.

50. The Department of Health and NHS England should require CCGs to publish data on levels of mental health spend in their Annual Report and Accounts, by condition and per capita, including for children and Adolescent Mental Health Services, from 2017/8 onwards. They should require CCGs to report on investment in mental health to demonstrate the commitment that commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall allocation increase.

## Ch.7: Fair inspection and regulation

The starting point for this chapter is that legislation and regulation underpinning mental health needs to be improved. Amongst the key points it makes are the need to:

- review provisions of the 1983 mental health act to promote parity with physical healthcare and ensuring that the full range of people's human rights are protected
- create parity between an individual's rights to physical and mental health care in the NHS Constitution (eg accessing consultant-led treating within 18 weeks) which means no legal right to recommended interventions or maximum waiting times
- strengthen inspection of mental health in primary and acute physical healthcare settings;
- measure people's experience of inpatient mental health care, including secure care;
- prioritise the implementation of the Crisp Commission recommendations on inequalities;
- improve the quality of internal investigations into preventable deaths

By 2020/21 the report envisages:

- A review of mental health capacity legislation should be applied in the use of the Mental Health Act to detail a person for compulsory treatment
- An updated inspection system covering all aspects of mental health provision in all settings and all physical and mental health care pathways
- Implementing the 'Future in Mind' recommendation to develop a CQC/OFSTED joint view on how health, education and social care are working together to improve mental health for children and young people;
- Extending the scope of the Healthcare Safety Investigation Branch to deaths from all causes in inpatient mental health settings, with attendant scrutiny of the quality of the investigation, local and national trends and evidence that learning is leading to improvement

This chapter includes recommendations 51 to 57, six of which are relevant to, or impact directly on mental health trusts and foundation trusts.

### Key recommendations impacting on providers

52. The Department of Health should carry out a review of existing regulations of the Health and Social Care Act to identify disparities and gaps between provisions relating to physical and mental health services. This should include considering how to ensure that existing regulations extend rights equally to people experiencing mental health

problems (e.g. to types of intervention that are mandated, to access to care within maximum waiting times).

53. Within its strategy for 2016–2020, the CQC should set out how it will strengthen its approach to regulating and inspecting NHS-funded services to include mental health as part of its planned approach to assessing the quality of care along pathways and in population groups.

56. The Department of Health should ensure that the scope of the Healthcare Safety Investigation Branch includes deaths from all causes in inpatient mental health settings and that there is independent scrutiny of the quality of investigation, analysis of local and national trends, and evidence that learning is resulting in service improvement.

57. NHS Improvement and NHS England, with support from PHE, should identify what steps services should take to ensure that all deaths by suicide across NHS-funded mental health settings, including out-of-area placements, are learned from, to prevent repeat events. This should build on insights through learning from never events, serious incident investigations and human factors approaches. The CQC should then embed this information into its inspection regime.

## Ch.8: Leadership inside the NHS, across government and in wider society

This final chapter covers broader implementation issues and how key parts of the system will be held to account. The report identifies that implementing the strategy for mental health will require robust leadership. Following a review by the Centre for Mental Health it sets out the 12 key elements of successful delivery (leadership, focus, funding, incentives, workforce, scrutiny, public opinion, partnerships, implementation, management and time). It also identifies there needs to be a robust governance framework with NHS England as the lead arms length body, and a new cross-ALB programme board. The framework should embed co-production, ensure the necessary level of resource nationally to oversee implementation and also appoint an equalities champion to focus on mental health inequalities.

In terms of investment, the report is clear that the strategy cannot be implemented without additional investment, with at least £1 billion available in 2020/21. Whilst the expectation is to broaden access, it recognises that these changes will take time. Therefore initial focus (2016/17) is on consolidating and expanding children and young people's services, perinatal care and Early Intervention in Psychosis, whilst laying the foundations for all priorities for action from 2017/18 onwards.

It also proposes that, at a minimum from 2016/17 CCGS would be expected to demonstrate how they will increase investment in mental health services in line with their overall increase in allocation each year or in line with the growth in recurrent programme expenditure.

The final, 58th recommendation in the report, asks for NHS England and the Department of Health to work with the Cabinet Office to determine by no later than summer 2016 the necessary governance arrangements needed to support delivery of the proposed strategy for improving mental health services put forward by the Taskforce, including public reporting on progress, and the appointment of a national mental health equalities champion.

## NHS PROVIDERS VIEW

We welcome today's publication of report from the independent taskforce on mental health. The report is comprehensive in its account of the challenges facing NHS mental health care, both within the health system and broader economic and social context both nationally and locally. It places a much needed focus on all elements of mental health provision, and acknowledges the scale of the task and signifies a new era in actions to reduce stigma.

We also welcome the Taskforce's recommendations that a number of areas remain centre stage: crisis care and building on the progress at local level of the crisis care concordat, widening access to a number of services including perinatal mental health and the need for sustained and further investment in liaison psychiatry.

The Taskforce reinforces points that our mental health providers and other partners across the system have been making for a long time – substantial underfunding and disinvestment over a number of years have led to mental health services being inadequately resourced to meet rapidly growing numbers, severity and complexities of mental health need. From a provider perspective we especially welcome the focus on reforming two key areas – the importance of commissioning and the need to transform data.

Despite this specific focus, there remain some unanswered questions about how the Taskforce's recommendations can be taken forward to deliver real change for services users:

- there is insufficient detail to appraise how the announced funding and investment works in practice. However, it is clear that funding will need to be linked to the introduction of further standards for mental health services, and the report sets out a roadmap for delivery of these standards over the next five years.
- It is also not clear given the scale of financial challenge in the NHS whether the Taskforce's recommended improvements have been funded adequately as none of the underpinning financial impact assessment is included in the report. There is also no upfront funding to support sustainability and transformation in mental health services.

Finally, although there is reference to the recently published findings and recommendations of the Independent Commission on acute adult inpatient care, led by Lord Crisp, the recommendations they made are not fully followed through. This is disappointing given the substantial contribution the Crisp report has already made to understanding the local and national context for the pressures on acute adult inpatient beds in mental health and factors impeding in-community care. .

In summary, the Taskforce report leaves much up in the air including full detail on implementation, governance arrangements and the flow of additional funding to frontline services. And although it ties in to wider NHS initiatives such as the New Care Models programme in the Five Year Forward View, it does not appear to fully join up and integrate with the range of programmes and initiatives already in place to improve the quality of provision in mental health.

## Media statement

### Taskforce report provides an ambitious programme of support and greater access

An independent Mental Health Taskforce, commissioned by NHS England as part of the NHS five year forward view and chaired by Mind chief executive Paul Farmer, has been published today.

Commenting in response to the taskforce, Saffron Cordery, director of policy and strategy at NHS Providers, said:

"Everyone in the mental health community should welcome this report. It provides important focus on what service users and patients experiencing every type of mental ill health need – an ambitious programme of support and greater access to services.

"However, against the backdrop of extensive financial challenge in the NHS, it remains to be seen whether the proposals set out in the report are genuinely affordable. It is notable that there is no additional upfront investment to help deliver what is an ambitious agenda outlined in the report. In acute services we are seeing substantial investment in transformation – it would be helpful to follow suit in mental health and community services. "

"The report rightly focuses on the need to get commissioning for mental health right, and makes a welcome intervention on data and transparency: we know the right kind of information, analysis and intelligence has been a low priority in mental health and that must change. This lack of transparency has held back progress in mental health.

"In particular, we welcome the emphasis in the report on crisis care, widening access to a range of services including perinatal mental health, improving the support people with mental health problems receive for their physical health needs; and highlighting the importance of physical and mental health together, including investment in liaison psychiatry.

"We will work with our members – providers of NHS mental health, acute, community and ambulance services – to identify what the recommendations in this extensive report mean for them and their service users and patients."

## CONTACT INFORMATION

Cassandra Cameron, Policy Advisor, cassandra.cameron@nhsproviders.org

# INTEGRATED PERFORMANCE MANAGEMENT FRAMEWORK

## EXECUTIVE SUMMARY

## TRUST BOARD – FEBRUARY 2016

### 1.0 INTRODUCTION

This report summarises the key highlights and exceptions in Trust performance up until the end of January 2016 for the financial year 2015/16.

### 2.0 KEY HIGHLIGHTS ON PERFORMANCE

- GP referrals continue to run at higher levels than last year and were 3.0% over last year at the end of January. Despite these rising referrals the Trust continues to meet the 18 Week RTT standard overall at Trust level for incomplete pathways as it has done each month this financial year.

- The Trust met the 31 day Cancer targets in quarter three of the year, having achieved the standards in each previous quarter this financial year.

- The Trust met the recovery trajectory for the 62 day cancer standard for the third quarter of the financial year.

- The percentage of stroke patients spending 90% of their time on a stroke ward at over 81% continues to exceed the 80% target.

- The Trust continues to see benefits from its carbon energy reduction programme which is achieving its targets.

- The percentage of staff who have completed their mandatory training has exceeded the Trust's target each month this financial year.

### 3.0 AREAS OF EXCEPTION ON PERFORMANCE

- Emergency admissions continue to run at levels over the plan for the year, ending as 6.8% over plan at the end of January. The percentage of patients spending less than 4 hours in the Emergency Department was 80.1% compared to the target of 95%. A recovery plan is in place. Year to date the number of ambulance handovers delayed over 30 and 60 minutes continues to run below the total for last year, although in January the number of handovers delayed over 30 minutes exceeded the number in the same month last year.

- The number of delayed discharges at month end and the number of medically fit patients remaining in a hospital bed continue to run at high levels and above agreed system wide standards. This inability to discharge has impacted on our performance.

- There was a rise in the number of operations cancelled on the day for a non-medical reason as a consequence of both the number of medically fit patients remaining in a hospital bed and the level of emergency admissions.

- There were 11 breaches of the mixed sex accommodation standard in January. This is related to high numbers of patients attending ED requiring admission to the Acute Care Units.

- There were six cases of Clostridium Difficile (C-Diff) post 48 hours in January which is above the monthly trajectory and takes the Trust four cases above the year to date

trajectory .There are however four cases that have been deemed unavoidable by the Trust and are being appealed. The target for 2015/16 is challenging and reflects the good performance in 2014/15.

- The 14 day cancer standard was just missed for the quarter for patients referred urgently by their GP for suspected cancer despite high numbers of referrals. The Trust met the standard for patients urgently referred with non-cancer breast symptoms.

- The number of patients waiting over six weeks for a key diagnostic test remains over target with capacity issues in MRI and neurophysiology. Action plans have been agreed with our Divisions.

**RECOMMENDATIONS**

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

Author: **Helen Munro, Head of Information**

Presenting Director **Helen Simpson, Deputy CEO & Executive Director of Finance**

Date: **February 2016**

# GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

## PERFORMANCE AGAINST MONITOR COMPLIANCE FRAMEWORK

## 1 Aim

This summary aims to highlight key trends and performance issues facing the Trust in Quarter 4.

## 2 Background

The detailed breakdown of performance is available within the Performance Management Framework; this summary aims to act as a means to assure the Board, in making the quarterly declaration of its Governance Risk Rating to Monitor.

## 3 Governance Declaration

| MONITOR TARGETS & INDICATORS | Target | 2014/15 Q1 | 2014/15 Q2 | 2014/15 Q3 | 2014/15 Q4 | 2015/16 Q1 | 2015/16 Q2 | 2015/16 Q3 | Oct | Nov | Dec | Jan | Monitor weighting | Current position for Q3 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| C-Diff Toxin Detection (post 48 hour annual target) | 37/yr | 9 | 6 | 8 | 13 | 8 | 10 | 10 | 3 | 4 | 3 | 6 | 1.0 | 1.0 |
| Incomplete pathways - % waited under 18 weeks | 92% | 92.2% | 92.0% | 92.3% | 92.1% | 92.3% | 92.0% | 92.0% | 92.2% | 92.3% | 92.0% | 92.2% | 1.0 | |
| A&E 4 Hour Wait | 95% | 93.3% | 94.3% | 89.5% | 82.7% | 93.4% | 89.7% | 85.6% | 86.1% | 88.2% | 82.6% | 80.2% | 1.0 | 1.0 |
| Cancer 31 Days for all subsequent drugs | 98% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | 1.0 | |
| 31 days for surgery | 94% | 99.0% | 100% | 100% | 98.8% | 100% | 100% | 99.5% | 98.8% | 100% | 100% | | | |
| 31 days to Radiotherapy | 94% | 100% | 98.6% | 99.8% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | | |
| 62 Days from referral to treatment from consultant screening ref | 90% | 91.4% | 97.1% | 92.4% | 91.3% | 97.3% | 94.0% | 95.6% | 97.1% | 92.3% | 96.8% | | 1.0 | 1.0 |
| 62 Days to Treatment (excluding rare cancers) | 85% | 88.1% | 86.1% | 78.4% | 77.1% | 73.9% | 75.6% | 79.5% | 78.7% | 81.8% | 79.4% | | | |
| 14 Days to First Appt | 93% | 90.5% | 94.1% | 94.3% | 88.8% | 91.5% | 90.9% | 92.4% | 94.6% | 93.2% | 89.7% | | 1.0 | 1.0 |
| 14 days symptomatic breast (cancer not initially suspected) | 93% | 66.1% | 93.6% | 96.6% | 94.9% | 95.2% | 91.8% | 93.4% | 91.3% | 94.6% | 94.4% | | | |
| 31 Days from Diagnosis to Treatment | 96% | 99.6% | 99.8% | 99.5% | 100% | 99.5% | 99.7% | 100% | 100% | 100% | 100% | | 1.0 | |
| | | 2.0 | 1.0 | 2.0 | 3.0 | 3.0 | 3.0 | 4.0 | | | | | | 4.0 |

KEY: Actual  Provisional 

Gloucestershire Hospitals NHS
NHS Foundation Trust

# PERFORMANCE MANAGEMENT FRAMEWORK 2015-16

February 2016

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**TRUST PERFORMANCE - as at end January 2016**

**DOMAIN: OUR BUSINESS**

| Measure | Standard | Target Set By | Frequency | Current Data Mth/Qtr | 2014/15 Q1 | 2014/15 Q2 | 2014/15 Q3 | 2014/15 Q4 | 2015/16 Q1 | 2015/16 Q2 | 2015/16 Q3 | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Year end position | Basis of year / quarter end assessment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Monitor Financial Risk Rating | level 3 | Monitor | M | Jan | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | | year end cumulative |
| Achieve planned Income & Expenditure position at year end | Achieved or better at year end | Monitor | M | YTD | -£0.6m | -£3.7m | -£3.3m | -£2.2m | -£1.4m | -£1.6m | -£1.6m | £0.1m | £0m | -£1.4m | -£3.1m | -£1.5m | -£1.6m | -£2.1m | -£2.1m | -£1.6m | £238k | | year end cumulative |
| Emergency readmissions within 30 days - elective & emergency | Q1<6%; Q2<5.8%; Q3<5.6%; Q4<5.4% | Trust | M in arrears | Dec | 6.3% | 6.4% | 6.2% | 5.8% | 6.4% | 6.4% | 6.1% | 6.5% | 6.5% | 6.3% | 6.3% | 6.5% | 6.5% | 6.4% | 5.9% | 6.1% | | | current quarter end |
| GP referrals year to date - within 2.5% of previous year | range +2.5% to -2.5% | Trust | M | YTD | 4.7% | 4.6% | 5.0% | 5.9% | 4.9% | 4.4% | 2.9% | 7.1% | 4.6% | 4.9% | 4.7% | 4.5% | 4.4% | 2.9% | 3.2% | 2.9% | 3.0% | | year end cumulative |
| Elective spells year to date - within 2.5% of plan | range ≥-1% to plan | Trust | M | YTD | 0.0% | -5.5%** | -4.6%** | -3.3%** | -1.3% | 5.1% | 5.0% | -8.7% | 1.3% | -1.3% | 1.0% | 3.1% | 5.0% | 5.1% | 4.8% | 8.0% | 7.7% | | year end cumulative |
| Emergency Spells year to date - within 2.5% of plan | range ≤2.5% over plan | Trust | M | YTD | -4.2% | -3.0%** | -2.3% | -3.1% | 2.4% | 4.0% | 6.9% | - | - | 0.1% | 1.4% | 1.6% | 4.1% | 5.1% | 6.0% | 6.9% | 6.8% | | year end cumulative |
| LOS for general and acute non elective spells | Q1 /Q2 <5.4days, Q3 /Q4 <5.8days | Trust | M | Jan | 5.9 | 5.6 | 5.8 | 6.4 | 5.8 | 5.6 | 5.7 | 6.1 | 5.9 | 5.5 | 5.7 | 5.4 | 5.6 | 5.6 | 5.9 | 5.5 | 6.1 | | year end cumulative |
| LOS for general and acute elective IP spells | ≤ 3.4 days | Trust | M | Jan | 3.7 | 3.8 | 3.6 | 3.5 | 3.6 | 3.6 | 3.6 | 3.2 | 3.7 | 4.0 | 3.5 | 3.8 | 3.4 | 3.5 | 3.8 | 3.5 | 3.4 | | year end cumulative |
| OP attendance & procedures year to date - within 2.5% of plan | range +2.5% to -2.5% | Trust | M | YTD | -3.0% | -3.2%** | -2.2%** | -1.3% | -0.5% | 0.6% | 0.6% | - | - | -0.5% | -0.7% | 0.1% | 0.8% | 0.8% | 0.7% | 0.7% | 0.6% | | year end cumulative |
| % records submitted nationally with valid GP code | ≥ 99% | Trust | M * | Dec | 99.9% | 100% | 99.8% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | | year end cumulative |
| % records submitted nationally with valid NHS number | ≥ 99% | Trust | M * | Dec | 99.6% | 99.7% | 99.8% | 99.8% | 99.8% | 99.7% | 99.7% | 99.8% | 99.8% | 99.8% | 99.8% | 99.6% | 99.7% | 99.5% | 99.5% | 99.8% | | | year end cumulative |
| Carbon Utilisation ** | -1.5% | Trust | M in arrears | Dec | -2.6% | -11.6% | -14.0% | -4.9% | -8.9% | -9.4% | -4.9% | -10.1% | -10.7% | -5.8% | -12.7% | -11.7% | -3.9% | -4.3% | -4.7% | -5.7% | | | current quarter end |

* in arrears/national timetable

**KEY:** **Actual** **Provisional**

**TRUST PERFORMANCE - as at end January 2016**

**DOMAIN: OUR SERVICES**

| Measure | Standard | Target Set By | Frequency | Current Data Mth/Qtr | 2014/15 Q1 | 2014/15 Q2 | 2014/15 Q3 | 2014/15 Q4 | 2015/16 Q1 | 2015/16 Q2 | 2015/16 Q3 | April | May | June | July | August | Sept | Oct | Nov | Dec | Jan | Year end position | Basis of year / quarter end assessment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **INFECTION CONTROL** | | | | | | | | | | | | | | | | | | | | | | | |
| Number of Clostridium Difficile (C-Diff) infections - post 48 hours | 37 cases/year | Monitor | M | Jan | 9 | 6 | 8 | 13 | 8 | 10 | 10 | 4 | 4 | 0 | 4 | 4 | 2 | 3 | 4 | 3 | 6 | | year end cumulative |
| Number of Methicillin-Resistant Staphylococcus Aureus (MRSA) infections - post 48 hours | 0 | GCCG | M | Jan | 0 | 0 | 1 | 1 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1* | 1 | 0 | | year end cumulative |
| **MORTALITY** | | | | | | | | | | | | | | | | | | | | | | | |
| Summary Hospital-Level Mortality Indicator (SHMI) | ≤ 1.10 | Trust | Quarterly, 6 months in arrears | Apr 2014 – Mar 2015 | - | - | - | - | - | - | - | 1.09 | - | - | - | - | - | - | 1.09 | - | - | | year end cumulative |
| Crude Mortality rates | <2% | Trust | M | Jan | 1.3% | 1.2% | 1.4% | 1.6% | 1.3% | 1.0% | 1.2% | 1.5% | 1.4% | 1.0% | 1.0% | 1.2% | 0.98% | 1.3% | 1.3% | 1.1% | 1.2% | | year end cumulative |
| **SAFETY** | | | | | | | | | | | | | | | | | | | | | | | |
| Number of Never Events | 0 | GCCG | M | Jan | 0 | 1 | 0 | 2 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | | year end cumulative |
| % women seen by midwife by 12 weeks | 90% | GCCG | M | Jan | 90.3% | 91.6% | 90.8% | 90.5% | 90.3% | 90.0% | 89.8% | 89.7% | 88.7% | 92.5% | 90.5% | 89.8% | 89.1% | 90.3% | 90.1% | 88.1% | 89.1% | | year end cumulative |
| % stroke patients spending 90% of time on stroke ward | 80% | GCCG | M | Jan | 82.9% | 80.7% | 74.6% | 67.4% | 80.4% | 78.7% | 91.4% | 70.6% | 82.6% | 86.0% | 70.5% | 81.7% | 88% | 91.3% | 95.6% | 82.4% | 81.8% | | year end cumulative |
| % of eligible patients with VTE risk assessment | 95% | GCCG | M | Jan | 93.1% | 93.2% | 93.0% | 93.8% | 94.5% | 93.7% | 93.3% | 94.3% | 93.9% | 95.4% | 94.6% | 94.4% | 93.1% | 94.1% | 93.6% | 92.3% | 92.8% | | year end cumulative |
| **ED** | | | | | | | | | | | | | | | | | | | | | | | |
| % patients spending 4 hours or less in ED | ≥ 95% | Monitor | M | Jan | 93.3% | 94.3% | 89.5% | 82.7% | 93.4% | 89.7% | 85.6% | 91.6% | 93.5% | 95.0% | 93.8% | 86.1% | 89.1% | 86.1% ** | 88.2% | 82.6% | 80.2% | | current quarter end |
| Number of ambulance handovers delayed over 30 minutes | < previous year | GCCG | M | Jan | 283 | 184 | 248 | 324 | 192 | 191 | 213 | 52 | 88 | 52 | 37 | 87 | 67 | 66 | 68 | 79 | 93 | | year end cumulative |
| Number of ambulance handovers delayed over 60 minutes | < previous year | GCCG | M | Jan | 37 | 26 | 27 | 51 | 13 | 21 | 28 | 3 | 7 | 3 | 3 | 11 | 7 | 6 | 2 | 20 | 5 | | year end cumulative |

* Pre 48 hour case of MRSA bacteraemia was found to be a contaminant under PIR process is automatically allocated to the Trust

** 86.2% of adjusted to take account of IT failure 31.10.15

**TRUST PERFORMANCE - as at end January 2016**

## DOMAIN: OUR SERVICES

### CQUINS

### NATIONAL CQUINS

| Measure | Standard | Indicator Weighting | Data Collection Frequency | Reporting Frequency | Current Data Mth/Qtr | 2015/16 Q1 | Q2 | Q3 | April | May | June | July | August | Sept | Oct | Nov | Dec | Jan | Year End Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Acute Kidney Infection (AKI) | Q1 - Audit/baseline, Q2 & Q3 negotiated Target from baseline, Q4 Key items in discharge summaries | 0.25% | M | Q | Q3 | 5% | 19% | 29% | 0% | 3% | 12% | 25% | 20% | 11% | 14% | 29% | 44% | 47% | Q4 Target |
| Sepsis Screening 2a | 2a to be completed before 2b implemented. Q1- 2a in place and baseline data established, Q2 2b baseline data established. Q3 locally agreed target from baseline achieved for 2a and 2b. Q4 Targets achieved (sliding scale to apply) | 0.25% | M | Q | Q3 | 69% | 83% | 96% | 69% | 54% | 84% | 82% | **83%** | **83%** | **100** | **95** | **93** | | Q4 Target |
| Sepsis Antibiotic Administration 2b | | | M | Q | Q3 | N/A | 32% | 43% | N/A | N/A | N/A | 33% | 36% | 32.0% | 46.0% | 36.0% | 50.0% | | Q4 Target |
| Safer Flow Bundle 1.1 Senior review - Implementation of the SAFER flow bundle for all inpatients (excluding Paediatrics and Maternity) within GRH and CGH. | End of Q4 - 80% | 0.5% | Q | Q | | | | Audit/ Report | | | | | | | Report | | Report | Report | 80% Senior Review |
| Safer Flow Bundle 1.2 All patients to have an EDD - Implementation for all inpatients (excluding Paediatrics and Maternity) within GRH and CGH. | Q Reporting | | Q | Q | | | | | | | | | | | Report | | Report | Report | Q4 Target |
| Safer Flow Bundle 1.3 - Flow from ACU for all inpatients (excluding Paediatrics and Maternity) within GRH and CGH. | Q Reporting | | M | Q | | | | | | | | | | | Report | | Report | Report | Q4 Target |
| Safer Flow Bundle 1.4 - Early discharge - Implementation of the SAFER flow bundle for all inpatients (excluding Paediatrics and Maternity) within GRH and CGH. | Q Reporting | | M | Q | | | | | | | | | | | Report | | Report | Report | Q4 Target |
| Safer Flow Bundle 1.5 - Daily senior review of long length of stay patients - for all inpatients (excluding Paediatrics and Maternity) within GRH and CGH. | Q Reporting | | M | Q | | | | | | | | | | | Report | | Report | Report | Q4 Target |
| Dementia - Seek/Assess (33.3%) | End Q1 – 86%<br>End Q2 – 87%<br>End Q3 – 88%<br>End Q4 – 90% | 0.25% | M | M | Nov | 25% | | | 88.8% | 88.1% | 89.2% | 90.7% | 91.1% | 86.2% | 88.0% | 89% | 90.0% | | |
| Dementia - Investigate (33.3%) | End Q1 – 86%<br>End Q2 – 87%<br>End Q3 – 88%<br>End Q4 – 90% | | M | M | Nov | | | | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | |
| Dementia - Refer (33.3%) | End Q1 – 86%<br>End Q2 – 87%<br>End Q3 – 88%<br>End Q4 – 90% | | M | M | Nov | | | | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100.0% | | |
| Delerium | Q1 - Develop Assessment tool, Q2 Roll out to selected wards Q3 Further wards rollout, Q4 Further ward rollout and audit | | M | Q | Nov | 25% | | | On target | On target | On target | On target | On target | On target | On target | on target | On target | | Achieve project aim and Q4 report |

### LOCAL CQUINS

| Measure | Standard | Indicator Weighting | Data Collection Frequency | Reporting Frequency | Current Data Mth/Qtr | 2015/16 Q1 | Q2 | Q3 | April | May | June | July | August | Sept | Oct | Nov | Dec | Jan | Year End Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Planned Process for the Transition from Child to Adult Services | Q1 - Develop Policy, Q2 Implement Q3 & Q4 test and audit - 2 year plan | 0.250% | Q | Q | | | | | | | | | | | | | | | |
| Frailty | Q1 - Develop Assessment tool, Q2 Implement Q3 Audit & locally agree baseline improvement Q4 agreed target with sliding scale | 0.187% | M | Q | | | | | | | | | | | | | | | |
| Configuring Emergency Surgical Services | Q1-Q2 - baseline, Q3 &Q4 agreed target from baseline | 0.187% | M | Q | | G | | | | | Report and baselines | | | REPORT | | | TARGET TBC | | Q4 TARGET |
| Reduction to the number/rate of Lower Limb amputations through the deployment of a MDT approach | Q1 - Develop Plan Q2 Program Report Q3 & Q4 audit | 0.187% | M | Q | | | | | | | REPORT | | | REPORT | | | TARGET TBC | | Q4 TARGET |
| Cancer Survivourship | Q1-Q3 Implementation Q4 Outcome measure | 0.500% | M | M | | | | | | | REPORT | | | REPORT | | | REPORT | | Q4 TARGET |

**SPECIALISED CQUINS**

**2015/16**

| Measure | Standard | Indicator Weighting | Data Collection Frequency | Reporting Frequency | Current Data Mth/Qtr | Q1 | Q2 | Q3 | April | May | June | July | August | Sept | Oct | Nov | Dec | Jan | Year end target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mandatory Clinical Utilisation Review (CUR) | No Q1. Q2 - establish projectr team for CUR installation and implementation. Q3 - Operational and mobilisation plan to be agreed w ith commissioners. Q4 - Softw are installed in accordance to agreed plan. Training completed by agreed 'Go live date (must be before 1/04/16; use of system can be demonstrated and daily of use CUR can be evidenced in agreed bed numbers.Payment based on % number days used | 0.4% | M | M | | N/A | | | | | | | | | | | | | | Q4 - 1a-1f met |
| Std 1 Clinical Utilisation Review Installation and Implementation: | | | | | | | | | | | | | | | | | | | |
| 1a) Provider has established and can evidence a project team | | | | | | | | | | | | | | | | | | | |
| 1b) Provider and commissioner have an agreed and documented plan w ith a scope of services w hich includes i) beds on w hich CUR w ill be used, ii) staff roles w hich w ill undertake the review function. iii)Number of staff to use tool and recieve training. iv) timeframe for installation and implementation including a "Go Live" date. | | | | | | | | | | | | | | | | | | | |
| 1c) Provider & commissioner have an agreed and documented operational /mobilisation plan including i) governance structure ii) reporting mechanisms iii) established IT softw are & interface methodology. | | | | | | | | | | | | | | | | | | | |
| 1d) Appropriate information flow s established, datasets and a schedule of regular reports are agreed w ith commissioners. | | | | | | | | | | | | | | | | | | | |
| 1e) Softw are installed in accordance to agreed plan.Training completed by agreed 'Go Live date', use of system can be demonstrated and daily use of CUR can be evidenced in agreed bed numbers | | | | | | | | | | | | | | | | | | | |
| 1f) Softw are & interfaces are installed and Live and training is completed by the agreed "Go Live" date. Daily use in practice of CUR can be evidenced in agreed bed numbers -payment is based on % of days used. | | | | | | | | | | | | | | | | | | | |
| Oncotype DX Testing and Data collection: | No Q1; Q2 - Q4 Data collection against indicators | 0.4% | Q | Q | | | | | | | | | | | | | | | Q4 Target |
| Increasing Home Renal Dialysis | Q1 baseline and targets agreed for Q1-Q4; Q2, Q3 & Q4 - achieve agreed targets | 0.4% | Q | Q | | | | | | | Report | | | target from baseline | | target from baseline | | | Q4 Target |
| Reduce Delayed Discharges from ICU to ward level care by improving bed management in wards | Quarterly reports | 0.4% | Q | Q | | | | | 100%; 8% | | | 100%; 2% | | | | | | | 99%; 0% |
| 2 Year outcomes for infants < 30weeks gestation | Completed design and implementation of action plan in year 1, 50% of eligible babies having data recorded in year 2 (based on 2014/2015 birth rate) and 75% of eligible babies having data recorded in year 3 (based on 2014/2015 birth rate) for full payment | 0.4% | | Q | | | | | On target | On target | Report | On target | On target | Report | On target | On target | Report | | Q4 target |

**TRUST PERFORMANCE - as at end January 2016**

**DOMAIN: OUR PATIENTS**

**PATIENT EXPERIENCE**

| Measure | Standard | Target Set By | Frequency | Data Mnth/Qtr | 2014/15 Q1 | 2014/15 Q2 | 2014/15 Q3 | 2014/15 Q4 | 2015/16 Q1 | 2015/16 Q2 | 2015/16 Q3 | April | May | June | July | August | Sept | Oct | Nov | Dec | Jan | Year end position | Basis of year / quarter end assessment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **18 WEEKS** | | | | | | | | | | | | | | | | | | | | | | | |
| Incomplete pathways - % waited under 18 weeks | ≥ 92% | Monitor | M | Jan | 92.2% | 92.0% | 92.3% | 92.1% | 92.3% | 92.0% | 92.0% | 92.4% | 92.3% | 92.2% | 92.4% | 92.1% | 92.0% | 92.2% | 92.3% | 92.0% | 92.2% | | current quarter end |
| 15 key Diagnostic tests : numbers waiting over 6 weeks at month end | <1% of nos waiting at month end | GCCG | M | Jan | 0.4% | 1.5% | 2.2% | 1.4% | 4.3% | 5.1% | 2.1% | 5.2% | 6.6% | 4.3% | 5.6% | 7.1% | 5.1% | 1.3% | 1.2% | 2.1% | 2.1% | | year end snapshot |
| Planned/surveillance endoscopy patients - nos. waiting at month end with and without dates | <1% of nos waiting at month end | GCCG | M | Jan | 60 | 138 | 2 | 79 | 400 | 206 | 142 | 219 | 353 | 400 | 455 | 505 | 206 | 83 | 79 | 142 | 190 | | year end snapshot |
| **CANCER** | | | | | | | | | | | | | | | | | | | | | | | |
| Max 2 week wait for patients urgently referred by GP | ≥ 93% | Monitor | M | Dec | 90.5% | 94.1% | 94.3% | 88.8% | 91.5% | 90.9% | 92.4% | 90.1% | 94.0% | 90.5% | 88.9% | 90.0% | 94.2% | 94.6% | 93.2% | 89.7% | | | current quarter end |
| Max 2 week wait for patients referred with non cancer breast symptoms | ≥ 93% | Monitor | M | Dec | 66.1% | 93.6% | 96.6% | 94.9% | 95.2% | 91.8% | 93.4% | 93.6% | 97.6% | 95.1% | 90.9% | 92.3% | 93.0% | 91.3% | 94.6% | 94.4% | | | current quarter end |
| Max wait 31 days decision to treat to treatment | ≥ 96% | Monitor | M | Dec | 99.6% | 99.8% | 99.5% | 100% | 99.5% | 99.7% | 100% | 100.0% | 99.5% | 99.6% | 99.7% | 99.6% | 99.7% | 100% | 100% | 100% | | | current quarter end |
| Max wait 31 days decision to treat to subsequent treatment : surgery | ≥ 94% | Monitor | M | Dec | 99.0% | 100% | 100% | 98.8% | 100% | 100% | 99.5% | 100% | 100% | 100% | 100% | 100% | 100% | 98.8% | 100% | 100% | | | current quarter end |
| Max wait 31 days decision to treat to subsequent treatment : drugs | ≥ 98% | Monitor | M | Dec | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | | current quarter end |
| Max wait 31 days decision to treat to subsequent treatment : Radiotherapy | ≥ 94% | Monitor | M | Dec | 100% | 98.6% | 99.8% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | | | current quarter end |
| Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) | ≥ 85% | Monitor | M | Dec | 88.1% | 86.1% | 78.4% | 77.1% | 73.9% | 75.6% | 79.5% | 74.4% | 72.0% | 72.9% | 70.8% | 85.1% | 72.9% | 78.7% | 81.8% | 79.4% | | | current quarter end |
| Max wait 62 days from national screening programme to 1st treatment *** | ≥ 90% | Monitor | M | Dec | 91.4% | 97.1% | 92.4% | 91.3% | 97.3% | 94.0% | 95.6% | 98.3% | 93.8% | 98.1% | 95.1% | 92.6% | 93.3% | 97.1% | 92.3% | 96.8% | | | current quarter end |
| Max wait 62 days from consultant upgrade to 1st treatment | ≥ 90% | GCCG | M | Dec | 85.7% | 100% | 94.1% | 100% | 60% | 92.9% | 100% | 50% | 100% | 60.0% | 100% | 88.9% | 100% | 100% | 100% | 100% | | | current quarter end |
| **DELAYED DISCHARGES** | | | | | | | | | | | | | | | | | | | | | | | |
| Number of delayed discharges at month end (DTOCs) | <14 | Trust | M | Jan | 9 | 5 | 14 | 13 | 11 | 13 | 19 | 8 | 8 | 11 | 11 | 16 | 13 | 8 | 26 | 19 | 16 | | year end snapshot |
| No. of medically fit patients - over/day | ≤ 40 | Trust | M | Jan | 55 | 60 | 57 | 66 | 40 | 56 | 51 | 67 | 55 | 52 | 64 | 51 | 56 | 40 | 54 | 51 | 54 | | Total days |
| Bed days occupied by medically fit patients | | Trust | M | Jan | 4120 | 4,799 | 5,637 | 5,264 | 1,189 | 1,334 | 1,486 | 1,566 | 1,398 | 1,189 | 1,638 | 1,581 | 1,344 | 1,264 | 1,652 | 1,486 | 1,354 | | Total |
| Patient Discharge Summaries sent to GP within 24 hours | ≥85% | GCCG | M in arrears | YTD | 86.5% | 87.1% | 85.4% | 86.7% | 87.7% | 89.1% | 88.6% | 88.3% | 89.2% | 87.3% | 90.0% | 89.6% | 88.7% | 89.2% | 88.7% | 88.6% | | | current quarter end |
| Number of Breaches of Mixed sex accommodation | 0 | GCCG | M | Jan | 0 | 0 | 0 | 0 | 0 | 0 | 17 | 0 | 0 | 0 | 0 | 0 | 0 | 9 | 0 | 8 | 11 | | year end snapshot |
| **CANCELLATIONS** | | | | | | | | | | | | | | | | | | | | | | | |
| Elective Patients cancelled on day of surgery for a non medical reason | ≤ 0.8% | Trust | M | Jan | 1.1% | 1.4% | 1.5% | 1.7% | 1.1% | 1.2% | 1.3% | 1.2% | 1.2% | 0.9% | 1.4% | 1.3% | 1.0% | 1.6% | 1.5% | 0.7% | 1.9% | | year end cumulative |
| Patients cancelled and not rebooked in 28 days | 0 | GCCG | M | Jan | 9 | 9 | 19 | 41 | 17 | 18 | 15 | 6 | 6 | 5 | 2 | 8 | 8 | 8 | 4 | 3 | 1 | | year end cumulative |

**NO LONGER A NATIONAL TARGET**

| Measure | Standard | Target Set By | Frequency | Data Mnth/Qtr | 2014/15 Q1 | 2014/15 Q2 | 2014/15 Q3 | 2014/15 Q4 | 2015/16 Q1 | 2015/16 Q2 | 2015/16 Q3 | April | May | June | July | August | Sept | Oct | Nov | Dec | Jan | Year end position | Basis of year / quarter end assessment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **18 WEEKS** | | | | | | | | | | | | | | | | | | | | | | | |
| Admitted pathways - % treated in 18 weeks * | ≥ 90% | Trust | M | Jan | 91.3% | 90.5% | 90.8% | 90.1% | 89.0% | 88.7% | 84.1% | 87.4% | 90.0% | 89.6% | 90.1% | 87.7% | 88.1% | 84.8% | 86.5% | 84.0% | 84.5% | | current quarter end |
| Non-admitted pathways - % treated in 18 weeks * | ≥ 95% | Trust | M | Jan | 95.2% | 95.2% | 95.0% | 95.1% | 95.1% | 94.3% | 94.9% | 95.0% | 95.2% | 95.1% | 95.0% | 94.5% | 93.5% | 92.4% | 92.1% | 90.9% | 90.0% | | current quarter end |
| Provider failure to ensure sufficient appointment slots available on choose & book (excluding 2 week waits) ** | <4% | GCCG | M | May | 9.9% | 8.1% | 6.8% | 8.1% | - | - | | 10.0% | 11.8% | - | - | - | - | - | - | - | | - | year end snapshot |

** National data, not available from HSCIC since move from national Choose and Book System to E-Referrals

*** Figures July - Sept refreshed to give final position at Q2 end.

**TRUST PERFORMANCE - as at end January 2016**

**DOMAIN: OUR STAFF**

| Measure | Standard | Target Set By | Frequency | Current Data Mth/Qtr | 2014/15 Q1 | 2014/15 Q2 | 2014/15 Q3 | 2014/15 Q4 | 2015/16 Q1 | 2015/16 Q2 | 2015/16 Q3 | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Year end position | Basis of year / quarter end assessment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total PayBill spend £'000 | target + 0.5% | Trust | M | Jan | £22,224 | £22,804 | £22,946 | £23,193 | £23,757 | £23,789 | £23,424 | £23,325 | £23,045 | £23,757 | £23,451 | £23,432 | £23,789 | £23,631 | £24,089 | £23,424 | £24,335 | | year end cumulative |
| Total worked FTE | target + 0.5% | Trust | M | Jan | 6,343.1 | 6,474.3 | 6,494.0 | 6,623.0 | 6,576.0 | 6,628.0 | 6,623.0 | 6,541.0 | 6,509.0 | 6,576.0 | 6,582.0 | 6,608.0 | 6,628.0 | 6,610.0 | 6,644.0 | 6,623.0 | 6,675.0 | | year end cumulative |
| Annual sickness absence rate * | <3.5 | Trust | M in arrears | Dec | 3.76% | 3.70% | 3.70% | 3.72% | 3.79% | 3.76% | | 3.80% | 3.79% | 3.80% | 3.78% | 3.79% | 3.76% | 3.76% | 3.76% | 3.76% | | | year end cumulative |
| Staff who have annual appraisal | 90% | Trust | M | Jan | 83.0% | 87.0% | 88.0% | 84.0% | 85.0% | 83.0% | | 83.0% | 85.0% | 85.0% | 84.0% | 83.0% | 83.0% | 83.0% | 83.0% | 85.0% | 85.0% | | year end cumulative |
| Percentage of staff having well structured appraisals in last 12 months | 45% | Trust | A | Mar | - | - | - | 38%## | 38%## | 38%## | 38%## | 38%## | 38%## | 38%## | 38%## | 38%## | 38%## | 38%## | 38%## | 38%## | 38%## | | |
| Staff who completed mandatory training | 90% | Trust | M | Jan | 89.0% | 91.0% | 91*% | 91.0% | 92%* | 92%* | | 91.0% | 92.0%* | 92.0%* | 92.0% | 92.0% | 91.0% | 91.0% | 91.0% | 91.0% | 91.0%* | | year end cumulative |
| Staff Engagement indicator (as measured by the annual staff survey) | 3.75 | Trust | A | Mar | 3.6%# | 3.6%# | 3.6%# | 3.66## | 3.66## | 3.66## | 3.66## | 3.66## | 3.66## | 3.66## | 3.66## | 3.66## | 3.66## | 3.66## | 3.66## | 3.66## | 3.66## | | annual |
| Improve Communication between senior managers and staff (as measured by the annual staff survey) | 40% | Trust | A | Mar | 30%# | 30%# | 30%# | 35%## | 35%## | 35%## | 35.0%## | 35.0%## | 35.0%## | 35.0%## | 35.0%## | 35.0%## | 35.0%## | 35.0%## # | 35.0%## | 35.0%## | 35.0%## | | annual |
| Turnover rate (FTE) | 7.5 -9.5% | Trust | M in arrears | Dec | 9.04% | 9.67% | 10.57% | 11.17% | 11.16% | 11.29% | | 11.17% | 11.22% | 11.09% | 10.79% | 10.99% | 11.29% | 11.14% | 11.03% | 11.18% | | | year end cumulative |

* 93% excluding Bank only staff
** 2012 annual Staff Survey result
# 2013 annual Staff Survey Result
## 2014 annual Staff Survey Result

The Monitor Plan includes GP Trainees who are excluded from figures reported here. From April 14 it has not been possible to obtain a plan figure to deduct from the overall total in order to derive the 'Plan without GP/PH Trainees'. Instead the actual cost/worked fte of these staff has been deducted from the total Planned expenditure/fte figure.
**Changes have been applied retrospectively to April 14.**
Further updates to FTE/Paybill targets applied Nov 14

*From 01 April 2015, Sickness Absence Rate excludes GP Trainees - this will have the effect of apparently increasing Sickness Absence initially.

**TRUST PERFORMANCE - as at end January 2016**

## RISK ASSESSMENT - FORWARD LOOK

| Measure | Standard | Target Set By | Comments |
|---|---|---|---|
| **OUR BUSINESS** | | | |
| Emergency Spells year to date - within 2.5% of plan | range ≤2.5% over plan | Trust | Emergency admissions are increasing to plan as the year progresses. |
| LOS for general and acute elective IP spells | ≤ 3.4 days | Trust | LOS remains an issue. Gloucestershire wide action plan to address admissions avoidance and discharge processes. Note as admission avoidance schemes deliver - LOS may increase. |
| **OUR SERVICES** | | | |
| % patients spending 4 hours or less in ED | ≥ 95% | Monitor | This remains a risk. Trust emergency care action plan in place plus Gloucestershire System wide resilience programme. This also impacts onto ambulance handovers and cancelled operations. |
| % of eligible patients with VTE risk assessment | 95% | GCCG | Although compliance was achieved in June 15 due to process and paperwork revisions, this has been an area of underperformance for some time so remains a risk until the Trust has assurance that new processes have been embedded. |
| **OUR PATIENTS** | | | |
| Max wait 62 days from urgent GP referral to 1st treatment (exl.rare cancers) | ≥ 85% | Monitor | A full recovery plan is in place and performance to this plan managed through the Cancer Management Board and the System wide resilience Group. |
| Number of delayed discharges at month end (DTOCs) | <14 | Trust | Actions are being picked up as part of the emergency services plan. |
| No. of medically fit patients - over/day | ≤ 40 | Trust | |
| **OUR STAFF** | | | |
| Total PayBill spend £'000 | ≥ 95% | Monitor | This main risk here is around workforce supply and in part the impact of Government policy where non-EU Nurses are not exempt from sponsorship rules that hinders planned reductions in agency staffing levels and complaince with Monitor direction on the capping of agency levels. |

## EMERGENCY READMISSION WITHIN 30 DAYS - ELECTIVE & EMERGENCY

**Trust Standard financial penalty**

**This relates to patients readmitted as an emergency within 30 days of either an elective or emergency discharge**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| <5.8% | Dec-15 | 6.1% | R |

**What is driving the reported overperformance**

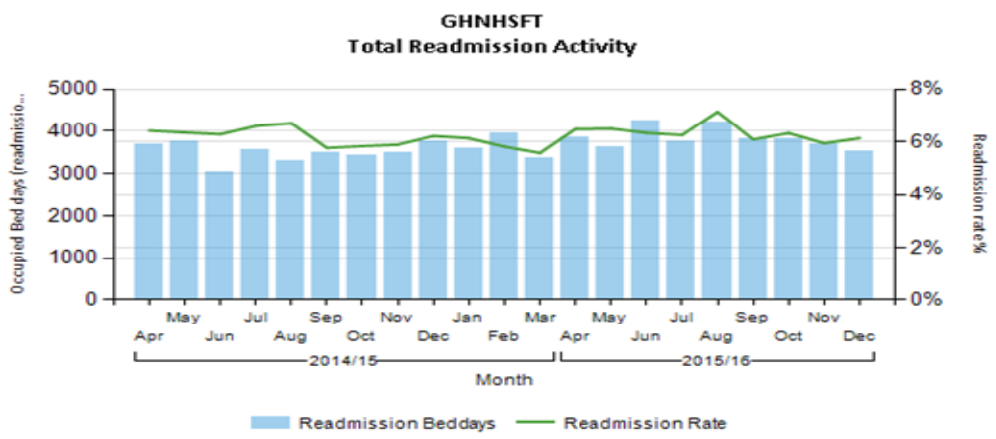
The emergency re-admission rate has been relatively constant this financial year although there has been a small decrease in the rate since November.

**Actions taken to improve performance**

This is being scrutinised by the Emergency Care Board. Specific actions have been agreed with Divisions as part of an overall improvement plan.

| | |
|---|---|
| **Expected date to meet standard** | Apr-16 |
| **Lead Director** | Director of Service Delivery |

**Activity**




## EMERGENCY SPELLS

**Trust Standard**

**Number of emergency spells year to date to plan. Non elective spells not included**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| within 2.5% of plan | YTD | 6.8% | R |

**What is driving the reported underperformance**

Emergency spells have increased in the winter months. The average/day is as follows;

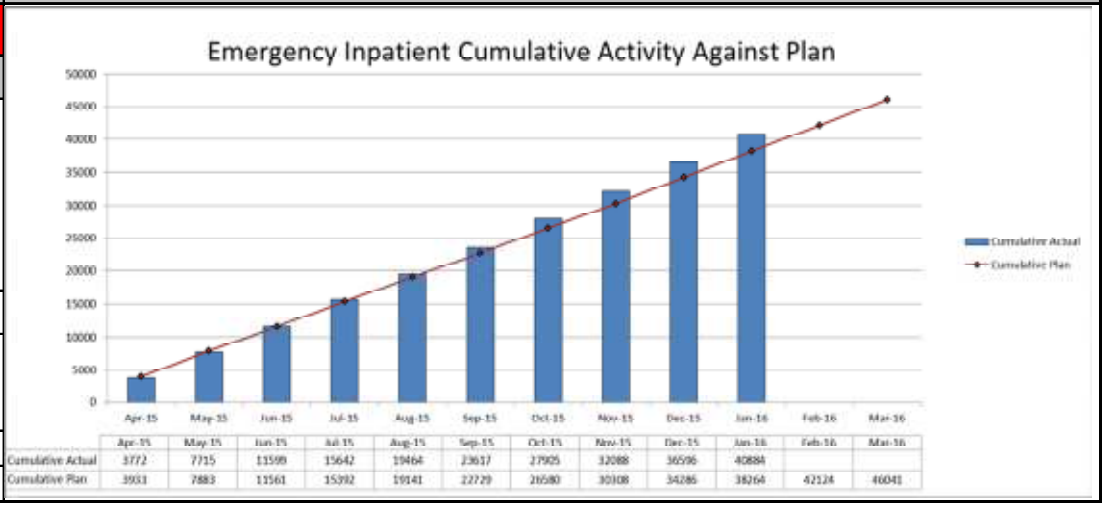
| April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan |
|---|---|---|---|---|---|---|---|---|---|
| 128 | 127 | 129 | 130 | 124 | 139 | 138 | 139 | 145 | 138 |

**Actions taken to improve performance**

Please refer to Emergency Pathway Report.

| | |
|---|---|
| **Expected date to meet standard** | Apr-16 |
| **Lead Director** | Director of Service Delivery |

**Activity**



# LOS FOR GENERAL & ACUTE NON ELECTIVE SPELLS

**Trust Standard**

**Bed days used by General and Acute Non Elective patients discharged in month; excludes Paediatrics, Maternity and private patients**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| ≤ 5.8 | Jan-16 | 6.1 | R |

**What is driving the reported overperformance**

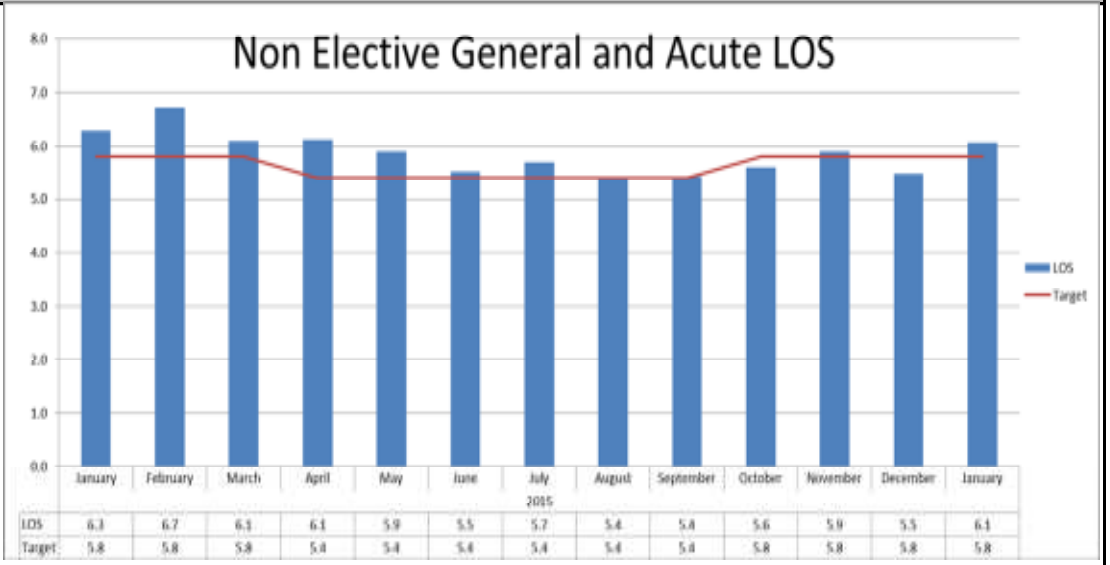
Please refer to Emergency Care Report

**Actions taken to improve performance**

LOS remains an issue. The Gloucestershire wide action plan has been reviewed across the health community to reflect the urgent requirement to improve performance. Increases in the numbers of medically fit patients has exacerbated the LOS. Details are in the emergency pathways report.

| | |
|---|---|
| **Expected date to meet standard** | TBA |
| **Lead Director** | Director of Service Delivery |

**Activity**



# CLOSTRIDIUM DIFFICILE

**Monitor Standard : quarterly**
**GCCG Financial Penalty**

**Number of Clostridium Difficile cases - post 48 hours admissions**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| 37 / year | Jan-16 | 6 | R |

**What is driving the reported underperformance**

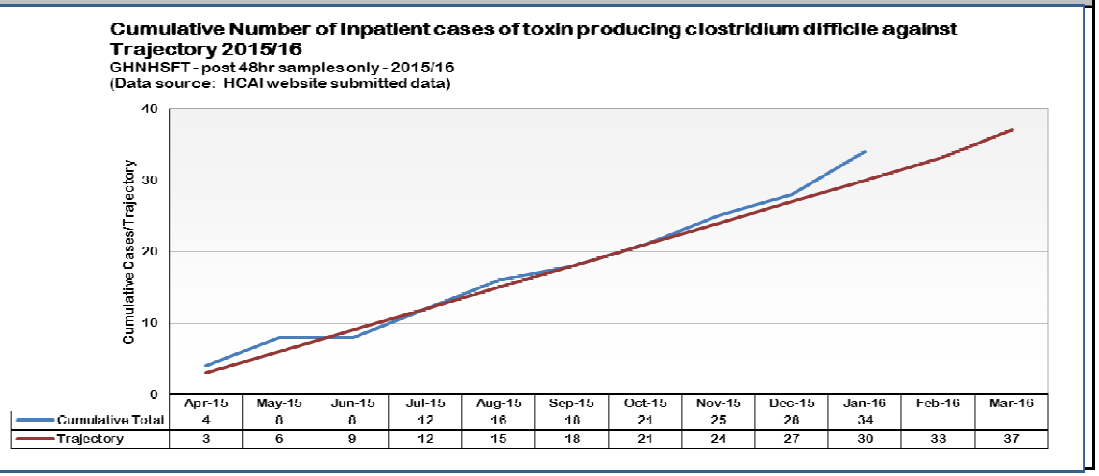
The monthly trajectory was 3 cases of post 48 hour cases and the actual number was 6.1 Case was deemed unavoidable and will be appealed with the commissioners. The total cases that have been unavoidable in 2015/16 and will be appealed are 4

**Actions taken to improve performance**

All cases have been revewied 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

| | |
|---|---|
| **Expected date to meet standard** | Yearly target |
| **Lead Director** | Director of Nursing |

**Activity**




| | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cumulative Total | 4 | 6 | 6 | 12 | 16 | 18 | 21 | 25 | 28 | 34 | | |
| Trajectory | 3 | 6 | 9 | 12 | 15 | 18 | 21 | 24 | 27 | 30 | 33 | 37 |

# % OF ELIGIBLE PATIENTS WITH VTE RISK ASSESSMENT

**GCCG Financial Penalty**

**This relates to the percentage of eligible patients with a VTE risk assessment**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| 95% | Jan-16 | 92.8% | R |

**What is driving the reported underperformance**

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

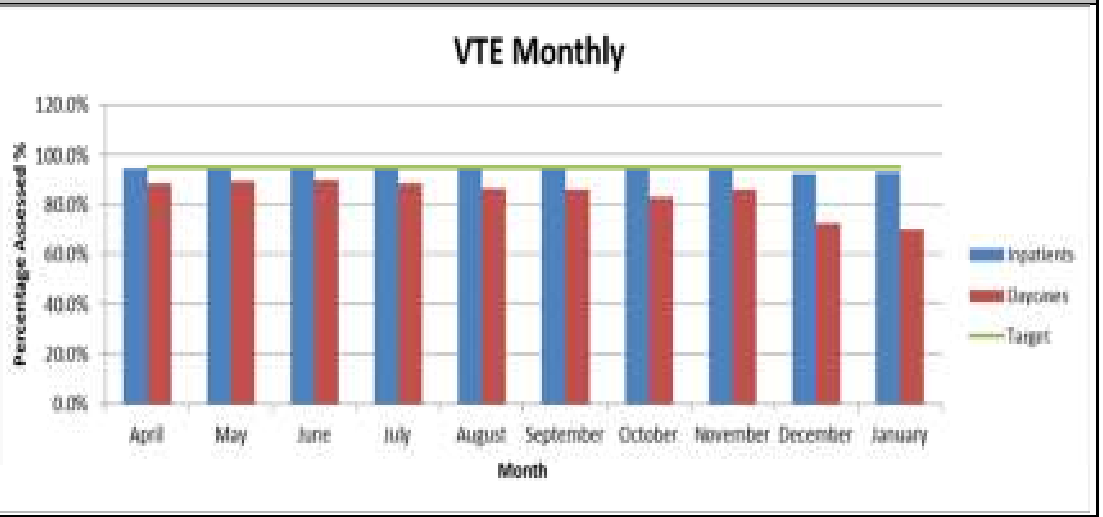
**Actions taken to improve performance**

Regular multidisciplinary team, doctors, nurses, pharmacists and ward clerks
Improve the rate of prescription charts arriving with the patient from ED
Optimise specific roles, pharmacists, ward clerk, doctors, nurses.

There has been a continued fall in Day case assessment. There has been an increase in the total number of eligible patients as our daycase numbers increase. The Surgical Division are taking steps to change the pathway for these patients, these results should show for the final quarter results. In addition the VTE committee will initiate a ward by ward review of performance and visit areas to identify improvement

| | |
|---|---|
| **Expected date to meet standard** | Mar-16 |
| **Lead Director** | Director of Safety |

**Activity**



## TOTAL TIME IN EMERGENCY DEPARTMENT

**Monitor Standard**
**GCCG Financial Penalty**

**This relates to the percentage of patients spending 4 hours or less in Emergency Department -Trust**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| ≥ 95% | Jan-16 | 80.2% | R |

**What is driving the reported underperformance**

Please refer to Emergency Pathway Report

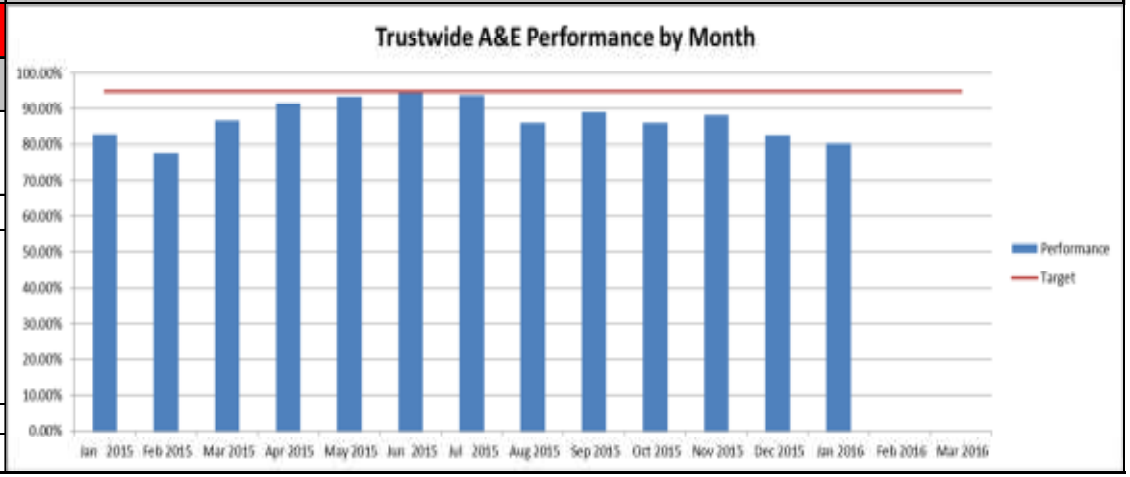
**Actions taken to improve performance**

Recovery plan in place focusing on:-
- internal flow
- ED Department
- Admission avoidance

The trajectory for ED is being reviewed in conjunction with the Monitor sustainablity and transformation requirements.

| | |
|---|---|
| **Expected date to meet standard** | As above |
| **Lead Director** | Director of Service Delivery |

**Activity**




## AMBULANCE HANDOVERS DELAYED OVER 30 MINUTES

**GCCG Standard**
**Financial Penalty**

**Number of ambulance handovers to ED over 30 minutes**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| < previous year | Jan-16 | 93 | R |

**What is driving the reported underperformance**

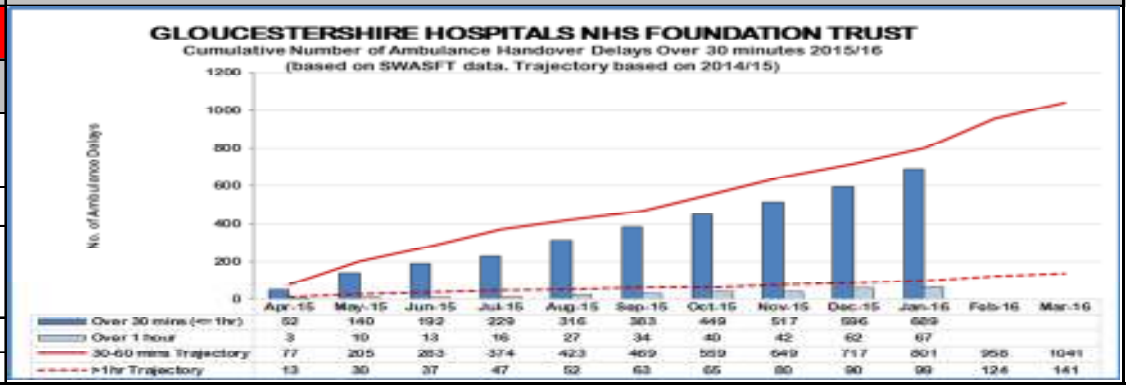
Please refer to Emergency Pathway Report

**Actions taken to improve performance**

Please refer to Emergency Pathway Report

| | |
|---|---|
| **Expected date to meet standard** | Apr-16 |
| **Lead Director** | Director of Service Delivery |

**Activity**



## ACUTE KIDNEY INFECTION (AKI)

National CQUIN Standard

**AKI Diagnosis, treatment and planned care after discharge.**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| >90% of 4 key items in discharge summaries Q4 | Jan-16 | 47% | R |

**What is driving the reported underperformance**

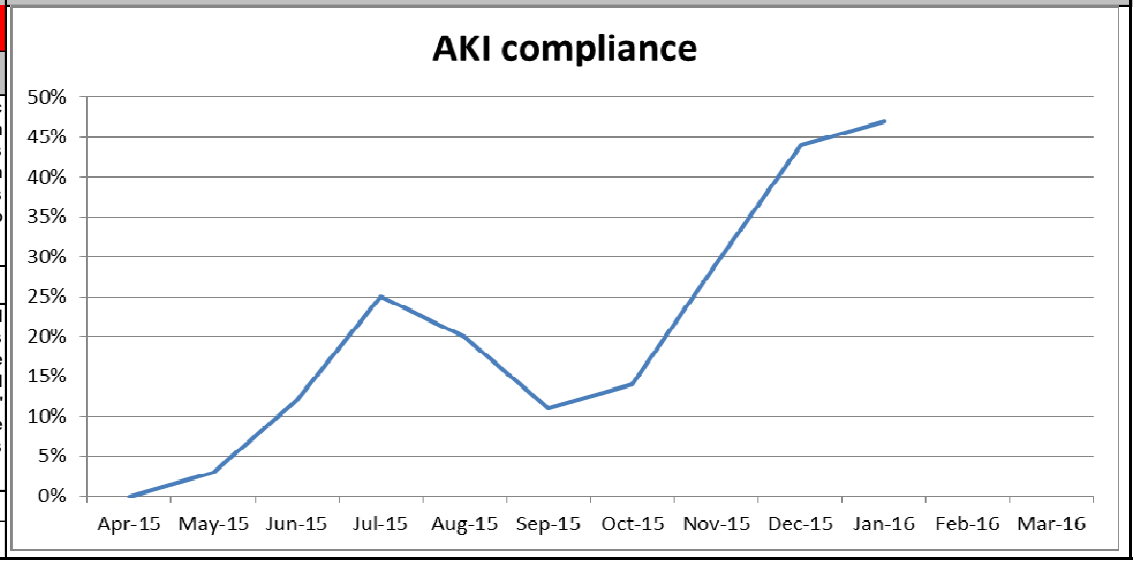
The project required us to create a new electronic recording process associated with the electronic discharge summary. This was launched on July 1st with supporting briefings and education, through testing several changes have been made through the 2nd quarter. It was predicted that the results would steadily improve but in Sept and October there was a significant and unexpected drop in results.With further changes the results have reached 44% in December from 14% in October. This means the target of 30% average over the 3rd quarter by 1%. Negotiations are ongoing with the CCG to mediate any loss of income.

**Actions taken to improve performance**

The F2 Improvement Group supported by the academy and the clincal lead contiue to evaluate and 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 consulatnts, SAS doctors and junior doctors. General awareness raising and screensavers. The most recent action includes launch of "Ned the Nephron" which will help the campaign and also be used as a visual reminder to complete the AKI discharge boxes. The target for the 4th quarter is 90% average which will be very difficult to achieve. Income loss is on a sliding scale starting from 40%.

| | |
|---|---|
| **Expected date to meet standard** | 2016-17 |
| **Lead Director** | Director of Safety |

**Activity**




## SEPSIS 2B

National CQUIN Standard

**Eligible patients receiving antibiotics**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| >90% eligible patients | Dec-15 | 50% | R |

**What is driving the reported underperformance**

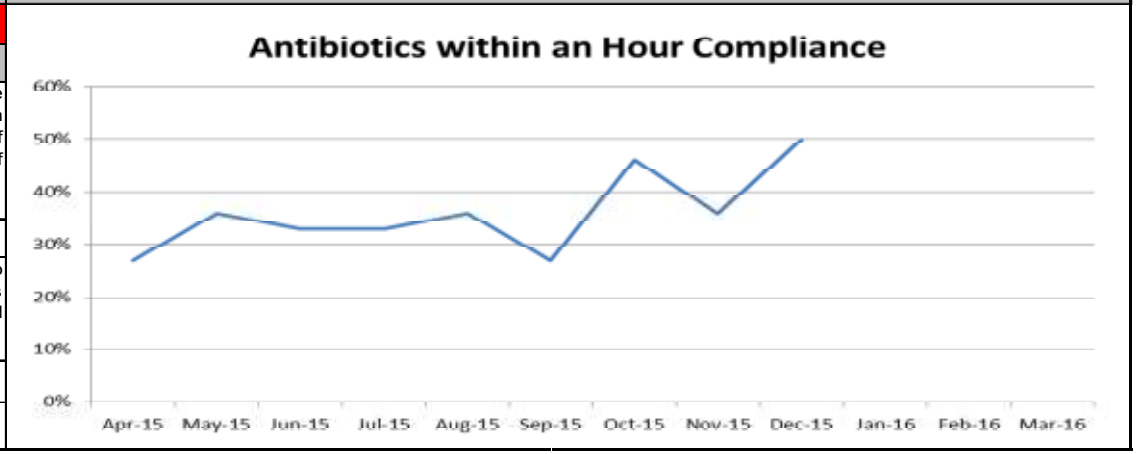
The target for Q3 was an average of 50%, this wasn't achived due to low compliance in November. The target for Q4 is 90% so it will be very difficult to make significant changes to the performance. Although the screening for sepsis (2a) is performing above 95% the time to antibiotics suffers from a range of problems, the clock starts from booking into ED (the old standard was from diagnosis or within 3 hrs of ED admission). This means that when ED is busy the time to antibiotics increases.

**Actions taken to improve performance**

To improve the performance a new ED sepsis team are looking at local practice. The Trust has also commneced the ED checklist programme which was succesfully tested at North Bristol, the project is being funded by the WEAHSN. This tool will allow earlier sepsis identification and is designed specifically for when the ED is at its busiest.

| | |
|---|---|
| **Expected date to meet standard** | 2016-17 |
| **Lead Director** | Director of Safety |

**Activity**



## OUR PATIENTS

# DIAGNOSTIC WAITS OVER 6 WEEKS

**GCCG Standard Financial Penalty**

**This relates to number waiting over 6 weeks for 15 key Diagnostic tests**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| <1% of nos waiting at month end | Jan-16 | 2.1% | R |

**What is driving the reported underperformance**

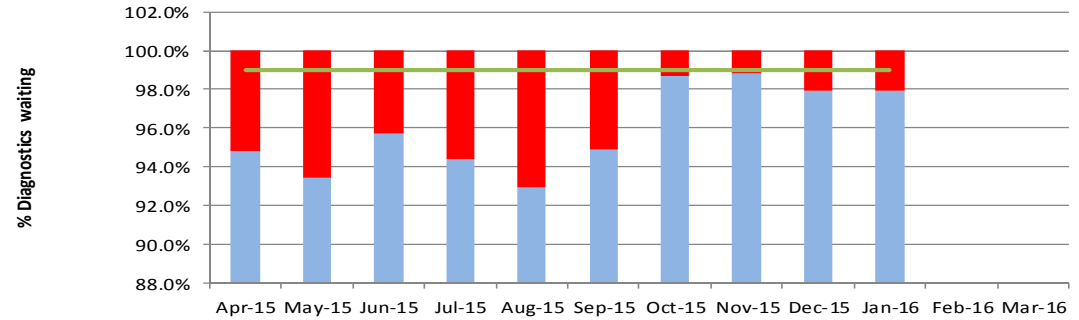
174 patients of which Neurophysiology 73, Urodynamics 23, Echos 12, MRI 54, Audiology 7, other imaging 2, Cystoscopy 2, Colonoscopy 1.

**Actions taken to improve performance**

Recovery plans in place with Divisions. Discussions with Commissioners to limit demand pressures.

| | |
|---|---|
| **Expected date to meet standard** | Mar-16 |
| **Lead Director** | Director of Service Delivery |

**Activity**




| | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % Breaches | 5.2% | 6.6% | 4.3% | 5.6% | 7.1% | 5.1% | 1.3% | 1.2% | 2.1% | 2.1% | | |
| % Non Breaches | 94.8% | 93.4% | 95.7% | 94.4% | 92.9% | 94.9% | 98.7% | 98.8% | 97.9% | 97.9% | | |
| Target | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% | | |

# PLANNED SURVEILLANCE ENDOSCOPY PATIENTS

**GCCG Standard Financial Penalty**

**Number of patients waiting over 6 weeks past their 'to be seen' date on planned endoscopy waiting list at month end**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| <1% of nos waiting at month end | Jan-16 | 190 | R |

**What is driving the reported underperformance**

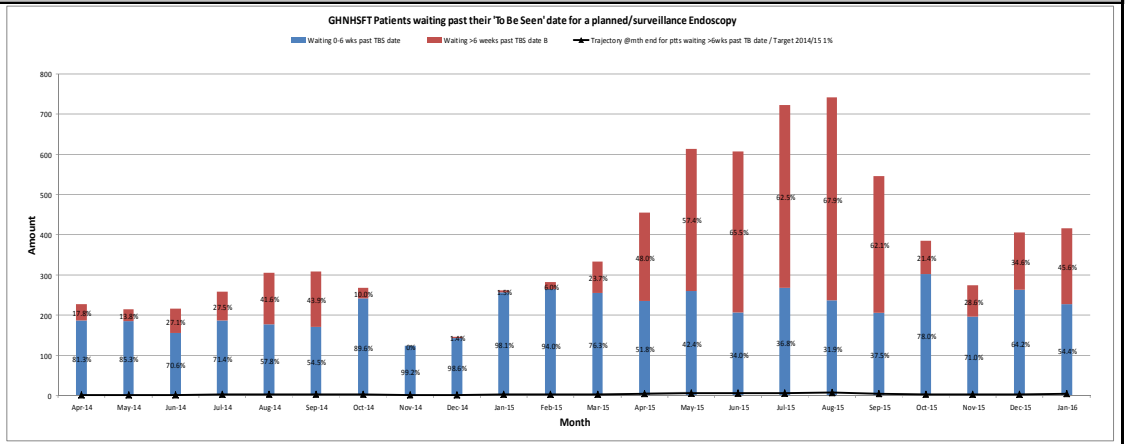
Demand continues to increase, particularly for 2ww Endoscopy, which has impacted on capacity available.

**Actions taken to improve performance**

Additional activity is being undertaken.

| | |
|---|---|
| **Expected date to meet standard** | Mar-16 |
| **Lead Director** | Director of Service Delivery |

**Activity**



## OUR PATIENTS

# TWO WEEK WAIT FOR PATIENTS URGENTLY REFERRED

**Monitor Standard**
**GCCG Financial Penalty**

**This relates to patients referred urgently by their GP for suspected cancer seen in 14 days**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| ≥ 93% | Dec-15 | 89.7% | R |

**What is driving the reported underperformance**

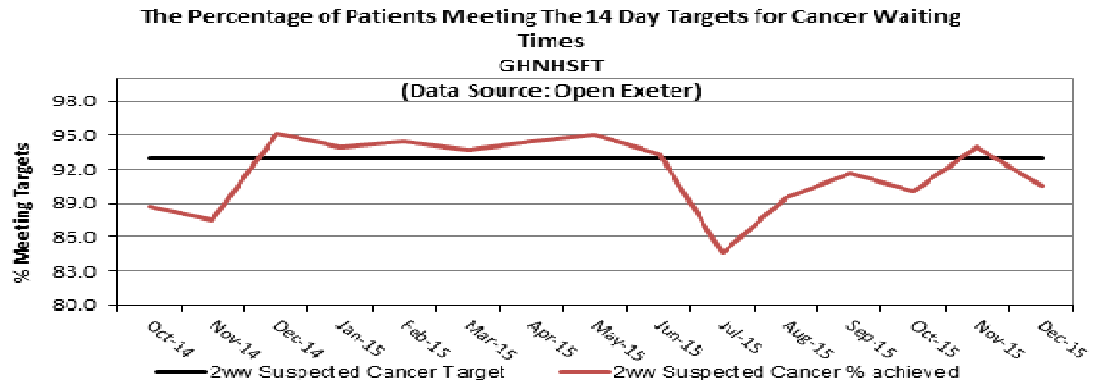
The underperformance relates primarily to Upper and Lower GI and Urology, all of which saw unusually high numbers of referrals in December.

**Actions taken to improve performance**

Action plans are iin place.

| | |
|---|---|
| **Expected date to meet standard** | Feb-16 |
| **Lead Director** | Director of Service Delivery |

**Activity**




# MAXIMUM 62 DAYS FROM URGENT GP REFERRAL TO 1ST TREATMENT

**GCCG Standard**

**This relates to patients referred urgently by their GP to first treatment date and excludes rare cancers**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| ≥ 85% | Dec-15 | 79.4% | R |

**What is driving the reported underperformance**

The position by tumour site for December is as follows. The position is on the Recovery Trajectory for December at 79.3%

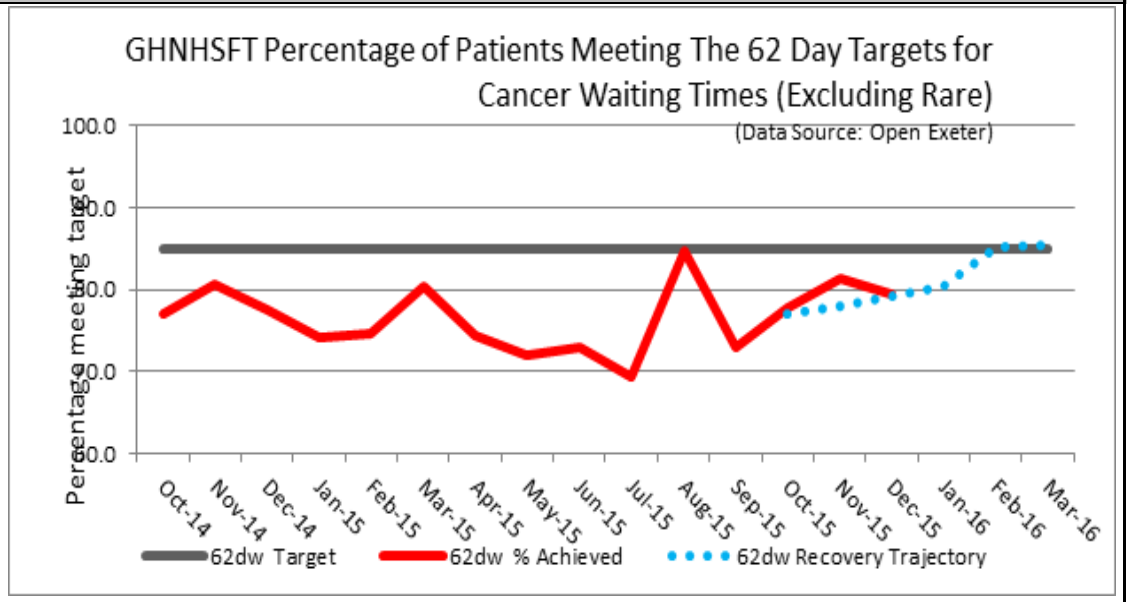
| Tumour Site | Total | Breaches | % |
|---|---|---|---|
| Brain | 1 | 0 | - |
| Breast | 27 | 0 | 100.0 |
| Gynae | 11 | 3 | 72.7 |
| Haematology | 9 | 3 | 66.7 |
| Head & Neck | 5.5 | 2 | 63.6 |
| Lower GI | 13 | 4 | 69.2 |
| Lung | 10 | 2.5 | 75.0 |
| Sarcoma | 1 | 0 | 100.0 |
| Skin | 17 | 0 | 100.0 |
| Upper GI | 15 | 2 | 86.7 |
| Urology | 20 | 10 | 50.0 |
| All Other | 1.5 | 0.5 | 66.7 |
| **Total** | **131** | **27** | **79.4** |

**Actions taken to improve performance**

A detailed cancer action plan prepared with help of Intensive Support Team. Progress to delivery of plan reviewed monthly at Cancer Services Managerment Group.

| | |
|---|---|
| **Expected date to meet standard** | Feb-16 |
| **Lead Director** | Director of Service Delivery |

**Activity**



## OUR PATIENTS

# DELAYED DISCHARGES AT MONTH END

**GCCG Standard**

**This relates to the number of delayed discharges at month end classified in national reporting**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| ≤14 | Jan-15 | 16 | R |

**What is driving the reported underperformance**

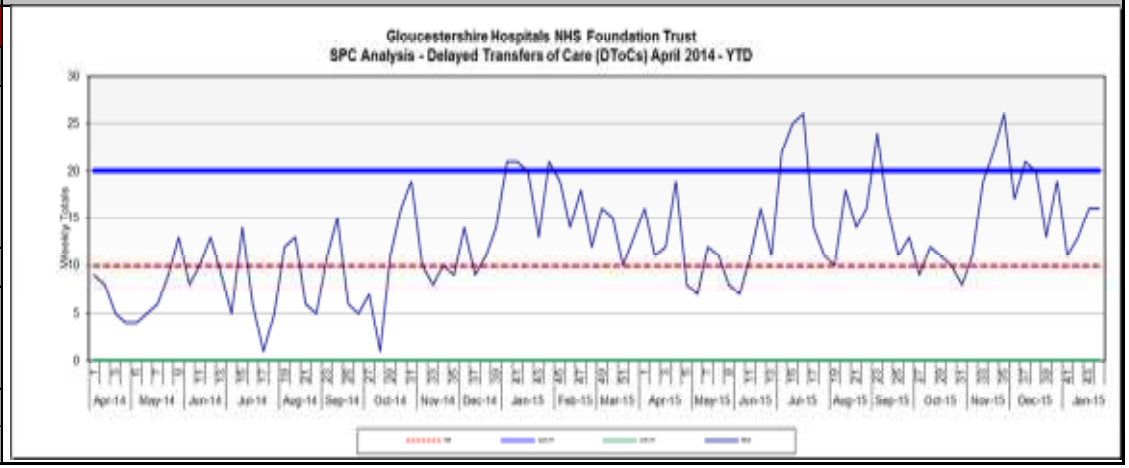
Please refer to Emergency Care Report

**Actions taken to improve performance**

Please refer to Emergency Care Report

| | |
|---|---|
| **Expected date to meet standard** | Apr-16 |
| **Lead Director** | Director of Service Delivery |

**Activity**




# MEDICALLY FIT PATIENTS

**Trust Standard**

**Average per day in month**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| ≤ 40 | Jan-16 | 54 | R |

**What is driving the reported underperformance**

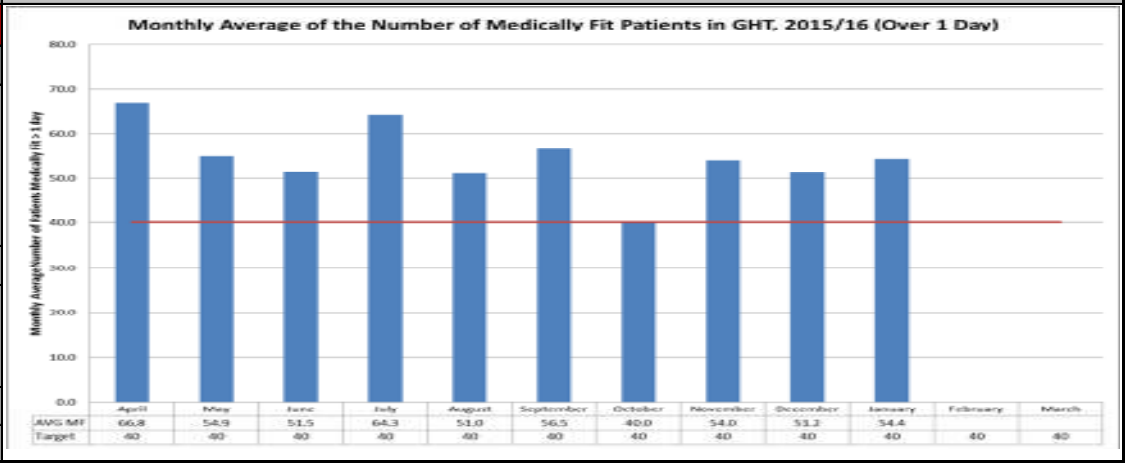
Please refer to Emergency Care Report

**Actions taken to improve performance**

Please refer to Emergency Care Report

| | |
|---|---|
| **Expected date to meet standard** | Apr-16 |
| **Lead Director** | Director of Service Delivery |

**Activity**



## OUR PATIENTS

# BREACHES OF MIXED SEX ACCOMMODATION

**GCCG Standard**
**Financial Penalty**

**Numbers of patients breaching same sex accommodation**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| 0 | Jan-16 | 11 | R |

**What is driving the reported underperformance**

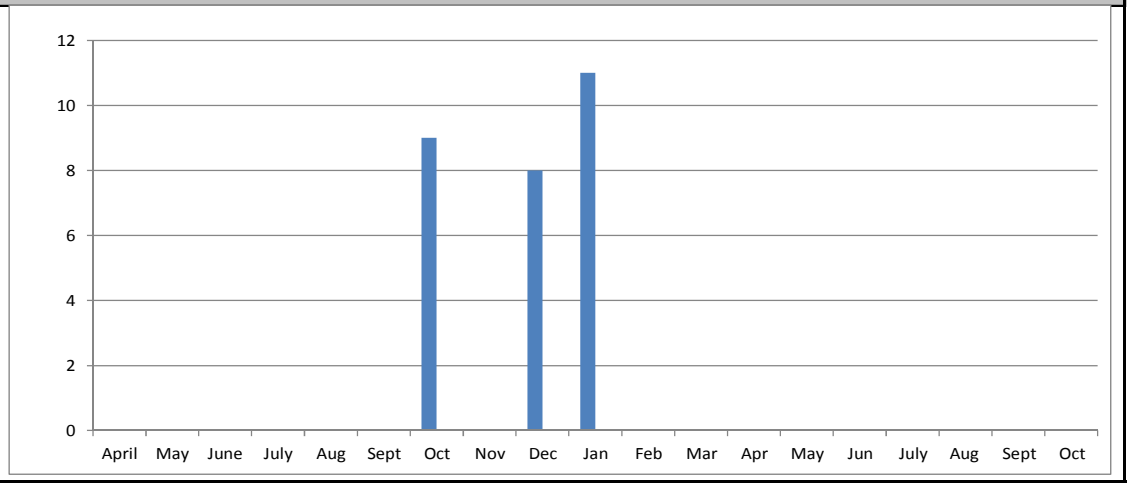
The underperformance has been due to the number of attendees in the Emergency Department requiring admission to the Acute Care Units where the breaches occurred.

**Actions taken to improve performance**

Review of patient flow in the Acute Care Unit

| | |
|---|---|
| **Expected date to meet standard** | Feb-16 |
| **Lead Director** | Maggie Arnold |

**Activity**




# ELECTIVE PATIENTS CANCELLED ON DAY OF SURGERY

**Trust Standard**

**Number of elective patients cancelled by hospital on the day for a non clinical reason as a % of elective admissions**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| ≤ 0.8% | Jan-16 | 1.9% | R |

**What is driving the reported underperformance**

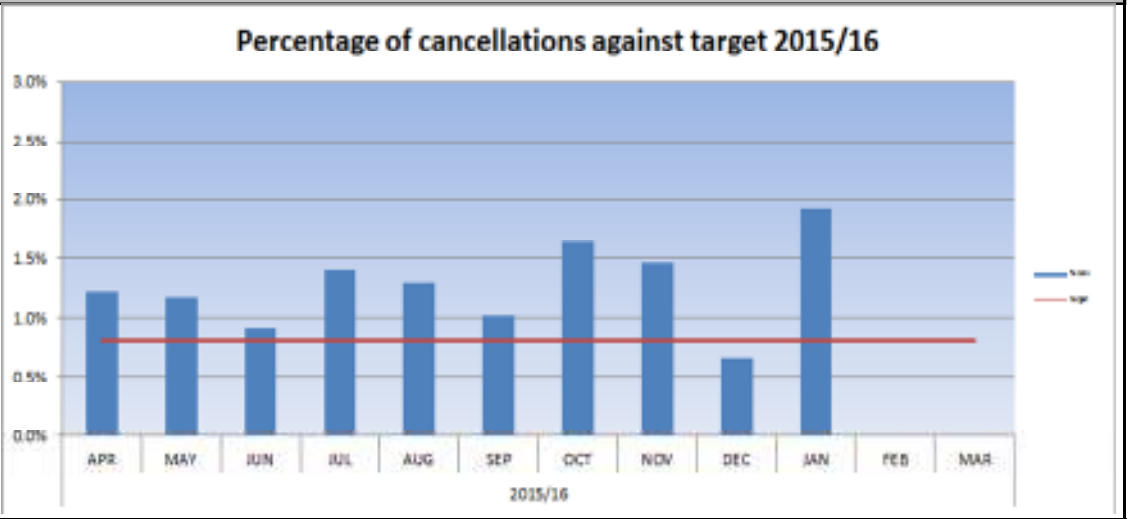
This is due to the pressure in Emergency care as described in the Emergency Care report

**Actions taken to improve performance**

Refocus by Surgical Division to reduce the number of cancellations on the day. Process establsihed in Surgical Division to review all elective activity daily

| | |
|---|---|
| **Expected date to meet standard** | Apr-16 |
| **Lead Director** | Director of Service Delivery |

**Activity**



# PATIENTS CANCELLED AND NOT REBOOKED IN 28 DAYS

**GCCG Standard**
**Financial Penalty**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| 0 | Jan-16 | 1 | R |

**What is driving the reported underperformance**

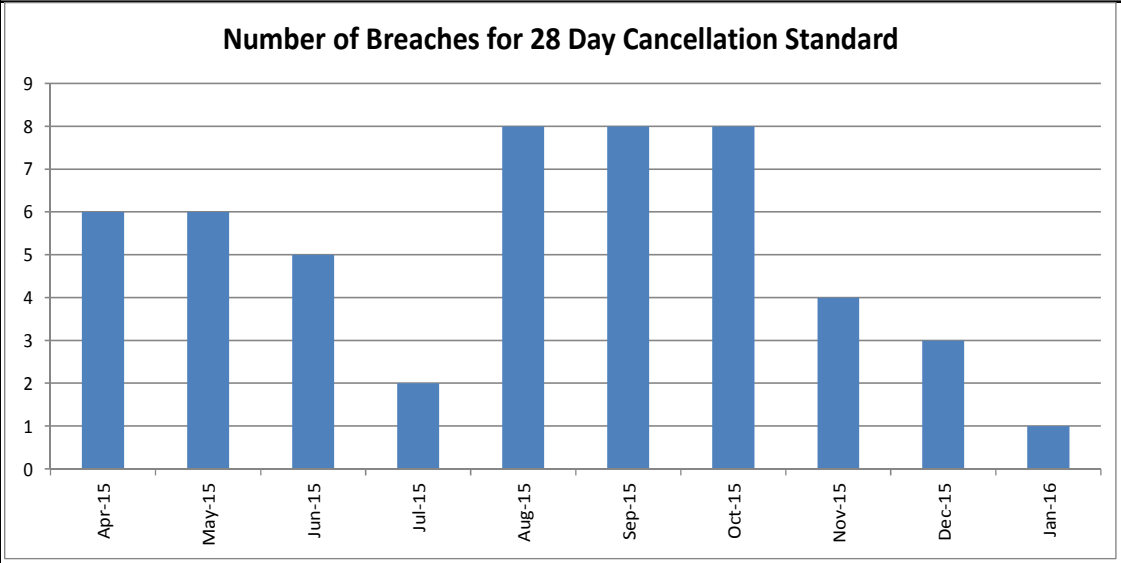
Although just one patient was cancelled on the day for a non medical reason and not rebooked, the Trust takes this very seriously and is committed to ensuring no patients breach this standard.

**Actions taken to improve performance**

Focus by Surgical Division.

| | |
|---|---|
| **Expected date to meet standard** | Apr-16 |
| **Lead Director** | Director of Service Delivery |

**Activity**



## OUR STAFF

# TOTAL PAYBILL

**Trust Standard**

**Total Paybill spend £'000**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| target + 0.5% | Jan-16 | £24,335 | R |

**What is driving the reported underperformance**

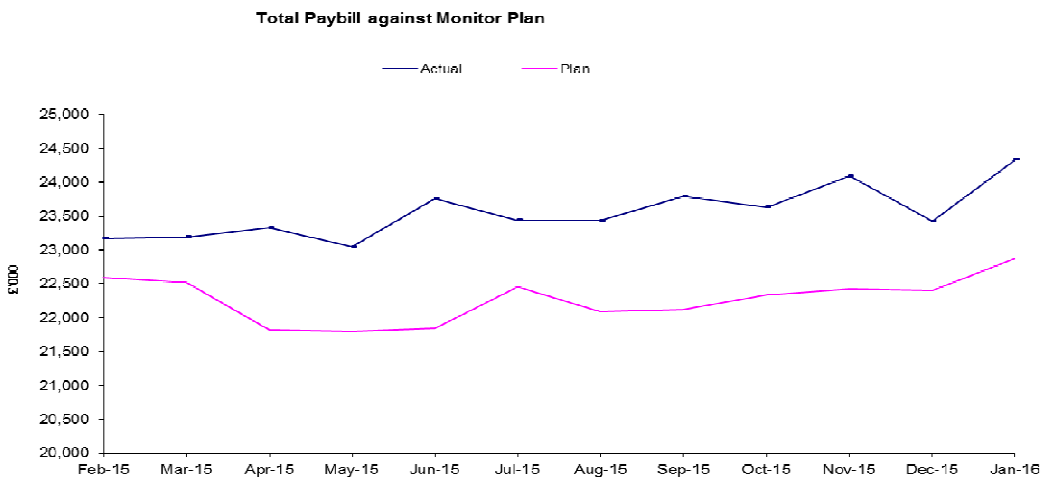
There is an overall increase of £910,000 from last month and in total, expenditure was approx. £1,458,000 or 6.37% over plan.
Agency expenditure increased by £201,100, Shared Services accounts for 45.6% & Women & Children's Division for 31% of this increase. Of the total £957,400 spent on agency staff last month, 46% is for Medicine Division. Temporary spending overall was £2,482,400 or 10.2% of the overall pay-bill.
Permanent expenditure also increased - by £483,200. Nearly 49% of this was on Medical Staff and a further 41% was on the Registered Nursing staff bill. Christmas period enhancements and the 7% uplift for some of Medical Divisions nursing staff would have had a significant effect.

**Actions taken to improve performance**

*An enhanced payments incentive for Nursing staff as an inducement to do additional shifts was introduced in early December. This payment is 'equivalent to overtime' which enables us to incentivise any shift over and above that worked in the contract. We have asked Nursing senior managers to promote this actively to ensure that we are cutting into the percentage of the nursing pay bill that is allocated to agency. A meeting has taken place with senior nursing staff to plan an exit from the more expensive 'off framework' agencies by April 1st, supported by additional recruitment in HCA's.*

| | |
|---|---|
| **Expected date to meet standard** | 2016-17 |
| **Lead Director** | Director of HR and OD |

**Activity**




# TOTAL WORKED

**Trust Standard**

**Total worked fte**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| On Target | Jan-16 | 6675.00 | R |

**What is driving the reported underperformance**

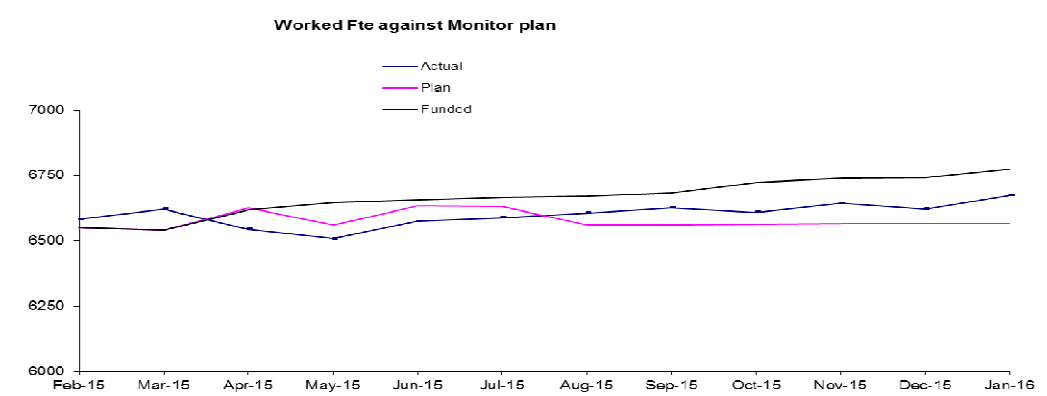
The worked FTE is lower than funded by 99 but higher than the Monitor Plan by 107 (1.6%).
Contracted fte was 79.34 higher than in March 15.
There are an additional 44.96 substantive Additional Clinical Staff & 20.47 Admin staff since March 15, these increases are offset by a reduction of 20.76 Estates & Ancillary & 18.92 Nursing staff.
Temporary staff usage is 23.57 fte higher than in March last year.

**Actions taken to improve performance**

Additional operational pressures in January saw the greater use of unfunded areas. We also need to reconcile the difference between the funded posts which will have increased as a result of business cases and the Monitor plan, which will have remained constant

| | |
|---|---|
| **Expected date to meet standard** | 2016-17 |
| **Lead Director** | Director of HR and OD |

**Activity**



# TURNOVER RATE (FTE)

**Trust Standard**

| Standard | Month | Actual | RAG for current month |
|---|---|---|---|
| 9.50% | Jan-16 | 11.18% | R |

**What is driving the reported underperformance**

Staff Nurse turnover has remained high in Medicine Division (22.89%), there has also been an increase in W&C Division, from 14.68 to 16.51%.

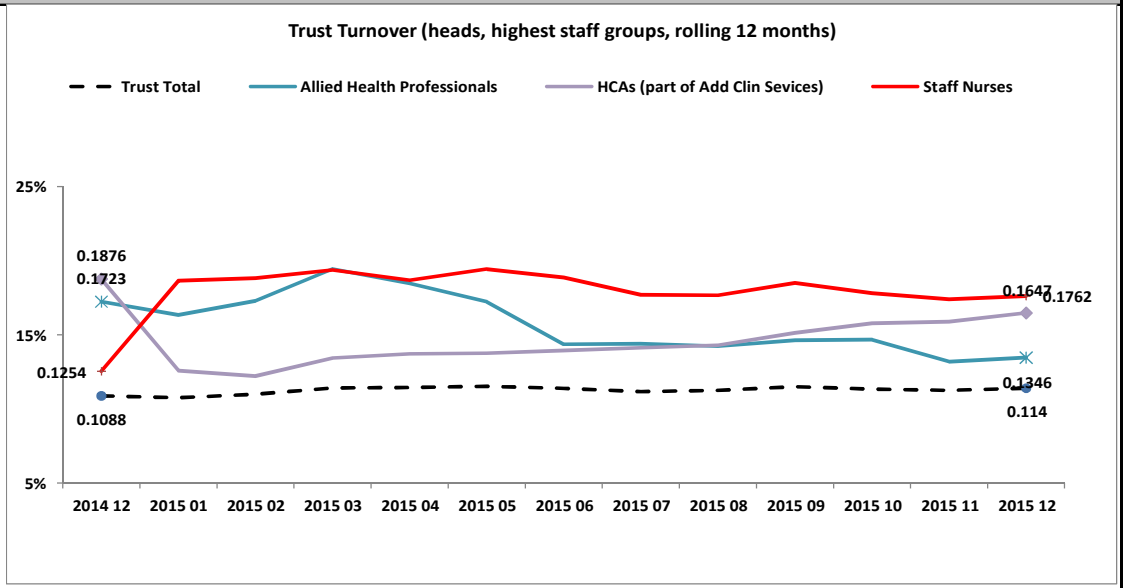
HCA Turnover in Medicine is now 22.29%

**Actions taken to improve performance**

*A Recruitment and Retention Premium Payment has been announced in GOAM and has been very well received, albeit it is too early to say if this is impacting significantly at this stage although we are told it has increased the flow of applications into this area. Recognising the particular challenges in Band 5 Nurse retention the Divisional Nursing Director has committed to personally interviewing every Nurse who resigns and will then make recommendations on mitigating actions to F+P Committee.*

| | |
|---|---|
| **Expected date to meet standard** | 2016-17 |
| **Lead Director** | Director of HR and OD |

**Activity**



PERFORMANCE MANAGEMENT FRAMEWORK

**RAG MEASUREMENTS : IM KPIs**

| OUR PATIENTS | | R | A | G |
|---|---|---|---|---|
| 18 weeks RTT | % of admitted patients seen in 18 weeks | Less than 90% seen in 18 weeks in last month | | 90%+ seen in 18 weeks in last month |
| | % of non admitted patients seen in 18 weeks | Less than 95% seen in 18 weeks | | 95%+ seen in 18 weeks |
| | % incomplete pathways under 18 weeks | Less than 92% waited under 18 weeks | | 92% or more waited under 18 weeks |
| Diagnostic Waits | Patients waiting over 6 weeks at month end for 15 key tests | More than 1.5% of patients waiting over 6 weeks | Between 1% and 1.5% of patients waiting over 6 weeks | Less than 1% of patients waiting over 6 weeks |
| | Patients waiting over 6 weeks from due date at month end for planned endoscopy | More than 20% of patients waiting over 6 weeks (small numbers) | Between 1% and 20% of patients waiting over 6 weeks (small numbers) | Less than 1% of patients waiting over 6 weeks (small numbers) |
| Cancer Waits | Patients referred urgently for suspected cancer seen in 14 days | less than 93% seen in 14 days | **For all cancer KPIs, a RAG of amber indicates underperformance but rectification plans in place to deliver by quarter end.** | 93%+ seen in 14 days |
| | Patients referred for breast symptoms seen in 14 days | less than 93% seen in 14 days | | 93%+ seen in 14 days |
| | Max 31 day wait from decision to treat to first treatment | less than 96% treated within 31 days diagnosis to 1st treatment | | 96%+ treated within 31 days diagnosis to 1st treatment |
| | Max 31 day wait from decision to treat to subsequent treatment (surgery) | less than 94% treated within 31 days | | 94%+ treated within 31 days |
| | Wait from decision to treat to subsequent treatment (drugs) | less than 98% treated within 31 days | | 98%+ treated within 31 days |
| | Wait from decision to treat to subsequent treatment (radiotherapy) | less than 94% treated within 31 days | | 94%+ treated within 31 days |
| | Wait from GP urgent referral to first treatment (*excludes rare cancers)* | 85% or less treated within 62 days | | 85% + first treated within 62 days from urgent GP referral |
| | Wait from national screening programme to 1st treatment | Less than 90% treated within 62 days from detection through national survey programme | | 90%+ treated within 62 days from detection through national screening programme |
| | Wait from consultant upgrade to 1st treatment | Under 90% treated within 62 days of consultant upgrade | | 90% + treated within 62 days of consultant upgrade |
| Discharges | Number of delayed discharges at month end | 17 or more at census | 16 or less at census | 14 or less at census |
| | | | | |
| | Bed days occupied by medially fit patients | | | |
| | % of discharge summaries sent by next working day | Less than 85% sent by next working day | | More than 85% sent by next working day |
| Cancellations | Patients cancelled by hospital on day of surgery for a non clinical reason as a % of G&A elective admissions | More than 0.9% cancelled on day | Less than 0.9% cancelled on day | Less than 0.8% cancelled on day |
| | Patients cancelled and not rebooked in 28 days | 2+ patients cancelled and not rebooked in 28 days | 1 patient cancelled on day and not rebooked | 0 patients cancelled on day and not rebooked in 28 days |

| OUR BUSINESS | | R | A | G |
|---|---|---|---|---|
| Re-admissions | Following either elective or emergency admission | More than 5.8% | Less than or equal to 5.8% | Less than 5.6% |
| Activity to Plan | Referrals to Plan | More than 5% above or below plan | Between 2.5% and 5% above or below plan | Within 2.5% of plan above plan or below plan |
| | Elective spells to plan | Less than -2.5% | More than -2.5% | More than -1% |
| | Emergency spells to plan | More than 5% above plan | Between 2.5% and 5% above plan | Within 2.5% of plan or below plan |
| | OP Attendance and procedures to plan | More than 5% above or below plan | Between 2.5% and 5% above or below plan | Within 2.5% of plan above plan or below plan |
| LOS | Admitted emergency patient provider spell General and Acute Specialities LOS | More than 6 days | Less than 6 days | Less than 5.8 days |
| | Admitted elective patient provider spell General and Acute Specialities LOS | More than 3.6 days | Less than 3.6 days | Less than 3.4 days |
| Data Quality | % records submitted nationally with valid GP code | More than 1% below national average | Within 1% below national average | National average or better |
| | % records submitted nationally with valid NHS number | More than 1% below national average | Within 1% below national average | National average or better |

| OUR SERVICES | | | | |
|---|---|---|---|---|
| Mortality | Hospital Standardised Mortality Ratio (HMSR) | >1.10 | | <1.10 |
| | Crude Mortality rates | >2.5% | <2.5% | <2% |
| Seen by Midwife | % of women recorded as seen by midwife at 12 weeks | Less than 81% | 81% or more | 90% or more |
| Stroke Patients | % of stroke patients spending 90% of stay on stroke ward | Less than 80% | | 80% or more |
| VTE | % of eligible patients with VTE risk assessment | Less than 94% | 94% or more | 95% or more |
| Waits in ED | % patients treated in A&E in under 4 hours - Trustwide | More than 95% seen in 4 hours in month | | 95% or less seen in 4 hours in month |
| Ambulances queuing | ambulances delayed 30 – 60 minutes | More than number at same time last year | | Less than number at same time last year |
| | ambulances delayed over 60 minutes | More than number at same time last year | | Less than number at same time last year |

# GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

## REPORT OF THE FINANCE DIRECTOR

## FINANCIAL PERFORMANCE FOR THE PERIOD TO 31ST JANUARY 2016

### 1. Executive Summary

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

| | Month 10 YTD actual | Month 10 YTD plan | Variance | Full Year Plan |
|---|---|---|---|---|
| | | | | |
| Delivering planned surplus | £0.5m | £0.3m | £0.2m | £4.0m |
| | | | | |
| Monitor Financial Sustainability Risk Rating | 3 | 3 | (0) | 3 |
| | | | | |
| Better Payment Practice Code (by value) | 67% | 95% | (28%) | 95% |
| | | | | |
| Capital expenditure | £9.5m | £11.4m | £1.9m | £16.5m |
| | | | | |

**Key Issues:**

- The financial position of the Trust at the end of month 10 is a surplus of £0.5m on income and expenditure. This is in line with the position reported in Month 9.

- Operational pressures continue and temporary staffing expenditure is £0.4m higher than the expenditure in Month 9. If agency pay expenditure in months 5 to 10 had been contained at the month 2 level the reported overall surplus would have improved to £4.2m.

- The Trust needs to continue to improve its controls on the use of agency staff, discretionary expenditure and accelerate the delivery of its Cost Improvement Programme to bring the overall position back in to line with plan as soon as possible.

- The Monitor risk assessment under the new framework shows a Financial Sustainability Risk Rating of 3.

- The surplus of £0.5m on the income and expenditure position represents a favourable variance of £0.2m from the planned position of £0.3m surplus of income over expenditure at the end of month 10.

- The cash position has improved to £7.2m at the end of the month. New measures are in place to improve this position over the coming months.

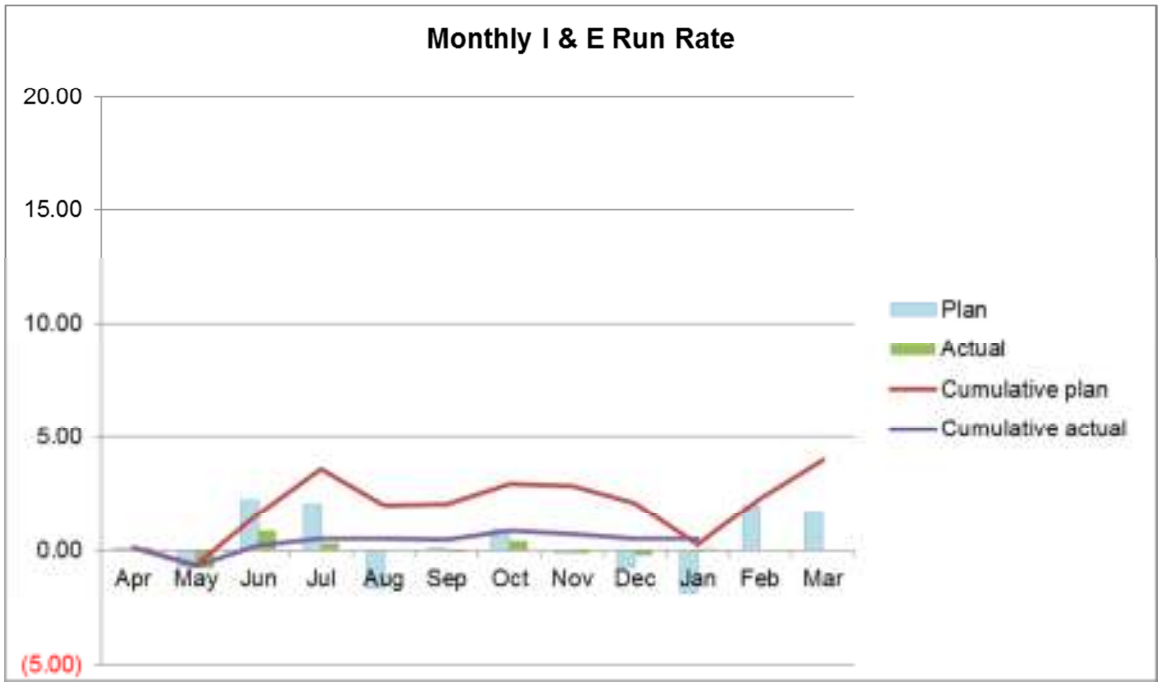
- The impact of the emergency cap cumulative to Month 10 was £1.2m.

### 2. Financial Position to 31 January 2016

The position at month 10 of the 2015/16 financial year is a surplus of £0.5m on income and expenditure, which represents a favourable variance of £0.2m against plan, as summarised in the table below.

| | Annual Plan £000's | YTD Plan £000's | YTD Actual £000's | YTD Variance £000's |
|---|---|---|---|---|
| SLA & Commissioning Income | 414,441 | 344,206 | 352,805 | 8,599 |
| PP, Overseas and RTA Income | 5,557 | 4,631 | 4,770 | 139 |
| Operating Income | 62,785 | 52,495 | 52,805 | 310 |
| **Total Income** | **482,783** | **401,331** | **410,380** | **9,049** |
| Pay | 294,713 | 244,454 | 258,426 | (13,972) |
| Non-Pay | 160,180 | 136,669 | 133,113 | 3,555 |
| **Total Expenditure** | **454,893** | **381,122** | **391,539** | **(10,417)** |
| **EBITDA** | **27,890** | **20,209** | **18,841** | **(1,368)** |
| **EBITDA %age** | **5.8%** | **5.0%** | **4.6%** | **-0.4%** |
| Depreciation | 12,391 | 10,326 | 9,069 | 1,256 |
| Public Dividend Capital Payable | 7,028 | 5,857 | 6,152 | (295) |
| Interest Receivable / Payable | 4,491 | 3,743 | 3,098 | 645 |
| **Funds Available for Investment** | **3,980** | **284** | **522** | **238** |

The graph below illustrates the run rate and performance against plan for the year.




The income and expenditure position at the end of January has been maintained with the surplus remaining at £0.5m. The variance from plan has improved by £1.8m between months.

Income from contracts is £8.6m above plan. However, the increased use of agency staff is having a negative impact on the Trusts savings plans and the overall pay expenditure. 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.

A breakdown of the Income and Expenditure information in the above table into Divisional financial positions can be found at Appendix A.

## 3. Income

Total income for the first ten months of the 2015/16 financial year was £9.0m above the planned level. This is due to an over performance of income from contracts of £8.6m and an over performance in other income of £0.4m.

The table below shows the commissioner income position to the end of Month 10 by point of delivery. A breakdown of income by commissioner is shown in Appendix B.

| | Activity | | | Contract Value £000 | | |
|---|---|---|---|---|---|---|
| **Service** | **Plan** | **Actual** | **Variance** | **Plan** | **Actual** | **Variance** |
| Referrals | | 44,036 | | | | |
| Elective Inpatient Spells | 10,142 | 9,636 | (506) | 32,888 | 32,636 | (252) |
| Daycase Spells | 39,042 | 43,329 | 4,287 | 29,951 | 32,472 | 2,522 |
| Non-elective Spells | 1,191 | 1,111 | (80) | 2,093 | 1,814 | (280) |
| Emergency Spells | 38,265 | 40,881 | 2,616 | 71,278 | 75,221 | 3,943 |
| Outpatient Attendances | 378,029 | 375,843 | (2,186) | 42,131 | 42,838 | 708 |
| Outpatient Procedures | 99,974 | 105,280 | 5,306 | 14,767 | 14,978 | 211 |
| A&E Attendances | 105,337 | 105,453 | 116 | 12,599 | 12,867 | 268 |
| Radiology Direct Access | 33,703 | 32,194 | (1,509) | 2,314 | 2,015 | (299) |
| Radiology Unbundled | 12,554 | 16,093 | 3,538 | 1,410 | 1,673 | 263 |
| Renal Dialysis | 40,335 | 50,992 | 10,657 | 4,950 | 5,728 | 777 |
| Excluded Drugs | | | | 36,120 | 39,148 | 3,028 |
| Other Non-PbR | | | | 93,704 | 91,415 | (2,289) |
| **Grand Total** | | | | **344,207** | **352,805** | **8,598** |

Key issues to note include:

- **Referrals**
  Referrals are 2.6% higher than the first 10 months of 2014/15 (+2.9% to month 9). Within this GP referrals are 3.0% ahead of the same period last year which is continuing to put significant pressure on divisions and their ability to deliver efficiency savings through cost improvement and QIPP schemes.

- **Elective/Daycase**
  Combined elective and day case activity is 7.6% above plan on activity and 3.6% above plan on income. When separated out, elective activity is 4.9% below plan on activity and 0.7% below plan on income whilst daycase activity is 7.0% above plan with income 4.8% above plan on the same comparative basis as last month.

- **Emergency Activity**
  The Emergency spells position is 6.8% above plan in activity terms, and income is above plan by 5.5%.

  The impact on income of the Emergency Cap at month 10 was £1.2m, which is £183k in excess of the planned level of £990k and is a further reduction to the total income for the Trust.

- **Emergency Department**
  Emergency Department activity and income are broadly in line with plan. Work is continuing with the CCG to reduce the pressures being experienced by Emergency Department services across the county as demand pressures continue.

- **Outpatients**
  Outpatient activity and income are above plan by 0.6% and 1.6% respectively.

- **Radiology Direct Access**
  Radiology Direct Access activity and income are below plan by 4.4% and 12.9% respectively.

- **Unbundled Radiology**
  Activity and income levels are above plan by 28% and 19% respectively.

- **Excluded Drugs**
  Excluded drugs remain at 8.3% ahead of plan after the first ten months of 2015/16.

## 4. Expenditure

Expenditure against plan for the first ten months of the 2015/16 financial year represents an overspending of £10.4m against approved budgets.

### Pay Expenditure

At Trust level for the ten months ending January 2016 pay expenditure was above plan by £14.0m.

At a Divisional level the main contributory factor to the overspend was the impact of operational pressures within the health system. The system-wide operational issues have increased the challenge of the CIP Programme due to the cost of medical outliers and agency staff. Unachieved CIP remains a concern with recovery plans supported by the CIP Director, Director of Finance and Director of Service Delivery being put in place. Financial review meetings have taken place with the Divisions and specific initiatives have been agreed to improve the expenditure position.

Actual pay expenditure by staff group is shown in the table overleaf.

| Pay Expenditure – Analysis by Staff Group | Annual Plan £000's | YTD Plan £000's | YTD Actual £000's | YTD Variance £000's | YTD Variance % |
|---|---|---|---|---|---|
| Divisional Pay: | | | | | |
| Senior Medical | 49,424 | 40,970 | 42,671 | (1,701) | -4.15% |
| Junior Medical | 28,229 | 23,248 | 26,802 | (3,553) | -15.28% |
| Nursing | 100,067 | 83,012 | 87,728 | (4,716) | -5.68% |
| Admin & Clerical and Management | 32,383 | 26,885 | 28,964 | (2,078) | -7.73% |
| Clinical Support Services | 42,631 | 35,406 | 36,449 | (1,043) | -2.95% |
| Other Non Clinical | 9,518 | 7,908 | 8,196 | (288) | -3.64% |
| Other staff (includes CIP target) | 866 | 695 | 473 | 221 | 31.78% |
| Divisional Pay sub total | | | | | |
| Hosted Services Pay | 25,974 | 21,645 | 22,199 | (554) | -2.56% |
| Shared Services and Other Pay | 5,620 | 4,684 | 4,944 | (260) | -5.55% |
| Total | 294,713 | 244,454 | 258,426 | (13,972) | -5.72% |

Key issues to note for the month include:

- Total Pay expenditure for January was just over £26.6m, which is £1.0m higher than December and the highest month this year.
- Total temporary staffing expenditure during the month was £2.5m, which was £0.4m higher than previous month and £600k above the monthly average for 2014/15. It is anticipated that the reliance on temporary staffing will reduce as a result of the recent recruitment campaigns, although staff turnover is also having a significant impact on divisions.
- The level of Pay expenditure over plan of 5.7% is not in line with the total income recovery over plan of 2.2%.
- Cumulative Divisional pay overspends were most significant within Medicine/USC (£7.5m overspent) and Surgery (£6.1m overspent) which relates to both Nursing and Medical staff.
- Whilst Nursing is still showing the highest financial variance against plan at £4.7m (5.68%), the largest variance in terms of percentage from plan is Junior Medical staffing at 15.28% (£3.6m).
- To cope with the demand pressures and to cover the hard to fill middle grade medical posts in the Emergency Department, additional payments are being made to senior medical grade staff who are working additional sessions to cover these gaps.
- Unachieved pay savings are in part linked to the use of agency staff to cover hard to fill posts and are still the main contributor to the adverse pay position within divisions with the CIP targets currently profiled over 12 months.

The table on the next page illustrates a sub set of the pay expenditure above and shows the temporary staffing expenditure by staff group and expenditure type. Comparison of trends from previous months shows January expenditure at £0.4m higher than December and £0.6m above the monthly average of 2014/15.

| Temporary Staffing Expenditure – Analysis by Staff Group | Expenditure to date £000's |
|---|---|
| Medical Agency & Locum | 7,660 |
| Nursing Agency | 5,460 |
| Nursing Bank | 5,439 |
| Other Clinical staff | 976 |
| Non Clinical staff | 3,588 |
| **Total** | **23,122** |

Monitor and the NHS Trust Development Authority (TDA) continue to scrutinise the level of nursing agency expenditure at each Trust. We anticipate that this level of interest will intensify over the coming months.

**Non Pay Expenditure**

During January non-pay expenditure was below plan and is now cumulatively below plan by £3.5m for the year to date. Within this total non-pay position, the Divisional non-pay underspend has increased to £1.8m in Month 10 with Hosted Services and Shared Services Non Pay underspend increasing to £1.7m in Month 10.

Actual monthly non pay expenditure is shown in the table below.

| Non-Pay Expenditure | Annual Plan £000's | YTD Plan £000's | YTD Actual £000's | YTD Variance £000's | YTD Variance % |
|---|---|---|---|---|---|
| **Divisional Non Pay:** | | | | | |
| Drugs | 51,851 | 43,010 | 43,937 | (927) | -2.16% |
| Medical and Surgical Equipment (MSE) | 40,527 | 34,219 | 33,862 | 357 | 1.0% |
| Contract Services and Service received | 20,126 | 17,100 | 18,416 | (1,316) | -7.69% |
| Energy / Utilities | 5,602 | 4,702 | 4,804 | (102) | -2.18% |
| Building and other Estate expenses | 5,916 | 4,987 | 4,998 | (12) | -0.24% |
| Establishment expenses | 11,618 | 9,998 | 9,000 | 997 | 9.98% |
| Other Non-Pay (includes CIP target) | 23,032 | 21,395 | 18,568 | 2,827 | 13.22% |
| Total Divisional Non Pay | 158,671 | 135,411 | 133,586 | 1,826 | 1.35% |
| Hosted Services Non Pay | 344 | 286 | 431 | (145) | -50.55% |
| Shared Services & Other Non Pay | 1,165 | 971 | (904) | 1,875 | 193.10% |
| Total | 160,180 | 136,669 | 133,113 | 3,556 | 2.60% |

Key issues to note for the month include

- Overall Non-pay expenditure underspent in comparison to plan by £1.8m.
- Drug expenditure underspent in comparison with plan in month 10 by £0.6m with a year to date position showing a £0.9m overspending.
- Medical & Surgical Equipment expenditure in month 10 underspent in comparison to plan by £0.2m and stands at £0.3m below plan for the year to date.
- Discussions continue with Gloucestershire Care Services around the charging arrangements to the Trust which is impacting on the non-pay position.

## 5. Savings Plans

The current status of CIP schemes is summarised in the table below.

| Divisions | 2015/16 In Year Targets £'000 | Green £'000 | Amber £'000 | Red £'000 |
|---|---|---|---|---|
| Surgery | 6,959 | 7,065 | 71 | 0 |
| Medicine | 5,680 | 5,467 | 0 | 213 |
| W&C | 2,473 | 2,185 | 108 | 180 |
| D&S | 5,793 | 1,826 | 410 | 3,557 |
| EFD | 1,417 | 1,383 | 0 | 34 |
| Corporate | 1,681 | 866 | 0 | 815 |
| Trustwide | | 200 | 0 | 0 |
| **Total (£'000)** | **24,003** | **18,992** | **589** | **4,599** |
| | | | | |
| **Total (%)** | | **79%** | **2%** | **19%** |

Green schemes have increased by 3% in the month with a corresponding decrease in the Amber schemes.

There have been changes made to support the delivery of CIP effective from 1st January 2016. The Director of Finance and Director of Service Delivery are reviewing and supporting divisions with the development of CIP proposals for next financial year in addition to the delivery of schemes for the final quarter of this year.

## 6. Risk Analysis

There are a number of financial and operational risks facing the Trust that could impact on its ability to deliver the forecast surplus. Work continues to improve the position in the remaining weeks of the year. The main risks are outlined in the following table, together with a brief summary of the plans for mitigation:

| Risk | | Mitigation |
|---|---|---|
| | **£m** | |
| Identified savings do not deliver required level of expenditure reductions in the financial year. | 2.8 | Savings devolved to divisions and monthly divisional executive reviews in place to performance manage delivery by CIP Director. Half Yearly Financial Review undertaken |
| Pay expenditure run rate does not reduce | 4.8 | Fortnightly Divisional meetings |
| Activity performance not in accordance with plan | 0.4 | Additional support and executive review |
| There are potential financial penalties for missing contractual targets | 2.0 | Improvement plan to mitigate risks, |
| **Total** | **10.0** | |

The Monitor Financial Sustainability Risk Rating is attached at Appendix C.

## 7. Statement of Financial Position 2015/16

The Trust's Statement of Financial Position is attached at Appendix D. There are no specific issues to bring to the Main Board's attention other than those outlined below.

### Capital Programme

Capital programme expenditure during the first ten months of the year totalled £9.5m. Details can be found in the table below.

| Capital Programme 2015-16 | Annual Plan £'000s | Mth 10 YTD Plan £000s | Mth 10 YTD Expenditure £'000s | Mth 10 Variance £'000s |
|---|---|---|---|---|
| Building schemes | 1,595 | 1,089 | 1,210 | (120 ) |
| Infrastructure maintenance | 2,438 | 2,565 | 1,885 | 679 |
| Other estates | 440 | 209 | 102 | 107 |
| Service reconfigurations | 1,180 | 873 | 131 | 742 |
| **Sub Total** | **5,653** | **4,735** | **3,328** | **1,408** |
| Major equipment infrastructure works | 1,336 | 724 | 203 | 521 |
| Medical Equipment | 3,006 | 1,480 | 1,479 | 1 |
| Information Management & Technology | 6,500 | 4,500 | 4,457 | 43 |
| **Total Expenditure** | **16,495** | **11,440** | **9,467** | **1,972** |

A detailed review of the capital programme is being undertaken by the Director of Estates and Facilities, Director of Finance and the Director of Service Delivery to confirm the 2015/16 forecast position and to inform the 2016/17 Capital Programme planning process.

### Better Payment Practice Code (Creditors)

Cumulatively to the end of January 2016 (month 10) the BPPC performance was 67% by value and 39% by Number. Whilst there is no formal Monitor assessed or measured target a good practice benchmark is 95% and work to improve the Trust position against this benchmark is ongoing.

| | Cumulative for Financial Year 2015/16 Month 10 | | Cumulative for Financial Year 2014/15 Month 10 | |
|---|---|---|---|---|
| | £'000 | Number | £'000 | Number |
| Total Bills Paid Within period | 272,946 | 100,181 | 274,770 | 93,398 |
| Total Bill paid within Target | 182,833 | 38,937 | 231,041 | 70,297 |
| Percentage of Bills paid within target | 67% | 39% | 84% | 75% |

Although the BPPC remains similar to month 9, the number of invoices paid has increased in comparison to the same period last year, with payments being targeted at small companies to ensure they are paid more promptly.

Measures have been taken to improve the actual bills paid within the target. This includes a review of the 'No Purchase Order, No Pay' system and improvements to receipting of orders in a more timely fashion. The trust is working with our commissioners to improve receipt of cash within the month and within contract terms.

## Debtors

The Trusts aged debt analysis at the end of January 2016 is shown in the table overleaf. 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 days | 120+days | Total |
|---|---|---|---|---|---|---|
| English CCGs | 5,691 | 4,206 | 957 | 145 | 804 | 11,803 |
| Other English NHS | 4,334 | 578 | 1,055 | 347 | 5,447 | 11,761 |
| Other Territory NHS | 197 | 24 | 37 | 10 | 431 | 699 |
| Overseas Patients | 40 | 28 | 8 | 14 | 297 | 387 |
| Private Patients | 235 | 54 | 37 | 19 | 216 | 561 |
| Other Non-NHS | 546 | 177 | 63 | 55 | 230 | 1,071 |
| | **11,043** | **5,066** | **2,157** | **589** | **7,426** | **26,282** |

## Cash Balances

The Trust cash balance at the end of January 2016 stands at £7.2m which is an improvement of £1.5m since last month. The position is illustrated in the table below.

| Trust Cashflow Statement Jan-16 | January £'000 |
|---|---|
| Opening Bank Balance | 5,761 |
| **Receipts** | |
| Main CCG SLAs | 33,510 |
| All other NHS Organisations | 5,013 |
| Other Receipts | 1,464 |
| Total Receipts | 39,988 |
| **Payments** | |
| Payroll | (24,828) |
| Creditor(including capital)payments | (13,707) |
| Other Payments | 0 |
| Total Payments | (38,535) |
| Closing Bank Balance | 7,214 |

## 8. Recommendation

The Board are asked to note:

- The financial position of the Trust at the end of month 10 is a surplus of £0.5m on income and expenditure. This is in line with the position reported at Month 9.
- The £0.5m surplus represents a favourable variance of £0.2m from the planned position of £0.3m surplus of income over expenditure at the end of January 2016.
- The Trust needs to continue to improve its controls on the use of agency staff, discretionary expenditure and accelerate the delivery of its Cost Improvement Programme to bring the overall position back in to line with plan as soon as possible.
- The new Monitor risk assessment framework shows a Financial Sustainability Risk Rating of 3.
- Actions to address the issues identified in this report will continue in 2015/16 and progress will continue to be reported monthly to the Finance and Performance Committee and the Foundation Trust Board.

**Author:** **Sean Ceres, Interim Director of Operational Finance**

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

**Date:** **February 2016**

**Appendices**

A Divisional budget positions
B Healthcare Contract Income by Commissioner
C Financial Sustainability Risk Rating
D Statement of Financial Position

**APPENDIX A**

**DIVISIONAL POSITION AS AT THE END OF MONTH 10 - JANUARY 2016**

| | TRUST TOTAL | | | DIVISIONAL VARIANCE POSITIONS | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Plan £'000 | Actual £'000 | Variance £'000 | Medicine & USC £'000 | Surgery £'000 | D & S £'000 | W & C £'000 | Corporate £'000 | EFD £'000 | Trustwide £'000 |
| Commissioning Income | 344,206 | 352,805 | 8,599 | 3,666 | 2,551 | 1,360 | 1,414 | 2,756 | 0 | (3,148) |
| Operating income | 57,125 | 57,575 | 450 | (2,120) | (3,229) | (283) | (306) | 88 | (776) | 7,077 |
| Pay expenditure | 244,454 | 258,426 | (13,972) | (7,497) | (6,075) | (922) | (566) | (729) | (704) | 2,521 |
| Non pay expenditure | 136,669 | 133,113 | 3,555 | (2,649) | 229 | (787) | (418) | 124 | 1,393 | 5,664 |
| Non Operating Costs | 19,925 | 18,319 | 1,606 | 0 | 0 | 0 | 0 | 0 | 0 | 1,606 |
| **Total** | **284** | **522** | **238** | **(8,600)** | **(6,525)** | **(633)** | **124** | **2,239** | **(87)** | **13,719** |
| **Last Month Variance** | **2,102** | **509** | **(1,593)** | **(7,516)** | **(5,318)** | **(1,441)** | **182** | **1,331** | **(33)** | **11,202** |
| **Movement** | **(1,818)** | **13** | **1,831** | **(1,084)** | **(1,207)** | **809** | **(58)** | **908** | **(54)** | **2,517** |

**APPENDIX B**

## HEALTHCARE CONTRACT INCOME POSITION AS AT MONTH 10

| 2015/16 Healthcare contracts position as at Month 10 | 2015/16 Full year plan £000 | Month 10 Plan £000 | Month 10 Actuals £000 | Variance £000 |
|---|---|---|---|---|
| NHS Gloucestershire CCG | 292,592 | 242,677 | 250,249 | 7,573 |
| Worcestershire Health Community | 10,828 | 8,970 | 8,976 | 5 |
| NHS Hereford CCG | 3,748 | 3,112 | 3,460 | 348 |
| Wiltshire Health Community | 2,979 | 2,469 | 2,182 | (287) |
| NHS South Warwickshire CCG | 250 | 207 | 168 | (39) |
| Oxfordshire CCG | 386 | 320 | 414 | 93 |
| Specialist Commissioning Group | 74,180 | 61,679 | 64,586 | 2,907 |
| Welsh Commissioners | 3,435 | 2,851 | 3,516 | 665 |
| Other Commissioner Income | 22,026 | 18,585 | 15,899 | (2,686) |
| Non Contractual Agreements (NCAs) | 4,017 | 3,336 | 3,354 | 19 |
| **NHS CLINICAL REVENUE** | **414,441** | **344,206** | **352,805** | **8,599** |

**APPENDIX C**

**Monitor Financial Sustainability Risk Rating calculation January 2016**

| | | | Jan-16 | |
|---|---|---|---|---|
| Continuity of Services | Balance Sheet Sustainability | **Capital Service** | | |
| | | Revenue Available for Capital Service | 19,563 | |
| | | Capital Service | (11,288) | |
| | | **Sum = (calc above x no. of days)** | **1.71** | **Key to scoring - Liquidity (25% weighting)** |
| | | **Rating** | **2** | |

| 4 | 3 | 2 | 1 |
|---|---|---|---|
| >2.5 | 1.75-2.5 | 1.25-1.75 | <1.25 |

| | | | Current month | |
|---|---|---|---|---|
| | Liquidity | **Liquidity** | | |
| | | Working capital balance | (12,962) | |
| | | Operating expenses within EBITDA | (391,540) | |
| | | **Sum = (calc above x no. of days)** | (9.9) | **Key to scoring - Debt Service Cover (25%weighting)** |
| | | **Rating** | **2** | |

| 4 | 3 | 2 | 1 |
|---|---|---|---|
| <0 days | (7) - 0 days | (14) - (7) days | >(14) days |

| | | | | |
|---|---|---|---|---|
| Financial efficiency | Underlying performance | **I & E Margin** | | |
| | | Normalised Surplus (deficit) | 522 | |
| | | Total Income | 411,028 | |
| | | **I&E Margin** | **0.13%** | **Key to scoring - I & E Margin (25% weighting)** |
| | | **Rating** | **3** | |

| 4 | 3 | 2 | 1 |
|---|---|---|---|
| >1% | 0 - 1% | (1) - 0% | <(1)% |

| | | | | |
|---|---|---|---|---|
| | Variance from plan | **I & E Margin Variance From Plan** | | |
| | | I & E Margin | 0.13% | |
| | | I & E Margin Variance from Plan | -0.55% | **Key to scoring - Variance in I& E Margin(25%weighting)** |
| | | **Rating** | **3** | |

| 4 | 3 | 2 | 1 |
|---|---|---|---|
| >0% | (1) - 0% | (2) - (1)% | <(2)% |

| | | | |
|---|---|---|---|
| | | **OVERALL RATING** | **3** |

**APPENDIX D**

Gloucestershire Hospitals NHS Foundation Trust
Statement of Financial Position

| Trust Financial Position as at 31 January 2016 | Opening Balance £000 | Closing Balance £000 |
|---|---|---|
| Non-Current Assests | 304,135 | 303,840 |
| Current Assets | | |
| Inventories | 7,250 | 7,926 |
| Trade and Other Receivables | 38,280 | 41,136 |
| Cash and Cash Equivalents | 5,761 | 7,214 |
| Total Current Assets | 51,291 | 56,276 |
| Current Liabilities | (57,582) | (61,312) |
| Net Current Assets | (6,291) | (5,036) |
| Non-Current Liabilities | (70,367) | (70,314) |
| **Total Assets Employed** | 227,477 | 228,490 |
| Financed by Taxpayers Equity | | |
| Public Dividend Capital | 165,519 | 166,519 |
| Reserves | 66,928 | 66,828 |
| Retained Earnings | (4,970) | (4,857) |
| Total Taxpayers' Equity | 227,477 | 228,490 |

# EMERGENCY PATHWAY REPORT
# MONTHLY PERFORMANCE REPORT: JANUARY 2016
# FOR MAIN BOARD IN FEBRUARY 2016

## 1. Executive Summary

### Key Messages

- The 95% 4 hour target for Emergency Department performance was not successfully met in January 2016, with Trustwide performance reported as 80.16%. Neither site achieved the 95% standard in January.

- The daily average number of Emergency Department attendances in January 2016 was 346 patients (10,734 for the month), compared to January 2015 (293 per day) and December 2015 (350 per day). The work of the GP in the Gloucestershire Royal Hospital Emergency Department is not included in the 2015/16 attendances.

- The daily average number of admissions from the Emergency Department in January 2016 was 120 patients (3,709 for the month), compared to January 2015 (108 per day) and December 2015 (123 per day).

- General and Acute average length of stay for non-elective admissions in January 2016 was 6.07 days compared to 5.48 days in December 2015. The internal target for Quarter 4 is 5.8 days.

- The number of patients on the medically fit list for one day and over has been at an average of 54 throughout January 2016. This is 3 patients more than the previous month, and remains above the system-wide plan of no more than 40 patients.

### New Services Commenced in January 2016

- Intra-venous Therapy Nurse has been appointed for a 12-month secondment, to facilitate earlier discharges for patients on IVs.

- 7 Day Services: Ward Clerk Manager in post and 22 wards will have weekend cover (70% of all Inpatient wards) by the end of February 2016.

### Key Risks

- Demand exceeding both the contractual plan and historical levels. As at the end of January 2016, admissions were 5.3% higher than last year.

- 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 the biggest 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 speed up discharge processes at the Trust. This involves close working with health and social care partners. Details of these projects are contained within this report.

- From February 2016, the Gloucestershire healthcare system has established the Six Week Improvement to Flow and Transfer (SWIFT) action plan.

## 2. 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 January 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.

## 3. Emergency Pathway Metrics

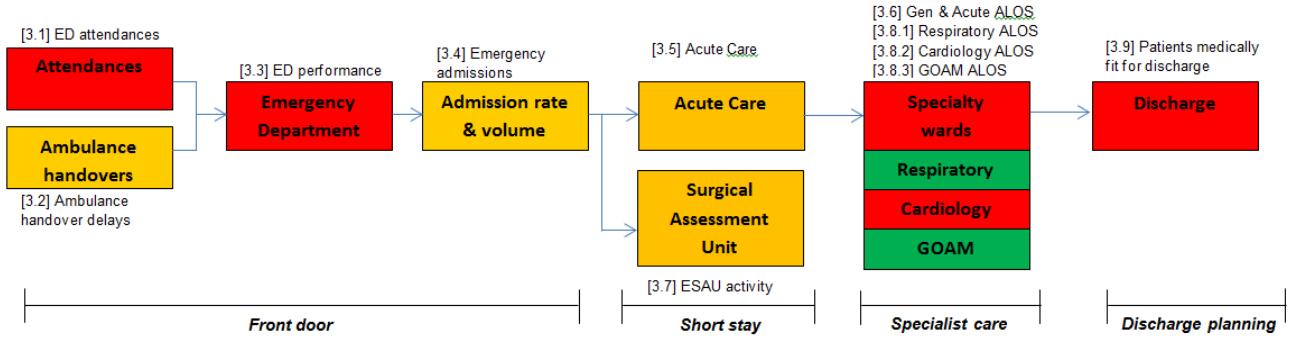
The diagram below shows the key processes within the emergency pathway.

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 Monitor and the Trust is focusing on three key areas:

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

### 3.1 Emergency Department Attendances

**Aim:** To ensure Emergency Department attendances remain in line with 2015/16 plan.

**How:** Work with:-

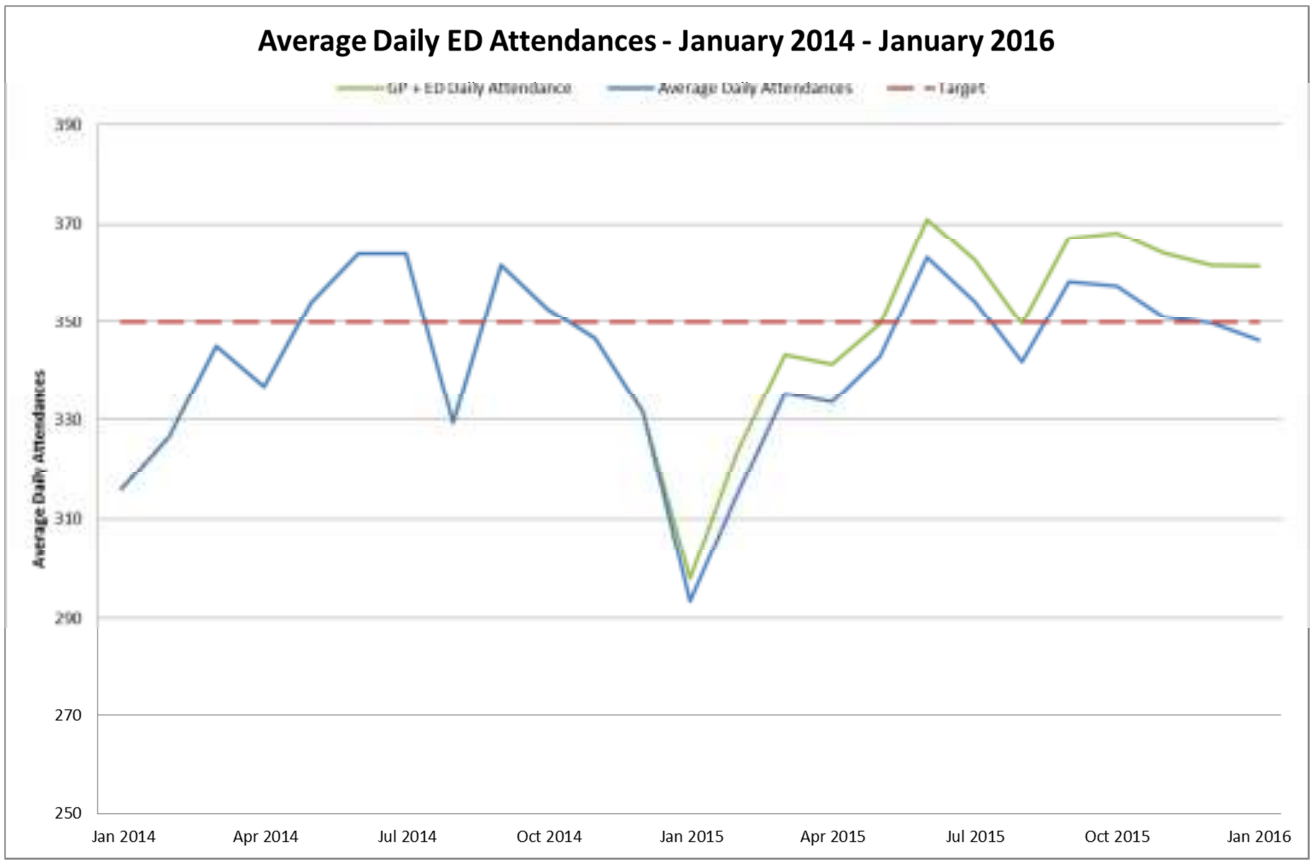
- South Western Ambulance Service NHS Foundation Trust (SWAST) to 'Smooth' emergency demand in the system;
- Integrated Discharge Team (IDT) within Emergency Department to increase direct admissions to community hospitals from Emergency Department;
- Develop the Older Person's Assessment and Liaison (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 10,734 attendances in January 2016 (average of 346 per day) which is in line with December 2015 and the plan of 350 per day, but significantly higher than January 2015.

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.

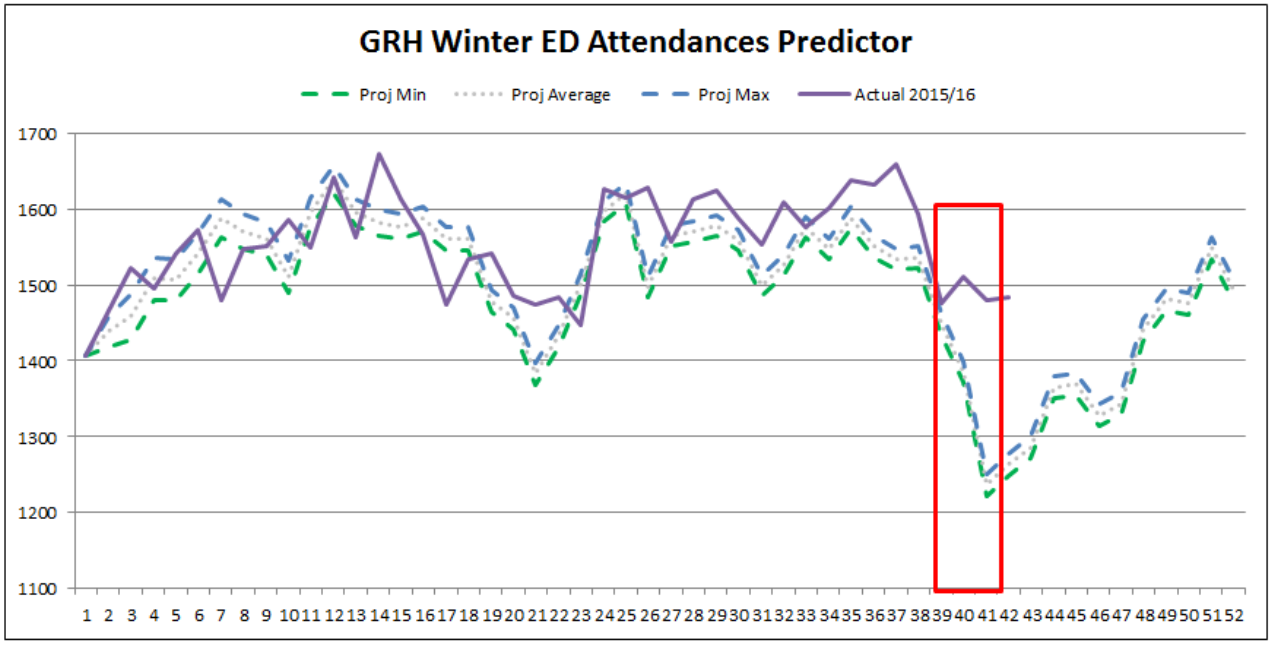
**Emergency Department Attendances Chart:**

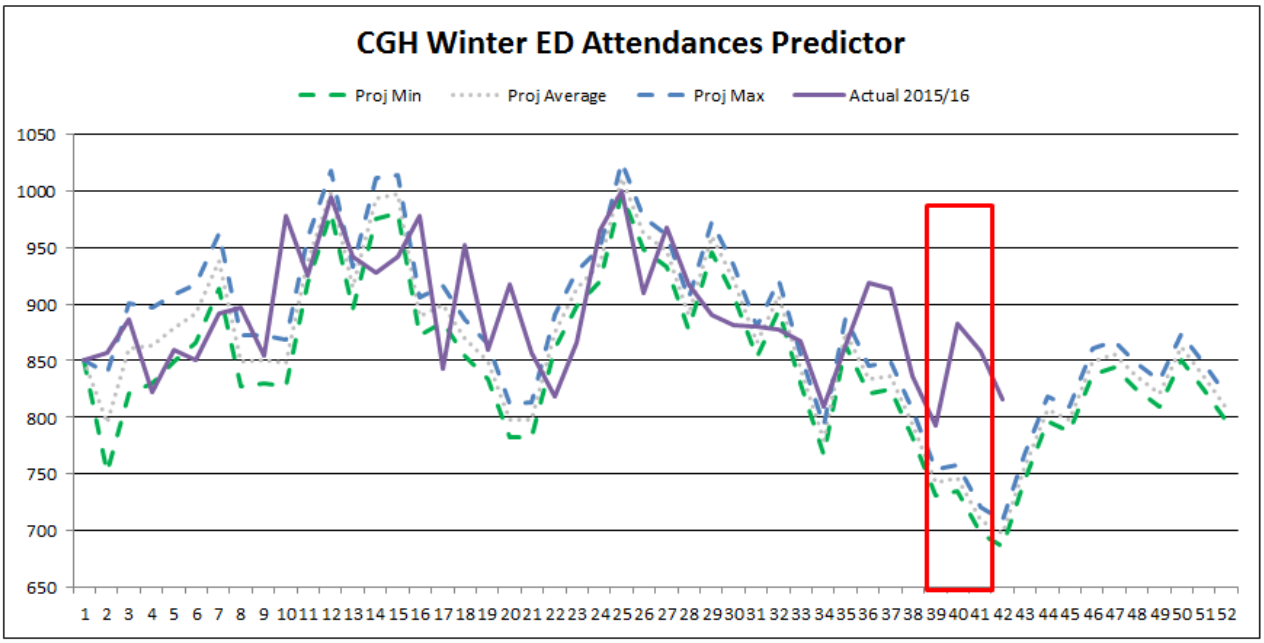


**Emergency Department Winter Predictor Charts:**

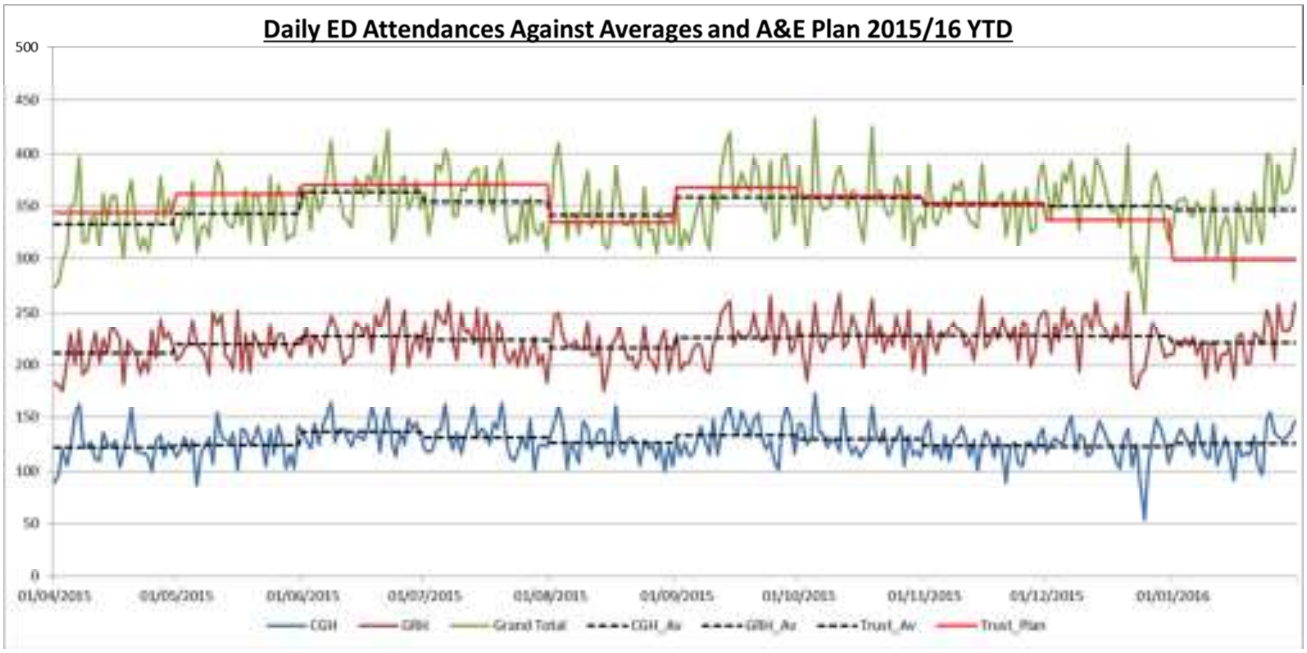
The chart above shows a significant increase in the average number of daily attendances in January 2016 compared to January 2015. The charts below were initially created as part of winter planning and the 2015/16 actuals were in line with the projections, which were based on 2014/15 activity. Therefore, it was assumed that Christmas and New Year weeks would also follow this pattern.

However, the updated charts which now include the actuals for the Christmas and New Year period (Christmas is week 39 and week 41 is week commencing the 4th January 2016), clearly show that activity was significantly higher this year. Trustwide, there was a net rise in attendances of 378 between 24th December 2015 and 6th January 2016.



**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.

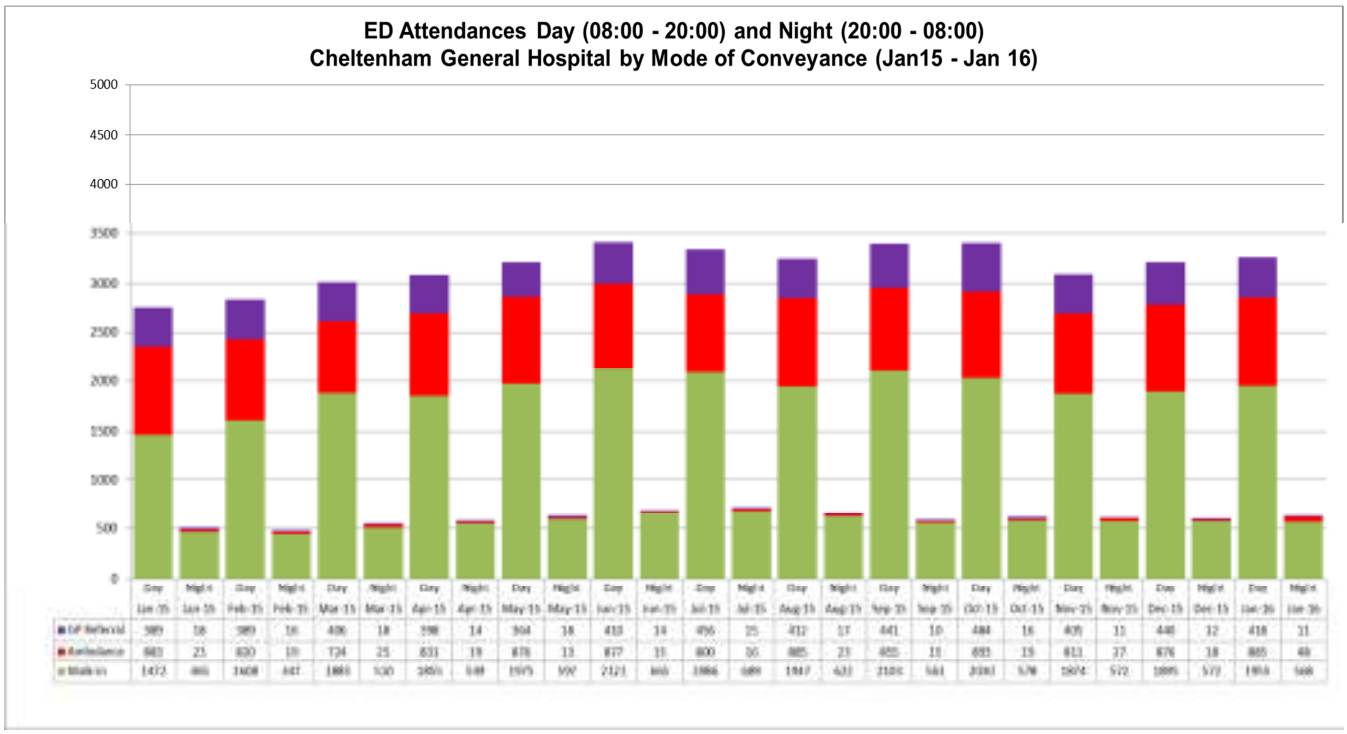
The table below shows a monthly breakdown of the impact of adding the number of Primary Care in Emergency Department cases (provided by Gloucestershire Clinical Commissioning Group), into the denominator of our Emergency Department performance calculation.

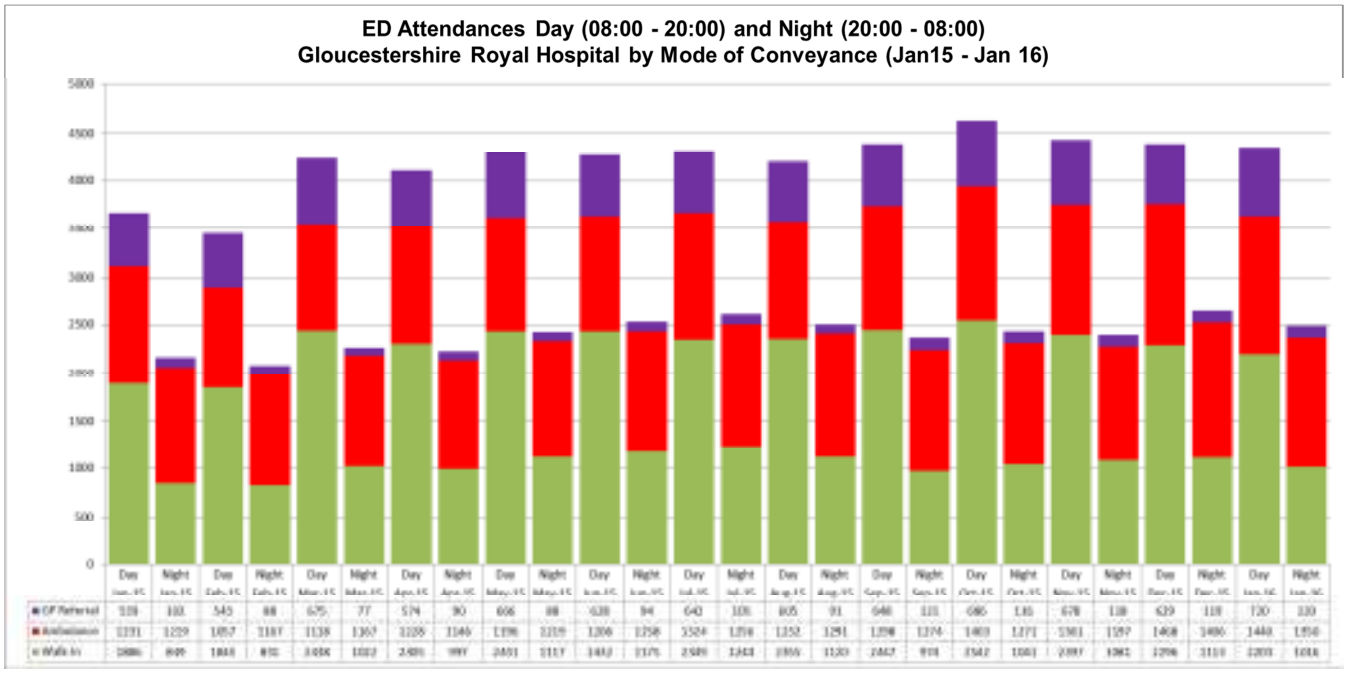
| Arrival Month | ED Attendances | 4 Hour Breaches | Performance | GP in ED Cases | Adjusted Performance |
|---|---|---|---|---|---|
| **June 2015** | 10895 | 541 | 95.03% | 234 | 95.14% |
| **July 2015** | 10982 | 679 | 93.82% | 256 | 93.96% |
| **August 2015** | 10600 | 1481 | 86.03% | 240 | 88.29% |
| **September 2015** | 10747 | 1187 | 88.96% | 268 | 89.22% |
| **October 2015** | 11079 | 1538 | 86.12% | 332 | 86.52% |
| **November 2015** | 10532 | 1252 | 88.11% | 386 | 88.53% |
| **December 2015** | 10844 | 1882 | 82.64% | 363 | 83.21% |
| **January 2016** | 10734 | 2130 | 80.16% | 468 | 80.99% |

**Actions to be taken:**

- Continue with Primary Care in Emergency Department pilot (now extended to March 2016) and managed by South West Ambulance Trust. The service is provided from a dedicated room near to Gloucestershire Royal Emergency Department reception (since September 2015). This has freed up the cubicle in the minors area;
- 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 March 2016, with a view to extend into 2016/17. Work is underway to ensure the Clinical Navigator is in place as soon as possible, including a comprehensive Memorandum of Understanding between the Trust and the Ambulance Service.
- Continued use of the Ambulatory Emergency Care service. The proposed Clinical Navigator would also be able to refer suitable patients presenting to the Emergency Department directly into the Ambulatory Emergency Care service.
- System-wide performance management of QIPP schemes.

## Emergency Department Attendances by Mode of Conveyance Charts




**Narrative:** In January 2016 there were 3,723 ambulance arrivals across both sites (average 120 per day). This is an increase of 11% on the same period last year, when there were 3,356 ambulance arrivals (average 108 per day). A number of patients can be referred by GPs direct into Cheltenham General overnight and although low numbers, this contributes to management of the bed base and in turn, reducing the level of diverts.

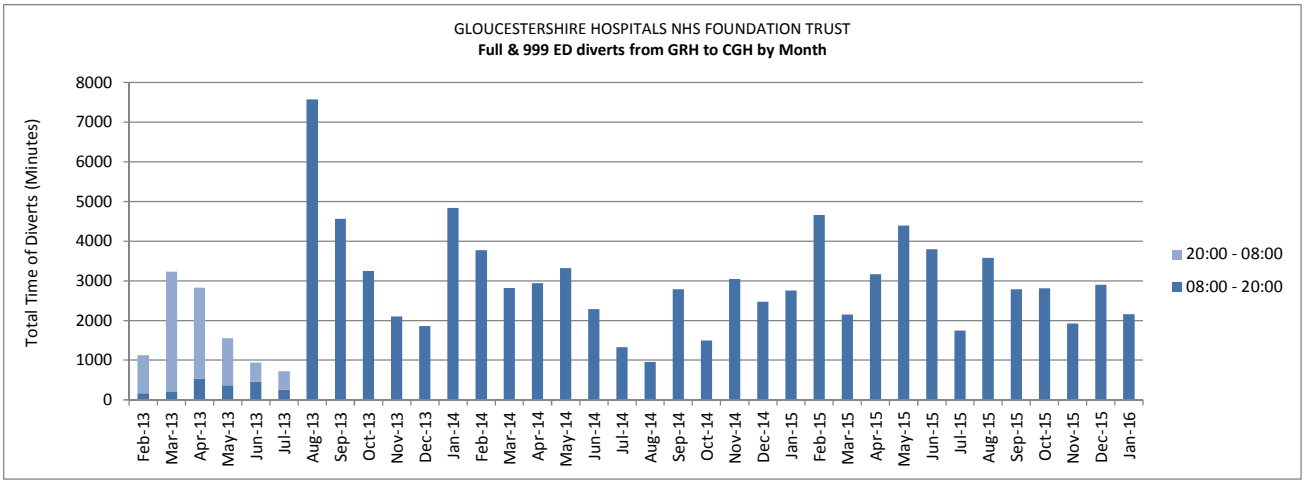
## Diverts Between Gloucestershire Royal Hospital & Cheltenham General Hospital

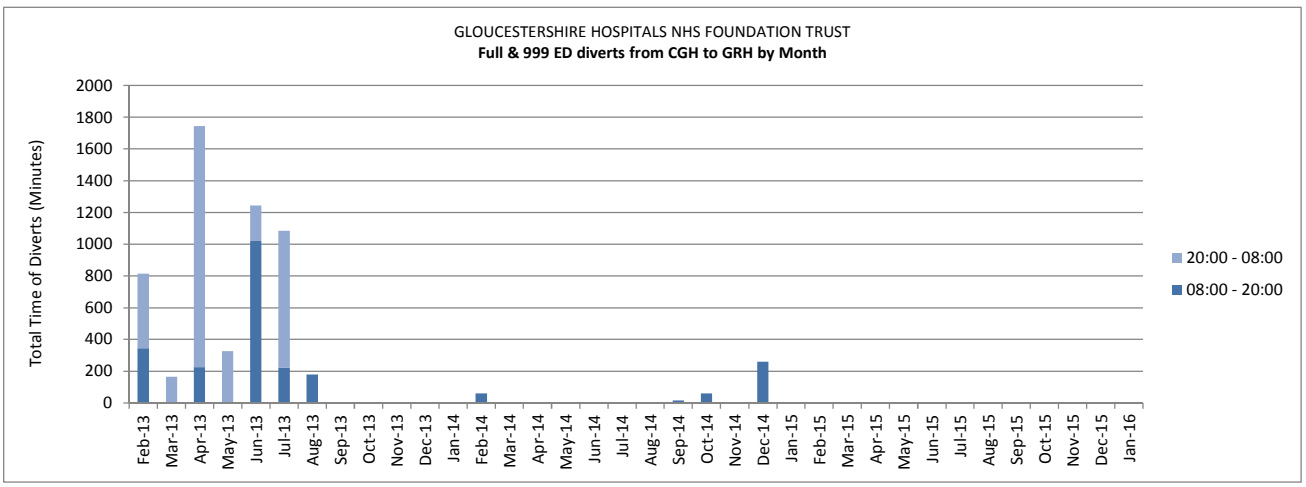
**Aim:** To reduce the number of across site diverts.

**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 10 occasions when a Full/999 divert took place in January compared to 11 last month. The total duration reduced from 48.3 hours to 36 hours (an average 4.4 hours per divert compared to 3.6 respectively).



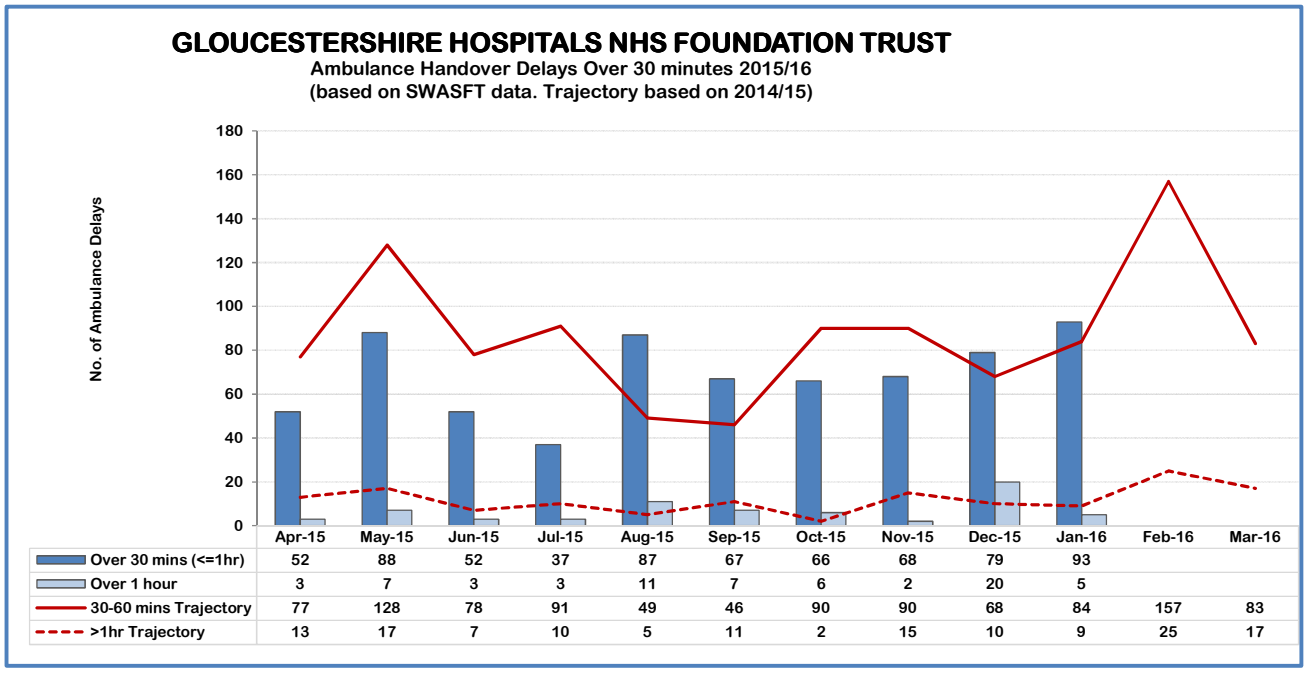
## 3.2 Ambulance Handover Delays

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

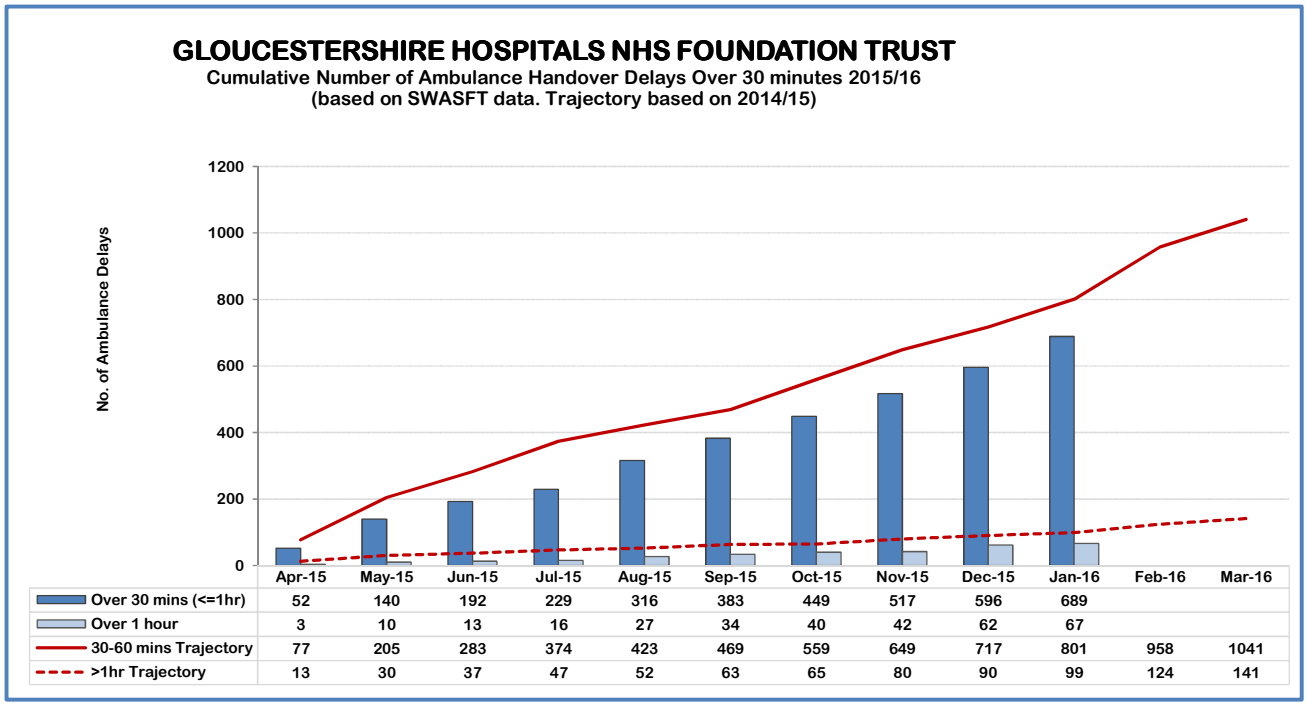
**How:** Doctor and nurse rotas better aligned to demand, revised handover process, improved reporting, trialling new 'flow coordinator' post, implementing capacity and escalation action cards and use of Rapid Assessment and Treatment (RAT) model.

**Narrative:** There were 98 ambulance handover delays in January 2016. This is comparable to last month; however over one hour delays have reduced from 20 to 5.

There is significant improvement compared to 2014/15, as shown in the cumulative graph below.




| | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Over 30 mins (<=1hr) | 52 | 88 | 52 | 37 | 87 | 67 | 66 | 68 | 79 | 93 | | |
| Over 1 hour | 3 | 7 | 3 | 3 | 11 | 7 | 6 | 2 | 20 | 5 | | |
| 30-60 mins Trajectory | 77 | 128 | 78 | 91 | 49 | 46 | 90 | 90 | 68 | 84 | 157 | 83 |
| >1hr Trajectory | 13 | 17 | 7 | 10 | 5 | 11 | 2 | 15 | 10 | 9 | 25 | 17 |




| | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Over 30 mins (<=1hr) | 52 | 140 | 192 | 229 | 316 | 383 | 449 | 517 | 596 | 689 | | |
| Over 1 hour | 3 | 10 | 13 | 16 | 27 | 34 | 40 | 42 | 62 | 67 | | |
| 30-60 mins Trajectory | 77 | 205 | 283 | 374 | 423 | 469 | 559 | 649 | 717 | 801 | 958 | 1041 |
| >1hr Trajectory | 13 | 30 | 37 | 47 | 52 | 63 | 65 | 80 | 90 | 99 | 124 | 141 |

### 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. January 2016 data shows that neither site successfully met the 95% standard. The overall Trust performance in January was 80.16%, which is the lowest since February 2015.

There were two >12-hour trolley waits within the Emergency Department on the 3rd and 4th of January. At this time, the Trust was in an internal critical incident.

#### 3.3.1 Four Hour Standard

| | Apr-14 | May-14 | Jun-14 | Jul-14 | Aug-14 | Sep-14 | Oct-14 | Nov-14 | Dec-14 | Jan-15 | Feb-15 | Mar-15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CGH actual | 97.60% | 96.88% | 97.14% | 95.93% | 96.99% | 97.08% | 93.02% | 94.90% | 85.34% | 86.95% | 83.36% | 93.10% |
| GRH actual | 91.69% | 91.43% | 91.06% | 89.45% | 95.61% | 93.54% | 93.08% | 89.93% | 82.77% | 80.59% | 73.93% | 83.31% |
| National std | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| Trust actual | 93.81% | 93.39% | 93.27% | 91.83% | 96.10% | 94.87% | 93.06% | 91.67% | 83.64% | 82.86% | 77.45% | 86.77% |

| | 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% | | |
| GRH actual | 89.50% | 92.27% | 93.70% | 92.41% | 82.40% | 85.61% | 83.27% | 85.86% | 79.06% | 76.08% | | |
| 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% | | |

NHS England (Type 1) Emergency Department performance for Quarter 3 2015/16 was 87.4%. The Trust's performance for the same period was 85.6%.

Factors affecting performance included:

- Admissions in excess of plan;
- 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 January 2016 is outlined in the following table:

| January 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** | 492 | 24 | 287 | 56 | 19 | 106 |
| **GRH** | 1638 | 188 | 909 | 131 | 179 | 231 |
| **Total** | 2130 | 212 | 1196 | 187 | 198 | 337 |
| **%** | | 9.95% | 56.15% | 8.78% | 9.30% | 15.82% |

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

### 3.3.3 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.

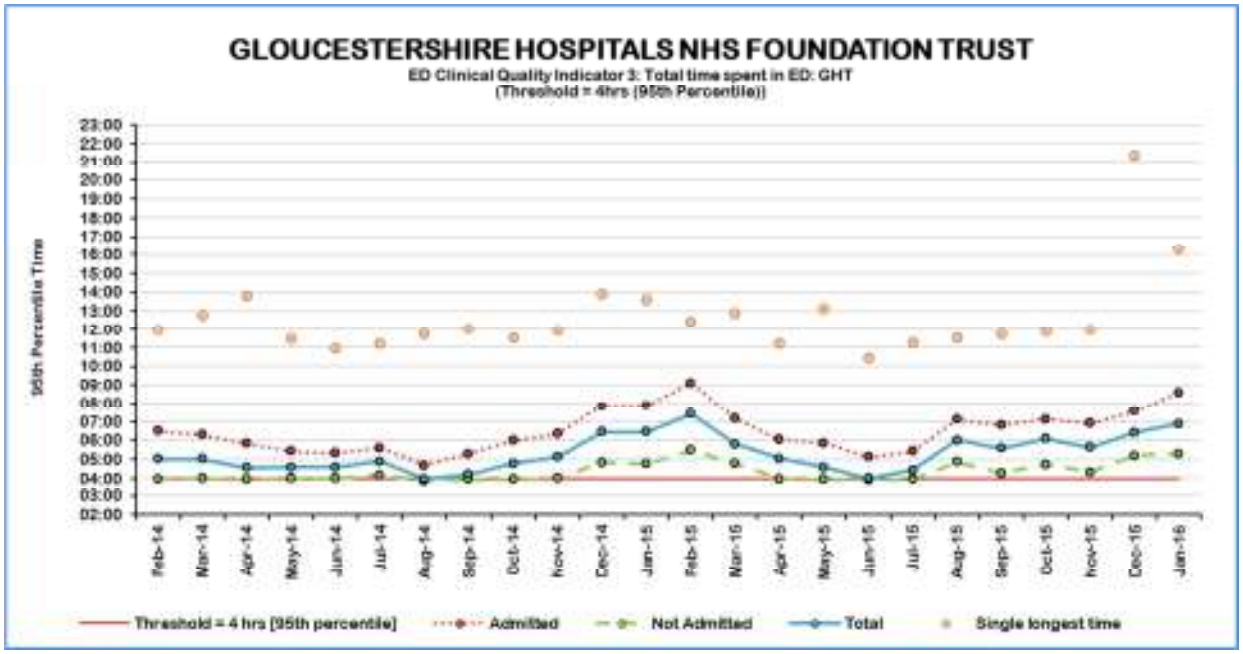
**Narrative:** The key Quality Indicators of Total Time in Department and Time to Treatment were not met in January. However, the median wait for Time To Treatment was two minutes over the 60 minute threshold.

| 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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% |
| 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 |
| 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% |
| 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 |

### Total Time Spent in the Department

**Narrative:** To better understand the distribution of 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 January was 6 hours 53 minutes, compared to 6 hours 26 minutes the previous year. The single longest wait was circa 16 hours within the department.



## 3.4 Emergency Admissions

### 3.4.1 Emergency Admission Rate

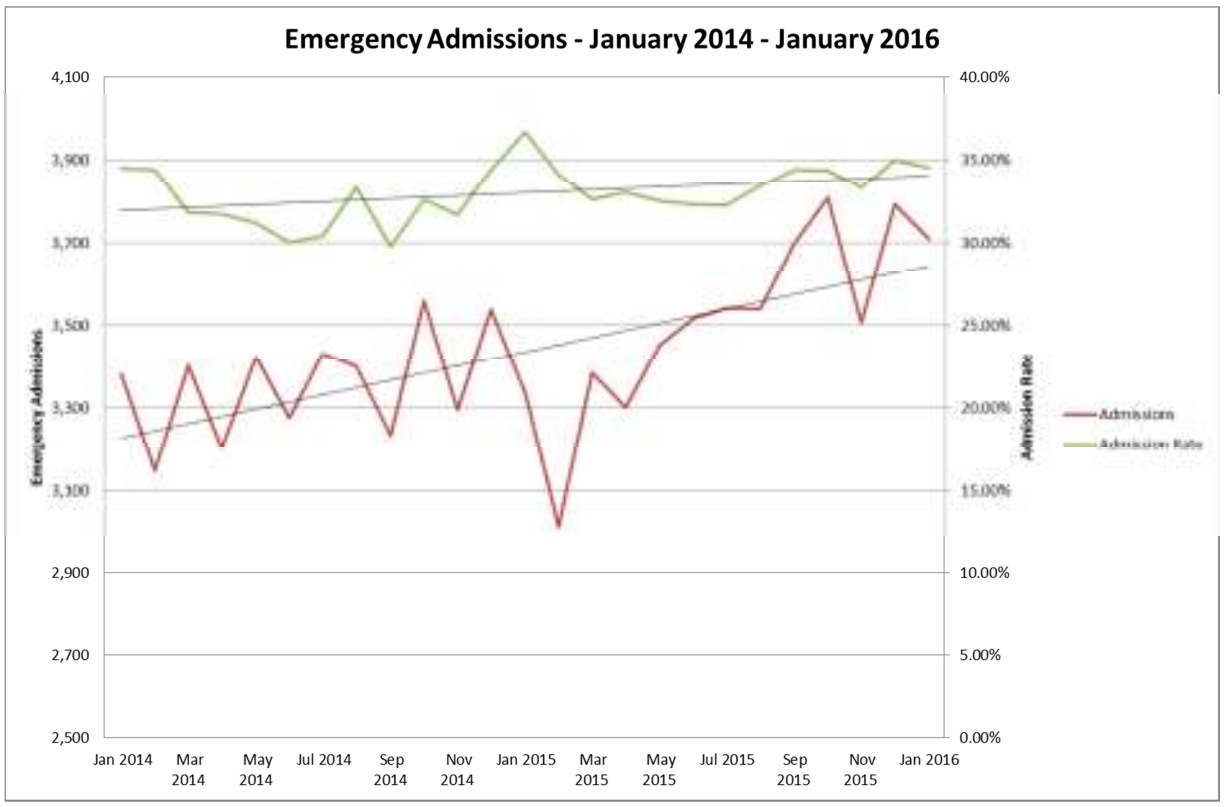
**Aim:** To ensure the admission rate from the Emergency Department remains in control.

**How:** By avoiding admissions through alternatives as appropriate.

**Narrative:** The Emergency admission rate in January 2016 was 34.55% compared to January 2015, when the admission rate was 36.68%. However, the number of patients admitted was lower. In January 2016 there were 10,734 Emergency Department attendances and 3,709 patients were admitted (average 120 per day), compared to January 2015 when there were 9,096 attendances but 3,336 patients were admitted (average 108 per day).

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.

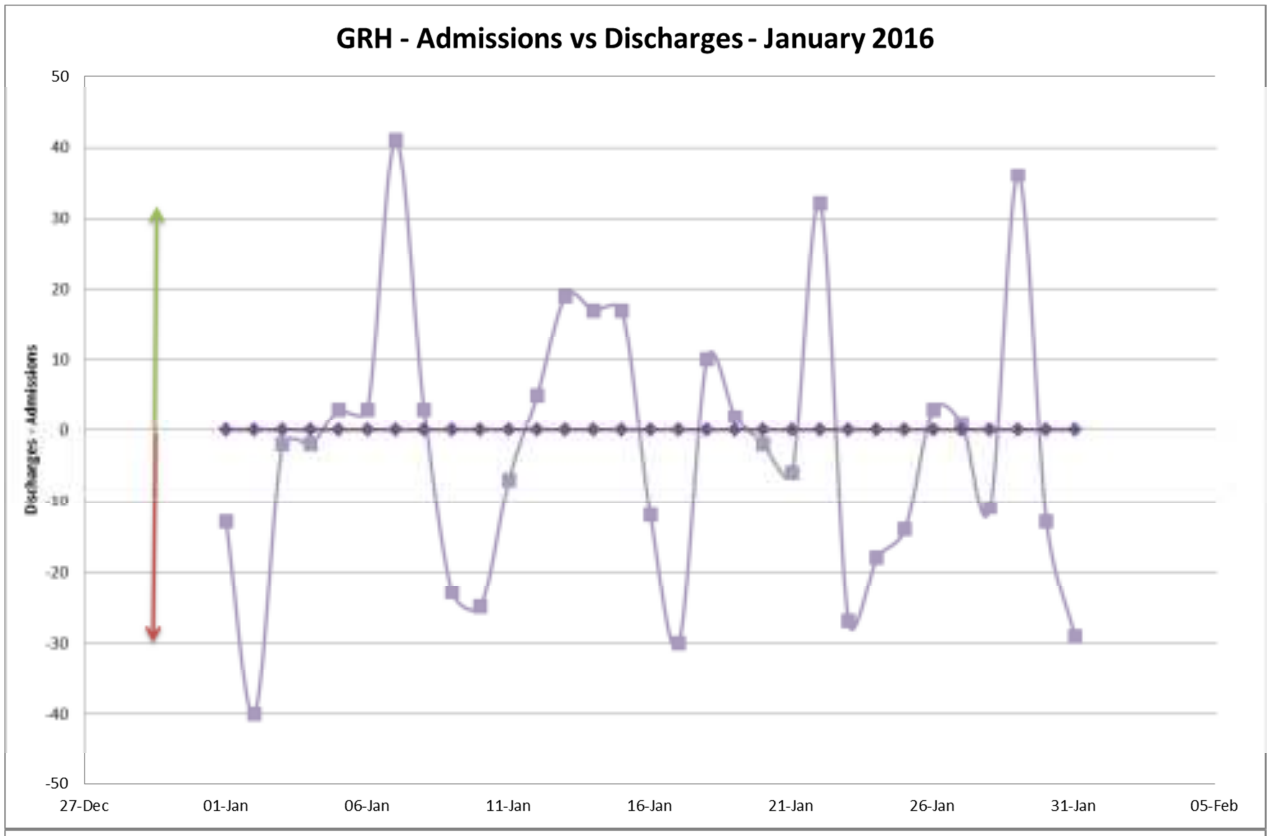


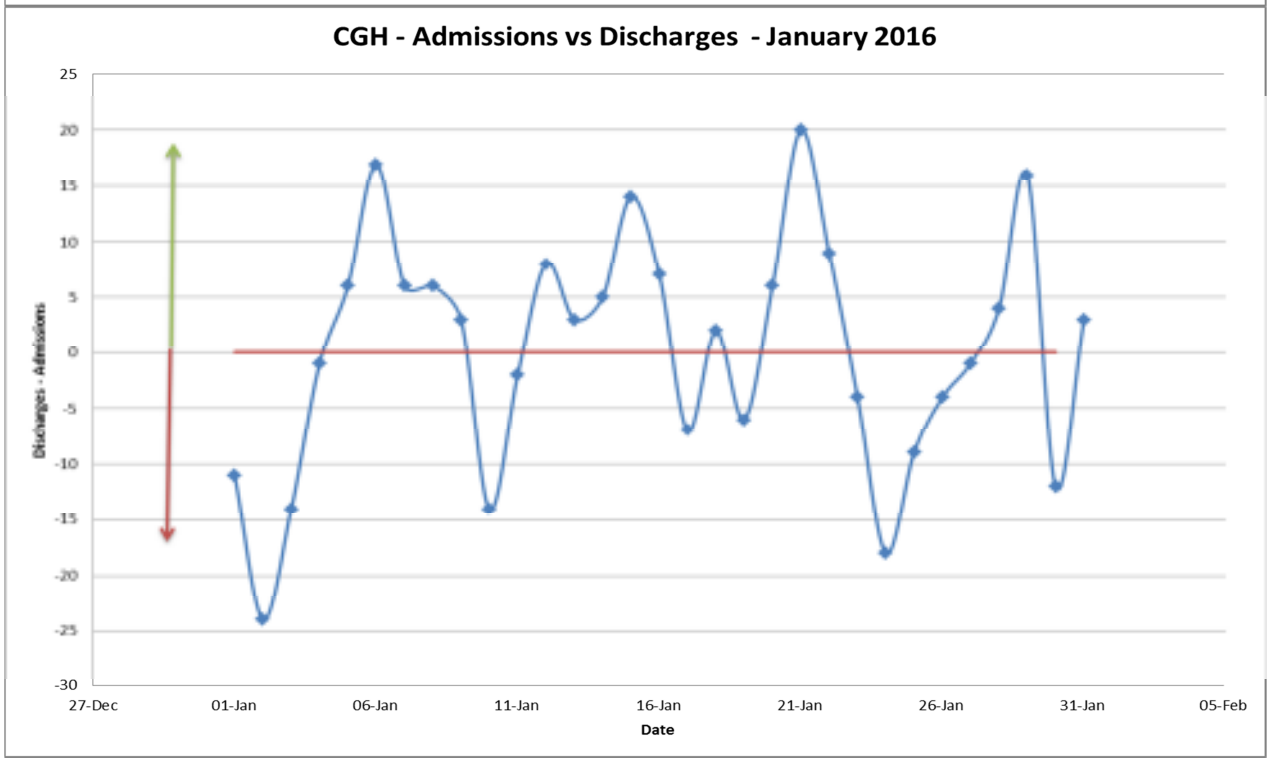
### 3.4.2 Admissions vs Discharges

**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.



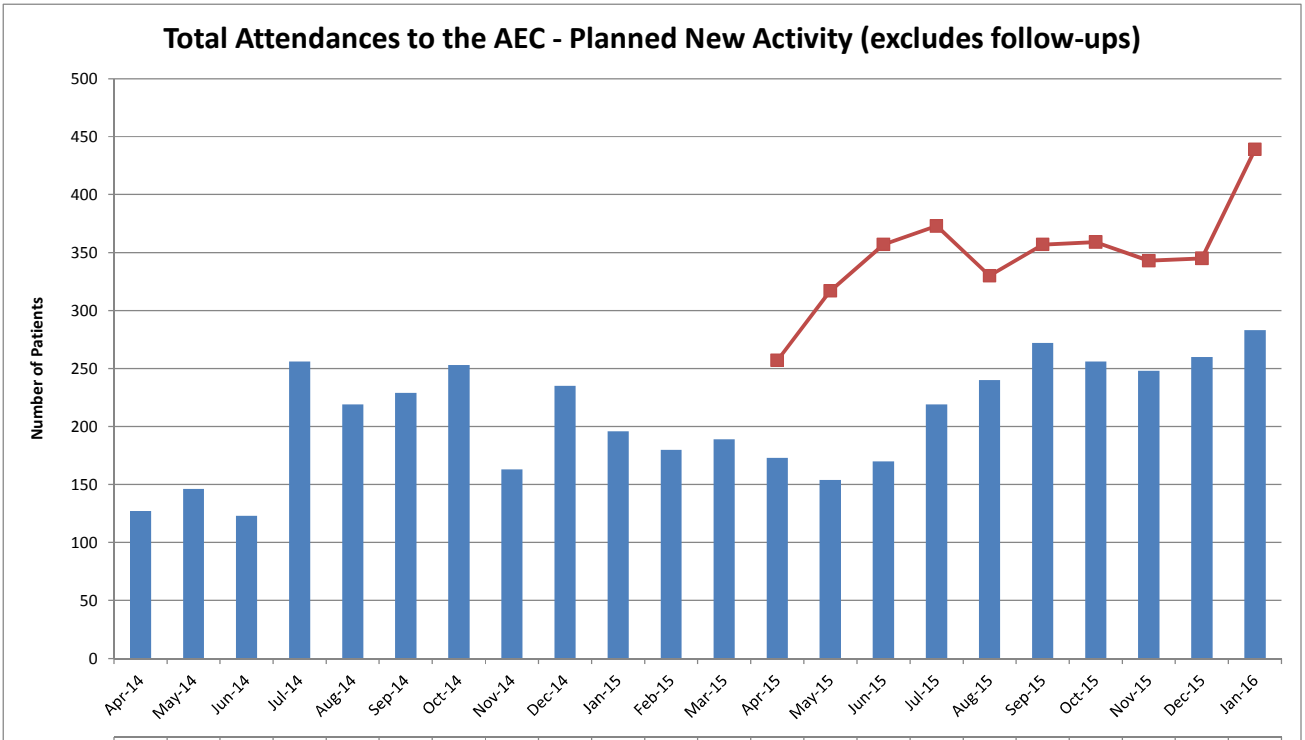
### 3.5 Ambulatory Emergency Care Attendances

**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 service is funded for 2015/16 on a block contract and the level of funding has enabled permanent staff to be recruited, which will increase opportunities to extend the opening hours and as a result, admission avoidance.

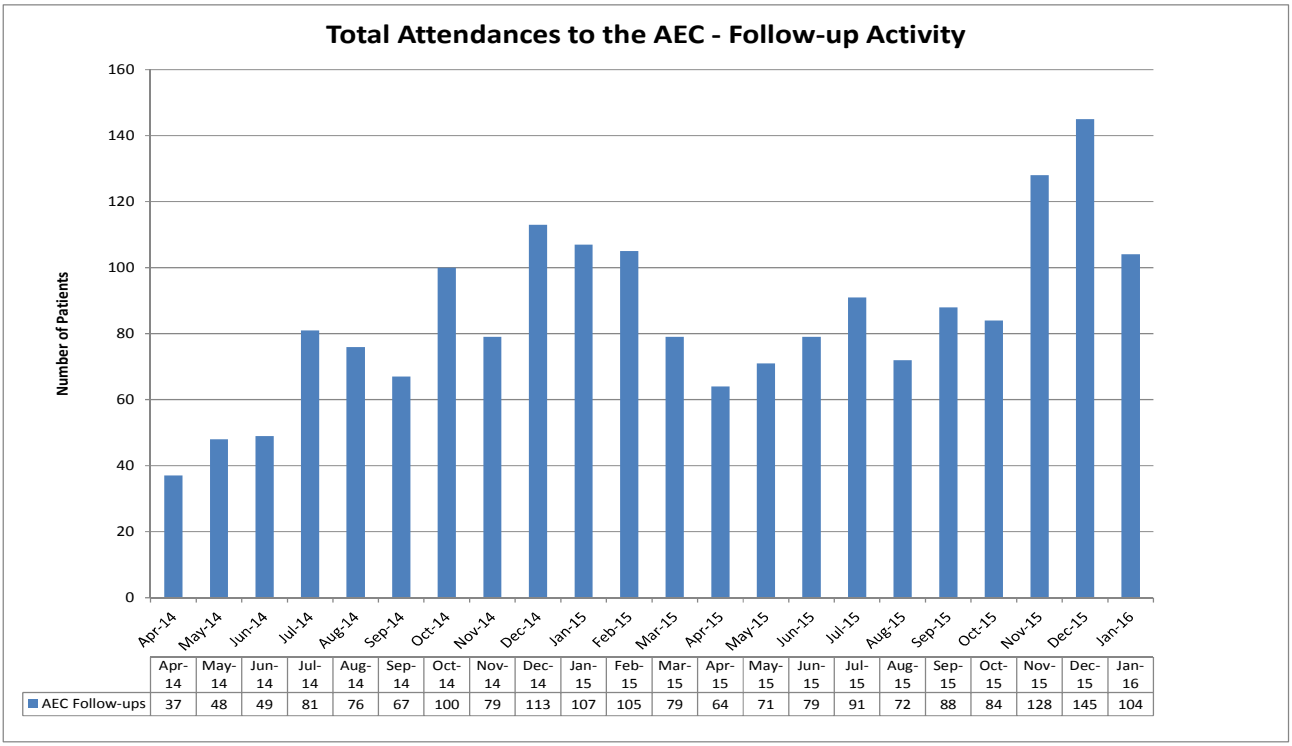
The chart below shows the actual number of new Ambulatory Emergency Care patients (excluding Follow ups) from April 2014. The plan for 2015/16 is based on actuals from 2014/15 plus the impact of the planned pathway developments. For Quarter 4 2015/16, it is projected that 22 new patients will be seen per day, across both sites. The actual average for January 2016 was 14.




| | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 127 | 146 | 123 | 256 | 219 | 229 | 253 | 163 | 235 | 196 | 180 | 189 | 173 | 154 | 170 | 219 | 240 | 272 | 256 | 248 | 260 | 283 |
| Plan | | | | | | | | | | | | | 257 | 317 | 357 | 373 | 330 | 357 | 359 | 343 | 345 | 439 |

The activity has been below the planned level of new attendances due to on-going issues with recruitment (and retention) and location of the units, particularly at Cheltenham General. However, there have been signs of improvement from August following implementation of initiatives identified with the Ambulatory Emergency Care Network.

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 2015 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AEC Follow-ups | 37 | 48 | 49 | 81 | 76 | 67 | 100 | 79 | 113 | 107 | 105 | 79 | 64 | 71 | 79 | 91 | 72 | 88 | 84 | 128 | 145 | 104 |

A service review was undertaken in November, 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.

Ambulatory Emergency Care is a key strand of the High-Level Priorities Plan agreed with Monitor. During February 2016, the short-stay Surgical Abdominal Pain and Low Risk Chest Pain pathways will be assessed, with a view to managing these high volume patients through an ambulatory pathway, potentially avoiding an Emergency Department attendance and an admission.

### 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).

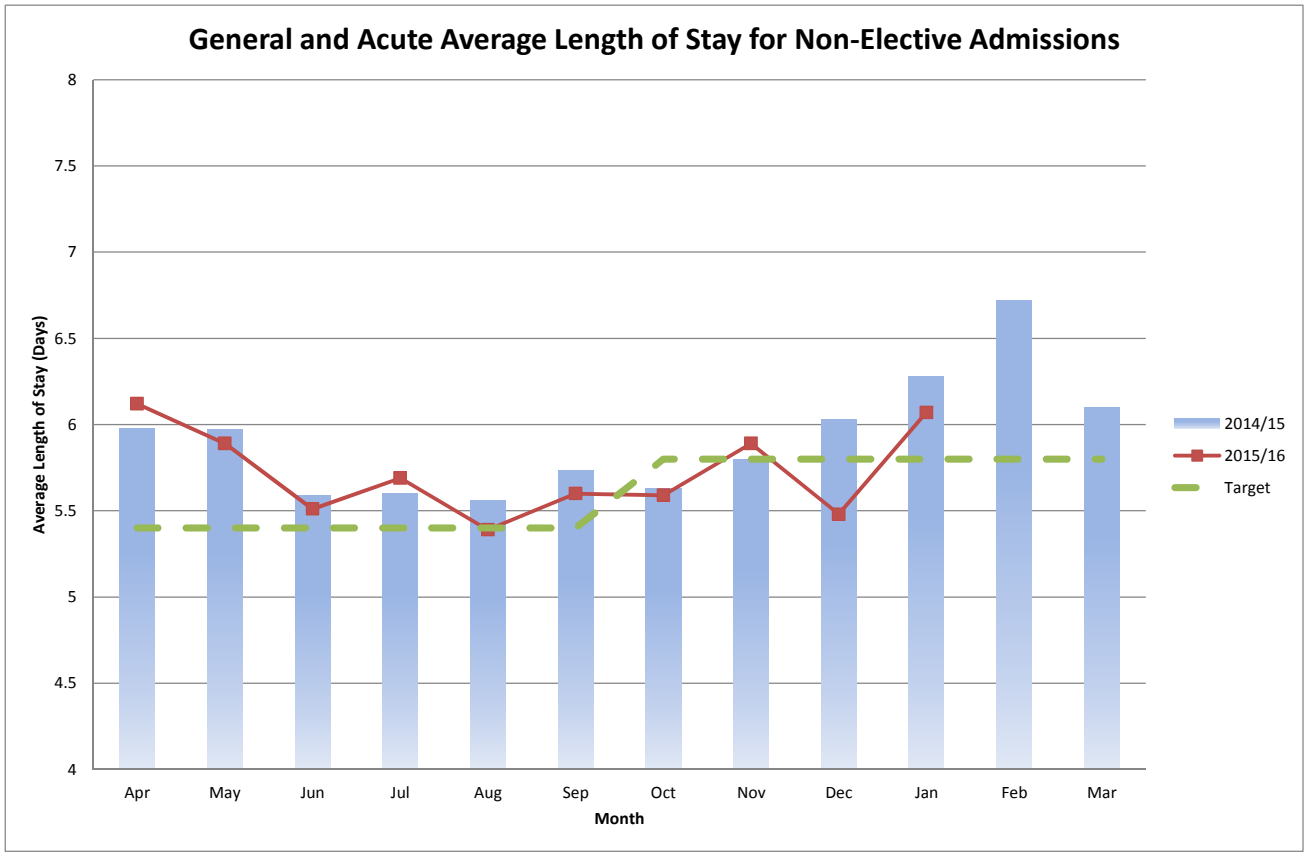
**Narrative**s January 2016 showed 1,776 patients with a length of stay of 2 days or less Trustwide; significantly lower than December which showed 2,026 patients. A short stay ward in Gloucestershire Royal for patients requiring a stay of 48 hours or less went live on 19th November 2014. This ward has been reviewed and is shown to be successful provided it is not used for long stay patients. This is what happened from December 2014 to February 2015, when the Trust was in escalation.


### 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 and Quarter 2 and 5.8 days in Quarter 3 and Quarter 4 2015/16.

**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:** Length of Stay targets have been set up for 2015/16. Divisions and Service Lines have been asked to develop internal action plans to bring down the Length of Stay in their area. In January 2016 the Average Length of Stay was 6.07 days which is a significantly up from December and exceeds the Q4 target of 5.8 days.



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

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

**A: A**ll 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: F**low 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: E**arly 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: R**eview - 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.

Dr Kate Hellier, Consultant Elderly Care Physician, along with Bob Pearce, Director of 7 Day Services is leading the delivery of structured and consistent board rounds across the Trust, reviewing timings and content with the aim of reducing overall length of stay across the Trust. Dr Hellier will be completing this work in collaboration with the Institute for Healthcare Improvement based in Boston, USA.

In order to increase awareness and embed the SAFER bundle practices into business as usual, the fourth Trustwide "SAFER Week" took place between 11th & 17th January. These focussed weeks will occur monthly throughout the winter period, identifying positive actions to embed into business as usual. January's SAFER week focussed on the Multi-Disciplinary Accelerated Discharge Event (MADE):

**Multi-Disciplinary Accelerated Discharge Event (MADE):**

In line with NHS England winter planning guidance, the Trust worked with healthcare system partners to conduct an event on 11th and 14th January, coinciding with the fourth SAFER week. The event focussed on accelerated discharge of patients on the day and identifying the main reasons for discharge delays (both internal and external to the Trust).

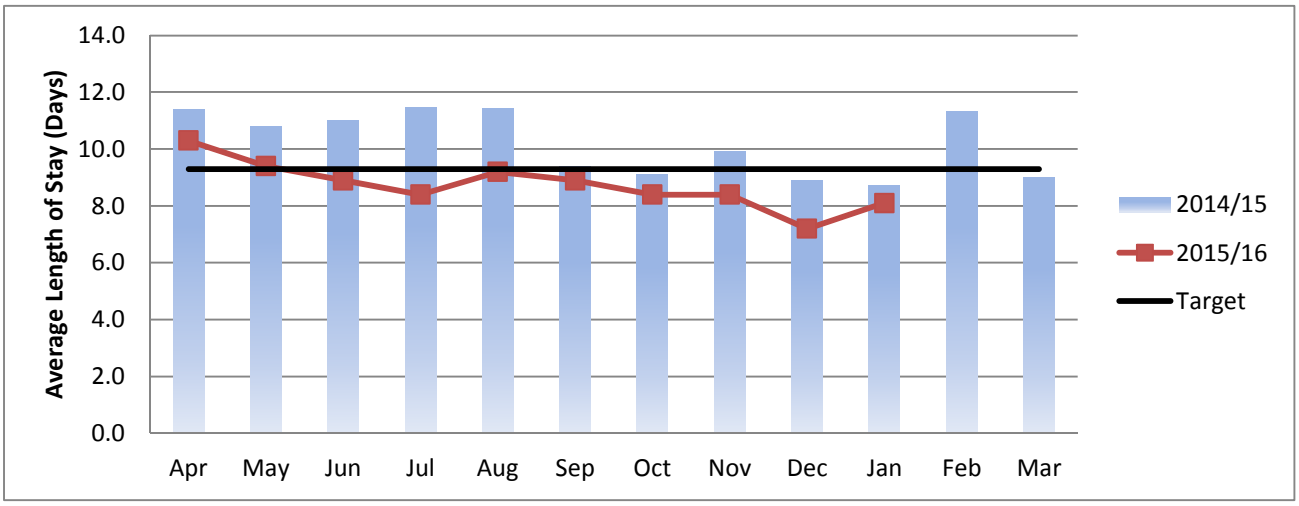
### 3.7 Average Length of Stay of Targeted Specialties

On continuation from last year Respiratory, Cardiology and General Old Age Medicine will be highlighted in this report. Their length of stay was benchmarked against the national average and best regional performances and improved targets have been set for these specialities. 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.

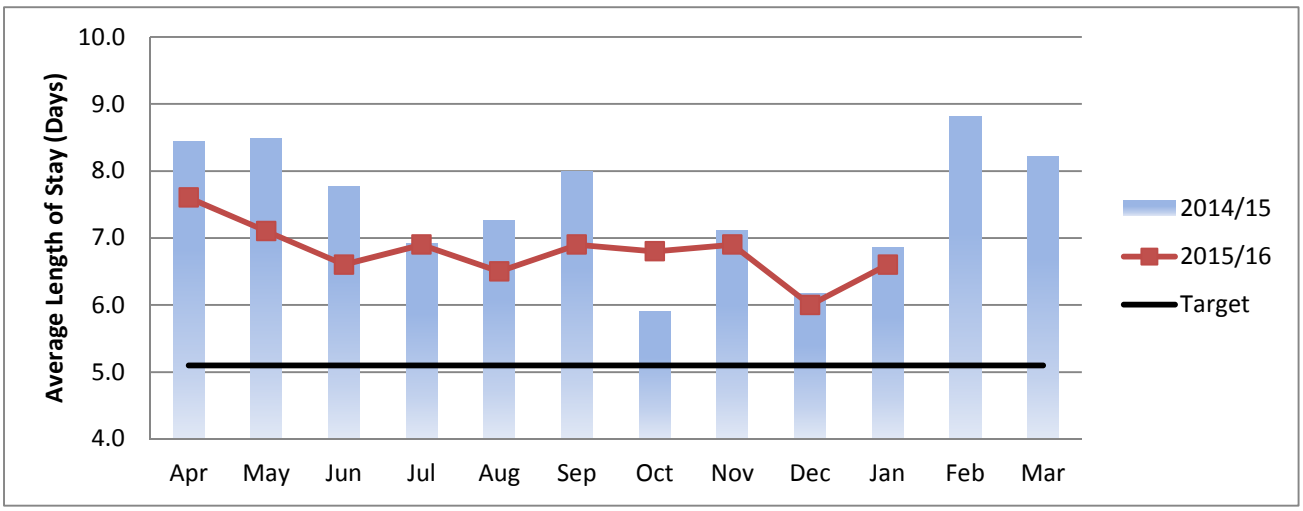
#### 3.8.1 Respiratory Medicine - Average Length of Stay

**Narrative:** The internal target is set at 9.3 days for 2015/16**.** The Average Length of Stay remains well within the threshold at 8.1 days in January 2016.



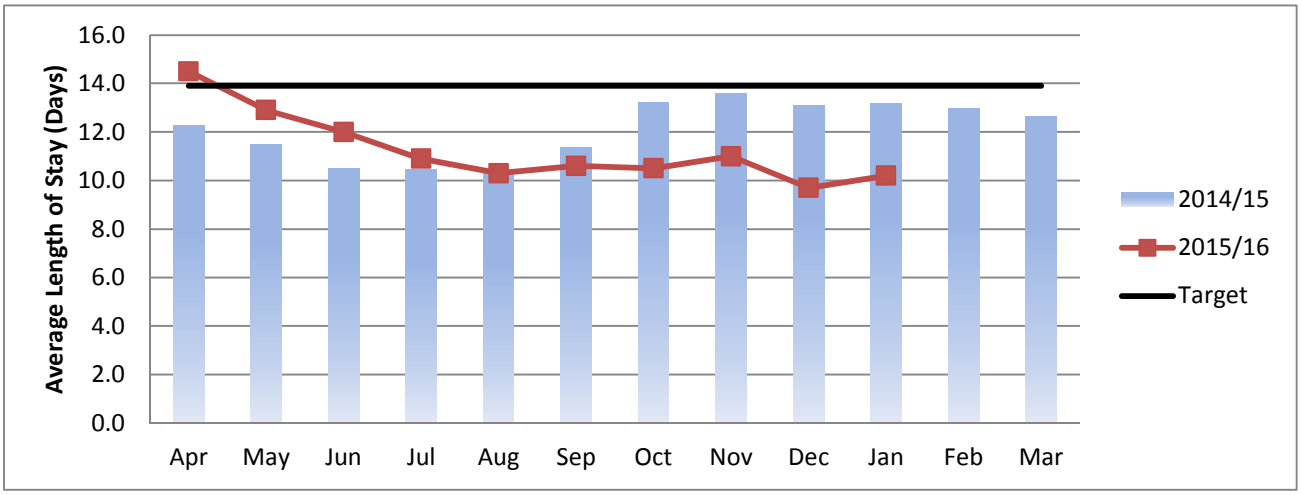

#### 3.8.2 Cardiology - Average Length of Stay

**Narrative:** The internal target is set at 5.1 days for 2015/16. The Average Length of Stay for non-elective Cardiology discharges was 6.6 day in January 2016.



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

**Narrative:** The internal target is set at 13.9 days for 2015/16. The General Old Age Medicine Average Length of Stay saw an increase in January to 10.2 days; however still remains well within 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.

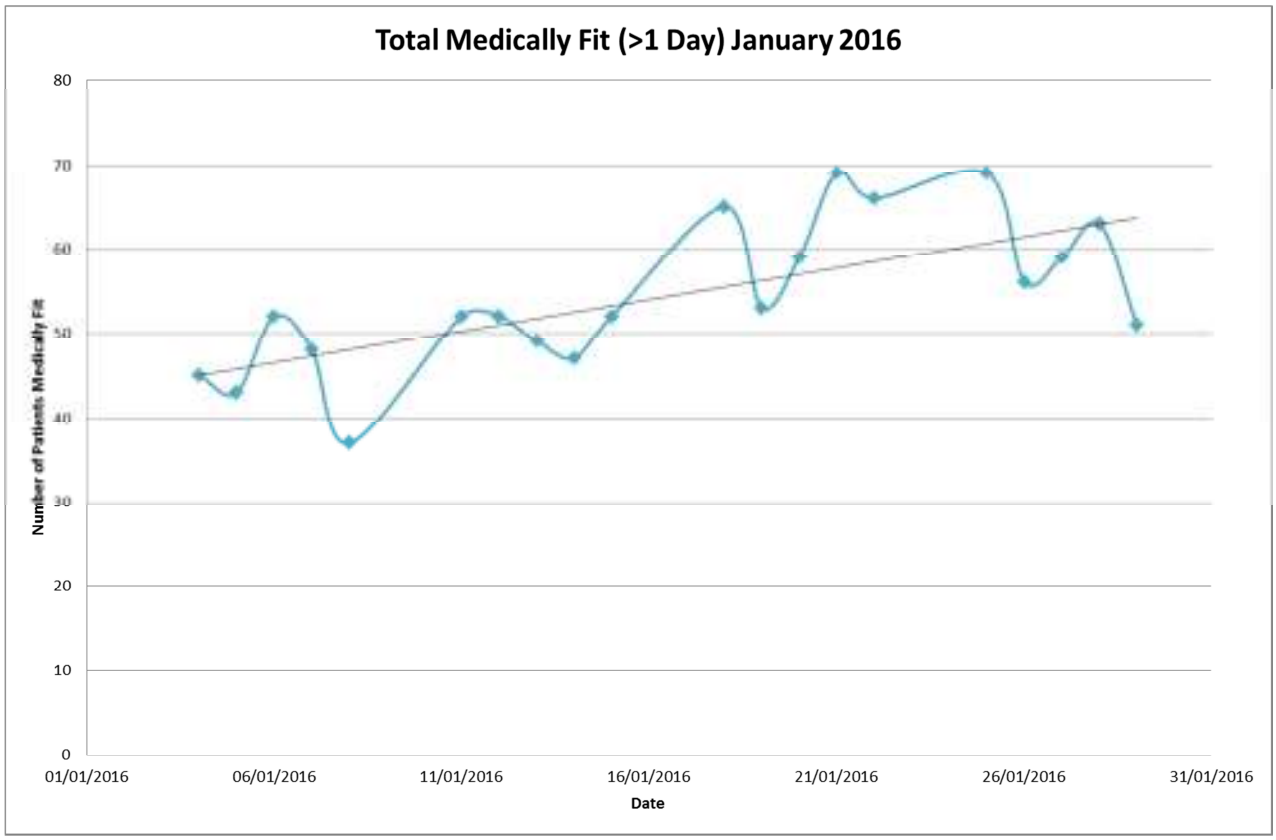
**How:** Focussing on a range of actions on safe and effective discharge processes. For the Trust and whole heath care system this is one of the key activities to manage.

**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.

**Total Medically Fit – average number of patients per week for December 2015:**

| | | | |
|---|---|---|---|
| **Week 1** | 45 | **Week 2** | 50 |
| **Week 3** | 62 | **Week 4** | 60 |

In December, there was an average of 45 medically fit patients who are occupying a nursing home bed, who would be occupying an acute bed if these nursing home beds were not available. As part of the system-wide resilience plan, the Clinical Commissioning Group will be investing in a total of 30 beds.




The number of patients medically fit has been an average of 54 for the month, with the number of medically fit patients increasing throughout January to 60 in week 4. This is on average an increase of 3 medically fit patients, compared to December 2015.

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.

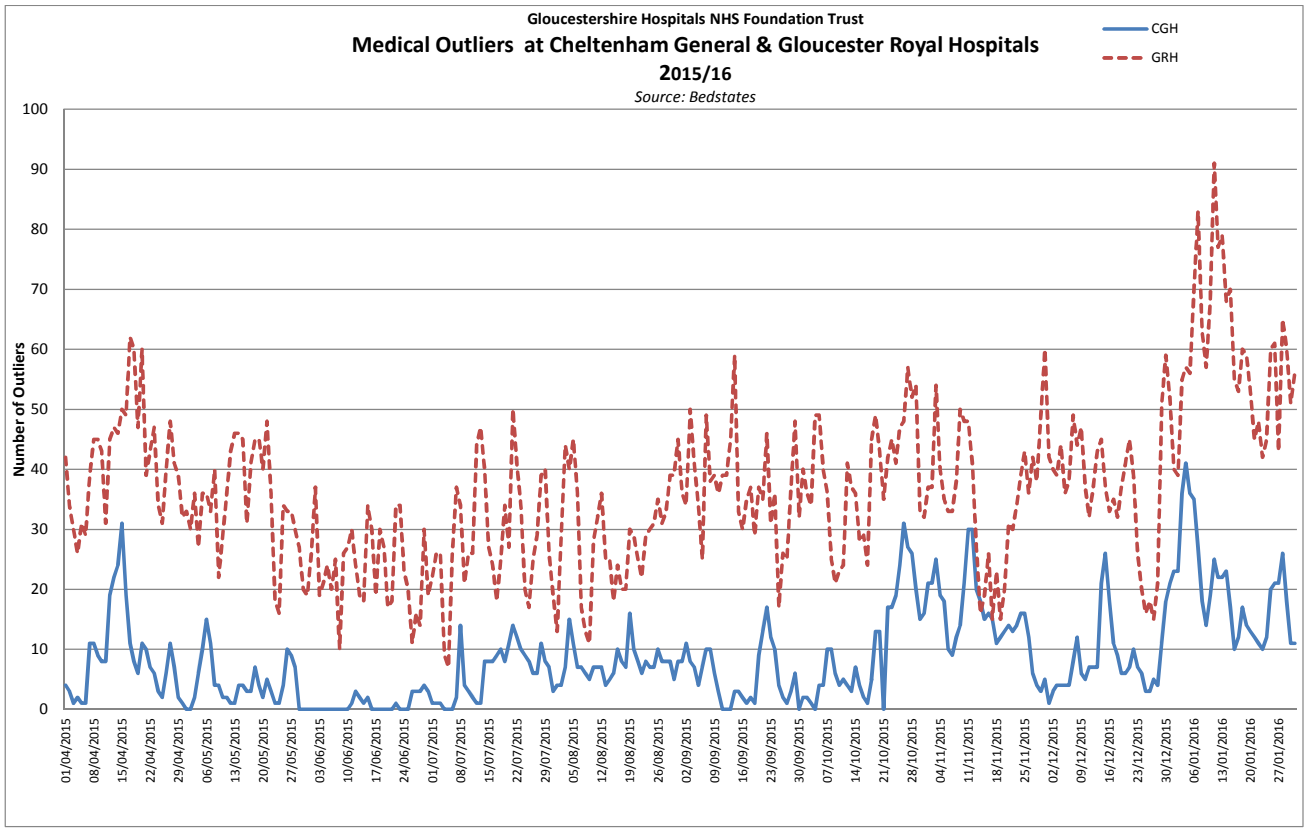
From September 2015, a weekly Senior Executive review of all Medically Fit patients takes place. This is being led by Mrs Arnold, Director of Nursing with her peers from across the system.

### 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 59 at Gloucestershire Royal and 20 at Cheltenham General in January; an increase from 43 and 11 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:** Bed occupancies in January 2016 were 29,709 (average 958 per day). In the same month last year bed occupancies were 29,298 (average 945 per day).

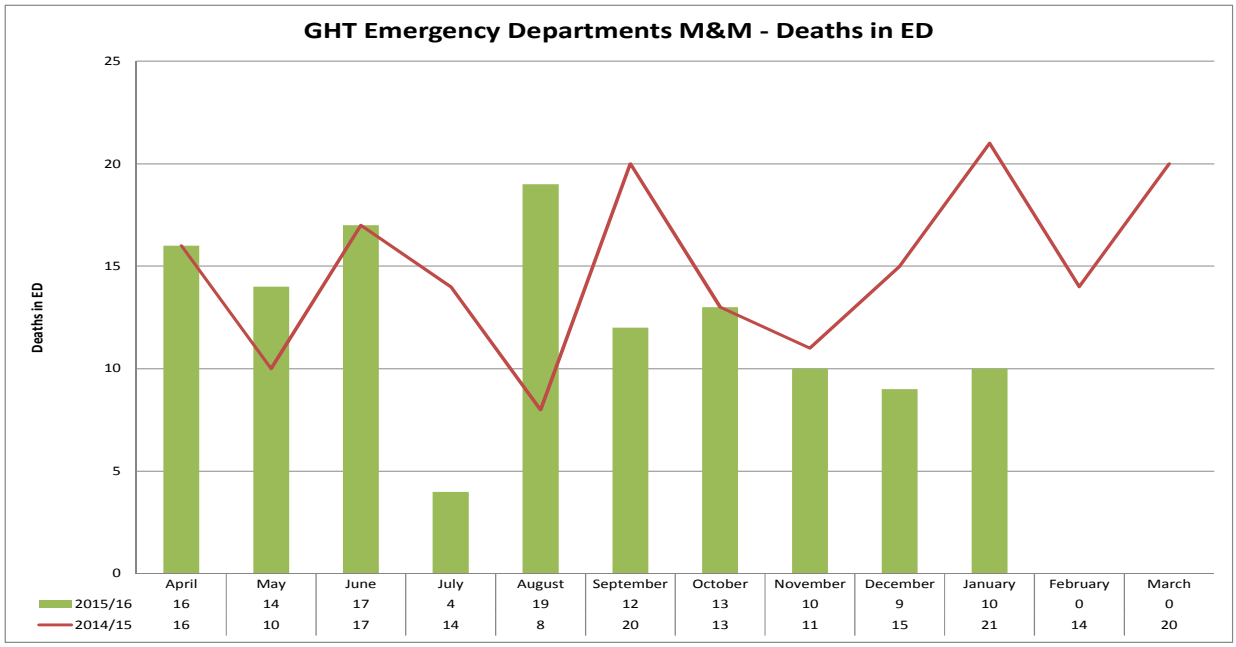
**% Bed Occupancy (as at Thursday snapshot)**

| Week ending: | CGH | GRH | Total |
|---|---|---|---|
| 03/01/2016 | 91.6% | 96.8% | **94.7%** |
| 10/01/2016 | 94.0% | 98.7% | **96.8%** |
| 17/01/2016 | 92.8% | 96.8% | **95.2%** |
| 24/01/2016 | 95.4% | 98.4% | **97.2%** |
| 31/01/2016 | 97.3% | 99.6% | **98.7%** |

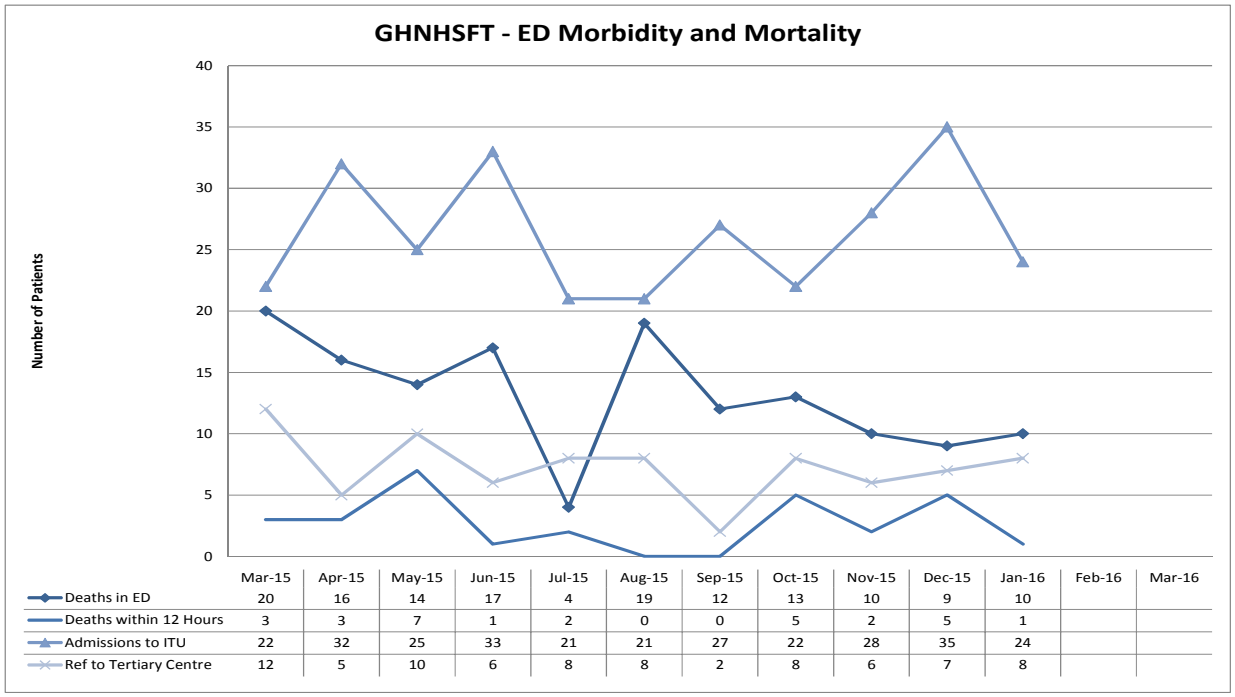
## 3.10 ED Morbidity and Mortality

**Aim:** To review the Morbidity and Mortality trend.

**Narrative:** During January 2016 there were 10 deaths in the Emergency Department, which is lower than January last year (-11). 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.




| | April | May | June | July | August | September | October | November | December | January | February | March |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2015/16 | 16 | 14 | 17 | 4 | 19 | 12 | 13 | 10 | 9 | 10 | 0 | 0 |
| 2014/15 | 16 | 10 | 17 | 14 | 8 | 20 | 13 | 11 | 15 | 21 | 14 | 20 |




| | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Deaths in ED | 20 | 16 | 14 | 17 | 4 | 19 | 12 | 13 | 10 | 9 | 10 | | |
| Deaths within 12 Hours | 3 | 3 | 7 | 1 | 2 | 0 | 0 | 5 | 2 | 5 | 1 | | |
| Admissions to ITU | 22 | 32 | 25 | 33 | 21 | 21 | 27 | 22 | 28 | 35 | 24 | | |
| Ref to Tertiary Centre | 12 | 5 | 10 | 6 | 8 | 8 | 2 | 8 | 6 | 7 | 8 | | |

### 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 January (wte) | Variance In Post vs. Establishment | Variance vs. in Post in December |
|---|---|---|---|---|---|
| **Emergency Department** | Consultants | 17.70 | 18.60 | +0.90 | +1.0 |
| | Trainee Doctors | 34.49 | 30.10 | -4.39 | +0.40 |
| | | | | | |
| **Acute Medicine** | Consultants | 11.03 | 8.33 | -2.70 | 0 |
| | Trainee Doctors | 86.25 | 67.60 | -18.65 | +1.60 |

A small team went to India in February 2015 with colleagues from Weston Area Health Care NHS Trust and three middle grade doctors were recruited, to start in August 2015. These doctors have now been delayed and the exact start dates are to be determined.

It is now unlikely that these doctors will start with the Trust and the department is looking at alternative ways to cover these gaps including the option to recruit Fellowship Doctors; Doctors from Europe (through other healthcare agencies) and other Doctors from India. The latter will take a different approach to the previous round, whereby only Doctors who have already passed their English exams will be considered, in order to expedite the process.

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.

**Key Actions Going Forward**

- A focus on the management of the daily site meetings at 10:00 and 15:00, with all Divisions and Wards to be represented.
- Continue to embed SAFER across the Trust and improving the delivery / effectiveness of Board Rounds.
- Increased use of the Discharge Waiting Areas.
- Increasing the number of weekend discharges.
- Continue monthly monitoring against the High-level Action Plan, based on the main Emergency Care Board Action Plan which highlights three key areas: Patient Flow; Emergency Department and Admission Avoidance. This will be submitted to the Monitor Operational Support Team.

# NURSE AND MIDWIFERY STAFFING
# FEBRUARY 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 January 2016.

## 2 Background

2.1 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.

2.2 The exception report on the Safer Staffing data will be uploaded to NHS Choices and the UNIFY system on 15th February.

## 3 Findings

3.1 In line with the set parameters for the Safer Staffing guidance there are no outlying exceptions for January. 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.

3.2 From the last report, work is ongoing to understand and action plans against the latest 'Care Contact Time' analysis focusing on Specialist Nurses. The Divisions continue to work on their data analysis and action plans and it has been asked that this is included in the Divisional quality reports. In addition there will be workshops throughout the year at the Nursing & Midwifery Strategy Days reviewing the contact time and action plan implementation.

3.3 The six monthly Keith Hurst benchmarking exercise has been undertaken led by the Deputy Director of Nursing & Midwifery involving all the other divisional nursing directors and matrons. Annex A demonstrates the current benchmarking both with and without additional beds with explanation. In summary, there is no significant change required at this time.

## 4 Key Workforce Initiatives

### 4.1 UK Pipeline

- There are currently 44 UK-based nurses in the recruitment process due to commence employment in February/March 2016. This is a significant increase from the figures reported last month (19 UK-based nurses) and is due to the increased recruitment activity in January, which we attribute in part to the introduction of Recruitment and Retention Premia (RRP) for a number of the hard-to-fill areas within Medicine.
- A selection event for the newly-qualifying nurses completing their studies in Summer 2016 will be held on Saturday 27 February at Redwood Education Centre. The application process for this event closes on 14 February (as at 10 February, the Trust has received 40 applications).
- A separate advertisement for newly-qualifying and experienced paediatric nurses closed on 28 January with 14 applications, interviews will take place during February.

4.2 **Overseas-Qualified Nurses**

- The first group of 9 overseas-qualified nurses took the IELTS examination on 23 January 2016. Only 2 nurses were successful in passing the exam at this attempt, and will now begin preparing for their Nursing and Midwifery Council (NMC) registration examination (likely to be June 2016). The further 7 candidates will retake the IELTS exam in the spring.
- A second recruitment campaign for overseas-qualified nurses will commence on 15 February, with a view to 40 successful candidates commencing employment in June 2016.

4.3 **EU Recruitment**

- There are currently 9 EU candidates being processed and due to start in March – April 2016, and a further 4 candidates booked for interview.
- We are working with our international recruitment partners to facilitate a streamlined approach to interviewing newly-qualified EU nurses that are likely to achieve the IELTS requirement set by the NMC. It is expected that we will target Belgium and the Netherlands throughout 2016.
- A tripartite recruitment event with representatives from Nurse Recruitment, Medical Staffing, and the Allied Health Professions has been approved for Thessaloniki and Athens in June 2016. Matron Liz Bruce will be representing the nursing workforce.

4.4 **Philippines Recruitment**

- The Migration Advisory Committee is currently preparing a report to the Home Secretary about the longer-term inclusion of nurses on the Shortage Occupation List. Currently, nurses are only considered a shortage occupation until 01 April 2016. It is expected that the new report, due to be published on 15 February 2016, will recommend that this date is extended by at least 12 months. Two local MPs have contacted the Home Secretary to ask for nursing to remain on the Shortage Occupation List until 2019.
- 2014 Campaign: 3 nurses from the recruitment campaign in 2014 (managed for us by Search recruitment agency) joined the Trust in January 2016. The final nurse from this campaign will join the Trust in March 2016. Once this final nurse is in post, the total number recruited through this campaign will be 25 nurses (see below). This was an extremely problematic campaign, since which we have ceased using Search recruitment agency and are now managing all of our international recruitment activity ourselves through direct engagement with overseas partners. This is saving the Trust approximately £500 per hire when compared with the Search campaign (total cost avoidance for 16/17 will therefore be c£50,000).

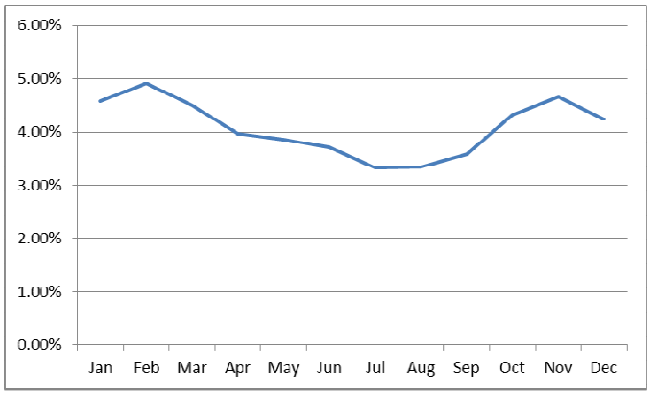
| **Situation** | **Numbers** |
|---|---|
| Staff Nurse with PIN, Band 5 | 13 |
| Undertaking Overseas Nursing Programme (Awaiting PIN – likely to be autumn 2016) | 2 |
| Undertaking OSCE training (Awaiting PIN – likely to be summer 2016) | 9 |
| Starting April 2016, awaiting Certificate of Sponsorship | 1 |
| **Total** | **25** |

- 2015 Campaign: It is expected that the first nurses from the November 2015 campaign will join the Trust in March/April 2016. It is not possible to accurately forecast how many of the 139 nurses to whom we made conditional employment offers will pass the English language examination and commence employment with us; however we anticipate it will be approximately 50 - 75, all of whom should be in post by summer 2016, and registered by winter 2016.
- 2016 Campaign: A further recruitment campaign in the Philippines has been re-scheduled from w/c 09 May 2016 to w/c 16 May 2016; this is due to the Filipino General Election on 09 May. The nurses attending this event will be Matron Fran

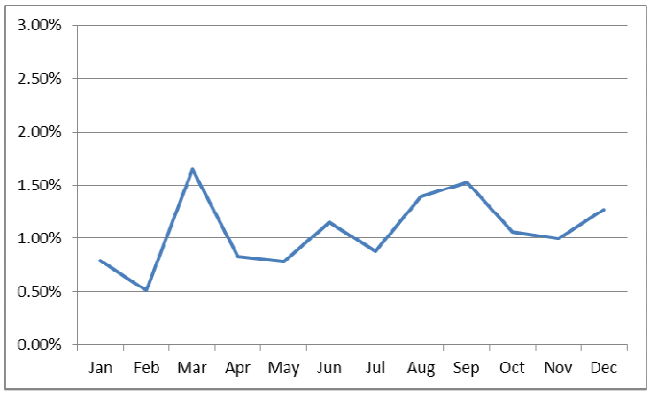
Wilson, Matron Sue McShane, Matron Judith Muir, and Senior Charge Nurse Jerome Ibarra. Our intention is to recruit approximately 50 – 75 nurses through this campaign, to join our Trust in Winter 2016, and be fully registered by Summer 2017.

### 4.5 Nursing Workforce Metrics

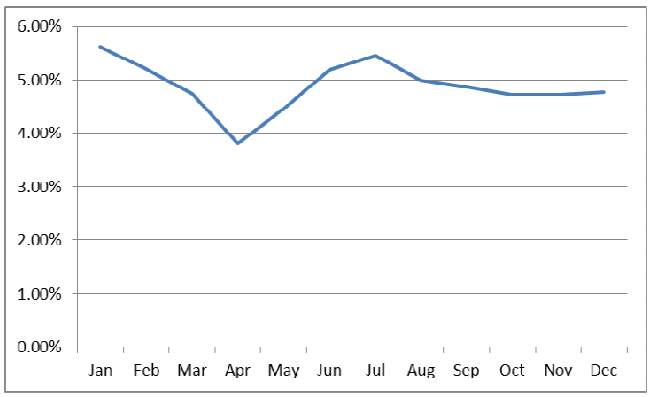
| Division | Band 5 Vacancies | Sickness | | Turnover | | Maternity |
|---|---|---|---|---|---|---|
| | | RGNs | HCAs | RGNs | HCAs | RGNs |
| Diagnostic & Specialist | 0 | 3.77% | 4.65% | 9.55% | 13.70% | 3.42% |
| Medicine | 79.85 | 3.99% | 5.33% | 18.25% | 22.29% | 3.23% |
| Surgery | 22.15 | 3.91% | 4.97% | 10.52% | 14.71% | 4.01% |
| Women & Children | 0 | 4.26% | 3.51% | 11.28% | 13.46% | 3.32% |



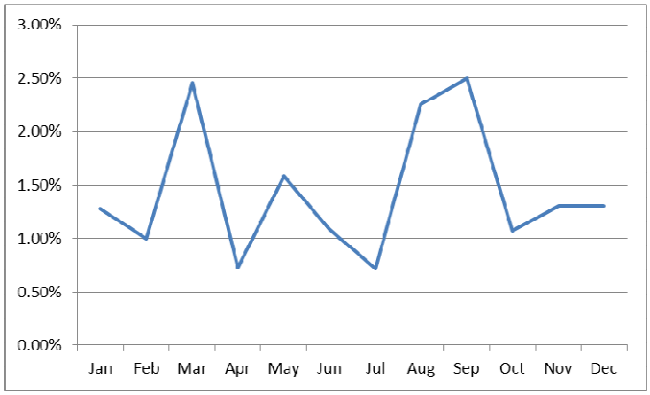

RGN: Sickness Absence by Month (Jan 15 – Dec 15)




**RGN:** Turnover by Month (Jan 15 – Dec 15)



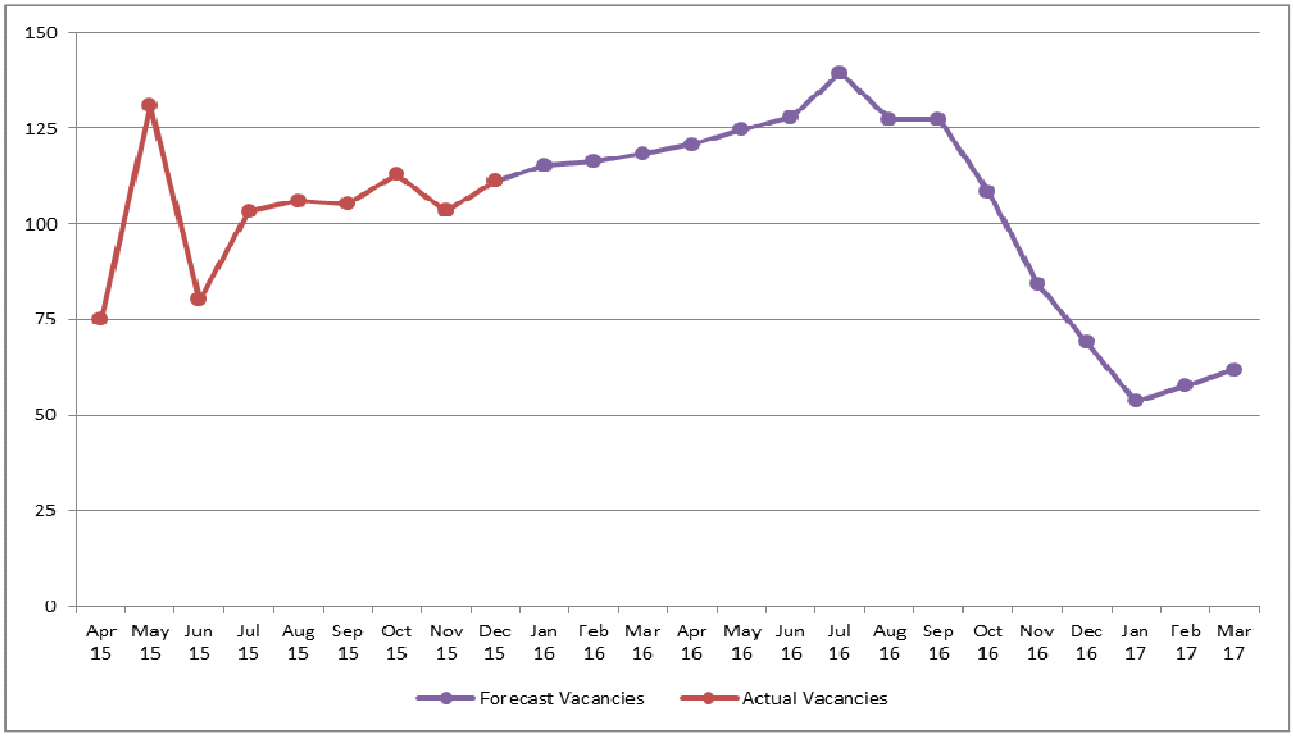
HCA: Sickness Absence by Month (Jan 15 – Dec 15)




**HCA:** Turnover by Month (Jan 15 – Dec 15)

### 4.6 Vacancy Forecast

The number of Band 5 Staff Nurse vacancies increased in January, which is expected due to a spike in leavers during December. The vacancies are expected to continue to rise for a number of months due to the limited number of student nurses and overseas nurses joining the organisation. This will be partly counteracted by increased recruitment at other bands. It is expected that the vacancies will reduce significantly during Autumn and Winter 2016 as a result of nurses arriving from the Philippines.




## 5 Next Steps and Communication

- Continue with proactive recruitment.
- Review the various incentive and reward schemes to ensure they have the requisite effect
- Publish data as required.

## 6 Recommendations

The Board is invited to endorse this report.

**Authors:** **Maggie Arnold, Director of Nursing & Midwifery**
**Adam Kirton, Nurse Recruitment Manager**

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

## Nursing Establishment Benchmarking against the Keith Hurst Database

As per the guidance from the Francis Report, twice a year, nursing staffing establishments are benchmarked against the agreed staffing tool, utilised within our Trust.

The Keith Hurst Benchmark database has been in use for four years within the Trust, therefore prior to the recommendations of the Francis Report. The 'Tool' has its origins in the Shelford Group work, and also has been known as the AUHUK (Association of University Hospitals United Kingdom) tool. The tool and resulting data base has been developed using the methodology of directly observing 'exemplar' wards, and the good patient outcomes they achieve. Therefore, the database is based on reality of effective and safe nursing staffing. The database is further developed into specialities, for example Cardiology, Gastroenterology, Vascular etc. This then allows a direct comparison of speciality wards against the denominator within the database. Most speciality wards within the database have a comparator of over a hundred wards contained. These high levels of comparator wards help eliminate usual variables of ward geography, and other extraneous factors.

The database allows the adding of a 'Specialing' component where the ward does this frequently. Also the 22% overhead (annual leave, sickness, and training) is also factored in. The resulting output from the data entered, for the ward being compared, includes the Senior Ward Sister/Charge Nurse in the overall establishment numbers, and this is taken into consideration when reviewing the available shift cover the recommended or actual ward establishment can deliver.

Finally, for this year, the additional unfunded beds opened has also been included to show the actual staffing required for these beds, as well as the staffing with these unfunded beds removed.

Therefore, reviewing the two reports, with unfunded and without unfunded beds, each ward has been separately analysed. With this information the Senior Ward Sister/Charge Nurse and the Modern Matron can agree what changes need to be made to move the skill mix closer to the recommended benchmark. It is best to review wards individually, or at the most, as a speciality rather than making an decisions on the 'grand totals' as these are more illustrative, and cannot be seen as an absolute recommendation. For example, in the table with unfunded beds removed, then it would appear that there are 12.28 fte more registered nurses then benchmark would suggest, however, moving in the separate ward detail, often there is a need to move registered nurse resources into Healthcare Assistant lines, and vice versa. Again, if the unfunded beds currently open, (and which have been open for most of the financial year), are factored in, then this registered nurse 'surplus' falls to just 2.93 fte, however the same caution is advised over interpreting too liberally, this 'bottom' line figure.

In summary, and reassuringly, the exercise shows a favourable comparison to the average ward staffing contained within the Keith Hurst database, but equally, does not show a massive surplus of staffing, when each individual ward staffing is examined. As explained previously, there is a requirement to change skill mix in some wards to better match the suggested establishment, however, this also requires an element of professional judgement on the part of nurse managers, to ensure this is done with care and consideration around the current dynamics of the care environment.

**ANNEX A**

**Nursing Benchmarking Exercise - December 2015 (based on the March 2014 dataset from Keith Hurst) version 2 with unfunded beds added**

| Division | Ward | KH RGN | KH HCA | KH Tot | Wd RGN | Wd HCA | Wd Tot | Diff RGN | Diff HCA | Recommendations from Director of Nursing & Midwifery |
|---|---|---|---|---|---|---|---|---|---|---|
| D&S | Lillybrook | 21.7 | 6 | 27.7 | 18.93 | 9.16 | 28.09 | -2.77 | 3.16 | Rebalance Skill mix |
| | Rendcombe | 20.1 | 10.1 | 30.2 | 22.36 | 10.03 | 32.39 | 2.26 | -0.07 | Rebalance Skill mix across Service |
| **D&S Div Totals** | | **41.8** | **16.1** | **57.9** | **41.29** | **19.19** | **60.48** | **-0.51** | **3.09** | |
| Medicine | 6a | 19 | 17.2 | 36.2 | 21.41 | 16.37 | 37.78 | 2.41 | -0.83 | Rebalance Skill mix across service |
| | 6b | 15.8 | 14.6 | 30.4 | 17.97 | 12.43 | 30.4 | 2.17 | -2.17 | Rebalance skill mix |
| | 7a | 22.2 | 14.4 | 36.6 | 21.96 | 15.39 | 37.35 | -0.24 | 0.99 | Rebalance skill mix |
| | 7b | 17.3 | 11.2 | 28.5 | 16.31 | 13.82 | 30.13 | -0.99 | 2.62 | Rebalance Skill mix |
| | 8a | 20.8 | 19 | 39.8 | 21.76 | 16.37 | 38.13 | 0.96 | -2.63 | Rebalance Skill mix |
| | 8b | 21.3 | 13.7 | 35 | 20.9 | 14.83 | 35.73 | -0.4 | 1.13 | Rebalance Skill mix |
| | Avening | 20.6 | 12.2 | 32.8 | 19.67 | 16.49 | 36.16 | -0.93 | 4.29 | Rebalance skill mix/Rebalance across service |
| | Knightbridge | 13.1 | 8.6 | 21.7 | 12.12 | 9.06 | 21.18 | -0.98 | 0.46 | Rebalance Skill Mix |
| | Cardiol GRH | 35.6 | 15.7 | 51.3 | 39.34 | 11.82 | 51.16 | 3.74 | -3.88 | Rebalance Skill mix across service |
| | Cardiol CGH | 24.2 | 4.6 | 28.8 | 25.58 | 2.87 | 28.45 | 1.38 | -1.73 | Rebalance Skill mix |
| | Hazelton | 16.8 | 10.8 | 27.6 | 15.53 | 14.55 | 30.08 | -1.27 | 3.75 | Based on 20 beds (funded 18) - Rebalance Skill mix |
| **Med Wd Totals** | | **226.7** | **142** | **368.7** | **232.55** | **144** | **376.55** | **5.85** | **2** | |
| GOAM | 4a | 21.8 | 16.7 | 38.5 | 21.37 | 18.21 | 39.58 | -0.43 | 1.51 | Rebalance Skill mix |
| | 4b | 19.2 | 16 | 35.2 | 20.1 | 17.57 | 37.67 | 0.9 | 1.57 | No Change |
| | 9b | 21.6 | 17.9 | 39.5 | 21.23 | 19.17 | 40.4 | -0.37 | 1.27 | Rebalance Skill mix |
| | Gall wd 1 | 21.6 | 17.9 | 39.5 | 21.36 | 17.73 | 39.09 | -0.24 | -0.17 | No Change |
| | Ryeworth | 22.5 | 18.6 | 41.1 | 21.81 | 20.52 | 42.33 | -0.69 | 1.92 | Rebalance skill mix |
| | Wood'cote | 22.5 | 18.6 | 41.1 | 22.23 | 19.3 | 41.53 | -0.27 | 0.7 | No Change |
| **GOAM Wd Totals** | | **129.2** | **105.7** | **234.9** | **128.1** | **112.5** | **240.6** | **-1.1** | **6.8** | |
| **Med Div Totals** | | **355.9** | **247.7** | **603.6** | **360.65** | **256.5** | **617.15** | **4.75** | **8.8** | |
| Unsch. | ACUA | 30.6 | 13.2 | 43.8 | 28.6 | 11.89 | 40.49 | -2 | -1.31 | Rebalance across service |

| Care | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | ACUC | 29.4 | 12.6 | 42 | 27.42 | 12.26 | 39.68 | -1.98 | -0.34 | Rebalance across service |
| | 9a | 12.4 | 9.6 | 22 | 13.42 | 9.04 | 22.46 | 1.02 | -0.56 | Rebalance skill mix across service |
| **U/C Div Totals** | | **72.4** | **35.4** | **85.8** | **69.44** | **33.19** | **80.17** | **-2.96** | **-2.21** | |
| **Division** | **Ward** | **KH RGN** | **KH HCA** | **KH Tot** | **Wd RGN** | **Wd HCA** | **Wd Tot** | **Diff RGN** | **Diff HCA** | **Recommendations from Director of Nursing & Midwifery** |
| **Surgical** | 2b | 18.7 | 6.6 | 25.3 | 17.8 | 5.27 | 23.07 | -0.9 | -1.33 | No change |
| | 5a | 19.3 | 10 | 29.3 | 18.33 | 11.65 | 29.98 | -0.97 | 1.65 | Rebalance Skill mix |
| | 5b | 29.1 | 15.1 | 44.2 | 28.66 | 13.73 | 42.39 | -0.44 | -1.37 | Rebalance Skill mix |
| | Guiting | 28.25 | 13.8 | 42.05 | 26.26 | 12.91 | 39.17 | -1.99 | -0.89 | Based on 34 beds (funded 30) - Rebalance Skill mix |
| | Prescott | 28.4 | 15.8 | 44.2 | 30.45 | 13.86 | 44.31 | 2.05 | -1.94 | Rebalance across service |
| | Bibury | 17.6 | 10.1 | 27.7 | 15.55 | 9.18 | 24.73 | -2.05 | -0.92 | Rebalance across service |
| | Snowshill | 16.2 | 7.2 | 23.4 | 15.4 | 6.3 | 21.7 | -0.8 | -0.9 | Based on 18 beds (funded 16) - Rebalance across service |
| **Surg Wd Totals** | | **157.55** | **78.6** | **236.15** | **152.45** | **72.9** | **225.35** | **-5.1** | **-5.7** | |
| **T&O** | 3a | 17.5 | 12.7 | 30.2 | 21.11 | 12.29 | 33.4 | 3.61 | -0.41 | Based on 24 beds (30 beds allocated) Rebalance Skill mix |
| | 3b | 23.4 | 17.9 | 41.3 | 23.41 | 13.78 | 37.19 | 0.01 | -4.12 | Based on 35 beds (29 beds allocated) Rebalance across service |
| | Dixton | 12.3 | 9.3 | 21.6 | 12.31 | 9.37 | 21.68 | 0.01 | 0.07 | Small ward therefore establishment acceptable |
| | Alstone | 18.4 | 11.2 | 29.6 | 19.58 | 9.59 | 29.17 | 1.18 | -1.61 | Rebalance Skill mix |
| **T&O Wd Totals** | | **71.6** | **51.1** | **122.7** | **76.41** | **45.03** | **121.44** | **4.81** | **-6.07** | |
| **Sur Div Totals** | | **229.15** | **129.7** | **358.85** | **228.86** | **117.93** | **346.79** | **-0.29** | **-11.77** | |
| **W&C** | 2a | 17 | 7.4 | 24.4 | 18.94 | 6 | 24.94 | 1.94 | -1.4 | Rebalance Skill mix (Reg Review & Helpline impact & Day Case Unit |
| **W&C totals** | | **17** | **7.4** | **24.4** | **18.94** | **6** | **24.94** | **1.94** | **-1.4** | |
| ***Grand totals*** | | ***674.45*** | ***420.2*** | ***1073*** | ***677.89*** | ***413.62*** | ***1069*** | ***2.93*** | ***-2.09*** | |

**Nursing Benchmarking Exercise - December 2015 (based on the March 2014 dataset from Keith Hurst)**

| Division | Ward | KH RGN | KH HCA | KH Tot | Wd RGN | Wd HCA | Wd Tot | Diff RGN | Diff HCA | Recommendations from Director of Nursing & Midwifery |
|---|---|---|---|---|---|---|---|---|---|---|
| D&S | Lillybrook | 21.7 | 6 | 27.7 | 18.93 | 9.16 | 28.09 | -2.77 | 3.16 | Rebalance Skill mix |
| | Rendcombe | 20.1 | 10.1 | 30.2 | 22.36 | 10.03 | 32.39 | 2.26 | -0.07 | Rebalance Skill mix across Service |
| **D&S Div Totals** | | **41.8** | **16.1** | **57.9** | **41.29** | **19.19** | **60.48** | **-0.51** | **3.09** | |
| Medicine | 6a | 19 | 17.2 | 36.2 | 21.41 | 16.37 | 37.78 | 2.41 | -0.83 | Rebalance Skill mix across service |
| | 6b | 15.8 | 14.6 | 30.4 | 17.97 | 12.43 | 30.4 | 2.17 | -2.17 | Rebalance skill mix |
| | 7a | 22.2 | 14.4 | 36.6 | 21.96 | 15.39 | 37.35 | -0.24 | 0.99 | Rebalance skill mix |
| | 7b | 17.3 | 11.2 | 28.5 | 16.31 | 13.82 | 30.13 | -0.99 | 2.62 | Rebalance Skill mix |
| | 8a | 20.8 | 19 | 39.8 | 21.76 | 16.37 | 38.13 | 0.96 | -2.63 | Rebalance Skill mix |
| | 8b | 21.3 | 13.7 | 35 | 20.9 | 14.83 | 35.73 | -0.4 | 1.13 | Rebalance Skill mix |
| | Avening | 20.6 | 12.2 | 32.8 | 19.67 | 16.49 | 36.16 | -0.93 | 4.29 | Rebalance skill mix/Rebalance across service |
| | Knightbridge | 13.1 | 8.6 | 21.7 | 12.12 | 9.06 | 21.18 | -0.98 | 0.46 | Rebalance Skill Mix |
| | Cardiol GRH | 35.6 | 15.7 | 51.3 | 39.34 | 11.82 | 51.16 | 3.74 | -3.88 | Rebalance Skill mix across service |
| | Cardiol CGH | 24.2 | 4.6 | 28.8 | 25.58 | 2.87 | 28.45 | 1.38 | -1.73 | Rebalance Skill mix |
| | Hazelton | 16.8 | 10.8 | 27.6 | 15.53 | 14.55 | 30.08 | -1.27 | 3.75 | Rebalance Skill mix |
| **Med Wd Totals** | | **226.7** | **142** | **368.7** | **232.55** | **144** | **376.55** | **5.85** | **2** | |
| GOAM | 4a | 21.8 | 16.7 | 38.5 | 21.37 | 18.21 | 39.58 | -0.43 | 1.51 | Rebalance Skill mix |
| | 4b | 19.2 | 16 | 35.2 | 20.1 | 17.57 | 37.67 | 0.9 | 1.57 | No Change |
| | 9b | 21.6 | 17.9 | 39.5 | 21.23 | 19.17 | 40.4 | -0.37 | 1.27 | Rebalance Skill mix |
| | Gall wd 1 | 21.6 | 17.9 | 39.5 | 21.36 | 17.73 | 39.09 | -0.24 | -0.17 | No Change |
| | Ryeworth | 22.5 | 18.6 | 41.1 | 21.81 | 20.52 | 42.33 | -0.69 | 1.92 | Rebalance skill mix |
| | Wood'cote | 22.5 | 18.6 | 41.1 | 22.23 | 19.3 | 41.53 | -0.27 | 0.7 | No Change |
| **GOAM Wd Totals** | | **129.2** | **105.7** | **234.9** | **128.1** | **112.5** | **240.6** | **-1.1** | **6.8** | |
| **Med Div Totals** | | **355.9** | **247.7** | **603.6** | **360.65** | **256.5** | **617.15** | **4.75** | **8.8** | |
| Unsch. Care | ACUA | 30.6 | 13.2 | 43.8 | 28.6 | 11.89 | 40.49 | -2 | -1.31 | Rebalance across service |
| | ACUC | 29.4 | 12.6 | 42 | 27.42 | 12.26 | 39.68 | -1.98 | -0.34 | Rebalance across service |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 9a | 12.4 | 9.6 | 22 | 13.42 | 9.04 | 22.46 | 1.02 | -0.56 | Rebalance skill mix across service |
| **U/C Div Totals** | | **72.4** | **35.4** | **85.8** | **69.44** | **33.19** | **80.17** | **-2.96** | **-2.21** | |
| **Division** | **Ward** | **KH RGN** | **KH HCA** | **KH Tot** | **Wd RGN** | **Wd HCA** | **Wd Tot** | **Diff RGN** | **Diff HCA** | **Recommendations from Director of Nursing & Midwifery** |
| **Surgical** | 2b | 18.7 | 6.6 | 25.3 | 17.8 | 5.27 | 23.07 | -0.9 | -1.33 | No change |
| | 5a | 19.3 | 10 | 29.3 | 18.33 | 11.65 | 29.98 | -0.97 | 1.65 | Rebalance Skill mix |
| | 5b | 29.1 | 15.1 | 44.2 | 28.66 | 13.73 | 42.39 | -0.44 | -1.37 | Rebalance Skill mix |
| | Guiting | 25.6 | 14.7 | 40.3 | 26.26 | 12.91 | 39.17 | 0.66 | -1.79 | Rebalance Skill mix |
| | Prescott | 28.4 | 15.8 | 44.2 | 30.45 | 13.86 | 44.31 | 2.05 | -1.94 | Rebalance across service |
| | Bibury | 17.6 | 10.1 | 27.7 | 15.55 | 9.18 | 24.73 | -2.05 | -0.92 | Rebalance across service |
| | Snowshill | 12.9 | 7.3 | 20.2 | 15.4 | 6.3 | 21.7 | 2.5 | -1 | Rebalance across service |
| **Surg Wd Totals** | | **151.6** | **79.6** | **231.2** | **152.45** | **72.9** | **225.35** | **0.85** | **-6.7** | |
| **T&O** | 3a | 18.7 | 13.2 | 31.9 | 21.11 | 12.29 | 33.4 | 2.41 | -0.91 | Rebalance Skill mix |
| | 3b | 20.4 | 15.5 | 35.9 | 23.41 | 13.78 | 37.19 | 3.01 | -1.72 | Rebalance Skill mix (based on 30 beds open to 35) |
| | Dixton | 12.3 | 9.3 | 21.6 | 12.31 | 9.37 | 21.68 | 0.01 | 0.07 | Small ward therefore establishment acceptable |
| | Alstone | 16.8 | 11.2 | 28 | 19.58 | 9.59 | 29.17 | 2.78 | -1.61 | Rebalance Skill mix |
| **T&O Wd Totals** | | **68.2** | **49.2** | **117.4** | **76.41** | **45.03** | **121.44** | **8.21** | **-4.17** | |
| **Sur Div Totals** | | **219.8** | **128.8** | **348.6** | **228.86** | **117.93** | **346.79** | **9.06** | **-10.87** | |
| **W&C** | 2a | 17 | 7.4 | 24.4 | 18.94 | 6 | 24.94 | 1.94 | -1.4 | Rebalance Skill mix (Reg Review & Helpline impact & Day Case Unit) |
| **W&C totals** | | **17** | **7.4** | **24.4** | **18.94** | **6** | **24.94** | **1.94** | **-1.4** | |
| ***Grand totals*** | | ***665.1*** | ***419.3*** | ***1062*** | ***677.89*** | ***413.62*** | ***1069*** | ***12.28*** | ***-1.19*** | |

**MAIN BOARD – FEBRUARY 2016**

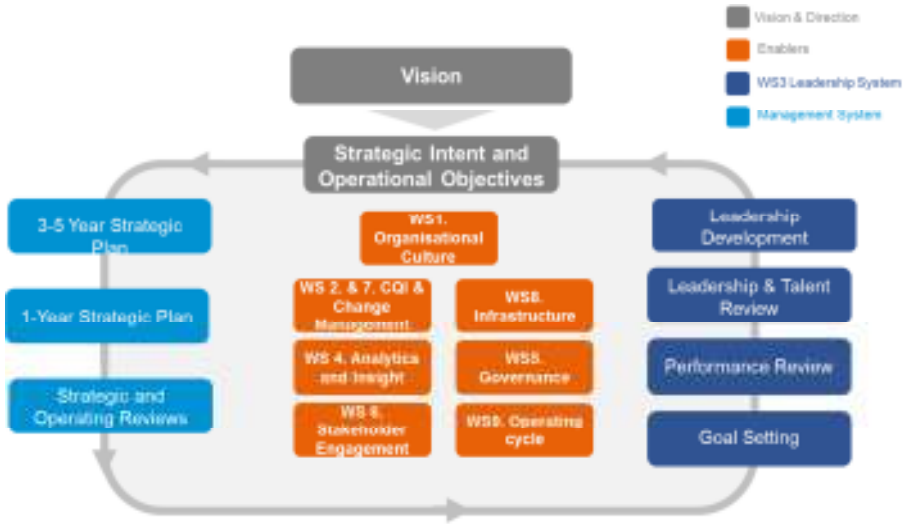
**CHIEF EXECUTIVE REPORT - CULTURE CHANGE PROGRAMME**

## 1. Executive Summary

1.1 The change programme is a key priority for the Trust.

1.1.1 It provides the framework and mechanism for the organisation to deliver its transformation programme and is embedded within the Trusts strategic intent and operational objectives.

1.1.2 The system elements, Management Systems and Leadership respectively, are responsible for translating the vision into strategic plans and ensuring that those plans flow down into individual and team goals. Nine enabling work streams together with a number of quick-wins aim to provide the necessary organisational tools and processes.




1.1.3 Each work stream is managed by a work stream lead drawn from our current teams, and is sponsored by an executive director.

| Work Stream | Board Sponsor | Work Stream Lead |
|---|---|---|
| 1. Culture Change | Dr F Harsent | |
| 2. Continuous Quality Improvement and | Dr F Harsent | Mr A Seaton |
| 7. Change Management | Dr S Pearson | Mr I Quinnell |
| 3. Leadership | Mr D Smith | Ms B Wheeler |
| 4. Analytics & Insight | Ms H Simpson | Mr P Hopwood |
| 5. Governance | Prof. C Chilvers | Mr M Wood |
| 6. Stakeholder Engagement | Dr S Pearson, Mr D Smith | Mr C MacFarlane |
| 8. Infrastructure | Ms H Simpson | Mr N Jackson |
| 9. Operating cycle | Dr S Elyan, Mr E Gatling | |

## 2. Quarterly Programme Summary Progress Report

# Culture Change Programme

## Quarterly Summary Progress Report

| Status | Last | Current | Next |
|---|---|---|---|
| | A | A | A |

### Key Achievements this Period

• Regular meetings with Board sponsors arranged. Board sponsors will also attend the monthly work stream meetings when possible. This is extremely valuable in quickly steering and/or unblocking issues.
• Following the November Board meeting, increased NED involvement has been implemented by supporting various work stream meetings. Prof. Chilvers has been particularly instrumental in managing this activity.
• The on-going communication of programme activity will play a key part in employee and stakeholder engagement. Each work stream will update on progress via Outline, relating how outputswill impact on day to day working.
• D Smith and R Wassell attended the second phase of the NHS programme Leading Transformational Change led by the Advancing Change Team 9-10 December 2015. Rebecca attended the final session on 11 February 2016
• All work stream activity has been uploaded to Sharepoint, accessible to all leads and sponsors. The work streams leads are responsible for keeping their documents up to date.

### Key Activity Next Period

• The Executive has been asked to support the programme in relation to requests for unplanned/unscheduled work from those staff members supporting work stream activity. Advance notice and a reasonably detailed brief on ad-hoc requests would enable the teams to plan resource utilisation more appropriately and avoid withdrawal of resources from work stream activity, which adds risk to programme delivery.
• CoS have been asked to consider whether a brief quarterly update at the Divisional meetings would be useful to ensure that the changes flow through the organisation, or whether the CoS would prefer some other level of involvement with the programme.
• Every effort is being made to pick up pace across the work streams, especially where there have been organisational issues affecting delivery against plan.
• A discussion paper vis-à-vis Service Line Management has been submitted to H Simpson and E Gatling for consideration. A further meeting to discuss potential proposals for Board consideration has been arranged for 25 February 2016.

### Key Milestones (see WS progress reports for detail)

| *WS* | *Milestone* | *Status* |
|---|---|---|
| *3* | Leadership behaviours & welcome | Met |
| *4* | Info. unit restructure & skills audit | R |
| *4* | Med., D&S dashbd informs Surg., | G |
| *4* | Information architecture, design and interface agreed | G |
| *5* | Revised NED Job Specification | Met |
| 6 | Branding refresh | Met |
| 6 | Programme communications plan | G |
| *7* | Develop revised training programme | A |
| *7* | Refine PM toolkit | Met |
| *7* | Process improvement toolkit | G |
| *8* | Phase 1 moves programme agreed | G |
| 8 | Phase 1 Lean improvement | G |

### Key Issues (see WS progress reports for detail)

• Monthly work stream meetings are in place, as are fortnightly catch ups with each individual work stream lead. Attendance at some meeting has been sporadic and a sharper focus on this via the Board Sponsors will follow.
• Slippage on some work streams due to late decisions /resource availability.
• Every opportunity to progress understanding and links to day-to-day Trust activity to be taken up.
• Focus and pace on achieving deliverables

### Decisions Required

• Identify and appoint work stream leads for the outstanding items in work stream 1 and, most especially, for work stream 9.
• CoS to determine level of divisional involvement/communication



Date of last Board report: 27-Nov-15

Next Board report: 20-May-16

| Key | | |
|---|---|---|
| *Risk Description (see individual WS progress reports for detail)* | *Risk Rating* | *Mitigation (Y/N)* |
| WS3: Insufficient resource identified within the L&OD team to explore senior leader key competency | A | Y |
| WS 4: The pace of capability & product development is not fast enough | R | Y |
| WS5: Loss of Focus from Programme in the light of the Trust's overall priorities | R | Y<br>Y |
| WS6: Website & intranet: Costs | A | Y |
| WS7: Inability to identify a suitable knowledge base in | A | Y |
| WS7: Capacity within HR OD to review, develop and deliver new Change Management training | A | Y |
| WS8: Resource to support policy development and engagement with 'Workstyles' programme | A | Y |

| Key Briefings & Communications planned over next period | | | |
|---|---|---|---|
| *When?* | *What?* | *Objective / Message* | *Medium / How?* |
| Feb-16 | Outline | Work Stream 8 - Infrastructure | Written article |
| Mar-16 | Outline | Work Stream 4 - Analytics & Insight | Written article |
| Mar-16 | 100 leaders | Making links to the vision at the local level | Work shops |
| Apr-16 | Outline | Work Stream 5 - Governance | Written article |
| May-16 | Board report | Progress report | CEO report |
| May-16 | Outline | Work Stream 7 - Change Management | Written |

| Key Assumptions / Interdependencies | |
|---|---|
| *Description* | *Impact* |
| WS 2 In-house leadership and management programmes | Accredited cohorts of CQI-enabled leaders distributed across the organisation |
| WS4: Interdependency on the SmartCare programme | Delivery of Trak, its infrastructure and associated workflow metrics |
| WS4: Internal prioritisation of Information Unit acivity allowing staff release to work on development | Failure to resource WS 4 will lead to slippage |
| WS 7 Leadership & Development | Design and development of programmes |

| Changes in Scope | |
|---|---|
| *Description* | *Impact* |
| Ws 4 expanded to include integration of Finance, HR and Facilities information | Revised high level plan |
| WS 5 has been reviewed and amended | Revised focus and timescales |

## 3. Individual Work Stream progress Reports

| WORK STREAM 2 - CONTINUOUS IMPROVEMENT | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Date completed** | 05.02.16 | | | | **Version** | V1 | |
| **Work Stream Sponsor** | Dr Frank Harsent | | | **Work Stream Lead** | Andrew Seaton | | |
| **Overall** | **Milestones** | **Benefits** | **Budget** | **Risks & Issues** | **Scope** | **Resources** | |

| | **Approved Budget** | **Expected spend to-date** | **Actual spend to date** |
|---|---|---|---|
| **Capital** | £0 | £0 | £0 |
| **Revenue** | £0 | £0 | £0 |

| **Progress in period covering November 2015 to February 2016** |
|---|
| Agreed initial approach for accreditation of the Improvement programme |
| Introduced Co-Design tool kit to the tools available |
| Delivery of Bronze course on new induction for leaders and consultants |
| Linked Academy graduations to Staff Awards |

| **Planned activities in next period March 2016 to May 2016** |
|---|
| Begin development of overarching strategy for improvement |
| Link Improvement programme to WEAHSN programme |
| Engage partners in Improvement programmes |
| Deliver Silver programme to CQuIN leads and teams |
| Initiate work to build planning and delivery process to identify and track improvement programmes |

| **Milestones** | | | |
|---|---|---|---|
| **Milestone** | **Date started** | **Target Completion Date** | **Comments** |
| Strategy | Feb 2016 | Sept 2016 | |
| Link Improvement programme | Sept 2015 | Sept 2016 | |
| Engage partners | Feb 2016 | TBC | Dependant on sign up to programmes |
| CQuIN lead training | March 2016 | March 2017 | |

| **Risks (Where score on Risk Log requires escalation)** | | | |
|---|---|---|---|
| ID | Risk description | RAG | Mitigation |
| | | | |

| **Issues (Where score on Issues Log requires escalation)** |
|---|

| ID | Issue description | RAG | Mitigation |
|---|---|---|---|
| | | | |

| Benefits Realisation Tracking | | | | |
|---|---|---|---|---|
| **Ref** | **Benefit** | **Definition** | **Owner** | **RAG Status** |
| 2.4 | To develop a clear vision and direction that meets the future requirements of the Trust | Improvement Strategy | AS | G |
| 1.18 | Added internal and external value of the improvement programme to provide achievement and recognition rewards and motivation | Accreditation of courses | AS | G |
| 1.19 | To build reputation externally to attract interest in future courses and Gloucestershire wide improvement. | Working with partners to explore opportunities | AS | G |
| 2.1 | Effective management of projects using the standardised approach and tool set | Bronze level improvement skills for managers. | AS | G |

| WORK STREAM 3 - LEADERSHIP | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Date completed** | 8 February 2016 | | | | **Version** | 1 | |
| **Work Stream Sponsor** | Dave Smith | | **Work Stream Lead** | | Becky Wheeler | | |
| **Overall** | **Milestones** | **Benefits** | **Budget** | **Risks & Issues** | **Scope** | **Resources** | |

| | Approved Budget | Expected spend to-date | Actual spend to date |
|---|---|---|---|
| **Capital** | £0 | £0 | £0 |
| **Revenue** | £0 | £0 | £0 |

**Progress in period covering November 2015 to February 2016**

The Leadership Behaviours have now been finalised on to a one page document incorporating the Leadership Charter and referring to the Kindness and Respect Behaviours. The behaviours are aimed at all staff and look at how we lead ourselves, our teams and our Trust. The behaviours have been synthesised into a revised appraisal document which is being finalised. The visual for the Leadership Behaviours as a stand-alone document is being produced by our Graphic Design Team.

The Leadership Welcome Day and Portfolio have been finalised, the targeting process established and the Welcome Day publicised via the 100 Leader Group and an article in Outline.

A more targeted and thorough approach to the recruitment for senior manager posts has been established.

**Planned activities in next period March 2016 to May 2016**

The Leadership Behaviours and updated appraisal paperwork to be launched.

Leadership Welcome Day to be launched.

Consultant Induction/Welcome Day programme to be finalised for the April launch.

Work will begin on defining a Knowledge, Skills and Experience Competency Framework for our clinical leadership model to align with our Leadership Behaviours Framework.

**Milestones**

| Milestone | Date started | Date completed | Comments |
|---|---|---|---|
| Leadership Behaviours aligned to our Trust Values | 1.9.15 | 31.10.15 | |
| Consultation re Leadership Behaviours | 17.11.15 | 27.1.16 | |
| Leadership Welcome Day programme established and publicised | 1.8.15 | 31.1.16 | |

**Risks**
**(Where score on Risk Log requires escalation)**

| ID | Risk description | RAG | Mitigation |
|---|---|---|---|
| BW | Insufficient resource identified within the L&OD team to explore senior leader key competency framework project. | A | Review to be undertaken to establish current priorities and resource implications. Discussion to be held with respect to further investment or slipping of other priorities. |

**Issues**
**(Where score on Issues Log requires escalation)**

| ID | Issue description | RAG | Mitigation |
|---|---|---|---|
| | | | |

| Benefits Realisation Tracking | | | | |
|---|---|---|---|---|
| **Ref** | **Benefit** | **Definition** | **Owner** | **RAG Status** |
| | To define leadership in GHNHSFT and refresh the leadership portfolio using a range of internal and external programmes to deliver the required skills and competencies. | Setting standards and expectations for our leaders | BW | G |
| | To embed 'what it means to be a leader at GHFT' in all relevant people processes e.g. recruitment, induction, training, appraisals, re-validation, performance management, reward and recognition. | Alignment of key processes with Trust requirements | BW | G |
| | To design and implement a leadership induction day (for new recruits and promotions), ensuring interview assessment results and gaps flow through. | Assessment of skills gap and initial identification of development plans | BW | G |
| | To design and implement robust succession planning processes at Service/Support line, Division and Trust wide level. | Appropriate processes in place to safeguard future Trust activities | DS | G |
| | To design and implement a talent retention and development programme to support the identification and development of talent at team, service/support line, division and Trust wide level. To establish a talent pool consisting of CVs, aspirations, knowledge and skills. | Ensuring that cohorts of skills are available to meet future Trust requirements and service demands, improving retention of hi-potential individuals and creating career pathways | DS | G |

| WORK STREAM 4 - ANALYTICS & INSIGHT | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Date completed** | February 2016 | | | | **Version** | 1.0 | |
| **Work Stream Sponsor** | Helen Simpson | | | **Work Stream Lead** | Phil Hopwood | | |
| **Overall** | **Milestones** | **Benefits** | **Budget** | **Risks & Issues** | **Scope** | **Resources** | |

| | Approved Budget | Expected spend to-date | Actual spend to date |
|---|---|---|---|
| **Capital** | £0 | £0 | £0 |
| **Revenue** | £0 | £0 | £0 |

## Progress in period covering November 2015 to February 2016

**Management**

During this period the outline project plan of the key areas of development has been agreed with the Information Unit and detailed planning of the tasks, resources required and delivery timeline is nearing completion in time for an inaugural Project Board on 9 February. To complement this, an approach to communication and engagement surrounding the workstream has also been documented.

A key theme of this development plan, given the interdependency of the workstream on the SmartCare programme, is the adoption of an incremental approach to gaining requirements and delivery. In this approach stakeholder engagement is key to delivering products that are fit for purpose. Hence products will be prototyped quickly, piloted or showcased, evaluated by the stakeholders/clients and if necessary adjusted or re-developed before moving them into operation. The first set of engagements with the Divisions as part of this approach is scheduled to take place in February.

Also during the period it was agreed that the scope of the workstream should be expanded to include the integration of Finance, HR and Facilities information and this has been factored into the high level plan.

**Delivery**

People. The restructure of the Divisional Information team within the Information Unit, required in order to shape the team to be ready to support a consultancy based operating model going forwards as well as developing the analytics skills, is nearing completion. Originally scheduled for delivery by November 2015, the slip has presented a brake on planning and development but the detailed planning mentioned above has highlighted some areas where catch-up of time may be achieved.

Also as part of developing the right capability within the Information team, a skills audit has been developed to baseline the current level of expertise and identify any gaps in order to develop a targeted staff development plan. This will be rolled out in February.

Product. A prototype daily seven-day forecast model for ED supply and demand has been developed and is currently being piloted with ED.

## Planned activities in next period March 2016 to May 2016

**Management**

In the next period the key engagement with stakeholders will commence in order to define and hone the Trust, Divisional and Specialty requirements as well as the boundaries with the SmartCare analytics delivery.

**Delivery**

People. The audit of skills will be completed and development plans detailed.

Offer. The future Information Unit offer will be defined and the re-brand to a Business Intelligence function commenced.

Product. A number of developments will begin in the next period with the most influential being:

- The architecture and interface between the users and the information will be re-designed based around

stakeholder feedback with proof of concept dashboards being piloted with Medical and Diagnostics & Specialisms Divisions in the first instance.

- These will include a "drill-down" as well as a rudimentary forecasting capability whilst more sophisticated algorithms that focus on the key drivers are concurrently researched and developed.
- Aligned to this an ability to verify all forecasting products will also be implemented so that the on-going accuracy of the techniques employed can be assessed and used not only in decision making but also in future development.
- In addition, the ability to access HR and Finance data from their respective systems will be assessed as a first stage of automation.
- Linked to Trak, the streamlining and "speeding-up" the response of existing reporting will be delivered.

| Milestones | | | |
|---|---|---|---|
| **Milestone** | **Date started** | **Date completed** | **Comments** |
| Agreed outline plan | Sep 2015 | Jan 2016 | Slippage from Nov 2015 |
| Information Unit restructure | Sep 2015 | | Slippage from Nov 2015 |
| Skills audit completed | Nov 2015 | | |
| Information Unit offer | Mar 2016 | | Slippage from Nov 2015 |
| Stakeholder engagement | Feb 2016 | | Routine activity over next 10 months |
| Information architecture, dashboard design & interface agreed | Feb 2016 | | |
| Medicine & D&S dashboards | Feb 2016 | | Piloted & refined to inform Surgery& Women's and Children's approach |
| Verification system | Jan 2016 | | |
| Streamlining & "speeding up" of reporting | Jan 2016 | | |
| Boundaries with Trak analytics identified | Feb 2016 | | Link to Trak deliverables |
| Assess access to HR & Finance information | Feb 2016 | | |

| Risks (Where score on Risk Log requires escalation) | | | |
|---|---|---|---|
| **ID** | **Risk description** | **RAG** | **Mitigation** |
| 1 | Risk: Operational - The pace of capability & product development is not fast enough<br>Cause 1: Resource required from the Information Unit cannot be released due to operational commitments &/or SmartCare delivery<br>Cause 2: Resource required from the Information Unit cannot be released due to vacancies & the need to deliver BAU<br>Cause 3: Funds are not available to support project augmented specialist resource<br>Impact: Delay in product delivery & benefit realisation | R | a) Prioritisation of tasking in the Information Unit<br>b) Reduce tasking on the information Unit<br>c) Provision of additional trained resource<br>d) Utilise SmartCare resource<br>e) Lengthen delivery timescales to match Information Unit resource load<br>f) Ensuring Information Unit is at complement |

| Issues (Where score on Issues Log requires escalation) | | | |
|---|---|---|---|
| ID | Issue description | RAG | Mitigation |

| | | | |
|---|---|---|---|

| Benefits Realisation Tracking | | | | |
|---|---|---|---|---|
| **Ref** | **Benefit** | **Definition** | **Owner** | **RAG Status** |
| 1 | Information Unit analysts become business consultants to the Divisions and Corporate centre with move from information provision to scenario analysis performed by data subject matter experts | Reduction in the number of requests for ad hoc data & increase in the number of deep dive requests | Head of Information / Divisional Ops Directors / Exec Team | A |
| 2 | Enhanced capability of Information Unit analyst staff covering statistical analysis & forward prediction with more assured & evidence based decision making and greater insight into root causes of Trust performance & likelihood of success of actions | Reporting contains references to benchmarks, historic trends and impact analysis | Head of Information | G |
| 3 | End users understand what information they need that is essential to their operational roles and key information informs operational decisions | Total number of required BI reports falls & number of reports with less than 10 views per year falls | Head of Information / Divisional Ops Directors | G |
| 4 | End users of information are sufficiently capable to interpret basic data & perform basic analysis giving reduction in Information requests for basic data & analysis allowing resource to be deployed onto deep-dive analysis | Number of requests for basic data & analysis | Head of Information / Divisional Ops Directors | G |
| 5 | Make operational information easier & quicker to interpret to increase use of operational information in decision making | Usage of reporting and analysis | Head of Information | |
| 6 | The Trust understands the key drivers to operational performance and can forecast from them | Action plans prioritised on most important drivers and operational decisions based of forecast performance metrics | Head of Information / Divisional Ops Directors / Exec Team | G |
| 7 | Development of a simulation capability to understand the impact of changes such as re-configurations on Trust & Divisional performance | Simulation is used as key evidence in re-configuration plan | Head of Information / Divisional Ops Directors / Exec Team | A |

| WORK STREAM 5 - GOVERNANCE | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Date completed** | 9 February 2016 | | | | **Version** | 1 | |
| **Work Stream Sponsor** | Prof Clair Chilvers | | | **Work Stream Lead** | Martin Wood | | |
| **Overall** | **Milestones** | **Benefits** | **Budget** | **Risks & Issues** | **Scope** | **Resources** | |

| | Approved Budget | Expected spend to-date | Actual spend to date |
|---|---|---|---|
| **Capital** | £0 | £0 | £0 |
| **Revenue** | £0 | £0 | £0 |

| Progress in period covering November 2015 to February 2016 |
|---|
| The recommendations in the Board Governance Review were considered at a Board seminar and an action plan determined to assist the workstream actions and deliverables. The person specification for future Non-Executive Director appointments has been revised to ensure the right balance of skills and is being used for the current Non-Executive Director recruitment. Work has commenced on refining the Committee structure and how this taken be taken forward at committees below Board level. The Board is to consider in February 2016 how to develop and maintain good personal relationships among Board members. |

| Planned activities in next period March 2016 to May 2016 |
|---|
| The Board is to begin discussions at its March 2016 meeting to revise Board agendas so that at least 60% are forward looking. The Trust standards for committee servicing including the timeliness of agenda, reports and minutes and how this can be championed throughout the organisation. Discussions are to take place involving Non-Executive Directors to seek their input in a programme to provide support, information and development to enable them to fulfil their role. The Council of Governors is to consider on 24 February 2016 establishing an ad hoc group to define a range of initiatives to develop a more productive relationship between the Board and the Council of Governors and this work will be taken forward. A range of initiatives are being developed to give greater visibility and accessibility across the Trust to Board members. |

| Milestones | | | |
|---|---|---|---|
| **Milestone** | **Date started** | **Date completed** | **Comments** |
| Revised Non-Executive Director person specification | Sept 2015 | Jan 2016 | |

| Risks (Where score on Risk Log requires escalation) | | | |
|---|---|---|---|
| **ID** | **Risk description** | **RAG** | **Mitigation** |
| | Loss of Focus from Programme in the light of the Trust's overall priorities. | R | Regular review of actions and outputs |

| Benefits Realisation Tracking | | | | |
|---|---|---|---|---|
| **Ref** | **Benefit** | **Definition** | **Owner** | **RAG Status** |
| 1 | Governance | To ensure that the Trust has good Governance arrangements in place | M Wood | G |

## WORKSTREAM 6 - STAKEHOLDER ENGAGEMENT

| Date completed | | | Version | |
|---|---|---|---|---|
| Work Stream Sponsor | Sally Pearson & Dave Smith | Work Stream Manager | Craig MacFarlane | |

| Overall | Milestones | Benefits | Budget | Risks & Issues | Scope | Resources |
|---|---|---|---|---|---|---|

| | Approved Budget | Expected spend to-date | Actual spend to date |
|---|---|---|---|
| Capital | £0 | £0 | £0 |
| Revenue | £0 | £0 | £0 |

## Progress in period covering November 2015 to February 2016

**Momentum**

A key deliverable for communications throughout the programme is to embed and develop momentum in the project throughout the organisation. This stretches back to the programme launch in June 2015. A programme of stakeholder engagement supported by communications was implemented over the summer period and into the autumn. This programme has continued into the winter period. Key deliverables are identified below:

Outline:

- Jan 2016 edition: Leadership feature article
- Dec 2015 edition: Feature article on refreshed templates
- Oct/Nov 2015 edition: Feature article on the philosophy underpinning continuous quality improvement i.e. 'marginal gains'

**Service improvements**

Global emails:

A new system allowing the organisation to be more targeted in how it communicates with its staff has been introduced. This Week, an electronic newsletter, is a weekly round-up of important messages from our Trust/Board to staff as well as messages that staff and departments want to convey to colleagues. Under the new process staff can also message in real time via the intranet.

Branding:

All corporate templates (letterheads, website etc.) have been refreshed to reflect the new visual identity of our Trust.

Trust website and intranet:

A paper setting out the business need to update our existing content management system (CMS)/website and intranet platforms has gone to IM&T. The paper explores a range of technical solutions/fixes and is seeking to achieve:

- Funding (in-year) against a scoping or discovery phase to outline in detail our Trust's key requirements
- Funding (capital programme 16/17) to secure build and implementation

Planning service change:

Closer working arrangements across communications, clinicians and project managers to embed a more holistic approach to service enhancement.

## Planned activities in next period February 2016 to May 2016

**Momentum**

Outline & Involve:

Continue to work with workstream leads to plan feature articles into the forthcoming coming editions of Outline i.e. February, March, April & May.

**Service improvements**

Qualitative/quantitative research:

A piece of work (survey, focus group etc.) to explore with staff what communication and engagement methods they prefer. This will help inform our Trust's future approach and methodology.

Website and intranet:

Develop a business case in support of a new website and intranet platform.

| Milestones | | | |
|---|---|---|---|
| **Milestone** | **Date started** | **Date completed** | **Comments** |
| Outline articles: Keeping momentum in the project | July 2015 | Ongoing | Developing interesting messages from workstream leads |
| Branding refresh: All material refreshed to reflect the new visual identity | September 2015 | October 2015 | Ensure staff use our refreshed visual identity consistently |
| Global emails: New system introduced | January 2016 | January 2016 | Continue to monitor for effectiveness |

| Risks (Where score on Risk Log requires escalation) | | | |
|---|---|---|---|
| **ID** | **Risk description** | **RAG** | **Mitigation** |
| | Website & intranet: Costs | A | • Stage costs over two years<br>• Explore external revenue sources |

| Benefits Realisation Tracking | | | | |
|---|---|---|---|---|
| **Ref** | **Benefit** | **Definition** | **Owner** | **RAG Status** |
| 1 | Refreshed vision breathes new life into the cultural change programme and refocuses efforts on quality, patient care and staff's role to contribute positively. | Refreshed visual identity. | Head of Communications | A |
| 2 | More targeted communications realised through the introduction of a new global cascade process. | Improved staff engagement through a more targeted approach to communication. | Head of Communications | G |
| 3 | A new website and intranet to reflect the radically changing landscape of digital communications. | Reach the full potential of stakeholder communication and engagement through modern and responsive digital communications. | Head of Communications & Head of CITS. | A |
| 4 | Better management of and increased understanding of communication and engagement processes linked to public perception around service change. | Communications planning embedded in service change processes i.e. The Future's Group. | Head of Communications/Associate Director of Service Improvement/ Divisional Ops Directors | G |

| | | | | |
|---|---|---|---|---|
| 5 | Improved staff engagement through enhanced mechanisms and supported by the ability to communicate back to staff effectively. | Scheduled meetings that enable staff to engage effectively and a commitment to inform colleagues rapidly on specific outcomes. | Head of Organisational Development/Head of Communications. | G |

| WORK STREAM 7 - CHANGE MANAGEMENT | | | | | | |
|---|---|---|---|---|---|---|
| **Date completed** | 08/02/16 | | | **Version** | 0.1 | |
| **Work Stream Sponsor** | Dr Sally Pearson | | **Work Stream Lead** | Ian Quinnell | | |
| **Overall** | **Milestones** | **Benefits** | **Budget** | **Risks & Issues** | **Scope** | **Resources** |

| Progress in period covering November 2015 to February 2016 |
|---|
| Project progressing to schedule<br>Current 'Leading change' training provision is being reviewed and to be aligned to the Quality Improvement Academy bronze award. Revised managing change course to be made available for signposting at the launch of the new leadership induction day in May.<br>Project Management tool kit now refreshed and online – to be communicated to all staff shortly<br>A project 'lite' approach has also been developed for smaller level changes. A 'Project in a file' has been developed and is currently being reviewed before incorporating into the tool kit<br>Process Mapping and how to run an improvement event guidance has been developed and being reviewed by the team prior to launch |

| Planned activities in next period March 2016 to May 2016 |
|---|
| • Finalise course content for 'Managing change'<br>• Provide Project Management content into revised course content to support the 'how to' aspect of the learning<br>• Project in a file launched<br>• Process Mapping and RIE guidance launched |

| Milestones | | |
|---|---|---|
| **Milestone** | **Target completion** | **Comments** |
| Review existing CM training provision and requirements | 28/02/16 | |
| Develop revised training programme | 31/05/16 | |
| CM training roll out as part of existing programmes | 31/07/16 | |
| Refine PM toolkit | 30/01/16 | |
| Process Improvement toolkit | 30/04/16 | |

| Risks (Where score on Risk Log requires escalation) | | | |
|---|---|---|---|
| **ID** | **Risk description** | **RAG** | **Mitigation** |
| | Inability to identify a suitable knowledge base in order to share lessons learnt and areas of expertise across the organisation | A | Fully define requirements and explore options for a solution (internal / external) |
| | Capacity within HR OD to review, develop and deliver new Change Management training | A | Early engagement and planning with OD to develop and schedule a programme |
| | Option to deliver the Project Management aspects of the CM course without PMSI team involvement | G | Explore innovative solutions to capture and deliver the training – video / eLearning etc.… |

| Issues (Where score on Issues Log requires escalation) |
|---|

| ID | Issue description | RAG | Mitigation |
|---|---|---|---|
| | | | |

| Benefits Realisation Tracking | | | | |
|---|---|---|---|---|
| **Ref** | **Benefit** | **Definition** | **Owner** | **RAG Status** |
| | Change Managers | Develop cohorts of managers to successfully deliver change across the Organisation | Ian Quinnell / OD | G |
| | Change Management Training provision | To provide a comprehensive training package to enable leaders to understand the theory, the process and the 'how to' of managing change | Ian Quinnell / OD | G |
| | Project & Process Management toolkit | To provide the organisation with flexible toolkits to help support the delivery of change | Ian Quinnell | G |

| WORK STREAM 8 - INFRASTRUCTURE | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Date completed** | 09 Feb. 16 | | | | **Version** | 1 | |
| **Work Stream Sponsor** | Helen Simpson | | **Work Stream Lead** | | Neil Jackson | | |
| **Overall** | **Milestones** | **Benefits** | **Budget** | **Risks & Issues** | **Scope** | **Resources** | |

| | Approved Budget | Expected spend to-date | Actual spend to date |
|---|---|---|---|
| **Capital** | £0 | £0 | £0 |
| **Revenue** | £0 | £0 | £0 |

**Progress in period covering November 2015 to February 2016**

The work stream scope and focus has been revisited following initial due diligence review by incoming Director of Estates and Facilities. New more focussed programme now in place focussing on two main areas, short turnaround (8 week) internal service improvements, and development of an overall strategic infrastructure transformation plan.

The internal improvement programme commenced in January 2016 with the start of the first programme of 7 service improvement projects.

The initial due diligence to inform the infrastructure transformation plan has identified possible efficiencies in the use of both clinical and non-clinical accommodation utilisation, opportunities to broaden impacts of new technology,

**Planned activities in next period March 2016 to May 2016**

During the next period the first wave of internal service improvement programmes will be completed and outcomes reported. The second wave of improvement work streams will be identified and commenced.

The opportunities for efficiencies and service improvement from moving to more 'Agile' works styles initially for 'non-clinical' staff will be explored by the team and with key stakeholders.

Review of telephony specification ahead of re-tender of service.

Initial scoping review of IMT strategy forward view.

Review of overall site strategy options.

Further work to define and quantify Benefits Realisation metrics.

**Milestones**

| Milestone | Date started | Date completed | Comments |
|---|---|---|---|
| Phase 1 LEAN Improvement Programme commenced | 22/01/2016 | 30/05/2016 | Key programme started to embed continuous improvement within E and F |
| Phase 1 moves programme agreed | 01/11/2015 | 31/04/2016 | Subject to final confirmation the move programme to close College Lawn 1 has commenced. |

**Risks**
**(Where score on Risk Log requires escalation)**

| ID | Risk description | RAG | Mitigation |
|---|---|---|---|
| | Resource to support policy development and engagement with 'Workstyles' programme | A | Planning impacts on key resources in collaboration with all work streams |

**Issues**

| (Where score on Issues Log requires escalation) | | | |
|---|---|---|---|
| **ID** | **Issue description** | **RAG** | **Mitigation** |
| | The extended period of decision making on the Phase 1 moves programme has resulted in a very challenging programme. | R | Project activities are being run in parallel to minimise duration, detailed review to ensure move locations for all affected staff in agreed ahead of start, all asked to ensure no further delays in process. |

| Benefits Realisation Tracking | | | | |
|---|---|---|---|---|
| **Ref** | **Benefit** | **Definition** | **Owner** | **RAG Status** |
| | Estates operational cost reductions | Reduction in overall floor area and associated operational costs. | NJ | G |
| | Capital asset value released to invest of priorities or leveraging investment or income. | Minimise leased or rented floor area, reduction in poor estate floor area, release of space for higher value use, release of surplus estate for disposal or investment/income leverage. | NJ | G |
| | Charitable Funds income | Increased income generation from charitable contributions | KG | G |
| | Work environments and infrastructure enable clinical and non-clinical efficiency and effectiveness | Environment supports and encourages agile, efficient and effective operational services. | NJ | G |
| | Customer experience improves | The environment and engagement with the E and F service feedback improves | NJ | G |

# GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

## MAIN BOARD – FEBRUARY 2016

## LEGAL SERVICES REPORT

### 1. EXECUTIVE SUMMARY

This Legal Services report is submitted to the February 2016 Board meeting. The information presented covers the period 1 October 2014 to 31 December 2015.

This report describes the range of work undertaken by the Legal Services Department (LSD) and gives further detail of some of these activities. Quantitative data is provided for claims, inquests, disclosure of confidential information and Freedom of Information (FOI) activity.

This report illustrates the wide reach of LSD within the Trust, and the degree to which we are embedded in the organisation. We provide advice and guidance to all staff involved in legal processes. We also contribute feedback, learning and changes in practice to individuals, clinical areas and other departments to facilitate improvements in professional standards, patient safety and quality of care

The Board is asked to note the following key points

- The Trust is below national average for time taken to resolve claims;
- The Trust has delegated authority to manage claims which is a quality mark;
- The number of new claims is consistently below the national average;
- Proactive work with complaints department identifies potential claims;
- No needlestick injuries for 12 months – trend identified from claims experience;
- Honest and candid approach to mistakes described in Case Studies One and Two
- Coordinated working between risk and LSD through the Complex Case Manager;
- Immediate feedback from court cases available from LSD ;
- Medico-legal advice is available to clinicians 24 hours per day;
- Unique teaching resources have been accumulated in LSD;
- LSD operates as a central point of contact for several outside agencies;
- LSD provides a central processing point for requests for confidential information;
- LSD prioritises staff support;
- The increasing inquest workload and the corresponding time pressure for clinical staff required to prepare and attend hearings;
- The impact on patient care where court cases cause appointments to be delayed or rearranged.

### 2. INTRODUCTION

The LSD has been present in the Trust for 15 years and is well known to Trust staff. We comprise 4 specialist healthcare lawyers plus administrative colleagues. We have additional expertise in two key areas, conducting litigation and managing cases in Court.

LSD has responsibility for the following across the Trust:

- Claims management
- Court cases and hearings
- Legal Advice
- Disclosure of confidential information
- Point of contact for external organisations
- Freedom of Information service
- Teaching, feedback and learning

- Staff Support

## 3. CLAIMS MANAGEMENT

### 3.1 Clinical negligence claims

All clinical negligence claims brought against the Trust are managed in accordance with the Claims Policy and the terms and requirements of the National Health Service Litigation Authority, Clinical Negligence Scheme for Trusts (CNST) Reporting Guidelines.

CNST is a contributory scheme which funds all costs associated with claims that have been referred to the NHSLA.

Delegated authority

The LSD claims manager holds a personal delegated authority from the NHS Litigation Authority (NHSLA). This means that the claims manager is authorised to investigate, evaluate and settle all claims within the financial authority given, without recourse to the NHSLA. All claims valued at less than the delegated authority limit are directly managed and settled by LSD. For claims above the financial authority, the majority of these remain within LSD until they are formally litigated and liaison maintained with NHSLA. Delegated authority is awarded on merit, to fewer than 10 Trusts in the country, and is recognised as a quality mark for claims management

Organisations without this delegated authority generally have their claims investigated and responses provided by the NHSLA's chosen panel solicitors. As such, defence costs for Trusts without delegated authority are significantly higher, and time to resolution of claims is longer.

Changes in funding

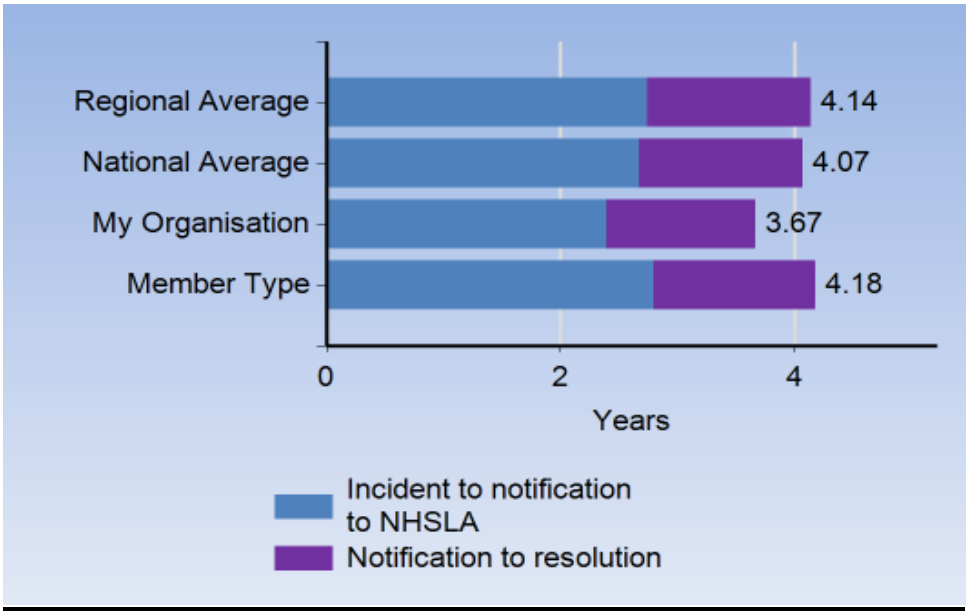
The number of claims received in the department has steadily increased over the last five years. Increases since late 2012/ 2013, have been due to a significant change in funding arrangements rather than a noticeable trend in any specific area of alleged negligence. Prior to 1st April 2013, Success fees and After the Event ('ATE') insurance premiums taken out by claimants were recoverable from the Trust. A change in law resulted in those success fees and ATE Insurance premiums entered into after 1st April 2013, being longer being recoverable from the Trust. Therefore many claims were issued in the run up to this change to ensure that the previous, more advantageous, funding arrangements applied to claimant's solicitors. The number of claims received for the period of this report is in line with national averages.

Score cards

The NHSLA commenced the production of 'score cards' for each member Trust from 2014. These score cards allow for some low level analysis of the overall number of claims received by the Trust, the number of claims by specialty, and the damages paid on those claims. The score card for 2015/2016 also provided data on the time between notification of the claim and settlement or withdrawal. Our score cards are reviewed in order to identify any trends or themes arising from the information provided. Review of the latest score card confirms the following:

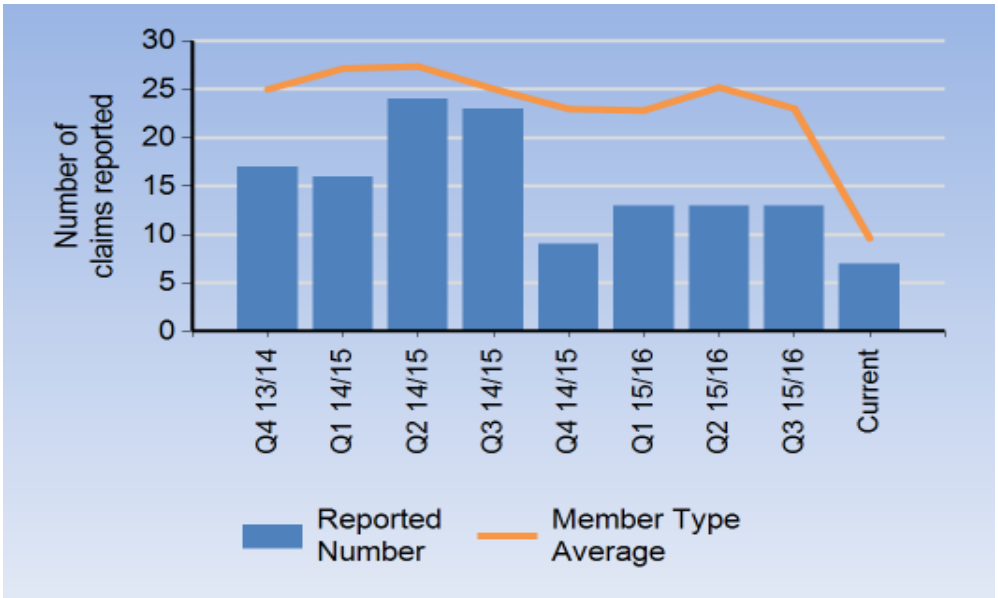
Time to Resolution ('shelf life')

The time taken for Claims brought against the Trust to reach a resolution is below the national average. The benefit obtained through the autonomy of delegated authority is shown below:




Formal notification of New Claims

The number of new claims received by the Trust is consistently below the national average. In Q3 2014/2015, our new claim numbers were just below the national average. We saw a dramatic drop, again in comparison to the national average, in Q4 2014/2015 and this remained the position throughout Q1 2015/2016 and Q2 2015/2016. The national average of new claims received came in line with our reported new claim numbers in Q3 2015/2016. Overall, we remain below the national average.



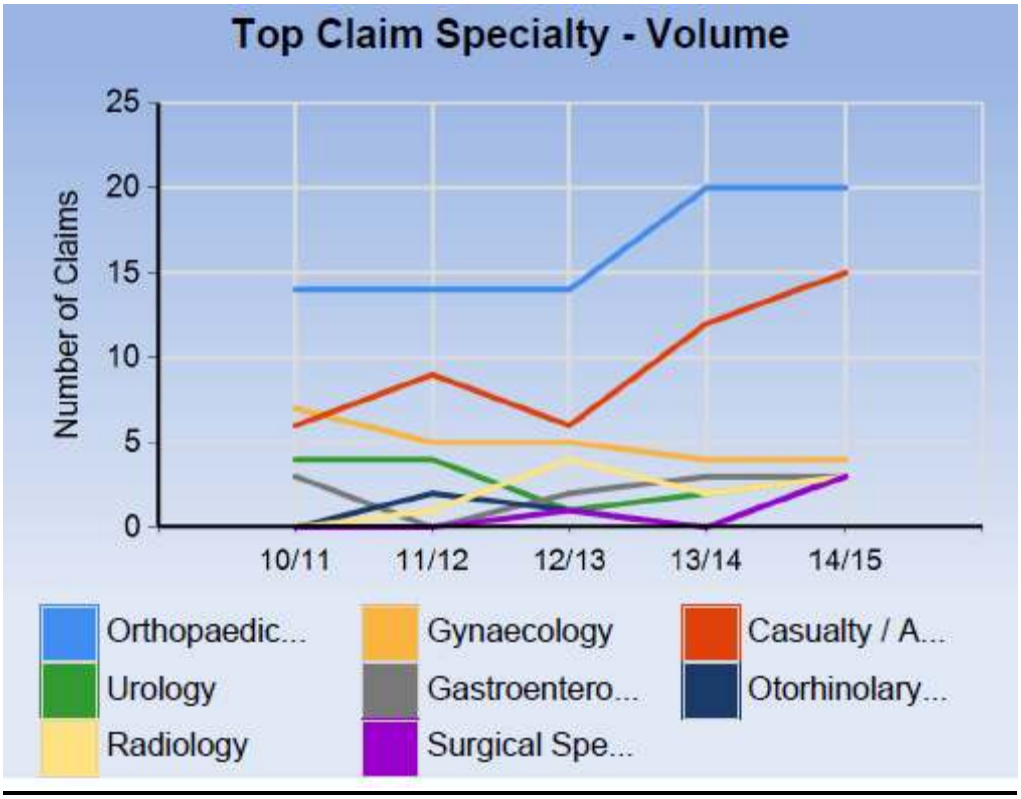

Claims by Specialty

The graph below confirms that we have seen a moderate increase in the number of Casualty/Emergency Department (ED) and Surgical Specialty Claims between 2013/2014 and 2014/2015.

For ED Claims, 12 new cases were reported in 2013-2014 and this increased to 15 in 2014/2015. Having reviewed these claims, we note that the majority relate to missed fractures. We have identified this as a trend, which is being addressed through the

'Sign up to Safety 'project (discussed further below). The number of incident reports relating to missed fractures has reduced significantly in the last four months.

For Surgical Cases, the increase is explained by not having reported any surgical cases in 2013/2014 and then having reported 3 in 2014/2015. There is no concerning feature or trend in those 3 cases.




Potential new claims

Notification of potential claims for clinical negligence are summarised in the table below. Not all of the 129 claims notified proceed to reportable claims that require investigation and a response by the Trust, as often initial investigations undertaken by patients and their solicitors indicate that the claim is without merit.

For the period of this report 48 claims have become reportable to the NHSLA requiring an investigation and figure does not necessarily represent 48 of the 129 notification of claims reported as many of them can and will have been reported as potential claims in previous financial years.

| **Division** | **Number of Notifications** |
|---|---|
| Medical Division | 33 |
| Surgical Division | 75 |
| Women's and Children's | 15 |
| Diagnostics and Specialties | 6 |
| **TOTAL** | **129** |

Withdrawn Claims

For the period of this report, 24 of the Claims reported to the NHS Litigation Authority in previous years were withdrawn. Withdrawal will have occurred where the Trust has denied liability either in the pre-action or formal court processes.

Settled Claims

The following table details the number of claims settled, per Division for the period of this report. Settlement involves a negotiated payment to the claimant. Not all settled cases have an accompanying statement of liability. Some cases may have been settled without admission of liability, the settlement being made on the basis of litigation risk rather than proven legal liability.

| **Division** | **Number of Claims Settled** |
|---|---|
| Medical Division | 16 |
| Surgical Division | 20 |
| Women's and Children's | 3 |
| Diagnostics and Specialties | 3 |
| **TOTAL** | **42** |

a. Medical Division (Scheduled and Unscheduled Care)

- P*atient fell from bed twice falling causing fractures in both hips*
- *Failure to apply a plaster of paris and refer the child (a minor) to fracture clinic and advise against sporting activity, causing a failure to prevent pain and suffering and a further injury*
- *Failure to take appropriate care of patient during transfer between wards. Patient sustained a leg injury when a cardiac monitor fell onto her leg*
- *Failure to identify and remove two wooden splinters in the Claimant's thumb, causing unnecessary pain and suffering*
- *Failure to diagnose a shin fracture*
- *Delay in diagnosing myocardial infarction and alleged failure to arrange timeous referral to Bristol for PPCI*
- *Failure to diagnose a lumbar fracture following a car accident*
- *Failure to diagnose a fracture of the right distal radius*
- *Failure to diagnose and timeously treat testicular torsion x 2*
- *Failure to identify and remove a denture from the patient's oesophagus following endoscopy*
- *Failure to diagnose fracture of the 5$^{th}$ metatarsal and refer the patient to the fracture clinic for plaster of paris*
- *Failure to remove cannula prior to self-discharge*
- *Delay in diagnosing myeloma*
- *Inappropriate discharge of cardiac patient resulting in occurrence of a myocardial infarction.*
- *Delay in diagnosing and treating a tibial fracture*

b. Surgical Division

- *Failure to provide timely ophthalmology follow up resulting in a full thickness macular hole*
- *Failure to diagnose central serous retinopathy resulting in decreased vision*
- *Failure to appropriately dress a post-operative wound resulting in a delay to infection clearing*
- *Spinal surgery performed on the incorrect vertebrae resulting in the need for a second procedure*
- *Failure/delay in detecting and repairing a bowel perforation during laparoscopy*
- *Failure to provide adequate post-operative instructions an physiotherapy following anterior cruciate ligament surgery*
- *Inappropriately performed hip replacement necessitating further revision surgery*
- *Fall from a commode resulting in injury to an already vascularly impaired patient's leg*

- *Bowel injury alleged to be due to a misplaced stitch during urological procedure*
- *Failure to provide appropriate nursing care and frequently change bandages resulting in infection and additional and unnecessary pain and suffering*
- *Perforated ear drum following removal of wax and grommet in 2009. Case proceeded to trial, where the Claimant was successful*
- *Delay to administering blood transfusion leading to respiratory arrest and psychological damage*
- *Partial retention of stent causing the need for two further interventional procedures*
- *Failure to diagnose and appropriately treat a bowel perforation during laparotomy*
- *Failure to diagnose and appropriately treat a duodenal polyp*
- *Damage to skin following inappropriately placement of diathermy plates*
- *Delay in diagnosing and offering palliative care for pancreatic cancer*
- *Failure to perform MRI scan, diagnose and treat cauda equine syndrome*
- *Failure to act upon abnormal CT and diagnose renal cell carcinoma*
- *Failure to following anti-coagulation protocol causing a haematoma and unnecessary pain*

c. Women's and Children's Division

- *Failure to diagnose and appropriately treat fourth degree tear x 2*
- *Delay to caesarean section of twins causing death of one twin*

d. Specialties and Diagnostics

- *Misinterpretation of a shoulder x-ray causing a delay in diagnosing a Pancoast tumour*
- *Failure to appropriately interpret a CT urogram leading to a delay in providing a ureteric stent*
- *Failure to appropriately interpret a wrist x-ray leading to a delay in diagnosing a scaphoid fracture*

**3.2 Employer and Public Liability claims**

The Trust is a member of the NHSLA's Liability to Third Parties Scheme (LTPS). This scheme provides financial assistance to Trusts in meeting damages and solicitors costs in respect of employers and public liability claims.

Unlike CNST the Trust is responsible for meeting the first £10,000 for employer's liability claims and £3,000 for public liability claims (including defence costs in cases successfully defended).

LSD investigates all claims for employer's liability and public liability, reporting their findings and recommendations for settlement or defence.

In August 2013, the NHSLA created a new system for reporting Employers Liability and Public Liability Claims. This resulted in Trust's having a limited time to undertake investigations before providing our response. Historically Trusts had a three month period to undertake an investigation. Under this system, investigations have to be completed within 30 days, in order to avoid significant cost burdens in claims that proceed outside of the portal and into litigation. Currently we are able to meet this new deadline.

The majority of employers and public liability cases where damages have been paid in the last three years relate to the following:

- *Slips/Trips and Falls*
- *Needlestick Injuries*
- *Injuries by a patient*

- *Injured lifting/moving or handling*

A trend in the numbers of claims relating to needlestick injuries was identified in 2013/2014. In response to this, the Safety Department issued new guidelines for the reporting and investigation of such injuries. Most notably managers were advised to seek witnesses to alleged injuries and to ensure that the needles were kept as evidence. An article in Outline also highlighted the dangers of needlestick injuries and staff were encouraged to use safer sharps bins.

We have not received notification of a needlestick injury in the last 12 months and anticipate that this is linked to the new guidelines issued.

Complaints leading to litigation

Of the successful claims referred to above, 17 were previously investigated through the NHS Complaints Procedure. LSD continue to see an increase in the number of complaints that proceed to litigation. This may be due the accessibility of litigation processes, but also reflects our open and honest approach to complainants and close working with the complaints department to identify potential litigation.

Group litigation – metal on metal orthopaedic implants

LSD is currently handling a number of claims arising from the historical practice of hip replacement surgery combining head components from one manufacturer with stem components from another. It is being claimed that combining components from different manufacturers results in excessive wear and/or corrosion and patients developing an adverse reaction to metal debris. A number of NHS Trusts and clinician's in the private sector are facing such legal claims. The NHSLA has instructed DAC Beachcroft (DACB) on behalf of all NHS Trusts involved and LSD is working alongside them. A number of legal arguments are being put forward by claimant solicitors as to why NHS Trusts and private clinicians should be responsible for the adverse outcomes of these patients. We are currently awaiting the outcome of a national case management conference that is due to take place in March 2016.

Sign up to Safety

The Trust is participating in this national programme which is aimed at improving patient safety. As part of this programme, the claims manager has examined the Trust's trend analysis provided by the NHSLA and identified themes arising from both our high value/low volume claims and our high volume/low value claims. As a result of this analysis, the claims manager is working with key staff in the Emergency Department to produce a Safety Improvement Plan in relation to missed abnormal results.

This improvement project is continuing. The aim of the project is to reduce claims arising from missed abnormal results by 25%. This figure is difficult to audit given the delay between incidents and claims being initiated. Progress is therefore monitored by reference to incident reports. The Project Team have reported a significant decrease in the numbers of missed abnormal results between October and December 2014.

Risk Management

LSD has close links with the Corporate and Divisional Risk Management Teams. A representative from the Legal Services Department attends the monthly Safety, Experience and Review Group feeding back on inquests and claims that have been settled and admissions that have been made, in the preceding month. The group discuss the reasons for settlement together with other risk related issues that have arisen and Divisional Risk Managers feedback to Divisions with lessons to be learned from those claims.

### 3.3 Complex Case Management

The Claims Manager works closely with the Trust's Risk Manager in the investigation of Serious Untoward Incidents. Reports prepared from the Serious Incident Investigation are key to both the Trust's approach to Inquests and subsequent claims and must be clear, concise and consistent. Where litigation is anticipated following a Serious Incident, the Claims Manager adopts a Complex Case Manager role, leading the investigation into the Serious Incident and meeting with patients and their families, providing open and honest feedback and appropriate channels for support. LSD and Risk Management team prioritise providing timely support and an honest approach, at the earliest opportunity.

Case Study One

*In October 2014, a 41 year old female presented to the Emergency Department of Cheltenham General Hospital with severe headaches and vomiting. Failure to undertake fundoscopy and identify papilloedema resulted in a failure to diagnose that the patient's symptoms were due to a colloid cyst. The patient's condition deteriorated such that it was not possible to offer surgery and she passed away 48 hours later.*

*The circumstances were investigated through the Serious Incident (SI) process. The Investigation team (Complex Case Manager, Specialty Director for Acute Medicine and a Consultant Neurologist) met with the deceased's next of kin (mother and brother) to feedback the findings. The family were informed of the identified failure to undertake appropriate investigations and were advised that had those investigations been undertaken, the deceased would have been transferred to our tertiary Neurosurgery Centre where on balance, she would have undergone surgery that would have prevented her death.*

*This death had been referred to the Coroner but on receipt of the Post Mortem report the Coroner considered the death was a natural cause, therefore no investigation or inquest was undertaken. The SI Investigation report was sent to the Coroner and in response she re-listed the matter for Inquest which took place in December 2015. The Coroner returned a narrative verdict.*

*The deceased's husband had not been involved with the SI Investigation as the deceased's mother was her next of kin. The findings of the Trust's investigation were shared with the deceased's husband through the Coroner's process. Contact was appropriately made with the deceased's husband to discuss financial assistance for the deceased's three minor children.*

*The deceased's family members have all provided their personal thanks for the Trust's openness and integrity in dealing with this matter, which would not have been known to them or the Coroner without the Trust submitting the SI report.*

Case Study Two

*A 46 year old patient presented to the Emergency Department in with generalised symptoms of being unwell. Initial review indicated that she may have been suffering with sepsis. Further investigation indicated the possibility of myocarditis and/or an Addisonian crisis. Whilst awaiting further investigation, the patient's condition deteriorated significantly. She suffered a cardiac arrest and passed away twelve hours following admission.*

*The death was investigated through the Serious Incident Process. This investigation identified a failure to diagnose and treat a myocardial infarction that had occurred prior to the deceased's admission.*

*The Investigation team (Complex Case Manager, Specialty Director for Emergency Medicine and Consultant Cardiologist) met with the deceased's husband, mother and son to feedback the findings. The family were informed of the identified failure to diagnose that the deceased had experienced a myocardial infarction prior to her admission and also of the failure to provide appropriate treatment for that. The deceased had a number of pre-existing co-morbidities and despite extensive discussion and research, the Investigation Team had not been able to reach agreement on whether earlier and appropriate treatment for heart failure would have prevented her death.*

*As with Case Study One, this patient's death had been referred to the Coroner but on receipt of the Post Mortem, the Coroner again considered the death to be due to a natural cause and no need for an inquest. The Trust shared the SI Investigation Report with the Coroner and in response she re-listed the matter for Inquest. The Coroner also instructed an independent Cardiologist to provide an opinion. The Coroner asked the independent expert to consider whether earlier treatment would have prevented the death and the expert, concluded that it would not have. The Inquest took place in January 2016. The Coroner returned a narrative verdict. We currently await confirmation of whether the family intend to pursue a claim for negligence.*

The two cases described above demonstrate the importance and effectiveness of collaborative working within LSD, and across the corporate and divisional risk teams.

Clear and decisive investigations, involving the most appropriate personnel are key to determining the Trust's position at the earliest opportunity. This enables effective subsequent actions in respect of liaison with patients, family/carers, our internal governance processes, a Coroner's inquiry and any claim for negligence.

### 3.4 Duty of Candour

The Claims Manager is managing the Duty of Candour (DOC) project, working closely with the Trust Risk Manager and Divisional Leads to design an effective process to deliver our statutory duty. Quarterly progress reports are submitted to the Trust Management Team. The Trust's current DOC process was recently presented at a national conference.

## 4. COURT CASES AND HEARINGS

LSD provides preparation, support and representation for all court cases in which the Trust or Trust staff are involved. Legal representation is provided for inquests and Court of Protection cases, and procedural advice and support for staff participating in criminal or family (child protection) cases.

### 4.1 Inquests

LSD has been managing Trust inquests for 14 years. The Coroner investigates any death which is either unnatural or unexplained, and requires the Trust to participate where there is recent or contemporaneous hospital treatment. Very unusually, we can be involved where historic treatment may be connected to a later death.

The number of deaths reported to LSD for investigation is high, although the number that result in an inquest hearing is much lower. Over the years the consistent pattern of several hundreds of inquests needing investigation is reducing, although the percentage requiring attendance may be trending upwards.

Investigations and inquest attendances for the last 5 years:

| | | |
|---|---|---|
| 2011 | 227 deaths investigated | 27 inquests attended (11.8%) |
| 2012 | 246 deaths investigated | 29 inquests attended (11.3%) |
| 2013 | 227 deaths investigated | 30 inquests attended (13%) |
| 2014 | 151 deaths investigated | 19 inquests attended (12.5%) |
| 2015 | 165 deaths investigated | 42 inquests attended (25.4%) |

Last year was busiest year yet for inquest attendances. It is important to recognise the burden on staff time this represents, time taken in preparing statements, meeting before the hearing and attending the inquest itself. An inquest hearing will typically have between 1 and 6 staff witnesses, last between half a day and three days, and may result in the cancellation of clinics, investigation and surgical lists to release the clinicians to attend.

These attendance figures do not include case management hearings for HLS where no witnesses attend.

Inquests dealt with for the period of this report

| | |
|---|---|
| 200 deaths investigated | 49 inquests attended (24.5%) |

Conclusions (previously known as Verdicts) for the period of this report:

| | |
|---|---|
| Narrative | 24.4% |
| Natural Causes | 34.6% |
| Accidental Death | 30.6% |
| Open | 2% |
| Suicide | 2% |
| Industrial Disease | 2% |
| Alcohol related | 2% |
| Drug related | 2% |

Clinical areas from which the deaths originated (not necessarily causative) for period of this report:

| | |
|---|---|
| Surgery | 40.2% |
| Medicine | 36.1% |
| Medicine +fall | 6.3% |
| Maternity | 4.2% |
| ED | 10.6% |
| Paediatrics | 2.1% |

Prevention of Future Death Reports

At the conclusion of an inquest, where the Coroner has heard evidence which - in her view - *"gives rise to a concern that circumstance creating a risk of other deaths will occur, or will continue to exist"* (CJA 2009 s. 7(1)) she has a statutory power to issue a Prevention of Future Deaths Report (PFDR).

This means that the Coroner will write to the Chief Executive stating her concerns and requiring a response on those concerns within 56 days. The requirement is to confirm what the Trust intends to do to rectify the concerns, or to state why no action is to be taken.

These are not commonly received by the Trust, and are effectively mitigated by the Root Cause Analysis (RCA) reports and proactive SI investigations which we undertake. These RCA/SI reports are shared with the Coroner in advance of the inquest (especially where we consider a PFDR is a possibility) to show that the Trust

has taken steps to remedy areas which have caused concern following Trust investigation of the death, and before they reach the inquest hearing.

We cannot always anticipate what the Coroner will find to be a concern, and occasionally we do not share those concerns, as below. PFDR reports and responses are sent to the family of the deceased, the Chief Coroner, CQC, and can be published on the Ministry of Justice website.

For the period 2010 – 2014 the Trust has been issued with 10 PFD reports, and attended 139 inquests

For the period of this report, the Trust has been issues with 3 PFD reports and attended 49 inquests, as below:

PFDR reports issued to the Trust for the period of this report:

*PFDR 1 – death in a residential home. The Coroner considered that if during an outpatient appointment the Trust directs that medication should be changed but do not issue a prescription, a delay will be caused if the GP is notified of the change only by letter. The Trust responded to say it was satisfied that the current practice was appropriate and there were opportunities to deviate from this practice if necessary. The GP surgery reviewed the case and took remedial action.*

*PFDR 2 – a surgical death where the patient died from septicaemia. Following receipt of the PFDR the Trust undertook to change surgical documentation so that postoperative antibiotic prescription instruction is clear. Learning disseminated to the clinical areas through the SI process and Safety, Experience and Risk Group (SERG).*

*PFDR 3– maternal death several days after delivery from a ruptured splenic artery aneurysm. Following receipt of the PFDR the Trust has changed policy instructions for junior doctors in obstetrics and reviewed policy instructions for ED management of post-partum patients. Learning disseminated through Maternity and ED through the SI process and SERG.*

*PFDR 4– see Case Study One above. Following this inquest the Coroner issued a PFDR but not against the Trust. It was accepted that the Trust SI report submitted to the Coroner before the inquest demonstrated that the Trust has been proactive in mitigating the risk of a reoccurrence by investing in fundoscopy equipment for the acute care units. The Coroner directed the PFDR to the Royal College of Physicians and other organisations involved in training junior doctors*.

Examples of clinical circumstances for Inquest deaths for the period of this report

*Haemorrhage and infection following displacement of biliary stent*
*Septicaemia following laparotomy*
*Hypothermia following exposure and reduced consciousness in drunken state*
*Suppurative peritonitis following surgery*
*Subdural haemorrhage as a result of fall on the ward (2 inquests)*
*Bronchopneumonia connected with fall several months earlier*
*Accidental drug overdose*
*Multi organ failure after elective surgery*
*Complications during interventional cardiology*
*Bronchopneumonia following fall on the ward*
*Stroke in young patient*
*Arrest during siting of dialysis line*
*Death after hip replacement surgery*
*Colonic pseudo-obstruction after ENT surgery*
*Complications following interventional radiology*

Teaching and learning from inquests

All upcoming inquests are shared with the risk department within the duty of candour process before the hearing. After the hearing the outcome and comments are presented to the Safety, Experience and Risk group (SERG) before and action plans for any learning actions are monitored through this group.

HLS takes the case and outcome back to the clinical areas and presents regularly on the wards. This feedback is available immediately as a benefit of handling the case in-house.

LSD has accumulated a unique library of inquest cases which are a rich and important source of educational material. These are frequently used by HLS to illustrate the real consequences of real circumstances, and the expectations of those who scrutinise us.

Teaching sessions are given to any staff group, on request, as part of planned study days, grand rounds, and as part of the doctors postgraduate educational programme.

Examples of learning arising from inquest deaths (not necessarily causative)

- *Patient's impaired vision not known on admission allowing fall (comprehensive admission records essential)*
- *Patient not seen by a Consultant after several ward transfers (The patient's journey should be able to be followed through the medical records)*
- *One missing observation could have prevented a death (Observations must be done)*
- *Referral to consultant for hands on review may have prevented a death (Senior review needed)*
- *Patient with head injury given anticoagulation therapy (Clinical decisions must be explained in the records)*
- *Patient found unconscious with too few observations (Neurological observations must be undertaken to doctor's instructions or Trust guidelines)*
- *Patient died day on discharge with no note that he was fit for discharge (Must document clinical decisions)*
- *No record of conclusion of acute care (No discharge letter to GP)*
- *Delay in giving medication contributed to death (document why a treatment plan is changed)*
- *Importance of listening to relatives' concerns about patients (nurses did not consider patient looked unwell)*
- *Patient had no surgical review as on-call surgeon continually busy in theatre (document reasons for delays)*

### 4.2 Other Court cases

We have a regular need to work with ED, Paediatric and maternity staff who are involved as witnesses in criminal cases and child protection hearings. These often involve detailed statements, long court days in Bristol and contentious hearings.

This year we have had our first involvement in a Court of Protection case with regard to a 'best interest' decision about where a patient without capacity should live after discharge. The interest for the Trust was managing a lengthy (90 day) admission when the patient was fit for discharge, while the legal process took its course. This case is to be reviewed to identify if alternative steps could have been taken to mitigate this problem, for the patient, and for the Trust.

## 5. Legal Advice

LSD is responsible for providing legal advice, where requested, for all Trust business. Where we cannot provide that advice in-house, we source it from Trust solicitors.

Medico-legal advice

Requests for help with clinical matters are dealt with by HLS. This includes direct management on the wards and in clinical areas of patient care situations, issues about consent, capacity, validity of advanced directives, powers of attorney, end of life care, and liaison with relatives and next of kin.

This is a busy but priority service for clinical colleagues, with situations arising on most days. Some situations are settled with a single decision whilst others last for the entire admission of the patient.

HLS also provides an out of hours (OOH) on call service (weekends and overnight) - examples of these situations are:

*Uncertainty about consent for a 17 year old in ED*
*Safeguarding decision where patient wants to self-discharge*
*Confidentiality concerns arising from inpatient wanted by the Police*
*ED patient with questionable capacity refusing treatment*
*Police asking for medical notes in the middle of the night*
*Dying patient wanting to make Will*
*Maternity patient at risk refusing care*
*How to/whether to treat overdose patient in ED*
*How to manage suicidal patient in ED*
*Interpretation of attorney and advance directive documents for unwell patient*
*How to manage restraint of sectioned patient*
*Family wanting to remove patient from ITU and take home.*

Non clinical advice

This can be provided in house to some degree, and issues that have required help recently include interpretation of CCG protocols, potential legal issues arising from redirecting patients out of ED, governance principles arising when NHS patients are treated in private hospitals and liability assessment of group ante natal care proposals.

Advice on commercial and contractual matters is managed collaboratively with DACB lawyers, as demonstrated by one large contractual dispute settled in this way at the end of last year.

Data protection and information governance

HLS is the Trust lead for data protection advice, and works closely on Information Governance matters with the Trust health records and IG manager.

DAC Beachcroft

The Trust contract with DAC Beachcroft (DACB) for the provision of legal services is managed by HLS who has a gatekeeper role. This ensures that all instructions to DACB for legal advice are vetted and approved, and appropriate instructions are made to the most appropriate lawyer. In some Trust departments contact with DACB is shared with other staff members.

For the period of this report, spend for legal advice with DACB is as follows:

- Human Resources £47,699
- Clinical £1,635
- Estates £39,243
- Commercial £13,467
- General £37,343

TOTAL £139,387

## 6. Point of contact

LSD are established as the point of contact for many outside agencies that are regularly in touch with the Trust:

- Local Authority – we work with social services and their legal department to facilitate child protection and safeguarding investigations. We receive the requests, find the staff involved and support them through their participation.

- Gloucestershire Police – we have established specific links and dedicated email contacts with the police to exchange requests and information. We have a continuous stream of requests for access to records and identification of staff who may assist them

- Information Commissioner – HLS is the named contact for statutory registration, and for DPA and FOI matters.

- NMC and GMC – we are named contacts for these organisations

- Coroners service – we manage the whole process

It has been essential to create reliable communication channels with these organisations for two risk management reasons. Firstly, all these agencies communicate within formal legal processes, and these processes need to be managed professionally to avoid problems developing. Secondly, we aim to avoid clinical staff having to engage in an unfamiliar and worrying legal process when we can do that for them.

We are striving to achieve a position where staff are not approached at their place of work or at home about any Trust legal issue, without LSD knowing about it first.

We are confident that this is the case for both the Coroner's service, and local authority matters, and have made considerable progress recently with redirecting police enquiries to LSD in the first instance.

## 7. Disclosure of confidential information

LSD are the central point in the Trust for the disclosure of confidential information, the majority of which is patient identifiable information (PID)

Requests from authorised parties for access to or copies of PID are handled in compliance with the Data Protection Act 1998 (living patients) and Access to Health records Act 1990 (deceased patients).

It is essential that this process is undertaken in LSD to avoid procedural and confidentiality breaches that would have significant implications for the Trust. It is also important to relieve Trust staff outside LSD of the responsibility of handling and disclosing PID.

For the period of this report LSD processed 3,578 requests for access to PID

These requests were made by patients, solicitors, insurance companies, Department of Work and Pensions, Criminal Injuries Compensations Authority, Police, Army, Local Authority, Veterans Agency, and some miscellaneous sources.

## 8. Freedom of Information service

This service has been managed in LSD since 2010. The number of requests received has grown year-on-year as shown in these figures:

| | |
|---|---|
| 2005 | 129 requests |
| 2006 | 160 requests |
| 2007 | 128 requests |
| 2008 | 131 requests |
| 2009 | 316 requests |
| 2010 | 272 requests |
| 2011 | 322 requests |
| 2012 | 344 requests |
| 2013 | 491 requests |
| 2014 | 554 requests |
| 2015 | 516 requests |

Common themes for national media requests are for information about:

- Spend on agency staff
- Nursing staffing levels
- Commercial contracts
- Overseas patients treatment and charges
- Organisational structures
- Use of biologics
- IT equipment and contracts

The most common requestors are local and national newspapers, TV and individual journalists.

## 9. Teaching

As described in other sections, much teaching is carried out by LSD on subjects ranging from new medico-legal concepts (eg Duty of Candour) to established and developing legal principles (consent, capacity, DOLS, DPA ), and legal updates on current case law.

These sessions are presented to groups as diverse as healthcare apprentices, manual handling link staff, nurses, doctors, therapists and medical secretaries

Style of teaching events are equally wide-ranging, from 1:1 teaching sessions to ward meetings, speciality groups, committees, grand rounds and regional postgraduate seminars for doctors.

We are well known and well used for learning purposes.

## 10. Staff Support

It is a priority for LSD that we support our colleagues when they are involved in legal processes. We understand that these are very unfamiliar and appreciate how worrying they can be.

We are proactive in approaching staff in advance of their involvement being required, we take time to identify their needs and to respond to them. We are able to update staff regularly during whatever process is involved, and we can anticipate developments that will be welcome, or not so welcome.

We are always available for colleagues and are visible around the Trust. It is our view that we can perform these responsibilities for the Trust and our colleagues much better from the position of being an in-house department.

**RECOMMENDATION**

The Board is invited to note this report.

| | |
|---|---|
| **Author:** | **Caroline Pennels, Head of Legal Services** |
| | **Jo Hunt, Claims Manager** |
| **Presenting Director:** | **Andrew Seaton, Director of Safety** |

Date: February 2016

**GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST**

**MAIN BOARD FEBRUARY 2016**

# COMBINED ASSURANCE FRAMEWORK & TRUST RISK REGISTER

## 1 Purpose of Report

1.1 To approve the updated Assurance Framework (AF) and combined dashboard and note the Trust Risk Register (TRR).

## 2 Background

2.1 The Assurance Framework (Appendix 1) is a Trust Board tool that monitors the most significant potential risks to the Annual Plan. The purpose of the AF is to confirm that the organisation is set up to control these potential risks and provide assurance that they are not adversely affecting the delivery of the plan. Where there is actual significant adverse impact of these risks at any point in the year they should feature in the Trust Risk Register.

2.2 Each year the Assurance Framework is refreshed so that it reflects the main potential risks to the current Annual Plan. The top risks from the plan are added or consolidated with the previous year's Assurance Framework to ensure continuity, in the coming year the updated Strategic Goals and Objectives will be added.

Risks from the Trust Risk Register (Appendix 2) that need to be mitigated to deliver the Annual Plan can also be included in the Assurance Framework.

2.3 To show themed risks of both the AF & TRR the risks have been brought together under the strategic headings (e.g. Our Business) so that the potential risks associated with the Annual Plan (AF) and the risks that are currently adversely affecting the delivery of the plan can be seen together.

2.4 To show the level of assurance carried by the monitoring evidence a simple rating scheme has been included as follows:

| | |
|---|---|
| Level 1 | Management reviewed assurance |
| Level 2 | Board reviewed assurance |
| Level 3 | Independently provided assurance |

2.5 It will be important for the Board to approve the assigned level of assurance as it will be relied on when reviewing the dashboard going forward.

2.6 In combination this provides the Board with a themed view of the Annual plan risks in the AF and the risks in the current TRR with an assessment of the level of assurance and control.

2.7 Detailed assurance will be found in many other Trust reports (e.g. PMF) that compliment this report.

## 3 Recommendation

**To approve the updated Assurance Framework**

**Author & Presenting Director: Andrew Seaton - Director of Safety**

Date February 2016

**February 2016 - Full Assurance Framework - Key - for reference**

**Strategic Objective……**

| **Principal Risk to the plan** | **Risk Owner (Executive Director & Committee)** | **Key Controls** | **Assurance on Controls** | **Current Assurances** | **Risk Rating** (Likelihood x Impact) |
|---|---|---|---|---|---|
| What could prevent the above principal objective being achieved? | Which Director is responsible and which assurance committee is responsible for monitoring? | What management controls/systems we have in place to assist in securing delivery of our objective<br><br>The controls and assurance are rated by level of assurance<br><br>**Management Reviewed Assurance = 1**<br><br>**Board Reviewed Assurance = 2**<br><br>**External Reviewed Assurance = 3** | Where we can gain independent evidence that our controls/systems, on which we are placing reliance, are effective | We have evidence that shows we are reasonably managing our risks, and objectives are being delivered | Assessment of the quality of the controls to manage the risk (not assessment of the risk itself) |
| | | | **Gaps in Control** | **Gaps in Assurance** | **Direction of Travel** |
| | | | Where do we still need to put controls/ systems in place? Where do we still need to make them effective? | Where do we still need to gain evidence that our controls/ systems, on which we place reliance, are effective | Are the controls and assurances improving?<br><br>↑ ↓ ↔ |
| **Potential Risk Exposure** | **Related risks on Trust Risk Register** | | | | |
| Key potential risks that may occur during the year and have a significant effect on achieving the annual plan. | Current risks that are related to the Principle risk and\or potential risks that have occurred. | | | | |

| **Actions Agreed for any gaps in controls or assurance** | | **By Whom** | **By When** | **Update** |
|---|---|---|---|---|
| **1** | | | | |
| **2** | | | | |
| **3** | | | | |

**Our Services -** **To improve year on year the safety of our organisation for patients, visitors and staff and the outcomes for our patients**

| Principal Risk to the plan | Risk Owner (Executive Director & Committee) | Key Controls | Assurance on Controls | Current Assurances | Risk Rating (Likelihood x Impact) |
|---|---|---|---|---|---|
| Inability to meet quality standards across all of our services | Nursing & Medical Directors<br>Quality Committee | 1. Quality Committee & Quality Framework (2)<br>2. Performance Management Framework (2)<br>3. Quality Standards Review Group (2)<br>4. Mortality Review Group (1)<br>5. Divisional Quality Committees (1)<br>6. Specialist Quality committees (1)<br>7. Senior Nurse & Midwifery Committee (1) | 1. Directors statement (2)<br>2. Divisional Quality Report (1)<br>3. Review of CQC Outcomes (1)<br>4. Quality Elements of the PMF (2)<br>5. CQC - Intelligent Monitoring Report (3)<br>6. Safer Staffing Report **including recruitment & Retention**(2) | CQC - Intelligent Monitoring Report (3)<br><br>CQC Inspection report (3) | **4x4=16**<br>(2x4=8) |
| | | | **Gaps in Control** | **Gaps in Assurance** | **Direction of Travel** |
| | | | None | **CQC actions** | ↑ |

| Potential Risk Exposure | Related risks on Trust Risk Register | | | | |
|---|---|---|---|---|---|
| 1. Breaches in CQC Outcomes<br>2. Validated Intelligent Monitoring Report risks<br>3. Major CQC inspection concerns<br>4. Failure to meet national standards\ targets | **M1**<br>Inability of the local health and social care system to manage demand within the current capacity leading to significant fluctuation of attendances in ED | **M1c**<br>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 | **S127**<br>The Trust has reported a higher than expected mortality rate for patients with fractured neck of femur | **N17**<br>Increasing number of adolescents (12-17yrs) stay longer periods of time in the acute (paediatric or adult) wards as there | **C3** Risk arising from surgical related Never Events leading to potential regulatory intervention and the potential effects on the reputation of the Trust |

| | | | | | |
|---|---|---|---|---|---|
| | **M1a -**<br>The clinical risk of delay in treating patients arriving at Accident and Emergency during periods of high demand or staff shortage<br>**M1b**<br>Lack of availability of key groups of staff in all clinical areas | **HR2b**<br>A lack of trained nurses (both permanent & bank\agency) due to insufficient training places, a higher than expected turnover and new restrictions on overseas (non-European) retention rules | **N 2276**<br>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. | appears to be insufficient external facilities | |

| | **Actions Agreed for any gaps** | **By Whom** | **By When** | **Update** |
|---|---|---|---|---|
| **1** | **CQC Action Plan** | **Executive team** | **As per plan** | **Completed** |
| **2** | **Internal Audit of "must do" evidence of CQC action plan** | **Internal Audit** | **Feb 2016** | **Underway** |

**Strategic Objective** **To improve year on year the safety of our organisation for patients, visitors and staff and the outcomes for our patients**

| Principal Risk to the plan | Risk Owner (Executive Director & Committee) | Key Controls | Assurance on Controls | Current Assurances | Risk Rating (Likelihood x Impact) |
|---|---|---|---|---|---|
| Inability of the local health & social care system to manage demand within the current capacity | Director of Service Delivery<br><br>Financial & Performance Committee | 1. Emergency Care Plan(2)<br>2. Planned Care Plan(2)<br>3. CCG Contract(3)<br>4. CCG Contract Review Board(3)<br>5. Financial & Performance Committee(2)<br>6. Gloucester System wide recovery plan (3)<br>7. Contract Levels (3)<br>8. 7 day service project<br>9. Safer Programme | 1. Emergency care Board & Report (2)<br>2. Planned Care Board (1)<br>3. Gap analysis on all IST actions 2013-14-15 (1)<br>**4. MONIOR - for performance support visit** | 1. CQC report (3)<br>2. **Monitor support of ED plan(3)** | 5x4=20<br>(4x4=16) |
| | | | **Gaps in Control** | **Gaps in Assurance** | **Direction of Travel** |
| | | | **2016-17 QIP plans** | None | ↑ |

| Potential Risk Exposure | Related risks on Trust Risk Register | | | | |
|---|---|---|---|---|---|
| 1. Shortage of clinical staffing\ recruitment to meet demand<br>2. Unexpected spiralling activity due to external changes .g. National cancer programmes<br>3. Surges of activity and variation - activity in ED | M1<br>Inability of the local health and social care system to manage demand within the current capacity leading to significant fluctuation of attendances in ED | **S118**<br>As consequence of increased emergency activity the Day care unit and other non inpatient areas with beds are opened overnight causing an increased patient safety risk, a reduced patient experience and a negative effect on Day Surgery activity and efficiency | **M1c**<br>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 ability to respond to mass casualties in a major incident | Blank | **C12**<br>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 |

| Actions Agreed for any gaps | | By Whom | By When | Update |
|---|---|---|---|---|
| 1 | Implement Monitor actions from visit | | December 2015 | Completed |
| 2 | Approve Winter plan at September Trust Board | Director of Service Delivery | September 2015 | Completed |
| 3 | Complete QIP process with partners | Director of Service Delivery | April 2016 | |

**Strategic Objective** **To ensure the organisation is stable and viable with the resources to deliver its vision**

| Principal Risk to the plan | Risk Owner (Executive Director & Committee) | Key Controls | Assurance on Controls | Current Assurances | Risk Rating (Likelihood x Impact) |
|---|---|---|---|---|---|
| Inability to meet national access standards across all our services. | Director of Service Delivery<br><br>Financial & Performance Committee | 1. Emergency Care Plan(2)<br>2. Planned Care Plan.(2)<br>3. Executive Reviews of performance (1)<br>4. Divisional Accountability Agreements (1)<br>**5. IST visit and support 2015(3)** | 1.Divisional Review (1)<br>2. PMF Report (2)<br>3. Cancer Management Board (1) | Cancer target performance (2) | 3x3=9 |
| | | | **Gaps in Control** | **Gaps in Assurance** | **Direction of Travel** |
| | | | | Blank | ↔ |

| Potential Risk Exposure | Related risks on Trust Risk Register | | | | |
|---|---|---|---|---|---|
| 1. Surges of activity and variation – National cancer<br>2. Sudden unplanned loss of capacity - physical or staffing<br>. | **S100**<br><br>Failure to meet 62 day cancer standard for 3 consecutive quarters<br>Increasing the risk of intervention by Monitor | **M1c**<br>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 | M1b<br>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 | **F7**<br>Delay in providing follow up appointments in a number of specialties - Neurology, Cardiology, Rheumatology, Paediatrics, Ophthalmology | **Blank** |

| Actions Agreed for any gaps | By Whom | By When | Update |
|---|---|---|---|
| | | | |

**Strategic Objective** **To improve year on year the experience of our patients**

| Principal Risk to the plan | Risk Owner (Executive Director & Committee) | Key Controls | Assurance on Controls | Current Assurances | Risk Rating (Likelihood x Impact) |
|---|---|---|---|---|---|
| Failure to discharge patients in a way which meets their, and our partners expectations | Director of Service Delivery<br><br>Financial & Performance Committee<br><br>Emergency Care Board | 1. System Resilience Group (3)<br>2. IDT Steering Board(1)<br>3. Emergency Care Board (1)<br>4. Emergency Care plan(2)<br>5. Integrated Discharge Team Implementation Plan(1)<br>6. Health & Wellbeing Board(1) | 1. PMF (2)<br>2. Emergency Care Report (2)<br>3. CCG Medically fit summits (3)<br>4. Weekly system wide call of all Nursing Directors to review medically fit list | Blank | 3x4=12 |
| | | | **Gaps in Control** | **Gaps in Assurance** | **Direction of Travel** |
| | | | | Blank | ↔ |

| Potential Risk Exposure | Related risks on Trust Risk Register | | | | |
|---|---|---|---|---|---|
| 1. Loss of capacity in Community and nursing care sector especially for complex patients - e.g. dementia<br>2. Increase in High Dependency patients in community<br>3. Effective use of the Better Care Fund<br>4. Delivery of QiPP | **C12**<br>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 | **C11**<br>Failure of timely transport arrangements provided by the new Commissioner led contract with ARRIVA, this detrimentally affects the patient experience, leads to cancellation of procedures and adds staffing costs to supervisor OP waiting for transport | **S118**<br>As consequence of increased emergency activity the Day care unit and other non inpatient areas with beds are opened overnight causing an increased patient safety risk, a reduced patient experience and a negative effect on Day Surgery activity and efficiency | Blank | Blank |

| Actions Agreed for any gaps | | By Whom | By When | Update |
|---|---|---|---|---|
| **1** | **Implement Discharge to Assess Model** | **DoSD** | **October 2015** | **Completed** |

**Strategic Objective** **To improve year on year the experience of our patients**

| Principal Risk to the plan | Risk Owner (Executive Director & Committee) | Key Controls | Assurance on Controls | Current Assurances | Risk Rating (Likelihood x Impact) |
|---|---|---|---|---|---|
| Failure to meet the expectations of patients for personalised compassionate care | Nursing & Medical Director<br><br>Quality Committee<br><br>Senior Nurse, Midwifery Committee | 1. Recruitment Standards(1)<br>2. Trust Education programmes (1)<br>3. Nursing & Midwifery Strategy (2)<br>4. Patient Experience Strategy (2)<br>5. Management of the 4Cs (1)<br>6. Senior Nurse and Midwifery Committee<br>7. **Safer Staffing Report including recruitment & Retention**(2) | 1. Directors statement (2)<br>2. Divisional Quality Report (1)<br>3. Family & Friends Test (3)<br>4. Patient Surveys (3)<br>5. Formal comments – Health watch, Governors (3) | CQC Inspection report<br>**PLACE Audit** | 4x4=16<br>(2x4=8) |
| | | | **Gaps in Control** | **Gaps in Assurance** | **Direction of Travel** |
| | | | Blank | Blank | ↑ |

| Potential Risk Exposure | Related risks on Trust Risk Register | | | | |
|---|---|---|---|---|---|
| 1. Significant breaches in CQC Outcomes<br>2. Validated Intelligent Monitoring Report risks<br>3. Major CQC inspection concerns<br>4. Negative External reports – Ombudsman, FFT | **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 clinical targets | **HR2b** A lack of trained nurses (both permanent & bank\agency) due to insufficient training places, a higher than expected turnover and new restrictions on overseas (non-European) retention rules | **S118** As consequence of increased emergency activity the Day care unit and other non inpatient areas with beds are opened overnight causing an increased patient safety risk, a reduced patient experience and a negative effect on Day Surgery | **N17** Increasing number of adolescents (12-17yrs) stay longer periods of time in the acute (paediatric or adult) wards as there appears to be insufficient external facilities | **C11** Failure of timely transport arrangements provided by the new Commissioner led contract with ARRIVA, this detrimentally affects the patient experience, leads to cancellation of procedures |

| | | | | | |
|---|---|---|---|---|---|
| | **N 2276**<br>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. | | activity and efficiency | | |
| **Actions Agreed for any gaps** | | | **By Whom** | **By When** | **Update** |
| **1** | Blank | | | | |

## Strategic Objective

**To develop further a highly skilled and motivated and engaged workforce which continually strives to improve patient care and trust performance**

| Principal Risk to the plan | Risk Owner (Executive Director & Committee) | Key Controls | Assurance on Controls | Current Assurance | Risk Rating (Likelihood x Impact) |
|---|---|---|---|---|---|
| Failure to match the workforce profile with the clinical/ service needs of the organisation | Director of HR & OD<br><br>Workforce Resourcing Group<br><br>Medical Staffing Review group<br><br>Efficiency & Service Improvement Committee | 1. Workforce plans by Specialty (1)<br>2. Nursing Recruitment Plan (2)<br>3. Quality Impact assessment in CISP Clinical Director (1)<br>4. 6 monthly review of Nurse staffing using recognised tool (2)<br>5. Overseas recruitment plan (2)<br>6. Monthly recruitment strategy meeting(1)<br>7. Report to Efficiency Savings & Improvement Board(1) | 1. Publication of nursing staffing levels (2)<br>2. Divisional Reviews (1) | Blank | 4 x 4 =16 |
| | | | **Gaps in Control** | **Gaps in Assurance** | **Direction of Travel** |
| | | | 1. Plan to manage expected medical shortfall in next 2 years<br>2. Recruitment & Retention incentive | | ↔ |
| **Potential Risk Exposure** | **Related risks on Trust Risk Register** | | | | |
| 1. Failure to recruit sufficient nurses to plan<br>2. Failure to deliver plan to manage medical staffing shortage<br>3. Sudden or unplanned loss of specialist staffing that affects the delivery of a service | M1b<br>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 | HR2b<br>A lack of trained nurses (both permanent & 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 | **F7**<br>Delay in providing follow up appointments in a number of specialties - Neurology, Cardiology, Rheumatology, Paediatrics, Ophthalmology | Blank | Blank |

| | | | | | |
|---|---|---|---|---|---|
| | targets and standards. | recruitment requirements. | | | |
| **Actions Agreed for any gaps** | | | **By Whom** | **By When** | **Update** |
| 1 | Develop plan to manage the expected medical staffing shortfall by developing Advanced Nurse Practitioners and aligning with Health Education South West on development of Physician Associate role - MD\Director of Nursing and DoHR&OD to agree numbers and timescales | | DoHR&OD Medical Director(MD) | October 2015 | MD awaiting projection numbers from specialties |
| 2 | Recruitment & Retention policy being developed for current nurses and HCA | | DoHR&OD | March 2016 | See actions below |
| 3 | Formation of recruitment strategy to include senior nurses and AHPs | | DoHR&OD | March 2016 | See actions below |
| **4** | **Pilot equivalent overtime rate for extra hours** | | **DoHR&OD** | **January 2016** | **Underway** |
| **5** | **Medical Divisional Nurse Director to interview all nurse leavers** | | **Medical Div Nurse Director** | **February 2016** | |
| **6** | **Recruitment & Retention premium launched in GOAM** | | **DoHR&OD** | **December 2015** | **Completed** |
| **7** | **Over recruit to HCA posts** | | **DoHR&OD** | **February 2016** | **Completed** |
| **8** | **Further planned overseas recruitment – Philippines** | | **DoHR&OD** | **May 2016** | |
| **9** | **Retention group developing proposals for AHP retention** | | **DoHR&OD** | **March 2016** | |

## Strategic Objective

**To develop further a highly skilled and motivated and engaged workforce which continually strives to improve patient care and trust performance**

| Principal Risk to the plan | Risk Owner (Executive Director & Committee) | Key Controls | Assurance on Controls | Current Assurances | Risk Rating (Likelihood x Impact) |
|---|---|---|---|---|---|
| Failure to engage appropriately with staff, leading to poor alignment of services and a de-motivation of the workforce | Director of HR & OD<br><br>Medical Staffing Review Group<br><br>Culture Change Steering group | 1. Divisional Engagement groups (2)<br>2. Annual Plan and Joint working with Staff side (1)<br>3. 100 leaders programme (1)<br>4. Executive walkabout programme (1)<br>5. Futures programme (1)<br>6. Medical Engagement Plan (1)<br>7. Issues raised at JSCC & LNC (1) | 1. Staff survey results (3)<br>2. Divisional Engagement group feedback (2)<br>3. Delivery of jointly authored policies (1) | Awaiting Staff survey results | 3x4=12 |
| | | | **Gaps in Control** | **Gaps in Assurance** | **Direction of Travel** |
| | | | | Blank | ↔ |

| Potential Risk Exposure | Related risks on Trust Risk Register | | | | |
|---|---|---|---|---|---|
| 1. Failure to improve engagement of medical staff<br>2. Worsening staff survey results. | F2<br>Failure to demonstrate expected savings through workforce projects | HR2b<br>A lack of trained nurses (both permanent & 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. | | Blank | Blank |

| | Actions Agreed for any gaps | By Whom | By When | Update |
|---|---|---|---|---|
| | | | | |
| | | | | |

**Strategic Objective** **To ensure the organisation is stable and viable with the resources to deliver its vision**

| Principal Risk to the plan | Risk Owner (Executive Director & Committee) | Key Controls | Assurance on Controls | Current Assurances | Risk Rating (Likelihood x Impact) |
|---|---|---|---|---|---|
| Failure to deliver financial plans | Director of Finance<br><br>Finance & Performance Committee | 1. Operational Plan (3)<br>2. Divisional & Corporate Budgets (1)<br>3. Cost Improvement Plans (1)<br>4. Quarterly Review by Monitor (3)<br>5. Executive Divisional Reviews (1)<br>6. CIP Delivery Board (1) | 1. Board F&P (2)<br>2. Finance Report(2)<br>3. E& SI Board (1)<br>4. Audit Committee (2)<br>5. Audit reports (3) | **Monitor Q2 letter (3)** | 4x4=16 |
| | | | **Gaps in Control** | **Gaps in Assurance** | **Direction of Travel** |
| | | | 1. Next phase of Service Line Management to increase operational and financial control | None | ↔ |
| **Potential Risk Exposure** | **Related risks on Trust Risk Register** | | | | |
| 1. Increase in GP referrals<br>2. Unscheduled care pressures<br>3. Changes in Key senior managers (C0S)<br>4. Delivery of CIPs<br>5. increasing Agency costs<br>6. Delayed Medically fit patients<br>7. Delivery of Elective Surgical. | **C13**<br>Increased LOS in excess of plan leading to unplanned opening of capacity increased agency cost and patient outliers and delayed closure or winter pressure beds | **M1c**<br>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 | **HR2b**<br>A lack of trained nurses (both permanent & 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. | **F2**<br>Failure to demonstrate expected savings through workforce projects | Blank |

| | Actions Agreed for any gaps | By Whom | By When | Update |
|---|---|---|---|---|
| 1 | Review Service Line Management approach | DoF | February 2016 | |
| 2 | Increase controls on agency spend and rostering | DoF& Exec team | January 2016 | Underway |

**Strategic Objective - To ensure the organisation is stable and viable with the resources to deliver its vision**

| Principal Risk to the plan | Risk Owner (Executive Director & Committee) | Key Controls | Assurance on Controls | Current Assurances | Risk Rating (Likelihood x Impact) |
|---|---|---|---|---|---|
| Failure of our supporting business systems impacting on patient care | Director Of Clinical Strategy<br><br>Emergency Planning Committee | 1. Emergency Preparedness Policy (2)<br>2. Emergency and Business Continuity Plans (1)<br>3. Programme of Exercises to test system e.g. Exercise Bugle (3)<br>4. Register of business Critical Systems held by IM&T Board.<br>5. Disaster recovery plans for all major IT systems | 1. Review of business critical systems by IM&T (1)<br>2. County Wide EPR (1)<br>3. Emergency Planning, Resilience & Response National Standards (3) | Positive EMERGO report (County wide exercise) (3)<br>**CCG & NHS England endorsement of National standards (3)** | 3x3=9 |
| | | | **Gaps in Control** | **Gaps in Assurance** | **Direction of Travel** |
| | | | 1. Unrecognised evolution of business critical systems | None | ↔ |
| **Potential Risk Exposure** | **Related risks on Trust Risk Register** | | | | |
| 1. Outage of business critical systems reported through incident system<br>2. Slippage on Smartcare implementation.<br>3. External IT system failures (e.g. 111) | DSp1<br>Inability to maintain business continuity for the OPMAS computer systems | Blank | **IT-2246**<br>Ageing and out of support Network hardware, Single internet Circuit causing increased likelihood of Hardware Failures, decreasing likelihood and increased 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 throughput (using manual processes) backlog of data entry | | Blank |

| Actions Agreed for any gaps | By Whom | By When | Update |
|---|---|---|---|
| None | | | |

**Our Business - To ensure the organisation is stable and viable with the resources to deliver its vision**

| Principal Risk to the plan | Risk Owner (Executive Director & Committee) | Key Controls | Assurance on Controls | Current Assurances | Risk Rating (Likelihood x Impact) |
|---|---|---|---|---|---|
| Failure to maintain the positive reputation of our organisation | Chief Executive<br><br>Trust Board | 1. Manage & monitor performance through the PMF(2)<br>2. Increase transparency of reporting through the Cultural Change Group (2)<br>3. Quality Committee & Quality Framework (2)<br>4. Operational Plan (3)<br>5. Finance & Performance Committee (2) | 1. PMF (2)<br>2. Directors Statement & Quality Report (2)<br>3. Finance Report (2)<br>4. CQC Intelligent Monitoring Report (3)<br>5. Trust Risk Register (2) | CQC Inspection Report | 2x4=8 |
| | | | **Gaps in Control** | **Gaps in Assurance** | **Direction of Travel** |
| | | | Organisational approach for Duty of Candour | None | ↔ |

| Potential Risk Exposure | Related risks on Trust Risk Register | | | | |
|---|---|---|---|---|---|
| 1. A series of connected Serious Incidents - e,g Never Events<br>2. Failure to deliver national standards<br>3. Negative External reports e.g CQC, Ombudsman | C3<br>Risk arising from the sequence of surgical related Never Events leading to potential regulatory intervention and the potential effects on the reputation of the Trust | N17<br>Increasing number of adolescents (12-17yrs) stay longer periods of time in the acute (paediatric or adult) wards as there appears to be insufficient external facilities | **C11** Failure of timely transport arrangements provided by the new Commissioner led contract with ARRIVA, this detrimentally affects the patient experience, leads to cancellation of procedures and adds staffing costs to supervisor OP waiting for transport | M1a -<br>The clinical risk of delay in treating patients arriving at Accident and Emergency during periods of high demand or staff shortage | **S127**<br>The Trust has reported a higher than expected mortality rate for patients with fractured neck of femur |

| | Actions Agreed for any gaps | By Whom | By When | Update |
|---|---|---|---|---|
| 1 | Agree project team to develop and deliver Duty of Candour based on current guidance\legislation | Director of Safety | September 2014 | Completed – Aim for full launch 1st October 2015 (Partial launch achieved in addition to SI approach – CQC revising guidance) |
| **2** | **CQC Action Plan** | **Executive team** | **As per plan** | **Completed** |

**TRUST RISK REGISTER –February 2016** **Appendix 2**

| Risk | Controls | Responsible Director & Key Meeting | Assurance Committee | Review date | Likelihood score | Impact score | Risk rating score |
|---|---|---|---|---|---|---|---|
| M1<br>Inability of the local health and social care system to manage demand within the current capacity leading to significant fluctuation of attendances in ED | • Weekly Emergency Care Board<br>• Emergency Care Plan<br>o Addressing three main areas of concern<br>▪ Demand<br>▪ Staffing (Medical & Nursing)<br>▪ Beds and capacity<br>• Monthly Emergency Care Board report<br>• Delivery of relevant QIPP plans & CQuINs<br>• Monthly County System Resilience group | Director of Service Delivery<br><br>Emergency Care Board | Finance and Performance | Monthly | 5 | 5 | 25 |
| M1a<br>The clinical risk of delay in treating patients arriving at Accident and Emergency during periods of high demand or staff shortage | | Director of Service Delivery<br>Emergency Care Board | Trust Board | Monthly | 5 | 4 | 20 |
| M1b<br>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. | • Develop plan to manage the expected medical staffing shortfall by developing Advanced Nurse Practitioners and aligning with Health Education South West on development of Physician Associate role. | Medical Director<br>Medical Staffing Review Group | Trust Management Team | Monthly | 5 | 4 | 20 |

| Risk | Controls | Responsible Director & Key Meeting | Assurance Committee | Review date | Likelihood score | Impact score | Risk rating score |
|---|---|---|---|---|---|---|---|
| HR2b<br>A lack of trained nurses ( permanent & bank\agency) due to insufficient training places, a higher than expected turnover & new restrictions on overseas (non-European) retention rules leading to a failure to match nursing recruitment requirements. | • Proactive nurse recruitment strategy<br>• Recruitment strategy group<br>• Nurse Recruitment business case<br>• Splitting of recruitment team to create dedicated nurse\HCA recruitment facility | Director of Human Resources & Organisational Development<br>Recruitment Strategy Group | Trust Management Team | Monthly | 5 | 4 | 20 |
| **M1c**<br>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<br>**This now incorporates C13 & C8** | • Implement the LOS plan to reduce LOS by 0.5 days, as part of the Emergency Care Plan<br>• Complete capacity modelling exercise to identify further improvement<br>• Examine wider community alternatives to support capacity surges<br>• Delivery of Winter plan<br>• Monitor Support visit plans<br>• The EPRR self-assessment standards & action plan | Director of Service Delivery<br><br>Emergency Care Board | F&P Board<br>TMT | Monthly | 5<br>(4) | 5 | 25<br>(20) |

| Risk | Controls | Responsible Director & Key Meeting | Assurance Committee | Review date | Likelihood score | Impact score | Risk rating score |
|---|---|---|---|---|---|---|---|
| **F2**<br>Failure to develop and implement in a timely fashion appropriate CIP projects and action plans to bring spend back to budgeted levels. Agency spend remains high and is impacted by both unfunded beds and supply of substantive | • Pay spend is reviewed by WRG, Delivery Board and ESIB and progress is discussed in detail within these meetings. Each Division is tasked with developing CIP programme to deliver appropriate savings in year. Nurse recruitment issues being addressed through comprehensive Nurse Recruitment Strategy, overseen by Recruitment Strategy Group. | Director of Human Resources & Organisational Development -<br><br>Workforce Review Board | Finance & Performance committee | Monthly | 4 | 5 | 20 |
| **C3**<br>Risk arising from the sequence of Never Events leading to potential regulatory intervention and the potential effects on the reputation of the Trust . | • Each event has had a full root cause analysis and resulting action plan and is monitored for closure and completion of the actions as part of our governance arrangements<br><br>• Introduction of National Standards for Invasive Procedures | Medical Director<br>Director of Safety<br><br>Patient Safety Forum | Quality Committee | Monthly | 3 | 5 | 15 |

| Risk | Controls | Responsible Director & Key Meeting | Assurance Committee | Review date | Likelihood score | Impact score | Risk rating score |
|---|---|---|---|---|---|---|---|
| **DSp1**<br>Inability to maintain business continuity for the OPMAS computer systems | • OPMAS contingency Mitigation Plan<br>• Chemotherapy Sub Group<br>• Oncology, Haematology and Palliative Care Board | Director of Service Delivery<br><br>Emergency Planning Group | TMT | Monthly | 3 | 5 | 15 |
| **N17**<br>Increasing number of adolescents (12-17yrs) presenting with self harming behaviour are admitted because of required medical care but stay longer periods of time in the acute (paediatric or adult) wards as there appears to be insufficient external facilities for their mental health care. There is significant risk of these patients further harming themselves or other patients and visitors. | • Updating following review of current process and incidents to enhance local controls<br>• The Local & Specialist Commissioners have been alerted.<br>• CQC and the Safeguarding Board (County Board and Executive County) Board have been informed of the concerns. | Director of Nursing<br><br>Safeguarding Board | TMT | Monthly | 4 | 4 | 16 |
| **C11**<br>Failure of timely transport arrangements provided by the new Commissioner led contract with ARRIVA, this detrimentally affects the patient experience, leads to cancellation of procedures and adds staffing costs to supervisor OP waiting for transport | • Agreed Recovery plan and monitoring<br>• Weekly performance dashboard<br>• Regular contract performance meetings<br>• Sharing of individual patient stories | Director of Service Delivery | TMT | Monthly | 5 | 3 | 15 |

| Risk | Controls | Responsible Director | Assurance Committee | Review date | Likelihood score | Impact score | Risk rating score |
|---|---|---|---|---|---|---|---|
| **C12**<br>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 | • Delivery of the Emergency care action plan<br>• Monthly County System Resilience group<br>• Weekly review of medically fit list by system Nursing Directors | Director of Service Delivery | Emergency Care Board | Monthly | 5 | 4 | 20 |
| **F7**<br>Delay in providing follow up appointments in a number of specialties - Neurology, Cardiology, Rheumatology, Paediatrics, Ophthalmology | • Establish Speciality specific plans<br>• Monitor performance at Divisional Operational performance meetings | Director of Service Delivery | Planned Care Board | Monthly | 4 | 4 | 16 |
| **S118**<br>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 | • Resource DCU as a 23hr Unit<br>• Day to day bed management systems including community wide capacity tele-conferences and escalation procedures<br>• Daily senior clinical manager meetings to manage safety, experience and activity whilst unit is open at night<br>• Monitor Support visit plans | Director of Service Delivery | Emergency care Board | Monthly | 5 | 4 | 20 |

| Risk | Controls | Responsible Director | Assurance Committee | Review date | Likelihood score | Impact score | Risk rating score |
|---|---|---|---|---|---|---|---|
| **S100**<br><br>Continued failure to meet 62 day cancer standard leading to delayed treatment, caused by increased demand and insufficient available capacity in the relevant timeframes. | • Improve the access information provided to patients<br>• Resolve pathway problems in Urology, Lower GI, Gynae, Lung & Head & Neck<br>• Weekly internal monitoring with leads by Executive and at Monthly performance reviews.<br>• Performance Management at Cancer management board<br>• Performance trajectory report for each specialty | Director of Service Delivery | Cancer Management Board. | Monthly | 5 | 4 | 20 |
| **S127**<br>The Trust has reported a higher than expected mortality rate for patients with fractured neck of femur | • Dedicated MDT fractured neck of femur clinical review group<br>• Fractured neck of femur action plan<br>• External review completed and action agreed<br>• Divisional Governance Monitoring | Medical Director | Quality committee Mortality Review Group | Monthly | 4 | 4 | 16 |
| **N 2276**<br>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. | • Continue with the current professional education support<br>• Appoint a coordinator to manage the internal system<br>• Establish a clear internal process<br>• Improve the monitoring and governance systems that advise the Board | Nursing Director | TMT | Monthly | 4 | 4 | 16 |

| Risk | Controls | Responsible Director | Assurance Committee | Review date | Likelihood score | Impact score | Risk rating score |
|---|---|---|---|---|---|---|---|
| **IT-2246**<br>Ageing and out of support Network hardware, Single internet Circuit causing increased likelihood of Hardware Failures, decreasing likelihood and increased costs of finding replacement parts, reduction in resilience Leading to<br>loss of IT services in physical locations and systems, operational disruption, reduces efficiency of clinical delivery and patient throughput (using manual processes)<br>backlog of data entry | • Network procurement in final stages of business case development and approvals<br>• Countywide Technology Blueprint Board, , IT Partnership Board | Director of Clinical Strategy &<br>Director of CITS | IM&T Board | Monthly | 4 | 4 | 16 |

# GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

## MAIN BOARD – FEBRUARY 2016

## 2015 STAFF SURVEY RESULTS

### 1. Aim

1.1 To present to the Trust Board the key findings from the 2015 staff survey results and to outline the process by which results will be shared with staff and the 'rolling' action plan from previous years updated and amended to effect the required improvements.

### 2. Background

2.1 Between October and December 2015, the national NHS staff survey was undertaken, inviting staff to share their experiences of working in Gloucestershire Hospitals Foundation Trust (GHFT). The Board opted to undertake a full census of all staff across the Trust recognising that the link between employee engagement and patient experience is so fundamental that it is vital to give the opportunity for all of our workforce to have their say. Our response rate in the 2015 survey dropped to 51% in comparison to 54% last year. This remains a national trend, possibly attributable to the amount of surveys being requested and we remain in the highest 20% of response rates for 'acute' trusts in England.

### 3. Context – Previous results and action plans.

3.1 The approach adopted has been to recognise that many issues raised require a consistent approach and therefore the plans to deal with those issues are 'rolling' in nature with some issues being resolved in year, others continuing with current issues being added to the rolling trust wide plan (recognising that each division will also have its own action plan). To arrive at the action plan, it has always been important to share the results with different groups of staff and that practise will continue this year. This helps make greater sense of the findings and to ensure that any action plan is fully informed. The priorities in the trust wide action plan for 2015 as presented to the Board in June 2015 were;

- *Improve focus on staff health and wellbeing.*
- *Understand the reasons why disabled staff report a worse employment experience.*
- *Improve the perception of staff in terms of learning and development opportunities beyond mandatory training.*
- *Improve medical engagement*
- *Continue to reduce incidence of stress felt by staff*
- *To understand the reasons behind the high numbers of staff experiencing physical violence from patients, relatives or the public in the last 12 months*

Each of these priorities had a detailed list of actions in support and an update on progress is provided in Section 5.

### 4. 2015 Staff Survey – Receipt of Results

4.1 The results of the survey are received by the Trust in two ways. The main survey provider (Quality Health) reports the 'raw data' scores for every single question, including a comparison with the average score for other Trusts as well as progress over the prior year. The scores, which are not widely published, are broken down into 5 main areas – *Your Job, Your Personal Development, Your Managers, Your Organisation and Your Health, Wellbeing and Safety at work*. The survey went through something of an overhaul in 2015 and whilst the majority of questions remained the same, a number had subtle changes involving a single word (eg 'care'

instead of 'patient care'), or a reclassification of responses. Therefore, for a number of questions, there is not a precise comparison with the prior year. This report does not break the score down into staff groups or divisions and as a consequence allows for general conclusions rather than targeted actions. The main published report sees the findings of the questionnaires summarised by the national survey centre PickerEurope on behalf of the Department of Health and presented in the form of 32 key findings (KF) categorised to reflect the four NHS Constitution pledges to staff.

*Staff Pledge 1*: *To provide all staff with clear roles and responsibilities and rewarding jobs*.

*Staff Pledge 2*: *To provide all staff with personal development, access to appropriate training for their jobs and line management support to enable them to fulfil their potential*.

*Staff Pledge 3*: *To provide support and opportunities for staff to maintain their health, well-being and safety*.

*Staff Pledge 4*: *To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services*.

*Additional theme*s: *Equality and Diversity, Errors and Incidents (a new key finding for this year) and Patient Experience measures*

4.2 There are some inconsistencies between the presentation of the scores given by Quality Health compared to Picker, given their distinct categorisation of themes. As an example, on one of the key findings (KF 18 – Percentage of staff feeling pressure to come to work in the last 3 months), the raw data provided by Quality Health showed improvements against prior year performance on each of the 4 subsidiary questions making up the key finding. Notwithstanding this the key finding as reported by Picker shows a 3% deterioration in performance from the prior year once the data is 'cleansed'.

## 5. Key Findings in the GHFT 2014 Survey

5.1 As mentioned in previous reports, the experiences of staff working in GHFT and the results of the survey are set in the context of ongoing challenges – both local and national. This year's survey results suggest that the many targeted work streams being undertaken throughout the Trust are leading to some level of improvement, but not at the pace required. There is still significant work to be done in maintaining and accelerating progress and this will require sustained energy and commitment over several more years yet. Appendix 1, provides a full breakdown of Trust scores, however summarised scores are presented below in the following way;

- Staff Engagement
- Progress against the rolling action plans
- Top and Bottom Ranking Scores
- Improvements and deterioration since last year
- Key observations by Division and Staff Group

5.2 Staff Engagement

The overall indicator of staff engagement has been calculated using the questions that make up KFs 1, 4 and 7, relating to the following aspects of staff engagement:

*Their willingness to recommend the trust as a place to work/receive treatment (KF 1);*
*The extent to which they feel motivated at work (KF 4).*
*Staff members' perceived ability to contribute to improvements at work (KF 7);*

The table below shows the progress made by our Trust in terms of employee engagement over the last 3 years with an increase in each of the scores this year. Whilst the increase in the engagement increase represents the 4th consecutive rise (with 2012 reflecting a score of 3.43) we have only narrowed the gap again by 0.01, with the national average for acute trusts being 3.79. Notwithstanding this, every single division and every single staff group increased their engagement levels over the year.

| | Staff Engagement | 2013 | 2014 | 2015 |
|---|---|---|---|---|
| | Overall Staff Engagement | 3.59 | 3.65 | 3.71 |
| KF1 | Staff recommendation of the Trust as a place to work or receive treatment | 3.43 | 3.57 | 3.62 |
| KF4 | Staff motivation at work | 3.77 | 3.77 | 3.85 |
| KF7 | Staff ability to contribute towards improvements at work | 65% | 66% | 67% |

5.3 Progress against the Rolling Action Plan

- *Improve focus on staff health and wellbeing.*
  The raw data shows a 10% improvement on staff believing their manager takes a keen interest in their health and wellbeing, reflecting the strong focus there has been on this agenda internally in the last year. This progress needs to be maintained and experienced in a more consistent fashion by all staff groups.

- *Understand the reasons why disabled staff report a worse employment experience.*
  Disappointingly there is no evidence of progress in this regard albeit there is a 0.07% increase in the engagement score for disabled staff. Focus will need to increase and this remains a key objective for the Equality & Diversity Steering Group, linking up with the Personal, Fair and Diverse champions.

- *Improve the perception of staff in terms of learning and development opportunities beyond mandatory training.*
  A variable performance with learning and development opportunities being highly valued by Nurses and Health Care Assistants (reflecting the focus given over the last 12 months to staff in Bands 1-4) and less valued by administrative and clerical staff and Estates Staff.

- *Improve medical engagement*
  The medical engagement score has shown the second biggest rise of any group (+0.11 to 3.65) however it remains below the trust average. Detailed comments on this group appear later in the paper.

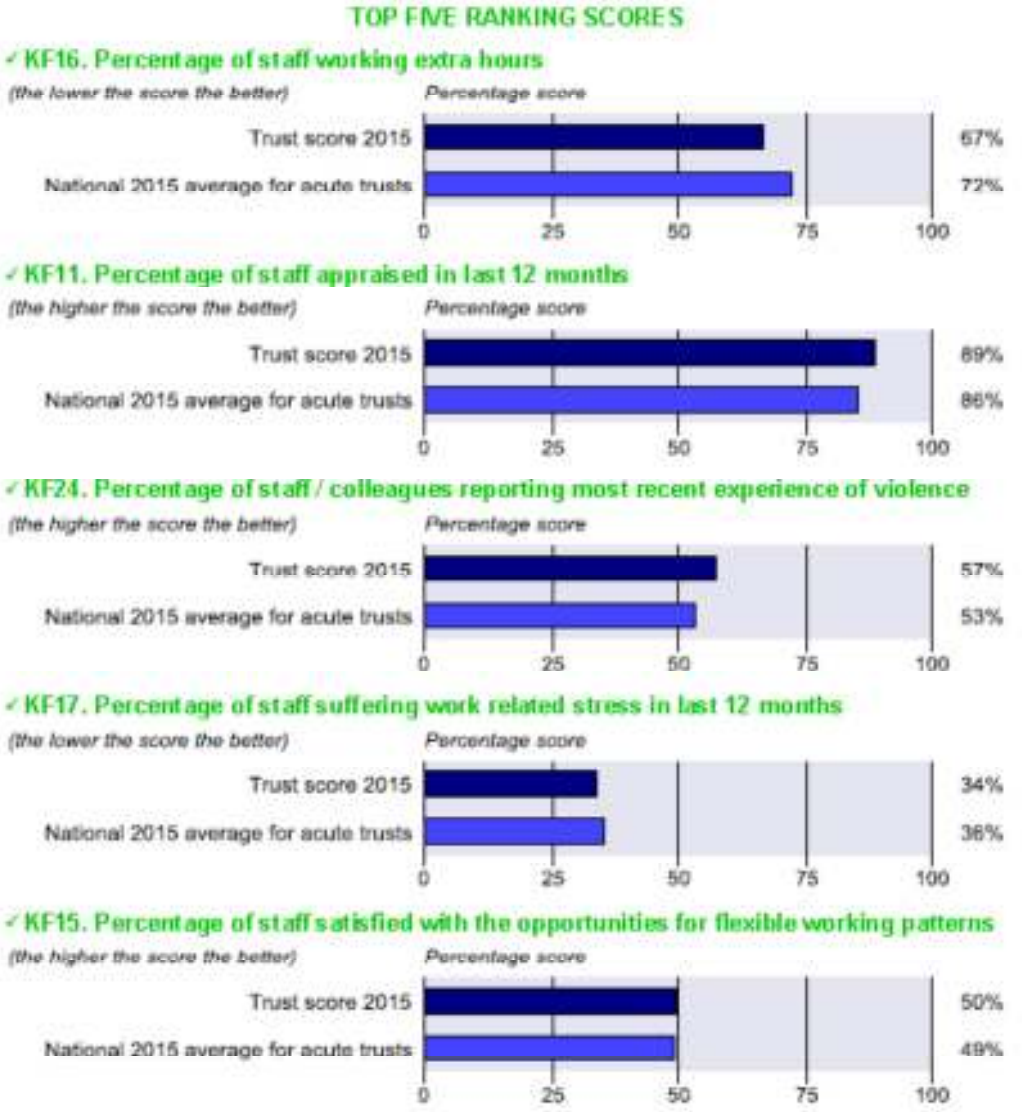
- *Continue to reduce incidence of stress felt by staff*
  A 2% reduction over the year reflects the significant work which has been put into this in the last 12 months and compares very favourably with trusts nationally. This positive general performance will need to be more consistently maintained across all staff groups.

- *To understand the reasons behind the high numbers of staff experiencing physical violence from patients, relatives or the public in the last 12 months*
  This has been a strong element of the trust safety programme over the last 12 months however the percentage of incidents reported has shown no improvement.

## 5.4 Top and Bottom Ranking Scores

### 5.4.1 Top Five Ranking Scores

This highlights the five key areas in which the Trust compares favourably with other acute trusts in England.

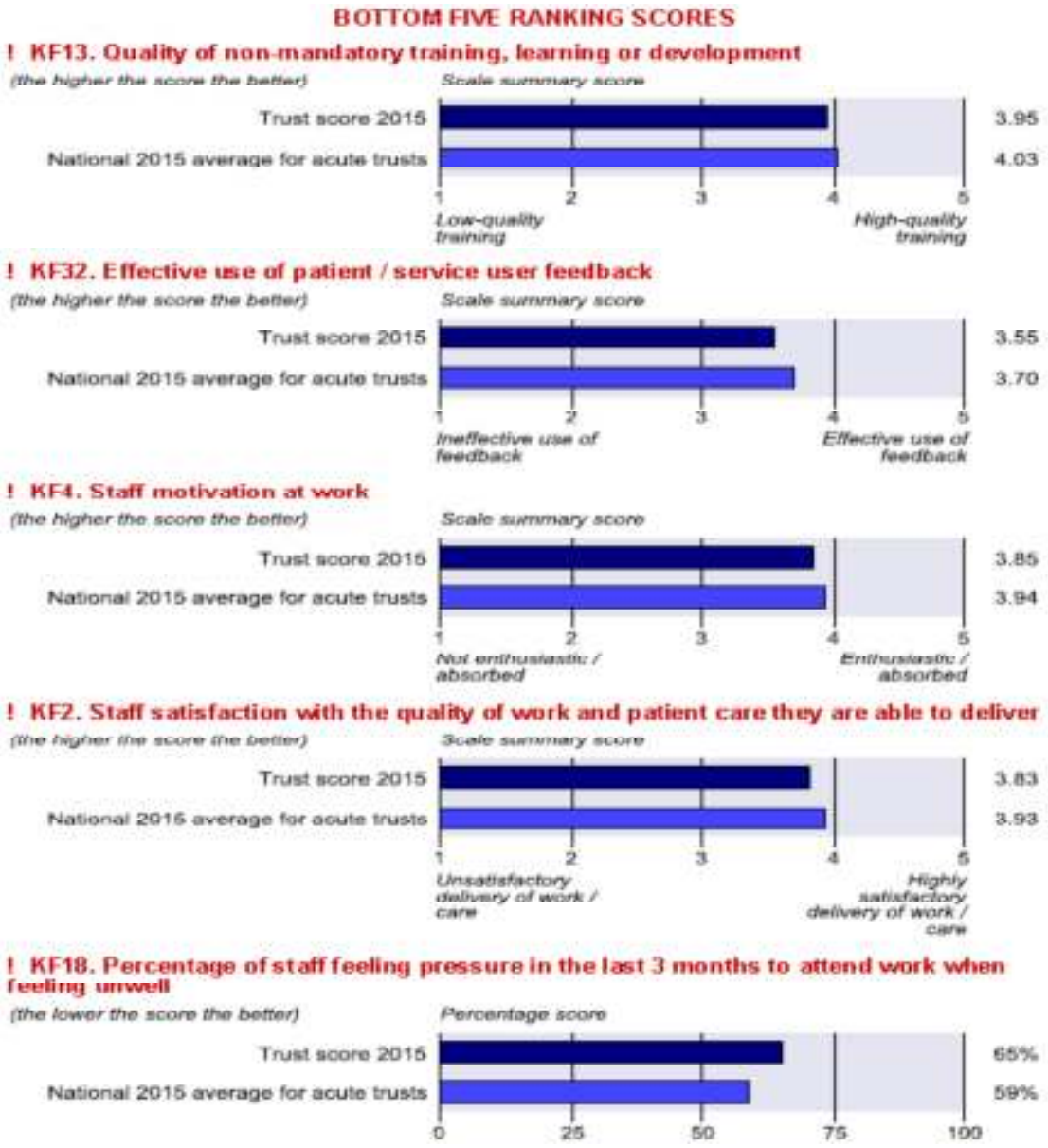



Two of these key findings ('working extra hours' and 'appraisals') are as described in the 2014 survey. The new strengths for us relate to a reduction in the percentage of staff suffering from stress (as described above), a new finding in terms of the percentage of 'staff reporting most recent experience of violence' and the percentage of 'staff satisfied with the opportunities for flexible working patterns'. These suggest that our emphasis on reporting of incidents is bearing fruit and that we do provide flexible working opportunities. This is surprising given the feedback from exit interviews (primarily from Nurses) where it is suggested that this has been an issue.

In addition to being our top five key findings, we score better than the national average in each of these.

Bottom Ranking Scores

These are the five Key Findings for which GHFT compares least favourably with other acute trusts in England.



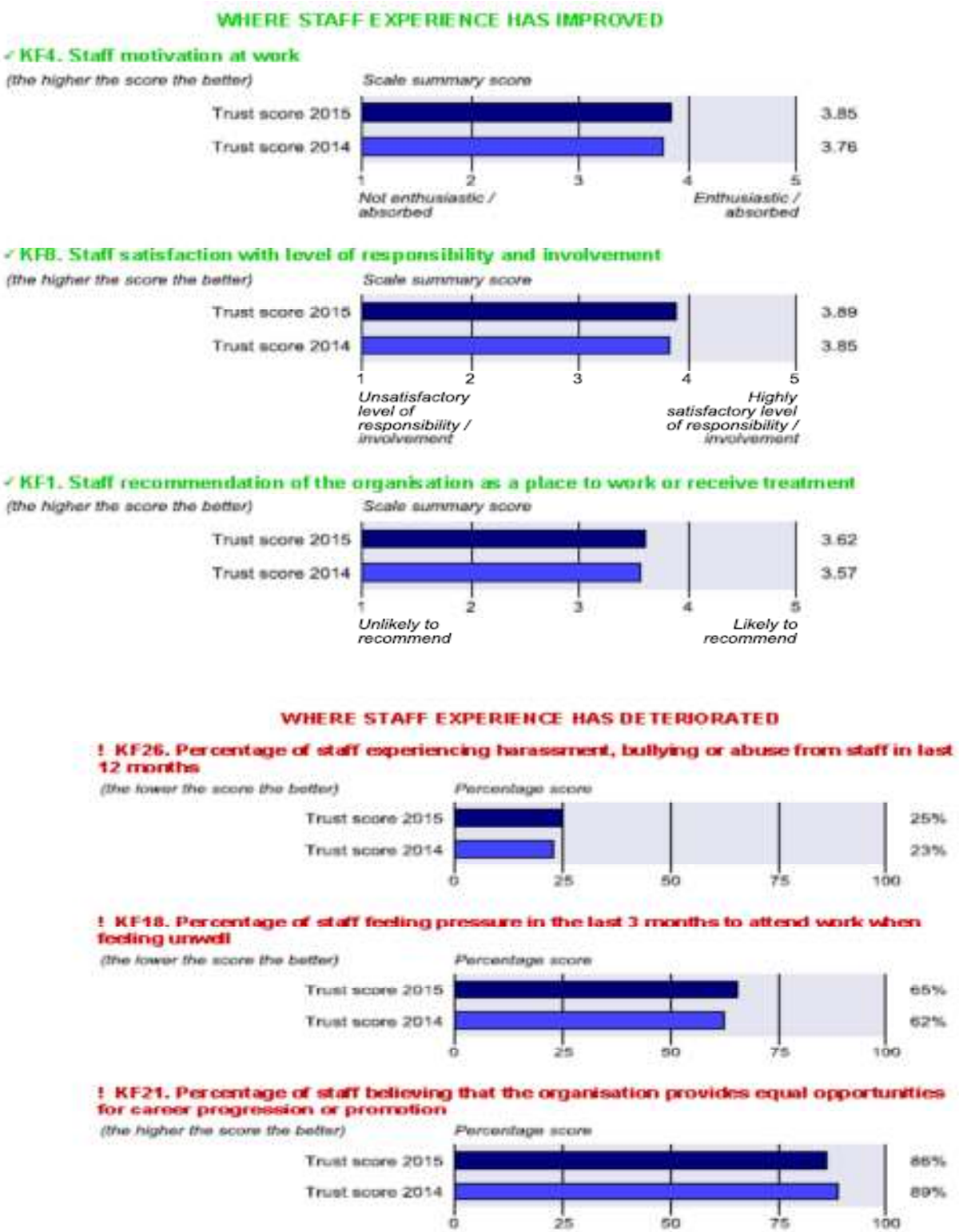

'Staff motivation' at work has improved however only at the same rate as it has nationally and so it remains in the 'bottom 5' as does 'effective use of patient/service user feedback' (last year this key finding was reported in percentage terms). It is disappointing to note the key finding on learning and development as this has been part of the rolling action plan and was commented on earlier in the paper. An explanation has been sought from Picker on the key finding relating to 'pressure to come to work' as to how 4 positive scores compared to the prior year could result in an overall deterioration. The biggest percentage contributor to this finding is staff who report that they have put themselves under pressure to come to work (particularly amongst Nurses and HCA's) and this is likely to be a reflection of challenges to supply in both of those staff groups. This key finding was one of our statistically significant improvers in the 2014 survey and it is disappointing that progress has not been maintained.

The most disappointing of all of the scores to appear in this category will be that of 'staff satisfaction with the quality of work and patient care' (again, a statistically significant improver in 2014). This was expressed in percentage terms last year and a

direct read across is difficult. In terms of clinical staff the group most satisfied in this regard are HCA's and the group expressing most concern are medical staff. This important finding is slightly mitigated by the improved score on the trust as a place to receive treatment (see below) but will clearly need to be a significant focus going forward.

5.4.2 Improvements and deteriorations since last year

The information below depicts the Key Findings where staff experiences have improved and deteriorated:



It is particularly pleasing to see the continued improvement in the key finding of recommending the trust as a place to 'work or receive treatment' and again, it is the pace of improvement that needs to be picked up. Similarly, 'improving staff satisfaction with levels of responsibility and involvement' is a key element of engagement. Conversely it is very disappointing to see the reduction in scores on bullying and harassment. We are not an outlier in this regard but it reflects a reversal of the progress from the year before and this subject is receiving national attention. Also, a previous comparative strength of the trust 'providing equal opportunities for career progression and promotion' has also been reversed and will require closer examination.

### 5.4.3 **Key observations by Division and Staff Group**

Whilst every division has made progress on their engagement score, there are a number of points to highlight;

- Estates Division has made the least progress and remains at the bottom of the pack. It is hoped that the appointment of substantive director will see a marked improvement as they address key issues around 'valuing staff' and 'communication', 'violence to staff' and 'discrimination'.

- Diagnostics and Specialties report the lowest engagement score in terms of the clinical divisions however they have made the biggest progress in year (0.10). Going forward they will need to focus on 'recognising and valuing staff' and 'communications'.

- Medicine have made steady progress. Lower comparative scores on 'satisfaction with 'quality of work and patient care' as well as 'satisfaction with resourcing' will undoubtedly be linked to retention issues in General and Old Age Medicine and activity volumes in Unscheduled Care. Programmes continue to aid retention and boost recruitment in these areas.

- Surgery Division have comparative high levels of satisfaction with 'quality of work and patient care' and continue their generally positive trajectory.

- The most positive employee experience within a clinical division is in Women's and Children. As the most 'independent' of the services and the smallest in terms of staff numbers, they have been able to create a positive working environment. Focus still needs to be put on 'resourcing' (reflecting shortages in certain occupations) and stress levels (likely to be linked to the same issue).

- Corporate Division improved moderately. It remains the division with the highest engagement score but only marginally from Women's and Children who are fast catching up.

In terms of staff groups, again, every group increased its score. Key observations are;

- Nursing and Midwifery staff maintain by far the highest levels of engagement despite increased national and local levels of turnover. These issues impact the extra hours nursing staff report to be working and the 'quality of work and patient care' and levels of stress. There is strong satisfaction with learning and development including non-mandatory.

- Health Care Assistants report the highest levels of satisfaction with 'quality of work and patient care'. Unlike their registered colleagues they do not experience high levels of stress and are also satisfied with non-mandatory training.

- Medical staff continue to report a variable experience. Engagement has improved (second highest improvement) with concerns expressed around 'quality of work and patient care' as well as 'resourcing', 'communication' and 'opportunities for flexible working patterns'.

- Estates staff report higher levels of violence, discrimination and poor communication (as reported above).

- Administrative staff report the second highest engagement levels with positive scores across a number of factors whilst also reporting fewer development opportunities than clinical colleagues.

- Professional, Scientific and Technical Staff, Allied Health Professionals and Healthcare Scientists report higher than average levels of stress but comparative satisfaction with development opportunities.

Each of the divisions and staff groups will be provided with very detailed reports to enable them to develop localised plans in relation to the priorities they identify.

## 6. Conclusions and Next steps

6.1 There are a number of work streams in progress and the intention is to check in with various staff groups to seek their views before presenting a consolidated plan to the Board, it is vital that these results are shared with key stakeholders to obtain their perspectives. These will include;

- Divisional Steering Group
- Divisional Engagement groups
- Divisional Boards
- Trust Management Team
- 100 Leaders
- Employee Representatives (JSCC)
- Senior Staff Groups (e.g. Senior Nurse Committee, Medical Staffing Committee)
- Council of Governors
- Health and Safety Committee
- Involve/open staff sessions

A number of these groups have been heavily involved in designing and participating in the current work plans and will feel a sense of ownership of the progress made and of work still to be done. It is also proposed to invite members of the Divisional Engagement groups to talk to the Board in April 2016 and to hear the comments from these (and others) before finalising a response and action plan. To date these groups have been populated primarily by managers and it will be important to improve the opportunity for staff at all levels to have their voice heard by the Board.

6.2 Whilst it is clear that we continue to make progress against the overall engagement index it is also true to say the step change in terms of significantly improved traction has not been achieved and is very disappointing. Of 32 key findings, only 6 have moved in a statistically significant fashion (3 in either direction). As ever, there will be a mix of national and local reasons for this. In common with the rest of the healthcare system, 2015 has brought significant operational and financial challenges, most notably in terms of workforce supply. Increased staff turnover (including retirements) is a reflection of these challenges and it is vital that the causes are both analysed and addressed. There are clear challenges with medical engagement albeit some of these will be inextricably linked with national contract negotiations as opposed to local issues. Notwithstanding the external issues a significant commitment has been made by this Board to improving the experience of staff and patients. 2015 also saw the biggest internal engagement exercise undertaken to date with the proposal for the new vision, clearly setting out our

aspirations for both patients and staff. Staff were pleased to participate in this exercise and in the main, pleased with the breadth and scope of the ambition. Crucially, having voiced their thoughts on the words contained, they were listened to and the vision was amended. However, the programme of work underpinning the delivery of the vision has yet to ignite and grab the imagination of staff. This presents our greatest opportunity in 2016 to make those explicit links between actions proposed and delivery of the vision and to make the step change required. It is likely that we need to narrow the focus of some of the activities and focus on clearer deliverables which staff would recognise as making a tangible difference to their day to day experience and also that of patients.

## 7. Recommendations

- The Board is asked to **note** the results from the 2015 staff survey.
- The Board is asked to **agree** to receive feedback from the Divisional Engagement groups at the April 2016 Board

**Author: David Smith**

**Presenting Director; David Smith, HR and OD Director,**
**February 2016**

## Table A3.1: Key Findings for Gloucestershire Hospitals NHS Foundation Trust benchmarked against other acute trusts

| | Question number(s) | Your Trust in 2015 | Average (median) for acute trusts | Your Trust in 2014 |
|---|---|---|---|---|
| **STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.** | | | | |
| KF1. Staff recommendation of the organisation as a place to work or receive treatment | Q21a, 21c-d | 3.62 | 3.76 | 3.57 |
| KF2. Staff satisfaction with the quality of work and patient care they are able to deliver | Q3c, 6a, 6c | 3.82 | 3.93 | - |
| KF3. % agreeing that their role makes a difference to patients / service users | Q6b | 89 | 90 | - |
| KF4. Staff motivation at work | Q2a-c | 3.86 | 3.95 | 3.76 |
| KF5. Recognition and value of staff by managers and the organisation | Q5a, 5f, 7g | 3.39 | 3.42 | - |
| KF8. Staff satisfaction with level of responsibility and involvement | Q3a, 3b, 4c, 5d, 5e | 3.90 | 3.91 | 3.85 |
| KF9. Effective team working | Q4h-j | 3.72 | 3.73 | - |
| KF14. Staff satisfaction with resourcing and support | Q4e-g, 5c | 3.25 | 3.31 | - |
| **STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.** | | | | |
| KF10. Support from immediate managers | Q5b, 7a-e | 3.67 | 3.69 | 3.65 |
| KF11. % appraised in last 12 mths | Q20a | 89 | 86 | 90 |
| KF12. Quality of appraisals | Q20b-d | 2.97 | 3.05 | - |
| KF13. Quality of non-mandatory training, learning or development | Q18b-d | 3.96 | 4.02 | - |
| **STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.** | | | | |
| **Health and well-being** | | | | |
| KF15. % of staff satisfied with the opportunities for flexible working patterns | Q5h | 49 | 49 | - |
| * *KF16. % working extra hours* | Q10b-c | 68 | 72 | 67 |
| * *KF17. % suffering work related stress in last 12 mths* | Q9c | 34 | 36 | 36 |
| * *KF18. % feeling pressure in last 3 mths to attend work when feeling unwell* | Q9d-g | 66 | 59 | 63 |
| KF19. Org and mgmt interest in and action on health / wellbeing | Q7f, 9a | 3.53 | 3.57 | - |

## Table A3.1: Key Findings for Gloucestershire Hospitals NHS Foundation Trust benchmarked against other acute trusts (cont)

| | Question number(s) | Your Trust in 2015 | Average (median) for acute trusts | Your Trust in 2014 |
|---|---|---|---|---|
| **Violence and harassment** | | | | |
| * *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths* | Q14a | 18 | 14 | 17 |
| * *KF23. % experiencing physical violence from staff in last 12 mths* | Q14b-c | 2 | 2 | 3 |
| KF24. % reporting most recent experience of violence | Q14d | 57 | 53 | 58 |
| * *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths* | Q15a | 30 | 28 | 30 |
| * *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths* | Q15b-c | 26 | 26 | 23 |
| KF27. % reporting most recent experience of harassment, bullying or abuse | Q15d | 37 | 37 | 37 |
| **STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.** | | | | |
| KF6. % reporting good communication between senior management and staff | Q8a-d | 29 | 32 | 29 |
| KF7. % able to contribute towards improvements at work | Q4a-b, 4d | 67 | 70 | 65 |
| **ADDITIONAL THEME: Equality and diversity** | | | | |
| * *KF20. % experiencing discrimination at work in last 12 mths* | Q17a-b | 10 | 11 | 10 |
| KF21. % believing the organisation provides equal opportunities for career progression / promotion | Q16 | 87 | 87 | 89 |
| **ADDITIONAL THEME: Errors and incidents** | | | | |
| * *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth* | Q11a-b | 33 | 31 | 34 |
| KF29. % reporting errors, near misses or incidents witnessed in the last mth | Q11c | 91 | 90 | 90 |
| KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents | Q12a-d | 3.65 | 3.70 | - |
| KF31. Staff confidence and security in reporting unsafe clinical practice | Q13b-c | 3.52 | 3.63 | 3.52 |
| **ADDITIONAL THEME: Patient experience measures** | | | | |
| KF32. Effective use of patient / service user feedback | Q21b, 22b-c | 3.54 | 3.70 | 3.51 |

# GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

## MAIN BOARD – FEBRUARY 2016

## APPOINTMENT OF ADDITIONAL NON-EXECUTIVE DIRECTOR - PROPOSED AMENDMENT TO THE CONSTITUTION

### 1 Introduction

To provide the Board with an opportunity to increase the membership of the Board of Directors by the appointment of one additional Non-Executive Director from the University of Gloucestershire and that the Trust's Constitution be amended accordingly.

### 2 Background

The Board will be aware of the links established with the University of Gloucestershire particularly with regard to training provision for nurses. It now seems appropriate that the link is established on a more formal basis at Board level and to follow the practice in other Trusts in having a Non-Executive Director from a training institution on the Board of Directors. It is proposed that the University nominate suitable persons which are considered by the Chair.

The appointment of an additional Non-Executive Director will make a total of seven Non-Executive Directors giving a clear majority on the Board rather than the Chair exercising any casting vote. This will fully fulfil the Monitor Code of Governance requirement in that the Board of Directors should comprise a majority of Non-Executive Directors. The person appointed will need to meet the requirements of the Trust's constitution and in particular that only a member of a public or the patients' constituency is eligible for appointment as a Non-Executive Director. The appointment will require the approval of the Council of Governors.

### 3 Changes to the Constitution

This proposal will require the changes to the Trust's Constitution in terms of membership of the Board of Directors. It is also proposed that the quorum of the Board be increased by one Non-Executive Director so that the quorum is one third of the total membership. The proposed changes are set out below:-

> Paragraph 12.1.1.2 Seven ~~six~~ non-executive Directors who are to be appointed (and removed) by the Council of governors in a General Meeting
>
> Paragraph 12.18 Five ~~Four~~ Directors including not less than two executive, and not less than three ~~two~~ non-executive Director's shall form a quorum
>
> Paragraph 25.1 states that the Trust's Head Office is at Trust Headquarters, 1 College Lawn, Cheltenham, Gloucestershire. With the planned moves to Alexandra House, it is suggested that the Trust Secretary be authorised to amend paragraph 25.1 to Trust Headquarters, Alexandra House, Cheltenham General Hospital, Cheltenham, Gloucestershire when the move takes place.

Amendments to the Constitution require approval of both the Board of Directors and the Council of Governors when more than half of the members of the Board and half the members of the Council of Governors voting approve the amendments. Changes take effect from the date of final approval.

### 4 Recommendation

The Board is invited to approve the increase in membership of the Board of Directors by the appointment of one additional Non-Executive Director and the changes to the Constitution set out in paragraph 3 above which will also require the approval of the Council of Governors.

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**Author and Presenter: Martin Wood, Trust Secretary**

Date: February 2016

# ITEM 18

# ITEMS FOR THE NEXT MEETING AND ANY OTHER BUSINESS

# DISCUSSION

# ITEM 19

# STAFF QUESTIONS

**(Two questions attached)**

**Prof Clair Chilvers**
Chair

# QUESTIONS FROM STAFF

## Questions on behalf of our Unscheduled Care Staff Engagement Group

1. What happens to the high risk assessments undertaken once they reach the top/ Trust level e.g. high risk of pressure sores to patients with fractured hips experiencing long delays on ED trollies waiting for a bed on ward?

2. In the light of the current ED situation and poor bed capacity within the Trust could there be an exception to the rule to having a bed in ED for such patients given that , sometimes the wait for some of these elderly and frail patients can exceed 10-12 hours?

# ITEM 20

# PUBLIC QUESTIONS

**(Procedure attached)**

**Prof Clair Chilvers**
Chair

# GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

## PROCEDURE FOR PUBLIC QUESTIONS AT BOARD MEETINGS

The Trust welcomes feedback from members of the public. We are committed to delivering the best care and constantly looking at ways to improve the services we provide at out hospitals. There are a variety of ways in which you can give your feedback. These are:-

- As a patient or visitor to the hospital by completing a comment card which is available on wards and departments.
- By contacting the Patient and Liaison Service (PALS) who offer confidential, impartial help, advice or support to any aspect of a patient's care. The team aim to help resolve issues and concerns speedily by liaising with appropriate staff on your behalf. PALS can be contacted by phone on 0800 019 3282; by text on 07827 281 266; by e-mail pals@gloucestershirehospitals@glos.nhs.uk or by writing to the PALS Office, Gloucestershire Royal Hospital, Great Western Road, Gloucester GL1 3NN. Complaints can be made to the Complaints Team by phoning 0300 422 5777, by e-mail complaints.team@glos.nhs.uk of by writing to the Complaints Team at Gloucestershire Royal Hospital/at the above address.
- By asking a question at our Board meeting by following the procedure below. Board meetings are open to the public and are normally held on the last Friday of the month at Trust HQ, 1 College Lawn, Cheltenham. Meetings normally start at 9.00am

All feedback is taken seriously and is used to either praise staff for the excellent care or service they have provided or used to make improvements where needed.

### Written questions for the Board Meeting

People who live or work in the county or are affected by the work of the Trust (including members of the Trust who live outside of the County) may ask the Chair of the Trust Board a question on any matter which is within the powers and duties of the Trust.

Ten minutes will be allocated at the end of the public section of each Board meeting for written questions from the public to be answered. Where it is not possible for all written questions to be dealt with within this timeframe a written response will be provided to the questioner and copied to all Board members within 7 working days of the meeting. In exceptional circumstances, the Chair may extend the time period for public questions.

### Notice of questions

A question may only be asked if it has been submitted in writing to the Trust Secretary by 12.00 noon 3 clear working days before the date of the Board meeting. Each question must give the name and address of the questioner. If a question is being asked on behalf of an organization then the name of the organization must be stated. Written questions are to be submitted to the Trust Secretary, 1 College Lawn, Cheltenham, GL53 7AT or by e-mail to martin.wood@glos.nhs.uk No more than 3 written questions may be submitted by each questioner.

### Procedure

At the Board meeting the questioner, if present, will be invited to read out the question. If absent, the Chair may read out the question. A written answer will be provided to a written question and will be given to the questioner and to members of the Trust Board before being read out at the meeting by the Chair. Copies of the questions and the responses will be recorded in the minutes.

**Additional Questions**

A questioner who has submitted a written question may, with the consent of the Chair, ask an additional oral question arising directly out of the original question or the reply.

An answer to an oral question will take the form of either:

- a direct oral answer; or
- if the information required is not easily available a written answer will be sent to the questioner and circulated to all members of the Trust Board.

**Unless the Chair decides otherwise there will not be discussion on any public question.**

Written questions may be rejected and oral questions need not be answered when the Chair considers that they:

- are not on any matter that is within the powers and duties of the Trust;
- are defamatory, frivolous or offensive;
- are substantially the same as a question that has been put to a meeting of the Trust Board and been answered in the past six months; or
- would require the disclosure of confidential or exempt information.

For further information, please contact Martin Wood, Trust Secretary on 0300 422 2932 by e-mail martin.wood@glos.nhs.uk