Gloucestershire Care Services NHS
NHS Trust

Agenda

Trust Public Board Meeting

Agenda

Date: Tuesday, 24 January 2017

Time: 11am

Venue: Oxstalls Tennis Centre
Plock Court
Tewkesbury Road, Gloucester
GL2 9DW

Item	Ref No.	Subject	Outcome	Presenter	Guide Time
1	01/0117	**Service User Story** Service User sharing her parents' experiences of care	To receive	Juliette Richardson, Matron Stroud & The Vale	**11:00**
		LUNCH			**12:00**
PRELIMINARIES					
2	02/0117	Welcome and apologies	To note	Chair	**12:30**
3	03/0117	Confirmation that the meeting is quorate	To note	Trust Secretary	
4	04/0117	Declaration of Interests	To note	Chair	
5	05/0117	Minutes of the meeting 24th November 2016	To approve	Chair	
6	06/0117	Matters Arising Action Log	To note	Chair	
7	07/0117	Questions from the Public	To discuss	Chair	
STRATEGIC					
8	08/0117	Chair's Report	To receive	Chair	**12.55**
9	09/0117	Chief Executive's Report	To receive	Chief Executive Officer	**13.05**
10	10/0117	Chief Operating Officer's Report	To receive	Chief Operating Officer	**13.20**
11	11/0117	Board Assurance Framework	To discuss	Director of Finance	**13.35**
QUALITY, SAFETY AND PERFORMANCE					
12	12/0117	Quality and Performance Committee update Communications and Engagement Strategy	To receive For approval	Chair of Quality and Performance Committee	**13.55**

Item	Ref No.	Subject	Outcome	Presenter	Guide Time
13	13/0117	Workforce and OD Committee update	To receive	Chair of Workforce and OD Committee	**14.10**
14	14/0117	Quality and Performance report – Month 8 Data	For review	Director of Nursing, Chief Operating Officer	**14.20**
15	15/0117	Understanding You – Summary Report	To receive	Director of Finance	**14.35**
		Break	**14.45**		
FINANCIAL					
16	16/0117	Finance Committee update	To receive	Chair of Finance Committee	**14.55**
17	17/0117	Finance Report – Month 8 Data	To receive	Director of Finance	**15.05**
18	18/0117	Audit & Assurance Committee Update	To receive	Chair of Audit and Assurance Committee	**15.15**
		Health, Safety & Security Strategy	For approval		
		Information Management and Technology Strategy	For approval		
ASSURANCE AND INFORMATION – Question only items					
19	19/0117	Forward Planner Review	To approve	Chair	**15.25**
20	20/0117	Any other business	To note	Chair	**15.30**

The next Trust Board Meeting will be held on:

Tuesday, 23rd March 2017

Edward Jenner Court
Gloucester Business Park
GL3 4AW

AGENDA ITEM 2

Welcome and apologies

AGENDA ITEM 3

Confirmation that the meeting is quorate

AGENDA ITEM 4

Declaration of Interests

Trust Board Minutes

Date: 22nd November 2016

Board Members	
Ingrid Barker	Chair (Voting Member)
Robert Graves	Non-Executive Director, Vice Chair (Voting Member)
Richard Cryer	Non-Executive Director (Voting Member)
Susan Mead	Non-Executive Director (Voting Member)
Nicola Strother Smith	Non-Executive Director (Voting Member)
Jan Marriott	Non-Executive Director (Voting Member)
Graham Russell	Non-Executive Director (Voting Member)
Paul Jennings	Chief Executive (Voting Member)
Glyn Howells	Director of Finance/Deputy Chief Executive (Voting Member)
Dr. Mike Roberts	Medical Director (Voting Member)
Susan Field	Director of Nursing (Voting Member)
Candace Plouffe	Chief Operating Officer
Tina Ricketts	Director of Human Resources
In attendance	
Gillian Steels	Trust Secretary
Louise Moss	Deputy Trust Secretary
Public/Press	
Tony Midgley	Chair - League of Friends Lydney

Ref	Minute
01/1116	**Service User Story – Inclusion Gloucestershire** Postponed due to illness.
02/1116	**Welcome and Apologies** The Chair, Ingrid Barker, welcomed colleagues and Tony Midgley, League of Friends.
03/1116	**Confirmation the Meeting is Quorate** The Chair **confirmed** that the meeting was quorate.
04/1116	**Declarations of Interest** Declarations of Interest previously declared were noted. There were no Declarations in relation to the agenda for the meeting.
05/1116	**Minutes of the Meeting Held on 20th September 2016** The Minutes were approved as a true record and approved for signing by the Chair.
06/1116	**Matters Arising (Action Log)** It was noted that items were on track or completed. It was confirmed that the Volunteer

	Strategy would be considered by the Workforce and Organisational Development Committee in December and subject to approval come to the Board in January 2017.
07/1116	**Questions from the Public** Tony Midgely, who had previously submitted his question, was invited to speak by the Chair. Question: The Friends of Lydney Hospital have offered to fund a replacement X-ray facility at Lydney Hospital in conjunction with the Trust. In view of the delays which are occurring over a final decision to proceed, and the on-going issues relating to the provision of health services in the Forest, can the Board give an assurance that maintaining state of the art health facilities in the Forest community hospitals will continue until a decision is taken on their future. The Chief Operating Officer confirmed that reports are regularly taken to the Board's Audit and Assurance Committee to provide assurance that Estates compliance is maintained. She confirmed that the Dilke and Lydney Hospitals had both been confirmed as fully Care Quality Commission (CQC) compliant and that funds had continued to be spent on the Forest hospital estate during the last year. Investment had been made in a Complex Leg Wound Service in Lydney and quotes to improve the Minor Injury and Illness Unit (MIIU) reception areas in both hospitals were currently being reviewed. The Chief Operating Officer apologised for the delays in relation to the X-ray equipment. She confirmed this had been approved in May and that she understood the Estates Manager had updated the League of Friends on progress at their meeting the previous day. She advised a quote had been received and that in Stroud delivery post order had been 8 weeks so that this should soon be in place. The Chief Executive responded on the wider strategic issues commenting that the Trust shared the League of Friends' disappointment at the delays in resolving the issues relating to the provision of healthcare in the Forest, and advised that unfortunately the process would now be further delayed until after the County Council Elections in May and that time would now need to be spent working up the consultation document. Tony Midgley thanked the Board for their response and confirmed he felt reassured.
08/1116	**Chair's Report** The Chair highlighted key aspects from her report which updated on Board Developments, Working with our Partners, Working with our colleagues and National and Regional Meetings attended. In particular: (i) The Chair formally recognised the **contribution of Paul Jennings**, noting this would be his last Board meeting. She commented on his contribution over the last three and a half years to ensure the Trust delivered successfully on quality and financial requirements. His role in leading on the 30,000 model within the STP footprint and embedding Listening into Action at the Trust was highlighted. (ii) It was noted that the Board looked forward to welcoming **Katie Norton** as Chief Executive from January 2017.

	(iii) Developments to create **a Board Membership Diversity pipeline,** working with other local Trusts. **(iv)** **Annual General Meeting & Exhibition –** had been well attended with informative and engaging stands from colleagues and other partners. (v) The change of **Chair at Gloucestershire Hospitals** NHS Foundation Trust, with the appointment of Peter Lachecki (vi) The **Gloucestershire Health and Social Care Awards** which had recognised many Trust colleagues. The Board **NOTED** the Chair's Report.
09/1116	**Chief Executive's Report** The Chief Executive highlighted the following aspects from his update: (i) The Listening into Action Accreditation achieved by the Trust – the first community trust, demonstrating the successful embedding of a culture change approach focused on improving patient outcomes. (ii) Care Quality Commission (CQC) re-assessment - the quality improvement plan had been completed and the CQC invited to re-inspect. (iii) Strengthening Finance and Accountability – new national policy guidance to respond to increasing financial pressures at many Trusts and Clinical Commissioning Groups. (iv) #take the lead – a well supported, well received leadership conference. (v) Black History Celebration – disappointment that this had been cancelled, but the Trust's commitment to celebrating cultural diversity and responding to the concerns raised within the Workforce Race Equality Standard was reiterated. (vi) Minor Injury and Illness Units – revised opening times successfully in place from 1 November 2016. Members watched a film celebrating the 60 Years in Nursing of Jenny Turner, which had been shown recently at the Nursing Awards to over 1,800 people, where Jenny had received a standing ovation. The Board welcomed this opportunity to celebrate the contribution Jenny Turner had made over more than 60 years, noting that in last year's rollout of a new clinical system she had been a Systm1 champion in the hospital where she works. (vii) Sustainability and Transformation Plan (STP) – the Memorandum of Understanding had now been updated and was proposed for signature. It was confirmed it incorporated the updated governance structure. The Board **NOTED** the Chief Executive's Report and **APPROVED** the signing of the STP Memorandum of Understanding.
10/1116 Chief Operating	**Chief Operating Officer's Report (including Agency Update)** The Chief Operating Officer presented key aspects within her report, in particular: (i) Supporting Urgent Care provision over the winter: Gloucestershire Urgent and Emergency Care Resilience Plan 2016/17 – a first draft had been reviewed by the Quality and Performance Committee. Late guidance had now been issued by the NHSE which needed to be incorporated to reflect escalation action

Officer	proposals. It was agreed the December Quality and Performance Committee would review the updated plan. (ii) Progress made on realigning Integrated Community Teams around GP Clusters. (iii) Work underway with Public Health in relation to Sexual Health and Public Health Nursing which would be considered by the Local Authority Cabinet in December. It was noted this the revised models for providing these services had been progressed within the Trust using the LIA approach. (iv) Agency Usage – it was confirmed this was regularly monitored by the Finance Committee but in response to NHSE guidance was being further highlighted to the Board. It was confirmed that the Trust was within planned trajectory and that this was the position for the rest of the year. She confirmed this position was planned to be held throughout the winter months, and that this position was supported by the decision of the Gloucestershire Clinical Commissioning Group (GCCG) not to open escalation beds. The Trust's position was the second best within the south west.
Chief Operating Officer	Members noted the focus within the Winter Resilience Plan on admission avoidance and commented on the need for an understanding of how community services needed to be strengthened to support this in the next iteration of the plan. The Director of Nursing commented that discussion at the Quality and Performance Committee had highlighted the need for system quality metrics which had been fed back to the GCCG. Susan Mead, Non-Executive Director commented that it was important to measure the patient experience to inform review of the process going forward.
Chair	Richard Cryer Non-Executive Director expressed his disappointment at the outcome of the Healthy Lifestyles Tender and commented on the need to support the Team. It was agreed the Chair would write formally to the staff to recognise their contribution. The Medical Director commented on the proposed Integrated Community Team (ICT) clusters, highlighting that those for Gloucester were not yet finalised. Jan Marriott, Non-Executive Director concurred with this assessment which reflected a longstanding joint working position. The Chief Operating Officer confirmed she was aware of the issue. Susan Mead, Non-Executive Director, queried the revised service models for public health services. The Chief Operating Officer advised the models reflected the reduced Public Health funding following the Public Spending Review. In relation to Children and Young People the Healthy Child checks were a national standard, proposed service model changes related to skills mix, use of a digital platform and a "chat" health service. For Sexual Health the proposed changes would introduce a triage system and create a specialised sexual health service. The Chief Operating Officer advised that the Trust had provided information to inform a report from Public Health which would be considered by the Gloucestershire County Council Cabinet in December. The Cabinet would then be responsible for any consultation required. The Chair queried how the introduction of the new Minor Injury and Illness Units opening hours had progressed. The Chief Operating Officer confirmed they had been in place from 1 November 2016 as advised and that revised staff rotas had been agreed with some local variation. The Chief Operating Officer confirmed the Trust was now meeting the CQC staffing requirements. The Chair requested an update on how contract negotiations were progressing with GCCG to meet the additional costs. The Chief Operating Officer advised

Chief Executive	that the GCCG had confirmed it would work with the Trust to mitigate the costs. The Chair commented that this issue was of greater significance given that the resultant cost pressure from the MIIU staffing changes would be extended given the delay at a county level to decisions relating to the hospital provision in the Forest. The Chief Executive advised he would raise the matter at the Trust's Contract Management meeting with the GCCG on 23rd November. The Board **NOTED** the Chief Operating Officer's report and **AGREED** the actions above to take forward issues raised.
11/1116	**Board Assurance Framework** Members considered the Board Assurance Framework. It was noted that the Risk Register was reviewed on a monthly basis by the Risk Steering Group, and that the Strategic Risk Register contained 12 risks, 9 of which had a rating which was the same as the previous month and three of which had reduced. Members queried the implications of the on-going high risk level of R**isk 6 relating to** "clinical record keeping". The Director of Nursing confirmed that significant work had been taken forward in this area but she was waiting until a review of the clinical audit in the New Year to confirm that the risk rating could be reduced. She advised that the risk had related to recording information in Systm1 and that new templates had been issued for the ICT and a new one for Children's' Nursing would be in place early in the New Year. She advised that there was still work ongoing in Community Hospitals in inpatients but that MIIU recording was good. Members queried when the risk would be re-assessed and were advised this would be in March 2017. Members queried whether this work would impact on a CQC inspection. The Director of Nursing advised it was not an issue they had identified previously and that work was ongoing to ensure improvement, as was evidenced in the work of the Quality and Performance Report.
Chief Operating Officer	Members considered **Risk 7 –** and queried when up to date ICT specifications would be available. The Chief Operating Officer agreed to raise the timeframe for this at the Contract Management Meeting. Richard Cryer, Non-Executive Director queried whether the Finance Risk 12 rating was sufficiently robust at amber give that three of the related corporate risks were red. The Director of Finance confirmed that these were assessed by managers as risks to an areas' financial budgets, and that overall the risk level had been reviewed by the Risk Management Steering Group as 12 when assessed against Trust level budgets. Richard Cryer commented on the financial position at GHNHSFT, which had significantly worsened without being identified by the Board, and stressed the need for the Board to maintain scrutiny. The Director of Finance updated that the outstanding recharge issues with GHNHSFT for the previous year had been finalised and the position for the current year was scheduled to be resolved in December 2016. Members considered Risk 11 relating to Leadership Capacity and queried what mitigation had been put in place for the change of Chief Executive and Director of Finance. The Chair advised that in relation to the Chief Executive: • The transition was taking place with only a 5 day gap which would minimise uncertainty.

	• A detailed induction programme had been drawn up by the Chair and current and incoming Chief Executives. • The incoming Chief Executive was attending a range of Board development events ahead of taking up post to support a smooth transition. In relation to the Director of Finance: • Interviews were scheduled for 16th December. • There had been a good range of applicants with a field which included existing Directors of Finance and Deputy Chief Executives. The issue of notice period would need to be considered post interview. The Board **NOTED** the Board Assurance Framework and confirmed the proposed actions planned to mitigate the risks to an acceptable level.
12/1116	**Quality and Performance Committee update - including Minutes 31/8/16** Susan Mead, Non-Executive Director, Chair of the Quality and Performance Committee, took the report as read, and advised that: **(i) The Quality and Performance Committee had Approved:** • The Trust's Mortality Report and agreed the next report would be published in November 2017. • The Trust's Controlled Drugs Annual Report and its publication where no issues were identified. **(ii) Recommended that the following be highlighted to the Board:** • Gloucestershire System Resilience and Escalation Plan for Winter 2016-17 - Noted breaching single sex wards require CEO approval - Concern that no quality or patient metrics were incorporated - No escalation beds planned • NICE Compliance Risks identified by the Clinical Records Group – confirmed action being taken and continued to be monitored by the Committee • Safety Thermometer (Harm free Care) on-going decline in performance – at the meeting the Director of Nursing updated that progress had been achieved following significant work in this area and that the November census reporting an achievement of 95.5% Harm free Care. Members were pleased with this reassurance and confirmed they would continue to keep the position under review to ensure this revised position was maintained. • MIIU and Mandatory Training CQC actions continue. • The terms of reference for the Committee are being revised and will come to the January Board. The Chair of the Quality and Performance Committee also updated on the Capacity and Demand tool which was being trialled and advised it would provide useful information to support patient care and effective staff deployment. The Chair of the Quality and Performance Committee commented on work being undertaken to review the Quality and Performance Report to provide updated metrics, ensured it remained reliable, robust, timely, combined exception reporting with highlighting of good practice but was a streamlined version to give Board integrated oversight of quality and performance.

	Jan Marriott, Non-Executive Director, commented on the Research and Development (R& D) issue raised in relation to the medical focus. The Director of Nursing updated on ongoing discussions to support non-medical clinician R&D with the R&D Consortium, which tendered to be acute delivery focused. It was confirmed 2gether NHS Foundation Trust had the same issues as Gloucestershire Care Services. It was noted the next meeting of the consortium would be at Edward Jenner Court, this was welcomed by Members. The Medical Director updated on the comprehensive Mortality Report which had been considered by the Quality and Performance Committee, this had reviewed data by site and times amongst other metrics, and not identified any points of concern. He advised it had been agreed the report would now be considered annually and questioned what reporting the Board required. The Director of Nursing advised this would be incorporated within the Quality and Performance Report review. She advised that the target was to bring a draft version of this revised report to the December Quality and Performance meeting with a number of questions for the Committee to consider in terms of: what was required by Board, what can be reviewed 6 monthly, frequency for safeguarding and mortality. She confirmed that the aim was to maintain the level of assurance but to provide a more focused report which provided clearer oversight. Members commented that they appreciated the current version's assurance but would review the developed report. The Chair commented on the Mortality Report issues relating to further work being required to ensure those who are receiving palliative care have Advanced Care Plans and Do Not Actively Resuscitate plans in place and whether there were implications relating to the shortage of domiciliary care. The Medical Director advised that the issues had been highlighted to the GCCG to take to the End of Life Steering Group. It was confirmed that District Nurses were working to support patients who wanted to die at home. Susan Mead, Non-Executive Director commented on the need for these requirements to be built into care pathways. The Chief Executive confirmed that the STP Choosing Wisely Group would incorporate looking at pathway and protocol issues. **The Board NOTED the report, received the minutes of the Quality and Performance Committee – August 2016 meeting and were assured of the reported position and actions taken.**
13/1116 **Board**	**Workforce and Organisational Development Committee update – including – August Committee Meeting Minutes** The Committee considered the report which included key workforce risks and areas of underperformance. The Committee highlighted that improvement in mandatory compliance continued, the Trust's sickness rate had improved and was now 4.4% and that work was ongoing to improve staff recommending the Trust as a place to work through a range of engagement schemes. Issues of concern highlighted were the Friends and family test staff rating and completion of Personal development Reviews. It was agreed that both these issues would be considered at the next Board Strategic session in December. The Board NOTED the Workforce and Organisational Development Committee update, **received** the approved minutes of the meeting 24 August 2016 and agreed further activity to take forward issues of concern as highlighted.

14/1116	**Quality and Performance Report - Month 6 Data** The Director of Nursing presented the report to the Committee. She commented that the data to August 2016 had been reviewed by Quality and Performance Committee in November, with this report updating on performance up to 30 September 2016. She highlighted the following aspects: MSKCAT (Musculoskeletal Clinical Assessment and Treatment)– over performance of activity but increased number of 8 week RTT (referral to Treatment) breaches - MSK – 87.7% against 95% 8 week RTT target Safety Thermometer 93.9% as at Month 6, however the Director of Nursing brought to the Board's attention that this had been recovered to more than 95% target in Month 7 where data had just been finalised. Mandatory Training Compliance – improving but remains below 80% trajectory MIIU time to initial assessment for ambulance to arrive but consistently below target of 15minutes (28 minutes) The decline in the number of Friends and Family Test responses was highlighted and members commented on the need for qualitative data. Members were pleased that the safety thermometer position had risen from that within the report. The Director of Nursing confirmed there had been no SIRIs (serious incidents requiring investigation) during September. There had been two complaints but 89% positive feedback on NHS Choices. She highlighted that the high level of bed occupancy remained an issue of concern, and that length of bed stay also remained high, reflecting increased acuity. In relation to MSK performance she advised that MSK pathways were being considered within the STP to work to resolve the issues. It was recognised that some of the performance metrics were no longer relevant given ongoing changes in provision and it was confirmed this would be adjusted in the revised Quality and Performance Report. The Director of Nursing commented on the need for clarity from the GCCG in relation to STP metrics and individual organisation metrics.
Director of Nursing	Jan Marriott, Non-Executive Director, queried the data relating to safeguarding which stated that safeguarding issues had risen from 7 to 27. The Director of Nursing confirmed she would investigate this and update Members.
Director of Nursing	The Director of Finance queried whether the new staffing model was reflected in the safer staffing reporting. The Director of Nursing advised this was being checked by the Head of Performance, but that his understanding was it was based on fill rate against the self-assessed requirement. She advised this would be confirmed within the next report. Robert Graves, Non-Executive Director, agreed it would be helpful to review a streamlined report format but stressed the need for the report to enable the Board to maintain its line of sight across the Trust. He thanked the Team involved in providing the report. The Director of Nursing confirmed that the comments of the Board would be reflected within the draft report format, and stressed that assurance should not be lost. The Chair expressed concern that the number of Pressure Ulcers had increased. The Director of Nursing commented that there were some recording issues, but that a detailed report on pressure ulcers would be considered by the December Quality and Performance Committee.

	The Medical Director commented on the metric relating to use of the Rapid Response Service, and the need for the GCCG to take a role in encouraging GPs to use the service. It was confirmed that NED visits to services were continuing as reported. The Board **NOTED** the report.
15/1116 Chief Operating Officer/Director of Nursing/ Director of Finance	**Finance Committee update** Robert Graves, Chair of the Finance Committee, took members through the key parts of the update. He confirmed that the Committee continued to monitor financial performance and the key risks to achieving the budget, and that at this time the Committee considered the Plan was on track to be delivered. The Cost Improvement Plans continued to be monitored to ensure achievement, although at this stage delivery is later than originally planned. He confirmed, as had been advised earlier in the meeting that Agency Usage was within planned trajectory. He advised that a very informative presentation had been provided by the Children and Young People's Service, which had highlighted the services challenges and opportunities. He also advised that a Special Finance Committee meeting had taken place to support the development of the Two Year Plan. The Director of Finance updated that he had reflected on the issues identified at GHNHSFT and considered ways to provide additional financial assurance to the Board and that he had developed an additional matrix for the Finance Committee which would allow the Board to more easily move between Trust level finance information and individual detailed budget holder reviews. Richard Cryer, Non-Executive Director confirmed this would be very helpful and commented that the Budget holder reviews enabled useful triangulation. The Chief Executive commented that the level of cash held was a key assurance for a Board, and confirmed that the Trust's level was above Plan. It was confirmed that reporting on speed of payment was reported to the Audit Committee, and that this was consistently at 90%. The Chair queried whether the Trust was meeting the Prompt Payment Requirements; the Director of Finance advised this was operating at 85-90% with delays reflecting issues with SBS service. Jan Marriott, Non-Executive Director, queried whether the review of Systm1 had looked at productivity on the wards, as she had received some concerns about this in visits to one of the community hospitals. The Director of Finance advised that increased productivity had been indicated across the Trust, not specifically the community hospitals, he and the Chief Executive commented on the benefits of the information being available across the Trust to support holistic care, subject to patient consent. The Director of Nursing commented that it also helped to assure quality of clinical record keeping due to the increased visibility. The Chief Operating Officer advised that members of the Systm1 team were available to spend 1:1 time with staff who were having difficulty with the system to train the in short cuts and operational efficiencies. The Director of Finance advised that if there was an issue around insufficient WOWs (Workstation on Wheels) that a requisition request could be made for additional supplies. It was confirmed that currently Systm1 could not be accessed by tablet, but that this was a capability that the designers were working towards. The Medical Director commented that the new system also supported patient confidentiality. The Chair suggested that a workshop session on the benefits of Systm1, incorporating impact on clinical time, patient experience and patient safety in February would be helpful to enable this to be further explored.

	The Board **NOTED** the report and **received** the approved the minutes of the Committee held on 22nd August 2016.
16/1116 Chief Operating Officer/Director of Finance	**Finance Report – Month 6 Data** The Director of Finance advised that he had inserted balance sheet information into the report to provide the Board with greater assurance. He advised that it reflected the GHNHSFT recharges within debts as SBS had not yet processed the payment which had been agreed and paid by GHNHSFT. He highlighted that there was an underspend on capital, reflecting delays with the Hatherley Road Project and the Network replacement project being managed by CITS. He confirmed that any full year underspend would not be lost to the central NHS or Treasury and would be rolled forward, although there was potential for NHSI to restrict capital spending in future years given the capital demands of the STPs. The Chair stressed that taking forward the Hatherley Road Project was an important strategic issue. The Director of Finance advised that he and the Chief Operating Officer were targeted to review the business case in 3 weeks. It was agreed this should be targeted to come to the January Board for approval. Members queried what level of approval was required from NHSI. The Director of Finance advised that if it was less than £3.2m an outline business case was required; if above this a full business case would be required. It was noted that the Trust could authorise up to 3% of turnover. Members noted that at Month 6 year to date surplus and full year forecast are both in line with plan. It was noted that the main risks at month 6 are: - QIPP (Quality, Innovation, Productivity and Prevention) risk share of £900k which is dependent on system wide admission avoidance - Agreeing GHNHSFT recharges in line with plan - Offsetting any in year shortfall on Cost Improvement Plan delivery with equivalent non-recurrent savings. The Board **NOTED** the financial position and actions being taken to mitigate the identified risks.
17/1116 Board	**Charitable Fund Update** The Board noted the work in the development of the Charitable Funds Strategy and the option to feed in comments for the January meeting of the Committee. They also noted plans to out-source the accounting function for the Trust to improve the service, given issues with SBS. It was confirmed control levels would be maintained. It was noted the updated Terms of reference would be brought to the January Board for approval. The Board **RECEIVED** the update and the July 2016 minutes of the Committee.
18/1116	**Audit Update**

	The Board noted the decisions from the Audit Panel regarding the extension terms for Internal and External auditors. They requested that the renewal of the Internal Auditors be reviewed, if the GHNHFT financial review raised any concerns about their practice. It was noted that the Business Continuity Strategy had been approved and was provided for endorsement. **The Board ENDORSED the re-appointment of KPMG as External Auditors until March 2019, and the re-appointment of the Internal Auditors until March 2018 subject to the issue above.** **The Board ENDORSED the Business Continuity Strategy.**
19/1116 Chief Executive	**Agenda Forward Planner** The Board reviewed the forward agenda document it was noted that STP engagement had been incorporated within the Chief Executive's Report and any further information would be circulated when it became available. It was noted that the Business Continuity Strategy had come to this meeting. It was agreed the Volunteer Strategy, Hatherley Road Business Case, Charitable Funds Strategy should come to the January meeting, with the quality Strategy to come to the following meeting. Additional the Systm1 workshop should come to the February Strategy session. It was **AGREED** the Forward Planner would be revised as detailed.
20/1116	**Any Other Business** None There being no further business the Chair closed the meeting at 14.55p.m.
	Date of Next Meeting in Public It was agreed that the next meeting of the Board be held on Tuesday 24th January 2017 and will be held at the Oxstalls Centre, Plock Court, Gloucester

Chair's Signature:

Date: Date

TRUST PUBLIC BOARD: PUBLIC SESSION - Matters Arising Action Log - 24 January 2017

Key to RAG rating:

- Action completed
- Action deferred once, but there is evidence that work is now progressing towards completion
- Action on track for delivery within agreed original timeframe
- Action deferred more than once

Minute reference/date	Item	Action Description	Assigned to	Completion Date	Progress Update	Status
B006/16 (2)	Membership Strategy	Organisational status under review and updates to Board	Chief Executive Officer / Chair / Head of Planning, Compliance and Partnerships	May 2017	Membership discussed at Board Strategy day, December 2016 and agreed further work to take place on this during 2017	
10/0516	Chief Executive Report	All Non-Executive Directors to engage in Quality visits at EJC – programme and process to be agreed	Director of Nursing/Nicola Strother Smith/NEDS	November 2016	Nicola Strother Smith trailed and confirming programme Director of Nursing	
10/0616/ 13/0916	Chief Operating Officer's Report Q&P Report	Review reporting to consider exception reporting Quality and Performance data to be reviewed	Trust Secretary	Sept 2016 Dec 2016	New style Q&P report used at A&P Committee in December and on agenda	
13/0616	Workforce and Organisational Development	Consideration from Executive where volunteers could contribute.	Director of HR	Nov 2016	Draft strategy submitted to WF and OD Committee	

Minute reference/date	Item	Action Description	Assigned to	Completion Date	Progress Update	Status
	Committee				Dec 2016 being taken forward by the Committee	
13/0616	Workforce and Organisational Development Committee	Communications and Internal Engagement Strategy to be reviewed once Communication and External Engagement Strategy combined.	Director of HR / Director of Finance	Jan 2017	Updated strategy on agenda, following consideration by Q&P Committee and WF and OD Committee	
18/0616	Understanding You	5 page summary – to be drawn up for future reports	Head of Planning, Compliance & Partnerships	Jan 2017	On agenda	
10/1116	Chief Operating Officer's Report	Supporting Urgent Care provision over the winter: Gloucestershire Urgent and Emergency Care Resilience Plan 2016/17 – a first draft had been reviewed by the Quality and Performance Committee. Late guidance had now been issued by the NHSE which needed to be incorporated to reflect escalation action proposals. It was agreed the December Quality and Performance Committee would review the updated plan.	Chief Operating Officer	Jan 2017	Plan was not ready to be considered by Q&P in December 2016 an update is provided within the COO report	
10/1116	Chief Operating Officer's Report	New opening hours MIIUs- The Chief Operating Officer advised that the GCCG had confirmed it would work with the Trust to mitigate the costs. The Chief Executive advised he would raise the matter at the Trust's Contract Management meeting with the GCCG on 23rd November.	Chief Executive	December 2016	Feedback awaited	
10/1116	Chief Operating Officer's Report	Healthy Lifestyles Tender- It was agreed the Chair would write formally to the staff to recognise their contribution.	Chair	Dec 2016	Closed – Circulated 20 December 2016	
11/1116	Board Assurance Framework	Members considered **Risk 7 –** and queried when up to date ICT specifications would be available.	Chief Operating	Jan 2017		

Minute reference/date	Item	Action Description	Assigned to	Completion Date	Progress Update	Status
		The Chief Operating Officer agreed to raise the timeframe for this at the Contract Management Meeting.	Officer			
14/1116	Quality and Performance Report – month 6	Safeguarding data query numbers increased from 7 to 27. DoN to investigate and update Members	Director of Nursing	Jan 2017	Revised data received from GCC shows lower numbers due to records allocated to GCS incorrectly. updated data shown in latest report.	
14/1116	Quality and Performance Report – Month 6	The Director of Finance queried whether the new staffing model was reflected in the safer staffing reporting. The Director of Nursing advised this was being checked by the Head of Performance, but that his understanding was it was based on fill rate against the self-assessed requirement. She advised this would be confirmed within the next report.	Director of Nursing	Jan 2017	The latest reported data is based on the new staffing model, the report includes the minimum staffing level for each ward and shift.	
16/1116	Finance Report - Month 6	Hatherley Road Business case The Chair stressed that taking forward the Hatherley Road Project was an important strategic issue. The Director of Finance advised that he and the Chief Operating Officer were targeted to review the business case in 3 weeks. It was agreed this should be targeted to come to the January Board for approval.	Director of Finance / Chief Operating Officer	Jan 2017	Update on agenda	
19/1116	Forward Planner	Sustainability and Transformation Plan, engagement – Any further information to be circulated when available	Chief Executive	Jan 2017	Information circulated	

AGENDA ITEM 7

Questions from the Public

Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: 24 January, 2017
Location: Oxstalls Tennis Centre, Gloucester

Agenda item 08/0117: Chair's Report

1. Background

The report provides updates on:

(i) Board Developments – Membership and Activities;
(ii) Work with Partners - Stroud Council, Sustainability and Transformation Plan (STP), local providers, Gloucestershire Clinical Commissioning Group, League of Friends, Health and Care Oversight and Scrutiny Committee;
(iii) Working with Trust Colleagues – including Non-Executive Director triangulation and engagement activities
(iv) National Networks

2. Board Developments:

Having said farewell to Paul Jennings on his retirement at the end of December, I am delighted to welcome Katie Norton as our new **Chief Executive**. Katie arrived on 9th January and I know we are all looking forward to working with her in leading the Trust through its next phase of development with a strong focus on service transformation, partnerships through the Sustainability and Transformation Plan (STP) and co-production with primary care and the communities we serve.

I am also pleased to report that a strong new appointment has been made to the **Director of Finance and Deputy Chief Executive** role. Sandra Betney arrives in early April and brings with her a wealth of experience. Sandra is currently Executive Director of Resources at Birmingham and Solihull Mental Health NHS Foundation Trust, where she leads on a wide portfolio of corporate services including finance, estates, ICT and business development. She was an outstanding candidate amongst a strong national field of applicants and I am absolutely delighted she is joining us. Of course, we will be very sorry to see the departure of Glyn Howells who has made an exceptional contribution to the Trust over the last five years. He will be leaving us at the end of March.

Colleagues will be aware of the financial challenges being faced by our partners in the acute Trust and their need for additional financially qualified Non Executive scrutiny and support. **Rob Graves** has been appointed as one of two new Non-Executive Directors at Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), the other being **Claire Feehily** who is therefore soon to stand down as Chair of Healthwatch. Both Rob and Claire take up their new roles at the beginning of February. Rob has served Gloucestershire Care Services in its various guises for

over a decade as a Non-Executive Director, Chair of Audit and as Vice Chair. I cannot overstate the contribution he has made to our strategic thinking, our good financial governance and performance and I know colleagues will join me in thanking him for his thoughtful challenge and support over the years. We are therefore in the process of recruiting a new Non-Executive Director with a strong financial background to compliment that of our Audit Committee Chair, Richard Cryer. Interviews are planned for mid February.

The Board held its annual two day **'strategic development'** session in December where amongst other items we discussed how we might work more effectively with the third sector and with primary care. A task and finish group is being set up to kick start the former while Katie Norton will be taking on the lead from Paul for the Place Based work and associated developments with primary care.

3. Working with Partners:
The Leader and Chief Executive of **Stroud Council** came to visit GCS in December for a general briefing about services delivered by us in their district. The Chief Operating Officer and I were able to update them on a number of developments which they had not been aware of, including Rapid Response and the new Leg Wound Clinic. This meeting was followed a week later by a meeting requested by all the Stroud Council party leaders (Councillors Lydon, Marjoram, Tucker and Cooper) with the Chairs and Chief Executives of the CCG, GHNHSFT and ourselves. They were seeking assurances about the future of services in Stroud and in addition we were able to outline some of the out of hospital services for which their support would be valued in raising public awareness and engagement, including the new 'Place Based/ 30,000 Model' developments.

The **STP** has been published and is currently subject to public engagement until mid February, with a fuller consultation period on detailed proposals being planned for the Summer. As part of the revised governance arrangements, the Gloucestershire Strategic Forum (GSF) is now the place through which the STP is accountable as the Chairs and Chief Executives who attend are able to provide a direct link to the Boards as the statutorily accountable bodies. At the most recent GSF in December, I chaired an item on how this meeting should run in the future to reflect its new status and to give greater time to development of strategic thinking around the 'big ticket' items associated with the STP. The STP has also hosted a meeting of its newly constituted Advisory Group - a forum where a wide range of stakeholders can be briefed and their views sought on key developments.

I had an introductory meeting with **Peter Lachecki, new Chair of GHFTNHST**. I have initiated a **gathering for the local provider Chief Executives and Chairs** in January, as we have had a number of new arrivals in recent months and would value getting to know one another to enhance our partnership working.

Following our Board Away Day, Paul Jennings and I met with the **Gloucestershire Clinical Commissioning Group** (GCCG) Accountable Officer and Chair before Christmas to discuss our on going partnership in the delivery of community services and the Board has been briefed on this. We agreed to reinstate our helpful monthly 'four way' meetings to ensure on-going good communications and partnership.

Paul Jennings and I held one of our quarterly meetings with Chairs of the **Leagues of Friends** in December. As well as giving them a general update on developments in the Trust, Nicola Strother Smith, as Chair of the Charitable Funds Committee, and Tina Ricketts introduced them to our thinking about a new approach to our Charitable Funds and offered on going dialogue with them to ensure continuing strong partnership and alignment of our efforts.

The Chief Executive and I attended the **January (Health and Care Oversight and Scrutiny Committee (HSCOSC)** meeting. Major items for discussion included Mental Health services being delivered in relation to the Recovery College, Crisis Cafe and other crisis response initiatives. There was also a presentation of the new End of Life Strategy for the County. Both presentations were warmly received.
The **Health and Wellbeing** Board meeting is to take place on 17th January with an independently facilitated development session the following day. I will provide a verbal update at the Board meeting.

4. Working with our Trust Colleagues:
I would like to thank the small planning group of colleagues (Bev Samuels, Katie Parker, Annie McCallum, Mark Lambert and Tina Ricketts) who spent significant time with me planning an appropriate farewell event for a Paul Jennings. Funded entirely by colleagues' donations, the party was a huge success with some moving film footage and an excellent choir.

The NEDs and I continue to undertake our regular **quality visits to services** Feedback from these is provided to the Patient Experience Lead, the service visited, the Director of Nursing, the Chief Operating Officer and the Chair to inform improvement and resolve issues as soon as possible; some issues may be longer term and be used to inform the Board's Strategic Planning. The Executive consider the issues raised each quarter to ensure they are being progressed and used to inform planning.

Quality Visits in Quarter 3 were to:
Wheelchair Service – Nicola Strother Smith
Physiotherapy, North Cotswold Hospital – Sue Mead
Tewkesbury Community Nursing Team – Richard Cryer
Dental Access Centre – Graham Russell
Cirencester Hospital – Robert Graves
Forest Integrated Community Team – Ingrid Barker
Tewkesbury Hospital Minor Injury and Illness Unit – Jan Marriott

We continue to hold our monthly **Non-Executive Director** meetings in clinical venues and combine them with a visit to services, most recently at North Cotswolds Hospital and Gloucester ICT. Other Non-Executive engagement activities have included attending the Volunteer Christmas Parties at Stroud, Cirencester and North Cotswolds Hospitals; the better management of Physio referrals into Stroud ICT session; meeting with the Ambassador for Cultural Change/ Freedom to Speak Up Guardian; judging the Edward Jenner Court (EJC) Festive Bake off and Prize Draw

at EJC and Stroud League of Friends presentation of ultrasound scanner at Stroud Hospital.

I would particularly highlight the new **Time for Tea** and **Meet the Executive** initiatives which were established to increase visibility of Directors and build mutual knowledge and understanding between colleagues and Directors. Five events have taken place at Edward Jenner Court and one at Stroud, all of which were attended by colleagues from a range of services. Feedback from these events will be updated to the Executive and the Board. Subject to positive feedback being received about these events, it is planned that they will continue as part of the Trust's work to develop internal communication and engagement between the Board and colleagues

A number of Board Colleagues and I were delighted to be part of the two very well attended **Admin and Clerical Celebration Days** held at Dowty's. It was a very important opportunity to thank this group of non-clinical collegues for their very valuable contribution and to hear their views. Over the two days almost 200 colleagues attended the event which included the launch of the **Administrative and Clerical Skills Map** – highlighting development and progression opportunities in the Trust. Information from the event is available on the Intranet

5. National Networks:
Several Board members joined me at the **Annual Conference of NHS Providers** held in Birmingham at the end of November. As usual, it provided an excellent opportunity to network, to learn from other providers and to hear from national leaders including the Secretary of State. Outputs from the conference have already been circulated to Board members.

Paul Jennings and I attended the national **NHS Providers meeting of Chairs and Chief Executives** in December. Chris Hopson, Chief Executive of NHS Providers, gave his usual excellent analysis of current policy and delivery issues. Mark Lloyd, Chief Executive of the Local Government Association, who spoke about local government, social care and healthcare working closely together to improve services for the public and ensure they are sustainable, as well as his experiences of the challenges and opportunities offered by STPs. Keith Conradi, Chief Inspector of the Healthcare Safety Investigation Branch – a new independent body which will be operational from 2017, outlined some of his early thinking on priorities to support NHS capability in conducting investigations and learning from serious incidents.

Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: 24 January, 2017
Location: Oxstalls Tennis Centre, Gloucester

Agenda item 9: Chief Executive's Report

Introduction

It is a great privilege to take up the position of Chief Executive at the Trust. I am looking forward to continuing the excellent work of my predecessor Paul Jennings, who has made a valuable and lasting contribution to the culture and identity of the organisation.

I am passionate about the role community services can play within Gloucestershire and beyond it. It is widely acknowledged that community health services are going to be a vital component of successful health and care systems which must innovate to meet the needs of the people we service, and in the face of demographic and financial challenges ahead.

Gloucestershire's Sustainability and Transformation Plan (STP) sets out the agenda we will be working with partners to ensure that Gloucestershire can continue to be confident in the quality and sustainability of its health and care services. There can be no question that high quality, effective community services are more important than ever, and we need to demonstrate the contribution we can make by keeping people independent and cared for in their own homes. Community services are going to be at the forefront of innovations in the NHS over the coming years, and I want to ensure that we play a leading role in the development of services and approaches to care.

In my first weeks I have been focusing on getting to meet as many people as possible. I am using the opportunity to test some assumptions which will frame my priorities in the short, medium and longer term. Those assumptions include:

- The Trust does not require restructuring at this point in time– we can and must focus on delivery of high quality care

- That Listening into Action (LiA) is an important part of the toolkit we will be using to drive improvement and is something we should continue to drive forward

- That, while the Trust has a solid financial position, the overall picture for the county's health and social care economy will require a fundamental change in how we approach delivery of services, and we understand that additional resources cannot be assumed.

- That we are in a position to offer a strong, credible, expert voice on the role that community services can play in supporting system change.

I will be continuing to focus on meeting as many people as I can to building networks and partnerships, ensuring that we continue to play a strong and purposeful role in the development of our system sustainability and transformation planning.

CQC review: Learning, candour and accountability

In December 2016, the Care Quality Commission (CQC) published a review of how NHS Trusts (acute, mental health and community) review and investigate the deaths of patients in England. The CQC set out to understand the picture across England and their approach included public engagement events with families, information requests being made to Trusts about their current death rates and review arrangements, and a cost benefit analysis.

As part of the review, members of the CQC invited a random sample of 12 acute, community and mental health Trusts and our Trust was one of those which actively participated. We have welcomed the CQC review findings and I have assured myself that GCS has good processes in place to that the importance of the involvement of families is integral to our approach .

I would like to take this opportunity to thank all of those colleagues who took the time to be interviewed as part of this review, many of whom put in considerable additional work providing data and evidence of our processes. I look forward to this work contributing to improvements nationally with regards to how patient deaths are reviewed.

Listening into Action (LiA)

Listening into Action (LiA) is continuing to drive innovation and change across the organisation.

An example to showcase this month relates to the Public Health Nursing Team. They are using the LiA approach to support their service redesign putting children and young people, their families and our colleagues at the centre of change. This is a very significant piece of work, with a total of 43 teams each contributing to process of change.

There are a series of Pass it On events planned for February and May 2017. Discussions are also underway around setting of LiA objectives for 2017-18 which reflect our Trust's ambitions.

Annual Planning Round

In the last month and as per the national timetable, the Trust completed its annual returns to NHS Improvement (NHSI) - these included the workforce and finance returns which were submitted on 30 December, as well as the 2017-19 Operational Plan which was submitted on 13 January. We understand that NHSI will be monitoring the Trust against these plans from April 2017 onwards.

Well-Led Framework

NHS Improvement and the Care Quality Commission have jointly launched a consultation into proposals for revisions to both the Use of Resources and Well-Led Assessments. This is set to conclude by 14 February, and I will be ensuring a full response on behalf of the Trust is offered.

Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 24 January 2017

Committee Name:	Trust Board
Agenda Ref:	10/0117
Author:	Candace Plouffe, Chief Operating Officer
Presented By:	Candace Plouffe, Chief Operating Officer
Accountable Exec:	Candace Plouffe, Chief Operating Officer

Subject:	**Chief Operating Officer's Report**
Appendices	Appendix 1: Gloucestershire's Urgent and Emergency Care Resilience Plan 2016-17 Appendix 2: Patient Access Policy

Provided for: ☒ Discussion ☒ Decision ☐ Approval ☒ Assurance ☒ Information ☐ Noting ☐ Statutory Purposes

1. Executive Summary:

The operational services continue to focus on the key priorities identified by the Board to ensure that Gloucestershire Care Services NHS Trust is delivering the vision and strategic objectives set for the organisation.

Of note this month:

- The Teams are continuing to support a robust **urgent care** provision for Gloucestershire, and in particular the focus is on system preparedness and recovery post-Christmas holiday period. The system-wide Gloucestershire Urgent and Emergency Care Resilience Plan 2016/17 is finalised, and recommended for ratification.

- An **Access policy** has been developed for the Trust to ensure the management of patient access to services is transparent, fair, and equitable and managed according to clinical priority.

- Work is continuing following the Gloucestershire County Council Cabinet meeting which proposed changes for both the **Public Health Nursing services and Sexual Health services**. Services are being redesigned to align with the new service model and funding framework agreed.

- Operational Services continue to engage with system partners, ensuring joined up care for the people of Gloucestershire. With primary care work has progressed on the **People and Place model** as part of the STP and the Gloucester city clusters are formed with cluster meetings underway.

- Discussions are progressing with Gloucestershire Hospitals Foundation NHS Trust to agree arrangements to manage challenges related to **radiology provision** and addressing issues that have arisen following their implementation of **Trakcare**, a new electronic patient record system.

Understanding You

- Work is about to begin with iMPOWER, a consultancy firm that has reviewed Adult social care and made recommendations in a number of areas (including the locality referral centres and reablement) to support a demand management system for social care,

- the Trust has been asked to become joint signatory to a Memorandum of Understanding which sets out the agreed approach to supporting the implementation of an integrated approach to the identification and assessment of Carers' health and wellbeing needs.

2. Recommendations:

The Board is asked to:

- **Note** progress in key Operational strategies and programmes of work
- **Approve** the Gloucestershire's Urgent and Emergency Care Resilience Plan 2016-17
- **Approve** the Trust Access Policy
- **Endorse** the *Integrated approach to identifying and assessing Carer health and wellbeing* Carers Memorandum of Understanding

3. Main Report

Delivery of High Quality Services

Supporting Urgent Care provision over the winter

The system wide Gloucestershire's Urgent and Emergency Care Resilience Plan 2016-17 is now finalised and included in Appendix 1 for information. Previous draft versions have been reviewed by the Quality and Performance Board Subcommittee, which has also overseen the Trust's actions during periods of escalation.

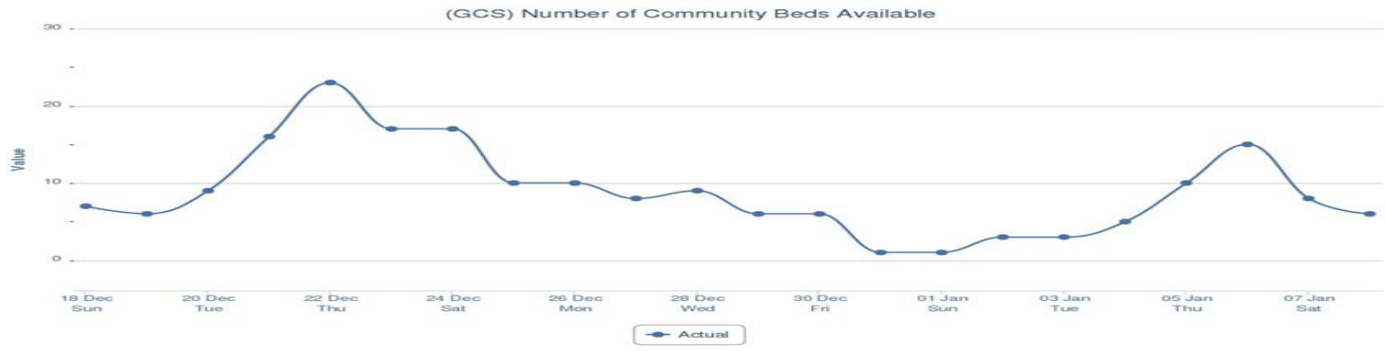
Robust planning was in place throughout the Christmas and New Year period with system partners, with an emphasis on

- Robust demand and capacity planning
- Assurance around adequate workforce available
- Understanding of any challenges for the system and priorities for each individual organisation
- Monitoring systems for demand spikes
- Confirmation of robust On call system and proactive communication between system partners, particularly when mitigating plans need to be enacted

The system coped well over the Christmas and New Year period, with peak demand occurring on the Monday, 2nd January, particularly for NHS111. Initial feedback has suggested that this was in part due to lack of appreciation that it was a bank holiday rather than a normal working day.

The overall 4 hour Performance in our Accident and Emergency departments is summarised in the table below.

The availability of community hospital beds is recognised as one element that has a direct impact on patient flow, with particular pressure experienced in the first week in January. Work to implement escalation actions have been enacted and remain a priority.



The Rapid response and the integrated admission avoidance team based at the front door of Accident and Emergency departments have been busy over both the holiday period and into the New Year. They have had a key role in identifying and redirecting appropriate patients to alternative pathways of care outside of the hospital. The Trust has secured additional investment to increase the Rapid response team capacity to support the “front door” and has been successful with recruiting additional practitioners who will join the Trust in February. As per plan, there are no Community Hospital escalation beds open.

Of note, there is evidence of rising levels of influenza in the County. This is impacting on patient flow and workforce availability and actions are being taken to mitigate risks of spread, including additional flu vaccine clinics being held by the PACE directorate and maintaining stringent infection control procedures.

To support patient flow, Trust colleagues participated in “Breaking the Cycle together” events in December and January with colleagues from Gloucestershire Hospitals NHS Foundation Trust. These sessions have focussed on utilising and embedding the “Red-Green “visual management system for patient flow. The philosophy underpinning the approach is that a non-value day adds to a poor patient experience, delays the patients’ progress in recovery and creates an unnecessary longer length of stay. A Red day signals a day when a patient is waiting for an action to progress their care. The aim of the events are to understand the organisational and system barriers in supporting patient flow, reducing the number of medically fit for discharge patients in the district hospitals and decreasing the number of escalation beds open in the acute setting.

A workshop is also planned for the 27th January to review the system performance. It will provide an opportunity to sense check the wider winter planning process, discuss what went well over the Christmas and New Year period, what could have been improved and the organisational/ system learning that we can draw on.

Service Reviews and Redesign update

Patient Access Policy

As part of the development of the Quality Implementation plan following the CQC inspection in June 2015, it was agreed that the Trust should develop ann access policy. The overall intent of the policy is to provide a clear, reliable and transparent standard for patient access, including provision for patient choice, waiting list management, booking and notice requirements.
There are two main principles that underpin the policy

- Ensuring that the management of patient access to services is transparent, fair, and equitable and managed according to clinical priority.
- Ensuring that the administrative processes enable patients to book their own appointments and treatment in a way which is simple and efficient.

By applying this structured and systematic approach, Gloucestershire Care Services NHS Trust will ensure that patients receive a high quality service and increase the likelihood of their choosing Gloucestershire Care Services NHS Trust for their treatment.

Of particular note the policy provides a framework to help all services manage clinical prioritisation, and offers a standard approach to patient referral and managing patients who either do not attend a planned appointment (DNA) or cancel appointments. .

The policy recognises the different routes of access to services, and the multiple referral methods that are used. It also provides safeguards to identify patients considered vulnerable, ensuring they are supported to attend their appointment and that there is a proactive approach taken where non-attendance occurs.

The Trust Board is asked to **approve** the Access Policy.

Public Health Services

The Trust has been working in collaboration with Public Health Commissioners to co-design new models of service for Public Health Nursing and Sexual Health services. The impetus for the service redesign is to ensure the ongoing provision of a service within the reduced financial envelope following the Comprehensive Spending review. Specifically, for Public Health nursing, the reduction in available funding from 2019/20 onwards (following implementation of the remodelled service) will be £1.387 million which equates to 18% of the current budget. For Sexual services, the County Council Medium Financial Strategy for 17/18 is planning a reduction of £570,000 in the overall sexual health budget (of which £300k will relate to GCS services).

On the 14th December 2016 Gloucestershire County council cabinet received and approved two new service models developed in collaboration with Gloucestershire Care Services NHS Trust.

The links to the Cabinet papers, impact assessments and decisions are provided below:

Public Health Nursing:
http://glostext.gloucestershire.gov.uk/ieDecisionDetails.aspx?ID=905

Sexual Health Services:
http://glostext.gloucestershire.gov.uk/ieDecisionDetails.aspx?ID=904

The Service leads have been actively engaging with colleagues on a design to delivery transformation plan, and as part of this are refreshing the current workforce model to take into account a richer skill mix, and the emerging GP clusters.

It is important to note the requirement of the Public Health Director to undertake consultation and engagement with children and families and other stakeholders to inform the development of the preferred Public health nursing model following the national review of mandated elements.
The service is working with Commissioners around the implementation plan for the new model and agreement on how to deliver the workforce changes in a manageable way, within the reduced funding envelope

Medical Cover for Community Hospitals

On the 19th December, the Trust began the re-procurement process for medical cover in the 7 Community Hospitals. There is procurement and implementation timetable of 17 weeks, with the start of the new contract planned for 1st April 2017.

The tender timeframe allows for an overlap between current and new providers, to support a safe handover of this vital service.

Healthy Lifestyle Service:

The transition of the Healthy Lifestyle service is completed with the new provider, Ice Creates Limited now providing a broad range of Health promotion and prevention services from the 1st January 2017.

As per the Board agreement, the TUPE challenge was resolved, and the consultation was completed with colleagues from the Healthy Lifestyle service. Out of the team of 12, 9 colleagues are undertaking a trial period in an alternative role, 3 resigned and 2 colleagues were made redundant

The Trust has been invited to participate in a “co-creation” workshop in February which will outline the new service model, and how services can work together to engage and encourage people to access the service and to develop the pathways into the service and out to the wider health and wellbeing services in the county.

Engaging with System Partners

Primary Care Engagement and Progression of People and Place Model

GP cluster groups are now confirmed with all practices aligned to one of the 16 clusters.

There continue to be regular cluster board meetings in Stroud and Berkeley Vale GP with defined programmes of work being progressed, with GCS fully involved in as appropriate.

The establishment of the Gloucester city clusters has been progressed, and all 5 clusters have now met and an overarching cluster board established. As the population profile of the patients in Gloucester city are much more diverse, there have been a wider number of our Trust services involved, including the countywide services and our children and young people services.

Although the STP plan was to establish the people and placed based approach in one rural locality (Stroud and Berkeley Vale) and one urban locality (Gloucester city) by the end of the year, there now needs to be a clear plan on how to progress the remaining locality clusters to use the same approach.

As the clusters are expanding their thinking on how to include other services into the service redesign work they are focussing on, all Operational services are detailing how they will support the cluster work and reconfigure their teams as appropriate.

Realignment of the Integrated Community Teams

As noted at the November Trust board there is an intention to realign our existing 21 Integrated Community teams around the 16 GP clusters. Phase 1 of this work is underway, with the realignment of the management structure to be completed and implemented by the 1st April 2017. Phase 2, the realignment of frontline clinical teams will begin shortly and will give an opportunity for the Trust to review the current skill mix and roles within the teams. Discussions are continuing with our Social care colleagues to ensure there continues to be integrated care provided by the teams and that the pathways are efficient and clear as possible

Managing Demand: Collaborative Working with Gloucestershire County Council

Gloucestershire County Council has secured the services of iMPOWER consultancy firm to review the social care pathways. This is intended to provide greater insight an understanding on demand on Adult social care.

This review was completed in December and the findings presented to partners, with recommendations made to develop a demand management model for Adult Social Care.

As the Trust continues to operationally manage a number of social care functions as part of the Integrated Community teams we will be involved in the ongoing work to implement the recommendations made. The intention is to focus on the following three areas:

- The “front door” both at Referral Centre and Contact Centre (and also prefront door).
- Learning Disability service
- Hospital discharge and reablement

iMPOWER will continue to work with the Council until the end of February 2017, and assist with defining the change programme required in each area to support the implementation of a robust demand management system.

Partnership working with Gloucestershire Hospitals Foundation NHS Trust

TrakCare

The Teams have been working to mitigate the risks associated with the implementation of TrakCare, the new electronic patient management system implemented by GHFT, and the impact on community services

A working group has been established to understand and oversee the changes to the care pathways to support the ongoing provision of seamless care. Regular meetings have also occurred with the project team from GHNHSFT. With go-live there have been a number of challenges identified by the operational and performance teams, which primarily relate to the ability to access and/or record on the new system, as well as receiving the agreed data transfers between the two organisations. These have been formally escalated to GHNHSFT and a meeting has occurred to share the impact of the new system on the delivery of Community services and to agree an action plan to address the issues detailed

The Board should note that there are a number of services, for example the Community Bone Health services, where the implementation of TrakCare is expected to have been significantly impacted and will become evident in future performance and quality reports.

Challenges with Radiology

On the 22nd December the medical Director was informed by Gloucestershire Hospitals Foundation NHS Trust that there would be a need to implement some temporary changes to the current provision of radiology services within the County from the 3rd January 2017. The reason for the temporary changes is due to a combination of a high number of radiographic vacancies, alongside some unexpected long term sickness, which subsequently impacted on the ability to provide a safe service. as a result of short term staffing issues.

To changes proposed as they impact on our community hospital services include:

- Temporary closure of Lydney X-ray with an additional Saturday morning clinical to provide additional capacity
- Reduced staffing in Cirencester for 3 days per week to one Radiographer
- Reduced staffing in Stroud Hospital for 2 days per week to one Radiographer

To accommodate these changes we have realigned outpatient clinics between the Lydney and Dilke hospital sites, with those services dependent on radiology temporarily moving to the Dilke, and those clinics not requiring this diagnostic service moving to Lydney.

We have sought assurance that the changes are temporarily and will be reversed as staffing issues are addressed.

It is noted that there has been ongoing discussion with the Lydney League of Friends confirming the , continued commitment to radiology provision. The temporary changes provide an opportunity to expedite the improvement work required to install the new equipment, which will be completed over the next 8-12 weeks.

Carers Rights Day

The third Carer's Rights Day was held on November 25th organised by the Gloucestershire Carers Alliance.

The session was very informative, and focused on reviewing the on the NHS England document "*An Integrated approach to identifying and assessing Carer health and wellbeing*"

The link to this document is as follows:
https://www.england.nhs.uk/wp-content/uploads/2016/05/identifying-assessing-carer-hlth-wellbeing.pdf

The aspiration is for all health and social care partners (commissioners and providers) to sign the Memorandum of Understanding (MOU) as detailed in the document and will be forwarded to the Health and Well Being Board.

The MOU sets out the agreed approach to supporting the implementation of an integrated approach to the identification and assessment of Carers' health and wellbeing needs. This is done by listing 7 Principles for organisations to commit to.

The 7 Principles include

i. Supporting the identification, recognition and registration of Carers in primary care.
ii. Carers will have their support needs assessed and will receive an integrated package of support in order to maintain and/or improve their physical and mental health.
iii. Carers will be empowered to make choices about their caring role and access appropriate services and support for them and the person they look after.
iv. The staff of partners to this agreement will be aware of the needs of Carers and of their value to our communities.
v. Carers will be supported by information sharing between health, social care, Carer support organisations and other partners to this agreement.
vi. Carers will be respected and listened to as expert care partners, and will be actively involved in care planning, shared decision- making and reviewing services.
vii. The support needs of Carers who are more vulnerable or at key transition points will be identified early.

The Board is asked to confirm its support for the MOU.

4. Which Trust strategic objective(s) does this paper link to?	
Achieve the best possible outcomes for our service users through high quality care	☒
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	☒
Actively engage with health and social care partners as well as local communities, in order to deliver seamless services	☒
Value colleagues and support them to develop the skills, confidence and ambition to deliver our vision	☒
Manage public resources wisely to ensure local services remain sustainable and accessible	☒

5. Explanation of acronyms used:

MOU – Memorandum of Understanding
TUPE - Transfer of Undertakings (protection of Employment) Regulations 1981
GHNHSFT – Gloucestershire Hospitals NHS Foundation Trust

NHS
Gloucestershire
Clinical Commissioning Group

FINAL: 14/12/16

VERSION 0.6

Gloucestershire Urgent and Emergency Care Resilience Plan 2016/17

Prepared by Gloucestershire Clinical Commissioning Group
in partnership with:

2gether NHS Foundation Trust (2G)
Arriva Transport Solutions Ltd (non-emergency PTS provider)
Care UK (NHS 111 provider)
Gloucestershire Care Services NHS Trust (GCS)
Gloucestershire County Council (GCC)
Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)
Healthwatch Gloucestershire
Primary care and membership practices
South Western Ambulance Service NHS Foundation Trust (SWASFT)

Joined up care
CCG

MINDFUL EMPLOYER

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1. Executive Summary

1.1. Developing the resilience plan

Gloucestershire's Urgent and Emergency Care Resilience Plan 2016/17 has been developed in collaboration with key stakeholders across the county. One of the reasons for having the plan, is to help improve the outcomes for health and social care in Gloucestershire and to enhance patient experiences.

Input has been received from Social Care, NHS Acute, Primary, Community and Mental Health Care Providers and Private Sector Providers, all of whom have contributed to improved performance and resilience. The Plan has been in development since early 2016 and incorporates:

- Gloucestershire Four Hour Improvement Plan.
- Resilience Funds Investment Programme.
- NHS England and NHS Improvement "A&E Improvement in 2016/17: Rapid Implementation Guidance for Local Systems".
- QIPP Programme.
- Escalation Framework.

Individual provider organisational winter plans have been incorporated within the 2016/17 Gloucestershire Urgent and Emergency Care Resilience Plan. Each of the key providers and service functions have submitted a return to GCCG outlining key areas of focus including demand and capacity plans, continuity plans, flu preparedness and adverse weather protocols - see section 7.

1.2. Learning from 15/16

To support and inform the approach for 2016/17, a series of actions have been identified as a result of the learning from winter 2015/16. The key learning points are summarised below and have been incorporated within this plan:

- Revised escalation measures and weighting which will ensure the system declares appropriate levels in accordance with system pressure.
- Review of actions taken during periods of escalation and improved processes to provide assurance that actions enacted are having a positive impact upon the system.
- The need to ensure appropriate de-escalation has occurred during the summer months in order that escalation resources are available during the winter months.
- The need for a relentless focus upon patient flow including minimising delays in discharge for medically stable patients in acute and community settings.
- A need to continue working as a whole system that holds each other to account using constructive challenge.
- Improved demand and capacity modelling including all key Health and Social Care providers, ensuring "beds" are not the predominant measure of capacity.
- The importance of producing clear and concise public information to help ensure successful communication.

1.3. Whole System Planning & Workshop Events

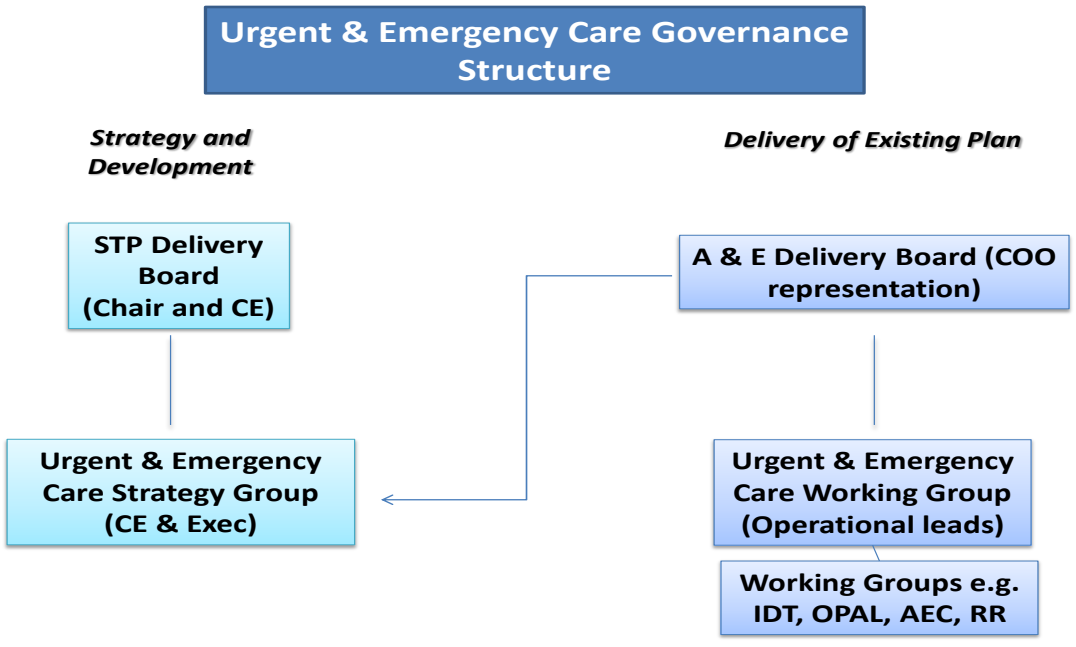
The winter planning and events timetable for GCCG and system partners is shown below:

Timetable for whole system planning & workshop events for winter 2016/17	
Date	Action
9th September 2016	Deadline for providers to submit 2016 /17 Winter Plans & Demand and Capacity modelling
28th September 2016	South Central Winter Escalation Workshop
11th October 2016	Final Winter Plan and System Escalation Plans - presented to A&E Delivery Board for approval
w/c 24th October 2016	Christmas and New Year Assurance templates to be sent to providers
14th November 2016	Gloucestershire Whole System Resilience & Escalation Workshop – all key organisations involved
25th November 2016	CCG/Provider event to review Christmas and New Year Assurance
14th December 2016	Final Provider submissions of Christmas and New Year Assurance plans

2. Governance: How the resilience plan will be monitored and implemented

Governance systems for leading, monitoring and delivering the required system transformation have been reviewed as part of this process. The revised governance approach is illustrated in figure 1 below.

Figure 1. Governance system for resilience in Gloucestershire



The purpose of the various groups is to promote quality in terms of patient experience and safety. Lay representatives attend some of these groups where patient experience and feedback is received and discussed.

2.1. Gloucestershire A&E Delivery Board

Purpose

The purpose of the Gloucestershire A&E Delivery Board (A&EDB) is to:

- Lead A&E recovery.
- Hold all parts of the system to account for delivery.
- Monitor delivery of and ensure consistent performance against agreed performance standards.
- Enable our system to make appropriate arrangements for delivering high quality resilient services.
- Develop information systems and processes that allow the A&EDB to monitor system delivery and make evidence-based decisions.

Role and Remit

The A&EDB is the forum where all partners across the Gloucestershire Health and Social Care community come together to plan for and monitor system resilience. The Group plans for the capacity required to ensure resilient services and holds each other to account for delivery.

Responsibilities

The A&EDB rigorously and continually reviews the drivers of system pressures, so that solutions to these pressures are developed within a system wide approach. Whilst decisions on some aspects of funding need to be made by the relevant statutory body or through shared governance arrangements, the A&EDB has a key role in building consensus across members and stakeholders.

Members of the A&EDB seek to hold each other to account for delivery, with member organisations sharing intelligence and pooling resources where possible, to improve system delivery against agreed key performance indicators. These arrangements do not supersede accountabilities between organisations and with their respective regulators.

2.2. Sustainability and Transformation Plan (STP) Delivery Board

Purpose

The Board brings together executive representatives from Health and Social Care organisations that are included within the Gloucestershire STP Footprint. The role of the Delivery Board is to oversee the progress of the STP and to drive consensus on change to be delivered and make recommendations to decision-makers. The Delivery Board is chaired by an appointed independent chair.

The primary objective of the Board is to ensure Chief Officer ownership, and take responsibility for addressing system issues and aligning resources to successfully deliver Gloucestershire's STP.

2.3. Gloucestershire Urgent and Emergency Care Strategy Group

Purpose

The Urgent and Emergency Care Strategy Group is comprised of Directors/CEOs (Managerial and Clinical representation) from all Health and Social Care providers. It provides strategic oversight for the delivery of robust and high quality Urgent and Emergency Care services within Gloucestershire and develops plans for those that have been defined nationally via the Urgent and Emergency Care review "Transforming urgent and emergency care services in England".

This Group also ensures alignment with the Severn Urgent Care Network and focusses upon the key elements contained within the Urgent Care Route map.

2.4. Gloucestershire Urgent and Emergency Care Working Group

Purpose

The Gloucestershire Urgent and Emergency Care Working Group supports the delivery of the Urgent Care Vision which is "Firstly, for those people with non-life threatening needs to provide highly responsive, effective and personalised services outside of hospital. These services should deliver care in or as close to peoples' homes as possible. Secondly, for those people with more serious or life threatening emergency needs, we should ensure that they are treated in centres with the very best expertise and facilities in order to reduce risk and maximise chance of survival and good recovery."

Objectives and Responsibilities

- Assure the A&EDB that the commissioned services have sufficient capacity and capability in place to deliver urgent care that is of high quality and is fit for purpose.
- Maintain an oversight of activity, performance and patient flow of all urgent care services commissioned by GCCG and identify bottlenecks, 'pinch-points', negative impacts, and subsequent opportunity for improvement.
- Identify opportunities to further manage demand and capacity within the urgent care system.
- Oversee the delivery of the 4-hour Improvement Plan, highlighting areas of concern to the A&EDB.
- Facilitate communication across all major providers and respond to any escalation of issues in relation to Urgent Care.
- To have overall responsibility for ensuring delivery of the Urgent Care Quality, Innovation, Productivity and Prevention (QIPP) schemes and Urgent Care resilience.
- To measure and monitor the efficacy of any service developments or changes, activity and performance/delivery against local and/or national targets. Ensure that outcome measures are articulated and measured.
- Ensure that best practice processes and exemplar models of care are adopted across the Urgent Care system.
- Streamline Urgent Care processes and support the development of integrated pathways.

- To consider the impact of service change proposals on the Urgent Care system, and provide resolutions to any identified adverse effects.
- To consider and resolve any service delivery issues such as provider workforce availability.
- To commission Task & Finish Groups as required in order to support achievement of the overall Urgent Care strategy and 4-hour recovery plan.
- To oversee the review of protocols, pathways and policies that impact upon Urgent Care service delivery and disseminate information to relevant groups.

2.5. Planned Care Programme Board

The Urgent and Emergency Care Resilience Plan sits alongside resilience planning for planned care services.

The Planned Care Programme Board meets monthly and reviews progress against delivery milestones for overall resilience milestones and key planned care priorities.

The Group includes key managers involved in Planned Care delivery alongside clinical representatives. The group has three key priorities:

- Monitoring delivery in detail against constituent schemes and national performance standards.
- Taking corrective action where schemes are behind on delivery.
- Deciding on whether to continue or change schemes if they are found to be unsuccessful or not feasible.

2.6. Daily whole system escalation call and escalation framework

A whole system call (frequency and membership dictated by declared escalation levels) is held between the key Health and Social Care organisations, chaired by GCCG. The format of the call is to review the previous day's performance based on data uploaded into a 'kitbag' of key system wide measures. Each organisation then provides an operational update for the current day and identifies where pressure is being experienced. Focused and proportionate actions and timescales are agreed and follow up calls are completed as required. During periods of escalation this daily call will also ensure that escalation actions are being implemented in line with the agreed Escalation Framework.

2.7. Bank Holiday Planning and Provider Assurance

In advance of bank holidays and any extended holidays identified as 'high risk' to the urgent care system, a prior planning process is implemented. Individual organisational assurance returns are completed using the assurance templates embedded below – the reduced template is used at generic, shorter bank holidays, i.e. early May & end May; the full template for longer periods, i.e. Easter and Christmas. The organisational returns are Red, Amber or Green (RAG) rated against a range of prescriptive criteria specific to each organisation.

A narrative outlining the level of risk and the mitigating actions to be enacted are also included in the organisational returns as well as demand & capacity profiling. For the longer bank holiday periods, this feeds into a system wide assurance document that is submitted to NHS England, stating the level of risk that has been identified (using the RAG rating system) as per templates below.

Assurance is determined through the organisational returns which include both the bank holiday position; extended holiday position and period shortly thereafter as appropriate. This offers support to the system to ensure anticipated 'spikes' in activity are managed effectively (see Appendix 1 for provider assurance templates).

3. Summary of A&E 4hr Improvement Plan

The Gloucestershire Urgent and Emergency Care System has developed an Improvement Plan in response to a need to secure performance, including a reduction in emergency admissions and delivery of the 4 Hour Emergency Department Standard. The plan is based upon five key areas of focus and involves all system partners. The five key areas of focus (the High Impact Actions) are made up of a cross-section of schemes with varying timescales to aid improvement, ensure the system meets the 4 hour performance target trajectory (as agreed by the A&EBD), and subsequently return the system to reaching 95%. The plan is not limited to the actions that are being taken across providers but consolidates the significant actions and efforts that are being taken to ensure that the people of Gloucestershire are provided with high performing services.

3.1. HIA.1 – Emergency Department Pathways

The national strategic aim is to ensure that those people with the most serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and good recovery.

The A&EDB will continue to develop and monitor the pathways within the Emergency Department (ED) and across the 'front door' of the acute hospitals.

The schemes are:

- **ED staffing**
  - Modelling the demand and capacity for the Emergency Department (ED) staffing using best practice guidance from NHS England & developing a recruitment plan in response to findings.
- **Streamlining Urgent Care**
  - Improving the flow through minors within the ED to ensure that patients entering the minors flow pathway receive optimum and timely care within four hours of arrival.
  - The Primary Care in ED scheme is to divert cases daily from ED supported by the clinical navigator role.
  - Ensuring an integrated review process is in place to improve "on the day" admissions and feedback to Primary Care with development of future pathways.
  - Redesigning pathways for General Practioner (GP) referred patients.
  - Rapid Response (RR) referrals are now reaching the target of 60 a week and the pilot with care homes has started well. A communication strategy to encourage Primary Care to step up the unwell patient to RR when appropriate continues.
  - The Integrated Discharge Team (IDT) review has recommended that the

interim arrangement in place for RR to manage the front door of IDT should be made permanent. The feasibility of continuing the Out of Hours (OOH) clinical advice line for RR clinicians, currently funded through the Prime Minister's Challenge Fund (PMCF), is currently being scoped.

- **Ambulatory Emergency Care (AEC)**
  - Developing AEC pathways to support ED attendance/admission avoidance, chest pain, respiratory Chronic Obstructive Pulmonary Disease (COPD) and abdominal pain.
  - Increasing streaming of GP and South West Ambulance Service Foundation Trust (SWASFT) referrals direct to AEC.
  - Ensuring availability of AEC is maximised to support periods of heightened demand.
- **Older Person's Assessment and Liaison Service (OPAL)**
  - To review, treat and discharge patients from ED and Acute Care Unit - A (ACU-A).
  - Streaming GP and ED referrals direct to assessment areas for frail/elderly patients.
  - Increasing availability of alternative services to support the prevention of avoidable admissions in frail/elderly patients.

3.2. HIA.2 – Acute Hospital Admission Avoidance

The national strategic aim is to help people get the right advice in the right place, first time in addition to the right response.

The A&EDB will focus on reducing demand and preventing unnecessary acute attendances and emergency admissions.

The schemes are:

- **GP in ED**
  - Providing GP care within ED (both front and back door) to reduce unnecessary admissions to hospital.
- **Surge management:**
  - Analysing the arrival patterns of ambulances and responding in accordance to findings.
  - Reducing the impact of peaks in GP arrivals through ED by encouraging a spread in home visit times and commencing home visits earlier in the day than traditionally occurs.
- **NHS111 – Making the "smart call"**
  - Reducing and maintaining the number of ambulance dispositions from NHS111 to 10%.
- **Mental Health Crisis & Liaison**
  - Psychiatric Liaison Service and Mental Health Acute Response Service will help improve the quality of patient care / reduce the number of inappropriate admissions and increase the speed of patient assessment.
- **SWASFT Right Care 2**
  - Reducing the number of ambulance arrivals to GHNHSFT ED by ten with

seven of those being before 18:00hrs. During January, shift patterns are being adjusted to meet demand patterns and aligned to the investment in double crew ambulances in November.

- **Joining Up Your Information**
  - Ensuring that electronic care plans are shared where appropriate to ensure coordination of care and inform clinical decision making.
- **Positive Risk Taking**
  - To have system awareness of positive risk taking.
  - Supporting staff in making decisions with positive risks.
- **Paediatric Admission Pathway**
  - To review the pathway for paediatric admissions.
- **Single Point of Clinical Access (SPCA)**
  - Promoting increased focus within SPCA on admission avoidance to reduce emergency admissions referred via the SPCA and increase utilisation of admission avoidance schemes. Progression of the QIPP milestones and SPCA development is being reviewed at joint GCS and GCC monthly meetings and progress/actions are recorded within a Milestone Tracker. Weekly Key Point Indicators (KPIs) are recorded and shared with the CCG. A six monthly review of this service is due which will identify improvements and/or areas for development.
- **Intravenous (IV) Therapy**
  - Providing a robust 24/7 community IV Therapy Service across Rapid Response/District Nurse and IV teams.

3.3. HIA.3 – Reduction in LOS >14 days

The national strategic aim is to ensure that patient care across the Health and Social Care system is connected and seamless.

The A&EDB will focus on the collaboration between system partners to effectively deliver a timely and coordinated approach to patient flow and discharge ensuring a reduction of patients who remain in the acute trust when medically stable and with a LOS greater than 6 days.

The schemes are:

- **Integrated Discharge Team and Rapid Response (front door)**
  - Providing an integrated admission avoidance team at the front door.
- **SAFER**
  - All patients will have senior medical review by 12 noon.
  - All patients will have an Estimated Date of Discharge (EDD) set within 24hrs of admission and will be aware of their EDD and will be discharged on their EDD.
  - Swift and timely flow from assessment units on bed allocation.
  - Early & weekend discharges achieved through increased use of discharge lounge and maximised discharge planning earlier in the day.
  - Regular review of patients with a length of stay (LOS) of greater than 14 days, moving to 10 and then 6 days, with a clear management plan in place.
  - Trust wide Red to green days with multi-organisational involvement.

- **Discharge to Assess**
  - A home-based pathway aims to align and streamline access to home care services to enhance the quality of life and improve outcomes in the home for patients.
  - A bed-based pathway aims to reduce utilisation of acute trust beds and will be achieved by a reduction in LOS.
- **Case Management**
  - Development of a robust case management service will ensure proactive management for patients with long term conditions, aiming to reduce admissions to hospital or for those requiring admission, a reduction in LOS.
- **Stroke Rehabilitation Pathway**
  - Development of a fast track stroke rehabilitation pathway will facilitate early discharge from acute hospital and overall LOS for individual stroke patients. This will be implemented post winter.
- **Voluntary Care Sector – Out of Hospital Service**
  - Procurement of The Out of Hospital Service provides a fully integrated community and voluntary sector response to discharge.

3.4. HIA.4 – Integrated Urgent Primary & Community Care

The national strategic aim is to deliver highly responsive urgent care services outside of hospital so people no longer choose to queue in ED.

The A&EDB will define and develop an agreed approach to delivering integrated urgent primary and community care.

The schemes are:

- **Integrated Primary and Urgent Care service**
  - Procurement of an Integrated Primary and Urgent Care Service will reduce ED attendances by ensuring localities are served by a fully integrated service. This will be implemented post winter.

3.5. HIA.5 – Improved Self-Care

The national strategic aim is to provide better support for people to self-care effectively.

The A&EDB will utilise a comprehensive and robust programme of case reviews to improve patient wellbeing and prevent hospital attendance and emergency admission.

The schemes are:

- **Case reviews**
  - Commissioning of a robust programme of case reviews via Clinical Programmes Team, GP Panel Review and Urgent Care Clinical Governance Group.
  - Provide a focussed and coordinated approach to the management of high intensity users.
  - Ensuring clear lines of communication within system escalation by reviewing and developing The Gloucestershire Escalation Framework & Plan as well as promoting System Improvement Days within the Health and Social Care Community.

4. Urgent and Emergency Care Summit: 20 October 2016

Providers and commissioners of Gloucestershire met at the Urgent and Emergency Care Summit on 20 October to agree a system wide approach to rebalance the system and achieve a level bed occupancy, which is commensurate with good patient care. Focus was also put on the high impact actions and obtaining commitment from all system partners to respond proactively to the increasing pressures across the system.

Specific areas of development

System wide

- Escalation Process: The system will further develop the current escalation process with a focus on early recovery from operational teams.
- Data Quality: All organisations will be dedicated to sharing accurate and up-to-date data which will help create transparency and awareness in the system, enabling an effective and reactive response to pressure.
- Demand and Capacity: Building on the winter demand and capacity modelling carried out by the system, work will be carried out with organisations to further scope and 'right size' each part of the system.

GHFT Bed and Flow

- There will be an immediate review of the schemes in place that support admission avoidance and A&E attendance reduction, with resources being diverted to more effective solutions if delivery cannot be demonstrated.
- Reflecting the agreed 'Onward Care Policy', the professional standards for each pathway are to be developed, monitored and made visible to all system partners in order to help staff make the most appropriate pathway decisions.
- The new discharge 'route map' (cited below) and professional standards for each pathway will be used to recalibrate the system during November, ensuring that patients within the services are on the most appropriate pathway.

Discharges

- Work will now be advanced around 'route mapping' discharges, with a greater emphasis on home based solutions for patients. This will form part of the new guidance which will be given to all key staffing groups involved in the discharge planning process.
- The current Integrated Discharge Team model will be reviewed to enable more efficient working; the individual 'front' and 'back' door teams will remain.
- To help reduce discharge delays, there is now a commitment to members of the hospital social work team and GCS to join key board rounds, initially targeting the General and Old Age Medicine (GOAM) wards. All Care co-ordinators will also be introduced at each acute site to help improve communication within the system.

Community Capacity and Flow

- All Community Hospital referrals will now to be assessed for appropriateness on a daily basis, with more suitable alternative community based pathways to be highlighted where appropriate.
- Following the Home First pilot, the community 'pull model' (which focuses on patients getting home faster) will now be rolled out.

- A rapid response pilot is to be formally evaluated and developed regarding using rapid response in nursing homes to ensure conveyance to hospital is avoided when clinically appropriate and ensure Rapid Response become actively involved in the ongoing care where required.

5. Agreed resilience focus for 2016/17

Following decisions made at System Resilience Group (SRG) (now A&EDB), four priority areas were identified for 2016/17:

1. Staffing and Rotas
2. GHFT Bed and Flow
3. Community Capacity and flow
4. Weekend Discharges

5.1. Staffing and rotas

There is recognition that there are two main issues around ED and ED rotas that have been evidenced by Intensive Support Team (IST) reviews, Newton diagnostics and in-person studies carried out in ED. Firstly, there are insufficient staff to consistently cover the late/night periods when demand is high and breaches occur and secondly, when recruited fully, rotas need to be redesigned to reflect demand. Key agreed actions which are being implemented to address this are outlined in the table below:

Name of Scheme	Description
ED Rotas	Recruitment of additional Consultants and middle grades will ensure senior presence until midnight consistently at Gloucestershire Royal Hospital (GRH) 7 days per week. (Previously this was variable and only to 6pm alternate weekends). This is highlighted in 'what good looks like' which identified senior cover later at night as a key factor in delivering improved flow through the ED. Due to the increase in attendances over the last 18 months staffing levels have needed to be assessed. Staffing at weekends will be less than levels during the week.
	Recruitment of additional 4.6 Emergency Nurse Practitioners (ENPs) to ensure 24/7 ENP cover in the EDs was unsuccessful. Evaluation of the resilience scheme investments has been undertaken. Alternative staffing will be sought.
Patient Transport Service Vehicle for Health Care Professional (HCP) referral to ED	This scheme has introduced a dedicated vehicle for HCP admissions to GHNHSFT coordinated by the Single Point of Clinical Access (SPCA) to ensure GP admissions arrive earlier in the day to increase chance of admission avoidance, where clinically appropriate. This scheme was initially provided by SWASFT, which was unsuccessful. Following review, it was agreed to trial it with Arriva, commencing September 2016, for a period of 6 months, followed by a further review of effectiveness.

5.2. Acute Capacity

Bed modelling has been undertaken which shows that, without a significant reduction in length of stay and improved flow (leading to a reduction in bed occupancy), a bed deficit will continue at GHFT (see section 8). Work has also been undertaken to model the capacity required at times of peak demand and winter pressures to ensure an effective capacity solution is in place. Actions in place to mitigate this risk are identified as follows:

Name of Scheme	Description
Patient Flow and Escalation Process	There is a recognised pressure on acute bed capacity particularly on the GRH site where a lack of capacity has resulted in recurrent use of day case and discharge lounge areas as inpatient facilities during escalation. The identified resilience resource is used to fund additional capacity to support flow during surges (e.g. additional nursing home beds and community beds).
Discharge to Assess	Achieving timely discharge requires a constant focus upon maintaining flow through the Urgent and Emergency Care system. Our 'Discharge to Assess' model focusses on ensuring that patients are assessed either at home, or in a temporary place of residence, so that they can be assessed outside hospital and gives a clearer indication of their longer-term independence. This has been shown in many areas to reduce length of stay, increase independence and reduce spending on packages of care. An agreed set of new pathways has been implemented to form the 2016/17 'winter' offer. During 2016 good progress has been made on the bed- based pathway, supported by Care Home Select and additional therapy and social work investment. Work on Pathway 1 (home-based) is also being progressed as a priority.
Integrated Discharge Team (IDT)	The IDT team has two functions; firstly, to provide an admissions prevention service to the acute hospital (Admission Prevention Team), and secondly, to support wards with patients who have complex discharge arrangements (Discharge Mini Teams). The IDT team has been reviewed by an independent consultancy. The review will conclude in time for the October IDT Board and subsequently the A&EDB and will include key areas of focus for winter 16/17. The front door IDT team has combined with Rapid Response to support admission avoidance, the early indicators illustrate this is having a positive impact.

5.3. Community Capacity

Following a detailed review of patient pathways and flow, a key area identified as a priority was in relation to community capacity. There was strong feeling that by focussing on reablement and domiciliary care, capacity could be freed up in community beds to support flow from GHNHSFT. Two key areas of focus that are being implemented are below:

Name of Scheme	Description
Reablement Capacity & Efficiency	This scheme aims to increase the efficiency and capacity of reablement across Gloucestershire.
Domiciliary Care Capacity	Funding for additional domiciliary care.

5.4. Weekend Discharges

It was identified that there is a need to focus on increasing discharges from hospital beds at the weekend and therefore improve performance during the weekend and into the beginning of the following week. Key actions implemented to address this are:

Name of Scheme	Description
Develop investment plan to improve discharges at weekends	Funding has been allocated to support an increase in weekend discharges. This includes increased access to senior decision makers at weekends and access to ward clerks to support and facilitate discharges. There is evidence (through Alamac) that the level of acute discharges has increased from the 2015 levels.
Integrated Discharge Team	See section 5.2 above. Impact across the weekend periods is included in the review.

5.5. Admission avoidance

A range of admission avoidance schemes are now in place or being developed in Gloucestershire including Older People Advice and Liaison (OPAL) teams, Ambulatory Emergency Care (AEC) and Integrated Community Teams (ICT). There is recognition that a renewed focus is needed on these schemes to ensure maximum impact, supported in part by the additional resilience investments outlined below:

Name of Scheme	Description
Pharmacy Minor Ailments scheme	Following successful roll out in 15/16 of these pharmacy enhancement schemes, they have been continued and extended into 16/17.
Pharmacy Urgent Repeat Medicines	
Streamlining Urgent Care	As part of the Streamlining Urgent Care project, funding has been identified to support and ensure appropriate redirection of patients from ED to alternative services by redesigning the ED 'front door', including Primary Care in ED, Out of Hours and Pharmacies, e.g. Minor Ailments Scheme.

Out Of Hospital (British Red Cross / Age UK)	This is a new partnership to facilitate risk positive discharges from the acute trust. The scheme is progressing well with full implementation from 1st November 2016. Key staff appointed and integration with existing teams commenced.
High Intensity User Role	Increasing focus is needed on high intensity users of Urgent Care services including ED, ambulances and mental health. This role has developed a whole system approach to case managing patients who are high intensity users of urgent care services with a view to significantly reducing the number of attendances through proactive cross-organisational, co-ordinated care. It has also developed a network of professionals involved in managing frequent attenders.
Directory of Services (DoS)	By recruiting a dedicated DoS coordinator, Gloucestershire has increased the breadth of services represented on the DoS to help ensure patients are directed to appropriate services.
Primary Care in ED	The Primary Care in ED pilot has been extended to support management of the high number of primary care attendances being seen in GRH. This scheme will remain in place for winter 16/17.
Maternity triage	This scheme pilots a midwife on the SWAST clinical desk to reduce unnecessary call outs. The review has been completed and the indications are that this scheme has been successful.

5.6. System Support

A robust and effective support system was implemented in 2014/15 and continues to improve year on year. On-line system support has been a key part of the management of the daily winter position. It enabled us to support effective, instant communication across system partners and to NHS England during this critical period.

Name of Scheme	Description
Online Performance System	The current online performance system and approach to calls has been recognised as supporting increased rigour of approach in managing Urgent and Emergency Care in the county. This will be maintained into the 2016/17 winter period. A separate exercise with Acute and Community colleagues moving to the next stage in forecasting activity levels is planned for November 2016. During the last year, measures have been continually reviewed and updated. It is recognised that these measures represent optimum “flow” through the system and delivery of 4 hour performance. The measures will continue to be monitored and developed in partnership with our data provider.

5.7. Escalation Reserve

Name of Scheme	Description
Discharge to Assess Beds (Pathway 2 – Bed Based)	GCCG purchased additional bed capacity in Gloucestershire in nursing homes; these were planned under the Discharge to Assess scheme. The support for the identification of patients to be placed in these beds is through the IDT. The management of the patients within this environment is through Care Home Select (CHS). The beds purchased have a maximum 4 week stay. The modelling presented at the A&EDB anticipates the need for up to 40 beds through November 2016 to February 2017.
Community Beds	The community provided an additional 12 Community Hospital beds across the period November 2015 to June 2016. The requirement for additional Community Hospital capacity will be kept under review during winter 2016/17.

Given the current budgetary position and recognising that a number of these projects are recurrently funded in nature, a paper to the October A&EDB will present an evaluation of their effectiveness of delivery of system capacity for winter 2016/17. The Board will agree which schemes are prioritised, and this may lead to changes in funding accordingly. All these schemes recognise that the largest risk is workforce capacity to deliver these schemes.

6. Urgent Care Quality, Innovation, Productivity and Prevention (QIPP)

Delivery of the Urgent Care QIPP Programme is vital to the delivery of this plan. Full delivery of the programme has been built into each organisation's financial and operational plans. Risk share has been agreed with each organisation based upon each organisation's ability to directly influence a scheme's delivery. It has been agreed that if QIPP schemes are under-delivering in year, that substitute schemes will be identified to drive the required changes. All schemes and delivery against the critical milestones and Key Performance Indicators (KPIs) are monitored via contracts.

6.1. Ambulatory and Emergency Care (AEC)

The AEC service is operational at both Cheltenham General Hospital (CGH) and GRH and is operative 5 days a week. Currently 8% of emergency referrals are supported within the AEC environment with the aim to increase to the nationally prescribed 25% of admissions. Prior to winter, the aim is to extend the current service to incorporate "surgical" pathways. The system is also considering delivery options in light of A&E Development Standards issued by NHS England (see section 10).

6.2. Integrated Discharge Team (IDT)

A review of the IDT team has been completed and further work is currently underway in order to ensure the service model is effective and high quality and meeting the needs of patients by 1st December 2016, a new hub model will be in place across

GRH and CGH that will effectively provide 'wrap-around' support to the wards. In conjunction with this, further work is being undertaken with GCC to ensure that a 'Home First' model is prioritised.

AEC will be opening at GRH for the three bank holidays over the Christmas period. Exact opening hours are still to be confirmed but it will be a minimum of 09:00 to 17:00 on 26th, 27th December and 2nd January.

6.3. Integrated Community Team

The service is commissioned to receive an average of 60 referrals a week and the current year to date average is 56. Several initiatives are underway to increase referrals including the following:

A Nursing Care Home Pilot involving Rapid Response and three Gloucestershire nursing care homes have seen very positive benefits and the care pathway is being further developed with the intention to extend the scheme to additional homes. The main measure for this pilot was around reducing the number of admissions to an acute environment from nursing homes; which had increased. The numbers of patients avoiding admission were recorded along with information about how these patients were supported in their normal place of residence and the interventions implemented. Another valuable measure was sharing of information between the Rapid Response Team and the nursing home staff with an emphasis on "Home First."

The Rapid Response team has assumed responsibility for the management of the front door element of the IDT at GRH and CGH since 1st June 2016. This has enabled a more joined-up approach and will potentially increase admission avoidance through the Emergency Department. The team are working closely with the PC in ED scheme which is proving effective. An evaluation of the effectiveness of the front door admission avoidance schemes will be undertaken to ensure we are delivering our key objectives for winter 2016.

Agreement to increase the investment in the Rapid Response service has been taken with the predicted aim of reducing the number of acute escalation beds by 25. Work is underway to develop a model that will support delivery with a requirement to commence recruitment as soon as possible.

Further work is underway to identify how the Integrated Community Teams and Rapid Response could work to support higher acuity patients within the Community with pilots being undertaken to support robust case management within defined Gloucestershire localities.

6.4. Mental Health Liaison

The Mental Health Liaison Team Service has three component parts:

- Emergency Department Liaison
- Older People Liaison
- Alcohol Liaison

Since September 2015, the ED Liaison element is available on a 24/7 basis. The Crisis Resolution and Home Treatment Teams provide night time cover on an in-

reach basis. This has proved problematic at times as staff have been diverted to undertake urgent community assessments and/or respond to s136 MHA assessments. 2gNHSFT are in the process of recruiting staff into the ED Liaison Team so that the service will no longer be diverted to other activity. Ongoing work is underway with 2gether to provide 24/7 cover and permanent night staff. This will be dependent on the recruitment of staff.

In line with the MH Five Year Forward View, there is a requirement that by 2020/21 all acute trusts will have Psychiatric Liaison services in place and that 50% will operate 24/7 in line with the Core 24 standard. The current range of Psychiatric Liaison services that are commissioned either directly by GCCG or via GHNHSFT do not meet the requirements of Core 24. Further work is required to develop the business case for additional investment to achieve the Core 24 standard.

6.5. Falls and Bone Health

The falls strategy has been developed and is now being rolled out. It will focus on the development and delivery of an integrated fall model. This will see a risk-stratified approach to assessment and intervention and will ensure that all high-risk patients are provided with a targeted exercise regime to improve strength and balance classes. The Falls Service has recruited three staff to lead the coordination of falls management and prevention. This group is currently establishing plans to ensure that stratification of patients at risk occurs early, people are referred to specialists, core physios, and Voluntary Community and Social Enterprise (VCSE) services that support exercise activation and balance work as soon as possible, and that physiotherapist in core carry out detailed falls assessments when required.

The falls project is also working with the fire service and SWAST (for whom there is a CQUIN this year) to ensure that non-injurious falls are attended to quickly by a fire-service led falls “pick up” service.

6.6. Highly Sensitive Troponin T testing

The reduction in urgent admissions for low risk chest pain relies on effective use of catheter lab capacity. Discussions around continuing with the mobile catheter lab at GRH through the winter to ensure additional capacity are available and this has been verbally agreed. In addition to this demand and capacity work is being undertaken for the static lab at CGH to ensure the elective waits are maintained and the waiting list is managed for angiograms. This work will also support better management of the inpatient flow and length of stay for chest pain admissions across both sites.

A highly sensitive troponin testing pilot took place in October 2016 with positive results. Plans are progressing to identify how this can be implemented to ensure sustainability.

The new low risk chest pain pathway has been agreed and includes referrals from ED and AEC.

6.7. Social Prescribing

As a part of GCCG’s prevention and self-care agenda, work has been undertaken with Primary Care and a range of voluntary and statutory partners to develop an innovative social prescribing model. Social prescribing is a structured way of linking patients with non-medical needs to sources of support within a community and of

providing one to one support where this is needed. These opportunities may include: arts; creativity; physical activity; learning new skills; volunteering; mutual aid; befriending; and self-help, as well as support for a wide range of problems including: employment; benefits; housing; debt; legal advice; and parenting problems.

This scheme is now fully operational across the county with social prescribing hub coordinators accepting referrals from all 81 GP Practices in the county and from staff in the county's 21 Integrated community Teams (ICTs) and staff from community hospitals.

6.8. Choice Plus

Current position

Choice+ appointments will be delivered in 7 localities (currently in 16 locations). The national core requirement for the GP Access Fund is 30 minutes per patient per week per 1000 population which equates to 318 hours per week in Gloucestershire. This requirement was set in April 2015 and Gloucestershire met this target in September 2016 and is planning to maintain 318 hours of Choice+ appointments per week. The majority of appointments will be delivered in hours but extended hours appointments will be offered at the following locations:

- Gloucester
- Cheltenham
- Cirencester Hospital
- Forest of Dean
- Stroud community Hospital
- Tewkesbury
- Corse and Staunton

Gloucester Health Access Centre (Eastgate House) in Gloucester City centre is contracted to offer walk-in and booked on-the-day appointments 8am – 8pm, 7 days a week. Additionally GP practices across Gloucestershire will prioritise on the day appointments on the days preceding and after bank holidays.

System Actions

GCCG will continue to work closely with GDOC (the service provider) to ensure that appointments offered are in the most appropriate location to ensure appointments offered are fully utilised.

6.9. Respiratory Pathways

A full review of the Chronic Obstructive Pulmonary Disease (COPD) pathway has been carried out linking with all key stakeholders. A series of detailed recommendations have been produced to support the development of an integrated, system wide pathway with prevention through to end of life. The major programmes of work have been identified as: prevention, integration of delivery supported by a range of key enablers such as care planning and Information Technology. The GCCG Clinical Programme Group is working to agree a series of 'quick wins' to implement in 16/17 for Urgent Care impact, which may include improved access to senior clinical decision making and access to speciality community support. Further development of the COPD Discharge Care Bundle is also being progressed.

In addition, a COPD Winter Review Scheme is under development for roll out from October 2016, targeted with a greater focus on co-morbidities.

6.10. Primary Care in the Emergency Department

For patients that walk into GRH ED they are effectively signposted by a Clinical Navigator who will identify patients that could be appropriately cared for by the Primary Care service that is collocated at the front door of the ED. Patients are also supported by a GP that works within the "back door" of the ED who is instrumental in identifying patients where alternative pathways to admission may be appropriate. All the resilience schemes and associated investments are under review and a paper was presented to the A&EDB in November 2016. The pilot will continue over the winter period.

6.11. IV Therapy

As part of the Gloucestershire Care Services (GCS) and GCCG QIPP Programme for 2016-17, GCS has been tasked to develop an integrated enhanced community intravenous service that provides equity for patients across Rapid Response, District Nursing and the existing IV service. This scheme follows a recognised need for a more collaborative and cohesive community IV therapy provision which is easy to access and has a more than once a day administration pathway. Work is underway within GCS to produce a revised model which will be considered by the CCG. Following agreement of the model, implementation timeframes will be approved.

7. Service wide winter plans (including organisational escalation plans)

In Gloucestershire, intensive activity profiling and demand modelling has been completed to inform critical decision making and planning assumptions, coupled with provider intelligence. All providers were requested to provide GCCG with organisational winter and escalation plans that have been formally ratified by their Boards. The content of provider plans have been utilised to inform the "Gloucestershire Urgent and Emergency Care Resilience Plan".

We have received Winter plans from all relevant providers (including escalation plans and demand & capacity modelling where required) and are satisfied that these meet the required levels of assurance. These documents are available upon request.

In addition to the Winter plan, each organisation will be producing additional winter assurance for the period 22nd December until 9th January and a workshop will be held to help the system work towards a position of full assurance for this period.

8. Demand and Capacity Modelling

8.1. Capacity and demand planning

The intent of this plan is to provide safe, high quality and effective services to patients and members of the public accessing the Trusts services during winter 2016/17.

Ensuring the correct services are in place and the public understand what services they should attend remains crucial, and therefore a collaborative understanding and joined up approach to planning is imperative.

During winter the Urgent Care system experiences seasonal surges in demand for services, this in turn impacts on the rest of the health community with pressure felt across all services. In order to mitigate the potentially negative impact of increased demand the health community have completed an in depth review of demand and have developed plans to meet that demand with the appropriate capacity.

A comprehensive review of provider demand and capacity plans has been completed to test the individual organisations assumptions. Assumptions and forecasts have also been reviewed to ensure that each of the providers have an understanding of demand and capacity across the Health and Social Care Community, in order to understand and mitigate any impact on organisations further down the pathway.

8.2. Bed Modelling

Robust bed modelling has been undertaken in conjunction with GCCG/GCS and GHNHSFT. Assumptions and modelling have been reviewed and approved at A&EDB. The modelling is fully dependent upon delivery of critical QIPP schemes and schemes relating to the Urgent Care System Reset which are reliant upon system wide delivery. Additionally the Urgent Care resilience schemes will be critical in ensuring that bed-based capacity is released and that patients are wherever possible cared for outside a hospital environment.

The bed modelling undertaken was based upon the following realistic assumptions which were supplied following review of evidence from previous years and understanding of current system wide delivery. A number of scenarios were modelled to understand the breadth of the issue and the two main scenerios were:

Gloucestershire Hospitals NHS Foundation Trust

Scenario One:

- Bed occupancy within the Acute Trust would be based upon 90% for Emergency Admissions and 85% for Elective.
- An Acute hospital bed stock of 799.
- Length of Stay based upon 15/16 average.
- Impact from potential Norovirus outbreaks based upon 15/16.
- The main months of pressure will be October 16, February and March 2017.
- Identified bed shortage 75-104
- The modelling has assumed that the medically fit list will average 56 based upon previous years but acknowledges work is required to focus upon key areas of growth.

Scenario Two:

- Bed occupancy within the Acute Trust would be based upon 95% for Emergency Admissions and 85% for Elective.
- An Acute hospital bed stock of 799.
- Length of Stay based upon 15/16 average.

- Impact from potential Norovirus outbreaks based upon 15/16.
- Identified bed shortage 35-62
- Between October 2016 and March 2017 the average bed shortage is 35.
- The main months of pressure will be October 16, February and March 2017.
- The modelling has assumed that the medically fit list will average 56 based upon previous years but acknowledges work is required to focus upon key areas of growth.

Gloucestershire Care Services

- Bed occupancy within GCS 97%.
- Bed base 196 beds.

In order to manage the predicted bed based deficit of 12 beds within the Community Hospitals the proposal is that GCS will work on initiatives to reduce Length of Stay from 23.8 days to an average length of stay of 22.2 days for weeks 30 to 52.

Mitigating actions are critical in order to assure system wide resilience for the winter period and based upon the above assessment the following actions and proposed impact has been identified:

- Full delivery of QIPP schemes (see section 5) will release 14 Emergency Admissions a day.
- The system will have available 50 Discharge to Assess beds.
- Additional 18 reablement flats/beds being sourced.
- There is a potential opportunity to utilise 32 beds that are currently void within an Independent provider. This is not currently an assured bed base.

There is also an expectation that much of the work that is underway across Gloucestershire will positively impact upon both the number of patients who remain in hospital once they are deemed medically fit as well as ensuring that length of stay is kept within agreed parameters. The A&EDB also agreed additional system wide actions that would enhance the mitigating actions that have already been identified and will monitor progress and delivery via the Urgent Care Working Group.

Action	Provider
Implementation of the principles of Onward Care procedure for Gloucestershire. This will be supported by the instigation of a task and finish group who will agree work prioritisation based upon views of greatest impact and gain for this winter.	System wide led by CCG
All major specialities will have a consultant immediately available on the telephone to provide advice and streaming for Emergency Departments and Primary Care.	GHT
GHNHSFT to deliver an extension of the OPAL service/ >60 year cohort.	GHT
Following review by Gloucestershire Care Services and Gloucestershire Hospitals NHSF Trust of the “Back door” Integrated Discharge Team , work	GCS/GHT

to commence on implementation of changes.	
Any patient over 10 days inpatient stay within the Acute Trust is reviewed and escalated to the Director Of Nursing.	GHT
Development of Home First offer supported by robust information supply.	GCS/GHT
Further develop responsiveness for Mental Health patients in the Emergency Department environment in line with Key Performance Indicators.	2 gether
SWAST to continue to deliver and develop use of alternatives to Emergency Departments and maintain non-conveyance rates of ambulances to the Emergency Departments.	SWAST
Choice Plus, following evaluation, to provide additional capacity in the areas of demand.	CCG
NHS111/Out of Hours to maintain clinical staffing and use of alternatives to 999 & Emergency Department.	Care UK/SWAST
Arriva to maintain operational fleet capacity and a responsive service.	Arriva

Additional to the above the A&EDB are committed to a number of actions which will reduce the daily emergency admissions by 40. These schemes have already been discussed within this Plan but include GP in ED, AEC, OPAL, IDT, Rapid Response, pathway review/compliance.

9. Gloucestershire Escalation Plan & Framework

The GCCG Escalation Plan & Framework sets out the procedures across Gloucestershire to manage day to day variations in demand across the Health and Social Care system as well as the procedures for managing significant surges in demand. The purpose is to ensure that all partners across Gloucestershire use a consistent and effective mechanism to access additional short term capacity in the right part of the system when demand peaks. This Framework is currently consistent with the escalation guidance provided by NHS England (South) and is being further updated in response to the recently received NHS England Operational Pressures Escalation Levels Framework (OPEL). The latest version of the Escalation Plan & Framework incorpororating the OPEL levels is embedded in Appendix 2.

10. NHS England: High Impact Actions

To build upon the resilience plans and help restore A&E performance to 95%, NHS England/NHS Improvement have provided guidance for local systems to deliver A&E Improvement in 2016/17. This includes five key areas of focus that have been proven to be effective, improve patient safety and reduce waste. Each of the five key areas have critical “must do” milestones and the below outlines the current position within Gloucestershire to deliver against these requirements.

A&EI:1	**A&E STREAMING AT THE FRONT DOOR:** A&E departments need to be able to access the most appropriate services for patients in a timely fashion to prevent delays and crowding of the department. This can be achieved by identifying the main services required and designing them around patient needs. There are several streaming paths for patients including primary care, ambulatory emergency care, out-patient referral, transfer to an assessment unit and transfer to a frailty service. A well designed streaming service supported by the availability of each of the streams during periods of high demand can reduce crowding and pressure on ED staff leading to an improved patient experience.
S1	All major specialties have a consultant immediately available on the telephone to provide advice & streaming for ED & primary care
S2	There is a primary care stream available (if activity levels justify it) with the capacity to meet the true patient demand
S3	Patients presenting with mental health illness are assessed, managed, discharged or admitted within the ED standard
S4	There is an ambulatory emergency care service available for 12 hours per day, 7 days per week which manages at least 25% of the emergency take
S5	There is an acute frailty service available 12 hours per day, 7 days per week which treats all eligible patients
S6	Community and intermediate care services respond to requests for patient support within 2 hours

Current position

Currently within Gloucestershire a majority of Urgent Care pathways are directed via the Emergency Departments. Alternative pathways that allow direct access include the Ambulatory Emergency Care service which is provided at both GRH and CGH. This service is not presently a 7 day a week service but during weekdays accepts a number of urgent care pathways.

Gloucestershire also provide a “front” and “back” door Primary Care Service which provides support to patients that have “walked in” to the Emergency Department at GRH and also provides Primary Care support and advice to patients that have arrived via their GP or through the 999 system. Ability to staff these pilots remains challenging due to workforce issues that have been acknowledged within the Primary Care workforce.

Currently within Gloucestershire patients that have been seen and referred for assessment by their GP are sent through the ED. Work is underway to identify pathways whereby patients can be referred direct to “assessment” units.

It is acknowledged that there could be great advantages in providing senior enhanced clinical advice to GPs from GHNHSFT speciality clinicians (which could be

accessed via the SPCA). This offer is presently limited and not formalised where operational (with exception of paediatrics).

There is an IDT presence within the EDs that provides an assessment and interface role with Community Services, ensuring wherever possible patients are supported in receiving care within their own home and Community. This service is provided 7 days a week and responds to assessment requests from both EDs.

Both EDs are supported by a 24/7 Liaison Service which is either provided by a dedicated Liaison Service or via the Mental Health Crisis Team. Patients are largely supported within the required standards but it is acknowledged that certain very complex cases can exceed these standards. The A&EDB is committed to ensuring that this matter is addressed but acknowledges the issues associated with recruitment of the required skilled workforce.

Within Gloucestershire an Older People's Assessment & Liaison Service (OPAL) is available which presently operates 5 days a week with limited cover at GRH during the weekends. As part of the A&E Improvement Standards, work is underway to explore opportunities for extension.

System gaps and future developments

Currently many of the "streaming services" are only available 5 days a week. The Gloucestershire system, via the A&EDB, will be considering over the forthcoming months which services could be effectively increased to support 7-day delivery.

Work is also underway to identify how the AEC can increase utilisation from the current position of 8% of the daily emergency activity being managed within AEC to 25% of admissions. It is anticipated that this will be achieved by extending the current surgical pathways that can be accessed via AEC.

Work is underway to review existing Urgent Care pathways and options to refer patients directly to "assessment units" for review, outside of the ED system. This work is being led through GHNHSFT Urgent Care Programme Board. In addition, identifying how GPs can be supported by robust access to Senior Clinical advice is being explored. It is acknowledged across the health community that this service would hugely benefit local GPs and ED staff.

A&EI:2	**INCREASE THE NUMBER OF % OF CALLS PASSED TO A CLINICAL ADVISOR:** The Integrated Urgent Care Commissioning Standards outline a new model of care which will result in improved outcomes for patients. A key part of this new model is to increase the amount of clinical input into calls to the NHS 111 number thereby enhancing patient assessment and ensuring the patient is directed or referred to the most appropriate point of care. The IUC model has eight key elements which commissioners are expected to achieve, these elements will to greater and lesser degrees contribute to increasing clinical input and ensure patients are directed appropriately. The Integrated Urgent Care part of the A&E plan is focussed on the following specific requirements: • To increase nationally from 22% to an interim threshold of 30% (or higher) of

	calls transferred to a clinical advisor by 31st March 2017 • To monitor A&E disposition rates to demonstrate a reduction in recommendations to attend • To ensure accuracy and development of the local DoS to ensure callers are streamed to the most appropriate service, and only to A&E when clinically appropriate NHS England will ensure that actions which are best undertaken centrally (e.g. Technical changes to NHS Pathways) are appropriately commissioned.
S1	Given there is a requirement to increase from 22% to a national interim threshold of 30% (or higher) of calls transferred to a clinical advisor by 31st March 2017, the A&EDB has plans in place to meet this requirement
S2	Clinical expertise availability is planned according to demand
S3	The A&EDB has a lead starting to integrate the NHS 111 service and local Out of Hospital Provision, particularly OOH
S4	The A&E DoS service type is ranked as low as possible, apart from other A&E-type services and services not commissioned within GCCG
S5	There are alternative services which can accept NHS Pathways outcomes for conditions that can be managed outside ED, e.g. limb injuries, bites, stings, plaster cast problems, suspected DVT, falls
S6	The A&EDB knows demographics of the area, including if there is a greater demand for OOH services which are generated from the elderly

Current position

Care UK, the NHS111 provider for Gloucestershire currently provides clinical advice from within the NHS111 service for approx. 22% of patients that contact the service. An additional 8% are passed to the OOHs service for clinical advice. A Clinical Prioritisation Model also ensures that clinical call back and advice is prioritised according to need.

NHS111 also provide an ambulance validation support line which requires all “Green” ambulance dispositions to be passed to a clinician for further enhanced assessment. This results in approx. 60% disposition downgrade.

Dispositions to the Emergency Department have been impacted by this work as often the “Green” ambulance downgrade disposition is to ED.

The current contract for Gloucestershire OOHs service is due to end in June 2017. Work is underway to identify how future procurement will secure a more integrated model for delivery of both OOHs and NHS111. GCCG and South Western Ambulance Service Trust (SWAST) work closely to monitor demand, including seasonal variation, ensuring workforce capacity can match demand. Further work will be undertaken during the autumn to identify trends in demand relating to geographical locations and age profiles. The inconsistency of offer provides further risk and the CCG and SWAST are looking at ways to resolve this issue.

The Gloucestershire Directory of Service (DoS) is regularly reviewed in accordance with best practice guidance and planned pathway upgrades. Work is underway to roll out MiDoS to services within Gloucestershire, with the Single Point of Access being the first service to go live. Planned work includes utilising MiDoS within the IDT service.

System gaps and future developments

Gloucestershire are presently undertaking a review on the delivery of an "Integrated Urgent Primary and Community Care Service". The review is encompassing the role and function of the Integrated Clinical Hub. Whilst this extensive review is underway, GCCG will continue to work with NHS111 to identify actions that can be taken to ensure that access to Clinical advice within NHS111 service is readily available for cases that would benefit from early Clinical intervention and advice. The work will include how disposition levels to the ED can be maintained or improved, ensuring wherever possible alternative pathways are selected where clinically appropriate. A significant amount of the focus will be in securing the level of clinical workforce to deliver the required service levels. Recruitment Nationally into NHS111 services is challenging so Care UK are working in accordance with an agreed plan to achieve staffing levels for the forthcoming winter months.

A&EI:3	**THE AMBULANCE RESPONSE PROGRAMME:** The Ambulance Response Programme (ARP) is a national programme led by NHS England to improve the outcomes and experience of patients contacting the 999 ambulance service. The ARP aims to achieve: • a more equitable and clinically focussed response from the ambulance service, that meets patient needs in an appropriate time frame • Better allocation and distribution of resources in the face of rising demand • Response standards that encourage the best possible patient outcomes • An improved experience for all patients
S1	There is an ambulance trust executive lead on the A&EDB able to deliver the required service changes
S2	There are working definitions of 'Hear and Treat' and 'See and Treat' agreed across the local health economy and a baseline workforce profile to deliver an increase in these dispositions
S3	There are alternative services which can accept ambulance dispositions or referrals and are mapped across localities
S4	The A&EDB has established local mechanisms for increasing clinical input into green ambulance dispositions particularly at times of peak demand
S5	The A&EDB has agreed workforce and service plans in place to deliver an increase in 'Hear and Treat' and 'See and Treat'

Current position

Following the Ambulance Performance Programme go live on 18th April 2016, SWASFT continue to implement the new code set changes. These changes are to support the right resource being deployed at the right time. This is a trial and the impacts will be reviewed by the University of Sheffield. Phase three of the trial is set to commence from October 2016, with Phase four planned for January.

A&EI:4	**PATIENT FLOW:** The following initiatives are the fundamental building blocks of good patient flow in Trusts. Effective implementation will reduce bed occupancy, improve performance, enhance patient safety and reduce costs.
S1	SAFER patient flow bundle implemented on assessment and medical wards as a bare minimum, to improve patient flow.
S2	The use of the red and green day approach has been considered.
S3	A baseline assessment of the effective use of EDDs and Clinical Criteria for Discharge has been carried out.
S4	Ward round checklists are in use in all wards in the acute hospitals.

Current position

GHNHSFT have been embracing the SAFER care bundle approach for the past 2 years, supported by contractual arrangements within the Commissioning for Quality and Innovation (CQUIN) schedule.

A majority of wards across the two hospital sites have been incorporated within the SAFER programme which has included engagement within the “red and green day” approach; this clearly identifies patients that are delayed due to internal and external reasons and allows staff to take proactive actions to ensure a return to green is achieved for every ward patient. The majority of in-patients within GHNHSFT have an established Estimated Date of Discharge (EDD) but it is recognised that additional work is required to improve accuracy. Ward round checklists have been established with the utilisation of “Sick patients, Out today or tomorrow, Rest of the patients, To come in” (SORT) to support delivery of effective board rounds

SAFER principles have also been endorsed within the Community Hospitals and the recruitment of a dedicated complex discharge coordinator has positively impacted on the number of patients that remain in hospital once deemed Multidisciplinary Fit.

System gaps and future developments

Continued focus and roll out of the SAFER Care Bundle principles is embedded within GHNHSFT Urgent Care Programme and supported by year 2 of the SAFER CQUIN schedule.

Multi Agency Discharge Events (MADE) have been undertaken both within GHNHSFT and Gloucestershire Care Services (GCS) with identification of areas for

improvement and agreed “30 day actions” in response. The plan is to ensure these events occur regularly to maintain focus on delivering system wide improvements.

A&EI:5	**IMPROVING DISCHARGE PROCESSES:** One of the major themes from the review of winter 2015/16 was the problems created by hospital discharge delays, caused by poor internal processes and external constraints. To combat this, all systems should implement best practice models to support their discharge processes and optimise patient flow.
S1	Systems are in place to review the reasons for any inpatient stay that exceeds six days.
S2	A ‘home first: discharge to assess’ pathway is in operation across all appropriate hospital wards.
S3	Trusted assessor arrangements are in place with social care and independent care sector providers.
S4	At least 90% of continuing healthcare screenings and assessments are conducted outside of acute settings.
S5	A standard operating procedure for supporting patients’ choice at discharge is in use, which reflects the new national guidance.
S6	There is a responsible director in the acute trust who will monitor the Delayed Transfers of Care (DToC) situation daily and report regularly to the Board on this specific issue.
S7	Related to the above, there is a named senior individual in every CCG and SSD who will be the single point of contact for the nominated trust exec.

Current position

GHNHSFT is currently focussing upon patients whose hospital stay exceeds 14 days. These patients are reviewed daily to ensure appropriate escalation and discharge plans are in place. Additionally, all patients are considered daily as part of the board round process to ensure robust discharge plans are being progressed. GHNHSFT aim to adjust the parameters to 7 days as part of the Red to Green day process.

A Discharge to Assess (DTA) bed based service model is in place across Gloucestershire and is accessible to all wards across the Acute Trust via the IDT. This service is intended to support capacity across the winter period but has been available throughout the summer. Clarity on criteria for DTA utilisation is being reviewed with plans to further develop the service to deliver a more home based model of care.

Medically fit patients are identified in the acute and community hospitals and this is reported daily as part of the whole system calls. Delays are escalated in accordance with agreed processes with Director level interventions when appropriate.

Gloucestershire currently reviews medically stable patients on a daily basis as part of whole system management with the aim to keep acute hospital medically stable patients below 40. Community Hospitals also identify the number of patients that are deemed multidisciplinary stable and ensure proactive management and escalation is in place to ensure timely progression to discharge.

System gaps and future developments

Clarity on criteria for DTA utilisation is being reviewed with plans to further develop the service to deliver a more home based model of care. Gloucestershire presently utilise a Trusted Assessor model. Further work is being progressed to extend the capacity and scope of this role and to ensure maximum coverage of the Gloucestershire Care Homes.

Onward Care Policy

Within Gloucestershire the NHS England South Central Onward Care Procedure has been endorsed by the A&E Delivery Board. The procedure describes the process for achieving a smoother process for accessing onward care for patients; ensuring patients get the right care, at the right time, in the right place. It defines that patients will be repatriated for onward care within defined time periods after referral and acceptance by the receiving service. Within Gloucestershire the A&E Delivery Board are eager to apply the principles to both out of county and in county onward care as well as ensure this applies to both health and social care wherever possible. It is acknowledged that this will need to be undertaken in a staged approach with the aim to identify high impact pathways that will be prioritised during the winter.

11. Planned Care

Gloucestershire has historically had good performance against elective care performance measures. A range of providers in the county offer elective care services plus choice of location and competition. The main acute provider is GHNHSFT but there are also a number of other independent providers offering a range of elective and diagnostic services across the county. Focus on Referral to Treatment (RTT) is given to all providers of elective and diagnostic services.

The Planned Care Programme Board (PCPB) is acutely aware of the interdependency between the planned and urgent care systems, and the potential direct effects during times of stress and/or increased demand in the system. It is anticipated that the work defined within the Resilience Planning will see the continued delivery of the Planned Care Strategy, and will draw together both systems to build further resilience.

11.1. Patient Access Policy

Current System

All acute providers have a patient access policy in place, and are required to meet consistent performance and access standards across all contracts.

The current policy in place at GHNHSFT is being reviewed; this work commenced in early 2016, and will result in the revised policy being publicly available in 2016/17.

System Gaps

The need to review policy across all providers has been highlighted as a gap and is essential to ensure consistency of services and equity of access. When this has been done a comprehensive programme of communication and engagement will need to follow, to ensure that there is clarity about standards that can be expected across the system and this will need to include the public, staff and referrers.

System Actions

The system aspiration is for there to be a clear and transparent policy and operating procedures across all providers for each treatment pathway, e.g. RTT, diagnostics, cancer etc., and this policy will be communicated to stakeholders so that there is clarity about what patients can expect to receive and when, across all range of services. As part of ongoing work undertaken by commissioners and regular contract management processes, further assurance will be developed.

11.2. Referral to Treatment (RTT)

Current System

GCCG has consistently met the targets for admitted and non-admitted care. However, performance against the incomplete target has been impacted by out of county performance. Delivery remains challenging, but we expect sustainable delivery of all three targets throughout 2016/17. RTT compliance, delivery and sustainability is likely to remain challenged over the winter period.

GHNHSFT has developed an online RTT training package that will be available to all appropriate staff. The package was launched in 2015 and roll-out of the programme continues during 2016.

System Gaps

There is a need to ensure that appropriate training is being planned by other providers of services across the county, as well as to ensure that referrers into services are aware of the policy and its application in the RTT rules.

System Actions

It is acknowledged that a system with maximum resilience will include stakeholders that all have a consistent and correct understanding of the RTT rules. This means that clinicians are aware of timescales associated with individual treatment pathways and this can also be communicated correctly to patients to inform their expectation of services. As part of ongoing work undertaken by commissioners working proactively with providers, further assurance will be developed.

11.3. Elective Capacity

Current System

Development of an annual capacity and demand plan for elective services at sub-specialty level was carried out as part of the 2016/17 contracting round. This was

undertaken for all providers with annual contracts, as well as those with Any Qualified Provider (AQP) procured contracts, to inform GCCGs expected activity and financial profile for 2016/17. Specific focus was given to GHNHSFT as the main provider of elective services.

Each contract has an Indicative Activity Plan (IAP) with explicit planning assumptions, embedded in the contract. Each IAP is monitored on a monthly basis as part of the contract monitoring process led by GCCG with each provider. This work will continue throughout 2016/17 and into 2017/18.

System Gaps

The contract monitoring process needs to be reviewed, to ensure that system-wide information and monitoring is as required across Planned and Urgent Care services.

System Actions

As part of resilience plan monitoring by the PCPB, the capacity and demand for services will be reviewed. A full and detailed analysis will be reviewed by the PCPB who will monitor all elective care activity of all providers across the county. The PCPB will escalate any areas of increased demand and gaps in services.

Bed modelling will be undertaken in August 2016/17 to provide an understanding of winter bed requirements for elective care within GHNHSFT – see section 8.

11.4. Pathway Design

Current System

Gloucestershire has undertaken significant pathway redesign work across the county including Clinical Programme Groups leading the review and understanding of specific pathways. These involve clinicians and managers from across GCCG and providers as well as lay and patient representatives from Healthwatch Gloucestershire who collaboratively review current pathways and identify areas for improvement. Examples in respiratory have led to renewed pathways, hot clinics and seven day working that has improved system resilience.

We have been working with our providers since 2014 to identify and document existing care pathways and guidance and have recently launched an online repository of this information to make them readily available across the clinical community. The G-CARE website also includes referral forms, patient information leaflets and service information.

System Gaps

Following on from the initial work at GHNHSFT initially, wider engagement and planning with other providers and clinical teams will need to be undertaken. It is anticipated that patient access policies and supporting procedures will support the development of these pathways. It is essential that this work is carried out in conjunction with the clinical teams and capacity planning. Consistent waiting list information will also need to be co-ordinated by GCCG as part of the assurance process for this work.

System Actions

Care Pathways are a fundamental part of the Planned Care Programme. We will work with our providers to:

- Develop a comprehensive planned care Directory of Services (DoS), to provide clarity on who our existing providers are, what services they provide, their location, and their access criteria, and will make this information available to patients and referrers.
- Refine and develop new pathways through the Clinical Programme Approach.
- Manage pathway reviews formally to ensure that they remain up to date and relevant.
- Agree a way to incentivise pathway development and compliance.
- Ensure clinicians have dedicated time put aside to devote to pathway development work.

The system will ensure there is a consistent waiting list profile that matches capacity planning and that can be delivered by all providers. In this way, there will be equity of access for patients with similar presenting clinical conditions. This will be developed by GCCG as part of commissioning responsibility and reported to the PCPB.

11.5. Waiting List Management

Current System

GHNHSFT has undertaken some initial work to 'right size' waiting lists as part of an independent review in urology. They plan to replicate this work in a number of specialties during 2016/17. A Validation Team has been in place within GHNHSFT for some time. The team will ensure that all waiting lists are validated, taking into account the application of RTT rules and making amendments where necessary.

A Business Intelligence system is in place at GHNHSFT to support performance management which includes a Patient Tracking List (PTL) which provides real-time information. This is reviewed daily by Local Service Teams and weekly at the Trust-wide performance group.

Other providers are required to comply with data quality standards and report performance on a monthly basis and this is actively managed by commissioners.

System Gaps

A full review across the system is needed, and will need to be informed by capacity mapping and monitoring. Additional independent support may be needed as this plan is developed. It is anticipated that as this work develops the opportunity to review waiting list profiles across the system will take place and, for example, divert clinically appropriate patients from hospital to community services.

Further work is needed to ensure that a full suite of KPIs is established and actively monitored across all providers and the elective care system. The outcome of validation also needs to be used to inform the staff training programme.

System Actions

GCCG will undertake further work to determine 'right size' waiting lists. Its aspiration for all elective care waiting lists across all providers to be appropriate to the population's clinical needs, and to be able to respond to peaks in demand and be consistent with agreed pathway timelines. GCCG is working collaboratively with GHNHSFT to transfer suitable patients to alternative providers.

The Planned Care Programme will also ensure that:

- Commissioning is outcome focused and evidence based, delivered through the Clinical Programme Approach.
- There is a clear focus on effective capacity and demand management, involving GCCG and providers. This includes making use of Community Hospitals.
- Robust contracting and performance management is in place to hold providers to account.
- Appropriate thresholds for treatment are in place and are adhered to by providers.
- Appropriate incentives (including CQUINs), contract penalties, and contract limiters are implemented.
- The market is managed effectively, potentially including procurement of new providers (through AQP and/or competitive procurement) to diversify provision if appropriate.
- Thorough evaluation of services is undertaken to support commissioning and decommissioning decisions (including in year review of AQP Diagnostic, Endoscopy, and Elective contracts).

11.6. Referral Management

Current System

As part of Planned Care QIPP programmes, GCCG has led a number of projects focussing on referral management with the aim of ensuring patients are able to access the appropriate clinical services in a timely way.

A number of other schemes are in place to ensure that referrals are appropriate and reflect best clinical practice; this includes Advice and Guidance services, effective clinical commissioning sub-group to inform commissioning policy, and a Clinical Programme Approach to the development of care pathways with clear criteria and thresholds.

As part of contractual process, there is also a requirement for all providers to return referrals at the point of receipt if they are not deemed clinically appropriate for their service.

System Gaps

Clinical pathways have been developed in areas such as musculoskeletal conditions, circulatory, children's, mental health, diabetes, healthy individuals, ophthalmology and cancer. Providers need to be empowered to return referrals that do not meet commissioning policy and patients need to be aware of access criteria. This work is

being undertaken as part of the Planned Care QIPP Programme and contract management.

System Actions

The strategic direction of GCCG for elective care is to have agreed and integrated care pathways. These care pathways will be supported at each decision point with the list of relevant providers and clinical inclusion and exclusion criteria and their respective waiting times, in order to inform patient choice. They will be developed by clinicians across the system and will therefore represent an integrated referral pathway supported by clinical consensus. It is anticipated that patients will be fully aware of the pathway so their expectation is managed and clinicians will take responsibility for each step of the pathway.

11.7. Pathway Design

Current System

GCCG is committed to delivering the constitutional rights and pledges for its patients; with the NHS constitution compliance embedded within its Operational and Financial Plan and forming an integral part of its performance framework. The constitutional rights are monitored along with other key local and national measures, reviewed by the GCCG Governing Body bi-monthly with interim reports review by the GCCG Directors. GP practices are aware that the requirement to discuss choice with each patient ahead of making a referral is essential and this is carried out either by clinical or clerical staff. For a cohort of residents who are registered with a Welsh GP, this process is managed through a Referral Assessment Service

Through the contractual process, GCCG encourages each provider to actively market their services with member practices and patients.

GCCG also has a process in place via the Patient Advice & Liaison Service (PALS) so that when a patient makes contact with a concern around waiting times or access to services, the patient is made aware of their NHS constitutional rights and if needed, and clinically appropriate, an inter-provider transfer can be made.

As part of the staff RTT training programme, GHNHSFT are including a module on NHS constitutional rights and patient choice, as well as reviewing all patient letters.

System Gaps

To gain further assurance across all providers and GP practices that choice conversations are proactively happening, and are part of staff training programmes.

System Actions

Ongoing assurance is needed to confirm that patients are aware of their NHS constitutional rights as are all stakeholders in the elective care system. The strategic direction of GCCG for elective care is to have agreed and integrated care pathways. These care pathways are being developed by individual Clinical Programme Groups (CPGs) led by GCCG. They will be supported at each decision

point with the list of relevant providers and their respective waiting times, in order to inform patient choice.

The GCCG is also implementing a Communications and Engagement Programme to ensure that GPs, practice staff and patients have the appropriate information to support referrals being made to clinically appropriate and convenient services. Patient awareness of their NHS constitutional rights will also be increased through the development of a Gloucestershire specific Patient Information Leaflet which outlines patient choice and local provider options.

11.8. Governance

GHNHSFT has an internal process in place to report on each element of the elective care system and the action plan for 18 week RTT management and performance. This process reports through to the Trust Finance and Performance Committee and Trust Board.

GCCG also have a Planned Care Programme Board. The purpose of the PCPB is to maintain strategic oversight and system-wide visibility of Planned Care services in Gloucestershire. The PCPB also leads on the development of an Elective Performance Improvement Plan, and subsequently monitors its implementation, to ensure that elective services meet local needs, are value for money and deliver quality for the patients of Gloucestershire

12. Primary Care

The Primary Care offer for winter is integrated into many of the existing schemes already outlined in this document for example section 5 includes detail on Choice+ and social prescribing whilst section 11 details the GP in ED and COPD winter pressures scheme for respiratory. In addition and in response to the General Practice Forward View (GPFV), the CCG's comprehensive Primary Care Strategy was written and subsequently ratified by Governing Body in September. Key programmes from the strategy which support system wide resilience in readiness for winter are described below.

12.1. Working together at scale

Practices in Gloucestershire were invited to from cluster groupings to enhance their sustainability. 15 clusters have formed to date and these are shown here:

Locality	Collaborations
Cheltenham (three clusters, circa 50,000 patients each)	**St Pauls** - Corinthian, Portland, Royal Well, St.Catherine's, St.George's **Central** - Berkeley Place, Crescent Bakery, Overton Park, Royal Crescent, Springbank, Underwood, Yorkleigh **Peripheral** - Leckhampton, Sixways, Seven Posts, Stoke Rd, Winchcombe
Forest of Dean (60,000)	All eleven practices in one cluster
Gloucester City (four clusters, 30,000-52,000)	• Rosebank and Hadwen • Bartongate, Gloucester City Health Centre, Partners in Health, Kingsholm • Brockworth, Cheltenham Road, Churchdown, College Yard, Hucclecote, Longlevens • Barnwood, London, Heathville, Saintbridge
North Cotswolds (29,000)	All five practices in one cluster
South Cotswolds (58,000)	All eight practices in one cluster
Stroud and Berkeley Vale (four clusters, 18,000-39,000)	**Cluster 1:** Acorn, Cam & Uley, Chipping, Culverhay, Marybrook, Walnut Tree **Cluster 2:** Beeches Green, Locking Hill, Rowcroft, Stroud Valleys **Cluster 3:** Frampton, High Street, Regent Street, Stonehouse **Cluster 4:** Frithwood, Minchinhampton, Painswick, Prices Mill
Tewkesbury, Newent and Staunton (43,000)	All four practices in one cluster

In clusters, practices have bid for additional funding to support their sustainability. The majority of clusters chose to enhance their workforce by seeking funding for clinical pharmacists, with other selecting mental health nurses and schemes which will enable practices to better manage frail patients at home and so relieve pressure on ED.

One cluster is testing an early home visiting service to support early identification of patients for urgent visits and facilitate earlier transfer to hospital where appropriate. The cluster is looking to use paramedics in primary care alongside GPs.

In addition the CCG has funded 7 GP clinical leaders, one for each locality to champion integrated ways of working and to act as conduits between Practices and the New Models of Care Board (NMOC). NMOC includes a system wide Place-based model involving some of the above clusters of practices working with partners across our health and care system in Gloucestershire. They seek new ways of supporting people as close to their home as possible and in so doing avoiding unnecessary pressure on ED when this is not the optimum location for treatment.

Work is being progressed led by GCCG to work with a number of cluster practices to look at ways in which we can positively impact on patient arrival patterns within the urgent care system, predominantly ED. At present, later arrivals into the Emergency Department is impacting negatively across the system so the proposal is to review current home visiting arrangements in order that these occur where necessary earlier in the day, maximising admission avoidance opportunities or earlier arrival into the acute trust for more enhanced assessment.

12.2. Vulnerable Practice and Practice Resilience Programmes

Practices who are vulnerable and those who would benefit from an enhanced level of support have already identified themselves. Common reasons for requesting support are the recognition of the need to develop the workforce and for specialist advice and guidance, for example HR and financial expertise.

12.3. General Practice Development Programme

As part of the General Practice Forward View (GPFV), expressions of interest have been sought by the CCG from all practices in relation to training for reception and clerical staff to act as care navigators and to adopt further back office functions

thereby freeing GP time. It is expected that many practices will apply in their cluster grouping.

Additional funding for online systems and practice manager development are expected.

12.4. Workforce

GCCG, as part of Delegated Responsibility for Primary Care Commissioning is supporting its member practices in the recruitment, retention and return of the GP workforce; Practice Nurse Education and Training; and supporting new skill mixes. Priority schemes have been identified and are aligned to the GP workforce 10 point plan, the General Practice Forward View and the Gloucestershire Primary Care Strategy.

Gloucestershire was approved to set up a Community Education Provider Network (CEPN or Training Hub) and we are working closely with various local stakeholders as well as the West of England Academic Health Science Network to develop the CEPN to support education and training requirements in Gloucestershire.

GCCG has invested in a campaign to support member practices to recruit general practitioners. The multi-media campaign entitled Gloucestershire General Practice is in the first instance being promoted through the British Medical Journal (BMJ) in print and online. Alongside this a campaign microsite includes promotional video content and a live feed to Gloucestershire GP job advertisements. Member practices are able to utilise one CCG-funded advertising package with the BMJ during 2016/17. As a development of this and alongside our countywide provider partners the CCG is hosting a recruitment event in November 2016 to encourage individuals looking to work in Health and Social Care in Gloucestershire to understand the benefits of living and working here, and the type of roles on offer.

We are supporting the retention of the workforce by offering more flexible options to encourage Newly Qualified GPs that qualified in Gloucestershire to practice in the county, and those GPs considering retiring or leaving the profession to continue to practice, albeit as a portfolio career.

12.5. Service Developments that will impact on urgent Primary Care

GCCG is leading a project is to design and agree a service model to deliver integrated primary and community based urgent care services seven days per week across Gloucestershire with agreed plans that can be commissioned and implemented from the Spring of 2017 onwards. Workshops with a range of stakeholders were held over the summer and the programme of work is now being taken forward in detail across three broad themes/tiers, with the aim of producing a business case by the end of November:

- 24/7 co-located urgent care centres.
- Community based urgent care centres (at least 16 hours a day, 7 days a week).
- Shared practice arrangements for same day demand.

13. Social Care

Further information awaited but will include work being undertaken to review current domiciliary care capacity alongside new Care Navigator roles.

13.1. Reablement

Reablement is offered and available across all localities and at any one time provides care for between 250 to 450 service users. The range in the number of users is dependent upon the level of complexity and need of the individuals in service. This emphasises the difficulty in demand planning due to the variance in the service user numbers. The reablement actions include:

- Continuing to accept 100% of acute referrals (which in turn has reduced the ability to take community based referrals from ICTs and prevention focus).
- Continuing to work on community hospital referrals.
- Continued focus to increase productivity, reduce down time / sickness and progress cases.
- New domiciliary care framework awarded Spring/Summer 2016 now allows Health and Social care to purchase reablement from the independent sector. Strategic review over remaining in-house reablement resource to ensure reablement outcomes are delivered and potential re-focus on high-end therapy-led reablement services.
- Under the reablement offer, up to 12 weeks of free community hot meals can be provided via Adult Social Care.
- 'Hospital to Home' Service provided by the two new urban domiciliary care providers which support timely acceptance of referral and discharge. Initial assessment over 48-72 hours to determine ongoing pathways which include no further service or diversion to voluntary sector, straightforward personal care and/or opportunities for reablement. Within this Service, we have adopted a Trusted Assessor approach.
- Reablement bed review recommended increased dependency within the three main units to enable transfers with two carers to be delivered in a reablement unit rather than Community Hospital beds. GP cover out of hours and weekend discharges enabled following review of GP SLA and therapy input from ICTs.
- Six additional reablement beds commissioned from a reablement unit to increase capacity.
- Four reablement flats being piloted for a year from October 2016 in extra care settings (2x1-bedroom; 2x2-bedroom) to support discharges of social admissions and hard to place patients such as bariatric.

13.2. Domiciliary Care

Domiciliary care is provided by 83 different providers and cares for approximately 1600 people. It should be recognised that the bulk of the demand for services are attributed to 'self-funders' which fall outside of the remit of adult social care. The domiciliary care actions include:

- Simplification of spot provider process for sourcing packages.
- Work being undertaken to understand how best to RAG rate cases – i.e. length of wait, complexity, location etc.

- Letters being drafted to Providers to reassure that any packages secured between now and the award of the new contracting arrangements would be honoured for up to a year after award.
- New role to include a faster response for brokerage to accept exceptions at time of escalation.
- Practice decision making – reiterate that when suitable packages are refused that people are offered direct payments and / or accept that they are declining the local authority offer to meet their needs.
- Procurement of an Out of Hospital Service to facilitate risk positive discharges from the acute trust.

The actions that have been outlined as part of the winter preparation for both domiciliary care and reablement are as follows:

- Undertake robust demand and capacity modelling based upon understanding of predicted demand versus available and predicted capacity.
- Seek to increase availability of respite care “offers” in lieu of packages of care
- Based upon demand modelling look to increase capacity with Domiciliary Care by bringing on line additional providers into the market.
- Develop RAG rating matrix and escalation plan to outline what actions can be taken at varying levels of escalation.
- Working with domiciliary care providers and reablement to understand how services could be scaled back safely and proportionately in periods of system wide escalation.

13.3. Care Navigators (2 FTE)

This role has been developed to support those people who require support in arranging care in a hospital setting, but would not be eligible for social care funding. The objective of this role is to support the deflection in increasing levels of inappropriate referrals, or referrals that require Social Work input without resulting in funding of care packages. The post is also intended to support patients resolve simple housing issues e.g. refer into other support services, support benefit claims and having access to the Commissioning and Brokerage for Older People Team. This follows a model promoted in Leicester, the ‘Lighthouse’ pilot.

14. Mental Health

14.1. 24/7 Liaison mental health (LMH) services in A&E

The Mental Health Liaison Team Service has three component parts:

- Emergency Department Liaison
- Older People Liaison
- Alcohol Liaison

Since September 2015, the ED Liaison element has been available on a 24/7 basis. The Crisis Resolution and Home Treatment Teams provide night time cover on an in-reach basis. This has proved problematic at times as staff have been diverted to undertake urgent community assessments and/or respond to s136 MHA assessments. 2gNHSFT are in the process of recruiting staff into the ED Liaison Team so that the service will no longer be diverted to other activity.

14.2. Crisis Care Concordat (CCC)

Gloucestershire's CCC has nineteen different signatories and nearly eighty separate actions spanning prevention, access to crisis care, quality of care and recovery/relapse prevention. One of the most significant developments is the investment in remodelling of the existing Crisis Resolution and Home Treatment Service (CRHTT). The remodelled service will be called the Mental Health Acute Response Service (MHARS) and will have increased capacity and resources to address gaps in the urgent care pathway. The service will operate a broader eligibility criteria, faster response times for initial contact, triage and full assessment. The service will be comprised of two elements:

1. Urgent Response Team (URT)
2. Rapid Assessment and Home Treatment (RAHT)

Full implementation of the MHARS service has been hampered by recruitment issues related to lack of qualified nurses. As such a phased implementation of the service is being currently agreed. Co-location with Police at Waterwells is in progress and 2gNHSFT staff are working to agreed protocols with the Police which are aimed at reducing s136 MHA detentions. The service is now working with 16+ and agreement on implementation of the reduced age range is currently underway.

15. Transport

Within Gloucestershire, Arriva Transport Solutions Limited (ATSL) is the main provider of non-emergency patient transport. ATSL are responsible for the safe, timely and comfortable transport of patients between their place of residence and the healthcare facility, between healthcare facilities and from the healthcare facility to their place of residence.

The main services that patients are transported to and from are:

- Outpatient appointments at any treatment centre.
- Day case and inpatient admissions and day care.
- Discharges from hospitals/treatment centres.
- Discharges from EDs/MIIUs.
- End of life patients.
- Renal dialysis patients.
- On site and dual site hospital transfers.

ATSL work closely with GHFT to support and maintain patient flow within the acute hospital:

- A dedicated discharge coordinator is employed at GRH and is a vital role in building relationships across the acute trust and ATSL, encouraging collaborative working and coordinated booking of patient transport. This collaboration allows ATSL to effectively manage their workforce and vehicle fleet as well as supporting the acute trust in the reduction of on-day transport bookings.
- A dedicated non-clinical crewed HCP Admission Vehicle provided by ATSL was launched on 19th September 2016 for an initial period of 6 months. The vehicle is supporting the surge of GP admissions into GRH ED department

between the hours of 12:00 and 18:00, Monday to Friday. An initial review, however, suggests underutilisation of the vehicle due to patient acuity. GCCG are now exploring further possibilities for this vehicle, including discharge support direct from ED GRH.

ATSL's demand and capacity modelling has been developed by use of an 8-week horizon planning tool allowing them to establish expected levels of demand, forecast journey numbers as well as mobility types based on historical data and intelligence gathered. Resourcing is mapped to the forecasted demand and is constantly reviewed and adjusted accordingly. At times of unpredicted high demand or system pressure, ATSL are able to consider pulling resources from other neighbouring CCG areas as well as third party support.

In order to minimise the impacts of adverse weather challenges, ATSL have a clear plan in place which complements their business continuity arrangements. The plan outlines their approach to ensuring the continued provision of services during periods of adverse weather and provides guidance to ATSL staff on actions to be taken.

16. Communications

16.1. Introduction

This plan sets out public communication arrangements for GCCG and its Health and Social Care partners during the autumn and winter period 2016/17.

It includes details for planned campaign activity to promote preventative action and appropriate use of services and also sets out escalation arrangements for periods of increased pressure in the system.

It incorporates local detail within a common framework that spans the whole of Gloucestershire, including GCCG, NHS England, local trusts, Public Health England and the County Council.
This joined-up approach recognises the advantages of:

- Sharing resources and reducing duplication of effort
- Aligning messages
- Aligning timings
- Complementing national/regional communication and campaign plans
- Handling inter-organisational issues, especially at time of escalation.

It also takes account of the national integrated Winter Campaign and describes how this will be supported locally.

16.2. Co-ordinated and consistent communications

As well as ensuring local winter messages are consistent and co-ordinated, GCCG working with the partners described above, will take account of national messaging and timings, make the most of the campaign resources available and use local partner networks and communication channels to maximise impact.

GCCG, working with community partners, will also co-ordinate the local Advice ASAP campaign – a targeted campaign that encourages appropriate use of services and provides care advice by condition.

Scope

The organisations involved in shaping the local framework are:

- NHS Gloucestershire Clinical Commissioning Group
- Gloucestershire County Council
- Gloucestershire Hospitals NHS Foundation Trust
- Gloucestershire Care Services NHS Trust
- 2gether NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust
- NHS England – Area Team.

Within this framework, the following issues are covered:

i. Flu vaccination, which begins in the early autumn, but will continue throughout the winter period
ii. Combatting Norovirus
iii. Keeping people well and encouraging best use of services
iv. Roles and responsibilities at times of increased pressure.

The plan has also been drawn up in recognition of the move towards supporting greater resilience across the whole healthcare system, regardless of the time of year.

As part of this process, communications leads will be identified to attend each of the local A&EDBs, in order to:

- Understand the local position and outlook
- Provide advice
- Share intelligence and facilitate communications planning across organisations.

16.3. Resources

The plan relies heavily on use of national promotional materials, existing local campaign materials e.g. ASAP, local Web and App tools already in place, direct marketing, targeted social media advertising, local media sponsorship arrangements and local funding for the ASAP App/campaign. The Information Bus can also be used to promote messages eg “Safe and Well” has been promoted in the last month

The aim will be to secure economies of scale by using common materials and maximising partner organisation communication channels, routes and audiences.

i. flu vaccination

Background

The Gloucestershire Health Community approach will fit with Public Health England's Flu Immunisation Communications Strategy and the national winter campaign when this is launched on 5 October.

The main public target audiences for the flu communication campaign are all children aged 2 to 7 (but not 8 years or older) on 31 August 2016, those aged 6 months to under 65 years in clinical risk groups, pregnant women, those aged 65 years and over, those in long-stay residential care homes and carers.

A marketing toolkit (part of the national winter campaign) will be available for all partners from mid-September.

For Health and Social Care staff, the NHS Employers' Flu Fighter campaign will be the primary means of increasing update of flu vaccination across all NHS organisations. A national CQUIN to increase the uptake of flu vaccination amongst Health Care Professionals will be implemented in the Trusts.

The GCCG external plan, developed in partnership with the County Council and Public Health England will focus on hard hitting preventative messages with the key feature being a high profile and targeted social media video campaign, supported also by traditional media, design and distribution of promotional material and internal communication.

The social media video campaign will focus on three broad audiences: pregnant women and parents of young children, people with long term conditions and people aged 65 and over and carers.

The Director of Public Health (DPH) and GCCG GPs will be media spokespeople for the flu immunisation campaign at a local level.

Local approach

Communications work on flu vaccination will focus on:

Activity	Roles	Notes	Timing
Internal Communication – to support Flu immunisation take up amongst front line staff/clinics	GCC and Trusts.	Trust magazines, Team Briefs, What's new this Week (GP practice bulletin), posters and team meetings.	From October 2016
Media Promotion	GCCG to issue primary care release/GCC to issue local launch release/photo opportunity. GCCG to work with GCC on sponsored Gloucestershire	Align with national messaging and marketing campaign. GCC releases to coincide with PHE national launch in Oct 16. GCC activities with Fire and	From 3 October 2016

	media health pages. GCCG to produce PowerPoint slides for GP surgery waiting room TV screens. GCCG to work with GCC on radio advertising with Heart FM, other independent stations and BBC Radio Gloucestershire.	Rescue, councillors etc.	
Social Media	GCCG to use "RT Friday" (including campaign cards) to spread preventative messages. RT GCC activities with councillors fire and rescue etc. Facebook messages.	Partner agencies to support.	From 3 October 2016
Web resources	GCCG/GCC home page carousel link to resources/key messages. Partner agencies to offer a home page link. ASAP App and website (latest news) to carry flu messages.		From 3 October 2016
Campaign videos	GCCG to promote commissioned short films and use to support a targeted social media/on-line campaign.		From 3 October 2016
Promotional material – including detail on the distribution and audiences	GCCG to liaise with GCC and PHE to tailor/confirm availability of promotional materials e.g. posters/leaflets and discuss distribution outlets e.g. Information Bus, Care Homes. GCCG to liaise with GCC over syndicated articles for community partner newsletters/sites. GCCG to liaise with GHT and GCS over chronic LTC Groups and pregnant women.	GCCG/GCC to co-ordinate distribution – GP surgeries, pharmacies, hospitals (acute and community), schools and care homes. Bus to be reserved and materials agreed for the Information Bus.	From 3 October 2016

ii. Norovirus

Background

Each year, norovirus is responsible for ward closures and delayed admissions for hospital patients. As with many easily-spread infections, norovirus tends to be at its worse over the autumn and winter period, when pressures on the system are already high. It is therefore essential to minimise the impact.

However, it is also important to make the public aware that norovirus is essentially a community-wide problem that is brought into hospitals, care homes and other settings where people are most vulnerable. It is therefore something that can be tackled at source.

There is real scope for campaign work to help prevent, or reduce the spread of, outbreaks. GCCG is working closely with GHNHSFT, GCS and other community partners and has plans to re-launch the Combat Norovirus campaign.

This campaign, which includes high visibility billboards on health sites, promotional materials in public places, social media and media promotion, will get underway in early October.

Local approach

Communication work on norovirus will focus on:

Activity	Roles	Notes	Timing
Internal Communication – to support infection control practices	GCC and Trusts.	Trust magazines, Team Briefs, What's new this Week (GP practice bulletin), posters, team meetings	From early October 2016
Media Promotion	Joint media activity with GHNHSFT and GCS.	Media release and photo call	From early October 2016
Social media	GCCG to use their 'RT Friday.'	Tweet links directly to a branded e-key messages card, Support from community partners	From early October 2016
Web resources	GCCG and Trust website home page (carousel).	Link to resources/key messages. Partner agencies to offer a home page link	From early October 2016
Promotional materials	GHT to organise billboard signs, posters & leaflets at DGHs. GCS to organise posters & leaflets at Community Hospitals. GCCG to organise posters & leaflets at GP surgeries and pharmacies. GCCG to liaise with GHT/GCS over syndicated article for community partner newsletters/sites. GHT Comms to look at the option of including NV promotional material in appointment letters. PowerPoint presentation slides on GP surgery waiting room TV	Distribution also via Information Bus and to Village and Community Agents.	From early October 2016 From early October 2016 From early October 2016 From early October 2016

	screens. Information Bus presence at acute and community sites. GCCG to co-ordinate Double sided A5 card to be included in Joining Up Your Information mailing.	Promoting Combat Norovirus to patients and visitors. To all registered patients in Gloucestershire. To include important winter messages e.g. flu reminder, norovirus, ASAP. Branding check with national campaign	From mid-October 2016

iii. Keeping people well and encouraging best use of services

Background

An essential part of winter planning is the avoidance of hospital attendances and admissions and encouraging people to use the right health service for their ailment. This includes encouraging people to:

- Keep warm and well
- Seek the right treatment early if they do become unwell
- Use their local health services appropriately through access to the right sources of information (both in-hours and out of hours).

The local NHS has developed a twin track approach to communicating messages about a) prevention, self-care and taking early action when unwell (target groups) and b) appropriate use of services.

1) Supporting the national Winter campaign – across all media – encouraging early action and preventing serious illness
2) Marketing and promotion of the local Advice ASAP campaign (care advice and service signposting). This includes promoting the overall ASAP 'ill or injured – not sure where to turn?' campaign message (App, Search the website, Ask NHS 111 and Pharmacy).

Local approach

Communications will focus on:

Track 1 – Supporting the national campaign
Campaign: National NHS Winter Campaign – 'Stay well this Winter' - supports prevention and encourages target audiences to take early action when feeling unwell. Aims to reduce pressure on the NHS Urgent and Emergency Care system (from October 2016).
Key theme: Encouraging people to take early preventative action. All activities below (apart from the first row)

cover the preventative themes of 'Keep warm and well', Flu immunisation and taking early action when feeling unwell.

Activity	Roles	Notes	Timing
Internal Communication – promoting use/availability of materials and supporting campaign messages.	All Health and Social Care organisations.	Trust magazines, Team Briefs, What's new this Week (GP practice bulletin), GP promotional cards, and campaign materials.	Late October 2016 TBC
Encouraging flu immunisation take up		Use of national materials (see flu section for specific actions).	From early October 2016
Media Promotion – media release/photo opportunity in healthcare setting	GCCG to co-ordinate and manage.	Also use of the GCCG sponsored media health pages.	Late October 2016 TBC
Social media	GCCG to promote media messages.	Tweet/share links directly to branded e-key messages cards – including RT Friday.	Late October 2016
Web resources	GCCG and care partner on-line resources/key messages.	Partner agencies to offer a home page link.	Late October 2016
Promotional materials	GCCG to organise.	Posters and leaflets at GP surgeries, pharmacies and hospitals and sent to Village and Community Agents. Articles/artwork for community partner newsletters/sites. Successful distribution via Information Bus has taken place	Wk/b 14 November 2016
Additional proactive actions during periods of particularly poor weather	GCCG/GCC to co-ordinate.	Proactive media (including ads and editorial). Social media channels (joint/co-ordinated approach in place with partners).	As required

Track 2 – The ASAP campaign

The campaign, which provides guidance to the public on the right self-care and service options has already generated 10,000 App downloads and over 15,000 website visits.

The initiative targets adults and parents of young children with advice on what to do if they are ill or injured and are unsure where to turn.

The promotional material encourages residents to check out the App (ASAP Glos NHS), Search the website (www.asapglos.nhs.uk), Ask NHS 111 or visit their Pharmacy.

The ASAP website and App allows users to 'Search by Service' or 'Search by Condition' – providing a step by step guide through symptoms, self-care and signposting to the appropriate NHS service/s. It actively encourages use of pharmacies, NHS 111 and Community Minor Injury and Illness Units where appropriate.

Campaign: local Advice ASAP campaign

Key theme: Provides self-care advice and signposts to appropriate services (from October 2015).

Activity	Roles	Notes	Timing
Internal Communication – promoting use/availability of materials and supporting campaign messages	All Health and Social Care organisations.	Trust magazines, Team Briefs, What's new this Week (GP practice bulletin), GP promotional cards, and campaign materials.	From October 2016
Media package (1) - Working with Gloucestershire Media group to develop an integrated 2 month (seasonal) media package	GCCG to co-ordinate.	To include newspaper, social media platforms, website take over (campaign web banners) – link to App download. Highlighting specific conditions.	From mid November 2016
Media package (2) - Working with other media organisations in Gloucestershire to develop an integrated 2 month (seasonal) media plan	GCCG to co-ordinate.	To include newspaper, social media platforms, website take over (campaign web banners) – link to App download. Highlighting specific conditions.	From mid November 2016
Targeted Facebook advertising	GCCG to co-ordinate through ICE Creates.	Targeting young parents and adult population (18-40). 3 month period. Single biggest contributor to App downloads to date. Including highlighting specific conditions.	From mid November 2016 (3 month duration).
Household Winter mailer	GCCG to co-ordinate.	All households in Gloucestershire postcodes.	w/c 28 November 2016
Further hardcopy collateral distribution– posters, flyers, leaflets, key message cards	GCCG to co-ordinate.	Supporting the ASAP campaign call to action including App downloads. NHS and community outlets.	Early November 2016
Bus advertising	GCCG to co-ordinate.	To coincide with the key seasonal campaign period and to link with other activities above. Bus needs to be reserved.	5 December 2016 – 2 January 2017
Information Bus	GCCG to co-ordinate.	Continuing roadshow presence e.g. Rugby Club, shopping centres, schools, other neighbourhood venues.	Winter 2016/17
Local radio advertising	GCCG to co-ordinate.	2 periods of 2 weeks. Heart FM.	Mid November 2016 & January 2017

Specific activity linked to Holiday periods e.g. Christmas/New Year period e.g. access to services, repeat prescriptions etc.	GCCG to co-ordinate.	Proactive media (including ads and editorial). Social media channels (joint/co-ordinated approach in place with partners).	December 2016/January 2017

iv. Escalation at times of increased pressure

Background

Escalation and incidents that only affect the NHS in one area (Level 1) are handled by GCCG and the individual Trust involved (this could involve other relevant providers where appropriate). Once the impact spreads to other providers and health communities (Level 2), NHS England and Public Health England take on responsibility for coordinating the response. Regional impact is categorised as Level 3, and national as Level 4. Examples are shown below:

Level	Description	Lead	Example
1	A health-related incident that can be responded to and managed by provider organisations within their respective business as usual capabilities.	CCG/Provider	• Power outage at provider site • Internal staffing issues • 'Red' declaration within the system
2	A health-related incident that requires the response of a number of health provider organisations and will require an NHS England Area Team to co-ordinate.	CCG/Area Team / PHE	• 'Black' declaration of a health community • Communicable disease outbreak • Flooding • Large RTA • CBRN incident • Multi-agency Strategic or Tactical Coordinating Group
3	As above but with regional implications including mutual aid requirements that necessitate NHS England Regional co-ordination to meet the demands of the incident.	Area Team/Region	• Mass casualties
4	As above but with national implications requiring NHS England National co-ordination to support the NHS and NHS England response.	Area Team/Region/National	• Pandemic flu • Any national plan activation

Even at local level, collaboration and coordination are critical for the smooth handling of incidents and escalation, not just to meet the needs of patients but to sustain confidence in the NHS.

CCGs are expected to invite their communications leads on to urgent care teleconferences. The relevant NHS England Area Team is expected to invite area team communications lead onto any teleconference called in light of a Level 2 incident.

Communications leads will also be assigned to each of the new System Resilience Groups, in order to:

- Understand the local position and outlook
- Provide advice
- Share intelligence and facilitate communications planning across organisations.

The grid below sets out likely scenarios and organisational roles. Note that, in all cases, individual organisations are responsible for communicating with their own staff.

Winter scenario	Who is responsible for communicating urgent messages to patients and public	Who is responsible for communicating with other organisations
Heavy snow/flooding affecting single CCG health economy (level 1 incident) Might involve staff unable to get to usual places of work	CCGs are responsible for coordinating the local communications response across providers (e.g. acute and community), including: • Issuing advice to patients and the public via the media to remind them only to use A&E/999 in an emergency and to use 111 or other local services as appropriate. • Advising where local hospitals have had to cancel operations due to bad weather and that patients will be contacted individually about this. Media responses will be developed between CCG and provider organisations, to ensure that the bigger picture is conveyed and messaging is consistent. Releases and statements to be shared in local health community, and with Area Team, Public Health England and local authority. Trusts to support via websites and	CCGs, as commissioners of secondary care, are responsible for communicating with GPs to advise on action to ease pressure on hospitals. CCGs, as commissioners of community services, are responsible for communicating with community providers about action to ease pressure on hospitals and reach vulnerable patients. Trusts are responsible for communicating with social care over discharge etc.

	social media, customising messages as necessary. Public Health England and the local authority are responsible for: • Providing general 'keep warm, keep well' advice to patients and the public (including vulnerable patients with long-term conditions).	
Heavy snow/flooding causing severe disruption across the region (a level 2 incident or above) Might involve staff unable to get to usual places of work	NHS England Area Team is responsible for co-ordinating the regional communications response, including: • Issuing advice to patients and the public via the media to remind them only to use A&E/999 in an emergency and to use 111 or other local services as appropriate • Advising where local hospitals have had to cancel operations due to bad weather and that patients will be contacted individually about this. Media responses should be developed between the Area Team, CCGs and providers, to ensure that the bigger picture is conveyed and messaging is consistent. Releases and statements to be shared across regional health community and with Public Health England and local authorities. As category two responders, CCGs to support area team communications colleagues as required to help disseminate messages to patients and the public via the local media. For example, CCG comms colleagues might be asked to distribute key messages/releases to local media contacts, while NHS England comms colleagues focus on regional media. Trusts to support via websites and social media, customising messages as necessary for local consumption. Public Health England and local authorities are responsible for: • Providing general 'keep warm, keep well' advice to patients and the public	CCGs, as commissioners of secondary care, are responsible for communicating with GPs to advise on action to ease pressure on hospitals. CCGs, as commissioners of community services, are responsible for communicating with community providers about action to ease pressure on hospitals and reach vulnerable patients. Trusts are responsible for communicating with social care over discharge etc.

	(including vulnerable patients with long-term conditions).	
Very cold weather, but no impact yet felt on services	Public Health England/local authorities are responsible for issuing 'keep warm, keep well' advice to local people urging them to stay indoors and take care of themselves; for example, reminding the frail and elderly not to go out in icy conditions to avoid slipping over. Media releases and statements to be shared across regional health community, and with Area Team and local authorities.	
Staff unable to get into work due to sickness (e.g. flu), causing disruption/ pressure/cancelled operations, but confined to an individual provider/ local CCG health economy	CCGs are responsible for coordinating the local communications response across providers (e.g. acute and community), including: • Issuing advice to patients and the public via the media to remind them only to use A&E/999 in an emergency, to use 111 or other local services as appropriate (link to local campaign resources) • Advising where local hospitals have had to cancel operations due to staff shortages and that patients will be contacted individually about this. Trusts to support via websites and social media, customising messages as necessary. Media responses should be developed between CCG and provider, to ensure that the bigger picture is conveyed and messaging is consistent. Releases and statements to be shared in local health community, and with Area Team, Public Health England and local authority. Public Health England is responsible for: • Providing public messages on flu/other communicable diseases.	CCGs, as commissioners of secondary care, are responsible for communicating with GPs to advise on action to ease pressure on hospitals. CCGs, as commissioners of community services, are responsible for communicating with community providers about action to ease pressure on hospitals. Trusts are responsible for communicating with social care over discharge etc.
Local GP surgery/surgeries have to close due to bad weather	CCGs with delegated commissioning responsibility are responsible for informing local patients and the public	CCG responsible for informing other organisations, including NHS111, CCGs,

	via the media and for setting out the alternatives (including use of 111). Individual practices responsible for informing individual patients who have appointments booked.	trusts, OOH providers, unaffected practices and pharmacies.
A&E department closed/accepting no patients/severe pressures, for example due to major internal incident (Level 1)	CCGs are responsible for coordinating the local communications response across providers (e.g. acute and community), including: • Issuing advice to patients and the public via the media to remind them what to do in an emergency and to use 111 or other local services as appropriate (link to local campaign resources) • Advising where the hospital has had to cancel operations and that patients will be contacted individually about this. Trusts to support via websites and social media, customising messages as necessary. Media responses should be developed between CCG and provider, to ensure that the bigger picture is conveyed and messaging is consistent. Releases and statements to be shared in local health community, and with Area Team and local authority. NHS England Area team responsible for coordinating any regional communications response if there are knock-on effects on other areas.	CCGs, as commissioners of secondary care, are responsible for communicating with GPs to advise on action to ease pressure on hospitals. CCGs, as commissioners of community services, are responsible for communicating with community providers about action to ease pressure on hospitals. Trusts are responsible for communicating with social care over discharge etc.
Closure of A&E department(s) due to major incident affecting a number of providers (level 2)	NHS England Area Team is responsible for co-ordinating the regional communications response, including: • Issuing advice to patients and the public via the media to remind them only to use A&E/999 in an emergency and to use 111 or other local services as appropriate (link to campaign resources) • Advising where local hospitals have had to cancel operations due to bad weather and that patients will be contacted individually	CCGs, as commissioners of secondary care, are responsible for communicating with GPs to advise on action to ease pressure on hospitals. CCGs, as commissioners of community services, are responsible for communicating with community providers about action to ease pressure on hospitals. Trusts are responsible for communicating with social

	about this. Trusts to support via websites and social media, customising messages as necessary for local consumption. Media responses should be developed between the Area Team, CCGs and providers, to ensure that the bigger picture is conveyed and messaging is consistent. Releases and statements to be shared across regional health community and with local authorities. As category two responders, CCGs to support Area Team communications colleagues as required to help disseminate messages to patients and the public via the local media. For example, CCG comms colleagues might be asked to distribute key messages/releases to local media contacts, while Area Team comms colleagues focus on regional media.	care over discharge etc.
Ward closed in local hospital due to Norovirus	Trusts (in partnership with the CCG) are responsible for issuing advice to patients and the public, reminding them to stay away from the hospital if they have symptoms and providing basic hygiene advice to stop the spread of the infection. Might involve signposting rather than media work, depending on seriousness of outbreak. Trusts to refer to Area Team before media work, in case other providers are affected and wider system response is needed. CCGs responsible for issuing wider advice to patients if outbreak serious enough to affect admissions/capacity to any significant degree.	CCGs, as commissioners of secondary care, are responsible for communicating with GPs to advise on action to ease pressure on hospitals CCGs, as commissioners of community services, are responsible for communicating with community providers about action to ease pressure on hospitals Trusts are responsible for communicating with social care over discharge etc.
Ambulances queuing outside A&E department, causing delays to patients	Provider and ambulance service to develop coordinated media response in collaboration with CCG. To work with Area Team if queuing extends across multiple providers.	CCGs, as commissioners of secondary care, are responsible for communicating with GPs to advise on action to ease pressure on hospitals. CCGs, as commissioners of community services, are responsible for communicating with community providers about action to ease pressure on

		hospitals. Trusts are responsible for communicating with social care over discharge etc.
Delayed discharges causing delays to admissions	CCG, local authority and Provider to develop coordinated response, focusing on system-wide solutions and admission-avoidance messages for patients.	CCGs, as commissioners of secondary care, are responsible for communicating with GPs to advice on action to ease pressure on hospitals. CCGs, as commissioners of community services, are responsible for communicating with community providers about action to ease pressure on hospitals.
111 service experiencing pressure and delay in calls getting through	NHS England Area Team and CCGs are responsible for co-ordinating the regional communications response, including: • Issuing advice to patients and the public via the media to on alternative sources of healthcare help and support (including link to campaign resources). Messaging to be developed with the 111 service provider. Trusts to support via websites and social media, customising messages as necessary for local consumption.	CCG responsible for informing other organisations, trusts, OOH providers, practices and pharmacies.

17. Mortuary

Gloucestershire County Council has a Managing Excess Deaths Contingency Plan that has been adopted by Multi Agency partners throughout the county and GCCG has worked extensively with the County Council's Mortuary Manager and the Coroner's office with regard to this.

The accommodation within the existing County Mortuary (62) was at no time under pressure during the difficult times last winter. The Excess Deaths Plan is to increase the capacity of the County Mortuary to 100 through the use of refrigerated units called "Nutwells" each of which holds 20 bodies.

There is additional capacity within both GRH and CGH Mortuaries that are no longer licensed for post mortems under the Human Tissue Act but still perform a refrigerated holding capacity for storage.

There are good working relationships across Gloucestershire between the County Council Mortuary, the acute mortuaries and the various undertakers which help facilitate prompt services and will continue to ease pressure into winter 2016/17.

18. Infection, Prevention and Control

18.1. Infection Control

There is an increased risk of infection control during periods of escalation. During winter, the levels of community acquired infections (predominantly Norovirus) are higher. In 2015/16 there was a total of 80 bed days lost at GHNHSFT throughout the year due to the outbreaks with a total of 103 patients affected with symptoms compared with 2014/15 when there were a total of 692 bed days lost at GHNHSFT due to the outbreaks with a total of 427 patients affected.

Within GHNHSFT, outbreaks of diarrhoea and vomiting will be managed using the Southwest Norovirus Toolkit detailing the escalation procedure for the management and communication of norovirus outbreaks within the Trust. There has been a programme of deep cleaning instigated over the summer in preparation for the winter. An enhanced programme of cleaning will be implemented as required. The Combat Norovirus Campaign will be refreshed and continued. This aims key messages at visitors, patients and staff including symptoms, promoting hand washing, restricting visiting and restrictions for returning to work.

From October 2016 to May 2017, Infection Control Nurses at the Trust will provide an additional service to review outbreaks of diarrhoea and vomiting at weekends and bank holidays from 08:30-12:15 hours by telephone from home. This is a limited and unfunded service. The Infection Control Nurses will work flexibly over the winter to cover the service. It is recognised that the availability of an Infection Control Nurse at these times has been beneficial and has contributed to managing the outbreaks and the operational pressures that occur as a result of ward closures. To provide this service there will be a reduction in Infection Control Nurse availability for some meetings and during normal working hours. The Department of Infection and Prevention Control (DIPC) is working closely with our local Public Health Team to provide extra information and training to private care home staff to try and prevent unnecessary admissions from them and reduce infection. A workshop is being organised by GCCG that will focus upon care homes and the prevention of norovirus spread.

Within the Community Hospitals, there are robust infection control policies in place with strict monitoring of adherence to policy in order to ensure that bed closures are minimised as a result of infectious outbreaks. Cleaning schedules are in place throughout the community hospitals with regular cleanliness reviews to ensure standards are maximised and consistent.

18.2. Seasonal Flu

NHS England working with Public Health England has a well-defined delivery and action plan for the 2016-2017 seasonal flu programme, integrated into a multi-organisation communications and marketing plan.

18.3. Staff

NHS England has identified Flu Preparedness as a priority for planning across all healthcare providers. Stocks of Tamiflu are available across the county with a rolling programme of vaccination campaigns across all Health and Social Care providers.

GHNHSFT has a comprehensive seasonal Flu Plan. A key part of this is staff vaccination and an internal communications strategy will be launched ahead of vaccination roll-out. It is expected that a proactive roll-out of the Trust vaccination programme commences in late September 2016. Occupational Health will use flu champions, targeting and vaccinating front-line staff in high risk areas and offering evening sessions for maximum uptake.

The aim is to vaccinate more staff than were vaccinated in 2015/16. For the 2016/17 staff vaccination programme, the Trusts have a national CQUIN to increase the uptake of flu vaccination amongst Health Care staff. A proactive campaign will be launched and staff will be strongly encouraged to take up the vaccine. Uptake of the flu vaccination will be regularly reviewed by staff group and clinical areas.

Organisations are looking at a number of ways of increasing the uptake of vaccinations by staff which include peer vaccination, Working Well (Occupational Health Service), opportunistic vaccination and increasing the focus on community based staff.

Arriva offer all employees (annually in October) a free flu vaccination voucher which is redeemable at Boots the Chemist. Staff sign up for their free vaccination via their line manager and the appropriate vouchers are purchased and distributed.

18.4. Gloucestershire citizens

Organisations are taking a pro-active approach this winter to maximise the vaccination uptake by Gloucestershire citizens, by making it more widely available. GCCG is working together with NHS England on a plan to achieve a greater uptake in all groups, including working with GP practices and care homes and delivering vaccinations through community pharmacy.

Below is evidence of previous uptake of seasonal flu vaccinations for 2014/15 and 2015/16: -

Patient Group	2014/15 %	2015/16 %
Patients >65years	74	72.7
Patients <65yrs with a long term condition	49.5	45.1
Pregnant women	42.6	43.9

A national service specification has been developed to assist implementation of community pharmacy vaccination.

GPs will be delivering to the various cohorts of people for 2016/17.

These initiatives, including extended GP working hours, will help capture many of these patient groups at more convenient locations and times, particularly for those people who are employed.

19. Adverse Weather

Appendix 1 of the National Cold weather plan identifies the impact of cold weather on the Health Economy. All members of the Local Health Resilience Partnership (LHRP) are required to refer to the National plan within their business continuity planning process which has been assured by GCCG against NHS England Core standards.

Severe weather warnings issued by the Met Office are received by those organisations through widespread warnings and briefings. These warnings contain actions that must be taken as per Appendix 3 of the National Severe Weather Plan.

Upon receipt of a warning of severe weather, if appropriate, a Multi-Agency teleconference will be called amongst the members of the Gloucestershire Multi Agency Local Resilience Forum. This group includes a member of staff for NHS England who will disseminate information across the Health Community via the format listed in Chapter 4 of the Health Community Response Plan.

20. Business Continuity Plans

All key stakeholders have resilience embedded within their Business Continuity Plans (BCP) with all organisations subject to a core standards “Deep Dive” assurance process by NHS England during Q2 of 2016. All stakeholder plans were found to be fit for purpose.

All Key stakeholder plans are aligned with good practice and appropriate guidance of ISO 22301.

The key elements of Business Continuity (listed below) have been tested by all organisations to ensure that their plan:

- Identifies and manages current and future threats to their organisation.
- Takes a proactive approach to minimising the impact of incidents.
- Provides a framework for building organisational resilience.
- Keeps critical functions up and running during times of crises.
- Minimises downtime during incidents and improves recovery time.
- Demonstrates resilience to stakeholders and suppliers.
- Protects reputation and brand.

Irrespective of the disruption, BCP need to cater for the loss or unavailability of the following:

- People.
- Premises and utilities.
- Technology.

- Information.
- Supplies.
- Transport.
- Stakeholders.

21. Conclusion

Gloucestershire Health and Social Care Community are committed to providing high quality and responsive services during winter 16/17. Significant work is underway to ensure resilience is embedded across the system and provide assurance that funds have been appropriately allocated based upon thorough review, analysis and learning from 2015/16.

The ability of the system to de-escalate during the summer of 2016 has been challenged which requires enhanced assurance that the system will be able to respond to the known challenges that the winter months present.

Ensuring that services have undertaken detailed demand and capacity modelling for individual services is regarded as critical, alongside robust bed modelling which has been based upon accurate assumptions.

It has been acknowledged by all Health and Social Care providers that “working together” and ensuring where possible that services are integrated and seamless for patient care delivery is pivotal. This will provide assurance to the staff and Gloucestershire citizens that “The system becomes more than just the sum of its part”.

22. Appendix

Appendix 1 - Bank Holiday Planning and Provider Assurance

Provider assurances FULL TEMPLATE

Provider Assurances REDUCED TEMPLATE

Appendix 2 – GCCG Escalation Plan & Framework 16/17

GCCG Escalation Plan Framework 16-17 v0

NHS
Gloucestershire
Clinical Commissioning Group

DATE: 21/12/16

VERSION: DRAFT v0.7

Gloucestershire Clinical Commissioning Group Escalation Plan and Framework 2016/17

Version v0.7

December 2016

Lead Directors:	Mark Walkingshaw	
Date:	December 2016	
Version:	v0.7	
Author:	Jennifer Ryan: Commissioning Manager Urgent Care	
Review date:	Committee	Comments
	A&E Delivery Board	

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1. SCOPE OF FRAMEWORK

i. The Gloucestershire Clinical Commissioning Group (GCCG) Escalation Framework sets out the procedures across Gloucestershire to manage day to day variations in demand across the health and social care system as well as the procedures for managing significant surges in demand. The purpose is to ensure that all partners across Gloucestershire use a consistent and effective mechanism to access additional short term capacity in the right part of the system when demand peaks.

ii. The document has acknowledged and adapted the NHS England South Central Escalation Framework Version 1.1and NHS England South Surge Management Framework 2016. It also reflects guidance contained within "Transforming urgent and emergency care services in England, Safer, faster, better, good practice in delivering urgent and emergency care".

iii. This framework will support the work being delivered via the Gloucestershire A&E Delivery Board (A&EDB) who is responsible for assuring effective and sustainable all round operational delivery. This will ensure that the Gloucestershire system is continually robust and provides a proactive approach to managing operational problems across the system all year round.

iv. This framework is designed for managers and clinicians involved in managing capacity and patient throughput at time of excess demand. This document will be circulated to all staff who participate in such events, to provide a practical working reference tool for all parties, thereby aiding co-ordination, communication and implementation of the appropriate actions in each organisation.

v. The escalation framework reflects the role of wider system escalation within Gloucestershire, and therefore should be regarded as 'in operation' on a year round basis. The framework applies to all organisations contributing to Urgent and Emergency care in Gloucestershire.

vi. The framework must be read in conjunction with individual provider internal escalation plans.

vii. The Framework also adheres to the 'National Operational Pressures Escalation Levels Framework' (OPEL) guidance 2016, which aims to create a consistent approach across health systems in times of pressure. The subsequent roles and responsibilities of GCCG, NHS England and NHS Improvement are in Appendix 2.

2. AIMS, OBJECTIVES AND EXPECTATIONS

Aim:	To ensure safe, efficient urgent care and emergency services for patients and the public.
Objective:	• The wider system is Green the majority of the time. • The system works collaboratively to ensure relevant national key performance targets are met (e.g. 4 hour performance, ambulance handovers). • The framework supports the wider working of the A&EDB.
Expectations:	• Each organisation has a robust, up-to-date escalation plan which dovetails effectively with this escalation framework. • Each organisation has clearly identified roles and responsibilities for escalation planning and management, and there is an Executive Director

	with overall responsibility for ensuring escalation plans are actioned and reviewed. • There will be an ethos of integration, transparency and collaboration embedded within the escalation process. • Organisational plans, policies and procedures, and their operation support delivery of safe, efficient services and delivery of key performance targets which help demonstrate this. • Where an issue is escalated in accordance with agreed pathways/protocols, the owner will retain responsibility for ensuring full resolution. • Pressures are managed at local system level, with the majority of issues being managed within local system calls and procedures and escalation to wider system level the exception. • Each organisation has responsibility for implementing the agreed actions (Appendix 3b) as agreed across the urgent care network in response to an increased escalation status. • All organisations are to take escalation actions based on system performance as well as own performance. • Risks will be taken proportionally across the system in line with the system risk register. • Providers work proactively with each other including agreeing the implementation of local escalation outside of local or wider system calls. • All organisations follow the policy and procedures as set out, including provision of daily accurate data and information in a timely way; internal and external communications are of a high standard. • Organisations join wider system calls as needed, represented by staff able to fulfil their organisations' role in the context of operating the policy and the specific call in question. • When email escalation alerts are received by organisations, immediate organisation dissemination and appropriate actions will commence. • Wider system calls will be pre-emptive as well as responsive, looking ahead to a potential period of pressure e.g. Bank holidays. • Where a 'Summit' level call is needed to take stock of serious concerns and agree exceptional action, it will be at Chief Executive Level and include Director Level input from the local NHS England (NHSE) Team. • Special action will be required where an Emergency Department (ED) has to close (as opposed to not being able to receive new attenders) as it will not be able to offer resuscitation facilities. • For any patients that are moved during escalation (e.g. a patient that is taken to Cheltenham during an internal divert instead of Gloucester), plans must be in place for the repatriation of patients transferred or initially taken to a receiving organisation. • The declaration of Black/OPEL 4 escalation status should only be in exceptional circumstances and automatically triggers mandatory actions within the 'OPEL' Framework. • The trigger for request for external assistance will be the declaration by GCCG on behalf of the whole system Black/OPEL 4 status. GCCG will inform the local NHSE Area Team of an imminent move to Black/OPEL 4 and if Black/OPEL 4 status is declared NHSE will inform Regional and National NHSE and NHS Improvement (NHSI). • It is expected that all A&EDB members work with GCCG to produce and sign off an exception report for NHSE and NHSI when the escalation status is raised to Red/OPEL3.

3. DEFINITIONS OF ESCALATION

The Gloucestershire system wide escalation follows the National NHS England alter levels, comprising of 4 distinct statuses:

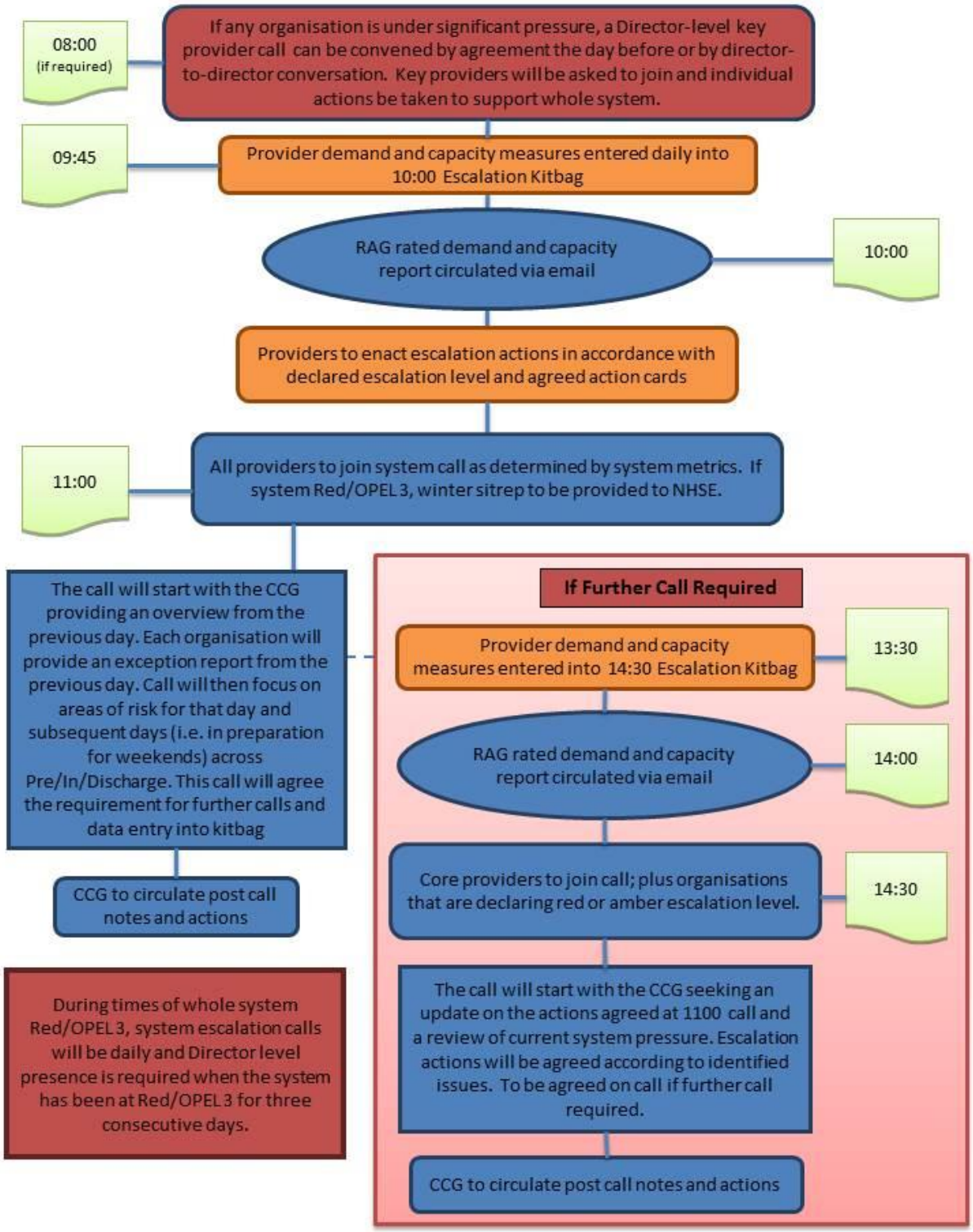
Definition of Escalation Statuses for A&E Delivery Boards	
GREEN (OPEL 1)	**Patient Flow Management** The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The local A&E Delivery Board area will take any relevant actions and ensure appropriate levels of commissioned services are provided.
AMBER (OPEL 2)	**Mitigation of escalation** The local health and social care system is starting to show signs of pressure. The local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible.
RED (OPEL 3)	**Whole system compromised** The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in Amber/Opel 2 have not succeeded. Further urgent actions are now required across the system by all A&E Delivery Board partners and increased external support may be required.
BLACK (OPEL 4) (whole system)	**Severe pressure and failure of actions** Pressure in the local health and social care system continues to escalate, leaving organisations unable to delivery comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions have been taken, and external extensive support and intervention may be required.

To enable local A&E Delivery Boards to align escalation protocols across systems, the National Escalation Framework now follows the standardised 'Operational Pressures Escalation Levels' Framework (OPEL 1 -4). The levels 1 – 4 mirror the system already used by Gloucestershire (as shown above), and will only be used when communicating with the public, media and other local health authorities.

4. OVERVIEW OF SYSTEM WIDE ESCALATION MANAGEMENT

Activation of whole system escalation

1. The system escalation process is led by GCCG on-call Director and will entail implementing escalation actions to manage, contain and reverse system pressure. The 7 day process is described in the flowchart below:



2. The daily system assurance level is created by all providers submitting data based on their demand and capacity measures and the status of their individual organisation pressure. All the data is weighted in accordance to the organisations potential impact on the whole system (Appendix 3a).

3. When the whole system daily assurance level is declared (via email), immediate organisation dissemination and appropriate actions (Appendix 3b) will commence in order to prevent and reverse further escalation.

4. Each provider organisation has defined and agreed actions to be taken to avoid the need for further escalation and to manage de-escalation effectively (Appendix 3b).

Daily Calls

1. The strategic and operational conference calls are a key vehicle for system wide demand and capacity planning, confirming actions taken and for identifying required solutions to maintain system flow and reduce escalation.

2. The frequency of calls is increased as needed during periods of escalation (as shown in the flowchart) and a whole system strategic conference call should be arranged before declaration of Black/OPEL 4 escalation status.

3. During Winter, daily system management calls take place Monday and Thursday at 11:00am as standard. During periods of escalation, calls will be increased to a frequency determined by the system metrics. Calls will be chaired by GCCG Directors. Calls will take place daily when the system is at level Red/OPEL 3 and the content will be focused around de-escalation and the required exception report. Director level representation will be expected if the system has been in Red/OPEL 3 for three consecutive days.

4. The remit of the system wide escalation call is to address issues and discuss mitigating actions. Where existing or building pressure has prompted the call, the aim will be to:

    i. Confirm that planned escalation actions and contingencies appropriate to the level of escalation have been carried out.
    ii. Discuss and agree additional or exceptional actions to address system flow.
    iii. Agree adjustment up or down of system escalation status.
    iv. Agree communications to a wider audience, where appropriate, to secure and coordinate additional support or capacity.

5. The responsibility of the individual representatives on the call is to

    i. Provide accurate and up to date information.
    ii. Circulate information internally within their organisation.
    iii. Follow up actions within the timescales agreed.
    iv. Work collaboratively in a solution focused approach.
    v. Ensure that decisions and actions are circulated to appropriate persons in their respective organisations.

Locally agreed processes and principles

- Escalation measures have been agreed and weighted which dictate the whole system escalation levels. These are defined within the escalation framework contained within Appendix 3a.

- The whole system declared level may differ from levels declared within individual organisations. All organisations are expected to undertake the actions related to the highest ranking declared level.

- During periods of escalation, levels of tolerance may be adjusted to reflect the whole system risk. This will be agreed under the direction of GCCG.

- Data will be entered into the 'Escalation kitbag' 7 days a week (where appropriate) which will activate alerts providing the escalation level trigger.

- GCCG in collaboration with A&EDB members have agreed that before opening beds at short notice the system must satisfy that:

    i. Every patient in every bed has been reviewed by his/her consultant that day.
    ii. There has been a rapid review of every patient who has been assessed to no longer require acute inpatient care by team of clinicians.
    iii. There is a clear de-escalation plan to close the beds as soon as possible.
    iv. Escalation wards will have dedicated consultant, nursing and therapy staffing with twice daily ward rounds.
    v. Escalation wards will not be used to accommodate frail older people moved from other wards to become outliers.
    vi. The hospitals full capacity protocol has been invoked.
    vii. All economy staffing has been deployed to ensure that patient safety in the Acute Trust is not compromised.

Exception Reporting to NHS England

For the winter period, there will be daily escalation status reporting processes to NHS England and NHS Improvement in place (by exception). The required level of reporting is dependent on the system daily escalation status generated by Alamac.

Reporting Requirements:

GREEN/OPEL 1: No reporting required.

AMBER/OPEL 2: No local reporting required (unless deescalating from RED/OPEL 3).

RED/OPEL 3: NHSE/I will require an exception report to be completed by the CCG (and signed off by the A&E Delivery Board). The reporting process is as follows:

- 10am - escalation status declared RED/OPEL 3 by Alamac.
- 11am - Daily call required, with the focus being the content for the exception report, de-escalation and ensuring that the appropriate action cards are being implemented.
- 3pm - CCG to complete exception report and circulate to A&EDB distribution list for comments and sign off (Appendix 1).
- 11am (next day) – Submit exception report to NHSE/I (Appendix 8).

If the reporting lands on a Friday, Saturday or Sunday, a handover will be required between the reporting leads (5pm on Friday and 9am on Monday), with the relevant reports being submitted by 11am on the Monday. If the reporting falls on a bank holiday, the reporting will need to be handed over to the reporting lead by 9am the next working day.

If the escalation status remains the same, daily updates on the situation will be required. If the escalation status increases to OPEL 4/BLACK or decreases to OPEL 2/AMBER, an updated exception report will be required. The reporting process will be the same as the above.

BLACK/OPEL 4: The CCG Chief Executive must be informed of this decision. NHSE-South Central are to be contacted regarding the move to BLACK/OPEL 4 on **07623505519, NHS43.**

5. 'BLACK' STATUS (OPEL 4)

Mandatory procedures prior to declaration of 'Black' status

1. If an organisation is predicted to move to Black/OPEL 4 escalation status, the GCCG on call director should be contacted.

2. Prior to declaration of 'Black' (OPEL 4) status, all actions must be taken to reduce pressure and all system partners must be fully involved in supporting the organisation at risk of this escalation. The expectation is that it would be extremely rare and the reasons exceptional for an organisation to declare 'Black' (OPEL 4) status whilst any of the Gloucestershire providers were reporting pressure less than Red/OPEL 3 level.

3. Prior to the declaration of 'Black' (OPEL 4) status by an organisation the whole system must ensure that the following actions have been implemented:

Actions to undertake before requesting escalation from 'Red' (OPEL 3) to 'Black' (OPEL 4)	
WHOLE SYSTEM	
1	All escalation actions listed in Appendix 4 have been implemented.
2	CEOs / Lead Directors have been involved in discussion and agree with escalation.
3	All providers to cease non-essential activities which will not positively impact on system status.
4	All actions from local escalation plans have been utilised.

**Please note, actions highlighted in blue are mandated by National NHSE guidelines.*

4. The GCCG on-call Director will then convene a system wide strategic conference call with all relevant partners to support the organisation at risk of Black/OPEL 4 system escalation to help put in place actions to de-escalate the situation.

5. Where escalation to organisational 'Black' (OPEL 4) status cannot be averted, the Executive Director on call for the organisation declaring 'Black' (OPEL 4) status must immediately inform the Executive Director On-Call for GCCG, which will result in the agreement of ongoing actions reflecting whole system status level.

6. The Executive Director On-Call for GCCG must then immediately inform the Local NHSE Team of the escalation status when at system level Black/OPEL 4.

Actions following Black/OPEL 4 declaration status:

At Alert Status 'Black' (OPEL 4) the following actions must be completed:	
WHOLE SYSTEM	
1	Continue to explore agreed Amber (OPEL 2) and Red (OPEL 3) actions and take decisive action to alleviate pressure.
2	Contribute to system-wide communications to update regularly on status of organisations (as per local communications plans).
3	Provide mutual aid of staff and services across the local health economy as appropriate.
4	Stand-down of 'Black' (OPEL 4) alert once review suggests pressure is alleviating.
5	**Post escalation:** Contribute to the Exception Reporting and lessons learnt process through the SIRI investigation.

**Please note, actions highlighted in blue are mandated by National NHSE guidelines.*

6. Communication

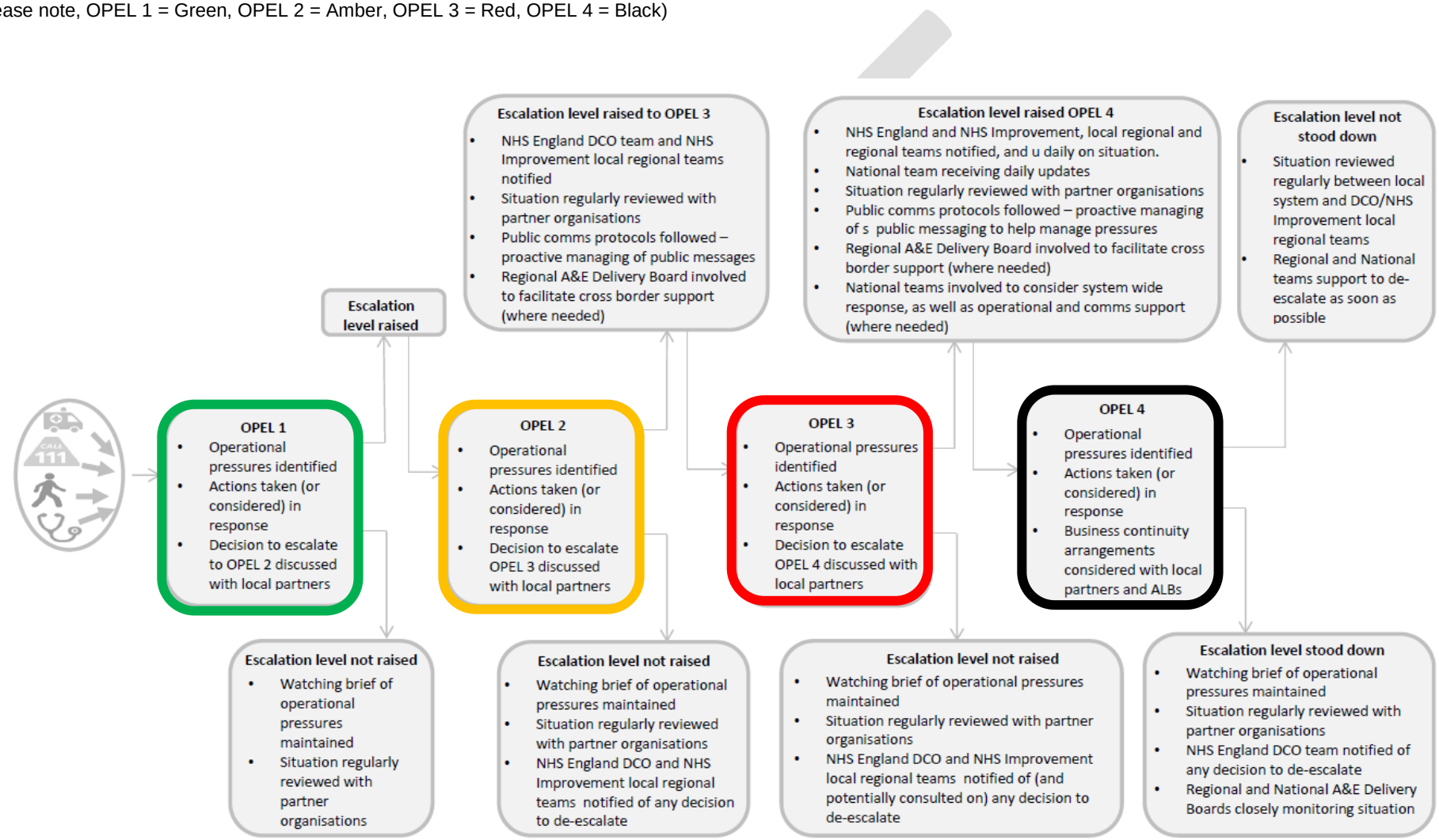
When communicating pressure to the public or media as a way of managing demand and bringing stability to the situation, it is important that all organisations in the A&EDB should take the following steps:

- Ensure all partner organisations are made aware of any public facing communications being issued in relation to operational pressures and escalation, and should be sighted on these communications ahead of time if possible;
- Ensure terminology consistent with the national framework is used when describing the operational pressures and escalation status within the local area; Ensure the description of the operational pressures and escalation status is accurate and responses being taken are proportionate;
- If the decision is taken by organisations within a local A&E Delivery Board area to communicate to the public that ED pressures are severe, and advise them to consider alternative places to seek treatment, then detailed information on all appropriate alternatives must be provided.

Appendix 1

Escalation and Protocol Flow Chart: Local partners, NHS England and NHSE Improvement

(Please note, OPEL 1 = Green, OPEL 2 = Amber, OPEL 3 = Red, OPEL 4 = Black)



Appendix 2

Commissioner Roles and Responsibilities: Local, Regional and National Level

Organisation	Role/ Responsibility
Local A&E Delivery Board	• All providers should: ○ Maintain timely updating of local information systems that monitor pressures in their patch ○ Ensure all trust level pressures are communicated regularly to all local partner organisations, and communicate all trust level escalation actions taken (e.g. opening escalation beds) • Acute providers should: ○ Investigate at a senior (executive or nominated deputy) level the reasons for diverts (last resorts) and identify and apply the lessons to prevent reoccurrence ○ Liaise with local ambulance services over pressure levels affecting EDs and address issues including increased ambulance handover times etc.
	• CCGs should: ○ Keep in touch with the day to day situation across the patch and be aware of any developing issues. This includes information on community services, mental health etc. ○ Maintain oversight of the A&E Delivery Board area (including social care system) and monitor receipt of hot/ cold/ flooding alerts and ensure appropriate actions are taken in response ○ Agree the measures taken by commissioned partners to address increased demand for NHS services. ○ Broker agreements across the patch and ensure mutual aid is available if required to re-balance pressures (e.g. acute and community services). If there is protracted failure to reach a conclusion favourable to patient care, NHS England may intervene to help reach a resolution ○ Liaise with bordering CCG/ CSUs on any issues which may impact upon their own pressures, and advise NHS England if there are any actions that cannot be taken locally in partnership ○ Commission additional resources (beds, staff etc.) and ensure local CCG demand management initiatives are working during times of surge ○ Ensure the NHS 111 Directory of Services (DoS) is kept up to date in respect of any changes to community capacity ○ Ensure a full investigation and debrief takes place following a system-wide escalation to OPEL Four, share findings with all A&E Delivery Board partners, and ensure actions are implemented to prevent reoccurrence

Joint NHS England/NHS Improvement teams (DCO and local regional footprint)	• Maintain arrangements to review daily pressure across the NHS • Put a process in place to inform providers of relevant alerts • Provide advice and guidance to CCGs on the handling of escalating situations • Where applicable locally NHS England to be informed of any agreed diverts • Agree reporting requirements at a local level • Ensure that communication protocols are followed if pressures affecting organisations outside of the local area are likely to impact across boundary and vice versa • Implement coordination arrangements as pressure levels increase across agreed thresholds (agree thresholds) • Ensure that 'lessons learned' events are held locally and updated plans reflect the actions identified and agreed • Inform NHS England regional operations and communications colleagues of system pressures • Inform NHS England regional team regarding system-wide escalation to OPEL Three or Four and actions being taken
Joint NHS England/NHS Improvement teams (Regional A&E Delivery Boards)	• Provide oversight and coordination to local NHS England teams where system-wide OPEL Four applies across a number of areas in the region • Proactively brief and liaise other NHS England regions and central team as appropriate • Support local NHS England teams as required (resource)
Joint NHS England/NHS Improvement teams (National A&E Delivery Board)	• Coordinate routine reporting arrangements e.g. winter sit rep • Provide oversight and coordination to regional NHS England teams where system-wide OPEL Four applies. Support cross-regional boundary working where required • Identify and implement national actions if required • Ensure comms support is available and comms responses are coordinated between local, regional and national comms teams

Appendix 3a

Escalation triggers and measures

Trigger	Lead	Measure	Kitbag Measure	Green	Amber	Red	Black
1	GHT	ED 4hr Target	(GHT) No. of Attendances at 1000	*null*			
			(GHT) No. of Breaches at 1000	*null*			
			(GHT) 4hr Performance at 1000	>=90%	85%	80%	<75%
2	GHT	Patient Flow and Discharges	(GHT) Bed Deficit at 1000	<=25	26 to 34	35 to 54	>=55
3	GHT/SWAST 999	Ambulance Handover in 60mins	(SWAST) Total Number of Minutes Lost to Handover Delays at 1000 (0000 to 1000)	<=15	15 to 60	61 to 120	>120
4	GHT	Demand and Capacity	(GHT) Trust Internal Escalation Status	1	2	3	4
			(GHT) Number of Escalation Beds	<=20	21 to 25	26 to 30	>30
5	GCS	Demand and Capacity	(GCS) SPCA - Escalation Status	1	2	3	4
			(GCS) Community Beds - Escalation Status	1	2	3	4
			(GCS) No. of Reablement Beds at 1000	>=6	5 to 3	2 to 1	0

Trigger	Lead	Measure	Kitbag Measure	Green	Amber	Red	Black
6	GCC	Demand and Capacity	(GCC) Total Number of Patients Waiting for POC	<=75	76 to 95	96 to 115	>115
			(GCC) Number of Patients in Acute Waiting for POC at 1000	<=5	6 to 10	11 to 15	>15
			(GCC) Number of Patients in Community Waiting for POC at 1000	<=10	11 to 15	16 to 20	>20
7	Primary Care / OHH	Demand and Capacity	(PC) Primary Care Level of Pressure	1	2	3	4
			(OOH) Number of Cases in Clinical Advice Pool at 1000	<20	20 to 60	61 to 100	>100
8	111	Demand and Capacity	(111) % Abandonment Rate at 1000	<=5%	6% to 8%	9% to 15%	>15%
9	All	Staffing	(GCS) Are There Staffing Concerns Within Critical Areas Impacting on the Urgent and Emergency Care System? (0 = Green; 1 = Amber; 2 = Red; 3 = Black)	1	2	3	4
			(GHT) Are There Staffing Concerns Within Critical Areas Impacting on the Urgent and Emergency Care System? (0 = Green; 1 = Amber; 2 = Red; 3 = Black)	1	2	3	4
			(SWAST) Are There Staffing Concerns Within Critical Areas Impacting on the Urgent and Emergency Care System? (0 = Green; 1 = Amber; 2 = Red; 3 = Black)	1	2	3	4
			(IDT) Are There Staffing Concerns Within Critical Areas Impacting on the Urgent and Emergency Care System? (0 = Green; 1 = Amber; 2 = Red; 3 = Black)	1	2	3	4
			(OOH) Are There Staffing Concerns Within Critical Areas Impacting on the Urgent and Emergency Care System? (0 = Green; 1 = Amber; 2 = Red; 3 = Black)	1	2	3	4

Trigger	Lead	Measure	Kitbag Measure	Green	Amber	Red	Black
			(111) Are There Staffing Concerns Within Critical Areas Impacting on the Urgent and Emergency Care System? (0 = Green; 1 = Amber; 2 = Red; 3 = Black)	1	2	3	4
10	All	Support Services (technology, facilities, pathology etc.)	(GCS) Are There Support Services Within Critical Areas Impacting on the Urgent and Emergency Care System? (0 = Green; 1 = Amber; 2 = Red; 3 = Black)	1	2	3	4
			(GHT) Are There Support Services Within Critical Areas Impacting on the Urgent and Emergency Care System? (0 = Green; 1 = Amber; 2 = Red; 3 = Black)	1	2	3	4
			(SWAST) Are There Support Services Within Critical Areas Impacting on the Urgent and Emergency Care System? (0 = Green; 1 = Amber; 2 = Red; 3 = Black)	1	2	3	4
			(IDT) Are There Support Services Within Critical Areas Impacting on the Urgent and Emergency Care System? (0 = Green; 1 = Amber; 2 = Red; 3 = Black)	1	2	3	4
			(OOH) Are There Support Services Within Critical Areas Impacting on the Urgent and Emergency Care System? (0 = Green; 1 = Amber; 2 = Red; 3 = Black)	1	2	3	4
			(111) Are There Support Services Within Critical Areas Impacting on the Urgent and Emergency Care System? (0 = Green; 1 = Amber; 2 = Red; 3 = Black)	1	2	3	4
11	All	Infection Control	(GHT) Are There Infection Control Challenges Within Critical Areas Impacting on the Urgent and Emergency Care System? (0 = Green; 1 = Amber; 2 = Red; 3 = Black)	1	2	3	4
			(GCS) Are There Infection Control Challenges Within Critical Areas Impacting on the Urgent and Emergency Care System? (0 = Green; 1 = Amber; 2 = Red; 3 = Black)	1	2	3	4
			(CCG) Are There Infection Control Challenges Within Critical Areas Impacting on the Urgent and Emergency Care System? (0 = Green; 1 = Amber; 2 = Red; 3 = Black)	1	2	3	4

Trigger	Lead	Measure	Kitbag Measure	Green	Amber	Red	Black
12	Arriva	Transport	(Arriva) Internal Escalation Status	1	2	3	4
13	SWAST 999	REAP Level	(SWAST) REAP Level at 1000	1	2	3	4

Appendix 3b

Actions taken during escalation

Please note, these do not replace organisational actions which should be enacted alongside those stipulated below. If the system is in a higher level of escalation than the organisation, the higher level actions must be taken. However, if it is agreed by the provider and CCG that an action is not appropriate or will not provide the desired outcome, the action will not need to be implemented. **The actions highlighted in blue have been mandated by NHS England Nationally.**

Further information regarding outcomes of actions and timeframe of implementation is available upon request.

Amber

Lead	Action
GHT	Inform patients who are waiting in minors of ED pressures and potential delays and alternative care pathways where appropriate.
GHT	Chiefs of service contacted to contact all speciality Directors to do walk around of their areas to increase discharges
GHT	Activate redeployment plan and allocate staff to areas of greatest pressure
GHT	Instigate RATing in ED and ACUs
GHT	All Matrons to attend their key areas of responsibility to ensure all escalation actions are underway
GHT	Ensure patient navigation in ED is underway, if not already in place.
GHT	Maximise use of nurse led wards and nurse led discharges.
GHT	Undertake additional ward rounds to maximise rapid discharge of patients.
GHT	Clinicians to prioritise discharges and accept outliers from any ward as appropriate.
GHT	Implement measures in line with Trust Ambulance Service Handover Plan
GHT	Ensure patient navigation in ED is underway if not already in place.
GHT	Notify CCG on-call Director to ensure that appropriate operational actions are taken.
GHT	Consideration to be given to elective programme, including clinical prioritisation and cancellation of non-urgent elective inpatient cases.
GHT	Senior ED Manager/Clinician to attend ED and ensure consistent and effective coordination
GHT	Acute physicians mobilised to review and discharge from ED and prioritise patients for transfer to ACUs
GHT	Patients to leave hospital in advance of TTAs with medications sent via taxi post discharge
GHT	Pharmacy services to prioritise TTOs for appropriate areas and ensure medications are delivered to wards without delay
GHT	Facilities, porters or transfer teams to prioritise cleaning and transfers
GHT	Clinicians to prioritise discharges and accept outliers from wards as appropriate
GHT	Arrange alternative forms of transport to discharge patients
GHT	Instigate deployment plan to respond to area of pressure
GHT	Undertake additional ward rounds to maximise rapid discharge of patients
SWAST 999	Review and reallocate resources to meet current emergency workload in accordance

	with REAP requirements
GCS	Escalation information to be cascaded to all community providers with the intention of avoiding pressure wherever possible.
GCS	All services (RR, DNs, CHs) to identify blockages to discharge and escalate to relevant Head of Service
GCS	SPCA lead to call IDT to prioritise working list
GCS	Task community hospitals to bring forward discharges to allow transfers in as appropriate.
GCC	Request part-time adult social care staff to work additional hours in the normal working week (overtime)
GCC	Request for adult social care staff to work additional hours at weekends (overtime)
GCC	Work with providers to identify where existing care packages can safely result in a **temporary decrease** ('traffic light system') to release domiciliary care capacity.
GCC	Maximise referrals into other services e.g. Out of Hospital (Age UK & British Red Cross), Community Meals, Care Navigators.
GCC	Locality social work teams to evaluate pathways and facilitate discharge to a short term setting (where appropriate) in order to free up capacity in the system.
GCC	Where possible, increase support and/or communication to patients at home to prevent admission.
GCC	Deploy additional social work capacity from localities (where safe to do so) between November and March to support hospital social work teams e.g. 2 FTE social workers and 3 FTE field work assessors
GCC	Maximise use of reablement/intermediate care beds.
IDT Back Door	IDT to work proactively with their ward HUBS, attending Red to Green board rounds/huddles and actively escalating where blocks to discharge appear. Each HUB is responsible for their Medically Stable Patients including facilitating discharge for their Fast Track and zero length of stay patients.
IDT Back Door	IDT will escalate issues and concerns via the site meetings to the whole system: feedback loop completed
IDT Back Door	IDT Leads will highlight to rest of system current pressures: feedback loop to be completed
OOH	Collate communication and actions to be disseminated to GPs if system moves to red.
OOH	In reach activity to EDs to be maximised.
OOH	Review staffing levels of GP OOH service.
OOH	Fully utilise the Choice+ availability
OOH	Initiate operational escalation options: move mobiles into treatment centres for triage, Instant message clinicians to triage between patients, block slots in areas of low activity to ensure that those clinicians focus on triaging.
OOH	Review staffing levels and contact staff to identify additional support or extended hours for those on duty.
OOH	Contact Remote Triage GP's for availability to work from Home.
OOH	Fully utilise available Choice plus appointments
PC	Alert GPs to escalation status and consider alternatives to ED referral be made where possible.
111	Staff requested to extend shift patterns.
111	Cease non vital training and redeploy staff on operational duties
111	Allocate clinicians to ensure robust floor walking in place to avoid demand being deflected to other services

111	Utilise HA to comfort call patients in the event of a large clinical queue
Arriva	At times of acute hospital escalation pressures, to assess internal capacity and, if required and agreed, to look at bringing in additional external resources.
2G	Ensure all staff in MHLT aware of escalation level and to reflect this within their working day and prioritisation of system.
2G	MHLT to ensure pathways are being used appropriately, confirm that guidance is accessible and communicate when information cannot be found
2G	Where possible, increase support and/or communication to patients at home prevent admissions.
2G	Expedite rapid assessment for patients waiting within another service.
2G	MHLT to ensure all referrals are verbally responded to within 2 hour target and subsequent response is in keeping with level of risk identified using risk matrix
2G	MHLT Manager to ensure that all patients awaiting review before discharge are to be prioritised so that they are seen within 4 hours where staffing capacity permits
CCG	Expedite additional available capacity in PC/OOH, community sector and independent sector.
CCG	Coordinate the redirection of patients towards alternative care pathways as appropriate.
CCG	Co-ordinate communication of escalation across the local health economy (including independent sector, social care and mental health providers).
CCG	Support providers to access patient transport and identify alternative solutions if commissioned capacity exceeded.

Red

Lead	Action
GHT	Ensure all support services (radiology etc.) continue working until activity completed
GHT	ED senior clinical decision maker to be present in ED department 24/7, where possible.
GHT	Enact process of cancelling day cases and staffing day beds overnight if appropriate.
GHT	All senior managers: GM and above to cancel meetings to drive operational recovery
GHT	Open additional beds on specific wards, where staffing allows.
GHT	ED to open an overflow area for emergency referrals, where staffing allows.
GHT	Notify CCG on-call director so that appropriate operational actions can be taken to relieve the pressure.
GHT	Reduce clinics by 1 hour to enable medical specialities with bed shortfalls to do extra ward rounds
GHT	Full capacity protocol to be implemented
GHT	Contact on-take and ED on-call.
GHT	Active management of elective programme including clinical prioritisation and cancellation of non-urgent elective inpatient cases.
GHT	Increase staffing in ED to manage queue
GHT	Provide additional beds in ED for patients
GHT	Provide 24/7 senior management support in ED to manage the situation
GHT	Senior Clinical decision makers to offer support to staff and to ensure emergency patients are assessed rapidly.
GHT	ED to open overflow area for emergency referrals, where staffing allows.
GHT	Alert Social Services on-call managers to expedite care packages

SWAST 999	Review Operational and clinical hub cover, to ensure resourcing is commensurate to current system pressure and activity.
SWAST 999	Review clinical appropriateness of all inter-hospital transfers.
SWAST 999	If emergency response is severely compromised consider use of Significant Incident and wider business continuity procedures.
SWAST 999	Implement appropriate level REAP and Demand Management actions
SWAST 999	A collective review with CCG and Acute Trust to be held bi-weekly to review all handover delays, including outliers and agree appropriate mitigating actions over the next 72 hours.
GCS	Review ring-fenced beds and consider releasing earlier in the day
GCS	Senior Nurses to review patients that could be moved with ongoing support requirements in order to realise capacity
GCS	Mix sex breach requests to be sent to CEO for review and decision - CEO agreement only.
GCS	Head of Services to escalate blockages to Execs
GCS	Capacity Manager / Deputy Director to monitor escalation status, taking part in teleconferences as required.
GCS	SPCA - Prioritise discharge from GRH
GCS	Capacity Manager / Deputy Director to monitor escalation status, taking part in teleconferences as required.
GCS	SPCA - call in bank staff to handle call volumes
GCC	Community providers to support (appropriate) ward rounds and support pre-referral contact to ensure efficient discharge planning.
GCC	All possible capacity has been freed and redeployed to ease systems pressures where risk is highest.
GCC	Liaison between RR red lead and colleagues within Rapid to understand community capacity and appropriate pathways.
IDT Front Door	Priority access to social care assessment within the Emergency Department (agreed at summit last month. Work in progress)
IDT Back Door	IDT Leads Interrogates each HUB Band 6 to ensure all discharges are timely and those that require escalation have been escalated.
IDT Back Door	IDT Leads attend operational and escalation meetings and liaises regularly with site management.
IDT Back Door	Review of allocation or resources by team leads and IDT manager to direct resources to areas of greatest need.
IDT Back Door	IDT Manager will highlight to rest of system current pressures.
OOH	Engage GP services and inform them of rising Operational pressure and to plan for recommending alternative care pathways.
OOH	OOH service to recommend alternative care pathways.
OOH	Initiate additional triage support from Dorset OOH's.
PC	All possible actions are being taken on-going to alleviate system pressures.
PC	Representative from Primary care to review patients within acute Trust beds to identify those that may be discharged.

PC	Engage GP services and inform them of rising Operational pressure and to plan for recommending alternative care pathways.
111	Request call streaming to OOH providers
Arriva	Ensure all capacity is being utilised to alleviate system pressures and instigate plans for bringing in additional vehicles to support demand.
2G	MHLT manager to prioritise ED referrals and recruit additional resources from off duty staff and staff bank.
2G	Mental Health teams to be prioritised to support both EDs and increase response times to 1 hour
2G	Continue to expedite discharges, increase capacity and lower access thresholds to prevent admission where possible.
2G	Review all discharges currently referred and assist within whole systems agreed actions to accelerate discharges from acute and non-acute facilities, where possible.
2G	Increase support to service users at home to prevent admission.
2G	Regardless of level of risk and within resource available will prioritise ED referrals
2G	MHLT manager to prioritise ED referrals and recruit additional resources from off duty staff and staff bank
2G	MHLT manager to recruit additional resources from off duty staff and staff bank.
2G	MHLT Manager to prioritise assessments in ED from 2 hours to 1 hour where staff capacity permits
CCG	NHSE/I notified of alert status and involved in discussions.
CCG	CCG to co-ordinate communication and co-ordinate escalation response across the whole system, including chairing the daily teleconferences.
CCG	Notify CCG on-call Director who ensures appropriate operational actions are taken to relieve the pressure.
CCG	Review NHS111 advice strategy with local DoS lead.
CCG	Notify local DoS Lead and ensure NHS111 Provider is informed.
CCG	Cascade current system-wide status to GPs and OOH providers and advise to recommend alternative care pathways.
CCG	Liaise with reablement bed providers to extend admission thresholds for reablement beds
CCG	Post escalation: Coordinate the completion and sign off of the Exception Report with the A&EDB
DoS	DoS lead to ensure that any changes to service provision are logged on the DoS and that NHS111 is aware of changes to service provision and the nature of pressure on the system.
DoS	Ensure that call centre staff are aware of and act on information about organisational capacity, changes to service provision and closures.

Black

Lead	Action
GHT	All actions from previous levels stood up.
GHT	Consultant Physicians to be present on wards and in ED department 24/7 where possible.
GHT	ED senior clinical decision makers to be on wards, in theatre and in ED department 24/7, where possible.

GHT	Surgical senior clinical decision makers to be on wards, in theatre and in ED department 24/7, where possible.
GHT	Contact on-take and ED on-call Senior clinical decision makers to offer support to staff and to ensure emergency patients are assessed rapidly.
GHT	GP to be present in ED department 24/7 where possible.
GHT	Executive Director to provide support to site 24/7, where possible.
GHT	An acute Trust wishing to divert patients from ED must have exhausted all internal support options before contacting the CCG to request authorisation to explore a divert to a neighbouring trust whether these are in or out of region.
SWAST 999	Consider evoking National mutual aid and the NACC when the criteria described within the National Ambulance Mutual Aid MOU are met.
SWAST 999	Implement appropriate level REAP and Demand Management actions
SWAST 999	Review the escalation status every 4 hours and communicate this across the system.
GCS	Review opening times of the Single Point of Clinical Access.
GCS	Cease non inpatient activity and redeploy staff to GCS inpatient unit(s)
GCS	Close Milus and reallocate staff to GCS inpatient unit(s)
GCS	Remove GP ring-fenced beds
GCS	Community providers to expand capacity where possible through additional staffing and services
GCS	Senior Management team and cabinet member involved in decision making regarding use of additional resources from out of county if necessary.
GCC	Ensure all actions from previous stages enacted and all other options explored and utilised.
GCC	Ensure all possible capacity has been freed and redeployed to ease system pressures.
GCC	Increase the provision of domiciliary and identify respite in lieu of dom care facilities where appropriate.
IDT Front Door	Clinically prioritise patients with the greatest acuity and ensure that all clinical resources allocated to the shop floor where the pressure is.
IDT Front Door	Clinical leads remove from non-clinical positions to work clinically with the team and assist with patient flow
IDT Back Door	IDT Manager Interrogates IDT team leads to ensure all HUBS are working to full capacity, have adequate staff etc. Decisions will be made about additional hours/overtimes
IDT Back Door	IDT Manager attends the hourly site meetings in order to facilitate flow
IDT Back Door	IDT Manager supports Whole System Escalation Call
IDT Back Door	IDT Manager and Leads to support in a physical way any HUBS under pressure
OOH	Ensure all actions from previous stages enacted and all other options explored and utilised.
OOH	Ensure all possible actions are being taken on-going to alleviate system pressures.
OOH	Contact Cross-Border OOH's providers for assistance.
PC	Fully utilise Choice plus and open access to SWAST and GHT.
PC	Ensure all actions from previous stages enacted and all other options explored and utilised.
PC	Ensure all possible actions are being taken on-going to alleviate system pressures.

2G	Ensure all actions from previous stages enacted and all other options explored and utilised.
2G	Continue to expedite discharges, increase capacity and lower access thresholds to prevent admission where possible.
CCG	Local regional office notified of alert status and involved in decisions around support from beyond local boundaries.
CCG	GCCG act as the hub of communication for all providers.
CCG	Ensure all system partners are informed of stand-down of 'Black' status once this information is received from the organisation previously at 'Black' status and oversee further de-escalation processes.

Appendix 4

Activation of diverts (internal/external)

Expectations

1. The protocol for an internal divert will only be used when GHNHSFT have exhausted all internal systems and escalation plans as well as local health and social care plans to reduce system pressure to a safe level.

2. Patient safety and dignity must take priority over everything and all actions must be focused upon providing patient access to definitive clinical assessment and treatment at the most appropriate receiving site.

3. Taking a patient to an alternative site is only appropriate if the closest receiving unit is physically incapable of providing the right care in a safe environment or demand result in ambulances queuing for significantly prolonged periods and escalation measures have been ineffective.

4. Internal diverts should only require the authorisation by a GCCG Director when GHNHSFT and SWAST cannot reach agreement locally.

5. Emergency Departments will not close other than in extremis (i.e. fire, flood) and therefore full requests for a deflect will be by exception only.

Procedure for Requesting an Internal Divert

1. GHNHSFT Director On-Call must provide executive authority for the On Call Manager to contact the SWAST Silver Commander to instigate an internal divert to support relief of the current situation.

2. GHNHSFT On-Call Manager must confirm that all internal actions are in place.

3. GHNHSFT On-Call Manager must confirm situation and internal divert requirements (e.g. rationale, timeframe required and review of requirements). The following should be included in agreeing the internal divert.

    a. GHNHSFT Director On-Call or On-Call Manager with Executive authorisation

    b. SWAST Silver Commander

4. All local escalation actions must have been taken, as far as is reasonably practicable before contacting the SWAST Silver Commander to requesting an internal divert.

5. If agreement on actioning an internal divert cannot be reached, the GCCG Director On-Call will be contacted for the request to be considered and if required, implemented.

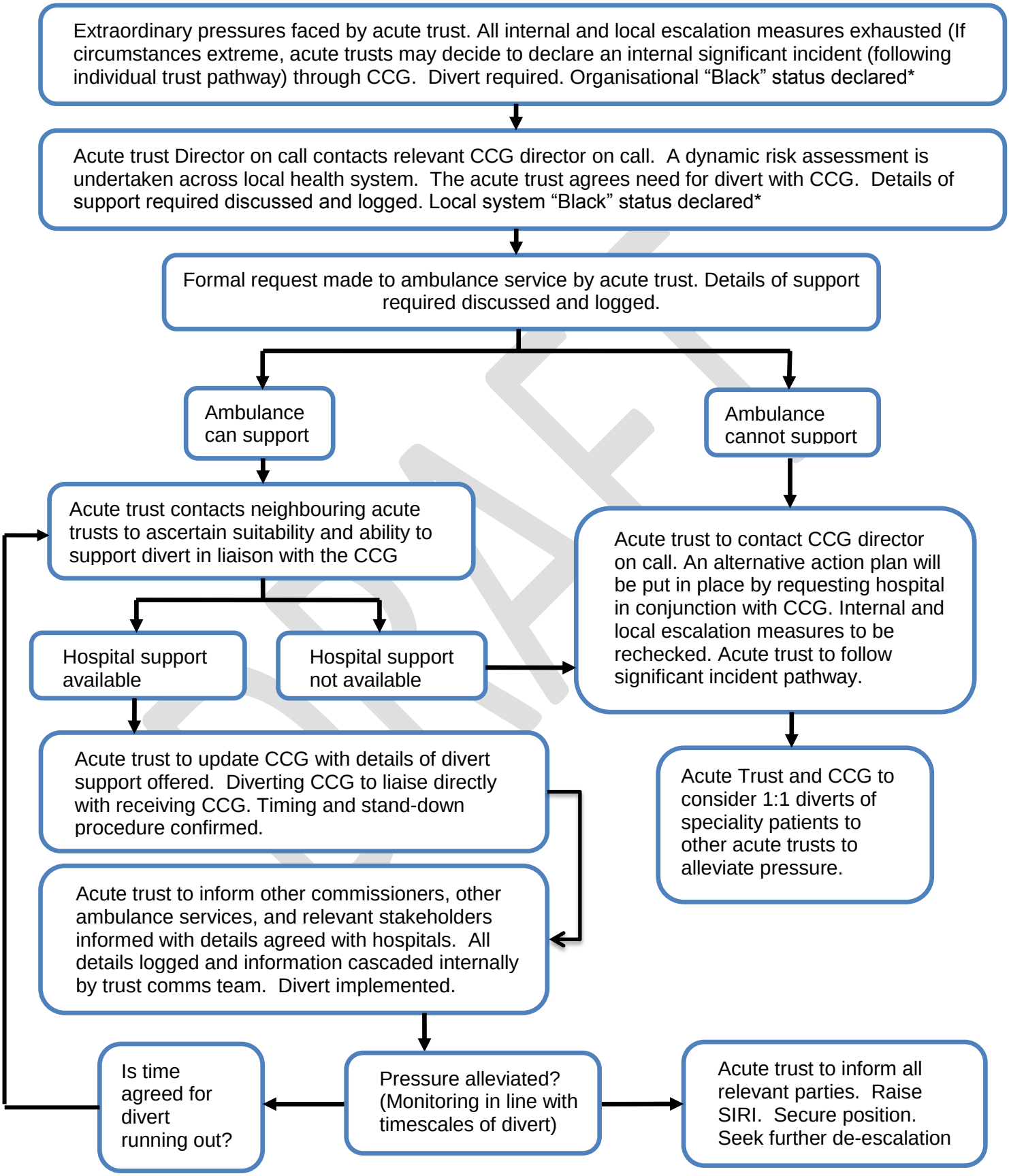
External Diverts

If an external divert is required, the system will follow the guidelines set out in Appendix 5. The following will be established by the Acute Trust prior to a divert request to GCCG:

- Have whole systems teleconferences taken place and actions taken to relieve pressure?
- Is the safety and care of patients in the hospital compromised?
- Are you considering declaring an internal significant incident?
- Are ambulances stacking outside/been stacking throughout the day?
- Are contingency plans in place for staffing for the next 24hours and 48 hours?

NHS
Gloucestershire
Clinical Commissioning Group

Implementation of an Out of County Divert



*It would be expected that the whole health economy would work together in the usual way to avert escalation and facilitate de-escalation at all levels. This flowchart does not indicate that the acute trust should wait until it declares Black status before contacting commissioners

Appendix 5

Serious Incidents Requiring Investigation (SIRIs)

The Framework applies to serious incidents which occur in all services providing NHS funded care. This includes independent providers where NHS funded services are delivered.

The emphasis in the updated framework is one of open and honest discussion and 'if in doubt – report it'. Downgrading can be agreed at any time.

Definition of Serious Incident

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
- Unexpected or avoidable death of one or more people. This includes
  - suicide/self-inflicted death; and
  - homicide by a person in receipt of mental health care within the recent past;
- Unexpected or avoidable injury to one or more people that has resulted in serious harm;
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:
  - the death of the service user; or
  - serious harm;
- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
  - healthcare did not take appropriate action/intervention to safeguard against such abuse occurring10; or
  - where abuse occurred during the provision of NHS-funded care.

This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident (see Part One; sections 1.3 and 1.5 for further information).

- A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death.
- An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:
- Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues (see Appendix 2 for further information);
- Property damage;
- Security breach/concern;
- Incidents in population-wide healthcare activities like screening13 and immunisation programmes where the potential for harm may extend to a large population;
- Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);
- Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services); or
- Activation of Major Incident Plan (by provider, commissioner or relevant agency)

Definition of Serious Harm

- Severe harm (patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care);
- Chronic pain (continuous, long-term pain of more than 12 weeks or after the time that healing would have been thought to have occurred in pain after trauma or surgery); or
- Psychological harm, impairment to sensory, motor or intellectual function or impairment to normal working or personal life which is not likely to be temporary (i.e. has lasted, or is likely to last for a continuous period of at least 28 days).

Responsibilities and Timescales

Event/Action	Timescale	Further Information/ Guidance	Responsibility
Serious Incident identified - Report to commissioner of service or lead commissioner (as agreed).	As soon as possible and within 2 working days of the incident being identified. Or Immediate where: - The provider or commissioner Major Incident Policy is invoked. - There is (or is likely to be) significant public concern and/or media interest. - Incident will be of significance to the police.	Report via STEIS (or if no access to STEIS, via the serious incident reporting form agreed with the commissioner, sent via e-mail to agreed e-mail address). Where immediate notification is required, this must be also by telephone (including use of On-Call system Out of Hours).	Provider where incident occurred
		If there is any doubt about whether an incident is serious or not, the principle is to report it as it can be downgraded later if necessary.	
If provider has no STEIS access, input details of incident from report form from provider onto STEIS.	On receipt of form.		Commissioner
Comply with any further reporting and liaison requirements with regulators and other agencies.	Within 2 working days of the incident being identified.	See appendix 2 of the Framework.	Provider where incident occurred
Carry out an initial review of the incident and provide a copy of the report of this to the commissioner.	Within 3 working days of the incident being identified.	This will inform the level of investigation required.	Provider where incident occurred

Requirements after the first few working days are included in the main summary (available from the Nursing and Quality Directorate team) document and within the full 'Serious Incident Framework, March 2015' which can be obtained from the NHS England website: https://www.england.nhs.uk/ourwork/patientsafety/serious-incident/.

Appendix 6

Key Contacts and Teleconference details

Conference call details: 0800 229 0687, **PIN**: 723435
Primary number for On-call Manager: 07623 948860
Email: GLCCG.HIC@nhs.net

TYPE	ORGANISATION	ON CALL 24/7	COMMENT	ICC SPOC EMAIL (not routinely monitored. Used as default SPOC on activation of plan)
NHS England	Bath, Gloucestershire Swindon and Wiltshire – South Central	07623 505520	Pager: Please leave a telephone number (numeric message) or hold for the operator.	england.bgsw-icc@nhs.net
	Bristol, North Somerset, Somerset, and South Gloucestershire – South West	0303 033 8833		england.bnsssg-icc@nhs.net
	NHS England South - Communications	0844 822 2888 and quote SCOMM01	Support for NHS England only.	N/A
	NHS England South Region	08445 449 633		
CCG	Bath and North East Somerset CCG	0303 033 9922		BSCCG.banesccgresilience@nhs.net
	Gloucestershire CCG	07623 948860	Primary number for on call manager. If this is unavailable page the On Call Senior on 07623 957544	GLCCG.HIC@nhs.net
	Swindon CCG	07699 759234 (On Call Pager)	Ask to speak to Director On Call.	emergencyplanning@swindonccg.nhs.uk
	Wiltshire CCG	07699 757981		WCCG.Dutyofficer@nhs.net The CCG will advise when to use this email
	North Somerset CCG	0303 033 9911		N/A
Acute Provider	Royal United Hospital	01225 42 83 31	Ask for Manager on Call	N/A
	Gloucestershire Hospitals NHS Foundation Trust	0300 422 22 22 (Direct Dial:0300 422 5800)	Switchboard ask for : *In hours*; Director of the day *Out of hours*: On Call Manager 1700 to 0800, weekends and bank holidays	N/A
	Great Western Hospital (Acute)	01793 604020	Ask for Acute Site Manager	incident@gwh.nhs.uk
	Salisbury Hospital Foundation Trust	01722 33 62 62	Ask for duty manager	shc-tr.SFTICC@nhs.net
Community Provider	Sirona	01225 831400		N/A
	SEQOL	07699 769554	Director on call.	incidentcontrol@seqol.org
	CARFAX	No single point of contact	Contact details held by Swindon CCG	N/A
	Gloucestershire Care	On-Call Manager Pager		GCSIncident.Control@glos-

TYPE	ORGANISATION	ON CALL 24/7	COMMENT	ICC SPOC EMAIL (not routinely monitored. Used as default SPOC on activation of plan)
	Services NHS Trust	Number 07623 512393 Exec Director Pager Number 07623 951454		care.nhs.uk
	Wiltshire Health and Care	On Call Director Pager Number 07699 713967 On Call Manager Pager Number 07699 747571	Alternative contact can be made via the GWH switchboard on 01793 604020 and ask for Wiltshire Health & Care On Call Director / Manager.	incident@gwh.nhs.uk
	Virgin Care	0333 2341127 – On Call Manager		
Partnership Trust	2gether	07699 734976	Please leave numeric message i.e. the telephone number you would like to be called back on. SPOC email address to be used for information.	2gnft.Incident-Room@nhs.net
	Avon and Wiltshire Mental health Partnership	01225 325 680	Ask for the Executive Director on call. NHS England South Central hold rota in ICC account.	awp.icc@nhs.net
Primary Care	BDUC	0300 123 1809	Ask for On Call Operations Manager-VoCare	N/A
	Medvivo Out of Hours GP	0300 111 4008 0300 111 5818		mg.outofhours@nhs.net
	GP / Pharmacies	N/A	NHS England South Central hold GP and Pharmacies distributions list in the ICC account. CCGs hold GP distribution lists	N/A
Ambulance	South West Ambulance Service Trust (SWAST)	Bristol ICC – 01454 454 856 Exeter ICC – 01392 261 675	Information received will be in the form of a METHANE report, more information will be able to be found from the following link. www.swast.nhs.uk/majorincident	N/A
	SWAST NILO (National Incident Liaison Officer)	0300 303 8608	The NILO can be contacted for tactical information and to link with SWAST directors on call.	
Patient Transport Services	Arriva	0845 600 3792	South West On call senior manager	N/A
111	Care UK	0117 240 1111		N/A
Local Authority (Public Health)	Bath and North East Somerset Council	01225 394067 (In hours) 07980 998560 (Out of hours)	In hours: Actioned by Public Health. Out of hours: Duty Emergency planning Officer	N/A
	Gloucestershire County Council	07920 766400	Public Health not available out of hours	N/A
	Swindon Borough Council	01793 444673 (General office – in hours only) 01793 466451/2/3 or 01793 488677 (Duty	Email address preferred method of communication. Telephone numbers for Duty EPO out of hours only,	emergencyplanning@swindon.gov.uk

TYPE	ORGANISATION	ON CALL 24/7	COMMENT	ICC SPOC EMAIL (not routinely monitored. Used as default SPOC on activation of plan)
		EPO) Director of Public Health 07824 081153 Consultant in Public Health 07824 081160	directly via contact centre. Public Health staff not officially on call but have provided mobile and would like to be alerted in a response.	
	Wiltshire Council	07699 719123	Public Health duty pager to alert Public Health On-Call. They will then alert the Associate Director On-Call as required.	eprr@wiltshire.gov.uk
Public Health England	PHE South West (North)	0300 303 8162 Option 1 followed by Option 2.	Opt 1 the Centre; Option 2 for the) Acute Response Centre (ARC). (Note your call may be answered by an administrator) Out of hours the caller will receive a message to redial the out of hours number.	AGWARC@phe.gov.uk
Multi agency (Operation Link)	Wilts. / Swindon. Local Resilience Forum	01380 734047	To request a multi-agency teleconference or cascade information for multi-agency information.	N/A
	Gloucestershire Local Resilience Forum	Phone Gloucestershire Police on 101 or 01242 538353 and state you wish to initiate 'Code word Operation Link Gloucestershire'		N/A
Police (Control Room)	Wiltshire	01380 734047	Information from scene (a good way to confirm information).	N/A
	Avon Somerset	01275 818181		N/A
	Gloucestershire	01452 754977		N/A
Fire and Rescue (Control Room)	Dorset & Wilts	03067 990019		N/A
	Avon & Somerset	01225 310846		N/A
	Gloucestershire	01452 753245		N/A
Met Office	Met Office	01392 886095	Met Office Duty Number 24/7	N/A
Voluntary	Wessex 4 x 4	07092 262428	Web bookings preferred.	www.wessex4x4response.org.uk/callout/
	Gloucestershire 4 x 4	07092 847407	Web bookings preferred. Technical support and logins accessible via webmaster&gw4x4r.co.uk.	www.gw4x4r.co.uk/tickets
	British Red Cross	07623 908026		

Appendix 7

Definitions

Complete Closure
When an Emergency Department accepts no patients at all. This will happen in very extreme circumstances only, e.g. when an Internal Incident is declared.

ECMO
In intensive care medicine, extracorporeal membrane oxygenation (commonly abbreviated ECMO) or extracorporeal life support (ECLS) is an extracorporeal technique of providing both cardiac and respiratory support to patients whose heart and lungs are so severely diseased or damaged that they can no longer serve their function.

Escalation Triggers
All organisations have adopted the common triggers to ensure equity of pressure; capacity and access (see Appendix 2).

Local Health Economy (LHE)
A health and social care whole system grouping (usually geographically defined). This is likely (but not exhaustively) to comprise a number of CCGs, Acute Trust(s), social care organisations, mental health trusts, ambulance service and OOH providers.

Major Incident
Any event which presents a serious threat to the health of the community, disruption to the service, or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by NHS England Local regional offices, NHS Trusts, ambulance services or CCGs.

Operational Pressures Escalation Levels
New National guidelines are to be used when communicating to the public, media and other local health authorities. The levels (1-4) directly mirror the levels of REAP, and also the green, amber, red and black escalation levels used by the Gloucestershire system in the Escalation Framework and on a daily basis.

Peripheral Divert
Border patients are taken by the Ambulance Service to neighbouring organisations to alleviate capacity issues.

Resourcing Escalatory Action Plan (REAP)
The REAP plan is essentially a set of pre-agreed actions to manage escalating demand by increasing capacity. It is always in operation, normally at level one, but higher levels are triggered as demand increases.

Responsible Person
A senior employee authorised by the Chief Executive of an individual provider to implement agreed diversions and to notify relevant parties in accordance with this framework. The responsible person must have decision making ability and authority, and an organisation wide view.

Appendix 8

Email addresses for NHSE and NHSI report submission

To: NHSIsouth-oncall@nhs.net
england.wintersouth@nhs.net
england.bgsw-icc@nhs.net
england.tv-icc@nhs.net
england.southcentraloperations@nhs.net

CC: felicitytaylor-drewe@nhs.net
maria.metherall@nhs.net
Jennifer.ryan@nhs.net
Sally.jones24@nhs.net

Please note, these email addresses are to be used for all correspondence regarding OPEL/Escalation.

Gloucestershire Care Services NHS
NHS Trust

Policy on Patient Access

Document reference:	
Version:	Version 3
Ratified by:	Quality and Performance Committee
Date ratified:	
Originator/author:	Candace Plouffe
Responsible committee/individual:	Executive Committee
Executive lead:	Chief Operating Officer
Date issued:	December 2016
Review date:	December 2018

THIS IS A CONTROLLED DOCUMENT

Whilst this document may be printed, the electronic version maintained on the Gloucestershire Care Services NHS Trust intranet is the controlled copy. Any printed copies of this document are not controlled.
It is the responsibility of every individual to ensure that they are working to the most current version of this document.

DOCUMENT CONTROL SHEET

Purpose of document:	This policy guides and supports all staff to effectively manage patient access to the services the Trust is commissioned to provide. It covers referrals, booking, notice requirements, patient choice and waiting list management.
Dissemination:	To all Operational staff
Scope:	All Operational staff
Review:	December 2018
This document supports:	Operational Service Delivery
Key related documents:	
Quality and Equality	An Quality and Equality Impact assessment has been completed and reviewed by the Clinical Reference Group
Consultation:	N/A
Financial implications:	N/A

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1. Introduction

In England, under the NHS constitution, patients 'have the right to access services within maximum waiting times'. Whilst specific national waiting times relate to consultant-led services only (of which Gloucestershire Care Services NHS Trust do not provide any of these services), both Gloucestershire Care Services NHS Trust and our commissioners, recognise waiting times as a relevant indicator for service quality.

2. Purpose

The purpose of this policy is to outline Gloucestershire Care Services NHS Trust requirements and standards for managing patient access to its services it is commissioned to provide. It covers referrals, booking, notice requirements, patient choice and waiting list management. The length of time a patient waits for their treatment and the notice and choice they have when they book their treatment are indicators of the quality and efficiency of services provided by Gloucestershire Care Services NHS Trust. Therefore all patient access and choice issues will be dealt with systematically within the principles and spirit of this policy.

There are two main principles that serve as the foundation to this policy:

- Gloucestershire Care Services NHS Trust will ensure that the management of patient access to services is transparent, fair, equitable and managed according to clinical priority.
- Gloucestershire Care Services NHS Trust will ensure that the administrative processes in services where patients can book their own appointments and treatment are simple, efficient and provide a high quality service to patients.

The overall intent of this policy is to provide a clear, reliable and transparent standard for patient access. By applying this structured and systematic approach, Gloucestershire Care Services NHS Trust will ensure that patients receive a high quality service and increase the likelihood of their choosing Gloucestershire Care Services NHS Trust for their treatment.

This policy applies to all administration and clinical prioritisation processes relating to patient access managed by Gloucestershire Care Services NHS Trust.

The scope of this policy is from a patient's referral into Gloucestershire Care Services NHS Trust through their care and assessment/ treatment, to their discharge. All staff involved in a patient's care and treatment should adhere to this policy.

The Chief Operating Officer within Gloucestershire Care Services NHS Trust has corporate responsibility for ensuring that the policy is effectively implemented through the Operational Management structure and for updating the policy as and when necessary.

3. Scope

The detailed principles of this Patient Access Policy are as follows:

a) All patients will experience equality of access and impartiality while waiting for their treatment

b) Patients will be treated in accordance with their clinical need or priority (urgent or routine)

c) Clinical need or priority can only be determined by suitably qualified clinical staff with authority to make those decisions

d) Patients should be ready and available for treatment at the point at which they are referred into the service

e) Patients will be able to have choice in the scheduling of their appointments and venues where they exist

f) Data concerning waiting lists and patient's waiting times must be secure, timely, accurate and subject to regular audit and validation.

g) Communication with individual patients and the wider public about waiting lists and waiting times should be clear, informative and timely.

4. Quality / Equality Impact Assessment

This document has been assessed for equality impact, in accordance with Gloucestershire Care Services NHS trust equality impact guidance. This guidance confirms that Gloucestershire Care Services NHS Trust will provide commissioned services to all patients, irrespective of their ethnic origin, nationality, gender, culture, religion or belief, sexual orientation, age or disability.

Gloucestershire Care Services NHS Trust is required to cater for all patients accessing services thereby having systems in place to accommodate people who have disabilities and who are unable to converse in English.

Gloucestershire Care Services NHS Trust has estates policies in place to ensure building access regulations are in line with the Equality Act 2010

5. Waiting Time Targets

Referral to Treatment (RTT) Time Targets

Referral to treatment time targets has been negotiated locally between Gloucestershire Care Services NHS Trust and their commissioners. Whilst Gloucestershire Care Services NHS Trust provides no 'consultant-led' services, it does provide services defined as 'onward referral' or 'interface' which provide intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care.

Gloucestershire Care Services NHS Trust also recognise that referral to treatment waiting times are a useful quality indicator and the following services are required to report formally against a waiting time target:

Gloucestershire Care Services NHS Trust has agreed with commissioners that 95% of patients will be seen within the wait times noted in Appendix 1. This performance indicator is reviewed annually as part of the formal contracting meetings.

However, the following services are excluded from formally reporting Referral to Treatment time performance.

- Children's Public Health Nursing Services (Health Visiting and School Nursing)
- Looked After Children Services
- Children's Immunisation Service
- Chldren's Communty Nursing Service
- Children's Complex Care Respite Service
- Community Hospital Inpatient Wards
- Minor Injuries and Illness Units
- Consultant led outpatients/theatre/endoscopy services provided by acute hospitals trusts within community hospital sites
- Community Nursing
- Rapid Response Service
- Reablement Service
- Early Supported Discharge (Stroke Service)

These services either do not provide any first definitive treatment for a clinical condition, or the service receives all of their referred patients after they have received first definitive treatment elsewhere, or the service is deemed as unsuitable due to the responsiveness that is intrinsic in its existence.

Any service that is being piloted will also not have an agreed RTT until it is fully established.

However all services will have internal monitoring of wait times.

6. Principles & Procedures

6.1 Reasonable Notice

Patients will be offered an initial appointment date a minimum of 7 calendar days from date of making the appointment where patients are required to travel to a clinic delivered from premises other than their home.

In the event of Gloucestershire Care Services NHS Trust having very short notice appointments available these will be offered to patients but they may refuse appointments at less than a week's notice without compromising their waiting list position.

For services which offer a direct response and have no waiting list, these principles do not apply.

The services will aim to find a date appropriate for a patient's clinical priority and convenient to that patient.

6.2 Clinical Urgency

Patients will be classified as either routine or urgent.
Urgent – indicates that any delay in treatment will result in a loss of clinical outcome
Routine – indicates that no loss of clinical outcome is expected if the patient is treated in waiting time order and within maximum waiting time standards

6.3 Receiving Referrals

All referrals which do not come via NHS e-referral service will be date stamped as received on the date of receipt by the service. This is the Referral to Treat (RTT) start date.

Although referrals may be received by telephone (particularly for those urgent referrals) a subsequent written referral (received electronically or by post) must be provided.

Services need to have a clear standard operating procedure for referrals, and ideally these need to be received by a central point to support triage and priorisation.

Referrals that are incomplete, or do not have sufficient information to be able to clinically triage will not be accepted until the required information is received.

All referrals should be registered within 1 working day of receipt by the service.

Where referrals are sent in via the NHS e-referral service, the appointment clerk for the relevant specialty must ensure that the appropriate clinician triage to accept or reject the referral within 48 working hours. The 8 week RTT start date will begin on the date the patient converts their unique booking reference number (UBRN) either directly from the referral point (ie GP practice) or via an Appointments Line service.

Where referrals are not made via NHS e-referral services these are normally triaged within 48 working hours. Services should use SystmOne and/or an electronic portal for referrals.

Where the referral was accepted, the accompanying referral letter should be available preferably within 24 hours after acceptance, with a cut off period of 5 days. This letter will either be emailed or printed and the appointment details added before being sent to the patient.

6.4 Appointments

For an appointment to be deemed reasonable patients must be offered an appointment with at least one calendar weeks' notice. Patients may be offered appointments at shorter notice but they may refuse such appointments without compromising their waiting list position (see section 6.1).

For clinically urgent appointments, two attempts to contact the patient will be made via telephone within 2 working days of prioritisation of referral and then an appointment

will be made for them and the details sent to them, which currently maybe by post or text messaging.

For routine appointments, two attempts to contact the patient may be made via telephone and then an appointment will be made for them and the details sent to them within 5 working days of prioritisation of referral.

All appointments should be entered onto the relevant clinical recording system on the day of the appointment being made.

All patients will be offered a choice of dates within the waiting times standard.

For services which offer a direct response and have no waiting list, these principles do not apply.

6.5 DNAs, Non-Access visits and Cancellations

A patient is said to have *cancelled* their appointment if they give more than 1 working day's notification that they will not attend it or if they arrive more than 30 minutes late from their scheduled appointment time. This includes appointments that are of a domiciliary nature.

If a patient cancels an appointment twice, then the patient is discharged back to their referrer who is informed in writing and the RTT clock stops. If the patient is a vulnerable adult or child and there are safeguarding concerns. then the patient's GP will also be informed in writing.

A patient who does not attend their appointment or gives less than 1 working days' notice of non- attendance is said to have *DNA*'d their appointment. This includes non-access visits for appointments arranged in the residential setting

When a patient *DNA*s an appointment the clock will be stopped. The service will establish why the patient did not attend or was not accessible for domiciliary visits. They will subsequently be discharged back to the referrer. If the patient is a vulnerable adult or child and there are safeguarding concerns then the patient's GP will also be informed in writing.

Patients who DNA as a result of a patient booked transport issue should not be unfairly penalised.

If the clinician wishes to offer another appointment rather than discharge the patient, the service lead must sanction this decision. In these instances the clock will be stopped following the DNA at the 1st appointment. A new RTT clock will start on the date that the patient agrees the new appointment date

Should the patient then DNA a further time, the patient will be discharged, back to the referrer. If the patient is a vulnerable adult or child and there are safeguarding concerns then the patient's GP will also be informed in writing.

6.6 Vulnerable Patients and Safeguarding Issues

Gloucestershire Care Services NHS Trust will make every attempt to ensure that where safeguarding issues have been identified or patients are considered vulnerable, they are supported to attend their appointment. These patients will routinely be offered a second appointment following DNA of a first appointment.

For all referrals the clock will be stopped following the DNA at the 1st appointment. A new RTT clock will start on the date that the patient agrees the new appointment date.

Patients who DNA a second appointment will usually be discharged back to their referrer with their GP informed, however a clinician may at their discretion offer another appointment rather than discharge the patient (the Service Lead must sanction this decision).

Further guidance is available from the Gloucestershire Care Services NHS Trust Safeguarding Team and by reference to Gloucestershire Care Services NHS Trust Safeguarding Child Protection Guidance: Management of Children and Young People Who Fail To Attend Appointments and the Safeguarding Adults Multi Agency Policy.

6.7 Patients who need to leave before their Appointment

Patients who attend for their appointment but have to leave prior to being seen due to the clinic not being able to deliver their appointment within 30 minutes of their scheduled appointment time, will be offered a further date whilst in clinic. The waiting list clock remains active.

6.8 Patients who are late for appointments

The service will attempt to see patients who attend for their appointment but are more than 30 minutes late from their scheduled appointment time. However, where it is not possible to see the patient, that patient will be deemed to have cancelled their appointment.

Patients who are late for their appointment as a result of a patient booked transport issue should not be unfairly penalised.

6.9 Patients transferring from another Provider

Where a patient is transferring from another provider for the same condition and first definitive treatment has not commenced, the patient transfers with their original RTT start date, and their treatment target date remains the same.

The referring provider must ensure that the RTT minimum data set is completed and accompanies the referral into Gloucestershire Care Services NHS Trust including clock start dates and any cancellation/suspension history. Only where Gloucestershire Care Services NHS Trust is unable to establish the original RTT start date from the referring provider will Gloucestershire Care Services NHS Trust assume that the date of referral into an Gloucestershire Care Services NHS Trust service will be the date the 8 week clock starts.

Upon receipt of referral, if there is any cause for doubt that the patient will receive

definitive first treatment within 8 weeks then the Service Lead for that service must be informed.

Patients who have received first definitive treatment at another provider who are then subsequently referred to Gloucestershire Care Services NHS Trust as an ongoing part of their treatment for the referred condition will be subject to an 8 weeks pathway through Gloucestershire Care Services NHS Trust, the referral date being the date the 8 week clock starts from.

6.10 Patients transferring from the private sector to the NHS

Patients can choose to convert between an NHS and private status at any point during their treatment without prejudice, however their treatment must not be expedited other than for clinical reasons. Normally patients would be under the care of one provider and joint provision NHS and private simultaneously should be avoided. Patients who are eligible for NHS treatment and have been seen privately and ask to go on to the NHS waiting list must be listed at the time the decision to treat is agreed with no delays. They do not need an NHS reassessment before being added to an NHS waiting list.

The RTT clock continues to tick with the start date being the date that the patient's referral is accepted by the NHS provider.

6.11 Patients transferring to another provider

Patients may be referred out from Gloucestershire Care Services NHS Trust to another provider to commence or continue their care. When this occurs the patient transfers with their original RTT start date, and their treatment target date remains the same if Gloucestershire Care Services NHS Trust have not commenced first definitive treatment for the patients referred condition. The person (admin or clinician) referring the patient on must include their RTT minimum data set with the information sent to the receiving provider.

The following list of services has a traditionally high onward referral rate to alternative providers for delivery of first definitive treatment. In order to ensure patients receive their treatment within 8 weeks from referral these services should endeavour to see the patient within 6 weeks of referral and, where appropriate, to onward refer to an alternative provider within 2 working days of that initial appointment. Performance against these standards will be monitored for these services:

- Tier 2 Musculoskeletal Service
- Tissue Viability
- Adult and Children's Continence services

7.0 Entitlement to NHS Treatment

It will be assumed that patients that are referred from an external source (e.g. GPs, acute trust etc) will have had their eligibility to receive NHS treatment confirmed by that external source and therefore Gloucestershire Care Services NHS Trust will only check eligibility for those patients that self-refer to a Gloucestershire Care Services NHS Trust service.

For patients that self-refer to a Gloucestershire Care Services NHS Trust service and for patients that have no NHS number, Gloucestershire Care Services NHS Trust will check every patient's eligibility to receive NHS treatment in accordance with and following the guidance contained within the Department of Health website.

8.0 Responsibility for achieving waiting times standards

It is the Head of each respective service responsibility to ensure that patients do not breach the national and locally agreed referral to treat standards in their service areas. They must liaise with relevant staff to ensure that patients are booked on time, with sufficient notice, and in order and that each patient's treatment status is accurately recorded at every stage in their pathway

9.0 Approval and ratification process

The policy is approved and ratified by the Trust Executive Committee

10.0 Dissemination and implementation process

This policy will be shared via the intranet. Training for referral to treatment time standards will be delivered by the Operational service leads, ensuring correct coding onto the relevant electronic patient record.

Appendix 1 Local and Nationally Commissioned Service Timeframes

Service Area	Referral to Treat Commissioned Timeframe
Children and Young People's Services	
Children's Physiotherapy	8 Week
Children's Occupational Therapy	8 Week
Paediatric Speech & Language Therapy	8 Week
Integrated Community Teams	
Adult Occupational Therapy	8 Week
Adult Physiotherapy	8 Week
Countywide Services	
Adult Community Speech and Language Therapy	8 Weeks
Podiatry	8 Week
MSK Physiotherapy	8 Weeks
Wheelchair Assessment Service	8 Weeks
Musculoskeletal Clinical Assessment and Treatment Service	8 Weeks
Sexual Health: Contraception Service	8 Weeks
Sexual Health: HIV Service	8 Weeks
Sexual Health: Psychosexual Service	8 Weeks
Parkinson's Nursing Service	8 Weeks
Diabetic Nursing Service	8 Weeks
Bone Health Service	8 Weeks
Heart Failure: Echocardiogram Diagnostic service*	6 Weeks

*National Target

Appendix 2

Brief descriptions of each of these possible stages along the treatment pathway

Starting the Clock

Referral received

An RTT clock starts on the date that a referral for a patient is received by the service. Or for e-referrals on the date the patient converts their unique booking reference number (UBRN) either directly from the referral point (ie GP practice) or via an Appointments Line service.

Transfer from another healthcare provider

A patient will sometimes be transferred from another healthcare provider without having received first definitive treatment from that provider. In this case their original RTT clock continues and their original RTT date remains valid for Gloucestershire Care Services NHS Trust.

Transfer from a consultant-led service within another healthcare provider

A patient will sometimes be transferred from a consultant led service within another healthcare provider without having received first definitive treatment from that provider. In this case their original RTT clock continues and their original RTT date remains valid for Gloucestershire Care Services NHS Trust.

Stopping the Clock

First definitive treatment given - Clock stop

This is the point at which the patient receives their first definitive treatment. A patient's First Definitive Treatment is an intervention intended to manage a patient's disease, condition or injury and avoid further intervention. This can be provided over the telephone (advice and guidance) or face to face. This can be provided in a 1-1 setting or a group setting. This stops the RTT clock started by the referral.

Transfer to another healthcare provider

A patient will sometimes need to be transferred to another healthcare provider without having received first definitive treatment from Gloucestershire Care Services NHS Trust. In this case their original RTT clock continues and their RTT date remains valid for the new provider. This is an Inter Provider Transfer and the service will complete an Inter Provider Transfer (IPT) Administrative Minimum Data Set form.

Following transfer to the other provider, the RTT clock will be stopped as 'Decision Not to Treat'.

Patient DNAs first appointment

When a patient DNAs their first appointment following the initial referral, the clock will be stopped. The service will establish why the patient did not attend and they will be discharged unless the patient is a vulnerable adult or child or there are safeguarding concerns.

Where it is more appropriate not to discharge the patient, the service will offer the patient another appointment and a new RTT clock will start on the date that the patient agrees the new appointment date

If the patient DNA's a second appointment they will be discharged back to the referrer and the clock stopped. If the clinician wishes to offer another appointment rather than discharge the patient, the Service Lead must sanction this decision.

Further guidance is available from the Gloucestershire Care Services NHS Trust Safeguarding Team and by reference to Gloucestershire Care Services NHS Trust Safeguarding Child Protection Policy: Management of Children and Young People Who Fail To Attend Appointments and the Safeguarding Adults Multi Agency Policy.

Patient DNA's any other appointment prior to first definitive treatment

When a patient DNAs any other appointment, prior to first definitive treatment, the clock will be stopped. The service will establish why the patient did not attend and they will be discharged unless the patient is a vulnerable adult or child or there are safeguarding concerns.

Where it is more appropriate not to discharge the patient, the service will offer the patient another appointment and a new RTT clock will start on the date that the patient agrees the new appointment date

Patient cancels an appointment twice in a single pathway - Clock stop

If a patient cancels an appointment twice (ie notifies the service of non- attendance more than 24 hours before the appointment is scheduled) regardless of whether it is a first or subsequent appointment, then the patient is discharged back to their referrer and the RTT clock stops. If the clinician wishes to offer another appointment rather than discharge the patient, the service lead must sanction this decision.

Patient declines or fails to comply with advised/offered treatment - Clock stop

Where a patient refuses to accept the treatment offered or comply with advised treatment this will constitute a clock stop. However, if the patient is considered vulnerable, and discharging them from the service is inappropriate, a period of active monitoring can be implemented.

Patient unfit for treatment - Clock Stop

If a patient is unfit for treatment and the period of sickness is likely to be more than 3 weeks, the patient may be discharged back to the original referrer until deemed fit for

treatment

Patient unfit for treatment – Clock Continuation

If the patient is expected to be unfit for up to 3 weeks their RTT clock will continue to run. The service will record an 'Earliest Clinically Appropriate Date' which will be used to calculate the actual waiting time. Patients showing as waiting longer than the RTT target time in these circumstances will not be considered a breach.

Decision not to treat/ no treatment required - Clock stop

This would typically involve discharge back to the GP / referring agent, where it is not appropriate to start an Inter Provider Transfer.

Patient Died - Clock stop

The patient's referral would be closed and the patient discharged which stops the RTT clock.

Inappropriate or Incomplete Referral – Decision not to treat

If a referral is deemed in appropriate or incomplete, the referral will be returned to the referrer and the clock stopped.

Active Monitoring

Start of a period of active monitoring initiated by the patient or the Care Professional - Clock stop

Active monitoring is where it is clinically appropriate to monitor the patient without clinical intervention or further diagnostic procedures, or where a patient wishes to continue to be reviewed as an outpatient, or have an open appointment, without progressing to definitive treatment.

Active monitoring can be initiated by either the patient or the clinician. The start of a period of active monitoring stops the RTT clock started by that patient's initial referral.

It is not appropriate to use active monitoring for patients that wish to delay an appointment.

End of active monitoring - Clock start

If after a period of active monitoring, the patient or the Care Professional then decides that treatment is now appropriate, a new RTT clock starts. This new clock starts at 0 weeks; it does not restart at the point at which the previous clock was stopped. There is then a new RTT period in which the patient must receive their first definitive treatment

Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 24 January 2017

Committee Name:	Trust Board
Agenda Ref:	11/0117
Author:	Rod Brown, Head of Planning, Compliance and Partnerships
Presented By:	Glyn Howells, Director of Finance and Deputy Chief Executive
Accountable Exec:	Glyn Howells, Director of Finance and Deputy Chief Executive

Subject:	Board Assurance Framework
Appendices	Board Assurance Framework

Provided for: ☒ Discussion ☐ Decision ☐ Approval ☒ Assurance ☐ Information ☐ Noting ☐ Statutory Purposes

1. Executive Summary:

The Board Assurance Framework (BAF) provides an overview of the strategic risks and operational risks that have the potential to impact on the achievement of the Trust's vision and strategic objectives.

The BAF presented reflects the position as at the end of November 2016. Updates on any escalated risks will be discussed at the Board.

2. Recommendations:

The Board is asked to:

- Receive the BAF and consider the actions being taken to mitigate risks
- Approve the proposal to close two risks where the target risk rating has been achieved for two consecutive reporting periods:
  - risk 003 - *Variable engagement practices with service users, families and carers, which may result in the public voice not being used to inform the Trust*
  - risk 014 - *Inability to gain a "Good" or "Outstanding" rating following a CQC Chief Inspector of Hospitals' assessment*

3. Main Report

The BAF is attached.

Of particular note:

- There are two risks where the target risk rating has been achieved for two consecutive reporting periods:
  - risk 003 - *Variable engagement practices with service users, families and carers, which may result in the public voice not being used to inform the Trust*
  - risk 014 - *Inability to gain a "Good" or "Outstanding" rating following a CQC Chief Inspector of Hospitals' assessment*

Understanding you

The following risk has increased in rating.

- Risk 013 – *Ability to maintain robust internal control/governance systems which may lead to reputational loss and impact on long-term sustainability* has seen an increase in risk score as a result of the issues associated with work to support the Information Governance Toolkit requirements. Actions to support the work to achieve level 2 compliance are ongoing and an update will be provided to the Board on progress.

4. Which Trust strategic objective(s) does this paper link to?	
Achieve the best possible outcomes for our service users through high quality care	☒
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	☒
Actively engage with health and social care partners as well as local communities, in order to deliver seamless services	☒
Value colleagues and support them to develop the skills, confidence and ambition to deliver our vision	☒
Manage public resources wisely to ensure local services remain sustainable and accessible	☒

5. Explanation of acronyms used:

BAF: Board Assurance Framework
CQC: Care Quality Commission

Gloucestershire Care Services NHS
NHS Trust

Board Assurance Framework:

Strategic Risks

November 2016

Overview

This part of the Board Assurance Framework (BAF) serves to summarise the **strategic risks** that are faced by the Trust, linked to the organisation's five strategic objectives.

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1. Strategic Risks

1.1 Summary of strategic risks

Trust strategic objectives	Strategic risks			
	Ref	Risk	RAG	Movement
Achieve the best possible outcomes for service users through high quality care	002	Inability to both embed and maintain consistent care pathways across all Trust services, and also ensure that staff observe these at all times	12	⟺
	003	Inability to observe robust record-keeping practices which may impact upon safety and care delivery	16	⟺
	004	Inability to maintain capacity, and match capacity to demand, which may impact upon service user and colleague safety, and the provision of continuous care	12	⟺
Understand the needs and view of our service users, carers and families so that their opinions inform every aspect of our work	005	Variable engagement practices with service users, families and carers, which may result in the public voice not being used to inform the Trust	3	⟺
Actively engage in partnerships with other health and social care providers in order to deliver seamless services	007	Lack of up-to-date service specifications for Integrated Community Teams limits the Trust's ability to effectively plan and deliver to plan	16	⟺

Trust strategic objectives	Strategic risks			
	Ref	Risk	RAG	Movement
Value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision	008	Inability to recruit and retain the right staff with the right skills in the right place which may have a detrimental impact upon the quality of provided care	16	
	009	Inability to develop a culture that engages and motivates colleagues which may have a negative impact upon the Trust's reputation as an employer of choice	12	
	010	Inability to provide robust assurance that colleagues have the clinical skills to create a workforce with the necessary knowledge and expertise to deliver best care	12	
	011	Insufficient leadership capacity and capability within the Trust which could have a detrimental impact upon service transformation and service user care	12	
Manage public resources wisely to ensure local services remain sustainable and accessible	012	Failure to deliver the Trust's financial plan, including CIP, CQUIN and QIPP programmes	12	
	013	Inability to maintain robust internal control / governance systems which may lead to reputational loss and long-term sustainability	15	
	014	Inability to gain a "Good" or "Outstanding" rating following a CQC Chief Inspector of Hospitals' assessment	5	

2.2 Detail of strategic risks

Risk	**Inability to both embed and maintain consistent care pathways across all Trust services, and also ensure that staff observe these at all times**					**Ref**	002		
Strategic objective	*Achieve the best possible outcomes for service users through high quality care*								
Description	Services have not developed, or are not following, evidence-based care pathways, to support the right person and provide the right care at the right time. This can result in ineffective and inefficient care being provided to service users.								
Date opened	30 March 2016					**Exec lead**	Candace Plouffe		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	5	2	5	4	4	4	4		
- Consequence	3	3	3	3	3	3	3		
- Total	**15**	**6**	**15**	**12**	**12**	**12**	**12**		
Controls	• Some services are adopting a care pathway approach and this is being incorporated into the service specifications: an exemplar of good practice has been the Complex Wound service • NICE guidance provides information on best practice and is utilised to develop and refresh care pathways • Work is underway to approach this a system as part of the STP clinical pathway programme – with a focus initially on respiratory illness and dementia					**Assurance**	• Clinical protocols which incorporate care pathways facilitate an audit based approach to ensure compliance		
Gaps in controls	• Older service specifications tend to be input and activity based, and do not incorporate evidence-based care pathways					**Gaps in assurance**	• Not all interventions have nationally recognised evidence-based pathways, and as such, these will need to be locally developed and tested		

Progress made in the previous period	• Demand and capacity tool for ICT localities completed, and presented to Quality and Performance Committee. Full roll-out scheduled for December • Demand and capacity tool for health visiting and school nursing has been completed • Arranged for Norfolk Community Trust to visit and demonstrate their demand-capacity tool • Draft operational service delivery plans regularly reviewed in management 1-1's • Ongoing review of service specifications, expected completion in Quarter 4 so can be included in new contract • Finalised care pathway for Community IV therapy service • Continued participation in STP clinical pathway workstream, which is directing operational services to move to a more consistent care pathway approach
Actions in the next period	• Finalise care pathways for stroke rehab services, continence service and Community IV therapy services • Demand and capacity follow-up workshop arranged for December • Training session with Norfolk Community Trust planned • Finalise operational delivery plans, down to individual service level, incorporating 2017/18 objectives • Complete outstanding service specification reviews as per agreed schedule • Contract meeting with GHFT scheduled in December, this will allow for discussion on key pathways identified by services subcontracted into the acute i.e. Adult SLT service for head and neck cancer
Slippages on reported actions in the last reporting period	• Finalisation of service specifications with the Commissioners; as there is now a view that some of the key service specifications need to be reviewed again to ensure alignment with the STP • Contract meeting with GHFT was expected to occur in October but now arranged for December
Links to the Corporate Risk Register	None

Risk	**Inability to observe robust record-keeping practices which may impact upon safety and care delivery**					**Ref**	003		
Strategic objective	*Achieve the best possible outcomes for service users through high quality care*								
Description	The quality of record keeping is variable across services, and is potentially impacting on the quality of provided care as insufficient information is available for colleagues to act upon. This also creates a risk for the organisation when incidents occur, as care is not being documented to the standard expected as per the professional regulatory bodies and the Trust's record keeping policy ***The evidence to support a decrease in risk rating will not be available until January 2017 when the results of record-keeping audits are known***								
Date opened	30 March 2016					**Exec lead**	Candace Plouffe / Susan Field		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	4	2	4	4	4	4	4		
- Consequence	4	4	4	4	4	4	4		
- Total	**16**	**8**	**16**	**16**	**16**	**16**	**16**		
Controls	• SystmOne allows for more robust record keeping audits, in which quality is the focus • All services carry out an annual record-keeping audit, and this process has been revised as the Trust has moved to an electronic records					**Assurance**	• Annual record keeping audits have been completed by professional heads of service, and subsequent action plans developed		
Gaps in controls	• Lack of standard operating procedures in SystmOne has resulted in information being recorded in various parts of the record, making it difficult to find easily, thereby impacting upon continuity of care • Training for clinical colleagues on how and what to record on electronic systems has yet to be provided – recognising this may require a different approach to paper based records					**Gaps in assurance**	• Need to review current record keeping and record management policy to ensure fits with new way of recording clinical information		

Progress made in the previous period	• Standard Operating Procedures have been developed on SystmOne, as well as redesign of modules to facilitate improved record keeping (i.e. tile approach). This work has almost been finalised by the Heads of Profession, whilst for Physiotherapy and OT ICTs, work is being tested • Training programme reviewed and finalised • Trust Record Keeping Policy ratified • Progress report presented to the October Quality & Performance Committee • Commenced re-audit activities beginning with children's services • Legal and Professional Body Training commissioned – 3 sessions • Community Nurse quality visits continue and indicate improvements in clinical record keeping	
Actions in the next period	• Continue work via the Quality Improvement Group action plans • Training programme to be implemented • Encourage (and mandate) colleagues to attend commissioned training (Jan-March) • Implement agreed work plan actions that include use of SystmOne templates and READ Codes	
Slippages on reported actions in the last reporting period	Some delay with community nurse template implementation due to the complexity, volume and breadth of community nurse activities	
Links to the Corporate Risk Register	SD35: Lack of compliance within ICTs with professional standards of clinical record-keeping	**16**
	NQ11: Record-keeping and records management processes are not compliant with clinical governance standards	**16**
	PCP01: Inconsistent record keeping means that allegations of negligence cannot always be refuted	**12**

Risk	**Inability to maintain capacity, and match capacity to demand, which may impact upon service user and colleague safety, and the provision of continuous care**					**Ref**	004		
Strategic objective	*Achieve the best possible outcomes for service users through high quality care*								
Description	Sustained and significant pressure for access to community services is reducing the ability to be proactive, as it is forcing the Trust to routinely react to the need to manage capacity. This not only distracts the organisation's senior operational staff from strategic planning, it also reduces the level of resource that is available elsewhere within the health and care system. Additionally, the demand to make additional community beds available to the acute sector may impact upon the quality of care being provided, and can place excessive strain upon colleagues, leading to higher turnover and lower morale								
Date opened	30 March 2016					**Exec lead**	Candace Plouffe		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	4	2	4	4	3	3	3		
- Consequence	4	4	4	4	4	4	4		
- Total	**16**	**8**	**16**	**16**	**12**	**12**	**12**		
Controls	• Alamac reporting enables a more measured and responsive approach to system-wide pressures, and is beginning to gather a body of information to support systemwide urgent care demand-capacity modelling • SystmOne is providing clearer evidence of Trust activity to underpin forward planning and a demand-capacity approach • Some services have demand-capacity models, and have used them to success in improving access times					**Assurance**	• Activity and performance against contracted service levels is reported on monthly through the Quality and Performance Report		
Gaps in controls	• The lack of service specifications which incorporate care pathways and demand-capacity models means that the Trust has very few cap-volume metrics agreed • There is insufficient clarity regarding step-up and step-down services to and from other providers • Without demand-capacity modelling, it is difficult to evidence when community services are "full" which impacts on the workforce and the quality of service delivered					**Gaps in assurance**	• There is not a consistent approach to proactive capacity planning across the whole of the health and social care economy: this should be one of the responsibilities of cross-organisational committees such as Gloucestershire Strategic Forum and the Strategic Resilience Forum • The Staff FFT is showing an increase in the number of colleagues identifying demand-capacity issues as increasingly significant		

Progress made in the previous period	• Agreement on revised IDT service offer following review of the service and outcomes of the MADE events and Home First pilot • Completion of the pilot of GP priority admission beds in Community hospital, with report shared at the Quality and Performance Committee and A&E Delivery Board. This initiative will continue with ongoing monitoring of impact on avoiding admissions into GHT • Progress by operational teams on demand-capacity frameworks for individual services, interlinked with defined care bundles • Beginning roll-out of demand and capacity tools in ICTs and CYPS • Agreed funding for additional capacity in Rapid Response	
Actions in the next period	• Review the implementation of the Medworxx system. Trial of Red-Green days as alternative • Arrange demand and capacity workshops in operations directorate • Arrange a session with Norfolk NHS Trust to understand their demand-capacity tool • Finalise a revised urgent care system pull model, incorporating demand and capacity tools to support patient flow and reduce number of acute sectors beds utilised • Agree a revised Reablement offer to support patient flow, both over winter and longer term	
Slippages on reported actions in the last reporting period	Delays with the implementation of the Medworxx system and alternative system (Red-Green days) being proposed	
Links to the Corporate Risk Register	SD5: Increasing demand for specialist services	**9**
	ST29: Bed occupancy levels consistently exceed CQC-advised thresholds and commissioned targets	**12**
	SD8: Failure to achieve the local 4-week wait for routine MSKCAT service users	**12**

Risk	**Variable engagement practices with service users, families and carers, which may result in the public voice not being used to inform the Trust**					**Ref**	005		
Strategic objective	*Understand the needs and view of our service users, carers and families so that their opinions inform every aspect of our work*								
Description	The Trust must ensure that it develops and maintains clear routes by which all service users, families and carers can provide feedback on their experiences so that this information may be actively used to improve service delivery and quality. This must include those service users who experience health inequalities or who traditionally find it hard to engage								
Date opened	30 March 2016					**Exec lead**	Susan Field		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	3	1	3	3	2	1	1		
- Consequence	3	3	3	3	3	3	3		
- Total	**9**	**3**	**9**	**9**	**6**	**3**	**3**		
Controls	• Use of the Friends and Family Test (FFT) across all Trust settings • Direct feedback to teams from FFT comments • The updated Complaints Policy • The Service User Experience team which manages surveys including the FFT as well as complaints, Duty of Candour, concerns and compliments • The Community Partnerships Team which manages a range of engagement activities to include focus groups, community events and consultation opportunities • Information provided by external agencies such as Healthwatch, NHS Choices and Patient Opinion • On-going review of all feedback so as to ascertain themes • The Quality Equality Impact Assessments that are conducted against all service improvements / redesigns / Cost Improvement Plans • The Trust's Annual Quality Account • Being Open Champions					**Assurance**	• The Your Care, Your Opinion Programme Board • Relevant metrics within the Quality and Performance Report received at the Quality and Performance Committee and Board • 6-monthly Understanding You Report • Service user stories at Board • The Complaints Oversight Group • Regular partnership meetings with Healthwatch and Quality Review meetings with the CCG • Groups within the Trust which have a specific focus upon improving the experiences of those with dementia or a learning disability • The outputs of focus groups which are reported to relevant Trust forums for learning • The outputs of other ad-hoc engagement and consultation activities		

Gaps in controls	• The Trust needs to actively engage with partners to truly evidence coproduction in service development	**Gaps in assurance**	• Service user feedback is not engrained in all service developments • Benchmarking data suggests that the Trust receives fewer complaints than other comparable Trusts
Progress made in the previous period	• Period of engagement on the local STP commenced (to run until February 2017) – first event held at the Forest of Dean Health Forum • Your Care, Your Opinion on 3 November looked at local innovations with a range of community partners and public attendees • Patient stories continue to be heard at Board and Board Development meetings • LiA LD scheme launched involving people living with LD. 30+ GCS colleagues attended reasonable adjustments training with 2gether Trust and patient/family involvement • Supported the Special Olympics on 25 October • Community Partnership Outreach Officer has commenced work on dementia working with the Clinical Pathways lead for dementia • Countywide Equalities Group now established • Trust AGM took place and well attended. Feedback has been positive • The Quality Equality Impact Assessment (QEIA) Policy finalised by the Trust Clinical Reference Group and due for ratification by the Quality & Performance Committee December 2016 • Disappointingly the Planned Black History event was postponed • Attended GOPA AGM on 24 October, at which GCS was highlighted as a critical friend • Community Health Event took place on 30 November – very positive feedback from the BME community		
Actions in the next period	• Continue to support the countywide STP Engagement • Launch focused discussion groups re: the Place-based Model in Stroud • Launch Trust compliance with the NHS Accessible Standard on 1 December • Launch a Trustwide Equalities Survey • Arrange training event with the CORE Colleague network re: WRES • Present the Communications and Engagement Strategy at the Workforce & OD Committee and Quality & Performance Committee • Identify new translation and interpretation provider for the Trust • Plan for Holocaust Memorial event		
Slippages on reported actions in the last reporting period	• Forest of Dean consultation delayed until June 2017		
Links to the Corporate Risk Register	None		

Risk	**Lack of up-to-date service specifications for Integrated Community Teams limits the Trust's ability to effectively plan and deliver to plan**					**Ref**	007		
Strategic objective	*Actively engage in partnerships with other health and social care providers in order to deliver seamless services*								
Description	Although the ICTs have been in existence for a number of years, the fundamental operational model has not been formally confirmed and agreed between partner organisations with a service specification. This, alongside further initiatives such as High Intensity/Enhanced Care service and case management, has resulted in a lack of agreed understanding between commissioners and the Trust of what is expected to be provided. The County Council has also introduced a change to the line management arrangements and responsibility for social work practice which has further impacted on the model. Overall, there is not a measure against which the Trust can effectively assess the success or otherwise of the ICTs. This results in an inability to set the service parameters and most significantly, the service cannot quantify when it is at capacity. With the development of the 30,000 people and place model, the Integrated Community Team will need to be redefined and service specifications refreshed								
Date opened	30 March 2016					**Exec lead**	Candace Plouffe		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	4	2	3	3	4	4	4		
- Consequence	4	4	4	4	4	4	4		
- Total	**16**	**8**	**12**	**12**	**16**	**16**	**16**		
Controls	• The Trust has created an ICT operational plan, based on previous business cases developed with the Commissioner and on draft and previous service specifications. • Individual action / recovery plans have been developed in respect of "hot spots" / areas of operational concern, such as reablement • Arrangements have been agreed with the Council to ensure that integrated care provision is provided by the ICTs, despite the change in line management and overall responsibilities for social work					**Assurance**	• Assurance and further direction is provided via the ICT Performance and Delivery Group which reports to the Joint Strategic Integration Panel. This in turn reports to the Contract Monitoring Board. • The refreshed governance structure has been agreed with Commissioners • Internal assurance is provided to the Operational Governance Group which reports to the Quality and Performance board subcommittee		

Gaps in controls	• The Trust does not have a final service specification for Integrated Community Teams within its core contract • The Trust does not have an agreed ICT service delivery model • Changes in operational management of Social Care services with competing organisational priorities between health and social care, may jeopardise the relationship between the Trust and Council, and thereby undermine delivery of integrated health and adult social care services. • The change to the social care management element has resulted in the need to review the overall management structure of the Integrated community teams	**Gaps in assurance**	• Although system wide key performance indicators are reported to the Commissioner, there is not a full set of metrics in which the individual elements of the Integrated Community Teams are reporting on
Progress made in the previous period	• Set management fee for the oversight of the social care elements that have remained with the Trust now formally agreed • Agreed with Commissioners on a reconfigured ICTs structure, in order to increase clinical leadership and thereby facilitate the implementation of case management and support the people and place (30,000) model as part of the STP • Agreement with GCCG on the funding for the revised ICT structure • Develop an organisational change plan to move to new structure in line with 30,000 model • Received direction from Commissioners following OT review. Action plan developed • Agreed priorities for redesigned reablement service		
Actions in the next period	• Undertake organisational change programme to realign ICT structures • Complete options appraisal following OT review • Agree detailed programme of change framework to redesign reablement service		
Slippages on reported actions in the last reporting period	• Not yet received the review of overarching service specification and appendices to ensure of the professional services/functions provided by the ICTs to ensure they are in alignment with emerging people and place 30,000 model of care		
Links to the Corporate Risk Register	ST31: Risk to service user safety, service effectiveness and Trust reputation as a result of competing developmental priorities in ICTs including the place-based model, frailty pathway and community matron model of care		**12**

Risk	**Inability to recruit and retain the right staff with the right skills in the right place which may have a detrimental impact upon the quality of provided care**					**Ref**	008		
Strategic objective	*Value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision*								
Description	The number of qualified nursing vacancies has improved within Community Nursing but has deteriorated within Community Hospitals over the last 12 months. This is set in the national context that qualified nurses are included on the national shortage occupational list and the recent introduction of agency cap rates. Furthermore, since April 2016 the number of band 5 physiotherapy and occupational therapy vacancies have been increasing due to strong competition from the private sector.								
Date opened	30 March 2016					**Exec lead**	Tina Ricketts		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	4	2	4	4	4	4	4		
- Consequence	4	4	4	4	4	4	4		
- Total	**16**	**8**	**16**	**16**	**16**	**16**	**16**		
Controls	• Monthly submissions of nurse staffing numbers within Community Hospitals so as to identify gaps and respond effectively • Recruitment drives / fayres to attract new staff • Revised establishment control process for community hospitals • Any gaps in staffing are addressed by the use of bank/agency workers so as to maintain safe staffing levels at all times • Centralised bank and agency function • Roll out of e-rostering across the Trust • Safer recruitment practices in place • Review of exit interviews, managed centrally in HR					**Assurance**	• Workforce data which is reported through the Workforce & OD Committee and thereafter to Board • Safer Staffing data which is included within the Quality and Performance Report which goes to Board • Top-level workforce plan submitted to Workforce & OD Committee • Agency working group chaired by the Chief Operating Officer • Recruitment and Retention Steering Group chaired by Head of HR		
Gaps in controls	• Lack of robust workforce information, particularly in terms of establishment & vacancies, which is essential in order to drive activity and response • Available staff banding does not help to retain talented staff – thus, for example, district nurses are unable to advance above Band 6 which results in them either having to specialise within other services, or leave the employ of the Trust • Low completion rate of exit interviews					**Gaps in assurance**	• Data is not available to review in real-time		

Progress made in the previous period	• Recruitment and retention report standing agenda item on Workforce and Organisational Development Committee • Contingent workforce plan in place with new initiatives including introduction of weekly payroll and peripatetic team • Positive news story in Nursing Times about the Trust's progress with Community Nursing recruitment • GCS ranked 2nd in Southwest regarding the management of agency spend • Participation in Gloucestershire Health and Social Care Recruitment Fayre • Visit by NHS Improvement as GCS seen as a best practice Trust with regard to nurse recruitment and retention	
Actions in the next period	• Recruitment and selection processes to be further reviewed under a Listening into Action scheme • Refresh of Recruitment and Retention Steering Group membership • Further targeted recruitment campaigns • Nurse Associate programme to be launched in April 2017 • BIRT is being developed to incorporate establishment figures enabling the Trust to view live vacancy rates by 1 April 2017	
Slippages on reported actions in the last reporting period	None	
Links to the Corporate Risk Register	NQ12: No formal consultant microbiologist to support antimicrobial stewardship and provide clinical guidance	**12**
	HR3: High number of nurse vacancies across the Trust, particularly in community hospitals	**16**
	HR7: Insufficient workforce information may be masking further recruitment hotspots	**15**

Risk	**Inability to develop a culture that engages and motivates colleagues which may have a negative impact upon the Trust's reputation as an employer of choice**					**Ref**	009		
Strategic objective	*Value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision*								
Description	Lack of a clear, consistent and positive working environment may negatively affect the Trust's ability to attract and retain staff. This may result in insufficient staff numbers and higher costs of employment due to increased bank/agency staff. More significantly, disaffected and demoralised staff can impact on the quality of provided care								
Date opened	30 March 2016					**Exec lead**	Tina Ricketts		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	4	1	3	3	3	3	3		
- Consequence	4	4	4	4	4	4	4		
- Total	**16**	**4**	**12**	**12**	**12**	**12**	**12**		
Controls	• Agreed Workforce and Organisational Development Strategy with corresponding implementation plan • Undertaking a fourth year of Listening into Action • Core Values Behaviour Framework • Annual staff survey • Quarterly Staff Friends and Family Tests • Workforce scorecards • Investors in People accreditation					**Assurance**	• Improvements in the Pulse Check for Listening Into Action between start and end of year three • Listening into Action accreditation • Investors in People accreditation until March 2017 • Workforce and Organisational Development Committee • Workforce Education & Development Group		
Gaps in controls	• The Trust's agreed Performance Management Framework is not widely understood or embedded across the organisation • High proportion of workforce risks relate to demand/ capacity issues • Inability to recruit to all qualified nursing vacancies having an impact on morale					**Gaps in assurance**	• Both the NHS Staff Survey and the Staff Friends and Family Test report below-target for staff recommending the Trust as a place to work. Hotspot identified at Edward Jenner Court.		

Progress made in the previous period	• Listening into Action accreditation • #takethelead conference held on 5 October 2016 • The launch of a further 32 Listening into Action schemes • Three Listening into Action schemes (communications, leadership, behaviours) being taken forward at EJC to address 3 priority areas identified in big conversations • Listening into Action Board Development session held in September 2016 • Timewise big conversation held in October 2016 • Timewise presentation to the Core Colleague Network	
Actions in the next period	• Continue to focus on improving the Trust's rating as a flexible working employer in conjunction with Timewise • Refresh of the combined Communications and Engagement Strategy • Investors in People assessment in February 2017 • NHS staff survey results due December 2016 • Continue to implement the Colleague Health and Wellbeing Plan	
Slippages on reported actions in the last reporting period	None	
Links to the Corporate Risk Register	HR13: Low staff morale within the Trust as a result of many changes and the mismatch between capacity and demand	**12**
	HR6: Low rates of Personal Development Reviews	**12**
	PCP23: The Trust's WRES report shows significant discrepancies between the experiences of different staff groups	**12**

Risk	**Inability to provide robust assurance that colleagues have the clinical skills to create a workforce with the necessary knowledge and expertise to deliver best care**						**Ref**	010	
Strategic objective	*Value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision*								
Description	The Board does not receive the necessary assurance that colleagues are suitably skilled. Moreover, the Trust needs to establish a clear link between Personal Development Plans and Service Development Plans in order to be able to evidence a competent and flexible workforce who are able to effectively provide care despite the changing profile of service users and their increasing acuity								
Date opened	30 March 2016					**Exec lead**	Susan Field / Tina Ricketts		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	4	1	3	4	4	3	3		
- Consequence	4	4	4	4	4	4	4		
- Total	**16**	**4**	**12**	**16**	**16**	**12**	**12**		
Controls	• The Trust has a policy regulating the use of Personal Development Plans • Clinical education programmes are in place and accessible via ESR • There is a defined pooled training budget • There are competency frameworks for statutory and mandatory training • The Trust is compliant with the Professional Bodies Registration requirements					**Assurance**	• PDRLA & and mandatory training rates are included in the Quality and Performance Report which goes to the Trust Board: these are also reported at team and locality level on a monthly basis • Workforce Education & Development Group which reports to the Workforce & Organisational Development Committee		
Gaps in controls	• Completion rates for PDR's is below the required threshold • There are no commissioned audits looking at PDR practice • Inconsistent provision of clinical supervision • Service Development Plans are not yet developed for all areas • Competency frameworks need to be developed across all roles and disciplines					**Gaps in assurance**	• Percentage of staff reporting access to relevant personal development • Percentage of staff compliant with statutory and mandatory training		

Progress made in the previous period	• Further development of the Oracle Learning Management system as to enable colleagues to access their own training records on line • Trust's statutory and mandatory training matrix promoted across the Trust • Intense statutory and mandatory training sessions arranged until December 2016 • Improved reporting now in place for safeguarding training • Access to e-learning simplified • Training booking system replaced enabling improved access • Apprenticeship roles in place • Refresh of the Trust's statutory and mandatory training policy completed • Refresh of the Trust's study leave policy completed • Workforce scorecard developed to include reporting of compliance on mandatory clinical training • Training data validation process with budget holders completed • Launch of ESR Self- Service in October • Targeted approach to improving statutory and mandatory training compliance – action plans in place for each subject area • Review Terms of Reference for Workforce and Education Group	
Actions in the next period	• Continue with Listening into Action "Enabling our People" schemes • Progress further definition of essential to role training matrices for each service (led by Professional Heads and Operational Leads) • Development of Trust strategy re Apprenticeship Levy	
Slippages on reported actions in the last reporting period	• Lack of capacity of services to release staff to complete the training	
Links to the Corporate Risk Register	HR12: Low essential-to-role training compliance could have a detrimental impact on the Trust's reputation and its ability to meet CQC standards	**12**
	HR20: Failure to meet national compliance requirements with regards to mandatory training and auditing of CPR equipment	**12**

Risk	**Insufficient leadership capacity and capability within the Trust which could have a detrimental impact upon service transformation and service user care**					**Ref**	011		
Strategic objective	*Value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision*								
Description	The Trust's cultural change programme requires all colleagues to be leaders so that service transformation and development can be driven from the front line. It is evident from staff survey results that leadership capability and capacity is varied across the Trust and this is having a detrimental impact on colleague engagement, service development and the ability to take forward service transformation at pace and scale								
Date opened	30 March 2016					**Exec lead**	Tina Ricketts		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	4	2	3	3	3	3	3		
- Consequence	4	4	4	4	4	4	4		
- Total	**16**	**8**	**12**	**12**	**12**	**12**	**12**		
Controls	• NHS Leadership Competency Framework • Workforce and Organisational Development Strategy • Listening into Action programme year 4 • CORE values behaviour framework					**Assurance**	• Investors in People Accreditation to March 2017 • Listening into Action Accreditation • Workforce Education & Development Group which reports to the Workforce & Organisational Development Committee • Monthly leadership meetings		
Gaps in controls	• The Trust does not currently have a Talent Management Strategy • The assessment of individual's ability against the NHS Leadership Competency Framework is varied and it not intrinsically linked to personal development plans					**Gaps in assurance**	• Percentage of colleagues who have participated in leadership development activities		
Progress made in the previous period	• Improved leadership scorecard results compared to September 2015 • Edward Jenner leadership programme available to all staff • CORE Colleague Network attendee list updated • Bespoke leadership programmes in place for Integrated Community Teams and Community Hospital Managers • Listening into Action coaching session for 32 colleagues took place in September 2016 • #takethelead conference held on 5 October 2016								

Actions in the next period	• Development of a Trust leaders/managers toolkit • Launch of an on line Wellbeing for Leadership programme	
Slippages on reported actions in the last reporting period	Delay in the development of a Talent Management Strategy	
Links to the Corporate Risk Register	HR15: Lack of management capability and capacity could be the root cause of low staff moral and increased staff turnover	**16**
	HR16: Lack of leadership capability and capacity could be the root cause of lack of progress against service transformation and the Workforce and OD Strategy	**12**
	TC31: Insufficient resources in the PCM team to deliver necessary change NEW	**12**
	PCP27: The ability of the Trust to coordinate all finance, activity, workforce, operational and strategic elements of the STP into a single response with limited capacity	**12**

Risk	**Failure to deliver the Trust's financial plan, including CIP, CQUIN and QIPP programmes**						**Ref**	012
Strategic objective	*Manage public resources wisely to ensure local services remain sustainable and accessible*							
Description	The Trust has a challenging £4m Cost Improvement Programme for 2016-17. Additionally, the Trust is challenged to meet all QIPP and CQUIN targets which have another £6m of risk in them. The CQUIN schemes agreed are challenging but deliverable: however, there is £900k QIPP risk which is based on system-wide improvement in KPIs that are outside the Trust's control							
Date opened	30 March 2016					**Exec lead**	Candace Plouffe	
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	4	2	3	3	3	3	3		
- Consequence	4	4	4	4	4	4	4		
- Total	**16**	**8**	**12**	**12**	**12**	**12**	**12**		
Controls	• Robust project structure and governance framework in place to ensure continual monitoring and reporting with clear escalation • Accurate baseline reports and activity data to evidence progress • Financial targets agreed at the outset between operations and finance with more financial involvement throughout the process • Good historical delivery against QIPP and CQUIN and additional QIPP schemes close to agreement • A clear communications plan linking CIP delivery to LiA; highlighting that CIP is a collective responsibility and requires engagement from everyone • QEIAs will be completed and signed off for all CIP schemes before they are implemented • The Trust's main commissioner is supportive of the areas being targeted by the CIP plans					**Assurance**	• Progress against CIP targets is monitored at the CIP Steering Group which reports to the Finance Committee • Quality Equality Impact Assessments are discussed at Clinical Senate with recommendations made to the Executive Team for ratification • Quality Equality Impact Assessments are included with future Clinical Senate reports which are provided to the Quality and Performance Committee		
Gaps in controls	• Clear evidence-base / intelligence / operational modelling upon which to build CIP plans • Financial understanding and accountability by operational leads is improving • Financial projections are improving • Understanding of CIPs across the Trust is improving					**Gaps in assurance**	• The ability to deliver in-year and future CIP savings without reducing frontline services or generate additional income through increased productivity and efficiency	

Progress made in the previous period	• QIPP and CQUIN schemes are now fully agreed with the main commissioner, full achievement in Quarter 1 and good achievement forecasted for Quarter 2 (not yet confirmed) and Quarter 3 (not yet completed) • Detailed CIP programmes in place, with good achievement in community hospitals and ICTs • QEIAs for CIP programme resulting in significant change being reviewed by Clinical Reference Group • CIP opportunities for 2017/18 now identified	
Actions in the next period	• Continue to complete QEIAs for relevant CIP initiatives before implementing • Review of QIPP and CQUIN milestones and agree evidence required with Commissioners to minimise potential non-achievement • Continued management and monitoring of all CIP, CQUIN and QIPP plans • Finalisation of CIP plans for 2017-18 • Provider to Provider contract meeting with GHT	
Slippages on reported actions in the last reporting period	• Provider to provider contract meeting with GHT has not yet occurred for 16/17	
Links to the Corporate Risk Register	SD38: The Trust is not receiving funding for all out-of-county HIV care	**12**
	FIN1: Ability to deliver CIPs against pay costs	**12**
	FIN2: Ability to achieve Gloucestershire Hospitals NHS Foundation Trust service recharges and adhocs	**16**
	FIN5: Inability to identify required targets or cost savings across a five year period	**12**
	FIN6: £900k of QIPP income is outside the Trust's control	**12**
	TC14: £900k admission avoidance QIPP scheme at risk of non-delivery	**12**
	TC27: CQUIN positive risk taking milestones are at risk	**12**
	TC29: Lack of commissioner assurance regarding achievement of QIPP milestones for IV Therapy NEW	**12**
	TC30: Complex leg wound service has reached capacity and there is reputational risk if not rolled out countywide NEW	**12**
	TC32: Risk that STP work cross cuts CIP initiatives NEW	**12**

Risk	**Inability to maintain robust internal control / governance systems which may lead to reputational loss and long-term sustainability**						**Ref**	013	
Strategic objective	*Manage public resources wisely to ensure local services remain sustainable and accessible*								
Description	Non-compliance with requisite standards is a constant risk, to which the Trust must adopt a proactive approach so as to maintain its effective performance and organisational reputation as a provider of high quality services. Governance arrangements for Board and sub-committees that have been discussed and agreed with NHS Improvement need to be quickly embedded in the Trust, and these new arrangements mapped to strategies, relevant sub-committees and matters arising under the previous governance arrangements.								
Date opened	30 March 2016					**Exec lead**	Glyn Howells		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	2	1	2	2	2	2	3		
- Consequence	5	5	5	5	5	5	5		
- Total	**10**	**5**	**10**	**10**	**10**	**10**	**15**		
Controls	• Clinical and corporate governance arrangements enable controls to be effectively managed • Committee / reporting structures enable controls to be monitored and reviewed • The Trust's strategy framework provides oversight of activity and controls in all key operational and support areas • The Trust maintains its Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation of Powers by which its authority is managed and controlled • Line management structures provide clarity in terms of responsibilities and accountabilities • Internal and external audit provides additional scrutiny					**Assurance**	• The sub-Board Committee structure, and in particular, the Audit and Assurance Committee, the Quality and Performance Committee, the Finance Committee, and the Workforce and OD Committee, provide assurance on all corresponding controls to the Trust Board		
Gaps in controls	• Revised committee structures need to be embedded and run through reporting cycles to provide assurance					**Gaps in assurance**	• Lack of ability to evidence how effectively the new governance structures work together • No consistent management of delegated authorities in committee sub-groups		

Progress made in the previous period	• Trust Secretary continues to make progress in improving the consistency and integration of all Board Governance and supporting committee Terms of Reference, agendas and papers • Head of Financial Accounting post is now covered on an interim basis by another member of the finance team and good progress is being made in devising work plans to improve the quality of service provided • Work on improving reporting on key workforce data is driving higher confidence in information which people are now acting on to improve training compliance • Revised governance arrangements have been audited by Internal Audit to measure their effectiveness and completeness • Work has commenced to streamline the reporting pack for the Quality and Performance Committee	
Actions in the next period	• Respond to actions from Internal Audit Report • Review the effectiveness of the new slimmed down Q&P reporting pack • Progress the appointment of substantive Head of Financial Accounting	
Slippages on reported actions in the last reporting period		
Links to the Corporate Risk Register	SD42: Capacity to correct / amend countywide services data quality in SystmOne	**12**
	SD45: Failure to have information on ICT capacity	**12**
	SD47: Lack of EPRR awareness and testing across operational teams	**12**
	SD57: The dental services' IT system has become unresponsive, and records are not accessible NEW	**12**
	HR18: No internal expert to support staff who have retained their local government pension scheme (LGPS)	**12**
	PI3: Areas of reporting inconsistency and poor data quality across some services	**12**
	PI4: Inaccurate data being used for delayed transfer of care (DTOC) statutory returns	**12**
	PI8: Delays in business intelligence reporting tool project	**12**
	PI9: TPP failing to provide daily event data in a timely manner to inform service planning NEW	**12**
	PI11: Reduced capacity of information team due to focus on BIRT development and new Sexual Health system NEW	**12**

	PI12: Lack of understanding of the new sexual health information system NEW	**12**
	PCP02: Failure to comply with Information Governance standards, resulting in the Trust no longer being at level 2 compliance with the Information Governance Toolkit	**20**
	PCP14: Low rates of Information Governance training across the Trust	**12**
	PCP28: Lack of control and policy on the use of data storage devices	**12**

Risk	**Inability to gain a "Good" or "Outstanding" rating following a CQC Chief Inspector of Hospitals' assessment**						**Ref**	014	
Strategic objective	*Manage public resources wisely to ensure local services remain sustainable and accessible*								
Description	The CQC report published 22 September 2015 awarded the Trust a rating of "Requires Improvement". It is the Trust's clear ambition to secure a "Good" rating as a minimum in order to provide assurance of the organisation's high-quality services, care and regulatory compliance.								
Date opened	31 May 2016 (re-entry)					**Exec lead**	Susan Field		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	3	1		3	2	1	1		
- Consequence	5	5		5	5	5	5		
- Total	**15**	**5**		**15**	**10**	**5**	**5**		
Controls	• The development of a detailed Quality Improvement Plan in response to the CQC Chief Inspector of Hospitals' report, which details all the actions being taken by the Trust to address the identified gaps / inconsistencies over time.					**Assurance**	• The Quality Improvement Activities will continue to be monitored by the Quality and Performance Committee and the Trust Board		
Gaps in controls	• The Trust is currently unable to provide full evidence / assurance to the CQC of a number of actions, which have been organised under the twelve themes of (i) leadership, (ii) staffing, (iii) training, (iv) incidents, complaints and risks, (v) policies / protocols (including audit), (vi) medicines management, (vii) accessibility, (viii) records management (including document security), (ix) equipment and supplies (including cleaning), (x) information, (xi) estates (including security), and (xii) partnership working • articular concerns noted about record-keeping and staff training rates					**Gaps in assurance**			
Progress made in the previous period	• MIIU revised model of service introduced at Stroud & Cirencester MIIUs on 1 November • 8 week MIIU CQC operational action plan completed and reported to Trust Board and Quality & Performance Committee (Nov 2016) • Progress against CQC compliance now moved to business as usual. • Trust has formally corresponded with CQC re: re-inspection request • Work has progressed with Datix CQC module development								

Actions in the next period	• CQC module within Datix to be tested at Cirencester Community Hospital – commencing January 2017 • Progress with embedding Learning Assurance and RCA/SIRI trackers	
Slippages on reported actions in the last reporting period	None	
Links to the Corporate Risk Register	NQ13: Lack of temperature controlled storage for drugs and dressings at sites across the Trust	**16**
	SD53: Failure of MIIUs to provide initial assessment for patients arriving by ambulance within 15 minutes	**12**

Operational risks not linked to strategic risks	
ST5: Rising trend of reported falls at Community Hospitals	**9**
SD49: Increase in the average length of stay in community hospitals, impacting upon reduced numbers of discharges	**12**
SD50: Failure to achieve harm-free care standards across community teams and hospitals	**9**
ES03: The EJC generator is not regularly load tested and could result in failure NEW	**12**

2. Definitions

The risk scoring mechanism in this BAF uses the descriptions provided by the NHS National Patient Safety Agency. These are shown below:

2.1 Description of consequence

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of service users, staff or public (physical or psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for less than 3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident Impacts on a small number of service users	Major injury leading to long-term incapacity/disability Requiring time off work for more than 14 days Increase in length of hospital stay by more than 15 days Mismanagement of service user care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects Impacts on a large number of service users
Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for service user safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major safety implications if findings are not acted on	Non-compliance with national standards with significant risk to service users if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of service user safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Business objectives/ projects	Insignificant cost increase/ schedule slippage	Less than 5% over project budget Schedule slippage	5–10% over project budget Schedule slippage	Non-compliance with national 10–25% over project budget Schedule slippage Key objectives not met	Incident leading more than 25% over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss with risk of claim remote	Loss of 0.1-0.25% of budget Claim less than £10,000	Loss of 0.25-0.5% of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5-1.0% of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1% of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/ business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

1.2 Description of likelihood

	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 24th January 2017

Committee Name:	Trust Board
Agenda Ref:	12/0117
Author:	Susan Field, Director of Nursing
Presented By:	Sue Mead, Non-Executive Director
Accountable Exec:	N/A

Subject:	**Quality and Performance Committee Update**
Appendices	Appendix 1 - Committee Minutes (November 2016) – to receive Appendix 2 - Quality & Equality Impact Assessment Policy – for approval Appendix 3 - Communications and Engagement Strategy – for approval

Provided for: ☒ Discussion ☒ Decision ☒ Approval ☒ Assurance ☒ Information ☒ Noting ☐ Statutory Purposes

1. Executive Summary:

The Trust's Quality and Performance Committee, with the responsibility for oversight of quality, performance and clinical activities and achievements on behalf of the Trust Board, met on 21st December 2016.

The key issues considered at the meeting in December, and highlighted to the full Board, are summarised below:

1) The work to develop a comprehensive **quality and performance report** has continued, with the aim of providing the appropriate level of information to provide assurance and enable effective scrutiny.

2) The operational arrangements to support the **urgent care system**, with particular reference to **escalation arrangements**.

3) The draft **Communications and Engagement Strategy** was discussed, and is recommended to the Trust Board for approval.

4) The draft **Quality Equality Impact Assessment (QEIA) policy** was discussed, and is being recommended to the Trust board for approval.

5) The work being progressed by the **Professional and Clinical Effectiveness** (PaCE) directorate.

6) The continued focus on **control of infection**.

The Committee also undertook a review of its terms of reference which will be considered by the Trust Board in March 2017.

Understanding You

2. Recommendations:

The Trust Board is asked to:

i. **Discuss and note** the contents of the Quality and Performance Committee report;

ii. **Approve** the Trust's Communication and Engagement Strategy

iii. **Approve** the Trust's Quality Equality Impact Assessment (QEIA) policy

3. Main Report

The Trust's Quality and Performance Committee is responsible for oversight of quality, performance and clinical activities and achievements on behalf of the Trust Board. The Minutes of the November Committee meeting are provided at Appendix 1.

This report provides a summary of the key issues considered by the Committee at the meeting held on 21st December 2016. It confirms:

1. Decisions made by the Committee in line with the scheme of delegation.
2. Progress made against the Trust's quality, performance and clinical activities.
3. The key risks and issues identified by the Committee and the actions taken.

1. Decisions made at the December Committee meeting

The Committee:

- Agreed that the Trust's **Quality Equality Impact Assessment (QEIA) Policy** should go to the Trust Board for formal ratification. This is a key policy that will ensure that the Trust has a systematic approach to assessing the impact of plans and future service changes. (Appendix 2)

- Agreed that the draft **Communication and Engagement Strategy** should be recommended to the Board for approval (with similar recommendation from the Trust's Workforce and OD Committee). This is an important strategic document which will inform and shape the approach to internal and external engagement across the Trust. (Appendix 3)

  Approved the Terms of Reference for the Clinical Reference Group (CRG) following a recent review. The CRG will continue to report to the Quality and Performance Committee on a bi-monthly basis

2. Progress in relation to quality and performance

Trust Quality and Performance report – the Committee recognised the significant work undertaken to review and refresh the format of the report with the intention of:

- Reporting Performance and targets information against the CQC domains – Caring, Safe, Effective, Responsive and Well-Led.
- Having a reporting framework that highlights more specifically significant risks, achievements or performance concerns to both the Quality & Performance Committee and ultimately the Trust Board.
- Reducing the volume of the current reporting format without losing the ability for the Committee and Trust Board members to gain assurances.

In reviewing the report in detail, a number of areas for further development were agreed, specifically:

- the narrative font size required further work to be accessible;
- developing the exception reporting to provide greater assurance and alignment with the risk register.
- to consider how the NED quality activities and visits can be included.
- timeliness of reporting and degree to which real time information can be used.
- some specific reporting requirements for Safety Thermometer information.
- the inclusion of performance data which may be "redundant" and how to manage

The Committee discussed the October quality and performance metrics and discussed a number of issues including:

- Safety thermometer reporting, noting that November data was over 95%.
- The need to ensure that performance metrics were "fit for purpose", noting as an example the rating for the Integrated Discharge Team (IDT) which did not fully reflect the proactive support in the context of the wider system resilience activities.
- Friends and Family Test (FFT) response rate.
- Professional Development Review (appraisal) compliance remains below trajectory – an improving picture continues.

Operational Service Developments – the Committee discussed in detail key aspects from the Chief Operating Officer (COO) report, which included:

- The Trust's contribution to facilitating patient flow in the urgent care system and **Gloucestershire's Emergency and Resilience Plan**. The Committee noted the changed escalation ratings from a Red, Amber, Green (RAG) to an OPEL number approach, which will be introduced within the plan - the Committee expressed some concerns about escalation level 4 (black) and the reference that the Trust's MIIUs were to be closed and colleagues re-deployed into community hospitals' inpatients. There was a suggestion that a more generic statement about "*The Trust's urgent care services be deployed at level 4"* rather than being specifically related to MIIUs; that any MIIU closure could be phased i.e. smaller units and that Integrated Community Teams (ICTs) be considered as part of any redeployment of staff.

- **Patient Flow Systems** – that the Trust will be progressing with a patient flow system known as "Red/Green", which is currently being trialled within Gloucestershire Hospitals Foundation Trust (GHFT) and the Gloucestershire Clinical Commissioning Group (GCCG) and NHS England are keen that GCS does the same. This decision will have an impact on its current Medworxx tool

and; because of this the COO and Director of Nursing have commissioned a rapid review of both systems including the longer term benefits and challenges of both systems – this will be shared with the GCCG.

With regards to patient flow within the Trust Community Hospitals, work is continuing to reduce Average Length of Stay (ALoS) and to maintain sufficient flow that supports System wide patients; the ALoS needs to be 22 days for the Trust.

- **Access policy** – this was reviewed by the Committee and feedback included:
  - That the policy was a "starting point" for the Trust to try and standardise i.e. in writing its referral processes and its management of Did Not Attend (DNA) appointments.
  - That those patients who experience patient transport difficulties should not be "penalised".
  - That there needed to be further clarity with adult safeguarding "fail safe" mechanisms so that, for example, those people who may self-neglect are not marginalised as a result of this policy. There needed to be some rigorous approach to that being applied across Children's Services e.g. GPs to be informed of any non-attendance or no access to patient concerns

It was confirmed that the operational Policy would be developed for ratification by the Executive team.

***Professional & Clinical Effectiveness (PaCE)* -** The Committee was updated and assured that work by the PaCE directorate had progressed with the following noted:

- Pressure Ulcer Quality Improvement Group – a clear action plan to mitigate risks was in place and activities remained clinically led.
- Trust's Clinical Strategy implementation – underway and being led by the Deputy Director of Nursing and Heads of Profession.
- Safety Thermometer – actions being implemented are beginning to demonstrate improved compliance in order to achieve 95% target.
- Commencing "test" of CQC module within the Datix reporting tool – due to start at Cirencester Community Hospital January 2017.
- Ongoing implementation of the Trust's Learning Assurance Framework – embedding and maintaining any learning from incident trends and SIRIs

3. Risks and Issues

The Committee discussed and noted the following issues:

- An **MRSA** bacteraemia had been reported – December – this was the first reported case for a number of years. A root cause analysis (RCA) was underway and that this was likely to be Serious Incident Requiring Investigation (SIRI)

- **CQC** – the Committee noted the activities which continued to support compliance with regulations and the recent communication with Prof. Sir. Mike Richards. The Committee also noted that the CQC had launched, with NHS Improvement (NHSI), a consultation document with regards to strengthening its well-led domain to include resourcing and financial governance - Phase 1 of the CQC Strategy published May 2016. It was confirmed that a the Trust would be responding to the consultation.

4. Which Trust strategic objective(s) does this paper link to?	
Achieve the best possible outcomes for our service users through high quality care	☒
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	☒
Actively engage with health and social care partners as well as local communities, in order to deliver seamless services	☒
Value colleagues and support them to develop the skills, confidence and ambition to deliver our vision	☒
Manage public resources wisely to ensure local services remain sustainable and accessible	☒

5. Explanation of acronyms used:
GCCG – Gloucestershire Clinical Commissioning Group ALoS- Average Length of Stay MIIUs – Minor Injury and Illness Units COO – Chief Operating Officer GHFT – Gloucestershire Hospitals Foundation Trust QEIA – Quality Equality Impact Assessment CQC – Care Quality Commission IDT – Integrated Discharge Team ICT – Integrated Community Team FFT – Friends and Family Test DNA – Did Not Attend RAG – Red, Amber, Green

Gloucestershire Care Services NHS Trust

Minutes of the Quality and Performance Committee

1st November 2016, 13.30am – 16.30pm

Boardroom

Committee members present:	
Sue Mead	Chair (Non-Executive Director)
Susan Field	Director of Nursing
Tina Ricketts	Director of HR
Nicola Strother Smith	Non-Executive Director
Jan Marriott	Non-Executive Director
Graham Russell	Non-Executive Director
Dr Mike Roberts	Medical Director
In attendance:	
Rod Brown	Head of Compliance and Partnerships (for agenda item 7)
Michael Richardson	Deputy Director of Nursing
Sian Thomas	Deputy Chief Operating Officer
Ian Main	Head of Clinical Governance
Gillian Steels	Trust Secretary
Val Welsh	Sexual Health Services Manager (for agenda item 22)
Hannah Williams	Quality Manager, Gloucestershire Clinical Commissioning Group
Jane Evans	Clinical Pathways Lead (for agenda item 13)
Dawn Allen	Professional Head of Community Nursing (for agenda item 8)
Charlotte Tucker	Physiotherapy Professional Lead
Nancy Farr	Clinical Team Leader
Sarah Tanner	Information Analyst
Christine Thomas	Minute Taker

Item	Minute
1.	**Welcome and Apologies** The Chair opened the meeting and specifically welcomed Graham Russell and Val Welsh and Sian Thomas (representing Candace Plouffe) to the meeting. Apologies were **Received** from: Glyn Howells, Director of Finance; Candace Plouffe, Chief Operating Officer
2.	**Confirmation that the meeting is quorate** The meeting was confirmed as quorate by the Chair
3.	**Declarations of Interests** In accordance with the Trust Standing Orders, all Committee members present were required to declare any conflicts of interest with items on the Meeting Agenda. No declarations of interest were made.

4.	**Minutes of the meeting held on 31st August 2016** The minutes of the 31st August 2016 were **Received** and **Approved** as an accurate record and that the Chair would sign accordingly.
5. COO	**Matters arising (action log)** The following matters were discussed and noted: 20/280616 – Overnight Hospitals Transfers Report – It had not yet been possible to get the required information from Arriva to enable the report to be completed. The Head of Capacity would be attending regular meetings with Arriva and SWAST to discuss these problems and a full report would come back to the December meeting. 04/311016 - The Director of HR (DoHR) requested a slight addition to the wording on the Quality Equality Impact Assessments (QEIA) for the Mutually Agreed Resignation Scheme (MARs) from the minutes of the 28th June - **Closed** 07.3/310816 - Healthwatch were also raising concerns over financial savings affecting packages of care. It was agreed that the Director of Nursing and Chief Operating Officer (COO) would formally raise with Tina Reid of Gloucestershire County Council (GCC). This was being escalated through formal routes with Gloucestershire Clinical Commissioning Group (GCCG). It was agreed that the next COO report should have an update on this. It has not yet been possible to raise with Tina Reid. 13/311016 - The COO to include an update on Safe Staffing progress in the COO Trust Board paper in September. This had now been agreed at Trust Board and implemented – **Close**
7.	**Corporate Risk Register - Quality and Performance Risk** The Director of Nursing (DoN) and The Head of Planning, Compliance and Partnerships (HoPCP) presented the Trusts corporate risk register. There were 6 new risks to note: • 2 Operational Quality Risks • Lack of Emergency Preparedness • Response and Resilience awareness across the Trust • Reduced Staffing in Single Point of Clinical Access • Data Quality and System Resilience in the Integrated Community Teams (ICTs). The HoPCP advised that the increase in risks was due to a review of risks with the Capacity Team. Concern was raised that some of the risks were long standing. The HoPCP agreed that this was the case and to some extent would continue due to the Trust not always having the ability to mitigate risks. It was also noted that some risks were on more than once, the HoPCP advised that this was due to the same risks "sitting" in different teams and demonstrated that each team were working towards reducing the risks. The Committee **Discussed** and **Approved** the Corporate Risk Register

8.	**Operational Services Report** The Deputy Chief Operating Officer (DCOO) presented the Operational Services Report. The DCOO reported that a review of the 5 GP ring fenced beds had been positive, it was planned to continue ring fencing and that a meeting with Gloucestershire Clinical Commissioning Group (GCCG) was planned to further discuss this. Jan Marriott noted that the problems in the Community Hospitals with staff shortages, increased acuity etc. does appear to have affected the safety thermometer activities. The Deputy Director of Nursing (DDoN) advised that it was hard to know whether this was due to data quality or a decrease in safety and therefore quality of care. The DCOO advised the group that finance performance meetings took place with operational teams and that safety was a consistent agenda item. The Professional Head of Community Nursing (PHoCN) presented an update on the demand and capacity tool that was currently being piloted in the Forest of Dean and Stroud localities. This has been developed for use by colleagues working in Community Services and identified and mapped time required per patient basis and according to clinical need. There is a standard time given to colleagues to complete a visit, but this can be changed depending on the needs of the patient travel time and this supports colleagues to better manage workloads and feel more in control. It was also felt that if colleagues were off sick or taking annual leave then the distribution of their workload could be managed more equitably and supported the management of patients expectations The pilot needed to be widened to an urban locality and it was agreed that it should next be rolled out in Gloucester City. An update to come to the Committee in April 2017. The Committee **Discussed** and **Approved** the Operational Services Report
COO	
9.	**Professional and Clinical Effectiveness (PaCE) Directorate Report** The Deputy Director of Nursing (DDoN) presented the Professional and Clinical Effectiveness (PaCE) report and highlighted the key areas of the report to the Committee, noting in particular that the specialist safeguarding nurses were now part of the PaCE directorate; all Children's deaths were now being entered onto Datix and an RCA completed if necessary and the work of addressing the Safety Thermometer risks. Jan Marriott raised concerns as to why the PaCE report noted that there were no MRSA cases, but the Chief Operating Officers report had said there was two. The Director of Nursing (DoN) to look into this and report back at the next meeting. **Post meeting note:** There is a need to report acquired MRSA Colonisation/infection (hence the two reported). The Trust does not report new MRSA infection if discovered upon admission as part of the criteria. There have been no MRSA bacteraemia reported. It has been agreed that MRSA reports will be included within the PaCE directorate report.
DON	

	Nicola Strother Smith expressed concern at the declining of response rates for the Friends and Family Tests (FFT). The Head of Clinical Governance (HoCG) acknowledged that it was disappointing and advised that they were looking at the distribution of the surveys. The Head of HR suggested that this should be taken forward as a Listening into Action approach. It was noted that a risk assessment had been undertaken for the outstanding NICE guidance's that still needed reviewing and this had been given a risk rating of 12. A new system was being introduced and it was hoped that this would be easier to use and reduce the risk. The Committee **Discussed** and **Approved** the Professional and Clinical Effectiveness Report
10.	**Clinical Reference Group Report** The Clinical Reference Group had been focusing on Research and Development across the Trust and had invited Julie Hapeshi (Associate Director, Research and Development) to the December Clinical Reference Group meeting. At the next Clinical Reference Group meeting they would be reviewing the Terms of Reference as it was recognised that the group's aims had changed since it had first started. It was also recognised that there were colleagues who wished to join, but there was currently not the capacity. The Committee **Discussed** and **Approved** the Clinical reference Group Report
11. **Chair/DoN** **DoHR**	**Quality and Performance Report** The Chair expressed concern that the data being reviewed in the Quality and Performance report was for August and queried whether this could be addressed outside of the meeting and as part of a wider reporting review and felt that this should be discussed external to the meeting as to how they could get more up to date data. The Director of Nursing (DoN) covered the key points from each of the objectives: **Objective 1** • MSKCAT team are continuing to provide against service requirments • There were 2 SIRIs declared in August • The safety thermometer saw a slight improvement although still not achieving the 95% standard **Objective 2** • Concerns re response rates for Friends and Family Test (FFT) **Objective 3** • The Trust was now engaging in more cross organisational working • Bed occupancy continues to be high

	Objective 4 • Personal Development Reviews (PDRs) continues to be below target but compliance rates have increased. The Director of HR (DoHR) advised that this would be brought up at the next Board Development session for discussion.
DDoN	Nicola Strother Smith commented that she had seen an excellent pressure map used at the Wheelchair service and asked if this was used across the Trust. The Deputy Director of Nursing (DDoN) confirmed they weren't but would be in touch with the service manager to find out more.
HoPI	It was noted that the quality metrics around IDT were all red, but this service was performing well and the metrics no longer were appropriate in light of recent service reconfiguration changes. It was agreed that these were obsolete and should be removed from the report with the support of the GCCG. The Committee **Approved** the Quality and Performance report
12.	**Mortality Annual Report**
DoN/MD	Jan Marriott raised the point that there appeared to be more deaths in the Dilke and Cirencester Community Hospitals, but queried whether this was due to the number of beds in each? It was acknowledged that there are more beds in Cirencester and that Dilke both had escalation beds. The Medical Director felt this raised the point of what information the Committee wanted to see within future reports. It was felt that it would be good to see more demographics such as age, expected, unexpected deaths and gender. This would be looked at for future reports and it was agreed this would come back to the Committee in 12 months' time. There was concern that there were still an unacceptable number of patients coming from the acute hospitals without End of Life care plans or DNAR orders. Hannah Williams explained that next year there would be a significant piece of work undertaken around discharging patients and these issues would be looked at. It was also requested that this report come to the Countywide End of Life Group as it would be good for other organisations to see and encourage them to undertake the same level of reporting and adopt a consistent methodology. The Committee **Discussed** and **Noted** the Mortality Annual Report
13.	**<u>Dementia Quality Improvement Work Plans</u>** The Clinical Pathways Lead for Dementia (CPL) presented an update on Dementia Work Plan that was currently taking place and which was currently a priority. Both the CPL and the Deputy Chief Operating Officer (DCOO) were on the Dementia Alliance Board, which was linking into STPs. Companionship volunteers were currently being piloted in the Forest Hospitals and a Tewkesbury locality network was also being developed. It was hoped that the organisation would become a dementia friendly organisation, not just for patients, but for colleagues as well.

CPL	The Chair asked how success was being measured. It was explained that these key indicators had not yet been developed. The Chair asked for a future report to be brought back, which would show outcomes from the current work being undertaken. The Committee **Noted** the progress made to date
14. **HoCG**	**Sign up to Safety Update** The Deputy Director of Nursing (DDoN) provided an update on Sign up to Safety; the current focus was about ensuring that the PaCE directorate were linked up to the 5 pledges. The Head of Clinical Governance presented the Learning Assurance Framework; this would demonstrate the numbers of SIRIs open and the current learning actions in place. The Chair asked that for a future meeting that a report was presented that focussed on a few themes and showed the process from start to finish. The Committee **Noted** the Sign up to Safety update
15.	**Dependency Audit** The Deputy Chief Operating Officer (DCOO) presented the Dependency Audit and advised that a separate Acuity Audit still needed to be undertaken. The Chair asked if this would affect Safe Staffing but the DCOO advised that this wouldn't affect as safe staffing levels for all hospitals had been defined and that the dependency of the patients had been factored into the revised staffing establishment. The Committee **Noted** the Dependency Audit
16. **DCOO**	**Winter Escalation Plans** The Deputy Chief Operating Officer (DCOO) presented the winter escalation plans that had been developed by the Gloucestershire Clinical Commissioning Group (GCCG) for approval. The DCOO explained that there was a feeling of nervousness around the coming winter, due to the fact that the winter 2015-16 escalation had never really finished. The Director of Nursing (DoN) stressed that the Trust must be clear that they would not breach the mixed sex policy that was currently in place and the DCOO advised that they would only consider this in a major emergency and only with sign off from the Chief Executive Officer (CEO). It was noted that the Commissioners had not yet asked the Trust for escalation beds. It was noted that no quality metrics had been set and the Chair asked that a piece of work be undertaken re quality outcomes after the end of the winter period. The Committee **Approved** the Winter Escalation Plans on behalf of the Trust Board

17.	**Annual Report Controlled Drugs** The Head of Medicines Management (HoMM) presented the second annual report on controlled drugs. It was noted that Physio's and Podiatrists could now prescribe a limited range of drugs, which was seen as positive news. It was also noted that the Government had introduced a new requisition form, which would mean a change to the back-end procurement process and would require bulk ordering. There had been 57 incidents recorded, though this was considered small compared to the total number of drugs issued. The HoMM explained that the 20% of incidents that occurred in the patients' home and that they were not Gloucestershire Care Services (GCS) own incidents, but for quality reasons were recorded on the GCS Datix system. The Committee **Approved** the Annual Report Controlled Drugs
18.	**CQC and Quality Update** The Director of Nursing (DoN) presented the CQC and Quality Update, which focused mainly on the higher risk areas of the MIIUs and training. There had been improvement seen in the uptake of numbers undertaking the Mandatory Training and the new service model for MIIUs at Cirencester and Stroud come into effect 1st November 2016. The Committee **Noted** the CQC and Quality Update
19.	**Terms of Reference** The Trust Secretary (TS) presented the updated Terms of Reference and asked the Committee for any comments. It was felt that the Committee needed to have an improved focus on quality and how the Trust was doing against its priorities, but it was felt that it was important for the Committee not to become overwhelmed as there was already a lot of pressure on meetings. The Deputy Chief Operating Officer suggested that an operational group should be set-up that looked at changes to get a better understanding and to monitor quality within services. The Committed **Noted** the Committee Terms of Reference review and acknowledged that these would be formally ratified at the Trusts Board meeting January 2017
6. **TS/DoN**	**Forward Planner** The forward planner was reviewed and it was agreed that the Trust Secretary (TS) and Director of Nursing (DoN) would be reviewing this. The forward planner would be populated up to October 2017.
20.	**Any Other Business** **November Trust Board Feedback** The Chair agreed that the next Quality and Performance report for the

	November Trust Board meeting should include the following items: • CQC Safeguarding Training • Patient Thermometer • Mortality Annual Report • Learning Tracker • Winter Escalation • Controlled Drugs • Issues with NICE • Research and Development It was also agreed that the outcomes of the Committee Part 2 discussion should go to the Part 2 section of the Trust Board meeting. There was no other business raised; the Chair thanked everyone for attending and formally closed the meeting.
25.	**Date of the next meeting** The next meeting of the Committee to be held on 21 December 2016 in the Boardroom, EJC at 1:30pm.

Signed …… Date ……

Gloucestershire Care Services NHS
NHS Trust

Quality Equality Impact Assessment (QEIA) Policy

Document reference:	
Version:	**Draft v5.2**
Ratified by:	**Quality and Performance Committee**
Date ratified:	
Originator/author:	**Director Of Nursing**
Responsible committee/individual:	
Executive lead:	**Director of Nursing**
Date issued:	**4 November 2016**
Review date:	**1 November 2019**

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DOCUMENT CONTROL SHEET

Purpose of document:	The policy details the process to be undertaken in order to assess the impact of Change Initiatives and Schemes including, Quality Innovation Productivity and Prevention (QIPP) plans, organisational Cost Improvement Plans (CIPs); business cases, strategies and any other plans for change or service re-design.
Dissemination:	Available on the Trust's intranet and notified via internal communication cascade
Scope:	Confirm which staff groups should observe the document. Applicable to all involved in change management, service redesign or improvement programmes of work.
Review:	Confirm expected review periods
This document supports:	Reflect relevant governance documents, standards and legislation
Key related documents:	Reference any related Trust policies or other control documents
Equality and diversity:	Confirm that an Equality Impact Assessment has been completed- not required given nature of policy
Quality:	Confirm that a Quality Impact Assessment has been completed – not required given nature of policy
Consultation:	Clinical reference Group
Financial implications:	Reference any financial implications of implementing the document

Version Control Information	
Summary of Key Changes	**Previous Version Archive Date**
Accountability Arrangements (June 2016) Clarity re: flow charts (July 2016)	

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1. Introduction

The starting point for any high quality and safe service is a good understanding of who is affected by change, who uses the service, and who delivers it. Understanding who these people are means you can anticipate their needs, make sure that the changes are safe and effective for them, and ensure that they will have positive experiences. This analysis also helps avoid unintended consequences.

2. Purpose

2.1 The purpose of the Quality and Equality Impact Assessment (QEIA) policy is to set out the process to be followed when undertaking a combined impact assessment. The QEIA will also examine the extent to which a policy, strategy including strategic decisions, service or function may impact, either negatively or positively, on any groups of the community and, where appropriate, recommend alternative measures to ensure equal access to services and opportunities.

2.2 Undertaking a QEIA enables the Trust to consider the impact of each with regard to the quality of provision and effect that this may have on patient outcome or experience. It is designed to ensure that 'due regard' is given to equality in relation to the services that we commission and where appropriate deliver, and the manner in which we recruit, train and develop our staff.

3. Definitions

Where there is terminology requiring common understanding, this should be made explicit, with an appendix as required

4. Roles and Responsibilities

4.1 The Chief Executive Officer has ultimate responsibility for quality and equality across the Trust.

4.2 The Chief Operating Officer is responsible for ensuring that Quality and Equality Impact Assessments are effectively considered as part of discussions and decision about significant Cost Improvement Programmes (CIP), business cases and other service re-design or quality improvement developments.

4.3 The Professional and Clinical Effectiveness (PACE) Directorate are responsible for ensuring the process is followed. This includes the QEIA database, (supported by Information Technology colleagues for system workflow) and ensuring QEIA reviews are managed and maintained.

4.4 Other colleagues of the Trust are responsible for oversight of the programme and assuring themselves that assessments are carried out correctly and consistently.

4.5 Operational managers and their delegated colleagues are responsible for completion of QEIA's within their service areas following the guidance and seeking support where appropriate. Operational managers are also responsible for the review of QEIA's.

4.6 The Trust Clinical Reference Group (CRG) is responsible for making recommendations to the Trust executive team following any QEIA discussions.

4.7 The executive team is responsible for signing off of completed QEIA's based on any recommendations made by the Trust's Clinical Reference Group.

5. Process

5.1 **When do you need to complete a Quality Impact Assessment?**

You need to conduct a Quality Equality Impact Assessment whenever you are introducing changes that affect:

- How people access or use our services;
- Our colleagues' working life and development opportunities;
- How people can take up work opportunities with the Trust.

This includes plans, proposals, service specifications, strategies and policies.

If you are uncertain whether to complete a Quality Equality Impact Assessment you may wish to use the decision-making tool available in the appendix of this policy to aid your decision.

5.2 It is essential that you complete an impact assessment **BEFORE** any decisions are made. Decision-makers must be able to demonstrate that they have considered the results of a Quality Equality Impact Assessment prior to any decisions.

5.3 **To support decisions making then the following should be considered**

5.3.1 **Patient Safety:**

- What is the impact on partner organisations and any aspect of shared risk?
- Will the proposed scheme impact on the organisations duty to protect children, young people and adults?
- What is the impact on patient?
- What is the impact on preventable harm?
- Will it affect the reliability of safety systems?
- How will it impact on systems and processes for ensuring that the risks of healthcare acquired infections to patients is reduced?
- What is the impact on clinical workforce capability care and skills?

5.3.2 **Clinical Effectiveness:**

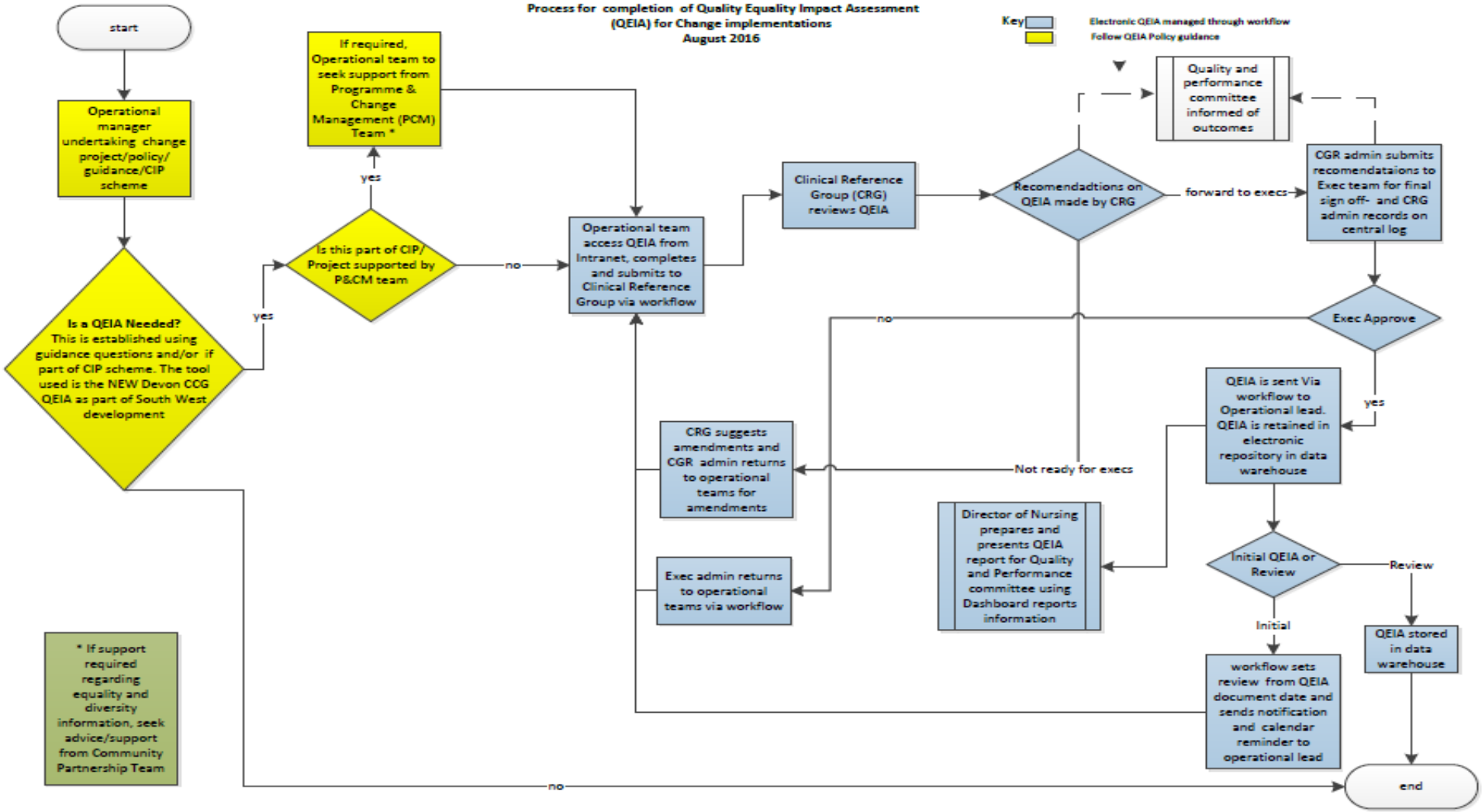
- What is the impact on implementation of evidence based practice?
- What is the impact on clinical leadership?
- Does it reduce or have a negative impact on variations in care provision?
- Does it affect supporting staff to stay well?
- Does it promote self-care for people with long terms conditions?
- Does it impact on ensuring that care is delivered in the most clinically and cost effective setting?
- Does it eliminate inefficiency and waste by design?
- Does it lead to improvements in care pathways?

5.3.3 **Patient Experience:**

- What is the impact on race, gender, age, disability, sexual orientation, religion and belief for individual and community health access to services and experience?
- What is the likely impact on self-reported experience of patients and service users? (Response to national/local surveys/complaints/PALS/Incidents).
- How will it impact on the patient choice agenda?
- How will it impact on the compassionate and personalised care agenda?

5.4 Process Flow

For ease the flow diagram supports colleagues with the QEIA process



6. Resources

6.1 PACE directorate will provide appropriate resource to administer the process- as agreed by executives.

7. Training

7.1 Formal training will not be required by operational teams completing the QEIA as the process sits within Roles and Responsibilities of post holders completing the QEIA.

8. Implementation

8.1 The process with be implemented from August 2016 with a communications cascade via Director leads and colleagues network meetings and the Trust's "CORE" weekly trust wide update.

9. Audit

9.1 The process provides integral audit though CRG and Exec sign off process.

10. Review

10.1 This policy will be reviewed every 3 years or as required should there be any legislation or trust changes that may impact on this policy

Appendix

Quality Equality Impact Assessment Determination Matrix

Quality Equality Impact Assessments (QEIA) are required for any change made in the organisation that has a significant impact on the way in which we deliver services.

In particular QEIAs are required for service developments and cost improvement schemes. It is important to provide assurance that as changes are made the organisation understands the potential impact of the change on patients and colleagues.

The QEIA Policy references the need to conduct a QEIA for any change that is of a 'significant' nature. However there is no current way to define what is interpreted as "significant" leading to potential inconsistency. This creates a risk in implementing the QEIA process appropriately and proportionately.

The matrix below allows consistent decision making to determine whether a QEIA is required

Instructions for use:

For grading the significance of the change, the scores obtained from the matrix are assigned grades as follows

1 - 3	Low Significance
4 - 6	Moderate Significance
8 - 16	High Significance

1 Define the change explicitly in terms of the impact that might arise from the risk.

2 Use table 1 to determine the impact score(s) (I) for the potential change(s)

3 Use table 2 (above) to determine the likelihood score (L) for the change.

4 Calculate the significance of the change score by multiplying the impact by the likelihood: I (impact) x L (likelihood) = Significance of the change score

5 Any significance of change score in the high range requires completion of an EQUIA

6 Any significance of change score in the moderate range Operational Development Forum to determine if requires completion of an EQUIA

Likelihood score	**1**	**2**	**3**	**4**
	Almost Certain	**Likely**	**Possible**	**Uncertain**
4 High	4	8	12	16
3 Medium	3	6	9	12
2 Low	2	4	6	8
1 Positive	1	2	3	4

	Change outcome (impact levels) and examples of descriptors			
	1	**2**	**3**	**4**
Domains	**Negligible**	**Low**	**Medium**	**High**
Impact on Service Users	Positive impact on how patient services are delivered	No impact on how patient services will be delivered	Change will have a minor impact on patients or impact a small number of patients	Significant change in the care pathway for the patient and how care will be delivered.
Workforce Impact	Positive impact for staff members	No impact for staff members	Minor impact for staff or impact for a few staff members only	Significant impact on staff which may include organisational change process and/or change of job roles
Stakeholder Impact	Will not be noticed by the commissioner and/or public	Potential for commissioner and/or public concern	Elements of commissioner and/or public expectation may not be met	Potential for long-term interest of the public and/or commissioners in the change and possible reduction in public confidence
Financial Impact	Savings or income generated is <5% of budget or <£10k	Savings or income generated is <30% of current budget or <£50k	Savings or income generated is >30% current budget or >£50k	Savings or income generated is >50% current budget or >£100k

Likelihood score	**1**	**2**	**3**	**4**
Descriptor	Almost Certain	**High Confidence**	**Medium Confidence**	**Low Confidence**
Frequency How likely this will be the outcome	Almost certain this will be the impact on the change	High confidence this will be the impact	Fairly confident this will be the impact	Uncertain of the impact

Gloucestershire Care Services NHS
NHS Trust

COMMUNICATIONS AND ENGAGEMENT STRATEGY

2017-22

To inform, involve, listen and respond to all people and communities across Gloucestershire, ensuring that they have the information necessary to make informed decisions and choices, and can contribute to the development of services wherever possible

Communications and Engagement Strategy 2017-22

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0. Executive Summary

This Communications and Engagement Strategy seeks to demonstrate that Gloucestershire Care Services NHS Trust ("the Trust") is fully committed to continually improving its interactions and dialogue with colleagues, partners, service users, carers and the wider local population, with the primary objective being to enable more people to be informed about, and directly involved with, Trust activities.

As such, this Communications and Engagement Strategy is focused upon:

- providing the public with clear and accurate information about the Trust and the community services it provides: this includes responsibility for using both traditional and new media as ways of communicating the Trust's key messages to as broad an audience as possible;

- increasing recognition of the Trust's services among key stakeholders to build the Trust's reputation as a provider and employer of choice;

- keeping colleagues informed and engaged, so that they feel valued, involved and clear about how their work connects to the strategic priorities of the Trust: this requires the implementation of an on-going programme of internal engagement so as to motivate and inspire staff to increase their sense of belonging and commitment to the Trust;

- working collaboratively with partners, stakeholders and all local people and populations in order to develop and deliver sustainable, high-quality services that meet the healthcare requirements of Gloucestershire: this will be realised by a multi-tiered approach to engagement, which ranges from awareness events, through to consultation regarding service changes, and ultimately to a demonstrable commitment to coproduction whereby service users are integral to the planning and delivery of care services;

- recognising, embracing and celebrating the diversity of all communities within Gloucestershire, adapting services wherever possible to reflect and accommodate people's different or extra needs. This mirrors the ethos of the NHS Constitution, which is founded on the principle that "Everyone counts", and that irrespective of people's background, status or position, services should be freely available to all: moreover, that all NHS organisations have a specific obligation to identify the vulnerable and disadvantaged in society, and ensure that they receive additional appropriate support.

This Strategy therefore seeks to outline the Trust's aspirations and direction of travel for communications and engagement over the next 5 years. The accompanying implementation plan will detail the practical actions that will be taken in the period 2017-22 to fulfil these aspirations.

1. Introduction

"Involving people, communities and stakeholders meaningfully is essential to effective service improvement and system transformation, from collectively identifying problems and designing solutions to influencing delivery and review. Effective communication and involvement throughout the process will help to build ownership and support for proposals to transform health and care, and will also help identify potential areas of concern."

Engaging Local People: A Guide for Local Areas Developing Sustainability and Transformation Plans (NHS England, 2016)

1.1 This strategy articulates the ambition of Gloucestershire Care Services NHS Trust ("the Trust") to communicate and engage effectively and consistently with colleagues, the public, service users and partners, so that everyone within local communities is suitably and reliably informed, and that everyone's voice can be heard and has equal opportunity to effect change. This commitment to best-practice communication and engagement is particularly critical during the period covered by this strategy, wherein the NHS is facing rising demand, financial constraints, and an ever-changing landscape of service provision.

1.2 To achieve this ambition, this strategy considers three key enablers:

- **communications**, which is the process of cascading information through any number of channels: to this end, the Trust will seek to ensure that its communications whether to internal colleagues or the Gloucestershire public, are always clear, accurate, credible, timely, honest, respectful, targeted and tailored;

- **internal engagement**, which is the process of involving Trust colleagues in discussions regarding strategic and business priorities, in a manner which is consistent with the Trust's CORE values and behaviours. As such, internal engagement is essential in service development, celebrating Trust successes, and driving greater candour and openness;

- **external engagement**, which is the process of involving local people in meaningful dialogue regarding the business of the Trust, whilst ensuring that these people represent the range of diverse communities within which the Trust works: moreover, capturing public views and opinions and reflecting these in future service design.

Whilst the Trust's Communications and Community Partnerships teams have specific responsibility to deliver the above functions, this strategy also recognises that all colleagues who have regular contact with service users, should reflect the organisation's approach to communications and engagement. Thus, ensuring that every service user, relative, GP or partner organisation benefits from high-quality communication and involvement, is not just the duty of a particular team, but requires everyone to play their part.

2. Ambition and Objectives

2.1 The ambition of this Communications and Engagement Strategy is "*To inform, involve, listen and respond to all people and communities across Gloucestershire, ensuring that they have the information necessary to make informed decisions and choices, and can contribute to the development of services wherever possible".* This aligns to the Trust's overarching vision which is "*To be the service people rely on to understand them and organise their care around their lives*", given that both intentions aim to position the local population firmly at the centre of focus, fully in accord with the principles of the NHS Constitution.

2.2 This five year Communications and Engagement Strategy seeks to ensure that by 2022, the following objectives have been achieved, linked to the Trust's overarching strategic objectives:

Trust Strategic Objectives	Communications and Engagement Strategy Objectives
Achieve the best possible outcomes for our service users through high quality care	• Communicating clearly with communities, stakeholders and service users so that everyone can understand the care and services that are available to them, and how these may be accessed • Ensuring an engaged and motivated workforce, able and inspired to deliver the best quality of care • Maintaining a clear commitment to promote public and service user co-production in the design of services, so that care delivery reflects the needs of local people
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	• Enabling an appropriate proportion of the population to be directly engaged with the Trust, gaining insight into their needs and influencing their local communities • Ensuring that the experiences of service users and carers are routinely captured and incorporated within Trust thinking, and are able to generate change in organisational practice

Actively engage in partnerships with other health and social care providers in order to deliver seamless services	• Enabling the implementation of the shared vision of all Gloucestershire health and social care providers by supporting delivery of the Sustainability and Transformation Plan via robust communications and engagement activities • Working effectively and consistently with a range of voluntary and community organisations to provide best care and support for local people • Further developing the Countywide Equalities Group with all other local provider and commissioning organisations so that the voices of all local populations can be heard, and that services irrespective of organisation, can be tailored accordingly
Value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision	• Ensuring that the Trust's governance and internal structures are clearly established and delineated so as to hear the voices of colleagues • Delivering a collaborative approach to communications and engagement which empowers clinicians and care professionals
Manage public resources wisely to ensure local services remain sustainable and accessible	• Ensuring that all the Trust's communications work together to deliver maximum benefits for an appropriate level of investment, and measurably advance the Trust towards its organisational objectives • Giving particular focus to those within the Gloucestershire population who experience health inequalities or may otherwise be disadvantaged, so that they are not precluded from access to care and support

3. National Context

3.1 The NHS Constitution is founded on the central tenet that "*The NHS belongs to the people*". Given this, the Constitution charges all NHS organisations to ensure that local people are afforded "*the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of these services*". This begets the need for clear communications and effective public engagement.

Similarly, the NHS Constitution commits all NHS organisations "*to engage staff in decisions that affect them and the services they provide, individually through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families*". This creates a challenge to maintain robust internal communication channels that actively seek to motivate, inspire and involve colleagues.

3.2 The Health and Social Care Act 2012 imposed a specific responsibility on NHS organisations to consult with the public, prior to making significant changes to local services so as to ensure that service user opinions and perspectives influence future care provision.

3.3 There are a number of high-profile studies (i.e. Boorman's *NHS Health and Well-being Review*, Department of Health, 2009), which demonstrate that staff who are motivated and involved, are far more likely to be successful, and thus deliver improved outcomes for service users, carers and families. This supports the need to maintain a robust colleague engagement programme.

3.4 The Equality Act 2010 seeks to provide people with protection from discrimination on the basis of nine protected characteristics, namely (i) age, (ii) disability, (iii) gender reassignment, (iv) marriage/ civil partnership status, (v) pregnancy and maternity, (vi) race, (vii) religion and belief, (viii) gender and (ix) sexual orientation.

As a public organisation, the Trust therefore has explicit responsibility to ensure equal opportunities for all colleagues - this includes duty to actively engage and involve everyone within the workforce, irrespective of their gender, status etc. Evidence of such is currently required via the annual submission of Workforce Race Equality Standard (WRES) data, and subsequently from 2018, Workforce Disability Equality Standard (WDES) data.

Equally, it requires the Trust in its public communications and engagement activities, to ensure that no group or population is disadvantaged or omitted from inclusion, and that therefore everyone in the local community has equal opportunity to become involved.

3.5 The *Five Year Forward View* (NHS England, 2014) established a clear direction for the NHS in order that it could successfully seek to address the disparities, inequities and challenges nationally in health and wellbeing, care and quality, and funding and efficiency.

To be successful in this undertaking, the *Five Year Forward View* outlined a need to build "*a new relationship with patients and communities*". In particular, all health and social care providers were encouraged to understand and work more closely with local people in order to co-produce services that are right for their demography, and that enable service users to take greater control of their own care. The way in which each organisation seeks to realise this ambition is articulated in local Sustainability and Transformation Plans (STPs).

3.6 As further support for the *Five Year Forward View*, in 2015, the People and Communities Board published *Six Principles for Engaging People and Communities*. This detailed a model for engagement aimed at improving local involvement, health outcomes and resource utilisation, and was based upon ensuring that:

- care and support is person-centred: personalised, coordinated, and empowering;
- services are created in partnership with citizens and communities;
- focus is on equality and narrowing inequality;
- carers are identified, supported and involved;
- voluntary community and social enterprise, and housing sectors, are involved as key partners and enablers;
- volunteering and social action are key enablers.

3.7 Furthermore, in September 2016, NHS England produced *Engaging Local People: A Guide for Local Areas Developing Sustainability and Transformation Plans*. This built upon the People and Communities Board framework as described in section 3.6 above, and reiterated the need for clear dialogue, engagement and/or public consultation as appropriate during the development of strategies for future public sector service provision.

More specifically, the document identified the key audiences for such communication and involvement as being service users, volunteers, carers, clinicians and other staff, citizens, the local voluntary and community sector, local government officers, local politicians and MPs, as well as networks such as Trust non-executive directors and governors, community networks and neighbourhood fora, Healthwatch, Health and Wellbeing Boards, Strategic Clinical Networks and Senates, and regional Academic Health Science Networks.

4. Local Context

4.1 The Trust maintains a Communications Team which is responsible for all communications activity, both internal and external to the Trust. This includes but is not limited to the:

- development of media relations and publication of press releases;
- management of multi-media campaigns to raise public awareness and visibility of services and service changes;
- production of the weekly CORE newsletter for colleagues;
- implementation of internal communications campaigns to ensure that staff are fully briefed on key issues;
- management of the annual Staff Awards;
- maintenance of the Trust's public website and staff intranet.

The Trust's Communications Team is also responsible for undertaking all internal engagement activity with colleagues across the organisation.

4.2 The Trust also maintains a Community Partnerships Team which is responsible for managing public engagement activity. This includes responsibility for:

- developing an active intelligence repository which includes details of all professional and public stakeholders across the county, findings from previous engagement activity, and local and national reports on experiences of care;
- continuously building and maintaining relationships with community groups and representatives across Gloucestershire, specifically including people who are "seldom seen, seldom heard", as well as those who traditionally experience health inequalities;
- promoting the benefits of, and opportunities for, engagement and co-production as described within this Strategy, both internally and externally;
- facilitating and managing engagement events, ranging from large public sessions to more discrete focus groups;
- collating and disseminating findings from engagement activities, so that feedback is included within future service designs;
- attending community functions and promoting the work of the Trust;
- managing translation and interpretation services on behalf of the Trust.

The Community Partnerships Team is also responsible for managing the equality and diversity agenda which encompasses both an internal and external focus.

4.3 In terms of governance:

- the Trust's Workforce and Organisational Development Committee receives routine progress reports regarding the Trust's communications and internal engagement functions. Additionally, the Committee receives updates from the Community Partnerships team regarding the equality and diversity agenda insofar as extends to Trust colleagues;
- the Quality and Performance Committee receives routine progress reports regarding the external engagement activity: this includes the six monthly public engagement and equalities report ("Understanding You") which is escalated to both the Committee and the Trust Board;
- the Community Partnerships Team manages the Your Care, Your Opinion group, which is a subcommittee of the Trust Board, overseen by the Trust Chair, and which meets twice yearly with a range of public members and key stakeholder groups in order to debate salient issues pertaining to service development and improvement plans;
- the Trust is a member of the Countywide Equalities Group, which is attended by all local NHS providers and commissioners, as well as the County Council, and which explores joint engagement and equalities opportunities across the local health and social care sector;
- key Trust representatives also attend the local STP Communications and Engagement Working Group which is part of the wider governance structure supporting the development and implementation of the Gloucestershire Sustainability and Transformation Plan.

4.4 As referenced in section 3.5 above, the local STP is the most significant declaration of strategic intent across Gloucestershire's healthcare economy, covering the period of this strategy. The vision statement of the STP clearly acknowledges the need to involve the public i.e. *"To improve health and wellbeing, we believe that by all working better together - in a more joined-up way - and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to all local people".* Moreover, the STP includes commitment to ensure that:

- the communication and engagement work programme is integrated into the governance and overall STP programme structure;
- robust and sustainable communication arrangements are in place so that all identified audiences are kept up-to-date with progress;
- communication and engagement is owned system-wide;
- materials and messages are timely and relevant to each target audience;
- engagement is with all interested stakeholders including seldom heard;
- stakeholders know how they can have their say and influence the STP;
- stakeholders are informed of the impact that their feedback has made.

5. Quality Goals

5.1 In order to ensure that this Communications and Engagement Strategy focuses upon achieving quality outcomes, the following goals have been identified:

- to provide the public with clear and accurate information about the Trust and the community services it provides;
- to increase recognition of the Trust's services among key stakeholders to build the Trust's reputation as a provider and employer of choice;
- to keep colleagues informed and engaged, so that they feel valued, involved and clear about how their work connects to the strategic priorities of the Trust;
- to work collaboratively with partners, stakeholders and all local people and populations in order to develop and deliver sustainable, high-quality services that meet the healthcare requirements of Gloucestershire;
- to recognise, embrace and celebrate the diversity of all communities within Gloucestershire, adapting services wherever possible to reflect and accommodate people's different or extra needs.

6. Priorities and Actions

The following priorities and actions have been identified, mapped against the Communications and Engagement Strategy's quality goals. Further detail on how the Trust will meet each of these priorities will be itemised within the Strategy's implementation plan.

6.1 To provide the public with clear and accurate information about the Trust and the community services it provides

6.1.1 Whilst actively promoting the Trust and its services, the organisation's communications will equally align to those issued by its partners in order to raise public awareness of initiatives and activities being undertaken as part of the countywide STP. Moreover, these communications will inform people how they can become more directly involved (see also section 6.4.2 below).

6.1.2 Social media will be embraced as a key method of communication, whilst simultaneously investigating new channels, tools and networks. The success of the Trust's social media presence will be routinely monitored and evaluated to ensure that its potential is being fully maximised and realised.

6.1.3 Opportunities will continue to be explored to present information online in new and innovative ways, whether using web graphics, new feeds, e-books, video or audio clips as appropriate to the context and the audience.

6.1.4 The Trust will continuously develop its public website so as to ensure that it remains fully responsive, and provides users with the ability to view content effectively on a range of mobile devices. The website content will also be formatted in such a way as to be accessible to all readers, irrespective of any different or extra needs.

In assessing the on-going effectiveness of the website, the Trust will seek to compile detailed analysis of how users currently use and navigate the site, including assessment of the most read content, search terms and technologies used.

6.1.5 The Trust will maintain a clear focus upon ensuring that its logo and brand is used and marketed appropriately across all media and associated materials, including upon Trust signage.

6.1.6 The reputation of the Trust will continue to be promoted and protected in relation to local and regional media. Equally, the Trust will aim to sustain the relationships which have already been established with print and broadcast media, and will respond promptly and robustly to all media enquiries, whether positive or negative.

In doing so, the Trust will aim to increase and improve the number of proactive stories which are communicated about the Trust, and will facilitate their exposure to the media.

6.2 To increase recognition of the Trust's services among key stakeholders to build the Trust's reputation as a provider and employer of choice

6.2.1 The Trust will explore opportunities to improve the ways in which to communicate with commissioners and primary care colleagues, to help the Trust be seen as the provider of choice for community services.

6.2.2 Relationships will be developed with secondary schools, as well as further and higher education establishments within Gloucestershire and neighbouring counties, using the opportunity to engage with education-based projects, knowledge share and networking events.

6.2.3 The Trust will seek to increase the number of targeted news stories in national clinical publications, in order to help attract and recruit new colleagues to the Trust.

6.3 To keep colleagues informed and engaged, so that they feel valued, involved and clear about how their work connects to the strategic priorities of the Trust

6.3.1 The Trust will ensure that colleagues continue to be fully informed about the STP, with opportunities for them to contribute wherever appropriate.

6.3.2 The Trust will seek to further enhance the Trust's intranet, through ensuring the content is up-to-date and is the main source of information for policies, procedures and corporate documents. As part of this work, the opportunity to introduce collaborative sharing tools and message boards will be explored so as to increase interactivity between colleagues across the Trust.

6.3.3 Executive roundtable discussions will be strengthened, ensuring that these sessions provide colleagues with an opportunity to have an informal and valuable conversation with a member of the executive team. To ensure equity of access, these discussions will be staged in different venues across the county, with each of the executive team taking it in turns to host a session.

6.3.4 The Trust will continue to build upon the significant success of the organisation's Staff Awards, maximising both the internal and external benefits of the event. Moreover, throughout the lifecycle of this Strategy, the awards will continue to develop and expand (for example, building long-service awards into the event, so that colleagues can be celebrated for extended contribution).

6.3.5 With a mobile, geographically dispersed and clinically focused workforce, the Trust has an ongoing communications challenge. To help mitigate this, the Trust will continue to investigate the development of mobile apps that will enhance colleagues' experiences. Thus, a mobile app could allow colleagues to view content any time across multiple channels, including both Trust-provided smartphones and personal devices.

6.4 To work collaboratively with partners, stakeholders and all local people and populations in order to develop and deliver sustainable, high-quality services that meet the healthcare requirements of Gloucestershire

6.4.1 Co-production is intrinsic to the Trust, as the organisation's vision, *To be the service people rely on to understand them and organise care around their lives*, engenders a clear commitment to create strong and mutually-respectful working partnerships between the NHS and the public. Thus for the Trust, co-production will not simply be a theoretical model, but more a cultural shift - a way of being, acting and thinking that will enable Trust services to be jointly developed and owned by professionals, together with service users, their families and carers.

By 2022 therefore, the Trust aims to have a fundamentally different approach to service design, one where service users and community representatives are highly visible and vocal in the whole development and delivery process. This requires the organisation to move from an experience-based approach which relies on focus groups, surveys etc to inform its thinking, to true co-production in which the power is shifted and the boundaries of the traditional 'service user' and 'professional' roles are blurred. It also requires the Trust to implement a robust co-production methodology which will conjoin Trust colleagues with service users and those with lived experience including carers and families. This will enable local communities to take equal responsibility for how the Trust's services look, feel and work across Gloucestershire.

6.4.2 The Trust will ensure that it fully informs and involves the Gloucestershire public in all key operational changes which may be effected by the STP. Where there are potential significant impacts, this will require formal consultation: however, the Trust will also seek to develop an on-going programme of engagement in respect of changes of lesser magnitude, so that the public voice is always sought and heard given proposals for reconfiguration. In undertaking these discussions, the Trust will seek to:

- utilise a range of media, forums and activities so that all local populations and people across Gloucestershire have equal opportunity to participate: this includes making specific effort to reach people from all backgrounds, as well as offering weekend and evening meetings as alternatives to the more regular weekday times which can alienate working-age adults and younger families;

- explore use of new technologies as a means of communication and engagement i.e. using social media to hold twitter chats on key topics, introducing technologies such as online forums and ChatHealth in order to engage with young people in a safe and secure way etc;

- give particular focus to involving people with extra or different needs by means of, for example, ensuring that all information and resources are readily available in a number of different forms including EasyRead;

- actively involve key partners and networks as well as the public - these to include for example, countywide GPs, voluntary and community organisations, Healthwatch Gloucestershire, the Health and Wellbeing Board, local MPs, housing associations, special interest groups etc;

- ensure that all people who contribute, receive feedback so that they can recognise that their input has been recognised and valued.

6.4.3 In addition to holding discussions about operational change, the Trust is also committed to an on-going programme of awareness and understanding, so that people across Gloucestershire may have heightened recognition of the Trust's community services and how they may be accessed. This will be realised by the Trust maintaining a schedule of information events which will include broad discussions such as those held at the Your Care, Your Opinion Programme Board: however, they will also include more targeted discussions, such as those held in 2016 which sought to impart specifically tailored health advice to local black and minority ethnic communities.

6.4.4 The Trust will also seek to directly involve service users and public alike in gathering feedback on their individual experiences of care and support - in particular, this will require the Trust to utilise insight received from complaints, surveys, feedback mechanisms such as NHS Choices etc as well as outcomes, in order to make improvement and inform the development of future care models.

6.4.5 Irrespective of whether undertaking engagement, consultation, awareness sessions or more robust work leading towards co-production, the Trust will remain fully committed to visiting and engaging people where they work, live and socialise, rather than relying on people to attend Trust-based events. This is essential as a way of respecting the individuals with whom the Trust works, and making people feel more comfortable when discussing matters regarding their personal health and experiences.

6.4.6 In working with external stakeholders, and particularly those from the third / voluntary sector, the Trust will increasingly seek to ensure greater formality. This will not be to dissipate personal relations, dissuade engagement or to place undue focus on process, but rather to ensure that partnerships are sustainable, built on mutual understanding and recognition, and enable appropriate governance and accountability.

6.4.7 The Trust will continue to recognise the value and importance of its volunteers as representatives of the public voice, and therefore ensure that they are fully engaged and involved with Trust plans and activities.

6.4.8 The Trust will explore a range of models for public involvement: this will focus upon securing a more in-depth, direct relationship with an agreed percentage of the local population, enabling the Trust's policies and services to be positively influenced by the public, and engaging the public in better discussion and use of the Trust's services.

6.5 To recognise, embrace and celebrate the diversity of all communities within Gloucestershire, adapting services wherever possible to reflect and accommodate people's different or extra needs

The NHS Constitution as referenced in section 3.1 above, is founded on the principle that "Everyone counts", and that irrespective of people's status, background or position, services should be available to all. More specifically, the Constitution recognises that the NHS "*has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population*".

6.5.1 As noted in section 3.6 above, one of the key principles of engagement is to ensure a clear focus on equality and narrowing inequalities. This requires the Trust to maintain distinct strategies for engaging with:

- people who represent the nine protected characteristics as described within the Equality Act 2010 (defined in section 3.4 above);
- people who experience the worst health, outcomes and experiences of care across the county, including as a result of poverty, deprivation, unemployment, poor housing etc. To this end, the Trust notes that there are not only significant pockets of deprivation within its two urban areas of Gloucester and Cheltenham, but equally that there are extremes of rural poverty and isolation within the Forest of Dean, and that therefore specific attention must be afforded to these areas;
- people who are traditionally less likely to use NHS services and who are therefore most likely to be overlooked or disregarded, including the homeless, gypsies and travellers, certain black and minority ethnic communities, eastern European populations etc.

6.5.2 In order to facilitate the commitment in section 6.5.1 above, the Trust will continue to develop and maintain profiles of all identified 'communities of interest' i.e. those local population groups who have greatest need of additional focus so as to ensure that they are neither explicitly or inadvertently excluded from consideration.

As such, the Trust's databases will seek to describe the size and distribution of these communities, their key contacts (including community leaders or peers), and will also serve to summarise each community's needs, preferences and experiences. The profiles will be routinely maintained so as to remain dynamic, and therefore able to reflect shifts in population types including local migrations. They will also give insight into predicted trends that will affect future demand and need.

More importantly, these profiles will not remain an academic exercise, but will provide the information necessary for the Trust to actively identify, reach and engage with all representative groups in Gloucestershire.

6.5.3 Each year, the Trust will develop and implement a set of equality objectives that will reflect the needs of the Gloucestershire population based on both hard and soft intelligence. These objectives will be included within the Trust's Quality Account, and will act as demonstrable evidence of the organisation's ambitions to support all local people and advance equality. Objectives will be specific and measurable, and progress will be reported through the Trust's governance structure.

6.5.4 The Trust will continue to provide support, guidance and resources for colleagues so that they may best understand how to support and effectively engage with all populations and groups across Gloucestershire. This will include for example, robust equality and diversity training at induction and at regular intervals thereafter, video films highlighting a range of equality, diversity, human rights and prejudice issues to be used either as part of mandatory training or in staff meetings, information on cultural diversity included within the CORE newsletter etc.

6.5.5 Ready availability of clear and concise information is fundamental to people's understanding of their care and treatment - and as such, is critical to demonstrating equality and respect for all service users including those with learning disabilities, cognitive impairments such as dementia, sensory impairments such as deafness or vision restrictions, as well as people who do not speak or write English as their first language, and people who feel disenfranchised or overlooked within society.

The Trust will therefore seek to observe the Accessible Information Standard, and thus make materials and resources to suit all people, irrespective of any physical or mental impairment. Equally, it requires the Trust to maintain a robust process to ensure exemplar translation and interpretation services, and to develop such services in line with emerging technologies (i.e. making interpreters available via Skype).

6.5.6 So as to monitor progress, the Trust will not only report against its equality objectives as described in section 6.5.3 above, but it will also use other tools and mechanisms. These will include:

- the Equality Delivery System (EDS2), which is a national assessment of validating whether NHS organisations are assessing and improving their performance in respect of services provided to people of all characteristics;

- the Workforce Race Equality Standards (WRES), which although primarily focused on ensuring equity for colleagues, seeks also to ensure that the Trust's workforce is representative of the local population;

- Board stories, by which service users are invited to meet with Executive and Non-Executive Directors to tell their experiences and highlight opportunities for improvement in services and care equality.

7. Quality Measures

7.1 The Trust's performance against each quality goal described above will be measured according to the metrics below.

These will be reported on a regular basis to the Quality and Performance Committee and the Workforce and Organisational Development Committee as appropriate, who will be jointly responsible for holding the Trust to account.

Quality Goal	Quality Measure
To provide the public with clear and accurate information about the Trust and the community services it provides	• Number of proactive media stories per month which are issued by the Trust and which subsequently appear in local, regional and/or national press • Response times to reactive media stories • Monthly quantitative evaluation of the Trust's use of social media
To increase recognition of the Trust's services among key stakeholders to build the Trust's reputation as a provider and employer of choice	• Increase in the number of applications for new Trust vacancies resulting directly from increased communications activity • Increase in the number of working partnerships with local / regional secondary schools, further and higher education establishments
To keep colleagues informed and engaged, so that they feel valued, involved and clear about how their work connects to the strategic priorities of the Trust	• Number of colleagues actively engaged via the interactive options on the Trust intranet • Number of Trust colleagues attending the executive roundtable discussions • Measured increase in the uptake and on-going use of the Trust mobile app

To work collaboratively with partners, stakeholders and all local people and populations in order to develop and deliver sustainable, high-quality services that meet the healthcare requirements of Gloucestershire	• Increase in the number of service developments and quality improvement programmes where service users are active participants • Quantitative evaluation to demonstrate that on-going engagement / consultation activities are reaching a broad cross-section of the Gloucestershire population • Minimum one awareness raising event per quarter • Increase in the number / percentage of the Gloucestershire public who are actively and directly involved with the Trust
To recognise, embrace and celebrate the diversity of all communities within Gloucestershire, adapting services wherever possible to reflect and accommodate people's different or extra needs	• Quantitative evaluation / achievement against the Trust's annual equality objectives • Measured increase in the Trust database of Gloucestershire populations • Annual refresh of equality and diversity training materials • Development and implementation of action plans to improve the Trust's position against EDS2 and WRES requirements

8. Accountabilities and Assurances

8.1 All Trust colleagues

As noted in section 1 above, colleagues at all levels and in all parts of the Trust have a fundamental role to play in communicating and engaging effectively with the people with whom they work, the people who use the Trust's services, professional stakeholders and communities. Specifically, for example, colleagues have responsibility for:

- ensuring that service users are suitably informed and involved not only in matters directly affecting their care, but also more broadly in understanding the range and accessibility of Trust services;
- participating openly and positively in staff engagement opportunities, and actively encouraging others to do the same;
- sharing their experiences and understanding about local stakeholders so that this information can be added to the Trust's collective knowledge.

8.2 Head of Planning, Compliance and Partnerships

The Head of Planning, Compliance and Partnerships is responsible for management of the Trust's engagement function and the Community Partnerships team. This includes responsibility for coordinating the Your Care, Your Opinion Programme Board, which is a formal subcommittee of the Trust Board, and for leading on all local engagement and consultation activities across Gloucestershire. In doing so, the roleholder is accountable to the Trust's Director of Finance.

8.3 Head of Communications

The Head of Communications is responsible for all communications activity including liaising with local, regional and/or national media as appropriate. The Head of Communications is also responsible for improving staff engagement. In doing so, the roleholder is accountable to the Trust's Director of Human Resources.

8.4 Chief Executive

The Chief Executive is the Trust's Accountable Officer, and as such, has overall responsibility for ensuring that the organisation maintains effective channels and methods by which to communicate with all relevant audiences.

8.5 Trust Board

The Board ultimately has responsibility for ensuring that the Trust is engaging fully and equitably with all local people, and specifically that any engagement / consultations across the county are managed in accordance with national requirements.

9. Enabling and Supporting Strategies

9.1 This Communications and Engagement Strategy complements the following additional strategy documents maintained by the Trust:

- the Quality Strategy, which seeks to champion a whole-system approach so as to ensure that consideration of quality becomes fundamental to every decision and action taken by the Trust;

- the Clinical Strategy, which seeks to empower the Trust to remain a leading provider of community-based healthcare services that provide optimum quality, safety and effectiveness, and enable every person in Gloucestershire to experience a positive journey and outcome;

- the Workforce and Organisational Development Strategy, which seeks to ensure that the Trust's projected staffing models are appropriate to deliver effective healthcare within Gloucestershire, and that all Trust colleagues are suitably involved, motivated, supported, resourced, trained and developed.

9.2 This Communications and Engagement Strategy is directly supported by the Communications and Engagement Implementation Plan which clarifies the actions to be undertaken by the Trust within the period 2017-22.

Appendix 1 - Stakeholder mapping

Throughout the lifecycle of this strategy, the Trust will maintain a clear understanding of its stakeholders. Each of them has different (and potentially changing) needs, expectations and interests which vary depending on the issue being considered. However, for the purposes of this Communications and Engagement Strategy, the Trust would broadly categorise its stakeholders as follows:

Key strategic partners	• Trust colleagues • NHS Improvement • Care Quality Commission • Gloucestershire Clinical Commissioning Group • Gloucestershire Hospitals NHS Foundation Trust • 2gether NHS Foundation Trust • Gloucestershire County Council • Healthwatch Gloucestershire • The Health and Wellbeing Board • Locality Executive Leads (GPs) • Health and Care Overview and Scrutiny Committee
Key local players	• Trust service users • Gloucestershire GPs • Gloucestershire MPs • NHS England • Public Health England • Community Hospital Leagues of Friends • South West Ambulance NHS Foundation Trust • NHS 111 • G-Doc • District Councils / Town Councils • VCS Alliance • Gloucestershire pharmacists / opticians / dentists • Local media

Keep informed and involved	• Carers Gloucestershire • Crossroads • Forest Voluntary Action Forum • Forest of Dean Health Forum • Stroud Against the Cuts • Stroud Older People's Forum • Gloucestershire Older People's Association • Gloucestershire Deaf Association • Inclusion Gloucestershire • Gloucestershire Village Agents • Gloucestershire Community Agents • Age UK Gloucestershire • Barnwood Trust • Gloucestershire Women's Institute • 38 degrees • The Gloucestershire public
Keep informed	• Arriva • Other voluntary sector organisations • Key local industries • Gloucestershire tourists / visitors

Further to the above, an up-to-date list will be kept for all of the Trust's stakeholders.

The Trust will also continue to analyse the list in terms of stakeholders' power, influence and the extent to which they are affected by any anticipated project or change.

Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 24th January 2017

Committee Name:	Trust Board
Agenda Ref:	13/0117
Author:	Tina Ricketts, Director of HR
Presented By:	Nicola Strother Smith, Chair of the Committee
Accountable Exec:	Tina Ricketts, Director of HR

Subject:	**Workforce and Organisation Development Committee Update Report**
Appendices	Appendix 1 – Minutes of meeting held on 10th October 2016 Appendix 2 – Workforce scorecard to 31st December 2016

Provided for: ☐ Discussion ☐ Decision ☒ Approval ☒ Assurance ☒ Information ☐ Noting ☐ Statutory Purposes

1. Executive Summary:

This report provides a summary of the key agenda items considered by the Workforce & OD Committee at its meeting on 12th December 2016.

Of particular note:

- Good progress is being made against the Trust's Workforce and Organisational Development Strategy which is evidenced by the continued improvement in the Trust's sickness absence, recruitment and retention of staff, and mandatory training compliance.
- Current workforce vacancy hotspots have been identified and actions agreed (Band 5 nurse vacancies within Community Hospitals, School Nursing, MSK and Physiotherapy Services).
- The Trust is performing well with regard to agency spend and was ranked 2nd in the Southwest for progress against the agency cap.
- The Communications and Engagement Strategy has been updated to combine both internal and external engagement and this is presented to the Board as a separate agenda item for approval.
- The first iteration of the Trust's Volunteer Strategy was considered and the Committee supported the recommendation that a short life working group be set up to take forward its further development.
- The Committee supported the recommendation for the Investors in People assessment process to commence in January 2017.
- The Trust is making good progress with the review of HR policies with the updated Relocation Policy and Corporate and Mandatory Training Policy being approved by the Committee.
- The Committee reviewed its terms of reference, which will be considered by the Board in March 2017.

Understanding You

2. Recommendations:

The Board is asked to **receive** this report and:

- **Note** the Committee's decision to launch the Investors in People assessment process in January 2017
- **Note** the Committee's approval of the updated Relocation Policy and Corporate and Mandatory Training Policy
- **Note** that a short life working group will be set up to further develop the Trust's Volunteer Strategy

3. Main Report

1. Introduction

The strategic workforce and organisational development priorities are:

- To ensure that a robust recruitment and retention plan is in place so that the Trust has the right staff with the right skills in the right place at the right time;
- To develop and sustain a culture that engages and motivates colleagues;
- To ensure that colleagues have the necessary knowledge, skills and expertise to deliver best care;
- To ensure that the Trust has the necessary leadership capability and capacity to deliver on the sustainability and transformation agenda;

To monitor the effectiveness of the workforce and OD strategy, a number of key performance indicators are monitored by the Committee and the performance as at 31st December 2016 is summarised below and the full workforce scorecard is attached in appendix 2.

Table 1: Key workforce performance indicators as at 31st December 2016

Key Performance indicator	As at 31/03/13	As at 31/03/14	As at 31/03/15	As at 31/03/16	As at 30/09/16	As at 31/12/16	Target by 31/03/17
PDR completion rate	67%	80.5%	71%	77.5%	76%	79%	95%
Staff FFT	N/A	53%	50%	37%	49%	55%	60%
Mandatory Training	64% (excludes clinical elements)	75% (excludes clinical elements)	71% (excludes clinical elements)	82% (excludes clinical elements)	66%	75%	95%
Sickness absence	4.5%	4.3%	4.9%	4.7%	4.4%	4.25%	4.0%
Turnover	12.2%	15.7%	14.7%	15%	14.38%	14.62%	12%
Nurse vacancy (band 5 & 6)	Not available	Not available	21% (08/14)	13.5%	13.6%	tbc	<10%

The Committee has recognised the need to prioritise work to understand and address the underlying issues impacting on the Staff FFT results and PDR completion rates which have not seen any improvement over the last three years. These two issues were discussed at the Board development session in December 2016 with a detailed report and action plan scheduled for the Committee meeting in February 2017.

2. Items considered by the Committee

The committee received the following reports, which were provided for assurance and discussion:

Table 3 Summary of the reports

Report title	Purpose	Brief summary of discussion
Workforce and OD Strategy progress report	Assurance	It was noted that 6 of the 12 agreed high impact actions had been completed: • Listening into Action (LiA) accreditation, • colleague health and wellbeing plan, • statutory and mandatory training matrices, • communications and internal engagement strategy, • review of raising concerns at work policy and • annual awards ceremony It was also noted that good progress was being made against the remaining 6 priority areas. “Green shoots” continue to be evident from the improvement in nurse recruitment, sickness absence rates and mandatory training compliance. The report also provided an overview of the workforce and organisational development priorities for Gloucestershire Sustainability and Transformation Plan and summarised the first iteration of the Trust’s top level workforce plan for 2017/18.
Communication and Internal Engagement Strategy progress report	Assurance	The Head of Communications provided an update to the Committee and confirmed that 12 of the 34 agreed high impact actions had been completed. Good progress was being made against 16 actions, with 6 in development. It was agreed that a scorecard should be developed to enable the Committee to monitor the on-going effectiveness of the strategy. The report provided an overview of the interactions on the Trust’s intranet, which has seen the number of sessions increasing month on month.
Workforce Education and Development report	Assurance	The Head of Learning and Development provided evidence of the month on month improvement in mandatory training compliance across all corporate and clinical elements. The Committee received assurance that an action plan was in place to achieve 85% compliance across all subject areas. The biggest risk to achieving the target remains the capacity of services to release colleagues to attend training.

		The report provided the Committee with an overview of the national reforms relating to apprenticeships, nurse associates, changes to the bursary system for healthcare degrees and the nurse degree apprenticeship programme.
Freedom to Speak up report	Information	The Ambassador for Cultural Change updated the Committee that there had been 31 concerns raised directly to the Freedom to Speak Up Guardian since March 2016. 10 concerns related to quality and safety, 8 to colleague behaviour and 13 to Trust policies, procedures and processes. 4 formal grievances had been received in the same reporting period, 2 of which had been a result of signposting from the Freedom to Speak Up Guardian.
Workforce Risk Register	Information	The Committee was presented with the workforce risk register which included risks rated 12 and above. Key risks were highlighted as the high nursing vacancy rates in community hospitals, the lack of "live" workforce information regarding vacancy rates and the limited operational management capacity and capability to tackle key workforce issues such as regular supervision and personal development plans. Actions to address these risks were discussed.
Workforce Report	Assurance	The Head of HR presented the Committee with a detailed report which highlighted the progress that is being made against the Trust's recruitment and retention and contingent workforce plans. The report also identified the following workforce hotspots: • Increasing number of vacancies within the School Nursing, MSK and Physiotherapy Services • The increase in demand on Capacity Services during the winter period which would have an impact on mandatory training and PDR compliance • An increase in salary overpayments due to late leavers forms It was agreed that the membership of the Trust's Recruitment and Retention Working Group would be refreshed and that monthly meetings would be reinstated. It was noted that the Trust is performing well with regard to agency spend and was currently ranked 2nd in the Southwest for progress against the agency cap.

3. Decisions made by the Committee

In line with the Scheme of Delegation, the Committee made the following decisions.

Report Title	Brief Summary
Volunteer Strategy	The Committee reviewed the first iteration of the Trust's Volunteer Strategy and **approved** the recommendation that a short life working group be set up under the listening into action programme to take forward the further development of the strategy. The group will include two Non-Executive Directors, the Head of HR, volunteers, volunteer supervisors and the volunteer co-ordinator.
Investors in People accreditation	The Head of OD provided the Committee with the results of a self – assessment that the Trust had undertaken against the Investors in People standards. The report confirmed that the Trust is likely to achieve "developed" level in all 9 indicators with the potential to achieve "established" in 4 areas and "advanced" in colleague health and wellbeing. The Committee **supported the recommendation** that the Trust commence the assessment process for reaccreditation in January 2017.
HR Policy Development	The Committee **approved** minor amendments to the following policies/ documents: • Pay progression policy and templates • Special Leave Policy • Personal Development Review policy, guidance and templates The Committee **approved** the following updated policies: • Relocation Policy • Corporate and Mandatory Training Policy

4. Items reviewed for Board approval

In line with the Scheme of Delegation the Committee considered the following reports prior to consideration by the Board.

Report Title	Brief Summary
Communications and Engagement Strategy	The Committee reviewed the newly combined Communications and Engagement Strategy to be recommended to the Board for approval.
Workforce and OD Committee Terms of Reference	The terms of reference of the Committee were reviewed with amendments proposed to the membership, quoracy and areas of responsibility. The proposed amendments will be considered by the Board in March 2017.

5. Which Trust strategic objective(s) does this paper link to?	
Achieve the best possible outcomes for our service users through high quality care	☐
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	☐
Actively engage with health and social care partners as well as local communities, in order to deliver seamless services	☐
Value colleagues and support them to develop the skills, confidence and ambition to deliver our vision	☒
Manage public resources wisely to ensure local services remain sustainable and accessible	☒

6. Explanation of acronyms used:
PDR – Personal Development Review FFT – Friends and Family Test MSK - Musculoskeletal

Minutes of the Workforce and Organisational Development Committee

Boardroom, Edward Jenner Court
10th October 2016

Members:

Nicola Strother Smith (NSS)	Non-Executive Director	CHAIR
Tina Ricketts	Director of HR	
Candace Plouffe	Chief Operating Officer	
Richard Cryer (RC)	Non-Executive Director	
Jan Marriott (JM)	Non-Executive Director	
Susan Field	Director of Nursing	

In attendance:

Lindsay Ashworth	Head of HR	
Linda Gabaldoni	Head of Organisational Development	
Stuart Bird	Deputy Director of Finance	
Sonia Pearcey	Ambassador for Cultural Change	
Mark Lambert	Head of Communications	
Michael Richardson	Deputy Director of Nursing	
Maria Wallen	Head of Professional Practice and Education	
Andy Mills	Workforce Systems Manager	
Gillian Steels	Trust Secretary	
Harriet Smith	Senior Personal Assistant	Minute taker

Ref No	Minute
16/HR081	**1. Welcome and Apologies** The Chair thanked everyone for attending the meeting and welcomed Andy Mills, the Workforce Systems Manager to the Committee.
16/HR082	**2. Confirmation of Quoracy** The Chair confirmed that the Committee was quorate.
16/HR083	**3. Declaration of interests** There were no conflicts of interest declared.
16/HR084	**4. Minutes of the meeting held on 24 August 2016** The minutes of the meeting held on 24 August 2016 were **received** and **approved** as an accurate record subject to minor amendments.

Ref No	Minute
16/HR085 Trust Secretary	**5. Matters Arising (Action Log)** The Action Log was **approved.** See Action Log for updates. The Trust Secretary stated that she is currently reviewing ToRs for all Committee's. The Trust Secretary is attending all of the Committee meetings and will then liaise with the Chair of the Committee to discuss. The updated ToR will then be brought back to the next Committee meeting in December for discussion.
16/HR086 DoHR	**6. Workforce and OD Strategy Progress Report** The DoHR presented the Workforce and OD Strategy progress report and updated the Committee with the progress made against each of the 12 high impact actions. The Workforce Systems Manager is developing PDRs (Personal Development Reviews) electronically which can be viewed through a colleague self-service system. This system will be delivered across the organisation by April 2017. The Workforce Team are actively chasing colleagues with regards to outstanding PDRs. NSS suggested that the timelines for the high impact actions be included in the next progress report. The Committee **noted** the progress made to date.
16/HR087 Head of Comms	**7. Communications and Internal Engagement Strategy Progress report** The Head of Communications updated the Committee on the progress being made against the Trust's Communication and Internal Engagement Strategy. RC commented on the high impact action relating to the intranet. RC enquired as to whether the intranet 'hit rate' can be shared with the Committee. This shows the 'hits' made on particular areas within the intranet. The Head of Communications agreed to share an analysis report of the amount of hits at the next meeting. The Chief Operating Officer (COO) stated that the 60 second videos which have been made across the Trust have been uploaded to the NHS recruitment pages. The Head of Communications stated that there will be 8 further '60 second' videos produced across the Trust. 7 have already been

Ref No	Minute
Head of Communications	produced. NSS asked for an update regarding the Staff Awards and the DoHR confirmed that a 'volunteers' category will be added to the Staff awards for 2017. The Head of Communications stated that the Communications team are offering 1:1 training with regards to social media (Twitter, Facebook and LinkedIn). JM asked whether this training can be rolled out to NEDs. The Head of Communications will liaise with JM outside of the Committee meeting with regards to this training. The Committee **noted** the progress made to date.
16/HR088 Head of Professional Practice and Education	**8. <u>Workforce, Education and Development report</u>** The Head of Professional Practice and Education presented the Workforce, Education and Development report to the Committee and outlined the priorities that have been addressed by the Trust to ensure effective strategies are in place to support the achievement of statutory and mandatory training compliance. The DoHR suggested that it would be helpful to focus on essential to role training for colleagues within the next report and also the development with local education providers. The Committee **received** the report and **noted** the progress made against statutory and mandatory training compliance.
16/HR089 Head of HR	**9. <u>Flexible working progress report</u>** The Head of HR presented the Flexible Working progress report and provided the Committee with an update on the progress made towards driving change through flexible working and becoming a Timewise Trust. The Director of Nursing stated that there needs to be a consistent approach to flexible working throughout the Trust and flexible working requests before any promotion of flexible working continues. A big conversation event was planned for October 2016 to take this forward. The Committee **reviewed** the report.
16/HR090	**10. <u>LiA progress report</u>** The Ambassador for Cultural Change updated the Committee on the progress to date since the last reporting period.

Ref No	Minute
	Two successful coaching sessions took place in September. The coaching session on the 20th September took place for members of the Board and the 21st September session was aimed at colleagues. There are now 32 new LiA coaches and 32 new schemes have been rolled out across the Trust for the next 20 weeks. The Committee **approved** the contents of the paper and **noted** the progress to date.
16/HR091	**11. EJC Staff FFT progress report** The Head of OD provided the Committee with a follow up on the progress on the action being taken in response to the results from Quarter 4 of 2015/16 on the survey carried out at Edward Jenner Court, GCS Headquarters. The Head of OD also presented the action log from the LiA workshops created from the themes of the comments from the Big Conversations following the Staff FFT results (Communication / Behaviours / Leadership). The Committee **noted** the action being taken in response to the results.
16/HR092 DoHR	**12. Workforce risk register** The DoHR presented the workforce risk register containing risks rated 12 and above. The DoHR agreed to add a column showing the measure since the last period onto the risk register for the next meeting. The Committee **reviewed** the risk register.
16/HR093 Head of HR	**13. HR policy development** LA presented the report and provided the Committee with an overview of the Trust's position regarding HR policy development and review. The COO requested that the Personal File policy be reviewed and a decision is made as to whether files should be paper or electronic. NSS asked for assurance that overdue policies will be up to date by 2 November 2016. LA stated that the Allegation regarding children and vulnerable adults policy and the Use of internet at work policy will be submitted to the JNCF sub policy group on 2 November 2016. New policies to be developed are the Drug and Alcohol Policy & the Organisational Change policy.

Ref No	Minute
	The Committee **noted** the contents of the report and **noted** the minor amendments to the Counter Fraud and Corruption policy.
16/HR094	**14. Workforce report** LA presented the Workforce report and provided the Committee with update on workforce information in relation to the hotspots. JM left the meeting at 11:55am. RC asked whether all colleagues need to complete resuscitation training and it was confirmed that all colleagues are required to complete awareness training, colleagues are required to watch a 3 minute video in order to complete this training. LG left the meeting at 12:00pm. The Committee **noted** the report which was provided for information and assurance.
16/HR095	**15. SystmOne update report** AM left the meeting at 12:01pm. CP presented the SystmOne update report and updated the Committee with progress made on the 8 workforce and OD issues. The Committee **noted** the progress that had been made and **noted** the lessons learnt in implementing clinical systems.
16/HR096	**16. Minutes from sub-committees** The Committee approved the minutes from the following sub-committees: • JNCF – 16 June 2016 • Workforce and OD Steering Group – 20 July 2016 • Workforce, Education and Development Group – 26 August 2016
16/HR097	**17. Forward agenda planner** **12 December 2016** • Investors in People update report • Terms of Reference review
	The Chair closed the meeting at 12:20pm. The next Workforce and OD Committee will take place on 12 December 2016, 10am-12pm in the Boardroom, EJC.

Gloucestershire Care Services NHS Trust

Human Resources Performance Report - To the End December 2016

Training Data is from - 06/01/2017

Sickness is to the end - November 2016

Trust Mandatory Training All Staff

Directorates		Headcount	SICKNESS % rate - 12 month rolling average to end November 2016.	TURNOVER FTE % for 12 month period to the end of this month	STABILITY FTE % for 12 month period to the end of this month	APPRAISALS	% of staff with Up to Date Appraisal	MANDATORY TRAINING	Equality, Diversity and Human Rights - 3 Years	Fire Safety - 1 Year	Health, Safety and Welfare - 3 Years	Infection Prevention and Control - Level 1 - 3 Years	Infection Prevention and Control - Level 2 - 1 Year	Information Governance - 1 Year	Moving and Handling - Level 1 - 3 Years	Moving and Handling - Level 2 - 1 Year	NHS Conflict Resolution (England) - 3 Years	Resuscitation - Level 1 - 3 Years	Resuscitation - Level 2 - Adult Basic Life Support - 1 Year	Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year	Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year	Safeguarding Level 1 - 3 Years	Safeguarding Adults - Level 2 - 3 Years	Safeguarding Children - Level 1 - 3 Years	Safeguarding Children - Level 2 - 3 Years	Safeguarding Children - Level 3- 3 Years	PREVENT Awareness - 3 Years	PREVENT WRAP - N
Training Targets: 85% to be achieved by Sept 2016; Sickness Target: 4.0% to be achieved by March 2017			**4.00%**	**11.00%**	**85.00%**		**95.00%**		**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**		**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**
Paul Jennings	Chief Exec Office	14	0.39%	26.67%	116.67%		85.71%		78.57%	42.86%	42.86%	25.00%	50.00%	35.71%	33.33%		35.71%	16.67%	50.00%			16.67%	50.00%	16.67%	50.00%		35.71%	100.00%
Paul Jennings Total		**14**	**0.39%**	**26.67%**	**116.67%**		**85.71%**		**78.57%**	**42.86%**	**42.86%**	**25.00%**	**50.00%**	**35.71%**	**33.33%**		**35.71%**	**16.67%**	**50.00%**			**16.67%**	**50.00%**	**16.67%**	**50.00%**		**35.71%**	**100.00%**
Glyn Howells	Finance	20	1.48%	31.40%	68.66%		70.00%		95.00%	100.00%	100.00%	95.00%		100.00%	95.00%		100.00%	90.00%				90.00%		100.00%			95.00%	
	IT & Clinical Systems	39	1.44%	28.16%	75.00%		97.44%		100.00%	94.87%	97.44%	94.74%		97.44%	97.37%		94.87%	100.00%				97.37%		100.00%			100.00%	
	Performance & Information	12	2.29%	8.77%	83.82%		100.00%		100.00%	100.00%	100.00%	100.00%		100.00%	100.00%		100.00%	100.00%				100.00%		100.00%			100.00%	
	Planning, Compliance & Partnership	7	0.26%	11.43%	107.14%		100.00%		100.00%	100.00%	100.00%	100.00%		100.00%	100.00%		100.00%	100.00%				100.00%		100.00%			100.00%	
	Trust Secretariat	2	0.81%	25.00%	16.67%		100.00%		100.00%	100.00%	100.00%	100.00%		100.00%	100.00%		100.00%	0.00%				100.00%		100.00%			100.00%	
Glyn Howells Total		**80**	**1.44%**	**24.57%**	**72.09%**		**91.25%**		**98.75%**	**97.50%**	**98.75%**	**96.20%**		**98.75%**	**97.47%**		**97.50%**	**94.94%**				**96.20%**		**100.00%**			**98.75%**	
Sue Field	Professional & Clinical Effectiveness	43	6.26%	23.19%	90.01%		76.74%		86.05%	53.49%	81.40%	91.67%	58.06%	46.51%	78.79%	11.11%	86.05%	50.00%	70.00%	55.56%	0.00%	66.67%	61.29%	75.00%	54.84%	28.57%	72.09%	74.19%
Sue Field Total		**43**	**6.26%**	**23.19%**	**90.01%**		**76.74%**		**86.05%**	**53.49%**	**81.40%**	**91.67%**	**58.06%**	**46.51%**	**78.79%**	**11.11%**	**86.05%**	**50.00%**	**70.00%**	**55.56%**	**0.00%**	**66.67%**	**61.29%**	**75.00%**	**54.84%**	**28.57%**	**72.09%**	**74.19%**
Tina Ricketts	Central Nursing Bank	102	0.00%	0.00%	66.67%		69.61%		58.25%	26.21%	65.05%	76.00%	38.46%	20.39%	40.00%	11.54%	59.22%	48.00%	38.96%			76.00%	16.67%	76.00%	14.10%		57.28%	30.77%
	Communications	4	0.16%	0.00%	100.00%		100.00%		100.00%	100.00%	100.00%	100.00%		100.00%	100.00%		100.00%	100.00%				100.00%		100.00%			100.00%	
	Human Resources	29	3.16%	26.83%	93.48%		96.55%		93.10%	86.21%	93.10%	92.86%	0.00%	86.21%	92.86%		93.10%	92.86%	100.00%			92.86%	100.00%	92.86%	100.00%		93.10%	100.00%
	Learning & Development	13	7.70%	7.08%	105.45%		92.31%		92.31%	76.92%	92.31%	100.00%	62.50%	84.62%	100.00%	50.00%	92.31%	100.00%	54.55%			100.00%	72.73%	100.00%	72.73%		84.62%	81.82%
Tina Ricketts Total		**148**	**3.95%**	**17.02%**	**95.34%**		**77.70%**		**69.13%**	**44.30%**	**73.83%**	**86.44%**	**40.23%**	**40.94%**	**73.02%**	**13.41%**	**69.80%**	**74.58%**	**41.57%**			**86.44%**	**24.44%**	**86.44%**	**22.22%**		**67.79%**	**37.78%**
Candace Plouffe	Capacity	148	4.96%	15.78%	86.72%		79.73%		85.71%	76.87%	84.35%	86.96%	79.65%	67.35%	79.55%	56.52%	89.80%	65.22%	68.87%		28.57%	82.61%	77.88%	73.91%	75.22%		81.63%	79.03%
	Community Hospitals	799	5.18%	14.76%	85.13%		71.84%		87.95%	69.39%	89.34%	88.89%	69.89%	64.49%	79.82%	56.89%	89.21%	71.30%	65.54%		76.39%	73.15%	67.82%	75.00%	63.29%		77.54%	70.87%
	Countywide	522	3.15%	12.67%	90.66%		84.10%		89.69%	72.14%	87.21%	88.33%	82.41%	75.57%	82.13%	40.70%	92.37%	55.83%	84.54%		57.14%	76.67%	79.25%	75.00%	75.25%	42.50%	82.82%	82.43%
	CYPS	461	3.87%	8.43%	92.34%		83.51%		89.50%	72.65%	89.72%	91.23%	74.12%	69.58%	83.20%	68.35%	94.09%	80.70%	40.00%	81.63%		84.21%	76.07%	89.47%	85.64%	50.00%	84.46%	86.00%
	ICTs	597	4.72%	18.62%	80.30%		79.06%		88.76%	69.63%	88.09%	95.92%	79.03%	67.62%	78.85%	59.96%	93.29%	59.18%	84.36%	100.00%		83.67%	75.38%	83.67%	71.54%	100.00%	79.19%	76.23%
	Estates	185	3.89%	12.03%	88.14%		86.49%		92.39%	82.07%	86.41%	85.79%		81.52%	78.69%		95.11%	65.57%				71.58%		73.77%			77.17%	50.00%
Candace Plouffe Total		**2712**	**4.34%**	**14.02%**	**86.63%**		**79.20%**		**88.91%**	**71.79%**	**88.24%**	**88.52%**	**75.93%**	**69.50%**	**81.48%**	**57.65%**	**91.98%**	**65.56%**	**78.19%**	**81.68%**	**74.43%**	**75.93%**	**74.08%**	**76.85%**	**72.65%**	**49.32%**	**80.30%**	**77.62%**
Mike Roberts	Medical	2	0.00%	0.00%	100.00%		100.00%		100.00%	50.00%	100.00%		50.00%	0.00%	100.00%		100.00%		0.00%		0.00%		50.00%		50.00%		50.00%	50.00%
Mike Roberts Total		**2**	**0.00%**	**0.00%**	**100.00%**		**100.00%**		**100.00%**	**50.00%**	**100.00%**		**50.00%**	**0.00%**	**100.00%**		**100.00%**		**0.00%**		**0.00%**		**50.00%**		**50.00%**		**50.00%**	**50.00%**
Trust Totals		**2999**	**4.25%**	**14.62%**	**86.44%**		**79.46%**		**88.11%**	**70.70%**	**87.50%**	**88.18%**	**74.19%**	**68.33%**	**81.56%**	**54.95%**	**90.68%**	**68.52%**	**75.74%**	**81.09%**	**73.72%**	**77.92%**	**71.81%**	**79.20%**	**70.28%**	**48.56%**	**79.82%**	**76.00%**
Comparative information as at 31 March 2016		3024	4.68%	15.16%	85.98%		77.45%		87.63%	78.60%	87.73%			64.68%			88.26%											
Comparative information as at 31 March 2015		2970	4.89%	14.70%	89.35%		70.91%		72.93%	60.03%	79.83%			61.58%			72.69%											
Comparative information as at 31 March 2014		2969	4.28%	11.71%	-		80.45%		50.20%	57.36%	88.37%			25.05%			65.90%											

* Bank Staff are shown under Human Resources for the benefit of reporting however Bank staff are spread across the Trust and responsibility for achieving performance targets rest with their Line Managers

Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 24th January 2017

Committee Name:	Trust Board
Agenda Ref:	14/0117
Author:	Matthew O'Reilly (Head of Performance and Information)
Presented By:	Susan Field (Director of Nursing) and Candace Plouffe (Chief Operating Officer)
Accountable Exec:	Susan Field (Director of Nursing)
Subject:	**Quality and Performance Report**
Appendices	Appendix 1 – Performance Report

Provided for: ☒ Discussion ☒ Decision ☒ Approval ☒ Assurance ☒ Information ☐ Noting ☐ Statutory Purposes

1. Executive Summary:

This is the second version of a new format Quality & Performance report. It incorporates data to the end of **November 2016** and the format of the report aligns targets and metrics to the Care Quality Commission (CQC) domains.

The report aims to report on performance against all key measures, focusing on any exceptions where performance improvement is required. Alignment with the Trust risk register is included where appropriate.

As the Trust's Business Intelligence Reporting Tool (BIRT) is developed this will allow drill-through to patient-level analysis of any exceptions reported. A plan for this further development has been ratified by the Corporate Systems Steering Group.

Notable performance improvements include:

- Safety Thermometer activity – 95% achieved for the first time this reporting year
- MIIU times for initial assessment for Patients arriving by ambulance (less than 15 minutes)

Notable risks to performance include:

- Single Point of Clinical Access (SPCA) abandoned call rate 75% against a<5% standard
- Referral to Treatment targets being missed by Adult Physiotherapy and Occupational Therapy services
- Friend and Family Test (FFT) response rates remains lower than target – 4.5% against 5.4%.

2. Recommendations:

The Trust Board is asked to **receive** the report.

Understanding You

3. Main Report

See Quality and Performance Report attached.

4. Which Trust strategic objective(s) does this paper link to?	
Achieve the best possible outcomes for our service users through high quality care	☒
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	☒
Actively engage with health and social care partners as well as local communities, in order to deliver seamless services	☒
Value colleagues and support them to develop the skills, confidence and ambition to deliver our vision	☒
Manage public resources wisely to ensure local services remain sustainable and accessible	☒

5. Explanation of acronyms used:

BIRT – Business Intelligence Reporting Tool
CAS – Clinical Alert System
CQC – Care Quality Commission
CYP – Children and Young People
DoC – Duty of Candour
ESD – Early Supported Discharge
GCS – Gloucestershire Care Services
GP – General Practitioner
GRH – Gloucestershire Royal Hospital
GSSS – Gloucestershire Stop Smoking Service
HCA – Health Care Assistant
HIV - Human Immunodeficiency Virus
HPV - Human papilloma virus
HSE – Health and Safety Executive
ICT – Integrated Community Teams
IDT – Integrated Discharge Team
MADE - Multi-agency discharge event
MDT - Multidisciplinary Team
MIIU - Minor injuries and illness Unit
MRSA - Methicillin-resistant Staphylococcus Aureus
MSKCAT - Musculoskeletal Clinical Assessment and Treatment
MSSA - Meticillin Sensitive Staphylococcus Aureus
NRLS – National Reporting and Learning System
PaCE - Professional and Clinical Effectiveness
PDR – Personal Development Review
PMSO - Parliamentary Health Service Ombudsman
RAG – Red / Amber / Green
RCA – Root Cause Analysis
RNC – Registered Nurse
RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
SIRI – Serious Incidents Requiring Investigation
SPCA – Single Point of Clinical Access
SUS – Secondary Uses Service
VTE - Venous Thromboembolism
WTE – Whole time equivalent
YTD – Year to Date

Gloucestershire Care Services NHS
NHS Trust

Quality and Performance Report

Trust Board
24 January 2017

Understanding you

Quality and Performance Dashboard – November 2016

CQC DOMAIN - ARE SERVICES CARING?

		Performance Target	2015/16 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	2016/17 YTD
1	Friends and Family Test Response Rate	No Target	5.4%	4.2%	4.0%	4.2%	4.8%	5.1%	4.3%	4.7%	4.4%	4.5%
2	% of respondents indicating 'extremely likely' or 'likely' to recommend service	No Target	95.2%	95.3%	94.3%	95.9%	95.7%	94.4%	94.2%	95.3%	95.3%	95.1%
3	Number of Compliments	No Target	333	13	39	43	19	37	62	37	56	306
4	Number of Complaints	No Target	87	8	6	4	8	3	2	7	12	50
5	Number of Concerns	No Target	315	29	28	36	43	37	34	39	43	289

CQC DOMAIN - ARE SERVICES SAFE?

		Performance Target	2015/16 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	2016/17 YTD
6	Number of Never Events	0	1	0	0	0	0	0	0	0	0	0
7	Number of Serious Incidents Requiring Investigation (SIRI)	No Target	22	3	2	4	1	2	0	1	1	14
8	Number of Serious Incidents Requiring Investigation (SIRI) where Medication errors caused serious harm	No Target	0	0	0	0	0	0	0	0	0	0
9	Total number of incidents reported	No Target	3,711	319	303	302	297	333	323	346	345	2,568
10	% incidents resulting in low or no harm	No Target	98.4%	96.2%	96.0%	98.7%	98.7%	94.6%	95.0%	97.4%	94.5%	96.4%
11	% incidents resulting in moderate harm, severe harm or death	No Target	1.6%	3.8%	4.0%	1.3%	1.3%	5.4%	5.0%	2.6%	5.5%	3.6%
12	% falls incidents resulting in moderate, severe harm or death	No Target	0.4%	1.2%	0.0%	0.0%	0.0%	0.0%	1.2%	2.6%	3.9%	1.1%
13	% medication errors resulting in moderate, severe harm or death	No Target	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
14	Number of post 48 hour Clostridium Difficile Infections	*12	9	0	0	1	1	2	2	0	0	6
15	Number of MRSA bacteraemias	0	0	0	0	0	0	0	0	0	0	0
16	Number of MSSA Infections	0	0	1	0	0	0	0	0	0	0	1
17	Number of E.Coli Bloodstream Infections	0	2	0	0	0	0	0	0	0	0	0
18	Safer Staffing Fill Rate - Community Hospitals	No Target	101.0%	98.7%	97.6%	96.0%	96.0%	95.4%	95.5%	97.2%	97.5%	96.7%
19	VTE Risk Assessment - % of inpatients with assessment completed	95%	87.8%	95.4%	96.0%	91.5%	96.7%	97.9%	96.8%	97.2%	98.2%	96.2%
20	Safety Thermometer - % Harm Free	95%	95.3%	93.6%	93.4%	93.1%	93.4%	93.8%	93.9%	94.0%	95.6%	93.9%
21	Total number of Acquired pressure ulcers	No Target	350	46	35	42	31	46	38	50	46	334
22	Total number of grades 1 & 2 Acquired pressure ulcers	No Target	310	37	33	34	30	39	33	44	38	288
23	Number of grade 3 Acquired pressure ulcers	No Target	30	7	2	5	1	6	3	5	8	37
24	Number of grade 4 Acquired pressure ulcers	No Target	10	2	0	3	0	1	2	1	0	9

Quality and Performance Dashboard – November 2016

		Performance Target	2015/16 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	2016/17 YTD
CQC DOMAIN - ARE SERVICES EFFECTIVE?												
Community Hospitals												
25	Emergency re-admission within 30 days of discharge following a non-elective admission	No Target	14.6%	12.4%	15.6%	12.8%	11.2%	11.5%	12.6%	8.4%	6.8%	11.4%
26	Sleeping Accommodation Breaches - Number of non-exempt same sex ward breaches	0	0	0	0	0	0	0	0	0	0	0
27	Inpatients - Average Length of Stay	No Target	20.9	24.3	24.1	23.5	25.6	23.0	27.1	29.2	24.5	25.2
28	Bed Occupancy - Community Hospitals	90%	96.6%	99.4%	99.4%	98.4%	98.3%	98.9%	98.3%	98.3%	98.6%	98.7%
29	% of direct admissions to community hospitals	No Target	29.3%	19.0%	22.1%	26.4%	25.4%	25.6%	23.7%	24.7%	27.0%	24.2%
30	Delayed Transfers of Care (average number of patients each month)	10	3	2	4	3	4	4	7	10	18	6
31	Average of 10 discharges per day (weekends) - Inpatients	10	4.4	5.1	4.4	4.9	4.2	3.3	3.5	2.6	4.3	4.0
32	Average of 20 discharges per day (weekdays) - Inpatients	20	11.3	11.3	9.6	9.5	9.4	9.2	8.8	9.3	9.2	9.5
33	Cancelled Operations - No urgent operation should be cancelled for a second time	0	0	0	0	0	0	0	0	0	0	0
34	Number of patients who have had operations cancelled for non-clinical reasons that have not been offered another binding date within 28 days	0	0	0	0	0	0	0	0	0	0	0
35	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	>99%	97.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
36	SUS Data Quality Index	TBC	99.0%	99.0%	99.0%	99.2%	98.9%	98.8%	98.8%	98.8%	++	98.9%
37	IDT Number of avoided admissions	*2,440	2,083	143	168	168	189	204	192	205	200	1,469
Other												
38	Rapid Response - Number of referrals	*2,092	2,639	257	232	236	264	275	234	255	235	1,988
39+	Stop Smoking Service - **3rd Party Providers**- Number of smokers successfully quit (Quarterly Data From September 2015 to June 2016)	*462	1,103			225			168			393
40+	Stop Smoking Service - **GSSS only** - Number of smokers successfully quit (Quarterly Data From September 2015 to June 2016)	*368	1,031			198			198			396
41	Single Point of Clinical Access (SPCA) Calls Offered (received)	No Target	38,767	3,553	3,625	3,794	3,625	3,598	3,965	3,938	3,813	29,911
42	SPCA % of calls abandoned	<5%	7.2%	5.1%	4.7%	5.1%	4.7%	3.8%	7.0%	7.9%	7.5%	5.7%
43	SPCA % of calls resolved with agreed pathway within 20 mins	95%	93.2%	96.3%	96.4%	96.6%	97.1%	97.9%	97.2%	97.2%	95.8%	96.8%
44	Chlamydia Screening of Gloucestershire residents aged 15-24 via the Chlamydia Screening Service (minimum positivity rate)	2,300 per 100,000 population	2,130	2,179	2,263	1,993	1,841	2,044	2,432	2,736	2,246	2,217
45	Chlamydia Screening - Number of Positive Screens	*779	1,116	97	104	92	82	99	116	127	105	822

*Cumulative YTD target
+ Service will no longer be provided by GCS from 1st January 2017
++ Data not currently available from NHS digital

Quality and Performance Dashboard – November 2016

CQC DOMAIN - ARE SERVICES RESPONSIVE?												
		Performance Target	2015/16 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	2016/17 YTD
Minor Injuries and Illnesses Unit (MIIU)												
46	MIIU % seen and discharged within 4 Hours	95%	99.8%	99.6%	99.8%	99.7%	99.6%	99.5%	99.6%	99.6%	99.7%	99.6%
47	MIIU Number of breaches of 4 hour target	No Target	178	25	17	22	30	31	27	22	18	192
48	Trolley waits in the MIIU must not be longer than 12 hours	<12hrs	0	0	0	0	0	0	0	0	0	0
49	Total time spent in MIIU less than 4 hours (95th percentile)	<4hrs	02:20	02:41	02:26	02:38	02:30	02:30	02:36	02:37	02:31	02:33
50	MIIU Time to initial assessment for patients arriving by ambulance (95th percentile)	<15 m	00:17	00:24	00:21	00:43	00:38	00:17	00:19	00:28	00:14	00:25
51	All handovers between ambulance and MIIU must take place within 15 minutes with none waiting more than 30 minutes.	0	0	0	0	0	0	0	0	0	0	0
52	All handovers between ambulance and MIIU must take place within 15 minutes with none waiting more than 60 minutes.	0	0	0	0	0	0	0	0	0	0	0
53	MIIU - Time to treatment in department (median)	<60 m	00:21	00:28	00:17	00:18	00:19	00:16	00:16	00:16	00:15	00:18
54	MIIU - Unplanned re-attendance rate within 7 days	<5%	4.4%	3.2%	3.6%	4.1%	3.7%	3.2%	3.6%	3.2%	3.6%	3.5%
55	MIIU - % of patients who left department without being seen	<5%	0.7%	0.7%	0.9%	1.0%	1.2%	1.0%	1.1%	0.8%	0.6%	0.9%
Referral to Treatment												
56	Speech and Language Therapy - % treated within 8 Weeks	95%	95.1%	84.8%	88.6%	94.1%	100.0%	97.1%	98.9%	98.1%	98.7%	95.0%
57	Podiatry - % treated within 8 Weeks	95%	98.3%	99.2%	99.3%	97.6%	92.6%	95.0%	96.0%	97.0%	96.6%	96.7%
58	Occupational Therapy Services - % treated within 8 Weeks	95%	87.0%	90.8%	90.5%	89.9%	92.8%	94.9%	94.6%	92.4%	91.8%	92.2%
59	Adult Physiotherapy - % treated within 8 Weeks	95%	92.9%	93.6%	93.9%	92.7%	92.5%	90.3%	88.3%	88.6%	91.9%	91.5%
60	Occasional Wheelchairs - % treated within 8 Weeks	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
61	Parkinson's Nursing - % treated within 8 Weeks	95%	100.0%	100.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%
62	Diabetic Nursing - % treated within 8 Weeks	95%	97.9%	95.8%	95.0%	100.0%	95.9%	100.0%	96.0%	100.0%	100.0%	97.8%
63	Bone Health Service - % treated within 8 Weeks	95%	99.8%	99.0%	99.5%	100.0%	100.0%	99.4%	99.4%	99.4%	100.0%	99.6%
64	MSKCAT Service - % treated within 8 Weeks	95%	94.1%	99.8%	98.5%	100.0%	99.3%	98.7%	89.3%	77.5%	77.7%	92.6%
65	Contraception Service and Sexual Health- % treated within 8 Weeks	95%	99.8%	99.8%	99.4%	99.3%	99.8%	99.5%	100.0%	98.7%	100.0%	99.6%
66	HIV Service - % treated within 8 Weeks	95%	97.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
67	Psychosexual Service - % treated within 8 Weeks	95%	99.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
68	Sexual Health - % of terminations carried out within 9 weeks and 6 days of gestation	80%	80.4%	87.8%	80.4%	75.0%	86.0%	86.5%	81.3%	80.4%	76.8%	81.8%
69	Paediatric Speech and Language Therapy - % treated within 8 Weeks	95%	93.6%	95.9%	92.8%	99.5%	98.7%	97.1%	99.1%	99.3%	98.8%	97.7%
70	Paediatric Physiotherapy - % treated within 8 Weeks	95%	99.3%	97.6%	98.3%	99.1%	97.2%	98.2%	94.0%	92.3%	87.9%	95.6%
71	Paediatric Occupational Therapy - % treated within 8 Weeks	95%	98.9%	97.2%	97.4%	96.9%	96.7%	100.0%	95.2%	96.2%	96.9%	97.1%

Quality and Performance Dashboard – November 2016

CQC DOMAIN - ARE SERVICES RESPONSIVE?												
		Performance Target	2015/16 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	2016/17 YTD
Other												
72	MSKCAT Service - % of referrals referred on to secondary care	<30%	11.2%	11.3%	9.8%	13.6%	12.2%	13.2%	10.9%	11.8%	12.0%	11.9%
73	MSKCAT Service - Patients referred to secondary care within 2 days of decision to refer onwards	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
74	MSKCAT Service - wait from referral for urgent patients to be seen not to exceed 2 weeks	95%	97.1%	95.8%	100.0%	97.8%	100.0%	100.0%	100.0%	96.3%	100.0%	98.7%
75	Stroke ESD - Proportion of new patients assessed within 2 days of notification	95%	96.7%	90.6%	95.8%	100.0%	100.0%	91.9%	100.0%	100.0%	92.6%	96.4%
76	Stroke ESD - Proportion of patients discharged within 6 weeks	95%	98.6%	96.3%	97.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.2%
77	Social Care ICT - % of Referrals resolved at Referral Centres and closed	No Target	67.9%	38.4%	37.8%	37.9%	36.7%	36.5%	35.0%	46.8%	47.7%	39.6%
78	Reablement - Current Cases Open Longer than 6 weeks	0	57	74	69	57	54	67	73	61	76	66
79	% community reablement completing after 6 weeks	No Target	17.2%	21.0%	17.2%	15.5%	20.6%	16.8%	16.9%	17.9%	17.0%	17.9%
80	Reablement - % progressed within 6 weeks from closing this month	100%	82.8%	79.0%	82.8%	84.5%	79.4%	83.2%	83.1%	82.1%	83.0%	82.1%
81	Reablement - % contact time	60%	40.3%	41.5%	42.1%	42.4%	40.7%	42.0%	39.4%	39.6%	41.2%	41.1%
82	Newborn Hearing Screening Coverage	97%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
83	Newborn Hearing Screens completed by 5 weeks (community sites) - Well babies	97%	99.4%	99.8%	99.6%	99.8%	99.6%	100.0%	99.8%	99.6%	100.0%	99.8%
84	Newborn Bloodspot Screening Coverage - by 17 days of age (responsibility at birth)	No Target	90.5%	91.7%	95.3%	94.4%	94.4%	94.8%	96.5%	94.0%	90.7%	94.0%
85	Newborn Bloodspot Screening Coverage - by 21 days of movement in (Movers In)	No Target	96.7%	92.3%	93.3%	100.0%	91.2%	93.3%	90.9%	100.0%	89.5%	93.8%
		Performance Target	**2015/16 Outturn**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**2016/17 YTD**
Immunisations			**2015/16 Outturn**	**ACADEMIC YEAR 2016/17 - Target 90% of all 2 immunisations by end of academic year (July 2017)**								**2016/17 YTD**
86	HPV Immunisation coverage for girls aged 12/13 years old (Target for all 3 Immunisations to be completed) - **2nd immunisation**	*65%	88.1%						35.5%	52.3%	76.8%	76.8%
87	1st HPV Immunisation coverage for girls aged 12/13 years old (Target for all 3 Immunisations to be completed) - **1st immunisation**	*50%	91.6%						7.5%	20.7%	63.8%	63.8%
Childhood Measurement Programme			**2015/16 Outturn**	**ACADEMIC YEAR 2016/17 - Target 95% of children measured by end of academic year - Cumulative target (July 2017)**								**2016/17 YTD**
88	Percentage of children in Reception Year with height and weight recorded	*25%	97.8%						2.3%	21.2%	52.7%	52.7%
89	Percentage of children in Year 6 with height and weight recorded	*60%	93.3%						9.9%	50.2%	76.1%	76.1%
CQC DOMAIN - ARE SERVICES WELL LED?												
		Performance Target	**2015/16 Outturn**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**2016/17 YTD**
90	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place of work	61%	47.0%			50.0%			49.0%			49.5%
91	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place to receive treatment	67%	80.0%			83.0%			79.0%			81.0%
92	Sickness Rate in Reablement workforce	3%	6.5%	4.3%	5.2%	4.4%	5.0%	3.7%	3.9%	8.1%	6.5%	5.1%
93	% of Staff with completed Personal Development Reviews (Appraisal)	95%	77.5%	74.7%	70.7%	66.2%	70.3%	74.8%	76.2%	77.7%	78.2%	73.6%
94	Sickness absence average % rolling rate - 12 months	<4%	4.7%	4.7%	4.6%	4.5%	4.5%	4.4%	4.3%	4.2%	4.3%	4.4%
95	Sickness absence % rate (1 month only)	<4%	4.4%	4.5%	3.9%	3.8%	4.3%	4.1%	4.4%	4.5%	4.9%	4.3%
96	Mandatory Training	**85%	81.1%	68.5%	72.9%	74.1%	75.7%	77.4%	78.4%	80.6%	80.3%	76.0%

**Mandatory training performance reported on this summary is based on the 5 requirements as reported in 2015/16 to enable direct comparison

*Cumulative YTD Target

Executive Summary

Are Our Services Caring?

- Friends and Family Test response rate (4.5% year to date) continues to be behind that in 2015/16 (5.4%), but response feedback continues to be positive (95.3% extremely likely or likely to recommend the Trust).

Are Our Services Safe?

- Safety Thermometer Harm Free Care target of 95% was achieved in November (95.6%) for the first time this reporting year.
- Reporting of acquired pressure ulcers continues to increase with particular respect to grade 1 and 2 pressure ulcers.

Are our Services Effective?

- Inpatient average length of stay improved significantly in November compared to the previous two months.
- Abandoned call rate in Single Point of Clinical Access continues to be above the threshold; however call volumes continue to be at a very high level.
- Rapid Response service referrals dropped in November after a slight improvement in October**.**

Are Our Services Responsive?

- MIIU time to initial assessment for ambulance arrivals achieved target for the first time this reporting year.
- Referral to Treatment targets have been missed by Adult Occupational Therapy and Physiotherapy, Paediatric Physiotherapy and MSKCAT primarily due to capacity issues.

Are Our Services Well Led?

- Personal development reviews completed indicates continued improvement.
- Mandatory training completed (based on the five previously reported measures) indicates slight decrease in performance during November compared to October.
- Sickness absence (rolling 12 months) and 1 month position have increased and both remain outside the target of 4.0%.

EXCEPTION REPORT | ARE SERVICES CARING?

Gloucestershire Care Services NHS Trust

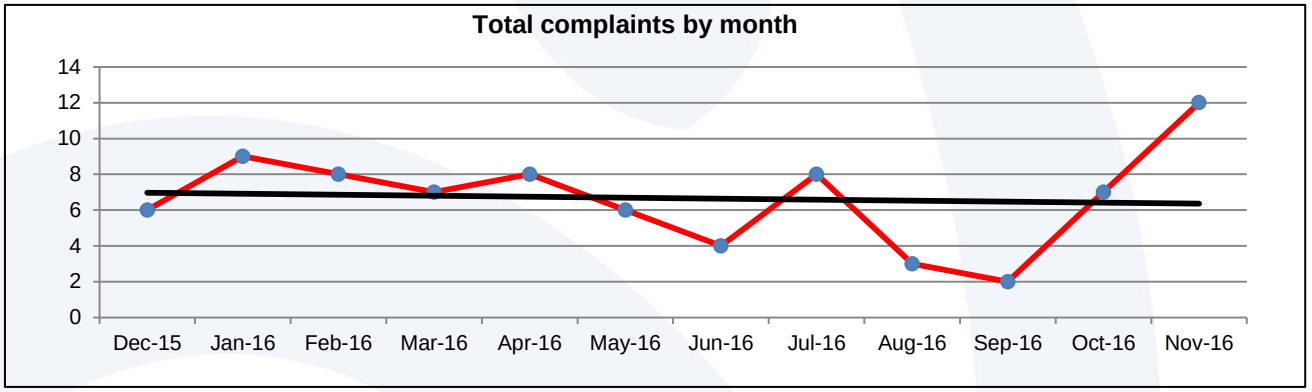
CQC DOMAIN - ARE SERVICES CARING?	Risk Register ref.	Risk Register rating	Performance Target	Sep	Oct	Nov
Friends and Family Test Response Rate	-	-	No Target	4.3%	4.7%	4.4%
% of respondents indicating 'extremely likely' or 'likely' to recommend service	-	-	No Target	94.2%	95.3%	95.3%
Number of Compliments	-	-	No Target	62	37	56
Number of Complaints	-	-	No Target	2	7	12
Number of Concerns	-	-	No Target	34	39	43

What is causing under achievement?	What actions have been taken to improve performance?
Friends and Family Test response rate and recommendations: • Response rate dropped in November to 4.4% and on a year to date basis (4.5%) remains below the 2015/16 outturn of 5.4%. • Respondents indicating 'extremely likely' or 'likely' to recommend service remains at 95.3%. On a year to date basis (95.1%) remains below the 2015/16 outturn of 95.2%.	• Review of the national guidance referring to eligible participants to ensure that the Trust are comparing like-with-like i.e. the appropriate denominator to the chosen numerator. • The Trust intends to change from current arrangement with Co-Metrica from April 2017 which will mean more in-house management of Friends and Family Test and adopting a more flexible and responsive approach i.e. census day, with some services such as ICT. Children's services census day planned for 18th January 2017 as a test for this.
Complaints, Compliments and Concerns: • More Compliments are forecast in 2016/17 (459) compared to 2015/16 (333) • More Concerns are forecast in 2016/17 (434) compared to 2015/16 (315) • Less Complaints are forecast in 2016/17 (75) compared to 2015/16 (87)	• N/A

EXCEPTION REPORT | ARE SERVICES CARING?

Gloucestershire Care Services NHS
NHS Trust

Complaints per month and by reason:



Complaints	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	2016/17 YTD
Community Hospitals	2	5	3	0	2	2	2	2	1	0	1	4	14
Countywide	2	1	1	4	0	1	0	2	1	1	3	3	11
ICTs	1	2	2	2	2	1	1	3	1	0	0	2	10
Urgent Care	1	1	2	0	3	2	1	0	0	1	0	1	8
CYP Services	0	0	0	1	1	0	0	1	0	0	3	2	7
Total	6	9	8	7	8	6	4	8	3	2	7	12	50

Complaint response times:

Response Time	Q1	Q2	Q3	Q4
Target time within agreed timescale (25 working days)	92.3%	100.0%	*TBC	

*Q3 not available at this point in time. December complaints responded to within 25 working days not currently available

There were 12 complaints in November, 4 related to inpatient services, 3 Countywide Services, 2 Community services, 2 Children and Young People's services and 1 Urgent Care service.

This means that the Trust is reporting 2.9 Complaints per 1,000 WTE (Dec-15 to Nov-16) compared to the average of 5.2 based on the Trusts within the Aspirant Community Foundation Trust group.

There were 2 complaints referred to the Parliamentary Health Service Ombudsman (PHSO) in November. No other cases have been referred in 2016/17.

The 2 cases relate to:

•Dilke Hospital regarding clinical care
•District Nursing - Cheltenham ICT regarding clinical care.

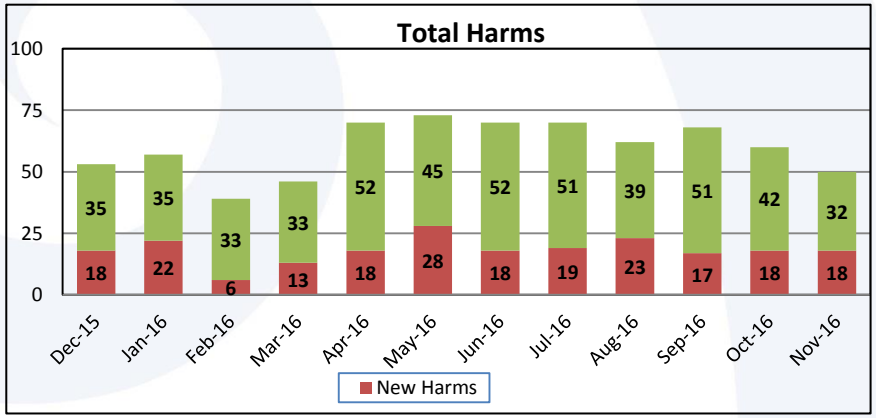
EXCEPTION REPORT | ARE SERVICES SAFE?

CQC DOMAIN - ARE SERVICES SAFE?

	Risk Register ref.	Risk Register rating	Performance Target	Sep	Oct	Nov
Number of Never Events	-	-	No Target	0	0	0
Number of Serious Incidents Requiring Investigation (SIRI)	-	-	No Target	0	1	1
Number of Serious Incidents Requiring Investigation (SIRI) where Medication errors caused serious harm	-	-	No Target	0	0	0
Total number of incidents reported	-	-	No Target	323	346	345
% incidents resulting in low or no harm	-	-	No Target	95.0%	97.4%	94.5%
% incidents resulting in moderate harm, severe harm or death	-	-	No Target	5.0%	2.6%	5.5%
% falls incidents resulting in moderate, severe harm or death	ST5	9	No Target	1.2%	2.6%	3.9%
% medication errors resulting in moderate, severe harm or death	-	-	No Target	0.0%	0.0%	0.0%
Number of post 48 hour Clostridium Difficile Infections	-	-	*10	2	0	0
Number of MSSA Infections	-	-	No Target	0	0	0
Number of E.coli Bloodstream Infections	-	-	No Target	0	0	0
Safer Staffing Fill Rate - Community Hospitals	-	-	No Target	95.5%	97.2%	97.5%
Safety Thermometer - % Harm Free	SD50	9	95%	93.9%	94.0%	95.6%
Total number of Acquired pressure ulcers	-	-	No Target	38	50	46
Total number of grades 1 & 2 Acquired pressure ulcers	-	-	No Target	33	44	38
Number of grade 3 Acquired pressure ulcers	-	-	No Target	3	5	8
Number of grade 4 Acquired pressure ulcers	-	-	No Target	2	1	0

*Cumulative YTD target

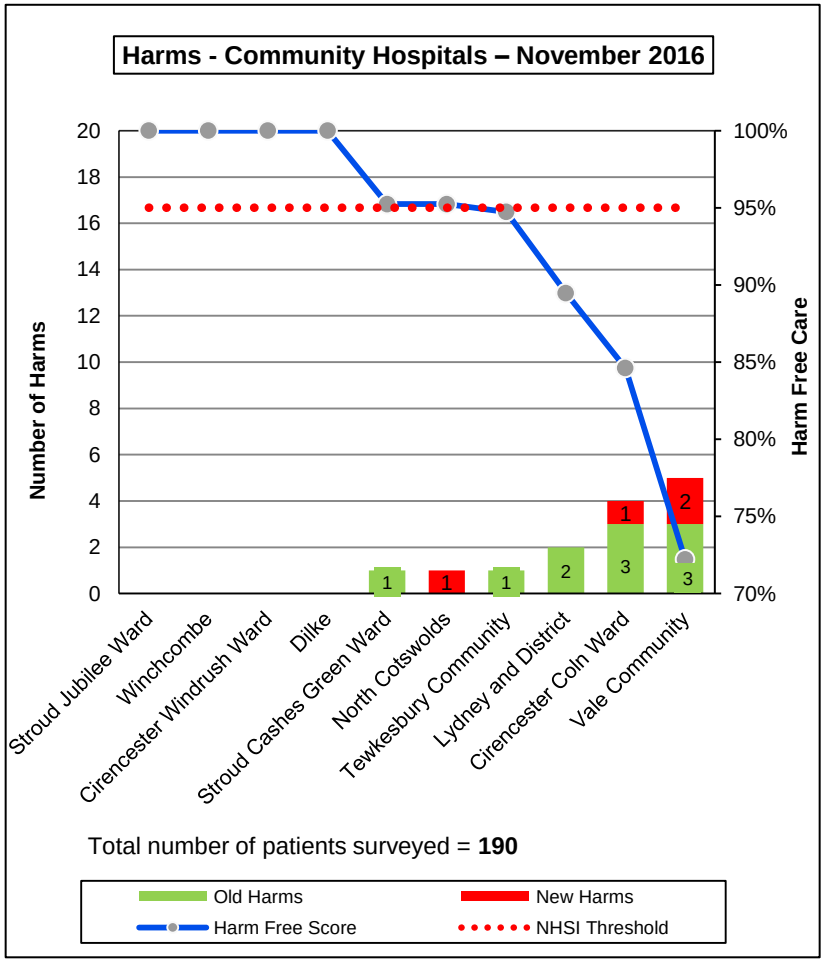
EXCEPTION REPORT | ARE SERVICES SAFE?

What is causing under achievement?	What actions have been taken to improve performance?
Number of post 48 hour Clostridium Difficile Infections: • There have been 6 cases reported to date in 2016/17 compared to a year to date threshold of 12. • There were no cases in November.	• N/A
Safety Thermometer: • Harm Free Care improved to 95.6%, above the 95% threshold (YTD 93.9%). The national average for harm free care was 94.3% (November 2016) • 1,142 patient episodes of care were surveyed for the November Safety Thermometer census. 1,092 patient's care was harm free. • Community Hospital inpatient care scored 92.6% harm free(YTD 89.5%) • Community Nursing scored 96.1% harm free (YTD 94.8%) • 50 harms were reported, of which 18 were new harms • This means that the Trust reported 1.6% new harms compared to national average of 2.1% new harms (November 2016).  	• The PaCE directorate continues to support operational teams to improve data quality. Current efforts to ensure that every reported harm is aligned to its corresponding Datix incident is yielding much better information accuracy and for the first time since March 2016 the Trust can now report that harm free care is now over the 95% threshold. • Some support is still needed in a minority of teams to enhance data quality, but the improvement in score is commendable to the operational teams who have needed to adapt to a new system for safety thermometer relatively quickly. Full alignment of incidents against safety thermometer recorded harms is providing valuable data for the Trust's safety agenda in the respective quality improvement groups. • Senior colleagues provide a monthly report detailing the recorded harms and whether they were avoidable or not. Harms identified as occurring during care by GCS and as avoidable are then investigated further. Learning and avoidance actions are then embedded into practice to avoid harms re-occurring. • The sign-off web page process will be improved to ensure that all harms reported as pressure ulcers and/or falls in both inpatient and community settings are fully cross-referenced with every reported incident (via DATIX). • This will be supported by a comprehensive communications plan and a revised standard operating procedure. **Risks** • Reference – SD50 • Rating – 9

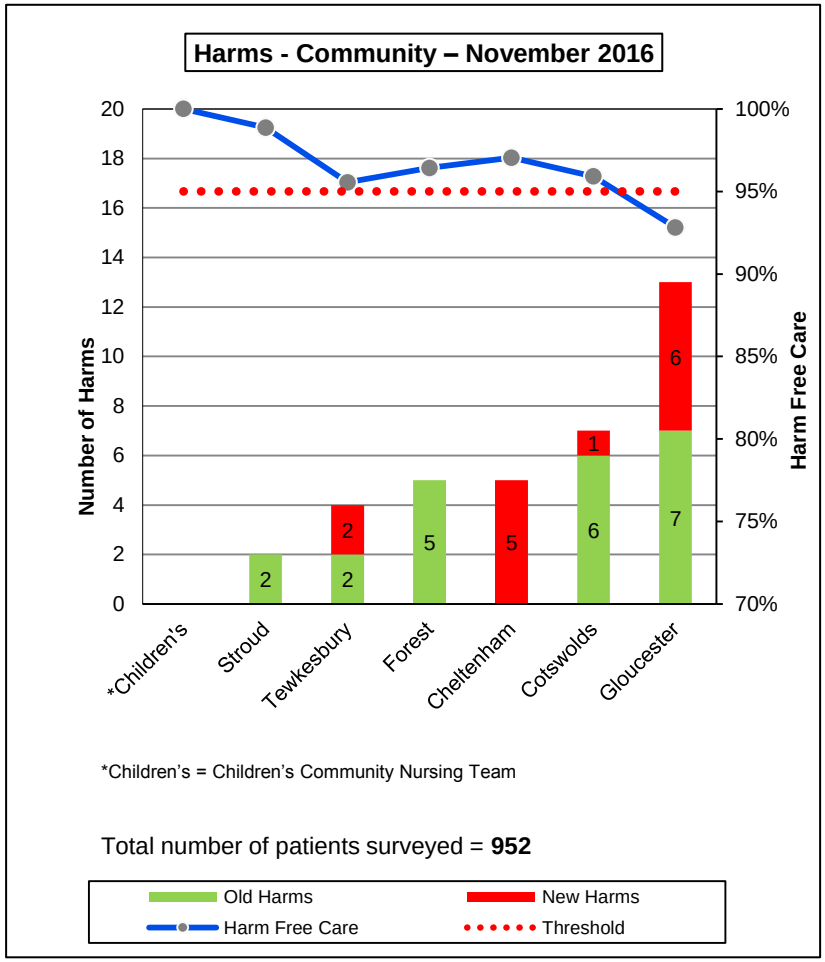
EXCEPTION REPORT | ARE SERVICES SAFE?

Gloucestershire Care Services NHS Trust

Safety Thermometer – Community Hospitals breakdown



Safety Thermometer – Community breakdown



EXCEPTION REPORT | ARE SERVICES SAFE?

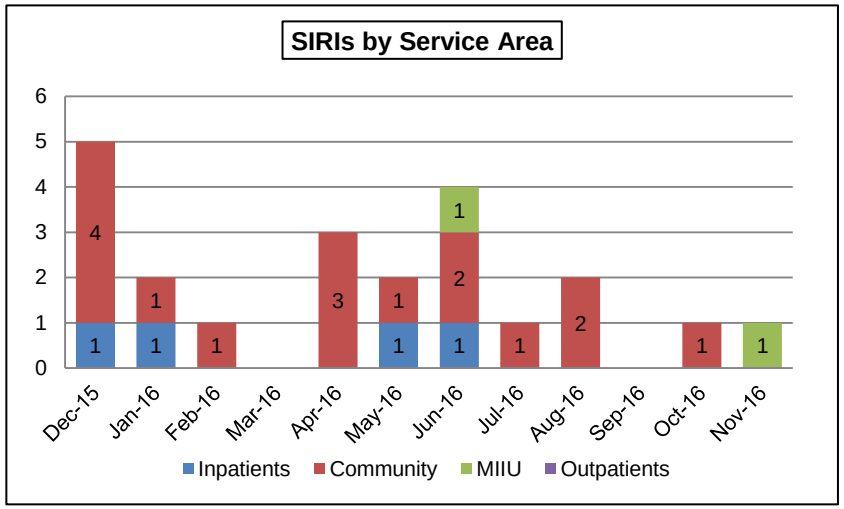
Gloucestershire Care Services NHS Trust

What is causing under achievement?	What actions have been taken to improve performance?

Serious Incidents Requiring Investigation (SIRI)

- There was one SIRI declared in November 2016 relating to a patient with a history of chest pain who attended the Vale Hospital MIIU and was advised to go home whilst a GP appointment was being arranged for him the same day. He was later admitted to the Gloucestershire Royal Hospital via SPCA where it was established that the patient had suffered a cardiac event.

- *The Trust is reporting a rate of SIRIs (1.8 average per month) which is below the average of the Trusts within the Aspirant Community Foundation Trust group (2.6 average per month).*



- The Executive led SIRI panel meeting highlighted the following questions for the Terms of Reference:

1. For the appointed Investigating Officer (IO) to make it an imperative requirement for the Choice Plus GP Service to engage with the SIRI.

2. To determine if SystmOne templates including categorisation and algorithms meet the safety requirements and quality assurance for patients, colleagues and the organisation.

3. Do Gloucestershire Care Services NHS Trust have a Standard Operating procedure (SOP) for the treatment of patients who attend MIIU with chest pain?

4. To ensure that there are clear guidelines to support both medical and nursing colleagues who assess and treat patients in MIIUs.

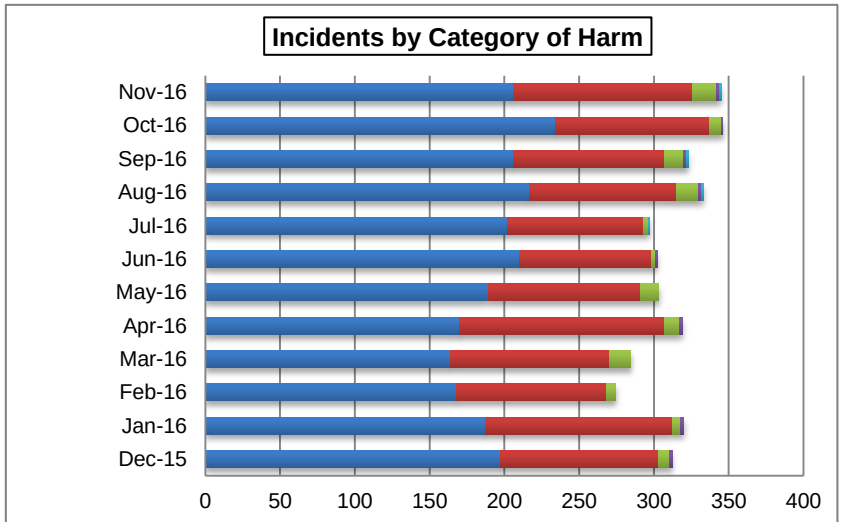
5. Do service users accessing MIIUs understand that this is a Nurse Led Service and how is this disseminated throughout the County?

EXCEPTION REPORT | ARE SERVICES SAFE?

What is causing under achievement?	What actions have been taken to improve performance?

Incident Reporting

- Total incidents reported are shown below. Incidents where no harm resulted has dropped in November compared to October but remains higher than was recorded from December 2015 to May 2016.



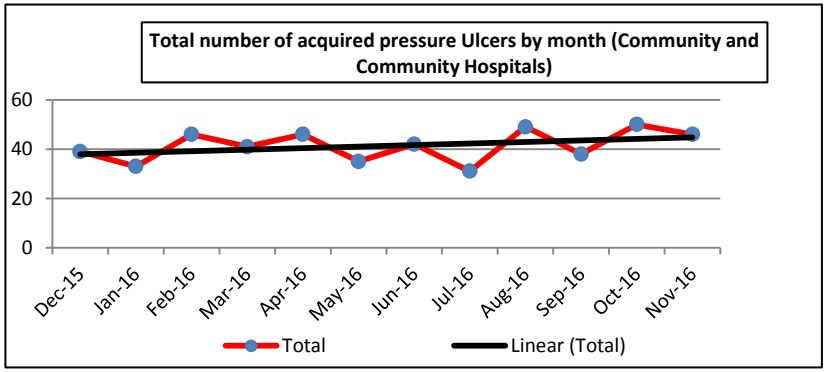
	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
No Harm	197	187	168	164	170	189	210	202	217	206	234	206
Low Harm	106	125	100	106	137	102	88	91	98	101	103	120
Moderate Harm	7	6	6	14	10	12	3	3	15	13	8	16
Severe Harm	2	2	0	0	2	0	1	0	2	2	1	2
Death	0	0	0	0	0	0	0	1	1	1	0	1

- November 2016 continued the trend in increased incident reporting. As identified in previous reports, this has been owing to how incidents are managed and reported by the PaCE Directorate.
- The one incident in November which is currently categorised as “Death” was subsequently declared as a SIRI in December; although it is included in the data for this time period, due to the timing of the incident. The initial concise Root Cause Analysis (RCA) did highlight that there were opportunities for shared learning regarding the care of a deteriorating patient.
- However, with the comprehensive investigation now underway; it is becoming evident that this case is more complex and involves our colleagues from Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) where the patient died. Upon completion of the SIRI and dependent upon its findings; the incident category will be reviewed before it is submitted to the National Learning and Reporting System (NRLS).

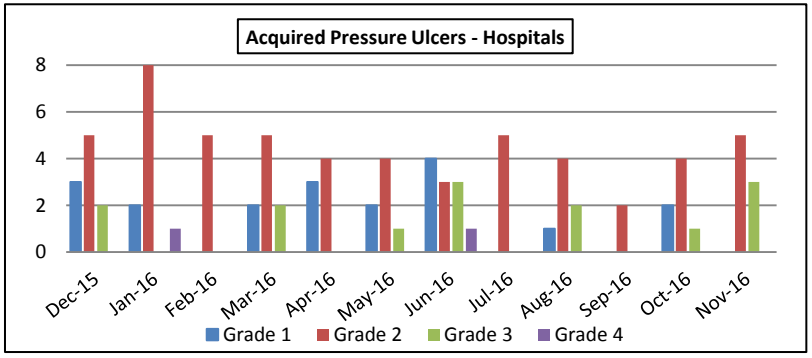
EXCEPTION REPORT | ARE SERVICES SAFE?

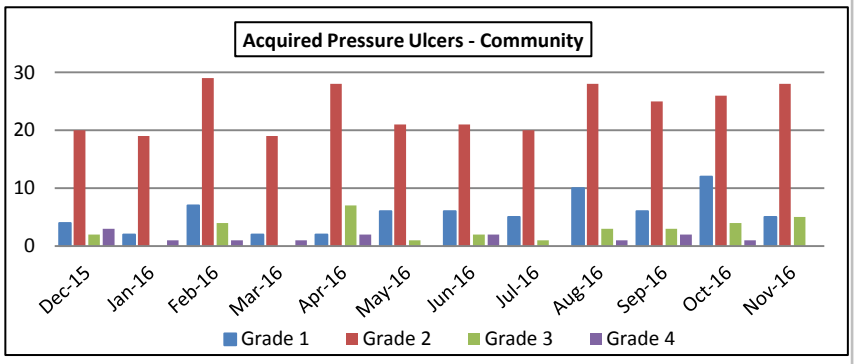
Gloucestershire Care Services NHS Trust

What is causing under achievement?	What actions have been taken to improve performance?
Duty of Candour (DoC) • Duty of Candour applied to 11 incidents from 1 April 2016 to 30 November 2016 but 1 incident from April was stepped down from a SIRI making a total of 10. • Patients and relatives have received a verbal apology and written apology as per DoC guidance	• N/A
Pressure Ulcers • Number of acquired pressure ulcers dropped slightly in November compared to October but overall continues to increase particularly those acquired in the community	• Pressure ulcer reporting continues to highlight issues regarding the coding. This relates to whether the patient has "acquired" the ulcer in the Trusts care or whether this was "inherited" from another organisation. • Recently, there have been cases whereby patients have presented with "inherited" pressure ulcers, but their wounds have deteriorated to either a grade 3 / 4 pressure ulcer whilst receiving our care. On these occasions initial concise Root Cause Analyses have been requested in order to establish whether these incidents meet the SIRI criteria. • There is now a Pressure Ulcer Quality Improvement Group in place with a clear action plan which was presented and discussed at the Trust Quality and Performance Committee December meeting.



- **Acquired Pressure Ulcers**





EXCEPTION REPORT | ARE SERVICES SAFE?

Gloucestershire Care Services NHS Trust

Safe Staffing – November 2016

Hospital	Ward	Day		Night		Bed Occupancy
		Average fill rate RN	Average fill rate HCA	Average fill rate RN	Average fill rate HCA	
Cirencester	Coln Ward	100.0%	96.7%	120.0%	86.7%	99.5%
	Windrush Ward	82.2%	107.6%	101.7%	101.7%	99.8%
	Thames Ward	Ward currently closed				
Dilke	The Ward	82.5%	100.4%	100.0%	115.0%	100.0%
Lydney and District	The Ward	103.3%	104.8%	118.3%	100.0%	99.0%
North Cotswolds	NCH Ward	83.9%	106.7%	100.0%	100.0%	94.7%
Stroud General	Cashes Green Ward	83.9%	99.5%	105.0%	101.7%	95.3%
	Jubilee Ward	100.0%	87.6%	100.0%	98.3%	99.4%
Tewkesbury Community	Abbey View Ward	85.0%	110.5%	101.7%	105.0%	100.0%
Vale Community	Peak View	83.3%	101.4%	100.0%	111.7%	99.7%
TOTAL		88.4%	101.6%	105.2%	101.4%	98.6%

Hospital	Ward	Bank Staff	Agency Staff
Cirencester	Coln Ward	15.2%	10.1%
	Windrush Ward	4.8%	5.0%
	Thames Ward	Ward currently closed	
Dilke	The Ward	7.7%	6.3%
Lydney and District	The Ward	4.0%	13.3%
North Cotswolds	NCH Ward	7.3%	5.1%
Stroud General	Cashes Green Ward	13.8%	10.3%
	Jubilee Ward	17.5%	13.2%
Tewkesbury Community	Abbey View Ward	1.4%	1.0%
Vale Community	Peak View	15.9%	16.7%
TOTAL		5.6%	8.9%

Minimum staffing levels

Hospital	Ward	Beds	Early Shift		Core Shift	Late Shift		Twilight (4hrs)	Night Shift	
			RN	HCA	RN	RN	HCA	HCA	RN	HCA
Cirencester	Coln Ward	28	3	4	1	3	4	0	2	3
	Windrush Ward	21	2	4	1	2	3	1	2	2
Dilke	The Ward	27	3	4	1	3	4	0	2	3
Lydney and District	The Ward	20	2	4	1	2	3	1	2	2
North Cotswolds	NCH Ward	22	2	4	1	2	3	1	2	2
Stroud General	Cashes Green Ward	22	2	4	1	2	3	1	2	2
	Jubilee Ward	16	2	3	0	2	3	0	2	2
Tewkesbury Community	Tewkesbury Ward	20	2	4	1	2	3	1	2	2
Vale Community	Peakview	20	2	4	1	2	3	1	2	2

Exception reporting required if fill rate is <80% or >120%

Coln Ward: Extra RN due to Thames ward staff who had shifts already booked for October and part of November.

***Thames ward is currently closed

The data in this report is based on revised staffing levels implemented from October 2016, latest minimum staffing levels per hospital, ward and shift are shown above.

EXCEPTION REPORT | ARE SERVICES SAFE?

Gloucestershire Care Services NHS Trust

Safeguarding

Total	2015-16 outturn	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	2016/17 YTD
Adult safeguarding concerns raised by GCS	**160**	6	4	4	5	5	8	8	8	7	12	14	12	84
Total county adult safeguarding concerns	**3,279**	217	226	171	134	164	129	138	155	153	149	172	160	1,220
GCS adult section 42 enquiries	**51**	2	2	0	2	2	2	3	6	6	4	6	5	34
Total county section 42 enquiries	**1,007**	51	67	54	54	64	53	63	96	99	72	82	85	614
Number of new Children's Serious Case Reviews	**1**	1	0	0	0	0	0	0	0	1	0	0	0	1
Number of new Safeguarding Adult Reviews	**2**	1	0	0	0	1	0	1	2	1	0	0	0	5
Number of children subject to a Child Protection Plan	**580**	**595** (Oct-Dec 2015)	**580** (Jan – Mar 2016)			**566** (Apr - Jun 2016)			**538** (Jul-Sep 2016)			**496** (Oct - Nov 2016)		

Adult Safeguarding Concerns

Two Safeguarding Adult Review reports have been published. Planning is in place to ensure that the recommendations are implemented & that learning is embedded. To this end the GSAB is launching a Self Neglect poster and communications campaign. There will also be two GSAB Roadshows in January & February 2017. The themes for these events will be Self Neglect and Modern Slavery.

A further two Safeguarding Adult Reviews (SAR) are underway and one case is undergoing a higher level of joint local scrutiny (GCS & Police).

In general the number of adult safeguarding concerns raised is lower than before the implementation of the Care Act. This reflects the national picture. Locally it is thought that the introduction of the Safeguarding Adults Professional Advice Line has been influential in reducing the number of concerns raised.

Children Safeguarding Concerns

There were no new serious case reviews for children in November 2016. The Serious Case Review (SCR) in August 2016 was also declared as a SIRI by GCS. The findings of the GCS SIRI investigation will feed in to the overall findings of the SCR. The number of children subject to a plan has fallen from 538 to 496.

***Breakdown of adult safeguarding enquiries (2016/17)**

Client group		Type of concern	
Other vulnerable	51	Physical injury	25
Physical Disability	23	Neglect	22
Learning Disabilities	13	Financial	15
Dementia	6	Psychological	13
		Sexual	6
		Organisational	4

September 2016 number of Adult Safeguarding concerns has been reduced. Following review, it was discovered some cases were wrongly assigned to GCS by GCC.

The figures for Total County section 42 enquiries have increased due to a change in the parameters identifying the cases. When the safeguarding threshold has been met, it is no longer counted as a concern but rather as an enquiry.

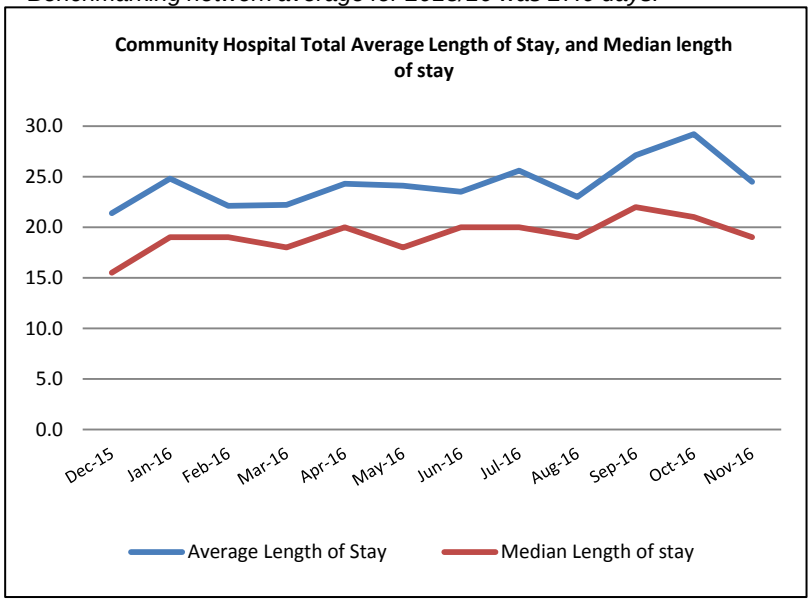
EXCEPTION REPORT | ARE SERVICES EFFECTIVE?

CQC DOMAIN - ARE SERVICES EFFECTIVE?	Risk Register ref.	Risk Register rating	Performance Target	Sep	Oct	Nov
Community Hospitals						
Emergency re-admission within 30 days of discharge following a non-elective admission	-	-	No Target	12.6%	8.4%	6.8%
Inpatients - Average Length of Stay	SD49	12	No Target	27.1	29.2	24.5
Bed Occupancy - Community Hospitals	ST29	12	90%	98.3%	98.3%	98.6%
% of direct admissions to community hospitals	-	-	No Target	23.7%	24.7%	27.0%
Average of 10 discharges per day (weekends) - Inpatients	SD49	12	10	3.5	2.6	4.3
Average of 20 discharges per day (weekdays) - Inpatients	SD49	12	20	8.8	9.3	9.2
SUS Data Quality Index	-	-	TBC	98.8%	98.8%	
IDT Number of avoided admissions	-	-	*2,440	192	205	200
Other						
Rapid Response - Number of referrals	-	-	*2,092	234	255	235
[+]Stop Smoking Service - 3rd Party Providers- Number of smokers successfully quit (Quarterly Data From September 2015 to June 2016)	-	-	*462	168	Data reported quarterly	
[+]Stop Smoking Service - GSSS only - Number of smokers successfully quit (Quarterly Data From September 2015 to June 2016)	-	-	*368	198	Data reported quarterly	
Single Point of Clinical Access (SPCA) Calls Offered (received)	-	-	No Target	3,965	3,938	3,813
SPCA % of calls abandoned	-	-	<5%	7.0%	7.9%	7.5%
Chlamydia Screening of Gloucestershire residents aged 15-24 via the Chlamydia Screening Service (minimum positivity rate)	-	-	2,300 per 100,000 population	2,432	2,736	2,246
Chlamydia Screening - Number of Positive Screens	-	-	*779	116	127	105

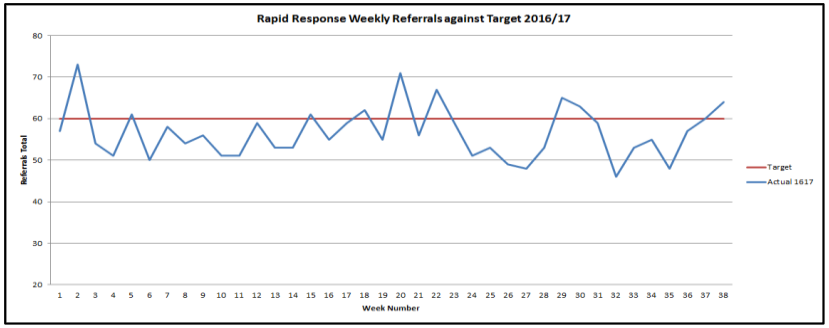
*Cumulative YTD target

[+]Service will no longer be provided by GCS from 1st January 2017

EXCEPTION REPORT | ARE SERVICES EFFECTIVE?

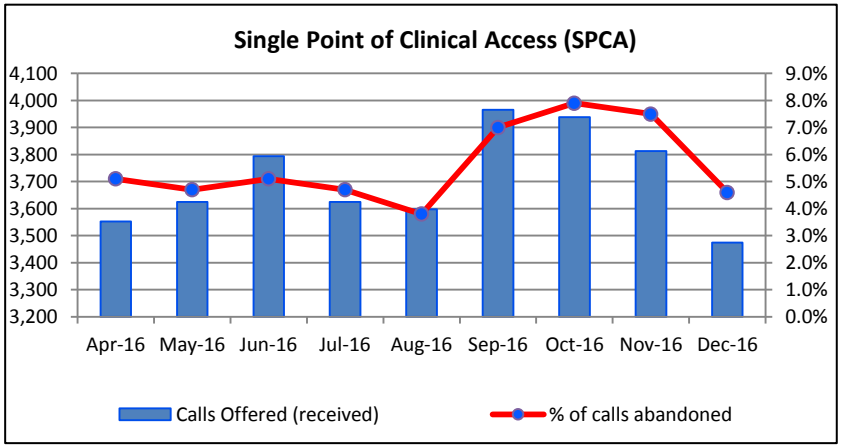
What is causing under achievement?	What actions have been taken to improve performance?
Bed Occupancy • Occupancy rates were 98.6% in November. *The NHS Benchmarking network average for 2015/16 was 91.36%.*	• The Trust continues to monitor quality metrics that are aligned to bed occupancy e.g. falls and infection rates to identify if there is any impact. The high bed occupancy rate remains on the risk register. • Review work has confirmed that patients are not at risk as a result of continued high bed occupancy figures. **Risks** • Reference – ST29 • Rating - 12
Inpatient Average Length of Stay • Average length of stay in Community Hospitals decreased to 24.5 days in November. The average in 2016/17 to date is 25.2 days which is above that in 2015/16 of 20.9 days. • The median (mid-point) in November was 19.0 days. *The NHS Benchmarking network average for 2015/16 was 27.6 days.*  	• A MADE event (multi-agency discharge event) took place on 3rd November where Matrons and colleagues from the integrated community teams reviewed all patients in the community hospital inpatient beds to: • (a) review the progress of each patients' pathway, and • (b) Highlight, challenge and unblock any delays to support a safe and timely discharge. • This event established that there was good MDT working in the community hospitals and identified a number of issues delaying discharge for some patients that were escalated and resolved on the same day. Formalising the daily board rounds so that they follow the 'SORT' methodology in terms of the order patients are reviewed: S – sick patients O – out today or tomorrow – those patients who are ready for discharge to check that all is in place to enable discharge to go ahead R – rest of the patients T – to come in – patients to be admitted today or tomorrow and to plan for the weekend • Weekly conference calls continue to review all patients who are MDT stable (i.e. ready for discharge) and identify any blockages to escalate to the weekly systemwide Director of Nursing call. **Risks** • Reference – SD49 • Rating - 12

EXCEPTION REPORT | ARE SERVICES EFFECTIVE?

What is causing under achievement?	What actions have been taken to improve performance?
Average of 10 discharges per day (weekends) – Inpatients • Average of 4.3 discharges was recorded on weekends in November. **Average of 20 discharges per day (weekdays) – Inpatients** • Average of 9.2 discharges were recorded on weekdays in November.	• A contract variation is expected from the GCCG to amend these targets. The targets will be amended on receipt of the contract variation. This is being chased up by the Head of Community Hospitals with the GCCG. **Risks** • Reference – SD49 • Rating - 12
Rapid Response - Number of referrals accepted • YTD performance remains behind trajectory • Number of referrals accepted in November was 235 against a target of 257 which was a decrease from November (255). • A challenge for the service is the pattern of referrals through the week heavily weighted towards the end of the week (45% on Thurs/Fri/Sat). This presents issues for capacity as it blocks the service during that time. • Staff sickness rate was very high at 18% in conjunction with 3 WTE vacancies which had a temporary effect on capacity. Posts being recruited to at present.  	• Engage GPs to increase referrals, including a GP in the ED who can target GPs not using the RR pathway. • Seconded Band 7 is now back in Rapid Response team which should improve the ability have a Red Lead presence in SPCA to direct referrals to the service. • Continued development of the Admission Prevention Team (APT) to ensure Rapid Response is used more appropriately. • Nursing Home developments are continuing. • Discussions are underway with commissioners to review whether the target is appropriate as the number of referrals received has increased significantly since the targets were set. • It should be noted that GCS cannot directly control the number of referrals made to the service as patients are referred by external services.
IDT Number of avoided admissions • Performance in November was 200 against a target of 300. • YTD performance is 1,469 against a target of 2,440. • Below target for avoided admissions in Gloucester Royal Hospital and Cheltenham General Hospital measured against a target of 5 avoided admissions per day in each hospital.	• The IDT has been reviewed and phase 1 of a restructure is underway whereby the front and back door teams will be split and have single line management, with the latter sitting with GHFT and the former sitting with GCS. • It has also been agreed at IDT Board to review all IDT dashboard measures as they are potentially no longer appropriate. Therefore assurance is not being sought as to performance against this KPI.

EXCEPTION REPORT | ARE SERVICES EFFECTIVE?

What is causing under achievement?	What actions have been taken to improve performance?
SPCA % of calls abandoned Performance was 7.5% in November compared to target of below 5%. • Capacity has been adversely affected by vacancies, absences and new staff starting (who then require additional support from experienced members of staff). In November, there were 15 out of 30 days where the priority 1 & 2 calls had an abandonment rate >5% (ranged between 5.2% – 17.4%). 22 days (73%) throughout November were declared as whole system RED escalation. 14 days throughout November had staffing levels in SPCA at only 5 +2 or less. We would generally expect to be working with a quota of at least 7 + 2 during these winter months. 10 days of the 30 saw at least 1 x full time clinician off sick. 26 days (86%) of the 30 SPCA were inducting new members of the team: of these 27 days – 2 days we accommodated 3 new staff members, 12 days we accommodated 2 and 13 days we accommodated 1 new member of staff.	• SPCA has now recruited 2 substantive members of staff – 1.0 WTE and 0.6 WTE and 3 bank members of staff. Service is still effectively working with vacancies until recruited staff are fully inducted which is likely to be by the end of December 2016. • There has been continued interest for bank nurse posts in SPCA and requests to spend time with clinical staff in order to obtain an overview of the service. Therefore, alongside increased call volume and staffing pressures, time was invested during the month of November in order to maintain long term staff resilience. • Administrator interviews have taken place, and preferred candidate confirmed, however, this person is not due to start until January 2017. • With new recruits yet to start, the Trust is struggling to implement more staff around the mid-morning to mid-afternoon timeframe. In order to provide a safe and effective service, time and quality needs to be given to our new staff members and this investment and time taken to explain and nurture their individual needs may be a causative factor in the periods of extreme high abandonment. • Performance is expected to improve to achieve percentage of calls abandoned target (below 5%) by January 2017.



EXCEPTION REPORT | ARE SERVICES RESPONSIVE?

Gloucestershire Care Services NHS Trust

CQC DOMAIN - ARE SERVICES RESPONSIVE?	Risk Register ref.	Risk Register rating	Performance Target	Sep	Oct	Nov
Minor Injuries and Illnesses Unit (MIIU)						
MIIU Number of breaches of 4 hour target	-	-	No Target	27	22	18
MIIU Time to initial assessment for patients arriving by ambulance (95th percentile)	-	-	<15 m	00:19	00:28	00:14
Referral to Treatment						
Occupational Therapy Services - % treated within 8 Weeks	-	-	95%	94.6%	92.4%	91.8%
Adult Physiotherapy - % treated within 8 Weeks	-	-	95%	88.3%	88.6%	91.9%
MSKCAT Service - % treated within 8 Weeks	SD8	12	95%	89.3%	77.5%	77.7%
Sexual Health - % of terminations carried out within 9 weeks and 6 days of gestation	-	-	80%	81.3%	80.4%	76.8%
Paediatric Physiotherapy - % treated within 8 Weeks	-	-	95%	94.0%	92.3%	87.9%
Other						
Stroke ESD - Proportion of new patients assessed within 2 days of notification	-	-	95%	100.0%	100.0%	92.6%
Social Care ICT - % of Referrals resolved at Referral Centres and closed	-	-	No Target	35.0%	46.8%	47.7%
Reablement - Current Cases Open Longer than 6 weeks	-	-	0	73	61	76
% community reablement completing after 6 weeks	-	-	No Target	16.9%	17.9%	17.0%
Reablement - % progressed within 6 weeks from closing this month	-	-	100%	83.1%	82.1%	83.0%
Reablement - % contact time	-	-	60%	39.4%	39.6%	41.2%
Newborn Bloodspot Screening Coverage - by 17 days of age (responsibility at birth)	-	-	No Target	96.5%	94.0%	90.7%
Newborn Bloodspot Screening Coverage - by 21 days of movement in (Movers In)	-	-	No Target	90.9%	100.0%	89.5%

*Cumulative YTD target

EXCEPTION REPORT | ARE SERVICES RESPONSIVE?

Gloucestershire Care Services NHS Trust

What is causing under achievement?

MIIU Time to initial assessment for patients arriving by ambulance (95th percentile)

- Performance was within target of 15minutes in November.
- 25 ambulance arrivals in November, all had initial assessments within 15 minute target.

Breakdown of ambulance arrivals by hospital MIIU in November

MIIU unit	Ambulance arrivals	Number triaged within 15 mins	95th Percentile (in minutes)
North Cotswold Community Hospital	3	3	00:13
Tewkesbury Community Hospital	4	4	00:13
Cirencester Community Hospital	7	7	00:12
Stroud Community Hospital	3	3	00:06
Dilke Community Hospital	2	2	00:04
Lydney Community Hospital	6	6	00:04
The Vale Community Hospital	0	0	00:00
Total	**25**	**25**	**00:14**

Previous issues with the 15 minute breaches can be summarised as:

- 25% confirmed breaches due to volumes and acuity
- A number of the breaches were within seconds of the 15 minute target and therefore minimal
- A further proportion were due to data quality and not genuine breaches; errors in recording times or delay in entry into the system due to volume of patients in the service.

What actions have been taken to improve performance?

- Previously notified actions are now in place and performance has improved markedly this month, now below target.
- Report was provided to commissioners covering a number of aspects of MIIU attendance.
- This has highlighted data quality issues need investigating.
- Performance team will develop some additional reports for the service to use to address these anomalies.
- Service lead has discussed with unit leads to emphasise records should be updated at time of treatment where possible and if not possible that the time of treatment needs to override the date/time stamp of entry.
- Service lead has reviewed every breach and is confident that appropriate medical care was given to patients in terms of visual triage/emergency care/analgesia.
- National guidance regarding definitions of triage and recording will be checked regarding points in the pathway to be recorded.

EXCEPTION REPORT | ARE SERVICES RESPONSIVE?

What is causing under achievement?	What actions have been taken to improve performance?
Adult Occupational Therapy Services • Performance in November dropped to 91.8% from 92.4% in October. • 25/303 patients were outside of the 8 week threshold. • Capacity is affected by vacancy rates, including at manager level. Some posts are being held vacant awaiting the outcome of the review.	• On going work by Professional Lead for OT to improve pathways, which has included a review of clinical pathways as well as training to ensure standardisation of data recording on Systm1. • The service is also implementing the demand-capacity model to ensure safe clinical caseloads and improve patient flow • Recruitment is occurring to fill vacant posts, with agency being used, to ensure patient flow during the busy winter period. • However work is underway around total service redesign in collaboration with Commissioners which may result in an overall change in workforce compliment. As such Operational leads have been cautious in recruiting and this is being closely monitored.
Adult Physiotherapy • Performance in November was 91.9%, an improvement from 88.6% in October. • 151/1,870 patients were outside of the 8 week threshold.	• The Professional Head of Physiotherapy has a detailed recovery action plan, with improvement noted in November. • The action plan has a number of actions to promote not only recruitment, but also retention and includes: 1. Developed a Band 5 and Band 6 Competency framework. Increased the number of rotation programmes in-County to 4. 2. Recruitment marketing materials and adverts detailing the level of clinical specialist services within GCS. There is a historic and widely held perception that Community organisations do not hold the levels of expertise located within Acute Trusts. 3. Strengthened of in-house Service Training programme. 4. Production of a 60 second clip on Rehab Physiotherapy to attach to adverts. 5. Meeting with key educational partners around the Undergraduate requirements for 2016/17 and have offered over and above to Worcester University to build links with a view to forward planning ahead of the bursary changes. 6. Visited neighbouring Universities to start to build links not only for Undergraduate recruitment but for additional Post Graduate developments. 7. Production of a recruitment flyer and circulated to neighbouring universities. 8. Utilisation of Social Media linking in with Physiotherapy / Health Science departments in neighbouring universities to raise the profile of our services.

EXCEPTION REPORT | ARE SERVICES RESPONSIVE?

What is causing under achievement?	What actions have been taken to improve performance?
Paediatric Physiotherapy • Performance in November declined further from October to 87.9%. • 48/396 patients were outside of the 8 week threshold. **Influencing factors:** • 1 WTE maternity leave. • 0.5 WTE vacancy • 3 members of staff were off sick with respiratory virus for >5 days.	• Impact of staffing pressure with 2 team members overlapping on maternity leave with no cover, and a full time band 5 vacancy which has been filled, and commenced in mid-December. • The service has carried significant sickness, which has resulted in a loss of 235 working hours (not including the vacancy). All staff now encouraged to have flu vaccine. • One team member on maternity leave due back on a part-time hours basis, and the full time Physio will commence with the team mid-December which will increase capacity.
MSKCAT Service • Performance in November was 77.7% and has shown a significant deterioration in performance since August. • 117/525 patients were outside of the 8 week threshold.	• Clinic capacity has been affected by a combination of issues: annual leave, sickness and the requirement for staff to complete mandatory training. • The service continues to hold vacancies in readiness for the Gloucester locality change as part of the wider MSK service redesign. This has reduced capacity and is gradually extending waits as there are less clinic slots than required for the number of referrals being received in comparison to when the service was fully established, when target was being met. • Referrals to the service are continuing to increase. • Follow ups have increased slightly, reflecting the increasing complexity of the caseload this in turn reduces new patient slots. • The service reserve new clinic slots but sometimes use these for follow ups when demand is high, particularly for MRI follow ups. • Personal Development Reviews moved forward to be completed before October impacted capacity. • This measure is likely to stay at this level for the rest of 2016/17. **Risks** • Reference – SD8 • Rating - 12

EXCEPTION REPORT | ARE SERVICES RESPONSIVE?

What is causing under achievement?	What actions have been taken to improve performance?
Stroke ESD - Proportion of new patients assessed within 2 days of notification Performance was outside of target (95%) in November at 92.6% **Influencing factors:** • Service had a patient waiting for social services package of care, though had completed rehab and ESD. Service was committed to a morning call with this patient for 7 days a week, which impacted on the capacity to take new patients from GRH. • Staff annual leave which subsequently reduced capacity.	• This issue has been escalated to Head of Countywide Services to review and identify any actions to improve this. Further work needs to be done to ensure impact of the change in domiciliary care contracts are understood across all services, not just Community hospital and reablement services. • One rehab assistant returned from Maternity leave at the end of November. This will increase future capacity.
Reablement Actual performance is reported for information and monitoring	• As reablement service model is being reviewed metrics will not be subject to RAG rating following agreement with Commissioners.
Newborn Bloodspot Screening Coverage Actual performance is reported for information.	• Target has been removed following contract variation.

EXCEPTION REPORT | ARE SERVICES WELL LED?

CQC DOMAIN - ARE SERVICES WELL LED?	Risk Register ref.	Risk Register rating	Performance Target	Sep	Oct	Nov
Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place of work	HR13	12	61%	49.0%		
Sickness Rate in Reablement workforce	-	-	3%	3.9%	8.1%	6.5%
% of Staff with completed Personal Development Reviews (Appraisal)	HR6	12	95%	76.2%	77.7%	78.2%
Sickness absence average % rolling rate - 12 months	-	-	<4%	4.3%	4.2%	4.3%
Sickness absence % rate (1 month only)	-	-	<4%	4.4%	4.5%	4.9%
Mandatory Training	HR12	12	**85%	78.4%	80.6%	80.3%

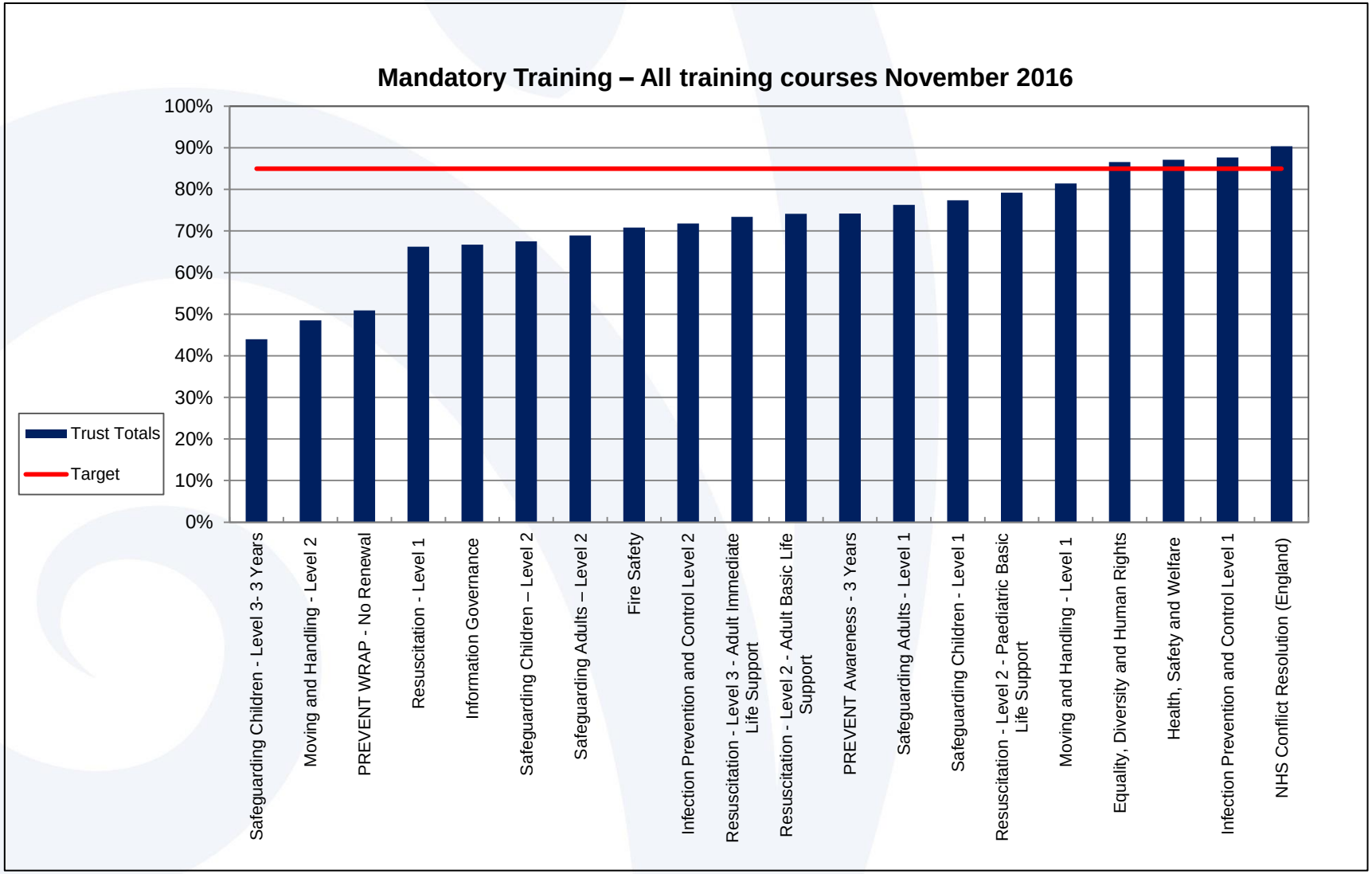
**Mandatory training performance reported on this summary is based on the 5 requirements as reported in 2015/16 to enable direct comparison

What is causing under achievement?	What actions have been taken to improve performance?
Staff Friends and Family Test • Positive results in terms of colleagues recommending the Trust as a place for treatment, however, significant opportunity to improve the Trust's recommendation as a place to work (49% compared to target of 61%)	• Presentations at CORE leadership meeting • Listening into Action programmes in place regarding Communications **Risks** • Reference – HR13 • Rating - 12
Staff with completed Personal Development Reviews (Appraisal) • Rate of reported completed PDR (78.2%) continues to be below the highest point of 79.4% (February 2016), although continued increase in November but remains significantly behind trajectory of 95%	• The onus remains on managers to ensure PDRs are scheduled, completed and reported. Operational managers will be asked to explain to the Workforce and Organisational Development Committee why they cannot achieve the required compliance. **Risks** • Reference – HR6 • Rating - 12

EXCEPTION REPORT | ARE SERVICES WELL LED?

What is causing under achievement?	What actions have been taken to improve performance?
Sickness absence • Rolling 12 months to November 2016 remains above target (4.3%) • November 2016 rate of 4.9% is also above target	• Reviewed in detail at Workforce and Organisational Development Committee (December)
Mandatory Training • Performance still behind target of 85% but showing some improvement since September, however November performance dipped slightly compared to October.	• Reviewed in detail at Workforce and Organisational Development Committee (December). Compliance for all training requirements shown on page 28. **Risks** • Reference – HR12 • Rating - 12

EXCEPTION REPORT | ARE SERVICES WELL LED?



HEALTH AND SAFETY | RIDDORs 2016-17

	2015-16 Total	Aggression or violence towards staff	Manual handling	Occupational ill health confirmed or suspected	Slips, trips and falls	Falling object / struck against	Hot, poisonous or corrosive substances	2016-17 Total
Service user / visitor	**1**	-	-	-	-	-	-	**0**
Colleague	**15**	-	2	-	6	-	-	**8**
Bank / agency	**0**	-		-	-	-	-	**0**
Total	**16**	**0**	**2**	**0**	**6**	**0**	**0**	**8**

Definition

A RIDDOR incident is reportable to the Health and Safety Executive (HSE) as a result of it causing (i) death or serious injury, (ii) inability of the injured party to work for more than 7 days, or (iii) inability of the injured party to work normally.

Trends

There were no RIDDORs reported in either October or November 2016.

RIDDOR details

1. District Nurse from Gloucester ICT carrying out patient dressings at sheltered premises (manual handling).
2. District Nurse from Cheltenham ICT slipped in unlit area outside service user's residence (slips, trips and falls).
3. District Nurse slipped off the kerb when returning to car (slips, trips and falls).
4. District Nurse slipped off step on service user's premises when taking waste to the bin (slips, trips and falls).
5. Colleague slipped on newly mopped floor despite clear signage in place (slips, trips and falls).
6. Care Home Support Nurse fell from step on 2gether premises (slips, trips and falls).
7. HCA felt pain after helping to move a bariatric patient (manual handling).
8. HCA tripped on mattress which was being used as a crash mat to prevent a service user from falling out of bed.

Clinical Alert System (CAS) - No overdue CAS alerts have been identified this year.

HEALTH AND SAFETY | INCIDENTS

2015-16	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Verbal Abuse	7	6	5	3	10	12	6	14	9	6	4	8	**90**
Needlestick	6	2	6	8	8	6	3	6	6	10	5	4	**70**
Buildings issues	7	3	5	7	6	3	6	7	4	6	9	6	**69**
Assault	5	6	1	7	4	8	9	3	4	8	5	1	**61**
Moving Handling	8	4	6	5	8	5	1	5	2	3	8	2	**57**
Slips/Trips/Falls	1	2	2	4	7	4	5	4	3	6	5	3	**46**
Stepping/Striking	-	1	-	1	-	1	3	-	2	-	1	1	**10**
Animals	-	1	2	-	1	-	-	-	-	2	-	-	**6**
TOTAL	**34**	**25**	**27**	**35**	**44**	**39**	**33**	**39**	**30**	**41**	**37**	**25**	**408**

2016-17	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Verbal Abuse	6	9	1	6	15	9	3	3					**52**
Buildings issues	7	7	8	10	5	4	6	4					**51**
Assault	3	13	6	8	4	2	1	4					**41**
Slips/Trips/Falls	5	1	4	1	6	2	2	5					**26**
Moving Handling	3	3	3	1	7	4	1	3					**25**
Needlestick	1	1	2	2	1	6	3	4					**20**
Stepping/Striking	5	-	2	2	-	-	3	1					**13**
Animals	-	1	1	1	-	1	1	0					**5**
TOTAL	**30**	**35**	**27**	**31**	**38**	**28**	**20**	**24**					**233**

- Pro-rata, there are currently fewer health and safety incidents in 2016-17 compared to the previous year (estimated outturn for 2016-17 of 350, compared to 408 for 2015-16).
- There has been a significant downturn in the number of needle-stick injuries as a result of increased focus on safer sharps.
- The increase noted in stepping / striking incidents is believed not to be an actual increase, but is attributable in improved reporting / recording of moving and handling events and increased oversight and scrutiny of reported incident numbers.
- There are no other apparent trends; the reduction is across all health and safety incident types.

FREEDOM OF INFORMATION REQUESTS | NOVEMBER 2016

	Number due in month	Number replied in month	Total % in month	Year-to-date %
Target time within agreed timescale (20 working days)	8	8	100%	100%

Freedom of Information request details

In November, the Trust received 8 Freedom of Information (FOI) requests re:

- the Trust contract for the management of asbestos
- the Trust's environmental and waste management practices
- details of the Trust's Chief Pharmacist and/or Medicines Information Manager (x2)
- details regarding the number of nurses and midwives awaiting DBS checks, plus staff parking
- organisational structure chart for HR
- postage spend and equipment used
- biologics and biosimilar prescribing

Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 24 January 2017

Committee Name:	Trust Board
Agenda Ref:	15/0117
Author:	Rod Brown, Head of Planning, Compliance and Partnerships
Presented By:	Glyn Howells, Director of Finance and Deputy Chief Executive
Accountable Exec:	Glyn Howells, Director of Finance and Deputy Chief Executive

Subject:	Understanding You report
Appendices	• Understanding You report (summary)

Provided for: ☐ Discussion ☐ Decision ☐ Approval ☒ Assurance ☒ Information ☐ Noting ☐ Statutory Purposes

1. Executive Summary:

Every six months the Trust undertakes an analysis of its activity against its commitment to hear and head the opinions of service users, their families and carers and also of our staff.

The approach seeks to combine both qualitative and quantitative information to enable areas of good practice and areas for improvement to be identified.

2. Recommendations:

The Board is asked to:

- **Receive** the summary report
- **Note** the key areas of best practice and learning identified for the period April – September 2016

3. Main Report

The "Understanding You Report – April – September 2016" summary is attached at appendix 1. This is the third report, which is now enabling greater ability to understand performance over time.

Key themes and issues of note include:

- 60% Trust contacts in the reporting period were with service users aged over 65 years of age;
- The Trust's recording / reporting of service users' disability remains poor - the information team is now working with the Head of Planning, Compliance and Partnerships to clarify definitions and thereafter promote the need for data quality improvement;
- There is a need to understand differences between length of stays for people who are inpatients at a community hospital within their home locality, compared to those who are inpatients in areas away from their home;

Understanding You

- The Women's Health Day in July provided a valuable opportunity to reach local people, and led directly to a similar event for the black and minority ethnic community in November;
- In the reporting period, the Trust experienced an increase in the number of concerns, although a decrease in the number of formal complaints. There are particular issues being raised on the NHS Choices website in relation to our Minor Injuries and Illness Units;
- Access to translations services remains a priority, with greatest demand for Polish, Czech and Romanian;
- There is some evidence that service users and staff who are not white British are experiencing a less positive experience of the Trust. This is being reviewed as part of a Listening into Action work;

4. Which Trust strategic objective(s) does this paper link to?	
Achieve the best possible outcomes for our service users through high quality care	☒
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	☒
Actively engage with health and social care partners as well as local communities, in order to deliver seamless services	☒
Value colleagues and support them to develop the skills, confidence and ambition to deliver our vision	☒
Manage public resources wisely to ensure local services remain sustainable and accessible	☒

5. Explanation of acronyms used:
Not applicable

Gloucestershire Care Services NHS
NHS Trust

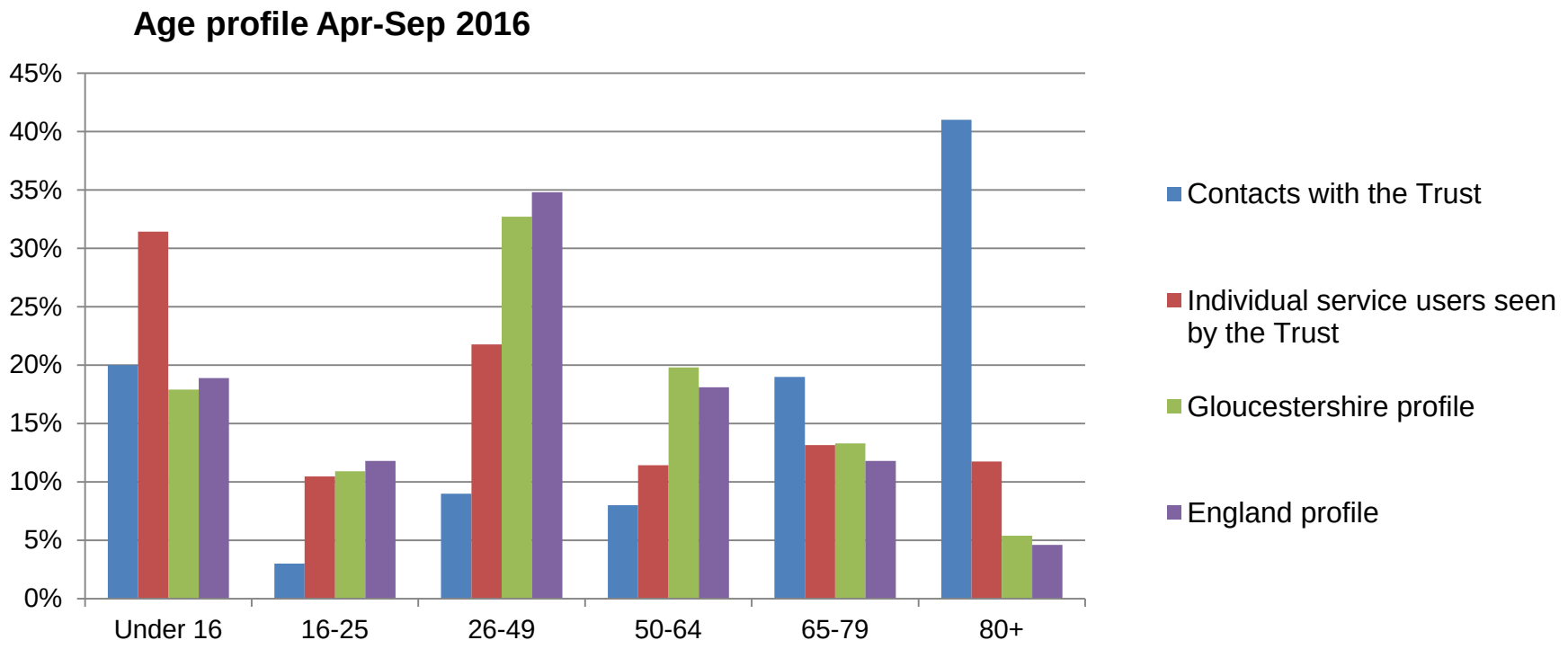
Understanding You
Summary Report

April - September 2016

Understanding You

Service user profile (1)

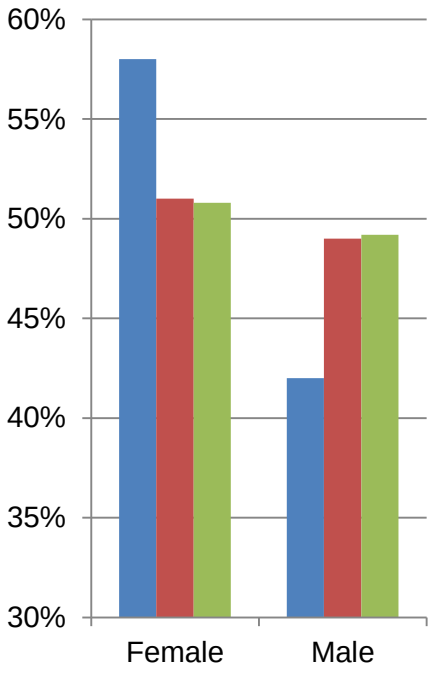
So as to best understand the population that the Trust is currently serving, it is first appropriate to look at the profile of local service users:



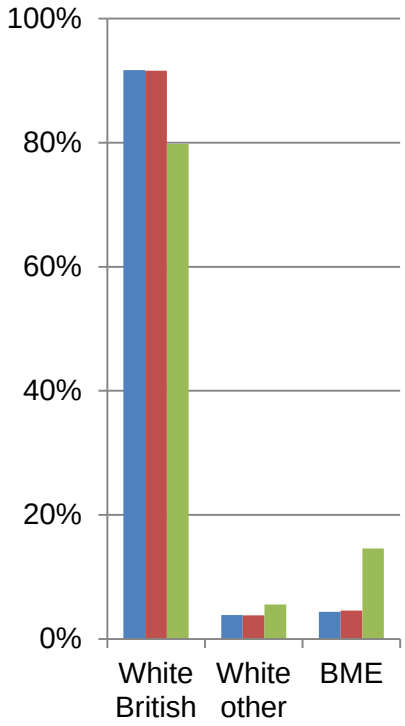
- Compared to 2015-16 data (12 months), the largest percentage increase in contacts with the Trust proportionally (+5%) was in the 80+ age range: indeed, in Apr-Sep 2016, 60% Trust contacts were with people aged 65+
- Compared to 2015-16 data (12 months), the largest percentage decrease in individual service users seen by the Trust proportionally (-4%) was in the 16-25 age range
- As previously and as a proportion of the population, the Trust continues to see more people than the Gloucestershire or England average in the lower (under 16 years) and higher (80+ years) age ranges

Service user profile (2)

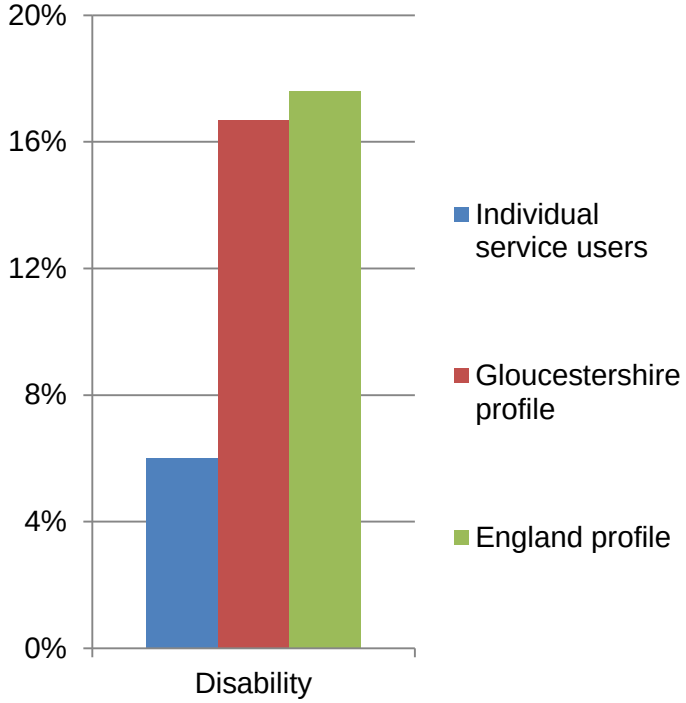
Gender profile Apr-Sep 16



Ethnicity profile Apr-Sep 16



Disability profile Apr-Sep 16



- The gender split of Trust service users remains generally constant compared to 2015-16, with greater proportions of females compared to national or local population profiles
- The ethnicity of service users now almost identically mirrors the Gloucestershire population
- The Trust data for disability continues to appear significantly low, and requires review
- Religion was not reported in 99% service user records so cannot be reported
- Marital status was not reported in 99% service user records so cannot be reported
- Currently, the Trust does not collect data on sexual orientation, gender reassignment or pregnancy/maternity

Listening to the voices of local people

The Trust seeks to ensure that the needs of all Gloucestershire communities and populations are fully understood and reflected in the services that are delivered. To this end, engagement activities during the reporting period, which aimed to capture the voice of local people, and which are not highlighted in greater detail elsewhere within this report, included the following:

- the engagement activities within the **Forest of Dean**, pending a formal consultation in respect of the future of health and social care services in that locality, continued in association with the Gloucestershire Clinical Commissioning Group;
- the Trust was instrumental in establishing a **Countywide Equalities Group**, attended now by all local NHS, social care and commissioning partners, with the aim of improving joint engagement and equalities working across Gloucestershire;
- the Community Partnerships team worked closely with **Inclusion Gloucestershire**, and in particular, agreed a process for evaluating EasyRead materials so as to ensure their suitability for people with learning disabilities;
- the Community Partnerships Team worked with service users and community representatives so as to ensure that the needs of different peoples and populations were explicitly recognised with the Trust's **end-of-life** work, including the staff training film;
- in June, the Community Partnerships team attended the **Gloucestershire Pride** event, providing advice and guidance to members of the local LGBT population; also in June, the Community Partnerships team exhibited at the **Age UK Gloucestershire** Garden Party, and helped raise awareness of Trust services;
- Trust colleagues met regularly with the **Leagues of Friends / Friends of Lydney Hospital** on a range of issues: there were also regular engagements with members of **Gloscats**.

Women's health day

On 17 July, approximately 350 ladies from the local black and minority ethnic community joined the Trust at a Women's Health Day at the Friendship Café, Gloucester. This was a fantastic opportunity for local people to understand more about the health and care services that the Trust provides, and enjoy a really fun day out!

Engagement on Minor Injuries and Illness Units

In the period July-August 2016, the Trust ran a seven week engagement programme across Gloucestershire in order to capture public opinion regarding three options for the future delivery of Minor Injuries and Illness Units (MIIUs). Engagement mechanisms include the following:

- a public survey (available in both hard-form and online) which elicited 1,170 responses;
- 8,000 information brochures which were distributed across the county in community hospitals, GP surgeries and Council buildings;
- a social media campaign, as part of which Facebook messaging reached 80,966 people;
- 18 “drop-in” sessions at key sites across the county and using the Information Bus;
- 3 closed drop-in sessions with key stakeholders, as well as local voluntary and community groups;
- 8 discussion events for Trust colleagues;
- joint promotion with partners including village agents, Healthwatch, Leagues of Friends, Forest Route Community Transport, Two Rivers Housing Association and Inclusion Gloucestershire, for whom materials were produced in EasyRead

Prior to the launch of the public engagement, the Trust worked with key partners to determine their views: these included:

- NHS Improvement
- the Clinical Commissioning Group
- the Health and Care Overview and Scrutiny Committee
- Healthwatch Gloucestershire
- Leagues of Friends
- Executive Locality GP Leads
- local MPs
- all local NHS providers
- Gloucestershire County Council
- local district, parish and town councils
- local voluntary sector organisations
- local housing associations
- Citizen Advice Bureaux
- Gloucestershire hospices
- Gloucestershire education establishments

Board stories

Board stories are used as a means of the Trust's Executives and NEDs hearing directly from local people as to how well services are designed to meet the needs of all local communities.

- In May 2016, **Openhouse** representatives and service users described the ways in which that organisation helps young, homeless and vulnerable people in Stroud, to realise their potential and build a community where they can live, learn, work and find their next step in life. As a result of the presentation, Non-Executive Director, Jan Marriott, and the Chief Operating Officer agreed to meet the Openhouse Chief Executive to identify how the Trust could provide support and assistance.

- In July 2016, the Trust heard from a carer about her and her husband's experiences of **end-of-life care**. This positive story emphasised the need for clinical professionals to be open with service users and families about diagnosis - also, to explore the need to provide increased post-bereavement support, especially for next of kin who may be socially isolated.

- In August 2016, the Trust heard from a carer who had experienced **poor discharge** planning in respect of her husband's return home from a community hospital. Board members were visibly moved by the story, and the Director of Nursing pledged to investigate the matter further, and review those processes and procedures which had proved less than positive.

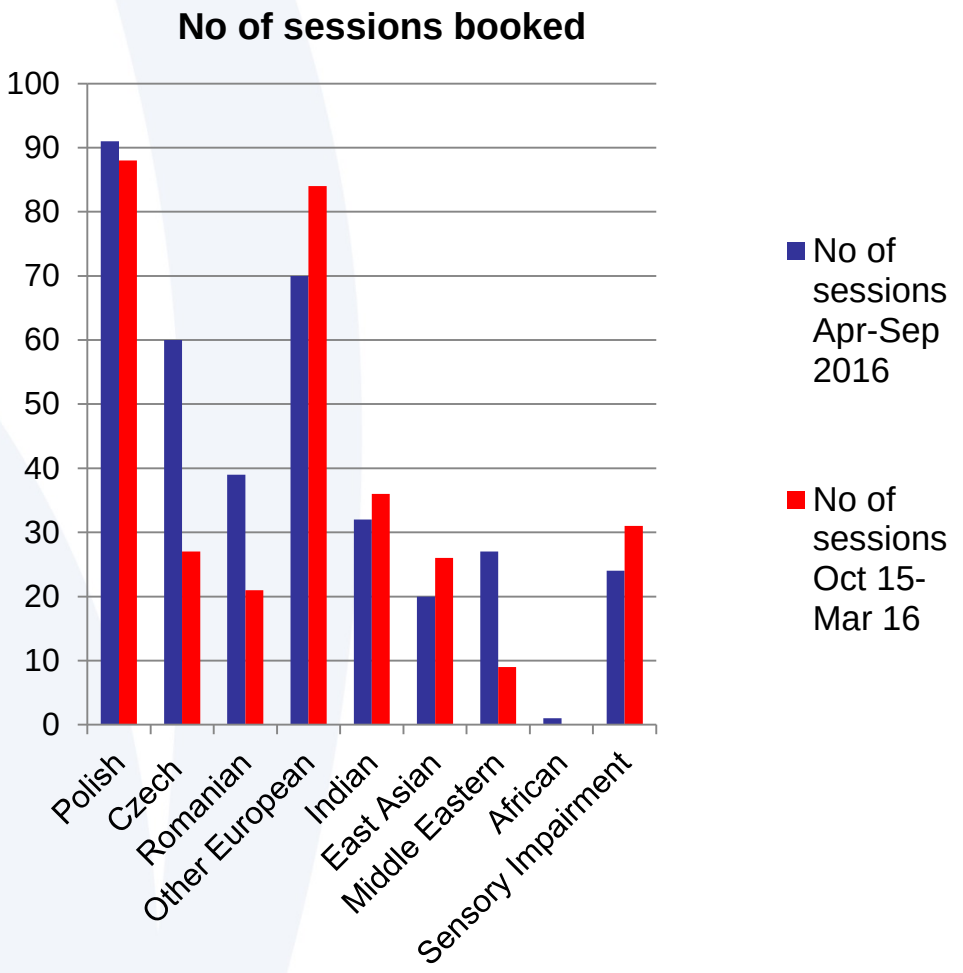
We also heard….

The NED visit to Lydney Hospital, (July 2016) showed that the inpatient unit was well managed, with a caring attitude to colleagues as well as to service users and families. The nurses and therapists demonstrated high standards of care, assessment, treatment and rehabilitation skills, whilst care was seen to be person-centred and compassionate at all times.

Translation and interpretation services

During the reporting period, the Trust booked the following interpretations:

- **Polish**
- **Czech**
- **Romanian** *(NB Polish, Czech and Romanian are separated as they are our three most frequently requested languages)*
- **Other European** - Albanian, Bulgarian, French, Hungarian, Italian, Latvian, Lithuanian, Portuguese, Russian, Slovak, Spanish, Turkish
- **Indian** - Bengali, Gujarati, Sylhetti, Tamil, Urdu
- **East Asian** - Chinese (Cantonese), Chinese (Mandarin), Tagalog, Thai, Vietnamese
- **Middle Eastern** - Arabic, Farsi, Kurdish
- **African** - Lingala
- **Sensory Impairment** - British Sign Language, Sign Supported English



Compared to October 2015-March 2016, there was been a 13% increase in the number of translations

NHS Choices (1)

NHS Choices provides an overview of people's experiences of care. In the period April-September, 65 comments were received (48% increase since the previous reporting period), with 54 being positive (83% compared to 68% for the previous 6 months). It is noted that the majority of positive comments related to the quality of care provided by Trust colleagues.

Below is a word cloud capturing all comments received.

NHS Choices (2)

In April-September, NHS Choices received more comments about Minor Injuries and Illness Units than any other service. 47 comments were received (72% of the total), of which 83% (39) were positive.

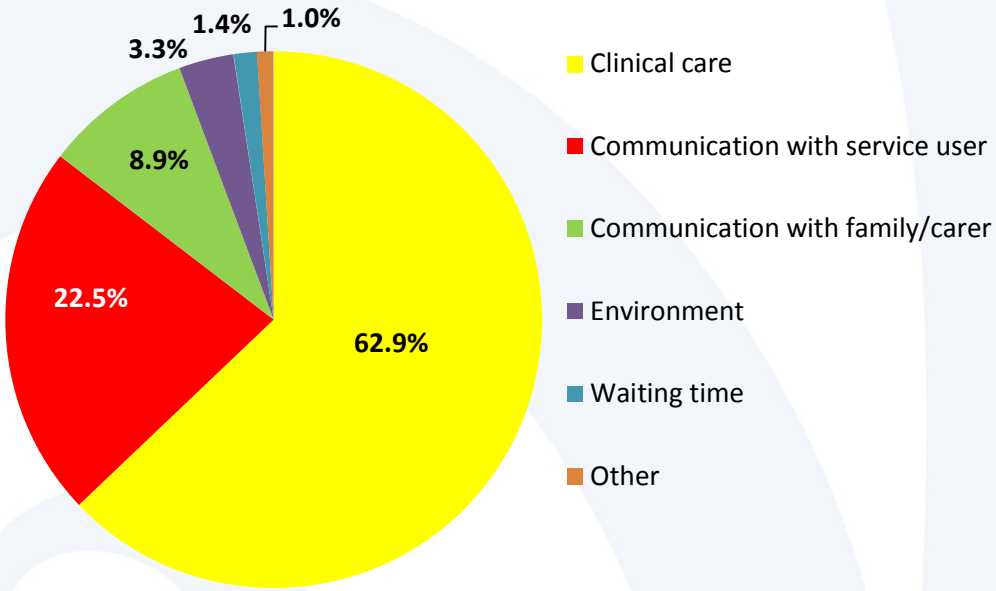
Positive comments focused upon:

- the professional, supportive staff;
- the speed and efficiency of the service.

Negative comments, focused upon the poor attitude of staff who were felt to have demonstrated rude, disrespectful behaviours.

Compliments

In April-September 2016, 213 compliments were received:



"A special mention for excellent service has to go to the Discharge Technician for helping with Dad's return home and following through with phone numbers and her knowledge of what we need to do. Thank you for listening - this was very much appreciated"

Stroud General Hospital

"I would like to convey my thanks to everyone involved in my father's care; Dad said that staff were 'marvellous'. Thank you also to the staff member who accompanied my parents to the hospital entrance, ensuring that my father was dressed in his coat and could walk safely to the car from the wheelchair provided"

Tewkesbury Hospital

"All members of staff were extremely friendly and helped to put me at ease at a difficult time"

Sexual Health Service, Hope House

"A special thank you to the team for the loving and efficient care they gave"

Rapid Response

Concerns

Concerns	Apr-15	May 15	Jun-15	Jul-15	Aug-15	Sep-15	YTD
Community hospitals	9	3	11	4	3	5	35
ICTs	1	3	2	6	3	5	20
Urgent Care	0	2	5	5	5	8	25
Countywide	15	17	16	25	14	8	95
CYP Services	2	1	2	3	2	2	12
Corporate	2	2	0	0	10	6	20
Total	**29**	**28**	**36**	**43**	**37**	**34**	**207**

Clinical Care	10	7	8	15	5	8	53
Attitude	1	0	3	3	2	3	12
Communications	6	9	17	7	6	9	54
Admin	9	9	0	6	15	9	48
Waiting Times	3	2	5	8	9	5	32
Environment	0	1	3	4	0	0	8
Total	**29**	**28**	**36**	**43**	**37**	**34**	**207**

Compared to the same period last year, this represents:

- 36% increase in the number of concerns year-on-year (152 for Apr-Sep 2015)
- with regards settings, the greatest reduction in the number of concerns relates to children's services (15 for Apr-Sep 2015)
- with regard settings, the greatest increase in the number of concerns relates to countywide (72 for Apr-Sep 2015) and corporate services (5 for Apr-Sep 2015)
- with regard type, the greatest reduction in concerns is about communications (60 for Apr-Sep 2015)
- with regard type, the greatest increase in concerns is about admin (15 for Apr-Sep 2015)

We also heard….

The NED visit to the Podiatry Service, Rikenel, Gloucester (May 2016) highlighted a number of concerns relating to the building and facilities: actions have now been taken to address these findings, particularly with regard the uncomfortable waiting areas, where also the Trust's information leaflets were not clearly visible and/or available

Complaints

Complaints	Apr-15	May 15	Jun-15	Jul-15	Aug-15	Sep-15	YTD
Community Hospitals	2	2	2	2	1	0	9
ICTs	2	1	1	3	1	0	8
Urgent Care	3	2	1	0	0	1	7
Countywide	0	1	0	2	1	1	5
CYP Services	1	0	0	1	0	0	2
Corporate	0	0	0	0	0	0	0
Total	**8**	**6**	**4**	**8**	**3**	**2**	**31**

Complaints	Apr-15	May 15	Jun-15	Jul-15	Aug-15	Sep-15	YTD
Clinical Care	5	2	1	4	2	2	16
Discharge	1	2	2	2	0	0	7
Attitude	1	1	1	0	0	0	3
Communications	0	1	0	1	0	0	2
Admin	1	0	0	0	1	0	2
Waiting Times	0	0	0	1	0	0	1
Environment	0	0	0	0	0	0	0
Total	**8**	**6**	**4**	**8**	**3**	**2**	**31**

Compared to the same period last year, this represents:

- 24% decrease in the number of complaints year-on-year (41 for Apr-Sep 2015)
- with regards settings, the greatest reduction in the number of complaints relates to community hospitals (16 for Apr-Sep 2015) and urgent care (14 for Apr-Sep 2015)
- with regard settings, the greatest increase in the number of complaints relates to ICTs (0 for Apr-Sep 2015)
- with regard type, the greatest reduction in complaints is about clinical care (26 for Apr-Sep 2015)
- with regard type, the greatest increase in the number of complaints is about discharge (4 for Apr-Sep 2015)

Community Health Hero

For the first time in 2016, the Trust's Understanding You Awards included a category voted for by the public, allowing them to recognise the contributions made by Trust colleagues. This was won by Mandy Hayward and Margy Allen-Hitchings from the Therapy Led Reablement Team, Stroud, who were nominated by Mike and Chris Castleton. Mike and Chris said:

We are nominating the two girls from the 'Therapy led reablement' team as follows: Mike was struck down with a nasty infection last year which unfortunately left him disabled and unable to walk. He was finally discharged after 7 months in hospital into the care of the team in Stroud. Although all the team worked well with Mike, the two girls showed much dedication and used their expertise and skills which they had developed by being part of the team.

They saw the potential in Mike and over a period of weeks, using different exercises and equipment, they encouraged and most importantly connected with Mike. Their goals were achieved when they got him from a hoist to a walking frame. This has made an incredible difference to both of our lives and we feel without the commitment from both Mandy and Margy, our lives would be very different. They have given Mike a better quality of life than we ever thought possible. We are both very grateful and feel they need recognition for the work they do.

Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 24 January 2017

Committee Name:	Trust Board
Agenda Ref:	16/0117
Author:	Glyn Howells
Presented By:	Graham Russell
Accountable Exec:	Glyn Howells

Subject:	**Finance Committee Update**
Appendices	1. Approved Minutes from 12th October 2016 Finance Committee

Provided for: ☐ Discussion ☐ Decision ☐ Approval ☒ Assurance ☒ Information ☒ Noting ☐ Statutory Purposes

1. Executive Summary:

This report provides an update on the meeting of the Finance Committee which took place on 12th December 2016. The minutes from the meeting of 12th October, are attached for information.

Decisions Made:
In line with delegated authority, the Committee:

(1) Approved the Annual Operating Plan and its submission to NHSI – completed in line with required submission deadlines.

(2) Approved the Renewal of the Patient Record System – SystmOne.

(3) Approved the Operational Development Forum Terms of Reference – to support business case development and review.

The Committee maintained its ongoing review of the Financial Position, reviewing month 7 data. Risks associated with GHNHSFT recharges; QIPP, CQUIN and CIP savings were noted.

Estates were the subject of a budget holder review and an update was requested for April 2017.

Issues Highlighted for the Board:
Estates utilisation, to be considered at a Board Development Session.

2. Recommendations:

The Board is asked to:

(i) **Note** the update from the 12th December Finance Committee Meeting;
(ii) **Receive** the approved minutes from 12th October Finance Committee Meeting. Attached as appendix 1

3. Main Report

1. Items for Decisions

Annual Operating Plan – delegated authority for approval by the Board
This was discussed in detail, and was approved subject to the related contract with Gloucestershire Clinical Commissioning Group being signed. (This position was achieved and the submission made to meet the required NHSI submission deadlines).

Renewal of the Patient Record System – SystmOne - delegated authority for approval
The case for renewal was considered and approved on the basis that it would provide GCS with system continuity and a stable clinical environment for another 5 years plus an optional 2 year extension. The decision reflected consideration of best value to be secured through a framework agreement, noting £42k cost pressure.

Operational Development Forum Terms of Reference
The terms of reference for the forum were agreed to support business case development and review.

2. Items for Discussion

Budget Holder Review - Estates
The Committee was reassured that the level of current overspend is being reviewed to remove account processing issues and that the correct position would be confirmed in the next Month's Accounts. It was agreed the Estates budget would be further reviewed in April 2017.

It was agreed that the Estates Strategy for 2018 onwards would be s a priority for the new Head of Estates once appointed (interviews scheduled January).

QIPP/CIP and CQUINS Update
The Committee noted that Quarter 1 Milestones had been fully achieved for QIPP and CQUIN. Quarter 2 milestone achievements were to be confirmed. Potential penalties of £75.9k for CQUIN were currently forecast.

CIP achievement was forecast as £3,220k (80%) against the plan of £4,000k.

Members noted the plans in development for 2017/18 and were assured that work was on going to agree measurable milestones, with defined evidence requirements, with commissioners. Areas which have been the focus of CIP delivery, and those which have not yet made a contribution were considered and it was noted that this analysis would inform the future CIP programme.

Corporate Systems Update
The Committee considered an update on the ongoing processes to rationalise Corporate Systems and supported the plans that were ongoing. It ratified the decision to move services away from SBS and implement the Capita system under a framework agreement – this would include the transfer of payroll and expenses services to the GHFT hosted shared services.

Finance Report – Month 7
The Committee noted that the plans were broadly on track, noting risks associated with CQUIN,CIP and QIPP and GHNHSFT recharges which were being actively managed. The risk of capital underspend was discussed and it was confirmed the Hatherley Road business case was being progressed.

3. Issues being highlighted for the Board

The Committee recommends that estates utilisation should be subject to a discussion at a future Board Development Session.

4. Which Trust strategic objective(s) does this paper link to?	
Achieve the best possible outcomes for our service users through high quality care	☒
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	☐
Actively engage with health and social care partners as well as local communities, in order to deliver seamless services	☐
Value colleagues and support them to develop the skills, confidence and ambition to deliver our vision	☐
Manage public resources wisely to ensure local services remain sustainable and accessible	☒

5. Explanation of acronyms used:

NHSI – NHS Improvement
CIP – Cost Improvement Plan
QIPP – Quality Innovation Productivity and Prevention
CQUIN – Commissioning for Quality and Innovation
GHNHSFT – Gloucestershire Hospitals NHS Foundation Trust.

Gloucestershire Care Services NHS Trust
Minutes of the Finance Committee Meeting
held on the **12 October 2016**
in the Boardroom, Edward Jenner Court, between 09:30– 12:30 hrs

Committee Members present:

Rob Graves	- Non-Executive Director (Chair)
Ingrid Barker	- Chair of Gloucestershire Care Services
Richard Cryer	- Non-Executive Director
Susan Field	- Director of Nursing
Sue Mead	- Non-Executive Director
Candace Plouffe	- Chief Operating Officer
Graham Russell	- Non-Executive Director

In attendance:

Stuart Bird	- Deputy Director of Finance
Johanna Bogle	- Head of Operational Finance
Sally Clark	- Senior PA
Amina Ismail	- Operations Finance Manager
Janet Mills	- Head of Children and Young People Service (item 11 only)
Louise Moss	- Deputy Trust Secretary
Gillian Steels	- Trust Secretary
Steven Wainwright	- Commercial Business Manager

Item & Actions	Minute
16/FC180	**Agenda Welcome and Apologies** The Chair welcomed everyone to the Finance Committee meeting. Apologies from Glyn Howells, Director of Finance, were noted.
16/FC181	**Confirmation that the meeting is quorate** The meeting was **confirmed** as quorate by the Deputy Trust Secretary.
16/FC182	**Declarations of Interests** Members were asked to declare any updates from their original declaration of interests and to declare interests relating to the agenda. No updates or interests were declared.
16/FC183	**Minutes of the Finance Committee held on the 22nd August 2016** The minutes of the meeting held on the 22nd August 2016 were **approved** as an accurate record and signed by the Chair.

16/FC184	**Matters Arising (Action Log)** All matters arising were noted as being: - on track for delivery within timeframe - on agenda for discussion at this meeting
16/FC185	**Finance Report – Month 5** The Deputy Director of Finance presented the report and highlighted the following key areas: - The Trust has a planned surplus for 16/17 of £1.793M - Conditions of the Sustainability and Transformation funding include a cap on agency spend of £2.379M which will be monitored throughout the year. Year to date (YTD) spend at the end of month 5 is £864k which is £231k less than plan. - YTD financial performance to August 16 (month 5) was on plan with a net surplus before Sustainability and Transformation (S&T) funding of £133k. Full year forecast is currently in line with plan at £713k (pre S&T funding). - Planned Cost Improvement Programme (CIP) for 16/17 is £4m to be delivered through 3 executive led workstreams using LIA principles. In year CIP delivery is progressing well but full delivery is a key enabler of the planned surplus. Risks highlighted include: - Continuing to manage agency spend within the cap of £2,379k to ensure the S&T funding will be available - Getting service level agreements in place with Gloucestershire Hospital Foundation Trust (GHFT) – until agreements are in place there remains a difference in opinion on the value of services of circa. £1m – it was confirmed encouraging meetings had taken place with the new Finance Team at GHNHSFT - Getting the ICT management structure revised following Gloucestershire County Council (GCC) removal of funding for joint positions (in agreement with the GCCG which may provide some additional funding). - Delivering CIP including managing non-recurrent savings where in year savings are later than planned). - Delivering Quality Improvement Programme Plan (QIPP) and Clinical and Quality Innovation Programme (CQUIN) milestones in line with plan and current forecast. Latest figures show under delivery in Q1 of approx. £200k across CIP and CQUIN milestones. - Earning the £900k of risk share QIPP that depends on system level admission avoidance schemes. - Managing the cost pressure arising from the outcome of the MIIU engagement. The Deputy Director informed the Committee that although the QIPP regarding a reduction in emergency admissions was not currently being met by GHNHSFT, the GCCG had indicated that they would still award GCS allocated funds. The Committee considered the timeframe for the staffing model implementation, and the cost pressures around the MIIU staffing changes, and recognised these would impact on the CIP target. Following detailed discussions the Committee: - **noted** the report and actions being taken to manage the risks - **noted** the financial position of the Trust

16/FC186	CIPs Report The Chief Operating Officer presented the report and drew the committee's attention to the following areas: - the year to date (YTD) financial position of the Trust's CIP 2016/17 as at 30 September - continued LiA engagement with all staff in the cost improvement programme (CIPP). The Chief Operating Officer confirmed that at month 6 £2.085m recurrent savings have been delivered against the plan of £4.0m. Achieving the remaining £1.915M will be challenging. It was recognised that there were particular issues relating to Children and Young Peoples Services, because of delays in confirmation of funding levels from the County Council. Further discussions with services will take place regarding the need for additional efficiencies. It was agreed that Quality and Performance Committee would review a Demand and Capacity Model Report once the new ICT Framework had been received to enable review of the wider impact on the system. Members noted that the CIP target for 2017/18 was envisaged to be set at around £5- 6m. Members debated whether such a high target was realistic given the Trust's position, based on the Reference costs which demonstrated efficiencies and the year on year CIP savings which had been achieved. The Chair asked for an analysis of historical CIP savings, which may help to highlight future areas where savings could be made. It was agreed this should also reflect the demographic growth which had been absorbed without additional funding. The need to be able to evidence capacity and demand to identify saving potential or opportunities for restyle of services was highlighted. It was noted that the CIP steering group would receive the trajectory for 17/18 at its next meeting. The Chief Operating Officer advised she would provide an update to the CORE leadership Group on CIP achievements to date and plans for 17/18. Following discussions the Committee noted the following: - delivery of the plan as at 30 September - the LiA process to ensure improved engagement with all staff in the cost improvement programme. -
Q&P Chief Operating Officer Chief Operating Officer	
16/FC187	**STP update** The first Sustainability and Transformation Plan (STP) for Gloucestershire was submitted in June 2016. It was reviewed by NHSI and NHSE in July and the feedback letter shared at confidential (part 2) Board in September. The Deputy Director of Finance advised that a recent requirement had been to provide information on corporate costs with an expectation that this should be below 7% or plans put in place for shared services. The consolidated position for Gloucestershire is under 4% with GCS at 5.2%. Concern was expressed that further reductions would impact on front line services. It was confirmed there was informal sharing of information between the Gloucestershire providers. Members noted that there would be a need to look at further reductions and a

	move away from SBS may realise potential savings along with looking at support services. Finance colleagues currently spend 40 per cent of their time focusing on STP work. The Committee **noted** the update and **recognised** that there would be a need for further STP savings.
16/FC188	**CQUIN Report 2016/17** The Director of Nursing presented the report highlighting the following: - progress made against the Trust's Quality Programme (CQUIN). - financial risks have also been outlined against Quarter 1 achievements, and has identified a financial risk (£151.9k) associated with the Positive Risk Taking CQUIN. - it is anticipated that this risk may remain against Quarter 2 milestones. Negotiations have commenced with the GCCG about what appropriate local milestones will be applied to the GCS specific CQUINs and there is an intention that these will be agreed and signed off no later than December 2016. The need for clarity on the evidence required for milestone sign off was highlighted. The Chief Operating Officer advised that she and the Director of Finance were to meet with GCCG to discuss the alignment of the STP and CIP and CQUIN work to get clarity on focus. The Chair queried whether the GHNHSFT financial position had impacted on funding and any implications for GCS. The Deputy Finance Director advised that GCCG had confirmed that GCS funding was not impacted. The Committee **noted**: - delivery of the estimated Quarter 1 CQUIN achievement - the forecast CQUIN Quarter 2 achievement
16/FC189	**QIPP Report 2016/17** The QIPP schedule for this financial year covers the following topics: • ICT: Admission Avoidance • Continuation of Phase 1 • ICT: testing & roll out of Phase 2 • ICT: Reablement • Integrated Discharge Team • Signposting for Single Point of Clinical Access • MSK New Service Model • Complex Leg Wound Service • Community IV Therapy provision • Occupational Therapy review • Rehabilitation The QIPP schedule is worth £3.9m with £900k attributed to acute admission avoidance. Schedules detailing the milestones within these schemes are available and the milestones will be monitored and recorded via the GCS Quality Programme Group which meets on a monthly basis.

	Members noted that GCS is likely to lose income on the ICT scheme, approximately £80k due to lack of clarity by GCCG on evidence required in order to meet this particular QIPP. Richard Cryer queried whether the GCCG reflect the work required for STP in considering process demands and was advised that an understanding of this issue was recognised at some levels of the GCCG but not at all. The Committee **noted** the report and concerns highlighted.
16/FC190	**Budget holder review – Children and Young Peoples Services (CYPS)** The Head of CYPS delivered a presentation defining the service, budgets and funding. The services covered in this area are: - Health visiting - Children's Physiotherapy - School Nursing - Speech and Language Therapy - Home Safety Checks Scheme - Children in Care Health Service - Children's Community Nursing Team - Children's Respite Team - Newborn Hearing Screening - Chilren's Occupational Therapy - Child Health Information Department Following the 2015 CQC inspection, CYPS achieved the rating of 'good' across all domains. There continues work to reflect the core values which has led to increased access to the services, greater integration and improvement to families' experiences of care. The service faces challenges in meeting their CIP target and in the future reflecting the significant changes resulting from the comprehensive spending review which there reduce Public Health Nursing (PHN) funds available to the local authority to support public health services. CYPS is working collaboratively with Gloucestershire County Council (GCC) on redesigned service options, reflecting an understanding that there is a need to continue to deliver the core elements of the Healthy Child Programme whilst making a significant level of savings over the next three years. The proposed new service will commence on 1st April 2019 with a phased approach. Members noted that the Child Health Information Service tender has recently been awarded to South Central and West Commissioning Support Unit (SCW CSU). This will mean that colleagues will be TUPE'd across to this new provider. Whilst the Complex Care Team has received investment from the GCCG to meet demand for the service, Richard Cryer asked about the impact if complex care continues to increase. Janet Mills confirmed that GCS has received additional Continuing Healthcare funding from the Commissioners for further recruitment to cover the increasing levels of respite provided to children with complex medical team. This has resulted in increasing both substantive as well as bank workforce. However with the rising number of children living in the community with complex needs there is a risk that increased agency usage will be required to meet the care

	packages. The Chief Operating Officer highlighted that there will need to be consideration by GCS if we continue to provide this service on behalf of the GCCG, or whether we look to implement a model in which the GCCG hold responsibility for the spend on this budget.
Chief Operating Officer	Sue Mead commented it would be helpful for the Trust Board to receive a report on CYPS updating on current issues. It was **agreed** that the Trust Board would receive a report at its January 2017 meeting, when it will be known how the GCC Cabinet intends to make further savings and what impact this will have on CYPS. Issues around the Block Tariff were being explored.
Trust Secretary	Graham Russell asked how CYPS address mental health needs for Children. The Head of CYPS responded that it is recognised the challenges in accessing services in a timely way for children and young people with mental health issues. As an organisation we work in conjunction with 2gether to ensure early identification of emotional health and wellbeing needs and to provide the necessary parental support. Along with the midwives and health visitors working together, school nurses provide drop-ins for children and young people who have "tier 1" level needs, and GCS is notified when children attend A&E and MIIUs to follow up any concerns. Colleagues also access the advice and guidance line provided by 2gether and work together in ensuring training is available for the CYPS in this area. CYPS risks were noted as: - PHN redesign - Newborn hearing screening - Impact of loss of CHIS tender - Children with Cerebral Palsy (CPIP) database funding - Underfunding of therapies in special schools, due to an increase in complex conditions. The Chair thanked the Head of CYPS along with colleagues of the Finance team for the comprehensive review presented and commented that the Committee had found it incredibly useful in raising awareness of current and future challenges for CYPS. The Head of CYPS confirmed she and her team felt supported and had regular meetings with Board members.
16/FC191	**Capital Schemes – Approvals Progress and Minutes** The Deputy Director of Finance presented the report and highlighted that there was a current underspend of £1.6m due to delays regarding Hatherley Road rebuild and renewal of the IT infrastructure and that this underspend presents a significant level of risk for the Trust as the ability to roll capital funding forward was uncertain. Members expressed concern at this uncertainty which could impact on these development plans and asked for an update at the next meeting. The Committee **noted** the current position of the Trust with respect to capital approvals and spends.

16/FC192 Trust Secretary	**Draft Annual Plan** The Deputy Director of Finance presented the report highlighting the changes to the planning and contracting round in the NHS which previously had started in late December running (and runs through) to the end of the financial year. For 17/18 NHS Improvement and NHS England, have pulled this forward by three months and increased the period covered to two years. The summary of provider and commissioner plans for an STP footprint area should equal the STP plan submission that is being made in mid-October. The initial plan submission date is now 24th November. Members noted that for 16/17 the Trust forecasts a £2.5m surplus and that CIP savings are expected to be around £3m. The challenges for 2017, include : - rising costs for drugs and maintenance - increase in fuel prices - unsustainable CIP saving targets of £6m - based on the Control Target advised the previous week by NHSI - the Trust will also need to recruit 60 apprenticeships in order to equate the Apprenticeship levy. Members **agreed** that the Control Target should be challenged at Board level, recognising its implementation would require a major redesign of the Trust's services (in order to deliver) and that GCCG would need to consider what services the Trust could cease to deliver. The Committee Chair asked members if there was a need for the Committee to hold an extraordinary meeting after the NHSI meets on 24th October. It was felt that forthcoming Trust Board away days should consider this matter once the outcome of the NHSI meeting was known. The Committee **noted** the planning guidance and took assurance on the Trust's actions to respond to the plan deadlines and provided direction on proposed governance around approval of the initial plan submission.
16/FC193	**Corporate Risk Register Finance** The Director of Finance presented the finance risk register. The high risk items and the mitigating actions were discussed by the Committee. The Committee **noted** the risks and took assurance from the mitigating actions.
16/FC194	**Agency Usage** The Chief Operating Officer presented the report and highlighted the following areas: - At month 5, the Trust continues to show an overall Agency Usage underspend of £232k against plan. Actual spend in July was below plan but over plan for August. - The overspend was primarily driven by nurse agency usage in the community hospitals and is the focus of a number of actions to reduce levels of vacancies and manage short term sickness coverage by creation of a relief team. - Good progress had been made with the implementation of E-rostering which would enable planning allocations to Bank staff thus reducing Agency spend.

	Members were pleased that Agency spend continued to be tightly monitored. The Committee **noted**: - delivery of the Agency usage plan as at September 2016 - the associated risks in delivery the Agency target set for 2016/17
16/FC195 M Parsons Chief Operating Officer Committee Chair	**Estates Compliance – Maintenance Costs** The Committee **received** the report and **noted** the financial stability of the service. Members requested a further report at its December meeting which incorporates a five year plan and includes future maintenance works; outlines the Trust's Estates Portfolio and property costs. It was agreed that confirmation on the level of detail required would be provided by the Chief Operating Officer and the Chair. The following risks were **noted**: - NHS Property Services (NHSPS) phasing-in of rent increases - Forest of Dean engagement and potential re-provision of property The Committee **noted**: - The key elements of compliance and the audit results achieved during the last 12 months - NHSPS movement towards market rent and the financial implications of this.
16/FC196	**Forward Agenda Planner** The Forward Planner was discussed and approved with the following changes as listed below: - Estates Review to be received at the December meeting of the Finance Committee - Draft Annual Plan - Countywide Budget Holder Review to be received at the February meeting Subject to the above changes, the Forward Agenda Planner was **approved**.
16/FC197	**Minutes from Steering Groups** - **CIP Steering Group** - **Quality Steering Group (CQUIN and QIPP)** The Minutes from the above Steering Groups were **received** and **noted.**
16/FC198	**Any Other Business or Business for any other Committee** No other business was reported for discussion. **Date and time of next meeting:** It was **agreed** that the next meeting of the Finance Committee be held on the: 12th December 2016, 1230-1600 hrs. Boardroom, Edward Jenner Court, Brockworth, GL3 4AW

Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 24 January 2017

Committee Name:	Trust Board
Agenda Ref:	17/0117
Author:	Stuart Bird, Deputy Director of Finance
Presented By:	Glyn Howells, Director of Finance and Deputy Chief Executive
Accountable Exec:	Glyn Howells, Director of Finance and Deputy Chief Executive

Subject:	Finance Report for Month 8 2016/17
Appendices	- Finance Report

Provided for: ☐ Discussion ☐ Decision ☐ Approval ☒ Assurance ☒ Information ☒ Noting ☐ Statutory Purposes

1. Executive Summary:

The report confirms:

- The Trust is on track to deliver the planned surplus of £1.8m in 2016/17 in line with plan.
- YTD spend on agency staff is significantly below target set by NHSI
- Planned CIP for 16/17 is £4m. The Trust was behind at month 8 (£1.3m compared to a planned ytd of £2.3m) however the full year forecast is for delivery of the full £4m though around £800k of this will be non-recurrent.
- Cash book balance at end of month 8 was £2.6m above plan at £7.4m. Forecast balance at year end is in line with plan at £6.3m
- Capital plan - the latest forecast is that the full planned amount of £5m will be spent in year. A detailed bottom up view of the full year forecast is now being prepared so the Trust can calculate and notify any potential underspend to NHSI.

2. Recommendations:

The Board is asked to **receive** the report.

3. Main Report

See Report attached.

Understanding You

4. Which Trust strategic objective(s) does this paper link to?	
Achieve the best possible outcomes for our service users through high quality care	☐
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	☐
Actively engage with health and social care partners as well as local communities, in order to deliver seamless services	☐
Value colleagues and support them to develop the skills, confidence and ambition to deliver our vision	☐
Manage public resources wisely to ensure local services remain sustainable and accessible	☒

5. Explanation of acronyms used:
YTD – Year to Date CQUIN – Commissioning for Quality and Innovation QIPP – Quality Innovation Productivity and Prevention CIP – Cost Improvement Plan GCCG – Gloucestershire Clinical Commissioning Group MIIUs – Minor Injury and Illness Units COO – Chief Operating Officer GHFT – Gloucestershire Hospitals Foundation Trust QEIA – Quality Equality Impact Assessment CQC – Care Quality Commission IDT – Integrated Discharge Team ICT – Integrated Community Team FFT – Friends and Family Test DNA – Did Not Attend RAG – Red, Amber, Green

Gloucestershire Care Services NHS
NHS Trust

Month 8 2016/17 Finance Report

V 2

Understanding you

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Overview

- The total planned surplus for 16/17 is £1,793k. This will be delivered through a £713k adjusted operating surplus from ongoing operations and £1,080k of non-recurrent sustainability and transformation (S&T) funding.
- Conditions of the S&T funding include operating within a “capped” level of agency spend of £2,379k. Usage of agency staff is monitored closely as a measure of recruitment effectiveness, staffing quality and ability to satisfy the S&T funding criteria (YTD spend at the end of M8 is £1,230k which is £474k lower than planned trajectory).
- YTD financial performance to November 16 (month 8) was on plan with a net surplus before S&T funding of £106k. Full year adjusted forecast is currently in line with plan at £708k (pre S&T funding).
- Planned CIP for 16/17 is £4m to be delivered through 3 exec led workstreams using LIA principles which is reported on in detail in the separate COO report but stands at month 8 at £1,324k compared to a planned ytd figure of £2,316k. In year CIP delivery is progressing well but full delivery is a key enabler of the planned surplus.
- QIPP (£3.9m) and CQUIN (£1.9m) are covered through separate reporting processes. The current income forecast is that these will both be delivered in full. Milestones have been agreed and operational teams and now working on delivery.
- Cash balance at 30/11/16 was £2,644k above plan at £7,429k. Forecast balance at 31/3/17 is in line with plan at £6.3m
- Capital plan for the year totals £5m with main projects on Hatherley Road and IT infrastructure. YTD spend is £2,197k compared to plan of £3,790k. The latest forecast is that the full plan amount of £5m will be spent in year. A detailed bottom up view of the full year forecast is now being prepared so the trust can notify any potential underspend to NHSI.

Income and Expenditure

At month 8 the trust is in line with plan with a YTD surplus before S&T funding of £106k and a full year forecast adjusted surplus in line with plan at £713k.

If S&T funding is included the full year surplus becomes £1,793k which is in line with plan which is in turn £13k higher than the NHSI control total.

Underspends on pay are linked to non achievement of new business targets (masked in income by other over-recoveries) and vacancy control measures that are being targeted for CIP through removal of recurrent vacancies. All changes of this type are subject to full EQIA – posts are considered for removal when they have not been filled for some time but targets continue to be met.

Overspends on non pay are in discrete areas where significant inflationary cost pressures are being experienced. Main areas of overspend are estates (£1,062k FY Forecast overspend), drugs (£269k forecast overspend) and clinical services & supplies (£199k forecast overspend). All areas of non pay spend are under review to establish if targeted savings can be made.

Full year agency spend in 15/16 was £3,717k, the ceiling for spend in 16/17 is set at £2,379k and year to date spend to M8 was £1,320k which is £474k lower than planned trajectory.

Risks associated with delivery to plan are as set out on page 6.

Statement of Comprehensive Income	Current Year to Date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Forecast	Variance
Revenue (exc STF)	73,797	73,785	**(12)**	111,657	111,229	**(428)**
Gross Employee Benefits	(54,518)	(52,379)	**2,139**	(81,878)	(78,945)	**2,933**
Other Operating Costs	(17,669)	(19,832)	**(2,163)**	(26,806)	(29,346)	**(2,540)**
PDC Dividend	(1,576)	(1,536)	**40**	(2,364)	(2,324)	**40**
Donated assets adjustment	72	68	**(4)**	104	99	**(5)**
Surplus/Deficit before STF income	**106**	**106**	**0**	**713**	**713**	**0**
STF Income	720	720	**0**	1,080	1,080	**0**
Adjusted Financial Performance	**826**	**826**	**0**	**1,793**	**1,793**	**0**

Balance Sheet

- Summary balance sheet at 30/11/16 shows impact of lower than planned capital spend ytd and slower than planned settlement of GHFT debtors and creditors
- Debtors at 30/11 includes £8,780 for GHFT (£3,415 current year and £5,365 prior year) and creditors includes £8,460 (£3,215 current year and £5,245 prior year). The GHFT balances were settled at the end of month 8 but the entries to match them off on the ledgers havent been processed as yet by SBS.

SUMMARY BALANCE SHEET		2015/16	Current Year to Date			Full Year 16/17
	Category	Accounts	Plan	Actual	Variance	Plan
NON-CURRENT ASSETS:	Property, Plant and Equipment	75,761	79,226	75,973	(3,253)	79,565
	Intangible Assets	1,256	822	1,518	696	988
	TOTAL Non Current Assets	**77,017**	**80,048**	**77,491**	**(2,557)**	**80,553**
CURRENT ASSETS:	Inventories	225	500	228	(272)	500
	Trade and Other Receivables	12,833	8,271	16,714	8,443	8,271
	Cash and Cash Equivalents	6,112	4,785	7,429	2,644	6,293
	Sub Total Current Assets	**19,170**	**13,556**	**24,371**	**10,815**	**15,064**
CURRENT LIABILITIES	Trade and Other Payables	(17,460)	(12,166)	(22,377)	(10,211)	(13,240)
	Provisions	(23)	0	(23)	(23)	0
	Total Current Liabilities	**(17,483)**	**(12,166)**	**(22,400)**	**(10,234)**	**(13,240)**
NON-CURRENT LIABILITIES	Provisions	0	(16)	0	16	(16)
	TOTAL ASSETS EMPLOYED	**78,704**	**81,422**	**79,462**	**(1,960)**	**82,361**
TAXPAYERS EQUITY	Public Dividend Capital	79,982	79,982	79,982	0	79,982
	Retained Earnings Reserve	(1,334)	(281)	(576)	(295)	658
	Revaluation Reserve	2,454	1,886	2,454	568	1,886
	Other Reserves	(2,398)	(165)	(2,398)	(2,233)	(165)
	TOTAL TAXPAYERS EQUITY	**78,704**	**81,422**	**79,462**	**(1,960)**	**82,361**

Capital Expenditure

Gloucestershire Care Services NHS Trust

Capital Spend 16/17		Year To Date			Full Year Plan
	Type	Actual	Plan	Variance to Plan	
Hatherley Road	Other	0	1,650	-1,650	2,000
IT replacement	IT	529	320	209	500
IT WAN / LAN	IT	793	500	293	500
Building compliance	New Build	518	660	-142	1,000
Building reconfiguration	Other	178	330	-152	500
Systm1	IT	127	330	-203	500
Medical Equipment	Equipment	52	0	52	0
		2,197	**3,790**	**-1,645**	**5,000**

- Trust full year capital plan is for a spend of £5m
- Year to date spend in 16/17 is £2,197k compared to a plan of £3,790k. There have been delays in pulling the Hatherley Road business case together and also in finalising some of the reconfiguration projects. A detailed bottom up view of the full year forecast is now being prepared so the trust we can flag any potential underspend to NHSI.
- The redevelopment of the Hatherley Road site is still planned but much of the spend is now likely to slip into 17/18. The business case for development of the site is now being prepared for consideration by the trust Board.

Risks

At this stage the risks being managed to ensure delivery of the planned surplus are:

- Getting service level agreements in place with GHFT – until agreements are in place there remains a difference in opinion on the value of services of circa. £500k.
- Getting the ICT management structure revised following GCC removal of funding for joint positions (linked to work with CCG on wrapping ICTs around GP clusters)
- Agreeing with CCG how to recurrently manage the cost pressure arising from the outcome of the MIIU engagement and related changes to staffing levels and rotas
- Delivering CIP including managing non-recurrent savings where in year savings are later than planned
- Delivering QIPP and CQUIN milestones in line with plan and current forecast.
- Earning the £900k of risk share QIPP that depends on system level admission avoidance schemes.

Trust Board

Date: 24 January 2017

Committee Name:	Trust Board
Agenda Ref:	18/0117
Author:	Glyn Howells, Director of Finance and Deputy Chief Executive
Presented By:	Richard Cryer, Chair of Finance Committee
Accountable Exec:	Glyn Howells, Director of Finance and Deputy Chief Executive

Subject:	Audit and Assurance Committee Update
Appendices	1. Approved Minutes from 13th September 2016 2. Health, Safety and Security Strategy 3. IM&T Strategy

Provided for: ☐ Discussion ☐ Decision ☐ Approval ☒ Assurance ☒ Information ☒ Noting ☐ Statutory Purposes

1. Executive Summary:

This report provides an update on the meeting of the Audit and Assurance Committee held on 5th December 2016. The approved minutes from the meeting of 13th September 2016 meeting are attached for information.

Decisions made by the Committee included:

(1) Approval of the Health, Safety and Security Strategy
(2) Approval of the Terms of Reference for the Health, Safety and Security Steering Group
(3) Approval of the Information, Management and Technology Strategy
(4) Approval of the Risk Management Policy

The Committee also undertook a detailed review of the risk register and Board Assurance Framework. There was a discussion on the risks associated with information governance compliance and the Privacy Impact Assessment for SystmOne.

2. Recommendations:

The Board is asked to:

(i) **Note** the update from the 5th December Audit and Assurance Committee Meeting.
(ii) **Receive** the Approved Minutes from 13th September Audit and Assurance Committee Meeting. Attached as appendix 1

3. Main Report

1. Decisions made by the Committee in line with Scheme of Delegation

The Committee considered a number of reports:

Health, Safety and Security Strategy
This was discussed in detail, following a significant refresh, and was **approved**. It is attached for information at appendix 2

Health Safety and Security Steering Group.
The Terms of Reference for the Steering group were approved.

Information, Management and Technology Strategy
The strategy was discussed in detail, and was approved. It is attached for information as appendix 3.

2. Items discussed by the Committee

Internal Audit update
The Committee was reassured on the improved position, actioning and evidencing completion of outstanding recommendations. Final reviews had been completed on Estates and Communications with assurances given that action plans were now in place and work underway. The need for wider discussion of the Communication Strategy by the Board was highlighted and this will be considered by the board once the stakeholder and third sector work being undertaken is further developed.

External Audit Update
KPMG presented their report to the Committee and highlighted recently published KPMG updates. There were no issues raised.

Counter Fraud update
Committee members received an update on current activity to date; there were no issues of concern. Benchmarking information was requested by the Committee once available and will be included in further updates to Committee.

Debtor Ageing and Write Offs
The Committee considered an update on the ongoing processes and explored the introduction of a minimum invoice level given capacity and the need to ensure efficient management of debts. A more detailed proposal is being presented to Committee members for approval in February 2017. The regular Finance Compliance report was considered with no issues raised.

Estates Compliance
Members discussed the manual systems currently in place and the roll out of the new electronic system (Atrium) and were reassured that this electronic system would assist with the record keeping and compliance issues currently highlighted within the recent internal audit report. A demonstration of the new system is scheduled to members in June 2017. PLACE results provided further assurance.

3. Issues discussed to be escalated to the Board

Information Governance Update
Progress on Information Governance Toolkit Compliance was presented and Members expressed concern at the significant slippage. It was agreed that the implications needed to be reflected in the Board Assurance Framework and regular updates should be provided at each subsequent Committee meeting. It was noted that additional resources was being sought to accelerate compliance.

Privacy Impact Assessment – SystmOne
Members discussed this matter in depth and concluded that a legal opinion should be taken to ensure that suitable mitigations are in place. The Head of Planning, Compliance and Partnerships is liaising with legal experts and will provide an update to Board members at the meeting January 2017

4. Which Trust strategic objective(s) does this paper link to?	
Achieve the best possible outcomes for our service users through high quality care	☒
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	☐
Actively engage with health and social care partners as well as local communities, in order to deliver seamless services	☐
Value colleagues and support them to develop the skills, confidence and ambition to deliver our vision	☐
Manage public resources wisely to ensure local services remain sustainable and accessible	☒

5. Explanation of acronyms used:
PLACE – Patient-led assessments of the Care Environment

Audit and Assurance Committee

Date: 13th September 2016

Members	
Richard Cryer	Non-Executive Director (Chair)
Sue Mead	Non-Executive Director
Robert Graves	Non-Executive Director
Graham Russell	Non-Executive Director
Jan Marriot	Non-Executive Director
In attendance	
Glyn Howells	Director of Finance
Laura Roberts	Head of Financial Accounts
Gillian Steels	**Trust Secretary**
Louise Moss	Deputy Trust Secretary
Duncan Laird	External Audit (KPMG)
Lee Sheridan	Counter Fraud Specialist
Tina Ricketts	Director of HR
Sonia Pearcey	Ambassador for Cultural Change

Ref	Minute	Action
16/AA044	**Welcome and Apologies** The Chair welcomed the members to the Committee	
16/AA045	**Confirmation of Quoracy** The meeting was confirmed as quorate by the Deputy Trust Secretary.	
16/AA046	**Declarations of Interest** Members were asked to provide relevant updates to their previous declarations of interest where appropriate. No updates were received.	
16/AA047	**Minutes from the meeting on 3rd May and 31st May 2016** Both sets of minutes were **Approved** as an accurate record and signed by the Chair	
16/AA048	**Matters arising (action log)** Members considered the Action Log and confirmed the status set. 15/AA080 – Letter to be forwarded from Lynn Pamment regarding completion of the review of the SFIs. The Director of Finance advised notification had been received verbally and he would request written confirmation. **Action closed** There were no additional matters arising.	**Director of Finance**

16/AA049	**Corporate Risk Register – Relevant Risks** The Director of Finance introduced the item and informed the members of the new processes in place. - Risk Management Steering Group meets with Executive colleagues on a monthly basis and reviews risk appetite. - Risks 12+ aligned to strategic risks and presented at Board bi monthly. Safety risk 8+ are also included. - Alternative months the risks relating to Audit and Assurance, Finance or Quality and Performance Committee are presented to the responsible Committees for assurance and scrutiny. The Chair questioned the timescales relating to mitigating the new risk on IG Training. The Director of Finance confirmed that a new IG Manager has now been in place for approximately 8 weeks and has produced an action plan to deliver the training and ensure compliance. He confirmed he would report at the next Committee meeting on the timeframes by which this work is expected to be achieved. Sue Mead questioned the issues of ensuring Information Governance requirements to require consent to share information did not put in place a barrier to safeguarding children and vulnerable adults, it was agreed the Quality and Performance Committee would discuss this matter in more detail. Graham Russell queried whether the risk register is indicating an acceptable level of risk and that risks are being managed effectively. The Director of Finance replied that the process was working well and that he would explore comparing our register with other Community Trusts as a comparator. Sue Mead commented that we also need to look at what has been on the Register for an extended period of time and why, to ensure that risks are being actively managed and mitigated within an acceptable timeframe and escalated if required. The Director of Finance confirmed he would action this piece of work and provide an update to the Committee at the next meeting. The Committee **NOTED** the Risk Register and confirmed the proposed actions planned to mitigate the risks to an acceptable level.	
16/AA050	**Internal Audit update** Due to a misunderstanding with dates no one was present for the meeting to represent Internal Audit. The Director of Finance confirmed he would take forward any concerns with them after the meeting. The Chair invited members to comment on the reports previously circulated by Internal Audit.	
16/AA051	**External Audit Update** Duncan Laird (DL) presented the technical update report providing the Committee with an anticipated work plan for the coming quarter and communicated recent policy announcements from NHS Improvement and the Department of Health.	

	DL updated members that since the last meeting in May 2016 KPMG have; • Completed external audit of the 2015/16 Annual Report and Accounts and submitted all required documents and audit reports to the Department of Health in advance of the deadline of 2 June 2016; • Started the planning and risk assessment process for 2016/17 audit by discussing emerging issues and key risks with the Director of Finance and Deputy. Work is currently underway on: • Completing the audit of the charitable funds financial statements; • Discussing with Internal Audit the timing and extent of work on which we can place reliance; and • Drafting External Audit Plan for the 2016/17 audit. DL highlighted STP (Sustainability and Transformation Plan) developments and it was proposed that consideration of STP developments in relation to balancing consideration of statutory requirements and system requirements should be considered by the Board at a Development session. Richard Cryer commented on the governance issues of shared services around the STP and potential conflicts of interest. The Director of Finance advised that he had recently attended the South West Chief Executive group on behalf of Paul Jennings and the feedback from Manchester (current outlier in STP) which had commented on the challenges of balancing the needs of the wider system against individual organisations responsibilities and duties. The Committee commended the work of colleagues to date on the Trust's plan and **AGREED** that this would be discussed by Board members at the next Board development day in October 2016.	**Trust Secretary**
16/AA052	**Counter Fraud Update** Counter Fraud Specialist, Lee Sheridan, directed members to the report which provides an update on activity and current cases for the period April to August 2016. He provided a verbal update on ongoing cases and awareness training which had taken place across the services. The streamlining of the service provided by NHS Protect and the proposal to use services from Cotswold District Council was further discussed and noted by members. The Director of Finance queried if the number of days provided could be added to the action plan. LS confirmed he would add this to the action plan ahead of the next Committee meeting in December. Graham Russell asked how dynamic the world of Fraud is. LS confirmed that cyber fraud is the biggest risk and one of the objections within the current action plan is to raise the profile across the Trust with colleagues.	**Counter Fraud Specialist**

	The Committee (i) **RECEIVED** the Counter Fraud Update. (ii) **APPROVED** the revised policy. (iii) **NOTED t**he activity to date in the Action Plan which is on track	
16/AA053	**Review of Waivers, special payments and write offs** The Deputy Director of Finance reported that there have not been any additions since the last report to the Committee. The Director of Finance confirmed he signed off the waivers as they occur. Any sensitive waivers or amounts greater than those delegated within the Standing Financial instructions would be presented to the Committee The Committee **RECEIVED** the Review of Waivers, Special Payments and Write-Offs Report.	
16/AA054	**Better Payment Practice Code (BPPC) and Purchase Order Usage** The Head of Financial Accounts presented the report noting that BPPC achievement continues to be an area that requires work by the Trust. The number of invoices that are processed through the non-purchase order route is still the main issue for this, along with the number of i-Proc holds on purchase orders that must be resolved before invoices will be paid when being processed down this route. Shard Business Services (SBS) are attending a meeting at the Trust week commencing 3rd October to discuss solutions to this issue. Richard Cryer asked for an update on the system replacement. The Director of Finance confirmed that two systems have been identified and the Trust would hope to have the preferred system implemented by 01/04/17. The Committee **NOTED** the content of the paper.	
16/AA055	**Review of debtor and Creditor Balances** The Head of Financial Accounts presented the paper to assure the Committee that sound financial controls are in place and that stewardship of Trust assets is safe and appropriate. The following issues were highlighted; • The cash position of the Trust is on plan • Debtors are kept under constant intensive review to ensure bad debt risk is minimised and cash flow is maintained. • Creditors are settled as they fall due. There is no manipulation of the cash management position by delaying payment or extending terms beyond those offered by the supplier. The Director of Finance confirmed that agreement has been reached with GHNHSFT for last year and the Deputy Director of Finance is now having regular meetings with the Trust.	

	Richard Cryer enquired if the Trust is able to charge interest for outstanding debts. The Director of Finance confirmed that a standard 2% can be charged for those outside of the payment terms. The Committee **NOTED** the content of the paper.	
16/AA056	**Raising Concerns at Work Report** The Director of Human Resources and Ambassador for Cultural Change presented the report and highlighted the following areas; In the last reporting period (1st March to 31st August 2016) one new concern has been raised. Five recommendations have been made as a result of the review into the recent concern and these will be taken forward by the Head of Children and Young People Services. It is recognised that further work is required to improve the reporting culture within the Trust. Rob Graves queried the number of patient safety issues raised and reported within the report. The Ambassador for Cultural Change confirmed that issues have been reported and are being addressed locally. Jan Marriot asked if action cards could be included within the policy to ensure the information was easily accessible. The Ambassador for Cultural Change noted this and agreed to include these in the final policy ahead of publishing. Members discussed the frequency of reporting and after discussion agreed a high level summary report should be provided annually. The Committee (i) **NOTED** the report (ii) **APPROVED** the updated Raising Concerns at Work (Freedom to Speak Up) Policy. (with minor amendments)	**Ambassador for Cultural Change**
16/AA058	**Information Governance Update** The Director of Finance presented the report and highlighted the following points; - Information Governance Toolkit Compliance was now assessed at 50% - a plan was in place to mitigate this by March 2017 for Level 2 compliance. - There was also concern at the level of IG Mandatory Training – it was confirmed it was now to be reincorporated within the Corporate Induction. The Chair asked if we have the resources in place across the Trust to achieve this target date. The Director of Finance confirmed that the Head of IT, Head of Performance and Information Governance Manager had been engaged to deliver the programme by this date and noted it would be achievable. Members requested a further update be provided at the December meeting.	**Head of Compliance Planning and Partnerships**

	Member discussed the "I Promise" declaration issued from the Information Commissioner's Office and confirmed that further clarification would be required. The Director of Finance noted that a further report would be brought back to the Committee in December.	
16/AA059	**Legal Claims Update** The Director of Finance took Members through the key parts of the Legal Claims update and confirmed that the payments to NHSLA are reducing year which indicates Trust claims are reducing and the Trust is not seen as high risk. Graham Russell queried if this information should also be available to the Quality and Performance Committee with cross referencing to Datix incidents and it was agreed this should be considered. Members reviewed the content and **NOTED** the report with no issues for concern.	
16/AA060	**Strategies** - The Risk Management Strategy was presented to members for consideration and approval. Members **approved** the Risk Management Strategy. The Business Continuity Strategy was considered by members for approval. The Chair requested further information regarding the changes made to the strategy; The Chief Operating Officer agreed to forward the previous version for comparison. Members agreed that the Strategy would be circulated outside of the Committee for comments and approval with approval delegated to the Chair unless there were significant changes or concerns.	
16/AA061	**Strategy On a Page** The Director of Finance presented the report which seeks to pull together the Trust's vision, values and strategic objectives. Sue Mead asked whether the strategies align to this, as this isn't clear within the illustration. Rob Graves commented that it was a good starting point however felt it looked too busy. Members agreed that this document is work in progress and that it should be further updated by the Director of Finance and then reconsidered at a further Board development session. Committee **noted** the concept and agreed to look in more detail at the document at a Board Development Session	**Trust Secretary**
16/AA062	**Governance Framework** The Trust Secretary presented the paper to review the Governance framework and streamline reports to maximise Board and Committee effectiveness.	

	All members **agreed** this approach and a further workshop session with Executive Directors, Committee Charis and the Trust Secretary to review the timetable and frequency of reports before making a recommendation to Board. The Committee; i) Noted the on-going review ii) Noted the planned timescales	
16/AA063	**NHS Protect Standards – Compliance** Members **noted** the report and action plan for 2016/17	
16/AA064	**Tendering Process for Internal and External Auditors** This item was taken in the confidential section by members of the Audit Panel only.	
16/AA065	**Information Items** The Committee **Noted** and **Received** minutes from; - Emergency Preparedness and Resilience Steering Group - Health and Safety Committee - Information Governance Group The Committee **Received** and **Approved** - Coroners Policy -	
16/AA066	**Forward Agenda Planner** The Chair requested that future meeting are scheduled for 2.5 hours and the forward planner is to be amended to reflect this.	Trust Secretary
16/AA067	**Any Other Business** There was no other business	
	Date and Time of Next Meeting 5th December 2016 14.00hrs – 16.30hrs Boardroom Edward Jenner Court	

Chair's Signature:

Date:

Gloucestershire Care Services NHS
NHS Trust

HEALTH, SAFETY & SECURITY STRATEGY

2016-21

To maintain robust health, safety and security systems in all locations wherein the Trust provides healthcare services, in order to ensure the optimum protection of service users and colleagues

Health, Safety and Security 2016-21

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Originator/author:	Rod Brown, Head of Planning, Compliance and Partnerships Adrian Warren, Health, and Safety Compliance Manager Max Boyce Local Security Management Specialist
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Consultation	Health, Safety and Security Steering Group
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0. Executive Summary

This Strategy serves to confirm the commitment of Gloucestershire Care Services NHS Trust ("the Trust") to maintain the health, safety and security of all Trust colleagues, service users, carers, as well as visitors to the Trust. It also seeks to ensure the protection of all buildings, systems, property and other assets owned and/or operated by the Trust, and deliver continuous improvement where appropriate. To achieve these goals, this Strategy seeks to:

- to ensure that service users, carers and families as well as colleagues, benefit from optimum health and safety whilst under the care of the Trust, irrespective of environment or setting. Thus, the Trust will be proactive in promoting best practice across the organisation, and will conduct regular inspections, audits and risk assessments in all Trust locations so as to identify weaknesses or failures in practice that could create risk to a person's health, safety or security. Moreover, should an incident occur, it requires the Trust to thoroughly investigate its cause and impact, and develop a corresponding action plan;

- to develop an integrated Trust-wide approach to the management of risk, incidents, governance, health, safety and security to ensure that all stakeholders are involved in decision-making. This requires close coordination of all clinical and non-clinical aspects of health, safety, security and governance operating from this shared strategic vision and the development and observance of complementary implementation plans;

- to maintain robust governance processes to facilitate the effective management of all health, safety and security matters, including clear responsibilities for leadership. This requires Trust colleagues to recognise their personal responsibilities to contribute to the maintenance of a safe and secure working environment, and abide by best practice. It also requires the development of a complete set of health, safety and security policies, adherence to reporting and data capture procedures, and empowerment of Trust forums to track and monitor actions and progress;

- to achieve the best possible security standards as required under the Standard Contract and NHS Protect Security Standards, safeguarding against loss or theft of - or damage to - Trust equipment, private property or materials, as well as against the unauthorised access to, and/or use of, any of the Trust's information.

This Strategy therefore seeks to outline the Trust's aspirations and direction of travel in respect of health, safety and security over the next 5 years in order to ensure the best possible protection of people and assets. The accompanying implementation plan will detail the practical actions that will be taken in the period 2016-21 to fulfil these aspirations.

1. Introduction

Gloucestershire Care Services NHS Trust ("the Trust") recognises that a safe and healthy environment for all colleagues, service users and visitors is not only a legal obligation under the Health and Safety at Work Act and associated regulations, but is also an organisational aspiration. In particular, the Trust is committed to ensure that accidents and incidents are reduced to the lowest possible level

1.1 This Health, Safety and Security Strategy serves to confirm this commitment which it aims to fulfil by building a visible and integrated approach to the management of risk, incidents, governance, health, safety and security so that each informs improvements in systems and processes, and is firmly embedded within standard ways of operating.

To this end the Trust commits to:

- identify and minimise threats to colleagues and service users through effective risk and incident management which ensures that any reported events are investigated in a timely way, and that outcomes provide shared learning and continuous improvement

- routinely undertake a health and safety culture survey to determine the maturity of the organisation and to help identify and remove any institutional barriers to improvements in operational safety and safety processes;

- provide the building blocks for effective health, safety and security management including training to allow managers to discharge their legal responsibilities;

- hold colleagues to account for ensuring best health, safety and security practices are in place for both colleagues and service user care;

- develop and maintain a safety communications plan to facilitate shared learning, and advise legislative and policy changes so that all employees are aware of change;

- ensure an effective approach to compliance with the NHS Protect Security Standards

1.2 In making this commitment, the Trust recognises not only its legal responsibilities, but moreover its ethical and professional duties, to ensure robust health and security systems that enable the provision of safe working environments. To this end, the Trust aims to:

- ensure a proactive and consistent approach to the development and adoption of best practice procedures in respect of health, safety and security;

- develop and publish a comprehensive portfolio of health, safety and security policies, supported by appropriate guidance and support documentation;

- routinely evaluate the relative protection of all the Trust's working environments by means of inspections, audits and risk assessments in order to recognise and respond to all opportunities for sustainable improvements in health, safety and security arrangements.

1.3 The resultant benefits of this approach will be to:

- minimise the number of colleagues suffering an injury in the workplace as a result of moving and handling, a slip, trip or fall etc, which may result in a loss of working days and/or a claim being made against the Trust;

- minimise the number of service users, carers or visitors suffering an injury in any of the Trust's buildings;

- reduce the number of colleagues suffering abuse of any description, including injury as a result of a violent or aggressive act;

- provide clarity in the reporting of crime or anti-social behaviour;

- respond to the national legal frameworks which serve to provide the Trust with the necessary assurance that requisite standards are being met.

2. Scope

2.1 The following are all included within the scope of this Health, Safety and Security Strategy:

- all colleagues who are employed or otherwise contracted or managed by the Trust, whether these colleagues are working within a Trust facility or are engaged on business on behalf of the Trust in some other setting;
- all service users, carers, families, visitors to the Trust, and other members of the Gloucestershire public as appropriate;
- all buildings, facilities, settings and environments in which the Trust provides its health and social care services: this includes those premises that are owned or leased by the Trust (refer to the Trust's Estates Strategy), as well as, when appropriate, service users' homes and other care environments in which the Trust provides care services such as residential and nursing homes, schools etc;
- all assets and resources tangible or intangible whether owned or managed by the Trust

2.2 The Trust recognises that health, safety and security matters are fundamental issues that have clear responsibilities and implications for all colleagues.

Thus, this Strategy serves to encourage all colleagues across the Trust to demonstrate care and concern for the safety and protection of all people, assets and resources, thereby ensuring the provision of a high quality service to the Gloucestershire community. Indeed, under sections 7 and 8 of the *Health and Safety at Work etc. Act 1974*, everyone who works for the Trust has personal responsibility to perform their duties in such a way that they do not create unnecessary risk to themselves or others who may be affected by their acts or omissions.

2.3 The considerations of counter fraud activity are embraced with the Trust's Financial Management Strategy.

3. Ambition and Objectives

3.1 The ambition of this strategy is "*To maintain robust health, safety and security systems in all locations wherein the Trust provides healthcare services, in order to ensure the optimum protection of service users and colleagues".* This aligns to the Trust's overarching vision which is "*To be the service people rely on to understand them and organise their care around their lives*", given that both intentions share a clear service user focus.

3.2 This five year Health, Safety and Security Strategy seeks to ensure that by 2021, the following objectives have been achieved, linked to the Trust's overarching strategic objectives:

Health, Safety and Security Strategy Objectives	Trust Strategic Objectives
• Ensuring that all service users receive the care they need in environments that provide the highest possible levels of health, safety and security • Continuing to improve the quality of health, safety and security arrangements for all health and social care services • Ensuring that anti-crime measures are effectively embedded at all levels across the Trust	Achieve the best possible outcomes for our service users through high quality care
• Engaging with local service users and their representatives, as well as with stakeholder groups and independent observers, to ensure that health, safety and security concerns are managed and reviewed • Responding promptly to service user comments, feedback and assessments • Raising public awareness of the impact and consequences of crime against Trust colleagues, stakeholders and service users	Understand the needs and views of service users, carers and families so their opinions inform every aspect of our work

• Maintaining strong links with NHS Protect and all relevant national and local forums in order to remain advised of emerging health, safety and security management standards that will benefit the Trust • Benchmarking against similar organisations so as to recognise any additional opportunities for improvement in health, safety and security practices	Actively engage in partnerships with other health and social care providers in order to deliver seamless services
• Ensuring strong organisational awareness of health, safety and security via the provision of specialist support, training, guidance and communications • Maintaining a robust network of health and safety representatives who are encouraged and supported to contribute to the wider health and safety agenda • Supporting colleagues to embed appropriate health, safety and security standards into daily practice	Value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision
• Ensuring that the Trust's health, safety and security management meets all contractual requirements, and provides a solid foundation for additional contracts that may be considered • Maintaining or improving prevailing compliance levels through robust monitoring, management and audit • Ensuring that crimes are detected and investigated, prosecuting those responsible and seeking redress • Discouraging individuals who may be tempted to commit crimes against the NHS and ensuring that opportunities for crime to occur are minimised	Manage public resources wisely to ensure local services remain sustainable and accessible

4. National Context

4.1. The Trust has a legal responsibility and duty of care under all prevailing health, safety and security legislation, and in particular the *Health and Safety at Work etc. Act 1974* (Health and Safety Executive), to ensure optimum protection within all relevant working environments. Moreover, the need to ensure compliance with the Act is enshrined in the contracts of all Trust colleagues.

Equally the Trust has the responsibility to abide by all of the supporting guidance including the *Fire Regulatory Reform (Fire Safety) Order* (2005), *Control of Asbestos Regulations* (2012), *Control of Legionella Bacteria in Water Systems (*-2013), *Control of Substances Hazardous to Health Regulations* (2002)

4.2 The NHS Litigation Authority (NHSLA) provides a series of risk management standards including considerations for a safe environment.

4.3 Within the Care Quality Commission (CQC) Outcomes Framework, Outcome 15 relates to the premises and equipment, and as such, requires the Trust to care for people in safe, accessible buildings that support their health and welfare.

4.4 Sign Up To Safety is a nationally supported programme designed to reduce incidents of service user harm via a series of initiatives to ensure senior management engagement and thorough learning from incidents

4.5 In 2012, revisions to the *Health and Social Care Act* changed responsibilities for property ownership. Thus, the Trust now has landlord responsibility for a number of its properties, as serves as a tenant elsewhere. Security arrangements are now included in the Standard Commissioning Contract.

4.6 Nationally, NHS Protect leads on identifying and tackling crime across the NHS. Its aim is to protect colleagues and resources from activities that would otherwise undermine their effectiveness and ability to meet the needs of service users and professionals, and provides leadership in tackling crime.

4.7 *NHS Protect Standards for Providers* detail the requirements of provider organisations to have appropriate security management arrangements in place in order to satisfy Service Condition 24 of the NHS Standard Contract.

4.8 The Prevent Strategy is fully supported with the Trust and complements the safeguarding processes overseen by the Trust's Professional and Clinical Effectiveness (PaCE) team.

5. Local Context

5.1 The Trust has a developed a systematic approach to health, safety and security management that involves the on-going testing and measurement of relevant services and systems in order to ensure their compliance and provide assurance, ultimately to the Trust Board. Responsibility for overseeing this process has been assigned to the Health, Safety and Security Steering Group which in turn, reports to the Audit and Assurance Committee.

5.2 The Gloucestershire Clinical Commissioning Group ("CCG") as the Trust's principal commissioner, is clear in its expectations of the organisation's health, safety and security arrangements. Specifically, the CCG requires the Trust to conduct routine assessments where significant risks are identified to health, safety or security, and thereafter, determine clear plans for changing service provision and/or the environments in which care is provided.

5.3 In support of its security management approach, the Trust has assessed its crime profile which identifies the organisation's local risks. At the time of writing, the current profile confirms the Trust as a Category One organisation (as defined annually in Standards for Providers Fraud, Bribery and Corruption, NHS Protect, 2013) which means that the Trust is an organisation with high-value NHS contracts, a high number of colleagues, high-value NHS assets, and a large number of service user interactions. This definition informs the level of security that must be met by the organisation.

The Trust will audit the security standards annually via the Security Review Tool which is submitted to NHS Protect and Gloucester Clinical Commissioning Group for assurance. By meeting the security standards, the Trust may most effectively combat crime, and safeguard its service users, colleagues and assets across all community settings within Gloucestershire.

5.4 There is clear synergy between the Trust's health, safety and security protocols and those encapsulated within the organisation's risk management processes. To this end, it is noted that this Strategy complements the guidance within the Trust's Risk Management Strategy and all supporting documentation including the Risk Management Policy, the Incident Governance Policy, the Complaints Policy etc.

5.5 For Sign Up To Safety, a separate plan has been developed to drive improvement based on the five core national campaign pledges, namely (i) putting safety first, (ii) continually learning, (iii) being honest, (iv) collaborating, and (v) being supportive.

Sign Up To Safety complements this Health Safety and Security Strategy and particularly the commitment to demonstrating learning from incidents. The plan will be monitored by the PaCE team and their goals are underpinned by the by Trust's strategic objective of 'Achieving the best possible outcomes for our service users through high quality care'.

5.6 The Trust recognises that its responsibility for ensuring the health and wellbeing of colleagues goes far beyond providing a safe working environment, and is therefore actively committed to supporting health and wellbeing and good mental health at work. As a result, it is intended that sickness absence will reduce, service user care will improve, and productivity and staff morale will increase.

Thus, the Trust has developed a Health and Wellbeing Plan that seeks to promote a workplace that is healthy and productive, and that conveys the principle that health and wellbeing is everyone's responsibility. The emphasis is clearly upon prevention, and provides a framework for colleagues in their everyday working environment for them to take responsibility for their own fitness, health and attendance.

6. Quality Goals

6.1 In order to ensure that this Health Safety and Security Strategy drives a culture of continuing improvement which maintains optimum focus upon achieving quality outcomes, the following goals have been identified:

- to ensure that service users, carers and families as well as colleagues, benefit from optimum health and safety whilst under the care of the Trust, irrespective of environment or setting;

- to develop an integrated Trust-wide approach to the management of risk, incidents, governance, health, safety and security to ensure that all stakeholders are involved in decision-making;

- to maintain robust governance processes to facilitate the effective management of all health, safety and security matters, including clear responsibilities for leadership;

- to achieve the best possible security standards as required under the Standard Contract and NHS Protect Security Standards.

7. Priorities and Actions

This section identifies the priority actions, mapped against the Strategy's quality goals. Further details regarding each of these priorities will be itemised within the Strategy's implementation plan, progress against which will be monitored on a regular basis by the Health, Safety and Security Steering Group and the Audit and Assurance Committee.

7.1 To ensure that service users, carers and families as well as colleagues, benefit from optimum safety whilst under the care of the Trust, irrespective of environment or setting

Threats to people's health, safety and security within the setting of a community hospital or clinic can stem from a range of hazards including slips, trips and falls, clinical risks, exposure to dangerous substances, fire, physical or verbal assault etc. Additionally, colleagues who travel offsite in order to provide care within service users' homes, schools or nursing or residential homes, can also face dangers as a result of lone working, occupational driving etc.

In order to minimise the dangers of all these threats, the Trust will seek to ensure the following actions:

7.1.1 The Trust will be proactive in its endeavours to ensure that best practice in health, safety and security is promoted and observed across the organisation, and that all colleagues are fully aware of national standards and guidance, including those given in section 4 above. This will include requirement for the Trust to conduct regular safety awareness campaigns in order to increase colleagues' understanding of salient health, safety and security issues. To this end, the Trust will develop and maintain a proactive communications plan that uses existing channels such as the CORE newsletter, notice boards etc to ensure that information is routinely and comprehensively disseminated.

7.1.2 Regular site visits by senior managers and Non-Executive Directors will include a health safety and security dimension as part of the Sign Up To Safety initiative. Issues identified will be captured and escalated as necessary

7.1.3 The Trust will also abide by a regular cycle of proactive health, safety and security audits of Trust premises in line with the organisation's Health and Safety Audit protocol. All such audits will be clearly scrutinised by the Health and Safety Compliance Manager. Outcomes will be subject to validation and issues identified will be followed up in order to provide assurance that actions have been implemented. Where necessary, and principally in response to newly identified health, safety and security risks, reactive audits will also be conducted.

7.1.4 The Trust will routinely undertake a health and safety culture survey in order to help identify and remove any institutional barriers to improvements in safety and safety processes: this will be managed by the Health and Safety Compliance Manager, and will require close working with operational teams.

7.1.5 The Trust will maintain a systematic and robust process to receive, disseminate and respond accordingly to all medical alerts which serve to identify pertinent concerns in respect of service user safety, as well as important public health messages and other critical safety information.

7.1.6 All Trust colleagues will be empowered with the skills and knowledge to manage service users who threaten violence. Moreover, the Trust will continue to investigate and assess the potential use of innovative solutions to manage the risk of violence to colleagues. In particular, the Trust will give consideration to the support that is necessary to protect all lone workers who operate away from Trust premises. Notwithstanding, should any untoward incidence of violence occur, the Trust will seek robust sanctions and redress against perpetrators where appropriate, through liaison with criminal justice departments or via civil proceedings.

7.1.7 Should an incident occur and there is impact upon a person's health or safety, the Trust will follow a robust process to investigate the cause and impact of the incident. The Trust will also provide support to all affected individuals whether colleagues or service users, and identify opportunities to improve systems or training so as to minimise the potential for such an incident to reoccur.

Where appropriate, such investigations will observe the protocols detailed within the Trust's Incident Governance Policy. Equally, such investigations will necessitate triangulation of data from a range of sources so as to enhance knowledge of the nature and scale of incidents. Investigations will also require the development of bespoke action plans in response to areas identified at high risk.

Specifically, the Trust will maintain robust procedures, to investigate all RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) incidents, in order to review and learn from all injuries that may arise from work-related accidents that result in for example:

- the death of a person;
- injuries to colleagues which result in their incapacitation for more than 7 days;
- injuries to non-workers which result in them being taken directly to hospital for treatment etc.

7.2 To develop an integrated Trust-wide approach to the management of risk, incidents, governance, health, safety and security to ensure that all stakeholders are involved in decision-making

In order to ensure coordinated and consistent practices across Trust directorates, and in line with the organisation's commitment to be an excellent partner in the health and social care community, the Trust will seek to ensure good communications with all relevant internal and external stakeholders. This will require close integration of all clinical and non-clinical aspects of health, safety, security and governance operating from this shared strategic vision and the development and observance of complementary implementation plans.

More specifically, it will include the following actions:

7.2.1 The Trust will maintain an active Health, Safety and Security Steering Group which will draw representation from all service areas from across the organisation.

In particular, this group will be responsible for championing and spearheading the alignment of health, safety and security incidents with clinical incidents in order to ensure the identification, recognition and management of risks and threats to both service users and colleagues.

7.2.2 All colleagues will be actively encouraged to record and report potential and/or actual risks to the health, safety and security of colleagues and service users using the Trust's electronic incident management system. This system will also be used to record and report all risks identified within the Trust, ensuring a coordinated and integrated approach to incident and risk management.

For further information, please refer to the Trust's Incident Governance Policy (which references organisational procedures for the appropriate management of clinical, health, safety, security and information governance incidents) as well as the Risk Management Policy.

7.2.3 In identifying health, safety and security incidents, the relevant authorities within the Trust's Planning, Compliance and Partnerships Team will work closely with the Professional and Clinical Effectiveness (PaCE) team who are responsible for maintaining the Trust's electronic incident management system.

7.2.4 As part of the investigation of health, safety and security incidents (see also section 7.1.7 above), the relevant Trust lead will be responsible for liaising with the Non-Executive Director who has specific nominated authority for safety and security.

There will also be responsibility to inform all relevant Trust Executives and forums (as detailed in section 7.3.4 below) to keep them apprised of any significant risks to the continued health and well-being of Trust colleagues, service users, carers, families or the wider Gloucestershire public.

Where appropriate, the PaCE, Security and Planning, Compliance and Partnerships leads will ensure that there is a consistent approach to managing risks and developing mitigation strategies.

7.2.5 The Trust will ensure that learning and outcomes from investigations will be systematically reported back to relevant authorities so that this learning can be subsequently incorporated within updates of policies and procedures, and reflected within the Trust's training programmes).

In particular, this will include:

- ensuring that all relevant operational teams from across the Trust have full oversight so that remedial actions can be taken to prevent reoccurrence;

- sharing the outputs of investigations with the Trust's communications team, so that learning can be cascaded across the Trust, thereby raising colleagues' awareness of salient issues and risks.

7.2.6 The Trust will work with all relevant professional stakeholders across Gloucestershire in order to exchange information, advice and best practice. This will include, for example, all other local NHS organisations who should be appraised of any prevailing themes or trends in local crime or risks, as well as other partner agencies such as the Gloucestershire police and Gloucestershire County Council.

7.2.7 The Trust will ensure that its nominated representatives attend pertinent conferences and other engagements, so as to understand changes in the environment or national thinking. Those attending will ensure that lessons can be shared to maximise the value of such engagements.

7.2.8 There will be active engagements with all staff groups across the Trust, so as to help the development and promotion of initiatives to improve the health and wellbeing of colleagues. In particular, this engagement will actively involve the traditionally hard-to-reach staff groups, such as volunteers, night workers etc. For further information, refer to the Trust's Workforce and Organisational Development Strategy and the Health and Wellbeing Plan.

7.3 To maintain robust governance processes to facilitate the effective management of all Health, Safety and Security matters, including clear responsibilities for leadership

The Trust has agreed a set of core values that will underpin all governance arrangements in respect of the management of Health, Safety and Security across the Trust. These values are described as follows:

- **Caring**: health, safety and security procedures will seek to extend the optimum protection, and provide the most compassionate service, to colleagues, service users, carers, families and visitors across Gloucestershire;

- **Open**: colleagues, service users, carers, families and visitors will have formal opportunity, via a variety of channels, to raise any concerns that they may have regarding health, safety or security;

- **Responsible**: everyone within the Trust will share accountability for health, safety and security, and Trust leaders in particular, will have unequivocal duty to ensure that all issues that are raised in respect of potential or actual weaknesses or vulnerabilities within Trust systems, are addressed with due urgency;

- **Effective**: management arrangements for health, safety and security will be evaluated by their successes which achieve measureable reduction in hazards, risks and incidents.

To enable the Trust to abide by these principles, the following actions will be observed:

7.3.1 All Trust colleagues must recognise their personal responsibilities to contribute to the maintenance and promotion of a safe and secure working environment. These responsibilities will be included within colleagues' job descriptions.

Moreover, individual accountabilities will be itemised within relevant health, safety and security policies and supporting guidance documentation.

7.3.2 The Trust will develop and publish a comprehensive and consistent set of health, safety and security policies and procedures, which will enable colleagues to clearly understand the best practice that they must consistently apply in order to keep themselves, service users, carers, families and visitors, as safe, secure and healthy as possible. These policies and all other Trust control documents will be reviewed on a regular basis, and amended and updated accordingly in order to reflect changes within the internal and external environment, and all corresponding security risks.

7.3.3 All hazards, incidents and near misses will be reported and assessed as necessary. In order to ensure a systematic approach, the Trust will:

- actively maintain an appropriate array of risk registers that together, will enable all risks to on-going health, safety and security to be recorded, reported and escalated;
- make standardised risk assessment and incident reporting forms readily available to colleagues via the Trust intranet;
- ensure that formal action plans are developed where appropriate, and specifically in response to risk assessments and incident investigations, these to be monitored by the relevant Trust forum;
- provide information to service users, carers, families and the wider public so that they know how they know how they may report any concerns to their health, safety and security.

7.3.4 The Trust will maintain a number of key forums in which issues relating to health, safety and security are addressed. These include the Health, Safety and Security Steering group, the Joint National Consultative Forum (JNCF), and the Audit and Assurance Committee. Robust Terms of Reference will regulate the activities of these forums, which will include:

- responsibility for the oversight of an annual work plan and Assurance Statement that will detail specific management actions to be undertaken in year, based on identified risks and gaps in the Trust's compliance with its health, safety and security policies;
- responsibility for the review of the Trust's annual organisational crime risk profile that will identify principle risks in relation to crime, prior to the document's submission to NHS Protect;
- responsibility for endorsing the output of the security standards self-review tool (SRT) which provides assurance to NHS Protect, NHS England and the Department of Health that the Trust has carried out a self-assessment against its contractual obligations;
- responsibility for the monitoring of corrective actions instigated as a result of health, safety or security inspections, audits, risk assessments and action plans;
- responsibility for performance monitoring health, safety and security activity at all levels of the Trust;
- responsibility for policy development on health, safety and security matters.

7.3.5 The Trust will provide appropriate instruction, training and supervision to all relevant colleagues across the Trust in respect of health, safety and security.

This will include:

- comprehensive introduction to health, safety and security as part of the induction training package that will be available to all new Trust colleagues;
- training on how colleagues may best manage hazards and emergency evacuations;
- training in how colleagues may best apply and maintain safe systems of work;
- provision of Conflict Resolution Training (CRT) that will enable colleagues to best understand how to de-escalate potentially violent, abusive or aggressive acts or individuals (see also section 7.1.6 above);
- professional development for those within the Trust who are personally and directly responsible for leading in health, safety and security. This will require, for example, the Local Security Management Specialist to undertake all necessary NHS Protect training and development updates, and the Health and Safety Compliance Manager to maintain knowledge of all prevailing legislation and standards.

Moreover, the Trust recognises that all health, safety and security training programmes and content need to remain flexible, so that they can adapt to emerging requirements and changes in local and national risk profiles.

7.3.6 The Trust will work with appointed Safety Representatives, who will be part of the Health and Safety Steering Group and the Joint National Consultative Forum to ensure the staff voice is an integral part of Health and Safety Management.

To this end, the Trust will seek to ensure that there are Safety Representatives within all relevant operational areas across the organisation.

7.4 <u>To achieve the best possible security standards as required under the Standard Contract and NHS Protect Security Standards</u>

The Trust has explicit responsibility to ensure that it maintains robust and suitable processes to ensure adequate protection against:

- the loss of, the theft of, or damage to, Trust equipment, private property or materials in store;
- the theft of and from, or damage to, Trust motor vehicles;
- the unauthorised access to, and/or use of, any of the Trust's information resources, including:
  - personal information relating to colleagues, service users or others;
  - Trust owned or licenced information (i.e. intellectual property);
  - any commercially sensitive or restricted information.

To this end, the Trust will ensure the following actions:

7.4.1 All colleagues across the Trust will be required to remain mindful of potential security threats: to this end, should anyone identify a weakness or vulnerability to the continued physical or electronic security of any of the Trust's assets or resources, they will be required to conduct a risk assessment and then follow the guidance contained within the Risk Management Policy. Where appropriate the risk should be carried to the Trust Risk Register.

This will help to develop a culture of responsibility across the Trust, and will serve to encourage a shared sense of ownership towards the protection of Trust assets.

7.4.2 Similar to the guidance in section 7.1, aimed at ensuring the security of individuals, the Trust will also observe a systematic process of proactive inspections, audits and risk assessments in order to validate and ensure the security of its assets.

7.4.3 The Trust will make every effort to maintain the physical security of its premises. This will require adherence to a strict identification procedure in order to verify the appropriateness of any individual to access Trust locations.

In particular, locations in which servers and other critical IT equipment are stored, will be rigorously safeguarded against the threat of theft, vandalism and other forms of malicious damage: thus, access to these secure areas will be strictly controlled and kept out-of-bounds to visitors and unauthorised colleagues.

7.4.4 In order to maintain overview of all Trust assets, the organisation will ensure that all tangible assets owned and/or operated by the Trust, whether static (i.e. desktop PC's) or portable / mobile (i.e. laptops used by all members of the Trust's Integrated Community Teams) will be appropriately security marked and asset tagged in line with appropriate policies.

Furthermore, an accurate and up-to-date list of all asset tagged equipment and its respective operators/users will be maintained as an integral part of the organisation's asset register.

7.4.5 The Trust will routinely explore all options to embrace technology in the pursuit of asset protection. Thereafter, any emerging technologies that are identified as having the potential to offer tangible benefit to the Trust will be subject to rigorous scrutiny so as to evaluate their perceived effectiveness, viability, sustainability and cost-efficiency prior to recommendation for use, which will be addressed via the Audit and Assurance Committee.

7.4.6 The Trust is wholly committed to protecting the confidentiality, integrity and availability of all information that it holds. To this end, the Trust will observe robust Information Governance standards, protocols and procedures - for further information, refer to the Trust's Information Management and Technology Strategy and supporting guidance.

7.4.7 The Trust is equally committed to ensuring the integrity and availability of its electronic systems, both clinical and non-clinical, and maintains agreed processes to realise this commitment - for further information, refer also to the Trust's Information Management and Technology Strategy.

7.4.8 The Trust will investigate all incidents that involve theft, attempted theft or damage to the organisation's property and assets, making recommendations to reduce the future risk, and addressing these through the Audit and Assurance Committee, via the Health, Safety and Security Steering Group.

7.4.9 The Trust will observe formal processes to enable effective response to all national alerts issued by NHS Protect.

8. Quality Measures

8.1 Each of the quality goals as identified in section 6 above, will be supported by a series of performance measures as detailed below, to be reported to, and monitored by the Health, Safety and Security Steering Group and the Audit and Assurance Committee on a routine basis:

Quality Goal	Quality Measure
To ensure that service users, carers and families as well as colleagues, benefit from optimum health and safety whilst under the care of the Trust, irrespective of environment or setting	• Reduction in the number of incidents relating to slips and trips recorded on Trust premises • Reduce the number of physical or verbal assaults on colleagues • Percentage of incident investigations completed to timescale. • Reduction in service user accidents • Reduction in staff accidents • Reduction in absences / days lost as a result of incident/accident in work
To develop an integrated Trust-wide approach to the management of risk, incidents, governance, health, safety and security to ensure that all stakeholders are involved in decision-making	• Evidence of partnership working including with other local NHS organisations and Gloucestershire County Council in order to share information about local crimes or emerging environmental risks to health, safety and security • Evidence of engagement with relevant authorities and partner agencies such as the Gloucestershire police, to inform the Trust's health, safety and security activities • Increase in the number of activities designed to improve the health and well-being of Trust colleagues

To maintain robust governance processes to facilitate the effective management of all health, safety and security matters, including clear responsibilities for leadership	• Development of an annual work plan to respond to (i) identified risks and gaps in the Trust's health, safety and security policies, (ii) identified gaps in health, safety and security audits, and (iii) outputs from the culture survey • Induction training in Health, Safety and Security provided to all new Trust colleagues • Percentage of scheduled Senior Manager visits completed
To achieve the best possible security standards as required under the Standard Contract and NHS Protect Security Standards	• Monitor, and where practicable, reduce the number of reported thefts and malicious damage to Trust property and assets • Robust investigations / action plans in respect of 100% reported thefts or incidents of crime • Effective response to 100% national alerts issued by NHS Protect • Annual completion of the security standards self-review tool (SRT) • Provision of security management in accordance with NHS Protect's Security Standards for Providers

9. Accountabilities and Assurances

9.1 Trust Board

The Board is responsible for the delivery of safe, effective health and social care, and for ensuring that resources are used efficiently. This includes responsibility for overseeing the application of robust systems to ensure that the organisation's estate is safe and secure, and that also all colleagues, service users, visitors and members of the public, are kept free from harm.

9.2 Chief Executive

The Chief Executive is the Trust's Accountable Officer, and as such, has overall responsibility for ensuring that the organisation maintains exemplar Health, Safety and Security practices that enable the delivery of the highest quality care services.

9.3 Audit and Assurance Committee

This Committee has responsibility for ensuring effective processes to enable compliance with core Health, Safety and Security standards, national practice and mandatory guidance including that issued by the Health, Safety and Security Executive.

The Committee is supported by the Health, Safety and Security Steering Group, an advisory forum which monitors the overall effectiveness of the Trust's Health, Safety and Security policy, procedures and training.

9.4 Director of Finance

The Director Finance is the Trust Executive with personal responsibility for the delivery of health, safety and security standards

9.5 Head of Planning, Compliance and Partnerships

The Head of Planning Compliance and Partnerships is responsible for overseeing the implementation of health, safety and security standards and practices, supported in these endeavours by the Health and Safety Compliance Manager and the Local Security Management Specialist.

9.6 Local Security Management Specialist (LSMS)

The LSMS is responsible for adhering to the NHS Protect Code of Professional Conduct, and for providing assurance that requisite security management requirements as outlined in this Strategy and NHS Protect Standards are fulfilled.

9.7 All Trust colleagues

All colleagues across the organisation have responsibilities for health, safety and security. This includes explicit obligation to perform their duties in such a way that they do not create unnecessary risk to themselves or others.

10. Enabling and Supporting Strategies

10.1 This Health, Safety and Security Strategy complements the following additional strategy documents maintained by the Trust:

- the Quality Strategy, which seeks to champion a whole-system approach so as to ensure that consideration of quality becomes fundamental to every decision and action taken by the Trust;

- the Risk Management Strategy, which serves to identify the framework and aspirations that will support the effective management of both strategic and operational risks (both clinical and non-clinical) across the Trust;

- the Clinical Strategy, which strives to ensure a robust approach to the auditing of the Trust's clinical and social care practices, so that the organisation is fully assured of the quality of its care functions, and understands how improvements can be made where necessary, in order to increase the continued effectiveness of Trust services;

- the Information Management and Technology Strategy that specifies the Trust's plans to achieve compliance with all requisite information governance standards, and thereby ensure that the information that is maintained by the organisation is complete, safe, secure, accurate, timely and reliable; and which seeks to ensure that information technology is used as an aid to empower Trust colleagues to provide service users with the best possible care;

- the Business Continuity Strategy, which seeks to outline the Trust's strategic approach to continuing its most critical services in light of a major incident, including the unavailability of the organisation's systems and networks;

- the Estates Strategy, which seeks to ensure that all users of the Trust's facilities receive the best experience the Trust is able to provide, offering safety, privacy and dignity, whilst respecting the need to match commissioned services, quality and environmental sustainability with cost-effectiveness.

10.2 This Health, Safety and Security Strategy is directly supported by the Health, Safety and Security Implementation Plan and the Sign up to Safety Implementation plan, which clarify the actions to be undertaken by the Trust within the period 2016-21 in order to fulfil the ambitions of this Strategy.

11. References

Control of Substances Hazardous to Health Regulations (2002)
http://www.hse.gov.uk/coshh/
http://adlib.everysite.co.uk/adlib/defra/content.aspx?id=18274

Disability Discrimination Act (2005)
http://www.legislation.gov.uk/ukpga/2005/13/notes/contents

The Control of Legionella Bacteria in Water Systems (2013)
http://www.hse.gov.uk/consult/condocs/cd258.htm

Control of Asbestos Regulations (2012)
http://www.legislation.gov.uk/uksi/2012/632/contents/made

Fire Regulatory Reform (Fire Safety) Order (2005)
http://www.legislation.gov.uk/uksi/2005/1541/contents/made

Essential Standards of Quality and Safety (Care Quality Commission, 2010)

Health & Safety at Work etc Act 1974 (Health & Safety Executive, 2013)

Management of Health & Safety at Work Regulations 1999
(Health & Safety Executive, 2013)

Occupiers Liability Act 1957 (Crown, 2013)

Children's Act (Home Office, 2004)

NHS Standard Contract 2016/17 (NHS England 2016)

NHS Protect Security Standards for Providers

Gloucestershire Care Services NHS
NHS Trust

INFORMATION MANAGEMENT & TECHNOLOGY (IM&T) STRATEGY

2016-21

To ensure the optimum availability, accuracy, completeness, relevance, reliability, confidentiality and security of all information that is collected and reported, thereby supporting delivery of the Trust's healthcare services

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0. Executive Summary

This Strategy identifies how Gloucestershire Care Services NHS Trust ("the Trust") will seek to develop and augment its IM&T services over the next five years. In doing so, this Strategy recognises that both its IT and information assets are key enablers to delivering continued improvement and modernisation in local healthcare services, not only to ensure better efficiency for the Trust, its workforce and professional partners, but also and more significantly, to help improve the experiences and outcomes of service users, their families and carers, and the wider Gloucestershire community. Similarly, the Trust acknowledges the role of information governance as a means of regulating the flow of information, and ensuring that optimum safety, security and confidentiality is maintained at all times.

As such, this document aims to provide the strategic foundations upon which the Trust will:

- use technologies that add distinct benefit to Trust operations and efficiencies, by, for example, continuing to improve Trust colleagues' abilities to securely access relevant information, communications and technology from any location and at any time in order to improve the quality of delivered care; also to better support service users by providing the public with access to their information, and implementing services such as self-help, appointment booking, secure messaging etc;

- rationalise the number of clinical and corporate systems in use across the Trust in order to deliver cost-efficiencies, and reduce the unnecessary need for additional system-specific training and system support services;

- use a robust performance management framework to deliver the Trust's vision, values and strategic objectives, and to cascade appropriate learning and improvement across all Trust services: this will help ensure that the delivery of high-performing, high-quality services is rightfully regarded across all teams in the Trust as a required standard;

- ensure that information is used intelligently, thereby enabling the production of reliable and credible reports that practically support the delivery of high-quality care: this begets the need to achieve the highest standards of data quality, and create fully coordinated and triangulated activity, finance, quality and workforce information so as to enable holistic analysis;

- ensure adequate control in information systems and processes, in order to conform fully with information governance legislation and standards.

This IM&T Strategy therefore outlines the Trust's corresponding aspirations over the next 5 years. The accompanying implementation plan will detail the practical actions to be taken in the period 2016-2021 in order to fulfil these goals.

1. Introduction

"*Better use of technology and data is a prerequisite for supporting and enabling the key developments needed to reshape the health and care system, which are at the centre of the Department of Health's vision for health and care and the NHS's Five Year Forward View, in response to increasing demand and constrained resources."*

Personalised Health and Care 2020: Using Data and Technology to Transform Outcomes for Patients and Citizens
*(*National Information Board, 2014)

1.1 This Strategy acknowledges information as a fundamental Trust asset, and a key enabler to supporting the provision and continued modernisation of local healthcare services. It also places clear focus upon the technology used to access and maintain that information, as well as key internal controls such as information governance which seeks to ensure that all types of information used by Gloucestershire Care Services NHS Trust (the Trust) are sourced, held and used appropriately, securely and legally.

1.2 This Information Management and Technology (IM&T) Strategy therefore combines the previous Information Technology (IT) Strategy, Information and Performance Management Strategy and Information Governance Strategy, in order to demonstrate the Trust's integrated approach towards:

- ensuring that technology is used as an aid to empower Trust colleagues both to improve planning and also to provide service users with the best possible care;
- achieving legal and regulatory compliance with information management standards;
- generating the ready availability of comprehensive and credible information that will:
    - highlight good performance, encourage learning across teams, and validate excellence to the Trust's service users, public and commissioners;
    - identify areas where service delivery improvements can be made;
    - ensure that the Trust is meeting all of its mandatory, statutory and contractual requirements;
    - recognise trends in activity, workforce and/or finance and their corresponding impacts on care delivery;
    - measure the relative success of healthcare interventions on the well-being of the local Gloucestershire population, so as to be assured that all viable actions are being taken to provide the highest possible quality services.

2. Ambition and Objectives

2.1 The ambition of this IM&T Strategy is "*To ensure the optimum availability, accuracy, completeness, relevance, reliability, confidentiality and security of all information that is collected and reported, thereby supporting delivery of the Trust's healthcare services*".

This aligns to the Trust's overarching vision which is "*To be the service people rely on to understand them and organise their care around their lives*", given that both intentions aim to enable the delivery of exemplar care and support to the Trust's service users, and provide increased choice so that local people may receive the care they want, where and when is most appropriate to them.

2.2 This five year strategy seeks to ensure that by 2021, the following objectives have been achieved, linked to the Trust's overarching strategic objectives:

Trust Strategic Objectives	IM&T Strategy Objectives
Achieve the best possible outcomes for our service users through high quality care	• Supporting a robust information technology, management and governance infrastructure that allows colleagues to focus on core clinical work, and that facilitates the best use of information and knowledge in order to improve standards of care • Continuing to provide service users across Gloucestershire with access to a range of specialist technologies that will enable them to maintain themselves with optimum safety and independence within the community • Maximising the Trust's analytical capacity by converting raw data into intelligent information that enables decision-makers to evaluate the outcomes of local healthcare activities and interventions
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	• Providing service users with appropriate access to information about their own care so that they may best understand their condition, and work with care professionals to improve the services that they receive • Ensuring an appropriate balance between openness and confidentiality in the management and use of information • Ensuring that the preferences of service users are recorded and respected, and seeking feedback from service users to monitor Trust effectiveness in the use of new technologies

Actively engage in partnerships with other health and social care providers in order to deliver seamless services	• Implementing the shared vision of all Gloucestershire health and social care providers by supporting delivery of the Local Digital Roadmap • Promoting effective information sharing through the implementation of Joining Up Your Information, which will allow data to be shared with other providers in a controlled manner consistent with the interests of the service user • Benchmarking Trust information to enable all relevant stakeholders to understand performance within the local, regional and national landscape
Value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision	• Continuing to assess and deploy the latest technologies to support new ways of working for colleagues to enable them to deliver highest quality care • Enabling clear understanding of the Trust's performance by all colleagues and teams across the organisation so as to create a shared single vision for improvement • Supporting operational colleagues to optimise the quality, accuracy, completeness and reliability of information that is recorded and reported
Manage public resources wisely to ensure local services remain sustainable and accessible	• Exploiting systems in order to deliver benefits, and achieve value from money from investments • Ensuring that reports are clear, meaningful, timely and accessible, and facilitate understanding of the Trust's progress in delivering its key objectives • Aiming to replace paper-based information at the point of care

3. National Context

3.1 The *NHS Operational Planning and Contracting Guidance 2017-19* published by NHS England and NHS Improvement (September 2016) describes how Trusts will work towards the development and implementation of local Sustainability and Transformation Plans (STPs), and how in turn this will serve to deliver the ambitions of the *Five Year Forward View* (NHS England, 2014), driving improvement in health and care, restoring and maintaining financial balance, and achieving core access and quality standards.

With specific reference to IM&T, the document describes how NHS England, the Department of Health and NHS Digital are working together as part of the National Information Board and Digital Delivery Board to oversee the delivery of Local Digital Roadmaps, which serve to articulate how individual health economies are aiming to digitise providers and achieve integration of information across care boundaries.

3.2 The strategy for innovation, sustainability and transformation being developed by NHS Digital as at September 2016, based upon the principles previously espoused within the paper *Personalised Health and Care 2020: Using Data and Technology to Transform Outcomes for Patients and Citizens* (National Information Board 2014), focuses upon achievement of the following ten programmes:

- **service user engagement: self-care and prevention**, which aims to help people take control of their own health, and reduce the pressure on frontline services;
- **urgent and emergency care**, which seeks to improve telephone and online triage, and provide better technology to support clinicians so that treatment is better targeted;
- **transforming general practice**, whereby technology will be used to free GPs from time-consuming administration and to provide patients with online services;
- **integrating health and social care**, so as to inform clinical decisions across settings and enhance the flow of service user information;
- **digital medicines**, which will give people greater choice and convenience by enabling them to choose where, when and how their medicines are delivered;
- **elective care**, which seeks to improve referral management and provide better treatment choice by automating referrals across the NHS;
- **paper-free at the point of care**, which aims to equip the NHS with technology that will transform care, and ensure that the workforce has appropriate skills;

- **data availability for outcomes, research and oversight**, which intends to improve the quality, availability and integrity of health data so that decision-makers are better informed;

- **infrastructure**, which seeks to enable information to move securely across settings by maintaining robust national systems and networks;

- **public trust and security**, which aims to respect the data sharing preferences of service users and keep their data secure in all settings.

3.3 In terms of information governance, the major national drivers include:

- UK legislation including the Data Protection Act 1998, the Freedom of Information 2000, The Common Law Duty of Confidentiality, the Access to Health Records Act 1990, the Computer Misuse Act 1990 etc;

- the European Union General Data Protection Regulation, which will take effect from 25 May 2018 (NB despite Britain's pending cessation of EU membership, it is anticipated that Britain will still adopt the Regulation);

- the review of information sharing and associated information governance policies, led by the National Data Guardian Dame Fiona Caldicott. (*Information: To Share or Not to Share?*, Department of Health, 2013), which led to an updating of the six original Caldicott principles, and the addition of a seventh (namely "The duty to share information can be as important as the duty to protect patient confidentiality");

- the Health and Social Care Information Centre's Cyber Security Programme (CSP) CareCERT Project;

- O'Donnell's *Data Handling Procedures in Government* and the Thomas/Walport report on data sharing, whereby organisations are required to report any Serious Incidents Requiring Investigation (SIRIs) and provide assurance of compliance with information governance standards within their annual reports;

- the agenda which has been developed from the *Open Data White Paper* (Department of Health, 2012), aimed at making increased levels of information available to all, in order to stimulate the information market and economic growth, as well as facilitating greater accountability;

- a stronger focus on improving health and wellbeing outcomes for the public at large, measured by the Outcomes Frameworks for the NHS, social care, public health and commissioning;

- *Everyone Counts: Planning for Patients 2014/15 to 2018/19* (NHS England, 2014), which describes an approach to transformational change across the NHS so as to achieve the continued ambition to secure sustainable high quality care for all, now and for future generations.

4. Local Context

4.1 The Trust has clearly defined directorates, roles and responsibilities for the management of IT, performance and information, as well as information governance, and recognises that in order to deliver the shared ambitions of this Strategy, leaders for these three disciplines must work together closely.

This management structure is ably supported by the following governance mechanisms:

- a comprehensive library of policies, procedures and guidance documents which support staff to work to prescribed standards;
- training programmes which facilitate colleagues' increased learning and education;
- internal management forums, such as the IM&T Steering Group and the Information Governance Steering Group, which report to the Audit and Assurance Committee and thereafter to Board, and which receive regular progress reports against this Strategy and the supporting implementation plan;
- countywide management forums such as the Local Digital Roadmap Infrastructure Delivery Group and the Gloucestershire Information Governance Group (GIGG) wherein local partner organisations share knowledge and information regarding IM&T development plans;
- countywide agreements such as the Gloucestershire Information Sharing Partnership Agreement (GISPA) which facilitate joint working across the local health and social care economy;
- a rolling programme of self-assessments including work to validate compliance with the requirements of the national Information Governance Toolkit;
- on-going programmes of development including the initiatives to:
    - further enhance the Trust's primary electronic clinical information system, working collaboratively with clinicians;
    - introduce Electronic Prescribing for all relevant services to include electronic transfer to countywide pharmacies directly.

4.2 In September 2015, a process began to enable local health and care systems to produce Local Digital Roadmaps as referenced in section 3.1 above. Working with partners across the Gloucestershire health community, the Trust continues to articulate and implement measures to progress this workstream and thereby achieve 'paper-free at the point of care' by 2020.

4.3 The Trust is also committed to working with local partners on the development and implementation of the Joining Up Your Information (JUYI) initiative which seeks to bring all countywide system information into one place.

4.4 The Trust's Performance and Information Team currently fulfils a range of mandated requirements from the Department of Health, NHS Digital, Public Health England, NHS England, NHS Improvement and the Health Protection Agency. These requirements include the following:

- completion of statutory returns for which information is routinely collated, validated and submitted to meet necessary deadlines;
- submission of nationally-mandated datasets within requisite timescales: these include, but are not limited to:
    - data flows to the Secondary Uses Services (SUS) in respect of admitted service user care, minor injuries and illness units and outpatients;
    - data flows on behalf of the Trust's sexual health services including the Chlamydia Testing Activity Dataset that is submitted to the Health Protection Agency, the Genito-Urinary Medicine (GUM) Clinic Activity Dataset that is submitted to Public Health England etc;
    - Safety Thermometer data, as well as the Children and Young People's Health Services (CYPHS) dataset, that is submitted to NHS Digital etc.

4.5 The Trust has recently updated its Clinical Strategy, which includes an explicit commitment to *"champion the use of technology to enhance our practice, reduce variation and increase consistency in our work".* Corresponding goals within this Strategy include delivering:

- monthly service activity reports that are accurate and appropriate to support service developments;
- a Clinical Systems User Forum that meets regularly, and is actively supported by services that contribute to the live forum work plan;
- clinical system templates which consistently and accurately support service data, and whose redesign is always completed within 8 weeks;
- an IM&T strategy that is developed with, and shared around the needs of, clinical services, reflecting their vision for future service needs;
- training to 100% colleagues, enabling them to use their electronic clinical systems, with refresher training available when required.

5. Quality Goals

In order to ensure that this IM&T Strategy maintains optimum focus upon achieving quality outcomes, the following five quality goals have been identified:

- to identify, promote and utilise technologies and systems that add distinct benefit to Trust operations and efficiencies, providing service users and the wider Gloucestershire public with increased choice, quality and flexibility;

- to consolidate corporate and clinical systems, enabling delivery of high quality care, and actively supporting system roadmaps;

- to ensure robust performance management that actively enables delivery of the Trust's vision, values and strategic objectives, and facilitates appropriate learning and improvement across all Trust services;

- to ensure that the Trust's information is of optimum accuracy, completeness and timeliness, and that information is used intelligently, thereby enabling the production of reliable and credible reports that practically support the delivery of high-quality care;

- to ensure adequate control in information systems and processes, in order to conform fully with information governance legislation and standards.

6. Priorities and Actions

The following priorities have been identified and mapped against the Strategy's quality goals. Further detail will be included within the Strategy's implementation plan, progress against which will be monitored on a regular basis by the Audit and Assurance Committee.

6.1 To identify, promote and utilise technologies and systems that add distinct benefit to Trust operations and efficiencies, providing service users and the wider Gloucestershire public with increased choice, quality and flexibility

6.1.1 Throughout the lifecycle of this IM&T Strategy, relevant authorities within the Trust, and ostensibly the Head of IT and Systems Management, will be responsible for maintaining an up-to-date view of the external environment, in order to recognise all opportunities for future IT acquisitions or enhancements. Thereafter, any emerging technologies that are identified as having the potential to offer tangible benefit to the Trust and its service users, will be subject to rigorous scrutiny so as to evaluate their perceived effectiveness, viability and cost-efficiency prior to recommendation for use, which will be addressed via the Audit and Assurance Committee.

6.1.2 Every electronic system in use within the Trust relies upon an operating system, which comprises the fundamental software and files that provide system functionality, and that communicate with the system's associated hardware. To this end, the Trust will routinely ensure that all operating systems that underpin both the organisation's clinical and corporate IT systems are kept up-to-date, offer optimum security and protection from hacking, computer viruses and all other forms of malicious software, and enable more seamless transfer of information both internally and externally.

In particular, the Trust must be aware of any technical vulnerabilities in software and/or systems which may increase the risk of a cyber-crime attack, and mitigating these risks to ensure that the Trust network remains as safe as possible.

6.1.3 In order to provide storage for its wealth of data, the Trust utilises a number of servers across the county. The Trust is committed to:

- centralise servers across the Trust establishing a primary data centre at Cirencester and a secondary site at EJC. This will improve the Trust's ability to protect, manage and support this business-critical equipment;
- provide better coordinated back-up of Trust data so as to support disaster recovery, and improve resilience and reliability;
- ensure the data warehouse server infrastructure remains fit-for-purpose as part of a resilient design, enabling the storage of all relevant system data including archived decommissioned system information;
- provide quicker access to applications, and ensure system availability 24/7.

6.1.4 The Trust will routinely identify the most efficient and cost-effective way in which to purchase and manage its licences, whether these are in relation to software, hardware, clinical / corporate systems or system servers. This focus upon efficiency will ensure that the organisation is able to remain legally compliant, whilst providing Trust colleagues with appropriate access to the systems and technology that they require in order to be able to deliver the highest quality of care.

6.1.5 In order to provide the most effective and reliable IT service, the Trust will utilise appropriate external support and agencies as necessary. To this end, the Trust will regularly review all such contracts and arrangements so as to ensure that each contains a comprehensive and binding confidentiality clause, and that the Trust will benefit from the most cost-effective solutions at all times.

6.1.6 The Trust will continue to use Information Technology to support colleagues who require access to organisational systems wherever and whenever they are working. The Trust will therefore continue to support the roll-out of appropriate mobile equipment such as laptops, phones and tablet devices, by which colleagues may be able to securely access all necessary information irrespective of their location. Moreover, this equipment will be regularly reviewed and updated in order to ensure the continued suitability of such devices, and to maintain an appropriate balance between improved efficiency and cost-effectiveness.

6.1.7 The Trust will continue to review the technical infrastructure that supports all forms of communication so as to maintain the most efficient and cost-effective ways of keeping colleagues and other appropriate health and social care professionals aware and informed. This will include:

- maintaining a robust network infrastructure which will underpin information exchange, whether internally across organisational locations or externally to partners and other stakeholders: moreover, the Trust will continually reassess this infrastructure so as to ensure that it remains fit-for-purpose, enables maximum flexibility of working, and provides clinical and care professionals with fast and easy access to service user records in any location and at any time;

- ensuring that the email services provided by the Trust are suitable, efficient and secure.

6.1.8 The Trust recognises the value of technology, not only as a way of enhancing Trust operations and efficiencies, but also as a means to directly support service users. The Trust is therefore committed to making relevant technologies accessible to service users where these may improve their experiences and quality of life.

This commitment is reflected by, for example, the Trust's plans to use communications technologies to improve service user contact with the Trust. This will include, for example, the use of technologies to:

- support the delivery of the NHS e-referral service (NHS e-RS, formerly Choose and Book) that will allow service users to make, change or cancel appointments online or by phone;
- enable appropriate messages, that include appointment and test result reminders, to be sent via text;
- provide free guest Wi-Fi across all clinical based Trust sites that will enable service users to link to service information, surveys etc.

Similarly, technology will be used to support those contact mechanisms that are designed for the use of local healthcare professionals, which will nevertheless also improve the speed and efficiency by which service users may access relevant services. These mechanisms include:

- online patient portals delivered by the Joining Up Your Information (JUYI) project which will enable service users to access and update details and be signposted to services as required;
- telecoms technology such as Skype or Webex which will allow for direct clinical contact with service users;
- robust and secure email technologies to keep service users informed.

6.1.9 The Trust will continuously explore technologies that will enable service users to remain safe and independent within the community. These technologies will include, for example:

- emerging smartphone applications which may allow, for example, service users to view their clinical records, track the progression of chronic conditions, provide a unified diabetes management system etc;
- specialist speech and language therapy software which can enable service users to trial speech support;
- upgraded diagnostic kits being used within the Trust's Minor Injuries and Illnesses Units.

6.2 To consolidate corporate and clinical systems, enabling delivery of high quality care, and actively supporting system roadmaps

6.2.1 The Trust will continue to rationalise the number of clinical and corporate systems that are in regular use across the organisation. Such rationalisation will ensure cost-efficiencies, as it will result in fewer systems requiring licensing and maintenance, and will reduce unnecessary need for additional system-specific training and system support services.

However, the Trust is clear that where there is a defined operational benefit to the maintenance of a separate standalone system (for example, where specialist care services such as Sexual Health have specific legislative requirements or unique data capture and reporting standards), rationalisation will not apply.

6.2.2 In addition, the Trust is committed to the Joining Up Your Information (JUYI) initiative which seeks to bring countywide system information into one place. Thus, for example, the Trust will be able to use a single system to monitor the care journey of any individual service user in real-time, irrespective of setting, rather than having to access this information from a number of different systems or having to request information over the phone or by post/fax/email.

The benefits of adopting this approach are that it will:

- facilitate improved care delivery and professional decision-making;
- reduce time spent unnecessarily searching and retrieving clinical and care information;
- reduce delays in processes such as referral vetting;
- introduce new control and security around access to information.

6.2.3 The Trust is actively committed to ensuring negligible use of paper and other consumables. This will create service efficiencies and enable the Trust to refine the use of clinical systems through clinically-led redesign in order to implement, for example:

- electronic referrals;
- e-prescribing;
- improved sexual health and dentistry systems.

6.2.4 The Trust will ensure the improved efficiency of its key corporate business areas (finance, human resources, governance, estates and performance and information) by delivering more robust IT solutions, creating a centralised team, rationalising software and by using free functionality where possible.

6.3 To ensure robust performance management that actively enables delivery of the Trust's vision, values and strategic objectives, and facilitates appropriate learning and improvement across all Trust services

6.3.1 The Trust will maintain a structured performance management system in order to ensure that:

- there is clear and consistent focus upon the Trust's achievement of its strategic, contractual and quality objectives, and attainment of its overarching vision and values;
- the delivery of high-performing, high-quality services is regarded across all teams in the Trust as a required standard;
- there is accurate reporting of performance at team-level so that all Trust colleagues are empowered to act and drive forward continuous quality improvement in service delivery;
- teams can be clear about their performance priorities and can communicate their performance against these priorities comprehensively and responsively to the Trust Board, Executive team, colleagues, service users, the public and commissioners;
- there is clear opportunity to recognise and identify any weaknesses in performance or delivery which can then be addressed proactively;
- the Trust is able to effectively promote the quality of its services and achievements in order to improve its credibility and reputation locally, regionally and nationally.

Functional details of this system will be articulated within the Trust's Assurance and Escalation Framework, which will also demonstrate how responsibility / accountability for performance management is defined across the organisation's governance structure. Thus, the Assurance and Escalation Framework will describe how individual Board-subcommittees, steering groups, working groups and other forums have specific responsibility for:

- validating information relevant to their particular speciality, discipline or area of influence;
- overseeing the implementation of action plans in respect of areas that have been reported as under-performing;
- identifying, reviewing and/or escalating concerns or risks;
- capturing learning about quality and performance, and ensuring that this is used to support future quality improvement.

6.3.2 To inform its performance management system, the Trust will develop a series of service scorecards and datasets based upon:

- indicators and metrics that are meaningful to colleagues;
- national requirements, including those within the Single Oversight Model launched by NHS Improvement in September 2016;
- national and local service specifications issued by the NHS Gloucestershire Clinical Commissioning Group and other commissioners, to which Trust colleagues will be expected to contribute.

These service scorecards and datasets will be regularly reviewed and updated in line with the Trust's business needs. As such, they should all serve to demonstrate:

- the Trust's ability to meet the needs of service users, carers and families;
- the Trust's ability to meet its contractual obligations as established with commissioners, and the mandatory standards set by regulators;
- the Trust's ability to meet its own internal standards, and in particular, those that are fundamental to achievement of the organisation's vision, values and strategic objectives;
- areas of current excellence by way of assurance, as well as areas for potential improvement so that appropriate investigative or remedial action can be taken proactively;
- the Trust's effective and efficient use of resources including finances, equipment, staff, estates etc;

Where a scorecard contains an indicator that is not achieving target, the responsible manager must develop an action plan to identify the necessary remedial actions so that performance will become satisfactory within a given timeframe.

The responsible manager must also ensure that all risks associated with non-delivery or poor performance are reported on the Trust's risk register: the Head of Performance and Information together with the Head of Planning, Compliance and Partnerships, will be responsible for ensuring the robustness of this process and validating relevant risks.

These service scorecards and datasets, together with the corresponding action plans, will be coalesced into a high level Quality and Performance report for the purview of the Board on a routine basis.

6.3.3 In line with the spirit of transparency and openness, the Trust will ensure that aggregated information about the performance of its services is also more readily available to the public so as to enable them to make informed decisions about their care. This will require the Trust to support national initiatives such as the MyNHS web portal, and also to submit data regularly to NHS Digital in order to assist in the production of national dataset publications.

It also requires the Trust to ensure that non-service user specific information is available in a range of settings and locations so as to inform the public. This includes the need, for example, to maintain information boards in community hospitals in order to provide detailed, up-to-date information about a range of metrics including service user experience, infection control, waiting times etc.

6.3.4 To enable relative understanding of Trust activity, the Trust will undertake benchmarking as appropriate. This will include local benchmarking, so that Trust services delivered by different teams can be assessed against each other to identify areas in which the Trust can develop greater consistency, and utilise national benchmarking information.

National benchmarking will enable comparison with other Community Trusts across the country; also to identify performance, against a number of criteria including quality, access, productivity, workforce and finance. This will allow the Trust to identify areas where improvements can be made, and strengthen the organisation's existing reputation for delivering high quality care.

6.4 To ensure that the Trust's information is of optimum accuracy, completeness and timeliness, and that information is used intelligently, thereby enabling the production of reliable and credible reports that practically support the delivery of high-quality care

6.4.1 In order to enable exemplar information reporting, the Trust remains committed to ensuring the highest possible data quality. This requires the Trust to undertake the following actions:

- ensure adequate built-in validation controls are available and operate in new and existing information systems and processes;
- empower all relevant operational and administrative colleagues across the Trust to have specific personal responsibility to gather data that is accurate and complete, and that is input into the relevant system or systems in a timely manner;
- facilitate clinical colleagues to add their own data directly onto the relevant system and thereby achieve real time entry, rather than relying on clerks or administrative staff to input data on their behalf at a later date;
- ensure that the Performance and Information Team produces regular reports that highlight missing or erroneous data so as to support operational and administrative colleagues;
- ensure that all colleagues understand the principles of data quality, their personal responsibility thereto, and the impact of poor data quality;
- ascribe and define accountability for data quality at both Board and team level, with Data Quality Leads receiving targeted support and dedicated training;
- maintain a clear and up-to-date Data Quality Policy which will be supported by other complementary guidance materials and documentation, all of which will be readily accessible to colleagues via the Trust intranet;
- regularly undertake a comprehensive review of data quality management processes against an agreed baseline in order to identify all possible opportunities for improvement;
- ensure that input data is validated to prevent incorrect or erroneous data being reported. For key validations, this requires a responsible owner and process to be defined: it also necessitates clinical colleagues to be involved in the validation of information that is derived from the recording of clinical activity. It may also require the Performance and Information Team to undertake batch tracing to validate key demographic data such as invalid or missing NHS Numbers or GP Practice codes.

6.4.2 The Trust will utilise a web-based Business Intelligence Reporting Tool (BIRT) so that information reports can be shared in a quick, easy and interactive way and provide the requisite level of granularity in reporting.

Throughout the lifecycle of this strategy, this tool will becomes the single repository for accessing information reports relating to Trust business in order to ensure that:

- all Trust professionals have access to the information that they need, when they need it;
- clinicians are able to run reports for purposes such as caseload management;
- information is readily available to managers to enable performance management and decision-making.

The Trust will continue to refine and enhance this capability to include other data that will be of relevance to Trust understanding - this will include, for example, benchmarking information, population data, cross-organisational pathway information etc. This will ensure that the Trust's reporting represents coordinated and triangulated activity, finance, quality and workforce information, to enable more intelligent analysis and understanding of organisational performance. It will also enable the Trust to more readily identify correlations and trends in activity, recognise and respond more swiftly to emerging risks and pressures, and ensure more efficient and cost-effective service delivery.

Additionally, the Trust will seek to ensure that this supports a drive towards predictive modelling, thereby enabling services to recognise previous trends and forecast future need and demand, rather than merely conducting retrospective analysis.

6.4.3 The Trust will ensure that all national reporting and requisite data submissions continue to be completed in line with prescribed timescales, and that these submissions are accurate and complete. Moreover, the Performance and Information Team will seek to remain aware at all times of any changes in national reporting requirements, and will respond accordingly.

6.4.4 The Head of Performance and Information will work closely with the Information Governance and Risk Manager so as to ensure that all Information Standards Notices (ISNs) issued by NHS Digital and announcing new, or changes to, information standards published under section 250 of the Health and Social Care Act 2012, are consistently reviewed and implemented across the Trust, and that responsible owners are identified in a timely manner.

6.5 To ensure adequate control in information systems and processes, in order to conform fully with information governance legislation and standards

6.5.1 The Trust is fully committed to maintaining the accuracy, completeness and timeliness of its information as described in section 6.4 above. Additionally, the Trust will seek to ensure the optimum confidentiality, security and accessibility of all information within its care, in particular that information which is either person-identifiable (relating to service users or colleagues) or confidential (relating to the business activities of the Trust). To order to support these commitments, colleagues with specific information governance responsibility within the Trust will work closely with other teams / directorates so as to ensure a fully integrated approach to relevant disciplines such as information security, data management, records management etc.

6.5.2 The Trust will maintain oversight of all local and national developments in information governance standards, directives and legislation so that these are reflected within organisational policy and actions, enabling the Trust to continue to improve upon its commitment to uphold the confidentiality, integrity and security of the information entrusted to it. This will require the Trust to routinely horizon-scan guidance issued by the Information Commissioner's Office, the Department of Health, NHS Digital etc, and interpret for local use. It will also require the Trust to actively engage with countywide forums such as the Gloucestershire Information Sharing Group.

6.5.3 The Trust will endeavour to maintain minimum Level 2 compliance with the requirements of the Information Governance Toolkit: to this end, the implementation plan which supports this Strategy will serve to demonstrate the improvements to processes necessary to achieve this, including the setting of clear responsibilities, disseminating robust operational policy via effective communications and training, undertaking proactive activities to identify and mitigate risks to system and data security etc.

6.5.4 The Trust will maintain an Information Governance Management System (IGMS) which will detail the responsibilities of colleagues to comply with all relevant information governance standards, including for example, data protection / confidentiality, information security, records management, incident management etc. Where appropriate, the IGMS will be supported and complemented by more detailed policy documents, such as the Incident Governance Policy which will provide more granular advice upon responding to all forms of adverse events (clinical, health and safety, information governance etc) which may occur across the Trust.

6.5.5 The Trust will facilitate all appropriate access to information: for sharing with service users, this will require adherence to relevant guidance within the Freedom of Information Act 2000, the Data Protection Act 1998 and the Access to Health Records Act 1990. Moreover, it will beget the Trust to ensure that suitable security and consent procedures are in place when looking to implement new technologies as a means of more widely sharing service user information.

It also requires the Trust to maintain robust information sharing processes for exchanging information with partner organisations, ensuring that relevant, timely and accurate information is available to those involved in the care of service users, but also that person-identifiable information is not shared more widely than is necessary.

6.5.6 The Trust will maintain appropriate procedures for the investigation and reporting of incidents where there is an information governance impact. These incidents will be managed in line with NHS Digital's *Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation* protocol. As such, any incidents assessed as a 'Level 1' will also be raised with the Trust's Senior Information Risk Owner and Caldicott Guardian, whilst any 'Level 2' incidents will also be reported to the Department of Health, NHS Digital and the Information Commissioner's Office. Data breaches will also be reported in the Trust's Annual Governance Statement.

6.5.7 The Trust will manage risks to information security and confidentiality - in addition to any risks which may impede the ability of the organisation to achieve Level 2 compliance with the Information Governance Toolkit – via those processes detailed within the Trust's Risk Management Policy.

6.5.8 Annual assessments of information governance arrangements and practices will be undertaken or commissioned by the Trust in order to demonstrate compliance and/or identify opportunities for further improvement.

6.5.9 A multi-layered approach will be taken to cascade policy, responsibility and accountability through the Trust, and ensure sufficient training and guidance is in place. This will include but will not be limited to:

- ensuring robust contractual clauses relating to confidentiality and other relevant information governance standards are included in the contracts of all colleagues and third parties;
- making suitable independent expert training available to inform and support the Trust's appointed Information Governance and Risk Manager, the Senior Information Risk Owner and the Caldicott Guardian;
- providing dedicated internal support to Information Asset Owners and departmental leads;
- mandating information governance training for all colleagues at induction, to be refreshed annually thereafter;
- maintaining a full suite of information governance policies, procedures, guidance documents etc, to be held on the Trust's intranet;
- cascading updates via regular Information Governance briefings, the Trust's CORE newsletter, visibility at the CORE Network etc.

7. Quality Measures

Each of the goals identified in Section 5 above, will be supported by a series of performance measures as detailed below, to be reported to, and monitored by, the Audit and Assurance Committee on a routine basis:

Quality Goal	Quality Measure
To identify, promote and utilise technologies and systems that add distinct benefit to Trust operations and efficiencies, providing service users and the wider Gloucestershire public with increased choice, quality and flexibility	• Increase in the number of electronic communications sent to service users in respect of appointments, reminders and other appropriate communications • Increase in the number of colleagues with access to suitable devices that support connectivity and real-time data access • Increase in the appropriate sharing of information with relevant external stakeholders, so as to build effective partnerships with both public and professional groups
To consolidate corporate and clinical systems, enabling delivery of high quality care, and actively supporting system roadmaps	• Increase in the number of Trust staff actively using JUYI, so as to share real-time information between all relevant local health and social care partners • Increase in the number of services actively using the Trust's primary electronic clinical information system in a standardised manner following clinically led redesign
To ensure robust performance management that actively enables delivery of the Trust's vision, values and strategic objectives, and facilitates appropriate learning and improvement across all Trust services	• Evidence of participation in all relevant benchmarking networks • Ensure 100% delivery of first draft performance scorecards to relevant teams by the fifth working day of each month, final scorecards by the tenth working day of each month, and Board and sub-Board Committee information reports to time, including evidence of action plans against metrics rated amber or red • Minimum annual update of service specifications including targets and KPIs

To ensure that the Trust's information is of optimum accuracy, completeness and timeliness, and that information is used intelligently, thereby enabling the production of reliable and credible reports that practically support the delivery of high-quality care	• Validate that Data Quality Leads are assigned and active at both Board and team level, ensuring minimum 96% data quality for information relating to admitted care, outpatients and Minor Injuries and Illness Units • Increase in the number of services with data available through BIRT • 100% compliance with mandated data flows
To ensure adequate control in information systems and processes, in order to conform fully with information governance legislation and standards	• Increase in compliance with the requirements of the Information Governance Toolkit • Decrease in the number of information governance breaches across the Trust • Compliance with requirements to share data with the public under the terms of the Data Protection Act 1998 and the Freedom of Information Act 2000

8. Accountabilities and Assurances

8.1 All Trust colleagues

All colleagues across the Trust will be responsible for using the IT, systems and information for which they are permitted access, with optimum responsibility and security in line with the Trust's policies and procedures. Moreover, it is the responsibility of all colleagues to ensure that information is accurate and up-to-date, and that it is used proactively.

8.2 Registration Authority Manager

The Registration Authority Manager is responsible for the control processes required to ensure that individuals who need to access computer systems linked to the NHS Spine, have their identity rigorously checked and are assigned appropriate access according to the user's business need. Thus, the Registration Authority Manager has responsibility to develop and review the procedure to monitor and enforce compliance with the Terms and Conditions of NHS Smartcard usage, in conjunction with the Information Governance and Risk Manager.

8.3 Head of Information Technology and Systems Management

The Head of IT and Systems Management is responsible for oversight of the Trust's IT function, as well as the clinical and corporate systems teams. The role is also responsible for the reporting of IT security and cyber-crime related risks and incidents, and will act as the Trust's nominated cyber-crime advocate to partake in the Cyber Information Sharing Partnership.

8.4 Head of Performance and Information

The Head of Performance and Information is responsible for the management of the Performance and Information Team and its portfolio of service delivery. The role is also responsible for overseeing the Trust's Data Quality leads who ensure that the organisation's data is of optimum accuracy, completeness and timeliness.

8.5 Head of Planning, Compliance and Partnerships

The Head of Planning, Compliance and Partnerships has specific responsibility for managing the Trust's information governance agenda, and ensuring that robust systems and processes are fully implemented Trust-wide. In doing so, the role is actively supported by the Information Governance and Risk Manager, who has particular responsibility for information governance policies and procedures, training and adherence to the Data Protection Act 1998 and Freedom of Information Act 2000.

8.6 Medical Director

The Medical Director is the Trust's Caldicott Guardian, and as such, has an advisory role in order to ensure the optimum confidentiality of service user information, and to enable appropriate information sharing with partner organisations.

8.7 Director of Finance

The Director of Finance is the Trust's executive lead for IM&T, and thus is responsible for overseeing all IM&T developments and implementation programmes across the Trust.

The Director of Finance is also the Senior Information Risk Owner (SIRO): as such, the Director of Finance has overall responsibility for ensuring the security of all information assets. In doing so, the Director of Finance is supported by nominated Information Asset Owners who provide assurance that information risk is being managed effectively in respect of the information assets that they oversee: they also have responsibility for ensuring the integrity and availability of information assets, and for defining and documenting requirements for both system and user access controls. In fulfilling their role, Information Asset Owners are supported by Information Asset Administrators.

8.8 Chief Executive

The Chief Executive is the Trust's Accountable Officer, and as such, has overall responsibility for ensuring that the organisation has access to the necessary resources in order to deliver the highest quality care services: this includes responsibility for the effective management of IM&T.

8.9 Board subcommittees

The Audit and Assurance Committee has specific responsibility for ensuring that all IT systems that are in use across the organisation are able to support relevant operational activity: additionally that there is an effective system of integrated governance and internal control across the whole of the Trust's activities. Thus, the Audit and Assurance Committee will receive regular reports from all relevant sub-groups and other forums including the SystmOne Deployment and Operational Project Board, the Information Governance Steering Group, and the Partnership Board that encompasses representation from the Trust as well as Gloucestershire Hospitals NHS Foundation Trust and 2gether NHS Foundation Trust in order to consider local shared IT services and countywide strategic planning.

Additionally, the Quality and Performance Committee, Finance Committee and Workforce and Organisational Development Committee have responsible for reviewing data and performance relevant to their respective areas of operation.

8.10 Trust Board

The Board has specific responsibility for ensuring that all resources are used efficiently: this includes the Trust's IT infrastructure which must remain fit-for-purpose, and provide optimum benefit and value to local service users, carers and families. Additionally, the Board has overall responsibility for ensuring optimum information governance standards are in place across the Trust.

9. Enabling and Supporting Strategies

This IM&T Strategy complements the following additional strategy documents maintained by the Trust:

- the Quality Strategy, which seeks to champion a whole-system approach so as to ensure that consideration of quality becomes fundamental to every decision and action taken by the Trust;

- the Clinical Strategy, which seeks to empower the Trust to remain a leading provider of community-based healthcare services that provide optimum quality, safety and effectiveness, and enable every person in Gloucestershire to experience a positive journey and outcome;

- the Health, Safety and Security Strategy, which serves to confirm the Trust's clear commitment to ensuring the optimum protection of all buildings, systems, property and other assets owned and/or operated by the Trust, and maintaining the physical and personal security of all Trust colleagues, service users, carers, families as well as the wider Gloucestershire public who attend any of the Trust's facilities;

- the Workforce and Organisational Development Strategy, which seeks to ensure that the Trust's projected staffing models are appropriate to deliver effective healthcare within Gloucestershire, and that all Trust colleagues are suitably involved, motivated, supported, resourced, trained and developed.

- the Business Continuity Strategy, which seeks to outline the Trust's strategic approach to continuing its most critical services in light of a major incident including the unavailability of the organisation's systems and networks;

- the Estates Strategy, which seeks to ensure that all users of the Trust's facilities receive the best experience the Trust is able to provide, offering safety, privacy and dignity to all, whilst respecting the need to match commissioned services, quality and environmental sustainability with cost-effectiveness.

This IM&T Strategy is directly supported by the IM&T Implementation Plan which clarifies the actions to be undertaken by the Trust within the period 2016-21.

Gloucestershire Care Services NHS
NHS Trust

TRUST PUBLIC BOARD - FORWARD PLANNER - 2016-2017

Month	January	March	May	July	September	November
Standing Items						
Service User Story - TBC	x	x	x	x	x	x
Questions from the public	x	x	x	x	x	x
Leadership Items						
Chair's Report	x	x	x	x	x	x
Chief Executive's Report	x	x	x	x	x	x
Chief Operating Officer's Report	x	x	x	x	x	x
Governance and Risk						
Board Assurance Framework	x	x	x	x	x	x
Quality, Safety and Performance						
Quality and Performance Committee update	x	x	x	x	x	x
Workforce and Organisational Development Committee update	x	x	x	x	x	x
Quality and Performance Report	x Month 8	x Month 10	x Month 12	x Month 2	x Month 4	x Month 6
Finance Committee update and Finance Plan - Draft	x	x	x	x	x	x
Finance Report	x Month 8	x Month 10	x Month 12	x Month 2	x Month 4	x Month 6
Charitable Funds Update (as required)	x	x	x		x	x
Audit Committee Update (as required)	x	x		x	x	x
Strategy						
	Health, Safety and Security Strategy 2017 (then every 3 years, due 2020)	Quality Strategy 2017 (every 3 years, due 2020)	Finance Strategy 2017 (every 3 years, due 2020)	Workforce and OD Strategy 2016(Every 3 years , due 2019)	Clinical Strategy 2016 (every 3 years, due 2019)	Business Continuity Strategy 2016 (Every 3 years, due 2019)
	Information Management and Technology Strategy 2017 (every 3 years, due 2020)	Estates Strategy 2017 (every 3 years)	Charitable Funds Strategy 2017 (every 3 years, due 2020)			
	Communication & Engagement Strategy 2017 (Every 3 years, due 2020)	Risk Management Strategy 2017(every 3 years, due 2020)				
Sustainability and Transformation Plan, including any consultation updates	x	x	x	x	x	x
Corporate						
Understanding You Report	x			x		
Listening into Action			x		x	
Assurance						
Charitable Funds Committee update						
Review of Board and Committees' Effectiveness		x				
Review of Quality and Annual Accounts			x			

Every routine meeting will also include:
Welcome and Apologies
Quoracy confirmation
Declaration of Interests
Approval of minutes from last meeting
Action Log
Forward planner
Any other business
Date of Next Meeting
Opportunity to informally review the meeting

AGENDA ITEM 24

ANY OTHER BUSINESS