Gloucestershire Care Services NHS
NHS Trust

Agenda

Agenda

Trust Board
Tuesday, 20 January 2015
9.30am – 4.00pm

Malvern & Coopers Room, Edward Jenner Court,
1010 Pioneer Avenue, Brockworth, Gloucester, GL3 4AW

Agenda No.	Item.	Outcome	Ref No.	Presenter
1.	Respiratory & HOAS Service	For information	14/B001	Annie MacCallum/Sally King/Angela Wixey
Refreshment Break				
2.	Apologies		15/B002	Chair
3.	Declaration of Interests	To receive	15/B003	Chair
4.	Minutes of the Meeting held on 25 November 2015	To approve	15/B004	Chair
5.	Matters Arising (Action Log)	To note	15/B005	Chair
6.	Forward Agenda Planner review	To approve	15/B006	Chair
7.	Questions from the Public All questions from the public should be received in advance	For discussion	15/B007	Chair
8.	Chair's Report	To receive	15/B008	Chair
9.	Chief Executive's Report	To receive	15/B009	Chief Executive
10.	Chief Operating Officer's Report	To receive	15/B010	Chief Operating Officer
Governance, Quality and Safety				
11.	Quality & Performance Report	To receive	15/B011	Director of Nursing & Quality
12.	Annual Infection Prevention and Control Report	To approve	15/B012	Director of Nursing & Quality
13.	Safer Staffing in Community Hospitals: Patient Dependency Review	To approve	15/B013	Director of Nursing & Quality
14.	Quality & Clinical Governance Committee update – minutes 16 October 2014	To note	15/B014	Chair of Q&CGC
15.	Equality Annual Report	To receive	15/B015	Director of HR
16.	HR & OD Committee update – minutes 22 October 2014	To note	15/B016	Chair of HR&OD
17.	Performance & Resources Committee update – 21 October 2014	To note	15/B017	Chair of P&R
Refreshment Break				
Service Delivery and Performance				

18.	Finance Report	To receive	15/B018	Director of Finance
19.	CIP, CQUIN & QUIPP update report	To receive	15/B019	Chief Operating Officer
20.	Audit & Assurance Committee update – minutes 6 October 2014	To note	15/B020	Chair of A&A
21.	Communications and Engagement Committee update – minutes June 2014	To note	15/B021	Chair of Comms & Engagement
22.	Your Care Your Opinion Committee Update	To note	15/B022	Chair of Your Care Your Opinion
Ratification of Strategies				
23.	Strategy Dashboard	To receive	15/B023	Chief Executive
24.	Financial Management Strategy	To approve	15/B024	Director of Finance
25.	Quality Strategy	To approve	15/B025	Chief Executive
Information				
26.	Any other Business	To note	15/B026	Chair
27.	Date of Next Public Meeting Tuesday, 17 March 2015 in The Pavilion, Hatherley Lane, Cheltenham, Gloucestershire, GL51 6PN			

GLOUCESTERSHIRE CARE SERVICES NHS TRUST BOARD

Minutes of the Meeting held on Tuesday, 25th November 2014 at Edward Jenner Court, 1010 Pioneer Avenue, Brockworth, GL3 4AW

Voting Board Members	
Ingrid Barker (IB)	Chair
Paul Jennings (PJ)	Chief Executive
Joanna Scott (JS)	Non-Executive Director, Vice Chair
Robert Graves (RG)	Non-Executive Director
Richard Cryer (RC)	Non-Executive Director
Susan Mead (SM)	Non-Executive Director
Christopher Creswick (CC)	Non-Executive Director
Nicola Strother Smith (NSS)	Non-Executive Director
Glyn Howells (GH)	Director of Finance/Deputy Chief Executive
Dr. Mike Roberts (MR)	Interim Medical Director
Board Attendees (Non-Voting)	
Duncan Jordan (DJ)	Chief Operating Officer
Susan Field (SF)	Director of Service Transformation
Candace Plouffe (CP)	Director of Service Delivery
Tina Ricketts (TR)	Director of Human Resources
Jason Brown (JB)	Director of Corporate Governance & Public Affairs
In Attendance	
Christine Thomas	Minute Taker

Ref	Minute	Action
TB 105/14	**"Patient Story" presentation – Rapid Response** IB opened the meeting and introduced two members of the NHS TDA who were observing the meeting (Penny Emerit, Sarah Hughes). IB then welcomed Helen Hodgson (HH), Head of Unscheduled Care and Capacity, Kathy Campbell (KC), Clinical Lead and Angela Cooper (AC), Rapid Response Practitioner from the Rapid Response Team. IB also advised that the presentation was being filmed. HH introduced her team and opened the presentation by giving an overview of the Rapid Response service year to date. The service is currently available in all areas except for Stroud and North Cotswolds, which are scheduled to be launched later in the financial year. HH handed over to AC who presented a	

	case study of a 93 year old female who was living with family and who had subsequently developed a chest infection. AC took the Board through the process of how they treated this lady from the moment of receiving the referral from the Out of Hours GP through to discharging her back into her GPs care where the District Nurses would then take over responsibility. KC explained how her role was to ensure the Rapid Response team had the correct competencies and skills to deliver an effective service. Following a series of questions IB thanked the team for their excellent presentation.	
TB 106/14	**Agenda Item 2: Apologies** IB opened the formal Trust Board meeting and welcomed the NHS TDA and the members of staff who were in attendance. Apologies were tendered by Elizabeth Fenton, Director of Service Delivery who was attending a Chief Nursing officers Summit.	
TB 107/14	**Agenda Item 3: Declarations of Interest** There were no changes to the recorded declarations of interest.	
TB 108/14	**Agenda Item 4: Minutes of the Meeting held 14 September 2014** The minutes of the Board meeting held on 14 September 2014 previously distributed were taken as read. Subject to minor amendments the minutes were approved for signing. **Subject to the agreed amendments, the minutes were APPROVED by the Board.**	
TB 109/14	**Agenda item 5: Matters Arising (Action Log)** The Board reviewed the Action Log. All items were closed. **The Board NOTED the updates to the Action Log.**	

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TB 110/14	**Agenda item 6 – Forward Agenda Planner review** The Board reviewed the Forward Agenda Planner and agreed that the following items should be added: (1) 17 March 2015, CIP Report (DJ) (2) 17 March 2015, Complaints Policy to be received (LF) (3) 17 March 2015, Approval of Budgets (GH) (4) 19 May 2015, Rapid Response Roll-out Report (SF) (5) 19 May 2015, SystmOne Update Report (GH) (6) 19 May 2015, Annual Accounts (GH) **The Committee APPROVED the Forward Planner subject to additional items added.**	**DJ** **LF** **GH** **SF** **GH** **GH**
TB 111/14	**Agenda Item 7: Questions from the public** No questions had been received from the public.	
TB 112/14	**Agenda item 8: Chair's Report** IB presented the Chair's report to the Board, highlighting the following areas: AGM – IB thanked everyone for attending the AGM, including all the visitors and colleagues who prepared and manned stands. More than 215 people attended the exhibition at Kingsholm Stadium on Tuesday 14 October 2014. Chris Creswick – IB advised the Board that CC was retiring and would be leaving the Trust at the end of January 2015. IB thanked Chris for all his help and support given over the last year. IB stated that the Trust is currently in discussion with the TDA about arrangements for recruitment of a NED to fill the forthcoming vacancy. Chair's Forum – IB had attended a Chair's forum and updated the Board that they would be looking at the next 5 years forward view at future meetings. Letter to Health & Wellbeing Board – The Chairs of the three Gloucestershire NHS provider Trusts have written to the Chair of the Health and Wellbeing Board following a letter from Health Secretary Jeremy Hunt, which advised that providers be centrally involved in the Board. IB stated that the Trust is currently formalising a response and will report back to the Board in due course. **The Board NOTED the report.**	

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TB 113/14	**Agenda item 9: Chief Executive's Report** PJ presented the Chief Executive's report to the Board, highlighting the following areas: Listening into Action – On Monday 3 November over 100 colleagues attended the Listening into Action (LiA) Pass it On Event to celebrate the achievements of the teams involved in the scheme. There were presentations by 13 teams, and the day focused on innovation and imagination in order to build on the momentum and enthusiasm for the programme as it flows through the organisation. Ebola – PJ confirmed that the Trust had taken a multi-disciplinary approach to resilience planning in the event of a case or suspected case of Viral Haemorrhagic Fever (Ebola). National Tripartite Meetings – PJ had attended one of the national tripartite meetings on Friday 31 October 2014 and had found the meeting to be useful in helping place a focus on working in partnership. 7-day Services Vision Workshop – SF and CP attended the workshop on Monday 24 November 2014, which aimed at pulling together a system-wide strategy to improve weekend outcomes for patients in a clinically and financially sustainable way. **The Board NOTED the report.**	
TB 114/14	**Agenda item 10: Chief Operating Officer's report** DJ presented the Chief Operating Officer's report to the Board, highlighting the following areas: Stroud Community Hospital – The Trust had been in the unfortunate position of reducing bed availability for a short period of time at its Stroud Community Hospital. This was due to significant operational pressures around staff numbers and patient acuity. Community Nursing – The Trust continues to work jointly with GCCG to strengthen the Community Nursing Service as part of the ICTs. Key areas of work include (1) Countywide Recruitment Programme targeting both community staff and district nurses, with media campaigns and four open days held in September and October 2014. (2) Benchmarking of workforce and performance with comparative community organisations (3) Training and skills analysis in community nursing, linked to review of community nursing practice to assess the effectiveness and quality of clinical care and to	

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	assess capacity to meet current service demands. External Care – DJ reported that overall, strong progress is being made in key areas and the trend data is very encouraging, but there is still a lot more work required. Out of Hours Contract – It was disappointing that the GCS would not be continuing with this service. DJ highlighted that they were facing a high risk period in handing the service over. **The Board NOTED the report**	
TB 115/14	**Agenda item 11: Media analysis** JB provided the Board with an overview of media and social media coverage regarding the Trust that was published in September and October 2014. **The Board NOTED the report.**	
TB 116/14	**Agenda item 12: Quality and Performance Report** MR presented the Quality and Performance Report, which provided information and assurance to the Trust against nationally and locally commissioned targets. The report highlighted the Trust position as of September 2014 against key quality and performance indicators, and reported a Green or Amber against targets on a year to date basis (April to September 2014) as follows: Nationally = 88.9%(32) Locally = 74.1%(27) The report had been further developed in response to feedback to enable more effective triangulation of data and aimed to humanise the picture given by talking in numbers of people rather than percentages. Key areas of concern were: MSKCAT - figures could be better - this was understood to be due to recording on SystmOne and some through staffing capacity. This service was seen to be a victim of its own success, which meant it received a very high referral rate. District Nurses – there were challenges in recruiting of District Nurses, though these recruitment challenges were seen to be National.	

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The Board reviewed each of the sections of the Quality and Performance Report in detail:

Safe:

The Trust reported 12 SIRIs year-to-date of which 58% current SIRIs relate to slips, trips and falls.

It was reported that performance against the 95% threshold for harm-free care has increased in September to 93.7%. The Trust is now exceeding the 95% in all aspects with the exception of pressure ulcers.

It was also reported that although the Trust's performance re: pressure ulcers is impacting upon the harm-free care totals, it is noted that there has been two acquired Grade 3/4 pressure ulcers this year: it was also noted that the Trust compares favourably with other Community Trusts.

Caring:

The Trust is committed to providing care in an environment that protects privacy and dignity. This is supported by providing care in a single sex environment. No breaches were reported during the period April to September 2014.

It was reported that the Minor Injuries Units are not achieving the requisite response rates for the Friends and Family Test and teams are reminded of the importance of asking for feedback.

Effective:

It was reported that following a review undertaken by the Matrons, the Early Warning Trigger Tool has been replaced by the Quality Snapshot Report. This makes more visible the quality metrics used as a temperature check and therefore makes a more robust tool for matrons to use as part of their quality assurance processes. Metrics to provide a similar temperature check within community based services is currently being developed.

Responsive:

It was stated that in September, the Trust reported 88.9% compliance with national health targets and 74.1% compliance with local health targets on year to date basis. This represents a slight increase in national targets and a slight decrease in local targets from the August position. However, there are

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	clear action plans in place in respect of all areas of under-performance. It was also reported that there are three social care indicators, currently RAG rated red, which are of particular priority for the Trust and Adult Social Care Commissioners, namely: (1) Percentage of service users who have been asked if they have a carer – it was believed that the reported under performance was attributable to data quality rather than a significant drop in people with carers. This assumption is currently being explored by the Trust. (2) Permanent admissions aged 65+ to residential and nursing care homes per 100,000 population – the external care programme is launching a campaign in September to keep more people at home than going into care homes. This is reducing the number of permanent admissions, but not quickly enough. CP reported that the Trust was looking at the assessment and re-assessment process with care homes. (3) Percentage service users who have had a full re-assessment of their needs within the last 12 months – it was reported that the numbers of both assessment and re-assessments are lower than last year, and it is the aim of the external care programme to agree productivity targets for all teams. DJ reported that the Trust was looking at the assessment processes. **Well-Led:** The majority of this section would come back in TR's report and therefore would be covered then. **The Board NOTED the report.**	
TB 117/14	**Agenda item 13: Managing Concerns & Complaints Policy** This item was withdrawn from the agenda.	

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TB 118/14	**Agenda item 14: Quality & Clinical Governance Committee update report** SM presented the Quality & Clinical Governance Committee report. SM highlighted the Quality Strategy. It had been agreed that the Q&CGC would pull out 4/5 high level items to focus on and they would report an update on this at the next Trust Board meeting. **The Board NOTED the report and APPROVED the minutes of the 13 August 2014**	**EF**
TB 119/14	**Agenda item 15: HR report & HR & OD Committee update** TR presented the combined HR report and HR & OD Committee update. The CCG were happy to adopt the Core Values Framework, they had identified five areas to test with the aim of launching the handbook to all staff on 1st April. The work on E-Rostering was being tested in three sites and the results from these were so far positive. Good progress was being made on band 5 recruitment for nursing staff, though this was not the case for band 6 positions. The majority of people that were being attracted to the roles were people who wanted to work locally. There were still issues being faced in completing all appraisals. Currently people were being incentivised by receiving a pay rise to ensure these were completed. However, as 58% of staff were already at the top of their pay band, it becomes challenging to incentivise these people. **The Board RECEIVED the contents of the report and APPROVED the minutes of the 18 August 2014.**	
TB 120/14	**Agenda item 16: Listening into Action (LiA) Presentation** Claire Powell (CP) presented an update on LiA to the Board. Key themes received from the presentations: • LiA was started in Dec 2013 with 5 other NHS organisations. • In the first 10 months they have had big conversations with over 300 people • Quick wins have been implemented across the Trust • The recent Pass it on event had been a big success • Pulse check to be started in January, last year had 1,300 people respond will hope for larger response this year with more interactive promotions planned.	

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TB 121/14	**Agenda item 17: Charitable Funds Committee Update** NSS presented the Charitable Funds Committee update and advised that there had been a huge amount of work completed in respect of aligning finances. JB advised that there had also been a large amount of work completed in developing the Charity vision. It was also reported that JB and NSS will be working closely with the League of Friends to ensure charitable initiatives are aligned where appropriate. **The Board NOTED the update and APPROVED the minutes of the 19 August 2014.**	
TB 122/14	**Agenda item 18: Finance Report** GH advised the board on the year to date actual and forecast full year out-turn position for the Trust at month 6 and also provided the board with an update regarding financial risks and priorities. It was reported that for health budgets, the Trust has planned for a full year surplus of £1.5m. The current forecast is in line with plan though there is a risk that this may need to reduce when the month 7 position is finalised. QIPP Schemes have been agreed at £3.9m and CQUINS at £2m. CIP Schemes are now forecast to deliver £2.5m in year and £3.4m recurrently which is significantly less than the £6.4m in the budget. Work is on-going to mitigate the shortfall in CIP and to ensure that the revised forecast of £0.5m is delivered. IB noted that there was a danger of not making the £1.5m surplus. GH advised that they would be dropping the capital spends to protect cash. **The Board RECEIVED the report and NOTED the financial risks.**	

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TB 123/14	**Agenda item 19: Annual Security Report** GH presented the Annual Security Report which the Trust were required to produce under the NHS Standard Contract and which was bought to the Board to ensure they had sight of the report. There was a query as to why some of the items were shown as Amber when processes were in place. GH explained that this was because there was no independent evaluation process. This would be followed up by the Audit & Assurance Committee to rectify. **The Board NOTED the report and AGREED that Audit & Assurance would give this further oversight.**	
TB 124/14	**Agenda item 20: Performance & Resources Committee update** RC presented the Performance & Resources Committee update on the meeting held on 21 October 2014. The minutes of the meeting held on 2 September 2014 were taken as read. GH bought to the Board's attention that the final two phases of the SystmOne rollout had now slipped from the original 1 December date and there is a risk that this could potentially slip to January 2015. **The Board RECEIVED the update and APPROVED the minutes of the meeting held on 21 October 14.**	
TB 125/14	**Agenda item 21: Quality Impact Assessment** DJ presents the Quality Impact Assessment. This report was a result of three months' work by Kate Calvert and Lucy Lea as to how we integrate quality assessments better. This report gives an overarching view and will allow a deep dive to be completed. **The Board RECEIVED the Quality Impact Assessment**	
TB 126/14	**Agenda item 22: Audit & Assurance Committee Update** RG presented the Audit & Assurance Committee update and the approved minutes from 4 June 2014. RG wanted to draw to the Committee's attention that they had, had an extensive discussion around the Whistleblowing policy and asked for a comprehensive communications plan to be developed. **The Board RECEIVED the update and APPROVED the minutes of the meeting held on 4 June 2015.**	

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TB 127/14	**Agenda item 23: SystmOne Paper – Community Hospitals and Minor Injury Units** GH presented a paper that proposed the Trust consider implementing the Community Hospitals and MIU SystmOne modules supplied by TPP under the Southern Communities Programme to replace the existing use of the Patient Administration System (PAS). The case for change and the high level benefits were discussed by the Board, and all were in support of the proposed programme of work. **The Board APPROVED the paper and AGREED for GH to implement the proposal with updates coming back to the Board.**	**GH**
TB 128/14	**Agenda item 24: Information and Performance Management Strategy** GH advised that the Information and Performance Management Strategy had been presented and approved by the Performance & Resources Committee but needed formal ratification from the Board. **The Board RATIFIED the Strategy**	
TB 129/14	**Agenda item 25: Any other Business** There being no other items for Business, the Chair closed the meeting at 14.30pm.	
	Agenda Item 26: Date of Next Public Meeting 9.30am – 13.00pm on Tuesday, 20 January 2015 at Edward Jenner Court, 1010 Pioneer Avenue, Brockworth, GL3 4AW	

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Chair's Signature ……...

Date ……..…….

Gloucestershire Care Services NHS Trust Board Action Log

Minute Reference	Action Agreed	Lead Exec	Update for 16 September 2014	Proposed Close Date	Status
Actions Carried forward from Gloucestershire Care Services Operational Board					
TB125/13	Present report on Charitable funds available and its uses for staff to Execs team and report to Board	Director of Finance	Report coming to September Board and will be of interest to League of Friends' Chairs. On Agenda	Sep-14	Closed
TB87/14	TR & JB to decide which Committee should receive the Social Values Strategy going forward	Director of HR/Director of Corporate Governance & Public Affairs	HR & OD to receive the strategy	Nov-14	Closed
TB89/14	A joint letter from GCS and GCCG to be compiled in response to GCC letter re a Community Hospital for Gloucester	Director of Corporate Governance & Public Affairs			Closed
TB95/14	It was requested that the Board receive detailed CIP report at the next Board meeting	Chief Operating Officer		Nov-14	Closed
TB95/14	The Board needs to understand exactly how much risk the Trust faces with respect to potential non-delivery of CQUINs and QUIPP. A report to come to the next Board meeting	Chief Operating Officer	Part 2 Agenda	Nov-14	Closed
TB95/14	The risk to delivery of both CQUINs and QIPP to be recorded by the respective owners on the Corporate Risk Register	Chief Operating Officer/Director of Service Transformation/ Director of Service Delivery	Part 2 Agenda	Nov-14	Closed
TB96/14	SF presented a service progress report which highlighted a number of performance and workforce issues. It was agreed that a workshop would be held to explore prevailing issues.	Director of Service Transformation		Nov-14	Closed
Gloucestershire Care Services NHS Trust Board Action Log					
TB110/14	CIP Report to come to March meeting	Chief Operating Officer		Mar-15	Open
TB110/14	Complaint policy to be received	Director of Nursing & Quality		Mar-15	
TB110/14	Approval of budgets	Director of Finance		Mar-15	
TB110/14	Rapid-response roll-out report	Director of Service Transformation		May-15	
TB110/14	SystmOne update report	Director of Finance		May-15	
TB110/14	Annual accounts	Director of Finance		May-15	
TB118/14	Quality Strategy - Q&CGC would pull out 4/5 level items to focus on and they would report an update on that at the next Trust Board meeting.	Director of Nursing & Quality	The Quality Strategy is on the agenda	Jan-15	Open
TB127/14	SystmOne to replace the exisiting use of the Patient Administration System. GH to implement proposal and bring updates back to the Board.	Director of Finance			Open

Board Part 1 2014/15								
Month	**20 January 2015**	**17 March 2015**	**19 May 2015**	**21 July 2015**	**22 September 2015**	**24 November 2015**	**19 January 2016**	**15 March 2016**
Venue:	Boardroom - Patient Story Coopers & Malvern Rooms, EJC	Pavillion, Cheltenham						
Patient Story / Service Presentation	Presenting Respiratory & HOAS Service	Gloucestershire Voices/LD Partnership Board	Healthwatch - Claire Feehily					
Standard Items								
	Apologies	Apologies	Apologies	Apologies	Apologies	Apologies	Apologies	Apologies
	Declaration of Interests	Declaration of Interests	Declaration of Interests	Declaration of Interests	Declaration of Interests	Declaration of Interests	Declaration of Interests	Declaration of Interests
	Minutes of previous meeting	Minutes of previous meeting	Minutes of previous meeting	Minutes of previous meeting	Minutes of previous meeting	Minutes of previous meeting	Minutes of previous meeting	Minutes of previous meeting
	Actions arising from previous meetings	Actions arising from previous meetings	Actions arising from previous meetings	Actions arising from previous meetings	Actions arising from previous meetings	Actions arising from previous meetings	Actions arising from previous meetings	Actions arising from previous meetings
	Chair's Report	Chair's Report	Chair's Report	Chair's Report	Chair's Report	Chair's Report	Chair's Report	Chair's Report
	Chief Executive's Report	Chief Executive's Report	Chief Executive's Report	Chief Executive's Report	Chief Executive's Report	Chief Executive's Report	Chief Executive's Report	Chief Executive's Report
	Chief Operating Officer's Report	Chief Operating Officer's Report	Chief Operating Officer's Report	Chief Operating Officer's Report	Chief Operating Officer's Report	Chief Operating Officer's Report	Chief Operating Officer's Report	Chief Operating Officer's Report
	Public Questions	Public Questions	Public Questions	Public Questions	Public Questions	Public Questions	Public Questions	Public Questions
	Forward Planner	Forward Planner	Forward Planner	Forward Planner	Forward Planner	Forward Planner	Forward Planner	Forward Planner
	Media analysis	Media analysis	Media analysis	Media analysis	Media analysis	Media analysis	Media analysis	Media analysis
Governance, Quality & Safety								
	Quality & Performance Report (EF/GH)	Quality & Performance Report (EF/GH)	Quality & Performance Report (EF/GH)	Quality & Performance Report (EF/GH)	Quality & Performance Report (EF/GH)	Quality & Performance Report (EF/GH)	Quality & Performance Report (EF/GH)	Quality & Performance Report (EF/GH)
	Medical Revalidation Report	Complaints Policy (LF)	Rapid Response - review roll out (SF)					
	Equality annual report (LL)		ICT Steering Group report.					
		Board Assurance Framework (JB)	Corporate Risk Register	Corporate Risk Register	Board Assurance Framework (JB)	Corporate Risk Register	Corporate Risk Register	Board Assurance Framework (JB)
Strategy								
	Financial Management Strategy (sign-off) (GH)	Membership Strategy (sign-off) (JBr)	Information Governance Strategy (sign-off) (JBr)					
	Quality Strategy (Sign off) (EF)	Public Consultation Strategy (sign-off) (JBr)						
Service Delivery & Performance								
	Finance Report (GH)	Finance Report (GH)	Finance Report (GH)	Finance Report (GH)	Finance Report (GH)	Finance Report (GH)	Finance Report (GH)	Finance Report (GH)
	Mortality Reporting (MD)	Approval of budgets (GH)	Receipt of annual accounts (GH)					
	Reference Costings Report	External Care Update (SF)	SystmOne update report (GH)					
	CQUIN, QUIPP & CIP update report (DJ)	CQUIN, QUIPP & CIP update report (DJ)	CQUIN, QUIPP & CIP update report (DJ)	CQUIN, QUIPP & CIP update report (DJ)	CQUIN, QUIPP & CIP update report (DJ)	CQUIN, QUIPP & CIP update report (DJ)	CQUIN, QUIPP & CIP update report (DJ)	CQUIN, QUIPP & CIP update report (DJ)
Communications								
Information								
	Sub-Committee minutes	Sub-Committee minutes	Sub-Committee minutes	Sub-Committee minutes	Sub-Committee minutes	Sub-Committee minutes	Sub-Committee minutes	Sub-Committee minutes
		Committees Annual Statement for March						
	Date of next meeting	Date of next meeting	Date of next meeting	Date of next meeting	Date of next meeting	Date of next meeting	Date of next meeting	Date of next meeting

Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: 20 January 2015
Location: Boardroom, Edward Jenner Court, Brockworth

Agenda item 8: Chair's report

Giving to Gloucestershire launch

On Monday 8 December I attended a successful Service of Light event at Holy Trinity Church in Stroud, to launch the Trust's charity Giving to Gloucestershire. This was a multi-faith service which involved colleagues from across the Trust and featured our excellent choir under the leadership of Annie McCallum.

Nicola Strother Smith, Chair of the Charitable Funds Committee and I were pleased to launch the Christmas hamper initiative. Funded through the Helping Hand strand of the six charitable funds, we worked in partnership with Mid Counties Coop who gave us generous discounts on food hampers to be distributed to individuals known to our services who are in particular need.

Tewkesbury Hospital opening event

I am pleased to say we will be welcoming The Princess Royal to the Trust who will be officially opening Tewkesbury Community Hospital on Wednesday 28 January. She will be given a tour of the hospital with an opportunity to meet colleagues from the hospital and community teams in Tewksbury.

It will be a great opportunity to recognise the hard work and effort which has gone into the re-opening from both staff and service users. Over 900 people attended the community open day last year a testament to how important the hospital is to the people of Tewkesbury.

Engaging with our services

- I attended two home visits with a member of the Early Stroke Discharge team where I observed great skill, caring and sensitivity from the physiotherapist. Two of our non-executive directors visited the Vaughan Centre, the base for our homeless health care team, as part of their ongoing monthly visits to services.

- I was please to be invited to assist one of our dental nurses with a project she is undertaking as part of her Mary Seacole development programme. Together with a parent carer, I visited the Dental Access Centre at Southgate Moorings to undertake the 'fifteen steps challenge'. This is a methodology for assessing quality from a service user perspective, observing a number of features of the service which are evident within the first fifteen steps of entering the service. We were able to make a number of suggestions which I

hope will be helpful in taking forward the nurse's ambition to further improve user experience.

- I was extremely concerned to hear of the perilous position of the Vaughan Centre which provides a drop in centre for homeless people and which hosts the Trust's health care team for homeless people. Gear projects will continue to provide support to the homeless health care team; however the day centre service closed its doors on 3 January. I have raised the matter with the chair of the Clinical Commissioning group to explore options going forward.

Your Care Your Opinion

I chaired the Your Care Your Opinion (YCYO) meeting on Tuesday 9 December and we discussed our initiative to gather user views through focus groups. We will be looking to develop an engagement cycle showing how decisions are fed back to the Board. It was also agreed an engagement plan will be introduced to reach seldom heard groups.

The Trust will be signing up to the Co-production Charter, which works with people who use services and carers as equal partners in the design, development, commissioning, delivery and review of Social Care Institute for Excellence's services.

We will also be aiming to host an YCYO engagement day to be held in June/July, this is to be first clarified with members.

HSCOSC Meeting

The Board will be aware of the media interest that followed public statements from the Chief Executive of GHFT regarding pressures in the urgent care system and board members have been briefed on the situation.

As a result of this intervention, a 'tripartite' meeting of GCS, GHFT and the CCG with Monitor, the Trust Development Authority and NHS England took place; this is covered further in the Chief Executive's report. The HSCOSC also called an extraordinary meeting in December in order to understand the nature of the pressures and to seek assurance that the system is working collaboratively. Minutes of this meeting are appended to this report.

The HSCOSC had concerns about the impact of these circumstances on relationships between key partners and instructed the Chairs to meet to agree on a position statement for the way forward, to be reported to the January Meeting of HSCOSC and to be followed by a more detailed report to HSCOSC in March.

At the end of December I met with the Chairs of GHFT, CCG, SWAST, 2gether and the GCC Cabinet lead for adult social care to discuss the situation and to agree on a position statement which is attached to this report.

The Chief Executives will also be meeting to draft the more detailed paper in readiness for the March HSCOSC. As I am on annual leave at the time of the

January HSCOSC, I will be represented at the meeting by Non-Executive Director, Chris Creswick.

Working with our partners

Candace Plouffe and I attended an event on Friday 28 November for Carers across the county to celebrate National Carers' Rights Day. Candace represented the Trust on the question panel and it gave us the opportunity to renew contact with a number of groups and individuals. I was pleased to meet Vikki Livingstone the leader of a new group, Physical Inclusion Network Gloucestershire (PING), which is giving a voice to people with physical disability in the county. Vikki has agreed to join Your Care Your Opinion as a regular member.

Together with executive colleagues, I hosted an informal meeting with HCOSC members during December. This very helpful session enabled us to give members a greater understanding and insight into the services we provide, in particular community hospitals and the Integrated Community Teams and Rapid Response services. Members were also keen to hear of our progress towards Foundation Trust status.

The Chief Executive and I have begun our schedule of visits to District Council leaders in order to strengthen our mutual understanding and identify areas for greater joint working. This is in line with the Board's desire to strengthen our locality partnerships. Our first visit was to Gloucester City Council were we met Leader Paul James and Cabinet Member Colin Organ, the lead for housing, health and leisure.

Board Developments

The Trust Development Authority met with the executive team and myself at the December Integrated Development Meeting and has made it clear we are expected to continue to make good progress towards achieving Foundation Trust status.

TDA executives observed our November Board meeting and held one to one interviews with myself, the Chair of Audit and the Chair of Integrated Quality Governance Committees as well as the voting Executive Directors. I have received feedback from these exercises and have shared it with Board colleagues. Together with the forthcoming feedback from TDA observation of our IGQC and Performance and Resources Committee, this will be used to inform an agreed Board development programme for the coming year.

The Board development session held in December focused on agreeing assumptions to underpin the five year plan, which was agreed at the last public board meeting in early January. In order to support this, the Chief Executive, Chief Operating Officer and I met with the Chair and executive colleagues from CCG in order to seek consensus on the approach to be laid out within that five year plan. This positive initial meeting will be followed by further meetings to agree on greater detail.

At the November meeting of the Gloucestershire Strategic Forum, the Chairs agreed to our proposal to hold facilitated Board level discussions about the 'Five Year View'

for the County. A facilitator has been agreed and he has received briefings from the relevant Chairs and Chief Executives to inform three sessions to be held during February and March.

Finally, the Chief Executive and I attended the December meeting of provider Chairs and Chief Executives of Trusts across England, hosted by NHS Providers (previously known as the Foundation Trust Network). We listened to a thorough overview of national system challenges from the Chief Executive of NHS Providers. We also heard presentations from Government Minister, Norman Lamb and from David Dalton on his recently published report on new options for provider configurations.

Appendix

2.5 Extraordinary HCOSC 16 December 2014

2.5.1 An Extraordinary Meeting of the Gloucestershire HCOSC was called for 16 December 2014 to discuss matters relating to hospital discharges, which had been the subject of public discussion following a media communication issued by GHNHSFT in early December 2014.

2.5.2 Representatives from Gloucestershire County Council (GCC), GCCG, GCSNHST, and GHNHSFT attended the Meeting to engage with the Committee.

2.5.3 There was a full and frank discussion regarding the issues raised, with the resulting outcome being a request from HCOSC Members for all Chairs of the NHS provider organisations and the Chair of the County Council's Health and Wellbeing Board to meet and to provide a full report on the outcome of their discussion for the HCOSC's meeting on 3 March 2015.

2.5.4 Chairs[1] met at the end of December 2014 and agreed the following Consensus Statement and Principles:

Consensus Statement

Pressures are being experienced across the urgent care system in Gloucestershire which are having a significant impact for patients including:

- *Longer waits in Emergency Departments.*
- *Delayed admissions of patients to appropriate inpatient areas.*
- *Admission of patients to areas which are not designed for inpatient care or to the wrong speciality ward.*
- *Delays in some discharges to community care or home (with a package of care).*
- *Cancellation of some non-urgent elective surgery.*

The resolution of these issues requires recognition of the problems at the earliest possible stage and a commitment from all five organisations to work collaboratively - to improve care for all our patients entering the urgent care system in Gloucestershire and to optimise patient flow.

*We **all** acknowledge that there are issues within each of our organisations that need to be addressed and that we must consider the whole system when managing the urgent and emergency care pathways for patients.*

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[1] Chairs of the NHS provider organisations and the Chair of the County Council's Health and Wellbeing Board met on 30 December 2015. The meeting was hosted by Dr Helen Miller, Clinical Chair Gloucestershire Clinical Commissioning Group, attendees were: Ingrid Barker, Chair Gloucestershire Care Services NHS Trust, Councillor Dorcas Binns, Chair Gloucestershire Health and Wellbeing Board, Professor Clair Chilvers, Chair Gloucestershire Hospitals NHS Foundation Trust and Heather Strawbridge, Chair South Western Ambulance Service NHS Foundation Trust.

We recognise that this requires continual 'fine tuning' and adjustment as the system changes.

We need to work collaboratively for the common purpose of delivering the safest, most effective and affordable care for the people of Gloucestershire.

Principles Agreed:

- We need to continue to take a whole system view across health and social care.
- Each organisation needs to be aware of the interdependencies between themselves and partner organisations.
- There needs to be a renewed commitment to delivering a shared action plan covering the whole system (including social care) and covering admission avoidance, hospital care and discharge arrangements - with clear metrics assigned to individual schemes to enable the performance of each organisation to be held to account.
- There needs to be strong Executive level engagement from all organisations in the governance structure for urgent care.
- A renewed commitment to follow the agreed escalation process with agreement to use the Alamac 'Kitbag'[2] as the single source of data for this purpose.
- If any organisation considers that their perspective has not been taken into account then the agreed escalation process will be followed. This will include an urgent meeting of CEOs. In these circumstances each organisation will agree to avoid directly contacting the press without the prior agreement of other partners.
- Commitment to communicate significant planned changes in services/provision to all partners in advance of the change. A protocol to enable this will be developed.
- Commitment to increase the pace of change by adopting best practice and reducing delays in committing resources – with an emphasis upon sharing risk and putting patients first.
- Create a shared risk register capturing and assessing the risks across the whole system to enable decisions to be taken that mitigate the risks across the whole system – to include SWASNHSFT (mindful that they cover a greater footprint than Gloucestershire). Agreed that this should also include social care and be explicitly linked to an agreed escalation process.

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[2] http://www.alamac-ltd.co.uk/
Alamac provides a cloud-based tool for collating and triangulating data - all together in one place. It is designed to help health and social care teams to understand performance trends, and the 'cause and effect' of key measures. The objective information provided by Kitbag creates the foundation for the daily assessment and evaluation of performance which sits at the heart of our clinical method.

- To use our respective Communication Teams when dealing with the media and not to engage with the media without full collaboration across the organisations To review jointly and ensure greater ownership of the Joint Communications Plan

- Review membership, focus and purpose of Gloucestershire Strategic Forum (GSF):

    - Invite SWASNHST to become a member.

    - Review attendees and ensure all CEO's and Chairs or equivalent attend.

    - Use these sessions to hold each other to account.

    - Strengthen the agenda.

    - Ensure Urgent Care is put on as a standing item.

    - Use the agreed common data set – Alamac – to share national requirements and metrics from all parts of the system including social care.

    - Suggest Chief Executive from each organisation takes a session to present their challenges.

    - Invite additional representative from Primary Care.

    - Commitment to provide regular reports to the Gloucestershire HCOSC.

2.5.5 A full report on the outcome of the Chairs' discussion and subsequent actions and outcomes will be prepared for the HCOSC's meeting on 3 March 2015.

2.5.6 As reported to the Extraordinary Meeting on 16 December 2014, a number of steps are being taken to reduce delays in patients leaving hospital, provide more care in patients' own homes and improve patient outcomes. These include:

- reviewing the timing of ward rounds by senior staff – including earlier in the day and increasing numbers of discharges at the weekend;
- additional investment in the Integrated Discharge Team. The team of nurses and social workers make sure everything is in place for patients to leave hospital in a safe and timely way;
- investment in a short stay ward for patients who require a short (24-48 hours) hospital stay;
- developing the Older People's Assessment and Liaison Service – reducing the need for admission to hospital or reducing the need for a longer stay in hospital;
- working to ensure maximum bed availability at Community Hospitals, including Stroud, through the recruitment of nursing staff and revised admission criteria and renewed focus on discharge;
- investment of £3.9 million in Integrated Community Teams – providing intensive support to patients in their own homes;
- continued focus on proactive care at home including self-care and domiciliary care; and

- working with the Ambulance Service, so that more patients can receive care at home or in the community – including expert advice from GPs, mental health professionals and specialist community teams.

2.5.7 GCCG believes that the strategic direction for the system is sound and this view has been externally confirmed by NHS England. There is consensus that system-wide success requires a relentless focus upon delivery and quality and that the health and care community in Gloucestershire has a collective responsibility to work positively together in the interests of patients. GCCG will continue to monitor the system closely, recognising that every patient deserves to receive timely, safe care in the most appropriate place to meet their on-going needs.

Footnote 1: Chairs of the NHS organisations and the Chair of the County Council's Health and Wellbeing Board met on 30 December 2014. The meeting was hosted by Dr Helen Miller, Clinical Chair Gloucestershire Clinical Commissioning Group, attendees were: Ingrid Barker, Chair Gloucestershire Care Services NHS Trust, Councillor Dorcas Binns, Chair Gloucestershire Health and Wellbeing Board, Professor Clair Chilvers, Chair Gloucestershire Hospitals NHS Foundation Trust and Heather Strawbridge, Chair South Western Ambulance Service NHS Foundation Trust.

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Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: 20 January 2015
Location: EJC

Agenda item 9: Chief Executive's Report

At the beginning of January the Trust was informed of the dates of inspections to be conducted by the Care Quality Commission. These are scheduled for the week of Monday 22 June 2015, covering all services provided by the Trust. This is the inspection known as the "Chief Inspector's Inspection". If the Trust achieves a sufficiently positive rating then it will be in a position to be granted a Foundation Trust License. The rating is valid for two years.

There will be a very considerable piece of planning required to ensure that the Trust can accommodate the requirements of the inspection which may well see up to seventy inspectors present in GCS during that week.

The outcome will be known shortly after and will of course be shared with colleagues and the wider health and social care system.

Winter pressures

The board will be aware that there was an extraordinary meeting of the Health and Social Care Overview Scrutiny Committee on Tuesday, December 16, following public claims about the state of the county's services by colleagues within the NHS.

The previous day Gloucestershire Hospitals NHS Foundation Trust (GHFT) had declared a 'major internal incident' due to bed pressures. It did so again over the weekend of January 3-4, 2015.

The period from December 2014 heading into the New Year has seen the health system in Gloucestershire under significant pressure and I would like to acknowledge the great efforts made by colleagues to ensure that patients and service users are cared for at home or are treated quickly and efficiently in a community hospital.

Colleagues have worked additional hours and extra shifts and shown both professionalism and pride in maintaining a focus on patient care and safety in spite of an increase in numbers of people being seen over the last few weeks, both by our integrated community teams and in our community hospitals.

We are committed to working in partnership with GHFT, Gloucestershire County Council, South West Ambulance Service and 2gether to ensure we maintain a timely and effective health service for people in the county.

On Wednesday 10 December 2014, I attended a 'tripartite' urgent care escalation meeting with GHFT and Gloucestershire Clinical Commissioning Group as well as the Trust Development Authority and NHS England.

That meeting included a commitment that the health system has to be in equilibrium – in other words that hospital discharge rates have to match admission rates – and that each organisation will "consider actions in terms of system impact rather than organisational impact – for example reducing a patient's length of stay in the system rather than in an individual service."

At the beginning of January a system-wide escalation plan was agreed between trusts as follows:

- Organisations submit data by 0915 to ensure escalation report runs
- Escalation level confirmed on 1000 call for each part of system
- Appropriate escalation actions agreed to recover position
- Director lead for each area agreed as below. Lead directors will ensure appropriate escalation actions across all involved organisations are implemented.
    - Pre hospital: Sue Field
    - In hospital: Eric Gatling
    - Post discharge: Mark Walkingshaw

I will give a verbal update to the board of any further developments subsequent to the preparation of this report.

Listening Into Action

A second Pulse Check survey was sent to all colleagues across the Trust at the beginning of December and the survey closed on December 19.

The idea behind these is to give a snapshot of opinion from within the organisation, with the first survey – in January 2014 - providing a baseline and subsequent surveys showing any shifts in attitude in the intervening time.

The results from the two surveys are included below.

Question	**First Pulse Check %**	**Second Pulse Check %**
I feel happy and supported working in my team/department/service	42	58.25
Our organisational culture encourages me to contribute to changes that affect my team/department/service	28.29	45.75

Managers and leaders seek my views about how we can improve our services	27.55	41.98
Day-to-day issues and frustrations that get in our way are quickly identified and resolved	15.26	29.01
I feel that our organisation communicates clearly with staff about its priorities and goals	19.06	34.79
I believe we are providing high quality services to our patients/service users	59.72	68.63
I feel valued for the contribution I make and the work I do	31.94	45.52
I would recommend our Trust to my family and friends	45.35	56.25
I understand how my role contributes to the wider organisational vision	46.24	57.78
Communication between senior management and staff is effective	17.87	26.55
I feel that the quality and safety of patient care is our organisation\'s top priority	47.8	64.15
I feel able to prioritise patient care over other work	39.91	50.12
Our organisational structures and processes support and enable me to do my job well	22.49	33.02
Our work environment, facilities and systems enable me to do my job well	25.61	38.09
This organisation supports me to develop and grow in my role	26.43	37.97

The results from the second survey show improvements over the first and I believe the Listening into Action programme is helping drive a cultural shift towards individual and team problem-solving and empowerment.

While I welcome this snapshot, it is also clear that there is still significant work required to engage and communicate well across the Trust, to support our colleagues in both their work and career development and to recognise and respond where people are being prevented from working effectively.

The programme will continue throughout 2015, with a decision to focus on community nursing and our wider integrated community teams and will undoubtedly be rewarded with fresh ideas to improve our organisation and the care it can deliver.

Planning Guidance

On December 19, 2014, the NHS Trust Development Authority (TDA) published its latest Planning Guidance, which it has developed in association with Monitor, NHS England, the Care Quality Commission, Public Health England and Health Education England. This requires us to refresh our strategic and operational plans for 2015-16, previously prepared in April 2014.

To further support us in the development of our plans, the TDA has also issued *The Forward View into Action*, based upon the *Five Year Forward View* released last October, which aims to set out the joint high-level ambitions and system priorities for both commissioners and providers.

Additionally, the TDA has drawn attention to a number of key issues for which we are required to give particular consideration. These include:

- the introduction of a default 50:50 gain and loss sharing price setting rule for acute prescribed specialist services activity above 2014/15 planned levels;

- changes to the standard contract which introduce higher penalties for non-delivery of NHS Constitutional standards and information reporting failures together with a shift to make all sanctions automatic in future;

- the ambition of making significant progress toward implementing 24/7 working in the absence of further investment; and

- the delivery of further efficiency gains of 3.8% after a sustained period of a 4% efficiency savings.

To evidence our plans, we were required to submit a series of returns on 13 January covering finance, workforce, quality, performance, technology and innovation. These returns received approval at an extraordinary Board meeting on 12 January.

We will continue to refine our plans pending additional returns to the TDA on February 27 and April 10.

GCS Leadership Meetings

The coming year will see a significant focus on efficiency at the Trust and I am proposing to set an example by arranging for a number of our monthly leadership meetings to be held via Webex.

These would be the largest networked meetings held by the Trust – involving up to 110 participants – and as such offer an opportunity to significantly reduce travel costs and time. The leadership meeting in February is slated to be held via Webex and I will keep the board updated as this plan progresses.

Meeting our teams

On Tuesday 9 December I attended a podiatry study day in Gloucester and met around 70 colleagues to give a presentation and then host a discussion on the strategic direction for the Trust. Similarly, I attended the dental services away day on Thursday 20 November and am keen to meet and engage with as many of our services and teams as I can throughout 2015.

Media coverage

There has been considerable media attention on the two ‘major internal incidents’ at GHFT due to bed shortages, with associated coverage of our Trust as one of the

partner organisations offering alternatives to the Emergency Departments at Gloucester and Cheltenham.

Our coverage has been predominantly neutral in tone in approximately 30 regional and national news stories in which we have featured on the topic. We have also featured in the broadcast media with a BBC Radio Gloucestershire interview and three television appearances by Susan Field – two on BBC Points West and one on ITV West.

Proactive media releases have resulted in Anna Gibbins, from the Healthy Lifestyles Team, featuring on a BBC Points West news item on Tuesday 16 December covering her work with the homeless at the Vaughan Centre in Gloucester. There was also coverage of the Service of Light in Stroud in December as the launch of the Giving to Gloucestershire charitable fund, and media stories around dementia-friendly modifications, along with additional staff training, at Dilke and Lydney Hospitals.

Between November 13, 2014 and January 6, 2015, the Trust appeared in around 65 print and online articles. A common metric is to assign those articles a 'value' based on the cost of an advert in that publication of equivalent size and prominence. The approximate value of articles featuring the Trust in this period was £75,900.

Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: 20 January 2015
Location: Edward Jenner Court, Brockworth

Agenda item 10: Chief Operating Officer's report

Winter Pressures

The Trust has been working to alleviate what are significant bed pressures at Gloucester Royal and Cheltenham General Hospitals which have prompted two separate 'major internal incidents' in the last month.

To support the acute trust we have increased staffing levels, opened an additional 16 beds in our community hospitals and are supporting up to a further 30 beds in nursing and care homes to provide greater community capacity.

We have been liaising with Gloucestershire Clinical Commissioning Group, South West Ambulance Service and Gloucestershire Hospitals NHS Foundation Trust on a daily – in some cases much more frequent – basis over the last month in line with our escalation procedures.

In addition to daily management within the system, the Trusts have jointly agreed a series of longer-term measures to help mitigate pressures, including:

- Reviewing the timing of ward rounds by senior staff – including earlier in the day and increasing numbers of discharges at the weekend
- Additional investment in the Integrated Discharge Team
- Investment in a short stay (24-48 hour) ward
- Further development of the Older People's Assessment and Liaison Service, which will help reduce the need for hospital admission to hospital and bring down lengths of stay
- Revised admission criteria and a renewed focus on discharge at community hospitals
- Ongoing investment in Integrated Community Teams
- Continued focus on proactive care at home including self-care and domiciliary care
- Working with the Ambulance Service to ensure more patients receive care at home or in the community

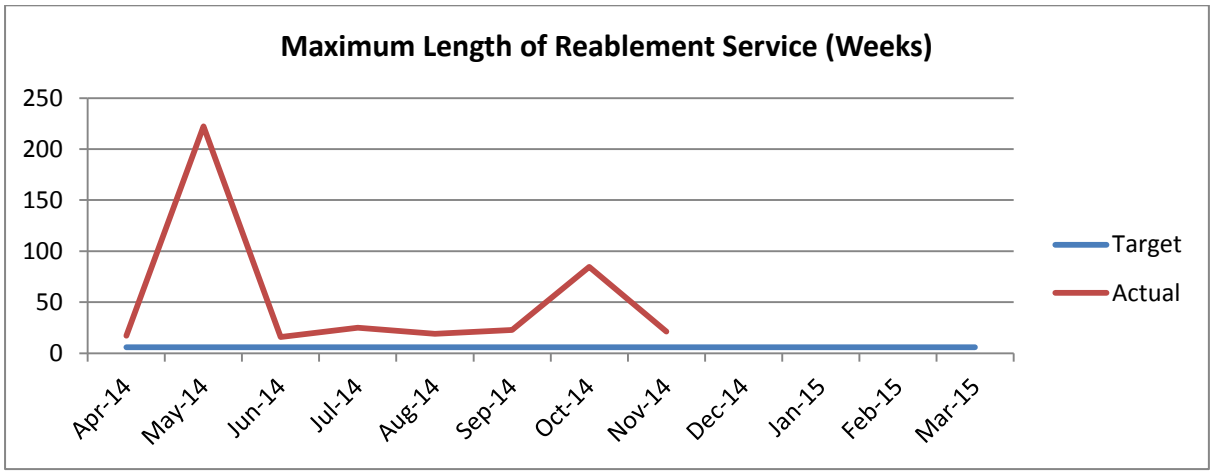
External Care

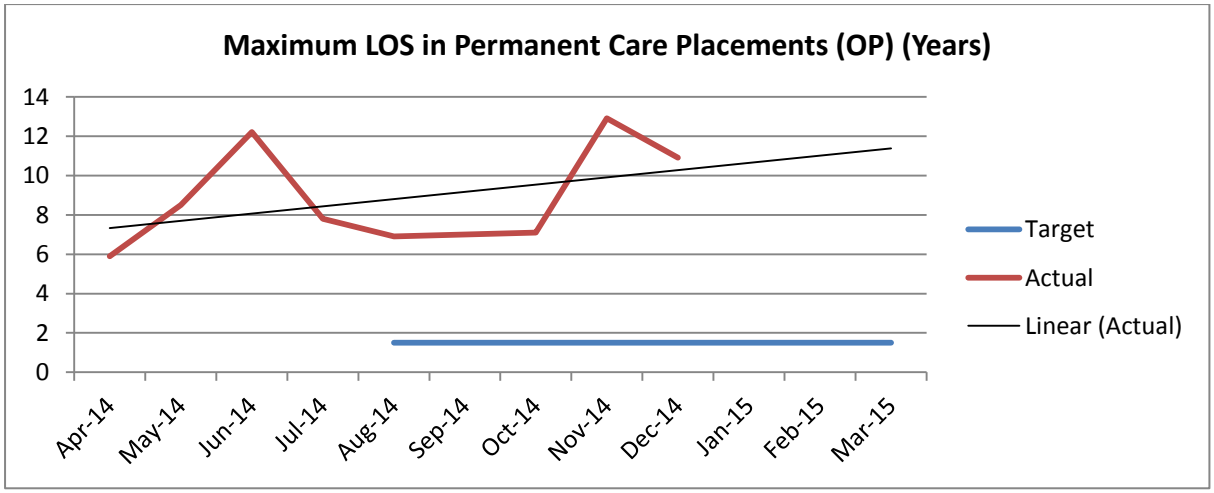
The External Care Recovery Plan encompasses a broad range of actions relating to our referral centres, telecare, reablement and admissions to permanent residential or nursing home care.

This activity is commissioned and paid for by Gloucestershire County Council (GCC), and targets within the recovery plan are associated with an ambitious savings projection which is significant in light of the authority's stated need to save £75m over the next three years.

Progress is being measured through 19 metrics. Figures for November show six ahead of target and 10 behind (the remaining three do not have targets at present). Of the 10 which are behind target, four are showing improvement towards target.

Areas where the Trust is not meeting its targets, and showing a deteriorating position, relate to the maximum time service users see the reablement team and the lengths of stay in permanent care placements.





Achieving against our performance targets has involved a process of cultural change as well as the introduction of greater management oversight and budgetary control. For example, there is now far greater controls on spending on Quick Support Plans, with Panel Assessments now covering the majority of care packages.

We are conducting approximately 380 reassessments per month, and are using each opportunity to fully reassess the needs of service users such that they receive appropriate care packages at all times, promoting independence while minimising the risk of dependence on care.

While our overall performance is improving against targets, this is not yet having the anticipated financial impact and the Trust continues to overspend the GCC budget against what are challenging savings targets for this programme.

Elements of the external care recovery plan could potentially impact other areas of the health economy – most significantly in the current climate was a concern that an attempt to bring down the numbers of people placed in residential and nursing homes could have a knock-on effect on delayed transfers of care out of hospitals.

Gloucestershire has historically performed well with regards to delayed transfers of care from hospital. The national average was 9.6 per 100,000 population in 2013/14 (3.1 attributable to adult social care). The current data indicates that performance remains well within the national average and has improved from last year, at 3.02 per 100,000 population in November 2014 (1.00 attributable to adult social care).

This is at a time when the numbers of people over 65 years of age who are placed in residential care or nursing home is down to 661.37 per 100,000 population (for November 2014) against a target of 731.9

This relates to work undertaken with both the Hospital Social Work team and ICTs around ensuring no life-changing decision is made during an acute episode of illness. Rather, support is provided to facilitate the individual to be discharged back into the home setting or appropriate community setting for further recovery and reablement and to regain independence.

Community Nursing Vision and Action Plan

A countywide District Nursing action plan was presented to both the Quality and clinical Governance committee and Performance and Resources committee in December with agreement to proceed with the plan as proposed.

This action plan includes key areas of focus to continue to improve the Community Nursing service provided in Gloucestershire. Actions are grouped under the following key themes (aligned with other strategic action plans within the Trust):

- Recruitment and retention
- Staff skills, competencies and behaviours

- Quality of care; including patient safety, patient experience and clinical escalation
- Leadership in Community Nursing
- Workforce resources including staffing levels
- Communication with colleagues in primary care
- Internal escalation processes
- Future vision for Community

With regards this final theme, a draft Scoping document has been prepared by Gloucestershire Clinical Commissioning Group in collaboration with the Trust. This proposes a multi-agency approach, and the engagement of primary care, to develop the future model for Community Nursing.

Recruitment and Retention Steering Group

A newly-established recruitment and retention steering group held its first formal meeting on Wednesday 7 January. Its role is to ensure co-ordinated action in attempts to recruit additional nurses and to ensure sufficient career and development options are available to retain existing staff.

The current focus for recruitment relates to Band 5 and 6 roles in Community Nursing and Community Hospital in-patient units.

Two recruitment Open Days have been held - in Cirencester on Saturday 10 January and Stroud on Saturday 17 January. Last year's four open days were held during the week, and a decision was taken to change to the weekend to assess any impact on attendance.

A bank recruitment campaign is underway and there is ongoing work to establish closer links with Worcestershire, Herefordshire and Swindon. Oxford Brookes University has agreed to advertise our vacancies.

The Trust's new Preceptorship Programme for newly-qualified Band 5 nurses and Return to Practice Students is being piloted in January. We are also seeking to develop the Band 4 Assistant Practitioner role as well as clear career pathways from Health Care Assistant (Band 3) through Band 4 to Registered Nurse (Band 5).

e-Rostering

The Trust is developing its e-rostering system to allow automated daily monitoring of staffing levels. Stroud went live on Thursday 1 December 2014 and Dilke and Lydney Hospitals followed on Monday 5 January 2015. Plans for the other community hospitals are progressing, while the long-term plan is for all Trust staff is to be loaded onto the system to improve scheduling and resource management capabilities.

Flu Vaccination programme

Each winter the Trust holds a programme to vaccinate colleagues against flu in partnership with Working Well, an NHS occupational health provider.

For the first time this winter the Trust introduced a peer vaccinator scheme – in which staff are trained to give the injection and then vaccinate their colleagues.

Uptake of the seasonal flu vaccination by frontline staff until end of December was at 38.9%, a significant increase on the 31.5% for the same period in 2013. Last year, the final survey captured a further 7% who had been vaccinated – that work is being carried out at the moment, and the team is hopeful of seeing a final vaccination rate amongst frontline staff of over 40% for the first time.

Contributions

Many thanks to the following for helping compile this report:

- Candace Plouffe, Director of Service Delivery
- Susan Field, Director of Service Transformation
- Matt Blackman, Communications Specialist

Gloucestershire Care Services NHS
NHS Trust

Quality & Performance Report

Ref: 15/B011

This report is for Publication

Gloucestershire Care Services NHS Trust Board

Quality and Performance Report
20 January 2015

Objective:

This report serves to provide information and assurance to the Board in respect of the Trust's quality performance against nationally and locally commissioned targets.

The Board is asked to:

Note the contents of this report, provided for information and assurance, with details of actions included.

Executive summary:

The report shows the Trust's position as of November 2014 against key quality and performance indicators and is showing Green or Amber against targets on a year to date basis (April to November 2014) as follows:

National = 94.7% (33 of 35)
Local = 82.5% (22 of 27)

The report has been further developed with the addition of more exception reporting.

Matthew O'Reilly/Liz Fenton

Please complete the Equality Checklist over…

Please select one of the following options:

☒	This paper requires no equality impact assessment as it does not propose changes to how people receive services or our colleagues' working lives.
☐	This paper proposes changes. Equality analysis identifies the following equality impacts: • • A copy of the EIA is appended.
☐	This paper proposes changes. Equality analysis has NOT been completed for the following reasons: • •

[Notes supporting questions]: Compliance with the Public Sector Equality Duty

Under the Equality Act 2010, we have a legal responsibility when we make decisions to have due regard to the need to:

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

Therefore, if this paper proposes changes that will affect how people receive services or our colleagues' working lives, you should complete an equality analysis. This is to determine the extent to which the changes will eliminate discrimination, advance equality, and foster good relations.

Gloucestershire Care Services NHS
NHS Trust

Quality and Performance Report

20th January 2015

Understanding you

Contents

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Quality overview	4
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Key Matters

MSKCAT Waiting times remain above trajectory for those requiring routine appointments. Actions to address under performance include:

- Recruitment above establishment to create capacity
- Provision of additional clinics
- Service to offer appointments outside of locality
- Quality Impact Assessment to review scheduling of follow-up appointments in comparison to new appointments

Podiatry Waiting times also remain above trajectory. The actions in place to address this are as for MSKCAT

Flu Vaccinations – Staff Programme GCS recorded uptake of the vaccination of 31.5% during the first two months of the programme. Actions are in place to encourage colleagues that have direct contact with patients and families to be vaccinated. Work has been completed by Working Well to address coding errors which were previously identified (see page 36)

Staffing at Stroud General Hospital A decision was taken on October the 8th to temporarily reduce the bed compliment at Stroud Hospital. This was as a result of sickness absence of nursing staff coupled with increased acuity of patients. A phased reopening commenced on October 13th.

Incident reporting GCS is a low reporter of incidents when compared with all peers using both the Aspirant Community Foundation Trust Group and National Reporting and Learning System (NRLS) data. The following actions are in progress:

- Staff survey completed to understand what may be barriers to reporting
- A review of Datix process to reduce the number of steps involved in reporting incidents
- Working with local teams to raise awareness of reporting, investigation and feedback
- Identification of colleagues to attend RCA training programmes

Quality overview - health performance against indicators (November YTD)

	November cumulative year-to-date (with comparators to October)							October cumulative year-to-date			Average year-to-date		
	Red		Amber		Green		Total	Red	Amber	Green	Red	Amber	Green
National	2 5.7%	↔	3 8.6%	↔	30 85.7%	↔	35	2 5.7%	3 8.6%	30 85.7%	2 5.3%	3 8.8%	30 85.9%
Local	5 18.5%	↓	1 3.7%	↑	21 77.8%	↔	27	6 22.2%	0 0.0%	21 77.8%	5 17.5%	1 2.8%	21 79.6%
Total	7 11.3%	↓	4 6.5%	↑	51 82.6%	↔	62	8 12.9%	3 4.8%	51 82.3%	7 10.5%	4 6.3%	51 83.2%

National indicators

Red	Safety Thermometer - harm free care	Page 11
	Friends and Family Test - MIU response rate	Page 27
Amber	MIU unplanned reattendance rate within 7 days	Page 39
	Health Visitors - Call to Action (number of WTEs)	Page 39
	Children in Reception Year with height and weight recorded	Page 39

Local indicators

Red	MSKCAT service - wait time for routine patients	Page 40
	MSKCAT service - wait time for urgent patients	Page 40
	MSKCAT service - referral to treatment	Page 40
	Chlamydia Screening - number of positive screens	Page 40
	Podiatry Service - referral to treatment	Page 40
Amber	Bone Health Service – referral to treatment	Page 40

Quality overview - health performance against indicators (in-month November 2014)

	November 2014			
	Red	Amber	Green	Total
National	4 11.4%	5 14.3%	26 74.3%	35
Local	6 23.1%	0 0.0%	20 76.9%	26
Total	10 16.4%	5 8.2%	46 83.6%	61

National indicators		
Red	Safety Thermometer - harm free care	Page 11
	Friends and Family Test - MIU response rate	Page 27
	Friends and Family Test - Inpatients Net Promoter Score	Page 25
	Friends and Family Test - Inpatients response rate	Page 25
Amber	MIU unplanned reattendance rate within 7 days	Page 39
	Health Visitors - Call to Action (number of WTEs)	Page 39
	Children in Reception Year with Height and Weight Recorded	Page 39
	Face to Face Consultation in PCC (Urgent to be seen within 2 hours)	Page 41
	Completion of valid NHS number in Social Care data sets	Page 41

Local indicators		
Red	MSKCAT service - wait time for routine patients	Page 40
	MSKCAT service - referral to treatment	Page 40
	Chlamydia Screening - number of positive screens	Page 40
	Podiatry Service - referral to treatment	Page 40
	Speech and Language Therapy (Adult) – referral to treatment	Page 41
	Single Point of Access – Abandoned Calls	Page 41

SAFE

Safe - key points

- The Trust has reported 15 SIRIs year-to-date of which 53% relate to slips, trips and falls *(see page 10)*

- Performance against the 95% threshold for harm-free care has increased in November to 94.5%. *(see page 11)*

- Falls within an inpatient setting continue to be of concern with our rate of injurious falls per 1,000 bed days considerably higher than our comparators. A detailed action plan is being developed by the Matrons that will be presented to the QCGC in April that sets out plans to reduce this risk to patients *(see page 13)*

- Although the Trust's performance re: pressure ulcers is impacting upon the harm-free care totals, it is noted that there have been only four acquired Grade 3/4 pressure ulcers this year. The Trust compares favourably with other community trusts *(see page 14)*

- The Trust is currently 40% below the agreed tolerance for C diff *(see page 16)*

Incidents by category of harm

Category of harm	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD	Forecast	2013-14 outturn
No injuries or harm	167	173	158	212	156	145	121	116					**1,248 53%**	**1,872**	**2,405**
Minimal harm: required extra observation or minor treatment	95	101	70	94	67	124	113	137					**801 34%**	**1,202**	**1,118**
Short term harm: required further treatment or procedure	44	31	40	44	27	43	32	18					**279 12%**	**419**	**456**
Severe, permanent or long-term harm	**0**	**5**	**2**	**1**	**1**	**1**	**2**	**0**					**12 1%**	**18**	**17**
Death	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**0**					**2 0%**	**3**	**1**
Total	**306**	**310**	**271**	**352**	**251**	**329**	**268**	**271**					**2,342**	**3,513**	**3,997**

Benchmarking		
Number of incidents (GCS)	**136.7 per 1,000 WTE staff**	**April-November 2014**
Number of incidents (Aspirant Community Foundation Trust Group)	**181.8 per 1,000 WTE staff**	**April-October 2014**

Incidents by type (top 10 only)

Category of harm /Type of incident (top 10 categories)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD	Forecast	2013-14 outturn
Slip, trip or fall (patient)	91	74	63	86	80	80	69	95					638	957	1,130
Medication or drug error	22	26	12	21	14	21	19	16					151	227	401
Staffing issues	12	18	11	27	12	17	18	14					129	194	145
Treatment or procedure problem	12	13	16	19	10	16	11	9					106	159	158
Pressure ulcer	24	18	15	9	2	10	15	4					97	146	211
Staff communications	10	12	18	14	6	13	9	9					91	137	133
Verbal/written abuse	7	19	12	9	9	9	5	7					77	116	90
Medical device/equipment	6	15	15	11	6	8	6	7					74	111	123
Hit by/against object	9	8	8	10	10	8	6	6					65	98	120
Property	12	6	7	13	8	10	3	4					63	95	104
Total (All)	306	310	271	352	251	313	268	271					2,342	3,513	3,997

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORs)

There have been 10 RIDDOR reportable incidents this year to date. 7 were staff incidents, 2 were patient incidents and 1 affected a member of the public. These are reviewed by the Health & Safety Committee.

RIDDOR Actions taken
Staff reminded to be aware of trip hazards while they are working
Falls risk process reviewed following a patient receiving a fracture as a result of a fall
Staff reminded to follow correct Moving & Handling processes
Staff reminded of the need to assess working area before commencing treatment
Handling for patient reviewed
Retraining on door security procedures

Clinical Alert System (CAS)

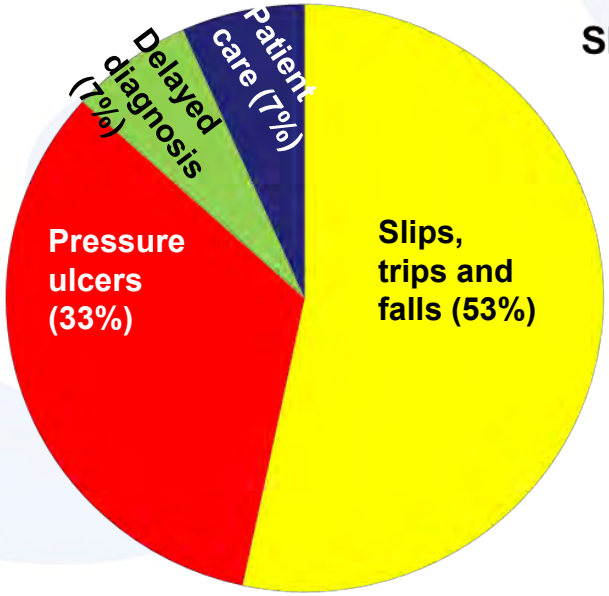
In 2014-15, the Trust has had one overdue CAS alert (June) which was due to a technical error

SIRIs / Never Events

SIRIs	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
Inpatients	1	4	1	2	0	1	1	0					10
Community	1	0	0	0	1	0	1	1					4
MIU	0	0	0	1	0	0	0	0					1
Total	2	4	1	3	1	1	2	1					15

No Never Events have been reported in 2014-15.
The learning from SIRIs has resulted in:

- Revision of the falls risk assessment process
- Alignment of the falls alerts in practice used to NICE guidance
- Review of the Braden Tool to ensure assessment captures all risks of pressure damage



SIRIs by type

- Slips, trips, falls (8)
- Pressure ulcers (5)
- Delayed diagnosis (1)
- Patient care (1)

Benchmarking	
New SIRIs (GCS)	**1.9 average per month, April-November 2014**
New SIRIs (Aspirant Community Foundation Trust Group)	**3.7 average per month, April-October 2014**

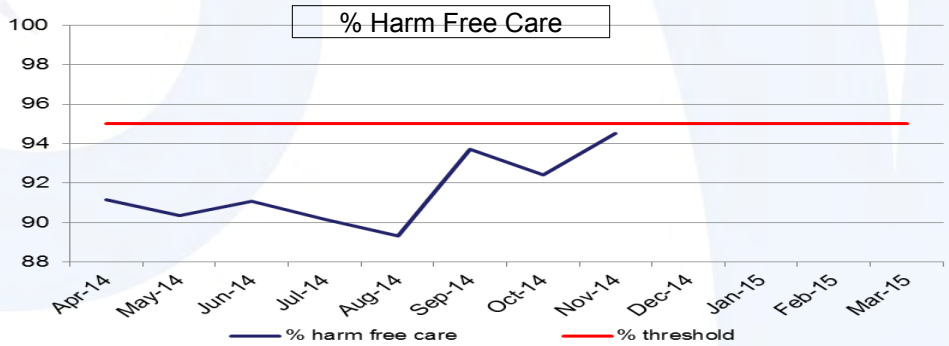
Always Events

GCS will be launching the 'Hello my name is' programme across the Trust in February as apart of a wider launch with LiA partners

Harm-free care / Safety Thermometer

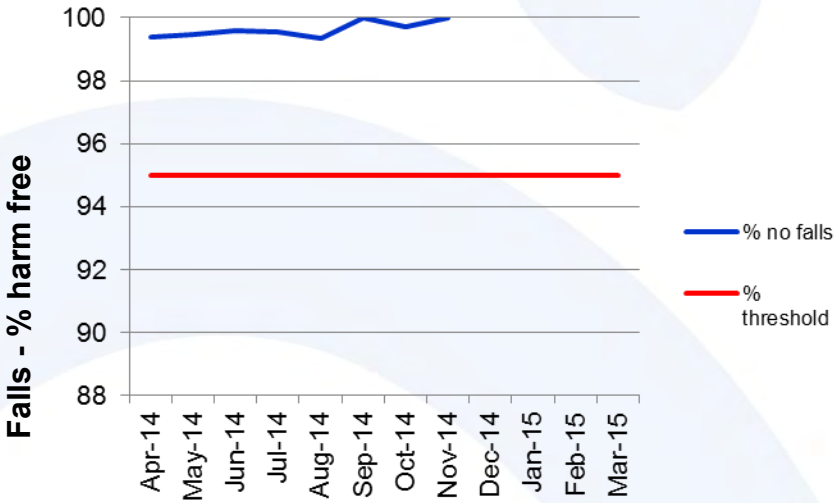
Total	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD	2013-14 outturn
No of service users surveyed	1,120	1,153	1,009	1,059	1,078	1,084	1,036	1,052					**8,591**	**13,175**
No of service users with harm free care	1,021	1,042	919	955	963	1,016	957	994					**7,867**	**11,806**
% harm free care	**91.2%**	**90.4%**	**91.1%**	**90.2%**	**89.2%**	**93.7%**	**92.4%**	**94.5%**					**91.6%**	**89.6%**
% Completeness of Submission	**94.7%**	**97.3%**	**100.0%**	**95.5%**	**98.6%**	**98.6%**	**100%**	**100%**					**98.1%**	**97.4%**

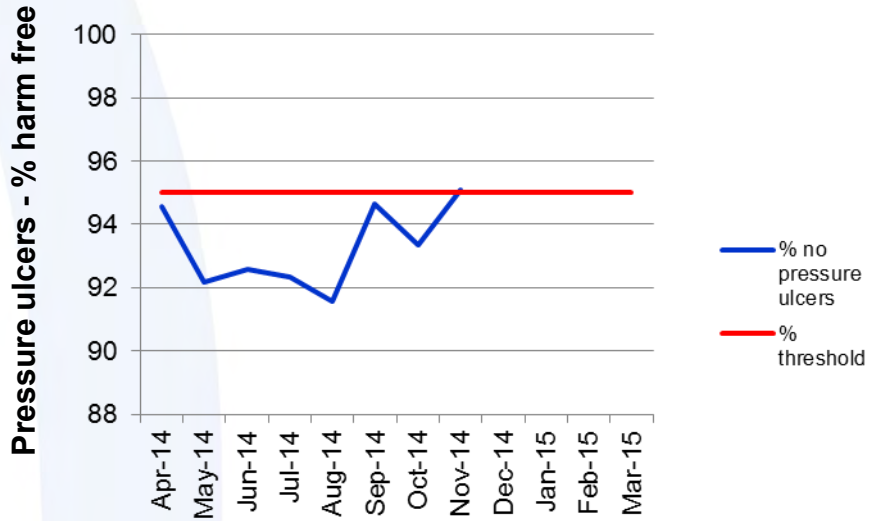
Total	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD	2013-14 outturn
New Harms	48	40	27	32	35	11	29	7					**229**	**666**
Old Harms	51	71	63	72	80	57	50	51					**495**	**703**
Patients who experienced Harm	**99**	**111**	**90**	**104**	**115**	**68**	**79**	**58**					**724**	**1,369**

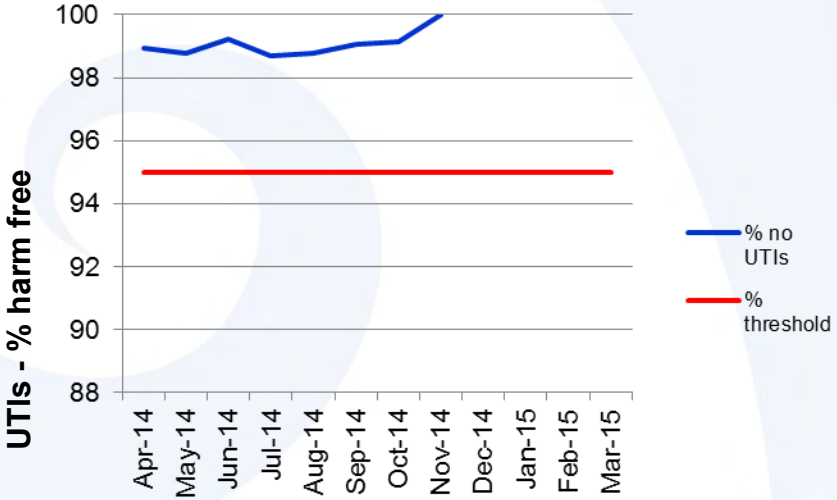


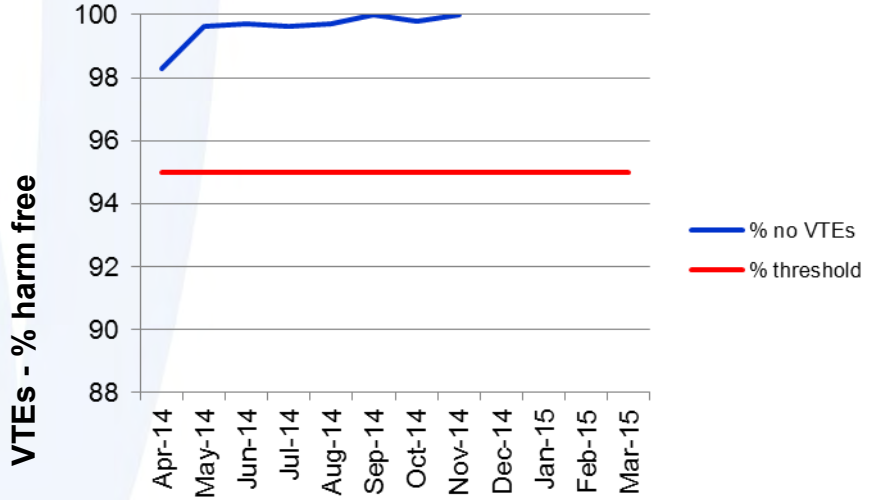
- 100% of teams submitted survey data in November
- Achievement of 94.5% harm free with variation of 77.8% - 100% across teams
- Focus remains on the key areas of falls and pressure ulcers looking at those patients who experienced harm and working across the health community to further reduce this risk

Harm-free care by type / Safety Thermometer









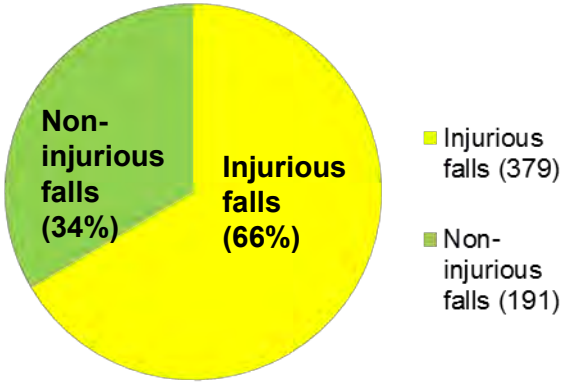
VTE risk assessment:
Performance in April to November showed 98% VTE risk assessments were completed against a target of 95%

Falls in an inpatient setting

Hospital	Total Falls				Injurious Falls			
	2014/15 Year to Date		2013/14 Total		2014/15 Year to Date		2013/14 Total	
	No of falls	Falls per 1,000 bed days	No of falls	Falls per 1,000 bed days	No of injurious falls	Injurious falls per 1,000 bed days	No of injurious falls	Injurious falls per 1,000 bed days
The Vale	107	26.5	146	20.9	79	19.6	88	12.6
Tewkesbury	86	21.3	95	12.9	56	13.8	37	5.0
North Cotswolds	97	22.2	141	18.8	57	13.0	60	8.0
Cirencester	144	14.3	264	12.9	91	9.1	139	6.8
Lydney	46	11.2	82	11.8	33	8.0	55	7.9
Dilke	44	10.0	87	9.3	31	7.1	51	5.5
Stroud General	46	6.9	191	13.0	32	4.8	102	6.9
TOTAL	**570**	**15.1**	**1,006**	**13.7**	**379**	**10.1**	**532**	**7.2**
FORECAST	**855**				**568**			

Benchmarking	
Injurious falls per 1,000 inpatient occupied bed days (GCS)	**10.1 average per month, April-November 2014**
Injurious falls per 1,000 inpatient occupied bed days(Aspirant Community Foundation Trust Group)	**3.2 average per month, April-October 2014**

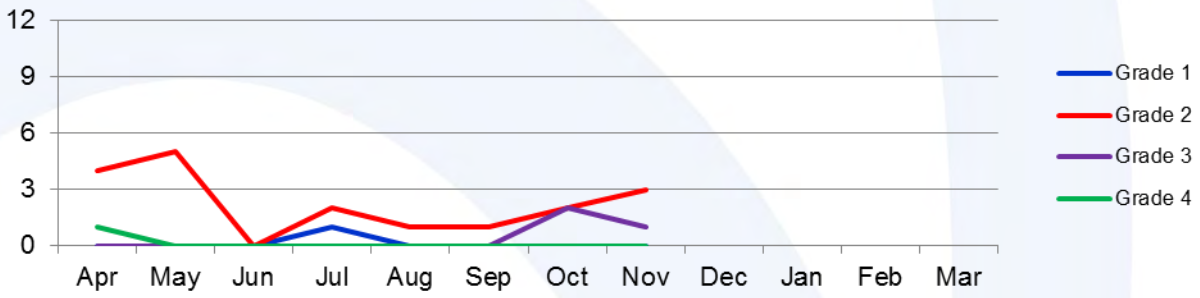
Result of falls
(year-to-date)



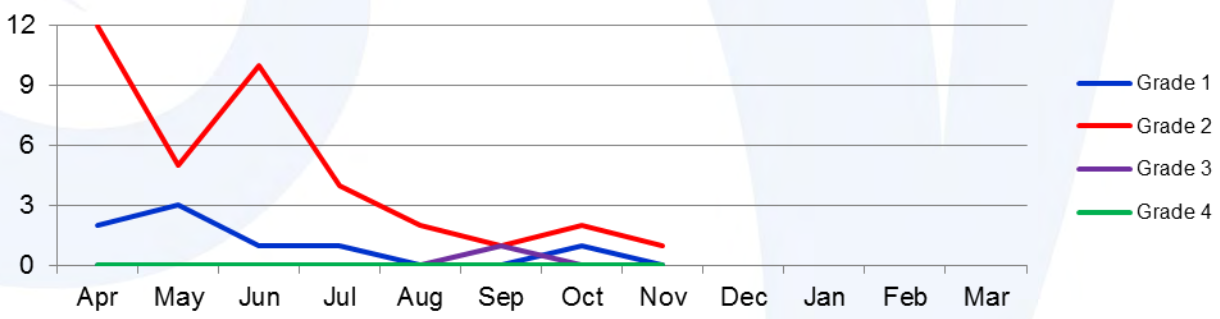
- Revised risk assessment tool being trialled in Tewkesbury Hospital
- Standardisation of falls alert signage across all sites in line with NICE guidance
- Action plan to be presented at QCGC in April 2015

Pressure ulcers

Community acquired	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
Grade 1	0	0	0	1	0	0	0	0					**1**
Grade 2	4	5	0	2	1	1	2	3					**18**
Grade 3	0	0	0	0	0	0	2	1					**3**
Grade 4	1	0	0	0	0	0	0	0					**1**



Hospital acquired	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
Grade 1	2	3	1	1	0	0	1	0					**8**
Grade 2	12	5	10	4	2	1	2	1					**37**
Grade 3	0	0	0	0	0	1	0	0					**1**
Grade 4	0	0	0	0	0	0	0	0					**0**



Benchmarking	
New Grade 2, 3 & 4 pressure ulcers (GCS)	**7.5 average per month, April-November 14**
New Grade 2, 3 & 4 pressure ulcers (Aspirant Community Foundation Trust Group)	**11.5 average per month, April- October 14**

Safeguarding (Quarterly Report)

Total	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD	2013-14 outturn
Adult safeguarding alerts raised by GCS	13	9	19	17	10	8	16	22	18				**132**	**176**
Total county adult safeguarding alerts	289	326	299	344	285	337	353	330	294				**2,857**	**4,008**
GCS adult safeguarding investigations*	3	4	7	11	6	6	5	7	13				**62**	**n/a**
Total county adult safeguarding investigations (health providers)	30	30	34	29	33	27	17	35	29				**264**	**n/a**
Number of new children's Serious Case Reviews	1	0	0	1	0	2	2	2					**8**	**n/a**
Number of children subject to a Child Protection Plan	428	391	408	403	416	426	419	426						**n/a**
Number of children identified as 'cause for concern' during supervision	756	1,114	1,505	n/a	1,932	n/a	n/a	n/a						**n/a**

***Breakdown of adult safeguarding investigations (Q1, Q2 and Q3 2014/15)**

Client group		Type of concern		Outcome of investigation	
Learning disabilities	3	Neglect	19	On-going	22
Dementia	25	Physical injury	19	Substantiated	7
Physical disability	30	Sexual	3	No further action	33
Mental health	0	Financial	13		
Other vulnerable	4	Psychological	7		
		Institutional	0		

GCS are currently supporting Serious Case Reviews relating to:

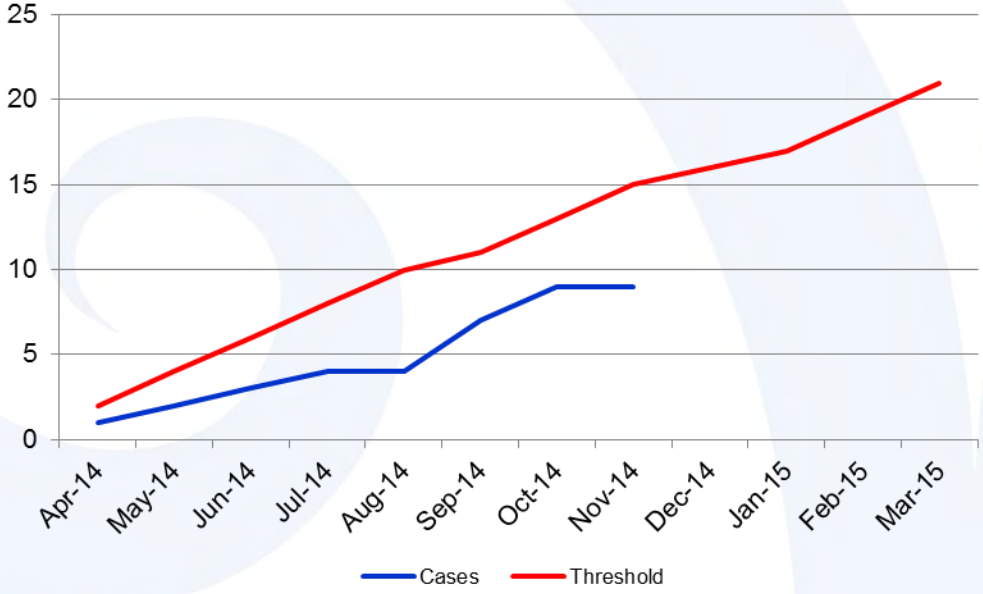
- The sexual and financial abuse of adults within a supported living home
- A domestic homicide/SCR review
- Death of baby in Cotswold Locality

Infection control

Infections	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
MSSA	0	0	0	0	0	0	0	0					0
MRSA	0	0	0	0	0	0	0	0					0
E. Coli	0	0	1	0	0	0	0	0					1
CPE	0	0	0	0	0	0	0	0					0

C diff	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
Actual	1	1	1	1	0	3	2	0					9
Threshold	2	2	2	2	2	1	2	2	1	1	2	2	15
Variance	-1	-1	-1	-1	-2	2	0	-2					-6

Incidence of C. Diff



November 2014

Lead Nurse- Infection Control is developing a patient information leaflet for service users and families to provide advise about keeping safe from infection, including guidance on hand hygiene. This will be presented to the Infection Control Committee in January 2015

Hand hygiene observation audits for November evidenced an average of 87% compliance

Medicines management

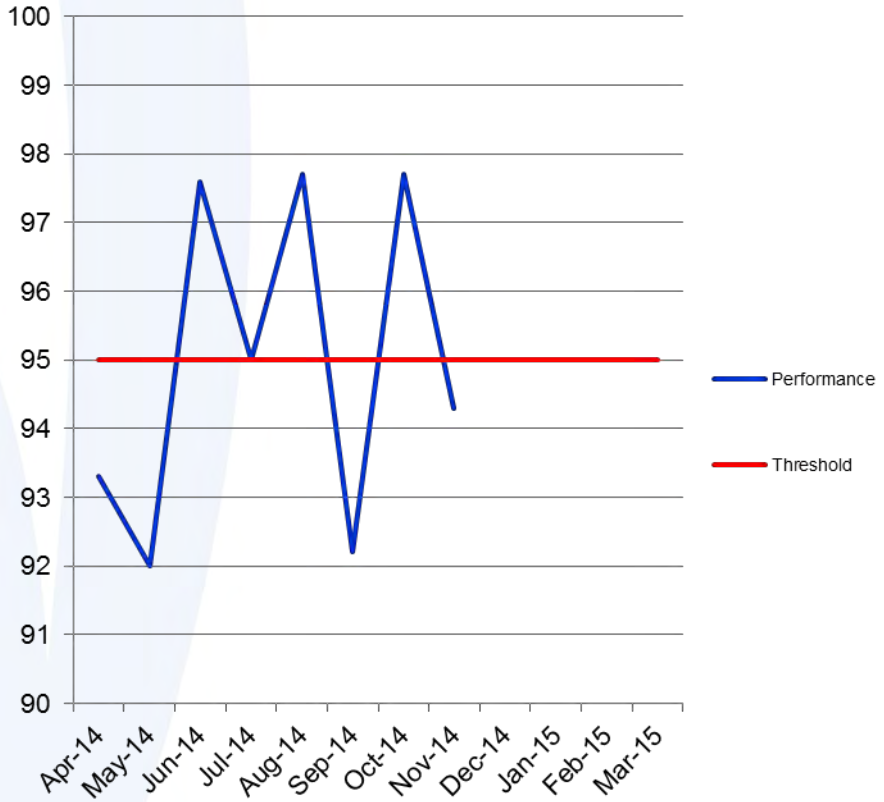
Medication incidents	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
2014-15	22	26	12	21	14	21	27	16					**159**
2013-14	29	26	39	65	46	26	36	39	36	49	55	27	**473**

Medication incidents by sub-category	Number
Omitted or delayed administration	52
Medication administered in error/incorrectly	34
Controlled drugs issue	24
Medication prescribed incorrectly/in error	13
Medication dispensed incorrectly	9
Storage Issue	8
Illegible or unclear information	8
Medication Missing	5
Information to patient wrong or omitted	3
Failure to follow-up or monitor	2
Discharge or transfer without TTOs	1
Total	**159**

Controlled Drug Issues (24) (see page 18)

- 4 incidents related to incorrect or omitted entries in the CD register
- 4 incidents related to incorrect counting or measuring of CDs
- 4 incidents were unaccounted losses (see page 18)
- 3 incidents involved a GP
- 2 incidents involved CDs being incorrectly stored
- 2 incidents involved District Nurses
- 5 incidents involved staff training/error

HAPPI (Hospital Antibiotic Prudent Prescribing Indicator) audits



Controlled Drug issues - key points

- All incidents involving Controlled Drugs (CDs) are reported to and investigated either directly by the CD Accountable Officer or under the direction of the CD Accountable Officer.

- The majority of the CD incidents reported were as a result of failure to follow the policy and procedure with regard to storage and recording of these medicines. The staff involved in these incidents have been supported by their managers and the CD Accountable Officer to reflect on their practice with training and supervision in place where this is necessary.

- 5 reported incidents did not relate to services GCS provided but were reported by GCS staff. These incidents have been shared with the appropriate provider for investigation/action.

- In 4 cases CDs were unaccounted for and remained unaccounted for after investigation.

Unaccounted losses:

1.Anticipatory drugs for end of life care including controlled drugs unaccounted for in a patient's home.

2.Tramadol 50mg tablets were unaccounted for at the stock check at the end of the day

3.A diamorphine 10mgs ampoule unaccounted for when DNs visited a patient to replenish syringe driver. The investigation concluded this had been thrown away in error by the family.

4.Two tramadol capsules where unaccounted for when the pharmacist undertook the 3 monthly CD stock check. The investigation concluded that the error arose from incorrect calculation when the tramadol stock was entered into the CD register

Service user transfers*

***transfers into community hospital inpatient wards between 23:00 and 05:59**

		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD	Forecast	2013-14 outturn
All Admissions	23:00-05:59	11	19	19	16	11	10	11	13					**111**	**167**	**153**
	%	3.29%	5.38%	5.35%	4.65%	3.12%	3.31%	3.55%	4.25%					**4.23%**	**4.23%**	**3.40%**
Direct Admission	23:00-05:59	3	8	7	5	6	7	7	6					**49**	**74**	**74**
	%	2.52%	7.02%	5.26%	5.38%	5.17%	7.00%	8.64%	6.52%					**5.85%**	**5.85%**	**4.10%**
Transfer	23:00-05:59	8	11	12	11	5	3	4	7					**62**	**93**	**79**
	%	3.72%	4.60%	5.41%	4.38%	1.95%	1.49%	1.75%	3.27%					**3.48%**	**3.48%**	**2.90%**

Transfer From	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD	Forecast	2013-14 outturn
Transfer from GRH	7	3	8	7	3	3	1	5					**37**	**56**	**47**
Transfer from CGH	1	5	3	4	3	0	3	2					**21**	**32**	**24**
Transfer from other	0	1	1	0	0	0	0	0					**2**	**3**	**4**
Internal transfer	0	2	0	0	0	0	0	0					**2**	**3**	**4**
Total	**8**	**11**	**12**	**11**	**6**	**3**	**4**	**7**					**62**	**93**	**79**

It is recognised that patient transfers that happen late at night are not good practice and can lead to patients being tired, distressed and confused and can have an impact on their recovery. Gloucestershire Care Services complete a datix incident report on each late transfer (after 21.00 hours) and are currently planning an audit with partner organisations to identify at what points in the transfer the delays have occurred and whether there are any common root causes that require further investigation

Safer staffing – November 2014

Hospital	Ward	Day		Night		Bed Occupancy
		Average fill rate RNC	Average fill rate HCA	Average fill rate RNC	Average fill rate HCA	
Cirencester	Coln Ward	86.3%	124.8%	100.0%	101.7%	95.5%
	Windrush Ward	93.3%	102.4%	100.0%	96.7%	97.7%
Dilke Memorial	The Ward	101.1%	130.0%	100.0%	150.0%	92.4%
Lydney and District	The Ward	100.0%	98.9%	100.0%	103.3%	92.2%
North Cotswolds	NCH Ward	101.7%	99.0%	98.3%	101.7%	92.0%
Stroud General	Cashes Green Ward	96.9%	117.6%	100.0%	145.0%	94.6%
	Jubilee Ward	100.0%	102.5%	100.0%	103.3%	98.3%
Tewkesbury Community	Abbey View Ward	81.7%	97.1%	100.0%	101.7%	94.6%
Vale Community	Peak View	103.3%	96.2%	100.0%	100.0%	94.8%
TOTAL		95.3%	107.6%	99.8%	111.5%	94.2%

Hospital	Ward	Bank Staff	Agency Staff
Cirencester	Coln Ward	14.1%	27.6%
	Windrush Ward	6.2%	15.4%
Dilke Memorial	The Ward	13.7%	26.6%
Lydney and District	The Ward	11.0%	37.2%
North Cotswolds	NCH Ward	16.8%	12.3%
Stroud General	Cashes Green Ward	12.8%	25.2%
	Jubilee Ward	0.8%	4.9%
Tewkesbury Community	Abbey View Ward	2.5%	10.2%
Vale Community	Peak View	19.5%	22.2%
TOTAL		11.6%	21.8%

The Dependency audit completed in October 2014 showed no significant change in patient dependency against the 2012 baseline that informed staffing levels. This paper will be presented to the Board in January 2015

Exception reporting required if fill rate is <80% or >120%

- Cashes Green - Increase in HCAs due to the number of patients on the ward who required one to one supervision overnight
- Dilke – Increase in HCAs due to one to one supervision with two patients during the month
- Coln Ward – Increase in HCAs due to one to one supervision with two patients

Safer Staffing Alert Levels – November 2014

Hospital	Ward	Shortfall of 8 hours or 25% of RN hours on the shift	Staffing levels as planned	Staffing levels below plan but care needs met	Staffing levels increased to meet care need
Cirencester	Coln Ward	5	55	14	16
	Windrush Ward	9	78	2	1
Dilke Memorial	The Ward	0	17	1	72
Lydney and District	The Ward	1	74	5	10
North Cotswolds	NCH Ward	3	72	8	7
Stroud General	Cashes Green Ward	6	22	8	54
	Jubilee Ward	1	88	1	0
Tewkesbury Community	Abbey View Ward	31	56	2	1
Vale Community	Peak View	0	82	7	1
TOTAL		56	544	48	162

A review of the data captured to date will be undertaken in Q4 in order to ensure:

- The alert levels are correctly assigned
- That the escalation policy is used appropriately
- The development of a RAG rating system

Safer staffing – October 2014

Hospital	Ward	Day		Night		Bed Occupancy
		Average fill rate RNC	Average fill rate HCA	Average fill rate RNC	Average fill rate HCA	
Cirencester	Coln Ward	89.1%	107.8%	101.6%	101.6%	95.6%
	Windrush Ward	94.1%	101.8%	100.0%	98.4%	98.5%
Dilke Memorial	The Ward	98.9%	115.2%	100.0%	119.4%	93.1%
Lydney and District	The Ward	100.0%	104.2%	101.6%	112.5%	96.4%
North Cotswolds	NCH Ward	96.8%	96.8%	100.0%	100.0%	96.0%
Stroud General	Cashes Green Ward	94.8%	133.3%	103.2%	148.4%	100.0%
	Jubilee Ward	98.3%	96.4%	96.6%	103.2%	96.8%
Tewkesbury Community	Abbey View Ward	78.5%	99.1%	100.0%	100.0%	97.4%
Vale Community	Peak View	100.0%	98.6%	100.0%	104.8%	99.2%
TOTAL		94.0%	106.6%	100.6%	110.2%	97.0%

Hospital	Ward	Bank Staff	Agency Staff
Cirencester	Coln Ward	17.6%	23.1%
	Windrush Ward	10.2%	23.5%
Dilke Memorial	The Ward	15.4%	19.5%
Lydney and District	The Ward	9.6%	24.0%
North Cotswolds	NCH Ward	13.4%	10.1%
Stroud General	Cashes Green Ward	13.1%	20.5%
	Jubilee Ward	6.2%	11.1%
Tewkesbury Community	Abbey View Ward	2.7%	3.9%
Vale Community	Peak View	16.7%	22.0%
TOTAL		12.2%	18.3%

Exception reporting required if fill rate is <80% or >120%

- Cashes Green - Increase in HCAs due to the number of patients on the ward who required one to one supervision over and above the planned staffing levels
- Tewkesbury – Decrease in RNCs is due to sickness and a planned decision to not have bank and agency staff based on care need

CARING

Caring - key points

- The Trust is committed to providing care in an environment that protects privacy and dignity. This is supported by providing care in a single sex environment. No breaches were reported during the period April to November 2014 *(not referenced elsewhere).*

- The Trust is not achieving the requisite response rates for the Friends and Family Test for the Minor Injury Units and teams are reminded of the importance of asking for feedback and learning shared from units achieving positive response rates. The QCGC is monitoring FFT response rates and Net Promoter Scores closely.

- The Trust has achieved 29% response rate for inpatient wards against a target of 30% in November. To improve the response rate and enable action on the learning, Inpatients from December 1st 2014 will be offered the option of a face to face discussion as an alternative to the postal questionnaire.

- The Trust receives a low number of complaints compared to other Community Trusts. The Patient Experience Team are looking at a number of actions to ensure that service users and families know how they can make a complaint and we make the process as easy as possible for them to do so. A revised complaints policy will be presented to QCGC in February 2015.

Gloucestershire Care Services NHS
NHS Trust

Friends and Family Test - Inpatient Units

Responses	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Average	Target
Cirencester	56%	43%	65%	24%	36%	22%	31%	29%					38%	30%
Stroud	74%	74%	65%	66%	17%	32%	20%	29%					47%	
Tewkesbury	39%	39%	57%	23%	57%	29%	47%	38%					41%	
The Vale	27%	28%	55%	47%	19%	37%	27%	33%					34%	
North Cots	45%	31%	40%	30%	16%	41%	25%	28%					32%	
Dilke	33%	39%	55%	63%	13%	0%	14%	27%					31%	
Lydney	57%	54%	57%	30%	17%	28%	22%	18%					35%	
Average	47%	44%	56%	40%	25%	27%	27%	29%					37%	
Total responders	172	167	205	140	50	60	52	77						
Sample Size	349	359	354	356	193	206	190	266						

- Patients are sent a questionnaire together with a letter from the Director of Nursing one or two days after discharge asking them complete this either on paper (return envelope included) or by logging on to a website and submitting the survey online.
- CoMetrica is responsible for collating the results and provide weekly comments reports to service leads as well as monthly reports on the results achieved.
- In order to address the disappointing response rates to the postal survey, from December the option of a face to face interview is being offered at the point of discharge

Net promoter	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Average	Target
Cirencester	60	57	62	75	71	54	33	25					55	60+
Stroud	90	96	65	69	80	0	80	91					71	
Tewkesbury	92	92	96	100	75	50	86	92					85	
The Vale	36	87	92	91	83	82	43	78					74	
North Cots	79	100	100	54	100	69	50	46					75	
Dilke	80	79	65	72	100		100	37					67	
Lydney	100	76	95	92	25	89	83	20					73	
Total	76	83	83	76	74	62	59	56					71	

Inpatient survey – November 2014

Description	Tewkesbury	Stroud Cashes Green	Stroud Jubilee	Vale	Dilke	Lydney	Cirencester Coln	Cirencester Windrush	North Cotswold
Q.4451 Did you have confidence and trust in the staff examining or treating you?	9.17	9.00	9.00	9.58	8.75	9.00	8.89	9.00	8.89
Q.4452 Were you involved as much as you wanted to be in decisions about your care and treatment?	7.69	7.00	10.00	6.25	5.63	7.00	8.00	7.50	6.50
Q.4453 In your opinion, was the area clean?	10.00	9.17	10.00	9.58	10.00	10.00	9.38	10.00	9.58
Q.4454 Overall, did you feel you were treated with respect and dignity?	10.00	10.00	10.00	10.00	9.38	10.00	9.00	9.44	9.00
Q.4455 Overall experience of this service.	8.39	7.78	8.97	7.61	7.22	7.20	6.43	7.93	7.69
Patients Surveyed	12	6	5	10.0	8	5	10	10	11

In addition to the Friends and Family question respondents to our in-patient survey are asked five questions about their experience of care whilst a patient in a community hospitals. The responses are presented as an average satisfaction score based on all responses received. The highest achievable score is 10.00

Friends and Family Test - Minor Injuries Units

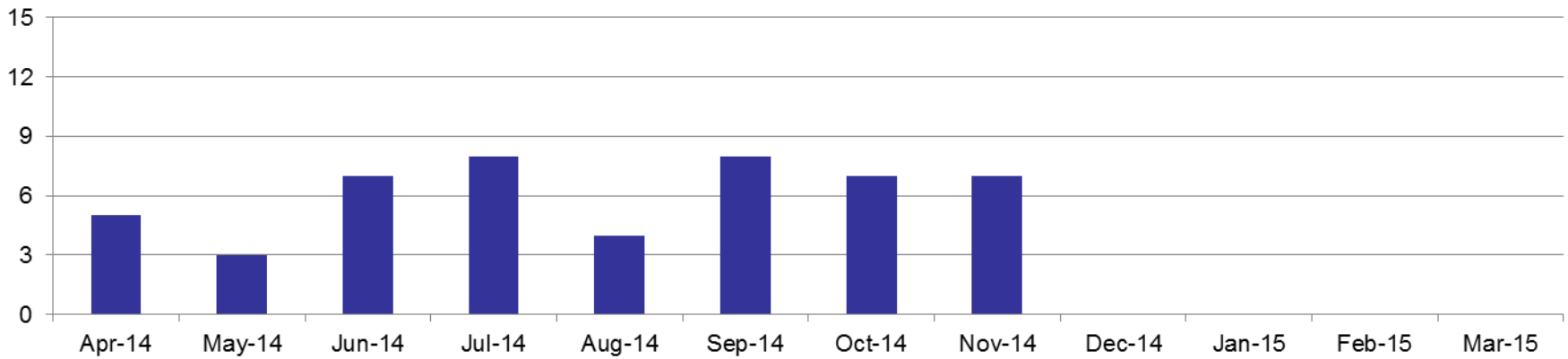
Responses	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Average	Target
Cirencester	15%	14%	16%	24%	28%	21%	24%	21%					20%	20%
Stroud	13%	10%	4%	11%	19%	14%	11%	17%					12%	
Tewkesbury	2%	19%	36%	14%	8%	22%	10%	22%					17%	
The Vale	30%	17%	17%	20%	27%	24%	23%	32%					24%	
North Cots	11%	17%	15%	13%	16%	18%	6%	20%					15%	
Dilke	30%	20%	21%	18%	20%	18%	16%	15%					20%	
Lydney	39%	34%	14%	14%	11%	13%	9%	6%					18%	
Average	20%	19%	18%	16%	18%	19%	14%	19%					18%	
Total responders	1100	1100	998	1147	1121	1090	841	952						
Attendances	6117	6348	6486	6810	5756	6042	5606	5146						

- Patients are provided with a copy of the FFT questionnaire whilst visiting the MIU and are asked to complete and put it in the comments box before leaving the premises. The completed forms are posted to CoMetrica on a weekly basis by GCS
- A further collection technique has been added by CoMetrica . Where mobile numbers are known, patients are sent a text message following their visit to MIU with a link to the questionnaire, providing them with an additional option to complete the questionnaire.
- CoMetrica is responsible for collating the results and provides weekly comments reports to service leads as well as monthly reports to GCS
- In order to achieve the response rate it is essential that the FFT is promoted by both admin and clinical staff and that posters and information as well as feedback about the survey is available in all units.

Net promoter	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Average	Target
Cirencester	85	78	77	78	85	85	86	90					83	46+
Stroud	80	70	87	66	65	65	65	68					71	
Tewkesbury	100	83	66	82	84	77	70	79					80	
The Vale	89	88	68	79	84	75	73	78					79	
North Cots	82	73	83	86	84	92	90	82					84	
Dilke	87	77	81	82	82	81	87	78					82	
Lydney	87	81	79	86	79	75	84	92					83	
Total	84	77	76	78	79	79	79	81					79	

Complaints

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD	2013-14
Number of complaints	5	3	7	8	4	8	7	7					49	78



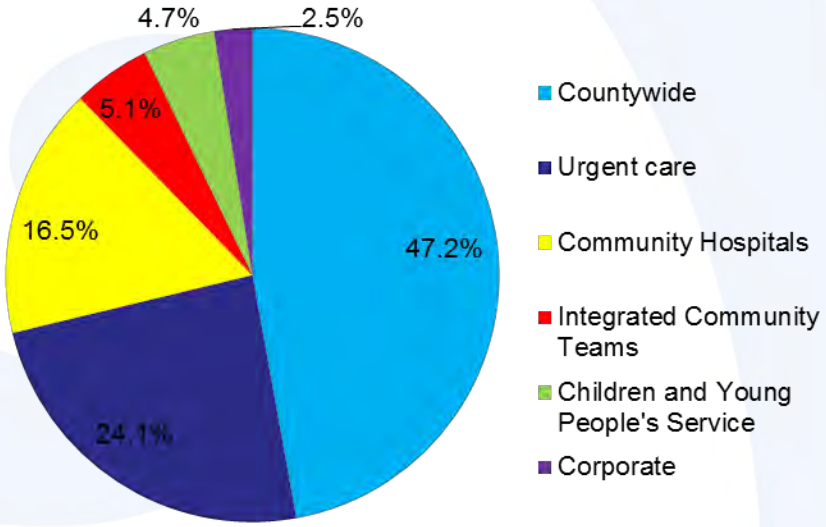
Response Time	April - November 2014-15	
	Number of responses	% of responses
Target time within agreed timescale	36	86%
Over the agreed timescale by 1-3 days	3	7%
Over the agreed timescale in excess of 4 days	3	7%
Awaiting investigation	7	n/a
Total	49	100%

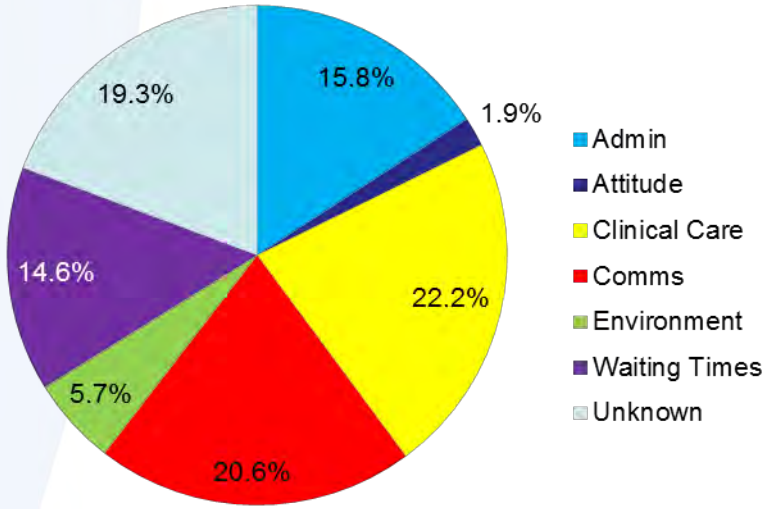
Benchmarking	
Complaints per 1,000 WTE staff (GCS)	**2.9 average per month, April-November 14**
Complaints per 1,000 WTE staff (Aspirant Community Foundation Trust Group)	**5.5 average per month, April-October 14**

Formal complaints are dealt with by the Complaints Manager who works closely with the investigation officer to undertake a full investigation of the complaint. The complainant is informed of the process and a full investigation process should be undertaken within 25 working days. Themes from complaints are collated into the quarterly patient experience report. A revised complaints policy will be presented to QCGC in February 2015.

Concerns

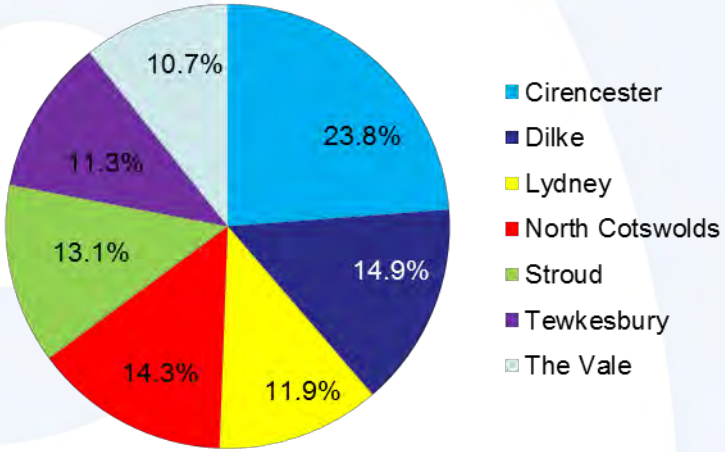
Concerns (year-to-date)	Admin	Attitude	Clinical Care	Comms	Environ	Waiting Times	Unknown	Total
Countywide	28	0	26	28	3	22	42	**149**
Urgent Care	7	3	25	18	2	14	7	**76**
Community Hospitals	3	3	12	10	13	2	9	**52**
Integrated Community Teams	1	0	4	5	0	6	0	**16**
Children & Young People's Service	6	0	3	3	0	1	2	**15**
Corporate	5	0	0	1	0	1	1	**8**
Total	**50**	**6**	**70**	**65**	**18**	**46**	**61**	**316**





Mortality Reviews: Community Hospitals

Hospital Site	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	2014/15
Cirencester	4	4	4	2	7	7	9	3					**40**
North Cotswolds	3	6	2	4	2	1	4	3					**25**
Dilke	6	5	2	3	2	2	3	1					**24**
Stroud	3	6	2	2	2	2	2	3					**22**
Lydney	1	4	1	2	4	2	2	4					**20**
Tewkesbury	2	2	4	4	1	0	2	4					**19**
The Vale	3	4	2	1	1	2	2	3					**18**
Total	**22**	**31**	**17**	**18**	**19**	**16**	**24**	**21**					**168**



This table shows the mortality numbers at each community hospital for the year to date. The Medical Director leads the process for reviews of all deaths in our hospitals in order that we may continually improve the care we provide. Learning to date shows a need to:

- Improve the recording and review of resuscitation status
- Improve the recording of conversations with the patient and their family
- Improve the legibility of recording in the medical record
- This is being taken forward through education sessions with medical staff and the professional cabinet

EFFECTIVE

Effective - key points

- The quality snapshot dashboard provides an 'at a glance' picture of a number of quality metrics for the month and the movement since the last report. This provides a valuable tool to use as part of Matron's Walkabouts and Peer Review Visits. A similar dashboard is being developed for Community Services (see page 33). The Director of Nursing and Quality and the Head of Community Hospitals will review this in Q4 and consider potential additional reporting fields and if a weighting score should be added to provide an overall RAG rating

- The Staff Flu Vaccinations Programme continues with a total of 655 of patient facing staff being vaccinated. The public health message about protecting those we provide care for is being emphasised.

Quality Snapshot – Community Hospital Inpatient Care November 2014

Hospital site	Inpatient wards	FFT response rate	FFT number of responses	FFT net promoter score	Complaints	Number of cases of C.Diff	Safety thermometer harm free care	Number of patients who fell					Number of patients with acquired pressure ulcers				Safer staffing fill rate (aggregated)		Sickness % (Previous Month)		Appraisal %		Movement against Previous Month
								No harm	Minimal	Short-term	Severe	Death	Grade 1	Grade 2	Grade 3	Grade 4	RNC	HCA	RNC	HCA	RNC	HCA	
SGH	Cashes Green	23%	6	83	0	0	89.5%	0	8	0	0	0	0	0	0	0	97.7%	126.2%	1.71% (10.27)	2.51% (15.08)	100.00%	100.00%	↓
SGH	Jubilee	42%	5	100	0	0	87.5%	1	0	0	0	0	0	0	0	0	100.0%	166.7%	1.27% (8.40)	2.11% (13.85)	90.0%	94.12%	↑
NCH	North Cotswold	28%	11	46	1	0	100%	0	16	2	0	0	0	0	0	0	100.8%	111.6%	1.30% (13.43)	10.58% (14.33)	70.59%	63.16%	↑
VLH	Peak View	33%	10	78	0	0	84.2%	2	9	1	0	0	0	0	0	0	102.5%	109.8%	5.33% (13.76)	18.88% (12.05)	76.47%	75.00%	↑
DLK	Dilke	27%	8	37	0	0	95%	0	8	1	0	0	0	0	0	0	100.8%	111.6%	5.36% (13.79)	5.66% (14.36)	84.21%	100.0%	↔
TWK	Abbey View	38%	12	92	0	0	77.8%	0	12	1	0	0	0	0	0	0	86.3%	130.4%	16.17% (16.24)	15.68% (16.53)	95.00%	100.0%	↔
LYD	Lydney	18%	5	20	0	0	90.5%	0	9	0	0	0	0	0	0	0	100.0%	150.0%	7.82% (13.40)	7.02% (15.12)	75.00%	95.00%	↔
CIR	Coln	29%	10	10	0	0	100%	0	13	0	0	0	0	1	0	0	89.0%	101.1%	6.94% (16.20)	12.85% (9.63)	81.82%	75.00%	↔
CIR	Windrush	29%	10	40	0	0	100%	0	4	1	0	0	0	0	0	0	95.0%	118.4%	1.51 % (11.35)	7.54% (16.15)	76.92%	80.95%	↑

Quality Snapshot - Community Teams November 2014

Locality	Safety thermometer harm free care	Number of patients with acquired pressure ulcers				Sickness % (Previous Month)	Appraisal %	Complaints	Movement against Previous Month
		Grade 1	Grade 2	Grade 3	Grade 4				
Cheltenham	97.4%	0	0	0	0	2.89% (73.5)	72.22%	0	↑
Cotswold	97.1%	0	0	1	0	6.07% (69.8)	71.91%	0	↓
Forest	92.5%	0	0	0	0	2.39% (61.0)	90.67%	0	↓
Gloucester	92.6%	0	0	0	0	5.40% (90.9)	69.81%	0	↔
Stroud	95.2%	0	3	0	0	4.60% (89.9)	77.27%	0	↑
Tewkesbury	93.3%	0	0	0	0	6.51% (53.2)	69.12%	0	↑

Effective – NICE guidance and Quality standards

Trust compliance with NICE guidance published May 2010 to November 2014

Type of guidance	Not Assessed	Not Implemented	Partially Implemented - Moderate Concern	Partially Implemented - Minimal Concern	Fully Implemented	Not Applicable
NICE Guidance	36	0	1	19	22	396

Trust compliance with NICE Quality Standards published June 2010 to November 2014

Type of guidance	Not Assessed	Not Implemented	Partially Implemented - Moderate Concern	Partially Implemented - Minimal Concern	Fully Implemented	Not Applicable
Quality Standards	33	2	0	0	5	32

- The Trust is undertaking a review of all NICE guidance and quality standards published after May 2010 (prior to the establishment of GCSNHST). This process will provide evidence of compliance and a gap analysis where there is work to be undertaken
- Work is ongoing to reduce the number of assessments which are outstanding and update evidence uploaded to NICEAssure.
- The Clinical Senate reviews all recently published guidance and all Quality standards, nominating a lead clinician to assess Trust implementation and compliance. It will continue to work on seeing more consistent reporting and oversight at all clinical governance meetings within the Trust.

Effective – Staff Flu Vaccination Programme

The Staff Flu Vaccination Programme commenced at the end of September 2014 supported by the Occupational Health Department 'Working Well'. Actions to promote uptake amongst colleagues include:

- Promotion of the programme including screen savers
- Vaccination clinics offered as part of team meetings and Corporate Inductions
- Development of the role of peer vaccinations.
- Survey in early 2015 to capture those colleagues receiving vaccinations from their GP or other providers

	October YTD	November YTD	December YTD	January YTD	Target	2013/14
%	13.6%	31.5%			75%	38.6%
Number of staff	282	655			2,077	807

- The disappointing results for October were partly attributable to a number of vaccinations incorrectly coded to the old PCT. This has been corrected and figures updated for November.
- Working Well are validating their data collection process to prevent recurrence.
- Performance by the end of December 2014 is expected to be above the outturn achieved in 2013/14.

RESPONSIVE

Responsive - key points

- In November 2014, the Trust is reporting 85.7% compliance with national health targets and 77.8% compliance with local health targets on year to date basis: this is consistent with the position reported in October.

- Details of action / remedial plans in respect of areas of under-performance are included *(see pages 39 to 41)*

- There are two social care indicators currently rated red, which are of particular priority for the Trust and Adult Social Care Commissioners *(see page 42)*

Performance targets – Year-to-date National

Indicator	YTD RAG	Performance	Actions	Projected date of remedy
Friends and Family Test - MIU response rate		See page 26 for details		
Safety Thermometer - harm free care		See page 11 & 12 for details		
MIU unplanned reattendance rate within 7 days		Performance in November was 5.2% compared to target of less than 5%	Issue identified with MSS Patient First following system upgrade where planned/unplanned do not show on system. Escalated to System Manager and supplier to identify resolution	Data Solution provided December 2014 System supplier to confirm patient episode screen resolution
Health Visitors – Call to Action (number of WTEs)		Performance in November was 114.64 against a target of 116.48	Decrease due to staff leaving. Expect 132 in January 2015 when students have completed training and qualified.	January 2015
Children in Reception Year with Height and Weight recorded		Performance in November was 22.4% compared to trajectory of 25%	Under performance due to scheduling of clinics determined by school availability. The service is confident that with the current scheduling in 2015 performance will return to trajectory.	March 2015

Performance targets – Year-to-date Local

Indicator	YTD RAG	Performance	Actions	Project date of remedy
Bone Health Service - referral to treatment within 8 weeks		Performance in November was 100% compared to a target of 95%, however year to date performance currently stands at 91%	The target has now been achieved for 4 consecutive months (formal contract query has now been removed)	Performance has been on target since August 2014
MSKCAT service - wait time for routine patients		Performance in November was 38% for routine and 100% for urgent patients against 95% targets. Year to date performance remains rated red	Actions include: • Monitoring of activity recorded on SystmOne (data quality) • Daily review of urgent patient waiting list • Additional clinics following recruitment • Fortnightly performance report to be provided from Service Lead to CCG • MSKCAT, MSK, Podiatry to be reviewed as one service area to ensure that changes in any of the component parts do not cause instability • Service to offer appointments outside of locality • Quality Impact Assessment to review scheduling of follow-up appointments in comparison to new appointments	Urgent target achieved since September 2014. Routine to be confirmed following completion of Quality Impact Assessment
MSKCAT service - wait time for urgent patients				
MSKCAT service - referral to treatment within 8 weeks		Performance in November was 89% against a target of 95%	See actions identified above	To be confirmed following completion of Quality Impact Assessment
Chlamydia Screening - number of positive screens		Performance in November behind trajectory by 364 positive screens, with 693 positive screens recorded compared to target of 1057.	The service have a number of actions in place to increase number of positive screens, including identifying and following up partner notifications and working with partner agencies. However these actions will not recover the performance required to achieve target.	Director of Service Delivery has notified Commissioner that target will not be achieved. Meeting February 2015 to discuss.
Podiatry Service - referral to treatment within 8 weeks		Performance in November was 88% against a target of 95%	The actions itemised above for the MSKCAT service apply equally to the podiatry service	As per MSKCAT

Performance targets – In month - National

Indicator	Month RAG	Performance	Actions	Project date of remedy
Face to Face consultations in PCC (Urgent to be seen within 2 hours)		Performance in November was 94% compared to 95% target. Year to date performance remains rated green	48 out of 812 urgent cases failed to meet the target. Of these, 17 patients missed the target by 5 minutes or less, and a further 11 patients by 15 minutes or less. There was also an increase in urgent cases of 12% compared to the previous month.	January 2015
Completion of valid NHS number in Social Care data sets		Performance in November was 77.1% compared to 80% target. Year to date performance remains rated green	GCS Performance team to flow details of all patients without a valid NHS number to tracing service for review. GCC Data and Performance Team to ensure any validated details are entered onto ERIC system during January before retracing at the end of the month. Tracing to continue on regular basis.	January 2015

Performance targets – In month - Local

Indicator	Month RAG	Performance	Actions	Project date of remedy
Speech and Language Therapy (Adult) – referral to treatment		Performance in November was 87% compared to 95% target. Year to date performance remains rated green	The target was not met due to staffing problems. Actions to include: • Monitoring of activity recorded on SystmOne (data quality) • Daily review of patient waiting list	Service to review and provide recovery trajectory
Single Point of Clinical Access – Abandoned Calls		Performance in November was 7% compared to 5% target. Year to date performance remains rated green	The target was not achieved due to telephony problems on two occasions in November whereby the queuing system did not operate correctly. There have also been a number of staffing vacancies that have now been appointed to. When staff have been trained this will mean staff numbers can be increased at peak times.	April 2015

Adult Social Care Key Indicators

Target description	2013/14 Outturn	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-14	Feb-14	Mar-14	Target 2014/15
% service users who have been asked at initial assessment whether they have a carer									98.5%					100.0%
Permanent admissions aged 65+ to residential and nursing care homes per 100,000 population	885.87	857.68	834.61	795.32	762.74	746.95	723.69	709.56	661.37					Smaller is better 731.90
% service users who have had a full re-assessment of their needs within the last 12 months	80.8%	79.3%	77.6%	76.2%	76.1%	74.2%	72.4%	72.1%	70.4%					80.0%

Notes

- **% service users who have been asked if they have a carer** - the indicator definition has been revised; performance this month is 98.5%
- **Permanent admissions aged 65+ to residential and nursing care homes per 100,000 population** – decreased further this month to 661.37 showing a significant improvement
- **% service users who have had a full re-assessment of their needs within the last 12 months:** performance decreased to 70.4% (target 80%). It is believed that ASMT reported figure includes some Service Users that would not fall under GCS responsibility (LD); work is being undertaken to show GCS Service Users as a comparison.

The above 3 indicators are those that have been agreed between the Trust and Gloucestershire County Council as highest priority

The target for Permanent admissions aged 65+ to residential and nursing care homes per 100,000 population has been achieved since September

Rapid Response - Key Indicators

Indicator	Target	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
Number of referrals		70	90	105	97	80	88	134	128					**792**
% of patients with assessment initiated within 1 hour	95%					88.0%	92.8%	92.5%	92.7%					**91.5%**
% of patients referred from SPCA who have an agreed patient led care plan in place	100%	100%	100%	100%	100%	100%	100%	100%	100%					**100%**
% of patients where the direct referrer reports that rapid response intervention avoids hospital admission		80.0%	76.5%	73.2%	70.7%	62.5%	80.0%	83.3%	85.0%					**77.3%**
Number of referrals where the direct referrer reports that rapid response intervention avoids a hospital admission		56	69	77	69	50	70	112	109					**612**

Rapid response referrals:

- Increased number of referrals in October and November following service roll-out in Forest and Tewkesbury localities
- Stroud locality roll-out December 2014
- 38% of referrals from GP Practices, 34% from SWAST, 28% from other sources
- 49% of referrals patients aged 65-84, 40% of referrals patients aged 85+, 11% of referrals patients aged under 65 years.

WELL-LED

Well-led - key points

- The Trust is currently performing well against its data quality targets i.e. in respect of the validity of 45 data indicators that are routinely submitted to the Secondary Uses Services (SUS), Trust performance is 96.4% against a target of 96% *(not referenced elsewhere)* based on the latest data available from the Health and Social Care Information Centre (HSCIC)

- The Staff Friends and Family Test is positive in terms of colleagues recommending the Trust as a place for treatment: however, there is opportunity to improve the Trust's recommendation as a place to work *(see page 46)*

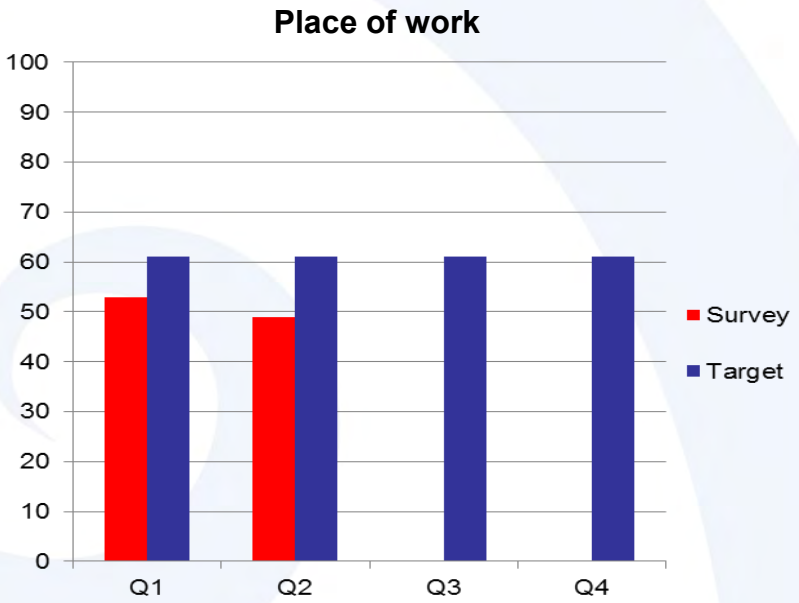
- The Trust is currently employing more staff than planned *(see page 47)*

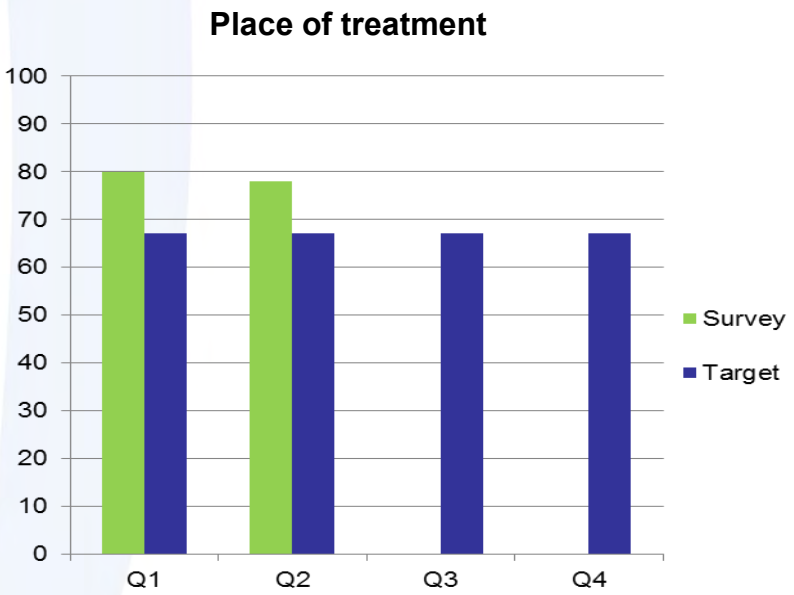
- Sickness absence levels, mandatory training rates and appraisals continue to under-perform *(see page 48)*

Please note that supplementary workforce data is provided to the HR/OD Committee

Staff Friends and Family Test

	Q1	Q2	Q3	Q4
Percentage of staff who would recommend the Trust as a place of work	53%	49%		
Percentage of staff who would recommend the Trust as a place to receive treatment	80%	78%		





Full analysis of the data is being undertaken. Report to Trust Board in November.

Workforce numbers

	Monthly Actual Staff in Post (WTE)	Planned Staff in Post (month) WTE	Vacancy Rate (%) (variance against plan)	Monthly Actual Spend (£000s)	Annual Plan Spend (month) £000s
Total workforce	**2,213.87**	**2,156.76**	**2.65%**	**£6,416**	**£6,538**
- Temporary workforce	**100.21**	**106.92**	Not applicable	**£437**	**£87**
- Bank	56.25	64.49	Not applicable	£160	£30
- Agency staff	43.96	42.42	Not applicable	£277	£57
Substantive WTE	**2,113.66**	**2,049.85**	**3.11%**	**£5,979**	**£6,450**
- Non-medical - clinical staff	1,864.71	1,783.22	4.57%	£5,141	£5,625
- Non-medical - non-clinical staff	218.81	232.8	-6.01%*	£617	£600
- Medical and dental staff	30.14	33.83	-10.91%**	£221	£225

*Non-medical – non-clinical staff vacancy rate of 6.01% compared to plan is within Administration and Estates cohort of staff
**Medical and dental staff - vacancy rate of 10.91% compared to plan is within Dental and Sexual Health services

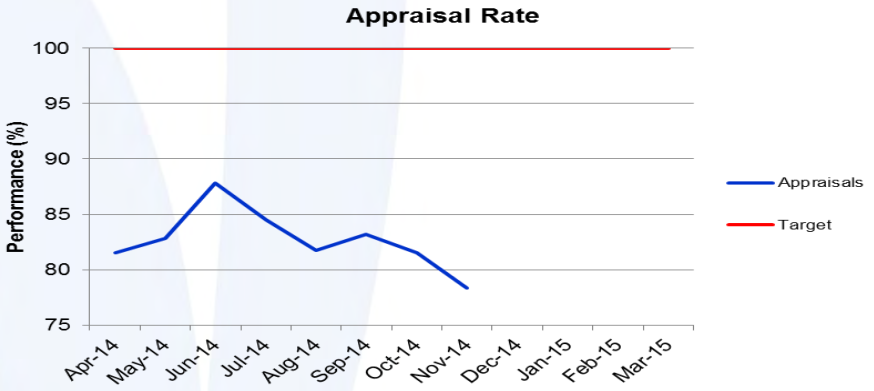
Staff Group	WTE (year-to-Nov)	Starters WTE (year-to-Nov)	Starters headcount (year-to-Nov)	Leavers WTE (year-to-Nov)	Leavers headcount (year-to-Nov)	Vacancy rates	Turnover WTE rates (year-to-Nov)
ICTs	440.51	65.68	74	61.07	86	TBC	13.77
Children, Family &Young People	364.13	37.99	50.00	35.85	48.00	TBC	11.16
Countywide	359.23	40.77	52	48.89	71	TBC	13.54
Community Hospitals	496.65	82.62	98	80.16	106	TBC	16.22
Support Services	108.78	34.28	38	14.48	24	TBC	14.87
Unscheduled Care & Capacity	344.35	66.91	76.00	53.86	66.00	TBC	16.37
Total	**2113.65**	**328.25**	**388.00**	**294.31**	**401.00**	**TBC**	**14.38**

Sickness absence / mandatory training / appraisals

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Target
Sickness absence average % rolling rate - 12 months	4.35	4.39	4.45	4.55	4.59	4.59	4.59	4.73					**3.00**
Sickness absence % rate (1 month only)	4.88	4.48	4.88	5.43	4.94	4.34	4.69	4.83					**3.00**

Mandatory training course	Target	Health performance
Infection Control	100%	**85.72%**
Health & Safety	100%	**85.72%**
Conflict Resolution	100%	**72.83%**
Equality & Diversity	100%	**70.58%**
Information Governance	100%	**70.02%**
Fire Safety	100%	**62.02%**

Appraisal rate	Target	Performance
November	100%	78.35



Appraisal rates remain behind target across all service areas. Regular reports are produced by the workforce team to highlight to managers the staff that have appraisals due in future months to allow them to be appropriately scheduled. The onus is on managers to ensure appraisals are scheduled and completed.

"Challenge and Support" peer review

October - CQC Outcome 16		
Is the service safe?	**Requires Improvement**	This Peer Review was led by Julie Ellery, evaluated Stroud General Hospital against CQC Outcome 16: Assessing and monitoring the quality of service provision. The review identified the following learning: Safe: Documentation and the high use of agency staff poses a risk to patients where risk assessments are incomplete. Effective: The ward needs to revise effective use of documentation Caring: Patients in all areas feel well cared for. Responsive: There is a real commitment to want to improve by staff Well led: Matrons walkabout is very positive and the sense of team work between Band 7 nurses is evident
Is the service effective?	**Requires Improvement**	
Is the service caring?	**Good**	
Is the service responsive?	**Good**	
Is the service well led?	**Good**	

November - CQC Outcome 7		
Is the service safe?	**Good**	This Peer Review was led by Mandy Hampton, evaluated North Cotswolds Community Hospital against CQC Outcome 7: Safeguarding people who use services from Abuse. The review identified the following learning: Safe: Staff demonstrated good knowledge of Safeguarding and their responsibilities in the process Effective: Good outcomes achieved through staff awareness Caring: Safeguarding issues in relation to equality and diversity are considered Responsive: Evidence of effective team communication. Further supporting evidence required to ensure everything is cascaded and received by staff Well led: Good progress on implementing actions in relation to Essential Standards and a structured process in place to discuss issues with clinical leads
Is the service effective?	**Good**	
Is the service caring?	**Good**	
Is the service responsive?	**Good**	
Is the service well led?	**Good**	

NED Quality Visits - Patient Experience Assessment (November)

Date	Who	Site/Service	Location
19th November	Nicola Strother-Smith	Children's Occupational Therapy	Quedgeley, Gloucester
26th November	Ingrid Barker	Stroke Early Support Discharge Service	Cheltenham

Gloucestershire Care Services NHS
NHS Trust

Annual report: infection prevention and control

Ref: 15/B012

This report is for Publication

Gloucestershire Care Services NHS Trust Board

Annual Report of the Director of Infection Prevention and Control 2013/14

20th January 2015

Objective:

The Director of Infection Control (DIPC) is required under the Health and Social Care Act 2008 to produce an annual report and make that report available to the public. This report covers the reporting period from April 1st 2013 until March 31st 2014 and relates to the services Gloucestershire Care Services NHS Trust is registered with the Care Quality Commission to provide.

The Board is asked to:

- Receive the report and approve it for publication via the Trust website
- Note the progress made in the reduction of the risk of healthcare acquired infection and the improvement actions in place to ensure continuous quality improvement

Executive summary:

The prevention and control of healthcare associated infection remains a key priority for Gloucestershire Care Services NHS Trust and the annual report from the Director of Infection Prevention and Control provide assurance of the Trust's compliance with the Hygiene Code throughout 2013/14. The Trust can confirm:

- The role of Director of Infection Prevention and Control is fulfilled by the Director of Nursing and Quality supported by an Infection Control Doctor and team of specialist nurses
- 19 cases of C.difficle against a tolerance of 18 were recorded in that period and the work plan for 2014/15 aims to work with our partners across the health community to achieve year on year reduction
- Zero cases of MRSA bacteraemia were reported
- A reduction of the number of patients affected and the number of outbreaks was achieved and this continues to be a focus

Liz Fenton, Director of Nursing and Quality
December 23rd 2014

☒	This paper requires no equality impact assessment as it does not propose changes to how people receive services or our colleagues' working lives.
☐	This paper proposes changes. Equality analysis identifies the following equality impacts: • • A copy of the EIA is appended.
☐	This paper proposes changes. Equality analysis has NOT been completed for the following reasons: • •

[Notes supporting questions]: Compliance with the Public Sector Equality Duty

Under the Equality Act 2010, we have a legal responsibility when we make decisions to have due regard to the need to:

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

Therefore, if this paper proposes changes that will affect how people receive services or our colleagues' working lives, you should complete an equality analysis. This is to determine the extent to which the changes will eliminate discrimination, advance equality, and foster good relations.

Gloucestershire Care Services NHS
NHS Trust

Infection Prevention and Control Annual Report
2013-2014

Chair: Ingrid Barker Chief Executive: Paul Jennings

Understanding You

Director of Infection Prevention and Control annual report 2013-2014

1. Executive Summary

The Director of Infection Prevention and Control is required under the Health and Social Care Act 2008 (Part 3, 1.3) to produce an annual report and make this available to the public. This report covers the period from April 1st 2013 to March 31st 2014 and relates to the services that Gloucestershire Care Services NHS Trust is registered to provide through the Care Quality Commission.

The prevention and control of healthcare-associated infection (HCAI) is a key priority for Gloucestershire Care Services NHS Trust, the Trust serves not only patients and the wider community, but also healthcare Commissioners and regulators including the Department of Health (DH). We have maintained compliance during 2013/14 in all areas shown in Table 1 below.

Table 1 - Health and Social Care Act 2008 - Code of Practice for Health and Adult Social Care on the prevention and control of infections

Compliance criteria	Gloucestershire Care Services NHS Trust can demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection.
3	Provide suitable accurate information on infection to service users and their visitors.
4	Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection of other people.
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Ensure, so far is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

The Director of Infection Prevention and Control gives the following assurances that Gloucestershire Care Services NHS Trust is fully compliant with the Hygiene Code:

- Gloucestershire Care Services NHS Trust practice a zero tolerance approach to Healthcare Associated Infections (HCAI) as stated by the Department of Health
- 100% of patients presenting for elective surgery are screened at pre-assessment
- Every case of *Clostridium difficile* infection is investigated and a Root Cause Analysis completed, with the clinical teams, to ensure lessons are learned and actions taken if non-compliance with policy or procedure are identified
- Gloucestershire Care Services NHS Trust take part in the Post Infection Review process for all MRSA bacteraemia as part of the countywide systems approach to healthcare
- The Infection Prevention and Control Team carry out an annual programme of audit as required by the Hygiene Code
- Gloucestershire Care Services NHS Trust meet compliance with the European Directive on preventing needle stick and sharps injuries
- Gloucestershire Care Services NHS Trust use national cleaning specifications to determine cleaning frequencies and methodology within the healthcare environment
- Gloucestershire Care Services NHS Trust use national methodology for monitoring of cleaning standards and report these to the Infection Control & Decontamination committee on a bi-monthly basis as per Hygiene Code requirements
- Gloucestershire Care Services NHS Trust carry out inspections of all in-patient areas in conjunction with the Patient Led Assessment of the Care Environment (PLACE)
- Gloucestershire Care Services NHS Trust has Occupational Health provision from an external provider – Working Well.
- Occupational Health screening is carried out on all staff at pre-employment checks and further surveillance and screening is carried out at agreed intervals and as necessary

During the year 2013/14, the infection prevention and control team continued to build on the progress of previous years, supporting a comprehensive programme of infection prevention and control across the organisation. The work has included staff from across Gloucestershire Care Services NHS Trust in continued promotion of hand hygiene including participation in the World Health Organisation's hand hygiene week in May 2013. There has also been continued policy reviews and development, education sessions for both employed and volunteer staff, surveillance and reporting of healthcare associated infections (Clostridium difficile, MRSA, MSSA and E. coli). Infection Control Nurses have provided locality based working and local liaison for advice and support, infection control audit, advice on estates planning, new builds and refurbishment and Legionella control, outbreak management, root cause analysis (RCA) investigation of all cases of Clostridium difficile infection, MRSA bacteraemia, and any infection control related serious incidents and resultant investigations.

2. Infection Prevention and Control Arrangements

The Chief Executive holds responsibility for Infection Prevention and Control within Gloucestershire Care Services NHS Trust.

The Director of Nursing and Quality is the designated executive lead and Director of Infection Prevention and Control and reports directly to the CEO and the Board. The Director of Infection Prevention and Control is also the chair of the Infection Control Decontamination Committee.

The Director of Infection Prevention and Control works in partnership with the Infection Control Doctor/Consultant Medical Microbiologist.

Infection Prevention and Control Team Establishment

The Gloucestershire Care Services NHS Trust Infection Prevention and Control Team are established as follows:

- Lead Nurse, Infection Prevention and Control, Band 8a X1 WTE
- Infection Control Nurse Band 7 X 1 WTE
- Infection Control Nurse Band 6 X 2 WTE
- Surveillance Band 5 X 20hrs/week
- Admin Support X 22hrs/week

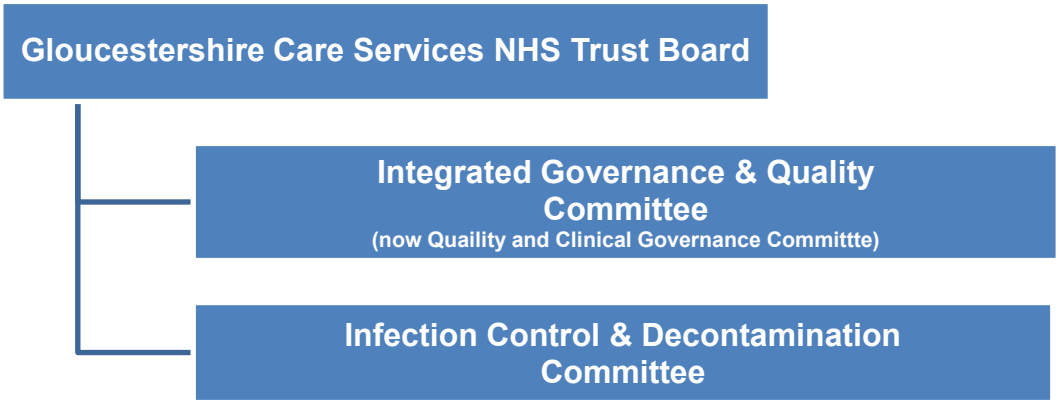
Additionally there are infection control link staff in all clinical areas that support the Infection Prevention and Control agenda.

Infection Control & Decontamination Committee and reporting

The purpose of the Infection Control and Decontamination Committee is to oversee the infection control agenda and to provide assurance to the organisation on the requirements of infection prevention and control and decontamination, by monitoring infection control policies, procedures and processes within the Trust.

Gloucestershire Care Services NHS Trust Infection Control and Decontamination Committee has membership from across the organisation and is chaired by the Director of Nursing/DIPC. The committee meets on a bi-monthly basis. It was established as a sub group of the Integrated Governance Committee now the Quality and Clinical Governance Committee. The Quality and Clinical Governance Committee reports directly to the Gloucestershire Care Services NHS Trust Board.

Table 2 below shows the reporting arrangements for the Infection Control and Decontamination Committee.



Links to other Infection Control Committees within the County are maintained as is the link with Public Health England. This is to ensure that the infection prevention and control is managed consistently across the patient pathway.

3. Surveillance

Surveillance is an integral component in the prevention and control of infection within Gloucestershire Care Services NHS Trust. Routine collection of data on infections amongst patients, clients or staff, is essential in order to prevent outbreaks or cross infection. Effective surveillance enables the assessment of infection levels over time in order to determine the need for enhanced infection prevention and control resource.

Decreasing numbers of health care associated infections demonstrate on-going positive results and improved patient outcome. Surveillance identifies susceptible or previously positive cases and instigates follow up so preventing relapse or cross infection.

Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia reporting

The reporting of MRSA bacteraemia (MRSA in the circulating blood) is mandatory for all NHS Trusts. The Gloucestershire countywide limit for cases of MRSA bacteraemia in 2013/14 was 6 with the agreed number of Post 48 hour MRSA bacteraemia for Gloucestershire Care Services NHS Trust set at zero.

Gloucestershire Care Services NHS Trust final position at the end of the year was zero MRSA bacteraemia for 2013/14.

	Tolerance	2013/14 number reported	Compliance
MRSA bacteraemia	Zero	Zero	Green

Meticillin Sensitive Staphylococcus aureus (MSSA) bacteraemia reporting

Whilst there remains no limit set for cases of MSSA bacteraemia (MSSA in the circulating blood) infections diagnosed, Gloucestershire Care Services NHS Trust monitors incidents and continues to report all cases to the Public Health England.

Gloucestershire Care Services NHS Trust final position at the end of the year was zero MSSA bacteraemia for 2013/14.

	Tolerance	2013/14 number reported	Compliance
MSSA bacteraemia	Zero	Zero	Green

4. Health Care Associated Infections

Meticillin Resistant Staphylococcus aureus (MRSA) acquisition

MRSA can live harmlessly in the nose or on the skin of an individual. This co-existence without harm is known as colonisation or carriage. Approximately 5% of the population are colonised with MRSA at any given time and while usually harmless colonisation has the potential to cause infection, especially if healthcare interventions are undertaken. Patients admitted to Gloucestershire Care Services NHS Trust inpatient facilities are screened to establish if MRSA is present. If MRSA is found the patient is treated to eradicate the MRSA colonisation. If a patient is found to be MRSA positive upon routine swabbing after clear the MRSA screen taken upon admission this is known as a MRSA acquisition. All new cases of MRSA acquisition (colonisation or infection) are reported to the Infection Control and Decontamination Committee and a root cause analysis is undertaken to establish how the acquisition occurred.

The total number of Post 48hr MRSA positive results for 2013/14 was one. This was a from a nose and groin screen taken after 48 hours from admission of a patient at the Vale Hospital. The root cause investigation and subsequent follow up meetings could not establish where the patient became colonised whilst at the Vale Hospital and it is believed that the initial admission screen was not undertaken correctly. This resulted in additional training on the admission screening process for Vale staff and the addition of a slide specifically covering the screening process on the infection control mandatory update and infection control induction session.

Clostridium difficile mandatory reporting

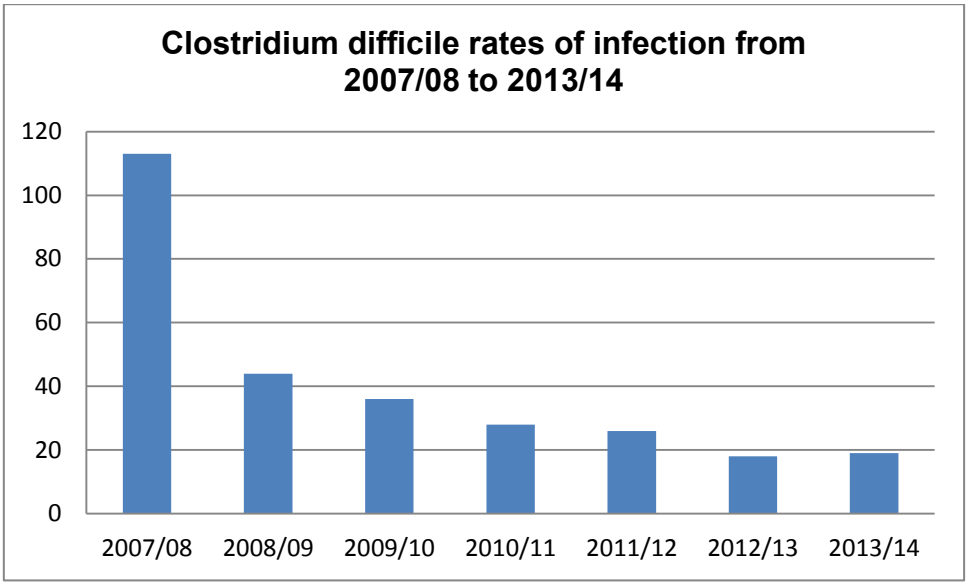
The Gloucestershire Care Services NHS Trust tolerance figure for 2013/14 was a maximum of 18 cases, diagnosed post 48 hours after admission.

There were 19 cases of C. difficile confirmed on Enzyme-linked immunosorbent assay (EIA) diagnosis. This equates to 0.023 cases per 1000 bed days.

	Tolerance	2013/14 number reported	Compliance
C. difficile	18	19	Red

The one case over the agreed tolerance figure is due to the cross infection identified at the Forest Inpatient Unit at the Dilke in April 2013 and is described in detail in the next section – Period of Increased Incidence

The table below demonstrates the year on year rates of C. difficile cases since 2007/08.



Period of increased incidence (PII)

A period of increased incidence is defined as 2 or more Clostridium difficile infections occurring on the same ward within a 28 day period that are both more than 48 hours post admission and not classified as relapses (a return of symptoms within 28 days).

Three PII were identified in 2013/14:

April to June 2013 – Forest Inpatient Unit, Dilke Hospital;
A total of four patients were involved in this event that was identified as a period of increased incidence on 23rd April 2014 when a second case of Clostridium difficile was diagnosed and ran on until 19th June 2013. Upon ribo-typing 3 of the four cases were identified as type 078 with the forth sample unable to be processed due to insufficient sample. The same ribo-type demonstrates cross infection. The root cause analysis undertaken on each patient found them to be susceptible to infection due to the number of courses of antibiotics administered and underlying medical conditions. However the cause of the cross infection in three cases is highly likely to have been due to ward refurbishment and the schedule of patient movement into a decant room. Upon inspection it was found that the macerator seal had failed and was the cause of contamination of surrounding toilet area/facility and this is likely to have been the cause of the fourth case. Upon identifying this potential the macerator was removed. Following the interventions, education and training no further cases occurred.

June & July 2013 - Lydney Hospital;
Identified as a period of increased incidence on June 20th 2013 after a second patient was diagnosed as Clostridium difficile positive. Cross infection was not identified as two separate ribotypes found as causative organisms. The PII ended on 18th July 2013 with no further cases.

June & July 2013 - Jubilee Ward, Stroud Hospital;
Identified as a period of increased incidence on Monday 24th June 2013 with a second patient being diagnosed as Clostridium difficile positive. Cross infection was not identified as two separate ribotypes found as causative organisms. The PII ended on 22nd July 2013 with no further cases

E. coli bacteraemia

Whilst there is no set tolerance for Escherichia coli bacteraemia infections diagnosed, Gloucestershire Care Services NHS Trust continue to report all cases to Public Health England.

In 2013/14 a single pre 48 hour E. coli bacteraemia was reported. As this diagnosis was made within 48 hours of the patients admission to the North Cotswold Hospital this infection is not attributable to Gloucestershire Care Services NHS Trust and the staff should be commended on the early identification of a patient with a bacteraemia.

	Tolerance	Pre 48 Hour	Post 48 hour	Compliance
E. coli bacteraemia	No set tolerance	1	Zero	Green

Glycopeptide resistant enterococcus (GRE) mandatory reporting

Again there is no set tolerance for Gloucestershire Care Services NHS Trust for glycopeptide resistant enterococcus bacteraemia and in 2013/4 zero cases were reported.

	Tolerance	Pre 48 Hour	Post 48 hour	Compliance
GRE bacteraemia	No set tolerance	Zero	Zero	Green

5. Outbreaks

An outbreak of infection can be described as:

- Two or more people with the same disease or symptoms or the same organism isolated from a diagnostic sample, who are linked through a common exposure, personal characteristics, time or location.
- A greater than expected rate of infection compared with the usual background rate for the particular place and time.
- A single case of a rare or serious disease such as diphtheria, polio, rabies, legionella etc.

During the reporting period from 1st of April 2013 to March 31st 2014 there were 12 episodes within Gloucestershire Care Services NHS Trust defined as outbreaks.

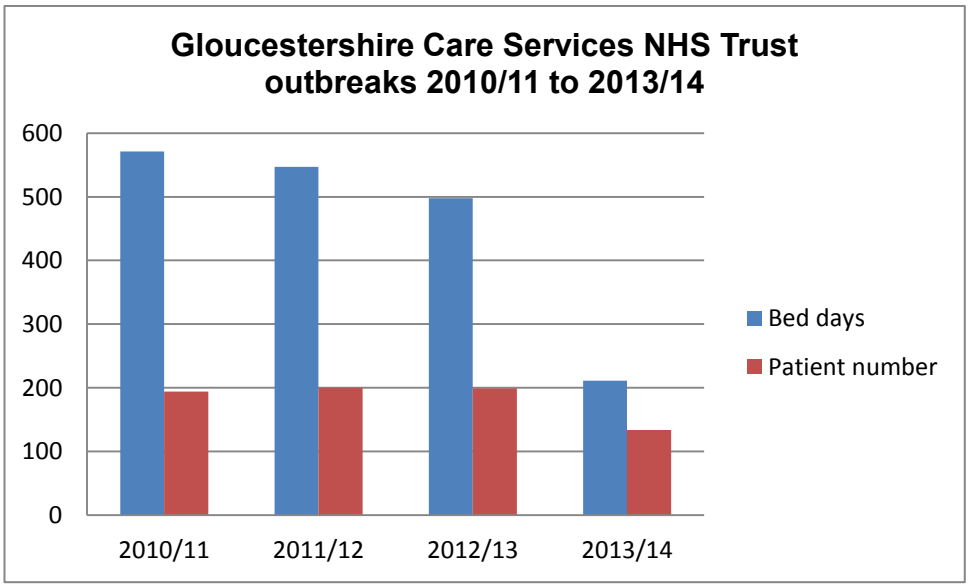
Norovirus

Norovirus was the confirmed as the causative organism for 10 of the twelve outbreaks.

The length of time the outbreaks lasted varied between 2 days (no causative organism identified) to a maximum of 14 days (Norovirus identified as the causative organism).

The total number of bed days lost was 211 (497 bed days were lost in 2012/13) with a total number of 134 patients affected (199 in 2012/13) and a total number of staff affected 43 (78 in 2012/13).

Table 4 below provides a clear illustration of the year on year reduction in the number of patients affected and the bed days lost.



This provides strong evidence that outbreaks are managed more effectively and the post outbreak reviews that are undertaken after each outbreak have improved patient outcome and the reduced the duration of the outbreak.

6. Audit

Audit is an essential activity that is instrumental in the organisation monitoring patient care, safe practice and the quality of the care environment.

The infection control audit tool has been developed by the infection prevention and control team combining three internationally recognised audit tools; the Infection Control Nurses Association Acute Audit Tool (2004), the Infection Control Nurses Association Community Setting Audit Tool (2005) and the Infection Prevention Society (IPS) Quality Improvement Tool (2011). By combining these three tools we are confident with have a robust, quality driven and patient care focused audit tool that covers all aspects of the audit process and provides detailed feedback on the following:

- Environmental
- Kitchen
- Disposal of Waste
- Spillage and Contamination
- PPE

- Sharps
- Linen
- Decontamination of Equipment
- Isolation

Extent of audit programme

The organisation's annual audit programme includes inpatient and outpatient facilities, x-ray departments, phototherapy units, therapy units, gymnasium, podiatry rooms, dentistry, treatment rooms etc. The audit report post the inspection is sent to the manager/matron/locality lead and the Hotel Services manager and the estates lead within 10 working days of the audit having taken place. A completed action plan detailing how elements found to be non-compliant during the audit are to be made compliant is required within 4 weeks of receipt of the audit report.

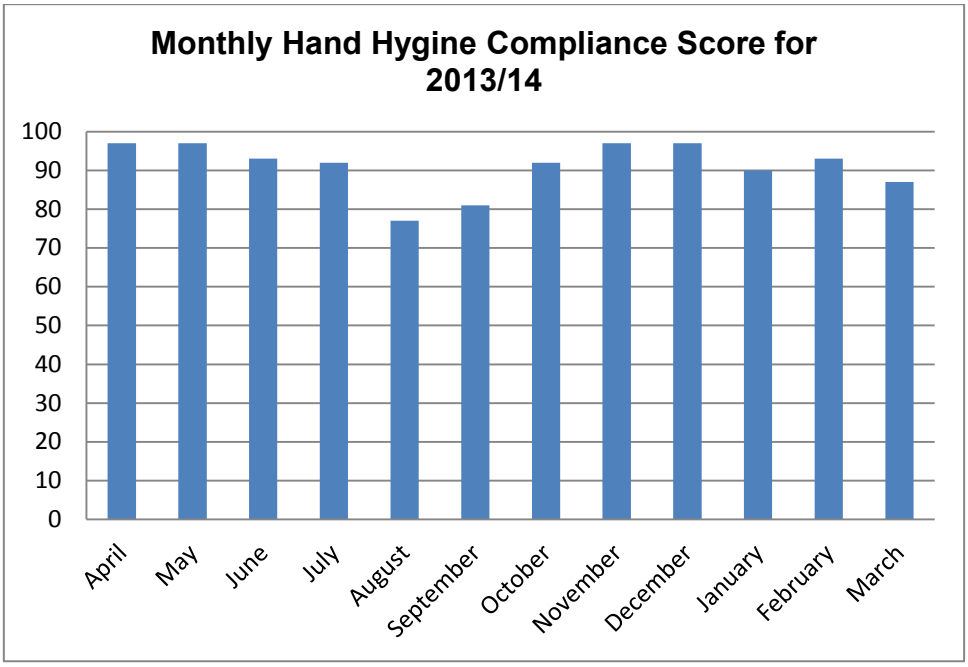
The overall average score for the organisation across all sites audited is maintained at 92% as was for 2012/13 compared with 90% for 2011/12.

Issues identified during the audit process can be addressed immediately by the local teams. In cases where this is not possible or there are opportunities for wider learning these are taken to the relevant local clinical governance groups.

Hand hygiene

Compliance with the hand hygiene policy is essential for effective infection prevention and control across our organisation irrespective of the staff members role. In recognition of the importance of hand hygiene across Gloucestershire Care Services NHS Trust observational hand hygiene compliance audits are undertaken in inpatient units, minor injury units, outpatient departments and theatres and results collated and monitored by the infection prevention and control team. These results are reported to the Board and at the Infection Control and Decontamination Committee.

Table 5 below provides the 2013/14 monthly average compliance score demonstrating the standard against the organisations compliance target of 90%. If an area reports a score below the minimum standard expected, additional support and education is provided and a re-audit undertaken within the same month.



The average monthly observation hand hygiene audit score for 2013/14 is 92% compared with the 2012/13 score of 98% compliance. Upon investigation at the time of these results it was found that some areas were not reporting the audit score having undertaken the audit. If the ward, area or unit undertaking the audit does not report the audit score before the month end then that ward, area or unit scores a zero and this has been reflected in the lower average compliance score for 2013/14.

7. Antimicrobial Stewardship

Antimicrobial stewardship includes not only reducing inappropriate use but also optimising antimicrobial selection, dosing, route, and duration of therapy to maximize clinical cure or prevention of infection while limiting the unintended consequences, such as the emergence of resistance, adverse drug events, and cost.

Antimicrobial stewardship is important for a number of reasons:

- Patient safety – cure or prevention versus adverse effects
- Minimise other “collateral damage” e.g. antimicrobial resistance
- Preserve utility pending alternative infection prevention or management developments
- Cost

The current position within Gloucestershire Care Services NHS Trust with regard to antimicrobial stewardship includes:

- The Head of Medicines Management is a member of the countywide Antimicrobial Stewardship Committee
- Antimicrobial prescribing guidelines are in place for inpatient and community based services. These guidelines are evidence based and compiled jointly by the

Head of Medicines Management and the consultant microbiologist. The guidelines are available both as hard copy and electronically

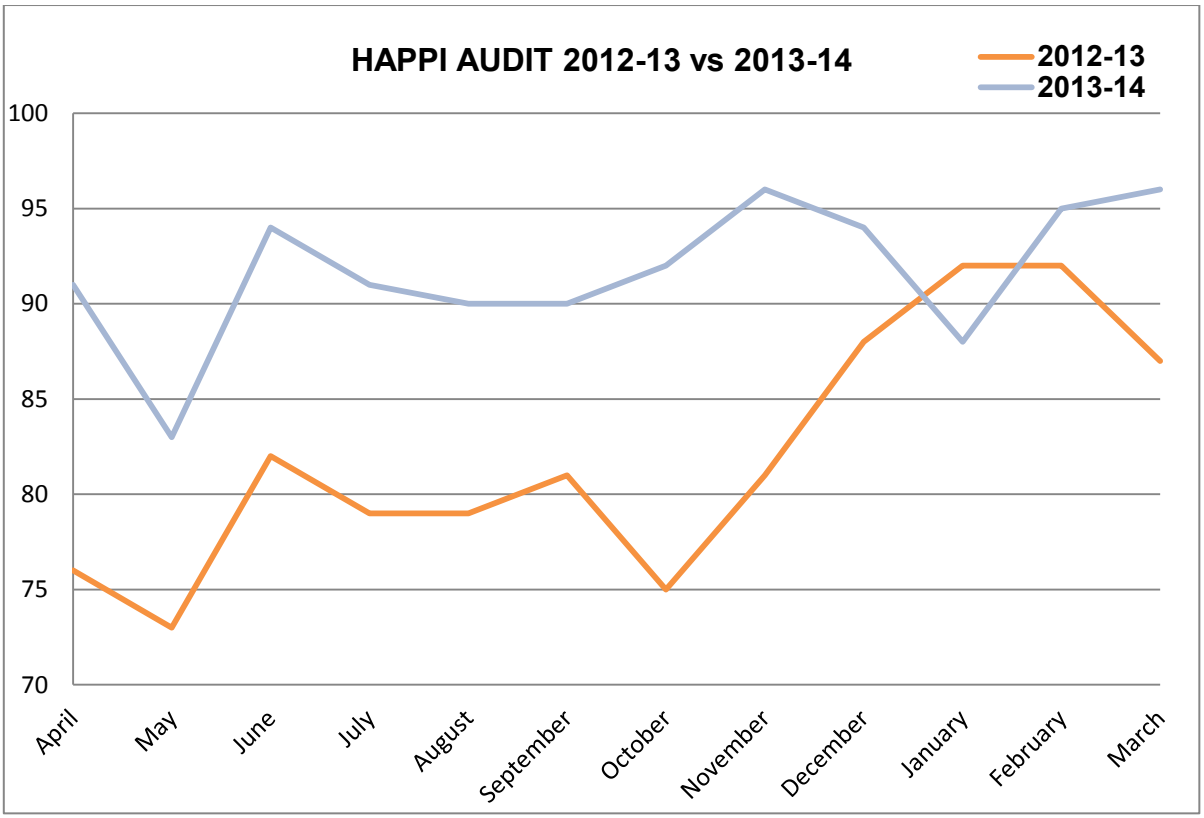
- HAPPI (Hospital Antimicrobial Prudent Prescribing Indicators) audit carried out monthly on all inpatient sites. The results are included in the locality dashboard
- Annual update for non–medical prescribers on antibiotic resistance and antimicrobial stewardship
- Promoting safe and rationale use of antibiotics by supporting European antibiotic awareness day

HAPPI Audit

The Hospital Antimicrobial Prudent Prescribing Indicator audit is carried out monthly on all in-patient wards. Five elements of antibiotic prescribing are audited:

- The allergy status is recorded (signed and dated) in the drug chart
- The indication for prescribing recorded on the drug chart
- A review date or stop date is recorded on the drug chart
- The antibiotic prescribed is on the agreed formulary or on the advice of microbiology
- The route of administration is appropriate

The graph below shows the HAPPI results from April 2013 to March 2014. This shows an improvement in compliance over the 12 month period.



The results of the audit are shared with matrons and locality managers for dissemination to all ward staff. The data collection sheet also records the name of the prescriber which ensures direct feedback to the prescriber on areas of non-compliance.

Influenza vaccination

Frontline health and social care staff have a duty of care to protect their patients and service users from infection and this includes vaccination to protect against seasonal influenza. As in previous years Gloucestershire Care Services NHS Trust employed staff have been offered a free seasonal flu vaccination through Working Well, the organisations occupational health provider. From October 2013 Gloucestershire Care Services NHS Trust were required to report the monthly uptake of seasonal flu vaccination by frontline health staff to NHS England through the ImmForm system. For the influenza season 2013/14 38.6% of frontline health staff had a seasonal influenza vaccination compared to 32.5% for 2012/13. Work will continue throughout 2014/15 to increase the uptake further.

8. Hotel Services

The Gloucestershire Care Services NHS Trust Hotel Services team have continued to maintain high standards throughout 2013/14. As part of the on-going monitoring of both cleanliness and the efficacy of the cleaning process two monthly audits are undertaken.

Adenosine triphosphate

Adenosine triphosphate (ATP) testing is undertaken at each inpatient facility. The ATP test can detect the amount of organic matter that remains after cleaning a surface, a medical device or item of equipment. The ATP results are available on the organisations intranet site and are reported bi-monthly at the Infection Control and Decontamination Committee providing clear information on the monthly cleanliness monitoring system and providing assurances that the areas that are ATP swabbed are clean.

Cleaning for Credits

Cleaning for Credits (C4C) is an audit process that enables the Hotel Services lead, Matron or ward manager to regularly adjust their functional area cleaning specification to meet the changing needs of their patients. The system is web based and can also identify what level of specification can be accommodated within given budgetary limits, identify the impact of the new national minimum cleaning frequencies and ensure that all cleaning services are properly deployed and balanced across the organisation. The C4C results are available on the Gloucestershire Care Services NHS Trust intranet system and are reported bi-monthly at the Infection Control and Decontamination Committee.

Patient Lead Assessment of the Clinical Environment

The Patient Lead Assessment of the Clinical Environment (PLACE) inspections took place between May and June 2013. PLACE inspections replaced PEAT – Patient Environment Action Team inspections. PLACE provide a stronger representation from the patient's perspective with twice the number of external inspectors than Gloucestershire Care Services NHS Trust staff and the PLACE inspection tool has undergone a complete revision so that it delivers a more comprehensive assessment than the previous PEAT inspection report.

This first year of PLACE inspection has provided the organisation with a number of learning points, e.g;

Inspections are based on the conditions seen at the time of the assessment with no allowance made for such things as inclement weather, building works or the next

scheduled cleaning, except for those items that are subject to scheduled but infrequent cleaning/maintenance.

The assessment is not made against how well a hospital is doing with what it has, but how well it is doing against the defined criteria and guidance. No allowance is made for shortcomings that are the product of infrastructural obstacles for example age or design of premises.

Table 5 provides the PLACE scores for 2013/14

Inpatient facility	Cleanliness	Food & Hydration	Privacy, Dignity & Wellbeing	Condition, Appearance & Maintenance
North Cotswold Hospital	91.04	88.39	86.05	89.08
Vale Hospital	94.42	85.09	81.08	92.02
Cirencester Hospital	85.89	74.30	81.20	80.11
Stroud Hospital	89.25	83.44	80.51	88.93
Lydney Hospital	94.75	87.17	82.73	75.54
Dilke Hospital	98.16	87.96	81.33	93.55
National Average	**95.75**	**85.42**	**88.90**	**88.78**

There was no PLACE assessment at Tewkesbury Hospital in 2013 due to the imminent move to the new hospital premises.

9. Decontamination

Gloucestershire Care Services NHS Trust has an identified Decontamination Lead who is supported in this role by the infection prevention and control team. In order to improve communications and reduce duplication the Decontamination Committee was merged with the Infection Control Committee during 2011/12.

The Infection Control and Decontamination Committee provide overall monitoring and assurance for decontamination across the organisation and also focus on specific projects. During 2013/14 the work programme achieved compliance with essential standards within Dental Services. There was also a review of the decontamination processes employed by our partner organisations, Gloucestershire Industrial Services (GIS) Healthcare. GIS provides aids and appliances to individuals across Gloucestershire and by working with GIS we are assured that the decontamination process for the equipment returned is safe so allowing for specialist items of equipment to be re-used for the benefit of the patient.

10. Education and Training

Gloucestershire Care Services NHS Trust staff reported that 95% of staff received infection prevention and control training during 2013/14. There was a 14% increase the number of infection control mandatory update and induction sessions provided during 2013/14 bringing the number to 163, in order to facilitate attendance.

In addition the team provide and lead two infection control study days for staff, as well as supporting infection control link staff with 6 dedicated educational sessions that focus on sharing learning. From root cause analysis undertaken for Clostridium difficile diagnosis and incidents of MRSA to innovations in infection prevention and control as well as new or emerging conditions, these learning opportunities are well attended at the venues where they are provided across the county.

11. Additional activity

In addition to providing full infection prevention and control services across Gloucestershire Care Services NHS Trust, infection control services are also provided under contractual arrangements to:

- 2gether NHS Foundation Trust (Gloucestershire)
- Tetbury Hospital Charitable Trust
- Sue Ryder Care (Leckhampton)
- Vanguard Healthcare

12. Priorities for 2014/15

That Gloucestershire Care Services NHS Trust maintains compliance with the Health and Social Care Act (2008) and meets compliance with essential standards as set by the Care Quality Commission.

That the tolerance figure of 21 cases of C. difficile infection that is agreed with Gloucestershire Clinical Commissioning Group is not exceeded and that Gloucestershire Care Services NHS Trust has no Post 48 hour MRSA bacteraemia cases.

The Infection Prevention and Control team will instigate a process of assurance of compliance with the Health and Social Care Act (2008) through an audit programme for the services provided by Gloucestershire Care Services NHS Trust.

The Infection Prevention and Control team continue to work proactively preventing infection and where infection is present act effectively in controlling infection.

That Gloucestershire Care Services NHS Trust maintains the zero tolerance approach to Healthcare Associated Infections (HCAI) as stated by the Department of Health.

13. Recommendations

The Board is asked to receive the Annual Infection Prevention and Control Report for 2013/14, and continue their active support of the infection prevention and control agenda as the organisation enters its new configuration.

The Board is asked to particularly note the performance against targets that were achieved for 2013/14.

The Board is asked to note that this report constitutes part of the organisational compliance with the Health and Social Care Act, and the report is required to be released publically.

The Board is reminded that the Health and Social Care Act (2008) requires in respect of criterion 1, part A that "board-level agreement outlining the Board's collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks" is required.

Prepared by: Sam Lonnen **Presented by:** Liz Fenton

Gloucestershire Care Services NHS
NHS Trust

Safer Staffing and Inpatient Dependency Audit

Ref: 15/B013

This report is for publication

Gloucestershire Care Services NHS Trust Board

Safer staffing and inpatient dependency audit
20th January 2015

Objective:

This paper continues the work and process presented to Board by the Director of Nursing and Quality in May 2014 which sets out GCS' compliance around the Safer Staffing requirements; namely the expectations contained within National Quality Board How to ensure the right people, with the right skills, are in the right place at the right time: guide to nursing, midwifery and care staffing capacity and capability (NQB) 2013, Hard Truths commitments regarding the publishing of staffing data 2014, and the NHS Standard Contract 2014-15.

The Board is asked to:

Note the actions undertaken to ensure appropriate staffing within the Trust inpatient wards and the developmental work to further enhance the assurance on a shift by shift basis of suitable staffing

Executive summary:

This paper intends to provide assurance of compliance against requirements by describing the work carried out to date to ensure the appropriate processes and systems are in place to monitor, report and display planned and actual staffing levels on community hospital inpatient ward areas and also the measures in place to respond to changes in staffing and patient need.

- The review of nurse dependency levels against the 2012 baseline suggests that the care needs are broadly consistent and therefore the planned staffing levels with flexibility based on patient need continue to be appropriate.
- Continuity of care will be enhanced by the recruitment programme that is currently attracting new staff to the organisation.
- Further work is required to address the multi professional aspect of care within the Community Hospital setting as well as evidencing that colleagues have the appropriate skills to meet changing care needs.

- An electronic reporting method is being reviewed by the Director of Service Transformation which will provide "real time" data around dependency and care needs.
- The Head of Community Hospitals is assessing the implications of the document published on November 26th by NHS England, Safer Staffing: A Guide to Care Contact Time.

Liz Fenton
Director of Nursing and Quality

Please complete the Equality Checklist over…

Please complete one of the following options:

☒	This paper requires no equality impact assessment as it does not propose changes to how people receive services or our colleagues' working lives.
☐	This paper proposes changes. Equality analysis identifies the following equality impacts: • • A copy of the EIA is appended.
☐	This paper proposes changes. Equality analysis has NOT been completed for the following reasons: • •

[Notes supporting questions]: Compliance with the Public Sector Equality Duty

Under the Equality Act 2010, we have a legal responsibility when we make decisions to have due regard to the need to:

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

Therefore, if this paper proposes changes that will affect how people receive services or our colleagues' working lives, you should complete an equality analysis. This is to determine the extent to which the changes will eliminate discrimination, advance equality, and foster good relations.

Gloucestershire Care Services NHS Trust Board

To be held on: January 20th 2015
Location: Edward Jenner Court

Agenda item 13

1. Purpose

In May 2014 the Trust Board received a paper that set out the requirements of the NHS Quality Board guidance in relation to safe staffing levels within in patient wards. "How to ensure the right people, with the right skills, are in the right place at the right time: guide to nursing, midwifery and care staff capacity and capacity" published in November 2013. This paper follows on from this work and provides the required six monthly update which must be presented to the Trust Board as part of those requirements.

2. Recommendations

The Board is asked to:

- Note the actions undertaken to ensure appropriate staffing within the Trust inpatient wards and the developmental work to further enhance the assurance on a shift by shift basis of suitable staffing

3. Context

This paper provides the six monthly update required on safer staffing (in patient wards) and provides a progress report on the following areas:

- National guidance on safer staffing published in January 2014
- Progress on actions outstanding from the previous report
- Review of patient dependency in the Trust in patient wards

4. National Guidance

The National Quality Board (NQB) issued the guidance "How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability" in November 2013. In order to optimise nursing and care staffing capacity and capability the paper set out nine key expectations that apply to the Trust, those being:

- Boards take full responsibility for the quality of care provided
- Processes to be in place to enable staffing levels to be met on a shift by shift basis
- Evidence based tools are used to inform nursing establishments
- Leaders foster a culture of professionalism and responsiveness that enables staff to feel able to raise concerns
- A multi professional approach is taken when setting staffing establishments
- Sufficient time is available to undertake caring duties in practice
- Monthly workforce information is provided to Board and staffing capacity and

capability is discussed in a public Board meeting at least every six months
- Information is clearly displayed about the nursing and care staff present by ward and on each shift
- Providers to take an active role in securing staff in line with their workforce requirements.

4.1 Acute Care staffing levels publications

Current guidance around safe staffing levels for adult inpatient areas (NICE 2014, RCN 2012) relates to NHS providers of acute hospital services and that there is no consensus on safe staffing levels for community hospitals. The National Institute for Health and Care Excellence (NICE) 2014 guidance recommends the implementation of systematic approaches at ward level to ensure that patients receive the nursing care they need and identifies processes that are required to support safe staffing levels.

It should be noted that GCS have adopted those principles as best practice while being committed to supporting the multi professional care delivery that is essential to those within our hospitals.

5. Patient dependency audit to review establishments

During September 2012 a patient dependency and nursing skill mix audit was carried out over a four week period on each of the (then) 11 inpatient wards across the seven Gloucestershire Care Services NHS Trust (GCS) Community Hospitals. The rationale for this audit was to assess patient care needs using an evidenced based methodology to review nurse staffing levels as there was much anecdotal evidence that the care needs of patients within these settings had increased as more care was provided closer to home.

Developed by Dr Keith Hurst (2009) the Nursing Workforce Planning software was utilised, specifically the medicine, elderly and single room modules to undertake the patient dependency assessments (see appendix 1) and review staffing skill mix and establishment.

This work resulted in a £2million investment made (in 2013) jointly by the GCCG and GCS to increase the nursing establishment and skill mix across all sites. These have been reviewed at six monthly intervals.

6. Outstanding safe staffing nationally required actions

The table below outlines the actions outstanding following the report to Board in May 2014 and the progress made in relation to these aspects:

	Action	Lead	By when	Progress
1.	Implementation of the NTDA mandated workforce assessment tool	Director of Human Resources	May 2014	Workforce data is uploaded and this aspect of

				the requirement is met. GCS currently liaising with TDA re: benchmarking against comparable Trusts and further development of tool.
2.	Escalation policy and procedure to be developed for ward teams to escalate staffing issues and concerns	Director of Service Transformation	June 2014	Complete
3.	Staffing to reflect nationally agreed evidence based model across all services	Director of Nursing and Quality	Within national timescales	NICE publication excluded C. Hospitals
4.	Monthly reporting of workforce data to include capacity metrics	Director of Human Resources	June 2014	In development
5.	Regular reporting through the Performance and Resources Committee	Chief Operating Officer	Bi monthly	Staffing data in monthly quality report
6.	Six monthly reporting on staffing capacity and capability including other teams and services within national timescales	Director of Nursing and Quality	September 2014	Dependency audit Sept 2014
7.	Development of innovative processes that includes recruiting to Trust values that makes GCS an employer of choice	Director of Human Resources	June 2014	In progress
8.	Publication of staffing information on the GCS website and on NHS Choices	Head of Communications	June 2014	Ongoing monthly

7. Current planned staffing levels

The ward staffing levels ratified at Board in May 2014, set a Registered Nurse to patient ratio of 1:8 during the day and 1:10.2 overnight, the critical role of the Health Care Assistant bringing the total WTE to patient ratio of 1:6.These figures are based on anticipated patient needs together with 100% bed occupancy. Careful consideration was given to the numbers of RNs on duty throughout the night shift to provide effective care with additional staff being rostered on should patients require one to one support.

The nursing staff skill mix evidenced an increase in Registered Nurse support in clinical care increasing from an average RN:HCA ratio of 42:58 in the 2012 audit to 50:50 in 2014.

In addition to the staffing levels and skill mix, valuable leadership resource has been planned for each inpatient ward to include rostering a Ward Sister/Charge Nurse (A4C Band 6) on duty for each early and late shift to provide enhanced clinical leadership and a richer skill mix. Each area also has a Senior Sister/Charge Nurse (A4C band 7) in a supervisory role to further strengthen clinical leadership and to be available to support and work alongside the ward team.

Hospital	Ward	Bed compliment	Early	Late	Night
Dilke Memorial		26	4:4	4:3	3:1
Lydney and District		21	3:4	3:3	2:2
Cirencester	Coln	28	4:4	4:3	3:1
	Windrush	21	3:4	3:3	2:2
Stroud General	Cashes Green	22	3:4	3:3	2:2
	Jubilee	22	3:4	3:3	2:2
Tewkesbury		20	3:4	3:3	2:2
North Cotswolds		22	3:4	3:3	2:2
The Vale		20	3:4	3:3	2:2

Key RN:HCA

8. Escalation and exception reporting

Nurse staffing levels are closely monitored, reviewed and reported by Matrons and the Head of Community Hospitals, this information is reported to the Board to demonstrate comprehensive planning and risk assessment of staffing in community hospital settings.

In addition, there is also a commitment to continuously review the actual versus the planned staffing on a shift by shift basis within all inpatient care settings, where gaps or shortages are identified there is an agreed escalation process in place to provide a robust framework for strategies such as accessing agency staff, reviewing bed resources, identifying and managing risks associated with such gaps or shortages. The monthly Quality Report provides exception reporting where levels may falls below 80% or above 120% and these figures will be triangulated with safety data to understand the impact on care within that ward.

A fundamental aspect of the strategies in place to meet the requirements of the above mentioned guidance documents is the additional investment made to develop a new role of Head of Community Hospitals in order to provide additional expert clinical leadership to all staff within community hospitals.

9. Re-audit Patient dependency

In order to measure the impact of the implementation of the safer staffing levels described above and in line with the National Quality Board requirements for a 6

month review, a re-audit was undertaken in September 2014 utilising the same methodology and tool in order to be able to make a valid comparison between the data gained from the original 2012 audit

The audit was undertaken across all wards over a 4 week period from Monday 25 August to 21 September 2014.

Every patient on each of the wards was assessed daily against the adult activities of daily living (ADL) and dependency assessment sheet (appendix 1) and a score attributed for each of the 7 measured ADLs. The levels of dependency are derived from the scores obtained and are summarised as follows;

Dependency level	ADL score	patient dependency category
Level 1	score less than 8	independent
Level 2	score 8-13	between dependence and independence
Level 3	score 14-22	dependent
Level 4	score more than 22	highly dependent

Ward	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Dependency 2012**	**Dependency 2014**	**% of previous score**	**Bed occupancy**
Coln	3	64	86	23	2.79	2.82	101%	90%
Windrush	3	43	71	19	3.29	2.91	88%	93%
Dilke	2	49	62	18	3.12	2.82	90%	89%
Lydney	5	60	52	8	2.66	2.49	94%	85%
North Cots	5	34	56	3	2.37	2.7	114%	62%
Cashes Green	2	26	58	19	2.95	3.08	104%	94%
Jubilee	1	18	86	2	2.92	3.07	105%	96%
Abbey View	3	24	88	22	NA	3.18	NA	98%
Peak View	1	41	75	5	2.85	2.8	98%	87%

The results from these audits reveal that patient dependency levels and therefore related care needs have remained broadly constant over the two year period covered by these audits. Similarly the bed occupancy figures are also comparable; this is as might be expected for audits of this nature carried out at the same time of year on both occasions.

10. Challenges

An area of challenge is the need to ensure staffing levels which are responsive to changing patient need in terms of acuity and/or dependency levels whilst ensuring optimal use of our finite resources. The processes outlined in section 8 offers assurance around how GCS is meeting this challenge and identifying and managing the related risks. The escalation process provides a framework for the deployment temporary staff to meet care need, the impact of professional judgement underpinned by credible clinical leadership is enabling ward staff to utilise resources more flexibly whilst maintain the essential elements of patient safety and positive care experience.

The recruitment of nurses is an area of focus both within Community Hospitals and the Community Nursing Service to strengthen our workforce in terms of both initial recruitment and measures to influence ongoing retention. This work includes a centralised countywide recruitment campaign with a specific focus of attracting both newly qualified and return to practice nurses. A series of four successful and well attended nursing recruitment Open Days have recently been held with colleagues effectively showcasing the services and experiences which are offered within GCS.

The need to balance the ratio of registered and unregistered staff is an essential component of workforce planning and the contribution made by our unregistered staff is an area for development. This is linked to enhancing the education and training opportunities available to this staff group together with the offer of better defined career pathways for our unregistered workforce. Within the inpatient areas the development of Assistant Practitioner roles at Band 4 level is being tested.

The recognition of the multi professional nature of the services provided by GCS needs to be considered when assessing appropriates staffing and, whilst there is no national recommendation for whole team staffing levels consideration is being given to our ward establishments including the contribution made by allied health professional (AHP) colleagues to patient care and safety.

11. Next steps

- A review of the RAG rating of the safer staffing work will be undertaken in January 2015, the outcome and resultant actions will be reported onwards.
- Developing effective utilisation of the e-rostering system to provide a “real time” oversight of staffing levels across the organisation. This will support the deployment of staff from one area to another to support changes to patient acuity or dependency and also necessary changes in staffing levels. In addition to reporting staffing numbers this will provide an oversight of the capability of the nursing workforce and the work to strengthen and develop clinical skills.
- The Community Hospitals workforce development group is reviewing the roles and skills of the workforce and will include development of the Band 4 Assistant Practitioner and rotational posts. This model is being tested in the Forest of Dean locality with Staff Nurses (A4C Band 5) offered a developmental post with clear learning and skills objectives during a rotation between the inpatient, Minor Injuries and Community Nursing. Underpinning these initiatives is the partnership between the operational services and the Education and Professional Practice Team within the Directorate of Nursing and Quality

There are three current initiatives taking shape to develop nursing clinical skills and capabilities to ensure our teams can meet the care needs of our increasingly sub-acute patient groups. They are:

- a locally agreed CQUIN (Commissioning for Quality and Innovation) scheme whereby clinical skills required by registered nurses to meet the increasing care dependency have been identified to enable a wider group of patients to receive high quality care closer.
- Additional roles at Band 6 level are being developed to introduce a Training and Development Sister/Charge Nurse role to work alongside nursing staff to provide training and assessment of clinical skills and capabilities
- Development of a programme of clinical care pathways to provide a framework and guidance for patient care and treatment

To enhance recruitment and retention a preceptorship programme has been established to support and develop newly registered nurses throughout their first year of practice. Consideration is being given to further build on this to support all nursing staff new to the organisation and yet further to include all members of the nursing workforce.

An enhanced induction programme is being developed for new nursing staff; 1.5 days of clinical training will be added to the current 2.5 days. This will enable some mandatory training sessions to be completed prior to starting in role (e.g. Medicines Management and Resuscitation Level 1) as well as providing an overview of essential requirements such as patient safety and governance considerations, clinical updates and an introduction to processes and procedures within clinical areas across GCS.

Further work will be undertaken to promote GCS in general and community hospitals in particular as an employer of choice within the area, this will include town centre information and recruitment events planned in Stroud in the January 2015 as well as reviewing the ways in which we market and promote ourselves as an employer.

Conclusions and recommendations

A review of patient dependency suggests that the care needs within our hospitals align with the results from previous reviews and therefore that the planned staffing with flexibility based on patient needs are therefore appropriate at this time. Continuity of care will be enhanced by the recruitment programme that are currently attracting new staff to the organisation

Further work is required to address the multi professional aspect of care within the Community Hospital setting together with ensuring those colleagues have the skills to meet the changing care needs of patient.

An electronic reporting method is being reviewed by the Director of Service Transformation which will provide “real time” data around dependency and care needs.

The Head of Community Hospitals is assessing the implications of the document published on November 26th by NHS England, Safer Staffing: A Guide to Care Contact Time.

Alison Reddock RN
Clinical Effectiveness Manager

Julie Goodenough
Head of Community Hospitals

26 November 2014

Appendices:

Appendix 1:
ADL patient dependency assessment sheet

Appendix 2:
GCS 2014 Inpatient Dependency audit results

Appendix 1
Adult ADL & Dependency Assessment Sheet

Nursing Attention (NA)	**Score**
a) Constant	4
b) Two hourly or more	3
c) Four hourly	2
d) Twice daily or less	1
Washing and Dressing (WaD)	
a) Daily bed bath or open bath needing two carers	4
b) Daily bath needing one carer	3
c) Washing and dressing/undressing assistance needed	2
d) Independent - relative attends to needs	1
Using the Toilet (UtT)	
a) Incontinent or catheterised	4
b) Four hourly or more help needed to use the toilet	3
c) Needs help to use the toilet	2
d) Independent - relative present	1
Moving (M)	
a) Immobile	4
b) Two carers needed to help patient walk or move around	3
c) Needs help to walk or move around/ safety observation	2
d) Independent - relative present	1
Eating and Drinking (EaD)	
a) Fed artificially; e.g., naso-gastrically, PEG	4
b) Depends entirely on carer to eat and drink/relative absent	3
c) Needs help to eat and drink	2
d) Independent once meal is served - relative present	1
Pressure Area Care (PAC)	
a) Necrotic areas	4
b) High risk, needing two hourly or more care	3
c) Moderate risk needing four hourly care	2
d) Low risk needing twice-daily check or less	1
Parents or Relatives (PoR)	
a) Relative needs constant explanation/reassurance/support/help	4
b) Relative needs frequent help/support	3
c) Relative needs occasional help/support	2
d) Minimum help/support needed	1

ADL Score	**Dependency Score**
<8	=1 (independent)
8-13	=2 (between dependence and independence)
14-22	=3 (dependent)
>22	=4 (highly dependent)

Total scores from here is your ADL score

Dashboard for Patient Dependency
Sep-14
Actual Occupancy

	The Vale Community Hospital	North Cotswolds Community Hospital	Lydney and District Community Hospital	Stroud Community Hospital	Stroud Community Hospital	The Dilke Memorial Community Hospital	Cirencester Community Hospital	Cirencester Community Hospital	Tewkesbury Community Hospital
				Jubilee	Cashes Green		Coln	Windrush	Abbey View
Total No. Patient days	**122.00**	**96.00**	**125.00**	**107.00**	**105.00**	**131.00**	**176.00**	**136.00**	**137.00**
Average Daily Patients	17.43	13.71	17.86	15.29	15.00	18.71	25.14	19.43	19.57
Bed Numbers	20	22	21	16	16	21	28	21	20
Occupancy %	**87%**	**62%**	**85%**	**96%**	**94%**	**89%**	**90%**	**93%**	**98%**
Patient Dependency	2.80	2.70	2.49	3.07	3.08	2.82	2.82	2.91	3.18
Prior Year Patient Dependency	2.85	2.37	2.66	2.92	2.95	3.12	2.79	3.29	N/A
% of prior year dependency	98%	114%	94%	105%	104%	90%	101%	88%	N/A
% Qualified (recommended 64%)	**47.3%**	**47.3%**	**47.3%**	**47.3%**	**47.3%**	**59.0%**	**59.0%**	**47.3%**	**47.3%**
% Unqualified	**52.7%**	**52.7%**	**52.7%**	**52.7%**	**52.7%**	**41.0%**	**41.0%**	**52.7%**	**52.7%**

Gloucestershire Care Services NHS
NHS Trust

QCGC Chair's Report

Ref: 15/B014

This report is for Publication

Gloucestershire Care Services NHS Trust Board

Quality and Clinical Governance Committee Report

20th January 2015

Objective:

To provide the Board with a summary of the key issues and actions arising from the meeting of the Quality and Clinical Governance Committee held on 11th December 2014.

The Board is asked to:

To receive the report and the approved minutes of the 16th October 2014 meeting for information and assurance

Executive summary:

The report sets out the key points discussed at the meeting of 11th December 2014 and highlights keys issues agreed for escalation to Board. The approved minutes of the meeting held on 16th October 2014 are attached for information

Sue Mead,
Quality and Clinical Governance Committee Chair

☒	This paper requires no equality impact assessment as it does not propose changes to how people receive services or our colleagues' working lives.
☐	This paper proposes changes. Equality analysis identifies the following equality impacts: • • A copy of the EIA is appended.
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a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
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Therefore, if this paper proposes changes that will affect how people receive services or our colleagues' working lives, you should complete an equality analysis. This is to determine the extent to which the changes will eliminate discrimination, advance equality, and foster good relations.

Meeting of Gloucestershire Care Services NHS Trust Board

To be held on: January 20th 2015
Location: Malvern & Coopers Room, Edward Jenner Court, Brockworth

1. Introduction

This report provides a summary of the key issues and actions arising from the meeting of the Quality and Clinical Governance Committee meeting held on 11th December 2014. The approved minutes of the 16th October 2014 meeting are attached for information.

2. Quality Matters

The Quality Report was presented to the Committee and each of the aspects of quality; safe, caring, responsive, effective and well led were debated in some depth. This assurance was underpinned by the reports received for the first time from the Unscheduled and Scheduled Care Directorates enhancing the reporting from the point of care. These were well received by the Committee. The aspects presented for particular attention by the Committee were:

- Influenza vaccinations for colleagues. Whilst the first month of the programme showed a disappointing level of uptake (13.6%) this increased to 31% in the second month of reporting. The Committee discuss the importance of this vaccination programme to protect those we care for and noted the actions in place to encourage colleagues with direct contact with service users and their families to be vaccinated. This includes the development of peer vaccination programmes.
- The response rate for the Friends and Family Test in MIUs deteriorated in October. There has also been deterioration in both response rates and net promoter scores for in patients. From December the community hospital wards have been offering the options for a face to face discussion at the point of discharge as an alternative to the postal questionnaire and there is confidence that this will increase the response rate. For MIU the learning from those units with good response rates is being shared, colleagues are encouraged to offer feedback cards at the point of booking. QCG saw this as key area for improvement and will monitor the impact of recent changes closely.
- Safety thermometer: While October showed a slight dip in performance, the Committee were advised of significant improvement in November towards achievement of the minimum of 95% harm free care. The Committee discussed the need to continue the focus on pressure ulcers and falls particularly in the inpatient setting while working with our partners across the health community to focus on the 5% harmed. Of particular note was the variation in performance across wards and services and this will be an area requiring further understanding and action to raise underperforming services to the level of the best.

- Discussion took place regarding the temporary reduction in beds at Stroud General Hospital from October 8th 2014 as a result of staffing pressures along with increased acuity of patients. The Director of Service Transformation informed the Committee of the trajectory to return the hospital to full capacity while noting that the net impact on the health community was 5 beds as additional beds had been opened within the Forest Hospitals.

3. Quality Strategy

The final draft of the Quality Strategy was presented to the Committee and submission to Board for ratification in January 2015 was approved. The importance of aligning clear and understandable quality goals and priorities across all publications was stressed.

4. Safer Staffing and Inpatient Dependency Audit

The Clinical Effectiveness Manager presented the results of the six monthly review of patient dependency within our Community Hospital wards. The report used the baseline data from 2012 and provided evidence from the audit undertaken in September/October 2014 that there was no significant change in the nursing dependency levels of patients. The report also evidenced the increase in skill mix as a result of the investment in nurse staffing while recognising the challenges of nurse recruitment at present. The Committee approved the paper to be presented to Trust Board in January 2015.

5. District Nursing Service: Action Plan

The Director of Service Delivery presented the District Nursing Service action plan that has been produced in partnership with Gloucestershire Clinical Commissioning Group (GCCG). This provided the Committee with both a progress report on the impact of the work to date as well as setting out the next steps. The Committee approved the action plan and the proposal that together with the GCCG and key stakeholder group be established to development a Future Vision for District Nursing Services within Gloucestershire. This plan will also be presented to the GCCG governing body for approval.

6. Other reports presented to the Committee

- Plans for the development of the 2014/15 Quality Account
- Social Care Governance Framework – plans for revision
- The Equality Annual Report
- Annual Report of the Director of Infection Prevention and Control
- CQC Children in Care review progress report on the implementation of actions

7. Conclusions and Recommendations

The Board is asked to:

- **Note** this report
- **Receive** the approved minutes of 16th October 2014 meeting for information and assurance

Report prepared by: Liz Fenton, Director of Nursing and Quality
Report Presented by: Sue Mead, Chair, Quality and Clinical Governance Committee

GLOUCESTERSHIRE CARE SERVICES NHS TRUST

QUALITY & CLINICAL GOVERNANCE COMMITTEE

Minutes of the Meeting
held on Thursday 16 October 2014

Voting Committee Members	
Sue Mead (SM)	Non-Executive Director
Richard Cryer (RC)	Non- Executive Director
Mike Roberts (MiR)	Interim Medical Director
Ingrid Barker (IB)	Trust Chair
Tina Ricketts (TR)	Director of HR
Nicola Strother Smith (NSS)	Non-Executive Director
Committee Attendees (Non-Voting)	
Louise Foster (LF)	Joint Clinical Director – Dental (Countywide representative)
Melanie Rogers (MR)	Interim Deputy Director of Nursing and Head of Clinical Governance
Sue Field (SF)	Director of Service Transformation
Deborah Greig (DG)	Head of Social Care
In Attendance	
Sarah Warne (SW)	Named Nurse Safeguarding Adults/Clinical Quality Manager
Rod Brown (RB)	Foundation Trust Programme Manager
Helen Hodgson (HH)	Head of Capacity and Unscheduled Care
Lucy Lea (LL)	Equality & Diversity Manager
(VG)	
Mark Parsons (MP)	Head of Estates
Pauline Edwards (PE)	Designated Nurse for Children in Care
Christine Thomas (CT)	Minute Taker

Ref	Minute	Action
83/14	**Agenda Item 1: Apologies** Apologies were received from: Elizabeth Fenton (EF), Duncan Jordan (DJ), Jason Brown (JB) & Candace Plouffe (CP). The Chair opened the meeting and welcomed attendees.	
84/14	**Agenda Item 2: Minutes of the meeting held on 13 August 2014** The Committee reviewed and **APPROVED** the minutes of the meeting held on 13 August 2014.	

85/14	**Agenda Item 3: Matters arising and action log** The action log was reviewed by the Committee and the following updates given for the items that were not closed or featured on this meeting's agenda: ***(Q&CG 41/14)*** – Equality and Diversity Manager to present an outline proposal of the Equality Annual Report in December 2014. *No change – expected to Committee in December 2014.* **(Q&CG 61/14.1)** – Director of Nursing to check on the overall achievements reported in the Quality & Performance report as it was unclear where these had originated from. *This was discussed at the September Trust Board. However, SM was not happy with the discussion so far and wanted further discussions with MOR.* **(Q&CG 64/14)** - The Director of Corporate Governance was asked to add in a field to the Risk Register to show who the owner of each risk was. **(Q&CG 65/14)** - CQC Inspection Report update on Action Plan to be bought back to the December meeting. *No change, due December.* **(Q&CG 66/14)** – Director of Corporate Governance to look at where the Health & Safety Forum now reports as this no longer comes to the Q&CG Committee. *These discussions were ongoing, carried forward to Dec 14.* **(Q&CG 72/14)** – An Out of Hours and Community Hospital update to be bought back to the Committee at a later date. *This to be added to the forward planner.* **(Q&CG 73/14)** – Director of Service Transformation to bring an update on the quality impact to reablement services due to the high levels of sickness. *This would now fall with the Director of Service Delivery and to be added to the forward planner.* The Committee **RECEIVED** the Action Log and **NOTED** the updates.	**SM** **JB**
86/14	**Agenda Item 4: Forward Agenda Planner** Assurance was required around Hotel services and it was asked for this to be added to the Forward Planner. NSS noted that the report from P&R Committee on waiting times was not on the agenda. RC advised that this would be going to the P&R Committee on the 21 October 2014 and an update	

	would follow on from this. The Committee **RECEIVED** the Forward Agenda and **NOTED** the items.	**JB**
87/14	**Agenda Item 5: Quality Strategy** RB presented the Quality Strategy presentation and advised that this would be going to the January Board. There were some ownership questions as to where this sat within the Committees but he proposed to discuss this today. It was proposed that the overall Quality Strategy would move to the Executive Team. Concern was raised though that this was not a natural place for this to sit as this was the Committee that dealt with Quality. There was also concern that this would not be subjected to a detailed scrutiny before going to Board. It was also felt that this strategy should be reviewed by a Committee that answered to the Board. RB agreed and a full draft will come to the next Q&CGC meeting in December. RB presented the strategic objectives. The Committee made various recommendations including: • New-born and Self-Funding should be measured • Matrix's to be defined as per strategic framework • Competency should be linked to framework RB to organise discussion on choosing the 5 key objectives. The Committee **NOTED** the report and agreed to **RECEIVE** the full draft services to the next Committee meeting on the 11 December 2013. TR joined the meeting RB left the meeting	**RB** **RB**
88/14	**Agenda Item 6: Preparedness for Chief Inspector of Hospitals Visit** SM proposed that there be no discussion on this item due to the absence of EF and that this would be better when they were able to have a more detailed discussion. The Committee agreed to defer to the next meeting. The Committee **NOTED** the decision to move the presentation to the next meeting.	**JB**
89/14	**Agenda Item 7: Quality & Performance Report**	

	SM advised that she would take the report as read and they would take questions on each section. **Safe:** • NSS asked where there were areas of no sickness was this correct and what was happening with this? TR advised that this was only 1 months' data and not 12 and therefore not beneficial so they were currently looking at alternative options. TR was currently speaking to the Chair of the HR&OD Committee regarding this. • It was felt that it would be good to see a correlation between staffing levels and quality issues. • SM asked if anyone could update on SIRIs. MiR had felt that they were now over reporting as opposed to under reporting in the past. It was acknowledged that there was a lot of work to do here including the tightening up of the reporting on Datix. • SF presented a paper on Safety Thermometer Frequently Asked Questions: October 2014, which included a frequently asked questions section and pictorial guidance for staff. **Caring:** • IB expressed concern that they still did not see the numbers of people surveyed when looking at the Inpatient Survey figures. It was agreed that SF would speak with EF to ensure these were included in all future reports. • There was concern from the Committee that they were still not seeing the full story and that people still did not know how to make a complaint. It was agreed that SF and TR would take this back to the Exec meeting and discuss a way forward and bring a report back to the next meeting. **Effective:** • SM asked if the early warning trigger tool was useful. SF felt that it was questionable and currently not fit for purpose. **Responsive:** • Waiting times were deemed to still be a concern. There had been a plan introduced to reduce these times, but they have not yet produced the results hoped for. It was	**SF/EF** **SF/TR**

	noted that urgent cases were not significant and had been dealt with quickly. It was questioned whether this was still a SystmOne issue or if there were other factors involved. SF to talk to discuss this with DJ. It was felt that due to MSKAT being a success that more people were being sent there, but that they then needed staff with a wider range of skills. RC agreed that he would challenge this at the next P&R Committee meeting. • SM asked if Adult Social Care was on target. SF advised that we were not on target but that improvements had been seen. **Well-Led** • TR informed the Committee that they were currently working on the way the data was presented as the current format wasn't always clear. The Committee **NOTED** the Quality and Performance Report.	**SF/DJ** **RC/DJ**
90/14	**Agenda Item 8: Clinical Record Keeping Report** SF presents a presentation on Patient Record keeping, which is in relation to CQUIN 7. This CQUIN is worth £175k within the £1.7m the organisation was hoping to achieve. There were some concerns around consent that have arisen during the audit and it is believed that these could be a mistake due to SystmOne, it is expected that this result will improve. The other area of concern is around mental capacity and how it is recorded, there is currently a review of this being undertaken. Part of the problem is that people do not always know when to ask as it is often difficult to do on admission and often in stressful circumstances. SF felt that it may be useful to do a global reminder to people to remind them of the need to do. It was agreed that SF would share the action plan with NSS. The Committee **NOTED** the content of the presentation and additional work needed to move this forward.	**SF**
91/14	**Agenda Item 9: Pressure Ulcers** SW presented the pressure ulcers presentation to the Committee and discussed the way these are now classified. Previously these had been classified as old and new, but this had now changed to developed and acquired.	

	SW advised that there were only two of them that could undertake the assessments for pressure ulcers. It was noted that it was difficult for pressure ulcers to always be identified within 72 hours, particularly for Community Nurses who may not return within that period. SW felt that it would be better to remove this 72 hour limit and just classify by avoidable and unavoidable, as it was more important for them to scrutinise each case in detail and make this decision. SW updated the Committee as to how a pressure ulcer was classified using the new terms of avoidable and unavoidable, which was felt to be really useful as some people had not found this clear. The Committee **NOTED** the presentation. MP Joined the meeting. The Chair agreed to take Agenda Item 11 next	
92/14	**Agenda Item 11: PLACE Report** MP presents the PLACE Report. Lessons had been learnt since the last report and they had acted on the actions raised. One of the key changes made was to make the audit group smaller to ensure a more consistent response. Last year they had been below the national average and this year they were above. It was not known yet where they were in the national average, but MP would try to find this out. IB asked if some of the Equality issues had now been sorted out. MP confirmed that they now offered a wider variety of food to accommodate more religious requirements. They were also able to translate menus if they were given notice of the requirement for this. MiR noted that sometimes there could be timing issues for food due to religious dates such as Ramadan; MP advised that they could offer cold foods for outside these periods but due to staffing restrictions could not offer hot. However, it was noted that there was no reason that members of the family could not bring in appropriate food, as long as it did not break any food restrictions imposed by the doctor. There was still work to be done on ensuring that any specialised requirements or religious needs were noted on admission to hospital, or if not possible on admission then at least within 48hrs through contact with family. SM thanked MP for the update. MP leaves the room	**MP**

	The Committee **RECEIVED** the PLACE paper and noted the improvements made. The Chair agreed to move agenda item 12 forward LB joins the meeting	
93/14	**Agenda Item 12: Controlled Drugs Accountable Officer Annual Report** LB presented the first annual Controlled Drugs Accountable Officer Annual Report. There were 50 incidents recorded, none of which resulted in harm to patients or staff. NSS asked if LB was confident on the levels of reporting, LB acknowledged that there was likely to be some under reporting occurring. NSS also asked about the control of drugs within a patient's home. LB advised that once a patient was sent home with drugs it was then their responsibility for the drugs and not GCS, though they do monitor and investigate if drugs go missing. They do follow national guidelines but there is a risk if someone dies from these drugs. The Committee **RECEIVED** the report. The Chair agreed to take Agenda item 14 next	
94/14	**Agenda Item 14: Working with the Pharmaceutical Industry Policy** LB presented the Working with the Pharmaceutical Industry policy to the Committee and asked the Committee to ratify it. The policy has been developed based on best practice guidelines. MiR asked what the Trust's stance was on staff accepting sponsorship. LB advised that staff shouldn't be accepting gifts, but that the process should be clarified with JB. Subject to some minor changes and final approval by NSS this policy was ratified by the Committee. The Committee **APPROVED** the Policy subject to minor amends and final approval by NSS. PE joins the meeting	**JB**
95/14	**Agenda Item 10: Unscheduled Care Governance Report** SF and HH presented the Unscheduled Care Report to the Committee. SF asked that as this was the first time she had presented the report, and due to the volume of information	

	available, to gain a steer on how the Committee would like to receive the report in future. SF and HH advised that the rapid response was now being expanded into more rural areas, this rapid response service would look different to that currently running in more built up communities and there would be a test period to enable them to get it right. SM asked that the presentation be circulated to the Committee so that they could refer to this if needed in the future. There was still a risk around staffing and falls within the Community Hospitals. Band 5 staffing levels in Community Hospitals were currently down by 27 to where they should be. SM felt that the report was useful but was unsure how this would link in with the Scheduled Care report and the Quality Report, due to the volume of information. It was felt that this reporting should be driven by Risk and Performance. RC also felt that there should be a focus on the key issues bought about by the reduced number of Band 5 staff and that may be they should look to the Assistant Practitioners to fill some of these gaps. The Presentation was **NOTED** and the Committee acknowledged the work still be done on this and key challenges faced.	**SF/CT**
96/14	**Agenda Item 15: Annual Report Children in Care** PE introduces herself to the Committee and gives a brief overview of her role advising that alongside a specialist nurse she works with the Council and a designated doctor. They had received a visit from CQC in March and this was overall a good visit with a good level of service found and improvements noted from the last visit. There were three recommendations made in the report: • That there is effective quality assurance of review health assessments carried out to ensure they are of a consistently high standard • That the use of SDQ information gained from young people and carers is recorded to a satisfactory standard and that health plans take account of SDQ findings so that appropriate plans can be put in place to respond to the needs identified • That over 16's and care leavers are properly equipped	

	with comprehensive, age appropriate health history information and contact details should they need to re-engage with the Children in Care team, in line with the specific requests made by care leavers as part of service user consultation in 2011. The Committee had previously seen the inspection report and noted that there seemed to be an issue with keeping up to date with health assessments. PE advised that this could be complicated to do as this included Health Assessments for Children going through adoption or moving. SM asked for assurance that these were being completed in a timely manner. PE advised that on the whole they were done in a timely manner, but it was difficult particularly when children were moving or relocating. SF noted that there were 52 children out of county and asked if there was an intention to bring these back into county? The Committee were advised that the CCG were required to place Children near where they live but that wasn't always possible and in these cases they needed to be reliant on colleagues in these areas to perform the assessments. The Committee **RECEIVED** the report and progress made to date. PE leaves the room	
97/14	**Agenda Item 13: DN Services Report** TR and SF presented the DN Services Report in the absence of the Director of Service Delivery. SM asked that this presentation is circulated to the Committee. TR advised that they were presenting this report to provide assurance around the level of staffing; this report had been put together in association with GCCG. TR advised that there had been some issues with reporting of staffing levels due to various reports not giving the correct information, additional reporting had now been put in place to try to rectify this. There was also currently a review of E-rostering taking place. The GCS were held to account by the CCG on a daily basis the biggest problem is around North Cotswold. They were also currently undertaking work around shift patterns and addressing the gap difference between night shift and day shift. It was advised that following some work done with Acute Trusts that they were struggling to fill band 6 posts, whereas this was band 5 in the Community Hospitals. Feedback had indicated that this could be because of the shift patterns introduced and people	**CT** **SF**

	did not want to do these. IB raised the concern that this presentation did not provide the assurance they needed that patient's safety was not compromised. SF advised that one of the issues they currently faced was that there was no service spec for the District Nurses, which meant that they were not always sure what they should be doing and they were sometimes called on to do things outside of their remit. It was acknowledged that this would also not be very easy to implement once confirmed. SM felt that they could take some assurance from the work currently being done but acknowledged that they needed further assurance on this. It was agreed that TR and SF would talk to EF before the next meeting and bring back to the Committee. The Committee **NOTED** the report and agreed this would come back to this Committee for a further update.	
98/14	**Agenda Item 16: Sub Group Reports:** • **Infection Control Committee Report** • **Clinical Senate Report** The Committee **NOTED** the reports.	
99/14	**Agenda Item 25: Any Other Business** SM asked to discuss the format of the Committee as this had more presentations than normal. It was felt that for Governance and assurance that presentations should be restricted for items such as case studies. If presentations are used then these should also be circulated in advance. SM closed the meeting	
100/14	**Date of Next Meeting** Thursday, 11 December 2014 at 1.30pm in the Boardroom, Edward Jenner Court	

Chair's Signature ……...

Date ……..…….

Gloucestershire Care Services NHS
NHS Trust

Equality Annual Report

Ref: 15/B015

This report is for Publication

Gloucestershire Care Services NHS Trust Board

Advancing Equality, Embracing Diversity: The Equality Annual Report January 2015

20th January 2015

Objective:

To present the Equality Annual Report to the Board and invite comments.

The Board is asked to:

Approve the report for publication by 31st January.

Executive summary:

This report is a wide-ranging review of the extent to which the Trust is advancing equality and embracing diversity amongst both its service users and colleagues. It is due to be published by 31st January 2015 and will ensure the Trust meets its obligations under the Equality Act 2010 (Specific Duties) Regulations 2011.

Appendices:

1. Advancing Equality, Embracing Diversity: Gloucestershire Care Services NHS Trust's equality annual report
2. Advancing Equality, Embracing Diversity: Appendices to report

Lucy Lea,
Equality & Diversity Manager

Please complete the Equality Checklist over….

Please select one of the following options:

☒	This paper requires no equality impact assessment as it does not propose changes to how people receive services or our colleagues' working lives.
☐	This paper proposes changes. Equality analysis identifies the following equality impacts: • • A copy of the EIA is appended.
☐	This paper proposes changes. Equality analysis has NOT been completed for the following reasons: • •

[Notes supporting questions]: Compliance with the Public Sector Equality Duty
Under the Equality Act 2010, we have a legal responsibility when we make decisions to have due regard to the need to:

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

Therefore, if this paper proposes changes that will affect how people receive services or our colleagues' working lives, you should complete an equality analysis. This is to determine the extent to which the changes will eliminate discrimination, advance equality, and foster good relations.

1. Why have we produced this report?

Under the Equality Act 2010 (Specific Duties) Regulations 2011 we are required to publish information that demonstrates how we meet our general statutory duties to eliminate discrimination, advance equality of opportunity, and foster good relations between groups. Information must relate both to our workforce and to our service users. This report aims to fulfil our statutory responsibilities.

It is hoped that the information in this report can also be used in the following ways:

- As evidence on how we perform against the NHS Equality Delivery System (EDS2)[1]. The Trust Development Authority has specified that all NHS Trusts should be using EDS2. The framework is also likely to become a mandatory requirement for all NHS Trusts through the NHS Standard Contract 2015. The report has been prepared with this in mind.
- To provide a solid evidence base for the new Quality & Equality Impact Assessment process we are implementing. This data should be used as part of the process to ensure we make sound, evidence-based decisions and deliver high quality services for the benefit of all our service users, colleagues and communities, especially the more vulnerable and those whose needs are easily overlooked.
- To influence the Trust's priorities for 2015-2016.

The report has been received by the Quality & Clinical Governance Committee and comments received from committee members have been incorporated in this report.

2. Points to note

When you read this report, please note the following points:

1. **Reporting periods:** The report contains a large number of different datasets from a range of different databases and information systems. We have tried to keep consistent reporting periods, but this has not always been possible due to limitations or changes in information systems. We recommend moving to a financial year reporting period from 2015 to overcome some of these issues. This would mean we publish a similar report in Summer 2015 based on 2014-15 data. This would be a timely opportunity to launch EDS2.
2. **Data gaps:** we have a number of gaps in the data which means that we do not have a clear picture of our performance in relation to some areas. Particular data gaps include:

[1] Find out more about EDS2 here: www.england.nhs.uk/ourwork/gov/equality-hub/eds/

a. Poor completion rates for ethnicity data for a number of services. This is partly down to the transfer over to SystmOne. This limits our ability to understand accessibility and outcomes by ethnicity. Please note that there is a drive within services to improve the quality of this data;
b. No or limited information on service users' disability status. This is a complex area to monitor, but other organisations do gather data and report on this;
c. We are missing data for some services and functions, e.g. dental services, school nursing. We will aim to include this in the next report;
d. We have not analysed data on service users' outcomes as a result of using services. We do not know whether length of stay, readmission rates, recovery rates etc. vary by age, gender and ethnicity;
e. We encountered some issues in analysing our service user survey responses. It is possible for us to look at responses by age, gender, ethnicity and disabilities. We have included some data for interest in the report, but are working on some more robust analysis of differences in experiences based on people's characteristics.

3. Future plans for reporting

We propose moving to a financial year reporting period for future equality annual reports, publishing a full year's worth of data in the early summer of each year. We suggest starting this in summer 2015, using the EDS2 framework to publish data. This report will include some of the missing data we have identified above, and we will attempt to include more comparators with similar Trusts within this report. We would use the report to kick-start the implementation of EDS2: the data would be the evidence on which colleagues, partners and local people can assess our performance against the EDS2 framework.

4. Recommendations for the Trust

Based on the evidence contained in this report, we recommend the Trust considers the following priorities for 2015:

- Addressing data capture and quality for both service users and colleagues. We need concerted effort to improve completion rates for service user ethnicity data and to scope an approach for gathering disability data. We also need to improve disclosure rates amongst colleagues with regards to disabilities, sexual orientation, and religion and belief. We also recommend identifying service performance/ outcome measures we can analyse by age, gender and ethnicity to

inform our understanding of our performance and to enable targeted improvements.

- Agreeing an organisational approach to taking services and information to people who do not historically access health and social care services.
- Improving the dialogue we have with people who use our services and with those who do not use our services, but could benefit from them. In particular, we need to involve people who do not traditionally respond to surveys and focus groups. We need to take active steps enable and encourage more people to share their experiences of services they have used (including through complaints procedures), and to have a say on the future direction of the Trust and its services.
- Investigating 'positive action' – and/or other proactive approaches – to increase the diversity of our workforce, particularly in relation to ethnicity and gender.
- Determined action across the Trust and at all levels to create a caring, inclusive culture for our colleagues, rooting out unacceptable behaviours and driving up a sense of belonging and pride in the Trust.

Gloucestershire Care Services NHS
NHS Trust

Advancing Equality, Embracing Diversity:

Gloucestershire Care Services NHS Trust's equality annual report

January 2015

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This report can also be supplied in alternative formats on request.

Please contact:

Lucy Lea
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DRAFT

1. Executive Summary: How are we doing?

1.1 Introduction

1. Gloucestershire is a broadly affluent and healthy place to live. However, we have a higher proportion of older people (over 65s) in the county than the country as a whole, and this age group is growing. Our ageing population has implications for care and employment. We will see rises in people with mobility issues, long-term conditions, dementia, hearing loss, and sight loss.
2. Our overall image as an affluent and healthy county can hide the fact that some of our communities face significant health and social inequalities, including some wards which are amongst the 20% most deprived in the country.
3. Social isolation is also a factor we need to pay heed to, especially as we are a largely rural county with a sizeable population of older people.
4. These demographics have an impact on what services we provide and how we provide care. There are communities and people with distinct needs who we should pay particular regard to. In particular, we need to consider those who are less likely to access or use services (in spite of perhaps being in greater need for healthcare and information), such as our Black and Minority Ethnic (BME), Eastern European, Gypsy and Traveller, transgender communities and people with learning disabilities.

1.2 Advancing equality and embracing diversity among service users

1.2.1 The issues we face

5. The majority of our services are used by people who are vulnerable and/ or have ongoing health problems. The exceptions are our Minor Injury Units, our Public Health Nursing Services, Sexual Health Services and our Healthy Living Services, all of which tend to be used by a broader cross-section of the population.
6. In our Community Hospitals, Integrated Community Teams, and Adult Specialist Services, most of our service users are older (many over 80). As a result, they are more likely to have disabilities, long-term conditions, hearing and/ or sight loss and have a higher prevalence of dementia.
7. This presents challenges in providing safe, effective care. These service users are at higher right of falls, pressure ulcers, urinary tract infections and healthcare-acquired infections.

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1.2.2 What are we doing well?

8. We have taken determined action on a range of types of harm over the past year and this appears to be making a difference for service users. We can report award-winning work to reduce pressure ulcers, drops in the numbers of falls and low levels of incidents of abuse, violence and harassment amongst patients.
9. Dedicated programmes around learning disabilities, dementia, end-of-life care and hearing loss are resulting in Trust-wide improvements to the care of people with very particular needs. These are discussed more fully in the body of the report.
10. We find high levels of satisfaction with our services amongst people who use them: of 14,404 people we asked in the year to October 2014, 97% would recommend the service they had used to family and friends.
11. This year we are able to report on many examples of efforts to take services and information out to communities who do not usually access them, such as Gypsy and Traveller communities, Trans people and Homeless people.
12. Most of our specialist services are used to – and good at – recognising and accommodating different needs, and they demonstrate an inclusive and proactive approach.

1.2.2 Where could we improve?

13. Initiatives to take services and information out to vulnerable communities are heavily reliant on the energy and enterprise of a few individuals. We have found little evidence of targeted work with some of our newer and growing communities, such as Eastern European communities. We also have few signs of an organisational approach to outreach activity to communities who struggle to access our services, and this is a gap the Trust will be looking to address.
14. In some of our other services, service users and colleagues describe having to 'make do': we are not always responding effectively to people with mobility issues, hearing loss, sight loss and communication difficulties. This was particularly noted with regards to reception areas and telephone contact with service users.
15. Early analysis of survey responses from our service users suggest disabled people rate 'service at reception' lower than non-disabled people. A small number of our complaints relate to colleagues not having the skills or understanding to respond appropriately to people with specific conditions or needs.
16. It is hoped that new initiatives in the Trust, including our new Engagement Framework, the Listening into Action programme, and Leading for Quality Care programme will help us better understand and respond to needs that are not met by mainstream approaches.

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1.3 Advancing equality and embracing diversity among colleagues

1.3.1 What we know about our workforce

17. Echoing trends in the NHS as a whole, our workforce has an older age profile and a higher proportion of women than the population as a whole.
18. We also have a higher proportion of 'White British' people working with us than in the population of Gloucestershire, so are not representative of the county on the basis of race.
19. We have a similar proportion of people with disabilities as the Gloucestershire population as a whole. Our sickness absence rate is slightly above that of other community trusts nationally, and we find that stress is the most prevalent cause of sickness absence.
20. Our 2013 staff survey results suggest that colleagues with disabilities do not enjoy the same access to training and development opportunities and that they are more likely to report bullying and harassment from colleagues and from service users.
21. Gender pay gap analysis suggests we have gender pay equality in our workforce when we compare the median hourly rates of all men and all women. However, we find the proportion of men increases in the higher pay bands, so there is a higher proportion of men amongst our senior managers than there are in the lower pay bands.
22. Our recruitment and leavers data suggests we are reinforcing the majority ethnic, age, and gender groups within our workforce through who we recruit and who leaves the Trust.
23. Staff survey data suggests that colleagues are more likely to experience bullying, harassment, and abuse (from both service users and colleagues) than in other community trusts. They are also less likely to recommend the Trust as a place to work.

1.3.2 What are we doing to address these challenges?

24. Over 2014, we have been undertaking work to improve colleagues' experiences of working with the Trust, and to improve their sense of belonging. Listening into Action and a range of leadership programmes are examples of this. However, we recognise that it takes time and considerable effort to create a change in culture, particularly in a large and dispersed organisation.
25. In early 2015 we will be launching a new Core Values Framework to ensure that all colleagues within the Trust are clear on the expected values and behaviours required of them.
26. In the next year, we need a concerted effort from our colleagues across the Trust to embed these approaches. We also need to look for additional ways to increase the ethnic, age and gender diversity of our workforce, root out unacceptable behaviours and nurture an inclusive culture which is welcoming of difference.

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1.4 Conclusions and next steps

27. Since our last report we have made considerable progress in cementing an 'equality and human rights'-based approach into the workings of the Trust, including publishing an Equality & Human Rights policy, agreeing equality objectives and an accompanying implementation plan, and developing a new approach to analysing the impact of our activities on quality and equality.
28. We anticipate that our new Quality & Equality Impact Assessment process will introduce a rigorous, intelligent approach to assessing how our activities will affect people who use (or should use) and deliver our services. The heart of this process is ensuring we have a thorough understanding of who will be affected by changes we make. We anticipate that the information included in this report will support this process. It should help ensure we make sound, evidence-based decisions and deliver high quality services for the benefit of all our service users, colleagues and communities, especially the more vulnerable and those whose needs are easily overlooked.
29. However, we recognise that we have gaps in our understanding of how well we are meeting service users' and colleagues' needs and expectations. In particular we are missing information to enable us to determine differences by 'protected characteristics', which would help us understand whether some groups have poorer access, outcomes and experiences than others. We recommend that there is concerted, organisation-wide action to improve our data quality and completion. This will become a priority when we implement the NHS Equality Delivery System (EDS2), which is likely to become a mandatory requirement under the 2015 NHS Standard Contract.
30. A focus on identifying and meeting different needs will be supported by our work to help colleagues recognise, understand and accommodate the needs of the people they come across in their day-to-day work. This includes our on End-of-Life, learning disabilities, Asset Based Community Development, and hearing loss programmes and the embedding of our new Core Values Framework.

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2. About Gloucestershire Care Services NHS Trust

Gloucestershire Care Services NHS Trust provides a comprehensive range of coordinated health and social care services across the county. These services are delivered in community hospitals and in local communities, and include children's services, health visitors, community nursing, physiotherapy services, specialist services, and adult social care services that are provided on behalf of Gloucestershire County Council.

To support the people of the county, the Trust employs more than 2,600 staff including nursing, medical and dental staff, allied healthcare professionals, as well as support services, administrative and clerical workers. The Trust also manages approximately 800 social workers and reablement workers from Gloucestershire County Council, who mostly work within the Trust's Integrated Community Teams.

Over the year 2013-14, we recorded 1,173,142 service user contacts across Gloucestershire.

Our services are described below.

1. Integrated Community Teams

The Trust's Integrated Community Teams bring together occupational therapists, social workers, physiotherapists, community nurses and reablement workers into single teams, who work closely with local GPs and provide care to service users at home or close to home. As such, these Integrated Community Teams help people to be in control of their choices, and to maintain their independence safely and appropriately. A number of the Integrated Community Teams also provide access to:

- A Rapid Response service, which operates 24 hours a day, 7 days a week, in order to provide assessment in the home for people who require urgent care within an hour and therefore avoid the need for hospitalisation;
- A high intensity service which supports people who have been stabilised by the rapid response team, and which can then provide high levels of support and monitoring during a person's recovery.

2. Community Hospitals

The Trust manages seven community hospitals across the county, namely: Cirencester and Fairford Hospital; North Cotswolds Hospital; Stroud General

Hospital; Vale Community Hospital, Dursley; Tewkesbury Community Hospital; Dilke Memorial Hospital; Lydney and District Hospital. The community hospitals provide the following services:

- Community inpatient rehabilitation and palliative care beds;
- Outpatient services including a varied range of nurse led and therapy services and clinics;
- Minor Injuries Units which can save people from unnecessarily attending Emergency Departments, and which can treat a range of less serious conditions and ailments such as sprains, minor burns, and simple fractures and wounds;
- Out of Hours GP services including Primary Care Centres;
- X-ray facility managed by Gloucestershire Hospitals NHS Foundation Trust.

3. Specialist Services

Our specialist services provide care in community clinics and in people's own homes. They support service users who are managing long-term or complex conditions such as diabetes, enable people to be discharged from hospital with appropriate support, offer rehabilitation services, and provide palliative care to those managing life-limiting conditions. Our teams also provide education and hands-on training to care homes.

A summary of our specialist services is provided below: however, for more comprehensive information, please visit our website at www.glos-care.nhs.uk.

a) **Specialist Nursing:** expert care for people needing support with, for example, bone health, heart failure, respiratory conditions, tissue viability, motor neurone disease, Parkinson's disease and homeless healthcare.
b) **Therapy Services:** services such as podiatry, occupational therapy, physiotherapy services, and speech and language therapy.
c) **Community Dental Services:** NHS dental care for people in Gloucestershire who are unable to access treatment from a general dental practitioner, include those with mobility issues or specific learning needs.
d) **Sexual Health Services:** free and confidential information to those looking for support and advice relating to sexual health, including issues regarding contraception and pregnancy, sexually transmitted infections, sexual assault, emergency contraception and routine testing such as chlamydia testing. Teams are also able to offer support and care to those either living with Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) or anyone caring for or supporting someone who is affected.

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e) **Independent Living Services:** help people be cared for in their own homes whilst providing vital links to community-based services such as GPs and hospitals. They offer advice on equipment to promote safety and reduce risk if mobility is an issue, and also provide telecare and wheelchair services.

4. Children and Young People Services

The Trust offers a full range of NHS health services specifically tailored towards the needs of children and young people, and provides a coordinated approach for children's health. The Trust also delivers the universal services of health visiting, school nursing and the neonatal hearing screening service.

Wider services available include home safety checks, and children specific occupational therapy, physiotherapy and speech and language therapy. We also have a specific service dedicated to children in care. The children's respite care team can additionally help children to be cared for in a familiar home environment where their illness is ongoing.

5. Support Services

These clinical and care services are supported by a range of corporate functions such as human resources, finance, performance, governance and risk management. Additionally, the service user experience team provides a key point of contact for service users, their families and carers.

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3. About this report

The principal aim of this report is to demonstrate how we have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations across and within our services. These are our duties under s.149 of the Equality Act 2010. Under the Act, we must have particular regard to nine 'protected characteristics': age, disability, gender reassignment, pregnancy/maternity, marriage/ civil partnership, religion/belief, race, sex, and sexual orientation.

A further aim of this report is to share progress against the Equality Objectives we published in July 2014. We also want to shine a light on some of our work over 2014 that we believe advances equality and embraces diversity.

We are publishing different types of information:

- Figures and explanations of our overall performance, regarding both services we provide and our employees' experiences. Where possible we look at how these differ by 'protected characteristics', to see whether some groups have better/ poorer access, outcomes or experiences;
- Figures and explanations which relate specifically to inequalities and potential discrimination or harassment;
- Views from service users, carers and members of our communities from surveys, workshops and engagement sessions;
- Descriptions of how we address inequalities and potential discrimination or harassment through specific services and initiatives.

A note about the data: One of our main challenges with producing and analysing data on our service delivery is that different services use different systems. We have fairly good data around the protected characteristics of age, race, and sex. However, our data on the other protected characteristics requires further development.

Improving service user equalities data is a priority for the organisation. Over the past year, we have been introducing a new patient data system (SystmOne) for most services. We anticipate that this should improve data collection and make analysis easier. However, we have found that some data on service user's protected characteristics has not been transferred from old systems, including ethnicity. Unfortunately this means that we have gaps in our service user ethnicity data as colleagues have to manually re-enter this.

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Our workforce data is fuller and broader. We have an Electronic Staff Record (ESR) for each individual who works for us. The ESR system lets us record age, disability, marital status, maternity or adoption leave, race, religion/ belief, sex and sexual orientation. We do not currently collect data on gender reassignment amongst our staff. For the purposes of this report, we have conducted anonymised analysis of our workforce based on the data we have relating to 'protected characteristics'. In some cases, numbers are so small that there is a danger that individuals could be identified. We do not report data in these cases. Where there are fewer than 10 individuals in a particular category, we have not included them in the data charts.

Reporting periods

You will notice different reporting periods in this report. We have published a year's worth of data where possible, for example in relation to some of our workforce data. This data generally picks up where the previous report left off, i.e. September 2013.

It has not been possible to publish a year's worth of service user data, as the way our reporting systems are set up – plus several changes to information systems – makes it hard to report across two financial years. Service user data in this report therefore runs from April 2014 to September 2014. We are considering moving to a reporting schedule which ties in with the financial year to enable us to report on a year's worth of data.

Where possible, we will compare and contrast findings in this report with those in the previous report.

Statistical significance

None of the data in this report has undergone statistical analysis to establish significance. As a result, trends we note are indicative, but we cannot say whether they are statistically significant. As far as possible, we use a range of data sources to understand an issue and to add robustness to the findings.

A note about terminology

In this report we have used the following terms to refer to different ethnic groups:

- 'White British' – People who describe themselves as white and British;
- 'White non-British' – People who describe themselves as white, but not British. This will include people who are Irish, members of Gypsy and Traveller communities, and people from Eastern European countries. In

this report we usually report on this group separately because their needs and experiences are often different from 'White British' people and from more 'visible' ethnic minority groups;

- 'Black/ Minority Ethnic' (or 'BME') – People who from a 'visible' minority ethnic background. This may include mixed/ multiple ethnic groups, Asian/Asian British, Black/ African/ Caribbean/ Black British, and people from other Ethnic Groups.

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4. About the communities we serve

Generally speaking, Gloucestershire is a healthy and affluent place to live relative to England as a whole. However, there are significant health and social inequalities between different parts of the county. There are also differences in the profile of our population by age, disability, race, religion and sex both within the county and compared to the national profile. A fuller description of the 'equality' profile can be found on the internet via this link: http://www.maiden.gov.uk/InstantAtlas/Equalities/summary.pdf.

In summary, the population of Gloucestershire is as follows:

Age and gender

- **More older people** than England as a whole[1];
  - And our age profile is older in our more rural districts – proportions of people aged 65+ in Cotswolds (23.3%), Forest of Dean (21.7%), Tewkesbury (21.1%) and Stroud (20.4%) all exceed national and county averages (16.4% of people in England and 19.4% of people in Gloucestershire are aged 65+);
  - Though Gloucester has the highest representation of children and young people (25%) and exceeds the national and regional average;
- **Slightly more women** (51%) **than men** (49%), reflecting national averages[2]
  - Though there are more women in the upper age ranges, as women have a longer life expectancy than men, for example 66.8% of people aged 85+ are women.

Disability

- A **smaller proportion of disabled people** than the English average (16.7% people in Gloucestershire have a long term limiting illness or disability, compared with 17.6% in England);
  - Though the proportion of people with disabilities is higher in the Forest of Dean than national average, at 19.6%[3];

[1] ONS (2012) 2011 Census - Table PP04 2011 Census: Usual resident population by single year of age, unrounded estimates, local authorities in England and Wales.
[2] ONS (2012) 2011 Census - Table PP05 2011 Census: Male usual resident population by single year of age, unrounded estimates, local authorities in England and Wales. ONS (2012) 2011 Census - Table PP06 2011 Census: Female usual resident population by single year of age, unrounded estimates, local authorities in England and Wales.
[3] ONS (2012) 2011 Census - KS301EW Health and provision of unpaid care, local authorities in England and Wales.

  - The proportion of people with long term limiting illness dramatically increases with age: nearly half (49%) of people aged 65+ report this;
  - And there are an estimated 8,667 people aged 65+ living with dementia in Gloucestershire, with a quarter of these people being 85-89.
- 1 in 10 residents who provide unpaid care to a friend or relative, equivalent to the proportion of unpaid carers in England as a whole[4];
- 2012 estimates suggest that there are at least 11,079 adults in Gloucestershire with a learning disability, of whom 2,274 have a moderate or severe condition. Additionally, there are at least 1,491 children with a moderate learning disability, and 162 with a severe learning disability[5].

Family and relationships

- There are **fewer people who are single or separated** – but **more people who are married, divorced or widowed** – when compared to the national average.
- Gloucestershire has **largest numbers of live births amongst the 25-34 year old age group**[6], continuing the national trend of later motherhood. There are notable regional variations:
  - Forest of Dean has the highest proportion of births amongst mothers aged 20 or under and exceeds the county and national average.
  - Cotswold has a higher representation of births to mothers aged 35-39 and 40+ than Gloucestershire and the country as a whole.

Ethnicity, Religion and Belief

- In Gloucestershire, **nearly 92% of people are White British**[7]. Our Black/ Ethnic Minority populations are considerably smaller (4.6%) than the national average (14.6%).
  - Gloucester has the highest proportion of people from a Black or Ethnic Minority (10.9%). However this is still considerably lower than the national average.
  - Forest of Dean has the lowest proportion of people from a Black or Ethnic Minority (1.5%).
  - People from a 'white non-British' background are under-represented when compared to the national average, but have higher representation in Cheltenham compared to Gloucestershire and England as a whole.

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[4] ONS (2012) 2011 Census - KS301EW Health and provision of unpaid care, local authorities in England and Wales.
[5] ONS (2012) 2011 Census - Long-term health problems by ethnic group by sex by age.
[6] NHS Information Centre Indicator Portal (2011) Live Births.
[7] ONS (2012) 2011 Census - KS201EW Ethnic group, local authorities in England and Wales.

- There are, however, notable variations in the ethnic profile of different age groups in Gloucestershire:
  - 9% of children aged 0-4 are not 'White British', compared with 1% of people over 80.
  - The greater proportions of White non-British people are in the 20-29 age group (6.6%) and the 30-39 age group (7%).
  - Figure 1 below shows this in greater detail.

- In Gloucestershire, we have a **higher proportion of people who are Christian, have no religion or have not stated a religion** than the national average[8]. In contrast it has a lower proportion of people who follow a religion other than Christianity, which reflects the ethnic composition of the county.

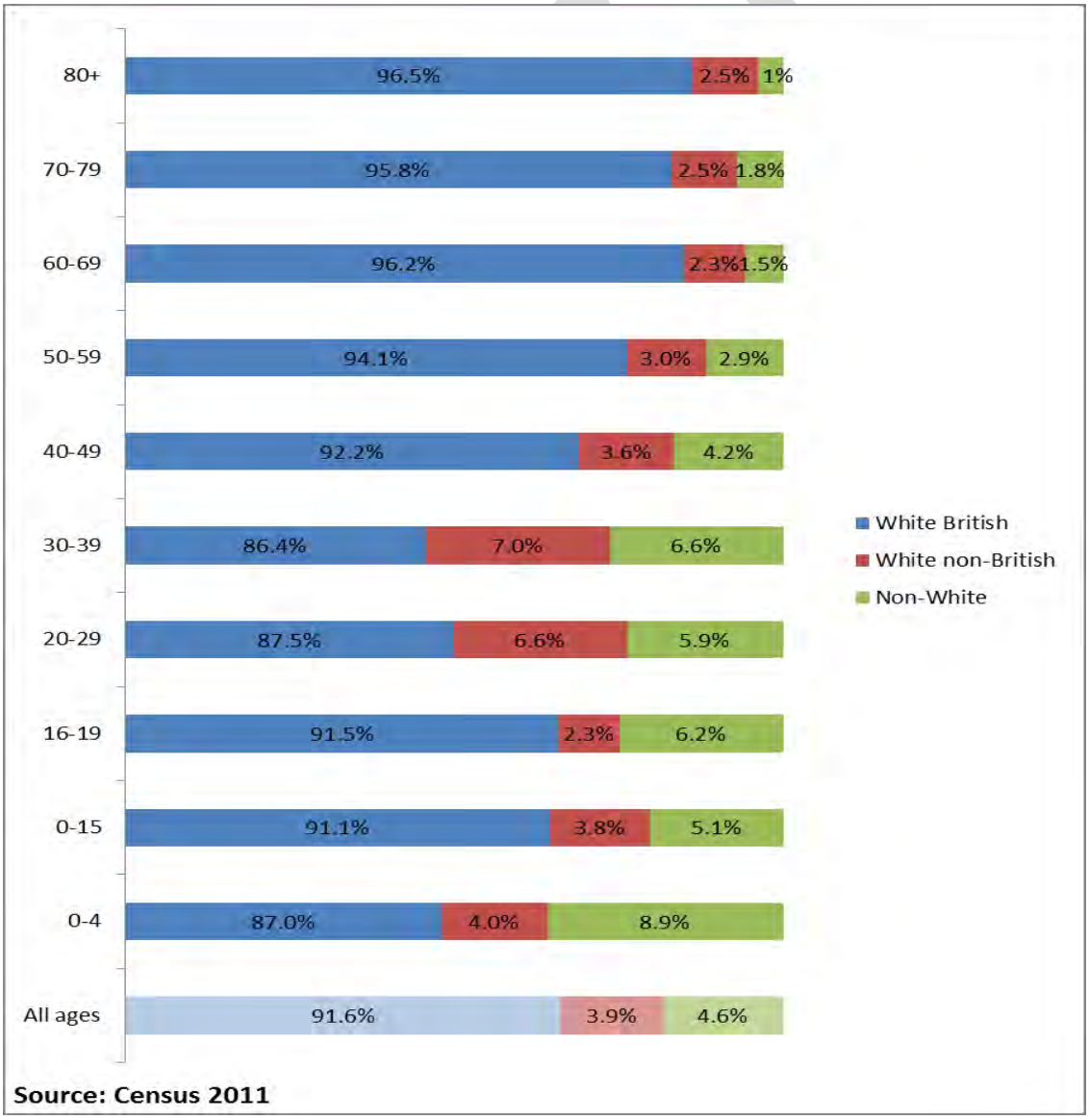

Figure 1: Ethnicity by Age in Gloucestershire

[8] ONS (2012) 2011 Census - KS209EW Religion, local authorities in England and Wales

Sexual Orientation & Gender Identity

There is no definitive data on sexual orientation or on gender identity at a local or national level, and we have no information to suggest that the profile by sexual orientation or gender identity is different to the national average. The best estimates of population figures at a national – and local – level are:

- Around 5-7% of the population aged 16+ are lesbian, gay or bisexual. This would mean somewhere between 24,500 and 34,300 people in Gloucestershire are lesbian, gay or bisexual[9];
- Between 0.6% and 1% of the UK's adult population experience gender variance to some degree, which would equate to between 2,900-4,700 people in Gloucestershire[10]. We know that Gloscats, the principal Transgender support network in Gloucestershire, has nearly 500 members.

Our vulnerable communities

Some of the communities we serve are more likely to experience social and health inequalities. This means they may find it harder – or be less likely – to use our services or they might have poorer health. They are also likely to find it harder to apply for and obtain jobs with us, or to remain in work with us if they do.

People on lower incomes, or those living in areas of deprivation, are more likely to experience poorer health and have lower life expectancy. Overall, levels of deprivation in Gloucestershire are significantly better than the national average. However, about 44,000 Gloucestershire residents (around 7% of the total population) live in areas that fall into the 20% most deprived in England.[11] These areas include Matson, Robinswood, Kingsholm and Wotton in Gloucester, and Hesters Way, St Pauls and St Marks in Cheltenham. Furthermore, about 14.7% (15,500) children in Gloucestershire live in poverty.

We also know that rural isolation can be a barrier to people accessing public services in Gloucestershire. Cotswolds District Council has done recently

[9] Stonewall (2009) How many lesbian, gay and bisexual people are there?

[10] Gender Identity Research and Education Society (2011) The Number of Gender Variant People in the UK – Update 2011

[11] Understanding Gloucestershire 2013: A high level analysis of need in Gloucestershire, Gloucestershire County Council, December 2013. Based on Index of Multiple Deprivation (IMD) 2010.

done some analysis to identify communities at greatest risk of social isolation in the county[12]. They base this on people who:

- Are aged 65+ - retired
- Live alone
- Do not own a car
- Have a household income less than £20,000 a year
- Left formal education aged 18 or younger
- Do not use the internet
- Have experienced mental health difficulties – anxiety / depression
- Describe themselves as lonely with low levels of social contact
  - Talk to neighbours less than once a month or never
  - Have no-one to listen to them
  - Have no-one to help in a crisis
  - Have no-one to relax with
  - Are dissatisfied with their social life

Analysis of households most vulnerable to social isolation shows that 7% of the total number of households in the County were likely to be the most vulnerable to isolation. The most vulnerable areas highlighted in the map below appear to be associated with the main urban centres and also the fringes of the more isolated market towns. There also appears to be a cluster of areas of moderate to higher vulnerability in the south west of Forest of Dean district and the north east of Cotswold district.

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[12] www.cotswold.gov.uk/media/777436/Appendix-1-Social-Isolation-in-Gloucestershire.PDF

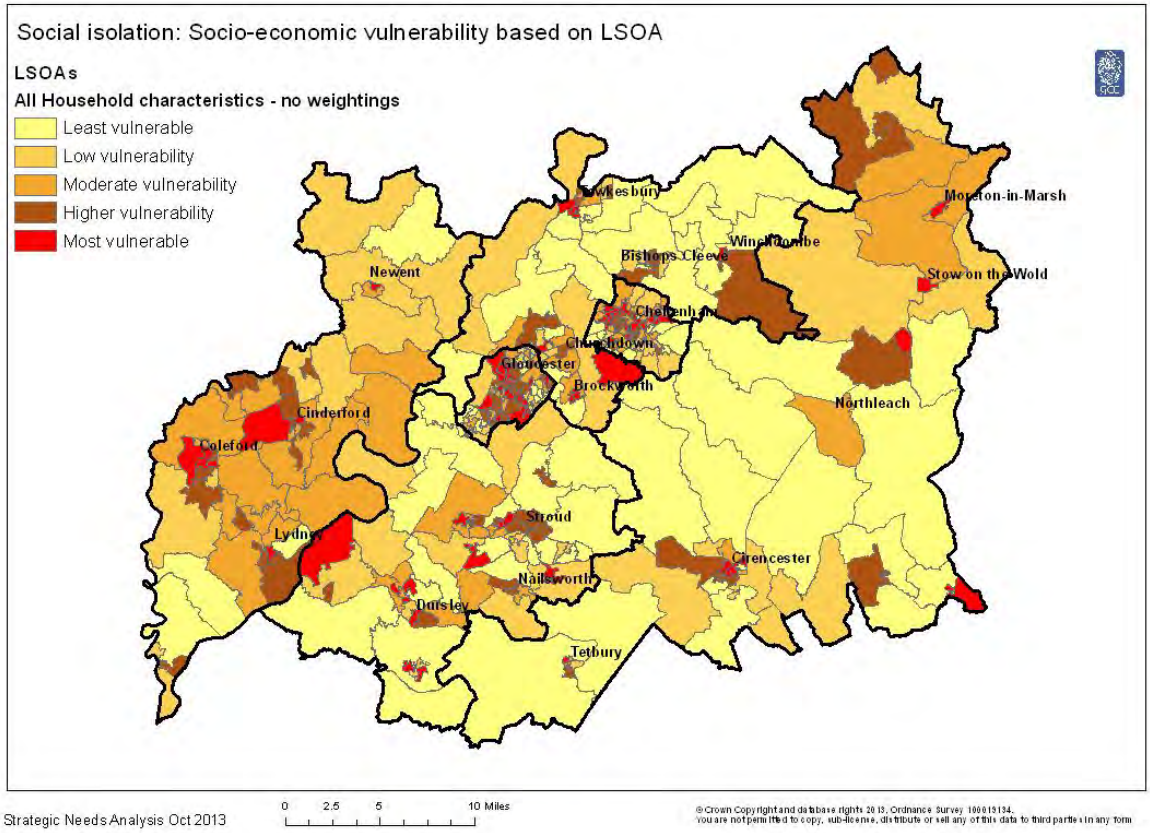

Figure 2: Vulnerability to social isolation in Gloucestershire

There is evidence to suggest that other groups who may be more prone to poor health outcomes include: the Gypsy and Traveller community, people with mental health issues, people with learning disabilities, people who are homeless and looked after children.

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5. Advancing equality through our services

5.1 Introduction

In July 2014 Gloucestershire Care Services NHS Trust published its first Quality Account. The Quality Account seeks to demonstrate how the Trust is providing high quality care. Quality is defined as care that is safe, caring, effective, responsive and well-led.

Equality and quality are intricately linked: we can only say that our services are of high quality if we can show that they benefit all of our residents and communities. The following table shows the equality aspects of each of the five components of quality:

Quality components	Equality Aspects
Safe	• Preventing avoidable harm, with a particular focus on vulnerable people • Safeguarding vulnerable people/ groups • Protecting service users from abuse and harassment whilst in our care
Caring	• Understanding people's lives, needs and preferences and accommodating these wherever possible • Ensuring service users are treated with dignity and respect, and that we respect their privacy and autonomy • Tackling prejudice and reducing service users' fear that they may face prejudice whilst receiving care from us
Responsive	• Understanding people's lives, needs and preferences and accommodating these wherever possible • Ensuring waiting times are kept to a minimum, and those in greatest need are seen soonest (based on a holistic assessment of need) • Seamless care pathways and easy transitions • Providing opportunities for everyone to give us feedback on the services we provide • Responding as quickly as possible to concerns and complaints
Effective	• Ensuring our services are accessible and effective for everyone in Gloucestershire who needs them • Making the best use of our resources – and the skills and resources of others in the county – to provide the best care and support for people who need it • Reducing inequalities

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Quality components	Equality Aspects
Well-led	• Ensuring decisions pay due regard to the needs of people who face inequalities, those who are vulnerable, and those who have extra or different needs • Ensuring that papers that come to Board and Committees identify equality-related impacts including risks, and say how these risks are to be managed • Fostering an inclusive culture and attitudes

In this section of the report, we will highlight findings from the Quality Account that show how we are advancing equality. You can find a copy of the 2013-14 Quality Account on our website or by contacting us[13]. We will also include further information and examples where appropriate.

5.2 Safe care for all

We know that some of our most vulnerable service users are at greater risk of certain types of harm. In particular, older people and people in poorer health are at greater risk of falls[14], pressure ulcers, urinary tract infections (UTIs) and healthcare acquired infections (HCAIs). These types of harm – especially avoidable pressure ulcers – can be an indicator of poor care.

Between 1st September 2013 and 31st August 2014, staff reported 3784 incidents in our care settings. These are categorised as follows:

Incident Type	Total incidents	% of total incidents
Personal Accident (Patient/Staff)	1379	36.4%
Clinical Incident	1051	27.8%
Estates, Staffing, Infrastructure, IT, Telecomms	379	10.0%
Security Incident	199	5.3%
Discharge, Transfer, Admission, Appointment	191	5.0%
Violence, Abuse or Harassment	191	5.0%
Communication	182	4.8%
Records, Information, Confidentiality	145	3.8%
Waste Environmental Incident	24	0.6%

[13] http://www.glos-care.nhs.uk/publications/what-are-our-priorities-and-what-are-we-doing or email contactus@glos-care.nhs.uk or call 0300 421 8100.

[14] Guidance on Falls Management issued by the National Institute for Health & Care Excellence (NICE) in June 2013 identified that people aged 65+ have the highest risk of falling, with 30% people aged 65+ and 50% people aged 80+ falling at least once a year.

Incident Type	Total incidents	% of total incidents
Vehicle Incident	23	0.6%
Fire Incident	19	0.5%
NHS 111 Incident	1	0.0%
Totals:	3784	

Figure 3: Incidents reported between 01/09/13 and 31/08/14 (Source: Datix)

Falls make up three quarters (75.3%) of all 'personal accidents' and account for over a quarter (27.5%) of all incidents reported in the year up to 1st September 2014.

Pressure ulcers make up nearly a fifth (18.6%) of all 'clinical incidents', accounting for 196 reported incidents in this period. This is a notable drop from the data presented in January 2014, when 42.7% of clinical incidents were down to pressure ulcers. This drop is partly down to a concerted effort to reduce the prevalence of pressure ulcers by improving the quality of care to our most vulnerable service users.

We have been putting considerable effort into reducing harm. In our Quality Account 2013-14, we shared some of the results of that effort:

- An 8% decrease in the number of service users who fall in community hospitals, which exceeded our in-year target;
- 89.6% service users assessed through the Safety Thermometer[15] were receiving harm-free care in 2013-14. This compared favourably with community Trusts nationwide which reported 89.1% harm-free care in the same period;
- A 17% reduction in acquired pressure ulcers;
- Innovations and Best Practice Award 2014 from the Community Hospitals Association (CHA) for outstanding work to improve the identification and early reporting of pressure ulcers.
- No cases of MRSA infection over the year. However, we did have 19 cases of C.difficile, which exceeded our tolerance of cases by 1 case;

Ties in with:
Equality Objective 1b: Reduce the number and severity of pressure ulcers amongst service users

[15] The NHS Safety Thermometer is a national tool that provides a way of us measuring and comparing our performance in four key areas of safety, namely falls, pressure ulcers, venous thromboembolism and urinary tract infections in service users with a catheter.

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In the year up to 1st September 2014, there were 11 reported incidents of abuse, harassment, or violence directed at a patient. In a number of these cases the person responsible for the incident is thought to have dementia or cognitive impairment. In other cases, the context for the abuse, harassment or violence was conflict between family members.

Our approach to safeguarding is critical to ensure that the most vulnerable do not experience avoidable harm. Safeguarding is defined by the Care Quality Commission as the means to "protect people's health, wellbeing and human rights, and enable them to live free from harm, abuse and neglect". Those most in need of such protection are children, young people, and adults whose circumstances make them vulnerable. We are committed to a multi-agency approach to safeguarding, and are active in the Gloucestershire Adults and Children's Safeguarding Boards. In addition, over 2013-14 we placed emphasis on ensuring our colleagues received high quality training to give them the confidence to identify, report and manage safeguarding concerns. This work continues.

5.3 Caring services

Providing caring services entails treating people as individuals, with compassion, dignity and respect, while maintaining their rights to privacy and autonomy. Many of our service users are particularly vulnerable, and need us to take extra care or a different approach to make sure they feel well cared for.

Some examples of how we are striving to understand and meet different needs are included below.

5.3.1 Dementia care

The number of people living with dementia in Gloucestershire is rising: currently there are an estimated 8,500 people living locally with dementia. This figure is expected to increase by at least a further 2,000 people in the next 6 years alone. Similarly, over 70% of our county's hospital beds are already used by people with some degree of cognitive impairment, but this too will rise over time[16].

[16] Gloucestershire Care Services Quality Account 2013-14.

In our 2013-14 Quality Account, we reported on the work we have done to improve the care of people with dementia in our services:

- We supported and delivered dementia training to staff across the organisation. This included a training session with the Board. The quality of the training was rated highly, with positive feedback from participants.
- Our dementia link workers completed a nine month course, equipping them with the skills to raise the profile of dementia care, review environments and processes, and support service users and carers.
- Our recent refurbishment of the dental clinics at Redwood House, Stroud, created a dementia-friendly environment through, for example, colour contrast furnishings and fittings, as well as graphics-based signage.
- The refurbishment of wards at the Dilke Memorial Hospital also created a dementia-friendly environment including access control doors, a newly-laid out nurses' station with a seating area, colour contrast furnishings and fittings, and a reminiscence room to help encourage memories.

What's new?

The Trust has recently established a Dementia Best Practice Group. There has been a positive response to the setting up of this group and the first meeting took place in early November 2014. The meeting focused on lessons from the CQC 'Cracks in the Pathway' report published in 2014 and from the Dementia Friendly Environment work already undertaken in the Trust.

5.3.2 High quality care for people with learning disabilities

People with learning disabilities experience a range of health inequalities. For example:

- People with learning disabilities are 58 times more likely to die before the age of 50;
- Respiratory diseases affect 46-52% people with learning disabilities, compared to 15-17% of the general population;
- Epilepsy affects 22% people with learning disabilities, compared to 1% of the general population;
- Dementia affects 21.6% people with learning disabilities aged 65+, compared to 5.7% of the general population aged 65+.

We have a detailed action plan in place to improve our care of people with learning disabilities. Our achievements over 2013-14 include:

- 26% staff either completed a specially designed e-learning package or attended face-to-face training provided by the Learning Disabilities Training Team.

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- 70 staff have now become champions for learning disabilities within their own areas of work.
- We hosted a multi-agency workshop in December 2013 in order to identify the range of actions that we need to undertake in order to offer a truly learning disability friendly service. The result of this workshop was the development of a robust quality implementation plan that seeks to:
  - Embed working partnerships countywide to ensure effective care across all health and social care pathways;
  - Establish a method to identify people with a learning disability on the Trust's main clinical IT system, so that staff can proactively recognise the need to make reasonable adjustments in their care delivery;
  - Introduce the systematic use of a reasonable adjustment tool within all clinical areas;
  - Update all relevant service user information leaflets into an easy-read format;
  - Further develop training opportunities across the Trust;
  - Facilitate improved service user and carer involvement.

Ties in with:
Equality Objective 1d: Respond effectively to gaps in the level of care provided to people with learning disabilities within Gloucestershire

5.3.3 End of life care

Providing high quality care at the end of someone's life is heavily reliant on understanding them as an individual – their culture, relationships, expectations, beliefs and preferences. This can be complicated by our reluctance to broach the subject of end-of-life: service users, their relatives and care givers can find it hard to know how to approach discussions in order to get a full understanding of someone's needs and preferences.

As set out in our Quality Account, over 2013-14 we made the following changes to improve experiences of end-of-life care:

- We worked collaboratively with all our partners across Gloucestershire to develop and implement a robust process to replace the Liverpool Care Pathway;
- We also worked with our partners to develop a complete care record which will better inform and measure coordinated care planning, service user and family involvement, and expression of care preferences;
- We provided extensive training, information events and other resources and support for staff in all settings, so as to facilitate best standards of

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care. In particular, training sessions included information about spiritual and emotional care and support for service users, as well as their families and carers.

What's new?

The End of Life Best Practice Group had its first meeting in September 2014 where members spent the session identifying what was positive in respect of current care provision and what they felt needed improvement. The group has a wide variety of members from professions representing many of our care settings. The group welcomed the prospect of an external review of End of Life Care provided by Gloucestershire Care Services to be conducted by Dr Susi Lund, Nurse Consultant in End of Life Care. The group is in the process of developing an action plan based on this review.

Ties in with:

Equality Objective 1c: Improve patients' experiences of care in the last days of life.

Spotlight on: Compassion in end of life care on our wards

The team on Coln Ward in Cirencester was caring for a young man who was terminally ill and deteriorating rapidly. His last wish was to marry his partner, and Ward staff supported them to get engaged and married on the ward in a very short space of time to enable this to happen. The couple were surrounded by family and friends as they married on the Ward. Very sadly he died the next day, but with his final wish fulfilled.

The team were awarded the 'Compassion in Care' award in our 'Celebrating You' staff awards in June 2014.

"*Compliments and thanks to the Windrush Ward sister and all her staff for the care of our elderly, terminally ill mother prior to her death*"
Comment from relative of patient at Cirencester Hospital, Autumn 2013

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5.3.4 'Understanding You': training and awareness programme to promote understanding of different needs

The Trust is currently developing an innovative and engaging approach to raising awareness of the lives of people whose needs are not easily met by mainstream approaches. The aim of the programme is to share with our colleagues how different people and communities live their lives, and what that means for us when we provide care or work alongside them.

Our focus for 2014-15 is hearing loss. We are working in close partnership with the Gloucestershire Deaf Association to create a film-based piece of training which will replace our current mandatory refresher training on equality and diversity.

This is part of the 'Listening into Action' programme – a scheme to empower colleagues to work together to fast-track changes they want to see to improve the lives of service users and staff. The first training package is due to be launched in Spring 2015.

Ties in with:

Equality Objective 1f: Review settings, processes and communications materials to assess suitability for people with sensory loss. Focus for 2014-15 will be deaf people and people with hearing loss.

Equality Objective 4c: Introduce an annual equality & diversity training programme to promote better understanding amongst colleagues of the lives and needs of people who are different from the 'mainstream'

5.3.5 Promoting dignity, respect, privacy and autonomy

Providing caring services means ensuring service users are treated with dignity and respect, and that we respect their privacy and autonomy.

In summer 2014, Patient Led Assessments of the Care Environment (PLACE) were undertaken in all seven Community Hospitals. We are pleased that our overall scores across the sites are above the national average, including for 'Privacy, dignity and wellbeing':

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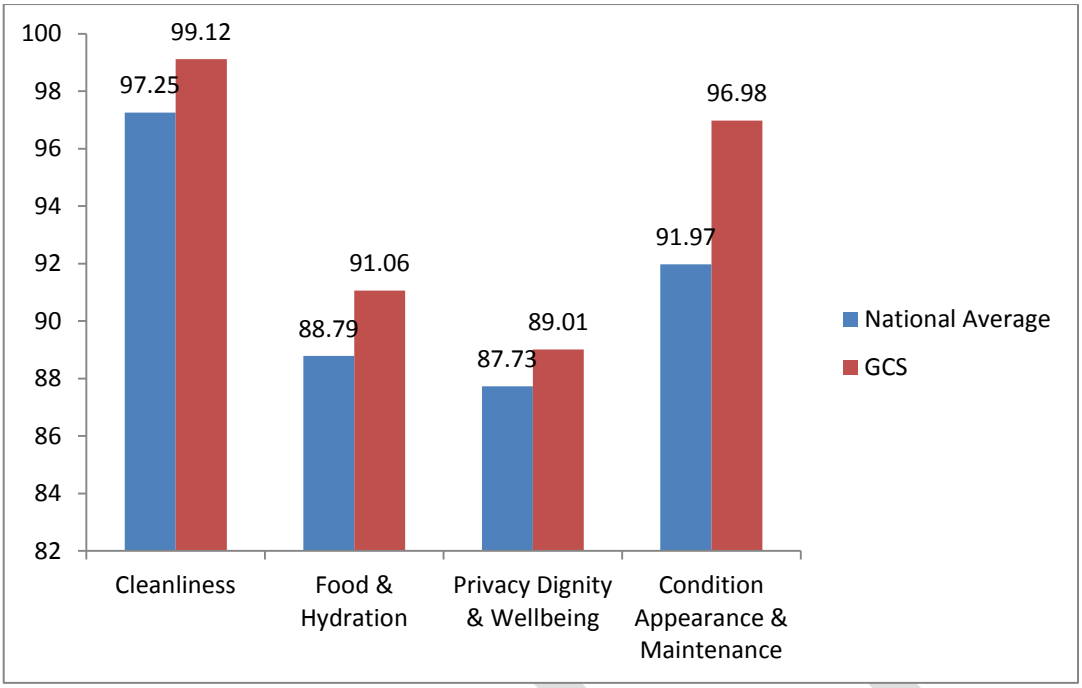

Figure 4: GCS PLACE scores compared with National Average, 2014

However, some sites fell just short of the national average on this factor, notably Lydney and the Dilke. For both sites, the 'Privacy, dignity and wellbeing' score was affected by the lack of separate treatment area for wound dressings which of course is not applicable for the new hospitals which all have single rooms.

We run surveys for all of our services to find out about service users' experiences. We have included more detailed information about the responses in Appendix D.

We ask our service users about the extent to which they feel they have been treated with dignity and respect. In all the surveys we ran across our services in the year up to September 2014, 99% rated our services as 'good' or 'excellent' at treating them with dignity and respect[17].

We have analysed a sample of 2817 of these responses by age (detailed data can be found at Appendix D). Our highest proportion of responses came from the over 75s age group (18.4% of respondents), and the lowest response rate was from 16-25s (9.2%), though there were still 259 respondents in this age group.

[17] Patient surveys from all services, October 2013 – September 2014 (n=3087)

We have calculated a 'satisfaction' score for dignity and respect[18]. Out of a total possible score of 4, our services achieved an average score of 3.9 for all age groups. However, there are interesting variations between ages: generally, the satisfaction score increases with age – averaging 3.83 for people aged 16-24, rising to 3.93 for people aged 65-74, but then dipping to 3.86 for the 75+ age group.

This variation by age is also reflected in response to the survey question: "How likely are you to recommend this service to your family and friends if they needed care or treatment?" for all our services (Detailed data in Appendix D). The overall response amongst the 14,404 people answering this question is that 97% of respondents were extremely likely or likely to recommend services they had used.

Given that so few service users would not recommend our services, we calculated a 'likelihood to recommend' score for a sample of 3874 responses to this question to give an indication of any differences between age groups[19]. In this case, the average score given by service users was 4.83 out of 5. This shows a high level of satisfaction with our services overall. People aged 16-24 are least likely to recommend our services, with a score of 4.62 out of 5. Likelihood to recommend increases with age, and is greatest amongst people aged 55-64, where the score is 4.92 out of 5. Likelihood to recommend services dips to a score of 4.76 out of 5 for people aged 75+.

From this data, it is hard to explain the pattern of responses where satisfaction and likelihood to recommend increase with age, before dipping with people aged over 75. This is something we can explore further in 2015.

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[18] The score is calculated by attributing points to each of the values: 'Excellent' = 4 points, 'Good' = 3 points, 'Fair' = 2 points, 'Poor' = 1 point. We then calculate the total number of points for each value by multiplying the number of responses for each value by its equivalent number of points; for example 2566 people rate a service as 'Excellent', so 2566 x 4 points = 10,264 points. We repeat this for each of the values, then add all the points together, before dividing total number of points by the total number of responses. This gives us an average score out of 4.

[19] The score is calculated by attributing points to each of the values: 'Extremely likely' = 5 points, 'Likely' = 4 points, 'Neither Likely nor unlikely' = 3 points, 'Unlikely' = 2 points, 'Extremely unlikely' = 1 point. We then calculate the total number of points for each value by multiplying the number of responses for each value by its equivalent number of points; for example 2566 people rate a service as 'Extremely likely', so 3348 x 5 points = 16,740 points. We repeat this for each of the values, then add all the points together, before dividing total number of points by the total number of responses. This gives us an average score out of 5. PLEASE NOTE: THIS IS A DIFFERENT CALCULATION TO THE 'FRIENDS & FAMILY TEST' SCORE USED NATIONALLY.

Please note: Problems with data extraction mean analysis by ethnicity, disability and gender are not ready for this report, but we will commit to look at how responses vary (if at all).

"I was so worried about coming in today but you have been so kind and caring and taken all your time to explain procedures and health implications properly. Thank you"
Comment card received Summer 2014

"*Most efficient, professional and compassionate service delivered in a very friendly and positive manner*"
Comment card received Summer 2014

In the six months up until October 2014, we had no breaches of the 'same sex accommodation' standard. That is, all of our service users in in-patient beds in our community hospitals were cared for in wards that provided single sex sleeping accommodation and bathroom facilities for use by a single sex.

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5.4 Responsive to a diversity of needs

5.4.1 Waiting times for services

Being responsive means keeping waiting times to a minimum, and seeing those greatest need soonest (based on a holistic assessment of need).

We have a large number of local and national targets relating to waiting times. You can find how we are performing against these targets in Appendix C.

As at September 2014, we were meeting most of our 2014-15 targets for waiting times:

- All sexual health services exceeded waiting times targets;
- The vast majority of people using our Minor Injuries Units are seen, treated and discharged well within the expected time limits;
- The majority of children's services waiting times targets are being met;
- The majority of specialist services are meeting targets, with the exception of the Bone Health service.

Our Musculo-skeletal and Podiatry services are struggling to meet their waiting times targets this year. This is predominantly down to challenges we face with staffing. We require a high degree of specialism for our MSKAT service, which has recently been expanded. As a result, it can be difficult to find sufficiently qualified staff to provide the service, and we have moved some of our staff from 'core' podiatry and physiotherapy services to meet this need. However, pressures on 'core' services means that there is a shortage of sufficiently qualified staff to meet the need. We have a detailed action plan in place to help bring down waiting times.

Findings from our patient surveys over the year up to September 2014 show that 'waiting times' is the lowest scoring factor in patients' experiences (see Appendix D). However, it should be noted that 93% of patients still rate 'waiting times' as 'excellent' or 'good'.

5.4.2 Taking our services to communities who find it hard to access mainstream services

Some people and communities find it hard to access mainstream services. This may be because they do not know the services exist, because they struggle to get to them, or because they fear they will face prejudice and misunderstanding. In these cases, we believe that the best approach is usually to take our services and information to them, rather than expecting them to come to us. Building a trusting relationship is critical. In last year's equality report, we described the work of our Homeless Healthcare Team, who are based at the homeless shelter in Gloucester. In this year's report, we

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have included a couple of further examples of how we are doing this as 'Spotlights' below.

Spotlight on: Our work with Gypsy and Traveller Communities

One of the communities in Gloucestershire that struggles to use mainstream public services is the Gypsy and Traveller community. National data shows that this community experiences substantial health inequalities, including substantially lower life expectancy, higher infant mortality and greater prevalence of long-term conditions. In the past year we have established links with several key members of the community, and have gained access to some of the larger traveller sites in Gloucestershire, taking 'healthy living' information to Traveller families.

We also took the Gloucestershire 'Health Bus' to the Stow Fair – a major event for Gypsy and Traveller families from across the UK. Two of our Stop Smoking advisors attended, and we engaged people on a range of 'healthy living' topics such as smoking, alcohol awareness and healthy eating. We were met with a friendly and positive reception, and many of our visitors took our Easy Read materials away to share with friends and family.

Spotlight on: Our work with the Transgender Community

The Transgender community also experiences substantial prejudice, misunderstanding and health inequalities. Their fears of people's reactions may mean that they are less likely to use public services, and many trans people experience social isolation and mental ill-health. They also have some very different needs of health and social care services, for example in provision of intimate care and in sexual health advice and information.

Gloscats is a support and advice organisation in Gloucestershire, which represents the interests and provides practical and social support to people in the county who experience some degree of gender dysphoria. Over the past year, we have been involved several discussions between members of Gloscats and the public services around improving understanding and access in public services for Trans people.

We have also been working with the Trans community to improve their access to relevant and targeted information and support, on both healthy living and sexual health. In November 2014 one of our Healthy Living advisors attended a Gloscats meeting in order to share information and help attendees make healthy choices. From January 2015 we will be pulling together information sources for Trans people on sexual health, and looking at how we can make our Sexual Health Services feel welcoming and inclusive for Trans people and lesbian, gay and bisexual people.

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Ties in with:
Equality Objective 1e: Develop targeted communications materials for communities with distinct communication and/or health needs (about our services and/or their health)

5.4.3 Responding to needs that are not met by mainstream approaches

Some people who use our services have extra or different needs that are not usually met through mainstream approaches. Examples include people with mobility issues, sensory impairments, and people who do not speak English/ speak English well.

We have a number of services that work almost exclusively with people who are vulnerable or have extra or different needs. Examples include some of our specialist services (who work with children and adults with long-term conditions, disabilities and challenging behaviour), our dental services (who see a lot of people who have learning disabilities, physical disabilities and dementia) and our independent living services. Our Integrated Community Teams are designed to wrap a tailored package of care around the individual, based on a holistic assessment of need. In a community event in October 2013, participants said they feel that our joined-up approach to providing holistic care is a real benefit[20].

However, we have anecdotal evidence that some of our services and functions find it harder to recognise, understand and respond to extra and different needs. In July 2014, we held a two-hour conversation with 24 colleagues on 30th July 2014. Participants were mostly reception and administrative staff who have patient/ service user contact (face-to-face and/or phone). Participants felt that our systems and processes do not always accommodate extra or different needs. Examples they gave included:

- Pressure at reception desk meaning that a patient with mobility issues had to stand and wait for receptionist to be free;
- There was no-one to guide patient with visual impairments to clinic;
- Patient with learning disabilities was not able to provide personal information (address and date of birth) when attending clinic without their key worker;
- Visually impaired patients relying on a carer/ relative to read letters;
- Deaf patients having to find carer/ relative to make phone calls for test results and appointments.

[20] Your Care, Your Opinion event (29th October 2013).

Some colleagues felt that those who frequently did not attend appointments sometimes could not attend clinics due to disabilities or long-term conditions.

Receptionists and administrative staff also talked about communication difficulties, e.g. patients/ care home staff with strong accents or limited English, and hard-of-hearing patients. They say this can cause frustration on both sides.

Colleagues feel they are filling the gaps, and they find their own ways of trying to help, but admit these are not always effective/ right for the patient, e.g.

- Leaving desk/ phone unattended to walk patients to appointments;
- Finding porters/ other staff who speak other languages for last-minute translation;
  - Sometimes after appointments with consultants where service users have not understood what they've been told;
  - NB these staff said they found it hard to get emergency/ last minute interpreters, in spite of the Trust's translation and interpreting contract;
- Having to shout on the phone/ over the desk to patients who are hard of hearing.

Looking at our patient survey data, 'service at reception' scores lower than other factors we ask people about (see Appendix D). On average across all responses, it scores of 3.79 out of 4. Although this is still a relatively high score, when we look at a sample of these responses, people with disabilities are likely to give this factor a lower score[21].

What's new?

Our new approach to Quality and Equality Impact Assessments mean that each time we make changes to services, we explicitly consider how we will recognise and address the needs of people who will use this service. Colleagues are specifically directed to consider the implications of mobility, sensory impairments and communication needs.

Our 'Understanding you' campaign aims to provide colleagues with an in-depth understanding of people whose needs are not met by mainstream approaches and how they can best care for – and work alongside – these people.

Ties in with…

[21] NB these figures are indicative. We plan to carry out more analysis on our survey results by disability to gain a more robust understanding of the differences in experiences. You can find out more about how we calculate satisfaction scores on p.29.

Equality Objective 4c: Introduce an annual equality & diversity training programme to promote better understanding amongst colleagues of the lives and needs of people who are different from the 'mainstream'
Equality Objective 1f: Review settings, processes and communications materials to assess suitability for people with sensory loss. Focus for 2014-15 will be deaf people and people with hearing loss

5.4.3 Inviting and responding to feedback on our services

A main focus for Trust colleagues and the Board continues to be listening to, and learning from, service users, carers and families. It is essential that we have robust processes to ensure that the public can easily contact us to share their views and experiences, and that we listen to and act on their feedback.

As well as running our patient surveys (see section 5.35: Promoting dignity, respect, privacy and autonomy), our Service Experience Team gathers, manages and analyses formal complaints, concerns and compliments about our services. The table below shows complaints, concerns and compliments we received between October 2013 and June 2014. It also shows our response times to complaints:

Time period	Complaints	Concerns	Compliments	Complaints responded to within 15 days
Q3 (Oct-Dec) 2013	9	124	492	90%
Q4 (Jan – Mar) 2013	23	164	377	84%
Q1 (Apr – Jun) 2014	15	156	463	86%

Figure 5: Complaints, concerns and compliments Oct 2013 - June 2014

Because we receive few complaints, it can be hard to identify definite themes. However, there are some indicative themes when we look back at the complaints over the nine months. A number of complaints relate to quality of care. In the majority of these, the investigation finds that – while care may not have met a patient's or relative's expectations – it was up to the expected standard.

Communication is also a theme in complaints and concerns – either lack of compassion, or gaps in communication resulting in a poor transition between services/ care professionals or poorer quality care. In these cases, extra training and/ or supervision was put in place.

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Three of these complaints over this period were found to be due to the care provider not having a sufficient appreciation of a specific condition (MS, Down's Syndrome, an unspecified learning disability). As a result, they did not necessarily provide appropriate care or communicate with the service user in the most effective way. In all cases, specific training was provided to enable our colleagues to provide effective, appropriate care for people with these conditions.

In two cases, service users complained that their privacy and dignity was not respected when they were weighed in public areas. In both cases, procedures have been changed, and there are now strict requirements that service users are weighed in private.

We respond to the vast majority of complaints within 25 days. Overall in 2013-14, we responded to 86% of complaints within this time period. Where we took longer than this, it was typically because a case was more complicated and/ or involved a wider number of people. During this period, we keep in close contact with complainants to keep them updated with progress.

The amount of compliments our colleagues receive vastly outweighs the number of complaints and concerns. The key themes in compliments we receive are the friendliness of our colleagues, their caring attitude, the efficiency and the high quality of care.

"Everyone was so helpful and lovely. Felt very well looked after. The best experience I've had ever... The team at Hope House are a credit to the healthcare system."
Comment card received Spring 2014

5.4.4 Engaging people in improving our services

We have recently published our new Engagement Framework. Its vision is:

"To engage and involve people from all backgrounds who are direct users of, or have an interest in, our services, in order to continuously improve the quality of care and treatment."

Currently as a Trust we have a number of methods to ensure that service users can shape our services and influence our decisions. These include:

- **Your Care Your Opinion Steering Group** – a forum with service users and representatives of local community organisations which encourages a dialogue, and identifies areas for joint working and for improvement;
- **Co-production with patients** – Service developments co-produced with service users, for example, work around multi-disciplinary teams in Stroud;
- **Patient stories at our Board meetings** – Service user stories are shared by a relevant clinician/team lead at the start of each Board meeting;
- **Site walkabouts** – The Trust non-Executive Directors and Chair conduct walkabouts across the whole organisation, as a result of which reports and action plans are developed and implemented;
- **Surveys and Friends and Family Test –** We currently collect feedback through annual surveys in each service, experience cards which are filled in upon discharge, and through the NHS Friends and Family test (FFT). We are moving to an integrated patient and service user experience measurement service run by CoMetrica, which will be rolled out across our services over the coming months. This system allows for real-time live reporting of feedback and results, which will enable us to continuously deliver service improvement. This new system will require minimum input from our staff, giving them more contact time with patients and service users.

What's new?

We are developing our engagement function in order to meet our engagement vision. We will be doing this in the following ways:

- **Consultations** with the public and colleagues to get feedback on ideas and changes to refine and improve proposals, and to identify possible alternatives for service delivery and/or improvement;
- **Reader's Panels:** Getting service users, families, carers and members of the public to review our information before it is printed;
- **Focus Groups** to explore issues in depth and to get qualitative information about service user and carer needs and views. For example, we are currently conducting focus groups on food and hydration amongst people who have used our services;
- **Staff engagement.** We are currently review how we involve our colleagues in developments and improvements. You can find out more about this in the 'Advancing equality in our workforce' section.

One or our core pledges published in our engagement framework is to:
"Promote equality by ensuring we engage with people who represent the diverse communities we work within, and in particular make sure we are engaging effectively with those facing health inequalities."

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An example of how we are doing this includes working with our BME communities to put on a targeted version of the exhibition we held for our Annual General Meeting. This will one way we are adapting the information we put out to meet the needs of specific communities.

Ties in with…
Equality Objective 3a: Publish a Communications & Engagement Strategy and implementation plan, which includes a systematic approach to involving external & internal stakeholders in decisions, including people with 'protected characteristics' and those in vulnerable groups

Equality Objective 1e: Develop targeted communications materials for communities with distinct communication and/or health needs (about our services and/or their health)

5.5 Effective for everyone

We strive to ensure that our services are accessible and effective for everyone in Gloucestershire who needs them.

Appendix B describes the profiles of people who used our services from April-September 2014 by their age, race and sex. When we compare this information with our county profile, it gives us an indication of how well the services are accessed by people from across our communities.

NB: it should be noted that this year we have gaps in our data around race: many of our services have changed the patient data system they use, moving over to SystmOne. When patient records were transferred to SystmOne, much of the patient data migrated automatically. However, ethnicity data was not transferred across. This means that our colleagues need to enter a service user's ethnicity manually from scratch. At the point of writing this report, not all patient records are complete. This is a priority for the organisation.

Ties in with:
Equality Objective 2a: Report biannually on the profile of users of all services provided by GCS NHST by age, gender, ethnicity and disability.

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5.5.1 Who is using our services? Are they representative of the Gloucestershire population?

We provide a number of services where we would expect the users to be representative of our county population as a whole in terms of age, race and sex. These services include Health Visiting, Minor Injuries and Illnesses Units, our Musculo-Skeletal services (MSK) and Stop Smoking Services.

The profile of our service users for these universal services often reflects our communities. For example:

- We know the ethnicity of 5,466 people who used our **Health Visiting Services** between April and September 2014[22]. Of these, 16% were non-'White British', largely reflecting our the ethnic profile of under 5s in Gloucestershire (13% not 'White British'[23]);
- 91.3% of people using **Minor Injuries Units** were 'White British' (91.6% of the Gloucestershire population is 'White British');
- 90.3% of people using **Stop Smoking Services** were 'White British', and 63.7% were under 50.

With many of our services, we expect a more defined group of people to use them. This is because the need or the condition might be more common amongst certain ages (e.g. long-term conditions, dementia, falls, Parkinson's disease, mobility issues), ethnic groups (e.g. diabetes, HIV), or sex (e.g. osteoporosis/ bone health, contraception services).

For example, in this period, People over 80 years old make up 70% of our **community hospital** admissions and 62% of those seen by our **district nursing service**. As a result:

- More were female than male (as women have a longer life expectancy than men);
- More were 'White British' than in the Gloucestershire population as a whole (the proportion of people who are over 80 and 'White British' is higher than in the general population).

There is greater use of our **adult community services** by people aged over 65, and accordingly, larger proportions are 'White British' than in our population as a whole. This reflects the ethnic profile of this age group in

[22] NB We do not know the ethnicity for 46% of people using the Health Visiting Service in this time period. We will be investigating the reason for this.
[23] Census 2011

Gloucestershire, where around 96% of people aged over 65 are 'White British'.

In most of these services, there are more women using them than men as there are more older women than older men in our population (55% of Gloucestershire residents aged over 65 are female). Analysis of our service user data shows there is greater demand on some services by one or other of the sexes:

- 72% of adults using our Speech and Language Therapy were over 65. However, only 51% of people using the service were female, suggesting there is a greater need amongst men.
- Everyone who used our **Bone Health service** was over 65, and 55% were over 80;
  - Most (85%) were female, largely because women are more likely to experience problems with their bones (osteoporosis) than men;
- 89% of people seeing our **Parkinson's Disease Nurses** were over 65, but more men used the service than women (53% were male);
- 61.5% of people using the physiotherapy service were male. This is similar to last year's usage, although there is a more even spread of ages using this service.

People using our sexual health services are quite different in make-up from our county population in terms of age, sex and race:

- They tend to be younger – over half of people using our contraception services are 25 or under;
  - Though our HIV service users have a slightly older age profile, and include more in the 50-64 age group;
- More women than men use our contraception services and psychosexual services – around 7 in 10 people using these services are female;
- Two thirds of people using our HIV services are male. This echoes national trends where 72% of new HIV diagnoses were male in 2012[24];
- Greater proportions of people who are not 'White British' use our sexual health services than make up our county population:
  - 26.6% come from BME groups (compared to 4.6% of the Gloucestershire population);
  - 13.6% come from White non-British groups (compared to 3.8% of the Gloucestershire population);

[24] Public Health England, Annual New HIV Diagnoses in UK

– 38% of people newly diagnosed with HIV in 2011 were from BME groups[21].

There are also indications in the data that our **Minor Injuries and Illnesses Units** (MIUs) we are reaching more communities who historically have found it harder to access healthcare. For example:

- Nearly one in four people using our MIUs are under 25 (39.5%). Only a fifth of people in Gloucestershire are under 25;
- More men than women use our **Minor Injuries and Illnesses Units** (54% men vs. 46% women);

However, echoing findings in last year's report, there are some notable differences by sex amongst children using some of our paediatric services:

- **Health Visitors'** patients are more likely to be recorded as female than male (70% female). This is because our information sometimes includes the parent/ carer's sex as well as the child's. Our health visitors predominantly have contact with the mother or a female carer;
- **Paediatric Occupational Therapy** patients are more likely to be male (66%). Studies demonstrate that there is a higher incidence of developmental co-ordination amongst boys than girls.
- **Paediatric Speech & Language Therapy** patients are more likely to be male (70%). Research into linguistics and speech disorders show that boys are more susceptible than girls.

Currently we do not have readily available information on our service users' disability status, gender identity, religion/ belief or sexual orientation. We will consider how to fill these gaps as part of our focus on data improvement in 2015.

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5.5.2 Translation and interpreting – are we responding to demand?

According to the 2011 Census, 96.7% of Gloucestershire residents speak English as their main language, compared with 92% across England as a whole.[25]

Between April and September 2014, we commissioned 498.3 hours of face-to-face interpretation on behalf of people using our services. This compares with 294.3 hours of face-to-face interpretation in the same period last year. The main languages requested were Czech (120 hours), Polish (102.5 hours) and Slovak (53 hours). A more detailed chart showing interpreting activity across different languages can be found at Appendix E.

What's new?

In 2015 we will be re-tendering our Translation & Interpreting Services. During this process we will review the needs and preferences of our local communities and explore what changes we need to make to ensure the service is effective and responsive for service users and colleagues.

5.5.3 Making the most of community resources for the benefit our service users

We recognise that – in order to be effective for everyone – we need to make the best use of people, expertise and knowledge beyond the boundaries of the Trust.

An aspect of this is sometimes called 'Asset Based Community Development' or ABCD. It as an approach which recognises that communities themselves often have the knowledge and resources to make lasting and effective changes, including in their health. It also encourages public sector (and other organisations) to direct people using their services to support available in their communities.

An example of this is the work we are doing with the Gloucestershire Deaf Association. We recognise their wealth of experience and expertise in meeting the needs of deaf and hard-of-hearing people, and are working with them to review our training and our interactions with service users. This will help our colleagues signpost support to hard-of-hearing service users they come into contact with. This will benefit those service users in their interactions with us, wider public services, and in life in general.

[25] 2011 Census: Main language (detailed), local authorities in England and Wales

We are also training our staff in ABCD and developing toolkits for them to look to community resources to enable them to achieve better outcomes for their staff.

Ties in with:
Equality Objective 4b: Ensure staff work within a culture which is designed to routinely connect or re-connect communities & individuals to the resources and assets within their community as part of a person- and family- centred approach to care

5.6 Well-led – embedding equality principles and an inclusive culture

Our senior management team plays an important role in promoting an inclusive culture and ensuring our activities further equality. One of their key roles is to ensure that the Trust's decisions pay due regard to the needs of people who face inequalities, those who have extra/ different needs, and those who are vulnerable.

Over the past months, we have developed a new combined approach to gauging the impact of our activities on both quality and equality. The aims of this revised approach are to:

1. Provide increased visible assurance to the Trust Board and Committees that we have considered the impact of service change decisions on quality, equality and human rights;
2. Provide a robust assessment framework that moves away from a computer-based tick-box process and towards a more open, collaborative approach, that can be embedded within the Transformation and Change Team's own business case and programme management processes, but can also be used with Business as Usual change activity;
3. Bring a stronger focus to understanding who will be affected by changes to services and functions (both service users and colleagues), evidenced by profiles of the affected populations. This is fundamental to understanding how they will be affected, and how we may then need to adapt what we're doing to enable people to use and benefit from our services/functions;
4. Ensure that our impact assessment process is flexible enough to allow a level of analysis that is proportionate to the scale and impact of the change.

Ties in with…
Equality Objective 2b: Have a single equality and quality impact assessment process for policies, plans and strategies, with robust arrangements for scrutiny and accountability.

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Other developments in the past year to support our Board and Committee members in their role in scrutinising decisions include:

- A Board development session in April entitled 'Small Group: Big Impact: How to manage minority needs in times of financial constraint'; and
- As a result of discussions in this session – changes made to all papers coming to Board and Committees to identify equality-related impacts.

Our Organisational Development Strategy sets out our aim to create "a supportive working culture, in which all Trust colleagues feel respected and valued, and which allows them to be productive, innovative and focused". To support this aim, The Trust has developed a Core Values Framework to ensure that all colleagues within the organisation are clear on the expected values and behaviours that are required of them. The Core Values framework will be embedded within induction, recruitment, appraisal and training, in order to achieve the culture described within our Organisational Development Strategy.

Ties in with:
Equality Objective 4a: Publish an Organisational Development Strategy and implementation plan, which includes plans to nurture a caring and open culture amongst our workforce.

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6. Advancing equality in our Workforce

6.1 Introduction

Our aims with regards to equality and diversity in our workforce are that – regardless of personal characteristics, circumstances and background – everyone who works with us (or who may in the future):

- Is part of a **diverse workforce** where people are able to learn from each other and work together to respond creatively to the diverse challenges we face;
- Feels comfortable and content in the workplace, in **an environment free from discrimination and harassment**;
- Has the **opportunity to thrive and contribute**. There is equality of opportunity to progress at work and to access employment and development opportunities.

6.2 Diverse workforce

As at 1st September 2014, we employed 2674 staff, excluding bank staff. Below we describe the make-up of our staff by characteristics protected under the Equality Act 2010.

6.2.1 Staff profile by age

By age, our staff profile is older than the county profile. Most of our colleagues (61%) are aged between 40-59 years. In comparison, just over a third (35.7%) of working age people in Gloucestershire fall in this age range. Whereas a fifth (20.3%) of working age people in Gloucestershire are aged 17-29, only a tenth (10.2%) of our colleagues are in this age bracket. This is reflective of the ageing profile of the NHS as a whole.

However, our age profile has changed over the past year, with increases in the younger age groups. The chart below shows the proportions of colleagues in the different age bands in September 2014 compared to October 2013 and the county population.

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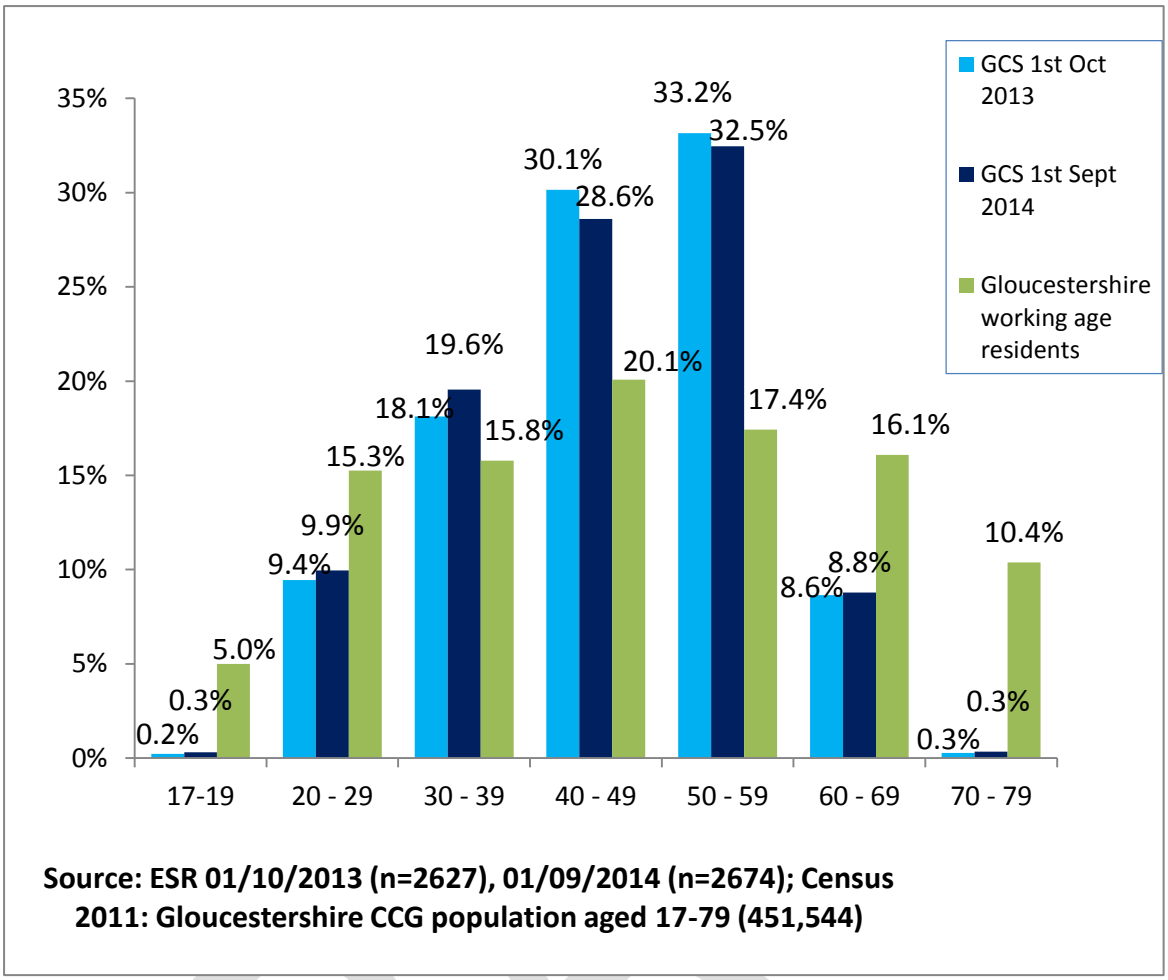


Figure 6: Age profile of staff September 2014 and October 2013 compared to working age adults in Gloucestershire

6.2.2 Staff profile by disability

17% of colleagues declared a long-standing illness, health problem or disability in our anonymous 2013 staff survey. This is comparable with other community trusts and with the Gloucestershire population as a whole, where 16.7% of people in Gloucestershire have a limiting long-term illness or disability.

As at 1st September 2014, 1.4% of colleagues are listed on our Electronic Staff Record (ESR) as having a disability, and 56.7% have no disability. However, based on ESR we do not know the disability status for 41.9% of our colleagues. By comparison, in our staff survey, less than 1% colleagues declined to declare their disability status. High rates of non-disclosure may because colleagues have actively declined to share their disability status with us, because colleagues have become disabled in the course of their

employment with us, or because the information was not initially recorded on legacy systems.

The low numbers of people listed on ESR as having a disability means we cannot conduct detailed analysis on the effect of colleagues' disability status on employment activities (such as training and performance management).

Our staff absence data shows that between 1st September 2013 and 31st August 2014, our sickness absence rate was 4.59%. This is slightly higher than other community trusts[26]. There are some notable differences based on occupation, age, and ethnicity. The table below demonstrates the differences based on occupational group and ethnicity (green indicates lower than average and orange indicates higher than average sickness absence rates):

Group	% Sickness absence rates
All staff	4.59
BME staff	3.41
Unregistered nursing staff	6.20
Registered nursing staff	4.49
Medical & Dental staff	5.48
Ancillary staff	5.85
Allied health professionals	3.20

Table 1: Differences in % Sickness absence in the year up to 1st Sept 2014

Generally speaking, staff in the youngest and oldest age bands are likely to have higher sickness absence rates. Staff aged 20-29 have the lowest sickness absence rates:

[26] On average, other community trusts experienced sickness absence rates of between 4.23% to 4.76% from September 2013 to June 2014 (July and August data was not available at the time of writing this report) Source: Health and Social Care Information Centre

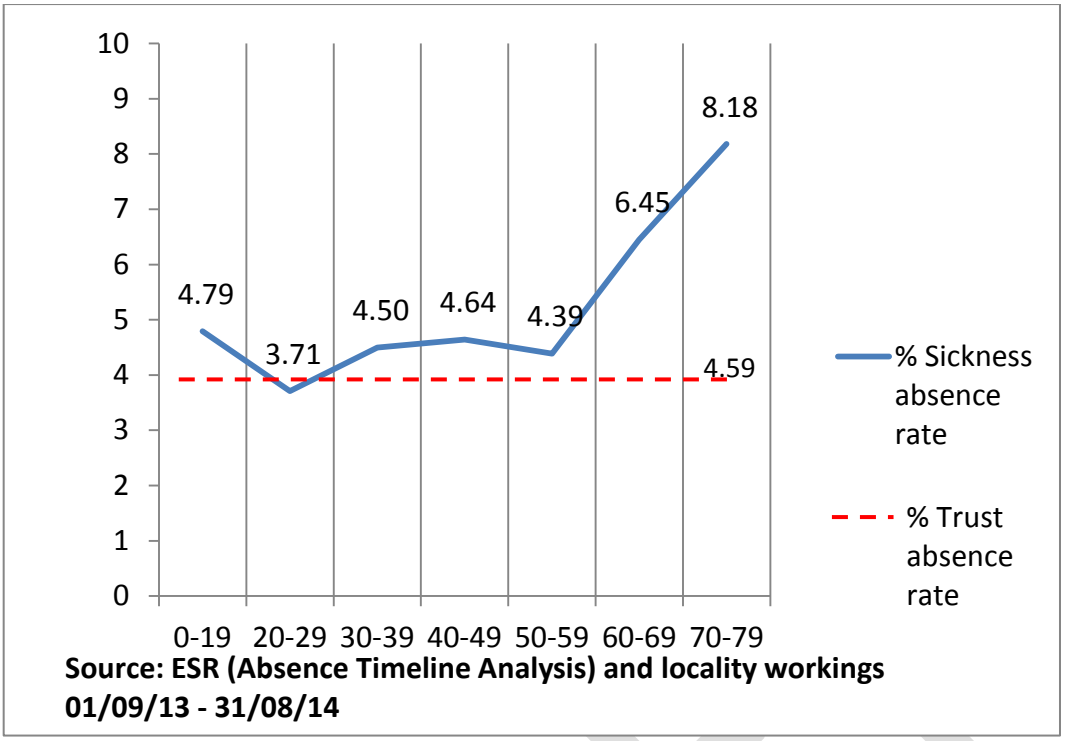


Figure 7: Sickness absence rates by age

From our staff absence data, we know that stress is the most common reason for staff being on sickness absence.

What are we doing about it?

The HR Department has been working closely with line managers in supporting them to manage individual long term sickness cases and progress has been made in this area. However, a recent review has identified that short term sickness management needs to be a priority for the Trust and action is being taken to ensure that managers are able to support staff but take action where absence is identified in excess of the Trusts agreed 'triggers'. HR Advisors are conducting sickness absence management workshops and feedback received to date has been extremely supportive of these sessions.

A detailed action plan has been developed which identifies a number of key actions that will be completed to ensure that sickness absence rates see a step change over the next 6-12 months. Further actions include:

- The development of a healthy workforce plan
- Further roll out of the Lighten up programme
- A review of the occupational health service and employee assistance programme
- A review of the Stress Management Policy and guidance supported by workshops for managers

6.2.3 Staff profile by gender reassignment

We do not ask colleagues or potential colleagues about their gender identity and whether their current gender is different from their sex at birth. We know that many people who experience gender dysphoria (or who live their lives in a different gender to their sex at birth) prefer to keep this to themselves.

Based on information collected by GIRES[27], 1% of people experience gender non-conformity to some degree. This would equate to around 27 of our colleagues.

GIRES recommend that organisations monitor gender identity and gender non-conformity, but only when they have established that they have a culture that supports transgender people and is free from potential discrimination. They recommend that organisations conduct attitude surveys towards gender non-conformity before monitoring. Further information on this can be found on the internet via this link:
http://www.gires.org.uk/assets/Workplace/Monitoring.pdf.

6.2.4 Staff profile by marital status

62.3% of our colleagues are married and 0.1% in a civil partnership. A quarter are not married or in a civil partnership. We do not know the marital status of 12% of our colleagues, either because they have chosen not to declare this, or because they have not been asked. There is very little change in these figures since 1st October 2013.

6.2.5 Staff profile by pregnancy/ maternity

As at 1st September 2014, 61 of our colleagues (2.1%) were on pregnancy or maternity leave. There is very little change in these figures since 1st October 2013.

6.2.6 Staff profile by race

As at 1st September 2014, nearly 95% of our colleagues describe themselves as 'White British', 3% are from BME groups, and 2% are 'White non-British'. There have been small changes in the ethnic diversity of our workforce since 1st October 2013, with minor increases in the numbers and proportions of colleagues who are White but not British and who come from BME backgrounds.

[27] The Gender Identity Research and Education Society

This chart shows the ethnic profile of our colleagues in 2013 and 2014 compared to that of working age residents in Gloucestershire as a whole:

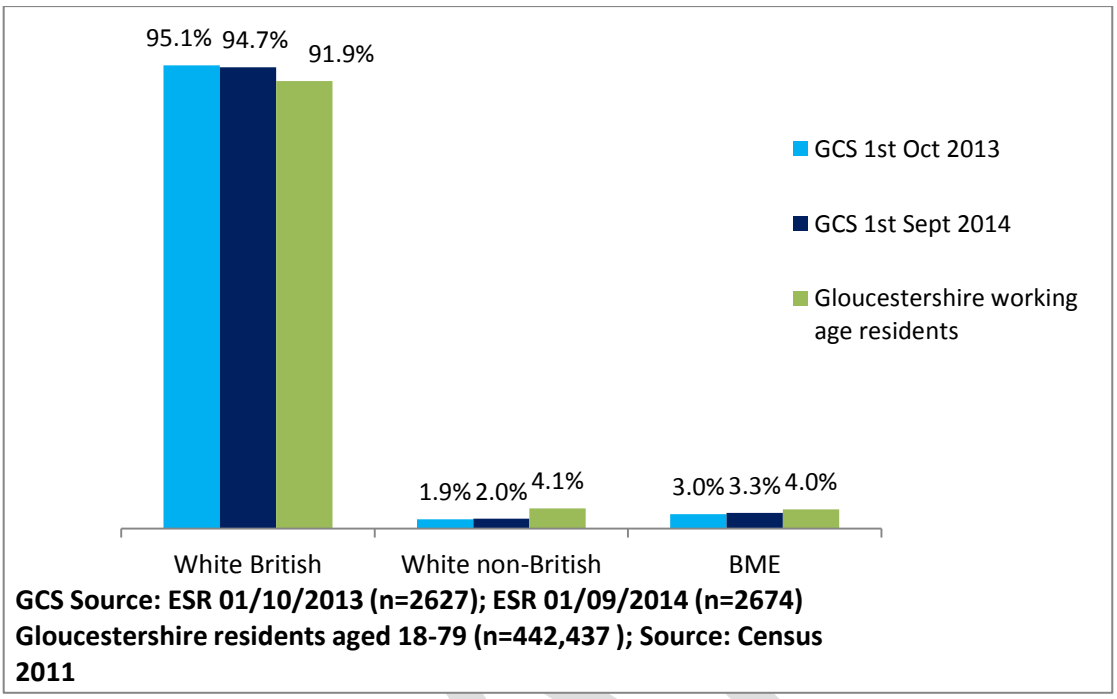


Figure 8: Ethnicity profile of staff in 2013 and 2014 compared with County profile

We are conscious that our staff profile does not fully reflect the county profile in terms of race. This follows a pattern in community trusts nationally, where 89% describe themselves as 'White British'[28], compared to 81% of the population of England[29].

There are a number of possible reasons for this:

- Our staff profile is older. A third of our workforce is aged 50-59. 94% of this age group county wide is 'White British'.
- The vast majority of our jobs require occupational registrations and/ or qualifications (or relevant equivalents). People who were born outside the UK are less likely to have the relevant occupational registrations and qualifications required of many of our posts.
- We require a high level of spoken English from our front-line staff (as per national requirements), as communication is a vital component of our work. This may exclude some people.

[28] NHS Staff Survey 2013
[29] Census 2011

Nonetheless, the figures on the race profile of our successful job applicants suggest that further analysis and work is needed to understand and address the mismatch in our staff profile compared to the county profile.

6.2.7 Staff profile by Religion/ Belief

The breakdown of colleagues' religion/ beliefs is as follows:

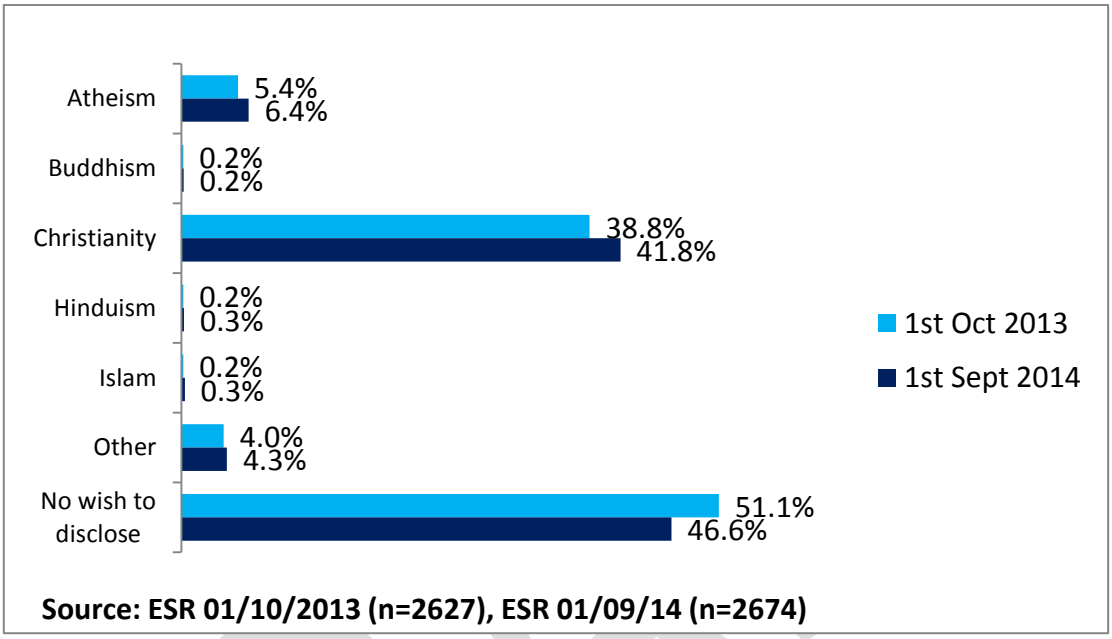


Figure 9: Religion/ Belief profile of staff in 2013 and 2014

Nearly half of our colleagues have chosen not to disclose their religion/ belief on ESR, though our disclosure rates are increasing. Of those who have disclosed their religion/ belief, the majority are Christian (42%). 62% of respondents to our latest staff survey (n=437) identified themselves as Christian. This is comparable with other NHS community trusts (63%[30]) and Gloucestershire as a whole (63.5%[31]).

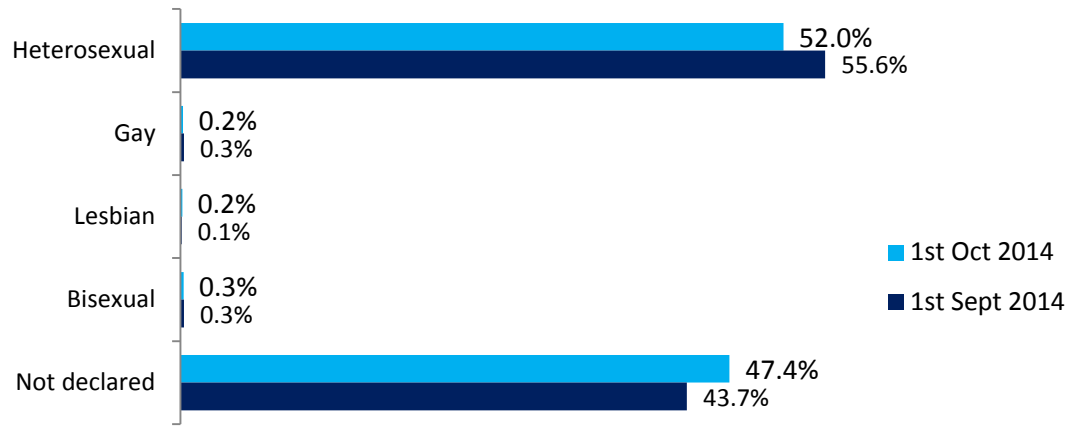
6.2.8 Staff profile by sex

91.2% of our colleagues are female and 8.8% are male. Historically, caring professions have been more likely to attract women than men, and this is demonstrated in the NHS as a whole, where 78% of staff are female[32]. In community trusts as a whole, 89% of the workforce is female[33].

[30] National NHS Staff Survey 2013
[31] Census 2011.
[32] National NHS Staff Survey 2013
[33] National NHS Staff Survey 2013

6.2.9 Staff profile by sexual orientation

55.6% of colleagues listed on ESR have declared themselves as heterosexual/ straight. However, nearly half have not disclosed their sexual orientation.



Source: ESR 01/10/2013 (n=2627), ESR 01/09/14 (n=2674)

Figure 10: Staff profile by sexual orientation Oct 2013

In our latest (anonymous) staff survey in 2013 (n=437), 93% said they were heterosexual, 1% said they were a gay woman/ lesbian and 5% did not wish to say.

6.2.10 Improving disclosure rates

There are a number of possible explanations for why so few of our colleagues have disclosed their sexual orientation, religious belief and disability status. Firstly, many of our colleagues have been with the organisation – and predecessor organisations – for many years. It is possible that their characteristics were not captured at the point when they were recruited. Secondly, it is possible that colleagues do not understand why it is important for us to collect information they might regard as 'personal'. Thirdly, colleagues may be unwilling to disclose this information because they have concerns that the data will not be stored securely, or that they may face prejudice if they share it with others.

What's new?

Our 2014 figures show slight increases in the proportions of staff who have shared their religion/ belief, sexual orientation and disability status compared with our 2013 data. However, we need to dramatically improve disclosure rates if we want to do meaningful analysis to understand whether colleagues

face disadvantages because of their personal characteristics (e.g. in access to training, promotion, and in regards to grievance and disciplinary action). In 2015 we plan to undertake a data validation exercise amongst all our staff, asking them to check and update the information we hold about them on the Electronic Staff Record.

6.3 An environment free from discrimination and harassment

6.3.1 Equality & Diversity Training

We strive to provide an environment free from discrimination and harassment for all our colleagues. All colleagues are required to complete Equality, Diversity and Human Rights training. The course aims to challenge prejudice, and help colleagues understand the value of diversity and how to challenge discrimination. 66% of our colleagues are listed on our training system as being up-to-date with their equality and diversity training. Our most recent staff survey shows us that 42% of colleagues said they had received equality and diversity training in the last 12 months, compared to a national average of 67% in other community Trusts[34]. There are a couple of reasons for this disparity. Firstly, we currently require colleagues to complete equality and diversity training once every three years. Secondly, we have a number of other training courses that advance equality and promote diversity by focusing on vulnerable people and people who face health inequalities, such as dementia awareness, learning disabilities training, and safeguarding training. However, we believe that colleagues do not recognise this as 'equality and diversity' training when they are answering the staff survey.

What's new?

From Spring 2015 colleagues will complete annual equality training updates (instead of once every three years). We are also radically changing the style and approach of the training: the new programme will be an engaging and practical look at the lives of people whose needs are different from the mainstream. The voice of service users will be at the heart of the training, which will be designed in collaboration with local community groups.

The 2015 training will focus on hearing loss. We are working closely with the Gloucestershire Deaf Association to develop a creative, touching and pragmatic piece of training. Its aim is to give colleagues an insight into the

[34] NHS Staff Survey 2013

lives of people with hearing loss and to provide practical guidance on what they can do to support them when providing care and in the workplace. The training will be available on our intranet to can be completed individually, or as a group, for example in team meetings.

Ties in with:
Equality Objective 4c: Introduce an annual equality & diversity training programme to promote better understanding amongst colleagues of the lives and needs of people who are different from the 'mainstream'
Equality Objective 1f: Review settings, processes and communications materials to assess suitability for people with sensory loss. Focus for 2014-15 will be deaf people and people with hearing loss

6.3.2 Discrimination, bullying and harassment?

To understand how well we are providing an environment free from discrimination and harassment, we look at staff survey data and reported incidents of bullying and harassment. We can look at breakdowns of these findings by age, sex and disability. Unfortunately, the numbers of BME colleagues answering the survey are too small to enable subgroup analysis on the basis of ethnicity. We can also look at information on how much our colleagues are paid, and see whether there appear to be any discrepancies based on colleagues' age, sex or race.

Our staff survey conducted in November 2013 asked colleagues about equal opportunities and discrimination. On the whole, our colleagues feel we are a fair employer:

- 91% believe the Trust provides **equal opportunities** for career progression or promotion (equivalent to community trusts nationwide);
- 8% had experienced **discrimination** at work in the past 12 months (equivalent to community trusts nationwide).

The survey also asked about their experiences of physical violence, harassment, bullying or abuse over the past 12 months. We found that:

- 13% had experienced **physical violence** from patients, relatives or the public, compared to 9% of staff in community trusts nationally;
  - And 30% of nurses and 38% of healthcare assistants had experienced physical violence.
- A third (33%) had experienced **harassment, bullying or abuse** from patients, relatives or the public;

  - Compared with a quarter (26%) of staff in community trusts nationwide;
  - And half (50%) of staff with disabilities had experienced harassment, bullying or abuse, compared with 31% of non-disabled colleagues.
- 22% had experienced **harassment, bullying or abuse** from staff, compared to 20% of staff in community trusts nationally;
  - This rises to 35% of colleagues with disabilities, compared to 19% without disabilities.

Between 1st September 2013 and 31st August 2014, colleagues reported 191 incidents of violence, harassment or abuse by patients or visitors in the Trust. Staff were affected in 180 of these incidents. The incidents were categorised as follows:

Verbal/written abuse	103
Actual Physical Assault	49
Threat of physical violence	23
Sexual harassment	3
Racial harassment	2
Grand Total	**180**

Table 2: Reported incidents of violence, harassment or abuse against staff (Source: Datix, 01/09/13 to 31/18/14)

In a number of the physical assault cases by service users, dementia is noted as a contributory factor. In the verbal abuse cases, some involve patients' relatives verbally abusing staff, and some involve patients abusing staff. Sometimes this is because they do not believe they/ their relative is receiving the right care and in some cases patients are abusive because they have dementia, mental ill-health or are in pain.

In the year up to the end of August 2014, we had few reported cases of abuse, harassment or assault on the basis of colleagues' personal characteristics. We had three recorded incidents of sexual harassment – two related to inappropriate comments, and the third to in appropriate touching. All three were recorded as 'low' grade incidents. These cases were dealt with by reporting the incidents centrally and to managers, and alerting others involved in the patients' care of the risk.

There were also two recorded incidents of racial harassment in this period. Both were incidents of racist verbal abuse. In one of these cases, dementia was thought to be a contributory factor.

What are we doing about this?

Equality Objective 4d: Introduce guidance and advice to support staff who face violence, abuse, and harassment from patients, relatives or the public, especially where this arises from patients who have a cognitive impairment.

We have a task force looking at this issue, made up of colleagues from our Community Hospitals, Human Resources, Communications, and the Security Management Service. They will lead on the development of guidance and advice and help embed this in the teams affected by abuse and harassment from patients.

6.4 Opportunity to thrive

We review the extent to which our colleagues feel able to thrive and contribute regardless of who they are by looking at our pay and conditions, recruitment data, access to training, survey data, and data on who has left the organisation, and why.

Since April 2014 the Trust has undertaken the staff friends and family test (FFT) on a quarterly basis. We are not currently able to analyse the results by protected characteristics, but in 2015 we plan to review whether to include monitoring questions in the FFT surveys.

Between April and September 2014, 4 out of 5 colleagues (80%) would recommend Gloucestershire Care Services as a place to receive care and only 3% would not recommend the Trust for care. This compares favourably with Trusts nationally: on average 76% of staff would recommend their Trust as a place to receive care and 8% would not recommend their Trust. The results of quarter one and two are summarised in the tables below:

	Total Responses Qtr. 1	**Qtr1 %**	**Total Responses Qtr. 2**	**Qtr2 %**
Extremely likely	174	31	127	28
Likely	279	49	238	52
Neither likely or unlikely	93	16	75	15
Unlikely	13	2	9	2
Extremely unlikely	6	1	9	2
Don't know	8	1	10	1
Total	**573**	**100**	**468**	**100**

Table 3: How likely are you to recommend the Trust to friends and family if they needed care or treatment?

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However, our colleagues were less likely to recommend Gloucestershire Care Services as a place to work in quarter one compared with Trusts nationally:

- 53% of our staff recommend the Trust as a place to work and 21% do not recommend it;
- An average of 62% of NHS staff nationally recommend their Trusts as a place to work and 19% do not recommend them.

	Total Responses Qtr. 1	**Qtr. 1 %**	**Total Responses Qtr. 2**	**Qtr. 2 %**
Extremely likely	86	15	66	14
Likely	217	38	162	35
Neither likely or unlikely	136	24	135	29
Unlikely	76	13	62	13
Extremely unlikely	49	9	35	8
Don't know	4	1	8	1
Total	**568**	**100**	**468**	**100**

Table 4: How likely are you to recommend the Trust to friends and family as a place to work?

Reasons cited for recommending the Trust as a place to work include team, environment and rewarding work. Reasons for not recommending it include poor communication, low morale, staffing levels/ workload, high levels of change, stress, lack of support from management and pay & conditions. Both the positive and negative themes are similar to the feedback received from the 2013 national NHS Staff Survey and Investors in People review.

The overall response rate for quarter one was 17% and for quarter two was 14%. By comparison, the highest completion rate nationally for community and mental health Trusts was between 4% and 20%[35].

What are we doing about this?

To address the issues identified above the Trust has developed an Organisational Development (OD) Strategy and a separate Workforce Strategy each being supported by a detailed implementation plan. The three priorities from the OD strategy for 2014/5 are the Listening into Action programme, investment in leadership and the Core Values Framework.

In January 2014 the Trust launched the **Listening into Action** programme which is a tool widely used in the NHS to change the culture within an organisation. The Trust has undertaken a range of activities under this programme which include:

[35] As reported by Quality Health, based on Trusts using Quality Health to administer the Staff FFT.

- A pulse check to obtain a base line of how it feels to work for the organisation
- Five big conversation events (attended by over 300 staff) to understand what gets in the way of providing the best care possible
- Implementing 'quick wins' identified during the big conversation events
- Supporting 13 teams across the organisation to make changes
- A "pass it on event" to allow the 13 teams to pass on what they have learnt from the change process.

During 2014/15, the Trust has invested over £160k in **leadership programmes** for middle managers. Since the Trust was formed in March 2013, 179 colleagues have participated in leadership programmes, including Leading for Quality Care (led by the Royal College of Nursing), Leading an Empowered Organisation and NHS Leadership Academy programmes (Mary Seacole, Elizabeth Garrett Anderson & Nye Bevan)

The Trust has developed a **Core Values Framework** to ensure that all colleagues within the organisation are clear on the values and behaviours that are expected of them. By embedding the framework within induction, recruitment, appraisal and training, it will support the Trust to achieve the culture as described within our Organisational Development Strategy.

6.4.1 Equality in pay and conditions

Our pay band analysis shows that women are more likely than men to be employed in the lower pay bands in the Trust: 87% of women are in Agenda for Change (AfC) pay bands 1-6, compared with 69% of men. The remainder are in AfC bands 7-9, or are on different pay structures (as medical specialists or 'other'). The chart below shows the increasing proportions of men in the higher pay bands:

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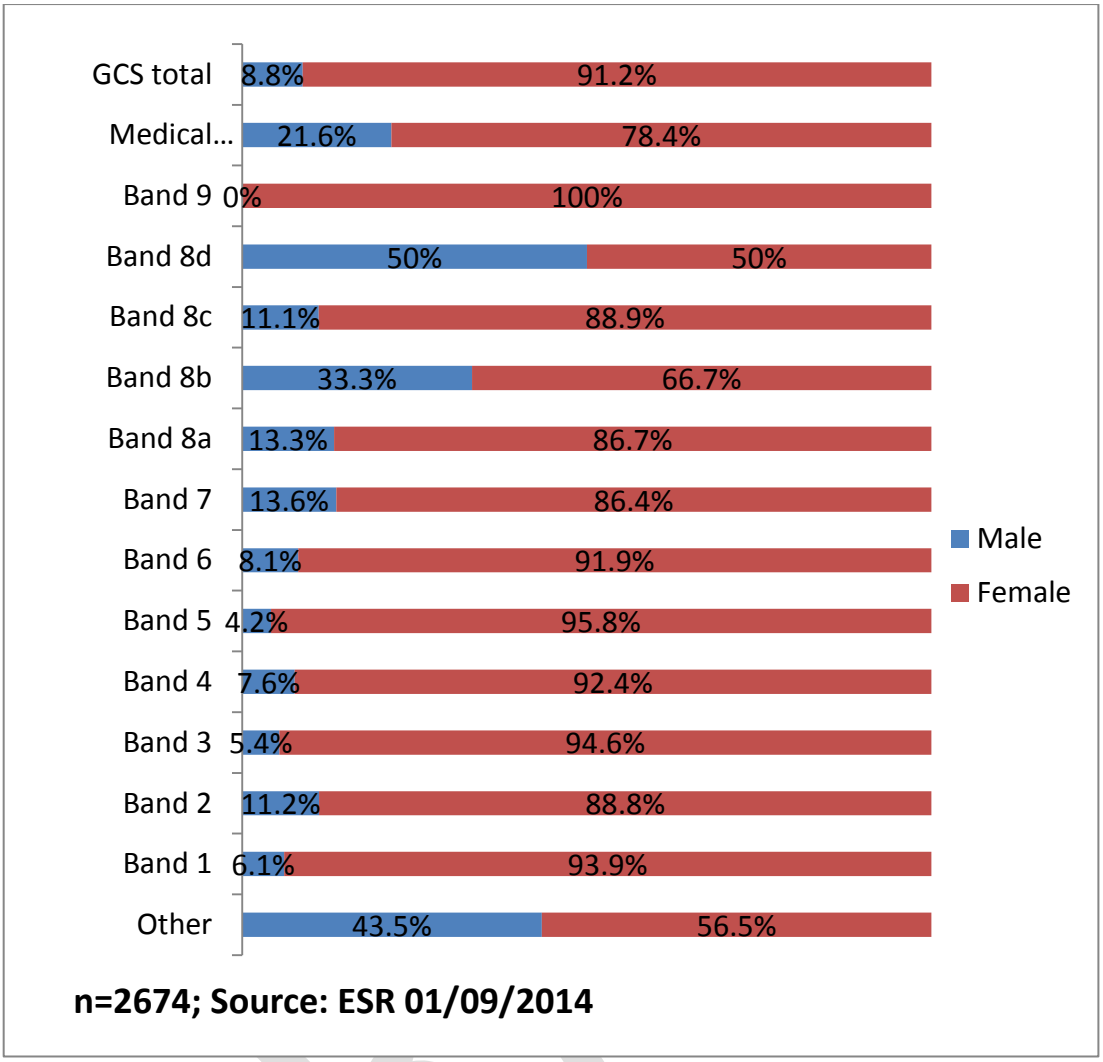

Figure 11: Gender by pay band

We have conducted gender pay gap analysis following the formula set out by the Equality & Human Rights Commission[36]. This calculation seeks to establish whether we pay men and women equally for equal work.

Based on this, we have no gender pay gap when comparing colleagues' pay across all of our staff. There is a pay gap when comparing all full-time colleagues' pay, which suggests that – on average – amongst full-time workers, women get a higher hourly rate than men. The analysis shows that women working part-time receive a lower hourly rate than men working full-time. The EHRC recommends this analysis as it is more likely that women are

[36] The full-time gender pay gap is calculated by dividing the median hourly earnings of female full-time employees by the median hourly earnings of male full-time employees, showing this as a percentage and subtracting the figure from 100 per cent. Thus a 0 per cent figure would indicate that for a particular category, there is no gender pay gap. http://www.equalityhumanrights.com/uploaded_files/research/Briefing_papers/bp_6_final.pdf

employed in part-time roles and historically part-time hourly rates have been lower than full-time hourly rates for equivalent work.

	GCS NHST	UK
Full-time gender pay gap: women F/T as % of men F/T	-4.03%	9.6%
Part-time women's pay gap: women P/T as % of men F/T	3.82%	38.8%
Women (all) as % of men (all)	0%	19.7%

Figure 12: Median hourly earnings of GCS NHST employees (Source: ESR, November 2014) compared to median hourly earnings of UK employees (Source: ECHR Gender pay gaps Briefing Paper 6, 2012)

These pay gaps are substantially smaller than the national pay gaps and they are smaller than the pay gaps we reported last year.

6.4.2 Equality in recruitment and retention

All our posts are advertised on NHS Jobs, and occasionally we use more targeted channels for inviting applications. NHS Jobs handles all of our applications. This includes monitoring the 'protected characteristics' of applicants. It is important to note that colleagues who shortlist applications do not see information on an applicant's name, age, sex, ethnicity, or religion. We run a 'Guaranteed interview' scheme for applicants who declare a disability, whereby we offer them an interview as long as they meet the minimum criteria.

Between 1st November 2013 and 31st October 2014[37] our recruitment activity was as follows:

	Applied	Shortlisted	Appointed
Number of applicants	8841	2796	418

When we break down these figures by age, race, religion and sex, it appears that these factors are linked with the likelihood of being shortlisted or appointed.

In terms of age, applicants under 30 were less likely to be shortlisted and appointed than older applicants (see chart below). Around a fifth (20.8%) of our applicants over this period were under 24. 12% of the total people

[37] A note on the reporting period: This data comes from NHS Jobs. NHS Jobs introduced a new website and database in 2014, and this only allows us to access one year's worth of data. As a result, the reporting period is a little later than other workforce data in the report.

appointed come from this age group. This is possibly because although nationally, unemployment is higher amongst younger age groups, they are less likely to have developed the experience and skills necessary for some of our posts.

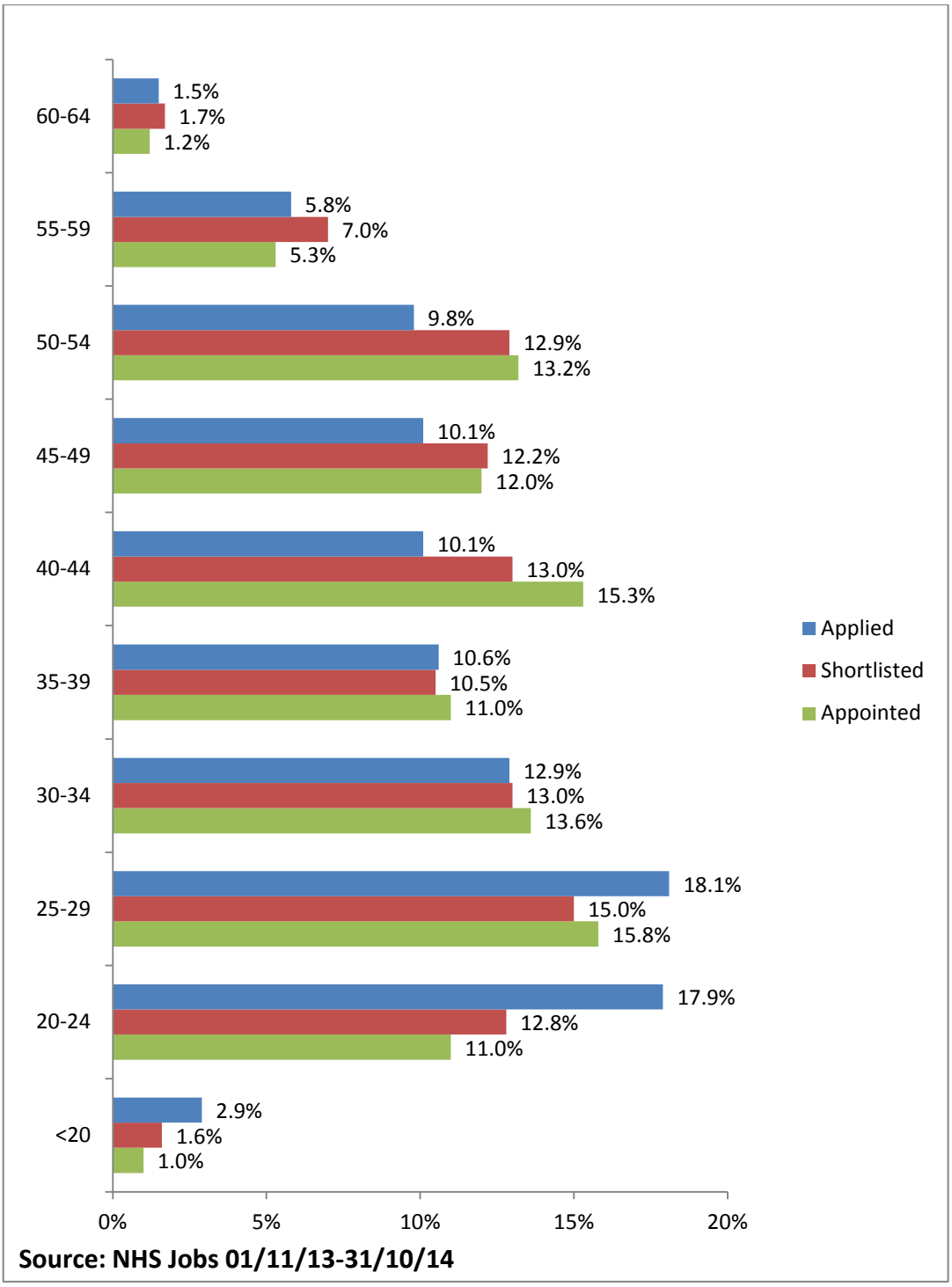

Figure 13: Recruitment by age

Ethnicity also accounts for differences between successful and unsuccessful candidates over this period. Just over three quarters of applicants (76.4%) described themselves as 'White British', but 'White British' people make up 89% of those appointed. People applying who describe themselves as BME or 'White' but not British are less likely to be shortlisted or appointed:

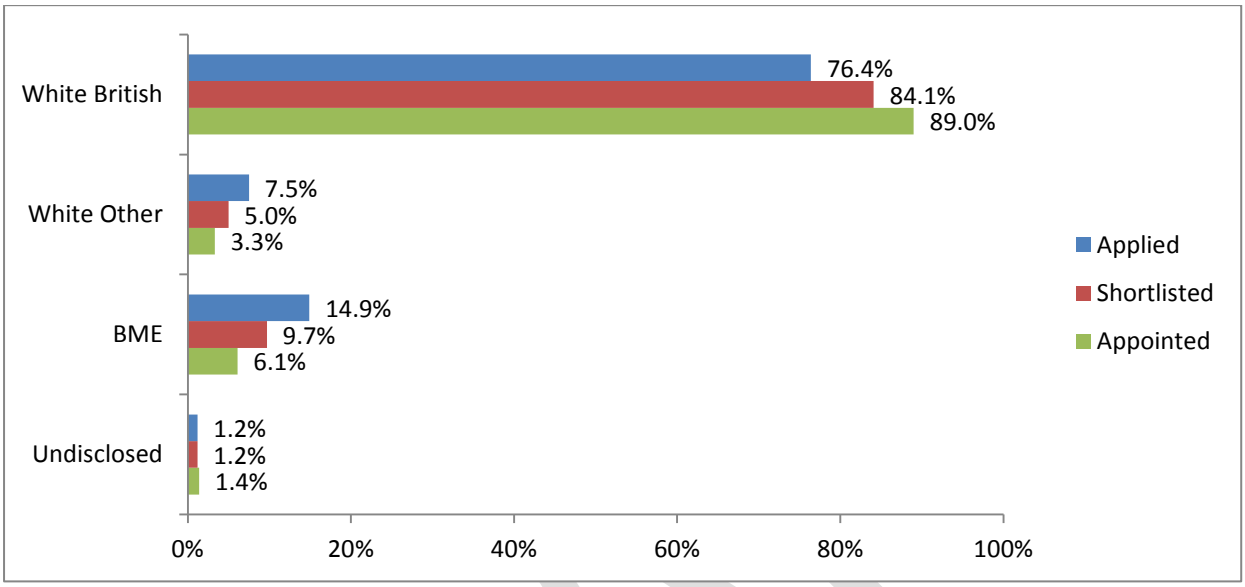

Figure 14: Recruitment by Race

This can partly be explained because all our posts are advertised on the NHS Jobs website, which can be accessed from across the globe. People applying from outside the EU (who are also more likely to be from BME groups) are less likely to have the right to work in the UK, and are therefore automatically screened out at the shortlisting stage. We require a high standard of spoken English in many of our roles, as communication is central to high quality care. This may account for some people from BME groups being shortlisted but not appointed.

This may also explain why an applicant's religion can affect their likelihood of being shortlisted and appointed. Figures for this period show that Christian and Atheist applicants were slightly more likely to be appointed, and Hindu and Muslim applicants were slightly less likely to be appointed. These figures are indicative, not statistically significant, but they do reflect previous data. It may be our Hindu and Muslim applicants are more likely to come from outside the EU. If so, they are less likely to have the right to work in the UK, and not shortlisted on this basis.

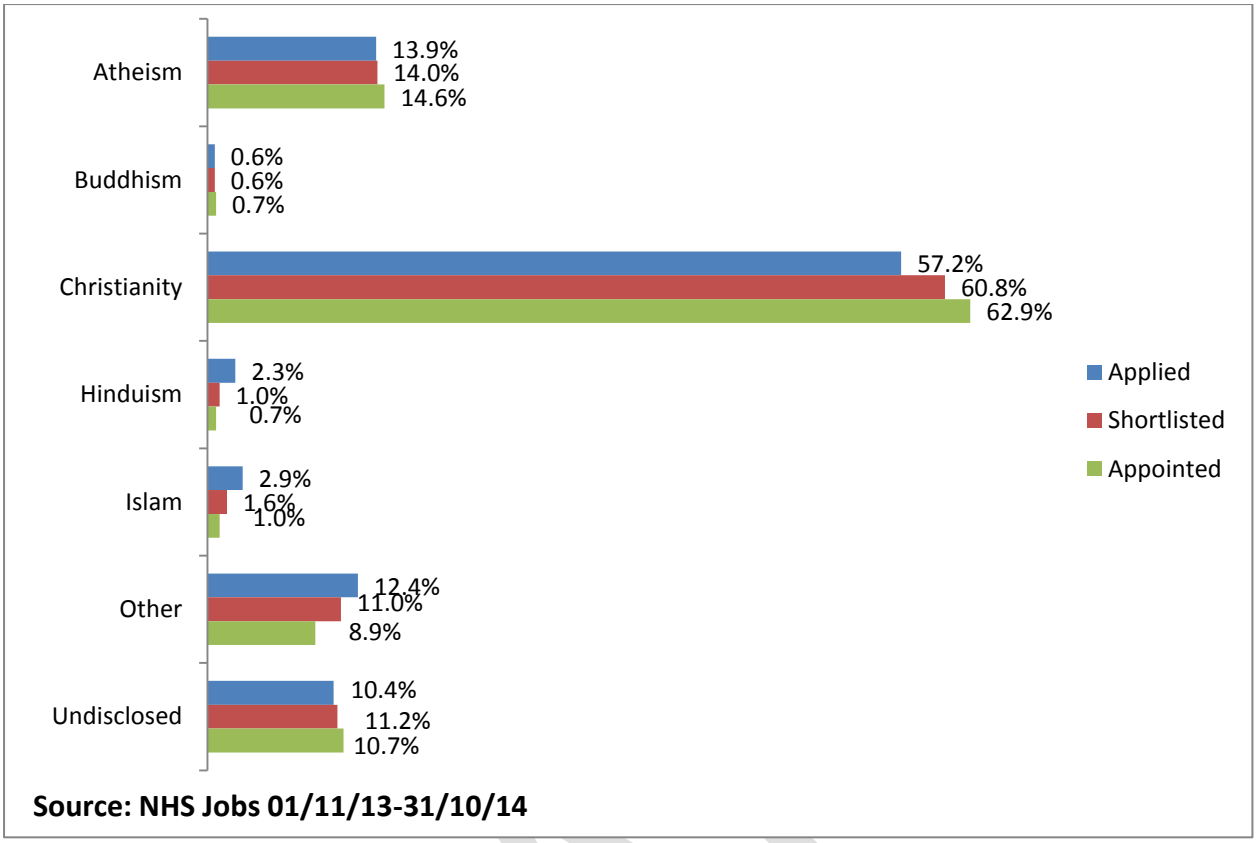

Figure 15: Recruitment by Religion

Our recruitment figures for this period also show that people are more likely to be shortlisted and appointed to jobs if they are female, echoing last year's figures:

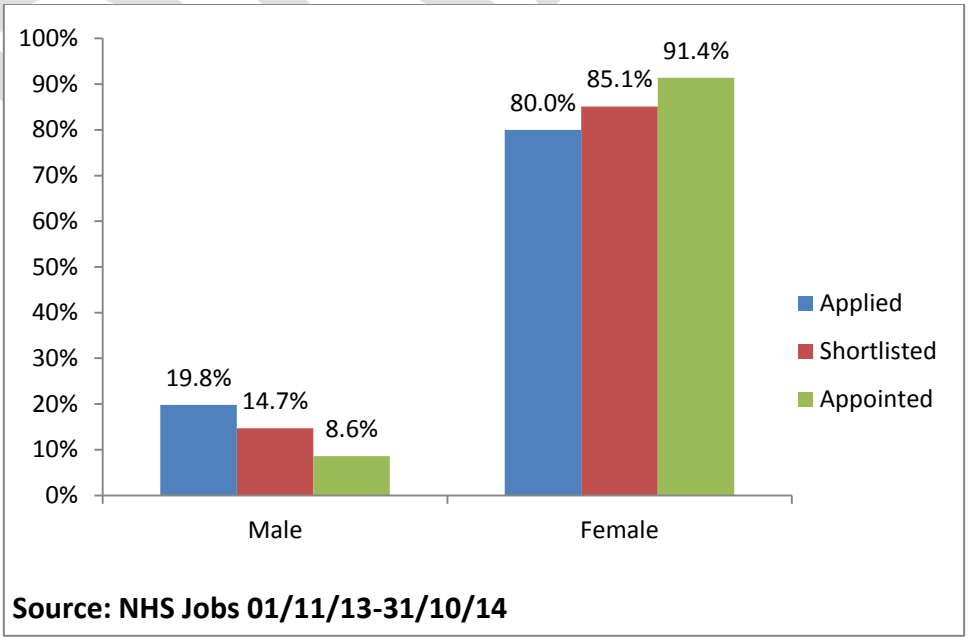

Figure 16: Recruitment by Sex

Recruitment data for November 2013 to October 2014 shows some differences based on disability and sexual orientation. However, the figures are not large enough for us to determine their significance. In comparison, in our last report (published January 2013), we found no notable differences on these characteristics. We have included this year's data on disability and sexual orientation in Appendix E.

The recruitment data on age, race, religion and sex echoes findings we published last year. It is important for us to further investigate the underlying reasons for these trends, particularly as they reinforce the demographic make-up of our existing workforce.

These trends are also reinforced by data we hold on leavers.

Between 1st September 2013 and 31st August 2014, 556 people left the employment of Gloucestershire Care Services. The reasons for leaving – and proportions in each of these categories – are as follows:

Reason	**Number**	%
Voluntary Resignation	344	61.9%
Retirement	96	17.3%
Bank Staff not fulfilled minimum work requirement	80	14.4%
End of Fixed Term Contract	24	4.3%
Dismissal - Capability	5	0.9%
Redundancy - Compulsory	5	0.9%
Death in Service	2	0.4%
Grand Total	**556**	100.0%

Figure 17: Reasons for leaving GCS NHST

We have analysed the leavers by age, race and sex. By age, the highest proportion of leavers – making up a fifth of all leavers – was in the 20-39 age group, though this is one of the smaller age groups in the Trust as a whole. This is in contrast to last year's leavers figures, where a quarter of leavers were aged 30-39. This year, our retention of this age group appears better. We would expect a higher number of leavers amongst the older age bands, and this is consistent with last year's data.

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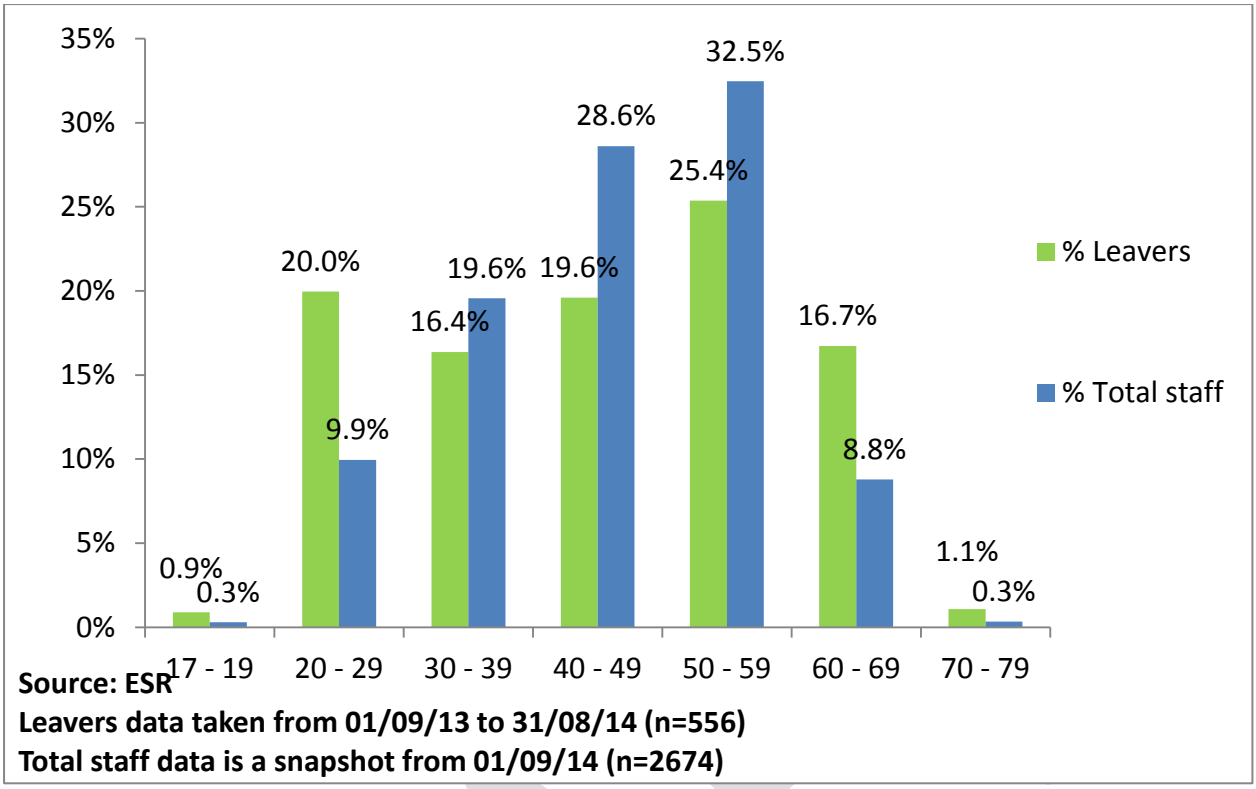

Figure 18: Age groups of leavers compared to total staff

We also had a higher proportion of men leaving the organisation than there are in the organisation as a whole, as shown in the chart below. This echoes the data we published last year.

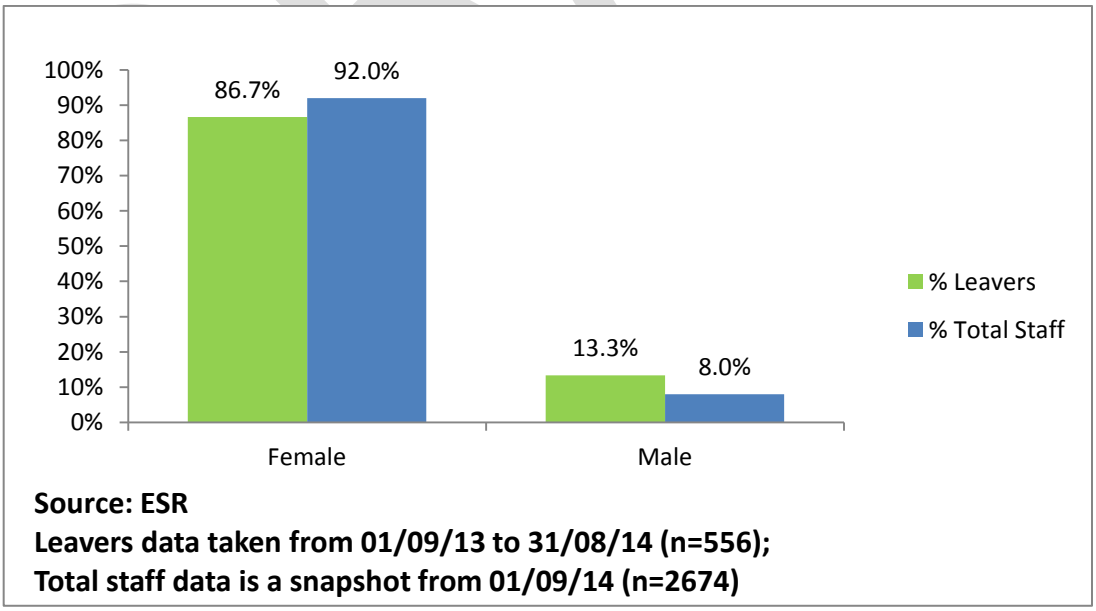

Figure 19: Sex of leavers compared to total staff

Analysis of leavers by race shows that we had a higher proportion of leavers from BME backgrounds than we have in the organisation as a whole. However, the difference appears to be less than it was between April and September 2013. The numbers are too small for us to draw firm conclusions, but we hope that this is indicative of improved retention of BME staff.

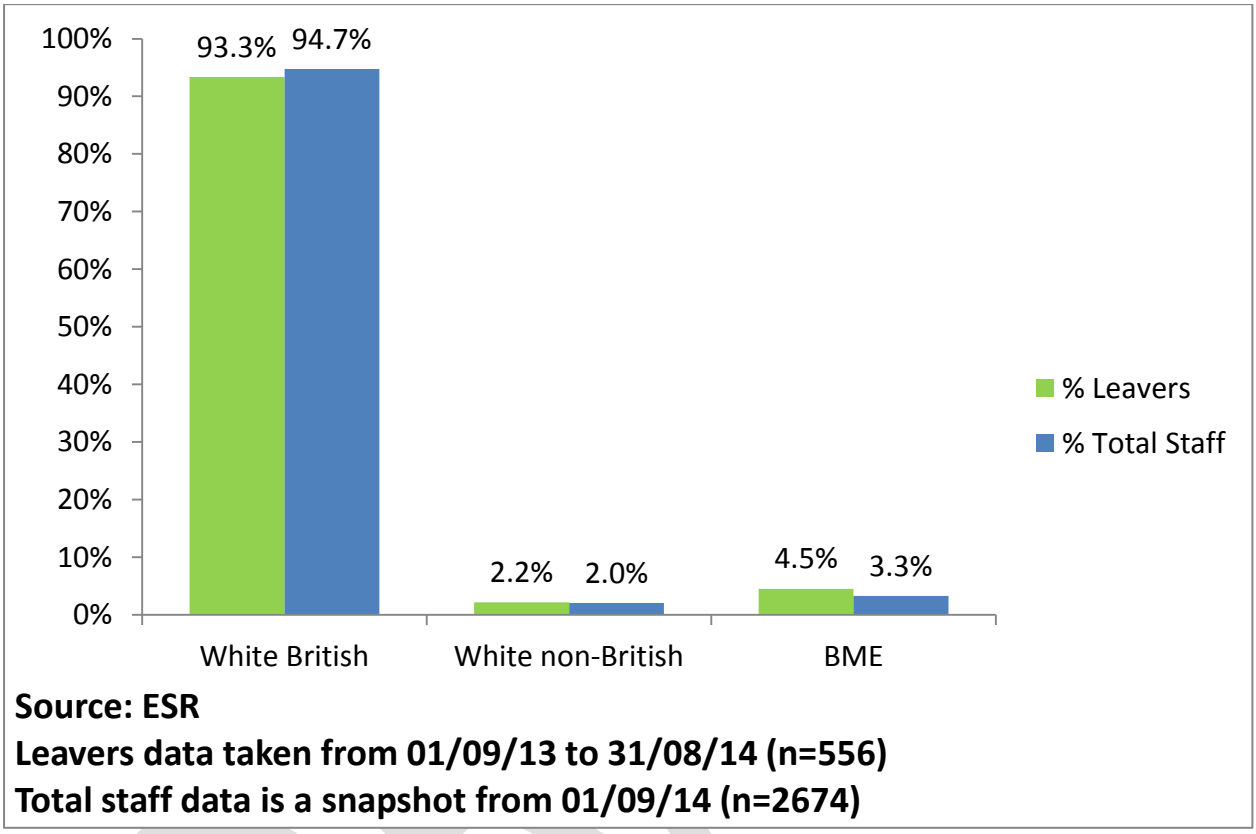

Figure 20: Ethnic groups of leavers compared to total staff

6.4.3 Equality in training and development

2443 (91%) of our existing staff attended at least one training course in the year up to September 2014[38]. This is a 33.8% increase on the figures we reported last year (for April-September 2013).

We have analysed access to staff training by age, race and sex (note: the levels of non-disclosure on disabilities, religion/ belief and sexual orientation mean that figures are too low to allow meaningful analysis of training data by these characteristics). Based on the training records we hold centrally, there are no notable discrepancies in access to training on the basis of age, race or sex. Detailed figures are provided at Appendix F. However, results from the

[38] It is important to note that a member of staff may well have attended more than one course, but that this data only shows one 'Training' episode per member of staff.

2013 staff survey do show some variation between different groups of staff with regards to training, education and personal development:

In the last 12 months…	Community Trusts	GCS	Full-time	Part-time	Maintenance/ Ancillary	Allied health professionals	Healthcare assistants & support staff	Nursing and health visiting
Received job-relevant training or development	82%	81%	84%	77%	47%	84%	60%	84%
Had an appraisal	87%	82%	81%	84%	64%	91%	59%	80%
Had a well-structured appraisal	38%	33%	34%	32%	18%	33%	15%	35%

Table 5: Staff survey responses by staff group (2013)

It should be noted that we cannot say whether the differences are statistically significant, as the numbers are too small. However, there are some indications that:

- Maintenance/ Ancillary staff and Healthcare Assistants/ Support Staff appear less satisfied with their training and development than staff as a whole. It should be noted that these staff tend to be in lower paid jobs;
- Colleagues are less likely to receive job-relevant training and development if they are part-time;
- Colleagues are more likely to have an appraisal if they work within the Allied Health professionals, though they are no more likely to feel it is well-structured.

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There are also some differences on the basis of age, sex and disability[39]:

In the last 12 months, I received…	Community Trusts	GCS	Men	Women	Disabled	Non-disabled	Age 18-30	Age 31-40	Age 41-50	Age 51+
Job-relevant training/ development	82%	81%	77%	82%	75%	82%	90%	87%	80%	77%
An appraisal	87%	82%	83%	83%	73%	86%	78%	83%	81%	85%
A well-structured appraisal	38%	33%	38%	33%	27%	35%	42%	32%	32%	33%

Table 6: Staff survey responses by demographic group (Nov 2013)

The indications here are that:

- Men seem slightly less likely to have received job-relevant training, but are more likely to feel they have had a well-structured appraisal;
- Colleagues who identify as disabled are less likely to have had job-relevant training or an appraisal, and are less likely to feel their appraisal was well structured;
- Access to job-relevant training appears to decline with age;
- Over 51s say are more likely to have an appraisal than staff as a whole, and colleagues aged 18-30 are less likely to have an appraisal. However, the younger staff are more likely to feel their appraisal was well-structured.

6.5 Opportunity to contribute: staff engagement

We have a range of different approaches to involve our colleagues in the direction and activities of the Trust:

- Meet the Chair and Chief Executive Sessions – presentations with the chair and chief executive
- Team Brief – a regular internal bulletin which goes to all colleagues

[39] Please note: the number of responses from BME colleagues is too low to enable us to undertaken analysis on the basis of race.

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- Staff Forums – nine forums currently exist, covering each locality area as well as children and countywide services, where topics are identified and raised by colleagues.
- Staff Council – Members of each of the staff forums are elected by their colleagues to sit on the Trust's staff council. The staff council is chaired by a Non-Executive Director thereby ensuring strong links to the Board.
- Listening into Action – Listening into Action is a new way of working which empowers staff within the NHS to achieve better outcomes for patients, colleagues and stakeholders. Listening into Action is a grass roots movement that shifts how the NHS should lead and operate.
- Staff survey – We run an annual staff survey, which enables colleagues to express their views anonymously. We are able to analyse anonymous views by a range of characteristics to compare the experiences of different groups of staff.
- The Joint Negotiating & Consultative Forum that is held at least bi-monthly where terms and conditions of employment are negotiated and discussed. The following trade unions are represented at this forum: Unison, Unite, Chartered Society of Physiotherapy, Royal College of Nursing, BDA, SCP, and BMA.

What's new?

We are currently reviewing our model for staff engagement, reassessing the channels that are currently used, and looking at possible alternatives and improvements.

A working group has been set up to review our staff engagement model. The group is working jointly with human resources to ensure that all colleagues across the Trust have the opportunity to contribute to this work.

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7. Looking back, looking forward

The Trust has a dedicated Equality & Diversity function to drive this agenda forward. Over 2014 we focused on establishing an equality and human rights approach in the founding frameworks of the Trust. Our achievements include:

1. Developing **equality objectives** in collaboration with our staff, service users and members of our communities. These was based on the evidence contained in the January 2014 'Advancing Equality' annual report.
2. Developing an **equalities governance framework** to structure future work and monitor progress against our equality objectives.
3. Setting up a short-life **Equalities Steering Group** to embed a focus throughout the Trust on addressing inequalities and meeting the needs of different people, and ensuring that there are systems and processes in place to make this happen.
4. Introducing more stringent requirements for **equality analysis** of our activities, and greater scrutiny in decision-making, including:
   a. Creating a combined quality and equality impact assessment process and embedding this in our service change process;
   b. Ensuring decision makers are confident in their ability to scrutinise decisions from an equalities perspective, for example by running a session with the Trust Board on scrutinising decisions for equality implications.
5. Publishing an **Equality & Human Rights Policy** to ensure staff and service users know what they can expect – and what is expected of them – with regards to equality and human rights. You can find our policy alongside this report on our website;
6. Developing and running **Equality & Human Rights training** sessions at induction and with individual teams, including starting to develop a new and engaging training programme as part of the Listening into Action programme (the 'Understanding You' team project).

Appendix A describes our equality objectives for 2014-16 and the progress we have made in achieving them.

Over 2015, we will continue our work to entrench an equality and human rights approach into our functions and decision-making. In particular, we will be rolling out and embedding our new combined approach to assessing the impact of our plans and activities on quality and equality. We will be training staff to use it to ensure services are developed in a way that ensures high

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quality for all who will use them, paying particular attention to people who experience inequalities, are vulnerable and have extra needs.

There will be several developments nationally and locally that will have an effect on our work in this area in the coming year:

1. The NHS **Equality Delivery System** (EDS2)[40] is likely be become a mandatory requirement for all NHS Trusts through the NHS Standard Contract from April 2015. The Trust Development Authority has specified that all NHS Trusts on the Foundation Trust 'pipeline' must implement EDS2. The Trust is well-placed to adopt it EDS2, and in 2015 we will work with colleagues and community representatives to establish how to implement EDS2 in a way that is meaningful and adds value for colleagues, service users, and our communities.
2. NHS England is also likely to introduce a new **National Workforce Race Equality Standard** as part of the Standard Contract. The Standard aims to tackle the lack of black & minority ethnic (BME) representation at senior levels in the NHS, and to galvanise cultural and organisational change. It will be underpinned by commissioning and regulatory action, and aims to address national inequalities BME staff face in the NHS, including adverse outcomes throughout recruitment and promotion, access to non-mandatory training, over-representation in disciplinary procedures, bullying and harassment.
3. Our **Translation & Interpreting Services contract** is up for renewal in 2015. This will involve reviewing current provision, and assessing local need (based on service user and staff feedback).
4. We will be moving towards **annual updates for Equality & Diversity training**. Currently colleagues are required to complete updates every three years. Once the new training programme is launched, all colleagues will be obliged to complete annual updates.

Alongside these pieces of work, we will be driving forward work to meet our equality objectives. Towards the end of 2015 we will begin the process of identifying new priorities to reduce health inequalities, provide high quality care to our most vulnerable communities and meet extra needs.

[40] This is a framework of 18 outcomes for service users and staff against which Trusts work with their local communities to assess their performance for people with 'protected characteristics'. Find more about EDS2 here: www.england.nhs.uk/ourwork/gov/equality-hub/eds/

8. Glossary of terms

BME	Black/ Minority Ethnic. Refer to the note about terminology on p. for further information on this.
'Disadvantaged groups'	Sometimes called 'marginalised', 'hard-to-reach' or 'seldom-heard' groups, these are people who experience inequalities in health, healthcare and employment, but who are not specifically protected by the Equality Act. They can include homeless people, sex workers, people who misuse substances, people with low socio-economic status, and people living in rural isolation.
ESR	Electronic Staff Record. An NHS system for capturing and analysing information about our colleagues.
GCS or GCSNHST	Gloucestershire Care Services NHS Trust
'Local interests' or 'Local interest group'	Patients, the public, voluntary sector organisations, members of the community, staff and staff-side organisations who have an interest in what we do.
'n='	The base/ total number on which we have calculated percentages
NHS	National Health Service
NHS Gloucestershire	The Primary Care Trust for Gloucestershire. NHS Gloucestershire has both commissioning functions and care providing functions (under Gloucestershire Care Services).
'Protected characteristics'	The nine characteristics protected under the Equality Act 2010: age, disability, gender reassignment, pregnancy/ maternity, marriage/ civil partnership, religion/ belief, race, sex, and sexual orientation

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Advancing Equality, Embracing Diversity:

Gloucestershire Care Services NHS Trust's Equality Annual Report

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Appendix A: Progress against Equality Objectives

Ref.	Equality Objective	Progress update
Aim 1: Address the health and care of people with extra or different needs by providing targeted, personalised support and information		
1a	Work proactively with GP Practices to administer a case management framework to identify individuals who are most at risk of losing their independence, e.g. being admitted to hospital, or residential/ nursing care	We have been working with commissioners and GP Practices to develop a model for identifying people who are at risk of losing their independence. This will be a proactive case management approach. The case management model has been agreed and we have a list of individuals who will benefit from this approach. We have trained Integrated Community Team (ICT) staff in approaches to promote resilience and independence. We are piloting the approach with two ICTs. By early 2015 we will evaluate the pilot and roll it out across the county.
1b	Reduce the number and severity of pressure ulcers amongst service users	Our approach to achieving this objective is to improve the quality of reporting of pressure ulcers, train colleagues in the recognition, recording and care of pressure ulcers. We are also conducting detailed investigations of pressure ulcers to establish whether they were avoidable, and what could have been done to avoid them if so. In these cases, our Tissue Viability Team will target expertise and support to improve skin inspections. So far we have held a pressure ulcer awareness and management study day in conjunction with industry. 80 nurses from around the county attended. We have conducted audits on pressure ulcers in our care settings to enable the Tissue Viability

Ref.	Equality Objective	Progress update
		Team to take a targeted approach. In Q2 we achieved a 35% reduction in pressure ulcers compared to Q1.
1c	Improve patients' experiences of care in the last days of life	Our plan for achieving this objective is to ensure people are informed of their diagnosis, and their choice relating to their preferred place of death is recorded and implemented where possible. We commissioned an external review of practices across our services which took place in Summer 2014. To address the findings of the review, we have set up an End of Life Best Practice Group. We are currently conducting an audit of patients in our Community Hospitals needing palliative/ end of life care to establish the extent to which this is happening. We are also running monthly training and development sessions for colleagues to equip them with the skills and confidence to begin difficult conversations and provide appropriate care to people in the last days of their life.
1d	Respond effectively to gaps in the level of care provided to people with learning disabilities (LD) within Gloucestershire	We have established a Learning Disabilities Steering Group, and recruited service users with learning disabilities as members. We have a detailed action plan, and are progressing well against this. Some of our recent actions include: • Identifying potential to flag learning disabilities on the patient record system SystmOne. • Developing and distributing a 'Reasonable Adjustments' tool to teams via our Learning Disabilities Champions, and drafted an audit to gauge the success of implementation.

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Ref.	Equality Objective	Progress update
		• Selecting an initial 10 leaflets from our services for translation into EasyRead. • Developing a bid for funding for a Learning Disabilities Liaison Nurse for 2015. • Setting up more face-to-face training dates for Learning Disabilities champions.
1e	Develop targeted communications materials for communities with distinct communication and/or health needs (about our services and/or their health)	We are involved in a range of outreach projects, taking healthcare and health information to groups with distinct needs. For example, attending Stow Fair, workshops with homeless people, the older Chinese community, the Hindu Elders, and more. We have begun discussions with some of our service leads on how we can take a targeted approach to specific communities, e.g. Stop Smoking Services to the Eastern European communities. We are planning an exhibition about our services specifically designed for a BME audience. This will take place in Spring 2015.
1f	Review settings, processes and communications materials to assess suitability for people with sensory loss. Focus for 2014-15 will be deaf people and people with hearing loss	We have been working with the Gloucestershire Deaf Association to develop training for all staff on how to best care for and work with people with hearing loss. We have developed an outline for the training and in 2015 will be working with particular staff groups who can improve the experiences of people with hearing loss (e.g. reception and administrative staff). We are also taking advice on addressing other areas of practice.

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Ref.	Equality Objective	Progress update
Aim 2: Ensure decisions are based on sound evidence of their potential impact on people affected, with particular regard for people who are vulnerable or who have characteristics protected under the Equality Act 2010		
2a	Report biannually on the profile of users of all services provided by GCS NHST by age, gender, ethnicity and disability	This report includes data on the profile of service users by age, ethnicity and gender. In spring 2015, we will be undertaking a review of our data and launching initiatives to improve the quality and completeness of patient and staff data.
2b	Have a single equality and quality impact assessment process for policies, plans and strategies, with robust arrangements for scrutiny and accountability	A draft combined approach to assessing the impact of our activities on quality and equality was presented at the Trust's Board meeting on 25th November. It is due to be finalised in December 2014. It has been piloted with several teams responsible for service transformation projects, and has been well received. Board and Committee papers now include an equality statement. The Board has received training on equality scrutiny.
Aim 3: Enable people to influence decisions which affect them, with particular regard for people who are vulnerable or who have characteristics protected under the Equality Act 2010		
3a	Publish a Communications & Engagement Strategy and implementation plan, which includes a systematic approach to involving external & internal stakeholders in decisions, including people with 'protected characteristics' and those in vulnerable groups	We published our Communications & Engagement Strategy in March 2014. The Strategy includes a commitment to improve its dialogue with members of the Gloucestershire public who represent people with protected characteristics, people who have extra or different needs, and people who traditionally experience social and health inequalities. The implementation plan is going to the Communications and Engagement Committee for comment in December 2014.

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Ref.	Equality Objective	Progress update
Aim 4: Support our colleagues to provide the best service they can so we can provide the best care to our diverse communities		
4a	Publish an Organisational Development Strategy and implementation plan, which includes plans to nurture a caring and open culture amongst our workforce	The Strategy was published in December 2013 and sets out how the Trust plans to nurture a culture 'in which all Trust colleagues feel respected and valued, and which allows them to be productive, innovative and focused'. A workforce plan and an organisational development plan have been developed.
4b	Ensure staff work within a culture which is designed to routinely connect or re-connect communities & individuals to the resources and assets within their community as part of a person- and family- centred approach to care	We have worked with commissioners and community partners to design and deliver a multi-disciplinary professional development programme for staff. We are focusing on 3 localities in the county to pilot this work. So far, 40 staff have completed the programme. Each staff member attending the course will complete a monthly reflective log over October, November, and December 2014. A further 20 staff will complete the programme by March. Their reflections will shape our plan to roll the approach out to the rest of the organisation and will help us demonstrate to patients and staff the benefits of links with learning site community builders.
4c	Introduce an annual equality & diversity training programme to promote better understanding amongst colleagues of the lives and needs of people who are different from the 'mainstream'	This work is a 'Listening into Action' programme, led by a small group of staff from across the organisation and sponsored by the Director of Service Delivery. So far, we have worked closely with the Gloucestershire Deaf Association to scope out an innovative and engaging training programme on hearing loss.
4d	Introduce guidance and advice to support staff who	We have established a 'taskforce' made up of members of

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Ref.	Equality Objective	Progress update
	face violence, abuse, and harassment from patients, relatives or the public, especially where this arises from patients who have a cognitive impairment	Community Hospitals, Human Resources, Communications, and our Security Management teams to look at this issue. They are due to meet in December 2014 to agree the best approach.

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Appendix B: Profiles of Service Users by Age, Race and Sex

B.1: Total numbers of service users (April-September 2014)

Services	No. patients
Adult Community Services	
Adult Speech and Language Therapy	1549
Podiatry	12430
Adult Occupational Therapy Services	1767
Adult Physiotherapy	9306
District Nursing Service	18534
Community Hospitals & MIIUs	
Community Hospitals Admissions	1748
Minor Injury & Illnesses Units	37089
Specialist Services	
Parkinson's Nursing service	389
Diabetic Nursing service	503
Bone Health Service	890
MSK Service	1725
Stop Smoking Service	2144
Sexual Health Services*	
Contraception Service	9960
HIV Service	353
Psychosexual Service	85
Children's services	
Health Visitors	10178
Paediatric Physiotherapy	1312
Paediatric Occupational Therapy	354
Paediatric Speech and Language Therapy	1147
Number of children in Reception with height and weight recorded	6193
Number of children in Year 6 with height and weight recorded	5826

Source: GCS NHST Performance & Information Team (April-Sept 2014)

* Sexual Health Services – we are awaiting verification of these figures from the Performance team.

** Please note: in the following charts we have not reported the data where there are less than 10 service users in a particular group.

B.2 Service user profiles by age

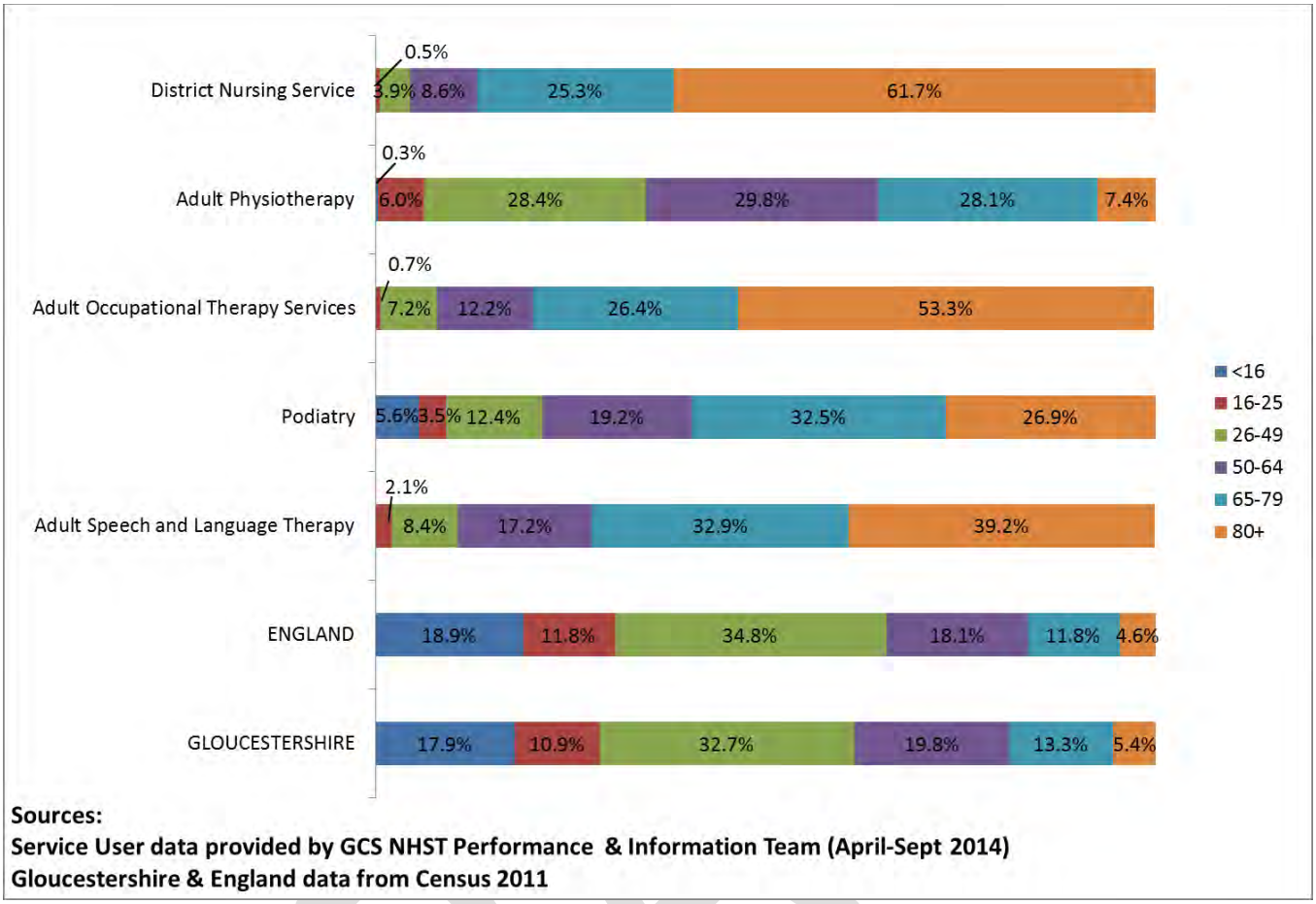

Figure 1: Adult Community Services – service user age profiles

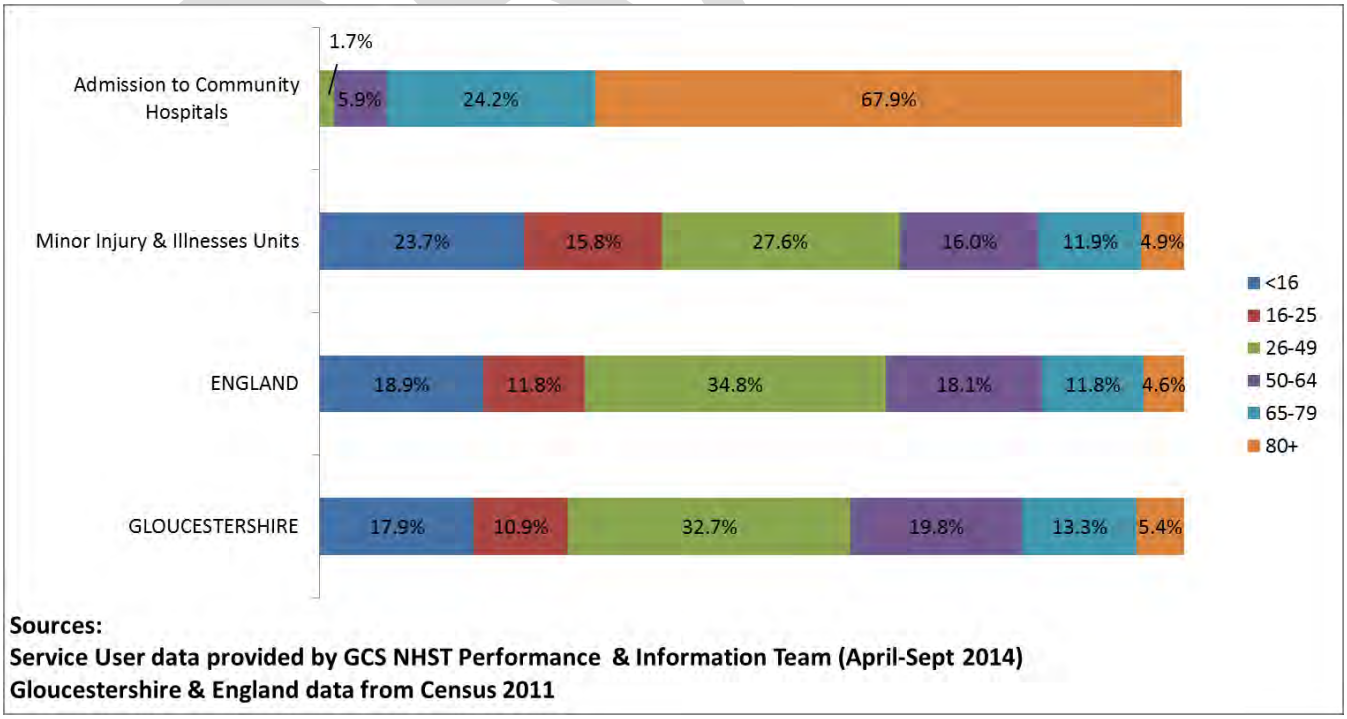

Figure 2: Community Hospitals and MIIUs - service user age profiles

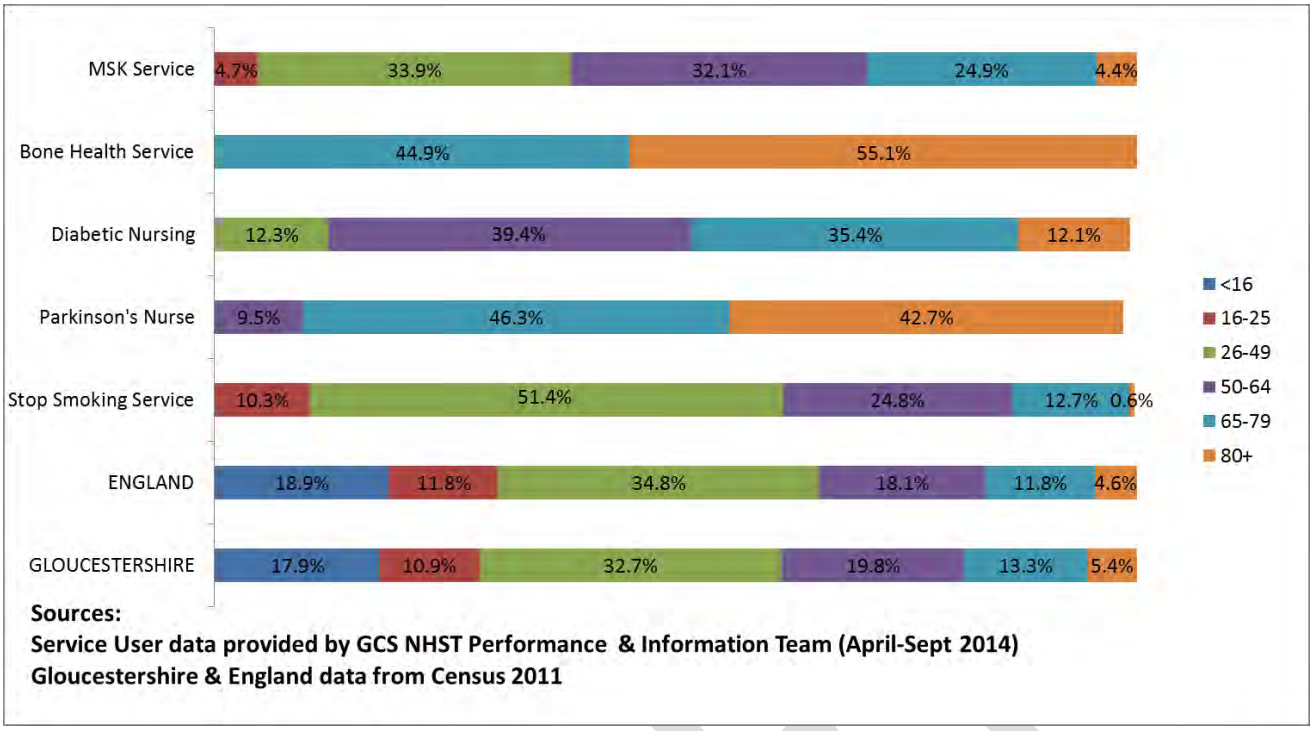

Figure 3: Specialist services - service user age profiles

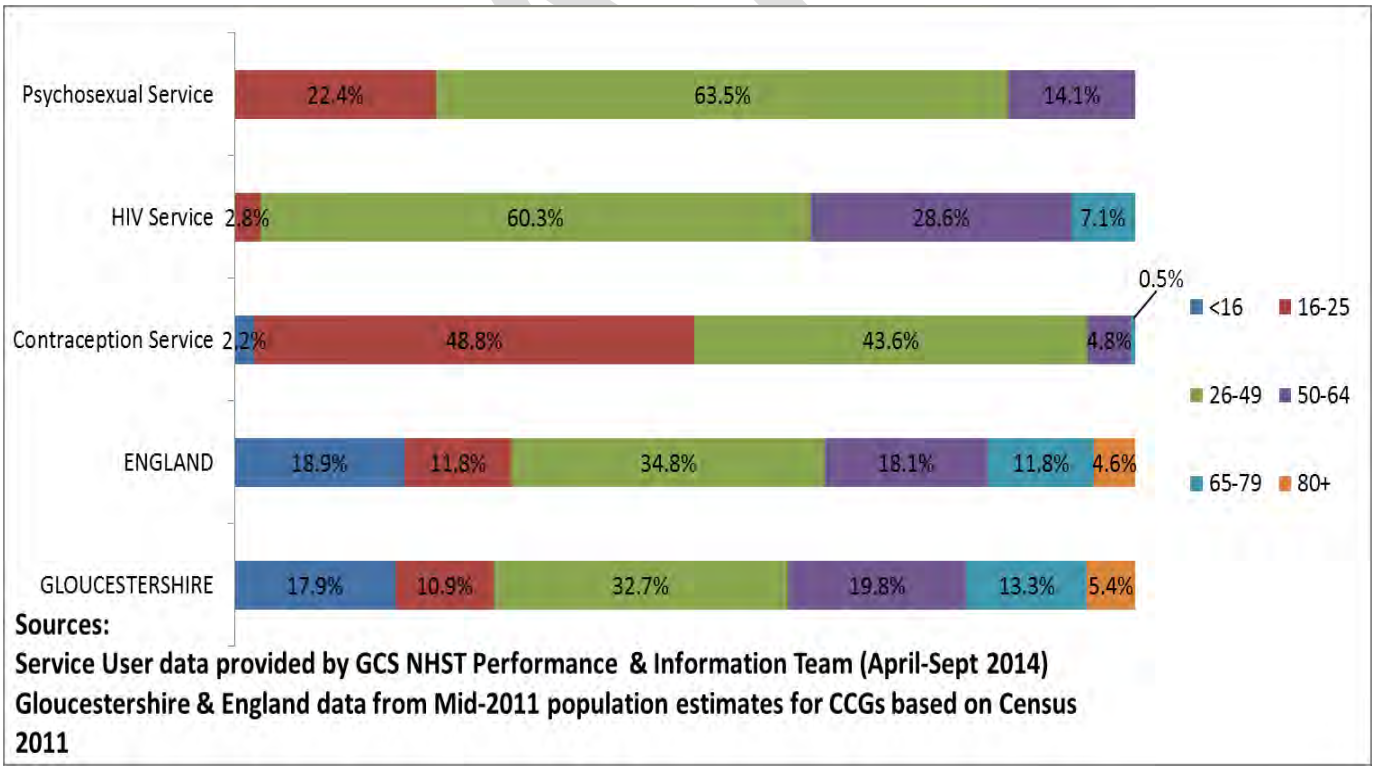

Figure 4: Sexual Health Services - service user age profiles

B.3 Service user profiles by race

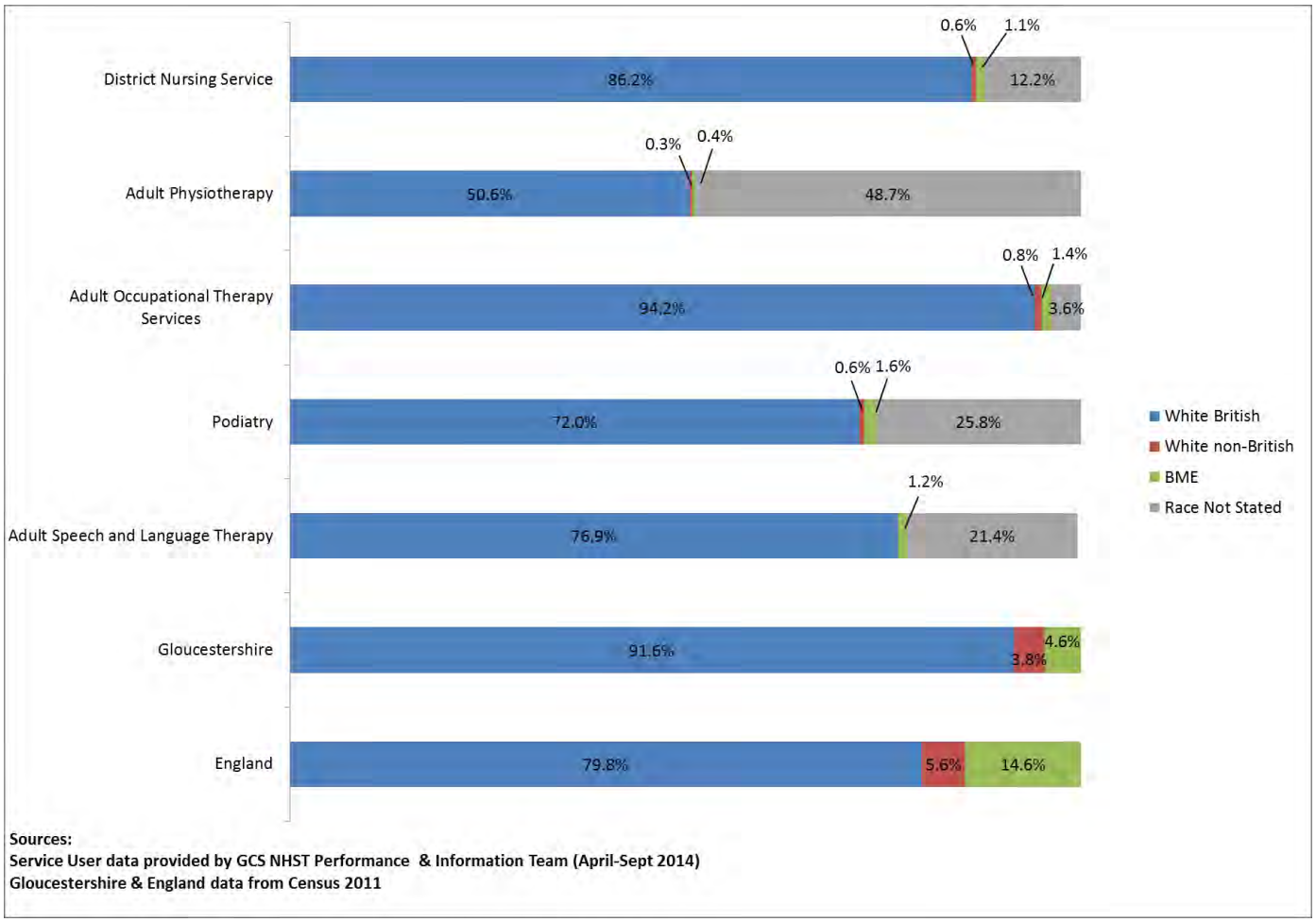

Figure 5: Adult Community Services: service user race profiles

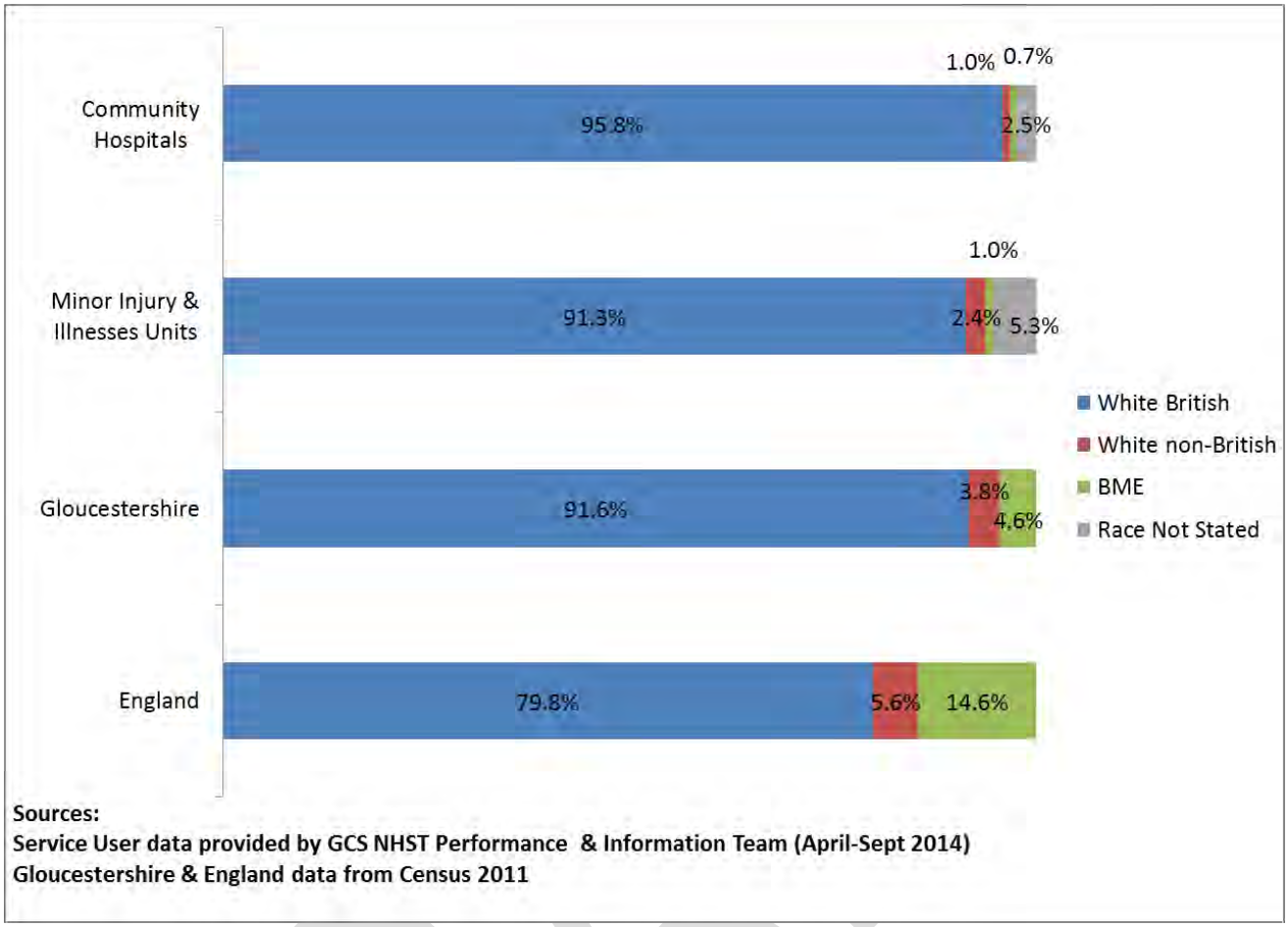

Figure 6: Community Hospitals and MIIUs - service user race profiles

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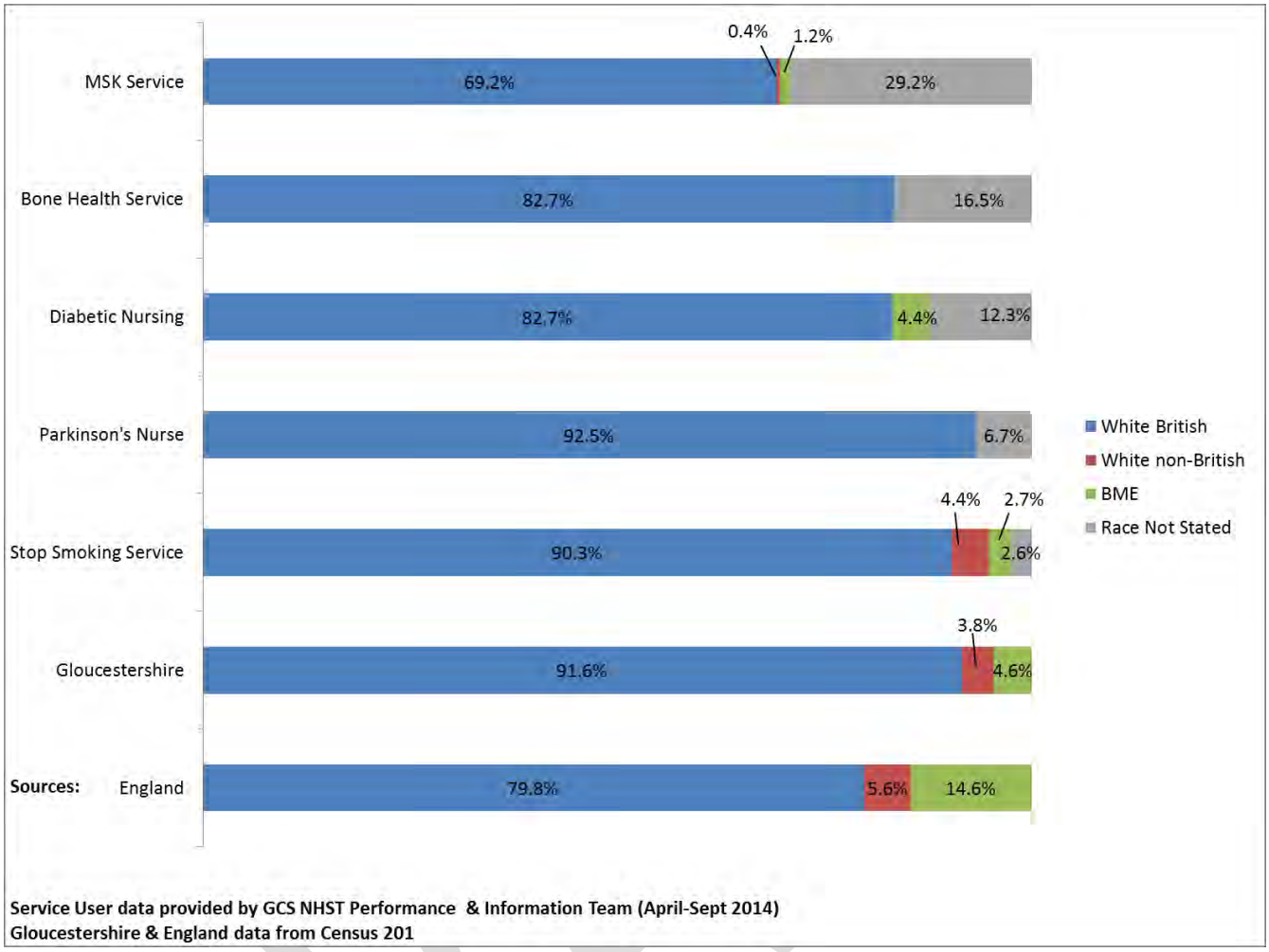

Figure 7: Specialist Services - service user race profiles

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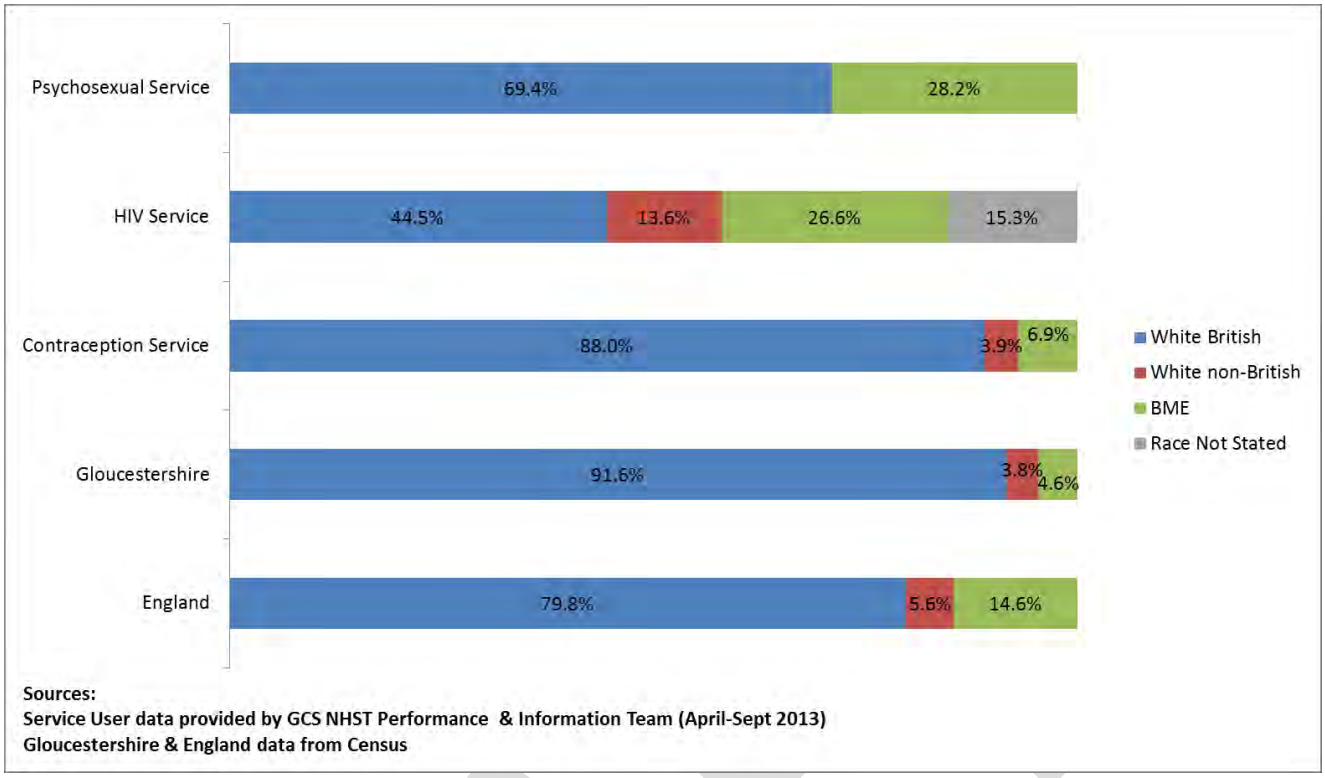

Figure 8: Sexual Health Services - service user race profiles

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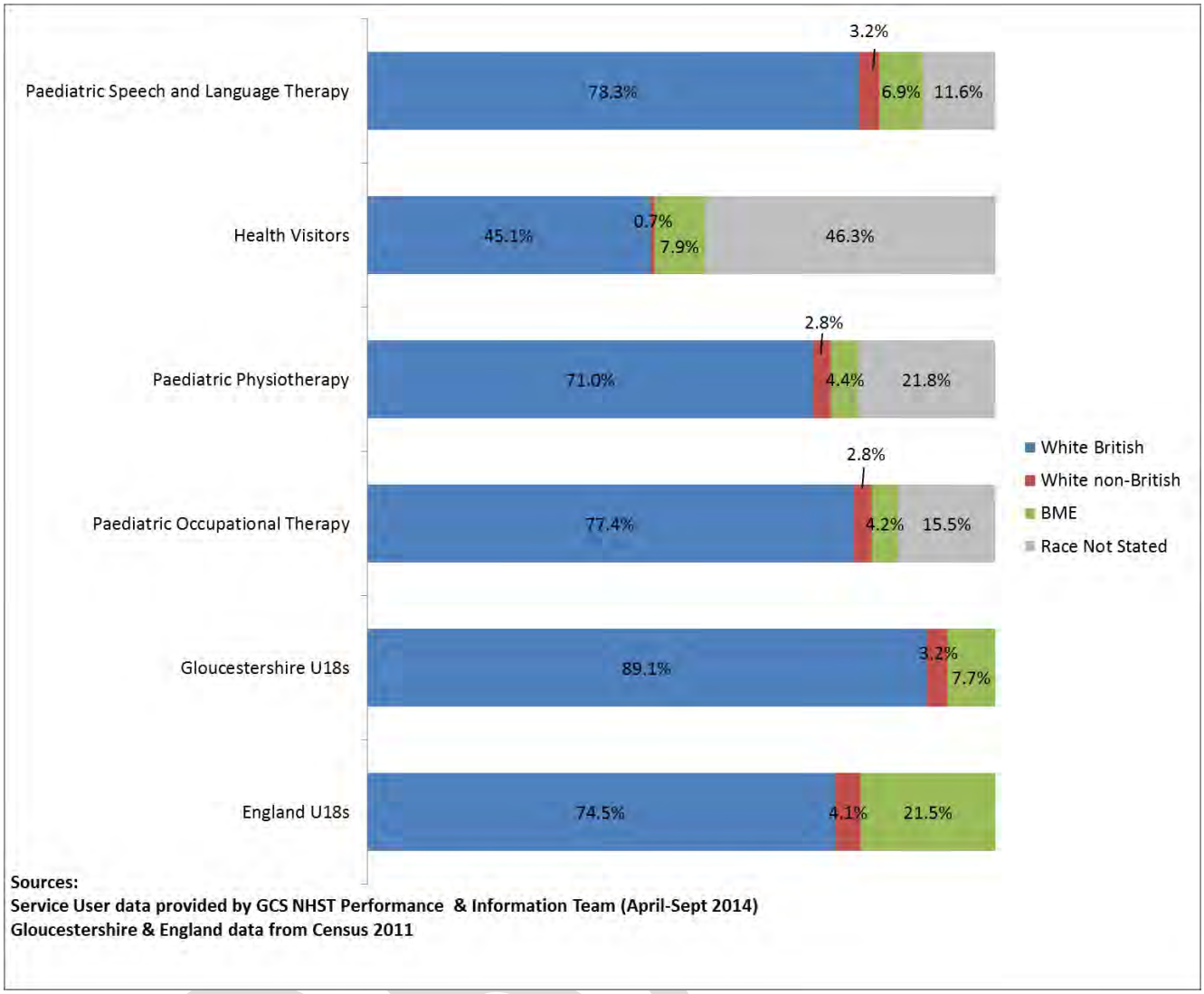

Figure 9: Children's Services - service user race profiles

B.4 Service user profiles by sex

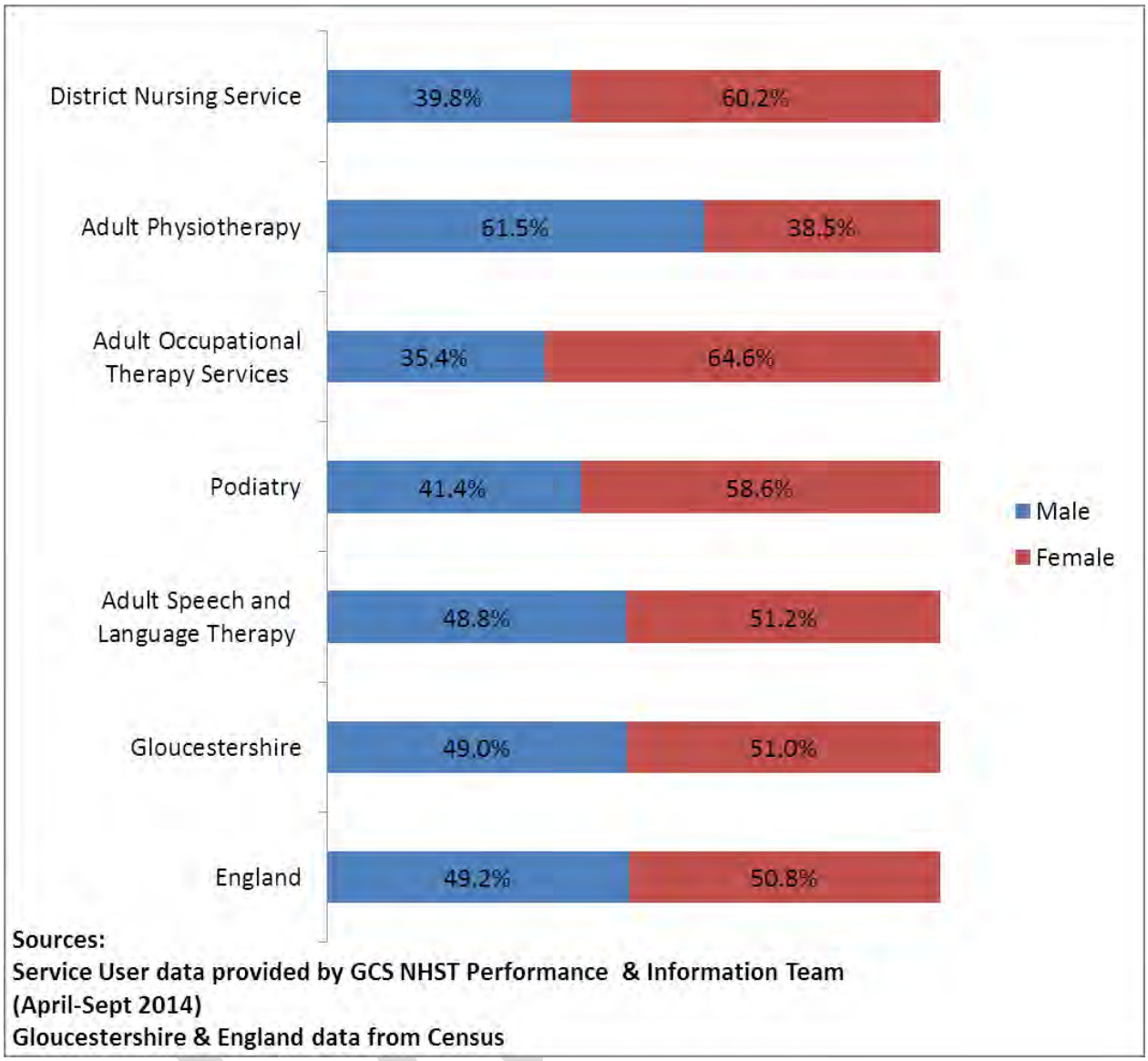

Figure 10: Adult Community Services - service users by sex

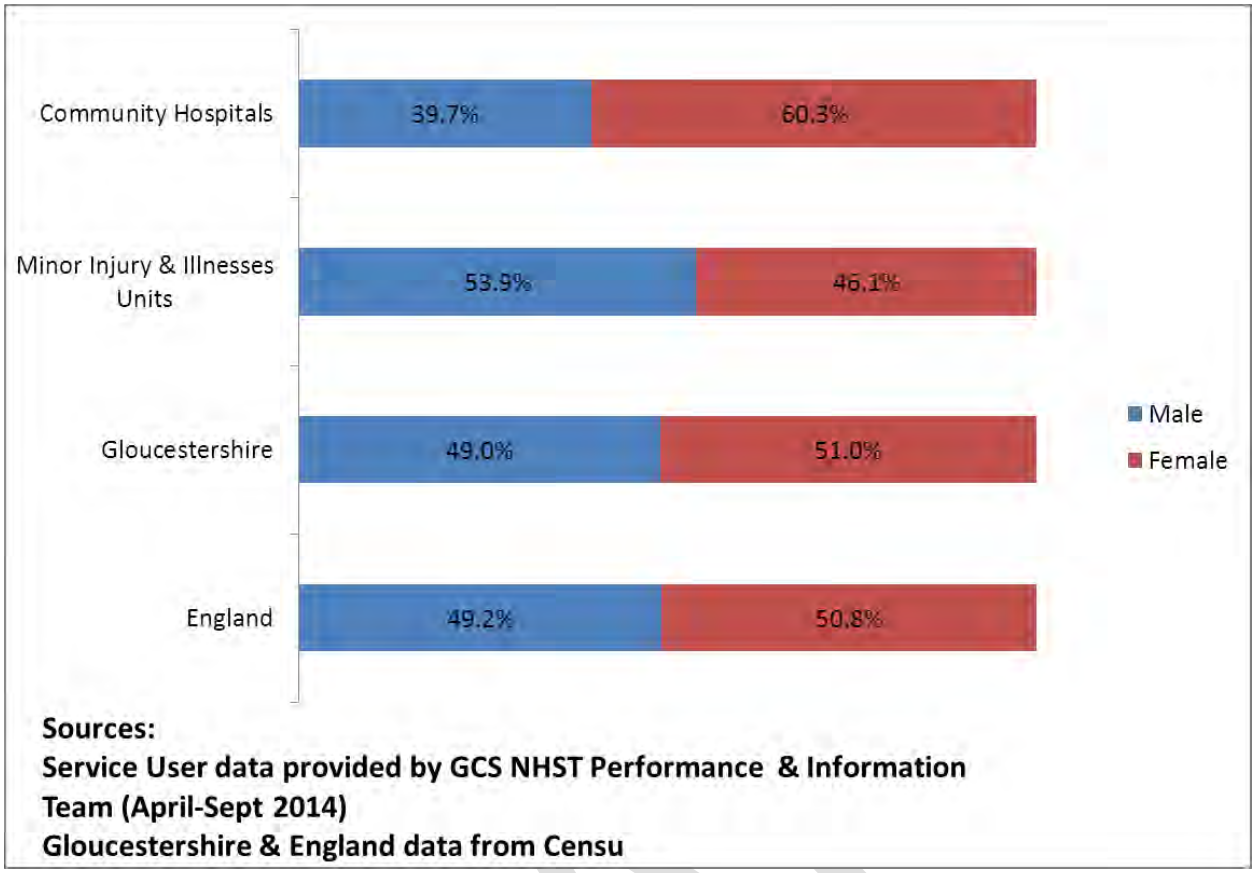

Figure 11: Community Hospitals and MIIUs - service users by sex

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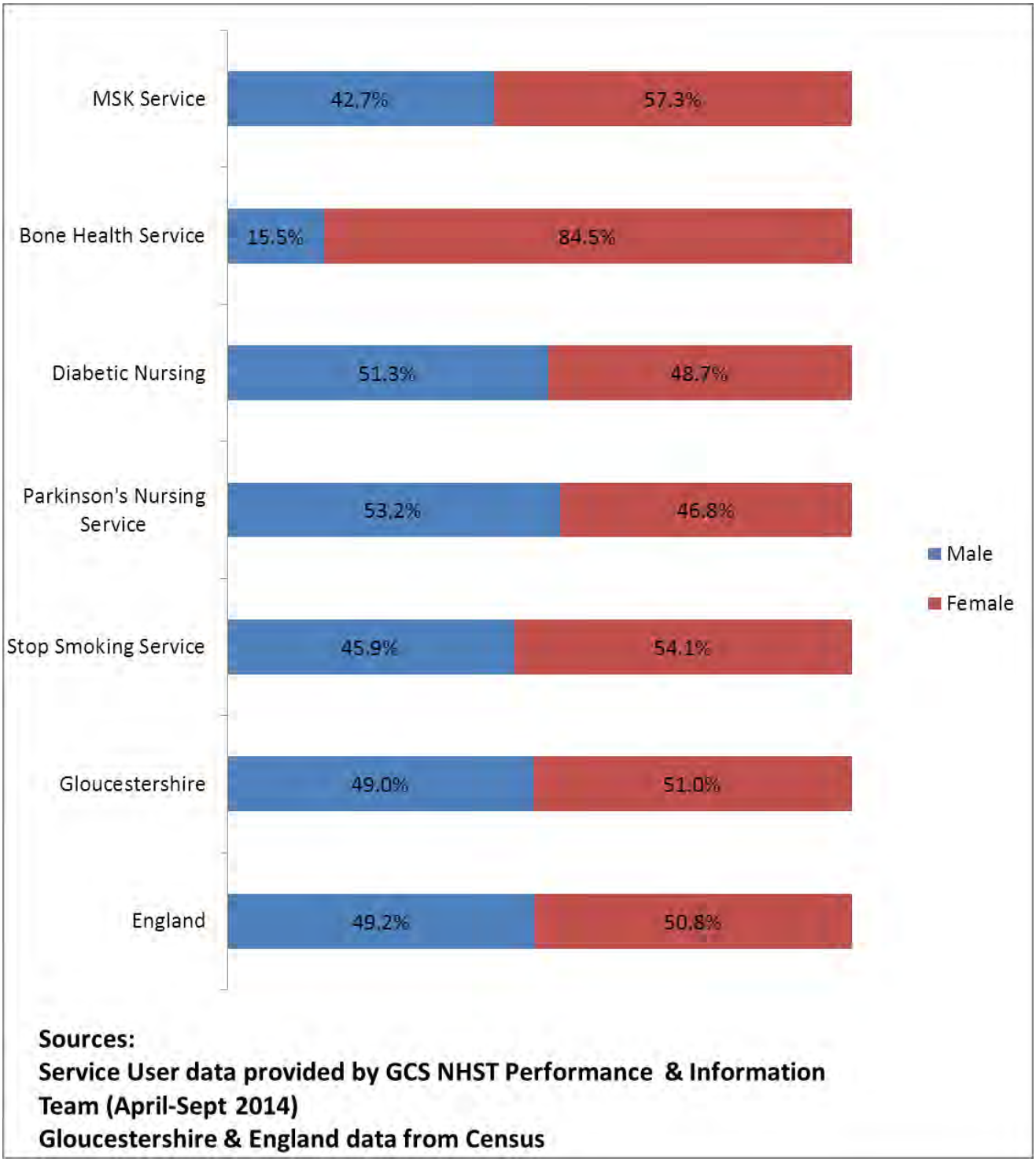

Figure 12: Specialist Services - service users by sex

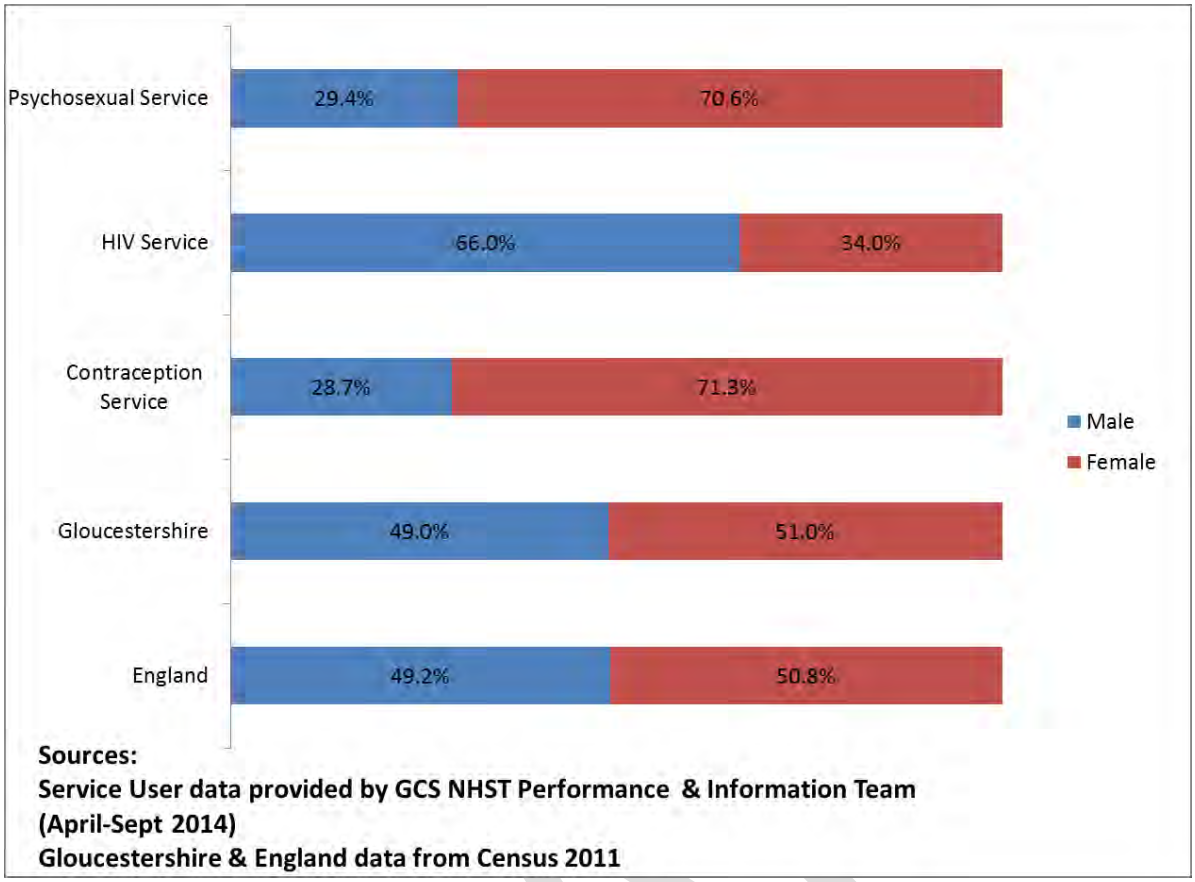

Figure 13: Sexual Health Services - service users by sex

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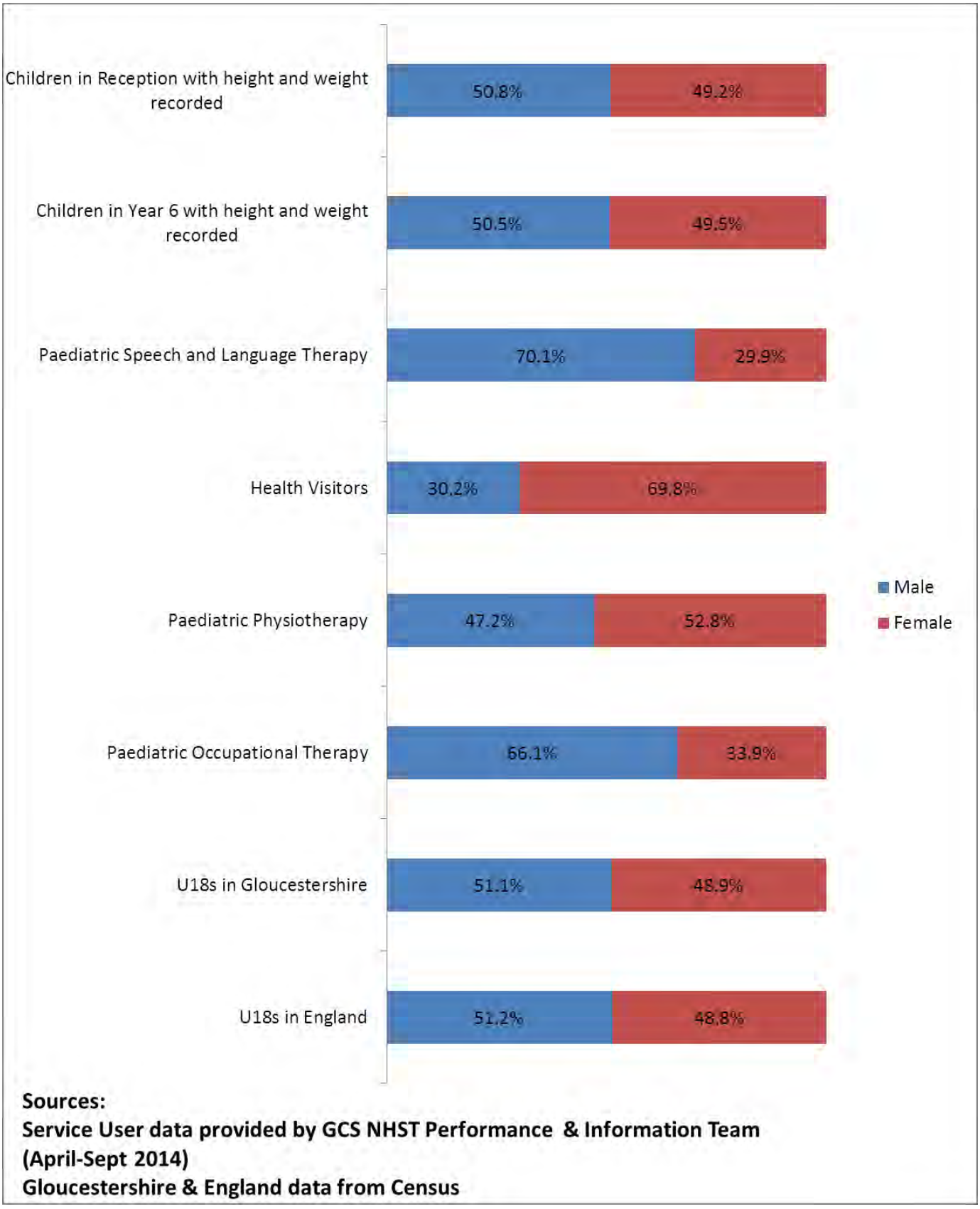

Figure 14: Children's Services - service users by sex

Appendix C: Waiting times for services

These tables show actual waiting times for services and how they compare with local and national targets.

Source: Locality performance reports Sept 2014

Service	Target	2013/14	2014/15 YTD[1]
Adult community services			
Integrated Community Teams physiotherapy service	Target % treated within 8 Weeks	95%	95%
	Actual	97%	95%
Musculo-skeletal Physiotherapy	Target average wait (weeks)	2.0	2.0
	Actual	2.2	3.1
	Target % treated within 8 Weeks	95%	95%
	Actual	97%	96%
Musculo-skeletal Clinical Assessment and Treatment (MSKCAT) Service	Target % treated within 8 Weeks	95%	95%
	Actual	98%	72%
	Target % of referrals on to secondary care	<30%	<30%
	Actual	5%	4%
	Target % wait from referral for routine patients does not exceed 4 weeks	4.0	95%
	Actual	3.2	42%
	Target % wait from referral for urgent patients does not exceed 2 weeks	2.0	95%
	Actual	1.7	60%
Podiatry	Target average wait (weeks)	2.0	2.0
	Actual	2.3	3.7
	Target % treated within 8 Weeks	95%	95%
	Actual	98%	88%
Speech and Language Therapy	Target % treated within 8 Weeks	95%	95%
	Actual	99%	97%
Occupational Therapy	Target % treated within	95%	95%

[1] YTD = Year to Date, i.e. April-Sept 2014

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Service	Target	2013/14	2014/15 YTD[1]
Adult community services			
Services	8 Weeks		
	Actual	100%	99%

Service	Target	2013/14	2014/15
Specialist services			
Parkinson's Nursing - % treated within 8 Weeks	Target	95%	95%
	Actual	100%	100%
Diabetic Nursing - % treated within 8 Weeks	Target	95%	95%
	Actual	99%	97%
Bone Health Service	Target % treated within 8 Weeks	95%	95%
	Actual	95%	87%
Combined Specialist and Non-Specialist wheelchair Service	Target average wait (weeks)	2.0	2.0
	Actual	1.0	1.0
Occasional Wheelchairs	Target % treated within 8 Weeks	95%	95%
	Actual	100%	100%

Sexual Health Services			
Service	**Target**	**2013/14**	**2014/15**
GUM	Target % offered to be seen within 48 hours	100%	100%
	Actual	100%	100%
	Target % actually seen within 48 hours	95%	95%
	Actual	99%	98%
Contraception Service	Target % treated within 8 Weeks	95%	95%
	Actual	99%	99%
HIV Service	Target % treated within 8 Weeks	95%	95%
	Actual	100%	100%
Psychosexual Service	Target % treated within 8 Weeks	95%	95%
	Actual	83%	100%

Children's Services			
Service	**Target**	**2013/14**	**2014/15**
Diagnostic test results – children's services	Target % of patients waiting less than 6 weeks from referral for a diagnostic test	>99%	>99%
	Actual	100%	100%

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	Target % of screens of well babies completed by 5 weeks in community sites	>95%	>95%
	Actual	98.8%	99.3%
Newborn hearing screening	Target % screens completed by 5 weeks (community sites)	>95%	>95%
	Actual	98.8%	99.3%
Newborn Bloodspot test	Target % of result by 17 days of age	95%	95%
	Actual	96.8%	TBC
Health Visiting	Target % of Children who have a two-year review by 32 months of age	>93.4%	>93.4%
	Actual	95.3%	96.9%

Waiting times in Minor Injuries Units

Target		**2013/14**	**2014/15**
% seen and discharged within 4 Hours	Target	95%	95%
	Actual	99.8%	99.8%
Number of breaches of 4 hour target	Actual	56	57
Number of hours spent waiting on a trolley in the MIU	Target	<12 hrs	<12 hrs
	Actual	0	0
Total time spent in MIU	Target	<4 hrs	<4 hrs
	Actual	01:49	01:59
Time to initial assessment for patients arriving by ambulance	Target	<15 m	<15 m
	Actual	00:10	00:11
Number of handovers between ambulance and MIU taking more than 30 minutes.	Target	0	0
	Actual	0	0
Time to treatment in department (median)	Target	<60 mins	<60 mins
	Actual	00:23	00:26

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Appendix D: Responses to patient surveys

Overall responses to service user survey questions

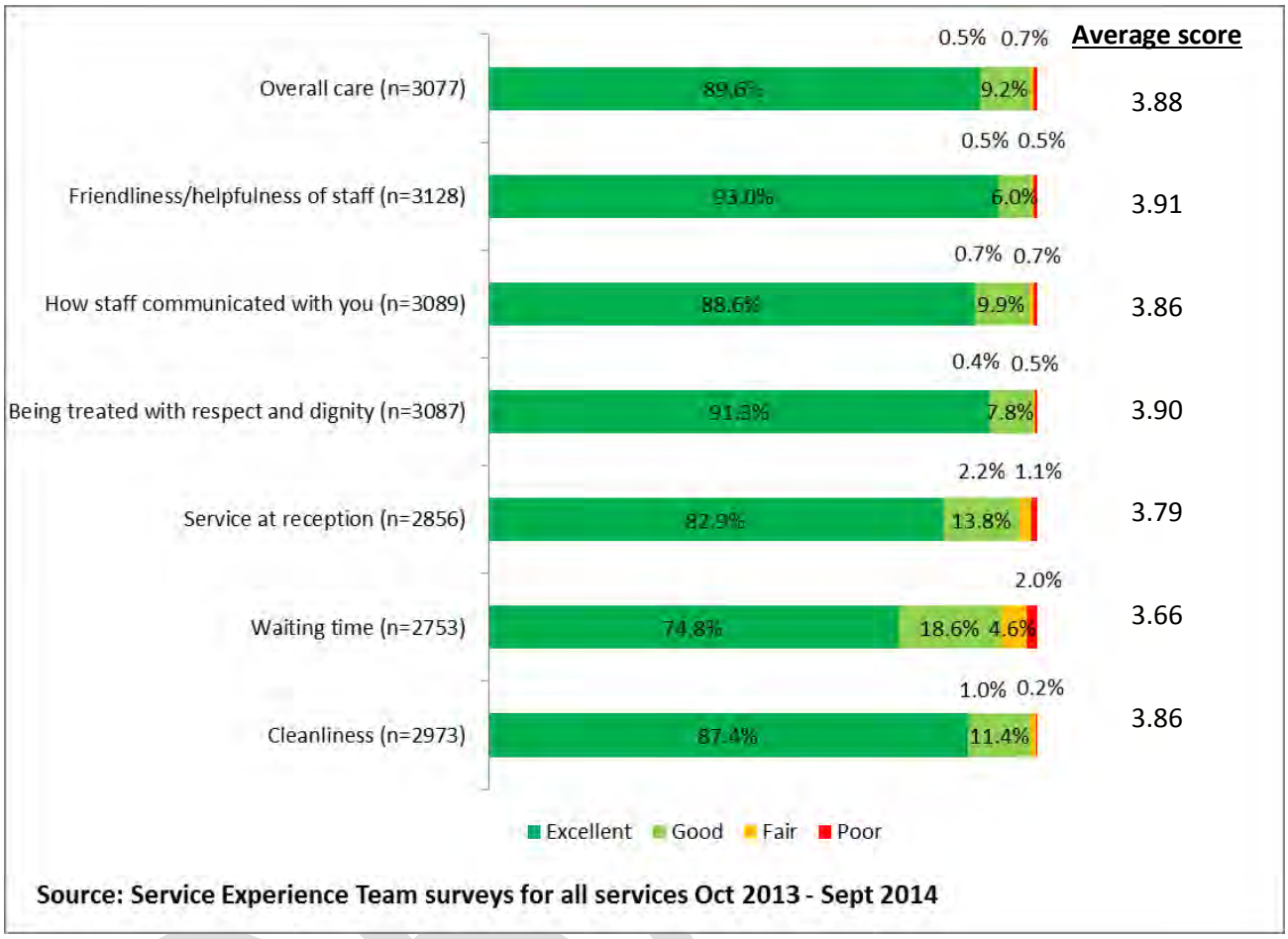

Figure 15: Experiences of service users (Source: Service Experience Team surveys for all services Oct 2013 – Sept 2014)

How likely are you to recommend this service to friends or family if they needed similar care or treatment?	Number of responses	% responses
Extremely likely	12058	83.7%
Likely	1905	13.2%
Neither Likely nor unlikely	178	1.2%
Unlikely	82	0.6%
Extremely unlikely	68	0.5%
Don't know	113	0.8%
Total	14404	100%

Figure 16: Likelihood to recommend services to family and friends if they needed similar care or treatment (Source: Service Experience Team surveys for all services Oct 2013 – Sept 2014)

Responses to service user survey questions analysed by age

	Total	16-24	25-34	35-44	45-54	55-64	65-74	75+
Excellent	91.1%	88.0%	91.6%	91.3%	93.0%	86.5%	93.9%	87.1%
Good	8.0%	9.3%	7.1%	7.6%	6.2%	6.7%	5.5%	12.3%
Fair	0.4%	0.8%	0.5%	0.8%	0.3%	0.0%	0.0%	0.4%
Poor	0.5%	1.9%	0.5%	0.2%	0.5%	0.0%	0.7%	0.2%
N/A	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%
Satisfaction score	3.90	3.83	3.89	3.90	3.92	3.93	3.93	3.86
Total number of respondents	2817	259	392	472	371	346	458	519
Age group as a % of total		9.2%	13.9%	16.8%	13.2%	12.3%	16.3%	18.4%

Figure 17: "To what extent did you feel you were treated with dignity and respect?" analysed by age (n= 2817; Source: Service Experience Team surveys for all services Oct 2013 – Sept 2014)

Likelihood to recommend	**Total**	**16-24**	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75+**
Extremely likely	86.4%	72.8%	82.5%	86.5%	90.6%	92.7%	91.2%	84.7%
Likely	12.0%	23.6%	15.7%	12.7%	8.5%	6.9%	7.9%	11.5%
Neither Likely nor unlikely	0.7%	3.0%	0.7%	0.4%	0.2%	0.2%	0.2%	1.5%
Unlikely	0.3%	0.0%	0.5%	0.0%	0.3%	0.2%	0.4%	0.9%
Extremely unlikely	0.2%	0.0%	0.5%	0.2%	0.2%	0.0%	0.0%	0.4%
Don't know	0.3%	0.5%	0.2%	0.2%	0.3%	0.0%	0.2%	1.1%
Likelihood score	4.83	4.68	4.79	4.84	4.88	4.92	4.89	4.76
Total number of respondents	3874	368	600	806	662	490	478	470
Age group as % of total		9.5%	15.5%	20.8%	17.1%	12.6%	12.3%	12.1%

Figure 18: "How likely are you to recommend this service to friends or family if they needed similar care or treatment?" analysed by age (n=3874; Source: Service Experience Team surveys for all services Oct 2013 – Sept 2014)

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Appendix E: Usage of Face-to-Face interpreting services

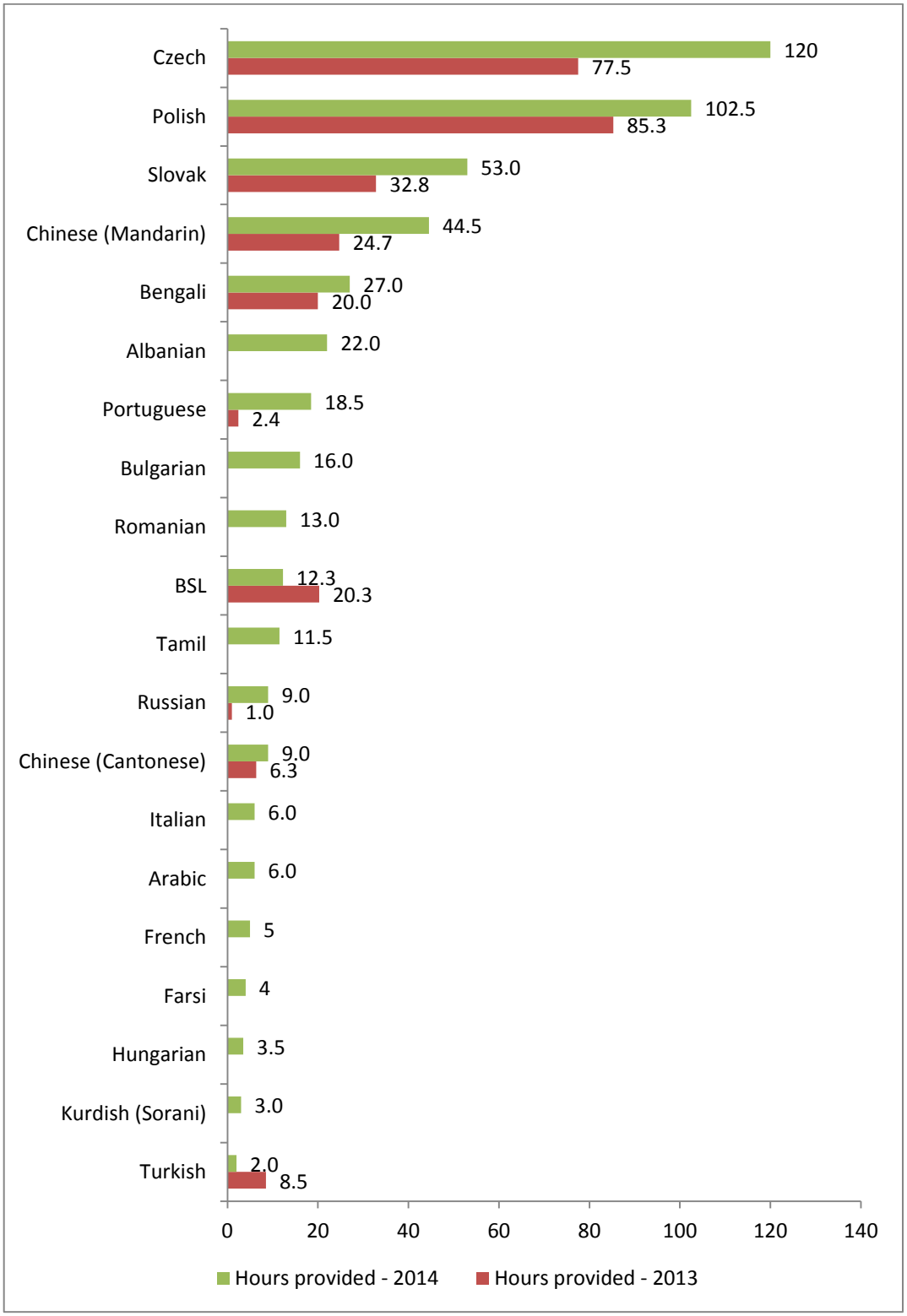

Figure 19: Face-to-face interpreting usage comparing April-Sept 2013 and April-Sept 2014 (Source: Prestige Network Ltd)

Appendix F: Recruitment data by protected characteristics

	Applied	Shortlisted	Appointed
Numbers	8841	2796	418
Disability	5.4%	4.9%	3.8%
No disability	94.6%	95.1%	96.2%
Heterosexual	91.4%	92.8%	92.1%
Gay	1.0%	1.2%	1.9%
Lesbian	0.6%	0.5%	0.5%
Bisexual	0.8%	0.6%	0.2%
Undisclosed	6.1%	4.9%	5.3%

Figure 20: Recruitment by Disability and Sexual Orientation
(Source: NHS Jobs 01/11/2013 – 31/10/2014)

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Appendix G: Access to training by protected characteristics

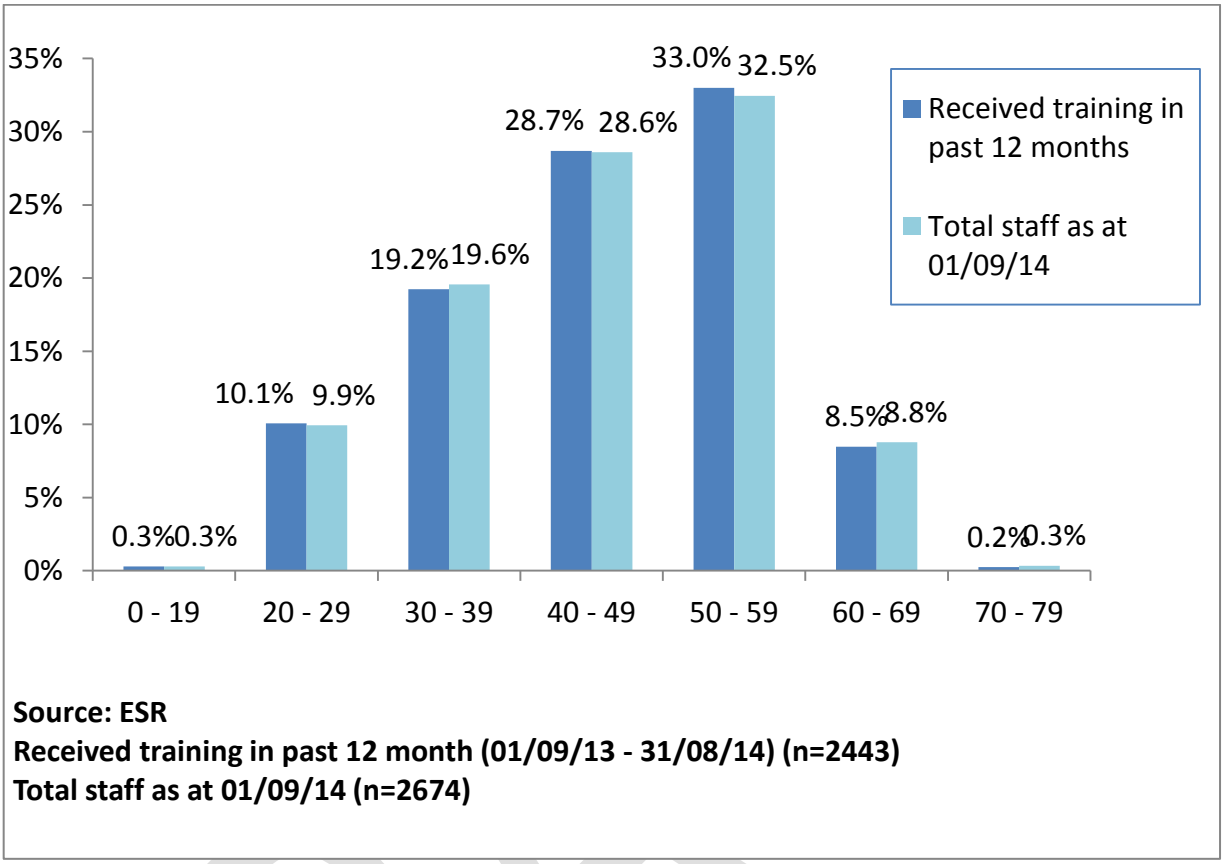

Figure 21: Access to Training by age

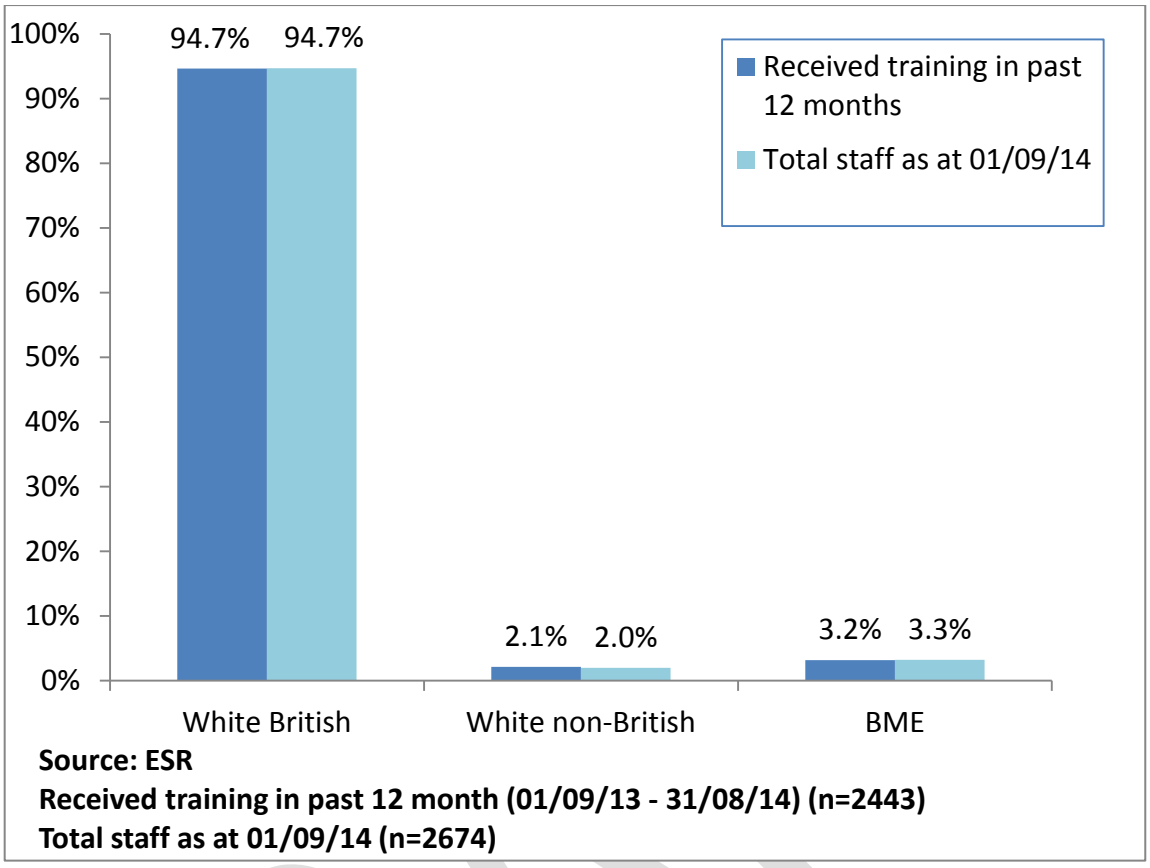

Figure 22: Access to training by Race

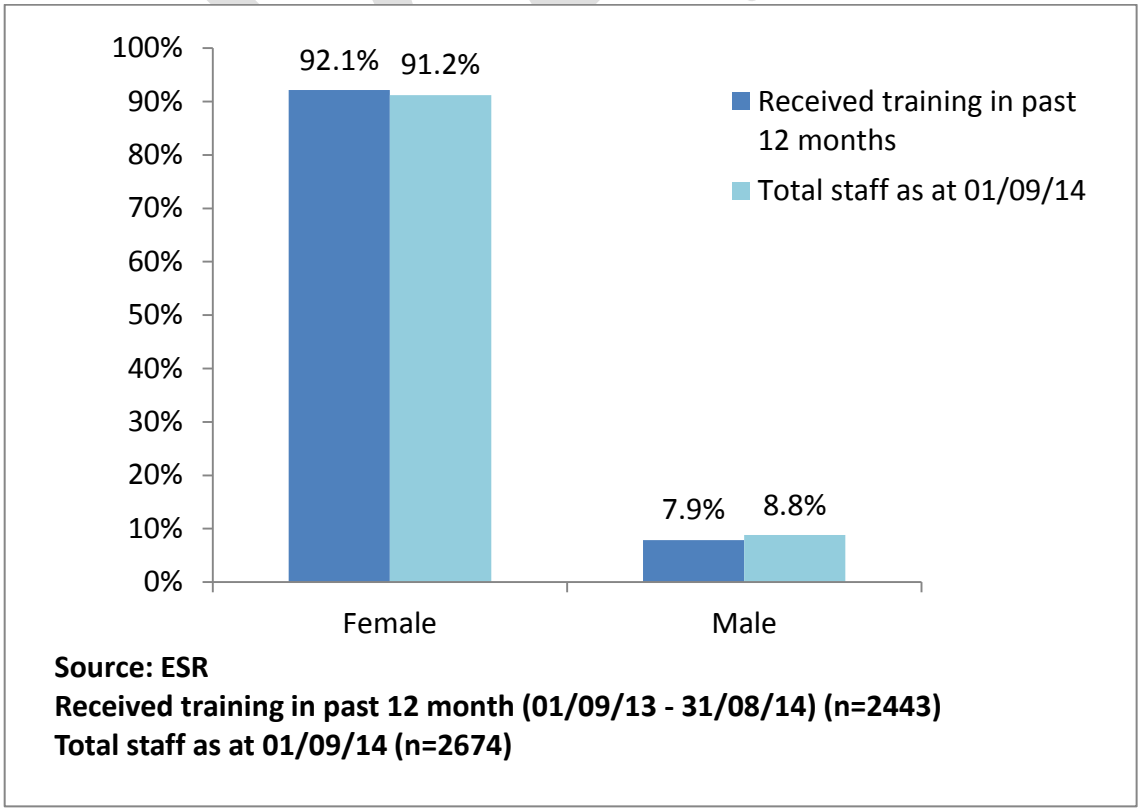

Figure 23: Access to training by Sex

Gloucestershire Care Services NHS
NHS Trust

HR & OD Committee Report

Ref: 15/B016

This report is for Publication

Gloucestershire Care Services NHS Trust Board

Human Resources & Organisational Development Committee Report

20th January 2015

Objective:

The objective of this report is to provide the Board with an overview of the key points of discussion at the HR & OD Committee meeting held on 19th December 2014.

The Board is asked to:

- Note the two additional workforce risks that have been added to the risk register (poor staff engagement and ageing workforce)
- Note that the committee has asked for further assurance around nurse recruitment and staff engagement
- Ratify the updates to the Organisational Development Strategy and approve the priority areas for 2015/16 as detailed in appendix two of this report
- Ratify the committee's decision not to progress with the Investors in People Bronze or Health & Wellbeing Good Practice awards during 2015

Executive summary:

As a reminder to the Board, a detailed workforce report was submitted in November which detailed the key workforce risks, the actions that are being taken to mitigate them and the key performance indicators that will monitor whether these actions are having a positive impact. The key workforce risks were listed as follows:

- Low staff morale (risk register ID 407)
- Early alert systems re staffing levels (risk register ID 433)
- Nurse recruitment and retention (risk register ID 409)
- Contingent workforce strategy (risk register ID 414)
- Mandatory training completion rates (risk register ID 411)
- Appraisal completion rates & quality of appraisals (risk register ID 406)
- Sickness absence rates (risk register ID 404)

In order to seek assurance regarding these risks the key agenda items considered by the HR & OD Committee were as follows:

Key Agenda Item	Summary of Discussion
Nurse recruitment and retention (to seek assurance around nurse recruitment & retention)	The Committee was provided with a report which detailed the current position with regard to nurse vacancies **(see appendix one for further information)**. Whilst some progress has been made in attracting new staff to the Trust the Committee was informed that challenges remain for Band 6 District Nurses in Community Nursing and Band 5 Staff Nurses within the Community Hospitals. A Recruitment and Retention Steering Group has been established to oversee this priority which will monitor progress against five quality goals: 1. Recruit to Establishment Levels 2. Reduce Nurse Turnover 3. Reduce Agency Spend 4. Improve time taken to recruit 5. Reduce Sickness Absence Levels The first Steering Group meeting was held on 7 January 2015 and was chaired by Duncan Jordan, Chief Operating Officer. The Committee requested a further update on progress against the five quality goals from the Steering Group and a further report will be circulated to Committee members by 31st January 2015.
Annual review of the Organisational Development Strategy (to seek assurance around low staff morale and low staff engagement)	The Committee was provided with an updated OD Strategy and details of the proposed priorities for 2015/16 under each of the quality goals **(see appendix two for further information)**. To help inform the Committee of the priority areas for 2015/16 the Director of HR shared a summary of the findings of the 2014 NHS Staff Survey. Following discussion of these results the Committee approved the following priority areas: • The testing, launch and embedding of the CORE Values Framework across the organisation • Year two of the Listening into Action Programme • Embedding of the Performance Management Framework across the Trust through service development & operational planning cycles • A trust wide review of management capability and capacity • The urgent development of a staff engagement

	relaunch plan
Investors in People Next Steps (to seek assurance around low staff morale and low staff engagement)	During the March 2013 Investors in People review the external assessor recommended that the Trust consider going for the Bronze IIP award and the Health and Wellbeing Good Practice Award. These options were reviewed by the Trust in 2013 but it was decided to take forward the Listening into Action Programme to improve the culture of the Trust before further IIP awards were pursued. The Trust committed to reconsider this decision by December 2014. All of the following options are open to the Trust: 1. To participate in a full assessment review against the IIP Core Standards by March 2016. 2. To be assessed against the Bronze award. 3. To be assessed against the Health and Wellbeing Good Practice Award Given the focus on the OD priorities as detailed in appendix one of this report the Committee recommended that that the Trust undertakes the full assessment against the IIP Core Standard in March 2016 but does not pursue the IIP bronze award or Health and Wellbeing Good Practice award during 2015.
Review of Staff Engagement activities (to seek assurance around low staff morale and low staff engagement)	The Committee was provided with a summary of the feedback that the short life working group had sought around the effectiveness of staff engagement activities across the Trust. The group took a presentation to the GCS Leadership Meeting in October 2014 and recorded feedback from the managers present at the meeting. The presentation was then cascaded by managers to their teams with feedback collected centrally. On reviewing the feedback received the Committee raised concerns about the lack of progress made to date and requested that a workshop be set up in early January 2015 to ensure that priority focus was given to the development of a robust staff engagement plan. The Committee requested that the plan be submitted to its February 2015 meeting for approval.
Workforce scorecard development (to seek assurance around mandatory training and appraisal completion rates and sickness absence)	The Committee was provided with a suite of workforce dashboards detailed down to community hospital and service area level, they contain an overview of the key workforce indicators This level of detail enables the Committee to identify

	workforce hotspots and areas of poor performance and it was agreed that this would be provided to every Committee meeting going forward A deep dive was requested into the age profile of the workforce to ascertain what actions the Trust need to take to mitigate any risk in this area. The Committee requested that a report on the findings of this deep dive be submitted to its next meeting.

As noted within the above text the Committee requested that two further workforce risks to be added to the corporate risk register around (1) Low staff engagement and (2) Ageing workforce. These risks have now been added and detailed reports on the actions that are being taken to mitigate them are scheduled for the next committee meeting.

Tina Ricketts
Director of HR

Please complete the Equality Checklist over….

Please select one of the following options:

☒	This paper requires no equality impact assessment as it does not propose changes to how people receive services or our colleagues' working lives.
☐	This paper proposes changes. Equality analysis identifies the following equality impacts: • • A copy of the EIA is appended.
☐	This paper proposes changes. Equality analysis has NOT been completed for the following reasons: • •

[Notes supporting questions]: Compliance with the Public Sector Equality Duty

Under the Equality Act 2010, we have a legal responsibility when we make decisions to have due regard to the need to:

a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

Therefore, if this paper proposes changes that will affect how people receive services or our colleagues' working lives, you should complete an equality analysis. This is to determine the extent to which the changes will eliminate discrimination, advance equality, and foster good relations.

Appendix One – Nurse Recruitment

Figure 1 – Communuity Hospital Vacancy Summary

Community Hospitals IP Vacancy Summary as at 09.12.14						
Band	WTE Funded	WTE Contracted	WTE Vacancies Before Recruitment	Remaining WTE Vacant taking account of In-Progress Recruitment	Vacancies as a % of WTE Funded for All Community Hospitals By Band	Remaining Vacancies after Recruitment as a % of WTE Funded for All Community Hospitals By Band
Cirencester Band 6	7.00	6.50	-0.50	-0.50	-1.6%	-1.6%
Stroud Band 6	7.00	5.00	-2.00	-2.00	-6.3%	-6.3%
Forest Band 6	7.00	5.40	-1.60	-1.60	-5.1%	-5.1%
The Vale Band 6	3.50	2.80	-0.70	-0.70	-2.2%	-2.2%
North Cotswold Band 6	3.50	2.80	-0.70	-0.70	-2.2%	-2.2%
Tewkesbury Hospital Band 6	3.50	4.78	1.28	1.28	4.1%	4.1%
All Community Hospital Band 6	**31.50**	**27.28**	**-4.22**	**-4.22**	**-13.4%**	**-13.4%**
Cirencester Band 5	29.15	20.30	-8.85	-2.60	-7.6%	-5.4%
Stroud Band 5	23.32	10.47	-12.85	-4.60	-11.0%	-7.1%
Forest Band 5	29.15	19.27	-9.88	-5.00	-8.5%	-4.2%
The Vale Band 5	11.66	9.97	-1.69	-1.60	-1.4%	-0.1%
North Cotswold Band 5	11.66	9.63	-2.03	0.00	-1.7%	-1.7%
Tewkesbury Hospital Band 5	11.66	10.67	-0.99	0.00	-0.8%	-0.8%
All Community Hospital Band 5	**116.60**	**80.31**	**-36.29**	**-13.80**	**-31.1%**	**-19.3%**

Figure 1 highlights that the key areas of concern for community hospitals are the recruitment of Band 5 staff nurses. Currently there are 22.49 FTE vacancies in total across community hospitals with particular challenges in Stroud, Cirencester and Forest of Dean.

Figure 2 - Community Nursing Vacancy Summary

Community Nursing Vacancy Summary as at December 2014						
Band	WTE Funded	WTE Contract	WTE Vacancies Before Recruitment	Remaining WTE Vacant taking account of In-Progress Recruitment	Vacancies as a % of WTE Funded for All ICTs By Band	Remaining Vacancies after Recruitment as a % of WTE Funded for All ICTs By Band
Cheltenham ICT Band 6	10.38	10.78	-0.40	-1.40	-0.7%	-2.4%
Cotswold ICT Band 6	9.04	8.70	0.34	0.34	0.6%	0.6%
Gloucester ICT Band 6	13.71	6.80	6.91	6.91	11.8%	11.8%
Forest of Dean ICT Band 6	7.22	6.96	0.26	0.26	0.4%	0.4%
Stroud ICT Band 6	10.44	10.03	0.41	0.41	0.7%	0.7%
Tewkesbury ICT Band 6	8.00	6.00	2.00	2.00	3.4%	3.4%
All ICT Band 6	**58.79**	**49.27**	9.52	8.52	**16.2%**	**14.5%**
Cheltenham ICT Band 5	26.12	19.76	6.36	4.56	4.2%	3.0%
Cotswold ICT Band 5	17.97	11.57	6.40	3.20	4.2%	2.1%
Gloucester ICT Band 5	31.74	30.33	1.41	1.41	0.9%	0.9%
Forest of Dean ICT Band 5	24.38	21.05	3.33	0.93	2.2%	0.6%
Stroud ICT Band 5	31.83	28.61	3.22	0.22	2.1%	0.1%
Tewkesbury ICT Band 5	19.11	17.83	1.28	-0.08	0.8%	-0.1%
All ICT Band 5	**151.15**	**129.15**	22.00	10.24	**14.6%**	**6.8%**

Figure 2 highlights that the current challenge within Community Nursing is with being able to attract Band 6 District Nurses (with the Specialist Practitioner qualification).

Appendix Two - Annual Review of OD Strategy

All Trust strategies are subject to an annual review, with the OD Strategy due in December 2014. The main updates to the strategy are summarised as follows:

- removal of references to Equality and Human Rights which will henceforth be incorporated within the Trust's Communication and Engagement Strategy (throughout);
- inclusion of contextual national directives including *Hard Truths: The Journey to Putting Patients First* (DH, 2014), the Care Quality Commission's Well-Led framework, and the *Fundamental Standards* Duty of Candour and Fit and Proper Person's Test (section 3);
- clearer references to the now-ratified Workforce Strategy (section 4);
- removal of workforce profile (which is now included in the Workforce Strategy), replaced by *Listening into Action* survey results which highlight OD concerns (section 4);
- inclusion of activities undertaken in 2014-15, namely the launch of the Staff FFT and the *Leading for Quality Care* training programme (section 4);
- clearer definition of expected behaviours (section 6.1);
- inclusion of the updated Performance Management Framework (section 6.2);
- inclusion of need for staff ownership of quality and safety issues (section 6.2);
- update of the NHS Leadership Framework (section 6.3).

The OD Strategy is supported by a detailed implementation plan and the priority areas for 2015/16 have been identified as follows:

Quality Goal	Priority Actions for 2015/16
To embed the Trust's core values across the organisation, ensuring that these are reflected in behaviours, and are used to inform and support the growth of the Trust culture	Embed the CORE Values Framework in key organisational policies, procedures and practices Further develop coaching cards to support the roll-out of the framework Test updated documentation & processes in five teams. Revise documentation according to feedback

	Launch CORE Values Framework to all staff by way of a booklet and covering letter Link CORE Values Framework to Pay Progression Policy
To maintain a supportive and learning culture, that emphasises the importance of team working to achieve common goals, and then shares the results of actions so as to improve future performance and outcomes;	Launch Year two of the Listening into Action Programme – "the year of tough love". Link LIA initiatives with OD/cultural change. Ensure further saturation of LIA across the organisation by supporting more teams to make change and by holding further pass it on events Embed the Performance Management Framework across the Trust through service development & operational planning cycles
To increase the capacity and capability of leadership across the Trust, encouraging corresponding behaviours in colleagues	Undertake Trust wide management capability and capacity review. Submit report to HR & OD Committee with recommendations Undertake skills audit and training needs analysis against the NHS Leadership Competency Framework. Develop leadership and management development programme based on skills gap
To support, encourage and motivate colleagues, and elicit their direct involvement with, and positive contribution to, all relevant Trust planning and decision-making	Develop Staff Engagement Relaunch Plan for 2015/16 based on the findings of the review of engagement activities.

GLOUCESTERSHIRE CARE SERVICES NHS TRUST
HUMAN RESOURCES & ORGANISATIONAL DEVELOPMENT COMMITEE

Minutes of the Meeting held on 22 October 2014 from 11:30am to 1:40pm in the Boardroom, Edward Jenner Court

Present:	Chris Creswick – Chair (CC)	Non-Executive Director
	Tina Ricketts (TR)	Director of HR
	Duncan Jordan (DJ)	Chief Operating Officer
	Jason Brown (JB)	Director of Corporate Governance and Public Affairs
	Nicola Strother-Smith (NSS)	Non-Executive Director
	Mel Rogers	Interim Deputy Director of Nursing
In Attendance:	Candace Plouffe (CP)	Director of Service Delivery
	Lindsay Ashworth (LA)	HR Business Partner
	Keith Dayment (KD)	HR Business Partner
	Stuart Bird (SB)	Deputy Director of Finance
	Harriet Howell (HH)	Minute taker
	Christine Thomas (CT)	Minute taker

Ref	Item	Action
HR001	**Apologies** Sue Field, Director of Transformation Sarah Curtis, HR Business Partner	
HR002	**Minutes of the meeting held on 18 August 2014** • Error with initials of Liz Fenton – minutes state EF and not LF throughout. Item 15 (HR/OD51) – Wording to be changed as CC had suggested to TR that the information should be made more accessible and not "more useful" as stated in the minutes. . Subject to the above minor amendments – Minutes approved	HH HH
HR003	**Matters arising / action log** • HR/OD2 – This action relates to agenda item 12 and not 14 as stated in the action log. The first phase of this draft is being tested. HR/OD 45 – Closed	

Ref	Item	Action
	• HR/OD 46 – Relates to agenda item 9 and not 10 as stated on the action log. • HR/OD 51 – Relates to agenda item 12 and not 13 as stated on the action log. HH to make amendments to the action log for the next meeting.	HH
HR004	**Forward agenda plan** • Agenda item for December 2014 – New Year's Honours. JB reported that he had started process with Ingrid and Paul for 2016 New Year's Honours. CC felt it may not be a matter for this committee. It was agreed that the process led by the Chair, Chief Executive and Director of Corporate Governance and Public Affairs was more appropriate. Remove from December's Agenda. • DJ suggested 'Nurse Recruitment and Retention' to be added as a standing agenda item. The committee approved - Item to be added as a standing item for the foreseeable future. • SB requested 'LTFM– workforce plan' to be added to the next meeting agenda (December 2014). The committee approved - To be added to the forward plan. • SB requested 'Workforce Plan' to be added to the February agenda to tie in with the 15/16 budget and reconciliation process. The committee approved - To be added to the forward planner.	HH HH HH HH
HR005	**OD Strategy Implementation Plan update** JB talked through his actions on the implementation plan. • Task 1 – Agreed first draft – circulated to colleagues within next two weeks and will go to Comms and Engagement on 19 December. • Task 2 – Booklet delayed due to number of strategies still outstanding – completion date now end of March 2015. HH to amend strategy implementation plan with revised date • Task 5 – Communication and Engagement Plan visual identity Task and finish group to be established in November. JB to liaise with TR regarding the setting up of a focus group. • Task 12 – JB speaking to Jenny Smith from Capsticks on Friday 24 October 2014 to negotiate a12 month contract to	HH JB / TR

Ref	Item	Action
	do further work on board effectiveness JB to update at next meeting with progress. CC noted that there is a lot going on regarding "engagement" in various guises, with the risk that it may cause confusion. A critical review is probably needed about engagement processes taking place already, mindful of resource and staff capacity. JB accepted need to ensure effective focus. • Task 4 and task 15 relate to the new "behaviours" framework. TR has put back the dates of key policies to tie in with the revised timeline. • Training for Band 6 and below – there has been progression since the last committee meeting in August 2014. There have been discussions with the Execs and a business case has been drafted regarding management development workshops, use of maximising the internal resources and resulting in a reduced cost of £60k. If this revised plan gets approved the RAG rating will go from Amber to Green.	JB
HR006	**Core values framework** TR reported that at the last meeting in August 2014, she had tabled coaching cards which identified two behaviours for each of the core values. At the suggestion of NSS, she had sourced a booklet produced by a Yorkshire-based NHS Trust providing a more developed framework. TR has adapted the framework and linked the behaviours more directly to this organisation. Appendix 1 is a draft of the core values framework and appendix 2 is the proposed approach to the implementation of the core values. The Committee endorsed the material that TR has produced and welcomed the way in which it reflected the Trust's strategic vision and values. JB suggested that we should also link the Trust's reward and recognition policies to the framework which was agreed. There are two phases to the proposed rollout. The first phase is to review the induction, recruitment, appraisal and training polices to embed the new framework. This will be worked on until the end of December 2014. Phase 2 will be the testing of the framework across four services (ICT team, Community Hospital, Support Service and Countywide service.) Champions from these services will need to be identified and during the beginning of 2015 workshops will be held with these Champions. A final review of the framework and updated	

Ref	Item	Action
	policies will be made in March 2015 with the framework being rolled out across the organisation from 1 April 2015. CC asked how the framework will be shared with staff. TR confirmed that a booklet would be issued to every member of staff with a covering letter and every member staff will be given a booklet at induction. The embedding of the framework will be supported through the roll out of the coaching cards by line management. MR stated that this needs to pre date the induction process and suggested it to be used at the recruitment process. TR confirmed that the Recruitment Policy would be reviewed to embed the framework. The committee agreed that in-house videos may be useful for new starters demonstrating what each behaviour means and what is expected of them during their GCS employment. TR to explore the feasibility of such videos.	TR TR
HR007	**Integrated Community Teams HR/OD Programme update** TR introduced the paper which had been shared in a slightly different format with GCC colleagues. It was written to demonstrate the different functions of health and social care staff.. TR confirmed that a joint HR/OD working group had been set up to take this work forward and that an 18 month programme had been identified which was outlined in appendix 3. TR talked through the four key areas of the programme and confirmed that £200k had been received from the Southwest Innovation Fund which would allow dedicated resource to be allocated to support the programme. MR stated that the programme did not seem to focus on maintaining quality of services. TR agreed to revisit the programme outline to ensure quality was explicitly embedded. TR asked how often the Committee would like progress reports. The committee confirmed every 6 months. HH to add to forward agenda map.	HH
HR008	**Draft Workforce strategy implementation plan** The first draft of the implementation plan was discussed amongst the committee –TR pointed out the workforce hotspots which are highlighted on the risk register and confirmed that this version of the plan only contained priorities for the next 12	

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	months. TR confirmed that the next iteration of the plan would contain longer terms objectives. SB stated that an action should be added around agency costs It was agreed that Item 7 on the implementation plan would be amended to include a review of agency spend.	TR
HR009	**Review of Bank and E-Rostering** Julie Cooper gave a presentation to the Committee on the Bank and E-Rostering review. She highlighted numerous problems and inconsistencies which needed to be addressed in the present local rostering systems. She confirmed that some of the information in the papers is historical but that the recent review has identified the same themes. JC presented a diagram in relation to how the bank and e-rostering link to operational services. JC confirmed that the e-rostering was going to be tested in two community hospitals with a view to a functional system being rolled out across the organisation. CP commented that the system will need to be fit for purpose for the ICT's as well. JC confirmed that the first test site is Stroud, looking at inpatient staffing. CC asked the Committee if they feel comments in the paper should be taken forward from the Committee. CP expressed concern, stating that the review in June did not include ICT and therapies and that a system cannot be set up which just focuses on hospitals. The Committee asked for the decision to be taken back to the Executive Team for discussion as to which services will be used to pilot the revised system.	TR / DJ
HR010	**Update on nurse recruitment** TR presented slides to the Committee and also handed out hard copies. The presentation included detail of the current position regarding nurse vacancies, the actions being taken to maximise recruitment and retention and the kpi's that had been identified to monitor progress. The Committee confirmed that the presentation was helpful. CC asked that the LTFM agenda item for the December Committee include the top level workforce plan for nursing.	TR/ SB

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HR011	**Workforce performance update** The update focused on Mandatory Training, Appraisals and sickness rates performance, the key problem areas. TR confirmed that Mandatory Training is the one that is currently the most challenging. The question currently being explored with lead specialists is "Do we have to deliver the same mandatory training to all staff groups or can we break them down for staff dependant on their role". The Trust's mandatory training requirements are based on the skills for Health Framework. Hotel Services and Bank staff are covered under HR staff and this is affecting the performance figures CC asked whether the appraisal training is user friendly to the member of staff being appraised and the Manager delivering the appraisal. TR confirmed that this was being reviewed as part of the core value framework rollout. The increase in sickness rates was noted and is under on-going review with line managers.	
HR012	**Workforce Scorecard Development** KD produced three versions of the workforce scorecard for the Committee. After discussion, the Committee confirmed that it would like two of the documents to be regularly submitted: 1. The workforce scorecard showing trend and benchmark data 2. The workforce dashboard which provided a snapshot for information. KD confirmed that he would further develop the scorecards as requested ready for the next Committee meeting.	KD
HR013	**HR Policy Review Progress Report** The purpose of this paper is to provide the Committee with the assurance that there is a plan in place to review all HR policies. It provided the Committee with an update on the progress made since August 2014. The HR Salary Sacrifice policy and procedure was circulated by Sarah Curtis ahead of the meeting. The main change to policy is	

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	the incremental date for new starters. Staff transferring from one post to another on the same pay band within the NHS will enter the band at the same incremental point that they were previously on. Staff transferring on the same pay band but in a different role will be treated as if they are new staff without the previous NHS employment. Staff transferring to a lower pay band will enter the band at the point they would of reached in previous employment. Staff promoted to a higher band within the NHS will enter the new pay band at the minimum of their first incremental point. The date to the appointment of the post will be their increment date. The Committee ratified the above amendments to the policy.	
HR014	**Workforce risk register** TR confirmed that the risk register is updated monthly through the review of the Board and Committee papers and through the Datix system. TR stated she is comfortable with the top down process but that the bottom up process is still work in progress. CP suggested that it may be possible to have a copy of the full Datix report regarding all workforce risks. CC expressed concerns regarding the wording "probably occur" and "may occur". TR explained that this is prescribed on the Datix systems. CC stated he would like to have time with TR and KD to understand how Datix captures information and how this is transferred onto the risk register. Meeting to be set up between CC, TR and KD before the next HR & OD committee meeting.	HH
HR015	**Annual Staff survey update** TR informed the Committee that the national NHS staff survey for 2014 was currently underway and has been sent to 750 GCS staff and 200 GCC This survey closes at the end of December 2014. TR confirmed that she had just received the Qtr 2 results of Staff Friends and Family Test and agreed to circulate these to the Committee. There has been no improvement since the Qtr1 results. TR will bring a report to the November Board on the actions being taken to improve these results	TR TR

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	NSS asked how staff are reminded to complete the surveys as a lot of staff may well not read the Team Brief circulated via email. There may need to be more ways of spreading such information. TR confirmed that written reminders are sent by the survey provider and that screen savers are also issued.	
HR016	**Any other business** None raised	
HR017	**Next meeting** 19 December 2014, 10am-12pm – Boardroom, EJC	

Chair's Signature ……...

Date ……..…….