NHS
Gloucestershire
Care Services
NHS Trust

GCS Trust Board

Tuesday, 24th July 2018 – 13:00-16:00

Malvern / Coopers Room

Edward Jenner Court, 1010 Pioneer Avenue, Brockworth, Gloucester, GL3 4AW

AGENDA

General Business			Presenter	Purpose
13:00 (guide time)	**1/0718**	**Apologies for Absence and Confirmation the Meeting is Quorate (**4 Directors, including two Executive Directors and two Non-Executive Directors, one of whom must be the Chair or Vice Chair). received from Sue Mead and Neil Savage	Chair	To note
13:05	**2/0718**	**Declarations of Interest** To receive any declaration of interest from Board members in relation to items on the agenda. Standing declarations are attached as Appendix 1	Chair	To note
	3/0718	**Service User Story – Safeguarding**	Director of Nursing	To note
13:35	**4/0718**	**Minutes of the previous Board Meeting –** held 7th June 2018	Chair	For Approval
13:40	**5/0718**	**Matters Arising Action Log** - matters arising not covered by other items on the agenda	Chair	To note
13:45	**6/0718**	**Questions from the Public**		To note
Leadership and Strategy				
14:00	**7/0718**	**Board Assurance Framework**	Chief Executive	To note
14:15	**8/0718**	**Chair's Report**	Chair	To note and approve
14:30	**9/0718**	**Chief Executive and Executive Team Report** .	Chief Executive	To note
14:45	**10/0718**	**Annual Report on Medical Revalidation**	Medical Director	To note and approve
Quality and Operational Performance				
15:00	**11/0718**	**Quality and Performance Committee Report**	Committee Chair	To note
	12/0718	**Quality and Performance Report – June 2018**	Chief Operating Officer & Director of Nursing	To note

Understanding You

15:15	**13/0718**	**Workforce and Organisational Development Committee Update**	Committee Chair	To note and approve
Finance				
15:30	**14/0718**	**Finance Committee Report**	Committee Chair	To note
	15/0718	**Month 3 Finance Report**	Director of Finance	To note
Assurance For Information				
15:45	**16/0718**	**Forward Planner Review**	Trust Secretary	To note
	17/0718	**Quality Account** Provided for Information only	Director of Nursing	To note
Other Items				
16:00	**18/0718**	**Any Other Business**		
Date of Next Meeting – Thursday, 30th August 2018				

The Trust Board will hold a private session during the morning of the day of the Board meeting, in keeping with (section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960), press and other members of the public are excluded from this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Standing Declarations of Interest

Ingrid Barker	• Board Members and Trustee NHS Providers • Governor Hartpury College • Husband Vice Chancellor Nottingham Trent University • Joint Chair 2g •
Paul Roberts	• Joint CEO 2gether •
Sandra Betney	• Director FTN Ltd (Subsidiary of NHS Providers- Trading Arm) • Co-opted member NHS Providers Finance and General Purposes Committee •
Graham Russell	• Chair Second Steps Bristol • Chair Governors Cirencester Deer Park Academy • Chair – Second Step, Bristol (Mental Health and Complex needs) • Wife works at Longfield Hospice •
Jan Marriott	• Director Jan Marriott Associates • Independent Co-Chair Gloucestershire Learning Partnership Board • Independent Chair Gloucestershire Mental Health Wellbeing Partnership Board • Independent Co- Chair Gloucestershire Physical Disability and Sensory Impairment Board • Community Hospitals Association member Trustee Prime Foundation •
Nicola Strother Smith	• Mentor Health & Justice Commissioner NHSE SW
Richard Cryer	• Trustee Action for Children, Action for Children Pension Fund •
Candace Plouffe	• Trustee Active Gloucestershire •
Mike Roberts	• GP Partner Rosebank Surgery Gloucester • Rosebank Health is a member of the Gloucestershire GP Provider Forum (GDoc) •
Neil Savage	•

- ***Please note that a nil declaration will not be shown above.***

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Trust Board Minutes

Date: 7th June 2018

Meeting on 7th June 2018
The Main Place, Coleford, Gloucestershire, GL16 8RH
12:30 hrs

Board Members	
Ingrid Barker	Chair (Voting Member)
Paul Roberts	Chief Executive (Voting Member)
Susan Mead	Non-Executive Director (Voting Member)
Nicola Strother Smith	Non-Executive Director (Voting Member)
Graham Russell	Non-Executive Director (Voting Member)
Jan Marriott	Non-Executive Director (Voting Member)
Sandra Betney	Director of Finance/Deputy Chief Executive (Voting Member)
Mike Roberts	Medical Director (Voting Member)
Richard Cryer	Non-Executive Director (Voting Member)
Susan Field	Director of Nursing (Voting Member)
Candace Plouffe	Chief Operating Officer (Voting Member)
David Smith	Interim Director of HR & OD
In attendance	
Gillian Steels	Trust Secretary
Louise Moss	Deputy Trust Secretary
Member of the public	
Bren McInerney	Member of the Public

Ref	Minute
1/0618	**Apologies and Quoracy** The Chair welcomed colleagues, particularly welcoming Paul Roberts to his first Board meeting of the Trust. Apologies were received from Nick Relph, Non-Executive Director. The Chair confirmed the meeting was quorate.
2/0618	**Declarations of Interest** Declarations of Interest previously declared were noted. The Chair highlighted her declaration as Joint Chair of GCS and the 2gether NHS Foundation Trust. The Chief Executive highlighted his declaration as Joint Chief Executive of GCS and the 2gether NHS Foundation Trust

Understanding You

3/0618	**Service User Story** - Freedom to Speak Up Guardian The Freedom to Speak Up Guardian and Cultural Ambassador gave a presentation to the Board to provide assurance on how the role and ethos of Freedom to Speak was in place throughout Gloucestershire Care Services. She outlined the national history which had led to the development of the Freedom to Speak Up role, in response to the investigations into the failings at Mid-Staffordshire. She advised that she was closely involved with the national work for the Freedom to Speak Up and had undertaken training in her role. It was recognised that the role had a high profile and that Ministers and the CQC considered Freedom to Speak Up of key importance. She outlined a number of Freedom to Speak Up issues which had been raised at GCS and the proportion which related to patient safety and quality. She advised that she was supported by a Freedom to Speak Up Executive Member: the Director of Nursing and a Freedom to Speak Up Non-Executive: Jan Marriott. She gave a case study to provide the Board with assurance on the processes in place and the mechanisms used to ensure that Freedom to Speak Up issues were tackled holistically with input from the teams impacted. The Chief Operating Officer queried whether there were Freedom to Speak Up Guardians in Social Care. The Freedom to Speak Up Guardian advised that she would raise this with the National Freedom to Speak Up Guardian. It was noted that the GCS Freedom to Speak Up Guardian had a regional and national profile. The Chief Executive commented on the strength this gave the organisation as a leader and the opportunity to gain from learning across the country. Richard Cryer, NED, queried what behaviours were cited by individuals raising concerns with the Freedom to Speak Up Guardian. The Freedom to Speak Up Guardian commented that behaviours tended to relate to bullying and harassment and confirmed that these were treated with input from HR and management where required. Jan Marriott, NED, reflected that the roots of the development of the Freedom to Speak Up Guardian related to poor care and noted that the incidents being raised at GCS currently appeared to be more HR related. The FTSU Guardian confirmed that care issues were also covered and appropriately investigated. The Board noted that advocate FTSU roles were being developed and supported this as a way of further promoting and encouraging Speaking Up. The Chair commented on how this role should help support the staff survey outcomes and engagement by ensuring mechanisms for individuals to speak out. The FTSU Guardian was thanked for her informative and helpful presentation. 13.10 the FTSU Guardian left the meeting.
4/0618	**Minutes of the Meeting Held on 29th March 2018** The Minutes were **APPROVED** as a true record.

5/0618	**Matters Arising (Action Log)** The Board considered the action log and noted the latest position.
6/0618	**Questions from the public** No written questions had been received. Bren McInerney, member of the public, thanked the Board for the response relating to the Constitution which he had raised at the previous meeting, stressing the need to ensure its visibility. He commented on the importance of health organisations considering actions and plans through the health and social inequality lens. The Chief Executive confirmed this would be an important element of the Trust's transformation programme and was at the core of the proposed merger between GCS and ^{2}gether NHS Foundation Trust.
7/0618	**Board Assurance Framework** The Board reflected on the risks relating to transformation and planned mitigations. It was agreed the Executive would further review the related risks. It was noted that the workforce issues remained an area of focus The Board **RECEIVED** the Board Assurance Framework and **NOTED** and **ENDORSED** the risk ratings and the actions being taken to mitigate the risks.
8/0618	**Chair's Report** The Chair presented her report highlighting in particular the Trust's positive Care Quality Commission inspection in spring 2018 which had confirmed the Trust's overall rating as Good. She thanked the colleagues who had contributed to achieving this. The Chair noted that following the placement of Pak Wong from the Insight Programme, which supported the development of diversity amongst Non-Executive Directors, the Trust was pleased to now formally welcome Bilal Lala for a placement which would last until September. She commented on the recent Celebrating You Awards which had showcased colleagues commitment to going the extra mile to support service users and colleagues. Richard Cryer, NED, also highlighted the very positive Learning Disability Big Health and Social Care Open Day which had demonstrated the vibrancy of work with third sector organisations. It was noted that there would be a similar event to mark World Mental Health Day in October. The Board: (i) **NOTED** the Chair's Report. (ii) **NOTED** the report on the activities of the Chair and the Non-Executive Directors

9/0618	**Chief Executive and Executive Team Report** The Chief Executive Officer outlined the key aspects of the report which updated on: • His commencement and induction • Progress on the Strategic Intent to merge with 2gether NHSFT • CQC inspection of services: Good Rating • Carter Mental Health Community Services report • One Gloucestershire Integrated Care System • National issues • Operational services overview: - System flow and resilience - Operational service development and challenges - Timely access to services - Estates development - Partnership working The Chief Executive highlighted the Strategic Intent timetable and the detailed work underpinning the processes. It was noted that there had been two initial stakeholder events, which had seen good engagement. He confirmed that there would be further work to engage with service users and other stakeholders. The Chief Executive update on the Carter Review, advising this was being taken forward jointly by the Executive of GCS and 2gether and that an update would be brought to the Board. He commented positively on the successful approval of an Integrated Care System for Gloucestershire noting that there would be a meeting with NHSE in July regarding this and that he would then report back to the Board. The Board was advised that there would be a new financial settlement and a new Workforce Plan and overall plan for the NHS which was expected to be provided in Autumn 2018. It was noted that NHSE and NHSI were increasingly integrating and there would be a movement back to regional working. **Chief Operating Officer** The Chief Operating Officer outlined ongoing operational matters, in particular positive feedback on management of system pressures. It was noted that the lease on Southgate Moorings had been signed that week and that plans to move in services were being developed. An update on this would be taken to the Finance Committee in June. The Board **NOTED** the report.
10/0618	**Learning Disability Mortality Review Update** The Board had been provided with a report on the Learning Disability Mortality Review programme across Gloucestershire which was being led by the University of Bristol to support local areas such as One Gloucestershire to review deaths of people with learning disabilities and identify learning from service improvements. It was noted that this process had commenced in Gloucestershire in January 2017 and that One Gloucestershire had established a Learning from Deaths Mortality Review Steering Group led by the Gloucestershire Clinical Commissioning Group (GCCG) which includes representation from GCS. It was confirmed that the Trust has supported two colleagues to undertake review training, and that they were supporting reviews across the county. It was noted that outcomes are shared and discussed with NHSE. It was highlighted that there

	was a backlog of cases which needed to be taken forward, and that this was the biggest risk to the process. It was noted that NHSE had released additional funding to train further reviewers and maintain the quality of the reviews. The Chief Executive commented that whilst Gloucestershire had a backlog, its position was ahead of the national one. The Board confirmed its support for the process and expressed its support for potentially providing further resource. It was noted that this work needed to be aligned to the system wide mortality review work and needed to be a focus of the wider transformation. It was confirmed this work should be part of the Trust's work with 2gether NHSFT. Jan Marriott, NED, stressed the important of ensuring learning at an early stage and it was confirmed that the Trust was working to ensure this. The Board **NOTED** the report.
11/0618	**Quality and Performance Committee Report** The Board received the report providing assurance that the Quality and Performance Committee continued to oversee the Trust's quality, performance, clinical expertise and achievements in line with its delegated authority. The report highlighted the following activities: • Confirmation that the Trust was on track to submit its Quality Improvement Plan to the Care Quality Commission by 21st May. • Assurance that the Trust 2017-18 Quality Priorities had in the main been achieved although further intensive work was required for the prevention of pressure ulcers • Assurance that performance had improved within a number of services including MSKCAT during quarter 4. Sue Mead, Chair of the Quality and Performance Committee, highlighted the consistent improvement within the therapy services performance. It was noted that the Committee had approved the Annual Report on Infection Control. It was noted that the Committee had reviewed the Learning from Deaths and been assured that there was a good framework in place which had been demonstrated in the recent review within the Community Hospitals. Concern was expressed at the number of C. Dificile cases which had been notified since the start of the year. The Director of Nursing advised that some of this could be attributed to the reduced availability of antibiotics during 2017-18.She advised that the infection control team was working with colleagues on the issue. She also advised that there had been a change in the reporting criteria which was impacting on the Trust. The Chief Executive advised that there had recently been a session at the Joint Senior Leadership Network for GCS and 2gether which had looked at CQC and the role of local leaders which was a helpful development process.

	The Board: (i) **NOTED** the Quality and Performance Committee report. (ii) **RECEIVED** the approved minutes of the Quality and Performance Committee held on 28th February 2018.
12/0618 **Chief Operating Officer**	**Quality and Performance Report – Month 1** The Board had been provided with the Quality and Performance report for April 2018. The Report confirmed progress made against performance achievements where there were action plans in place for services that required improvement. It also provided assurance that quality of care was being maintained. The Chief Operating Officer confirmed she would clarify the MSK performance which was inconsistent within the papers. The Board noted the generally improving position in relation to performance and they discussed avoidable / unavoidable pressure ulcers and recognised the need to maintain focus in this area. The Interim Director of HR&OD advised that steady progress was being made in relation to personal development reviews. He advised that a simpler format had been developed and that there would continue to be focus and review in this area. The Board considered mandatory training compliance and noted this continued to be an improving picture with further work to be undertaken. The Board considered the safety thermometer data, recognising that this had only been achieved for one month within the previous year. The Director of Nursing advised that there had been a number of meetings with clinical colleagues to consider this further and that GCS was to be part of a national review with NHSI. The Chair stressed the importance of identifying the reasons behind the decline against the previous year. The Director of Nursing commented that the validation process had been transferred to operations 18 months previously and this would be further reviewed. Jan Marriott, NED, queried whether the position reflected a dilution of skills mix. The Chief Operating Officer advised that she did not understand this to be the position and drew attention to the quantity of service users included in the survey. The Chair reflected on the recent patient story which had identified a lack of co-ordination between the Trust and a range of agencies and carers, and stressed the need to ensure learnings were identified and implemented from the ongoing work. Sue Mead, Chair of the Q&P Committee, updated on the deep dive that had been undertaken at the Q&P Committee, noting the issues it had identified. The Board considered the Staff Friends and Family Test position noting that the feedback from 2gether NHSFT was above that achieved by GCS. The importance of understanding the Trust's data and responding to local issues of concern was stressed. Graham Russell, NED, commented positively on the significantly improved delayed transfer of care (DTOC) position and queried how this had been achieved. The Chief Operating

	Officer advised that a revised escalation process was in place and an improved relationship with the County Council was in place to support this. Additionally, a clear definition of DTOC had been put in place. The Board was pleased with the more appropriate bed occupancy levels which had also been achieved. The Board **NOTED** the report. 14.30 – the Chief Executive left the meeting.
13/0618	**Audit and Assurance Committee Update** The Board had been provided with an update from the Audit and Assurance Committee confirming that it was discharging its responsibility for oversight of the Trust's Independent and Objective Review of its financial systems, financial information and compliance with laws and guidance regulation covering the NHS. Richard Cryer, Chair of the Audit Committee, highlighted the ongoing improvement in progressing audit recommendations, the positive feedback from the external auditors which had confirmed that they would provide an unqualified opinion and confirmed that the Committee had approved the Trust's Annual report and Accounts in line with its delegated responsibilities. The Chair formally recorded thanks to the Director of Finance and her team for the work in ensuring the smooth running of the end of year audit and noted that no significant points had been raised and that the going concern basis had been signed off. It was noted that the Committee had approved the Board's self-certification as delegated and endorsed the Annual Counter-Fraud report. It was noted that the Committee had undertaken a self-assessment. The Board **NOTED** the Audit and Assurance report.
14/0618	**Finance Committee Report** It was noted that the Committee had considered the Month 12 Finance Report; Quality, Innovation, Productivity and Prevention (QIPP) performance and Commissioning for Quality and Innovation (CQUIN) achievement as well as progress again the Trust Cost Improvement Plan, the Trust's performance against the 2017/18, Data Security and Protection requirements and work in place to minimise exposure to cyber attack. It was confirmed the Committee had discussed and approved the submission of the Operating Plan refresh submission in line with the delegation from the Board in March and also considered a number of confidential issues. The Board **NOTED** the update from the Committee.
15/0618	**Finance Report – Month 1** The Director of Finance took the Board through the overview of the Trust's position at Month 1 and confirmed the 2017/18 position, highlighting that the accounts had been finalised and that the unqualified accounts had been signed off by the auditors and submitted to NHSI. The Board considered the 2018/19 context and performance to date. It was confirmed an update on the Capital Plan would be discussed at the Finance Committee.

	The Board considered current risks. It was noted that the level of risk associated with the Cost Improvement Plan delivery was reducing but that further work was ongoing. The Board noted the new risk relating to delayed agreement of capital limits impacting Cost Improvement Plan and Sustainability and Transformation Plan work. The Board considered the balance sheet. It was noted that Sustainability and Transformation funding had not yet been received. Nicola Strother Smith queried when Quality Equality Impact Assessments (QEIA) were undertaken. The Director of Finance confirmed these were undertaken in line with the agreed procedure. The Director of Nursing advised the QEIAs were taken back to the Cost Improvement Plan Steering Group where issues were identified to explore alternative approaches. She confirmed the process was working well. The Board **NOTED** the report.
16/0618	**Year End Governance Update** The Board noted the confirmation of assurance on compliance with statutory register maintenance. The Board **NOTED** the report.
17/0618	**Forward Planner Review** The Board considered the Forward Planner. It was noted the Workforce Race Equality Standard would come to the July Board if finalised. The Board **NOTED** the forward agenda planner.
18/0618	**Items approved through Delegated Powers and provided for completeness.** Annual Report and Accounts – confirmed these were on the Trust's website and would be uploaded to Boardpad.
19/0618	**Any Other Business** The written Board evaluation process was highlighted. Noting this would be trialled for 3 months. The Board confirmed there were no issues relating to quality that required further discussion. There being no further business the Chair closed the meeting at 4pm.
20/0618	**Date of Next Meeting in Public** It was agreed that the next meeting of the Board be held on 24th July 2018. It was noted the Annual General Meeting would take place on 19th July and would be followed by the 2gether NHS Foundation Trust AGM.

Chair's Signature:

Date:

TRUST PUBLIC BOARD: PUBLIC SESSION - Matters Arising Action Log – as at the 24 July 2018

Key to RAG rating:

- Action completed (items will be reported once as complete and then removed from the log).
- Action deferred once, but there is evidence that work is now progressing towards completion.
- Action on track for delivery within agreed original timeframe.
- Action deferred more than once.

Minute reference (Item No.& Date)	Item	Action Description	Assigned to	Target Completion Date	Progress Update	Status
10/0318	Business Plan	**Quality Priorities -** to be further considered for incorporating within the business plan following a review of the plan at the end of Quarter 1	Executive	September 2018	Business Plan Monitoring being scheduled.	
09/0818	Southgate Moorings	Update to be provided to Finance Committee	Chief Operating Officer	June 2018	Action complete – update provided to Finance Committee	
12/0618	Quality and Performance Report	MSK Performance – to be updated within latest Q&P Report	Chief Operating Officer	July 2018	Complete	

Gloucestershire Care Services NHS Trust

Item 6

Questions from the Public

NHS
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Trust Board

Date of Meeting: 24th July 2018

Report Title: Board Assurance Framework

Agenda reference Number:	07/0718
Accountable Executive Director: (AED)	Chief Executive
Presenter: (if not AED)	
Author(s):	Gillian Steels – Trust Secretary
Board action required:	To Receive, Review and note
Previously considered by:	Executive Team
Appendices:	Board Assurance Framework

Executive Summary

The Board Assurance Framework (BAF) provides an overview of the strategic risks that have the potential to impact on the achievement of the Trust's vision and strategic objectives. The BAF has been updated by the Executive to reflect latest actions.

The actions detailed now reflect the ongoing work to develop an integrated physical and mental health offer, against the backdrop of the current Strategic Objectives and the outcome of the Trust's recent CQC inspection and the identified actions being taken forward through the Quality Improvement Plan.

Following the last meeting, the Executive reviewed Risk 14 in detail and agreed that the Transformation element should be reflected within other risks, particularly Risk 8, given the ongoing focus on Transformation within the Strategic Intent work.

Since the last meeting, two risks have reduced, SR14 and SR10. The reduction in SR10 reflects the latest staff survey feedback. This will continue to be kept under review recognising this is only one measure, but the movement is seen as a significant change reflecting the focus there has been on improving the position.

There continues to be progress against the actions to mitigate the strategic risks.

The Executive continue to focus on:

SR5: The risk that we fail to recruit and retain colleagues with the right knowledge, skills, experience and values required to deliver sustainable services and support transformation. While actions taken continue, this risk continues to be significant and requires further focused work on recruitment and retention.

SR11: The risk that we do not support colleague's health and wellbeing in an environment of constant change and demand. While significant positive progress can be evidenced, including the performance against flu vaccination, support for MSK and health and hustle, levels of sickness absence continue and further targeted work to support colleagues will be a priority.

SR12: The risk that we under invest in leadership and management development. This continues to be a priority for the Executive, with focused work being progressed to develop a clear and targeted plan to improve leadership and management development activities that are recognised and valued by colleagues.

Consideration of these risks is being built into the Strategic Intent work, in particular the work on Transition to ensure that business as usual concerns receive appropriate focus.

It is also noted that the Risk Management Group, is maintaining oversight of the Corporate Risk Register.

Additionally, at the Programme Management Executive, it was noted that consideration needs to be given to ensuring that any overarching risk that relates to the merger is reflected within the Corporate Risk Register and, if appropriate, the Board Assurance Framework. This will be put in place for the September meeting.

Recommendations:
The Board is asked:

1) **RECEIVE** the BAF
2) **REVIEW** the current risk position and actions being progressed

Related Trust Objectives	**1,2,3,4, 5**
Risk Implications	Risk issues are clearly identifed within the report
Quality/Equality Impact Assessment (QEIA) Requirements and Implications	Implications are clearly referenced in the report
Financial Implications	Finance implications are clearly referenced in the report
Legal/Regulatory Implications	Legal/Regulatory implications are clearly referenced in the report

Gloucestershire Care Services NHS Trust

Board Assurance Framework

July 2018

Contents

1.1 Strategic Risks - Summary of strategic risks

Trust strategic objectives	Strategic risks: Ref	Risk	RAG	Exec Lead	Assurance Body	Inherent Risk Score	Current Risk Score	Target Risk Score
*We will be **recognised** locally and nationally as an **outstanding** provider of community services, **caring** for people in their homes and local communities*	SR1	There is a risk that we are not recognised locally as a key and valued provider; resulting in the Trust not having an equal voice in discussions with providers, commissioners and the community compromising our ability to deliver outstanding community services	⇔	CEO	Board	16	12	4
	SR2	There is a risk that we do not provide a clear vision for community based services and the case for change to promote increased investment in new models of care is not made robustly; resulting in investment continuing to be focused on acute provision	⇔	CEO	Board	16	12	8
	SR3	There is a risk that we do not effectively celebrate our successes internally, locally and nationally; resulting in lack of knowledge of the range and quality of our services.	⇔	Dir. HR/ D of N	WF&OD	16	12	8
	SR4	There is a risk that we fail to maximise the use of clinical innovation, business intelligence (including demand) and research and development to maintain and improve the quality of care; resulting in possible harm to patients, poor experience, reduction in quality of care, and loss of reputation for excellence.	⇔	D of N/ Med. Dir.	Q&P	16	9	6
	SR5	**There is a risk that we fail to recruit and retain colleagues with right knowledge, skills, experience and values required to deliver sustainable services and support transformation; resulting in care which does not meet the needs of service users.**	⇔	**Dir of HR**	**WF&OD**	**20**	**16**	**8**

Trust strategic objectives	Strategic risks							
	Ref	Risk	RAG	Exec Lead	Assurance Body	Inherent Risk Score	Current Risk Score	Target Risk Score
*We will make sure the **needs** and **views** of service users, carers and families **shape** the way **we plan** and **deliver care***	SR6	There is a risk that we do not invest time to actively listen, learn, reflect, engage and respond to our local population; resulting in services which are not optimumly designed to meet the needs of service users and carers.	⇔	COO	Board	16	12	8
	SR7	There is a risk that we don't recognise and value the contribution of service users and carers in designing their own care; resulting in poorer outcomes and experiences.	⇔	COO	Board	12	9	6
*We will provide services in **partnership** with other providers so that people experience **seamless care** and support.*	SR8	There is a risk that we are too internally focused and do not support system transformation; resulting in services being fragmented and disjointed thereby impacting on quality and service user experience.	⇔	CEO	Board	16	12	8
	SR9	There is a risk that lack of mutual understanding of the services and assets provided by ourselves and by other system partners compromises the experience of service users; resulting in service users experiencing care and support which is not seamless.	⇔	CEO	Board	16	12	8
*We will have an energised and enthusiastic **workforce** and each individual will feel valued and supported.*	**SR10**	**There is a risk that we do not invest time to actively listen, learn, reflect, engage and respond to colleagues; resulting in disengagement by colleagues and a culture that does not promote openness.**	⇑	**Dir HR**	**WF&OD**	**20**	**12**	**4**
	SR11	**There is a risk that we do not support colleagues health and wellbeing in an environment of constant change and demand management; resulting in poor morale and increased levels of sickness and absence.**	⇔	**Dir HR**	**WF&OD**	**20**	**16**	**8**

Trust strategic objectives	Strategic risks							
	Ref	Risk	RAG	Exec Lead	Assurance Body	Inherent Risk Score	Current Risk Score	Target Risk Score
	SR12	**There is a risk that we under invest in leadership and management development ; resulting in a lack of capacity to nurture a highly engaged and motivated**	⇔	I Dir HR	WF&OD	16	16	8
*We will manage **public resources** effectively so that the services we provide are **sustainable.***	SR13	There is a risk that we fail to maintain and develop an infrastructure fit for future services; resulting in fragmented service delivery models and escalating costs.	⇔	D of F	Finance	16	12	8
	SR14	There is a risk that we do not invest in long term sustainability, resulting in inability to sustain quality and compromising year on year cost improvement.	⇑	D of F	Finance	20	15	15
	SR15	There is a risk we do not maintain robust internal controls and governance systems; resulting in potential financial and organisational instability.	⇔	D of F/TS	Audit & Assurance	20	9	6

1.2 Detail of strategic risks

Strategic Objective	*We will be **recognised** locally and nationally as an **outstanding** provider of community services, **caring** for people in their homes and local communities*		
Risk SR1	There is a risk that we are not recognised locally as a key and valued provider; resulting in the Trust not having an equal voice in discussions with providers, commissioners and the community compromising our ability to deliver outstanding community services –		
Type	Reputation	**Executive Lead**	Chief Executive
Risk Rating	(Likelihood x impact)	**Assurance Committee**	Trust Board
Inherent (without controls being applied) Risk Score	4 x 4 = 16	**Date Identified**	1st April 2017
Previous Risk Score	3 x 4 = 12	**Date of Review**	July 2018
Current Risk Score	3 x 4 = 12	**Date Next Review**	September 2018
Target Score	2 x 4 = 8	**Date to Achieve Target**	1st April 2019
Key 2017/18 Deliverables		**Relevant Key Performance Indicators**	
Gloucestershire Strategic Forum (GSF) STP (Sustainability and Transformation Plan) agendas and approach informed by the needs of GCS as a partner - **work to continue in 2018/19 and extended to reflect Strategic Intent with 2gether.**		360 feedback from partners and stakeholders – **postponed during Strategic Intent development process, to be reviewed in relation to Strategic Intent workstream plans**	
Readiness for CQC with aim for good or outstanding overall rating. – **Grading of Good Assessment confirmed April 2018**		Visability of our leaders and staff in local events and programmes Reports to Workforce Committee confirms this has been maintained in 17/18	
Development of Joint Strategic Intent with 2gether NHS Trust – **Strategic Intent Formalised and now being progressed through joint processes**			
We will have established an effective working relationship with the new Health and Care Oversight and Scrutiny Committee – **continues to be a focus for 2018/19**			
Key 2018/19 Deliverables		**Relevant Key Performance Indicators**	
Gloucestershire Strategic Forum (GSF) STP (Sustainability and Transformation Plan) agendas and approach informed by the needs of GCS as a partner - work to continue in 2018/19 and extended to reflect work towards developing an integrated Physical and Mental Health Care Offer with 2gether NHS Foundation Trust.		Updates to GSF on GCS business as usual and Integrated Physical and Mental Health Care developments.	
CQC Outcome Rating of Good formally celebrated and recognised across Healthcare System and action plan work to further improve and spread good practice implemented		CQC Rating CQC Action Plan implementation Progress (completion of must dos with timeliness)	

Strategic Case Submitted to NHSI autumn 2018	Strategic Case approved by Board and NHSI
We will have established an effective working relationship with the new Health and Care Oversight and Scrutiny Committee – continues to be a focus for 2018/19 (extended to reflect work towards developing an integrated Physical and Mental Health Care Offer with 2gether NHS Foundation Trust.	Joint induction/seminar in place for autumn 2018

Rationale For Current Score (Identifying progress made in previous period)

The joint work with 2gether has raised the profile of community based physical and mental health services, and increased understanding of the benefit of integrating this offer. This work will continue through a range of stakeholder events and activities to ensure that stakeholders are the best advocates for our services and champion greater equity of resources for community and mental health services. The current score reflects that the wider stakeholder engagement activities are commencing 29th May and will be part of a wide programme of events.

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance
Development of programme to integrate community based physical and mental health services.	Monitoring by Strategic Intent Leadership Group and Board	Board Oversight
Communications and External engagement strategy	Workforce and OD Committee	Board Oversight
Regular reports to Health and Care Oversight and Scrutiny Committee (HOSC)	Regular Chair and Chief Executive reports	Board Oversight
Chair and Chief Executive Membership of Gloucestershire Strategic Forum (GSF)	Regular Chair and Chief Executive reports	Board Oversight
Member of Emergency Planning Preparation and Resilience Forum	Regular Chief Executive reports	Board Oversight
Chair membership of Health and Well Being Board	Regular Chair Reports	Board Oversight
Active member of NHS Providers and Community First Network	Regular Chair and Chief Executive reports	Board Oversight
Stakeholder Transformation events	Updates on Transformation at Board	Board Oversight
Quality Account	Review of Quality Account	Board oversight

Gaps in Controls and Assurance (additional controls and assurances should we seek)		Mitigating Actions (what more should we do)		
		Action	**Owner**	**Deadline**
1	Stakeholder Engagement informing integration with 2gether plans)	Stakeholder engagement processes launched and feedback mechanisms in place.	Chief Executive	Stage 1 complete June 2018
2	Clarity on GSF Decision Making (controls), particularly following announcement that One Gloucestershire has been granted status as a shadow Integrated Care System.	Memorandum of Understanding to be developed for Integrated Care System which reflects roles of GCS and 2hether and the planned integration.	Chief Executive	August 2018
3	Develop Relationship new HOSC members (assurance)	Joint induction session planned autumn 2018 and HOSC members to be fully integrated in Stakeholder events	Chief Executive	September 2018
4	Must dos identified by CQC	CQC Quality Improvement Plan actioned with timeliness	DoN	Ongoing

Links to Primary Regulatory Framework

Strategic Objective	*We will be **recognised** locally and nationally as an **outstanding** provider of community services, **caring** for people in their homes and local communities*		
Risk SR2	There is a risk that we do not provide a clear vision for community based services and the case for change to promote increased investment in new models of care is not made robustly; resulting in investment continuing to be focused on acute provision		
Type	Reputation	**Executive Lead**	Chief Executive
Risk Rating	(Likelihood x impact)	**Assurance Committee**	Trust Board
Inherent (without controls being applied) Risk Score	4 x 4 = 16	**Date Identified**	1st April 2017
Previous Risk Score	3 x 4 = 12	**Date of Review**	July 2018
Current Risk Score	3 x 4 = 12	**Date Next Review**	September 2018
Tolerable (Target) Score	2 x 4 = 8	**Date to Achieve Target**	1st April 2019

Key 2017/18 Deliverables	**Relevant Key Performance Indicators**
Documented service vision for community services aligned to place base model - to be progressed in 18/19	**I**ncrease system investment in community based services – limited achievement during 2017/18
Documented business development plan in place March 2018	Delivery of QIPP priorities – **achieved**
Agreed benefits realisation framework developed through the STP to support community based service developments - to be progressed in 18/19	

Key 2018/19 Deliverables	**Relevant Key Performance Indicators**
Documented service vision for community services aligned to place base model tol be progressed as part of the Transformation work to develop an integrated Physical and Mental Health Care Offer with 2gether NHS Foundation Trust.	**I**ncrease system investment in community based services
Achieved business development plan	Delivery of QIPP priorities, CQUIN priorities and quality priorities and business plan milestones
Agreed benefits realisation framework developed through the STP to support community based service developments - to be progressed in 18/19	Benefits realisation framework

Rationale For Current Score (Identifying progress made in previous period)

The development of the Joint Strategic Intent has provided an opportunity to develop a new vision for integrated physical and mental health services and move to a new look organisation better able to champion the role of community based services. It is, however, clear that the ability to influence patterns of investment in the shorter term remains challenging, particularly in light of ongoing financial issues with the main acute service provider in Gloucestershire. The progression of the shadow integrated care system (wave 2) will be an opportunity for these issues to be further reviewed.

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**

Production of annual operational plan	NHSI Confirmation	Board oversight Regulator Oversight
Agreement of quality priorities	Regular reports on performance	Board Oversight
Contractual agreements	Regular contract monitoring meetings	Executive

Gaps in Controls and Assurance (what additional controls and assurances should we seek)		**Mitigating Actions (what more should we do)**		
		Action	**Owner**	**Deadline**
1	Development of clearly documented service vision for our community services. This will now reflect the developing integrated Physical and Mental Health Care Offer with 2gether NHS Foundation Trust	Will now be part of wider discussion with 2gether to reflect intent to deliver new physical and mental health offer. This will be a key element of the transformation strand of this work and included within the Strategic Case to be submitted to NHSI autumn 2018	CEO/COO	September 2018
2	Business plan to be delivered	Business Plan agreed and in place. To be monitored through Executive and Board	DoF	March 2019
3	Development of benefits realisation methodology across the STP	This will now be a key element of the Integrated Care System work	DoF/CEO	**September 2018**
4	Place based model processes embedded – One Place One Budget	To be developed through ICS development and work with 2gether.	CEO	March 2019
5.	Clear processes and structures to support progress on joint strategic intent with 2gether to develop shared vision for strengthened physical and mental health offer	Programme Delivery Structure reviewed and revised following appointment of Strategic Intent Programme Director. Workstream leads identified for Transition, Transaction and Transformation. Programme being implemented and monitored by PME.	CEO/Chair	Stage 1 complete July 2018

Links to Primary Regulatory Framework

Single Oversight Framework Well Led Framework			
Strategic Objective	*We will be **recognised** locally and nationally as an **outstanding** provider of community services, **caring** for people in their homes and local communities*		
Risk SR3	There is a risk that we do not effectively celebrate our successes internally, locally and nationally; resulting in lack of knowledge of the range and quality of our services.		
Type	Quality	**Executive Lead**	Director of HR
Risk Rating	(Likelihood x impact)	**Assurance Committee**	Workforce & OD Committee
Inherent (without controls being applied) Risk Score	4x 4 = 16	**Date Identified**	April 2017
Previous Risk Score	4x 4 = 16	**Date of Review**	July 2018
Current Risk Score	3 x 4 =12	**Date Next Review**	September 2018
Tolerable (Target) Score	2 x 4 = 8	**Date to Achieve Target**	March 2019

Key 2017/18 Deliverables	**Relevant Key Performance Indicators**
Increase the Trust's profile on social media and that this focusses on quality	Number of national, regional and local awards
Increase the number of entries to national, regional and local awards	Number of positive media stories
Raise profile of range and breadth of services with primary care	
Review methodology of the friends and family test to increase completion rates	Friends and family Test - **increased completion**

Key 2018/19 Deliverables	**Relevant Key Performance Indicators**
Increase the Trust's profile (and that of the work with 2gether) on social media and that this focusses on quality	Number of national, regional and local awards
Increase the number of entries to national, regional and local awards	Number of positive media stories
Raise profile of range and breadth of services with primary care	Integrated Locality Board meetings well attended and positive feedback on role from primary care
Maintain and further increase number of FFT responses and increase use of information provided.	Friends and family Test - increased completion and impact on services

Rationale For Current Score (Identifying progress made in previous period)

The Trust has improved its national, regional and local profile each year with good news stories outweighing negative stories. This has included the development of the 60 second service video's and the increased use of social media including Twitter by a range of Trust colleagues. The Trust's performance was recognised by CQC and a range of stakeholders in relation to winter pressures etc.

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**
Communciations and engagement strategy and plan in place	Monitored through Workforce and OD Committee	Board
Calendar of entry dates for national, regional and local awards used to support entrants	Montiored through the Executive Team	Management
Investment in Annual Understanding You Awards	Trust Understanding You awards	Managemt & Board

Regular attendace at LMC meetings, Locality Meetings and Integrated Locality Boards	Feedback at Board from Executive and partners	Executive

Gaps in Controls and Assurance (what additional controls and assurances should we seek)	Mitigating Actions (what more should we do)		
	Action	**Owner**	**Deadline**
1 Monitoring and targets for media presence (positive, negative etc)	Communication Plan agreed by WF&OD Sept 2017 and now being progressed and monitored by WF&OD Committee.	DoHR	Sept 2018
2 Clear targets to improve response rates for the friends and family test (FFT) and to demonstrate use of information to drive engagement activities including the merger.	Significant engagement activity has been ongoing and also the importance of FFT completion reiterated to colleagues. Feedback recently received is indicating an improved position. Q1 Staff FFT and the results are as follows: • Response rate to staff recommending the Trust as a place to work has risen from 49% in Q4 2017/18 to 63% in Q1 2018/19. • Response rate to staff recommending the Trust as a place to receive treatment has also risen from 85% in Q4 2017/18 to 88% in Q1 2018/19. We also had a higher response rate than in previous FFTs at 22.1% Engagement remains a key strand within the merger processes. Response rates for service user FFT are also increasing and being monitored by the Quality and Performance Committee.	DoHR/Director of Transition Director of Nursing	Ongoing Ongoing
3 Mechanism to improve Service User Feedback systematically shared through organisatiion	Key element of Stakeholder Engagement programme which is at the Core of the work to develop an integrated Physical and Mental Health Care offer	Exec	September 2018
Links to Primary Regulatory Framework			

Strategic Objective	*We will be **recognised** locally and nationally as an **outstanding** provider of community services, **caring** for people in their homes and local communities*			
Risk SR4	There is a risk that we fail to maximise the use of clinical innovation, business intelligence and research and development to maintain and improve the quality of care; resulting in possible harm to patients, poor experience, reduction in quality of care, and loss of reputation for excellence.			
Type	Quality	**Executive Lead**	Director of Nursing	Med Director
Risk Rating	(Likelihood x impact)	**Assurance Committee**	Quality & Performance Committee	
Inherent (without controls being applied) Risk Score	4 x 4=16	**Date Identified**	April 2017	
Previous Risk Score	3 x 3 =9	**Date of Review**	July 2018	
Current Risk Score	3 x 3 =9	**Date Next Review**	September 2018	
Tolerable (Target) Score	3 x 2 =6	**Date to Achieve Target**	April 2019	

Key 2017/18 Deliverables	**Relevant Key Performance Indicators**
Implementation of plan for use of BIRT reporting to inform CIPS, Service Development & Pathways Reference Group which supports use of research and development and innovation by identifying variation – initial stages	Safety Thermometer (Fall and Pressure ulcer levels) – improvement in Falls over year, futher working on going re Pressure Ulcers
Increased use of technology to support clinical practice, eg smartphones for clinical support - ongoing	Quality Priorities performance (incorporating research and evidence based development)
Achievement Quality Priorities.	Progress to Quality Priorities

Key 2018/19 Deliverables	**Relevant Key Performance Indicators**
Implementation of plan for use of BIRT reporting to inform CIPS, Service Development & Pathways Reference Group which supports use of research and development and innovation by identifying variation – further work to deliver ongoing	Safety Thermometer (Fall and Pressure ulcer levels)
Increased use of technology to support clinical practice, eg smartphones for clinical support – continuing to be investigated and implemented – in discussion with service users	Quality Priorities performance (incorporating research and evidence based development)
Achievement Quality Priorities.	Progress to Quality Priorities

Rationale For Current Score (Identifying progress made in previous period)

There has been good progress in investing and developing clinical innovation, for example systm one, use of smart phones, developing use of virtual consultations, rapid response diagnostic testing, e-prescribing, internal R&D Group, End of Life, Complex Leg Wound Service. These are now to be further embedded and work undertaken with service users to ensure benefits are recognised and understood.

Key Controls To Manage Risk	Assurance on Controls	Type of Assurance
Clinical Reference Group Monitoring	Quality Visits	Board Oversight
Internal R & D Group	Benchmarking Review	Board & Management
PACE Team Workplan, including Clinical Audits	Quality & Performance Report	Board & Management
Quality Improvement Monitoring (Quality Priorities)	Clinical Reference Group and Quality & Performance Committee	Management & Board
Staff Development Investment – supported through – Essential to Role and Statutory and mandatory training matrices	Quality and Improvement Networks	Management
CQC Compliance Processes	Quality & Performance Committee	Board
Investment in specialist practitioners	Workforce & OD Committee	Board

Gaps in Controls and Assurance (what additional controls and assurances should we seek)		Mitigating Actions (what more should we do)		
		Action	**Owner**	**Deadline**
1	More in depth Benchmarking Review to identify areas of significant variation and any aresponsive action identified	Further work to ensure benchmark information easily accessible on BIRT implemented	DoF	September 2018
2	Development BIRT reporting on this area to inform CIPS and Service Development.	Discussions with DoN ongoing to ensure BIRT used to inform quality and performance priorities and the quality dashboard.	DoF	September 2018
	R&D Strategy	To be developed and reviewed in conjuction with [2]gether NHS Foundation Trust	DoN	October 2018
3	Project reviews on impact of new technology to learn lessons for implementation	Project Review Proforma implemented and feedback reviewed for learning	Executive	Complete
4	CPD Offer and Personal Development to be linked to quality priorities	CPD and Personal Development Budget focused for 2018/19. And monitored for impact. Updated PDR document issued.	IIDHR&OD&OD	July 2018

Links to Primary Regulatory Framework

Strategic Objective	*We will be **recognised** locally and nationally as an **outstanding** provider of community services, **caring** for people in their homes and local communities*		
Risk SR5	There is a risk that we fail to recruit and retain colleagues with right knowledge, skills, experience and values required to deliver sustainable services and support transformation; resulting in care which does not meet the needs of service users.		
Type	Quality	**Executive Lead**	Director of HR
Risk Rating	(Likelihood x impact)	**Assurance Committee**	Workforce & OD Committee
Inherent (without controls being applied) Risk Score	4 x 5 = 20	**Date Identified**	April 2017
Previous Risk Score	3 x 4 = 12	**Date of Review**	July 2018
Current Risk Score	4 x 4 = 16	**Date Next Review**	September 2018
Tolerable (Target) Score	2 x 4 = 8	**Date to Achieve Target**	March 2019

Key 2017/18 Deliverables	**Relevant Key Performance Indicators**
Reduction in hard to fill roles (nursing and physiotherapy including specialist functions) – ongoing issue	Vacancy levels – less than 10% - achieved (a limited number of areas above)
Reduce turnover rates in line with Community Trust average – ongoing issue	Turnover rates – below 16/17 baseline – not achieved
Reduction in agency spend - achieved	Agency spend – in line with cap set (if no national cap then in line with budget) - achieved
Jointly support the delivery of educational programmes (pre and post registration)	
Key 2018/19 Deliverables	**Relevant Key Performance Indicators**
Reduction in hard to fill roles (nursing and physiotherapy including specialist functions)	Vacancy levels – less than 10% - to monitor for all areas
Reduce turnover rates in line with Community Trust average;	Turnover rates – below 16/17 baseline
Reduction in agency spend	Agency spend – in line with cap set (
Jointly support the delivery of educational programmes (pre and post registration) – increased emphasis on post registration support	
Local plans to respond to issues raised in staff survey	

Rationale For Current Score (Identifying progress made in previous period)

Turnover rate has remained consistent (not worsened), demonstrating Trust is still able to attract to the organisation. There is uncertainty about the impact of National bursary scheme ceasing for pre-reg learning. Variances remain in rate of applications received. There is a hot spot in Band 5 hospital nurses which is not reducing. The Staff Survey 2017 indicates on going challenges to staffing resilience.

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**
Recruitment drives / fayres to attract new staff	Workforce data which is reported through the Workforce & OD Committee and thereafter to Board	Board Oversight

Revised establishment control process for community hospitals	Safer Staffing data which is included within the Quality and Performance Report which goes to Board	Management & Board Oversight
E-rostering across the Trust	Top-level workforce plan submitted to Workforce & OD Committee	Board Oversight
Centralised bank and agency function	Agency working group chaired by the Chief Operating Officer	Management
Gloucestershire Nursing Degree programme in place	Recruitment and Retention Steering Group chaired by Head of HR	Management
Monitor impact & effectiveness of Gloucestershire Trainee Nursing Associate programme	Strategic Workforce Group (system-wide)	Management (Educational)

Gaps in Controls and Assurance (what additional controls and assurances should we seek)		**Mitigating Actions (what more should we do)**		
		Action	**Owner**	**Deadline**
1	Real time workforce information, particularly in terms of establishment & vacancies, which is essential in order to drive activity and response	**I**nformation now in place for HR and Service Leads and Managers. Business planning process and monitoring to confirm effectiveness.	Head of Performance and Information	Complete
2	Clear progression pathways for clinical colleagues	Talent management programme to be developed to be undertaken jointly with ^{2}gether NHS Foundation Trust. This will be incorporated within the Transition work for the merger. .	Head of OD	September 2018
3	Process to learn from exit interviews	Triangulated against latest staff survey information March/April 2018 and discussed at June Workforce Committee. Issue also highlighted within presentation from Freedom to Speak Up Guardian at June Board. Freedom To Speak Up Guardian now part of the process to ensure learning from exit interviews.	Head of HR	Complete
4	Ensure CQC Must dos in relation to mandatory training and PDR compliance are achieved	CQC Improvement Plan achieved with timeliness. Monitoring is ongoing, monitored by the Quality and Performance Committee and also the Executive. .	DON	Ongoing

Links to Primary Regulatory Framework
CQC.

Strategic Objective	*We will make sure the **needs** and **views** of service users, carers and families **shape** the way **we plan** and **deliver care***		
Risk SR6	There is a risk that we do not invest time to actively listen, learn, reflect, engage and respond to our local population; resulting in services which are not optimumly designed to meet the needs of service users and carers (Service Transformation Focus).		
Type	Quality	**Executive Lead**	Chief Operating Officer
Risk Rating	(Likelihood x impact)	**Assurance Committee**	Trust Board
Inherent (without controls being applied) Risk Score	4 x 4 = 16	**Date Identified**	20/04/17
Previous Risk Score	3 x 4 = 12	**Date of Review**	July 2018
Current Risk Score	3 x 4 = 12	**Date Next Review**	September 2018
Tolerable (Target) Score	2 x 4 = 8	**Date to Achieve Target**	31/3/19

Key 2017/18 Deliverables	**Relevant Key Performance Indicators**
Mechanism for initial impact on projects developed – to be further developed	FFT Response Rate
Negative assurance, eg complaints etc, being fed into the business planning process **- achieved**	FFT % recommend service – likely , extremely likely
Examplars of co-design – **achieved but to be further enhanced**	Number compliments, complaints, concerns
Policy on Policy updated to include co-design and patient centred care focus. –	

Key 2018/19 Deliverables	**Relevant Key Performance Indicators**
Mechanism for initial impact on projects developed – to be further developed in conjunction with 2gether NHS Foundation Trust. Transformation centred on co design with service users.	FFT Response Rate
Negative assurance, eg complaints etc, being fed into the business planning process **–** to be monitored to ensure happening across GCS and also that learning are across both Trusts**.**	FFT % recommend service – likely , extremely likely
Examplars of co-design – examples of Transformation Centred co design	Number compliments, complaints, concerns
Policy on Policy updated to include co-design and patient centred care focus. – Policy now being reviewed against 2gether Policy as element of Strategic Intent work	Feedback from service users at engagement events

Rationale For Current Score (Identifying progress made in previous period)

While strong progress is being made in a number of areas through place based working to develop local solutions to meet local needs, we have recognised that there is further work to progress in the context of the Transformation strand of the Trust's work with 2gether NHS Foundation Trust.

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**
Use of the Friends and Family Test (FFT) across all Trust settings	Operational Meetings	Management

Direct feedback to teams from FFT comments	Relevant metrics within the Quality and Performance Report received at the Quality and Performance Committee and Board	Board Oversight
Complaints Policy	6-monthly Understanding You Report	Board Oversight
The Service User Experience team which manages surveys including the FFT as well as complaints, Duty of Candour, concerns and compliments	Service user stories at Board	Board Oversignt
The Community Partnerships Team which manages a range of engagement activities to include focus groups, community events and consultation opportunities	The Your Care, Your Opinion Group	Board Oversight
Annual Report and Quality Account	Board	Board
Information provided by external agencies such as Healthwatch, NHS Choices and Patient Opinion	Regular partnership meetings with Healthwatch and Quality Review meetings with the CCG	Management Oversight
On-going review of all feedback so as to ascertain themes	Groups within the Trust which have a specific focus upon improving the experiences of those with dementia or a learning disability	Management Oversight
QEIAs will be completed and signed off for all appropriate CIP schemes before they are implemented	Reports to Q and P Committee	Board Oversight
Learning Assurance Framework	Reports to Q and P Committee	

Gaps in Controls and Assurance (what additional controls and assurances should we seek)		**Mitigating Actions (what more should we do)**		
		Action	**Owner**	**Deadline**
1	Control – ensuring opinions we collect feed into service design and development	Mechanism to ensure feedback captured through Transformation strand of work with 2gether NHS Trust	COO/DoN	Dec 2018
2	Your Care Your opinion , Understanding You report to be reviewed against planned wider stakeholder engagement to identify any areas where GCS specific areas required	Review of your care your opinion against planned wider service user engagement to be undertaken. Merger engagement activity within the Transformation strand will be a key element of this.	COO/DoN	Dec 2018
3**.**	Skills for Co-production require further development	Co production development of teams to be undertaken. In conjuction with work with 2gether to learn from good practice.	COO	Dec 2018
4	Service audits to be reinstated.	Service audits reinstated and monitored for impact	COO	September 2018
		Increase use of “You said We did” feedback processes. This is an element within the merger processes.	COO	July 2018
5	Business Planning Process incorporates feedback.	Business Planning monitoring to include consideration feedback	DOF	Ongoing

Links to Primary Regulatory Framework
CQC
Constitution Right and Pledges

Strategic Objective	*We will make sure the **needs** and **views** of service users, carers and families **shape** the way **we plan** and **deliver care***		
Risk SR7	There is a risk that we don't recognise and value the contribution of service users and carers in designing their own care; resulting in poorer outcomes and experiences.		
Type	Quality	**Executive Lead**	Chief Operating Officer
Risk Rating	(Likelihood x impact)	**Assurance Committee**	Trust Board
Inherent (without controls being applied) Risk Score	4 x 3 = 12	**Date Identified**	20/04/17
Previous Risk Score	3 x 3 = 9	**Date of Review**	July 2018
Current Risk Score	3 x 3 = 9	**Date Next Review**	September 2018
Tolerable (Target) Score	2 x 3 = 6	**Date to Achieve Target**	March 2019

Key 2017/18 Deliverables	**Relevant Key Performance Indicators**
Revised Policy on Policies to reference co-design and person centred care –	FFT Response Rate
Core Values reinforced to incorporate valuing contribution service user.	FFT % recommend service – likely , extremely likely
Patient stories and evidence of impact.- **Regular item at Board**	Number compliments, complaints, concerns
Delivery 17/18 CQUIN on Increased use of Personal Care Plans.	
Key 2018/19 Deliverables	**Relevant Key Performance Indicators**
Revised Policy on Policies to reference co-design and person centred care – now being reviewed with 2g policy as part of Strategic Intent work	FFT Response Rate
Core Values reinforced to incorporate valuing contribution service user.	FFT % recommend service – likely , extremely likely
Patient stories and evidence of impact.- Regular item at Board	Number compliments, complaints, concerns
Transformation with co-design at the heart of work with 2gether.	Stakeholder events and feedback

Rationale For Current Score (Identifying progress made in previous period)

There continues to be a clear focus on patient experience, including regular patient stories at Trust Board, regular training and development events, and through the Understanding You Group. To move forward to achieve target risk we recognise the need to progress training and development as part of essential to role training frameworks. To be further reviewed against Transfor

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**
Person focused initiatives eg End of Life	Groups within the Trust which have a specific focus upon improving the experiences of those with dementia or a learning disability	Management Oversight
Promotion of Patient First Culture through CORE behaviours, values and strategic objectives	Relevant metrics within the Quality and Performance Report received at the Quality and Performance Committee and Board	Board Oversight
Positive Risk Taking	6-monthly Understanding You Report	Board Oversight

Policies to support colleagues to make patient focused decisions		Service user stories at Board	Board Oversignt
Specification increasing personalisation requirements		Regular partnership meetings with Healthwatch and Quality Review meetings with the CCG	Management Oversight
Gaps in Controls and Assurance (what additional controls and assurances should we seek)		**Mitigating Actions (what more should we do)**	
		Action	**Owner**	**Deadline**
1	Strength & consistency of processes throughout organisation to ensure value of service users contribution recognised and built in. Review with 2gether Policy now ongoing.	Update Policy on policies to make sure patient involvement in own care is appropriately reflected. Being undertaken jointly with 2gether.	Trust Secretary	Sept 2018
2	Patient Activation Measures and Personalised Care Plans not in place as standard.	Review Core values and behaviours to ensure they reflect positive risk taking and emphasis on service user perspective. This will now be part of wider vision and values work with 2gether.	CEO	Dec 2018
		Trial of Patient Activation Measures (goal setting to inform decision making)for patients with long term needs. **Actions to date** trialled in MacMillan Service and being tested across two other services, prior to review for further development across Trust.	COO	Sept 2018
		Actions to date - Engaging Individuals in personal commissioning – personal health budgets – developing process. Presentation to CORE leadership Group July 2017 to develop understanding. Further system workshops scheduled with Senior leads in April and June following Gloucestershire being a pilot site for Integrated personal care plans and budgets	COO	July 2018
Links to Primary Regulatory Framework CQC – Well led, Responsive Constitution – Rights & Pledge				

Strategic Objective	*We will provide services in **partnership** with other providers so that people experience **seamless care** and support*		
Risk SR8	There is a risk that we are too internally focused and do not support system transformation; resulting in services being fragmented and disjointed thereby impacting on quality and service user experience.		
Type	Quality	**Executive Lead**	Chief Executive
Risk Rating	(Likelihood x impact)	**Assurance Committee**	Trust Board
Inherent (without controls being applied) Risk Score	4 x 5 =20	**Date Identified**	1st April 2017
Previous Risk Score	3 x 4 = 12	**Date of Review**	July 2018
Current Risk Score	3 x 4 = 12	**Date Next Review**	September 2018
Tolerable (Target) Score	2 x 4 = 8	**Date to Achieve Target**	31st March 2019

Key 2017/18 Deliverables	**Relevant Key Performance Indicators**
1. Establishment of locality provider boards – **Key development work undertaken**	1. Completion of realignment of GCS services to locality working
2. GCS effective in discussions to progress system working - **Ongoing**	2. Reablement KPIs agreed and achieved
3. Reset of GCC relationship - **ongoing**	3.

Key 2018/19 Deliverables	**Relevant Key Performance Indicators**
1. Locality provider boards embedded with Executives now linked to localities	1. Completion of realignment of GCS services to locality working
2. GCS effective in discussions to progress system working with establishment of shadow Integrated Care System	2. Reablement KPIs agreed and achieved
3. Reset of GCC relationship	3.

Rationale For Current Score (Identifying progress made in previous period)

The STP has provided a stimulus for imporved partnership working, particularly the opportunities offered through place based working. The development of the joint strategic intent has also demonstrated our commitment to system transformation. The risk remains unchanged however given the potential increase in risk associated with service continuity in the short term. The approval of Gloucestershire as a shadow Integrated System provides further opportunities to further develop system working.

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**
Quality and performance reporting	Q&P Committee oversight	Board
Place Based Pilot board reports	Executive oversight	Management
Regular STP reports to the Board	Regular reports to Board	Board
System QIPP priorities	Q&P	Board
Active membership of HWBB, GSF and attendance at HOSC	Board reports	Board

Gaps in Controls and Assurance (what additional controls and assurances should we seek)		**Mitigating Actions (what more should we do)**		
		Action	**Owner**	**Deadline**
1	Lack of whole system performance framework	Work with GSF to develop whole system performance using the drivers within the Integrated Care System	CEO	Sept 2018

2	Move Strategic Intent into Action, with focus on service users	Strategic Intent Leadership Group and Programme Executive Group in Place and regular meetings scheduled to take forward required actions. Governance processes in place Executive Workstream processes in development. Engagement activities. Transformation strand work to be further developed.	CEO DoN	Sept 2018 Sept 2018
Links to the Primary Regulatory Framework: **CQC**				

Strategic Objective	*We will provide services in **partnership** with other providers so that people experience **seamless care** and support*		
Risk SR9	There is a risk that lack of mutual understanding of the services and assets provided by the Trust and by other system partners compromises the experience of service users; resulting in service users experiencing care and support which is not seamless.		
Type	Quality	**Executive Lead**	Chief Executive
Risk Rating	(Likelihood x impact)	**Assurance Committee**	Trust Board
Inherent (without controls being applied) Risk Score	4 x 4 = 16	**Date Identified**	1st April 2017
Previous Risk Score	4 x 4 = 16	**Date of Review**	July 2018
Current Risk Score	3 x 4 = 12	**Date Next Review**	September 2018
Tolerable (Target) Score	2 x 4 = 8	**Date to Achieve Target**	31st March 2019

Key 2017/18 Deliverables	**Relevant Key Performance Indicators**
Effective Provider Locality Boards	Friends and Family test, complaints, compliments
Delivery of priority care pathways including MSK and respiratory	Organisational 360
Establishment of cluster MDT working with full participation by GCS	
Key 2018/19 Deliverables	**Relevant Key Performance Indicators**
Effective Provider Locality Boards creating advocates for the Trust	Friends and Family test, complaints, compliments
Establishment of cluster MDT working with full participation by GCS	Regular Integrated Locality Board Meetings

Rationale For Current Score (Identifying progress made in previous period)

While good progress has been made to develop new ways of working with primary care, including MDT working and redesign of ICTs, progressing public health nursing services transformation and the development of the joint strategic intent to improve the interface between physical and mental health, we have seen significant pressures impacting across the wider system, in particular: pressures in relation to domiciliary care which are impacting on service user experience; the additional pressures to mitigate the issues associated with the GHFT implementation of TrakCare and the responsiveness of Arriva.

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**
Partnership working through STP - **Key development work undertaken**	MDT KPI Messures	Management
Leadership of place based model and meetings - **Key development work undertaken**	Reports to Board on STP	Board
Regular Exec to Exec networks and LMC – **in place**		

Gaps in Controls and Assurance (what additional controls and assurances should we seek)		**Mitigating Actions (what more should we do)**		
		Action	**Owner**	**Deadline**
1	Lack of formal and relevant frameworks for joint working with key partners	Develop formal frameworks for joint working with 2G and GCCC **Actions to date** Strategic Intent Leadership Group and Programme	CEO/COO	Complete

		Executive Group in Place and regular meetings scheduled to take forward required actions. Joint Working Framework strand of agreed activity		
2	System quality indicators	Develop Business Plan incorporating Estates	COO	Complete
3	Relationship building with provider partners to resolve issues swiftly.	Trakcare escalation processes in place**.** Monitoring on going. Proposals for Joint action groups being progressed, for example re SIRIs and Mortality. Reablement support for Domiciliary Care. Development of Intergrated Care System	COO DoN COO CEO	Complete Nov 2017 Complete Complete **Above all complete indicating developing relationship building** September 2018

Strategic Objective	*We will have an energised and enthusiastic **workforce** and each individual will feel valued and supported.*		
Risk SR10	There is a risk that we do not invest time to actively listen, learn, reflect, engage and respond to colleagues; resulting in disengagement by colleagues and a culture that does not promote openness		
Type	Quality	**Executive Lead**	Director of HR
Risk Rating	(Likelihood x impact)	**Assurance Committee**	Workforce & OD Committee
Inherent (without controls being applied) Risk Score	4 x 5 = 20	**Date Identified**	April 2017
Previous Risk Score	4 x 4 = 16	**Date of Review**	July 2018
Current Risk Score	3 x 4 = 12	**Date Next Review**	September 2018
Tolerable (Target) Score	1 x 4 = 4	**Date to Achieve Target**	March 2019

Key 2017/18 Deliverables	**Relevant Key Performance Indicators**
Manager toolkit in place – launched Jan 2018 across STP	• Staff engagement levels (from annual staff survey)
Improvement in staff friends and family test (colleagues recommending the Trust as a place to work – **NOT ACHIEVED**	• Staff friends and family test results
Increase in metric in staff survey on number of individuals willing to raise concerns the number of informal and formal concerns raised – increased.- **INCREASING PROCESSES TO RAISE CONCERNS – METRIC TO BE DRILLED DOWN**	• Staff Survey Question on feeling supported to raise concerns.
Key 2018/19 Deliverables	**Relevant Key Performance Indicators**
Manager toolkit in place to be reviewed with 2gether NHS Trust to monitor impact	• Staff engagement levels (from annual staff survey)
Improvement in staff friends and family test (colleagues recommending the Trust as a place to work	• Staff friends and family test results
Continuing increase in metric in staff survey on number of individuals willing to raise concerns the number of informal and formal concerns raised –	• Staff Survey Question on feeling supported to raise concerns.
Local Plans to spread good practice and target issues identified by the staff survey	

Rationale For Current Score (Identifying progress made in previous period)

Staff Friends and Family score is consistently below community trust average as place of work . Overall Staff Engagement outcome in NHS survey whilst improving remains below average for a community trust.

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**
Fourth year of listening into action	Improvement in staff engagement levels (from survey results)	Independent
Investors in People standards/ accreditation	Improvement in the number of colleagues recommending the	Independent

		Trust as a place to work	
Further embedding of the CORE values behavioural framework		Number of informal and formal grievances and concerns raised (awaiting benchmark data)	Management/Board
Review of Freedom to Speak Up (Raising Concerns at Work) Policy.		Report to Audit & Assurance Committee and Workforce & OD Committee	Board
Investment in Freedom to Speak Up Guardian – active in national network and regional Chair		Report to Audit & Assurance Committee and Workforce & OD Committee	Board
Monthly Core Colleague Network Meetings		Review & Feedback of CORE	Management
Annual celebration events (AHP, Nursing, Admin & Clerical etc)		Review of Events for levels of engagement & impact internally and externally	Management
Range of Mechanisms to encourage raising of concerns - Katie's Open Door, Meet the Execs, Chair and CEO meetings		Feedback at Execs and Board	Management/Board
Workforce and OD Plan		Workforce and OD Committee	Board
Gaps in Controls and Assurance (what additional controls and assurances should we seek)		**Mitigating Actions (what more should we do)**	
		Action	**Owner**	**Deadline**
1	Low completion rate of staff friends and family test	Q1 Staff FFT results are as follows: • Response rate to staff recommending the Trust as a place to work has risen from 49% in Q4 2017/18 to 63% in Q1 2018/19. • Response rate to staff recommending the Trust as a place to receive treatment has also risen from 85% in Q4 2017/18 to 88% in Q1 2018/19. We also had a higher response rate than in previous FFTs at 22.1%	Head of OD	July 2018 Improved position noted. To be reviewed at next quarter.
2	Management Toolkit	Launched Jan 2018 with funding from SW Leadership Academy Funding CORE Leadership Session discussed Jan 2018 To review as part of transition work	Head of OD	Complete
3	Staff Engagement Framework	Review Staff Engagement Framework to ensure embedding of CORE values and LiA – through development of a "quality Academy" Being taken forward within the Engagement processes relating to the merger.	Head of OD Head of Comms	Sept 2018
Links to Primary Regulatory Framework. CQC				

Strategic Objective	*We will have an energised and enthusiastic **workforce** and each individual will feel valued and supported.*		
Risk SR11	There is a risk that we do not support colleagues health and wellbeing in an environment of constant change and demand management; resulting in poor morale and increased levels of sickness and absence.		
Type	Quality	**Executive Lead**	Director of HR
Risk Rating	(Likelihood x impact)	**Assurance Committee**	Workforce & OD Committee
Inherent (without controls being applied) Risk Score	4 x 5 = 20	**Date Identified**	April 2017
Previous Risk Score	3 x 4 = 12	**Date of Review**	July 2018
Current Risk Score	4 x 4 = 16	**Date Next Review**	September 2018
Tolerable (Target) Score	2 x 4 = 8	**Date to Achieve Target**	Not applicable

Key 2017/18 Deliverables	**Relevant Key Performance Indicators**
Reduction in overall sickness absence rate – not achieved	Rolling 12 month sickness absence rate
Reduction in absences relating to stress – not achieved	Reasons for sickness absence
Reduction in absences relating to muscoskeletal conditions - reduced	

Key 2018/19 Deliverables	**Relevant Key Performance Indicators**
Reduction in overall sickness absence rate	Rolling 12 month sickness absence rate
Reduction in absences relating to stress	Reasons for sickness absence
Reduction in absences relating to muscoskeletal conditions	

Rationale For Current Score (Identifying progress made in previous period)

While a significant amount of work has been progress to support colleague health and wellbeing, we are seeing an increase in sickness absence rates in a number of areas with increasing pressure on colleagues to meet competing demands. This suggests that this risk is increasing and further focus is needed. Related CQUIN not achieved. Following consideration of the Staff Survey outcomes at Board local plans are being developed which should help to reduce the risk. The need for work on supporting the mental well being of colleagues was also flagged.

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**
Working Well services including in house fast track physiotherapy	Contract review meetings with working well	Management
Employee Assistance programme	Contract review meeting with Care First	Management
Employee health and wellbeing plan including health and hustle initiative	Employee health and wellbeing plan monitored through Workforce and OD committee	Board
Healthy eating initiative	CQUIN	Independent
Mental health first aid training	CQUIN	Independent
Stress management workshop, including mindfulness and resilience.	CQUIN	Independent
Stress management policy	Annual staff survey results regarding the organisation taking positive action on H&W.	Independent

Employee Health and Wellbeing Charter achieved	Employee Health and Wellbeing Charter achieved	Independent

Gaps in Controls and Assurance (what additional controls and assurances should we seek)		**Mitigating Actions (what more should we do)**		
		Action	**Owner**	**Deadline**
1	Line manager capability and capacity to undertake stress risk assessment audits	To further develop managers toolkit and guidance. Further guidance and support issued to managers.	Head of OD	July 2018 Complete
2	Review of Application of Sickness Policy to ensure follow up	Regular workshop on Absence Management in place, attendance to be reviewed. Executive monitoring of application to be implemented**.** Monitoring and Review ongoing	IDHR&OD	Dec 2017 Sept 2018
3	Local Staff Survey response plans with focus on well being to be developed	Development session at CORE to provide support for development. Plans now being monitored.	IDHR&OD Heads	Ongoing
4	Ensure CQC Must dos in relation to mandatory training and PDR compliance are achieved	CQC Improvement Plan achieved with timeliness. Being montored by the Quality and Performance Committee and the Executive.	DON	Ongoing
5	Ensure CQC Must do's in relation to training (in particular End of Life) are in place	CQC Improvement Plan achieved with timeliness. Being montored by the Quality and Performance Committee and the Executive.	DON	Ongoing
Links to Primary Regulatory Framework				

Strategic Objective	*We will have an energised and enthusiastic **workforce** and each individual will feel valued and supported.*		
Risk SR12	There is a risk that we under invest in leadership and management development ; resulting in a lack of capacity to nurture a highly engaged and motivated workforce.		
Type	Quality	**Executive Lead**	Director of HR
Risk Rating	(Likelihood x impact)	**Assurance Committee**	Workforce & OD Committee
Inherent (without controls being applied) Risk Score	5 x 4 = 20	**Date Identified**	April 2017
Previous Risk Score	3 x 4 = 12	**Date of Review**	July 2018
Current Risk Score	4x 4 = 16	**Date Next Review**	September 2018
Tolerable (Target) Score	2 x 4 = 8	**Date to Achieve Target**	March 2019

Key 2017/18 Deliverables	**Relevant Key Performance Indicators**
Refresh of leadership development plan including talent management – Dec 17	Level of support provided by manager (measured through staff survey)
360 appraisal programme - Nov 2017 – not currently being progressed	PDR compliance rates
Managers induction (March2018) and toolkit (Jan 2018)	Number and percentage of managers participating in leadership development programmes
Key 2018/19 Deliverables	**Relevant Key Performance Indicators**
Refresh of leadership development plan including talent management – combining with review of 2gether processes	Level of support provided by manager (measured through staff survey)
	PDR compliance rates
Managers induction implemented and monitored	Number and percentage of managers participating in leadership development programmes

Rationale For Current Score (Identifying progress made in previous period)

While continuing to support a number of leadership development activities, Professional Development Review and Mandatory Training levels remain below target with limited resources to support required investment in system and transformational leadership. This is becoming an increased risk in light of the level of change and transformation required at a time of signficiant service pressure. Identified for action within Transition and Transformation workstreams

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**
Range of leadership programmes in place	Workforce Education & Development Group which reports to the Workforce & Organisational Development Committee	Board
Annual leadership conference	Leadership plan approved and monitored through Workforce & OD Committee	Management
Monthly leadership Core Colleague Network meetings	Exec Planning and Review	Management Oversight
CORE values behaviour framework	Reports to Workforce and OD Committee	Board Oversight

Gaps in Controls and Assurance (what additional controls and assurances should we seek)		Mitigating Actions (what more should we do)		
		Action	**Owner**	**Deadline**
1	Talent Management Strategy	Strategy to be developed and approved through Workforce & OD Committee. Also to be supported by the merger transition work.	Head of OD	July 2018
2	The assessment of individual's ability against the NHS Leadership Competency Framework is varied and it not intrinsically linked to personal development plans	360 Programme in development to increase self-awareness and personal impact. Also to be supported by the merger transition work.	Head of OD	July2018
3	Managers induction	Managers toolkit and induction delivered. Review whilst planned manager development within transition workstream being considered.	Head of OD	July 2018

Strategic Objective	*We will manage **public resources** effectively so that the services we provide are **sustainable***		
Risk SR13	There is a risk that we fail to maintain and develop an infrastructure fit for future services; resulting in fragmented service delivery models and escalating costs.		
Type	Financial	**Executive Lead**	Director of Finance
Risk Rating	(Likelihood x impact)	**Assurance Committee**	Finance Committee
Inherent (without controls being applied) Risk Score	5 x 4 = 16	**Date Identified**	20/4/17
Previous Risk Score	4x 4 = 16	**Date of Review**	July 2018
Current Risk Score	3 x 4 = 12	**Date Next Review**	September 2018
Tolerable (Target) Score	2 x 4 = 8	**Date to Achieve Target**	Mar 2019

Key 2017/18 Deliverables	**Relevant Key Performance Indicators**
1. Estates Strategy – **Agreed**	1. Capital Servicing capacity
2. Financial Strategy – **Business Plan Process Resilience element support**	2. Income and Expenditure Margin
Key 2018/19 Deliverables	**Relevant Key Performance Indicators**
Business Plan delivered	1. Capital Servicing capacity
Operational Plan delivered	2. Income and Expenditure Margin
Capital Plan delivered	3.Reference Cost Index
	3.Reference Cost Index

Rationale For Current Score (Identifying progress made in previous period)

Development of clear service led estates strategy and IMT is progressing with a number of priority areas now moving forward e.g. Forest of Dean. JUYI

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**
Information and Management Technology (IM&T) Strategy	IM&T Steering Group	Management oversight
Capital Programme	Capital Expenditure Steering Group Group	Management oversight
Health and Safety and Security Policy	Health & Safety Steering Group – reporting to Audit and Assurance Committee	Management /Board oversight
	Board and Committee approval of IM&T , Estates and Financial Strategy and overall operating plan	Board oversight
	Finance Committee ERIC (Estates Return Information Collection) and PLACE (Patient Led Assessment Care Environment) monitoring	Board oversight

	Finance Committee Monitoring of Capital Programme	Board oversight

Gaps in Controls and Assurance (what additional controls and assurances should we seek)		Mitigating Actions (what more should we do)		
		Action	**Owner**	**Deadline**
1	Assessment of what required for future delivery of services needs to be undertaken	To be undertaken in tandem with work with integration with 2gether NHS Foundation Trust	Executive	Sept 2018
2	Business Plan implemented	Business Plan Monitoring	DoF	Nov 2017 Ongoing
Links to Primary Regulatory Framework **NHSI Single Oversight Framework** **CQC – Well led**				

Strategic Objective	*We will manage **public resources** effectively so that the services we provide are **sustainable***		
Risk SR14	There is a risk that we do not invest in long term sustainability, resulting in inability to sustain quality and compromising year on year cost improvement.		
Type	Financial	**Executive Lead**	Director of Finance
Risk Rating	(Likelihood x impact)	**Assurance Committee**	Trust Board
Inherent (without controls being applied) Risk Score	4 x 5 = 20	**Date Identified**	20/4/17
Previous Risk Score	4 x 5 = 20	**Date of Review**	July 2018
Current Risk Score	3 x 5 = 15	**Date Next Review**	September 2018
Tolerable (Target) Score	3 x 5 =15	**Date to Achieve Target**	March 2019

Key 2017/18 Deliverables	**Relevant Key Performance Indicators**
Updated Financial Strategy - **Business Plan Process Resilience element supports**	Forecast Trend for Return on Capital
Business Development Strategy – **Agreed focus on Business Planning Process**	Service User Outcome data –(Mortality, Readmission, MSKat, reablement)
Key 2018/19 Deliverables	**Relevant Key Performance Indicators**
Updated Operating Plan	Forecast Trend for Return on Capital
Business	Service User Outcome data –(Mortality, Readmission, MSKat, reablement)

Rationale For Current Score (Identifying progress made in previous period)

While good processes are in place, the operating environment is increasingly challenging and requires a longer term response which reflects the challenges within the operating plan, Cost Improvement Plan Targets and Control Totals. The work with 2gether NHS Foundation Trust will target the building of resilience

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**
Monthly Financial Reporting	Finance Committee monitoring	Management
CIP Steering Group	Progress against CIP targets is monitored at the CIP Steering Group which reports to the Finance Committee – Good historical delivery against QIPP and CQUIN. Trend on proportion of CIP delivered	Management/Board Oversight
QEIAs will be completed and signed off for all CIP schemes before they are implemented	QEIA Review at Clinical Reference Group and Executive or Board and Committees if necessary.	Management/Board
CIP Development Plan	NHS Benchmarking Group Report	Independent

		CIP Steering Group monitoring and Finance Committee		Management/Board
Gaps in Controls and Assurance (what additional controls and assurances should we seek)		**Mitigating Actions (what more should we do)**		
		Action	**Owner**	**Deadline**
1	Updated Financial Strategy linking to STP	Review Financial Strategy and update	DOF	July 2018
3	CIP Plan 2018/19 delivery	CIP Plan 2018/19 in Place and monitoring processes on going	DOF	March 2019
4	Work Force Plan 2018/19	Work Force Plan 2018/19 to be reviewed by Workforce and OD Committee and Board	IDHR&OD	July 2018
		Benchmark against Carter Metrics (once issued) **Update July 2018** – not yet issued	DOF	July 2018
Links to Primary Regulatory Framework **CQC – Well led**		**NHSI Single Oversight Framework**		

Strategic Objective	*We will manage **public resources** effectively so that the services we provide are **sustainable***		
Risk SR15	There is a risk we do not maintain robust internal controls and governance systems; resulting in potential financial and organisational instability.		
Type	Financial	**Executive Lead**	Director of Finance
Risk Rating	(Likelihood x impact)	**Assurance Committee**	Audit & Assurance Committee
Inherent (without controls being applied) Risk Score	4 x 5 = 20	**Date Identified**	1st April 2017
Previous Risk Score	4 x 4 = 12	**Date of Review**	July 2018
Current Risk Score	3 x 3 = 9	**Date Next Review**	September 2018
Tolerable (Target) Score	2 x 3 = 6	**Date to Achieve Target**	31st March 2019

Key 2017/18 Deliverables	**Relevant Key Performance Indicators**
Review of SFI Compliance – carried forward	No high priority Internal Audit Recommendations (with IA assignments continuing to be risk based)
Timely compliance with Internal and External Audit recommendations - achieved	At least 50% of Internal Audits give Substantial assurance

Key 2018/19 Deliverables	**Relevant Key Performance Indicators**
Review of SFI Compliance	No high priority Internal Audit Recommendations (with IA assignments continuing to be risk based)
Timely compliance with Internal and External Audit recommendations	At least 50% of Internal Audits give Substantial assurance

Rationale For Current Score (Identifying progress made in previous period)

While good progress made to strengthen internal controls, current significant pressure on capacity could distract from maintaining control if not effectively managed, recognising that cumulative gaps can lead to a significant impact.

Key Controls To Manage Risk	**Assurance on Controls**	**Type of Assurance**
Clinical and corporate governance arrangements enable controls to be effectively managed	The sub-Board Committee structure, and in particular, the Audit and Assurance Committee, the Quality and Performance Committee, the Finance Committee, and the Workforce and OD Committee, provide assurance on all corresponding controls to the Trust Board	Board
Committee / reporting structures enable controls to be monitored and reviewed	Internal Audit of Governance December 2016, Reported to the Audit and Assurance Committee February 2017, classified Corporate Governance – Governance Framework as low risk and advised;	Independent
The Trust's strategy framework provides oversight of activity and controls in all key operational and support	"Our review of corporate polices and documentation, including committee structure, terms of reference,minutes,board papers and other	Independent

areas	ad-hoc document sidentified that, overall, the Trust has appropriate structures in place to support good governance.". – Internal Audit	
The Trust maintains its Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation of Powers by which its authority is managed and controlled	IA and EA feedback	Independent
Line management structures provide clarity in terms of responsibilities and accountabilities	Management Review	Management
Internal and external audit and plans provides additional scrutiny	Degree that Internal Audit is risk based.	Board
Robust project structure and governance framework in place to ensure continual monitoring and reporting with clear escalation	Internal Audit Review	Independent
IT Investment to maintain Cyber Security Protection	Reports to Audit & Assurance Committee through IM&T Group	Board

Gaps in Controls and Assurance (what additional controls and assurances should we seek)		**Mitigating Actions (what more should we do)**		
		Action	**Owner**	**Deadline**
1	Confirmation of Compliance with SFIs	Review of Compliance SFIs	DOF	Sept 2018
2	Well led framework needs further consideration by Board following consultation changes	To be further reviewed as part of the work with 2gether NHS Foundation Trust. Development work with 2gether will take this forward.	TS/Board/SILG	Sept 2018
3	Up to date Board development programme to support understanding of roles and appreciative enquiry	Board Development Programme implemented. Development process ongoing.	Chair	Sept 2018
4	Confirmation governance TOR and Effectiveness processes for use end of year 2017/18	Complete ToR and Review of Effectiveness for all Board Sub-committees and mechanism for management committees to update. Incorporated within Annual Report. No significant issues highlighted, but proposal to combine Workforce and Finance Committees currently ongoing. **Actions to date –** process ongoing.	TS	Sept 2018
	Preparation for Use of Resources	Use of Resources implications considered at Execs Sept 2017. To be considered by Board. Financial Report revised to include metrics from Use of Resources. Initial actions complete, further information awaited from	DoF	Sept 2018

		NHSI on implementation date for Community Trusts. Actions to date shared with 2gether.		
		Timely Actioning of EA and IA – follow up process embedded. Confirmation at end of year Audit Committee that this is being achieved.	DoF	Complete
		Reference Costs Monitoring to support best value. Programmed for discussion CORE & Finance Committee	DoF	April 2018 Complete
Links to Primary Regulatory Framework **SOF, Well Led, CQC**.				

Definitions

The overall risk ratings below are calculated as the product of the Probability and the Severity

Score. **I M P A C T S C O R E**

LEVEL	INJURY / HARM	SERVICE DELIVERY	FINANCIAL / LITIGATION	REPUTATION / PUBLICITY
5. CATASTROPHIC	Fatality, Multiple fatalities or large number injured or affected.	Complete breakdown of critical service/ 'Significant under-performance' against key targets.	Losses; claims/damages; criminal prosecution, over-spending; resourcing shortfall: >£1M.	National adverse publicity/reputation irreparably damaged.
4 Major (HIGH)	Fatality/multiple serious injuries/major permanent loss of function/increased length of stay or level of care >15 days.	Intermittent failures of a critical service/'under-performance against key targets'.	£501K - £1M	Adverse national publicity
3 Moderate (MEDIUM)	Semi-permanent harm (1 month-1 year). Increased length of stay / level of care 8-15 days, >1 month's absence from work.	Failure of support services/under-performance against other key targets'.	£51K - £500K	>3 days local media publicity
2 Minor (LOW)	Short-term injury (<1 month). Increased length of stay or level of care <7 days, 3 days-1 month absence for staff.	Service Disruption	£11K - £50K	<3 days local media publicity
1 (Insignificant)	No harm. Injury resulting in <3 days' absence from work for staff.	No service disruption	<£10K	

LIKELIHOOD SCORE		
Level		
5	Almost certain	Will occur frequently given existing controls
4	Likely	Will probably occur given existing controls
3	Possible	Could occur given existing controls
2	Unlikely	Not expected to occur given existing controls
1	Rare	Not expected to occur, except for in exceptional circumstances, given existing controls

RISK RATING MATRIX

	IMPACT				
Likelihood	**1**	**2**	**3**	**4**	**5**
5	**5** (LOW)	**10** (MEDIUM)	**15** (HIGH)	**20** (CATASTROPHIC)	**25** (CATASTROPHIC)
4	**4** (LOW)	**8** (MEDIUM)	**12** (MEDIUM)	**16** (HIGH)	**20** (CATASTROPHIC)
3	**3** (LOW)	**6** (MEDIUM)	**9** (MEDIUM)	**12** (MEDIUM)	**15** (HIGH)
2	**2** (LOW)	**4** (LOW)	**6** (MEDIUM)	**8** (MEDIUM)	**10** (MEDIUM)
1	**1** (LOW)	**2** (LOW)	**3** (LOW)	**4** (LOW)	**5** (LOW)

Impact Score x Likelihood Score = Risk Rating:

NHS
Gloucestershire
Care Services
NHS Trust

Trust Board	
Date of Meeting:	24th July 2018
Report Title:	Joint Chair's Report

Agenda reference Number:	8/0718
Accountable Executive Director: (AED)	Not Applicable
Presenter: (if not AED)	Ingrid Barker - Chair
Author(s):	Ingrid Barker - Chair
Board action required:	Note
Previously considered by:	Not Applicable
Appendices:	

Executive Summary

Recognising the Strategic Intent work and my role as both Chair of Gloucestershire Care Services and ²gether this report format has been revised to reflect the breadth of my activities across both Trusts. The production of a joint report does not impact on my existing accountability as the appointed Chair of each Trust.

The Report also provides an overview of Gloucestershire Care Services Non-Executive Director (NED) activity.

Recommendations

The Board is asked to:

1. **NOTE** the Report.

Related Trust Objectives	1,2,3,4,5
Risk Implications	No risks identified
Quality/Equality Impact Assessment Requirements/Implications (QEIA)	Implications are clearly referenced in the report
Financial Implications	No finance implications identified
Legal/Regulatory Implications	Legal/Regulatory implications are clearly referenced in the report

Understanding You

Joint Chair's Report

1. INTRODUCTION AND PURPOSE

This report seeks to provide an update to both Boards on Chair and Non-Executive Director activity in the following areas:

- Strategic Intent
- Board Development
- Working with our partners
- Working with our colleagues
- National and Regional Meetings attended and any issues highlighted

1.1 Strategic Intent Update – Moving towards developing an integrated physical and mental health care offer with ²gether NHS Foundation Trust

GCS continues to work with ²gether NHS Foundation Trust to take forward its ambition. The work is being overseen by the Strategic Intent Leadership Group with the operational processes being led by the Programme Management Executive. The Strategic Intent Leadership Group is focusing particularly on ensuring the focus remains on the two Trusts' overarching strategic ambition of delivering improved services for our service users as well as ensuring the required governance and programme processes are in place. The Group maintains an ongoing oversight on ensuring that stakeholders are fully involved in this key development and that their feedback informs and drives our plans.

Regular briefings to update colleagues on the Strategic Intent activity has continued to support ongoing engagement. ²gether Governors have received a detailed briefing on their role in relation to the transaction. Governors will continue to be fully informed and engaged in the process.

I was pleased to support the Joint Chief Executive in hosting two stakeholder meetings to progress wider engagement in the Transformation theme. One was held in Gloucester at the Guildhall and the other in Hereford at the Kindle Centre.

1.2 Gloucestershire Care Services and ²gether Trust AGMs –19th July 2018

The Gloucestershire Care Services NHS Trust AGM will be followed by the ²gether NHS Foundation Trust AGM. This will provide an opportunity to update on the planned merger and joint working plans as well as meeting both Trusts' individual statutory responsibilities. We are pleased to be hosted this year by our partner, the University of Gloucestershire, which has a key role to play in supporting the development of the future workforce required by both Trusts. As always, the AGM will showcase services and the work of colleagues.

1.3 Board Development

A **Joint Board Seminar** event took place on 28th June and a **Joint Board Development** session took place on 11th July. These sessions are an important part of the work we are doing to bring GCS and 2gether together ensuring that our shared values stay at the heart of what we are working to achieve and that knowledge of both organisations is maintained and enriches our working practices. A full programme of Board development is planned.

1.4 Working with our Partners

Maintaining **business as usual** remains a priority across both organisations. As part of this I have continued my regular meetings including:

- Together with the Joint Chief Executive, individual meetings with Gloucestershire MPs – David Drew, Sir Geoffrey Clifton-Brown, Laurence Robertson, Mark Harper, Richard Graham and Alex Chalk. Meetings with the two Hereford MPs, Bill Wiggin and Jesse Norman, are planned.
- Gloucestershire County Council Corporate Peer Challenge on 13th June (represented by GCS Vice-Chair, Sue Mead)
- NHS Providers Chairs and Chief Executives meeting, London on 19th June
- NHS Providers Board in London on 4th July
- Gloucestershire Strategic Forum on 26th June
- Sustainability and Transformation Partnership Advisory Group on 26th June (represented by GCS Vice-Chair, Sue Mead)
- Forest of Dean Health Forum on 3rd July Health and Social Care Overview and Scrutiny Committee meeting on 10th July.
- Gloucestershire Health and Wellbeing Board on 17th July
- I have been represented at the Worcestershire and Herefordshire STP Chairs' meeting by Marcia Gallagher, 2gether NED.
- I have been represented at the Herefordshire health and wellbeing Board workshop by Duncan Sutherland, 2gether NED.

On Friday 29th June, **Mark Harper, MP for the Forest of Dean**, spent time at the Dilke Hospital visiting the Children's Physiotherapy team, before going on to Colliers Court in Cinderford, where 2gether's Forest of Dean community services are based, including children's mental health, dementia and memory assessment. Mr. Harper has advised how informative and helpful he found the session, which built on his previous visits.

The Chief Executive and I were invited to attend the **Forest of Dean Health Forum** on 3rd July where we gave updates on the proposed merger with 2gether NHSFT, the Forest of Dean Community Hospitals and Integrated Locality Boards.

A r**egular meeting of the Health Care Overview and Scrutiny Committee (HCOSC)** took place on 10th July where items discussed included how Integrated Care Systems will benefit Gloucestershire and the proposed Stroke Rehabilitation unit at the Vale Hospital in Dursley. It was a helpful meeting, supporting the progress of these important matters.

The **quarterly meeting of the County's Health and County Council Chairs** took place on 10th July where we discussed the current issues facing the NHS and future plans.

The Gloucestershire Health and Wellbeing Board met on 17th July 2018. This discussed the Joint Health and Wellbeing Strategy for Gloucestershire, the Draft Children's Partnership Framework, Adverse Childhood Experiences, Permanent Exclusion Task Group Report, Restorative Practice in Schools and the Joint Commissioning Annual Report. The focus on working to overcome inequalities is a key part of the work of this group and the agenda helped to give a real sense of how as organisations we can work together to make a difference.

This meeting was followed by a special event to sign up to the consensus statement introduced by the national **Prevention Concordat for Better Mental Health** to make a local collective commitment to promoting good mental wellbeing and preventing mental illness. We heard examples of inspirational activity already taking place in Gloucestershire and officially launched the local approach to delivering the Prevention Concordat and making good mental wellbeing everybody's business.

I held one of my quarterly meetings with the **Chair of Gloucestershire Hospitals NHS Foundation Trust**. This meeting was held at Alexandra House in Cheltenham. These sessions reflect the interdependencies of our organisations and are an opportunity to ensure we are working together effectively to support provision of seamless care to our community.

2. Working with the Communities and People We Serve

I attended the **Bishop of Gloucester's Summer Garden Party** which was held at Bishops Court in Gloucester on the 19th July.

Lydney League of Friends held their annual fete at the Hospital on Saturday 21st July. Richard Cryer, NED, attended.

The Joint Chief Executive and I held our regular **quarterly meeting** with **Chairs of Leagues of Friends** relating to the community hospitals.

3. Engaging with our Trust Colleagues

3.1 NHS70 celebrations

I have been delighted to be part of a range of celebrations marking the key part the NHS has played, and continues to play, in so many lives. The NHS continues to be an organisation at the heart of the community which makes a real difference because of the commitment, caring and compassion of colleagues – I am proud to continue to have a role ensuring the needs of service users, the NHS Constitution and its founding tenets are central to everything we do as Trusts.

I attended the [2]gether Exhibition and Open Day at Blackfriars Priory which brought to life the support that has been provided people with a range of difficulties over the last 70 years, and indeed before then. Graham Russell (GCS NED) attended the celebrations at Cirencester Hospital and Sue Mead (GCS NED) attended celebrations at North Cotswolds Hospital – both advised that they were heart-warming occasions – a testament to colleagues and also service users.

I attended and spoke at the Cirencester Hospital NHS70 Service held at the Church of St. John the Baptist in Cirencester on Sunday 15th July and also attended the Herefordshire NHS Thanksgiving Service at Hereford Cathedral on 10th July.

I continue to meet regularly with Trust colleagues at GCS and [2]gether and visit services at both Trusts to inform my triangulation of information. I have undertaken service visits with [2]gether Governors to Wotton Lawn and Stonebow inpatient units. I also attended part of the Gloucestershire Care Services Conference on Children's Safeguarding. The Joint Chief Executive and I were pleased to attend a meeting of the Herefordshire Psychiatric Division at Stonebow Unit.

3.2 2gether ROSCAs Awards Evening, Friday 20th July 2018

At the time of writing I am looking forward to attending the ROSCAs at which we will recognise and celebrate the contribution of ²gether colleagues in delivering excellent services. We will also recognise our longest serving colleagues, including those who have served the NHS for 40 years.

4. NED Activity

Since my last Board report the Gloucestershire Care Services Non-Executive Directors (NEDs) held a meeting at Edward Jenner Court. We invited the Deputy Chief Executive of ²gether NHSFT, Colin Merker, to join the meeting to give an overview of ²gether services and performance.

The [2]gether NED team has also met and further joint NED meetings are planned.

Other activities undertaken by the GCS NEDs - key meetings and events have included:

- Attendance at Trust Board, Committees, Board Development and Board Seminars (both GCS and joint with [2]gether)
- Attendance at AGM
- Sustainability and Partnership Transformation Advisory Group (Sue Mead)
- Attendance at Transformation Collaboration Conference, Manchester (Graham Russell)
- Meeting with Director of HR (Nicola Strother Smith)
- Appraisal with Chair (Graham Russell)
- Strategic Intent Leadership Group (SILG) meetings (Sue Mead and Graham Russell)

- NED Meeting at Edward Jenner Court
- Quality Visit (Nick Relph)
- Volunteer Strategy Group (Jan Marriott)
- Volunteers Tea Party (Nicola Strother Smith)
- Clinical Reference Group (Jan Marriott)
- Meeting with Freedom to Speak Up Guardian) (Jan Marriott)
- Mortality Review Group meetings (Jan Marriott)
- NHS70 Celebration Events (Graham Russell and Sue Mead)
- Meetings with Bilal Lala (Insight Programme) (Nicola Strother Smith and Sue Mead)
- GCC Corporate Peer Challenge (Sue Mead)
- Lydney Hospital Summer Fete (Richard Cryer)
- Oversight Meeting (Nicola Strother Smith and Nick Relph)
- Meeting with Cate Carrington-Green (CCG) (Jan Marriott)
- Meeting with Director of Finance (Nick Relph)
- Interview with PWC (Sue Mead)
- Chaired Learning Disability Expert Reference Group (Richard Cryer)
- Meeting regarding new format of NED visits (Nicola Strother Smith)

The NED Quality Visit Reports are taken forward within the Quality and Performance Committee.

5. CONCLUSION AND RECOMMENDATIONS

The Board is asked to **NOTE** the Report.

Trust Board	
Date of Meeting:	24th July 2018
Report Title:	Chief Executive and Executive Team's Report

Agenda reference Number:	09/07618
Accountable Executive Director: (AED)	Not Applicable
Presenter: (if not AED)	Paul Roberts – Joint Chief Executive
Author(s):	Paul Roberts – Joint Chief Executive
Board action required:	Note
Previously considered by:	Not Applicable
Appendices:	Appendix 1 – Lord Carter Review on Mental Health and Community Services

Executive Summary

Recognising the Strategic Intent work and my role as both Chief Executive of Gloucestershire Care Services and ^{2}gether this report reflects the breadth of my activity across both Trusts. I remain accountable separately for the performance of each of these roles.

The Report also provides an overview of Gloucestershire Care Services operational service activity.

Recommendations:

The Board is asked to:

1. **NOTE** the Report.

Related Trust Objectives	1,2,3,4,5
Risk Implications	No risks identified
Quality/Equality Impact Assessment Requirements/Implications (QEIA)	Implications are clearly referenced in the report
Financial Implications	No finance implications identified
Legal/Regulatory Implications	Legal/Regulatory implications are clearly referenced in the report

Chief Executive's Report

1 Chief Executive Engagement

I remain committed to spending a significant proportion of my time visiting front-line services in both organisations and continue to be impressed and heartened by the professionalism and commitment of colleagues across the organisations and in the pride that they take in the delivery of, in many cases, outstanding services.

Services I have visited in recent weeks include:

Gloucestershire Care: Cirencester Community Hospital, the **I**ndependent Living Centre in Cheltenham, the Podiatry Centre, at St Paul's Medical Centre, in Cheltenham where some enthusiastic colleagues gave me an off-the-cuff lecture on podiatry and its importance to service users and how they work as part of some key multi-disciplinary teams such as diabetes; and as a springboard to visiting the GCS County-wide services (which include among other services: tissue viability, early supported discharge for stroke, muscular skeletal advanced practitioners, cardiac rehabilitation, community dental, sexual health, podiatry, speech and language therapy, adult physio therapy, integrated community equipment service) I had a really informative presentation from the Head of Countywide and members of the team about these services, the triumphs and challenges, which has set me up well to make more visits over the coming weeks.

2gether Services: an **"**Open Door" event in Charlton Lane; Wotton Lawn, the adult inpatient unit in Gloucester; Working Well Centre, in the Orchard Centre, in Gloucester, Herefordshire psychiatrists at their regular divisional meeting and the Stonebow Inpatient Unit. Having met the Gloucestershire psychiatrists at their regular medical staff committee meeting, it was good to have the opportunity to introduce myself to their Herefordshire counterparts we had a useful discussion which focussed on the particular context of Herefordshire. The county, whilst large in square miles, is small in population: 190,000 compared with 620,000 in Gloucestershire. Historically, partly due to particularly severe NHS financial pressures, it has not invested as much in mental health and learning disability services as in Gloucestershire – the team therefore is relatively small and has to be flexible. I was impressed by the passion for the County and the determination to ensure that Herefordshire plays a significant part in the development of our new integrated organisation.

2 Progress on the strategic intent to merge Gloucestershire Care Services NHS Trust (GCS) with [2]gether NHS Foundation Trust

The development of outstanding integrated mental and physical health services firmly rooted in local communities is the vision that lies behind the proposed merger of [2]gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust. This vision is a major vehicle for delivering both the One Gloucestershire Programme. This vision will remain central the complex work required to ensure this merger happens over the coming months.

A range of initial engagement events have now been held with colleagues and wider stakeholders to start to develop an engagement process which will ensure that the people that we serve and those we work with are genuinely engaged in the co-production of outstanding services which meet the needs of our communities and tackle inequalities. The Strategic Intent Leadership Group, which is comprised of Non-Executive Directors from both Trusts, with myself and the Joint Chair is committed to keeping this as the bedrock to all our joint work.

We are beginning to consider how the vision and values of both organisations can be taken forward to inspire our new organisation to achieve our ambitions. This work will involve colleagues, Board and our stakeholders.

The practical processes required to take forward a merger are being taken actioned by the Programme Management Executive Group, monitored by the Strategic Intent Leadership Group, and to date we are on track for the Boards to consider the Strategic Outline Case, which must be submitted and approved by NHSI, by the end of September 2018. We would then expect to hear from NHSI in November 2018.

3 Carter Mental Health Community Services Work

As advised in my last report (see Appendix 1 attached), the Lord Carter report into the "Operational Productivity and Performance in English NHS Mental Health and Community Health Services: unwarranted variations" was published on 24th May 2018. Given [2]gether NHS Foundation Trust's input into the report as a "high performing" Mental Health Trust a breadth of comparator information has been made available to them which was discussed at a meeting of the Joint Executives of both Trusts who are now taking forward opportunities for learning and improving efficiencies. This type of joint work, which uses the joint expertise of both Trusts is just one example of how our planned joint work can improve the way we work.

4 "One Gloucestershire" Integrated Care System

The proposal for establishing an integrated care system (ICS) in Gloucestershire was one of four approved by NHS Improvement and NHS England as this paper was being finalised. This means Gloucestershire will be one of only fourteen ICSs nationally. The paper approved at the NHSi and NHSE Board meeting said: "These systems demonstrate strong leadership teams, capable of acting collectively, and with an appetite for taking responsibility for their own performance…. They have also set out ambitious plans for strengthening

primary care, integrating services and collaborating between providers. Although they experience the operational and financial pressures that other systems do, our assessment is that they are more likely to improve performance against NHS Constitutional standards and financial sustainability by working together as a system".

The ICS provides an additional impetus not only for the joint work being pursued through the STP programme but also for the intended merger between 2gether and Gloucestershire Care Services NHS Trust.

5 National issues

5.1 The NHS Funding Settlement from NHS Providers Summary which will be used to inform debate within the Trusts and nationally

The government has announced a 3.4% real terms funding rise for the NHS over five years. This is a welcome investment, but there are many demands on this funding. It must pay for recovering current performance and financial gaps, pay rises for staff, keeping up with NHS cost and demand growth, and any early steps to either transform the service or enhance performance in areas like cancer and mental health. It is important not to lose this opportunity to reform NHS services and look to invest in the right services for patients.

- We need to recognise how dependent the NHS is on wider public services, in particular public health and social care. Ensuring that these services are sustainably funded is crucial to the success of the health and care system over the next ten years.

Full briefing available on the NHS Providers website

5.2 NHS 70

By definition, the NHS has had an impact on everybody reading this – you are part of it, whether as a member of staff, a volunteer, a non-executive director or a governor. You and your family will have depended on it at some time in your life. For many of us the NHS is more than a job – it is a vocation. **The values implicit in the NHS are inherently civilised**– the NHS is a commitment to each other, an agreement to ensure that our health and wellbeing when we are at our most vulnerable is the responsibility of us all. I am delighted to have been able to join in local celebrations of this milestone but also to see the NHS recognised across the country for the key role it plays in our society.

5.3 Ministerial Changes – Rt. Hon Matt Hancock MP, Secretary of State for Health and Social Care

Conservative MP for West Suffolk since 2010.

Portfolio

The Secretary of State for Health and Social Care has overall responsibility

for the business and policies of the department, including: financial control; oversight of all NHS delivery and performance; mental health and championing patient safety.

Parliamentary career

- Secretary of State for Digital, Culture, Media and Sport, Jan 2018 – July 2018
- Minister of State at the Department for Digital, Culture, Media and Sport, 2016-18
- Paymaster General and Minister for the Cabinet Office, 2015-16
- Minister of State at the Department of Energy and Climate Change; Department for Business, Innovation and Skills.
- Joint Minister of State at the Department for Business, Innovation and Skills and the Department for Education, 2013-14
- Joint Parliamentary Under-secretary of State at the Department for Education and the Department for Business, Innovation and Skills, 2012-13
- Member of the Standards and Privileges Committee, 2010-12
- Member of the Public Accounts Committee, 2010-12

Following the visit of Jeremy Hunt earlier in the year we hope to have the opportunity to showcase our services to the new minister in coming months.

6 Integrated Care System

Following my update in June I am pleased to update that memorandum of understanding is being developed which will set out the principles of collaboration between the partners for development of services and use of resources. HSCOC will be involved as the system progresses through the ICS process and we will all have a significant ability to influence what enhanced integrated care will look like for One Gloucestershire. Work to define the priorities for the ICS are also underway.

7 Operational Service Overview

7.1 System flow and Resilience

Gloucestershire urgent care system continues to experience high levels of demand, with average Emergency Department (ED) attendance in June at 418, slightly higher than the anticipated daily level of 404 but in line with activity levels in May.

Gloucestershire ED performance for May (last formally reported position) was at 91.58%, which is the third best in the Southwest, and the most improved provider when comparing May last year to this year, seeing a 10.2% improvement in performance.

Within the Minor Injury and Illness Units (MIIU) services June has seen an additional 241 attendances against May. Overall MIIU attendances have

increased by 6.2% 18/19 YTD when compared to the same period last year equating to 1,009 additional attendances.

Summary of weeks 1-13 – Hospital site breakdown

	Cirencester	Dilke	Lydney	North Cotswold	Stroud	Tewkesbury	Vale	Total
17/18	2944	2398	1567	1518	4322	1807	1602	16158
18/19	3365	2167	1778	1686	4540	1750	1881	17167
Change	421	-231	211	168	218	-57	279	1009
%	14.3%	-9.6%	13.5%	11.1%	5.0%	-3.2%	17.4%	6.2%

Only Dilke and Tewkesbury have seen fewer attendances than this time last year. The Vale has been the highest percentage growth, with Cirencester seeing the highest volume increase. This illustrates that pressures across the urgent care system are not restricted to the Acute hospital setting.

Informal discussions with primary care have noted that although they are busy, they are no busier than normal. An audit undertaken in June has demonstrated that waits for routine appointments have reduced as Improved Access capacity has increased.

The reason for the high attendances continues to be investigated, including the use of patient audits. To date there does not seem to be any specific clinical reason for this change in demand, however the pattern of attendances (higher across both ED and MIIU on a Monday by “walk-ins”) suggests the public is seeking a more “open-access” service rather than accessing booked primary care appointments that have been enhanced to offer greater capacity.

The Delayed transfers of care (DTOC) across the system remains within the 3.5% target, with Gloucestershire Hospitals Foundation trust rate at 2.98% for May and Gloucestershire Care Services NHS trust at 1% for May and 1.2% for June.

For the Trust, the community hospital bed occupancy for June has reduced to 91.8% and below our target of 92%.

Length of stays in June for direct admissions was 24.0 and for transfers from the acute trust stays were 30.3 days and continues to be an area of focus.

7.2 Operational Service Development and Challenges

7.2.1 Timely Access to Services

June performance has seen improvement with only **4** service areas experiencing challenges in providing services in a timely way. Detailed action plans are in place, monitored regularly and further scrutiny takes place in the Quality and Performance Board subcommittee.

Adult speech and language therapy service continues to perform below local access target (57.1% in June) and a deterioration from the May position. Although there has been significant improvement in capacity following successful recruitment, it will take a period of time to clear the backlog of

service users and “long waiters”. Those with highest clinical needs will be prioritised which then impacts on this performance target.

MSK physiotherapy, did not meet the local 8 week referral to treat target, and it is recognised that performance has shown a steady deterioration since April. Demand has been particularly high in June, and as a result additional capacity is being sought to provide additional new appointments alongside a number of actions to improve efficiency of the service (e.g. reducing Do not attend (DNA) rates and changes to how ledgers are populated to ensure clinic capacity is maximised.

Adult Physiotherapy and Occupational therapy (OT) in the Integrated Community teams are both below local target, however OT has improved on performance from May, with Physiotherapy worsening. Both clinical areas continue to experience challenges with staffing; a commissioner agreed plan on how to address the challenges within the context of the transformation is underway.

Despite the local performance it is important to note that three out of four of these most challenged services (MSK Physiotherapy, ICT physiotherapy and ICT Occupational therapy) have all achieved the national 18 week referral to treat target.

7.3 Service Updates and Developments

7.3.1 Modernising Cashes Green Ward at Stroud Hospital

As part of the planned capital works, Cashes Green ward will be decanted and undergo extensive refurbishment to modernise the space in which inpatients services are provided and support infection control measures during periods of outbreaks.

The work is anticipated to begin in at the start of August and will be completed by the end of October to ensure disruption does not extend into the winter period.

The nature of the works will require closing the ward and opening beds in other sites to ensure sufficient bed capacity to support patient flow.

7.3.2 Progress with Community Hospital Proposal – Forest of Dean Locality

A Citizens jury, comprised of 16 individuals from a cross section of residents in the Forest of Dean has been selected and will be meeting for four-and-a-half days from 13.00 on Monday 30 July to 17.00 on Friday 3 August 2018.

The jury will hear and consider a range of information, as well as receive a number of presentations, including the outcome of the recent public engagement in which views on the area (Cinderford, Coleford or Lydney) for the new community hospital were sought.

Following this public engagement and the Citizen’s Jury, the GCCG governing body and the Board will meet in August to consider the recommendations made by the Citizens Jury, information from the public engagement currently underway and views of local clinicians.

7.3.3 Integrated Community Teams Bases – Maintaining Co-location to Support Integrated care Provision

Progress has been made in resolving the previous issue raised to the Board concerning the potential accommodation issues for the Integrated Community teams and this has been shared with the Finance Committee.

This issue arose following a change in charging practices by Gloucestershire County Council.

Four principles detailed below, were used to reach a mutually recommended solution

1. The aim is to keep Integrated Community Team workforce co-located wherever possible. At minimum, the Locality referral centre needs to stay as one unit to support service delivery for both health and social care
2. Agreement to rebalance the location of the ICTs base across both GCC and GCS sites, to redistribute the burden of estates costs
3. Should it be unable to find a workable solution in co-locating a team, then each respective health and social care base in the area will allow for hot-desking by members of team who are not based in that site
4. Solutions proposed need to align and support the delivery of the Sustainability and Transformation Plan estates strategy

The proposal has been developed on how to maintain the current co-location of colleagues from both health and social care for all but one locality (Cheltenham) due to estates challenges for both organisations in this area. However there is a commitment to monitor and audit the impact of integrated working and care provision following the separation of the Cheltenham team and reconsider options in the future.

7.3.4 Transfer of the Community Lymphoedema Service

The Macmillan Lymphoedema Service, which initially moved into our Trust building at Southgate Moorings in Gloucester, in December 2016, has now transferred from Gloucestershire Hospitals NHS Foundation Trust to Gloucestershire Care Services on the 1st July 2018.

The service, delivered in partnership with Macmillan, sees patients in their own homes, in community clinics, on wards and in care homes. The main clinics are held in Gloucester, Cheltenham, Stroud and Coleford.

This service is a natural fit with our community services and will complement other specialist countywide teams, including tissue viability, the complex leg service and Macmillan Next Steps.

7.3.5 Proposal to improve Specialist Stroke Rehabilitation Services

A presentation was provided to the Health and Social care overview scrutiny committee on the 10th July, detailing the proposed changes to the Stroke clinical pathway which has been reviewed and enhanced as part of the One Gloucestershire STP Clinical transformation work.

The presentation can be found at the link below.

http://glostext.gloucestershire.gov.uk/documents/s47473/Stroke%20Rehabilitation%20HCOSC%20July%20FINAL%20-%20with%20link%20to%20story.pdf

The new care pathway will include investment of a Community stroke rehabilitation unit, which will offer specialised rehabilitation for those patients who move out of the acute phase of stroke care and rehabilitation, but are now able to go home to receive this input.

The Trust has completed an options appraisal of available sites in which this new 14 bed unit could be sited, with a preferred option of the Vale Community hospital. This ward provides the greatest match to the clinical recommendations made surrounding accommodation, and bed modelling has provided assurance that there will continue to be sufficient inpatient beds in the Stroud and Berkeley Vale locality to meet the needs of the local population.

Targeted engagement with stroke survivors and other stakeholders is underway and this, along with the further work to identify the transport concerns noted by HSCOC will be considered by the Gloucestershire Clinical Commissioning Group governing body in August.

The link to the engagement information is:

https://www.gloucestershireccg.nhs.uk/stroke-rehab

It is hoped that following the governing body meeting the Trust can proceed with a deployment plan at pace to ensure this enhanced service is available for this winter.

Chief Executive and Executive Team's Report – July 2018

APPENDIX 1

NHS operational productivity: unwarranted variations. Mental health services and Community health services – Summary of report

Lord Carter's review on NHS Operational Productivity makes 16 recommendations on how mental health and community services can improve productivity and efficiency. To carry out the review, the Carter team worked closely with a total of 23 mental health and community trusts (including 2gether NHS FT) across England where the findings suggested how the elimination of unwarranted variation can be used to improve quality and access to care whilst saving up to £1 billion across the NHS by 2021.

The report highlights the need of community health services' roles to be recognised by NHSI and NHS England in a way that builds on new models of care. This will need to overcome the barriers of integrating community health services and the wider system to support patient recovery in the comfort of their own home. Services delivered in the community account for 70% of mental health and community trust's clinical work which is partly due to the current lack of technology within organisations making the use of clinical systems time consuming and difficult to use. Carter recommends that, by autumn 2018, NHSI have developed guidance on good operating practices that includes technology and mobile working. Providers in the community should, by April 2019, use the guidance to create a plan that will increase workforce productivity and efficiency.

The findings showed how having pharmacy staff in a community setting improves the access to and safety of medicines use at a reduced cost. The provision of clinical services such as this accounts for between 38% and 30% of mental health and community costs respectively. The findings also recommend investigating opportunities such as making a change to corporate services. This could include the sharing of functions or investing in technology to aid transactional services. He then goes onto analyse how The Model Hospital can be expanded into a community setting and not just focussed on a 'hospital'. To implement this, there is a need for patient-level costing to be implemented in mental health and the community so that there is a tool for trusts to analyse their services and 'transform productivity'.

This summary only highlights a part of the Carter report. To ensure the implementation of the recommendations, best practice needs to be shared and support is needed from our partners.

Full report can be accessed here:

https://improvement.nhs.uk/documents/2818/20180524_NHS_operational_productivity_-_Unwarranted_variations_-_Mental_....pdf

Trust Board

Date of Meeting: 24th July 2018

Report Title: Annual Report on Medical Revalidation

Agenda Reference Number:	10/0718
Reason for Being Heard in Confidential Session:	
Accountable Executive Director: (AED)	Dr Mike Roberts
Presenter: (if not AED)	N/A
Author(s):	Amanda Bye, Dr San Sumathipala
Board action required:	Note and Approve
Previously considered by:	N/A
Appendices:	**Appendix 1** Appraisal Activity: Appraisal Year 1st April 2017-31 March 2018 **Appendix 2** Quality Governance information **Appendix 3** A Framework of Quality Assurance for Responsible Officers and Revalidation Annex E - Statement of Compliance

Executive Summary

The Trust employs 11 medical colleagues, none of whom were due revalidation in the appraisal year 1st April 2017 – 31st March 2018. None are due revalidation in the appraisal year commencing 1st April 2018. The Medical Director will be making recommendation regarding revalidation for 4 colleagues in the appraisal year commencing 1st April 2019.

A report was submitted which detailed the Quality and Performance Committee in April 2018, which detailed significant work undertaken to ensure that the Trust is discharging its responsibilities for medical appraisal and revalidation. This was evidenced by audits and information in the report.

Recommendations

The Board is asked to **NOTE** the content of this report and to:

Approve the Statement of Compliance, completed by the Medical Director to confirm the Trust's compliance with the statutory Responsible Officer duties. This is to be signed by the Chief Executive and is due to be submitted to NHS England by October 2018, (Appendix 3).

Related Trust Objectives	
Risk Implications	Risk issues are clearly identifed within the report
Quality/Equality Impact Assessment (QEIA) Requirements/Implications	No equality implications identified
Financial Implications	Finance implications are clearly referenced in the report
Legal/Regulatory Implications	Legal/Regulatory implications are clearly referenced in the report

Medical Director's Annual Report to the Board

1 Introduction And Purpose

This report aims to assure the Board of the effective clinical governance processes designed to ensure that the Responsible Officer is fully supported in his role, enabling the Chief Executive to sign the Statement of Compliance with confidence. Supporting evidence is provided at Appendix 1, 2 and 3.

2 Background

As a designated body for revalidation purposes, Gloucestershire Care Services NHS Trust has a statutory duty to comply with the Medical Profession (Responsible Officers) (Amendment) Regulations 2013. The Medical Director, as Responsible Officer for the Trust, plays a crucial role in improving and maintaining the quality and safety of patient care. NHS England requires designated bodies to submit a Statement of Compliance following an Annual Report to the Board.

3 Appraisal Information (Appendix 1 and 2)

Appraisal data, in the format submitted to NHS England, for quarters 3 and 4 of the 2017-18 appraisal year is shown below. There has been 100% compliance.

There has been no requirement to make a recommendation to the GMC regarding revalidation in quarters 3 and 4.

1. Name of Designated Body: **Gloucestershire Care Services NHS Trust**			
		QUARTER 3 1/1/2017 – 31/12/2017	**QUARTER 4** 1/1/2018 – 31/3/2018
2	Number of doctors with whom the DB has a prescribed connection	9	12
3	Number of doctors **due** to have an appraisal in the reporting period	2	5
4	Number of doctors who **had** an appraisal meeting in the reporting period	2	5
5	Number of doctors in question 3 above, who **did not** have an appraisal meeting in the reporting period	0	0
6	Number of doctors in question 5 above for whom the RO **accepts** the postponement is reasonable	N/A	N/A
7	Number of doctors in question 5 above, for whom the RO **does not** accept that the postponement is reasonable.	N/A	N/A

GCS has a small number of connected doctor**s but has recently expanded the** pool of appraisers to include a third, highly experienced senior appraiser.

Dr M S is a consultant in respiratory medicine and a regional appraiser of ROs for NHS England. He has undertaken 3 of the 5 appraisals in quarter 4.

The cost implication for appraisals is £500 per appraisal with 11 appraisals expected to take place in the financial year 6/4/18-5/4/19.

3.1 Support for Doctors

A "*Guide to the GCS Appraisal Process for Appraisees (March 2018)"* has been produced and circulated, together with pertinent information sheets on topics such as confidentiality in appraisal reflection.

The GCSNHST Medical Appraisal & Revalidation policy has been updated to reflect current GMC, NHS England and local GCSNHST requirements.

Personal advice and support is available to doctors on all aspects of medical appraisal and revalidation.

3.2 Collaborative Working

The majority of doctors providing care to GCSNHST service users are <u>not</u> connected to GCS as their Designated Body. They are GPs on the National Performers' List, connected to NHS England, or Elderly Care consultants, connected to GHNHSFT. As such, the RO for GCSNHST does not have oversight of medical appraisal documentation.

Discussions have been held with appraisal leads for NHS England (South Central Region) and GHNHSFT, both of whom supported the GCSNHST initiative requiring non-connected doctors to complete and return an "Annual Declaration Form".

Responses to pertinent questions asked in this simple form should provide assurance to GCSNHST that the doctor is up to date, fit to practise, is discussing their GCSNHST work at appraisal and is fully engaged with the appraisal and revalidation process.

The first tranche of forms have been disseminated, with the second tranche to be sent out by the end of April. The response so far has been encouraging with a high rate of compliance.

3.3 Information Sharing

Good practice dictates that doctors and ROs share relevant information; i.e. where a doctor takes up or leaves employment and changes DB; pre- and post-appraisal and regarding any 'information of note'.

3.4 **Permanent Staff**

So that GCS is able to correspond with ROs of newly recruited doctors, it is important to capture relevant information about a doctor's appraisal and

revalidation status during the recruitment process.

The GCS Medical Application Form has therefore been updated to include pertinent questions.

In order to communicate with ROs of organisations when a doctor leaves the employ of GCS and moves to another DB, a process has been set up to ensure that the relevant form is sent to the doctor's new DB a timely manner.

3.5 Locum Staff

Investigations into the information captured by locum agencies has revealed that not all agencies are required to record appraisal and revalidation status when registering locums.

Work is ongoing to amend the locum agency "Assignment Checklist form", used by GCS for certain agencies, to stipulate that information regarding appraisal and revalidation must be supplied to GCS when recommending individuals for locum cover.

4 CONCLUSION AND RECOMMENDATIONS

The Board is asked to:

1. **Note** the content of this report and

2. **Approve** the Statement of Compliance, completed by the Medical Director to confirm the Trust's compliance with the statutory Responsible Officer duties. This is to be signed by the Chief Executive and is due to be submitted to NHS England by October 2018, Appendix 3.

Abbreviations Used in Report

GCS	Gloucestershire Care Services NHS Trust
GHNHSFT	Gloucestershire Hospitals NHS Foundation Trust
NHS	National Health Service
RO	Responsible Officer

APPENDIX 1

Appraisal Activity
Appraisal Year 1st April 2017 - 31st March 2018

The following data was included in the Annual Organisational Audit sent to NHS England in May 2018. This shows full compliance, with explanations recorded for any variance against the completed appraisal as defined at 1(a) in the key.

Appraisal Category					
Number of doctors with a connection to GCSNHST at 31/3/18	**Completed Appraisal 1(a)**	**Completed Appraisal (1b)**	**Incomplete or Missed (Approved)**	**Incomplete or Missed (Unapproved)**	**NOTES**
			1		Worked abroad, with no licence to practise in UK, Aug 2016 – Jan 2018. GMC aware. Licence resumed on return to UK. Commenced employment at GCS March 2018.
		1			Appraisal one week later than date of last year's appraisal due to appraiser/doctor availability.
	1				
	1				
	1				
	1				
	1				
		1			Appraisal 2 weeks later than date of last year's appraisal due to appraiser/doctor availability.
	1				
		1			Appraisal one week later than date of last year's appraisal due to appraiser/doctor availability.
	1				
11	**7**	**3**	**1**	**0**	

KEY
1(a) Appraisal in the 3 months preceding the due date, signed off within 28 days and completed between 1/4/17 and 31/3/18
1(b) Appraisal between 1/4/17 and 31/3/18 but 'no' to any of the 3 statements above
Incomplete or Missed (approved) Appraisal did not take place and was not signed off between 1/4/17 and 31/3/18 but RO agreed to the 'missing' appraisal in advance
Incomplete or Missed (Unapproved) Appraisal did not take place and was not signed off between 1/4/17 and 31/3/18 but the RO did <u>not</u> agree to the missing appraisal in advance

Medical Director's Annual Report on Medical Revalidation

APPENDIX 2

Doctors providing care within the Trust but connected to another designated body for medical appraisal and revalidation

GCS employs 11 medical colleagues to provide care within the Sexual Health department and at Cirencester Community Hospital. Alongside these employees, approximately 30 doctors provide care to service users throughout the Trust, being connected to the either the Hospitals Trust or NHS England for appraisal and revalidation purposes.

Having no oversight of their medical appraisal documentation, the Medical Director sought confirmation, by means of a declaration form, that they are discussing their work at GCS with their appraiser and engaging with the appraisal and revalidation system. Doctors will be asked to complete this form on an annual basis. (See example overleaf, sent to GPs. A variation was sent to hospital doctors.)

At 24/6/18, 30 doctors had completed the declaration form. One doctor, providing occasional ward cover at the Vale Hospital, had been sent a form on 13/6/18 but had not yet returned it.

All 30 forms returned provided the assurance required. The Medical Director is aware of each doctor's Responsible Officer so that any sharing of information can take place, should the need arise.

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NHS
Gloucestershire
Care Services
NHS Trust

DECLARATION

Dear Doctor

You provide care and services under the auspices of Gloucestershire Care Services Trust (GCS). Since you are not connected to GCS as your designated body, Dr Mike Roberts (Medical Director and Responsible Officer for GCS) requires assurance that you are engaged in the appraisal and revalidation process and include GCS in your scope of work at appraisal.

To that end, I would be grateful if you could complete this form and return it to me via the email address below.

Kind regards

Amanda Bye
Medical Appraisal & Revalidation Coordinator
amanda.bye@glos-care.nhs.uk

Name	
GMC registration (yes/no)	
GMC number	
Inclusion on National Performers List (yes/no)	
I have appropriate indemnity covering work within GCS (yes/no)	
Date of last appraisal	
Date last revalidated	
Date of next revalidation	
GCS work is included in my scope of practice at appraisal (yes/no)	
Evidence is available from GCS for inclusion in my appraisal (yes/no)	
Any comments:	

Collaborative Working

General Medical Council

The Medical Director and Deputy Medical Director meet the regional GMC Employer Liaison Adviser on a biannual basis. The ELA works together with Responsible Officers, providing advice and support to ensure GMC fitness to practise thresholds are applied consistently and to discuss any pertinent issues, e.g. concerns about underperforming doctors.

Gloucestershire Hospitals NHS Foundation Trust

Liaison between the Medical Directorate and the Hospitals Trust Medical Directorate continues, with GCS appraisers being invited to attend Medical Appraisal Networking and Update events at the Hospitals Trust. Full support was given by the GHNHSFT RO and Appraisal Lead for consultants to be sent the Annual Declaration form discussed above.

NHS England (South West Region)

Liaison between the Medical Directorate and NHS England (South West Region)'s Appraisal and Revalidation team continues, Full support was given by the Performance Management team for GPs to be sent the Annual Declaration form discussed above.

2gether NHS Foundation Trust

Initial contact has been made with the Responsible Officer and Appraisal & Revalidation Manager. A meeting is planned to consider the potential requirement to work more closely together as the merger process develops.

Recruitment of permanent staff

There is a process in place for obtaining relevant information when the Trust enters into a contract of employment for the provision of services with doctors. This ensures the doctor is sufficiently qualified and experienced to carry out the role. A wide variety of checks are undertaken and relevant references obtained, both for permanent and locum doctors.

This process has recently been enhanced so that the job advert for medical practitioners is approved by the Medical Director/Deputy Medical Director prior to release. Additionally, in order to obtain appraisal and revalidation data *prior* to doctors being appointed to a permanent role, the NHS Jobs' application form used by GCS HR team has been revised. Obtaining this information prior to employment allows appropriate contact to be made with the previous RO in an expedient manner, as soon as the post is filled.

Work is ongoing to obtain the same information from locum agencies prior to engaging locum doctors to provide cover in the community hospitals.

Quality assurance audit of appraisal inputs

An audit was undertaken to assess the quality of evidence provided by doctors being appraised. Three appraisal portfolios were audited with the following results.

The audit highlighted 2 themes, both requiring action:

1. That doctors need to complete patient and colleague feedback exercises by year 3 of the revalidation cycle, thus allowing time for reflection and any change in practise before a revalidation recommendation is submitted. This was addressed by a communication to all doctors, reminding them of the requirement and sending the relevant NHS guidance on the matter.

2. That doctors need to use the latest version of the NHS England Medical Appraisal Guide (MAG) form. This was addressed by a communication to all doctors, reminding them that the MAG form had been updated and sending a link to this form and the User Guide.

Appraisal inputs	**Sample 3**	**Sample 2**	**Sample 3**
Appraisal inputs	yes	yes	yes
Scope of work: Has a full scope of practice been described?	yes	yes	yes
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	yes	yes	yes
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	yes	yes	yes
Patient feedback exercise: Has a patient feedback exercise been completed?	no	no	no
Colleague feedback exercise: Has a colleague feedback exercise been completed?	no	no	no
Review of complaints: Have all complaints been included?	yes	yes	yes
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	yes	yes	yes
Is there sufficient supporting information from all the doctor's roles and places of work?	yes	yes	yes
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed by year 3? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Have all types of supporting information been included?	no – need patient and colleague feedback by year 3	no – need patient and colleague feedback by year 3	no – need patient and colleague feedback by year 3

Quality assurance audit of appraisal outputs

Doctors are required to provide written evidence relating to their professional practise ("appraisal inputs"). Evidence is categorised into four domains:

1. Knowledge, Skills & Performance
2. Safety & Quality,
3. Communication, Partnership & Teamwork
4. Maintaining Trust.

This evidence forms the basis of the appraisal discussion.

The medical appraiser has a responsibility to check that the doctor has produced evidence of an appropriate quantity and quality to facilitate a productive appraisal meeting.

Using the NHS England Appraisal Summary and PDP Audit Tool (see overleaf), an audit was undertaken during the first half of the appraisal year to gauge the quality of appraisal outputs produced by appraisers (i.e. the summary of appraisal, personal development plan and appraiser statements). Three appraisals were assessed for each appraiser and the scores are shown below:

Appraiser	**Average Score (Maximum of 50)**
1	44
2	44
3	43

The quality of appraisal outputs is extremely high, providing reassurance that GCS fulfils its duty to support doctors through the 5 year revalidation cycle by provision of formative, motivating and supportive appraisals.

Appraisal Summary and PDP Audit Tool Template

Appraiser identifier	Click here to enter text.
Doctor identifier	Click here to enter text.
Date of appraisal	Click here to enter a date.
Organisation	Click here to enter text.
Auditor (usually the senior appraiser)	Click here to enter text.

Scale:
0 Unsatisfactory
1 Needs improvement
2 Good

Score each item out of two

1.1.1 Setting the scene and overview of supporting information

a) The appraiser sets the scene summarising the doctor's scope of work	Choose an item.
b) The evidence discussed during the appraisal is listed *(not all senior appraisers feel that this is necessary, so if not required score 2)*	Choose an item.
c) There is documentation of whether the supporting information covers the whole scope of work	Choose an item.
d) Specific evidence is summarised with a description of what it demonstrates	Choose an item.
e) Objective statements about the quality of the evidence are documented	Choose an item.
f) All statements made by the appraiser are supported by evidence	Choose an item.
g) Appraiser comments about evidence refer/fit in to the four GMC domains and associated attributes set out in the GMC guidance *Good medical practice framework for appraisal and revalidation*	Choose an item.
h) Reference is made to whether speciality specific guidance for appraisal has been followed e.g. college recommendations for CPD and quality improvement activity *(this is not a GMC requirement so if the senior appraiser does not feel that this is necessary, score 2)*	Choose an item.
i) Reference to completion of locally agreed required training (e.g. safeguarding training, basic life support training) is made *(please insert agreed requirements, score 2 if none agreed)*	Choose an item.

This form has been extracted from, and should be used in accordance with, the NHS England Medical Appraisal Policy, version 2, April 2015, MAPS Annex J: Routine Appraiser assurance tools (http://www.england.nhs.uk/revalidation/appraisers/app-pol/).

Comments: Click here to enter text.

1.1.2 Reflection and effective learning

a) There is documentation of evidence showing that reflection on learning has taken place or that the appraiser has discussed how the doctor should document their reflection	Choose an item.
b) There is documentation of evidence showing that learning has been shared with colleagues or that the appraiser has challenged the doctor to do so	Choose an item.
c) There is documentation of evidence showing that learning has improved patient care/practice or that the appraiser has explored how this might be taken further with the doctor	Choose an item.
Comments: Click here to enter text.	

1.1.3 The PDP and developmental progress

a) There is positive recording of strengths, achievements and aspirations in the last year	Choose an item.
b) There is documentation of appropriate challenge in the discussion and PDP e.g. significant issues discussed and new suggestions made	Choose an item.
c) The completion (or not) of last year's PDP is recorded	Choose an item.
d) Reasons why any PDP learning needs that were not followed through are stated *(if the PDP was completed then score 2)*	Choose an item.
e) There are clear links between the summary of discussion and the agreed PDP	Choose an item.
f) The PDP has SMART objectives (specific, measurable, achievable, relevant, timely)	Choose an item.
g) The PDP covers the doctor's whole scope of work and personal learning needs and goals	Choose an item.

h) The PDP contains between 3-6 items	Choose an item.
Comments: Click here to enter text.	

1.1.4 General standards and revalidation readiness

a) The documentation is typed and uploaded onto an electronic toolkit in clear and fluent English	Choose an item.
b) There is no evidence of appraiser bias or prejudice or information that could identify a patient/third party information	Choose an item.
c) The stage of the revalidation cycle is commented on	Choose an item.
d) There is documentation regarding revalidation readiness relating to supporting information (e.g. states that feedback and satisfactory QIA are already done). Any outstanding supporting information/other requirements for revalidation are commented on with a plan of action to address them	Choose an item.
e) Appraisal statements (including health and probity) have been signed off or if not, an explanation given *(if signed off score 2)*	Choose an item.
Comments: Click here to enter text.	

TOTAL SCORE (OUT OF 50)	Click here to enter text.

General comments from the senior appraiser:

Click here to enter text.

The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

This form has been extracted from, and should be used in accordance with, the NHS England Medical Appraisal Policy, version 2, April 2015, MAPS Annex J: Routine Appraiser assurance tools (http://www.england.nhs.uk/revalidation/appraisers/app-pol/).

Audit of Feedback from doctors regarding their GCS medical appraisal

Since 1st April 2018, doctors have been asked to provide feedback following their appraisal by completion of a simple form. The following results assure the Medical Director that doctors feel well supported by the Trust's appraisers and administrative systems, though the value doctors place on the GMC revalidation system is more variable.

Appraiser	The appraiser (55 = lowest score 11 = highest score)	The administration and management of the appraisal system (30 = lowest score 6 = highest score)	The GMC appraisal and revalidation system (30 = lowest score 6 = highest score)
1 (Feedback from the 3 appraisals undertaken since 1/4/18.)	11	7	11
2 (Feedback from the 1 appraisal undertaken since 1/4/18.)	11	6	6
3 (Feedback from the 2 appraisals undertaken since 1/4/18.)	11	10	13

Comments received

"… highly professional in his approach and was able to focus down very quickly to important areas. He was reassuring and his level of experience …. I felt confident that he was able to guide me appropriately"

"I feel, done badly, appraisal is at worst an opportunity to reflect on the past year, but done well is a great way of ensuring fitness to practise."

"I found this appraisal meeting hugely useful. My appraiser had clearly spent time reviewing my portfolio which meant we could have a really meaningful discussion about my progress over the past year and plans for the future. This was by far the best appraisal I have had."

"…the allocated room felt claustrophobic and small with no windows other than those facing into the open plan office with people walking past."

"Preparing for appraisal takes quite a long time and it is not all time well spent."

Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level[1]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern		1		1
Capability concerns (as the primary category) in the last 12 months				0
Conduct concerns (as the primary category) in the last 12 months		1		1
Health concerns (as the primary category) in the last 12 months				0
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2017 who have undergone formal remediation between 1 April 2016 and 31 March 2017 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*				0
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				0
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				0
General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-				0

[1] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

term employment contracts, etc.) All Designated Bodies	
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc.) All Designated Bodies	0
TOTALS	0
Other Actions/Interventions	
Local Actions:	
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	0
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	0
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	0
GMC Actions: Number of doctors who:	0
Were referred by the designated body to the GMC between 1 April and 31 March	0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	0
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	0
Had their registration/licence suspended by the GMC between 1 April and 31 March	0
Were erased from the GMC register between 1 April and 31 March	0
National Clinical Assessment Service actions:	1
Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment	1
Number of NCAS assessments performed	1

NHS England

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

Statement of Compliance

Version number: 2.0

First published: 4 April 2014

Updated: 22 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Publications Gateway Reference: 03432

NB: The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Designated Body Statement of Compliance

The Board of Gloucestershire Care Services NHS Trust can confirm that:

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Yes

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

   Yes

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

   Yes

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Yes

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

   Yes

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;

   Yes

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

    Yes

Signed on behalf of the designated body

Official name of designated body:

Gloucestershire Care Services NHS Trust

Name: _ _ _ _ _ _ _ _ _ _ _ **Signed:** _ _ _ _ _ _ _ _ _ _ _

Role: Chief Executive

Date: _ _ _ _ _ _ _ _ _ _

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Trust Board	
Date of Meeting:	24th July 2018
Report Title:	Quality and Performance Committee Report

Agenda reference Number:	11/0718
Accountable Executive Director: (AED)	Susan Field, Director of Nursing
Presenter: (if not AED)	Sue Mead, Non-Executive Director
Author(s):	Susan Field, Director of Nursing
Board action required:	To Note and Receive
Previously considered by:	N/A
Appendices:	Appendix 1 Approved Minutes of the Quality and Performance Committee 26th April 2018

Executive Summary

This report provides assurance to the Trust Board that the Quality and Performance Committee continues to discharge its responsibility for overseeing quality and performance activities on behalf of the Trust Board.

The report also confirms decisions made by the Committee in line with the Trust's Scheme of Delegation and; highlights a number of key discussion points that require attention of the Board. Of particular note:

- Recognition that the Trust has submitted its Quality Improvement Plan (QIP) to the Care Quality Commission (CQC) and assured the Committee that work is well underway in order to meet the requirements of the agreed milestones.

- Assurance that the Trust 2018-19 Quality Priority improvement metrics have been agreed and that the Committee will receive quarterly progress report.

- Recognition that significant efforts have been made by those services that needed to improve and; most notably the Musculoskeletal Clinical Assessment and

Treatment (MSKCAT) service which is now back to meeting its required referral to treat requirements.

- Approval on behalf of the Trust Board to publish its 2017-18 Quality Account onto the NHS Choices website (30th June)

- Acknowledged and discussed the recently published Gosport Memorial Hospital Inquiry Report and that further assurances will be sought against the review findings.

Recommendations:

The Trust Board is asked to:

1. **Note** the contents of the Quality and Performance Committee Report.

2. **Receive** the approved minutes of the Quality and Performance Committee that took place on 26th April 2018.

Related Trust Objectives:	1, 2, 3
Risk Implications:	Risk issues are clearly identifed within the report
Quality and Equality Impact Assessment: (QEIA)	Implications are clearly referenced in the report
Financial Implications:	No finance implications identified
Legal/Regulatory Implications:	Legal/Regulatory implications are clearly referenced in the report

Quality and Performance Committee Update

1 INTRODUCTION AND PURPOSE

This report confirms:

- Decisions made at the Trusts Quality and Performance Committee meeting held on the 28th June 2018.
- Key achievements, risks and issues being overseen by the Committee, in order to provide assurance that the Trust continues to deliver high quality care, good patient experiences and good or improved performance across its services.

2 Decisions made by the Committee in line with Scheme of Delegation

2.1 2017-18 Quality Account

The Committee received this annual account and noted the favourable feedback from external stakeholders. The Quality Account has since been published and can be viewed on the national NHS Choices Website.

2.2 Quality and Performance Committee Meeting

The Committee **approved** the minutes of its meeting that took place 26th April 2018 Appendix 1.

2.3 Quality Priorities 2018-19

For 2018-19 the quality improvement metrics were **approved** by the Committee and these are associated with End of Life, Falls, Health and Well-being of colleagues, deteriorating patient (Sepsis), effective management of medication errors, hydration and nutrition and preventing pressure ulcers.

3 ISSUES ESCALATED TO BOARD

The Committee **discussed** a range of matters and would like to specifically highlight the following issues to the Board:

3.1 Pressure Ulcers

Preventing pressure ulcers remains a priority and a concern for the Committee. The clinical and patient safety drivers for reducing pressure ulcers are clear and well established. The Trust continues with its quality improvement activities and must remain focussed with these work plans. In addition to this NHS Improvement has now published a number of recommendations and definitions that will be utilised by all NHS Trusts by April 2019. This is very much welcomed as it is anticipated that this will provide a benchmarking platform for all to work towards and will, we understand, be supported by a clinical audit framework.

3.1 Timely Access to Services

The Committee **noted** and were **assured** that the Musculoskeletal Clinical Assessment and Treatment (MSKCAT) service had improved considerably and were back to a position of good performance in terms of Referral To Treat (RTT).

3.2 Clostridium Difficile (C.Diff)

The Committee was alerted about the reported number of C.Difficile cases since April – 7 within 2 months against an annual threshold of 18 in total. The Committee intends to seek further assurance from the Trusts Infection and Prevention Control Lead and to understand further if there is more that Trust colleagues could be doing.

3.3 Gosport Memorial Hospital Inquiry Report

This report published on 20th June 2018 centres around the end of life care of older people following the persistence of family relatives for a full inquiry for the period 1988 – 2000. The Committee discussed the key findings, which included:

- The lives of 465 patients were shortened because opioid drugs were administered without medical justification.
- A further 200 patients may have had their lives shortened but their clinical records were missing.
- That there was a disregard for human life by Dr Jane Barton.
- Trust nursing staff raised concerns (1988 and 1991) about poor prescribing practices.
- Consultants were aware of Dr Barton's actions but did not intervene.
- That there was evidence that a range of public bodies including the General Medical Council (GMC); Nursing and Midwifery Council (NMC); coroners; crown prosecution service and Hampshire Constabulary failed to act in ways that could have better protected patients and relatives.

Initial responses from the Committee have included the need to seek assurances that the risk of this occurring within Gloucestershire is low. These additional assurances will be sought by:

- Undertaking a gap analysis of the report's findings, acknowledging that there are now within the NHS and Trust a number of failsafe mechanisms in place, Freedom to Speak Up being one example.
- Undertaking a review of opiate prescribing practices associated with those patients deaths that have occurred in the Community Hospitals during the past 12 months – this will be completed by our Head of Medicines Optimisation.
    - Ensure that the confidence level with our prescribers isn't diminished due to the findings of this report.
    - Confirm that Graseby Syringe drivers are not in use across the Trust – completed and have not been used for many years.
    - Work with partners and the public in order to maintain confidence levels that the end of life care we provide is of the highest quality.

3.4 Bed Modelling

The Committee was appraised of this work that had been underway using the expertise of an external provider. It was acknowledged that to date the information was:

- The best level of intelligence the Trust has had.
- That it can be broken down into localities, pathways and could potentially take into account increasing age profile of the population.
- "Fitted" with the One Gloucestershire bed modelling work that was currently underway so as to inform future strategic decision e.g. Specialist Stroke and Forest of Dean Community Hospitals.

The Committee was formally asked that the Trust revise its bed occupancy rate from 92% to 95%, in line with the revised Gloucestershire Hospitals Foundation Trust (GHFT) elective bed base occupancy levels. This recommendation was **not supported** until the Committee received assurances that a qualitative focussed assessment had been undertaken as part of the GHFT decision and; until it was supported by the Gloucestershire Clinical Commissioning Group (GCCG). Please note: the issue is to be discussed at the July Clinical Quality Review Group with the GCCG.

3.5 System Flow – Quality Care

Although it was acknowledged by the Committee that patient flow across health and care providers had seen some improvement and; that Trust colleagues were active partners there remained concerns about the quality of the patient discharge and transfers. It was reported to the Committee that some early work had commenced with GHFT in particular but a considerable amount of progress was still needed regarding timely, accurate information about patients and the reasons why they were being transferred to community hospitals especially. Both the Director of Nursing and Medical Director are actively pursuing improvements alongside operational colleagues.

4 CONCLUSION AND RECOMMENDATIONS

The Trust continues to maintain its high standards of delivering high quality care and continues to effectively manage any risks as they emerge.

The Trust Board is asked to:

1. **Note** the contents of the Quality and Performance Committee Report.

2. **Receive** the approved minutes of the Quality and Performance Committee held on the 26th April 2018.

ABBREVIATIONS USED IN THE REPORT

CQC	Care Quality Commission
QIP	Quality Improvement Plan
MSCKAT	Musculoskeletal Clinical Assessment and Treatment
GHFT	Gloucestershire Hospitals Foundation Trust
GCCG	Gloucestershire Clinical Commissioning Group
GMC	General Medical Council
NMC	Nursing and Midwifery Council

NHS Gloucestershire Care Services NHS Trust

Quality and Performance Committee

Date: 26th April 2018

Meeting on 26th April 2018, 14.00pm, Boardroom, Edward Jenner Court, Brockworth, GL3 4AW

Committee Members	
Sue Mead	Chair
Susan Field	Director of Nursing
Candace Plouffe	Chief Operating Officer
Mike Roberts	Medical Director
Nicola Strother Smith	Non-Executive Director
Jan Marriott	Non-Executive Director
Graham Russell	Non-Executive Director
In attendance	
Sian Thomas	Deputy Chief Operating Officer
Ian Main	Head of Clinical Governance
Lindsay Ashworth	Head of HR
Michael Richardson	Deputy Director of Nursing
Gillian Steels	Trust Secretary
Laura Bucknell	Head of Medicine Optimisation (for agenda item 14)
Christine Thomas	Minute taker

Ref	Minute
01/0418	**Welcome, Apologies for Absence and Confirmation the Meeting is Quorate** The Chair, Sue Mead, welcomed colleagues. Apologies were received from the Interim Director of HR, Director of Finance and Quality Manager for Gloucestershire Clinical Commissioning Group. The Chair confirmed that the meeting was quorate.
02/0418	**Declarations of Interest** In accordance with the Trust's Standing Orders, members were required to declare any conflicts of interest with items on the Meeting Agenda. No declarations of interest were made.
03/0418	**Minutes of the previous meeting 28th February 2018** The minutes of the 28th February 2018 were **Received.** The Chief Operating Officer (COO) provided minor clarifications to agenda item number 5 and 6. Subject to these

	changes the minutes were **Approved** as an accurate record.
04/0418	**Matters Arising Action Log** The Committee **NOTED** those items that were on track or completed and updates were received on open actions
05/0418 **Director of Nursing/ Chief Operating Officer**	**Corporate Risk Register** The Trust Secretary (TS) presented the corporate risk register. Risk 562 – Pressure Ulcers – it was agreed that the risk rating for this should go back to 16. Risk 828 – School Nursing – the Director of Nursing (DoN) highlighted this risk and the increased demand relating to safeguarding concerns. The risk was impacting particularly on School Nurses and Health Visitors time. Processes had been put in place to support the wider county safeguarding requirements. It was agreed that the DoN and Chief Operating Officer (COO) would bring an update on school nursing to the next meeting. Risk 735 – End of Life/RESPECT form – The Deputy Director of Nursing (DDoN) advised that the Trust was working with the Academic Health Science Network (AHSN) to implement the RESPECT form, the End of Life Clinical Lead was on the working group. Risk 746 – Patient Transport – The risk on patient transport had been raised with urgent care commissioners. The Trust had its own transport escalation arrangements in place, which at times meant using a different provider from Arriva. It was noted that the present Countywide service, currently provided by Arriva, was due to go out to tender in June. It was confirmed evidence of issues was being raised with CCG. The Infection Control IC net system risk was discussed. Wider system concerns were considered. It was noted the Trust would be changing to a manual system to be reviewed after 3 months. The issue had been discussed with the Gloucestershire Clinical Commissioning Group (GCCG). The use of the manual system would be reviewed in three months' time. The Committee were reassured that the Trust still had the option to join the wider system at a later stage. The Committee **Approved** the Corporate Risk Register**.**
06/0418	**Operational Services Exception Report** The Deputy Chief Operating Officer (DCOO) presented the Operational Services report, noting that the Trust had done well in its performance of system flow over the winter period and that no escalation beds had been opened. Gloucestershire had been in the upper quartile across the Country and Gloucestershire Hospitals Foundation Trust (GHFT) had recognised the management of patient flow by the Trust. Access to the podiatry service had improved since January and was now in the green as was the MSK service. The Musculoskeletal Clinical Assessment and Treatment (MSCKAT) Service continued to see an improvement in its performance. A service improvement manager had been taken on to look to improve the access to all therapies.

Director of Nursing	The Chair asked for more sight of discharge incidents and the Director of Nursing (DoN) advised that there were meetings set up with the Gloucestershire Hospitals Foundation Trust (GHFT) Director of Nursing (DoN) to look at these. It was agreed that the DoN would bring an update to the next meeting. The Committee **Approved** the operational services report
08/0418 **Chief Operating Officer/Deputy Director of Nursing** **Director of Nursing** **Chief Operating Officer/ Director of Nursing/ Deputy Director of Nursing**	**Quality and Performance Report (March 2018 data)** The Committee reviewed the report and were asked to consider particularly whether the trial place based report elements in the Quality and Performance report were helpful. It was noted that this was the last report of the financial year 2017-18. It was also noted that both mandatory training and Personal Development Reviews (PDRs) had improved and it was recognised that the focus on this needed to be maintained for the coming year. Retention of staff would also be focused on in 2018-19. Graham Russell asked what was preventing mandatory training being fully compliant. The Head of HR (HoHR) explained that this was due to a number of factors such as capacity to complete, staff not able to be released to complete, maternity etc. The Chief Operating Officer (COO) advised the group that the harm free care target for 2018-19 should be 100% and not 98% as it currently was. The Deputy Director of Nursing (DDoN) advised that it was 98% due to acquired pressure ulcers being either avoidable or unavoidable. The Chair recommended that this target be discussed outside of the meeting. It was noted that the total number of C.Difficile cases were close to the Trust's annual threshold of 18 and that this was partially due to the unavailability of an antibiotic (a previously highlighted national issue). The Deputy Director of Nursing (DDoN) also updated the group that the Trust had recently found out that there had been a review of the way the microbiologist had been rating C.Difficile cases against the national standard, this had identified increased reporting of the number of cases by two. The Committee felt that the place based reporting offered limited value. It was agreed that the Director of Nursing (DoN) should share the report with Nick Relph, Non-Executive Director and if no value was deemed to be added then they would discontinue with the place based reporting in this format at this time. The Committee also discussed the duplication of information between the Operational Services Exception report, Clinical Quality Assurance report and the Quality Report. It was agreed that the COO, DoN and DDoN would look at this external to the meeting. The Committee **Approved** the Quality and Performance Report and noted the actions around Place base reporting.
07/0418	**Clinical Quality Assurance Report** The Deputy Director of Nursing (DDoN) reviewed the quality priorities for 2017-18: • Falls with harm had improved and the Trust was currently taking part in #PJParalysis. • Health and wellbeing was on track • End of Life - there had been variable results over the last year, the education

Deputy Director of Nursing	programme had now been agreed. • Dementia had achieved good results over the last year • Pressure ulcers, this would be looked at in more detail later in the meeting. The Committee were pleased with the progress on dementia but raised concerns that the Clinical Lead looking after dementia would now also be looking after End of Life. It was agreed that a snapshot audit would be undertaken to ensure that progress was being maintained. It was noted that the health and well-being priority had positive outcomes, but this was not reflected in the staff survey. It was felt that this result needed to broken down into local areas to provide improved insights. It was noted that the Trust audit programme had been included for approval by the committee. The DDoN assured the group that a tracker was kept to ensure that all services had an audit, all services were required to do a record keeping audit and one other. The Trust would be undertaking the national End of Life audit. It was confirmed the Quality dashboards were almost completed and were in the process of being finalised. The Committee **Approved** the Clinical Quality Assurance Report.
09/0418 **Head of Clinical Governance**	**Non-Executive Directors (NED) Quality Visits Annual Report** Nicola Strother Smith had raised concerns that the Non-Executive Directors (NEDs) quality visits were not given a high enough profile, to support triangulation and follow up of issues raised, it had therefore been agreed that these would be included within reporting to this Committee. The visits were currently co-ordinated between the NEDs Executive Assistant and the Professional and Clinical Effectiveness (PaCE) directorate. The Director of Nursing (DoN) would welcome some feedback on how the NEDs would like these visits organised, should they be aligned to quality priorities, keep to localities as they are currently organised or go to areas of concern. It was noted that the quality reports following these meetings were not consistent and the DoN asked if reports should be mandatory? It was felt that the NED visits should be used for areas of concern, but it was important to remember these were keep in touch opportunities and this shouldn't be lost. It was therefore felt that the NEDs needed to understand from Executive colleagues areas of concern so they could follow these up if possible. It was agreed that the NEDs would do a minimum of three visits a year and provide an exception report at the end of each visit. The Head of Clinical Governance (HoCG) would produce a template to be used for the reporting of these visits and would get approval for this from the NEDs. The Trust Chair would continue to report these visits in her board report. The Committee **Noted** the actions from the NED Quality Visits Annual Report
10/0418	**Learning from Deaths – Oct 2017-March 2018** This report followed on from the Midas data to update the group on the learning from deaths. All deaths were reviewed by the mortality group and this was shown to be working well following the concerns raised due to a number of deaths occurring in a short period of time in Dilke Hospital (which had subsequently been confirmed as not requiring further

Medical Director	investigation) A discussion would be held with Countywide partners on patients coming into the hospitals classed as rehabilitation, when they were actually end of life. It was noted that the Commissioners felt that hospitals should not be used for end of life, but this was not always possible and sometimes was the wish of the patient. Concern was raised about the confusion and distress for colleagues and family if a patient was bought in for rehabilitation but was soon deemed to be end of life. It was agreed that the Medical Director (MD) should discuss this with his counterpart at Gloucestershire Hospitals Foundation Trust (GHFT). It was agreed that a case audit would come back to the next meeting. The Committee **Noted** the Learning from Deaths paper
11/0418 **Head of Clinical Governance**	**Care Quality Commission (CQC) Inspection Plan Outcome and draft Quality Improvement Group** The Committee acknowledged the achievement of colleagues throughout the Trust on achieving the recent Good rating from the Care Quality Commission (CQC). The Trust was required to submit a quality improvement plan that was required to be submitted to the CQC by the 21st May, which was enclosed for the Committees information. Milestones would be added for each of the areas requiring improvement and this would include an owner for each of the actions. The Gloucestershire Clinical Commissioning Group and the Quality and Performance Committee would oversee the implementation of the quality improvement plan. The Head of Clinical Governance (HoCG) raised the issue that the printable materials developed by the CQC for the Trust to use to advertise their results was incorrect, this had been highlighted to the CQC and they were waiting on amends to be made. The CQC had said that the Trust was able to produce its own promotional material and the HoCG was asking the Trust for permission to use their own poster to advertise the results, whilst they waited for the official documentation to be updated. The Committee agreed to these posters being used and that this paper would be reported at Board and that at the next meeting the completed quality improvement plan would come to the June meeting. The Committee **Approved** the CQC quality improvement plan, **Approved** the use of the Trusts own poster for advertising results and **Agreed** that the final quality improvement plan would come to the June meeting.
12/0418	**Quality Improvement Pressure Ulcer Case Review Report** A deep dive had been completed into 15 pressure ulcer cases and it was felt by the Committee that this had raised more questions than answers, but was a good starting point for the Trust to use as an opportunity to progress work to reduce pressure ulcers. It was noted that it was difficult to control situations with patients based at home that Trust colleagues did not see on a regular basis and it was felt there was a need to understand which staff were visiting patients, and how often, to understand why and how pressure ulcers were not detected, it was also felt that there was a need to understand the skill set of colleagues visiting service users. It was noticed in the report that there remained a lack of understanding with colleagues on the definition of avoidable and unavoidable. It was also raised that there were no national guidance for the Trust to refer to. It was felt it would be useful to benchmark these results against other Trusts but this information was not

	available and would rely on a reciprocal agreement with another Community Trust. The Committee welcomed the review, whilst recognising it opened up many questions it was felt this also opened up a way to move forward. The Committee **Noted** the CQC update and the work needed to progress.
13/0418 **Deputy Director of Nursing**	**Annual Infection Control Report** The Deputy Director of Nursing (DDoN) presented the infection control report, which was generally positive. Key highlights were: • The concerns on C.Diff and IC Net, which had been discussed in agenda item 8. • A national drive on reducing E.coli was being run this year and the Trust would support this initiative. • The results of the hand washing audit had been positive. The Chief Operating Officer (COO) asked if it would be possible for outbreaks to be broken down by locality; the DDoN would discuss this with the Infection Prevention & Control Team Lead. The Director of Nursing (DoN) advised the group that the DDoN had got into the national infection control programme, which was very positive news. It was agreed that the outcome of the C.Diff results would be raised to the Trust Board. The Committee **Approved** the Annual Infection Control Report and **Noted** the issues on C.Diff and IC.Net.
14/0418	**Medicines Optimisation Report** The Head of Medicines Optimisation (HoMO) presented an update on e-prescribing actions that had been recommended by the PWC internal audit. All the actions except for two had been completed and these two the Trust was unable to complete due to TPP, the producers of the SystmOne system, being unwilling to make the changes; steps had been taken to mitigate the risks from this with the Trust's clinical systems team and the issues had been logged with TPP. One of the quality priorities for 2018-19 would be reducing medication errors and a quality improvement plan had been developed to achieve this. Nicola Strother Smith suggested that this quality priority could be looked at during Non-Executive Director (NED) quality visits. It was noted that the outcomes of the e-prescribing work would go to the Audit and Assurance Committee for assurance as part of the audit recommendations. The Committee **Approved** the report and **Noted** the Quality Improvement Plan
15/0418	**Medical Revalidation Report** The Medical Director (MD) presented the medical revalidation report. All the Trust's

	doctors were up to date with their revalidation but it had been noted that there was no means of knowing if there were any concerns about the doctors working for the Trust but not directly employed by the Trust. A process had been put in place to ensure that the MD knew that all doctors working for the Trust were revalidated and that there were no concerns. Jan Marriott asked if this was also in place for dentists, but the MD advised that there were currently no requirements for the dentists to be revalidated. The Committee **Approved** the Medical Revalidation Report
16/0418	**Forward Planner Review** The Committee **noted** the forward planner
17/0418	**Operational Governance Forum and Infection Control Exception Reports** The Operational Governance and Infection Control Exception Reports were **Noted**
18/0418	**Any Other Business** The Committee Chair reviewed the meeting and it was agreed that there was some positive progress shown in the papers received and it was good to see what was being done well.
19/0418	**Minutes of the previous meeting – confidential part 2 – held 28th February 2018** The private part 2 minutes of the 28th February 2018 were **Received** and were **Approved** as an accurate record. There being no other business the Chair closed the part 1 meeting.
	Date of Next Meeting It was agreed that the next Committee meeting will be held on Thursday 28th June 2018

Chair's Signature:

Date:

Trust Board	
Date of Meeting:	24th July 2018
Report Title:	Quality and Performance Report

Agenda reference Number:	12/0718
Accountable Executive Director: (AED)	Susan Field, Director of Nursing
Presenter:(if not AED)	Susan Field, Director of Nursing Candace Plouffe, Chief Operating Officer
Author(s):	Susan Field, Director of Nursing
Board action required:	To Note and Receive
Previously considered by:	N/A
Appendices:	Appendix 1 Quality and Performance Report – June 2018 data

Executive Summary

This report is an overview of the Trust's Quality and Performance activities as at June 2018. It highlights achievements made as well as how the Trust is responding to those areas where improvements are either continuing or need to improve further.

Recommendations:

The Trust Board is asked to:

1 **Receive** this exception report.

Related Trust Objectives	1,2,3
Risk Implications	Risk issues are clearly identifed within the report
Quality and Equality Impact Assessment (QEIA)	Implications are clearly referenced in the report

Financial Implications	No finance implications identified
Legal/Regulatory Implications	Legal/Regulatory implications are clearly referenced in the report

Quality and Performance Report

1 Introduction and Purpose

This report relates to the Trust's June 2018 Quality and Performance data.

2 Background

The Trust Board and the Quality and Performance Committee has a key role in ensuring it maintains strategic oversight of the quality and performance of services provided by the Trust.

The attached report is an exception based report and the Quality and Performance Committee reviewed May 2018 performance data.

3 Key areas to Note

The June report confirms a number of notable achievements and risks, which include:

- As of June 2018 there have been 8 post-48 hour Clostridium difficile infections against an end of year threshold of 18. This is a cause of concern and some actions were agreed at the June Quality and Performance Committee meeting.

- The Musculoskeletal Clinical Assessment and Treat (MSKCAT) Service has improved significantly again in June by achieving 100% of people being treated within 8 weeks and 97.6% of urgent referral seen in 2 weeks against a target of 95%. This is a real achievement by Trust colleagues.

- Mandatory training compliance for June is on average 86% - a continued improving picture.

- 81.4% of colleagues' Personal Development Reviews (PDRs) were achieved during June and for active assignments this equates to 84%. The executive team continue to have oversight of these improvements alongside mandatory training.

- For 2018-19 the Trust has identified three new quality priorities – deteriorating patients (SEPSIS); nutrition and hydration; and effective management of medication errors.

- For Qtr. 1 colleagues "likely" or "extremely likely" to recommend the Trust as a place to work was 63% compared to 49% in Qtr. 4 the previous year. This has been a significant improvement.

- In June there were 26 avoidable and 23 unavoidable acquired pressure ulcers 24 of the avoidable ulcers were grades 1 and 2; increasing the

reporting of lower grade pressure areas continues to be one of the major goals for this quality priority.

- Safety thermometer harm-free scores have improved during June to 94% compared to 91.9%. In June harm-free score based on new harms was 97.8% against a national April benchmark of 96.3% and an internal Trust target of 98%.

- MIIUs continue to perform well against a range of targets.

4 Conclusion and Recommendations

The Trust Board is asked to:

Receive this June 2018 quality and performance report.

Abbreviations Used in Report

MSKCAT	Musculoskeletal Clinical Assessment and Treatment
VTE	Venus Thromboembolism

Agenda Item 12.1

Gloucestershire Care Services NHS
NHS Trust

Board Report

Trust Board Meeting
26th July 2018

Data for June 2018

Understanding you

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Gloucestershire Care Services NHS Trust

Executive Summary

Gloucestershire Care Services NHS Trust

Are Our Services Caring?

- The overall Friends and Family Test response rate in June was **13.8%,** a slight decrease compared to May response rate of **15.2%**. The proportion of patients indicating Likely or Extremely Likely to recommend our services increased slightly to **92.4%** in June compared to 92.0% in May.

Are Our Services Safe?

- The nationally reported Safety Thermometer Harm free score increased to **94.36%** in June compared to 91.9% in May, against a target of 95%. Furthermore, based on new harms only, the Trust achieved harm-free care of **97.8%** in June, compared to a target of 98%. This was an improvement on the May performance of 95.8%.

Are our Services Effective?

- The Bed Occupancy rate was **91.8%** in June, an decrease compared to 95.1% in May. This is a positive change and moves the RAG status from amber to green.
- Delayed Transfer of Care (DToC) rate in June was **1.2%,** below the target of <3.5% but a slight increase from 1.0% in May. There was an average of 2 patients delayed per day in June.

Are Our Services Responsive?

- The number of 4 hour breaches in MIIUs have increased significantly to 106 in June compared to 514 for 2017/18 as a whole. June performance in the '% seen and discharged within 4 hours' measure, at **98.9%,** remains above the 95% target.
- For countywide services, the Musculoskeletal Clinical Assessment and Treatment service (MSKCAT), achieved the 95% target for patients seen within 8 weeks of referral in June at **100**%; this is a significant performance improvement after a difficult previous year and demonstrates maintained good performance over the last three months.
- SPCA have maintained good performance of their abandoned call rate measure at **1.4%** in June, which continues to be below the threshold of <5%. For priority 1 and 2 calls, the percentage of calls answered within 60 seconds is slightly below the 95% target at **94.6**%, a small reduction compared to 95.6% performance in May.

Are Our Services Well Led?

- Mandatory training compliance rate in June was an average of **86%**, an improvement compared to the 2017/18 average of 82.6% and an increase against the 85.8% performance in May.
- National Staff survey results for Quarter 1 2018/19 indicate that **88.0%** of staff responding would recommend the Trust as a place to receive treatment (target is 67%). **63.0%** of staff indicated that they would be 'Extremely Likely' or 'Likely' to recommend the Trust as a place to work (target is 61%). Both of these measures are therefore showing an improvement against 83% and 49% performance respectively in Quarter 4 of 17/18.
- Sickness absence (rolling 12 months to June) is **4.7%,** against a local target of <4%; this is consistent performance through the year.
- **81.4%** of all staff Personal Development Reviews were completed by the end of June 2018, an increase from 80.9% achievement in May. For active assignments only this rises to **84.0%,** a reduction from 85.4% in May

Quality and Performance Dashboard (Trustwide)

NHS Gloucestershire Care Services NHS Trust

CQC DOMAIN - ARE SERVICES CARING?

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report May Figure
1	Friends and Family Test Response Rate	N - T	15%	8.3%	13.2%	15.2%	13.8%										14.1%		
2	% of respondents indicating 'extremely likely' or 'likely' to recommend service	N - R L - I	95%	94.2%	93.5%	92.0%	92.4%										92.6%		90.5%
3	Number of Compliments	L - R		924	75	76	91										242		
4	Number of Complaints	N - R		44	3	7	3										13		
5	Number of Concerns	L - R		391	43	37	52										132		

CQC DOMAIN - ARE SERVICES SAFE?

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report May Figure
6	Number of Never Events	N - R		1	0	0	0										0		
7	Number of Serious Incidents Requiring Investigation (SIRI)	N - R		23	0	1	2										3		
8	Number of Serious Incidents Requiring Investigation (SIRI) where Medication errors caused serious harm	N - R		0	0	0	0										0		
9	Total number of incidents reported	L - R		3,946	352	408	428										1,188		
10	% incidents resulting in low or no harm	L - R		94.8%	93.2%	97.8%	96.3%										95.8%		
11	% incidents resulting in moderate harm, severe harm or death	L - R		5.2%	6.8%	2.2%	3.7%										4.2%		
12	% falls incidents resulting in moderate, severe harm or death	L - R		1.5%	0.0%	1.3%	4.5%										1.9%		
13	% medication errors resulting in moderate, severe harm or death	L - R		0.0%	0.0%	0.0%	0.0%										0.0%		
14	Number of post 48 hour Clostridium Difficile Infections	N - R L - C	*1	16	3	4	1										8	Y	
15	Number of MRSA bacteraemias	N - R L - C	0	0	0	0	0										0		
16	Number of MSSA Infections	L - R	0	0	0	0	0										0		
17	Number of E.Coli Bloodstream Infections	L - R	0	0	0	0	0										0		
18	Safer Staffing Fill Rate - Community Hospitals	N - R		100.2%	100.5%	99.8%	100.7%										100.3%		
19	VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	95.0%	87.9%	93.0%	91.0%										90.6%	Y	
20	Safety Thermometer - % Harm Free	N - R L - C	95%	94.1%	92.8%	91.9%	94.4%										94.1%	Y	
21	Safety Thermometer - % Harm Free (New Harms only)	L - I	98%	98.0%	97.2%	95.8%	97.8%										96.9%		
22	Total number of Acquired pressure ulcers	L - R		652	71	51	50										172		
23	Total number of grades 1 & 2 Acquired pressure ulcers	L - R		578	62	46	44										152		
24	Number of grade 3 Acquired pressure ulcers	L - R		64	7	5	5										17		
25	Number of grade 4 Acquired pressure ulcers	L - R		10	2	0	1										3		

***In-month threshold (i.e. April)**

Quality and Performance Dashboard (Trustwide)

NHS Gloucestershire Care Services NHS Trust

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report May Figure
CQC DOMAIN - ARE SERVICES EFFECTIVE?																			
Community Hospitals																			
26	Re-admission within 30 days of discharge following a non-elective admission	N - R		10.7%	6.6%	9.0%	11.1%										8.9%		
27	Inpatients - Average Length of Stay	L - R		26.8	28.0	27.2	28.8										28.0		28.0
28	Bed Occupancy - Community Hospitals	L - C	92%	96.7%	93.2%	95.1%	91.8%										93.4%		88.9%
29	% of direct admissions to community hospitals	L - R		25.3%	26.3%	27.4%	21.8%										25.2%		
30	Delayed Transfers of Care (average number of patients each month)	L - R		11	3	3	2										3		
31	Bed days lost due to delayed discharge as percentage of total beddays	L - R	<3.5%	5.9%	1.4%	1.0%	1.2%										1.2%		11.4%
32	Average of 4 discharges per day (weekends) - Inpatients	L - C	**4	3.1	2.6	3.5	1.7										2.6	Y	
33	Average of 11 discharges per day (weekdays) - Inpatients	L - C	**11	8.1	8.7	7.4	9.3										8.5	Y	
34	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	N - T	>99%	100.0%	100.0%	100.0%	100.0%										100.0%		
CQC DOMAIN - ARE SERVICES RESPONSIVE?																			
		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report May Figure
Minor Injury and Illness Units																			
35	MIIU % seen and discharged within 4 Hours	N - T	95%	99.3%	99.4%	98.8%	98.6%										98.9%		
36	MIIU Number of breaches of 4 hour target	L - R		514	35	90	106										231		
37	Total time spent in MIIU less than 4 hours (95th percentile)	L - I	<4hrs	02:53	02:39	02:50	03:15										02:54		
38	MIIU - Time to treatment in department (median)	L - I	<60 m	00:26	00:30	00:34	00:35										00:34		
39	MIIU - Unplanned re-attendance rate within 7 days	L - C	<5%	2.4%	0.8%	0.8%	0.9%										0.8%		
40	MIIU - % of patients who left department without being seen	L - C	<5%	2.2%	2.4%	3.6%	3.7%										2.4%		
Referral to Treatment																			
41	Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	84.4%	60.7%	59.5%	57.1%										59.1%	Y	
42	Podiatry - % treated within 8 Weeks	L - C	95%	92.8%	97.5%	98.4%	98.6%										98.2%		
43	MSKCAT Service - % treated within 8 Weeks	L - C	95%	57.1%	95.8%	99.7%	100.0%										97.6%		
44	MSK Physiotherapy	L - C	95%	90.7%	91.4%	99.7%	85.7%										92.3%	Y	
45	ICT Physiotherapy	L - C	95%	85.0%	84.3%	84.5%	81.1%										83.3%	Y	
46	Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	82.8%	77.4%	70.1%	76.8%										74.5%	Y	
47	Diabetes Nursing - % treated within 8 Weeks	L - C	95%	96.2%	94.5%	85.5%	97.6%										92.5%	Y	
48	Bone Health Service - % treated within 8 Weeks	L - C	95%	99.5%	96.0%	99.5%	99.3%										98.3%		
49	Contraception Service and Sexual Health- % treated within 8 Weeks	L - C	95%	100.0%	100.0%	100.0%	100.0%										100.0%		
50	HIV Service - % treated within 8 Weeks	L - C	95%	100.0%	100.0%	100.0%	100.0%										100.0%		

*Cumulative YTD target.

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report May Figure
51	Psychosexual Service - % treated within 8 Weeks	L - C	95%	100.0%	100.0%	100.0%	100.0%										100.0%		
52	Sexual Health - % of terminations carried out within 9 weeks and 6 days of gestation	L - C	80%	77.4%	75.0%	72.1%	83.3%										77.0%	Y	
53	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	97.7%	93.3%	99.5%	95.6%										96.7%		
54	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	99.0%	96.9%	99.1%	97.4%										97.8%		
55	Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	96.6%	97.6%	98.6%	96.4%										97.5%		
56	MSKCAT Service - % of referrals referred on to secondary care	L - C	<30%	12.4%	12.0%	10.2%	9.2%										10.4%		
57	MSKCAT Service - Patients referred to secondary care within 2 days of decision to refer onwards	L - C	100%	100.0%	100.0%	100.0%	100.0%										100.0%		
58	MSKCAT Service - wait from referral for urgent patients to be seen not to exceed 2 weeks	L - C	95%	95.9%	84.6%	96.3%	97.6%										93.7%	Y	
59	Stroke ESD - Proportion of new patients assessed within 2 days of notification	L - C	95%	88.6%	65.2%	72.7%	44.4%										61.9%	Y	
60	Stroke ESD - Proportion of patients discharged within 6 weeks	L - C	95%	98.9%	100.0%	96.3%	100.0%										98.8%		
61	Social Care ICT - % of Referrals resolved at Referral Centres and closed	L - C		45.9%	45.2%	44.8%	47.4%										45.8%		
62	Newborn Hearing Screening Coverage	N - T	97%	100.0%	100.0%	100.0%	100.0%										100.0%		
63	Newborn Hearing Screens completed by 5 weeks (community sites) - Well babies	N - T	97%	99.6%	99.6%	100.0%	100.0%										99.9%		
64	Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R		40,511	3,212	3,309	3,195										9,716		
65	SPCA % of calls abandoned	L - C	<5%	2.7%	1.6%	1.6%	1.4%										1.5%		
66	95% of priority 1 & 2 calls answered within 60 seconds after introductory message finishing	L - C	95%	90.5%	91.7%	95.6%	94.6%										94.0%		
67	Rapid Response - Number of referrals	L - C	*922	3,726	309	290	319										918		
CQC DOMAIN - ARE SERVICES WELL LED?																			
		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report May Figure
70	Mandatory Training	L - I	92%	82.6%	86.3%	85.8%	86.0%										86.0%	Y	88.7%
71	% of Staff with completed Personal Development Reviews (Appraisal)	L - I	95%	79.9%	84.4%	80.9%	81.4%										82.3%	Y	66.3%
71a	% of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only	L - I	95%	N/A	87.4%	85.4%	84.0%										86.4%	Y	
72	Sickness absence average % rolling rate - 12 months	L - I	<4%	4.6%	4.7%	4.6%	4.7%										4.7%	Y	

*Cumulative YTD target.

QUALITY PRIORITY | ARE SERVICES SAFE?

NHS Gloucestershire Care Services NHS Trust

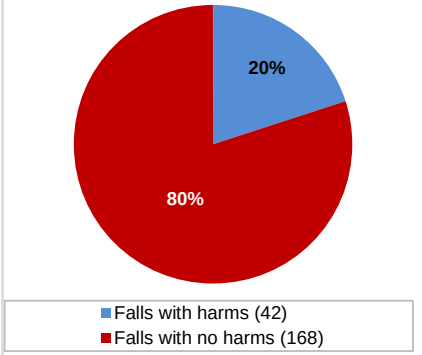
2018/19 Quality Priorities		Quality Domain
1. Falls Prevention and Management	Our aim will be to continue focusing on preventing and managing falls, particularly in areas where falls cause harm.	SAFE
2. Health and Well-being of Colleagues	Our aim is to maintain or reduce colleague sickness and absence, and to continue our work relating to health and wellbeing. We will also aim to achieve a 75% uptake rate of colleagues having their flu vaccinations	CARING
3. End of life Care	Our aim will be to consolidate further our End of Life care developments with the intention of being able to increase the proportion of people who are able to die in their preferred place of choice.	EFFECTIVE
4. Nutrition and Hydration	Our aim is to build on what we have achieved through PLACE with regards to our community hospitals and to include a focus on nutrition and hydration with our wider community services.	WELL-LED
5. Preventing Pressure Ulcers	The prevention of pressure ulcers remains one of our top priorities with regards to patient safety. Our aim will be to continue to monitor the number and incidences of pressure ulcers and to continue to drive our reduction plans forward	SAFE
6. Reducing Medication Errors	Our aim is to improve patient safety and to get a more detailed understanding of our medication errors by improved reporting which will enable further learning to support safer practice.	WELL-LED
7. Deteriorating Patient, Including Sepsis	Our aim will be to support and develop our clinical colleagues in the recognition and early identification of deteriorating patients to include sepsis and other life threating conditions.	RESPONSIVE
8. CQUIN	National Commissioning for Quality and Innovation (CQUIN)	WELL-LED

QUALITY PRIORITY | ARE SERVICES SAFE?

1. Falls Prevention and Management

Hospital	Total Falls				Injurious Falls			
	2017/18 Total		2018/19 YTD		2017/18 Total		2018/19 YTD	
	Number of falls (cumulative)	Falls per 1,000 Bed Days	Number of falls (cumulative)	Falls per 1,000 Bed Days	Number of injurious falls (cumulative)	Injurious falls per 1,000 Bed Days	Number of injurious falls (cumulative)	Injurious falls per 1,000 Bed Days
The Vale	68	9.9	43	24.5	12	1.7	9	5.1
Tewkesbury	73	12.1	26	14.9	13	2.1	6	3.4
Stroud General	120	8.9	39	12	32	2.4	10	3.1
Dilke	131	14.7	25	11.7	40	4.5	2	0.9
Cirencester	197	11.4	47	11.3	44	2.5	10	2.4
North Cotswolds	103	13.2	18	9.3	21	2.7	3	1.6
Lydney	66	9.7	12	7.5	16	2.3	2	1.3
TOTAL	**758**	**11.3**	**210**	**12.7**	**178**	**2.6**	**42**	**2.5**
Expected year end outturn			**864**		**156**			

Number and percentage of inpatient falls (2018-19 YTD)



Risks (Falls)
Reference – 693
Rating – 9

Monthly figures	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Rolling 12 months total
Falls in Community Hospitals (inpatients only)	68	68	72	60	63	66	53	59	53	65	79	66	772

Additional information related to performance

Falls in an inpatient setting

- 80% of all falls reported in the year to date are **without harm.**

Benchmarking

- The Trust is reporting a rate of 11.1 falls per 1,000 occupied bed days (6 month period between Dec-17 to May-18) compared to an average of 8.4 falls per 1,000 bed days based on the Trusts within the latest NHS Benchmarking Network monthly indicator report.
- Internal benchmarks have now been set in recognition that the NHS benchmark changes every month and to allow for more accurate reporting of variances across the different community hospitals. The internal benchmarks are 8 falls per 1,000 bed days and 3.5 falls with harm per 1,000 bed days.

What actions have been taken to improve performance?

- The improvement plan is reviewed by the community hospitals Falls Prevention Group on a monthly basis and reported to the Quality Steering Group, and Quality and Performance Committee.
- Improvement trajectories have been set and are reported on a monthly basis.
- There remain some issues with data quality around the training reports and this is being reviewed
- A detailed report from the Falls Prevention Quality Improvement Group was provided to the June Quality and Performance Committee and this included the new action plan for 2018/19

Gloucestershire Care Services NHS Trust

Performance against trajectory is from the April 2018 Quality Assurance Report
Narrative and performance for the Quality Priorities will be updated quarterly in accordance with availability of updated Quality Assurance Reports

1. Falls Prevention and Management

Additional information related to performance	What actions have been taken to improve performance?
1.1 Compliance with NICE Guidance (CG161)	• The updated multifactorial falls risk assessment which is now on SystmOne (S1) is compliant with CG161 which means that all patients have a full assessment of their individual risk factors which might contribute to their risk of falling. A patient's individual risk factors and the actions required to reduce their individual risk are now recorded. This is reviewed on at least a weekly basis and following any falls • In addition, the post falls "SWARM" (a rapid multidisciplinary assessment), is now used in all inpatient wards which allows colleagues to quickly review the patient and the environment to ascertain whether there were any contributory factors to the patient falling that can be easily and quickly remedied to reduce the risk of future falls. • Q1 2018/19 - Re-audit of falls assessment and management documentation and use of post falls SWARM. Audit planned for June/July, aiming for a larger sample size than previous audit. • Q2 2018/19 - Action(s) to address any areas of non-compliance identified in audit will be implemented
1.2 Education and Training	• The Trust continue to have difficulty accessing accurate data on the numbers of colleagues trained in falls assessment. A request has been made to Performance and Information to clarify which staff groups should be included and to exclude the rest and Training and Development Sisters have been asked to update ESR directly or ensure attendance records are sent to the learning and development team to be uploaded • It is proposed for Year 2 of this Quality Priority that the training report is split to show those colleagues who have received falls awareness training (all community hospital inpatient colleagues), those who have received falls prevention and assessment (FallSafe) training (all qualified nurses and therapists on community hospital inpatient wards) and those senior colleagues (Band 6 and 7 community hospital inpatient colleagues) who have received Care Fall training. Targets to be set for each of the 3 training pathways • Q1 2018/19 – 43.7% of staff reported to have received training, compared to 95% target
1.2.1 Orthostatic Hypotension	• Orthostatic hypotension can increase a patient's risk of falling. Careful assessment is needed so that treatment and management strategies can be implemented. The aim therefore is for all community hospital colleagues to be trained on correct, consistent techniques for taking lying and standing blood pressure. • Accurate training reports are still not being produced due to data not being inputted. Training and Development Sisters have been reminded to send attendance lists for falls training and lying and standing blood pressure measurement to the learning and development team at EJC to ensure they are updated on ESR or for the training and development sisters to gain access to update the training directly onto ESR. • Q1 2018/19 – 47.7% of staff reported to have received training, compared to 95% target

Gloucestershire Care Services NHS Trust

Performance against trajectory is from the April 2018 Quality Assurance Report
Narrative and performance for the Quality Priorities will be updated quarterly in accordance with availability of updated Quality Assurance Reports

1. Falls Prevention and Management (cont'd)

Additional information related to performance	What actions have been taken to improve performance?
1.3 Reducing Falls with Harm and Reducing Variation	• Analysis has evidenced a variance against the local benchmark for all falls and falls with harm across all the community hospitals. It can be seen that none of the hospitals are within the target of 10% tolerance for all harms however all hospitals (with the exception of Dilke) are below the benchmark for falls with harm of 3 per 1,000 bed days. • The Quality and Performance Committee were asked in April to clarify whether for Year 2 of this Quality Priority the focus should be on falls with harm rather than both all falls and falls with harm, and also to discuss whether the target trajectory for falls with harm should be reviewed as the Trust has been consistently below the local benchmark set at 3 per 1,000 bed days. • There was previously no clear definition of what a fall is and what a fall with injury is in terms of how incidents are reported and it was felt that this was contributing to the variation in the incidence of falls reported across the inpatient wards. Definitions were agreed and implemented and in May 2018 the community hospital Matrons audited a sample of incident reports to check compliance against the agreed definitions. The results showed that in 97% of cases the risk grading was reasonable.
1.4 Positive Risk Taking	• Leaflets are in place and there is now a "tick box" on SystmOne so that colleagues can record that the leaflet has been shared with the patient and/or relatives as part of their falls assessment. This will be audited in June/July.
1.7 #endPJparalysis	• The Trust is participating in the national 70 day #EndPJParalysis challenge as part of the celebrations of 70 years of the NHS. The idea is to measure every day for 70 days how many patients are up and dressed in their own clothes and have undertaken some sort of activity. • This information is then uploaded onto an app that feeds into a national database to be displayed on a dashboard. The idea being that our community hospital teams can see how they compare with one another and also with other hospitals participating in this national campaign. • It has not yet been possible to access data to gain an update but the Trust will continue to address this.

Gloucestershire Care Services NHS Trust

2. Colleague Health and Well-being

Additional information related to performance	What actions have been taken to improve performance?
The Trust is committed to providing a healthy and safe working environment to support colleagues in maintaining and enhancing their personal health and wellbeing at work. The Trust also recognises that supporting staff to improve their quality of life is crucial to the delivery of high quality, person centred care across the organisation's health and social care services.	Qtr 1 2018/19 – **Proposed Metrics 2018-2019** a) Measure – Achieving an improvement in the answer "yes, definitely" to Question 9a of the staff survey: "Does your organisation take positive action on health and well-being?" Q4 2018/19 Target – 91% b) Measure – Achieving an improvement in the answer "no" to Question 9b: "In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?" Q4 2018/19 Target – 85% c) Measure – to achieve an improvement in the answer "no" to Question 9c: "During the last 12 months have you felt unwell as a result of work related stress?" Q4 2018/19 Target – 75%

Gloucestershire Care Services NHS Trust

3. End of Life Care

Additional information related to performance	What actions have been taken to improve performance?
Leadership	• It has been agreed that the Clinical Pathways Lead for Dementia Care will now also take the lead for End of Life (EoL) Care and this came into effect in April 2018. • End of Life Care work plan and quality improvement metrics are being redeveloped to support outstanding actions from our CQC inspection and to align with countywide and regional work streams such as the Clinical Programmes Group and the ReSPECT roll out.
Quality Metrics	• The quality metrics are currently under development and will support the delivery of quality care and allow clarity on performance within the organisation. The metrics will be based around the key themes of: 1. Improved identification of patients in the last 12 months of life and utilisation/uptake of the SystmOne template 2. Identification of staff who have received End of Life Care training 3. Patient and family experience 4. Mortality reviews and learning from deaths (to include preferred place of death)
Development of the metrics to date	1. **Understanding Performance – two "must dos" for improving End of Life care:** • CQC "must do": A process to monitor the effectiveness and outcomes of key end of life care indicators – to enable leaders to understand performance in this area. • GCCG contract "must do": The SystmOne End of Life template will be used for all individuals identified as potentially being in their last 12 months of life. At least 75% of Trust colleagues are using the template as appropriate. 2**. Skilled and Trained Colleagues** • CQC "must do": Ensure all staff providing End of Life care are suitably trained and skilled to do so. • Measure: Clinical colleagues have access to End of Life Care training and there is a visible evidence of an uptake in training **3) Mortality Case Reviews** • CQC "should do": Consider the use of audits and other methods that will enable to accurately assess the effectiveness of record keeping and medicines prescriptions in end of life care. • Measure: To effectively review the care received by patients who have died to support learning and development of quality care within the organisation. The challenge, but opportunity is making sure the Trust aligns and enhances the current mortality reviews process
Training and Education	• The masterclasses for End of Life Care champions are underway and being well received by colleagues (running from May to October 2018). • The End of Life Development Programme for Registered Practitioners begins in July 2018 with all places fully subscribed into. The Clinical Pathways Lead alongside the Training and Development Team will provide support for participants in developing and progressing their work-based projects.

Gloucestershire Care Services NHS Trust

3. End of Life Care (cont'd)

Additional information related to performance	What actions have been taken to improve performance?
National Audit of Care at the End of Life (NACEL)	• Our community hospitals are involved in this national audit for the first time this year and data collection is now open.
ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)	• Gloucestershire has committed to supporting the roll out of ReSPECT within the county and is linking into the West of England Academic Health Science Network (WEAHSN) to support this work.
Countywide roll out of the new Shared Care Plan and diamorphine to morphine swap in End of Life Care	• These 2 changes commenced on 11th June 2018 with countywide sessions for colleagues and the development of local Train the Trainers to support the awareness and safe swap over. A pragmatic approach has been agreed and following 11th June all new patients will follow the new guidance but existing patients will remain on their existing regimes as both systems support quality of care. The swap from diamorphine is due to its cost and reduction in availability, diamorphine and morphine provide equally good pain control.

Gloucestershire Care Services NHS Trust

4. Nutrition and Hydration

What actions have been taken to improve performance?

To meet CQC regulation 14 providers must make sure that people have enough to eat and drink to meet their nutrition and hydration needs and receive the support they need to do so.

Metric 1: To increase the usage of the malnutrition universal screening tool (MUST)
- 80% of community nursing patients (including complex leg) will have a MUST assessment completed on initial assessment
- 95% of in-patient patients will have a MUST assessment completed within 24 hours of admission

Metric 2: To deliver a "Do one more thing" campaign in every ICT locality to promote the uptake of fluids in patients in their homes

Metric 3: Proxy measure to metric 2 - To decrease the incidence of CAUTIs possibly associated with dehydration.
- Retrospective records audit planned between summer 2018 and summer 2019

Metric 4: Healthy workforce campaign: Promote the 3Rs campaign in every community hospital and community site
- Rest – Rehydrate – Refuel

Metric 5: Increase the uptake of MUST training to include the usage of upper arm measurements in the absence of scales in people's homes

Metric 6: Staff colleagues are aware of and can apply the International Dysphagia Diet Standard Initiative

Metric 7: Leadership: Non-Executive representation of Nutrition and Hydration

These proposed metrics are commensurate with the 8 commitments of the Trust's Quality Improvement group nutrition and hydration strategy as well as CQC standard 14, and should provide demonstrable evidence of quality activity and outcomes.

A clinical pathways lead vacant appointment is currently out to advert and it is anticipated that the successful post holder will lead on this programme as part of their portfolio.

QUALITY PRIORITY | ARE SERVICES SAFE?

5. Preventing Pressure Ulcers

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report May Figure
CQC DOMAIN - ARE SERVICES CARING?																			
CQC DOMAIN - ARE SERVICES SAFE?																			
22	Total number of Acquired pressure ulcers	L - R		652	71	51	50										172		
23	Total number of grades 1 & 2 Acquired pressure ulcers	L - R		578	62	46	44										152		
24	Number of grade 3 Acquired pressure ulcers	L - R		64	7	5	5										17		
25	Number of grade 4 Acquired pressure ulcers	L - R		10	2	0	1										3		
CQC DOMAIN - ARE SERVICES EFFECTIVE?																			

Avoidable Pressure Ulcers (Community hospitals and community)	Jun-18
Total number of Grades 1&2	24
Number of Grade 3	2
Number of Grade 4	0
Total	**26**

Unavoidable Pressure Ulcers (Community hospitals and community)	Jun-18
Total number of Grades 1&2	20
Number of Grade 3	3
Number of Grade 4	1
Total	**24**

Additional information related to performance

Pressure Ulcers (Pressure Ulcers)

- In June there were 50 acquired pressure ulcers:
  1 was reported in Community Hospitals
  49 were reported in Community services

Benchmarking

- In the 'Rate of new grade 2,3,4 avoidable pressure ulcers acquired in a Community Hospital setting per 1,000 occupied bed days' the Trust submitted a figure of 1.74 in May. In a Community Setting this was 0.0. The benchmarking figure is 0.39 for Community Hospital settings and 0.71 for Community settings.

Risks (Pressure Ulcers)

Reference – 562
Rating – 16

Risks (Acquired Pressure Ulcers)

Reference – 710
Rating – 9

• What actions have been taken to improve performance?

• Re-issued the public facing prevention leaflets and the development of the 'easy read' version is nearing completion

• Clarified the tissue viability and pressure ulcer education offer for 2019 and increased the available sessions, including some being offered in localities.

• The Trust education offer to care homes continues including Pressure Ulcer awareness training with reablement colleagues with more planned

• Plans are in progress to offer pressure ulcer datix reporter training to all localities and community hospitals as part of brief intervention support

• The trajectories have been reviewed and some closed, leaving 6 measurable, quantifiable metrics which continue on quarterly review

• The Trust is reviewing recently nationally published Pressure Ulcer recommendations (NHSI, June 2018)

NHS Gloucestershire Care Services NHS Trust

6. Reducing Medication Errors

What actions have been taken to improve performance?

- Medication errors and the harm caused by them are a worldwide problem and they are the second highest area of reporting across GCS. In March 2017, the World Health Organisation (WHO) launched its third Global Patient Safety Challenge: Medication without Harm. The aim of this Challenge is to reduce severe avoidable medication-related harm globally by 50% in the next 5 year. The Challenge focused on three priority areas of medication safety that most affect patients; these three areas are high-risk situations, polypharmacy and transitions of care. Each area is associated with a substantial burden of harm and therefore, if appropriately managed, could reduce the risk of harm to many patients.

Metric 1: Increase the number of medication related incidents reports

- In order to fully understand the size and nature of the problem it is important that an open reporting culture for medication errors is prevalent throughout all teams in all settings.

Metric 2: to identify themes and trends and provide training on these areas to colleagues handling medicine

Metric 3: To reduce the number of medication related incidents causing harm or with the potential to cause harm by 5%

Metric 4: To reduce the number of insulin related incidents in the community by 10%

Metric 5: To continue to use technology to improve medication safety in inpatient units

- This measure is still to be developed fully by the group.

All measures will need baseline figures based on incident data; these are currently being determined. The quality improvement group will also be working closely with the Training and Development department when trends have been identified for focusing on raising awareness.

Gloucestershire Care Services NHS Trust

7. Deteriorating Patient, Including Sepsis

What actions have been taken to improve performance?

Improvements in early detection, escalation, treatment and reporting of deteriorating patients are a new quality and safety priority for the Trust this year. The National Early Warning Score ((NEWS, and now updated NEWS2) is a shared common language to quickly identify deteriorating patients. This supports clinicians to quickly identify and communicate deterioration across acute, community and primary care settings. Early detection of deterioration can aid treatment of suspected sepsis and improve patient health outcomes.

Policy & awareness for clinical colleagues (outcome measure for 2017-18)

- Milestone Achieved - The Adult Policy for the deteriorating patient has been completed, ratified and uploaded onto the intranet. Engagement is currently underway across patient facing services to promote awareness of deterioration and escalation principles.
- New Outcome Measure 1: Paediatric deteriorating patient review and agreement on policy. PEWS – Paediatric Early Warning Score
- Outcome Measure 2:- Deteriorating Patient (Adult) policy roll out and awareness training for all patient facing staff
- Outcome Measure 3 - All appropriate patients will have a NEWS score recorded on admission to community hospital or caseload as a baseline
- Outcome measure 3 - will also incorporate the following milestone: Revised National Early Warning Score (NEWS2) upgrade

Sepsis

- Outcome Measure 4 – All patients who are identified as being at risk of SEPSIS (using NEWS/Sepsis risk stratification tool data from SY1) are managed/escalated appropriately on the sepsis pathway (see deteriorating patient policy).

EXCEPTION REPORT | ARE SERVICES SAFE?

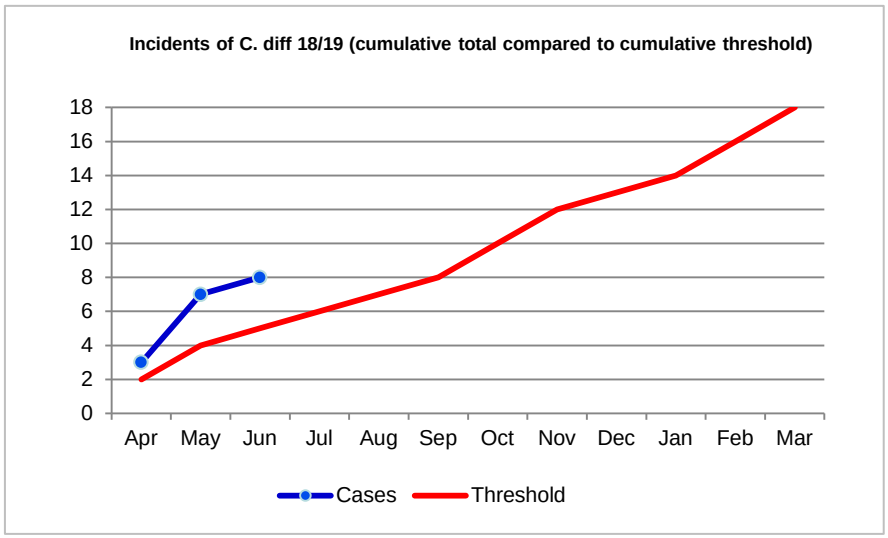
NHS Gloucestershire Care Services NHS Trust

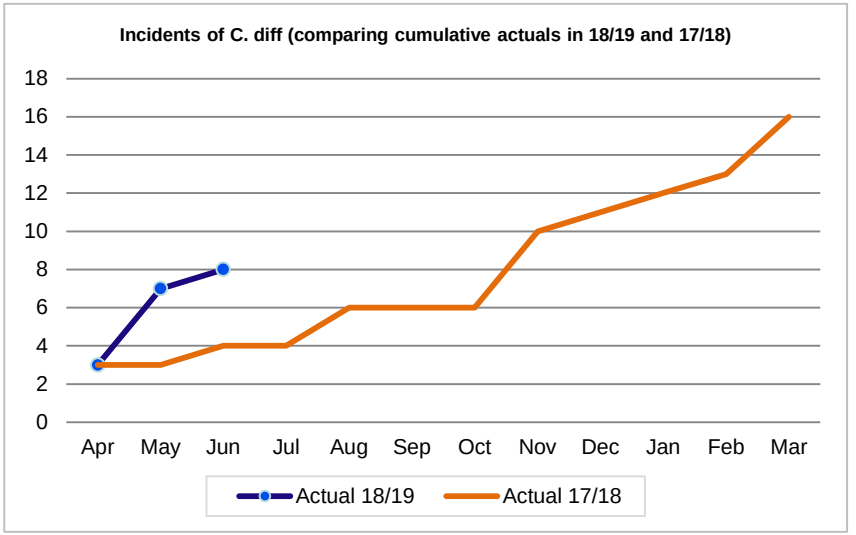
Infection Control

CQC DOMAIN - ARE SERVICES SAFE?

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report May Figure
14	Number of post 48 hour Clostridium Difficile Infections	N - R L - C	*1	16	3	4	1										8	Y	
19	VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	95.0%	87.9%	93.0%	91.0%										90.6%	Y	

	2017/18 Outturn	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sept-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018/19 YTD
C. difficile Cases	16	3	4	1										8
Avoidable cases in GCS care	1	0	0	0										0
Unavoidable cases in GCS care	15	3	4	1										8
Norovirus Outbreaks	9	0	1	0										1





*In-month threshold (i.e. April)

EXCEPTION REPORT | ARE SERVICES SAFE?

• Additional information related to performance	What actions have been taken to improve performance?
There has been one C. difficile case to report for June 2018: 1. The patient was admitted to Cirencester Hospital from Gloucestershire Royal Hospital. The patient suffered with and was treated for recurrent urinary tract infections. This case is considered to have been **unavoidable**.	• Several courses of antibiotics for pneumonia and urinary tract infections with a three month stay in the GHFT meant it was likely that the patient had become colonised with C. difficile. • Predisposing factors being collated to develop an Early Warning System to consider C. difficile as a risk. • Identified that the SIGHT-T mnemonic was not immediately instigated and improvements in communication between medical team and care staff is required.
Norovirus There have been no Norovirus outbreaks to report.	
Hand Hygiene Gloucestershire Care Services NHS Trust aims for a compliance figure of 90%. **Compliance figure for June** 2018 = 94%	• If a department does not submit an audit within 14 days of the next month then a score of zero is recorded. Reminders are sent at the end of the month and then 7 days later to prompt a return that would then maintain the organisations overall compliance score.
Benchmarking • In the 'Number of Incidences of post 48 hour C.Difficile per 1,000 occupied bed days' measure, the Trust submitted a figure of 1 in May. The benchmarking figure is 0 for May.	

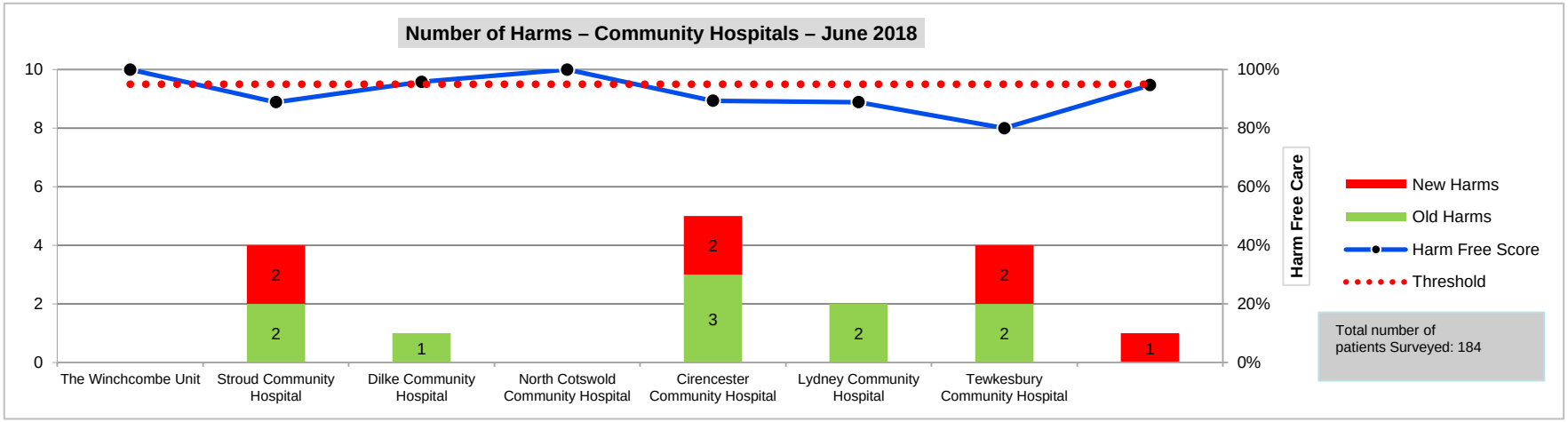
EXCEPTION REPORT | ARE SERVICES SAFE?

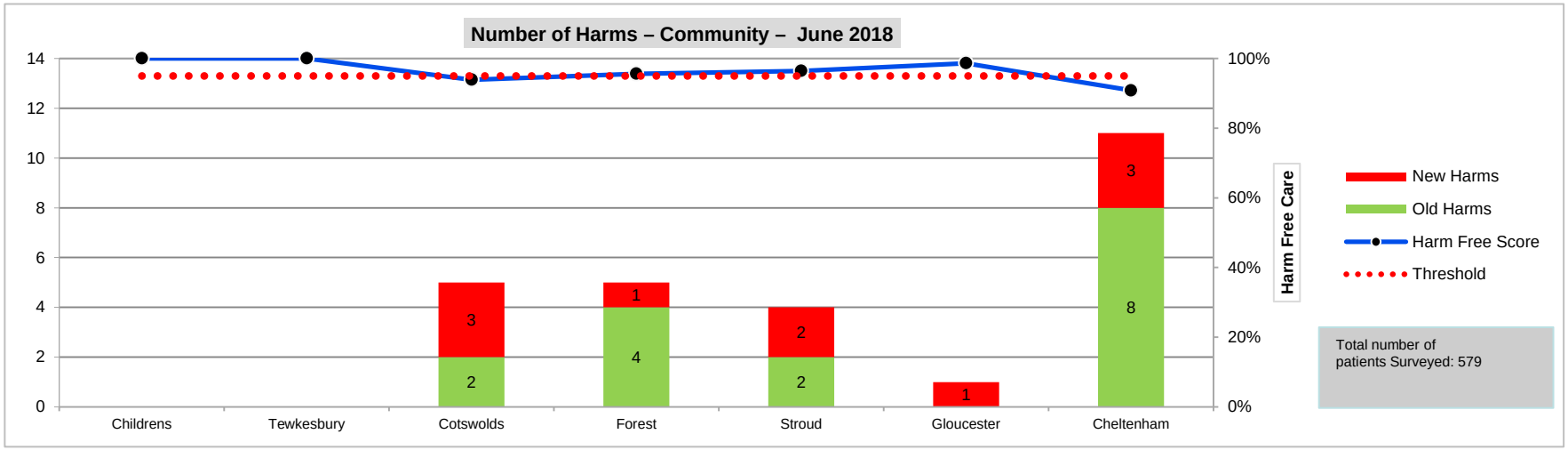
Safety Thermometer (Page 1 of 3)

NHS Gloucestershire Care Services NHS Trust

CQC DOMAIN - ARE SERVICES SAFE?

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report May Figure
20	Safety Thermometer - % Harm Free	N - R L - C	95%	94.1%	92.8%	91.9%	94.4%										94.1%	Y	

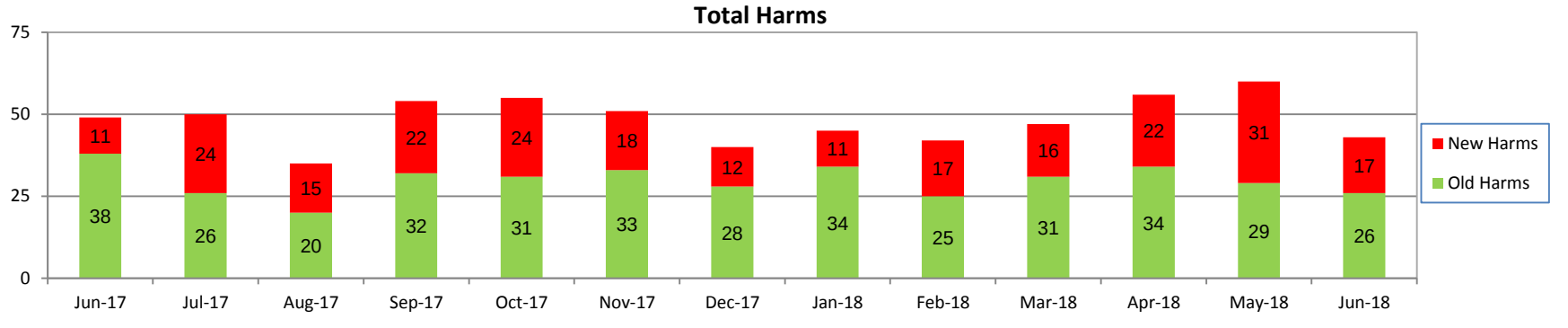




EXCEPTION REPORT | ARE SERVICES SAFE?

NHS Gloucestershire Care Services NHS Trust

Safety Thermometer (Page 2 of 3)



Additional information related to performance	What actions have been taken to improve performance?
Safety Thermometer: • 763 patient episodes of care were surveyed for the June Safety Thermometer census, out of which 720 patients' care was harm free. The Trust's Harm Free Care score was therefore **94.4%**, missing the target of 95% by 0.6%. Based on new harms only, Harm Free Care in June was **97.8**% compared to an internal target of 98%. • The Community Hospital inpatient harm free care performance was **90.8%** in June. Based on new harms only, the inpatient performance was 96.2% in June. • Community Nursing harm free care performance was **95.5%** in June. Based on new harms only, Community Nursing harm free care was 98.3% in June. 43 harms were reported in June, of which 17 were new harms. In June, **2.2%** of all patients surveyed had a new harm. In 2017/18, 205 new harms were reported, representing 2.0% of all patients surveyed for safety thermometer in 2017/18.	• It is encouraging to see that as an organisation for June we were performing more favourably than the national benchmark of new harms (97.8% against the latest quarterly national benchmark of 96.3%), but this still did not reach the Trust's stretch target of 98%. The total harm free care which is reflective of harms in the whole system and not just those attributed to the Trust was better than previous months but still short of the 95% or more that we aspire to. • An urgent Safety Thermometer meeting for members of the clinical reference group, performance team and operational governance forum was held on 15 June 2018 where actions to improve data collection and develop a semi-automated census process were agreed. **Risks** Reference – 562 Rating – 16

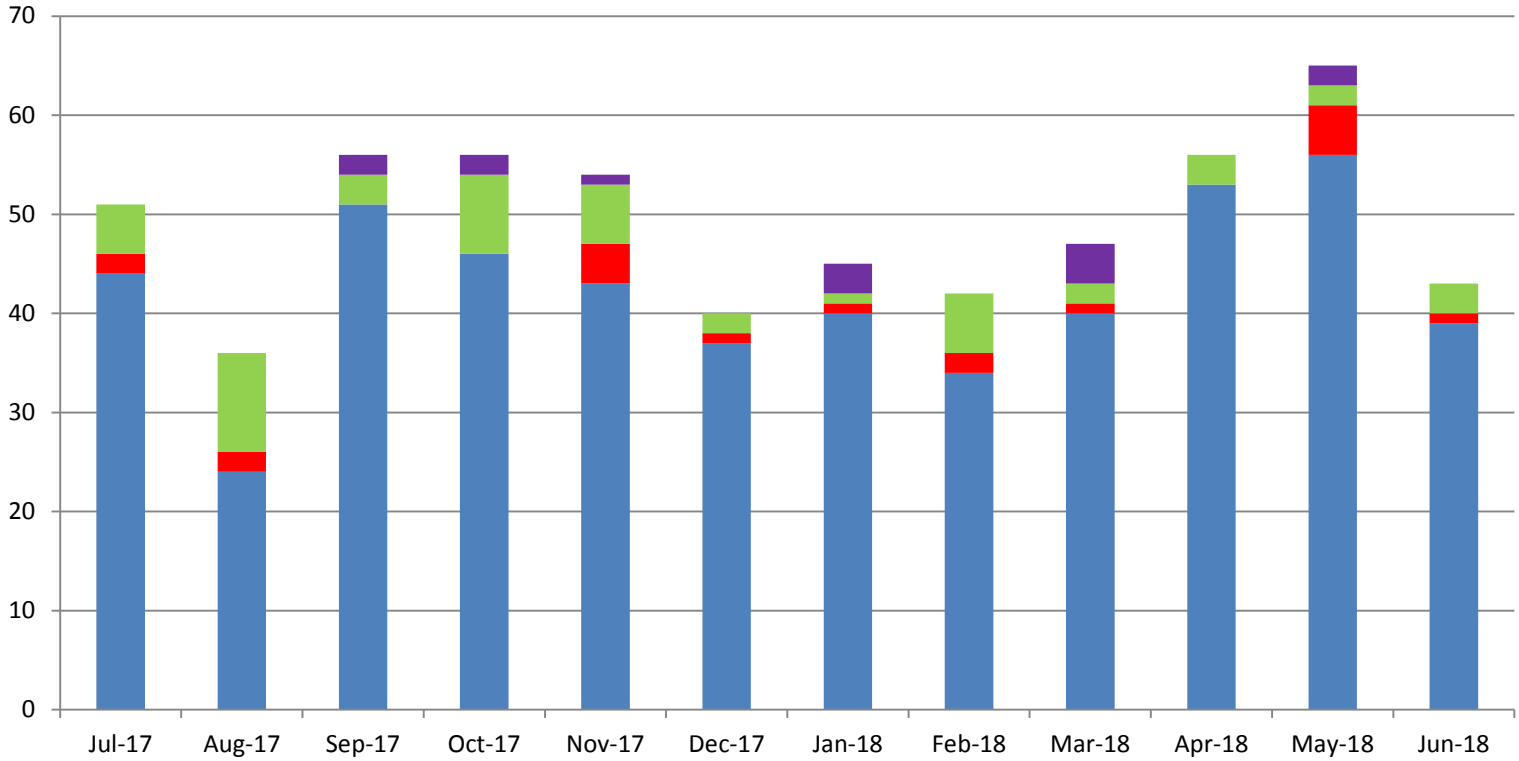
Benchmarking

- In the 'Safety Thermometer – Percentage of 'Harm Free Care (New Harms Only)' measure, the Trust submitted a figure of 95.6% in May. The benchmarking figure is 96.5% for May.

NHS Gloucestershire Care Services NHS Trust

Safety Thermometer (Page 3 of 3)

Safety Thermometer Harms by type (Jul 2017 – Jun 2018)



	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
VTE	0	0	2	2	1	0	3	0	4	0	2	0
UTI/catheter	5	10	3	8	6	2	1	6	2	3	2	3
Falls	2	2	0	0	4	1	1	2	1	0	5	1
Pressure Ulcer	44	24	51	46	43	37	40	34	40	53	56	39

EXCEPTION REPORT | ARE SERVICES EFFECTIVE?

NHS Gloucestershire Care Services NHS Trust

Community Hospitals

CQC DOMAIN - ARE SERVICES EFFECTIVE?																				
		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report May Figure
Community Hospitals																				
28	Bed Occupancy - Community Hospitals	L - C	92%	96.7%	93.2%	95.1%	91.8%										93.4%	Y	88.9%
32	Average of 4 discharges per day (weekends) - Inpatients	L - C	4	3.1	2.6	3.5	1.7										2.6	Y	
33	Average of 11 discharges per day (weekdays) - Inpatients	L - C	11	8.1	8.7	7.4	9.3										8.5	Y	

Additional information related to performance	What actions have been taken to improve performance?
Bed Occupancy 92.0% - 94.0% 94.0% - 96.0% >96.0%	
Discharges per Weekday and Weekend • Following the bed modelling project underway, this metric will be reviewed to determine if the average discharge rate aligns with the expected AVLOS for each patient cohort.	• Discussions continue with Commissioners on the expected level of discharges per day to support patient flow.

Benchmarking

- In the 'Percentage of beds occupied by DToCs due to NHS delays' measure, the Trust submitted a figure of 0.7% in May. The benchmarking figure is 5.8% for May.
- In the 'Percentage of beds occupied by DToCs due to Social Care delays' measure, the Trust submitted a figure of 0.1% in May. The benchmarking figure is 3.8% for May.

EXCEPTION REPORT | ARE SERVICES RESPONSIVE?

NHS Gloucestershire Care Services NHS Trust

8 Week Referral to Treatment (RTT) Measures

CQC DOMAIN - ARE SERVICES RESPONSIVE?																			
		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report May Figure
Minor Injury and Illness Units																			
Referral to Treatment																			
41	Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	84.4%	60.7%	59.5%	57.1%										59.1%	Y	
44	MSK Physiotherapy	L - C	95%	90.7%	91.4%	99.7%	85.7%										92.3%	Y	
45	ICT Physiotherapy	L - C	95%	85.0%	84.3%	84.5%	81.1%										83.3%	Y	
46	Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	82.8%	77.4%	70.1%	76.8%										74.5%	Y	
47	Diabetes Nursing - % treated within 8 Weeks	L - C	95%	96.2%	94.5%	85.5%	97.6%										92.5%	Y	
66	95% of priority 1 & 2 calls answered within 60 seconds after introductory message finishing	L - C	95%	90.5%	91.7%	95.6%	94.6%										94.0%	Y	
67	Rapid Response - Number of referrals	L - C	*922	3,726	309	290	319										918	Y	

Referral to Treatment – comparison between local 8 week standard and 18 week target (June 2018)

Jun-18	8 week RTT target	% seen within 8 weeks	Number seen within 8 weeks	Number seen above 8 weeks	18 week RTT target	% seen within 18 weeks	Number seen within 18 weeks	Number seen above 18 weeks	Median RTT in days
Speech and Language Therapy - % treated within 8 Weeks	95%	57.1%	52	39	92%	90.1%	82	9	51
MSK Physiotherapy	95%	85.7%	1405	235	92%	100%	1640	0	28
ICT Physiotherapy	95%	81.1%	352	82	92%	96.5%	419	15	18
Occupational Therapy Services - % treated within 8 Weeks	95%	76.8%	365	110	92%	93.1%	442	33	22
Diabetes Nursing	95%	97.6%	40	1	92%	100%	41	0	28

Other Access measures not included in 8-week RTT table above

CQC DOMAIN - ARE SERVICES RESPONSIVE?																			
		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report May Figure
52	Sexual Health - % of terminations carried out within 9 weeks and 6 days of gestation	L - C	80%	77.4%	75.0%	72.1%	83.3%										77.0%	Y	
58	MSKCAT Service - wait from referral for urgent patients to be seen not to exceed 2 weeks	L - C	95%	95.9%	84.6%	96.3%	97.6%										93.7%	Y	
59	Stroke ESD - Proportion of new patients assessed within 2 days of notification	L - C	95%	88.6%	65.2%	72.7%	44.4%										61.9%	Y	

EXCEPTION REPORT | ARE SERVICES RESPONSIVE?

NHS Gloucestershire Care Services

Additional information related to performance	What actions have been taken to improve performance?
Adult Speech and Language Therapy (% treated within 8 weeks) • Performance was **57.1%** in June compared to 59.5% in May (target is 95%). • 39 out of 91 patients were seen outside the 8 week threshold. • Performance against the 18 week target was 90.1% (9 out of 88 patients were seen outside the18 week threshold) • Profile of breaches in June (number and percentage): **Wait band** / **Number** / **%** 8-9 / 52 / 5.8% 9-10 / 4 / 4.4% 10-18 / 24 / 2.7% 18+ / 9 / 10.1%	We have seen a significant increase in capacity since the start of the year, going from an average of 30 patients a month to an average of 75, in June we saw 91 patients. This is due to the staffing issues starting to improve as we have recruited to clinical posts, have locum cover and have admin staff back from sick leave. In addition, we have met and agreed a way forward for changes to SystmOne processes.
MSK Physiotherapy (% treated within 8 weeks) • Performance was **85.7%** in June compared to 99.7% in May (target is 95%). • 235 out of 1405 patients were seen outside the 8 week threshold. • Performance against the 18 week target was 100% (0 out of 1640 patients were seen outside the18 week threshold) • Profile of breaches in June (number and percentage): **Wait band** / **Number** / **%** 8-9 / 181 / 77% 9-10 / 29 / 12.3% 10-18 / 25 / 10.7% 18+ / 0 / 0%	We saw 200 patients more in June than in April or May. The MSKAPS have agreed to provide some triage time which will free up MSK clinicians to deliver new appointments. We have met to look at demand and capacity and as a result the service is undertaking some work to reduce the number of cancellations (average 14.33%) through better applying the access policy; alongside work to better understand day-to-day issues e.g. empty ledger slots, first contact cancellations that rebook. In addition one of the MSK B7s has gained a place on the NHSI demand & capacity training .
Adult ICT Physiotherapy (% treated within 8 weeks) • Performance was **81.1%** in June, compared to 84.5% in May (target is 95%). • 82 out of 434 patients were seen outside the 8 week threshold in May. • Performance against the 18 week target was 96.5% (15 of 434 patients were seen outside the18 week threshold) • Profile of breaches in June (number and percentage): **Wait band** / **Number** / % 8-9 / 19 / 23.1% 9-10 / 8 / 9.8% 10-18 / 40 / 48.8% 18+ / 15 / 18.3%	Challenges remain in staffing. A locality by locality demand and capacity plan is in development and work is underway to improve SystmOne recording.

EXCEPTION REPORT | ARE SERVICES RESPONSIVE?

Gloucestershire Care Services NHS Trust

<table>
<tr><th>Additional information related to performance</th><th>What actions have been taken to improve performance?</th></tr>
<tr><td>

Adult ICT Occupational Therapy (% treated within 8 weeks)

- Performance in June was **81.7%** in June compared to 70.1% in May (target is 95%). 82 out of 434 patients were seen outside the 8 week threshold in June.
- Performance against the 18 week target was 96.5% (33 out of 434 patients seen outside the18 week threshold)
- Profile of breaches in June (number and percentage):

<table>
<tr><th>Wait band</th><th>Number</th><th>%</th></tr>
<tr><td>8-9</td><td>14</td><td>12.7%</td></tr>
<tr><td>9-10</td><td>13</td><td>11.8%</td></tr>
<tr><td>10-18</td><td>50</td><td>45.5%</td></tr>
<tr><td>18+</td><td>33</td><td>30%</td></tr>
</table>

</td><td>

Challenges remain in staffing. A locality by locality demand and capacity plan is in development and work is underway to improve SystmOne recording.
As part of the OT review we are now in year one of a decrease in OT staffing levels equating to £350,000 alongside a movement of resource from core ICT to prevention services of a further £300,000.
We have now started work on a more detailed OT specific scorecard to monitor the change and impact of the OT review which monitors the productivity of the service as capacity decreases.

</td></tr>
<tr><td>

Sexual Health - % of terminations carried out within 9 weeks and 6 days of gestation

- Performance was **83.3%** in June compared to 72.1% in May.
- 73.7% of terminations this year have been provided within the 9 week 6 day target

</td><td>

We have a clear project plan in place and have undertake patient shadowing, this has demonstrated where we have ‘waste’ in the process. We undertaking a PDSA on a telephone assessment process and have mapped a proposed change to how the clinic will run.
This will offer options to women sooner, free up some consultant capacity for the surgical procedures (as well as potentially increasing the number of medical terminations that can be offered). Alongside this recruitment options are being explored by the service.

</td></tr>
<tr><td>

MSKCAT Service - wait from referral for urgent patients to be seen not to exceed 2 weeks

- Performance was **97.6%** in June compared to 96.3% in May. 1 out of 42 patients was seen outside the 2 week target.
- The amber YTD performance is caused by lower performance in April compared to subsequent months. The target has been achieved and has improved in the last two consecutive months.

</td><td></td></tr>
</table>

EXCEPTION REPORT | ARE SERVICES RESPONSIVE?

Gloucestershire Care Services NHS Trust

<table>
<tr><th>Additional information related to performance</th><th>What actions have been taken to improve performance?</th></tr>
<tr><td>

Diabetes Nursing service – % treated within 8 Weeks

- Performance was **97.6%** in June compared to 85.5% in May. 3 out of 41 patients were seen outside the 8 week threshold.
- Performance against the 18 week target is 100%.
- Profile of breaches in June (number and percentage):

<table>
<tr><th>Wait band</th><th>Number</th><th>%</th></tr>
<tr><td>8-9</td><td>2</td><td>66.6%</td></tr>
<tr><td>9-10</td><td>1</td><td>33.3%</td></tr>
<tr><td>10-18</td><td>0</td><td>0%</td></tr>
<tr><td>18+</td><td>0</td><td>0%</td></tr>
</table>

</td><td>This month the service is back on track following the actions put in place which included; review of caseload, recording and referrals undertaken. Staff capacity back to establishment.</td></tr>
<tr><td>

95% of priority 1 & 2 calls answered within 60 seconds after introductory message finishing.

- Performance was **94.6%** in June, compared to 95.6% in May (target is 95%). 109 out of 2,474 Priority 1 & 2 calls were answered outside of the 60 second target.

</td><td>Significant improvement in performance from 16/17 to 17/18 and then to 18/19. This is due to redesign of staff rotas, change in skill mix, remodelling of physical space and improved live reporting. Have had ongoing discussion with CCG regarding appropriateness of target</td></tr>
<tr><td>

Rapid Response

- In the year to date there have been 918 referrals with the target to the end of June being 922, missing the target by four referrals. The target was achieved in June; the amber YTD figure is influenced by performance in May which was comparatively lower than other months.

</td><td>Daily monitoring of target by teams. Quiet weeks tend to be influenced by a quiet system. Clear actions in place if capacity is not being utilised.</td></tr>
<tr><td>

Stroke ESD (% of new patients assessed within 2 days of notification)

- The reported performance in June was 44.4% against a target of 95%, with a YTD figure of 61.9%.

</td><td>Performance to be investigated.</td></tr>
</table>

EXCEPTION REPORT | ARE SERVICES WELL LED?

NHS Gloucestershire Care Services NHS Trust

Workforce / HR (Page 1 of 4)

CQC DOMAIN - ARE SERVICES WELL LED?

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report May Figure
70	Mandatory Training	L - I	92%	82.6%	86.3%	85.8%	86.0%										86.0%	Y	88.7%
71	% of Staff with completed Personal Development Reviews (Appraisal)	L - I	95%	79.9%	84.4%	80.9%	81.4%										82.3%	Y	66.3%
71a	% of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only	L - I	95%	N/A	87.4%	85.4%	84.0%										86.4%	Y	
72	Sickness absence average % rolling rate - 12 months	L - I	<4%	4.6%	4.7%	4.6%	4.7%										4.7%	Y	

Additional information related to performance	What actions have been taken to improve performance?
Staff FFT In Quarter 1 of 2018/19, **63%** of staff would recommend the Trust as a place to work (target is 61%) and **88%** would recommend the Trust as a place to receive treatment (target is 67%).	• The Trusts Workforce & OD Committee is overseeing action plans to improve this further. These plans will continue align to the wider Organisational Development agendas. **Risks (Recruitment/ Retention)** Reference – 609 Rating – 16 **Risks (Staff FFT)** Reference – 622 Rating – 12 **Risks (Leadership Capacity)** Reference – 623 Rating – 12
Staff with completed Personal Development Reviews (PDRs) • **81.4%** of Personal Development Reviews were completed by the end of June 2018, an increase compared to **80.9%** in May. For active assignments, performance was **84.0%** in June, however this also a decrease compared to the Active Assignments performance of 85.4% in May. **Risks (PDR)** Reference – 643 Rating – 9	• The Trust is working with colleagues to proactively monitor both their own training and PDR compliance levels with through Electronic Staff Record (ESR). Self-service functionality has been launched to allow managers to submit details of completed PDRs via ESR. • This is a recognised priority for the Executive Team. A variety of initiatives are being explored to assist teams with improving PDR completion rates. This includes a weekly executive-led review of outstanding PDRs, which has proved to be very effective in improving the completion rates. • A new PDR form has been developed and agreed at the Workforce and Organisational Development Committee and JNCF. The new form is being launched through the Core and HR matters on the 11th July 2018. All the relevant PDR documentation has been updated on the intranet.
Sickness absence • The rolling 12 months performance was **4.7%** in June, above target of <4.0%, and a slight increase from May. **Benchmarking** • In the 'Sickness absence rate (Short and Long Term)' measure, the Trust submitted a figure of 4.5% in May. The benchmarking figure is 4.4% for May. **Risks (sickness absence)** Reference – 633 Rating – 12	• This remains a priority for the Executive Team. A variety of initiatives are being explored to assist teams with reducing sickness absence rates. • Actions taken to date include review of policy, guidance and letter templates, review of the workshops offered by HR, dedicated HR support in Community Hospitals and ICTs as a trial, discussion at the Performance and Finance meetings and an HR business partner model being implemented to offer consistency and local intelligence for each area. • Review of actions above to be completed to assess the impact on sickness levels. • Health and Well Being agenda adopted by the Trust to promote healthy lifestyles. • Employee assistance programmes include Care first and Working Well. • In house fast track musculo skeletal service in place.

EXCEPTION REPORT | ARE SERVICES WELL LED?

Workforce / HR – Mandatory Training (Page 2 of 4)

Gloucestershire Care Services NHS Trust

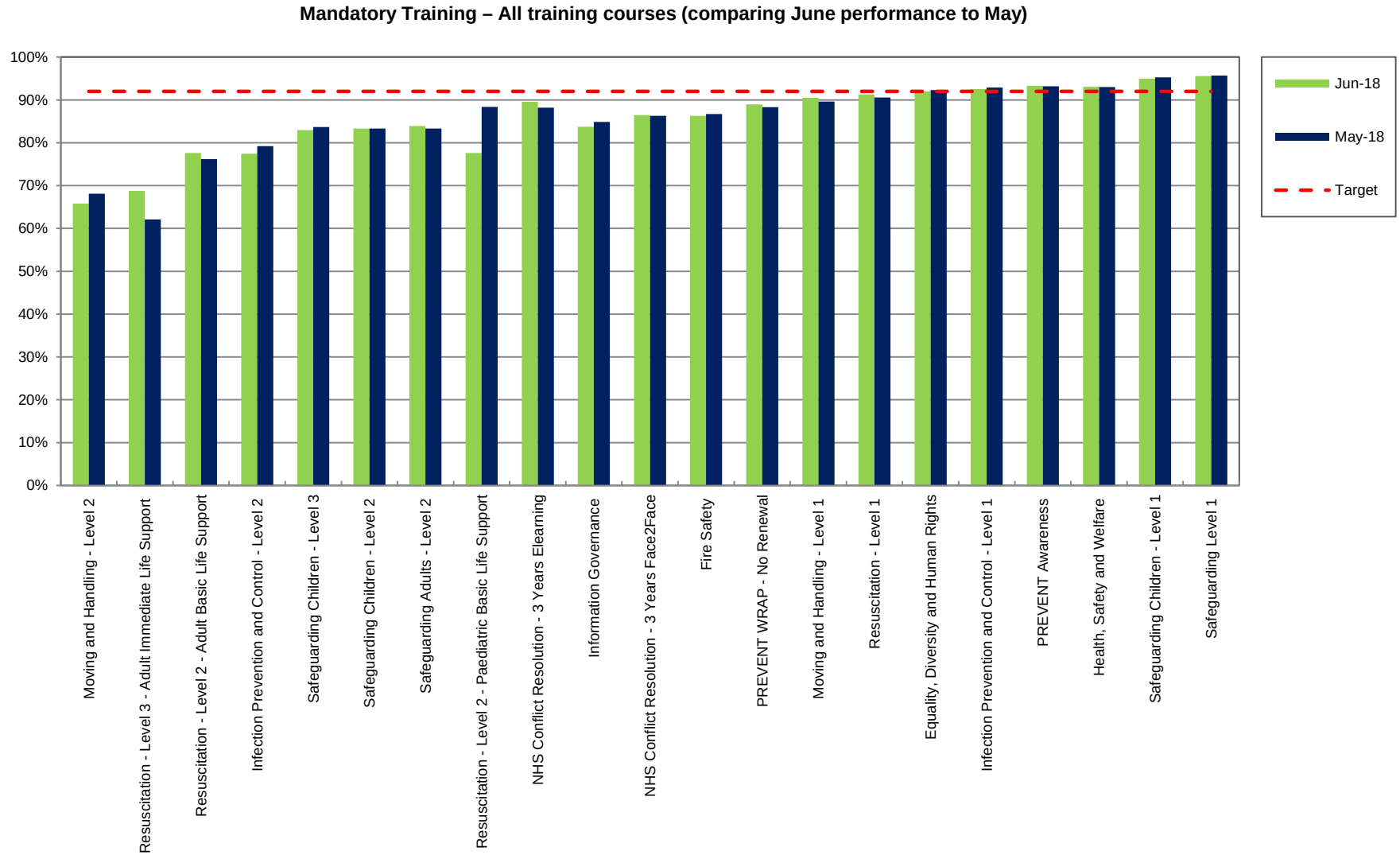
Additional information related to performance	What actions have been taken to improve performance?

Mandatory Training
 	
• Average June performance was **88.8%** with 6 measures above the 92% target:
  • Equality, Diversity and Human Rights
  • Infection Prevention and Control - Level 1
  • PREVENT Awareness
  • Health, Safety and Welfare
  • Safeguarding Children - Level 1
  • Safeguarding Level 1
 	
• **9** out of 21 measures have reduced in performance in June compared to May:
  • Equality, Diversity and Human Rights
  • Fire Safety
  • Infection Prevention and Control - Level 1
  • Infection Prevention and Control - Level 2
  • Information Governance
  • Moving and Handling - Level 1
  • Resuscitation - Level 2 - Adult Basic Life Support
  • Safeguarding Level 1
  • Safeguarding Children - Level 1
 	
Risks (Mandatory training)
Reference – 634
Rating – 9
	• A request has been made to provide training review dates by month for each service to support release of necessary capacity to allow colleagues to undertake training.
	
	• Every subject area below 92% has detailed action plan.
	
	• Executive oversight has increased for Resuscitation, Moving and Handling, Information Governance Mandatory training.
	
	• The Learning and Development Team review capacity on a monthly basis to ensure there is enough classroom training to meet demand.
	
	• Facilitated E-Learning Workshops are delivered, around the county to ensure learners with IT, ESR and learning issues are supported in their place of work.
	
	• There is also a potential risk that Moving and Handling compliance will reduce further as a result of the relocation of training facilities from the Independent Living Centre (ILC) in Cheltenham to Cirencester Hospital.
	
	• Overall, compliance remains below the Trust's target rate of 92%. Progress will also be monitored and reviewed as part of the Trust CQC Quality Improvement Plan.

EXCEPTION REPORT | ARE SERVICES WELL LED?

Workforce / HR – Mandatory Training (Page 3 of 4)

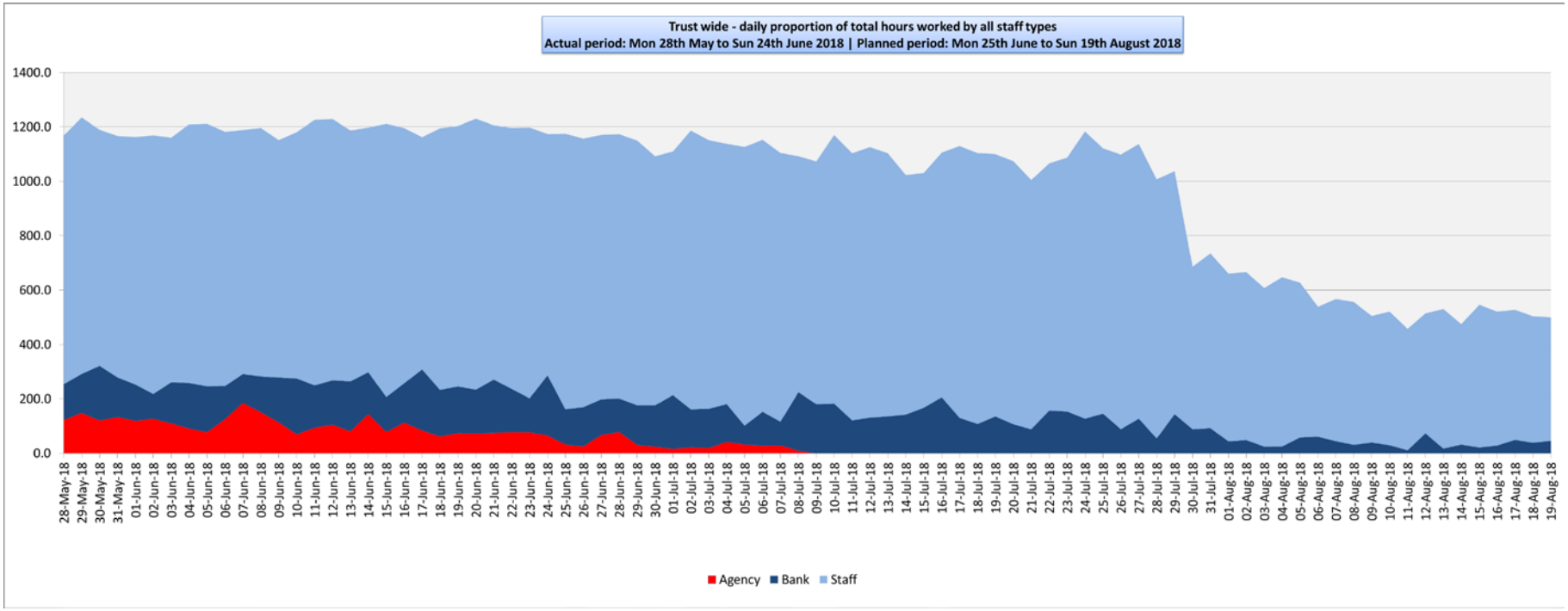
Gloucestershire Care Services NHS Trust

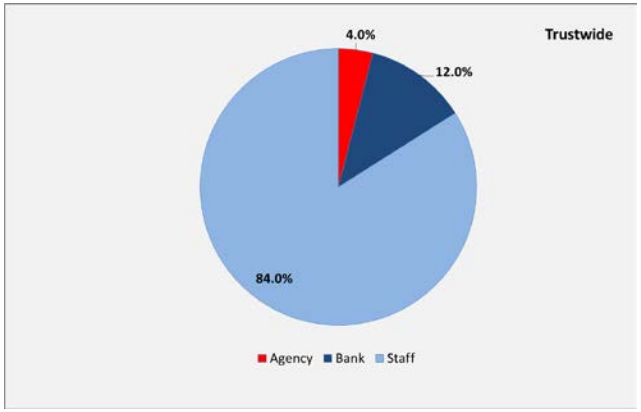


EXCEPTION REPORT | ARE SERVICES WELL LED?

Workforce / HR – Agency Usage (Page 4 of 4)

Gloucestershire Care Services NHS Trust





- The graphs are based on data extracted at the end of June, thereby showing actual figures up to the end of that month and planned figures from that point onwards.
- The data is taken from rota information in E-Roster.
- Other information made available to the Trust on a monthly basis includes:
  - ❑ Reasons for agency usage
  - ❑ Which agencies have been used
  - ❑ Agency usage as a percentage of total hours worked, by Hospital ward
  - ❑ Of Bank hours, percentages of HCA or RCN
- Workforce definitions:
  - ❑ Agency means staff sourced from a private agency with associated cost
  - ❑ Bank means sourced through the Trust's internal bank staff
  - ❑ Staff means staff directly contracted to Trust and in the establishment of that hospital/ward

Benchmarking

- In the '% Spend on Agency Staff' measure, the Trust submitted a figure of 2.1% in May. The benchmarking figure is 3.7% for May.

NHS Gloucestershire Care Services NHS Trust

Dashboard Key:

N - T	National measure/standard with target
N - R	Nationally reported measure but without a formal target
L – C	Locally contracted measure (target/threshold agreed with GCCG)
L – I	Locally agreed measure for the Trust (internal target)
L – R	Locally reported (no target/threshold) agreed
N – R L – T (e.g.)	A measure that is treated differently at a national and local level, e.g. nationally reported but also has a locally set target

Report Content:

- The report is constructed on an exception basis, i.e. narrative and improvement actions will only be given against measures that are missing the agreed target.
- Performance against all measures are shown in the Performance Dashboard on pages 4-6; those that are included in the report are indicated by a 'Y' in the 'Exception Report?' column. This will happen under the following circumstances:
  - Current reporting month is red
  - Current and previous consecutive reporting months are amber
  - YTD is amber or red regardless of current reporting month performance

APPENDIX 2 – NHS BENCHMARKING NETWORK

Gloucestershire Care Services NHS Trust

Benchmarking Methodology

Benchmarking figures included in the report are as at **May 2018**

Benchmark Indicators

A set of 35 metrics are collected on a monthly basis covering patient safety and quality, productivity, workforce, data quality and finance. The project covers provision both within the community and inpatient community hospitals and provides timely feedback to participants.

Outputs include a monthly toolkit, showing participant positions against agreed benchmarks.

Annual project collections are also underway and data will be incorporated where relevant once available to the Trust.

Submitting Trusts

- Birmingham Community Healthcare NHS Trust
- Buckinghamshire Healthcare NHS Trust
- Cambridgeshire Community Services NHS Trust
- First Community Health and Care
- Gloucestershire Care Services NHS Trust
- Guys and St Thomas' NHS Foundation Trust
- Hertfordshire Community NHS Trust
- Kent Community NHS Foundation Trust
- Leeds Community Healthcare NHS Trust
- Lincolnshire Community Health Service NHS Trust
- Norfolk Community Health and Care NHS Trust
- North Somerset Community Partnership
- Pennine Care NHS Foundation Trust
- Sussex Community NHS Foundation Trust
- Solent NHS Trust
- Staffordshire & Stoke-on-Trent Partnership Trust
- Wirral Community
- Wiltshire Health and Care

Comments

- There are a range of outputs and measures generated by the Benchmarking project to which the Trust contributes. Some of these measures are an exact match for one of those included in the Performance Dashboard, some are related but not exactly the same (for example rate of pressure ulcers per 1,000 occupied bed days, or number of C.difficile infections per 1,000 occupied bed days).
- Where one of these measures is an exact match for a measure in the Performance Dashboard, the figure has been added to the dashboard for comparison. The figure provided is the average across all Trusts that have submitted a figure that month.
- Where there is a related measure, this has been included for context in the Exception Report section. The figures provided are the average of all Trusts that have submitted that month.
- It should be noted that Benchmarking figures are available one month later than the Trust's produced performance data so any comparison with the Trust's May data will be with an April benchmarking figure provided by the NHS Benchmarking Network.

Trust Board	
Date of Meeting:	24th July 2018
Report Title:	Workforce and Organisation Development Report

Agenda reference number:	13/0718
Accountable Executive Director: (AED)	Neil Savage, Director of HR & OD
Presenter: (if not AED)	Nicola Strother Smith
Author(s):	David Smith, Director of Transition and Sonia Pearcey, Ambassador for Cultural Change
Board action required:	The Board is asked to note the report which is provided for assurance and to receive and agree the Workforce Race Equality Submission and to receive the updated action plan at the September Board meeting
Previously considered by:	Workforce and OD Committee
Appendices	1. Workforce Implementation plan update 2. Workforce Race Equality Submission (WRES)

Executive Summary

The Trust, in common with most healthcare organisations across the country has faced significant workforce challenges. Securing and retaining a skilled, engaged workforce is a key priority and is reflected in both the operational and strategic risk registers. Whilst a number of solutions are nationally/centrally driven, it is vital that we take responsibility for and drive performance against our own workforce goals.

The original workforce plan considered by the Workforce and OD Committee contained 42 areas for action. The Interim Director of HR & OD suggested to the February meeting of the Workforce and OD Committee that a revised implementation plan with fewer areas of focus would be likely to yield improved results. An update on that revised plan was presented to the June Workforce and OD Committee (Appendix 1). The majority of workforce metrics had remained fairly static (although the revised plan had only been in operation for 2 full reporting months), however it was pleasing to see a reduction in the turnover of Nurses. Given the very strong focus on improving engagement, the continuing poor results from the

Staff Friends and Family Test continue to cause concern. It should be noted that because of the quarterly collection schedule, the (poor) results reported were as of the end of March, whereas the most recent results received (end of June) showed a considerable improvement (albeit to a level that we would still regard as unacceptable), however these figures were not available to the Workforce and OD Committee.

Also presented (appendix 2) is our Workforce Race Equality Standard submission. There is a requirement to upload our data onto a national database in early August and for the Board to receive and agree to the data. There is no doubt that our figures remain very disappointing in this arena and a revised action plan to improve our performance will be brought to the Board for consideration in September.

Recommendations:

The Board is asked to;

- Note the current report and progress within the areas of the revised Workforce Implementation Plan.
- Receive and approve the submission of the Workforce Race Equality Standard and to note that the updated action plan will be presented at the September Board meeting.

Related Trust Objectives	1, 2,4,5
Risk Implications	Risk issues are clearly identifed within the report
Quality/Equality Impact Assessment Requirements/implications (QEIA)	Implications are clearly referenced in the report
Financial Implications	No finance implications identified
Legal/Regulatory Implications	Legal/Regulatory implications are clearly referenced in the report

Workforce Report

1. Introduction and Purpose

The purpose of this report is to provide the Board with an overview of;

- Key workforce metrics
- Progress against the Trust's workforce and organisational development priorities
- Progress with colleague engagement including the Staff Friends and Family Test
- An update on STP workforce activity.
- Our proposed submission under the Workforce Race Equality Standard for 2017/18.

2. Workforce Position

A number of workforce metrics are monitored to evaluate the effectiveness of the Trust's Workforce and OD strategy.

Key Performance indicator	As at 31/03/16	As at 31/03/17	As at 31/01/18	As at 30/04/18	As at 30/06/18	Target
PDR completion rate	77.5%	76%	87.28%	87.4%	81.57%	95%
Staff FFT (recommend Trust as a place to work)	51%	55%	53%	49%	63%	65%
Mandatory Training	82%	78%	88.62%	86.3%	89.38%	95%
Sickness absence (rolling 12 month)	4.7%	4.5%	4.66%	4.63%	4.66%	4%
Turnover	15%	14.6%	16.54%	16.31%	15.67%	<12%
Nurse vacancy rates	13.5%	8%	12%	8.90%	10.05%	<6%

Clearly, there remains significant work to improve overall performance. In particular, the executive team continue to drive performance in the areas of PDR completion and mandatory training, identifying local areas for scrutiny and improved performance. Progress has recently reversed on PDR completion and has recovered on mandatory training. The two current major initiatives to improve performance are the launch of revised PDR paperwork reducing both the size and complexity of the original paperwork and the developing plans to reschedule face to face training to support shift working (the current situation of staff having to travel during the middle of a shift to complete training has resulted in increased cancellations).

Sickness rates remain stable despite an increased focus on this area and it is noted that there has been more than a doubling of long term sickness cases being actively managed by the HR Team. As stress and mental health issues

remain the number one reason for sickness, the work being done jointly between ourselves and Bath Spa University on the environmental conditions for stress will be reported (with outcomes and recommendations) to the next Workforce and OD Committee.

However it is pleasing to see some movement in the turnover figures which in turn are reflected in the nurse vacancy rates. Both reflect a degree of traction with the retention work streams, albeit the improvements remain relatively fragile. In particular, nurse vacancy rates did rise to 10.71% in May however have now reduced again to 10.05%. To support our increased focus on retention, we are aligning with 2gether who have been selected to be part of a cohort of Trusts who will work with NHSI on staff retention plans. Given the challenges of workforce supply generally and Nursing in particular, this is of the highest priority.

It is particularly pleasing to see the improvement in the Staff Friends and Family Test score which was also supported by an increased participation rate. There are a number of potential reasons for such an increase including;

- The appointment of a new CEO and the post appointment visibility of the CEO, including an increase in communication vehicles such as 'Team Talk' broadening the visibility of the whole executive team across all sites.
- The receipt of a 'Good' rating from the CQC following the last inspection and the self-confidence that such external validation can provide.
- An element of traction from the localisation of engagement plans in relation to the staff survey.

Whilst this score has improved from 49% to 63%, it is still some way short of what we would consider to be acceptable, however a significant number of colleagues have worked very hard to effect change and those efforts deserve recognition. The challenge now is to develop and maintain traction against the background of the proposed merger, which offers both opportunity and challenge.

3. STP Workforce Update

Recently the architecture for workforce governance within the context of the STP has undergone considerable change. A Local Workforce Action Board (LWAB) chaired by Mary Hutton has been formed to replace the former HR and OD Workforce Group (previously chaired by Shaun Clee).

The LWAB's role is to:

- Develop a strategic workforce plan for the Gloucestershire STP.
- Develop a strategic 5-year Learning and Development plan for the Gloucestershire STP.
- Agree the work programmes to support delivery of the plans.
- Oversee implementation of the workforce programmes.

- Support the STP's delivery plan, in particular the Clinical Programme priorities, Primary Care and Urgent Care workforce plans.
- Ensure that leaders in Gloucestershire are supported in developing the required skills to provide transformational system leadership.
- Develop a culture where staff work to a set of agreed values and:
    - Feel supported to innovate and empowered to challenge.
    - Feel valued with a focus on their health and wellbeing.
    - Are enabled to work across organisational boundaries with a focus on the patient and service users.
- Enable staff to provide system leadership and exhibit the behaviours expected of staff working in One Gloucestershire..

To deliver on these aspirations, the work has been divided into two main sub-groups, the 'Workforce Steering Group' chaired by HR Director Neil Savage and the OD and Culture Steering Group chaired by Transition Director David Smith. It will be important to ensure that not only is there connectivity between these two groups, but also with the operational and clinical work streams within the STP.

4. Workforce Race Equality Standard

This is the third year of completion for the Workforce Race Equality Standard (WRES). Our data, reflecting the year 2017/18 has to be submitted by the 10th August having been signed off by the Trust Board. This is submitted as Appendix 2. There are 9 indicators within the WRES, 4 of which relate to data concerning BME staff in terms of percentage of the workforce, shortlisting of BME applicants, likelihood of BME staff entering formal disciplinary action and percentage of BME staff accessing non-mandatory training and development. A further 4 indicators are linked to the annual staff survey, reflecting BME staff experience in terms of bullying from patients, bullying from staff, experiencing discrimination at work and believing the Trust provides equal opportunities. The final question relates to BME representation on the Board.

The data suggests a mixed bag of results. It is pleasing to see an increase in the percentage of BME colleagues in the workforce, in excess of the countywide census population. We continue to deteriorate our position in terms of the percentage of shortlisted BME candidates for roles, without any obvious explanation being available. The percentage of BME staff entering formal disciplinary processes has also reduced on a 2 year basis. The numbers of staff involved in such processes are very small.

Disappointingly we have seen increases in the percentages of BME staff experiencing bullying and harassment from patients and colleagues, however they are not out of step with the experience of white staff. It is clear that fewer BME staff believe the Trust provides equal opportunities for progression despite the fact that there is no significant difference between the percentage of BME and white staff accessing non-mandatory training and development. There has

also been a 1% increase in the percentage of BME staff personally experiencing discrimination at work.

The Board remains unrepresentative of the Gloucestershire community and workforce with no BME members, albeit the Board has wholeheartedly embraced the development programme for future NHS Board members from a BME background.

What is clear is that the figures seesaw over time with marginal improvements or deteriorations but nothing has resulted in a sea change in approach or activity. A revised action plan will be brought to the Board in September. Making significant progress and truly effecting a sea change will be the underpinning principle for the action plan.

Recommendations:

The Board is asked to;

- Note the current report and progress within the areas of the revised Workforce Implementation Plan.
- Receive and approve the submission of the Workforce Race Equality Standard and to note that the updated action plan will be presented at the September Board meeting.

Abbreviations used in the report

WRES	Workforce Race Equality Standard
BME	Black and Ethnic Minority
LWAB	Local Workforce Action Board

Agenda Item: 13.1

Appendix 1: Implementation plan areas for key focus.

Priority themes	Strand	Key areas of focus	Current updates
Valuing colleagues	1. Flexible working	• There are significant differences in views across the organisation as to what we mean by 'flexible working'. Head of OD to pull together a short life working group consisting of operational, clinical and HR Leads to ensure consistency of approach	On 16th May Head of OD issued a survey through the Core on flexible working and mobile working in GCS. The results will be analysed to inform future priorities and actions for the working group. As of 5th June 2018 there were 136 responses, which have yet to be analysed.
	2. Culture and Engagement	• Re-commission Listening into Action (LiA) to carry out a Q4 Pulse Check incorporating the Staff FFT. • Staff Survey response to incorporate 'corporate plan' and localised plans. Approach to be presented at Core Colleague network in February by Head of OD/HRD.	LiA licence not renewed therefore the Ambassador for Cultural Change to outline how we use LiA in 2018/19 alongside other tools. Review with the PMT to scope out commitment within CYPS. Head of OD and AFCC supporting culture change in Dental Services. Localised approach presented to Core in February and March. Head of OD working with individual areas to support development of action plans. Head of OD has met with many Heads of Service and teams about their data and next steps. NHSI endorse the approach
	3. Colleague recognition	• The Ambassador for Cultural Change, supported by the HRD and Head of HR, to lead and develop a shared programme of work with Staff Side colleagues including eradicating non-core behaviours. • Ambassador for Cultural Change/HRD to meet with Head of Community Partnership to agree/support actions to improve performance on Workforce Race Equality Scheme (WRES). • Head of Comms to upgrade profile of annual awards event and implement simple local recognition systems.	Freedom to Speak Up (FTSU) Advocate model advertised in the CORE and on-site visits. 20 colleagues have volunteered from across the Trust with commitment from JNCF May 2018 to support development. Presentation to Trust Board in June with training and implementation by September 2018. Responsibility for WRES moves from Community Partnership to HR via Ambassador for Cultural Change. 12 June. Supporting plan to be taken to Workforce and OD in June. Annual awards event took place on Wednesday 23rd May 2018. Over 250 colleagues attended along with guest presenters, including the Chair of the HCOSC. A simple recognition scheme is launching at the end of June 2018
Realising colleagues full potential	4. Education, learning and development	• Head of Learning and Development to meet with operational and finance leads to get buy in to the Apprenticeship Plan • Head of Learning and Development to meet with operational leads to understand requirements for new and developing roles, ensuring linkage with STP colleagues on	An Apprenticeship Modelling exercise has been completed and approved by the Executive Team on 24th May 2018. An operational plan will now be discussed and agreed with the Director of Operations

Priority themes	Strand	Key areas of focus	Current updates
		educational pathways and funding streams	and discussions on implementation will take place with the Operational Leads via the Operational Development Forum.
	5. Leadership		The Apprenticeship updates and planning events booked at the Core Colleague Network meetings have been cancelled due to other Trusts priorities. This has resulted in some delays in prioritising activities for 2018/19.
	6. Workforce planning		A local event hosted by GCS for AHP's took place in April 2018, to identify requirements for the Assistant Practitioner role for AHP's. Individual Trust are now scoping requirements and identifying priority areas of focus. Trust Education Leads to review plans for a January 2019 cohort – using the Apprenticeship standards.
			The Learning & Development Team are working with AHP Heads of Profession/Service to develop JD's and competencies. This will then inform requirements for the Trainee Assistant Practitioner programme for AHP's.
			A further co-hort of Trainee Nursing Associates (TNA's) will commence in September 2018 as part of a 3rd wave pilot. The Apprenticeship contract for this cohort was awarded to the University of Gloucester on 6th June 2018, as part of the procurement process. A review meeting is planned for July 2018 (chaired by the Director of Nursing) to confirm placements and plans for operational funding.
		• HRD and Director of Nursing to confirm with Director of Finance element of CPD budget included in savings for this year. • Head of OD to accelerate introduction of Managers Toolkit	Actioned
		• HRD/Head of HR to carry out succession planning audit to identify gaps/opportunities	The toolkit forms part of the pilot STP wide 5 elements for successful leadership programme. This pilot started in March 2018 and 3 elements of the toolkit have been now been completed and are being piloted by participants.

Priority themes	Strand	Key areas of focus	Current updates
		• Head of OD to draft talent strategy • HRD to identify all workforce planning capability across the organisation between HR, Finance, Education and Operations	In May 2018 HRD requested Exec colleagues to pilot a succession planning template for direct reports Pilot succession planning template circulated for completion to HR team in May 2018 Head of OD has drafted a plan on a page which needs further discussion with the HRD HRD requested Exec colleagues to identify distributed resource and Clare Hines to do same on STP wide basis
Supporting colleagues	7. Health and wellbeing 8. Executive HR function	• Head of OD to review priorities of Colleague Health and Wellbeing Group • HRD and Head of HR to review market for alternative OH suppliers or re-contract with Working Well with stronger focus on performance of KPI's. • HRD/Head of HR to review current operational service against HRBP model, taking soundings from operational and clinical leads on current service/performance. • All areas of department to review current systems for efficiency/delivery.	This is ongoing and links will be made to the CQUIN requirements and the STP H&W group. HRD discussing options with NS at 2g to agree appropriate contract. Will only contract externally if internal discussions unsuccessful Moving towards HRBP model and this well received by operational leads. Need identify supervision of 'Service Centre' and agree/publish service offering
Recruitment and retention	9. Recruitment and retention	• Head of HR to seek agreement of recruitment and retention group to implement compulsory face to face exit interviews for Band 5 nurses, all areas where turnover perceived to be at an unacceptable level and for all leavers in the first 2 years. • Head of HR to contact NHSI to see if we can join the 70 trusts receiving support with retention issues.	Head of HR attended Operational Governance Forum and informed all managers that face to face exit interviews should be completed for all hard to recruit posts. Clinical Careers Advisor will undertake all in community hospitals and will work with Head of HR to review the exit interview questions. HR Advisors will pick up face to face exit interviews were appropriate Head of HR in contact with NHS Employers and NHS Improvement to join both national networks: - NHSI retention programme awaiting cohort 4 - NHS ERs Head of HR to complete 'application' once operational teams have agreed R&R action plan

Agenda Item: 13.2

NHS Gloucestershire Care Services NHS Trust

Appendix 2 - WRES data submission 2017-18

		White	BME	Un/k	Notes	
1	Number of staff in workforce	2790	139	1	There is an increase in the proportion of BME colleagues compared to 2015-16 (4.1%) and 2014-15 (3.6%): we compare to BME representation in Gloucestershire (4.6%): **data by grade is shown below**	✓
	Percentage of BME		**5%**			
2	Number of shortlisted applicants (total)	3044	341	41	This is a continually worsening position compared to 2.29 2016-17 2.20 in 2015-16 and 1.29 in 2014-15	X
	Number appointed from shortlisting (total)	689	33	9		
	Relative likelihood of shortlisting/appointed (total)	0.22	0.09	0.21		
	Relative likelihood of White staff being appointed from shortlisting compared to BME staff (total)		**2.34**			
3	Number of staff in workforce	2790	139	1	Although proportionally, BME colleagues are more likely to enter the formal disciplinary process than white colleagues, this is a significant reduction compared to 1.67 in 2016-17, 2.21 in 2015-16 and 1.80 in 2014-15	✓
	Number of staff entering formal disciplinary (2016-17)	22	1	0		
	Number of staff entering formal disciplinary (2017-18)	9	1	0		
	Number of staff entering the formal disciplinary process (two year rolling average)	16	1	0		
	Likelihood of staff entering formal disciplinary	0.6%	0.7%	0		
	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff		**1.17**			

		White	BME	Un/k	Notes	
4	Number of staff in workforce	2790	139	1	This is a slightly worse figure than 2016-17 (1.04), reflective of the 2014-15 figure of 1.08.	–
	Number of staff accessing non-mandatory training/CPD	2022	92	1		
	Likelihood of staff accessing non-mandatory training/CPD	0.72	0.66	1		
	Relative likelihood of White staff accessing non-mandatory training/CPD compared to BME staff		**1.09**			
5	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	31%	33%	-	The experiences of BME colleagues have worsened since 2016-17(26%) to align more closely with the experience of white colleagues in this regard.	X
6	% of staff experiencing harassment, bullying or abuse from staff in last 12 months	21%	17%	-	Whilst the experiences of BME colleagues are better than those of white colleagues, there has been a negative increase from 13% in 2016-17. Until this last year BME colleagues had seen a decrease in actual terms (13% compared to 25% in 2015-16 and 31% in 2014-15). Also, the experiences of white colleagues had improved (21% compared to 22% in 2015-16 but 18% in 2014-15)	X
7	% staff believing that trust provides equal opportunities for career progression or promotion	90%	77%	-	2016-17 was the first time that there was a sufficient response from BME colleagues to include data from this colleague subgroup. This is a worsening picture for both colleague (89% and 87% respectively) groups although significantly worse for BME colleagues.	X
8	% staff personally experienced discrimination at work from Manager/team leader or other colleague	7%	8%	-	This represents consistency of 1% from 2016-17, as significant improvement in the response of BME colleagues, which was 17% in both previous reporting years. However, the experiences of white colleagues has worsened from 4% in both the previous reporting periods	–

		White	BME	Un/k	Notes	
9	Total Board members	13	0	-	There remains a difference between the Board - where there is no BME representation - and the overall workforce	
	of which: Voting Board members	12	0	-		
	Non-Voting Board members	1	0	-		
	Total Board members	13	0	-		
	of which: Exec Board members	6	0	-		
	Non-Executive Board members	7	0	-		
	Number of staff in workforce	2790	139	1		
	Total Board members - % by Ethnicity	100%	0%	-		
	Voting Board Member - % by Ethnicity	100%	0%	-		
	Non-Voting Board Member - % by Ethnicity	100%	0%	-		
	Executive Board Member - % by Ethnicity	100%	0%	-		
	Non-Executive Board Member - % by Ethnicity	100%	0%	-		
	Overall workforce - % by Ethnicity	95%	5%	0%		
	Difference (Overall workforce - Total Board)	5%	-5%	0%		

Full details of banding (question 1)

	2016-17			2017-18		
	White	BME	Unknown	White	BME	Unknown
Non-clinical						
Under Band 1	-	-	-	9	1	-
Band 1	118	5	-	109	6	-
Band 2	189	6	-	173	4	-
Band 3	162	6	-	164	7	-
Band 4	48	2	-	41	2	-
Band 5	60	5	-	62	5	-
Band 6	42	1	-	39	1	-
Band 7	24	-	-	33	-	-
Band 8a	14	2	-	13	2	-
Band 8b	10	-	-	11	-	-
Band 8c	5	-	-	6	-	-
Band 8d	4	-	-	3	-	-
Band 9	-	-	-	1	-	-
VSM	5	-	-	8	-	-
Clinical						
Under Band 1	-	-	-	7	-	-
Band 1	-	-	-	-	-	-
Band 2	337	21	2	270	13	-
Band 3	225	11	-	217	10	-
Band 4	129	7	-	113	9	-
Band 5	647	42	3	588	42	-
Band 6	651	16	-	605	21	-
Band 7	204	7	1	207	5	1
Band 8a	46	1	-	44	2	-
Band 8b	12	-	-	11	-	-
Band 8c	4	-	-	3	-	-
Band 8d	-	-	-	1	-	-
Band 9	-	-	-	-	-	-
VSM	1	-	-	-	-	-
Of which Medical & Dental						
Consultants	5	1	-	4	1	
Of which Senior Medical Manager						
Non-consultant career grade	25	4	-	31	5	-
Trainee grades	-	-	-	-	-	-
Other	26	2	-	5	1	-

Trust Board

Date of Meeting: 24th July 2018

Report Title: Finance Committee Report

Agenda reference number:	14/0718
Accountable Executive Director: (AED)	Sandra Betney, Director of Finance
Presenter: (if not AED)	Graham Russell, Non-Executive Director
Author(s):	Sandra Betney, Director of Finance
Board action required:	Note
Previously considered by:	Not Applicable
Appendices:	None

Executive Summary

This report provides assurance to the Trust Board that the Finance Committee is discharging its responsibility for oversight of the Trust's finances on behalf of the Board.

It confirms:

- Decisions made by the Committee in line with the Trust's Scheme of Delegation.
- Progress made against the Trust's financial plan.
- The key risks and issues identified by the Committee and the actions taken to mitigate these risks.

Recommendations

The Board are asked to **NOTE** the update from the Committee.

Related Trust Objectives	5
Risk Implications	Risk issues are clearly identifed within the report
Quality/Equality Impact Assessment (QEIA) Requirements and Implications	No equality implications identified
Financial Implications	Finance implications are clearly referenced in the report
Legal/Regulatory Implications	Legal/Regulatory implications are clearly referenced in the report

Finance Committee Report

1 Introduction and Purpose

This report provides assurance to the Trust Board that the Finance Committee is discharging its responsibility for oversight of the Trust's finances on behalf of the Board.

2 Issues Considered by the Committee

The Finance Committee met on 26th June 2018. Key aspects considered included the Month 2 Finance Report; Quality, Innovation, Productivity and Prevention (QIPP) performance and Commissioning for Quality and Innovation (CQUIN) achievement as well as progress again the Trust Cost Improvement Plan, the Trust's approach to Reference Costs and some estates matters.

2.1 Finance Report Month 2

The Committee was assured that at Month 2 the Trust was ahead of plan. It was confirmed that all the single operating framework indicators were green. It was noted that currently capital spend was not in line with plan, but processes were in place to take forward capital spend in the next month.

2.2 CIP/QIPP/CQUIN Progress

The Committee discussed progress on the Cost Improvement Plan (CIP) and the QIPP scheme milestones, noting that discussions on the milestones were still ongoing with the GCCG. The Committee had been advised that CQUINS for 2018/19 related to the national CQUINS as had previously been advised.

2.3 Estates Matters

The Committee had been updated on the plans for moving to Southgate Moorings and the process for ensuring the transition. The Committee also received assurance on the agreement reached by Gloucestershire Care Services, Gloucestershire County Council and the Gloucestershire Clinical Commissioning Group relating to the accommodation used by the workforce within the Integrated Community Teams (ICTs).

2.4 Reference Cost Approach

The Committee considered the reference cost approach for the Trust and confirmed that this would be taken forward by the Director of Finance with discussion with the Chair of the Committee.

3. Confirmation of decisions made by the Committee in line with Scheme of Delegation

None.

4. Conclusion and recommendations

The Board are asked to **NOTE** the update from the Committee.

Trust Board

Date of Meeting: 24 July 2018

Report Title: Finance Report

Agenda reference Number:	15/0718
Accountable Executive Director: (AED)	Sandra Betney
Presenter: (if not AED)	N/A
Author(s):	Johanna Bogle
Board action required:	To note
Previously considered by:	Not Applicable
Appendices:	**Appendix 1** Main M3 Finance Report

Executive Summary:

This report provides an overview of the Trust's financial position for Month 3 (M3) of 2018/19.

1. Background

The Trust financial context for 2018/19 is summarised below.

- Control Total surplus is £2.238m including £1.436m of Provider Sustainability Funding "PSF" (the new acronym for STF)
- Capital spend plan is £7.85m, CRL initial allocation is £5.021m
- Cost Improvement Plan (CIP) target is £5.3m
- Agency spending cap is £2.232m
- Income potential Commissioning for Quality and Innovation (CQUIN) and Quality, Innovation, Productivity and Prevention (QIPP) are £1.9m and £3.9m respectively

M3 year to date performance is as follows:

- Year to date surplus is £567k which is £3k better than plan and budget of £564k
- Capital spend to date is £27k compared to plan of £4,270k.
- Cash at the end of Month 3 is £12.2m compared to plan of £10.7m. (capital spend is £4.2m below plan)
- YTD agency spend is £432k compared to a plan figure of £558k

Single Operating Framework indicators are all green. Details are on page 7 of Appendix 1 to this report.

Recommendations:

The committee is asked to note the content of the report and in particular the risks at page 6 of Appendix 1 to this report.

Agenda Item: 15.1

NHS
Gloucestershire
Care Services
NHS Trust

2018/19 Month 3 Finance Report v 1.0

Understanding You

Overview

Gloucestershire Care Services NHS Trust

- Month 3 year to date surplus is in line with plan and budget at £544k. The current full year forecast is in line with plan at £2.238m (including PSF of £1.436m).
- Agency spending cap is £2.232m (17/18 full year spend was £2.044m) Full year forecast is in line with the cap, Month 3 year to date is £432k compared to a plan of £558k.
- Full year Cost Improvement Plan (CIP) target for the full year is £5.3m . The amount removed from full year budgets in respect of CIP is £2.388m so far. This is made up of the following schemes: 1% Schemes £1.060m; Differential Targets £0.954m and Challenge Schemes £0.374m. The CIP steering grouping are working to assess the remainder of the differential schemes and firm up challenge schemes.
- Full year Income from Quality, Innovation, Productivity and Prevention (QIPP) schemes is forecast as the full amount available of £3.4m. Apart from the MSK risk share, all schemes are finalised with the CCG.
- Full year from Commissioning for Quality and Innovation (CQUIN) schemes is currently forecast in line with plan at £1.9m.
- Cash balance at the end of month 3 is £1.5m above plan at £12.2m.
- Capital spend for the year to date is £27k compared to a planned YTD figure of £4.3m. Full year plan is £7.85m and the amount approved by NHSI at present (via the CRL allocation process) is £5.021m.

Understanding You

Income and Expenditure

Gloucestershire Care Services NHS Trust

Year to date performance to Month 3 is in line with plan at £544k and full year forecast is in line with plan at £2.262m.
The summary I&E below shows differences to plan on Year to Date Income, Pay and Non Pay Costs. At service level there are overspends in community hospitals offset by underspends in Integrated Community Teams, Countywide and Children's services.

Statement of comprehensive income £000	Prior Year	Year to Date			Full Year
	Actual	Plan	Actual	Variance	Plan and forecast
Operating income from patient care activities	109,889	27,208	27,380	172	109,635
Other operating income exc PSF	1,048	345	371	26	1,342
Employee expenses	(78,529)	(19,437)	(19,526)	(89)	(79,746)
Operating expenses excluding employee expenses	(28,918)	(7,347)	(7,473)	(126)	(28,765)
PDC dividends payable/refundable	(1,666)	(450)	(422)	28	(1,760)
Surplus/(deficit) before impairments and transfers	**1,824**	**319**	**330**	**11**	**706**
Remove capital donations/grants I&E impact	97	30	22	(8)	120
Surplus/(deficit) exc PSF	**1,921**	**349**	**352**	**3**	**826**
Provider sustainability fund (PSF) income	3,642	215	215	0	1,436
Surplus/(deficit) inc PSF	**5,563**	**564**	**567**	**3**	**2,262**

Control total including PSF	**1,986**	**558**	**558**	**0**	**2,238**

Understanding you

Balance Sheet

NHS Gloucestershire Care Services NHS Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		Mar-18	Year To Date			Mar-19
		Audited PY	Plan	Actual	Variance	Plan
Non-current assets	Intangible assets	1,000	1,000	1,082	82	1,000
	Property, plant and equipment: other	58,709	62,379	57,966	(4,413)	64,159
	Total non-current assets	**59,709**	**63,379**	**59,048**	**(4,331)**	**65,159**
Current assets	Inventories	228	228	228	0	228
	NHS receivables	4,817	1,000	6,269	5,269	1,000
	Non-NHS receivables	1,939	3,130	2,163	(967)	3,130
	Cash and cash equivalents:	12,354	10,745	12,244	1,499	10,438
	Total current assets	**19,338**	**15,103**	**20,904**	**5,801**	**14,796**
Current liabilities	Trade and other payables: capital	(1,533)	(500)	(228)	272	(500)
	Trade and other payables: non-capital	(8,283)	(8,211)	(10,008)	(1,797)	(8,211)
	Provisions	(160)	(138)	(138)	0	(138)
	Total current liabilities	**(9,976)**	**(8,849)**	**(10,374)**	**(1,525)**	**(8,849)**
Non-current liabilities	Borrowings	**(221)**	**(250)**	**(184)**	66	**(115)**
	Total net assets employed	**68,850**	**69,383**	**69,394**	**11**	**70,991**
Taxpayers Equity	Public dividend capital	79,982	79,982	79,982	0	79,982
	Revaluation reserve	610	609	609	0	609
	Other reserves	(2,398)	(2,398)	(2,398)	0	(2,398)
	Income and expenditure reserve	(9,344)	(8,810)	(8,799)	11	(7,202)
	Total taxpayers' and others' equity	**68,850**	**69,383**	**69,394**	**11**	**70,991**

NHS Debtors includes £2.978m of STF money relating to 17/18.

Understanding You

Capital and Cash

Capital schemes	Year to Date		2018/19	2018/19	2019/20	2020/21	2021/22
	Plan	Actual	Initial CRL Allocation	Plan	Plan	Plan	Plan
Gloucester base	3,400	0	3,400	3,400	0	0	0
Cheltenham Base	0	0	0	0	2,000	0	0
Forest of Dean	0	0	0	800	5,500	4,700	-1,500
Building refurbishment	525	22	1,160	2,250	750	1,250	1,250
IT replenishment	150	0	0	600	600	600	600
IT Network replacement	75	3	300	300	300	300	300
Medical Equipment	120	2	161	500	200	200	200
Total	**4,270**	**27**	**5,021**	**7,850**	**9,350**	**7,050**	**850**

- Year to date spend for month 3 is £27k. The Gloucester base lease is being finalised.
- Current level of spend approved is £5.021m.
- Capital steering group has now met and agreed the allocation of the revised CRL allocation. Risks to CIP delivery and STP collaboration resulting from the allocation being lower than planned spend are included at page 7 of this report.

Cash position at the end of the month 3 is a positive balance of £12.2m

- This is £1.5m higher than plan as capital spend is significantly below plan for the year to date.

Cash Flow Summary

Statement of Cash Flow £000	ACTUAL YTD 2018/19		FORECAST 2018/19	
Cash and cash equivalents at start of period		**12,354**		**12,354**
Cash flows from operating activities				
Operating surplus/(deficit)	**950**		**3,868**	
Add back: Depreciation on donated assets	22		120	
Adjusted Operating surplus/(deficit) per I&E	**972**		**3,988**	
Add back: Depreciation on owned assets	666		2,739	
(Increase)/decrease in STF receivable	0		0	
(Increase)/decrease in inventories	0		0	
(Increase)/decrease in trade & other receivables	(1,676)		1,367	
Increase/(decrease) in provisions	(22)		(22)	
Increase/(decrease) in trade and other payables	(3)		(293)	
Net cash generated from / (used in) operations		**(63)**		**7,779**
Cash flows from investing activities				
Increase/(decrease) in Finance Lease Payables	17		34	
Purchase of property, plant and equipment	(27)		(7,850)	
Net cash generated/used in investing activities		**(10)**		(7,816)
Cash flows from financing activities				
PDC Dividend (Paid)/Received			(1,760)	
Finance Lease Rental Payments	(37)		(120)	
Net cash generated used in investing activities		**(37)**		**(1,880)**
Cash and cash equivalents at end of period		**12,244**		**10,437**

Understanding You

Risks

Gloucestershire Care Services NHS Trust

Risks in delivery of full year position are as set out below

	Intial Risk/ (Opportunity) identified at plan	Mitigated Risk at month 3	Month 3 Change
Delivering required recurrent CIP	1,500	500	0
Delivering required non recurrent CIP	500	0	0
Delivery of non rec savings in year to offest CIP phasing	1,000	0	0
Delayed agreement of capital limit impacts STP and CIP work	300	0	-300
Potential for unfunded elements of July pay award	600	250	0
Unbudgeted elements of 2G integration work	200	200	0
VAT changes impacting recovery on Sysm1	100	100	0
Delivering Milestone QIPP	1,500	20	0
QIPP risk share (MSK)	900	393	-57
Delivering CQUIN in line with plan	2,000	400	0
Managing agency spend within cap	663	0	0
GCC rental charges on ICT bases	500	238	0
GCC Management Charge	150	100	50
	9,913	**2,201**	**-307**

Note that plan includes £1,436k of PSF (formerly STF) income.

If risks cannot be mitigated and pre PSF surplus of £802k isnt delivered then PSF income will also be lost and surplus impact will be magnified.

Understanding You

Single Operating Framework

NHS Gloucestershire Care Services NHS Trust

All indicators are currently green

Finance and use of resources rating	Audited PY 31/03/2018 Year ending Number	Actual 30/04/2018 Month 1 Number	Actual 31/05/2018 Month 2 Number	Actual 30/06/2018 Month 3 Number	Actual 30/06/2018 YTD Number	Forecast 31/03/2019 Year ending Number
Capital service cover rating	1	1	1	1	1	1
Liquidity rating	1	1	1	1	1	1
I&E margin rating	1	1	1	1	1	1
I&E margin: distance from financial plan	1	1	1	1	1	1
Agency rating	1	1	1	1	1	1

Understanding You

Agenda Item: 16/0718

Gloucestershire Care Services NHS Trust

TRUST PUBLIC BOARD - FORWARD PLANNER

Month	January	March	May / June	July	September	November
General Business						
Service User Story	x	x	x	x	x	x
Freedom to Speak Up Story			x			x
Questions from the public	x	x	x	x	x	x
Leadership & Strategy						
Chair's Report	x	x	x	x	x	x
Joint Strategic Intent update *			x	x	x	x
Executive Team Report	x	x	x	x	x	x
One Gloucestershire - Sustainability and Transformation Plan, including any consultation updates	x	x	x	x	x	x
Forest of Dean *			x	x	x	x
CQC Final Report			x			
Business Plan		x				
Quality And Operational Performance						
Quality and Performance Committee update	x	x	x	x	x	x
Workforce and Organisational Development Committee update (as required)	x	x	x	x	x	x
Quality and Performance Report	Month 9	Month 11	Month 12 and 1	Month 3	Month 5	x Month 7
Finance						
Finance Committee update	x	x	x	x	x	x
Finance Report	Month 9	Month 11	Month 1	Month 3	Month 5	Month 7
Budget		x				
Assurance						
Board Assurance Framework	x	x	x	x	x	x
Charitable Funds Update (as required)	x		x		x	
Audit and Assurance Committee Update	x		x		x	
Review of Quality and Annual Accounts				x		
Governance Update			x			
Strategies						
	Health, Safety and Security Strategy 2017 (every 3 years, **DUE 2020**)	Risk Management Strategy 2017(every 3 years, **DUE 2020)**		Workforce and OD Strategy 2016 (every 3 years , **DUE 2019**)	Clinical Strategy 2016 (every 3 years, **DUE 2019**)	Business Continuity Strategy 2016 (every 3 years, **DUE 2019**)
	Information Management and Technology Strategy 2017 (every 3 years, **DUE 2020**)	Charitable Funds position statement 2017 (every 2 years) **DUE 2019**		Finance Strategy 2017 (every 3 years) **DUE 2020**		
	Estates Strategy **DUE 2018** (every 3 years)					
	Communication & Engagement Strategy 2017 (every 3 years, **DUE 2020**)					

Corporate						
Understanding You Report			x			x

* These items are contained within the Chief Executive or Chair's Report.

Every routine meeting will normally include:

- Welcome and Apologies
- Quoracy confirmation
- Declaration of Interests
- Approval of minutes from last meeting
- Action log
- Forward Planner
- Any other Business
- Date of next meeting
- Opportunity to informally review the meeting

NHS
Gloucestershire
Care Services
NHS Trust

Quality Account
2017-18

Contents

QUALITY ACCOUNT 2017-18

If you have any comments about this Quality Account, please email sue.field@glos-care.nhs.uk. Alternatively, you can write to:

Mrs. Susan Field, Director of Nursing
Gloucestershire Care Services NHS Trust
Edward Jenner Court
1010 Pioneer Avenue
Gloucestershire Business Park
Brockworth
Gloucester GL3 4AW

QUALITY ACCOUNT 2017-18

PART ONE: INTRODUCTION

Welcome from the Chair and Chief Executive

Once again we are delighted to introduce our annual Quality Account for 2017-18. This report describes the work we have been undertaking to improve the quality of care and services we provide in order to achieve our vision "to be the service people rely on; to understand them and to organise their care around their lives".

2017-18 has been a busy year across our community services and we continue to be challenged with increasing demands and pressures on our precious resources. Despite this we were pleased to have the Care Quality Commission (CQC) inspect our services during January and February 2018. Colleagues across the Trust are absolutely delighted that the Care Quality Commission confirmed our overall rating as GOOD. At our last inspection in 2015 we received a 'Requires Improvement' rating, so it is heartening that the efforts of all our colleagues to make improvements and deliver safe, effective care have been acknowledged.

We are particularly pleased that the CQC recognised improvements to our Minor Injury and Illness Units. They also acknowledged areas of outstanding practice. Colleagues have shown unstinting commitment and worked incredibly hard at a time of substantial pressure on our services. They are dedicated to improving the experience and outcomes for our patients and our CQC inspection results reflect their success in doing so. Inspectors highlighted the dignity and respect with which patients are treated, co-ordination of care between teams and effective communication with patients, as well as praising the leadership of the Trust from a strong team of executive and non-executive directors.

The Trust Board and all our colleagues continue to have a focus on delivering high quality safe care and in line with our CORE values – Caring, Open, Responsible and Effective. To that end we are delighted to welcome Paul Roberts, who took up position as Joint Chief Executive of both Gloucestershire Care Services NHS Trust and 2gether NHS Foundation Trust on 16th April. Paul's track record as a chief executive and in developing inter-relationships between the acute, community and mental health sectors will be invaluable as we move into this new chapter for our organisations.

On behalf of the Trust Board we can confirm that the information contained in this Quality Account represents what we have achieved during 2017-18 and our commitment to quality improvement. We hope that after reading this Quality Account you will be assured that we have continued to make progress with our quality activities during the past 12 months.

Ingrid Barker
Chair

Paul Roberts
Chief Executive Officer

QUALITY ACCOUNT 2017-18

An overview of the Trust – Our Vision, Values and Strategic Objectives

Gloucestershire Care Services NHS Trust (GCS) is privileged to be the main provider of NHS funded community health and care across Gloucestershire. Our teams deliver essential nursing, therapy and specialist care to adults, children and young people, many of whom are among the most vulnerable people within our communities.

The Trust employs approximately 2,700 colleagues who are working in teams to deliver and support the delivery of care. During 2017-18 the Trust had over 1.3 million contacts with patients – which equates to an average of over 3,800 people every day.

Trust Strategic objectives

The Trust's strategic objectives describe the principle aims that the organisation aspires to achieve. In 2017-18 the Trust's Strategic Objectives were:

- To achieve the best possible outcomes for our service users through high quality care
- To understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work
- To actively engage in partnerships with other health and social care providers in order to deliver seamless services
- To value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision
- To manage public resources wisely to ensure local services remain sustainable and accessible.

2017

April 2017

Camera donation by Stroud League of Friends enables dentists to give patients additional focus, to help make a decision over treatment or a referral so much easier and quicker.

June 2017

Repair work to flooring at Tewkesbury Community Hospital. Alternative capacity for the hospital theatre and inpatient beds were provided at Cirencester Community Hospital.

August 2017

The Trust launched a school nurse text service for young people – called Chat Health. The service is an easy way for young people to confidentially ask for help with a range of issues.

October 2017

flu fighter care

Our seasonal flu campaign was well underway, with numerous opportunities for colleagues to receive their free flu vaccination. Ongoing communications activity reached colleagues via multiple channels.

December 2017

The Trust launched a brand new website for the Gloucestershire Wheelchair Assessment Service (GWAS) - www.gloswheelchairservice.nhs.uk

February 2018

Di Gould is all smiles in new dental role – the Trust's Clinical Director for community dental services was elected president of the British Dental Association Community Dental Services Group.

2018

CS47576 NHS Creative

May 2017

Understanding You Awards – Macmillan Next Steps Cancer Rehabilitation Team named Countywide Team of the Year.

July 2017

Hope House Sexual Health Service – You can now click-in or phone-in to book your sexual health appointment.

September 2017

Gloucestershire Clinical Commissioning Group and the Trust started a 12 week consultation on community hospital facilities in the Forest of Dean.

November 2017

End of life care should help you to live as well as possible until you die, and to die with dignity.

The Trust ran an End of Life care workshop, which included a key note address from Louise Corson, Programme Manager from NHS England.

January 2018

Trust colleagues given the prestigious title of Queen's Nurse - indicating a commitment to high standards of patient care, learning and leadership.

March 2018

Gloucestershire Care Services NHS Trust apprentices best in the South West – three colleagues won accolades at Health Education England's Star Awards.

PART TWO: REVIEW OF 2017-18 QUALITY PRIORITIES

Introduction

Trust colleagues continue to focus on delivery high quality safe care in line with our CORE values.

In part two of our Quality Account we set out our progress against the six priorities identified for focused work during 2017–18.

1. **Priority 1** – Falls Prevention and Management
2. **Priority 2** – Health and Well-being of Colleagues
3. **Priority 3** – Equality and Diversity
4. **Priority 4** – End of Life Care
5. **Priority 5** – Dementia Care
6. **Priority 6** – Pressure Ulcers

1

Falls Prevention and Management

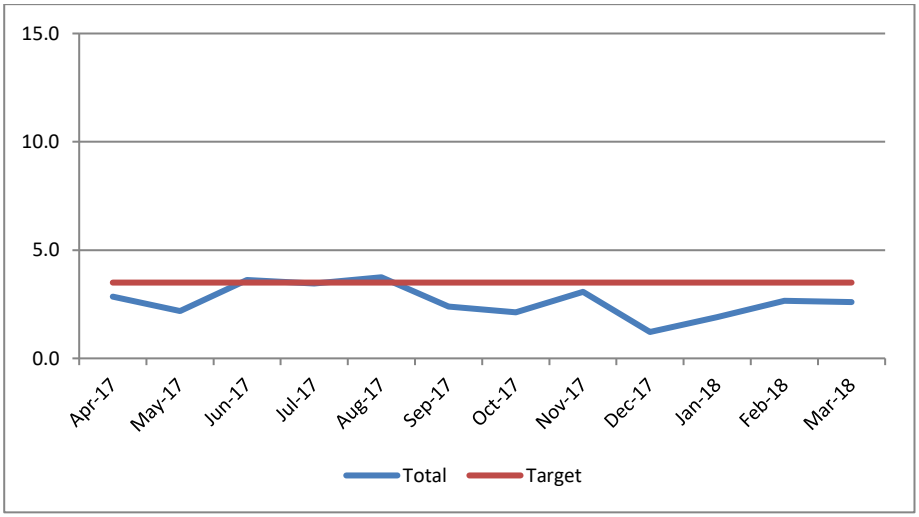
Our target was for the incidence of falls with harm in the community hospital inpatient setting to be at or below the locally set benchmark of 3.5 per 1000 bed days.

During the year we have seen a reduction in the number of injurious falls, which is significant and has been achieved by progressing with a range of activities led by our Falls Prevention Quality Improvement Group**.**

Our Results:

The graph below indicates the number of falls with harm per 1000 bed days across all community hospital inpatient wards from April 2017 to the end of March 2018. It demonstrates that for the majority of the time, we have been below the target of 3.5 falls with harm per 1000 bed days and that overall there appears to be a downward trend which is good news.

As falls prevention and management is going to be a quality priority for 2018/19 we are looking to reduce the target further to ensure our drive for improvement continues



We continue to be active participants in national quality audits. An audit was undertaken to assess our compliance with NICE guidance related to Falls prevention and management (CG161). This audit identified the need to change how we assessed patients with regard to their risk of falling. As a result of this we now have a multifactorial falls risk assessment which means that all patients have a full assessment of their individual risk factors which might contribute to their risk of falling. A patient's individual risk factors and the actions required to reduce their individual risk are now recorded and reviewed on at least a weekly basis and following any falls.

In addition, our post falls “SWARM” is now used in all inpatient wards which allow colleagues to quickly review the patient and the environment to ascertain whether there were any contributory factors to the patient falling that can be easily and quickly remedied.

Education and Training

We have since progressed with all community hospital colleagues being trained on falls prevention and assessment, and the management of patients who have fallen using the “Fall-Safe” platform which is a nationally validated tool.

Our falls prevention quality improvement group have also identified a number of specific educational targets with the focus during 2017-18 was on Orthostatic hypotension

Orthostatic hypotension (sometimes known as ‘postural drop’) whereby a patient’s blood pressure can suddenly drop when they change position from lying to standing, can increase a patient’s risk of falling. Careful assessment is needed so that treatment and management strategies can be implemented. Our aim will be to continue training for all community hospital colleagues on the correct consistent techniques for taking lying and standing blood pressure.

Positive Risk Taking

In a study about the association between bed rest and functional decline, it was determined that 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over the age of 80 years. It is important to ensure that we take a positive risk taking approach to rehabilitation; making sure that patients are as active as they can be, to prevent functional decline and muscle wasting which leads to an increased risk of falling

In order to promote this message, and to enable patients, their relatives and visitors to be better informed in how they can reduce their risk of falls, we have developed a leaflet that is given to all patients on admission to our community hospitals

Trust colleagues will also be participating in the national 70 day #EndPJParalysis challenge as part of the celebrations of 70 years of the NHS. The idea is to measure every day for 70 days how many patients are up and dressed in their own clothes and have undertaken some sort of activity from here we plan to ensure that the ethos of #EndPJParalysis becomes embedded within our teams so that it becomes the way we do things rather than being an initiative.

Safety Briefings

A standard format for safety *briefings* has been agreed for all our community hospitals. This takes place at every handover and is mandatory.

2

Health and Well-being of Colleagues

To maintain or reduce sickness and absence and improve scores in our staff survey relating to health and well-being

In 2017-18 the Trust continued with its programme of activities as we continue to recognise that there is a direct correlation between colleague wellbeing and the quality of patient care delivered.

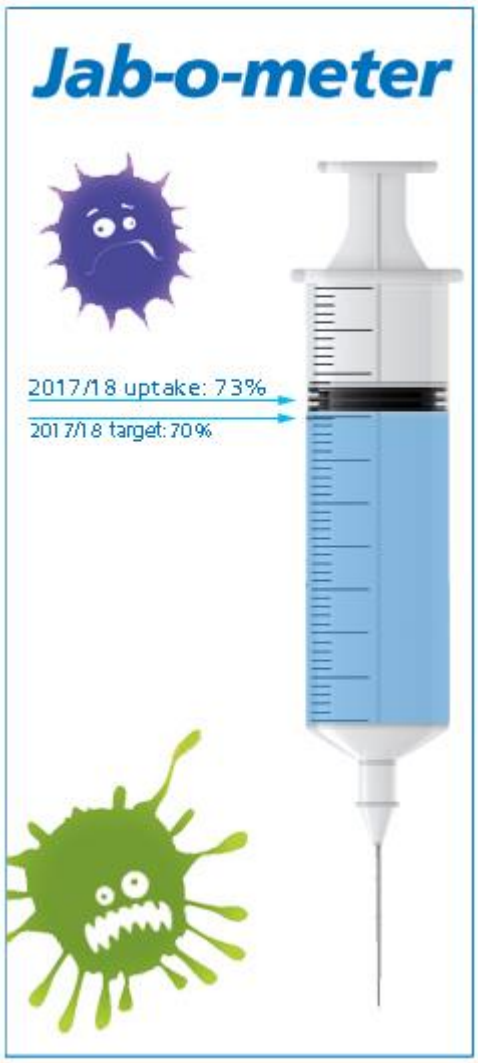
During August 2017 we were awarded The Workplace Wellbeing Charter, a National Award for England for its commitment to workplace health. We continue to work hard to support colleagues with absence management, health and safety, physical activity, smoking, healthy eating, alcohol and mental health.

One of our most successful programmes is our 'Health and Hustle' which encourages colleagues to participate in physical activity by recording movement and steps through the use of Fitbits. One of the many strengths of 'Health and Hustle' is that it caters for all levels of activity ranging from mid- week walks, through to running groups, encouraging colleagues to share and celebrate their experiences and successes. Participation continues to grow and we continue to expand our activities to include local partner organisations.

In April 2017 we launched a colleague physiotherapy service which "fast tracks" our colleagues into our Musculoskeletal Physiotherapy service, for conditions which are limiting their ability to work. The service is easily accessible; our physiotherapist works from locations across the Trust and provides the option of telephone consultations. In the last 6 months of 2017-18 there were **178** colleague referrals into the service and

feedback from colleagues has been that it improves their ability to perform their job.

Our brilliant team of peer vaccinators from across the Trust helped us to achieve **73%** of colleagues having their annual flu vaccination, which was a significant improvement compared to our previous year where we achieved 56%.



3

Equality and Diversity

To be able to evidence progress through the Workforce Race Equality scheme returns, staff survey and other key indicators.

We have made considerable improvements against these commitments during 2017-18 with a range of activities that have intentions of embedding the accessible information standards; improving the recording of protected characteristics; continuing to take information and advice out to communities who do not currently access our services and to ensure that vulnerable older people, as well as carers and families, are directly involved with the development of our services across the County.

Our accessible Information Standard compliance within the Trust has improved from **2%** in March 2017 to **82.7%** in March 2018;

We have developed an intranet area with dedicated resources for colleagues in different formats, to support better communication with patients

We have worked with local communities to develop a cultural awareness app for colleagues, providing information about different religions and cultures of communities across Gloucestershire. We will continue this work.

We have raised confidence levels with our colleagues to enable them to have conversations with patients about their religion, ethnicity, and what matters to them

Colleagues continue to attend a number of events during 2017-18:

- Polish Family Days, in Kingsway and Cheltenham
- Oakley Resource Centre Easter Egg Hunt
- Barton & Tredworth Fayre
- Hartpury Wellfest – ChatHealth
- Brockworth GP Patient Participation Group Event
- Carers Rights Day

We also held a number of focussed events about developing frailty services. In addition to this we continue to understand and learn about what *local* assets and services are available – health (physical & mental), social, community, well-being groups or organisations; improving links and partnerships with service providers, so that we all keep up to date and know who to go to. Also it is important to understand how we could work differently to support better outcomes for people considered to be frail. We are delighted to have achieved Disability Confident accreditation, which works to the principles of Mindful Employer, with a number of initiatives focussed on colleague's health and wellbeing.

4

End of Life Care

To increase the proportion of people who are able to die in their preferred place.

We provide end of life care across various settings delivered by colleagues in our community hospitals and community based teams. The end of life care we provide is based upon the national "6 Ambitions for End of Life Care" and the One Gloucestershire End of Life strategy (2016-19).

Our CQC inspection of our end of life services during February 2018 rated end of life care as "Good" where they found that ***"staff were motivated and proud to be providing end of life care and support across the Trust…"***

Our work with partner organisations across the County to help increase the proportion of people who are able to die in their preferred place continue and we have had mixed success about how we evidence this although we continue to receive wonderful comments from many of those families who have been witness to the great end of life care we provide.

We have continued to promote close working with partners through collective improvement meetings and work streams. This included our Trust hosting a countywide workshop in November 2017 where we shared good practice and agreed new ways forward for better ways of working. For example piloting the "Just in Case" boxes of medications in people's homes in the Forest of Dean locality which demonstrates how this helps those individuals who want to die at home have medications ready in anticipation for when needed. We anticipate these being in people's homes across the County by 2018-19.

We have developed a comprehensive ongoing training programme for Trust colleagues ranging from basic awareness to advanced knowledge and skills.

We still have some improvements to make in standardising our record keeping through our electronic records processes and refining outcome and performance indicators (which was also recommended by the CQC) however we feel that great strides have been made hence our favourable CQC rating.

In addition to the above we are planning to participate in the NHS Benchmarking Network-National Audit of Care at the End of Life (NACEL). It is envisaged that many of these audit measures will be incorporated into the performance indicators for 2018-19.

5

Dementia Care

To increase the number of colleagues who are dementia friends and to improve joint working with partners to improve outcomes for people living with dementia and their care.

We are delighted that our priorities for Dementia Care have all progressed as planned. Some of our highlights include our commitment to being a Dementia Friendly organisation and we have progressed this with the support from colleagues and raising awareness throughout the Trust. We now have over **350** colleagues in the organisation that are a Dementia Friend and over **500** clinical colleagues have received face to face dementia awareness training.

Our volunteers working with us are an amazing group of individuals with vast life experience and many having personal experience of supporting someone living with dementia. We continue to learn as much from them as they do from us and it is wonderful to see the difference they can bring to someone's hospital stay.

The majority of our community hospital wards now have digital reminiscence technology and we also utilising other resources such as music, hand massage and activity events (afternoon tea a visiting lama, pet therapy dogs and weekend movie afternoons).

P	Pain – assess and manage pain, use the Abbey Pain Scale
I	Infection – monitor NEWS, minimise/monitor invasive devices
N	Nutrition – MUST, weight, food charts and care rounding
C	Constipation – monitor each shift, communicate and action
H	Hydration – drinks within reach, fluid chart, care rounding
M	Medication – review with doctor and pharmacist
E	Environment – involve family and carers, minimise bed moves

All our clinical colleagues now have access to delirium resources which includes; clinical guidance, patient information leaflets, educational videos, PINCH ME pocket guide and information from the 'Don't Discount Delirium' campaign. During the year we have delivered face to face Delirium Awareness training to over **237** clinical staff from hospital wards and our Community Teams.
GCS PINCH ME pocket guide – THINK DELIRIUM

We identified that our clinical staff were often struggling to know the trigger points on a patient's journey with dementia that could indicate that they were entering the last stages of their life. To support our colleagues we have developed a Dementia and End of Life Awareness training

session. We tested this session out on a group of clinical experts (from the fields of dementia and end of life care) and have a final product that is now available; to date we have delivered this to 23 clinical colleagues with many more sessions booked up.

6

Pressure Ulcers

To reduce the incidence of acquired and avoidable pressure ulcers across all service areas

Much of our efforts during 2017-18 has been focused on raising the profile about pressure ulcers across the Trust. We now believe that we are in a much better position about pressure ulcers being *"Everyone's Business"* We also know that we have much more to do in order to reduce the incident of pressure ulcers across the health and care system across Gloucestershire. Raising awareness about pressure ulcers also meant that we now have improved reporting in place. During 2017-18 we reported 652 Acquired Pressure Ulcers, these were broken down as:

Grade 1 & 2 Acquired Pressure Ulcers	**578**
Grade 3 Acquired Pressure Ulcers	**64**
Grade 4 Acquired Pressure Ulcers	**10**

These numbers continue to remind us about the focus on our activities and how we will continue to work with our One Gloucestershire patients during 2018-19.

Our multi-profession Pressure Ulcer Prevention Quality Improvement group is now well established and is starting to witness positive change in practice, with clear progress now being demonstrated.

There has been a consistent increase in pressure ulcer reporting and not all associated with nursing services – podiatrists, physiotherapists and occupational therapists are now reporting. This we believe is clear evidence that our 'Everyone's Business' campaign is reaching many different colleagues and opportunities for education, encouraging and enabling skin reviews and pressure reduction approaches to be applied early and by anyone.

Our patient and public facing leaflet has been produced and to date 3000 have been issued across the organisation, to care homes and to the Voluntary Care Sector (VCS). This provides clear advice, information and education to people to enable early detection and to reach out to health care professionals as soon as possible. This has also been applied to our website for public download. In addition posers have been shared with care homes promoting effective seating and re-positioning.

We have provided simple, but effective assessment tools into practice, mirrors for skin inspection, measuring guides for accurate wound assessment and consistent grading guides to improve accuracy of wound assessment and recording.

Our incident reporting process for pressure ulcers has been overhauled with clearer reporting fields and a structured clinical validation process, which has enabled through our specialist Tissue Viability Nurses, to help reduce subjective interpretation and provide more timely clinical management advice to colleagues.

We are now seeing a reduction in the number of acquired and avoidable pressure ulcers reported in the organisation and an increase in the number of grade 1 pressure ulcers reported, demonstrates earlier detection and proactive clinical appraisal.

PART THREE: SPOTLIGHTS – 2017-18

Introduction

Sue Mead
Non-Executive Director

Susan Field
Director of Nursing

Sue Mead is our Non-Executive Director (NED) and Chair of our Quality and Performance Committee. This sub-committee of the Trust Board is responsible for providing assurance with regards to the quality and performance of services provided by the Trust. Susan Field is the Trust's Director of Nursing and has executive responsibility for leading on quality and patient safety across the Trust.

The Quality and Performance Committee has continued to focus its attention on the 2017-18 quality priorities and performance over the year, it also continues to answer two key questions:

1. How do we know that we are delivering the best possible service to each and every person across the whole range of our services?

2. When on occasions, things do not go right, how do we learn and improve so that such eventualities never re-occur?

In addition to this we are both delighted to report that during 2017-18 we have strengthened our quality and capacity across the Trust with the appointment of clinical and quality lead roles that are intended to support and guide operational colleagues with quality improvement activities and that these are aligned to our overall priorities. This approach will continue during 2018-19.

Spotlights

This part of our Quality Account outlines a "Spotlight" approach around our Care Quality Commission (CQC) domains and our CORE values:

Care Quality Commission	Trust Value
Safe Effective Responsive Well-Led Caring	Caring Open Responsible Effective

SAFE

We are required to register with the Care Quality Commission (CQC) and we were inspected early 2018 and those services the CQC inspection team visited included:

- End of Life
- Community Adult Services
- Urgent Care – our Minor Injury and Illness Units (MIIUs)
- Inpatient units – SAFE domain
- Well-led

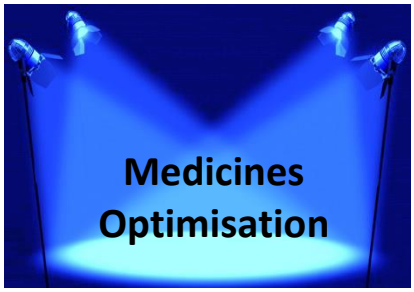
We were proud to receive an overall rating of **GOOD**, which demonstrated considerable improvements since our last comprehensive CQC inspection in June 2015. We believe this reflects the hard work and dedication Trust colleagues have to great quality care and to continuous service improvements. The CQC also highlighted areas of **outstanding** practice. Spotlights within the CQCs report included recognition of the Trusts leadership, safe reporting cultures, staff engagement and well established systems of governance that provides assurance that we have a culture of putting patients and quality care first. The table below highlights our CQC results by service and domain.

Overall rating	Inadequate	Requires improvement	**Good**	Outstanding

	Safe	Effective	Caring	Responsive	Well led	Overall
Community dental services Sept 2015	Good	Good	Good	Requires improvement	Good	Good
Community end of life care Apr 2018	Good	Requires improvement	Good	Good	Good	Good
Community health inpatient services Apr 2018 (safe) Sept 2015 (others)	Requires improvement	Good	Outstanding	Good	Good	Good
Community health services for adults Apr 2018	Good	Good	Good	Good	Good	Good
Community health services for children, young people and families Sept 2015	Good	Good	Good	Good	Good	Good
Sexual health services Sept 2015	Good	Good	Good	Requires improvement	Good	Good
Urgent care services Apr 2018	Good	Good	Good	Good	Good	Good
Overall Apr 2018	Good	Good	Good	Requires improvement	Good	Good

As part of our CQC inspection report we have a number of recommendations to progress during 2018-19, which include:

Theme:	Must Do's
End of Life	Ensure processes are implemented that allow the Trust to monitor the effectiveness and outcomes of key end of life care indicators.
	Ensure all staff providing end of life care are suitably trained and skilled to do so.
Community Adults	Ensure all staff are up to date with all mandatory training, including all safeguarding modules.
Urgent Care	None
Inpatients	Ensure nursing staff consistently follow systems to ensure that clinical equipment is regularly cleaned.



Our medicines management service is provided by a dedicated team of two, working with a range of partner organisations in order to provide distribution of medicines, clinical pharmacy support including medicines optimisation, safe prescribing, medicines advice and clinical audits.

Medication errors and near misses are an indication of patient safety incidents where there has been an error or near miss in the process of prescribing, preparing, dispensing, administering, destructing, monitoring or providing advice on medicines.

We recognise that medication errors have potentially significant implications on patient safety. Research indicates the following medication error rates include:

- Prescribing error rates in hospital: 7% of prescription items
- Prescribing errors rate in General Practice: 5% of prescriptions of which 0.18% were severe errors.
- Dispensing error rate in hospitals: 0.02 – 2.7% of dispensed medicines
- Dispensing error rates in community pharmacies: 0.01 – 3.32% dispensed medicines
- Medicine administration errors in hospital: 3 – 8%

We will continue our work associated with medicines and will have a focus on medication errors during 2018-19.

Each year our children and adults safeguarding team continue to work collaboratively with colleagues and partner organisations. Our Childrens service is required to provide evidence that it is meeting its statutory compliance with regards to safeguarding children (Section 11, Childrens Act (2004)). We do this as a self-assessment exercise using markers of good practice which assess our performance across themed areas, which include:

- Ensuring the voice of the child is heard
- Safeguarding governance systems
- Learning from Serious Case Reviews
- Domestic abuse
- Neglect
- Child sexual exploitation
- Recruitment practical and training compliance

Of the **30** standards that we assessed ourselves against **27** of these were green and we have been able to embed these ratings accordingly. Our adult safeguarding team has continued its work on focused activities associated with the Mental Capacity Act, which provides a framework for achieving and making decisions on behalf of individuals who lack the mental capacity to do these themselves. Both our teams have continued to deliver training and safeguarding supervision for colleagues across the Trust.

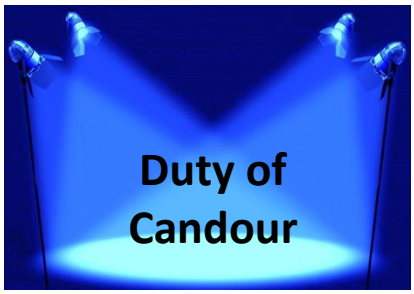
RESPONSIVE

During 2017-18, the Trust reported 25 Serious Incidents Requiring Investigation (SIRIs). Of these 25 incidents 11 were related to pressure ulcers and five related to miss fractures at our Minor Injury and Illness Units (MIIU).

One "Never Event" (serious medical errors or adverse events that should never happen to a patient) was reported by our community dental service during 2017-18.

A non-blame approach and a culture of learning from incidents has contributed to an increase in incident reporting of 5.7%compared to the previous year. Focused training and support has also improved the grading of incidents.

Our Learning Assurance Framework ensures all incidents have agreed action plans following a Root Cause Analysis (RCA) investigation to promote wider learning and a culture of continuous improvement. Our recent CQC inspection found that ***'The trust was committed to improving services by learning from when things go well and when they went wrong, promoting training, research and innovation and it enabled divisions to share learning across the trust.'***



We always consider whether or not Duty of Candour applies to each complaint. During 2017-18 Duty of Candour applied to 2 of the 45 complaints received and the SIRI approach was used to respond to this particular complaint.

Between 1st April 2017 and 31st March 2018, the Trust received 45 complaints from patients and their families. This is a decrease compared to 73 complaints received 2016-17.

These complaints were wide-ranging across our services:

Community Hospitals: 7
Urgent Care: 10
Integrated Community Teams (ICTs) 10
Countywide services: 11
Children & Young People Services 7

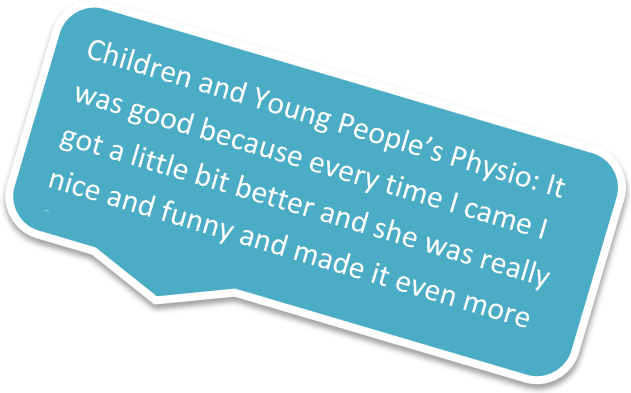
58% of our complaints related to clinical concerns; 20% to communication issues; 15% related to waiting times, and 7% to attitude and behaviour.

If complainants remain dissatisfied by the response from the Trust they can seek support from the Parliamentary and Health Service Ombudsman (PHSO) for review. During the last 12 months, three complaints have been referred to for independent review by the PHSO. None of these were upheld.

The Friends and Family Test (FFT) is a nationwide initiative to allow patients and their families to give feedback about their experiences at the point of, or immediately after contact with the service.

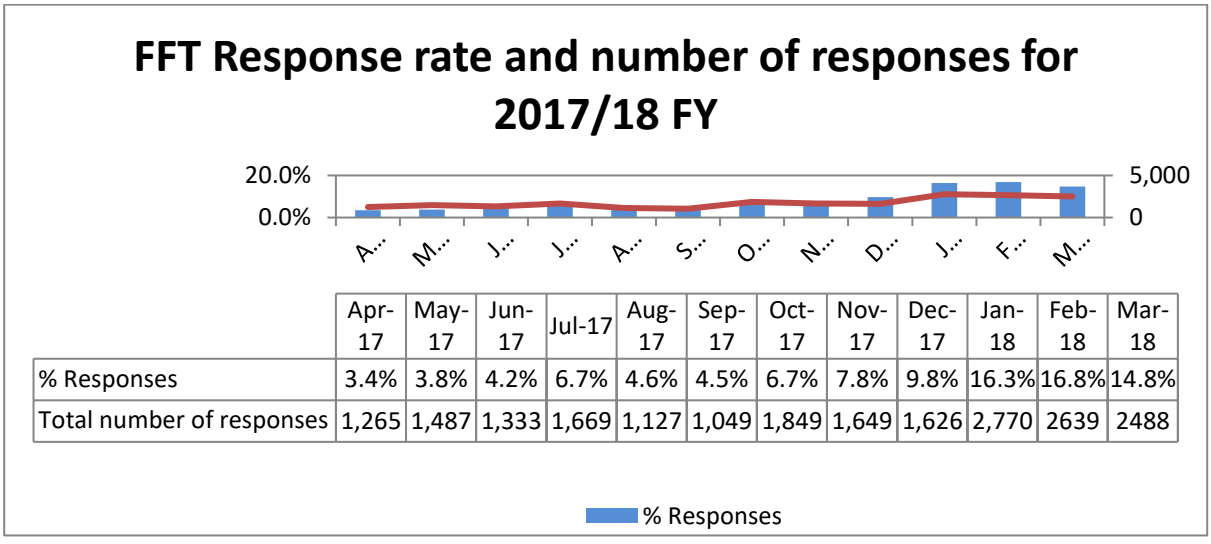
The FFT is used across all our services and helps services celebrate successes and identify areas for improvement. Results are reported monthly both locally and nationally.

During 2017-18 **93.7%** of respondents were "extremely likely or likely to recommend our services to friends and family". In addition to this we have focused our attention on improving our FFT response rates as historically this has been low; typically at around 3.5-4.5% against a national standard of 15%.



During 2017-18 we have seen the number of responses to the FFT increasing in most service areas and the overall response rate has started to reach the 15% target. Our FFT process now also allows patients and their families to raise concerns and have these responded to in a timely manner.

The graph below shows the increase in number of response and response rate during 2017/18



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
% Responses	3.4%	3.8%	4.2%	6.7%	4.6%	4.5%	6.7%	7.8%	9.8%	16.3%	16.8%	14.8%
Total number of responses	1,265	1,487	1,333	1,669	1,127	1,049	1,849	1,649	1,626	2,770	2639	2488

With respect to Learning from Deaths, we have continued to report deaths in each community hospital using the MIDAS process. The Countywide Medical Examiner service is involved in this process, and the Trust's Mortality Review Group has visited five of the seven community hospitals to discuss and share learning from deaths that have occurred in that hospital, as well as across the other hospitals and also any regional and national learning. The Trust is also represented in the recently established One Gloucestershire group who are reviewing how we can integrate the Learning from Deaths across the County.

Applied effective learning from mortality reviews: we have improved our processes whereby all people who die in our community hospitals have their clinical care reviewed. Relatives are invited to complete a sensitively worded questionnaire to elicit their views and experiences. Learning from these reviews now takes place at monthly meetings which sometimes include joint meetings with our partner organisations.

The total numbers of deaths we have had in our community hospitals were **221**.

EFFECTIVE

Reducing the risk of infection and prevention continues to be an important aspect of our daily work and across all our services. In addition to this we have had a challenging year with an increase in the number of influenza and Norovirus outbreaks compared to previous years. There have been a total of 11 viral gastro enteritis outbreaks with 9 of these with Norovirus as the confirmed causative agent. The total number of bed days lost due to viral gastroenteritis was 284 with a total number of 100 patients affected (67 in 2016-2017) and the total number of staff affected was 59 (34 in 2016-2017).

We have in the past 12 months instigated a series of additional actions to prepare inpatient facilities for the potential of an influenza outbreak. These actions have included training in the use of personal protective equipment (PPE) including the use (and fit test training) of respirators, the increase in the correct stock of PPE so that staff were properly protected, peer vaccination, a review of the influenza policy etc.

Between January and March 2018 we experienced six influenza outbreaks, 4 type A and two type B with many other single cases cared for in the inpatient units across the county. In total 95 bed days were lost (55 in 2016-2017 with three outbreaks) reflecting the increase in flu cases across the South West region.

We have reported 16 cases of C.Difficile against a set tolerance figure of 18 and no MRSA bacteraemia cases.

Whilst there is no agreed tolerance figure for the number of Gram negative blood stream infections, these have been reduced to one case that was confirmed when a patient was transferred from a different provider.

Good hand hygiene remains the single most effective way to prevent the spread of infection. Our compliance hand hygiene rates remain high at 93%.

We continue to undertake a schedule of quality assurance visits, which are broadly based on risk, service developments and patient focused. In addition to this we have introduced Time for Tea, meet the executive team across our localities and members of our executive, non-executive directors and management teams undertake visits with clinical teams, which also focus on the Trusts quality priorities as well as to then understand the day to day issues colleagues are experiencing. These visits continue to be valued by Trust colleagues and feedback from our 2018 CQC inspection included **"*had experienced executive and non-executive directors…who worked hard to ensure staff at all levels understood them in relation to their day roles and a commitment to lead the delivery of high quality services*".**

We continue to ensure that we achieve meaningful outcomes for patients, families and carers and one mechanism of doing this is by undertaking clinical audits. Our focus is to ensure that all clinical audit activities results in learning and in improvement to care. We strongly believe that participation in clinical audit enables us to provide effective, responsive and safe care. We have participated in a range of national audits which included:

- National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP): Pulmonary Rehabilitation work stream
- Sentinel Stroke National Audit Programme (SSNAP)
- National Diabetes Foot Care Audit
- National Audit of Intermediate Care (NAIC)
- National Audit of Cardiac Rehabilitation
- National UK Parkinson's Audit

The Trust has, over the past 12 months, increased its research activities. We remain partners of the "Research 4 Gloucestershire" consortium and West of England Clinical Research Network, and key developments have included:

- Participating in a national research trial to understand more fully the experiences of people living with HIV
- Launching a study to measure the effectiveness of medication creams for sexual health problems
- Working with Bath Spa University on two projects; researching how to increase health and wellbeing in NHS staff and recruiting patients in to a prostate cancer study
- Measuring how well a new physiotherapy programme works for patients with bone problems in partnership with the COBALT Health Imaging Centre
- Progressing with a doctoral research study that will measure how well special types of equipment work for people with speech and language difficulties
- Recruiting patients to a national trial to understand how people at very high risk for HIV take HIV medicines daily to lower their chances of getting infected
- Working with Gloucestershire Hospitals NHS Foundation Trust and Sue Ryder Care to replicate a successful Australian study that showed that family carers can be involved in providing breakthrough pain relief to patients who are nearing the end of their lives.

In addition, we are in early exploratory talks with 2gether NHS Foundation Trust to assess if a joint research strategy for the two organisations would bring greater benefits to healthcare research both locally and nationally.

During 2017-18 there were a total of 187 NICE guidelines and Quality Standards published and reviewed by the Trusts Clinical Reference Group. Of these 71 were applicable to our community services.

CARING

There have been **955** Compliments recorded 1 April 2017 – 31 March 2018! There will be many more that have gone unrecorded. Some notable spotlights include:

Elmbury Suite at our Tewksbury Community Hospital where many compliments are received describing our colleagues as kind and compassionate, the environment is clean and that we put the patient at ease.

Our Community Hospitals receive grateful compliments from patients and their families. This includes our colleagues being cheerful, kind, keeping the families informed when the patients themselves may not have full capacity and not rushing the families to leave.

Our Rapid Response service continues to receive many heartfelt compliments from families especially with regards to the End of Life care they provide and; our MIIUs have received many compliments from younger people with mental health issues where they feel they were treated very kindly and without judgement.

In addition to this our Children and Young People's Service received feedback about the care they provide in supporting child's mobility and confidence. Not to mention our adult services who have received compliments for transforming people's lives by initiating and organising support services.

In summary, of our recorded **955** compliments key words from patients, families and carers about the care we provide include:

Our Children in Care (CIC) team continue to be amazing and have been enhanced further during 2017-18 with the support of commissioner funding. We believe it is important to never underestimate the difference that can be made to a child or a young person's life by spending time to get to know them. This is not just through direct work, it can be through ensuring all important information and support is communicated to the relevant people and so that the child or young person gets the right support at the right time.

One of our team members say that "***We are already seeing that being a constant within these young people's lives is bringing positive outcomes".*** We are able to get to know the adults in their lives and build excellent working relationships, all with the child or young person's best interests at the heart of what our team do.

One of our stories:
"*I went to visit a 15 year old young person for his review health assessment. He was already under the care of the School Nursing Continence Clinic but was not engaging. I was able to spend time getting to know him, and empower him around his own health and well-being. He engaged really well and began to talk about his emotions. We were able to identify what interests him, and highlight the barriers that prevented him from accessing support. Despite this he initially denied any issues, but then as I was leaving he asked if I could be the person to work with him. This was agreed and we have been working together for 3 months. He has been to the GP for review, is now following the recommended continence guidelines, taking medication as prescribed and has been dry at night for longer than ever before. As this relationship has developed, the CiC Nurse was best placed to deliver other care as well. As a result, this young person is now engaged and informed about healthy relationships, sex education, healthy living and emotional health. This is hugely rewarding as each visit reflects on the last and the young person is able to talk about how we have influenced his lifestyle, including being dry at night, reducing drug use and joining a gym! I feel really proud of him and his progress, which makes me smile every time I think of it."*

Well-Led

Throughout 2017-18 the Trust Board has worked to maintain strong oversight of the strategic and operational performance of the Trust. This includes a process of review against the CQC Well-Led framework, which was subject to a CQC inspection during February 2018. We were assessed around the overall management of our Trust, the quality of our service, the quality of our leadership and our governance arrangements. We received a well-led Good rating with comments made that included:

"The Board and senior leadership team had set a clear vision and values that were at the heart of all the work within the organisation…"

"The Trust strategy was directly linked to the vision and values of… the Trust involved clinicians, patients and groups from the local community…"

We remain committed to encouraging colleagues to speak openly about any issues that may be of concern to them. We have a number of mechanisms that allow colleagues to do this including our Ambassador for Cultural Change who continues to champion the Freedom to Speak Up agenda, providing independent and confidential support to colleagues. This year colleagues have raised **62** concerns through the Guardian, 1/3 relating to patient quality and safety and 2/3 inappropriate behaviours respectfully.

Our Guardian continues to network nationally and chairs the South West Freedom to Speak Up Guardian Network, sharing best practice, challenges and as a region a collective commitment to making the South West a leading region for Speaking Up.

Moving forward and in response to the NHS Staff Survey 2017, Workforce Race Equality and Disability Standards, and the National Guardian recommendations 2017 we will be;

- Introducing across the Trust a network of 'Freedom to Speak Up Advocates' to further promote a culture of inclusion, challenge inappropriate behaviours and further support colleagues to speak up
- Delivering bespoke training to support managers to receive concerns well, investigate appropriately and share learning

The National Guardian, Dr Henrietta Hughes will also be visiting the Trust later in the year and we look forward to welcoming her and sharing our commitment to the Freedom to Speak Up agenda.

The NHS Staff Survey gives our staff a chance to have their say about our working life in the NHS. It seeks views on areas such as job satisfaction, colleague wellbeing, training and development and health and safety.

The results of the survey, which took place between October and December 2017, were published nationally on 6th March 2018.

Disappointingly the key findings of engagement within the Trust for this survey reflect a reverse in the steady improvements which had been achieved over the last few years, albeit is subject to significant variations between professions, locations and service areas.

The overall staff engagement score for the Trust fell from **3.78** to **3.71** against a continuing average of 3.78 for trusts of a similar type.

Key scores from the survey were:

	Staff Engagement	Trust 2017	2017 National Average	Trust 2016
	Overall Staff Engagement			
KF1	Staff recommendation of the trust as a place to work or receive treatment	3.71	3.78	3.78
KF4	Staff motivation at work	3.68	3.76	3.72
KF7	Staff ability to contribute towards improvements at work	65%	71%	69%

There are a number of areas where we are doing well in comparison to colleagues nationally. There is undoubtedly an improvement in our reporting culture with colleagues being prepared to report violence, harassment, bullying or abuse. This is important and reflective of efforts to promote an open culture, whether through the 'Freedom to Speak Up Guardian' role or 'Katie's Open Door' (now morphed into 'Paul's open Door'). We also compare relatively well in terms of colleagues experiencing work related stress and in terms of working extra hours.

It is also pleasing to see that on the whole, staff believe that our Trust does provide equal opportunities for career progression and promotion.

Turning to those areas where we do less well, the scores reflected in the raw data related to 'job' are clearly reflected in these key findings in terms of effective team working, contribution to improvements as well as support and recognition from managers.

Clearly, it is disappointing to see the steady progress of previous years arrested in the last survey, particularly as there are and have been a number of positive indicators in the year. The CQC gave praise for the welcome they received from colleagues across the Trust and their professionalism and dedication to patient care. Most recently, the efforts of so many colleagues to maintain services in very challenging weather conditions, demonstrated a

willingness to go ‘over and above’ the expected norms and this would typically be the behaviours of a highly engaged workforce.

There have been a number of contextual national and local issues, which have undoubtedly contributed to these results and need to be understood. Notwithstanding these however, we believe it will be important to focus on the actions we can take forward and we will do this by having more emphasis on highly detailed action plans and more on fewer high impact actions as it is likely that our colleagues and their managers will have the solutions and we need to listen and respond to these once received.

PART FOUR: LOOKING FORWARD TO 2018–19

Introduction

Part four of our Quality Account looks forward to our 2018-19 priorities. In deciding these priorities, the Trust Board took in to consideration the One Gloucestershire Sustainability and Transformation Programme (STP), risks and issues identified through our own performance and quality information.

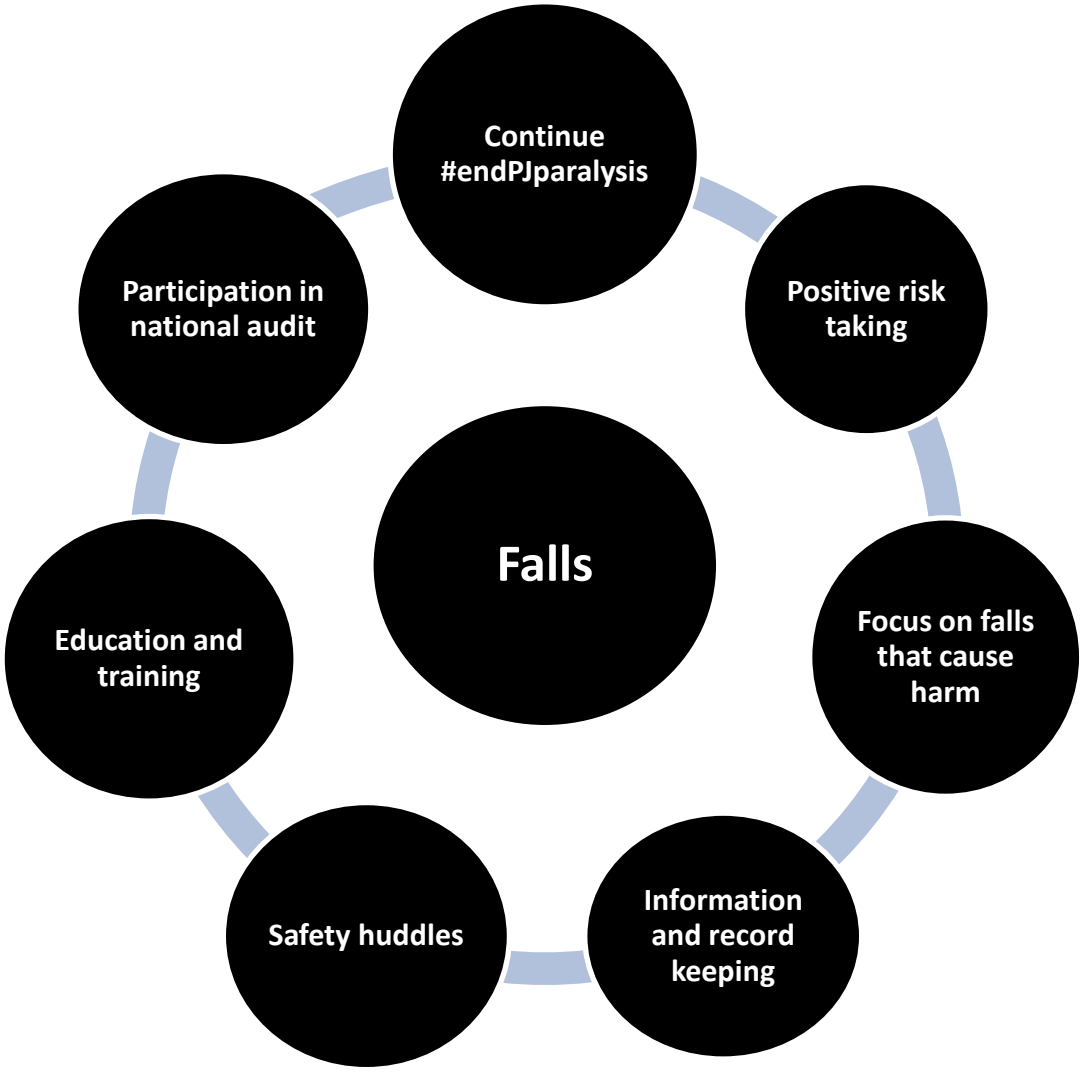
2017/18 Quality Priorities		Quality Domain
1 Falls Prevention and Management	Our aim will be to continue focussing on preventing and managing falls and particularly in areas where falls cause harm.	SAFE
2 Health and Well-being of Colleagues	Our aim is to maintain or reduce colleague sickness and absence and to continue our work relating to health and wellbeing. We will also aim to achieve a 75% uptake rate of colleagues having their flu vaccinations.	CARING
3 End of Life Care	Our aim will be to consolidate further our End of Life care developments with the intention of being able to increase the proportion of people who are able to die in their preferred place of choice.	EFFECTIVE
4 Nutrition and Hydration	Our aim is to build on what we have achieved through PLACE with regards to our community hospitals and to include a focus on nutrition and hydration with our wider community services.	WELL-LED
5 Preventing Pressure Ulcers	The prevention of pressure ulcers remains one of our top priorities with regards to patient safety. Our aim will be to continue to monitor the number and incidences of pressure ulcers and to continue to drive our reduction plans forward.	SAFE
6 Medication Errors	Our aim is to improve patient safety and to get a more detailed understanding of our medication errors by improved reporting which will enable further learning to support safer practice.	WELL-LED
7 Deteriorating Patient (SEPSIS)	Our aim is to support and develop our clinical colleagues in the recognition and early identification of deteriorating patients to include sepsis and other life threating conditions.	RESPONSIVE
8 CQUIN	National Commissioning for Quality and Innovation (CQUIN)	WELL-LED

These priorities are described in more detail in the following pages.

1 Falls Prevention and Management

Our aim will be to continue focussing on preventing and managing falls particularly in areas where falls cause harm.

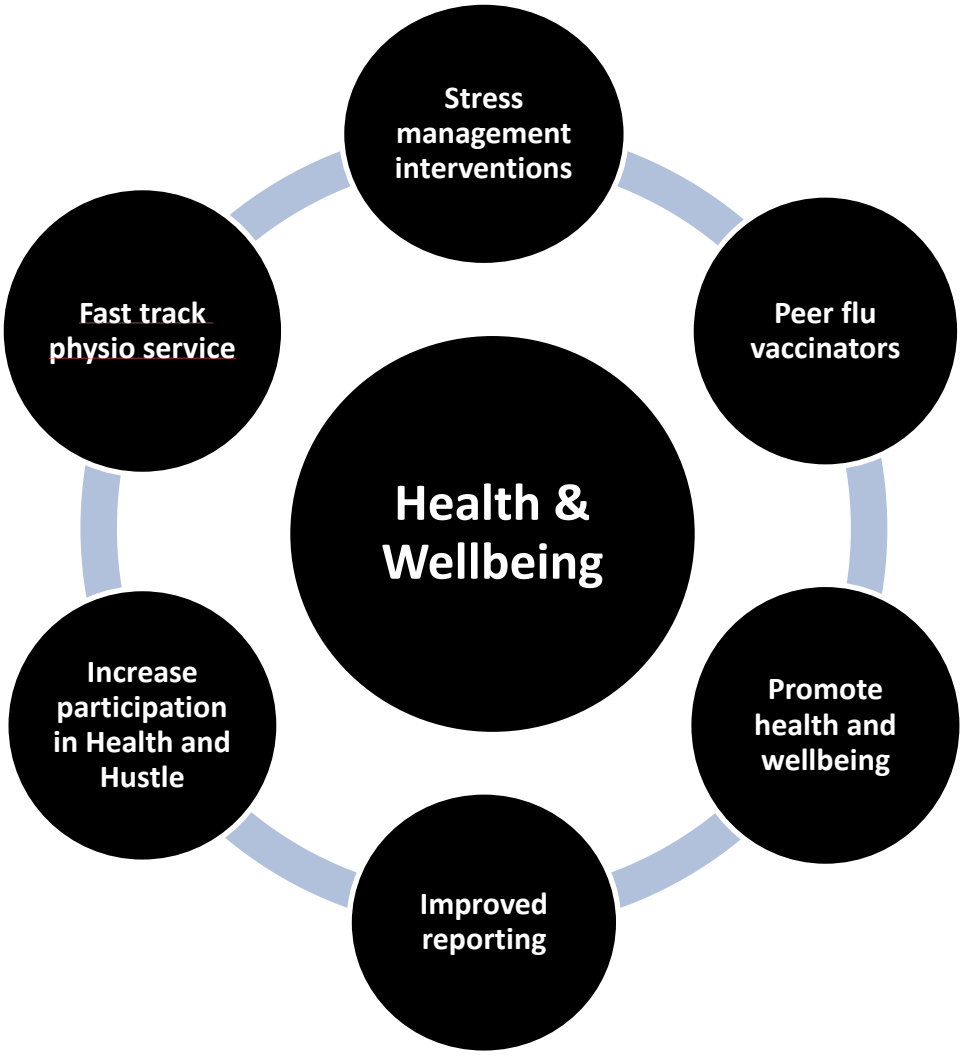
Our plan:



2 Health and Wellbeing of Colleagues

Our aim is to reduce colleague sickness absence and to continue our scores in our work relating to health and wellbeing. We will also aim to achieve a 75% uptake rate of colleagues having their flu vaccinations.

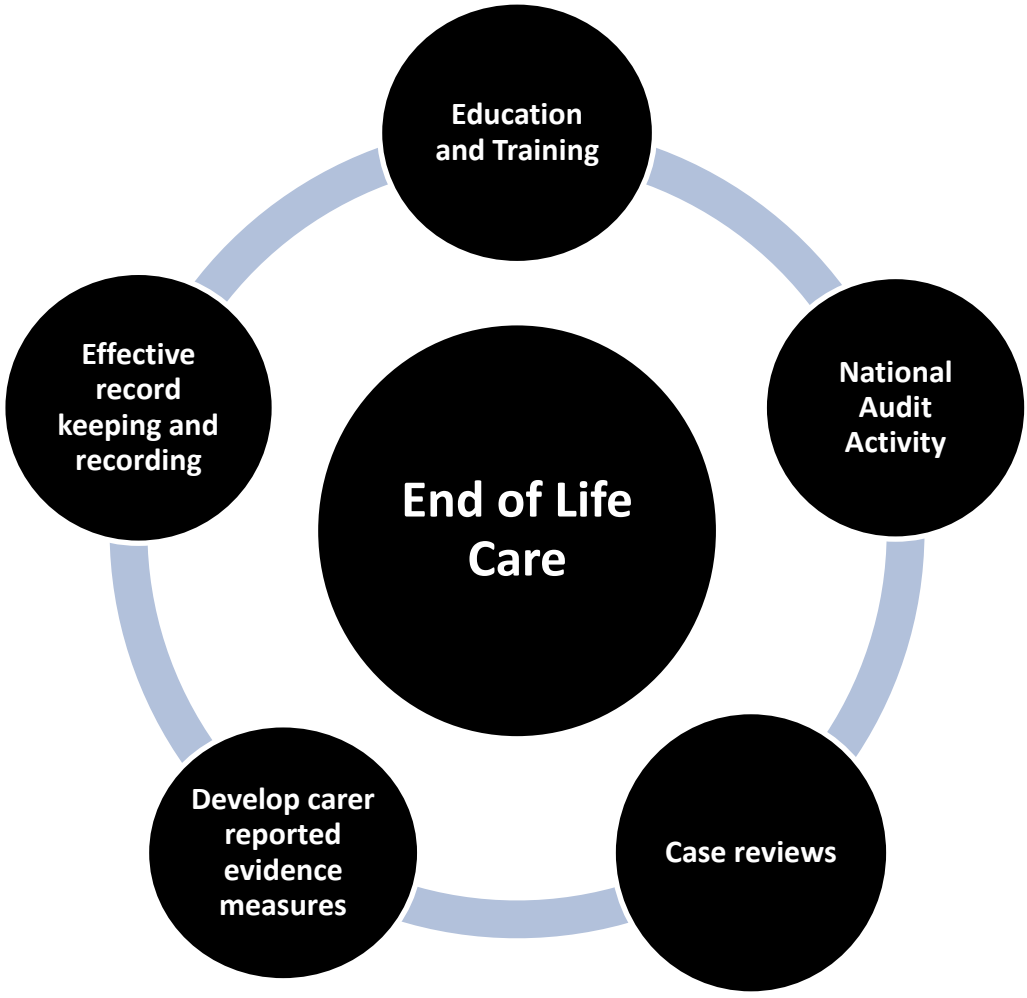
Our plan:



3 End of Life Care

Our aim will be to consolidate further our End of Life care developments with the intention of being able to increase the proportion of people who are able to die in their preferred place of choice.

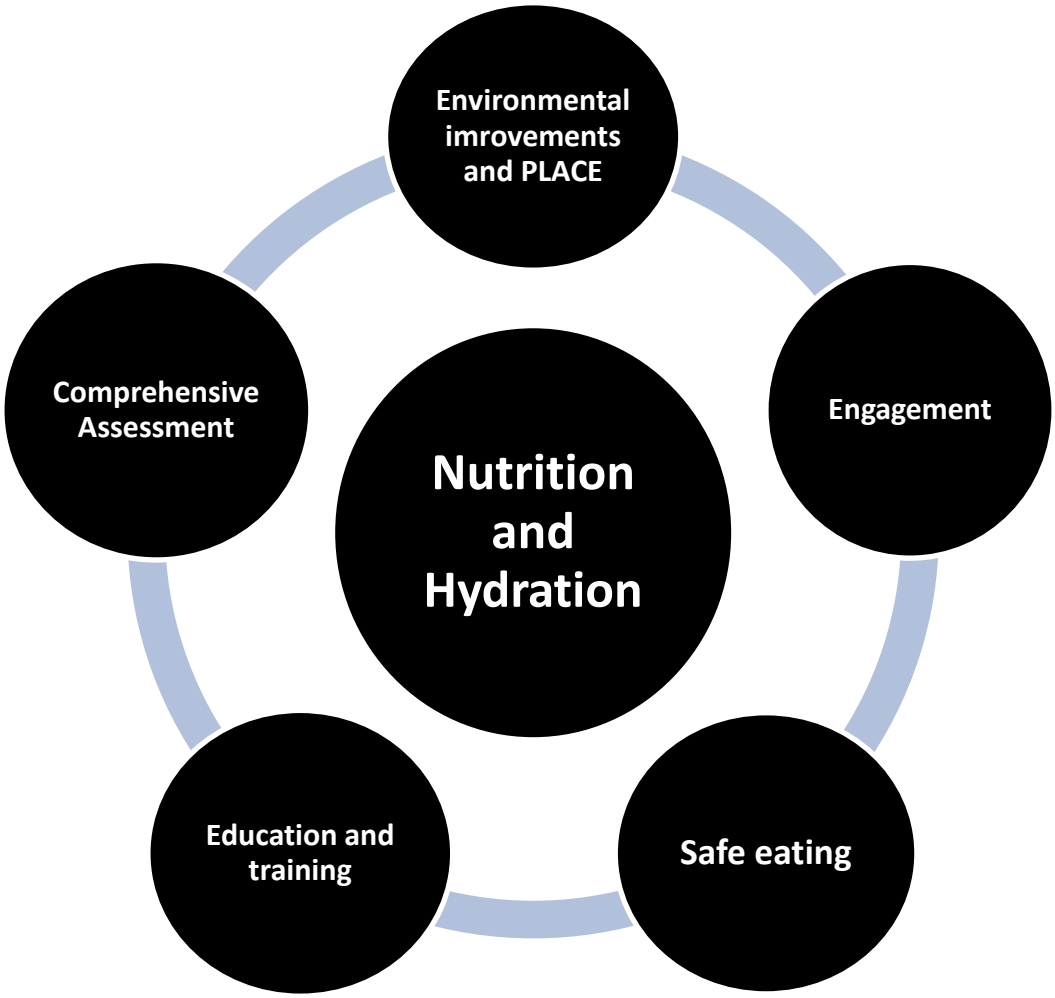
Our plan:



4 Nutrition and Hydration

Our aim is to build on what we have achieved through PLACE with regards to our community hospitals and to include a focus on nutrition and hydration with our wider community services.

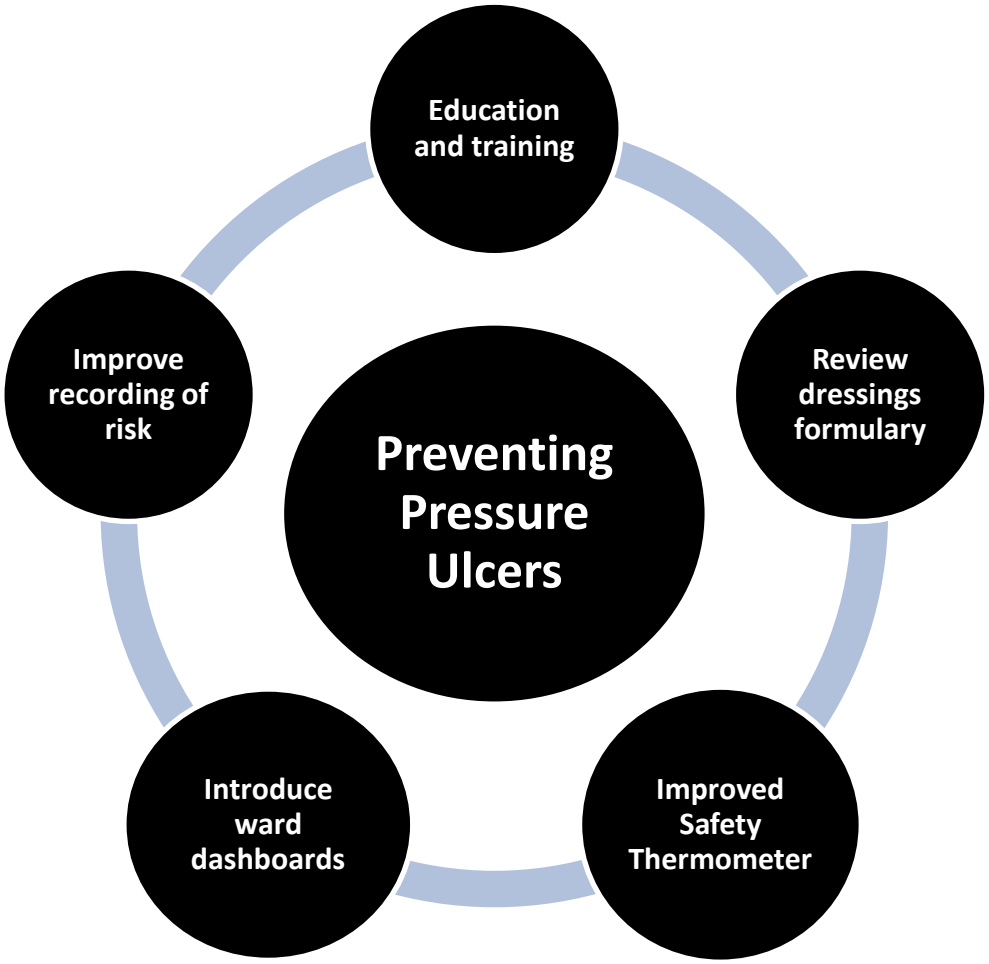
Our plan:



5 Preventing Pressure Ulcers

Our aim of preventing pressure ulcers will remain one of our top priorities. We will continue to respond to pressure ulcers' incidences and progress with our drive to reduce the number of pressure ulcers reported.

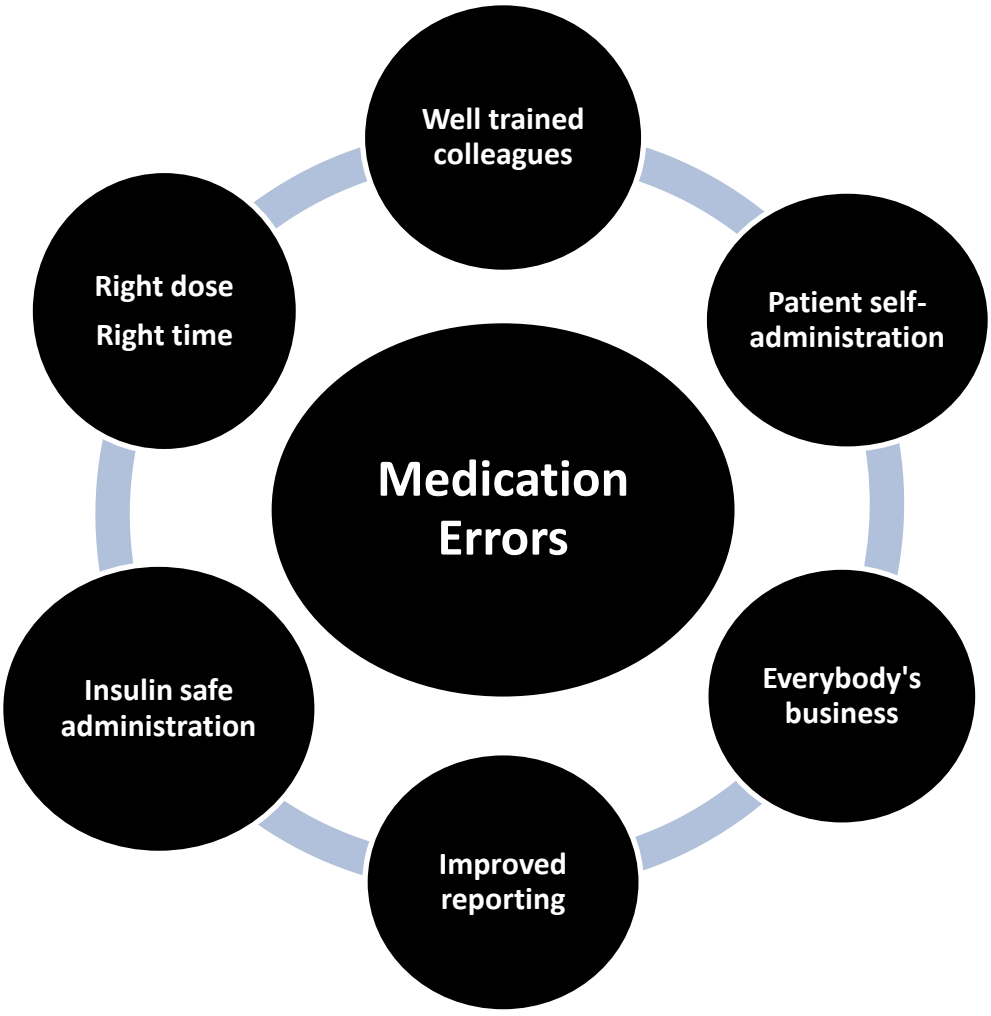
Our plan:



6 Medication Errors

Our aim is to improve patient safety and to get a more detailed understanding of our medication errors by improved reporting which will enable further learning to support safer practice.

Our plan:



7 Deteriorating Patients

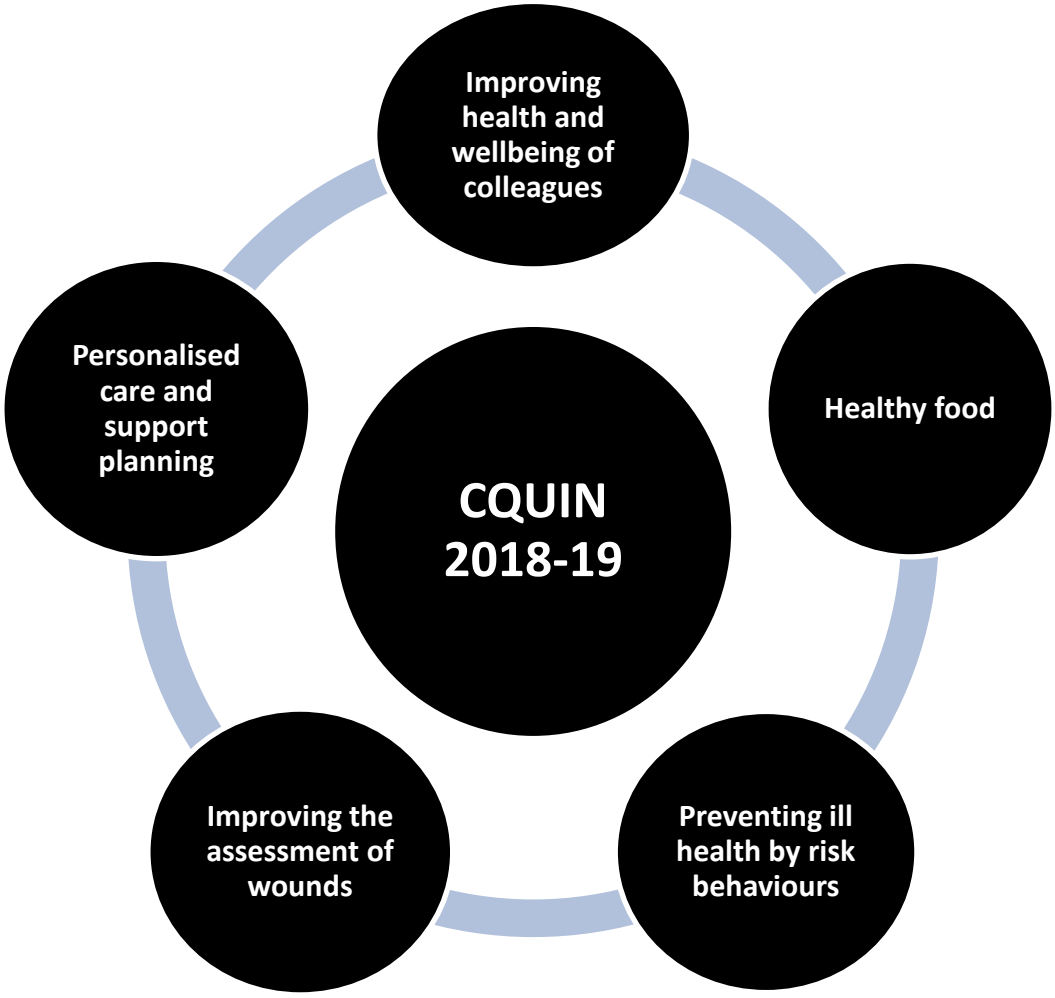
Our aim is to support and develop our clinical colleagues in the recognition and early identification of deteriorating patients to include sepsis and other life threating conditions.

Our plan:

8 Commissioning for Quality and Innovation

Our aim will be to work with a range of colleagues in order to deliver a nationally led CQUIN programme which includes:

Our plan:



PART FIVE: STAKEHOLDER FEEDBACK

NHS Gloucestershire Clinical Commissioning Group

NHS Gloucestershire Clinical Commissioning Group's (GCCG) response to Gloucestershire Care Services NHS Trust's Quality Account 2017-18:

GCCG is pleased to have the opportunity to pass comment on Gloucestershire Care Services NHS Trust Annual Quality Account.

The past year has continued to present major challenges across both Health and Social care in Gloucestershire and we are pleased that GCSNHST have worked jointly with partner organisations, including the CCG and colleagues within the local authority during 2017/18 to deliver a system wide approach to maintain, further develop and improve the quality of commissioned services and outcomes for service users and carers. We wish to acknowledge the Trust's continued contribution and ongoing commitment to the development of the Sustainability and Transformation Plan for Gloucestershire (STP).

Following the CQC inspection in January 2018 GCSNHST have been awarded an overall rating of 'Good' which is an improved rating from their previous inspection. The CCG would like to congratulate the Trust on this and note that 9 areas of outstanding practice were identified by the CQC.

The 2017/18 Quality Report is clear, easy to read and identifies how the Trust performed against the agreed quality priorities for improvement for 2017/18 and also outlines their priorities for improvement in 2018/19. The report is open and transparent and it is noted that the Trust have acknowledged the areas where the achievements have not been realised as quickly as they had aimed for. The CCG endorses the quality priorities that have been selected for 2018/19, whilst acknowledging the very difficult financial challenges GCSNHST have to address in the coming year.

Delivering harm free care remains a priority for the Trust. The CCG is pleased to see the continued efforts to improve data quality in order to provide assurance of safe service delivery. The CCG are particularly pleased to see that 'Pressure Ulcers' and 'Falls reduction' have been prioritised for continued improvement in 2018/19, building upon the previous years' work. Of particular note is the promotion of preventing pressure ulcers being 'everyone's business' and the associated learning programmes for all front line staff. The CCG fully support GCS in prioritising a reduction in medication errors during 2018-19 as we recognise the potentially significant implications on patient safety, experience and overall outcomes.

The CCG note the predominantly successful delivery of the previous year's quality priorities, in particular the CCG were pleased to see that GCS NHS Trust was awarded The Workplace Wellbeing Charter, a National Award in England for its commitment to workplace health. We note the continued focus on supporting staff with absence management, health and safety, physical activity, smoking cessation, healthy eating, alcohol and mental health. The CCG were pleased to see a significant improvement in the

number of staff having their annual flu vaccination, the figure rose in 2017/18 to 72% from 56% the previous year.

The CCG welcome the continued focus that GCS NHS Trust have had on improving Dementia Care and acknowledge that all of the planned objectives in year have been met. In particular, the commitment demonstrated at all levels across the organisation to become a 'Dementia Friendly organisation'. It is pleasing to see over 500 clinical staff have received face to face dementia awareness training.

The CCG recognise the improvements that GCS NHS Trust have made in relation to their Friends and Family test response rate and are pleased to see that the trust are nearly achieving the target of 15%. It is noted that changes have been made that enables patients and their families to raise concerns and have these responded to in a timely manner.

The CCG note that the yearly NHS staff survey results for GCS NHS Trust were disappointing when compared to previous years. The CCG have sight of the approaches that the Trust are deploying in order to improve and acknowledge that in some areas there was an improvement in results, in particular; reporting culture with staff being prepared to report violence, harassment, bullying or abuse.

Gloucestershire CCG wishes to confirm that to the best of our knowledge we consider that the Quality Account contains accurate information in relation to the quality of services provided by GCS NHS Trust. During 2018/19 the CCG wish to continue working with GCS NHS Trust, all stakeholders and the population of Gloucestershire to further develop ways of receiving the most comprehensive reassurance we can regarding the quality of services that our citizens receive.

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

Health and Care Overview and Scrutiny Committee (HCOSC)

Health and Care Overview and Scrutiny Committee response to Gloucestershire Care Services NHS Trust's Quality Account 2017-18:

On behalf of the Health and Care Overview and Scrutiny Committee I welcome the opportunity to comment on the Gloucestershire Care Services NHS Trust Quality Account 2017/18.

This has been a challenging year for the Trust with not only the consultation on the future of community hospitals in the Forest of Dean, but also the decision to merge with the 2Gether NHS Foundation Trust, all while continuing business as usual.

The committee welcomed the start of the consultation on Community Hospitals in the Forest of Dean and received the outcome report in January 2018. The committee agreed that the consultation process was appropriate and proportionate, but did identify concerns particularly relating to bed numbers and transport. The committee also supported future stages of this work being developed and tested through a citizen's jury approach. The committee continues to monitor progress.

In the longer term the merger of the two Trusts has the opportunity to make a real difference to how community and mental health services are delivered in the community. The committee looks forward to meeting with the Trusts to look at this matter in more detail and develop a timeline through which the committee can be regularly updated on this matter.

The committee was pleased to hear that the CQC has improved its overall rating for the Trust to 'Good'. This is a reflection on the dedication and commitment of all members of staff at the Trust.

I would like to thank the Trust for its willingness to work with the committee.

Cllr Carole Allaway Martin
Chairman

Healthwatch Gloucestershire

Healthwatch Gloucestershire's Response to Gloucestershire Care Services NHS Trust's Quality Account 2017-18 is…

This statement is provided on behalf of Healthwatch Gloucestershire. The role of Healthwatch is to promote the voice of patients and the wider public in respect to health and social care services and we are pleased to have had the opportunity to review the Quality Accounts for 2017/18 for the Gloucestershire Care Services.

Healthwatch Gloucestershire is pleased to note the progress made in translating objectives into actual quality of care. We are particularly pleased with the improvements noted in falls prevention - and the obvious intent to continue with that improvement in 2018/19. Across the local health system, it is clear that efforts that have been taken in preventing falls has a positive impact over many areas. The vast improvement in accessible Information Standard compliance (2% to 87%) is also noted, along with pleasing performance improvements in end-of-life and dementia care. HWG will continue to support all efforts in these fields that translate to an improved patient experience.

Healthwatch Gloucestershire endorses the quality priorities listed for 2018/19 and looks to see evidence of further improvement in these fields. We note the comments relating to complaints and would encourage the development of a blame free culture where the number of complaints is not the primary metric for year-on-year comparison. We would be pleased to see more evidence of an embedded learning culture being developed.

Healthwatch Gloucestershire is aware of the intention to integrate community with mental health care in Gloucestershire and fully supports the intent where it will lead to an improved patient experience.

Healthwatch Gloucestershire look forward to developing the relationship with GCS over the coming year and supporting them to ensure that the experience of patients, their families and carers are heard in order to inform service improvement.

PART SIX: CONCLUSION

We are immensely proud to publish our 2017-18 Quality Account.

Our quality improvements would not have been achieved without the dedication, leadership and support demonstrated by colleagues throughout the Trust. Our colleagues are our greatest asset and we recognise that to provide great care we need to look after them well hence one of our priorities being that we will continue to work with our teams to build on our vision of the Trust and Gloucestershire being a great place to work. We would also like to take this opportunity to thank all those colleagues who work for the Trust and for the people of Gloucestershire.

We recognise that there are some areas of service and care we still need to improve and because of this we will continue to focus on quality improvements during 2017-18, reflecting our ongoing commitment to safe and high quality care for service users and carers, and to providing a safe and caring environment for colleagues.

We remain determined to continue to listen to our service users and carers, and to our colleagues, to use their insight and experience to improve quality and safety. Our ambition is to ensure that when we are visited again by the CQC we can collectively be confident that our services will be recognised as being good or outstanding.

PART SEVEN: GLOSSARY

The following is a list of helpful abbreviations:

AHP: Allied Health Professionals

C.Diff: Clostridium Difficile

CPE: Carbapenemase-Producing Enterobacteriaceae

CQC: Care Quality Commission

CQUIN: Commissioning for Quality and Innovation

EoL: End of Life

GCCG: Gloucestershire Clinical Commissioning Group

GHFT: Gloucestershire Hospitals NHS Foundation Trust

HCAI: Healthcare Associated Infection

HCOSC: Health and Care Overview and Scrutiny Committee

ICT: Integrated Community Team

INMP: Independent Non-Medical Prescribing

MIDAS: Mortality Information Data Analysis System

MIIU: Minor Injuries and Illness Unit

MRSA: Methicillin Resistant Staphylococcus Aureus

MSK: Musculoskeletal

MSKCAT: Musculoskeletal Clinical Assessment and Treatment

NED: Non-Executive Director

NHS: National Health Service

NICE: National Institute for Health and Care Excellence

NMC: Nursing and Midwifery Council

OT: Occupational Therapy

PII: Period of Increased Incidence

PLACE: Patient-Led Assessments of the Care Environment

R&D: Research and Development

RCA: Root Cause Analysis

SIRI: Serious Incident Requiring Investigation

VCS: Voluntary Care Sector

WRES: Workforce Race Equality Standard

Appendix 1

Statement of Directors' responsibilities

Under the terms of the Health Act 2009, amendments made in the Health and Social Care Act 2012, the National Health Service (Quality Accounts) Regulations 2010 and the National Health Service (Quality Account) Amendment Regulation 2011, Trust Directors are responsible for ensuring the preparation of a Quality Account for each financial year. Equally, the Department of Health has issued guidance on the form and content of Quality Accounts (which incorporates the above legal requirements).

In preparing this Quality Account, the Trust's Directors have satisfied themselves that:

- The Quality Account presents a balanced picture of the Trust's quality performance over the period covered
- The information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in this Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with national guidance.

The Trust's Directors confirm that to the best of their knowledge and belief, they have complied with the above requirements in the preparation of this Quality Account. The Trust's Board membership, as at 31st March 2018, is as follows:

Ingrid Barker	Chair
Susan Mead	Non-Executive Director Senior Independent Director
Katie Norton	Chief Executive
Sandra Betney	Director of Finance
Richard Cryer	Non-Executive Director
Susan Field	Director of Nursing
Nick Relph	Non-Executive Director
Jan Marriott	Non-Executive Director
Dr Michael Roberts	Medical Director
Graham Russell	Non-Executive Director
Nicola Strother Smith	Non-Executive Director
Candace Plouffe	Chief Operating Officer
David Smith	Interim Director of Human Resources (non-voting)

Changes in Board Composition

There were the following changes in the composition of the board in the year:

Nick Relph joined the Board as a Non-Executive Director in June 2017 (replacing Robert Graves who left the Board in January 2017).

Katie Norton, Chief Executive led the management team through the year, stepping down in April 2018 with the appointment of Paul Roberts.

Tina Ricketts, Director of Human Resources left the Trust in January 2018 and has been replaced by David Smith who takes on the role of Interim Director of Human Resources.

The Trust would like to thank Robert Graves, Katie Norton and Tina Ricketts for their contribution to the development of Gloucestershire Care Services NHS Trust.

Appendix 2: PLACE scores for 2016/17

SITE	Cleanliness	Food	Org Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
National Average %	98.38	89.68	88.8	90.19	83.68	94.02	76.71	82.56
Organisation Average %	98.93	93.85	90.28	97.01	88.59	94.49	87.23	89.01
Org Av. vs Nat Av. %	+0.55	+4.17	+1.48	+6.82	+4.91	+0.47	+10.52	+6.45
Cirencester %	99.42	95.04	90.82	98.84	88.19	93.6	81.95	85.11
Vale %	99.42	94.82	90.01	98.91	94.55	95.59	89.94	91.03
Tewkesbury %	100	88.52	91.09	86.06	87.29	96.99	94.94	93.34
Dilke %	98.98	94.16	89.37	98.77	91.04	97.24	84.08	89.77
Lydney %	98.56	94.22	89.47	98.77	84.38	95.42	88.48	89.47
Stroud %	97.82	94.97	90.01	98.97	88.07	92.57	90.34	89.95
North Cots %	99.28	91.87	91.09	92.88	87.5	93.29	85.15	88.46

The criteria did change again and so a direct comparison with previous results is not possible. The domain relating to disability was an addition to the PLACE schedule for 2016-17, along with a number of wording changes.

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