NHS
Gloucestershire
Care Services
NHS Trust

GCS Trust Board

Thursday 7th June 2018 – 12.30-15:30 hrs

Coleford Community Centre, the Main Place, Old Station Way, GL16 8RH

AGENDA

General Business			Presenter	Purpose
12.30 (guide time)	1/0618	**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)	Chair	To note
	2/0618	**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
12.35	3/0618	**Freedom to Speak Up**	Freedom to Speak Up Guardian	To note
13.00	4/0618	**Minutes of the previous Board Meeting –** held on the 29th March 2018	Chair	For Approval
13:10	5/0618	**Matters Arising Action Log -** matters arising not covered by other items on the agenda	Chair	To note
13:15	6/0618	**Questions from the Public**		To note
Leadership and Strategy				
13.35	7/0618	**Board Assurance Framework**	Chief Executive	To note
13.45	8/0618	**Chair's Report**	Chair	To note and approve
14:00	9/0618	**Chief Executive and Executive Team Report**	Chief Executive	To note
14.15	10/0618	**Learning Disability Mortality Review Update**	Director of Nursing	To note
Quality and Operational Performance				
14.30	11/0618	**Quality and Performance Committee Report**	Committee Chair	To note
	12/0618	**Quality and Performance Report – Month 12**	Chief Operating Officer & Director of Nursing	To note

General Business			Presenter	Purpose
14.50	**13/0618**	**Audit and Assurance Committee update**	Committee Chair	To note
Finance				
15.00	**14/0618**	**Finance Committee Report**	Committee Chair	To note
	15/0618	**Finance Report – Month 1**	Director of Finance	To note
Assurance For Information				
15.10	**16/0618**	**Year End Governance Update**	Trust Secretary	To note
15.15	**17/0618**	**Forward Planner Review**	Trust Secretary	To note
For Information				
	18/06/8	**Items Approved through Delegated Powers and provided for completeness** Annual Report and Accounts		
Other Items				
15.20	**19/0618**	**Any Other Business**		
Date of next meeting – 24th July 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.

Appendix 1

Standing Declarations of Interest

Ingrid Barker	• Board Members and Trustee NHS Providers • Governor Hartpury College • Husband Vice Chancellor Nottingham Trent University • Joint Chair 2gether NHS Foundation Trust
Paul Roberts	• Joint Chief Executive 2gether NHS Foundation Trust
Sandra Betney	• Director Summerhill Supplies Ltd (wholly owned NHS Subsidiary) resigned 12/05/17 • Director FTN Trading Ltd (wholly owned trading arm NHS Providers) • Co-opted member NHS Providers Finance and General Purposes Committee
Richard Cryer	• Trustee Action for Children, Action for Children Pension Fund
Nicola Strother Smith	• Mentor Health & Justice Commissioner NHSE SW
Jan Marriott	• Director Jan Marriott Associates • Independent Co-Chair Gloucestershire Learning Partnership Board • Independent Chair Gloucestershire Mental Health Wellbeing Partnership Board • Acting Independent Chair Gloucestershire Physical Disability and Sensory Impairment Board • Vice Chair Community Hospitals Association • Research Interviewer National Centre for Social Research
Mike Roberts	• GP Partner Rosebank Surgery Gloucester • Rosebank Health is a member of the Gloucestershire GP Provider Forum (GDoc)
Candace Plouffe	• Trustee Active Gloucestershire
Graham Russell	• Chair Second Steps Bristol • Chair Governors Cirencester Deer Park Academy • Wife works at Longfield Hospice

All other Directors have provided a return which is a nil return

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Trust Board Minutes

Date: 29th March 2018

Meeting on 29th March 2018
Cirencester Town Football Club, The Corinium Stadium,
Kingshill Lane, Cirencester. GL7 1HS

Board Members	
Ingrid Barker	Chair (Voting Member)
Susan Mead	Non-Executive Director (Voting Member)
Nicola Strother Smith	Non-Executive Director (Voting Member)
Graham Russell	Non-Executive Director (Voting Member)
Sandra Betney	Director of Finance/Deputy Chief Executive (Voting Member)
Mike Roberts	Medical Director (Voting Member)
Nick Relph	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

Ref	Minute
1/0318	**Apologies and Quoracy** The Chair welcomed colleagues. Apologies were received from Richard Cryer, Non-Executive Director, Jan Marriott, Non-Executive Director and Katie Norton, Chief Executive. The Chair confirmed the meeting was quorate.
2/0318	**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.
3/0318	**Service User Story** Minor Injury and Illness Units (MIIU) – development since 2015. The Matron for MIIU Countywide – Lee Iddles - gave a presentation on how the MIIU service

Understanding You

	had been remodelled following the Care Quality Commission (CQC) inspection in 2015. She advised that it was a service led by Emergency Nurse Practitioners (ENPs) and Paramedics that provided planned and consistent care. She highlighted the significant changes that had been made which included a revised staffing model, revised triage processes, an improved culture of learning from incidents, and planning for the future through education and development, both for the public and staff. The Chair thanked the Matron for MIIU Countywide for her inspiring presentation which had demonstrated clearly how the service had been redeveloped and refocussed to meet the needs of service users. The Interim Director of HR & OD commented that the presentation demonstrated the importance of local leadership and provided an excellent model of how cultural change could be implemented. The Director of Nursing commented that the development had been a significant change for the nursing staff and it was satisfying to see the clear demonstration of improvements that had been achieved. It was confirmed that patient feedback was very positive. The Chair asked the Matron for MIIU Countywide to pass on her thanks to the wider MIIU team and her job-share colleague, Sarah Deo for the work that had been done to remodel the service. 1.50pm Lee Iddles left the meeting.
4/0318	**Minutes of the Meeting Held on 25th January 2018** The Minutes were **APPROVED** as a true record.
5/0318	**Matters Arising (Action Log)** The Board considered the action log and noted the latest position. 10/116 – Minor Injury and Illness Units – Members were pleased to note this issue had been resolved.
6/0318	**Questions from the public** **How many times has NHS Gloucestershire Care Services cited the NHS Constitution in its strategic work over the last 12 months?. If so, in what context has this been cited?** **Response provided:** It has not been possible to establish how many times we have cited the NHS Constitution in our Strategic work over the last 12 months, although we are able to say in what context it has been cited. The Constitution is reflected in almost every element of the Trust's work, including the high quality services we give fair and effective access to, our policies and procedures, and the right to complain or raise concerns and have those concerns and complaints responded to and acted upon. Our Code of Governance published in our Annual Report confirms that we have adopted our own governance framework, which requires Directors and colleagues to

	have regard for recognised standards of conduct, including the overarching objectives and principles of the NHS, the seven Nolan Principles, the NHS Constitution and the NHS Foundation Trust Code of Governance. Some specific examples of the constitution in our work include: • Our Core Values, built upon the principles of the Constitution and presented to all colleagues joining the organisation • Strategically it influences our business plan and there is a statement relating to constitution as a driver in our NHSI draft submission paper considered by the Board this month. • Operationally it drives our KPIs and dashboard with national targets being derived from constitution, although not explicitly referenced • From a governance perspective we review compliance once a year for our certification to NHSI about compliance with license and the constitution is heavily referenced in that paper.
7/0318	**Board Assurance Framework** The Board discussed the latest iteration of the Board Assurance Framework. It was confirmed that the risks relating to workforce were the focus of the Workforce & OD Committee. The Interim Director of HR&OD confirmed the work that had been undertaken in relation to the Workforce and OD Strategy to support this. He stressed the importance of local leadership and ownership to take the agenda forward and the work being done to support this. It was noted that significant actions had been undertaken in relation to supporting the health and wellbeing of colleagues for physical health and that further work needed to be done to support mental wellbeing, recognising there was currently a deteriorating picture in relation to stress. The levels of sickness were noted and it was confirmed that further work was ongoing to reduce these risks. The Board **RECEIVED** the Board Assurance Framework and **NOTED** and **ENDORSED** the risk ratings and the actions being taken to mitigate the risks.
8/0318	**Chair's Report** The Chair formally recorded her thanks to colleagues within the organisation who had worked so effectively through the winter responding to winter pressures, influenza outbreaks and the snow, commenting that their behaviour embodied the Trust's CORE values. The Chair highlighted key aspects from her report: Paul Roberts, Joint Chief Executive, Gloucestershire Care Services and 2gether NHS Foundation Trust, would start on 16th April. He had confirmed that transformation would be at the heart of his agenda. She congratulated Stroud League of Friends on the appointment of the Princess Royal as their Patron. The work being undertaken by the Non-Executive Directors to take the temperature within the organisation, provide a strategic lead and hold the Executive to account. It was noted that Nicola Strother Smith had attended the Gloucestershire Hospitals

	Foundation Trust Board meeting to further develop system understanding. The Board had been provided with an update on the Non-Executive Director portfolios which set out the Non-Executive Directors and Chair's Strategic Intent responsibilities. The Board: (i) **NOTED** the Chair's Report. (ii) **NOTED** the report on the activities of the Chair and the Non-Executive Directors (iii) **NOTED** and **ENDORSED** the Non-Executive Director portfolios which had been amended to reflect the Strategic Intent work. .
9/0318	**Chief Executive and Executive Team Report** The Deputy Chief Executive Officer and Executive Team outlined the key aspects of the report. • Following the Board decision to approve the preferred option to invest in a new community hospital in the Forest of Dean to replace the Dilke Memorial Hospital and Lydney and District Hospital, we are actively progressing the recommendations including the arrangements for the combined panel to consider location; • We are continuing to maintain regular and strong relationships with our regulators, ensuring guidance issued and information requested is provided in a timely way; • There has been considerable work undertaken by our operational teams to support the Gloucestershire urgent care system, with clear evidence of strong system working to manage the severe weather conditions experienced in early March; • We are expecting the outcome of our annual Care Quality Committee Inspection which took place during January and February; • The Trust is continuing to take a lead role in supporting new models for place based working, with proposals now in place to pilot Integrated Locality boards in three areas; • The Trust is continuing to work closely with partners to support the work within Gloucestershire County Council to respond to the Children's Safeguarding OFSTED recommendation, recognising that safeguarding is everyone's business; • There have been some notable individual, team and organisational successes. • The Licence Self-Certification process that would be put in place. Directors were pleased to see that the Delayed Transfer of Care (DTOC) rate had reduced and confirmed they would continue to monitor this. The Board: (i) **NOTED** the report. (ii) **APPROVED** the delegation to the Audit Committee of approval of the annual self-certification in accordance with the requirements of the provider licence in line with the process set in place in 2017.
10/0318	**Business Plan** The Board had been provided with the Business Plan which had been developed in conjunction with the Trust's main priorities and the key deliverables for the One Gloucestershire Sustainability and Transformation Plan for 2018/19, including the One Place One Budget One System Programme centred around the Place Based Model of Care.

	It was confirmed that the Plan reflected the Trust's strategic ambitions and the CORE values together with the key elements of the NHS Constitution. It was confirmed that the Business Plan had been developed with the Operating Plan and budget setting process to assure alignment and affordability of objectives. The Deputy Chief Executive Officer set out the key themes which had been incorporated in the approach. It was noted this was the first year that the business planning process had been used. It was recognised that the Board had been involved in the business planning process through development and committee discussions, and were pleased with the progress and implementation. Graham Russell, Non-Executive Director, queried whether the Business Plan embedded the work with 2gether NHS Foundation Trust as part of the transformation process. The Deputy CEO advised that the objectives of some areas reflected closer working with 2gether NHS Foundation Trust. It was noted that the Business Plan incorporated a balanced scorecard to monitor progress.
Executive	Sue Mead, Non-Executive Director, commented that the report demonstrated excellent progress in implementing the first year of the Business Plan, noting that it would need to be supported by SMART objectives. She queried whether the Quality Priorities should be reflected within the Business Plan. The Director of Nursing commented that, at this stage, it had been considered business as usual, but it was agreed this could be looked at in the Quarter 1 review.
Executive	The Chair commented that the issues raised within the Board Assurance Framework relating to workforce were clearly reflected within the Plan, but queried whether it sufficiently reflected service users. The Director of Nursing suggested that different metrics could be used to measure quality which would ensure service users were appropriately reflected. The Chief Operating Officer commented that this aspect would be developed as the business planning process became embedded with more co-design being reflected. It was agreed that the Business Plan would help to avoid silo working and ensure the Trust's objectives had appropriate focus throughout the organisation. The Board **APPROVED** the Business Plan.
11/0318	**Budget** The Board had been provided with a paper which set out the budget, including the setting process followed during 2018/19. It highlighted the links with NHSI planning, contracting and business planning processes and set out risks and opportunities within the financial targets that have been set for each service and directorate. Budget targets had been established for each service prior to detailed budgeting and business planning exercises to understand how these could be delivered. The report included a year on year budget overview to show the resulting income and cost budgets that are proposed for each service. It was confirmed that the budget reflected the Business Plan. The Board considered the risks that were highlighted within the Budget paper noting in particular the discussions that had taken place relating to the training budget, the Cost Improvement Plan (CIP), potential GCC accommodation charge changes, the milestones

	relating to CQUIN and QIPP, potential pay inflation and cost pressures. The Chair commented positively on the process which had clearly been robust and involved engagement with budget holders which would support deliverability. Nick Relph, Non-Executive Director, confirmed the budget had been discussed at the Finance Committee, providing further assurance on the process and understanding of the risks detailed. Graham Russell, Chair of the Finance Committee, confirmed that the Finance Committee endorsed the process and the budget. The Board: (i) **NOTED** the budget-setting process and linkages within business planning and Cost Improvement Plan (CIP) development processes. (ii) **NOTED** the level of budget holder sign off to date. (iii) **NOTED** the risks within the financial targets**.** (iv) **APPROVED** the summary income and cost budgets set out for each service.
12/0318 **Director of Nursing**	**Director of Public Health Annual Report** The Board welcomed the Annual Report, noting its increased emphasis on prevention. It was agreed that the report was very accessible which was welcomed. However the Board expressed concern that the aspirations and ambitions did not reflect the reduction in the level of financial resources, currently being made by Public Health. The level of financial resources would impact on resources overall which would impact on delivery of the important ambitions for the county for children and young people. It was agreed that the Board's concerns would be formally fed back by letter. It was agreed that it was important that metrics were in place to enable delivery to be monitored effectively. The Chief Operating Officer highlighted the importance of investment in public health nursing and recognised the challenges. It was noted that the data was not place based which made it less easy to target to reflect deprivation indicators. It was noted the report had been well received at the Health and Wellbeing Board. The importance of investing in Children and Young People at an early stage was stressed – given the impact of intervention delivered early. The Board **NOTED** the report.
13/0318	**Staff Survey** The Board had been provided with a detailed report on the outcome of the Annual NHS Staff Survey. It was noted that the survey had been conducted between October and December 2017, with the results published on 6th March 2018. It was recognised that the results for GCS had been disappointing, with the progress that had previously been made being largely arrested in 2017. It was recognised that there were national challenges in relation to Workforce and Engagement, but considered that the variability of the results demonstrated that local (Trust wider factors) were impacting on the results. The paper outlined planned

	responses to the staff survey outcomes, which will incorporate a corporate leadership plan, but also local action plans given the local variability. It was noted that the Trust response rate had dropped from 47% to 44% and that of the 88 questions actions scores on 18 had improved, 20 had remained static, with a decline on the other questions, although not all of the movement was statistically significant. The paper also set out the Trust's progress against the Workforce Race Equality Scheme (WRES) which demonstrated BME staff reporting a better employment experience than their white colleagues. It was confirmed that the Trust was taking the Staff Survey outcomes extremely seriously, and that work would be undertaken with the Workforce & OD Committee to ensure the required action plans were in place. It was confirmed that the CORE leadership team had considered the results and also been provided with support on the development of action plans. It was noted that the results showed a disconnect with the findings of the CQC and the Board was advised that Staffside had also recognised this disconnect. Nick Relph, Non-Executive Director, commented on the need for champions to spread good practice and it was confirmed that the Trust had the processes to put this in place. The Board considered the work that also needed to be done in relation to supporting colleagues with disabilities. It was confirmed that work on this had started. Nicola Strother Smith queried whether the results reflected that Listening Into Action had been less visible over the last year. It was noted that this was an issue that would be explored further. The Board: i) **NOTED** the key results from the 2017 Staff Survey ii) **AGREED** the twin approach of localised action plans supported by corporate led priorities iii) **AGREED** that oversight of the plan be scheduled into the Plan for the Workforce & OD Committee.
14/0318	**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: • Recognition that the Trust had now experienced its Care Quality Commission (CQC) inspection and is awaiting their draft report. • Assurance that the Trust 2017-18 Quality Priorities continue to progress into Qtr. 4 and that any risks associated with improvements are aligned to the Trust's strategic risk register. • The recommendation to agree the Trust's 2018-19 Quality Priorities.

Director of Nursing	• Recognition that the Trust has over-achieved over 15% for the first time. • Assurance that the Trust has progressed with the reporting of more timely performance and quality data. The Chair of the Quality and Performance Committee, Sue Mead, highlighted the progress being made in relation to the Trust's quality priorities including falls, but noted that pressure ulcers remained an issue where further work was required. It was confirmed that a detailed piece of work was now being undertaken using a random sample of pressure ulcer cases to consider causation and what could have prevented the pressure ulcers occurring. The Director of Nursing confirmed this report would be presented to the Quality and Performance Committee. The Chair recognised the good work that was ongoing within the Trust and the progress that had been made in a number of areas. The Board considered the recommended Quality Priorities, noting that these focused on areas where further work was required. The Board: (i) **NOTED** the contents of the Quality and Performance Committee report. (ii) **RECEIVED** the approved minutes of the Quality and Performance Committee held on 19th December 2017 (iii) **APPROVED** the Quality Priorities for 2018/19.
15/0318	**Quality and Performance Report – Month 11** The Board had been provided with the Quality and Performance report for February 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 care was being maintained. The report highlighted in particular the improved level of mandatory training compliance, which was currently at 86% with 5 areas achieving 92%. It was noted that there was continued focus on three priority areas: information governance, moving and handling and resuscitation training. It was confirmed that focus had been maintained on reducing Delayed Transfers for Care to ensure patients were not subject to a longer patient stay than was clinically necessary. It was noted that completed PDRs for all colleagues was 87.6% (90.8% for colleagues within the active assignment category). It was noted that work continued in relation to the safety thermometer and the MSKAT service which was improving, but still below target. Nick Relph, Non-Executive Director, queried what further work was required to improve the MSK performance. The Chief Operating Officer confirmed the action plan in place and advised that the February performance had been significantly better than January. It was noted that vacancies were impacting on speech and language and podiatry performance. Graham Russell, Non-Executive Director, commented that the report format and style was

Trust Secretary	very helpful in enabling the Board to focus on areas of concern. He queried how information was communicated within the organisation to support cultural change, which would be required to support the work highlighted by the staff survey. The Director Nursing commented that the CORE colleague leadership network was a key element of dissemination of information and confirmed that success and issues were discussed by the group. The importance of celebrating good performance was highlighted and it was agreed this should be considered by the Executive for the CORE colleague network. It was agreed that the Board would reinstate updates on its activities as part of the improved communication. The Board **NOTED** the report.
16/0318	**Workforce and Organisational Development Committee Update** This report provided assurance that the Workforce and Organisational Development (OD) Committee was discharging its responsibility for oversight of the Trust's Workforce and OD Strategy on behalf of the Board. The Board was updated on the work of the Workforce & OD Committee. It was noted that the February Committee had confirmed that continuing good progress was being made in relation to statutory and mandatory training compliance and that the Trust was actively working to address sickness absence. It was noted that additionally the Committee had considered progress against the Workforce & OD priorities and endorsed an updated implementation plan. The Committee had also considered an update on the equality survey and approved recommendations to be incorporated into a wider action plan. The Board **NOTED** the report.
16.1/0318	**Workforce Gender Pay Gap Report** The Board had been provided with a Gender Pay Gap analysis of the Trust workforce data at 31st March 2017. It was noted that when the Workforce & OD Committee next met it would review the data in more detail. It was noted that gender pay reporting legislation requires employers with 250 or more employees to publish statutory calculations every year showing how large the pay gap is between their male and female employees. The Trust is required (as a public sector organisation) to publish this information by 30th March 2018 on both the Government website and the Trust's public facing website and was on track to meet this requirement. It was clarified that gender pay reporting is different to equal pay. Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs, or work of equal value. It is unlawful to pay people unequally because they are a man or a woman. The headline focus is on the gender pay gap as a mean average. The Trust's data suggests that on average female employees are paid 10.91% less than male colleagues. The initial review suggested that this is primarily a result of higher levels of male colleagues appearing in the upper quartiles and illustrated specifically through the gender make up of certain staff groups. It was confirmed that the Trust's focus must be on removing/minimising any gender pay gap unless there is an objective justification for such a gap. It was noted that it was planned that the analysis is repeated immediately after the 31st March 2018 to track movement between the required 'snapshot date' set by the government and the Trust's current position and that a deeper dive into the specific staff groups identified be undertaken. It was confirmed that the comparative analysis will be presented to the

Interim Director of HR & OD	Workforce and OD Committee at the June meeting. The Board considered the proposed statement and agreed that the Executive should revise this to demonstrate more clearly the Board's active commitment to this agenda. . The Board: (i) **NOTED** the current report and agree to ongoing scrutiny of current data via the Workforce and Organisational Development Committee. (ii) **AGREED** to publish this report on the Trust website with a link to the government website. (iii) **AGREED** to delegate to the Executive the finalisation of the statement that will be published on the Trust website and via the government website.
17/0318	**Finance Committee Report** Graham Russell, Non-Executive Director and Chair of the Finance Committee, introduced the report highlighting that the Committee had considered the Month 10 Finance Report; Budget Review – Urgent Care, 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 and also considered a number of confidential issues. The Board **NOTED** the update from the Committee.
18/0318	**Finance Report – Month 11** The Director of Finance introduced the report which provided an overview of the Trust's financial position at month 11. Of particular note the Board considered the forecast full year position and how different elements of STF income have been treated ("base" STF of £1,020k and "incentive" STF of £900k are both included but no "bonus" STF is in forecast as the value is unknown until April 20th. The Board agreed that the position was looking strong for the outturn for 2017/18. It was confirmed that the Trust expected to meet its planned capital expenditure. It was noted that there was to be a detailed presentation on asset valuation following the Finance Committee in April. The Board **NOTED** the report.
19/0318	**Audit & Assurance Committee - update** The Board was provided with an update on the work of the Audit & Assurance Committee at its meeting in February. It was noted that key issues considered had been Internal Audit reports and External Audit planning. It was noted that a detailed review of the Governance Framework had been undertaken the previous year and that at this time there were no significant issues identified to be amended within the framework. The Committee had also endorsed the Annual Health and Safety Report; the Freedom of Information Publication Scheme and the Records Management Audit Plan. It was noted that the Committee would receive an update on GDPR at its next routine meeting.

	The Board **NOTED** the Audit and Assurance Committee update and the Minutes from 6th December 2017.
20/0318	**Forward Planner Review** The Board considered the Forward Planner The Board **NOTED** the forward agenda planner.
21/0318	**Any Other Business** There being no further business the Chair closed the meeting at 4pm.
22/0318	**Date of Next Meeting in Public** It was agreed that the next meeting of the Board be held on 7th June 2018.

Chair's Signature:

Date:

TRUST PUBLIC BOARD: PUBLIC SESSION - Matters Arising Action Log – 7 June 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
16/1116	Finance Report Month 6	**Gloucester Hub –** To be progressed by the Board.	Chief Operating Officer	Revised date May 2018	Gloucester Hub discussions complete LM CHECK CEO REPORT	
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 Qtr 1	Executive	September 2018	Business Plan Monitoring being scheduled.	
10/0318	Public Health Annual Report	**Concerns to be formally fed back to Director of Public Health** regarding the ambitions did not reflect the reduction in the level of financial resources.	Director of Nursing	September 2018	Issues raised with Director of Public Health by Director of Nursing and also by Deputy Head of Children and Young People's Services.	
14/0318	Quality and Performance Committee report	Detailed piece of work to be completed and reported back to Quality and Performance Committee regarding Pressure Ulcers	Director of Nursing	June 2018	Closed –Report sent to Quality and Performance Committee on 26th April 2018	

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Agenda Item 06

Questions from the Public

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Trust Board

Date of Meeting: **7th June 2018**

Report Title: **Board Assurance Framework**

Agenda reference Number	07/0318
Accountable Executive Director (AED)	Chief Executive
Presenter (if not AED)	
Author(s)	Gillian Steels – Trust Secretary
Board action required	To Receive and Review
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.

Actions not yet completed have been rolled forward for 18/19. 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.

The report incorporates an update against deliverables for 17/18 as well as adding in proposed deliverables for 2018/19.

While there continues to be progress against the actions to mitigate the strategic risks, the BAF highlights a number of areas where internal capacity and/or changes in the external context are impacting on our ability to achieve our target risk position.

The Executive have highlighted the following as areas where the risk continues to be significant. The following risks continue to be areas of focus:

Understanding You

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.

The staff engagement issues which were reported at the March Board continue to be the subject of local and corporate focus. The Chief Executive has put colleague engagement at the heart of his first hundred day plan, as set out in his report. A number of actions relating to these risks are identified within the Trust's CQC Quality Improvement Plan and will be monitored through this mechanism and the position additionally updated through the Board Assurance Framework.

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

Recommendations:
The Board is asked:

1) **RECEIVE** the BAF
2) **REVIEW** the current risk position and actions being progressed
3) **NOTE** and approve the deliverable position achieved for 2017/18 and plans for 2018/19.

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

Board Assurance Framework:

June 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**	**16**	**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 lead on, and invest in, transformation to secure long term sustainability of services; resulting in inability to sustain quality and compromising year on year cost improvement.	⇔	D of F	Finance	20	20	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**	May 2018
Current Risk Score	3 x 4 = 12	**Date Next Review**	July 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 to be launched and feedback mechanisms built in.	Chief Executive	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

CQC, NHSI, Well Led Framework, Single Oversight 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**	May 2018
Current Risk Score	3 x 4 = 12	**Date Next Review**	July 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 [2]gether NHS Foundation Trust	Will now be part of wider discussion with [2]gether 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 to be identified and Programme to be implemented	CEO/Chair	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**	May 2018
Current Risk Score	3 x 4 =12	**Date Next Review**	July 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			
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**	May 2018	
Current Risk Score	3 x 3 =9	**Date Next Review**	July 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[2g]ether 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	Ongoing
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	IIDHR&OD&OD	October 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**	May 2018
Current Risk Score	4 x 4 = 16	**Date Next Review**	July 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	September 2017
2	Clear progression pathways for clinical colleagues	Talent management programme to be developed to be undertaken jointly with ^{2}gether NHS Foundation Trust .	Head of OD	September 2018
3	Process to learn from exit interviews	To be triangulated against latest staff survey information March/April 2018 and discussed at June Workforce Committee	Head of HR	July 2018
4	Ensure CQC Must dos in relation to mandatory training and PDR compliance are achieved	CQC Improvement Plan achieved with timeliness.	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**	May 2018
Current Risk Score	3 x 4 = 12	**Date Next Review**	July 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 caputerd through Transformation strand of work with 2gether NHS Trust	COO	Oct 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.	COO/DoN	Sept 2018
3**.**	Skills for Co-production require further development	Co production development of teams to be undertaken	COO	September 2018
4	Service audits to be reinstated.	Service audits to be reinstated and monitored for impact	COO	September 2018
		Increase use of “You said We did” feedback 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**	May 2018
Current Risk Score	3 x 3 = 9	**Date Next Review**	July 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	Trust Secretary	July 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	Dir HR	July 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	July 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	June 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**	May 2018
Current Risk Score	3 x 4 = 12	**Date Next Review**	July 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.	CEO	September 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**	March2018
Current Risk Score	3 x 4 = 12	**Date Next Review**	June 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	July 2018

		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	Oct 2018
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	Nov 2017 July 2018 Nov 2017 **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	3 x 4 = 16	**Date Identified**	April 2017
Previous Risk Score	3 x 4 = 12	**Date of Review**	May 2018
Current Risk Score	2 x 4 = 16	**Date Next Review**	July 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	Discussed at Board Summit – agreed area of focus for Interim Director of HR	Head of OD	July 2018
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	July 2018
3	Staff Engagement Framework	Review Staff Engagement Framework to ensure embedding of CORE values and LiA – through development of a "quality Academy"	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**	March 2018
Current Risk Score	4 x 4 = 16	**Date Next Review**	June 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	Indepemdent
Mental health first aid training	CQUIN	Indepemdent
Stress management workshop, including mindfulness and resilience.	CQUIN	Indepemdent
Stress management policy	Annual staff survey results regarding the organisation taking positive action on H&W.	Indepemdent

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	Head of OD	July 2018
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 & Review ongoing**	IDHR&OD	Dec 2017 May 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 in development	IDHR&OD Heads	July 2018
4	Ensure CQC Must dos in relation to mandatory training and PDR compliance are achieved	CQC Improvement Plan achieved with timeliness.	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.	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**	Mary 2018
Current Risk Score	4x 4 = 16	**Date Next Review**	July 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	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.	Head of OD	July2018
3	Managers induction	Managers toolkit and induction delivered	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**	May 2018
Current Risk Score	3 x 4 = 12	**Date Next Review**	July 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 lead on, and invest in, transformation to secure long term sustainability of services; 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**	May 2018
Current Risk Score	4 x 5 = 20	**Date Next Review**	July 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 **NHSI Single Oversight Framework** **CQC – Well led**				

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**	May 2018
Current Risk Score	3 x 3 = 9	**Date Next Review**	July 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	July 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	TS/Board/Silg	Sept 2018
3	Up to date Board development programme to support understanding of roles and appreciative enquiry	Board Development Programme implemented	Chair	June 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. **Actions to date –** process ongoing.	TS	June 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 NHSI on implementation date for Community Trusts. Actions to date shared with 2gether.	DoF	Sept 2018

		Timely Actioning of EA and IA – follow up process embedded	DoF	June 2018
		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

RI S K R A T I N G M A T R I X

	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: 7th June 2018

Report Title: Chair's Report

Agenda reference Number	08/0618
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

The Report provides an overview of Chair and 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

Chair's Report

1. Introduction and Purpose

This report seeks to provide an update to the Board on Chair and Non-Executive Director activities 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

Additionally I am formally recording the outcome of our recent CQC inspection.

2. Care Quality Commission Outcome – Spring 2018

With colleagues from across the Trust, I am absolutely delighted that the Care Quality Commission confirmed our overall rating as Good, following inspections in January and February 2018. At our last inspection in 2015 we received a 'Requires Improvement' rating, so it is heartening that the efforts of my colleagues to make improvements and deliver safe, effective care have been acknowledged. Of course, we are restless for excellence, so our sights are now set on working towards Outstanding!

I am 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.

3. Strategic Intent Update – Moving Towards Developing an integrated Physical and Mental Health Care Offer with 2gether NHS Foundation Trust

Joint Chief Executive Officer

Following the last Board meeting where I updated on the appointment of Paul Roberts as the Joint Chief Executive for 2gether NHS Foundation Trust and Gloucestershire Care Services I am delighted to welcome Paul formally to the Trust. Since 16th April Paul has been active in getting to know the organisations and the wider health care system partners and is already helping to shape how we work going forward.

Governance Arrangements

The Strategic Intent Leadership Group and Programme Management Executive Group, which are supporting our joint working plans, continue to meet regularly and

a range of stakeholder activities have now started to take place to help inform and shape our thinking. These include recent events in the Guildhall Gloucester and the Kindle Centre Hereford, which will be built on through the months ahead. Both Paul and I are committed to ensuring that as we move from Intent to Action that the needs of our service users are the heartbeat that drives transformation throughout the organisations.

Regular briefings to update colleagues on the Strategic Intent activity has continued.

A Joint Board Seminar event took place in April.

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:

- NHS Providers Board in London on 2nd May
- Gloucestershire Strategic Forum 24th April
- Health and Social Care Overview and Scrutiny Committee meeting on 8th May
- Health and Wellbeing Board on 15th May

Along with Chief Executives and Chairs from across England Paul and I attended the newly launched Community Trust Network which will help ensure the Community Trust voice – and the communities we serve - is heard at a national level and can inform policy.

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A r**egular meeting of the Health Care Overview and Scrutiny Committee (HCOSC)** took place on 8th May 2018. This included an informative presentation by the Non-Emergency Patient Transport Service, patient transport is key to effective system working and it was helpful to gain a greater understanding of their processes and challenges. The Public Health Annual Report was formally presented and welcomed by members. The Committee was also updated on the work of One Gloucestershire, the Gloucestershire Clinical Commissioning Group, Public Health and Adult Social Services.

Gloucestershire Health and Wellbeing Board met on 15th May 2018. This was a development session which gave the opportunity to review the current Gloucestershire Health and Wellbeing Strategy and consider areas for improvement based on reflections by the group and peer review challenge. It was a helpful and honest session focusing on the core role of the group to improve the Health and Wellbeing of the people of Gloucestershire.

We were pleased that Jeremy Hunt, Secretary of State for Health, was recently able to visit Stroud Hospital to present his thinking on patient safety and meet colleagues who are providing compassionate care.

3. Working with the Communities and People We Serve

I enjoyed attending the Learning Disability Big Health and Social Care Open Day on 22nd May which provides an excellent forum to increase understanding of services and opportunities available to support those with Learning Disabilities in our community.

Colleagues on the Board and I received briefings from Malcolm Oswald on Citizen's Jury, and the process which will be used in the Forest as part of the Forest of Dean Community Hospitals Review. Continuing the engagement with the Forest Community remains central to this work.

I was pleased to be invited to be a key note speaker at the FestivAll event at Gloucester Cathedral. This was an event for people to learn more about local community and statutory organisations to promote inclusive communities – an agenda I am passionate about to help reduce inequalities, particularly health inequalities, across the area we serve.

A quarterly meeting with the **League of Friends Chairs** was held on 29th May. The support the Leagues of Friends provide to enrich the experience of service users and colleagues is much appreciated. Our congratulations are extended to Stroud League of Friends on securing the Princess Royal as its Patron.

In April executive colleagues from both GCS and 2gether NHS Foundation Trust and I gave a presentation to the Women's Institute on Mental Health as part of our work to raise the profile of mental health across the breadth of our community. Particular thanks are due to Katie Parker, Community Partnership Manager for fostering this link.

4. Engaging with our Trust Colleagues

Celebrating You Colleague Awards – I was delighted to celebrate the outstanding work of Trust colleagues at our recent Celebrating You Award Ceremony. This was a fantastic opportunity to showcase the way colleagues go the extra mile to support service users and other colleagues. I was pleased that so many colleagues were nominated and were able to attend the event. The Awards are based around the Trust's Vision and CORE values and additionally this year also included **Trust Champion Awards**

- Achievement Award
- Partnership Award
- Innovation Award

to recognise individuals that were real advocates and ambassadors for the Trust.

I continue to meet regularly with Trust colleagues at GCS and 2gether NHS Foundation Trust and visit services at both Trusts to inform my triangulation of information. As part of this process in April I met with the Freedom to Speak Up Guardians for both Trusts and was pleased to confirm that each Trust has in place a commitment to openness and candour which has ensured that national expectations for these roles is reflected in the ways we are already working. I was also pleased to undertake a quality visit on 6th June to a Spotlight on Safeguarding Children conference. This is a key area where the Trust works across organisational borders to help safeguard the vulnerable children in our community.

6. NED activity

Since my last Board report the Non-Executive Directors (NEDs) held one meeting at Stroud Hospital. This was the first of a new way of working, with the meeting incorporating a joint session with the NEDs from GCS and 2gether NHS Foundation Trust. Regular meetings at GCS and 2gether services/hospitals will continue to be held throughout the year.

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

- Attendance at Trust Board, Committees and Board Development
- Appraisals with Chair (Jan Marriott and Sue Mead)
- Chair's Appraisal
- Celebrating Colleagues at the Understanding You Awards
- Strategic Intent Leadership Group (SILG) meetings (Sue Mead and Graham Russell)
- Clinical Reference Group (Jan Marriott)
- End of Life Quality Improvement Group (Nicola Strother Smith)
- Opening of Pullman Place – 2gether NHS Foundation Trust Service Centre (Richard Cryer and Nicola Strother Smith)
- NED Meeting
- Quality Visit to Lydney Hospital – Complex Leg Wound Service – Nicola Strother Smith
- Volunteer Strategy Group (Nicola Strother Smith and Jan Marriott)
- Mortality Review Group meetings (Jan Marriott)
- Citizens Jury Briefing (Nicola Strother Smith, Richard Cryer, Jan Marriott)
- HFMA Forum – Integrated Care – Workforce (Nick Relph)
- Learning Disability Big Health and Social Care Open Day (Richard Cryer)
- Quality Visit Stroud Hospital (Graham Russell)
- Quality Visit Podiatry Department, Lydney Health Centre (Richard Cryer)
- Meeting re Podsmead Regeneration (Graham Russell)
- Quality visit with Childen's Health Visiting team (Jan Marriott)
- NHS Parliamentary Awards with Richard Graham MP (Nicola Strother Smith)

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

I would also like to formally welcome Bilal Lala to the Trust as the next individual attached to the Trust through the Insight Programme which was developed by Gatenby Sanderson to help tackle the barrier of lack of NHS experience from aspiring Non-Executive Directors, with the impact being felt more among candidates from a BAME background, female or disabled. The Trust Board recognises that diverse boards help ensure services reflect the needs and experiences of the people they serve, leading to more effective decision-making and are pleased that Bilal will be attending the Board as part of his development, building on the experience he gained at an acute Trust in Somerset.

7. Conclusion and Recommendations

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

NHS
Gloucestershire
Care Services
NHS Trust

Trust Board

Date of Meeting: 7th June 2018

Report Title: Chief Executive and Executive Team's Report

Agenda reference Number	09/0618
Accountable Executive Director (AED)	Not Applicable
Presenter (if not AED)	Paul Robert – Joint Chief Executive
Author(s)	Paul Robert – Joint Chief Executive
Board action required	Note
Previously considered by	Not Applicable
Appendices	

Executive Summary

The Report provides an overview of the Chief Executive's focus, system and policy changes and an operational service update which highlights recent activity to meet the needs of our community.

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. Commencement and induction

I am delighted to have taken up my post as Joint Chief Executive of 2gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust (GCS) on 16th April. I am delighted to be attending my first public meeting of the Board of Directors, I have already attended number of informal meetings of Board Members jointly with 2gether NHS Foundation Trust..

I have been made very welcome by Trust colleagues and have commenced a 100 day programme of induction and clarifying the programme management and timescales for the proposed merger between the two Trusts. A high proportion of my time is being spent visiting front-line services in both organisations and I have already been struck by the professionalism and commitment of colleagues across the organisation and in the pride that they take in the delivery of, in many cases, outstanding services. I am grateful to the Executive Directors, and in particular to Deputy Chief Executive Sandra Betney, for the support they have given me by continuing to lead the Trust on a day to day basis to allow me to do this.

2. Progress on the strategic intent to merge with Gloucestershire Care Services NHS Trust (GCS)

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 2gether 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.

Progress has been made through the Strategic Intent Leadership Group (SILG) and the Programme Management Executive with establishing programme management arrangements for the merger and developing a detailed Programme Plan.

Both deputy Chief Executives: Colin Merker and Sandra Betney reporting to me, SILG and to both Boards have taken significant roles in progressing key aspects of the programme and Philip Baillie has taken up the post of integration programme director.

As I am finalising this report we will be sharing an outline timetable for the merger programme with the wider organisation and with key partners together with summary descriptions of the two organisations to aid wider mutual understanding of our roles.

In April two leadership events were held for clinical leaders and senior managers across both Trusts to start the detailed process of exploring and realising the opportunities to benefit from the close integration of physical and mental health services. On 29th May a further event was held with partner organisations and service user representatives to explore the same issues and shortly a programme will be commenced that engages a wide range of interested partners in developing the service strategy for a an integrated organisation. It is envisaged that Board members will participate in this programme to inform strategic decision-making.

3. CQC Comprehensive Inspection of Services – Good Rating

As detailed in the Chair's report GCS was delighted to receive a rating of Good following the CQC inspection in Spring 2018. The assessment recognises the dedicated work of colleagues across the Trust – confirming that GCS is an excellent position to take forward its plans with 2gether NHS Trust with a secure foundations in place. The full report is available on the CQC website

https://www.cqc.org.uk/news/releases/cqc-inspectors-rate-gloucestershire-care-services-nhs-trust-good

4. Carter Mental Health Community Services Work

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 (as this report was being finalised).

2gether NHS Foundation Trust was asked to be part of the Lord Carter review as a "high performing" Mental Health Trust. The Trust has participated in a number of significant work programmes relating to staffing and/or clinical practice, as well as having returned a wealth of data relating to the full operational and strategic delivery of our services.

An initial review of the report indicates a number of key themes which will need to be reviewed over the coming months by 2gether NHS Foundation Trust many in conjunction with Gloucestershire Care Services NHS Trust as part of our joint work on merger. These themes include: clinical and workforce productivity, estates rationalisation, extending the "Getting It Right First Time" Programme into community and mental health services, standardised commissioning frameworks, improved procurement and the development of further plans for use of technology and mobile working.

5. "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.

6. National issues

At the joint meeting between NHS England and NHS Improvement last week further details were announced of the increased joint working between NHS England and NHS Improvement. The two organisations will share a number of Board level roles and "the focus of decision-making will be centred more on regional directors" with the appointment of seven new joint regional teams. The South West Region (incorporating Gloucestershire) remains the same with the establishment of a new region for the Midlands as a whole (incorporating Herefordshire).

At the same meeting an outline proposal to establish an "NHS Assembly" to oversee the continued implementation of the Five Year Forward View and the co-design a new ten-year plan was also agreed. The Assembly will be drawn from national clinical, patient and staff organisations, partner sectors and NHS bodies and partnerships.

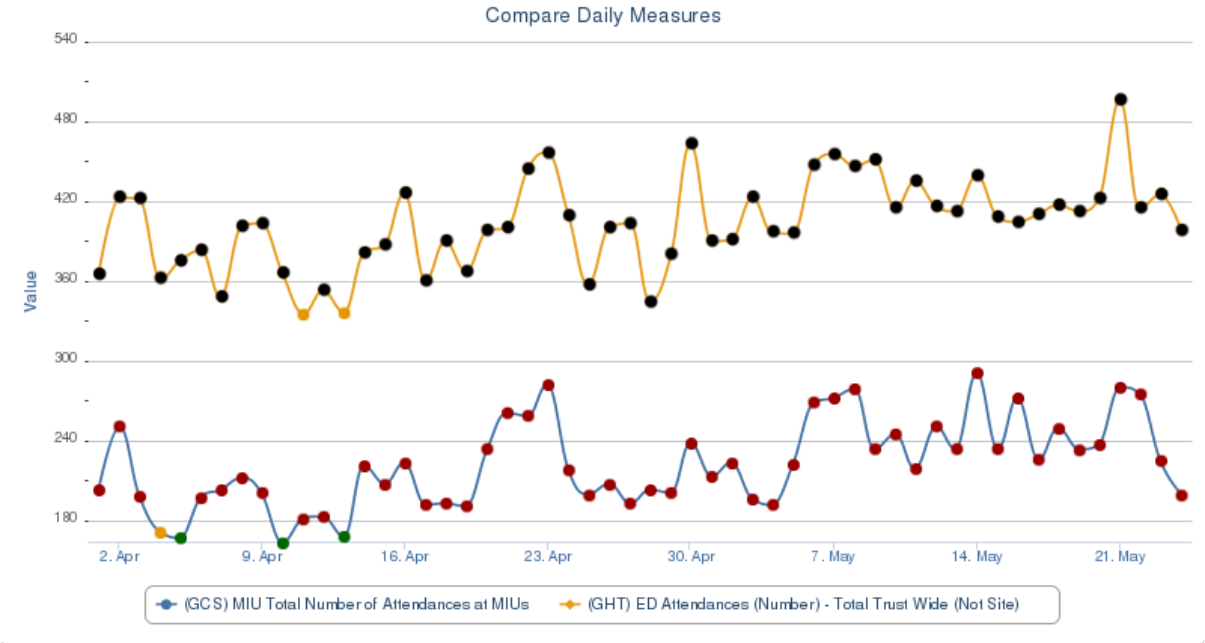
7. Operational Service Overview

7.1 System flow and Resilience

Gloucestershire urgent care system continues to experience high levels of demand, and this is translating into extraordinary attendances at both the A&E departments (on average 388 in April) and our Minor Injury and Illness units (on average 207 in April).

Over the first three weeks in May this has risen, with an average attendance at A&E departments of 422 (with the highest day of 496 attendances on the 21st May) and an average attendance at MIIUs of 241(with the highest day of 291 attendances on the 14th May).

The reason for the high attendances has been investigated, and to date there does not seem to be any specific reason for this change in demand.



Partnership working continues to be strong in Gloucestershire and focussed work across the system is ensuring we deliver the agreed performance and a high quality, safe service for patients.

As a result, despite the high level of attendances, the performance on the 4 hour A&E target continues to be strong, with April performance at 91.98%, and second highest performer in the Southwest. The week ending 29th April saw the best performing week at 95.13%.

This system working has been **recognised nationally**, and on the 23rd May, the Urgent care task workforce had a visit from a team of colleagues from NHSE central to learn what we have implemented to improve patient flow in the system. They were particularly complementary about the collaborative problem solving, determination to improve and the ability to for the system to recover performance quickly.

For the Trust, the community hospital bed occupancy for April has reduced to 93.2% and just above our target of 92%.

The Delayed transfers of care (DTOC) across the system remains low at 2.3% for the last reported position of 31st March. For the Trust the DTOC rate for April was 1.4%, with an average of 3 patients per day experiencing a delayed transfer of care.

Length of stays in April for direct admissions was 21.4 and for transfers from the acute trust stays were 30.1 days.

Recent reviews of length of stays has highlighted that bed modelling completed we have a substantial number of patients who are in our hospital beds over 30 days, and a small cohort over 50 days. Work is underway to understand and reduce this, recognising the detrimental impact of long stays on patient's independence and likelihood to be able to return to their normal place of residence.

7.2 Operational Service Development and Challenges

7.2.1 Timely Access to Services:

April performance has seen improvement across the 6 therapy service areas in which timely access has been an ongoing challenge. Detailed action plans are in place and being monitored regularly.

Podiatry services has met their key performance indicator for 2 consecutive months, and although MSK physiotherapy has dipped to 91.4% after a strong performance in March, it is anticipated that they will recover in May.

Musculoskeletal Clinical Assessment and Treatment Service has shown significant improvement, with performance at 95.8% up from 85.6% in March.

Although Adult speech and language therapy service be performing below local access target (60.7% in April) this has shown a significant improvement from March

performance (41.9%) indicating the actions undertaken to recover is having a positive impact.

Adult Physiotherapy and Occupational therapy in the Integrated Community teams have both shown a slight dip in April performance, with average waits improving in Occupational therapy and deteriorating in Physiotherapy. As a result the action plan is being reviewed, and recovery trajectories agreed with Commissioners, particularly for Occupational therapy as it implements a new care model following the Commissioner service review.

Despite this it is important to note that all of three most challenged services (Adult Speech and Language, ICT therapies) have **all achieved the national 18 week referral to treat target.**

To support strong performance a number of Operational service leads have been put forward for the **NHS Improvement's Demand and Capacity Trainer programme**. This is a free, accredited, six-month programme designed to support organisations to develop internal capability and skills in demand and capacity modelling.

The approach is designed to equip staff to train others in demand and capacity and thereby spread this knowledge more widely at a local level. It is anticipated that this will result in local areas being better equipped to develop credible activity plans that support the delivery of reduced waiting times for patients.

7.3 Estate Development

7.3.1 Progress with Community Health Services Hub – Gloucester Locality

A long term lease has been signed for Southgate Moorings, which is the current location of the Trust's community dental service. The lease includes additional space which will accommodate a number of the countywide specialist services that are currently dispersed across Gloucester, including in Edward Jenner Court.

This includes those services based at Gloucester Royal Hospital following a request from Gloucestershire Hospitals Foundation NHS trust to vacate the current space occupied by Podiatry and Adult Speech and Language therapy. Those teams in which the Trust is subcontracted to provide inpatient services will continue to be based at the hospital, along with the Sexual Health services based at Hope House.

Work continues on the Gloucester and other locality estates plans, which is now being developed within the context of the strategic intent to merge with the ^{2}gether Foundation NHS Trust.

7.3.2 Progress with Community Hospital Proposal – Forest of Dean Locality

Trust Board and Gloucestershire Clinical Commissioning group governing body members received a briefing on the 10th May from Malcolm Oswald, Director of

Citizens Juries CICC on the process and progress in creating a Citizen's jury to support the determination of the location for a new Community hospital in the Forest of Dean.

A number of applicants have registered their interest in being part of the Citizen's jury which will comprise of 18 individuals, comprising a cross-section of adults from across the Forest of Dean District. The Citizen's jury will meet for four-and-a-half days from 13.00 on Monday 30 July to 17.00 on Friday 3 August.

To support the Citizen's Jury work, a 6 week public engagement exercise began on the 21st May, to hear from the residents of the Forest of Dean their views on the location of a new community hospital i.e. in or near Cinderford, Coleford or Lydney.

Public Drop In Sessions have been arranged across Forest venues, an engagement booklet has been produced, which includes a freepost survey, and an online survey.

The Outcome of Engagement Report will be presented to the Citizens' Jury members. This Report, together with the recommendation from the Citizens' Jury, plus further travel, transport and equalities analysis, which will have also been presented to the Citizens' Jury, will all be taken into account by the Board of GCS and the Governing Body of GCCG when they meet in August 2018.

7.3.3 Integrated Community Teams Bases – Focus on Cheltenham Locality

Discussions are underway with Gloucestershire County council concerning the accommodation for the Integrated Community teams in all localities. Both health and social care colleagues are currently co-located, however this is being reviewed due to change in the charging approach by the council.

The most pressing need has been in relocating the Cheltenham ICT, and unfortunately it has not been possible to accommodate the team in one location, with health colleagues using the Independent Living Centre as their primary base, and social care colleagues based in a location on St George's road. The impact of this change is being closely monitored, to determine the impact on the delivery of integrated care. This also includes a separation in the locality referral centre, which is the first point of contact into the team and benefits the most from co-location in responding in an appropriate and timely way to service users needs.

8 Partnership Working

8.1 Supporting Primary Care Improved Access in Localities

Gloucestershire primary care has implemented Improved access to their services, and now provide both routine and urgent care GP appointments 8:00 – 8:00 pm, and Saturday mornings.

Both the South and North Cotswolds GP clusters have expressed an interest in exploring how GCS can better integrate and align our Minor Injury and Illness services with this improved access initiative.

This work is being considered alongside the One Gloucestershire Sustainability and Transformation plan (STP) work on transforming the Integrated care service for the county, and mindful of the NHS England July 2017 published guidance on the creation of Urgent Treatment centres nationally.

NHS England's aim with the development of Urgent Treatment centres is to end the confusing mix of Urgent Care Centres, Minor Injury Units and Walk-in Centres by standardising opening hours and improving access to diagnostic tests. The aspiration is to have 150 urgent treatment centres by December 2018, and by December 2019, all designated urgent treatment centres will be required to meet the guidelines issued.

8.2 Proposal to improve Specialist Stroke Rehabilitation Services

As part of the One Gloucestershire STP Clinical transformation work, the Trust has been involved with system provider partners in reviewing the type and level of rehabilitation offered to individuals who have experienced a stroke. This follows on from the previous commissioned review done in 2015.

A revised clinical pathway has been designed, and will be presented to the Health and Social Care Overview scrutiny committee in July. The proposal is to increase the level of rehabilitation services available in the community, to ensure the best change of recovery for individuals following a stroke.

Trust Board

Date of Meeting: 7th June 2018

Report Title: Learning Disability Mortality Review (LeDeR) Programme

Agenda reference Number	10/0818
Accountable Executive Director (AED)	Susan Field, Director of Nursing
Presenter (if not AED)	
Author(s)	Susan Field, Director of Nursing Clare Hicks, Specialist Nurse Safeguarding Adults
Board action required	To Note and Receive
Previously considered by	One Gloucestershire LeDeR Steering Group (May 2018)
Appendices	Appendix 1 – One Gloucestershire LeDeR Performance to date

Executive Summary

The LeDeR programme across Gloucestershire is led by the University of Bristol and was established to support local areas such as "One Gloucestershire" to review the deaths of people with learning disabilities (LD); identify learning from these deaths and; take forward any learning into any service improvement agenda's. The national 2017 LeDeR annual report was published on 4th May 2018 https://www.hqip.org.uk/resource/the-learning-disabilities-mortality-review-annual-report-2017/#.WuwrNPkvzAV

The LeDeR process commenced in Gloucestershire January 2017 and One Gloucestershire has an established LeDeR Mortality Review Steering Group, led by the Gloucestershire Clinical Commissioning Group (GCCG), which has representation from Gloucestershire Care Services NHS Trust (GCS). The Trust has also supported two colleagues to undertake the LeDeR reviewer training programme and from here they have supported LeDeR reviews across the County.

Quality reports about the outcomes of the One Gloucestershire Steering Group are shared and discussed with NHS England with the most recent being May 2018 extracts from which are included within the appendices of this report.

Recommendations:

The Trust Board is asked to:

1 **Discuss** and **note** the contents of this 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

Learning Disability Mortality Review (LeDeR) Programme

1 Introduction and Purpose

The LeDeR Programme (mortality review of people with a learning disability) is being led by the University of Bristol and follows on from the Confidential Enquiry into Premature Deaths of people with LD (CIPOLD) the findings of which demonstrated that on average someone with an LD lives 20 years less than someone without.

The LeDeR Programme supports local areas in England to review the deaths of people with learning disabilities aged 4 years and over. A confidential telephone number and website is also available and enables families and other key people to notify the LeDeR team of the death of someone with learning disabilities.

An initial review of the death will then take place. The purpose of this is to provide sufficient information to be able to determine if there are any areas of concern in relation to the care of the person who has died, and if any further learning could be gained from a multiagency review of the death that would contribute to improving practice. If indicated, a more in-depth, multiagency review will be conducted.

As part of the review, a local reviewer would speak with family members, friends, professionals and anyone else involved in supporting the person who has died to find out more about their life and the circumstances leading to their death.

2 Background

The national LeDeR Annual Report for 2017 was published on 4th May 2018 and a summary of the national findings include:

- By the end of November 2017, all but two of the 39 LeDeR Steering Groups were operational.

- The most significant challenge to programme delivery has been the timeliness with which mortality reviews have been completed, largely driven by four key factors: 1) large numbers of deaths being notified before full capacity was in place locally to review them; 2) the low proportion of people trained in LeDeR methodology who have gone on to complete a mortality review; 3) trained reviewers having sufficient time away from their other duties to be able to complete a mortality review and 4) the process not being formally mandated.

- From 1st July 2016 to 30th November 2017, 1,311 deaths were notified to the LeDeR programme. By 30 November 2017, 103 reviews had been completed and approved by the LeDeR Quality Assurance (QA) process. As of 2nd May

2018, 2,349 notifications had been received. 200 reviews have been completed and approved by the QA process.

- The most commonly reported learning (and recommendations) made related to the need for:

    a. Inter-agency collaboration and communication

    b. Awareness of the needs of people with learning disabilities

    c. The understanding and application of the Mental Capacity Act (MCA).

Key information about the people with learning disabilities whose deaths were notified to the LeDeR programme includes:

- Just over half (57%) of the deaths were of males
- Most people (96%) were single
- Most people (93%) were of White ethnic background
- Just over a quarter (27%) had mild learning disabilities; 33% had moderate learning disabilities; 29% severe learning disabilities; and 11% profound or multiple learning disabilities.
- Approximately one in ten (9%) usually lived alone
- Approximately one in ten (9%) had been in an out-of-area placement.

3 One Gloucestershire Performance

The One Gloucestershire LeDeR Steering group oversees Countywide activities and the respective partners have endeavoured to ensure that the LeDeR programme actively aligns to their own Learning from Deaths policies and procedures. In the case of the Trust this includes having:

- A ratified Learning from Deaths Policy.
- A nominated non-executive director and executive director lead.
- An established multi-professional mortality review group in place to review those deaths that occurs within our seven community hospitals.
- Clear governance and reporting procedures in place.

In addition to this the themes from completed LeDeR reviews across Gloucestershire are regularly reviewed by the LeDeR Steering group and communicated to all stakeholders via a bi-monthly Gloucestershire LeDeR Newsletter.

Of the 20 completed reviews, all had received adequate or good care, some with recommendations for minor service improvements that would not have impacted on the outcome for these individuals.

In addition, to the national themes, there is some local learning for service Improvements, which include:

- Communications and support for people to access primary care Learning Disability Annual Health Checks
- Reasonable adjustments made for people to access to mainstream healthy lifestyles
- Preventative services e.g. smoking cessation & weight management
- Suitable reasonable adjustments being put in place in mainstream health services
- End of life care communications and protocols

Key information about the people with learning disabilities whose deaths were notified to the national LeDeR programme when compared with the local programme includes:

- Just over half (57%) of the deaths were of males - **in Gloucestershire this figure is 71%.**
- Most people (96%) were single - i**n Gloucestershire this is 99%**
- Most people (93%) were of White ethnic background - **97% were of white ethnic background in Gloucestershire**
- Just over a quarter (27%) had mild learning disabilities, 33% had moderate learning disabilities, 29% severe learning disabilities, and 11% profound or multiple learning disabilities - f**or Gloucestershire this would be: Mild Learning Disability 35%, moderate Learning Disability 29%, Severe 17%, Profound & Multiple Learning Disability 5%**

See Appendix 1 with regards to the LeDeR programme One Gloucestershire performance to date (as at May 2018).

3.1 One Gloucestershire Themes

A number of themes have been identified from the reviews to date and include:

- Ensuring further information is available on the G-Care website (this is accessed by Clinical colleagues including GPs)
- Working with ICE Creates to support reasonable adjustments & pilot a clinic in the Treasure Seekers Hub in Gloucestershire.
- The need to work with Health providers to implement suitable and improved reasonable adjustments.
- Need to improve paper records as they have at time been challenging to read and handwriting in medical records needs to improve.

3.2 Future Activities for One Gloucestershire

NHS England funding (£11.5k) has been received to support completing those outstanding LeDeR reviews. Seven new reviewers have been recruited. On average reviews take 1½ days to complete.

Copies of [2]Gether NHS Foundation Trust mortality reviews have been obtained and uploaded to the LeDeR System to support reviewers to undertake proportionate and considered reviews.

Work is ongoing with NHS Providers and key stakeholders to develop an improved wider mortality surveillance review process.

4 Conclusion and Recommendations

There is currently a backlog of LeDeR reviews requiring completion. These are therefore outstanding and although additional reviewers have been recruited this remains a risk for One Gloucestershire. It is acknowledged that any reviews are undertaken on top of the reviewer's usual role, and are time consuming. Further resources are required in order for Gloucestershire to meet the demand for the number of LeDeR reviews to be undertaken.

The Trust Board is asked to:

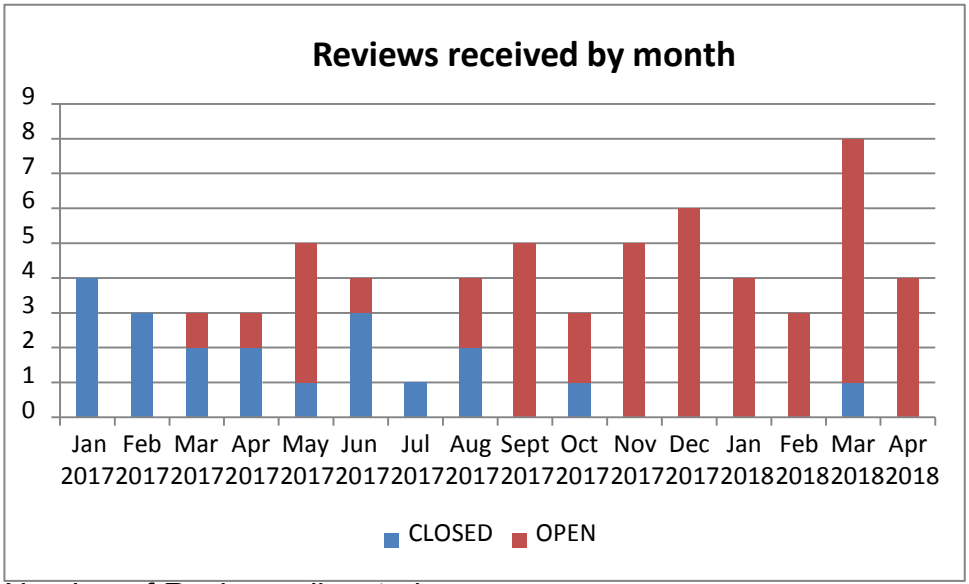
1 **Discuss** and **note** the contents of this report.

Abbreviations Used in Report

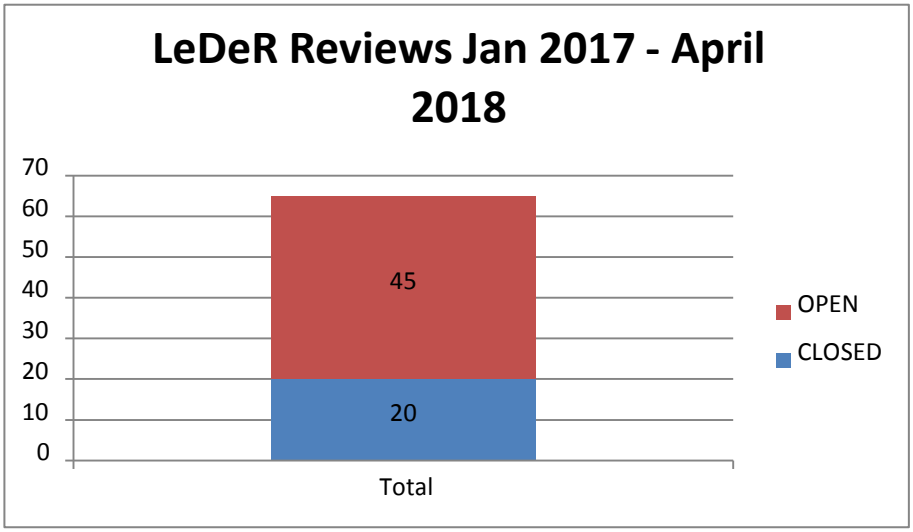
LeDeR – Learning Disability review
MCA – Mental Capacity Act
CIPOLD - Confidential Enquiry into Premature Deaths of people with LD
QA – Quality Assurance

Gloucestershire Performance to date

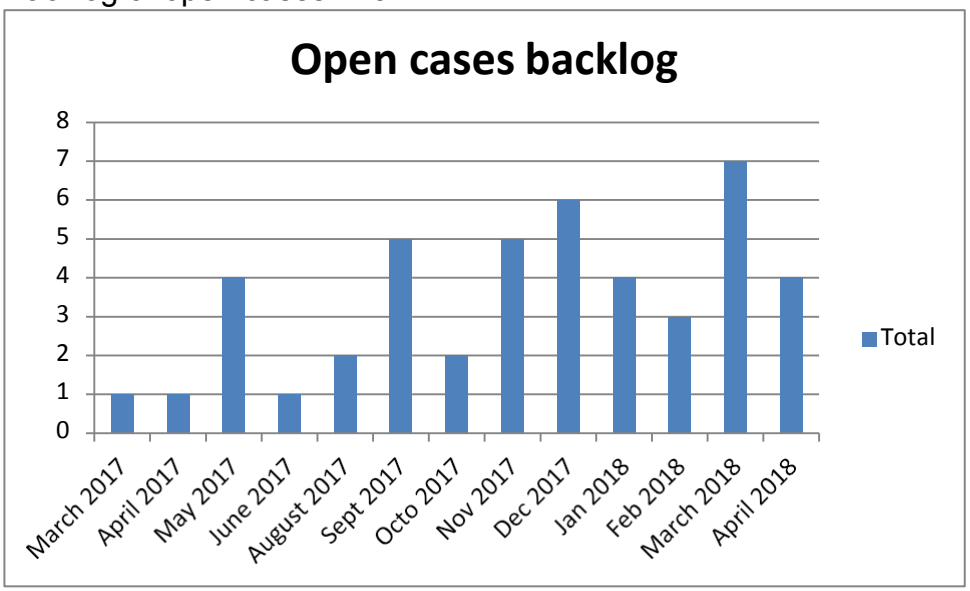
Number of Reviews received by Month



Number of Reviews allocated



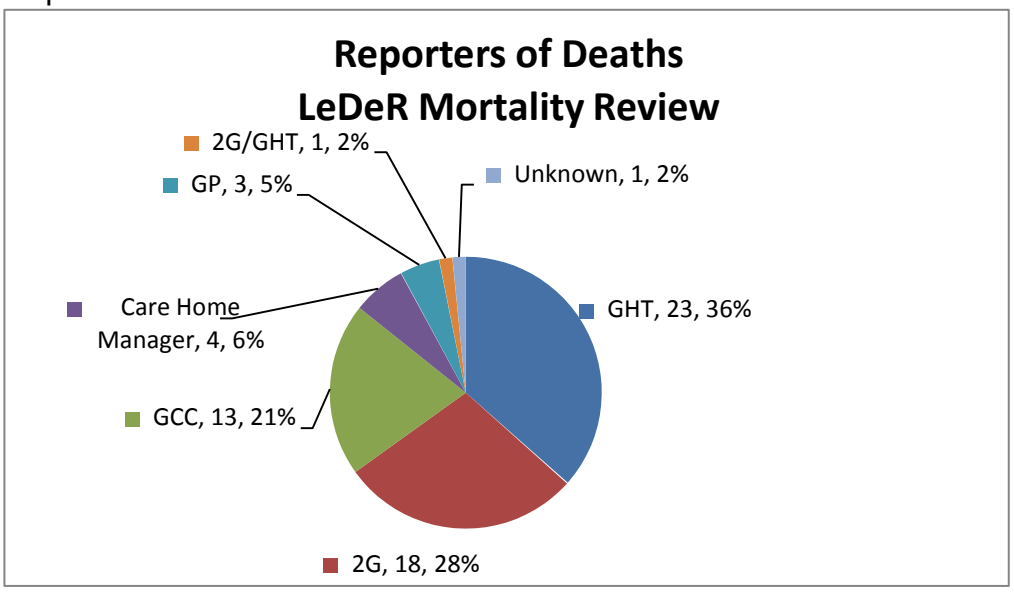
Backlog of open cases n45–



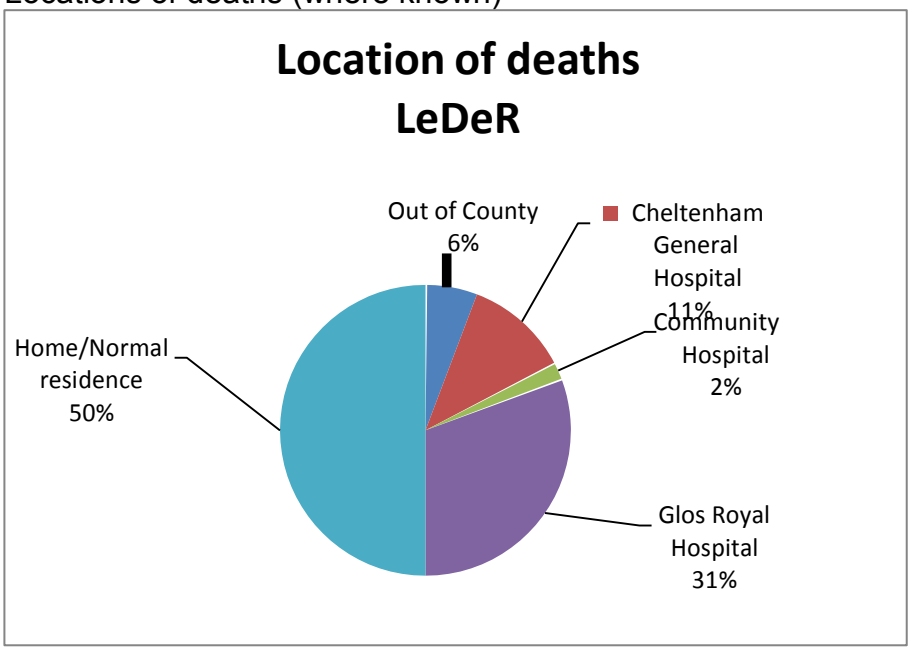
Unallocated cases backlog n19

Month review received	Number of unallocated reviews
Dec 2017	2
Jan 2018	4
Feb 2018	3
March 2018	6
April 2018	4
Grand Total	**19**

Reporters of Deaths



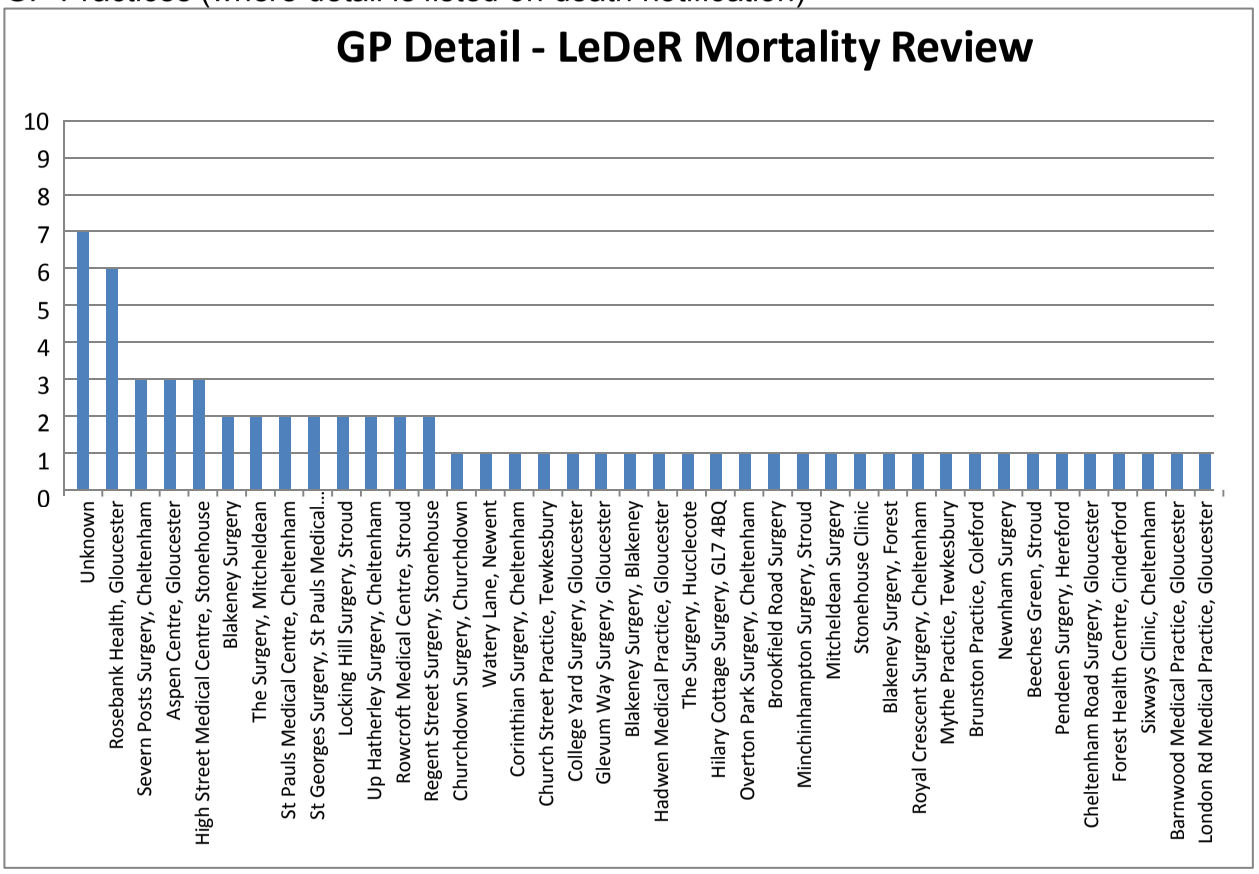
Locations of deaths (where known)



Comparison with national LeDeR data

	NHS England South Region (n261)	England from Jan 2018 (n848)	England from Jan 2017 – Dec 2017 (n1338)
Hospital	61%	66%	64%
Usual place of residence	32%	28%	30%
Other	7%	6%	6%

GP Practices (where detail is listed on death notification)



Duplicate Cases Reported by locality/month

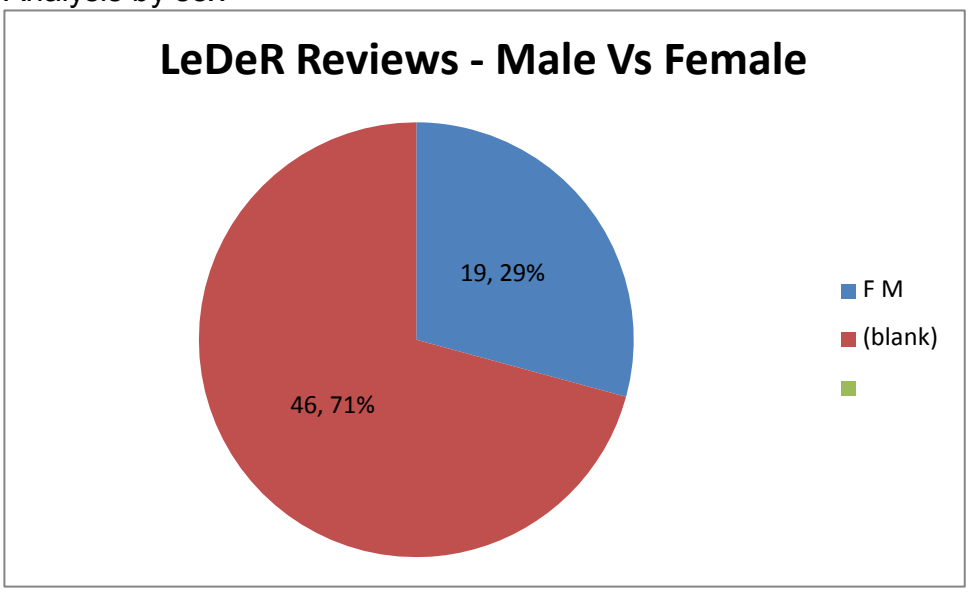
Locality & Month	Yes - with 25248061	Yes 25188498 & 25234691	Yes 25240011 & 25242286	Yes 25244232 & 25246325	Grand Total
Stroud & Berkeley Vale		**2**		**1**	**3**
Dec 2017		1			1
Mar 2018		1		1	2
Gloucester			**2**		**2**
Mar 2018			2		2
Cheltenham	**1**				**1**
April 2018	1				1
Grand Total	**1**	**2**	**2**	**1**	**6**

3. Analysis of cases received (n65)

Analysis by Location

Locality	CLOSED	OPEN	Grand Total
Gloucester	4	14	18
Cheltenham	2	11	13
Stroud & Berkeley Vale	5	7	12
Forest	4	8	12
Unknown	3	4	7
Tewkesbury	1	1	2
Out of county	1		1
Grand Total	**20**	**45**	**65**

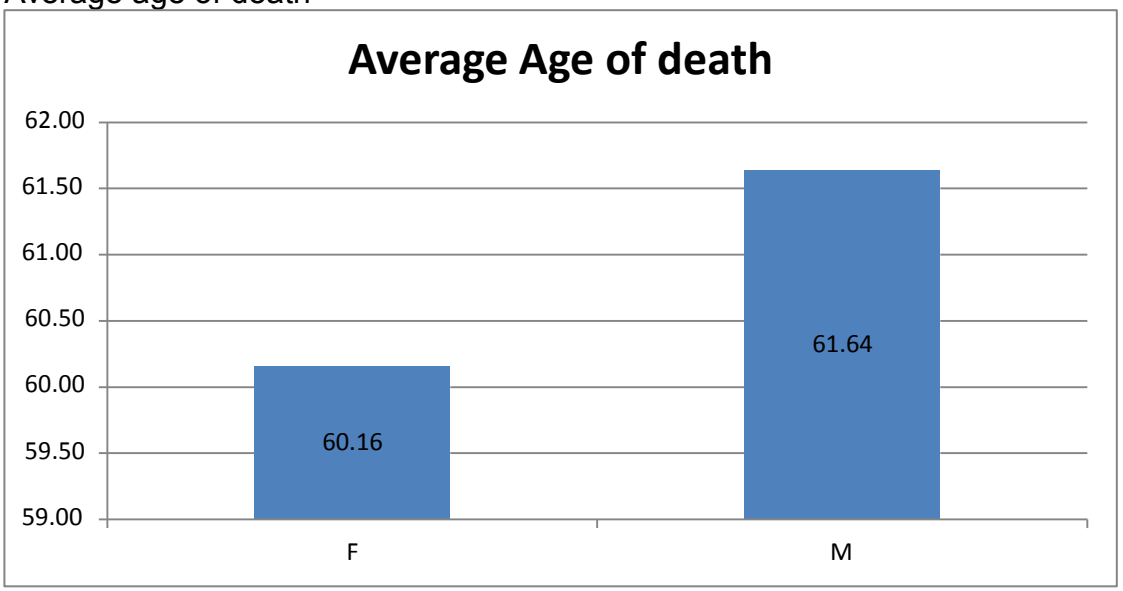
Analysis by sex



Comparison with national LeDeR data

	Gloucestershire (n65)	NHS England South Region (n279)	England from Jan 2018 (n910)	England from Jan 2017 – Dec 2017
Male	71%	60%	56%	58%
Female	29%	40%	44%	42%

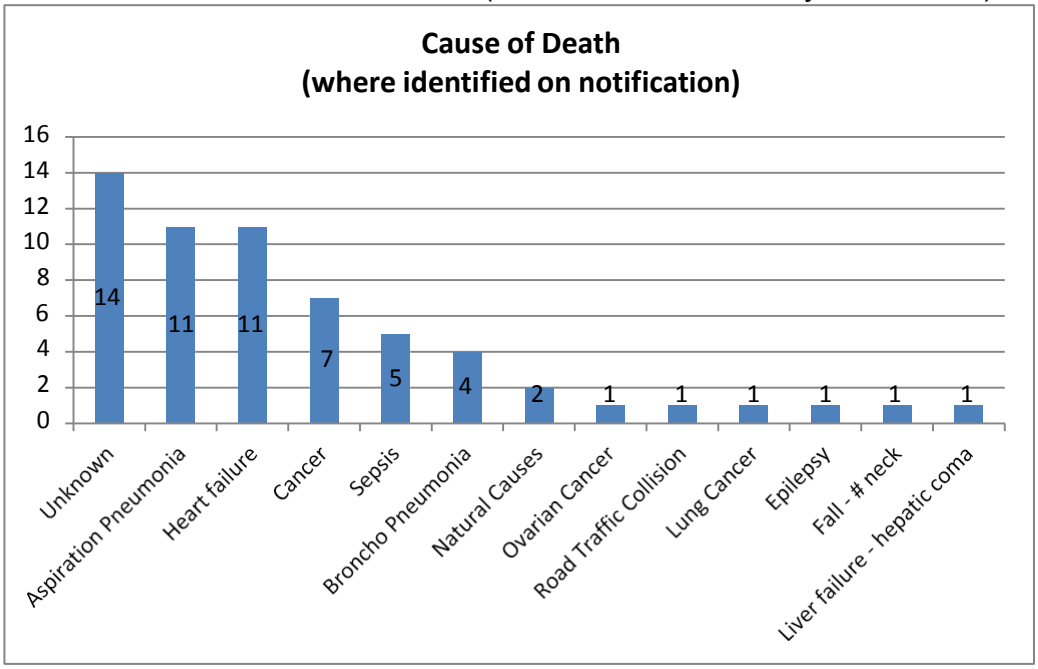
Average age of death



Comparison with national LeDeR data

	Gloucestershire (n65)	**NHS England South Region**	**England from Jan 2018**	**England from Jan 2017 – Dec 2017**
Median age of death (LeDeR Reviews)	61.19	60 **(n279)**	59 **(n910)**	58
Average life expectancy			Male 79.1 Years old Female 82.8 years old	
National LeDeR Difference against Gloucestershire			> 1 year	> 2 years
Local LeDeR age vs national life expectancy			Male <17.46 years Female < 22.64 years	

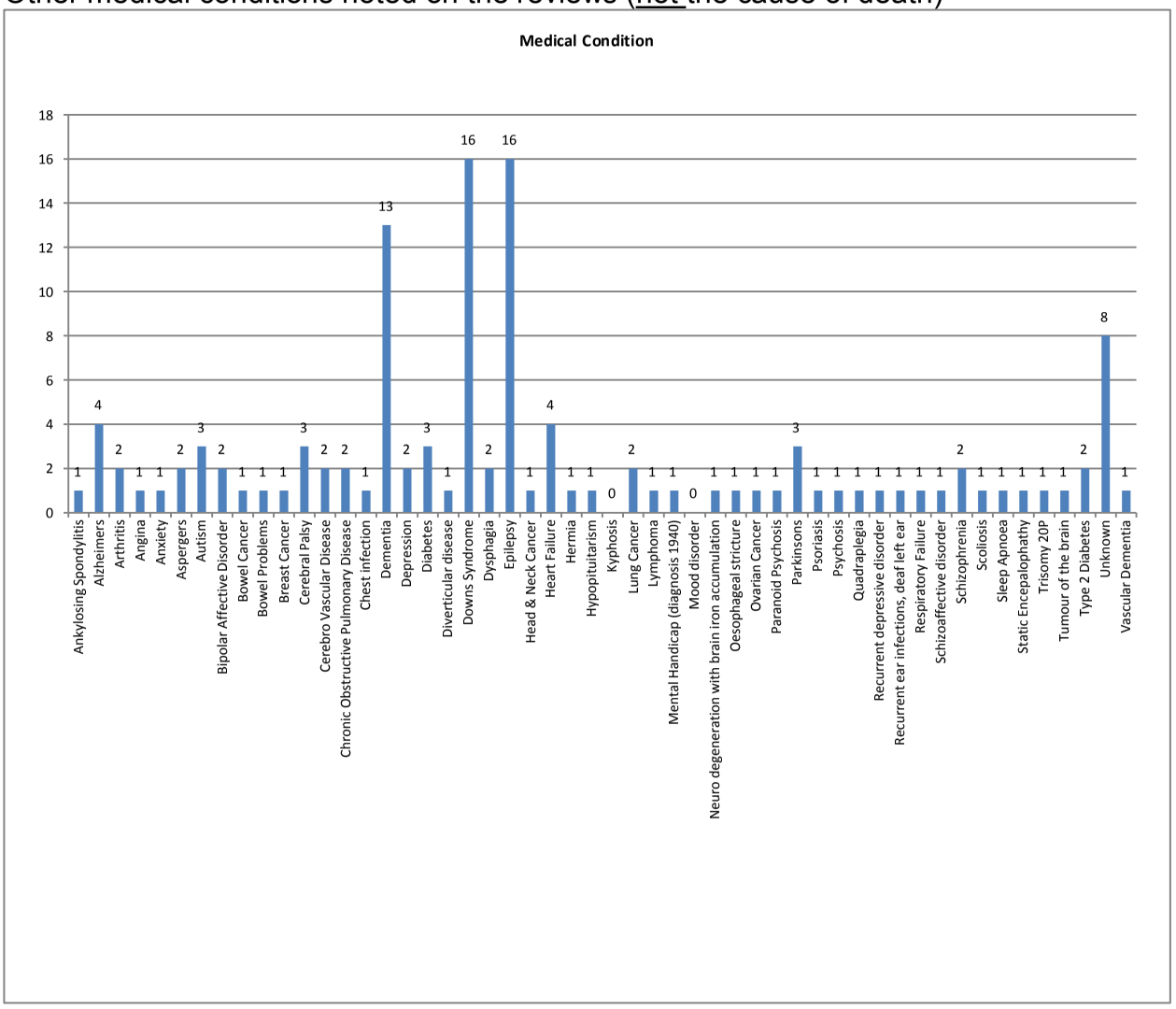
Cause of death - where recorded (unknown = cases not yet reviewed)



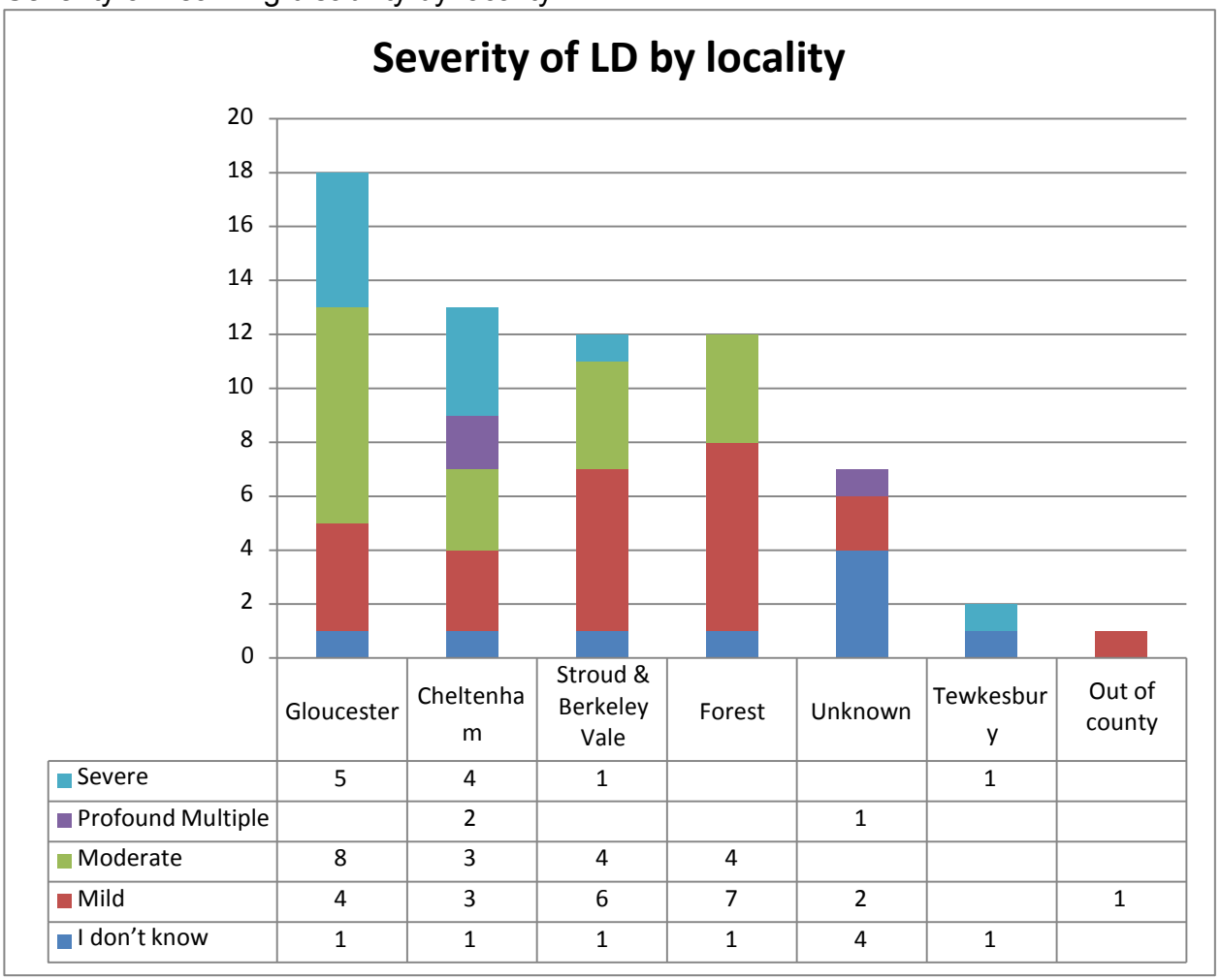
Comparison with national LeDeR data

	NHS England South Region (n107)	England from Jan 2018 (n346)	England from Jan 2017 – Dec 2017 (n610)
Respiratory diseases	34%	34%	31%
Cancers	13%	12%	10%
Circulatory system	19%	14%	18%
Other	35%	40%	41%

Other medical conditions noted on the reviews (not the cause of death)



Severity of Learning disability by locality



	Gloucester	Cheltenham	Stroud & Berkeley Vale	Forest	Unknown	Tewkesbury	Out of county
Severe	5	4	1			1	
Profound Multiple		2			1		
Moderate	8	3	4	4			
Mild	4	3	6	7	2		1
I don't know	1	1	1	1	4	1	

NHS
Gloucestershire
Care Services
NHS Trust

Trust Board

Date of Meeting: 7th June 2018

Report Title: Quality and Performance Committee Report

Agenda reference Number	11/0618
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 28th February 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 is on track to submit its Quality Improvement Plan (QIP) to the Care Quality Commission (CQC) by 21st May 2018.
- Assurance that the Trust 2017-18 Quality Priorities had in the main been achieved, although it was recognised that further intensive work is needed to continue with the prevention of pressure ulcers.
- Recognition that performance had improved with some services including MSKCAT during Qtr. 4

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 28th February 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 Trust's Quality and Performance Committee meeting held on 26th April 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

The following decisions were made by the Committee at its meeting on 26th April 2018.

2.1 Medical Revalidation

The Committee received this annual report. Medical Revalidation is the process by which the General Medical Council (GMC) confirms the continuation of a doctor's licence to practise in the UK. All doctors who wish to retain their licence to practise need to participate in revalidation. The Trust's Medical Director, as the Responsible Officer, is accountable for the quality assurance of the appraisals that support doctors in effectively developing their practice. As part of this the Medical Director is required to publish an annual assurance report that all those doctors employed by the Trust are compliant with the national revalidation requirements. The Committee was **assured** that the 11 doctors employed by the Trust are 100% compliant with their appraisals and that there have been no recommendations required for revalidation during the preceding 6 months.

2.2 Infection Control Annual Report

The Committee congratulated the Infection Control and Prevention team and the work they had progressed during 2017-18. It also noted that the C.Difficile threshold of 18 was "contained" although it was acknowledged that this had been challenging in light of the national shortage of Tazozin (anti-biotic) during the year; that 95 bed days had been lost during 2017-18 due to influenza and; that hand hygiene audits demonstrated a 93% level of compliance. The Committee **Approved** on behalf of the Trust Board that the 2017-18 Infection Control Annual Report be published.

2.3 Quality Improvement Plan (QIP) – Care Quality Commission (CQC)

The Committee discussed the draft QIP plan, which was due to be submitted to the CQC on 21st May 2018. Highlights from the CQC final inspection report included:

- 9 areas of **outstanding** practice

- 5 “Must Do” actions
- 25 “should do” actions
- 4 Improvement areas under the Well-led domain

After a few amendments being made the Committee **Approved** the QIP and that it be submitted to the CQC.

2.4 Quality and Performance Committee Minutes

The Committee **approved** the minutes of its meeting that took place on 28th February 2018 – Appendix 1.

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 Quality Priorities

For 2018-19 these have been agreed and were previously reported to the Board and include End of Life, Falls, Health and Well-being of colleagues, deteriorating patient (Sepsis), effective management of medication errors, nutrition and hydration and preventing pressure ulcers.

Preventing pressure ulcers remains a priority and concern for the Committee to oversee improvements about. There continues to be varied impact in the reduction of pressure ulcers. The Committee discussed in detail an in-depth case review of 15 patients that had been undertaken by one of the Trusts Clinical Leads. The outcome from this review included:

- It being a helpful internal benchmarking process highlighting causal factors of pressure ulcers

- That there appeared to be improved clinical practice in terms of assessment skills of pressures, which is one of the outcomes of the Trusts quality improvement activities.

- Highlighted the need to understand further which colleague and/or organisation were visiting patients and the frequency of these

- Confirmed that nationally there is a need for health and care organisations to consistently collect data of pressure ulcer incidences – or the avoidability or otherwise the harm (damage) caused. This would support more accurate benchmarking activities between Trusts of a similar nature.

The clinical and patient safety drivers for reducing pressure ulcers are clear and well established. The Trust has continued its quality improvement activities and must remain focussed with these work plans. In the absence of national definition categories there is a need to categorise and report avoidable and unavoidable

pressure damage and although this could be considered controversial we need to start including this within our quality indicators reporting during 2018-19 – starting April/May 2018. This approach will support the Trusts open culture of reporting, its documentation and investigation of pressure damage and; in turn this will help us to achieve even more uniformity in data collection and a continued focus to reduce (pressure ulcers) especially those avoidable ones.

3.2 System flow of Patients

The Committee acknowledged that Trust colleagues had operated its System Partnership working to full effect during the winter months of 2017-18. It was highlighted that patient flows had been relatively smooth; that there was now a system wide quality dashboard in place and; that no escalation beds had been opened by the Trust. There remains further work to be done in terms of categorising the right patients for the Community Hospitals and especially those who were identified as requiring "rehabilitation" when this may not be the case.

3.3 Timely Access to Services

The Committee **noted** and was **assured** that there was now evidence that performance, most notably with the Musculoskeletal Clinical Assessment and Treatment (MSKCAT) service was improving and that the respective service action plans are continuing to have some impact.

3.4 Learning from Deaths Report

The Committee reviewed the Trust's recent Learning from Deaths Report (Jan – March 2018) and were **assured** that the Trust remains compliant with current national guidance. Key areas noted by the Committee included:

- There being 62 deaths reported by community hospitals for the period Jan – March 2018 and that a high percentage of these were attributed to malignancy and were expected deaths.

- 34 out of the 62 deaths reported were reviewed by the (community hospitals) multi-disciplinary teams with oversight by the Trust's Mortality Review Group.

- The findings of these reviews indicate that out of the 34 reviews 27 had care rated as good practice.

- Of the remaining reviews four related to clinical issues where the multi-disciplinary team believed care could be improved and; three were considered to relate to more organisational issues and specifically with regards to patient information being transferred with the patient from a different healthcare setting.

4 Conclusion and Recommendations

The Trust continues to maintain its high standards of delivering high quality care, which has now been endorsed with a “good” rating from the CQC who inspected the Trust early 2018. It also 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 28th February 2018.

Abbreviations Used in Report

CQC – Care Quality Commission
MSCKAT - Musculoskeletal Clinical Assessment and Treatment
GMC – General Medical Council

Quality and Performance Committee

Date: 28th February 2018

Meeting on 28th February 2018, 13.30pm, Boardroom, Edward Jenner Court, Brockworth, GL3 4AW

Committee Members	
Sue Mead	Chair
Susan Field	Director of Nursing
Candace Plouffe	Chief Operating Officer
David Smith	Interim Director of HR
Sandra Betney	Director of Finance
Nicola Strother Smith	Non-Executive Director
Jan Marriott	Non-Executive Director
Graham Russell	Non-Executive Director
In attendance	
Louise Moss	Deputy Trust Secretary
Ian Main	Head of Clinical Governance
Nettie Young	Public Health Inequalities Lead
Hannah Williams	Quality Manager, Gloucestershire Clinical Commissioning Group
Robert Mauler	Patient Experience and Safety Manager, Gloucestershire Clinical Commissioning Group
Marit Endresen	Patient Experience Lead (for agenda item 10 and 11)
Laura Bucknell	Head of Medicine Optimisation (for agenda item 14)
Christine Thomas	Minute taker

Ref	Minute
01/0218	**Welcome, Apologies for Absence and Confirmation the Meeting is Quorate** The Chair, Sue Mead, welcomed colleagues, particularly the Health Inequalities Lead, the Patient Experience and Safety Manager for Gloucestershire Clinical Commissioning Group and the recently appointed Interim Director of HR. Apologies were received from the Medical Director, and the Deputy Director of Nursing. The Chair confirmed that the meeting was quorate.
02/0218	**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.

03/0218	**Minutes of the previous meeting 19th December 2018** The minutes of the 19th December 2017 were **Received** and were **Approved** as an accurate record.
04/0218	**Matters Arising Action Log** The Committee **NOTED** those items that were on track or completed and updates were received on open actions
05/0218	**Corporate Risk Register** The Deputy Trust Secretary (DTS) presented the corporate risk register. There were 33 risks and it was expected this would reduce following the next Risk Steering Group, due to meet imminently. It was noted that the Infection Prevention and Control Lead (IPaCL) was reviewing the infection control risk and it was expected this rating would reduce. Concern was raised that there was a potential financial impact for the Trust with regards to the proposal by Gloucestershire County Council (GCC) to introduce rental charges for ICT teams co-located within their properties. Graham Russell raised concern that many of these risks were workforce related. It was recognised that recruitment and retention was a significant risk to the Trust. The Chief Operating Officer (COO) updated the group that Countywide services were currently looking to restructure increase resilience within the teams and to support improved recruitment and retention rate. It was questioned as to whether these risks sat with the Quality and Performance Committee or the Workforce and OD Committee. The Interim Director of HR (IDHR) advised that these were being reviewed and actioned by the Workforce and OD Committee. The Committee **Approved** the Corporate Risk Register**.**
06/0218	**Operational Services Exception Report** The Chief Operating Officer (COO) noted that the Delays in Transfers of Care (DToC) rates were acceptable. Bed occupancy was higher than the 92% target but was lower compared to the same time period in 2017. It was noted that Dilke Hospital was the only hospital to have agreed occupancy levels. It was asked of the Quality Manager (QM) from Gloucestershire Clinical Commissioning Group (GCCG) if a more targeted approach could be taken for patient experience. The QM advised that funding had been approved to recruit to a role that would review patient experience across the entire pathway. The Committee welcomed this development. Areas of note from the report were: • There had been an increase in workforce issues for the Speech and Language Therapy (SLT) service. The service was also sub-contracted to Gloucestershire Hospitals Foundation Trust (GHFT) and sometimes this work was more prioritised.

	• The Podiatry performance had seen a decline during January; this was seen as partly due to the weather, although all referrals were seen within 8-9 weeks. • The Musculoskeletal Clinical Assessment and Treatment (MSKCAT) action plan was on track, which involved moving clinicians to support other areas as needed. • The early discharge target had been missed. There was some concern noted as to the way this was being recorded and the way they were being reviewed accordingly. • The COO had been invited to weekly Trakcare meetings with GHFT. It was noted that training was needed for colleagues using this system and that some colleagues did not have a right to access Trackcare under current contracts. The finalised Trust Discharge Policy, which had been requested to be brought to this Committee, had been attached. The Committee **Approved** the report and **Noted** the Discharge Policy
10/0218	**Family and Friends Test (FFT) Progress Report** The Patient Experience Lead (PEL) presented the progress report on the Family and Friends Test. The Committee was pleased to note the Trust had reached its 15% response rate. Nicola Strother Smith asked if the change to the denominators had an influence on this increase. The PEL advised that it was thought not and that this was due to an increase in response rates. There had been a positive response from services who had been able to personalise the Family and Friends Test to their particular service needs. It was agreed that an update would come back to the Committee in February 2019. The Committee **Noted** the Family and Friends Test update
11/0218 **Head of Clinical Governance**	**Compliments, Complaints and Concerns – Qtr.3 Report** The Patient Experience Lead (PEL) presented the Compliments, Complaints and Concerns report. The Chief Operating Officer (COO) noted that two of the concerns regarding the sexual health service were due to lack of access to GP services and that these were services that the Trust was not commissioned to undertake. The Head of Clinical Governance (HoCG) advised that they were currently reviewing the management of complaints and concerns. It was questioned as to what happened if someone asked for a concern to be reviewed but not under the auspices of a complaint. It was agreed that the HoCG would distribute national guidance document to the Committee for comments. The Committee **Noted** the Compliments, Complaints and Concerns update.
07/0218	**Clinical Quality Assurance Report**

	It was noted that the 2018-19 priorities included: • Effective management of medication errors • End of Life (year 2) • Deteriorating patient (SEPSIS) • Pressure ulcers (year 2) • Falls (year 2) • Nutrition and Hydration Progress was also noted on NICE guidance, though it was acknowledged that maintaining this work would be difficult due to limited resources (operational and assurance). Improvements had been made in the Qtr. 3 with regards to falls and pressure ulcers. It was noted that the Trust had limited influence on care homes pressure ulcer rates. It was also recognised that pressure ulcers were more of a risk in the Community as opposed to hospitals. There was currently no standardised methodology to report pressure ulcers although it was hoped that NHS Improvement would be defining this. The Committee remained **partially assured** with regards to progress with pressure ulcers. The End of Life (EoL) improvement trajectories would be revisited and updated. The Trust had been asked to be part of the testing of the RESPECT form working with the Academic Health Services Network. It was **noted** in the Falls update that there was no mention of diabetes being a factor in falls. It was agreed that The Deputy Director of Nursing (DDoN) would pick this up. It was also **noted** that any outcomes from the Care Quality Commission (CQC) inspection report would become an integrated part of the Trusts 2018-19 quality priorities. The Committee welcomed the proposed format for the Trusts Quality dashboards to be displayed in the Community Hospitals and Minor Injury and Illness Units (MIIUs). The Committee **Approved** the Clinical Quality Assurance Report
08/0218	**Clinical Reference Group Report** The Director of Nursing (DoN) presented the Clinical Reference Group report and advised the group that in future exception reports would be received and fuller reports would go to the Executive team. It had also been agreed that the Deputy Director of Nursing (DDoN) would host a One Gloucestershire safety summit which would include sharing more openly Gloucestershire's quality priorities, incident trends and operational priorities to share and develop patient safety initiatives. The Committee **Approved** the Clinical Reference Group Report
09/0218	**Quality and Performance Report (January 2018 data)** The Committee was pleased to see more up to date data. Of note from the report included:

	• Average daily discharges in community hospitals were at 4.4, which were recognised as being positive. • Future reports would include the use of agency staff and the impact this had on quality and patients experience. • The April report would include place based data, which would initially be on a "test and learn" basis. • Workforce remained challenging although there were improvements with regards to Performance Development Reviews (PDRs) and mandatory training compliance rates. • The Family and Friends Test for colleagues indicated that 55% of colleagues would recommend the Trust as a place to work, which was an increase to previous quarters although there remained challenges with this. Nicola Strother Smith raised concerns that data provided to the League of Friends (LoF) was considerably different to that presented here. The Chief Operating Officer (COO) advised that the data given to the LoF had unfortunately not been verified. Graham Russell noted the improvement in the Minor Injury and Illness Units and that much of this was green. The Committee were pleased to see this improvement and recognised the work undertaken by colleagues to achieve this. The Committee **Approved** the Quality and Performance Report and **Noted** the January 2018 data.
12/0218	**CQC Update** The feedback from the recent CQC visit had been positive and that it had felt different from the 2015 inspection visit. There had been a recent request for additional information for End of Life evidence and this had been provided. Colleagues across the Trust had the opportunity to meet the inspectors. There was concern that any services not inspected would still retain their old rating. The draft report from CQC was expected week commencing 19th March. The Committee **Noted** the CQC update
13/0218	**Health Inequalities Monthly Evaluation Outcomes** The Public Health Inequalities Lead (PHIL) presented the first Health Inequalities evaluation outcomes report to the Committee. This was a pilot scheme funded by NHS England that is intended to identify barriers to accessing health care for vulnerable groups. It was hoped that there would be 3 PHILs for the South West region. NHS England had defined the areas that they would initially like reviewed and these were Children; School Immunisations; Bowel and Cervical Screening programmes. The PHIL would be looking to identify opportunities for improved working practices. The PHIL would also look to identify local barriers, report progress back to NHS England and then identify ways to improve processes. The PHIL was currently looking at Health Visiting and School Nursing and target groups had been identified.

	The Committee welcomed the pilot programme and asked the PHIL to ensure that the impact of what was being progressed was being recorded accordingly. The Committee **Noted** the update
16/0218	**Trust Quality Account** The Director of Nursing had received guidance from NHS Improvement on production of the Trusts 2017-18 Quality Account. It was noted that there was nothing significantly different from the previous year although the Family and Friends Test was being requested to be included. The Committee **Noted** the Quality Account guidance timelines and delegating autonomy.
15/0218	**Effectiveness of Committee Review** The Deputy Trust Secretary (DTS) presented the proposed Committee Effectiveness Review self-assessment and asked Committee members to support the self-assessment process. The Committee agreed that the self-assessment would be sent to them individually to complete and return to the DTS. The Terms of Reference were approved and it was noted that the Non-Executive Director (NED) visits would be owned by this Committee. The Committee **Approved** the self-assessment procedure and **Approved** the Committee Terms of Reference
14/0218	**E-Prescribing Action Plan** The Head of Medicines Optimisation (HoMO) provided an update on the E-Prescribing action plan. Since the last update there had been a conference call with the clinical director of TPP, the supplier of SystmOne, which had not produced the desired outcomes. The terminology of stop medication on the system was different for the Trust to that of TPP, which was causing concern. The Trusts clinical system team because of this have put in measures to ensure safe practices are in place and that this included a two-step process to ensure that medications weren't wrongly stopped. Standard Operating Procedures had been updated to reflect this change. The Director of Nursing (DoN) advised that the Medical Director would be setting up a dedicated email address for the Hospital doctors to use too advise of concerns and communicate with the doctors and vice versa. It was noted that Pricewaterhouse Cooper (PWC) who had undertaken the original audit had asked the HoMO for an update at the end of Summer. It was agreed that further Committee updates would be included in future medicines optimisation reports. The Committee **Approved** the report and **Noted** the actions taken

17/0218	**Forward Planner Review** The Committee **noted** the forward planner
18/0218	**Operational Governance Forum and Medical Devices Exception Reports** The Operational Governance and Medical Devices Exception Reports were **Noted**
19/0218	**Any Other Business** It was agreed that the following items would be included in the report to the Trust Board: • Positive progress on patient flows • Quality priorities and progress being made • Quality dashboards • Progress on Family and Friends Test • Support for improvement in Quality and Performance reporting format • Quality account including timelines • CQC update There being no other business the Chair closed meeting.
	Date of Next Meeting It was agreed that the next Committee meeting will be held on Thursday 26th April 2018

Chair's Signature:

Date:

NHS
Gloucestershire
Care Services
NHS Trust

Trust Board

Date of Meeting: 7th June 2018

Report Title: Quality and Performance Report

Agenda reference Number	12/0618
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 Candace Plouffe, Chief Operating Officer
Board action required	To Note and Receive
Previously considered by	N/A
Appendices	Appendix 1 – Quality and Performance Report – April 2018 data

Executive Summary

This report is an overview of the Trust's Quality and Performance activities as at April 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 Committee Update

1 Introduction and Purpose

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

2 Background

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

The Trust's Quality and Performance Committee utilising its scheme of delegation powers reviewed March 2018 and the 2017-18 year end position at its meeting in April.

The attached report is an exception based report

3 Key areas to Note

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

- The Musculoskeletal Clinical Assessment and Treat (MSKCAT) Service has improved significantly by achieving **95.8%** of people being treated within 8 weeks and **100%** of urgent referrals being seen within 2 weeks. This is good news for Gloucestershire people and a real achievement by Trust colleagues after a period of reduced performance.

- Mandatory training compliance for April is on average **86.3%** - a continued improving picture.

- **84.4%** of colleagues Personal Development Reviews (PDRs) were achieved during April. 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. The quality improvement metrics for these and end of life year 2 will be discussed at the June Quality and Performance Committee and from here will be included in future quality and performance reports.

- Patients "likely" or "extremely likely" to recommend the Trust's Service for April was **93.5%** compared to **92.4%** the previous month.

- With regards to pressure ulcers April data, this now includes further categories of avoidable (19) and unavoidable (52) pressure ulcer reporting.

- Completion rates of Venus Thromboembolism (VTE) risk assessments (page 4, line 19) within community hospitals has declined during April and a subsequent review has been undertaken, which has highlighted in some cases patients were not under the care of the Trust after admission for a VTE to be completed. Work is underway to improve this situation with some additional “failsafe” mechanism being put into place.

4 Conclusion and Recommendations

The Trust Board is asked to:

1 **Receive** this April 2018 quality and performance report.

Abbreviations Used in Report

MSCKAT - Musculoskeletal Clinical Assessment and Treatment
VTE - Venus Thromboembolism

Gloucestershire Care Services NHS
NHS Trust

Quality and Performance Report

Quality and Performance Committee
26th April 2018

Data for March 2018

Understanding You

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Executive Summary

Gloucestershire Care Services NHS Trust

Are Our Services Caring?

- The overall Friends and Family Test response rate in April was **13.2%** compared to March response rate of **14.8%**. The number of patients indicating Likely or Extremely Likely to recommend our services was **93.5%** in April compared to **92.4%** in March.

Are Our Services Safe?

- The nationally reported Safety Thermometer was **92.8%** in April compared to **92.9%** recorded in March. Target is 95%. However, based on new harms only, the Trust achieved harm-free care of **97.2%** in April.
- Reducing pressure ulcers, which is the cause of the highest number of new harms, will remain a key quality priority for 2018/19

Are our Services Effective?

- The Bed Occupancy rate was **93.2%** in April compared to 96.3% in March.
- Delayed Transfer of Care (DToC) rate in April was **1.4%,** below the target of 3.5%, with an average of 3 patients delayed per day in April.

Are Our Services Responsive?

- MIIUs continue to perform very well against the range of targets.
- For countywide services, the Musculoskeletal Clinical Assessment & Treatment service (MSKCAT), achieved the 95% target for patients seen within 8 weeks of referral in April at **95.8%. 100%** of urgent referrals to the service were seen within two weeks of referral.
- SPCA have maintained good performance of their abandoned call rate measure at **1.6%** in April, which continues to be below the threshold of 5%. For priority 1 and 2 calls, the percentage of calls answered within 60 seconds remains below the 95% target at **91.7%.**

- **Are Our Services Well Led?**
- Mandatory training compliance rate in April was an average of **86.3%** compared to 2017/18 average of 82.6%.
- National Staff survey results for Quarter 4 indicate that **85.0%** of staff responding would recommend the Trust as a place to receive treatment (target is 67%). **49.0%** of staff indicated that they would be 'Extremely Likely' or 'Likely' to recommend the Trust as a place to work, this means that the Trust did not meet the target of 61% in 2017/18.
- Sickness absence (rolling 12 months to March) is **4.7%,** against a local target of 4%; this is consistence performance through the year.
- **84.4%** of all staff Personal Development Reviews were completed by the end of April 2018. For active assignments, this rises to **87.4%**.

Report Review

- The report has been redesigned as an exception report following Committee and Trust Board discussion about ensuring focus through targeted discussion. The following developments are planned to further develop this and includes:
    - Greater transparency of exception reporting criteria, particularly on local targets (*delivered)*
    - Development of assurance and contextual appendices in addition to this for more detailed discussion and Quality and Performance Committee (*delivered in January report)*
    - A review of the total quantum of the dashboard to establish if it is comprehensive in relation to our services *(to be determined based on Committee discussion*)
    - Information regarding Agency use will be included in the next Quality and Performance Committee report *(in June regarding May data)*
    - Consideration of how Benchmarking comparisons can be included for context (to be delivered in June report)

Quality and Performance Dashboard (Trust wide)

NHS Gloucestershire Care Services NHS Trust

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2017/18 YTD	Exception Report?
CQC DOMAIN - ARE SERVICES CARING?																		
1	Friends and Family Test Response Rate	N - T	15%	8.3%	13.2%												13.2%	
2	% of respondents indicating 'extremely likely' or 'likely' to recommend service	N - R L - I	95%	94.2%	93.5%												93.5%	
3	Number of Compliments	L - R		924	75												75	
4	Number of Complaints	N - R		44	3												3	
5	Number of Concerns	L - R		391	43												43	
CQC DOMAIN - ARE SERVICES SAFE?																		
6	Number of Never Events	N - R		1	0												0	
7	Number of Serious Incidents Requiring Investigation (SIRI)	N - R		23	0												0	
8	Number of Serious Incidents Requiring Investigation (SIRI) where Medication errors caused serious harm	N - R		0	0												0	
9	Total number of incidents reported	L - R		3,946	352												352	
10	% incidents resulting in low or no harm	L - R		94.8%	93.2%												93.2%	
11	% incidents resulting in moderate harm, severe harm or death	L - R		5.2%	6.8%												6.8%	
12	% falls incidents resulting in moderate, severe harm or death	L - R		1.5%	0.0%												0.0%	
13	% medication errors resulting in moderate, severe harm or death	L - R		0.0%	0.0%												0.0%	
14	Number of post 48 hour Clostridium Difficile Infections	N - R L - C	*2	16	3												3	Y
15	Number of MRSA bacteraemias	N - R L - C	0	0	0												0	
16	Number of MSSA Infections	L - R	0	0	0												0	
17	Number of E.Coli Bloodstream Infections	L - R	0	0	0												0	
18	Safer Staffing Fill Rate - Community Hospitals	N - R		100.2%	100.5%												100.5%	
19	VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	95.0%	87.9%												87.9%	Y
20	Safety Thermometer - % Harm Free	N - R L - C	95%	94.1%	92.8%												94.1%	Y
21	Safety Thermometer - % Harm Free (New Harms only)	L - I	98%	98.0%	97.2%												97.2%	
22	Total number of Acquired pressure ulcers	L - R		652	71												71	
23	Total number of grades 1 & 2 Acquired pressure ulcers	L - R		578	62												62	
24	Number of grade 3 Acquired pressure ulcers	L - R		64	7												7	
25	Number of grade 4 Acquired pressure ulcers	L - R		10	2												2	

*Cumulative YTD target

Quality and Performance Dashboard (Trust wide)

NHS Gloucestershire Care Services NHS Trust

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2017/18 YTD	Exception Report?
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%												6.6%	6.6%
27	Inpatients - Average Length of Stay	L - R		26.8	28.0												28.0	
28	Bed Occupancy - Community Hospitals	L - C	92%	96.7%	93.2%												93.2%	
29	% of direct admissions to community hospitals	L - R		25.3%	26.3%												25.3%	
30	Delayed Transfers of Care (average number of patients each month)	L - R		11	3												3	
31	Bed days lost due to delayed discharge as percentage of total beddays	L - R	<3.5%	5.9%	1.4%												1.4%	
32	Average of 4 discharges per day (weekends) - Inpatients	L - C	**4	3.1	2.6												2.6	Y
33	Average of 11 discharges per day (weekdays) - Inpatients	L - C	**11	8.1	8.7												8.7	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%	
CQC DOMAIN - ARE SERVICES RESPONSIVE?																		
		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2017/18 YTD	
Minor Injury and Illness Units																		
35	MIIU % seen and discharged within 4 Hours	N - T	95%	99.3%	99.4%												99.4%	
36	MIIU Number of breaches of 4 hour target	L - R		514	35												35	
37	Total time spent in MIIU less than 4 hours (95th percentile)	L - I	<4hrs	02:53	02:39												02:39	
38	MIIU - Time to treatment in department (median)	L - I	<60 m	00:26	00:30												00:30	
39	MIIU - Unplanned re-attendance rate within 7 days	L - C	<5%	2.4%	0.8%												0.8%	
40	MIIU - % of patients who left department without being seen	L - C	<5%	2.2%	2.4%												2.4%	
Referral to Treatment																		
41	Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	84.4%	60.7%												60.7%	Y
42	Podiatry - % treated within 8 Weeks	L - C	95%	92.8%	97.5%												97.5%	
43	MSKCAT Service - % treated within 8 Weeks	L - C	95%	57.1%	95.8%												95.8%	
44	MSK Physiotherapy	L - C	95%	90.7%	91.4%												91.4%	
45	ICT Physiotherapy	L - C	95%	85.0%	84.3%												84.3%	Y
46	Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	82.8%	77.4%												77.4%	Y
47	Diabetes Nursing - % treated within 8 Weeks	L - C	95%	96.2%	94.5%												94.5%	
48	Bone Health Service - % treated within 8 Weeks	L - C	95%	99.5%	96.0%												96.0%	
49	Contraception Service and Sexual Health- % treated within 8 Weeks	L - C	95%	100.0%	100.0%												100.0%	
50	HIV Service - % treated within 8 Weeks	L - C	95%	100.0%	100.0%												100.0%	
51	Psychosexual Service - % treated within 8 Weeks	L - C	95%	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%	77.5%												77.5%	Y

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2017/18 YTD	Exception Report?
50	HIV Service - % treated within 8 Weeks	L - C	95%	100.0%	100.0%												100.0%	
51	Psychosexual Service - % treated within 8 Weeks	L - C	95%	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%	77.5%												77.5%	Y
53	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	97.7%	93.3%												93.3%	
54	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	99.0%	96.9%												96.9%	
55	Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	96.6%	97.6%												97.6%	
56	MSKCAT Service - % of referrals referred on to secondary care	L - C	<30%	12.4%	12.0%												12.0%	
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%	
58	MSKCAT Service - wait from referral for urgent patients to be seen not to exceed 2 weeks	L - C	95%	95.9%	84.6%												84.6%	Y
59	Stroke ESD - Proportion of new patients assessed within 2 days of notification	L - C	95%	88.6%	83.3%												83.3%	Y
60	Stroke ESD - Proportion of patients discharged within 6 weeks	L - C	95%	98.9%	100.0%												100.0%	
61	Social Care ICT - % of Referrals resolved at Referral Centres and closed	L - C		45.9%	45.2%												45.2%	
62	Newborn Hearing Screening Coverage	N - T	97%	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%												99.6%	
64	Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R		40,511	3,212												3,212	
65	SPCA % of calls abandoned	L - C	<5%	2.7%	1.6%												1.6%	
66	95% of priority 1 & 2 calls answered within 60 seconds after introductory message finishing	L - C	95%	90.5%	91.7%												91.7%	Y
67	Rapid Response - Number of referrals	L - C	71 per week	3,726	309												309	

CQC DOMAIN - ARE SERVICES WELL LED?

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2017/18 YTD	Exception Report?
68	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place of work	N - R L - T	61%	53.3%														Y
69	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place to receive treatment	N - R L - T	67%	83.0%														
70	Mandatory Training	L - I	**92%	82.6%	86.3%												86.3%	Y
71	% of Staff with completed Personal Development Reviews (Appraisal)	L - I	95%	79.9%	84.4%												84.4%	Y
71a	% of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only	L - I	95%	N/A	87.4%												87.4%	Y
72	Sickness absence average % rolling rate - 12 months	L - I	<4%	4.6%	4.7%												4.7%	Y

QUALITY PRIORITY | ARE SERVICES SAFE?

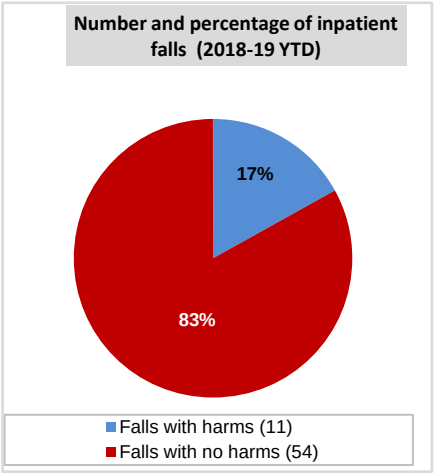
Gloucestershire Care Services NHS Trust

2018/19 Quality Priorities		Quality Domain
1. Falls Prevention and Management	To reduce the number of people falling or at risk of falling through an effective falls prevention and education programme to reduce the number of incidences of falls across the Community Hospitals.	SAFE
2. Colleague Health and Well-being	To improve the health and well-being of colleagues and increase the number actively involved in health and wellbeing activity.	CARING
3. Nutrition and Hydration		RESPONSIVE
4. End of Life Care	To continue to improve our end of life care activities, building on what we did during 2017-18.	WELL-LED
5. Deteriorating Patient (Sepsis)		EFFECTIVE
6. Pressure Ulcers	To reduce the number of avoidable acquired pressure ulcers, focusing on preventing pressure ulcers developing, providing education and training for colleagues.	SAFE

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	18	30.6	12	1.7	1	1.7
Cirencester	197	11.4	17	12.3	44	2.5	3	2.2
Dilke	131	14.7	8	11.4	40	4.5	0	0.0
Stroud General	120	8.9	12	11.0	32	2.4	4	3.7
Tewkesbury	73	12.1	5	8.7	13	2.1	2	3.5
North Cotswolds	103	13.2	3	4.6	21	2.7	0	0.0
Lydney	66	9.7	2	4.1	16	2.3	1	2.1
TOTAL	**758**	**11.3**	**65**	**11.9**	**178**	**2.6**	**11**	**2.0**
Expected year end outturn								



Risks (Falls)
Reference – 693
Rating – 9

Monthly figures	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Rolling 12 months total
Falls in Community Hospitals (inpatients only)	61	73	68	68	72	60	63	66	53	59	53	65	761

Additional information related to performance

Falls in an inpatient setting

- 83% of all falls reported in April are **without harm.**

Benchmarking

- The Trust is reporting a rate of 10.5 falls per 1,000 occupied bed days (Oct-17 to Mar-18) compared to an average of 8.7 falls per 1,000 bed days based on the Trusts within the 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 1000 bed days and 3.5 falls with harm per 1000 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 are 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 April Quality and Performance Committee

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 against NICE guidance due
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
1.3 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.
1.4 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 1000 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 1000 bed days.

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?
1.5 Safety Briefings	• The standard format for safety briefings has been agreed. This takes place at every handover and is mandatory. For those wards that are able to have the mid-shift safety huddle, the same format should be used and it has been agreed that these are optional as it is not always possible to accommodate them due to staffing pressures.
1.6 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
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. • The Trust is planning to use this challenge to ensure that the ethos of EndPJParalysis becomes embedded within the teams so that becomes the way we do things rather than an initiative.

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 3 2017/18 - **Achieved** • Gained accreditation of the Workplace Wellbeing Charter. Looking at three key elements of the Charter – Leadership, Culture and communication has helped us to see where we can further develop sustainable H&W initiatives. • Maintained Disability Confident Employer and developed a Disability Employer self-assessment and action plan to continue to maintain and improve our support to employing disabled people.
	Qtr 4 2017/18 - **Achieved** • To work on the implementation of feedback from the workplace wellbeing charter. • To work with Bath Spa University as part of a research project to develop stress management interventions specifically designed for the NHS and our Trust. • A Healthy Outcomes at Work (HOW) survey has now been carried out by Bath Spa University and the results are now being analysed • Continue to promote H&W activities including Health and Hustle, stress workshops, Care First, and healthy eating.
	Qtr 1 2018/19 – **Activities Being Planned** • To develop our action plan for 2018/19 based on feedback from the workplace wellbeing charter, the outcomes of the 2017 NHS staff survey, the H&W CQUIN and the HOW survey. • To continue to work with Bath Spa University on developing and implementing a colleague's toolkit for managing stress and mental health issues. • To continue to develop and promote the support to colleagues on personal health and wellbeing including improving the promotion of healthy eating and alcohol awareness • To improve the promotion and take up of the Colleague Fast track physiotherapy service, including preventative support.

3. Nutrition and Hydration

Additional information related to performance	What actions have been taken to improve performance?
2018/19 Quality Improvement Metrics are currently being finalised.	

4. End of Life Care

Additional information related to performance	What actions have been taken to improve performance?
Year 2 Quality Improvement Metrics are currently being finalised.	

5. Deteriorating Patient (Sepsis)

Additional information related to performance	What actions have been taken to improve performance?
2018/19 Quality Improvement Metrics are currently being finalised.	

QUALITY PRIORITY | ARE SERVICES SAFE?

NHS Gloucestershire Care Services NHS Trust

6. Pressure Ulcers

CQC DOMAIN - ARE SERVICES CARING?

		Reporting Level	Threshold	2017/18 YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?
22	Total number of Acquired pressure ulcers	L – R		652	71												71	Y
23	Total number of grades 1 & 2 Acquired pressure ulcers	L – R		578	62												62	Y
24	Number of grade 3 Acquired pressure ulcers	L – R		64	7												7	Y
25	Number of grade 4 Acquired pressure ulcers	L – R		10	2												2	Y

Avoidable (Community hospitals + Community)	Apr-18
Total number of grades 1 & 2 Avoidable pressure ulcers	16
Number of grade 3 Avoidable pressure ulcers	3
Number of grade 4 Avoidable pressure ulcers	0
Total	**19**

Unavoidable (Community hospitals + Community)	Apr-18
Total number of grades 1 & 2 Unavoidable pressure ulcer	46
Number of grade 3 Unavoidable pressure ulcers	4
Number of grade 4 Unavoidable pressure ulcers	2
Total	**52**

Additional information related to performance

Pressure Ulcers (Pressure Ulcers)

- In April there were 71 acquired pressure ulcers:
  - 10 were reported in Community Hospitals
  - 61 were reported in Community services

Benchmarking

- The Trust is reporting a rate of 1.6 grade 2,3,4 avoidable pressure ulcers per 1,000 occupied bed days in a community hospitals setting (Oct-17 to Mar-18) compared to the average of 0.3 based on the Trusts within the NHS Benchmarking Network monthly indicator report.

Risks (Pressure Ulcers)

Reference – 562
Rating – 16

Risks (Acquired Pressure Ulcers)

Reference – 710
Rating – 9

What actions have been taken to improve performance?

- Three additional dates for full day Tissue Viability and pressure ulcer awareness and education have been booked and made live on ESR.
- The Pressure Ulcer Prevention Quality Improvement Group are developing some additional resources to be sent to all domiciliary care agency providers to copy and share with their staff in a bid to receive more timely referral and earlier detection in those high risk care dependent patients.
- The Pressure Ulcer Prevention Quality Improvement Group is exploring links with Community Wellbeing to offer leaflets to them to share, as well as with carers Gloucestershire. This will include easy read versions of the carers/patient leaflet.
- The pressure ulcer policy is in final review before going through policy group for ratification and adoption.
- The Standard Operating Procedure for validation by the Tissue Viability team of Datix submissions is completed and being trialled with a new member of staff presently to reduce subjectivity and improve accuracy of the Datix submissions.
- Bespoke resources for Allied Health Professional colleagues to be sourced/developed and shared, recognising their unique role in early detection, screening at risk patients and promoting the value of positioning and movement.
- The training offer in care homes led by the Care Support Team has been aligned to GCS internal training to ensure consistency of message.
- The SSKIN bundle (**S**urface; **S**kin Inspection; **K**eep patients moving; **I**ncontinence/moisture; **N**utrition/hydration) is about to go live across all units for use and will replace the top-to-toe assessment, this follows trial in an ICT for 6 months where it has been well received.
- Waterlow risk assessment has been trial in a small scale at the community hospitals to compare to Braden when identifying those at risk. This will be further explored and may result in a wider trial to aid accuracy of monitoring.

EXCEPTION REPORT | ARE SERVICES SAFE?

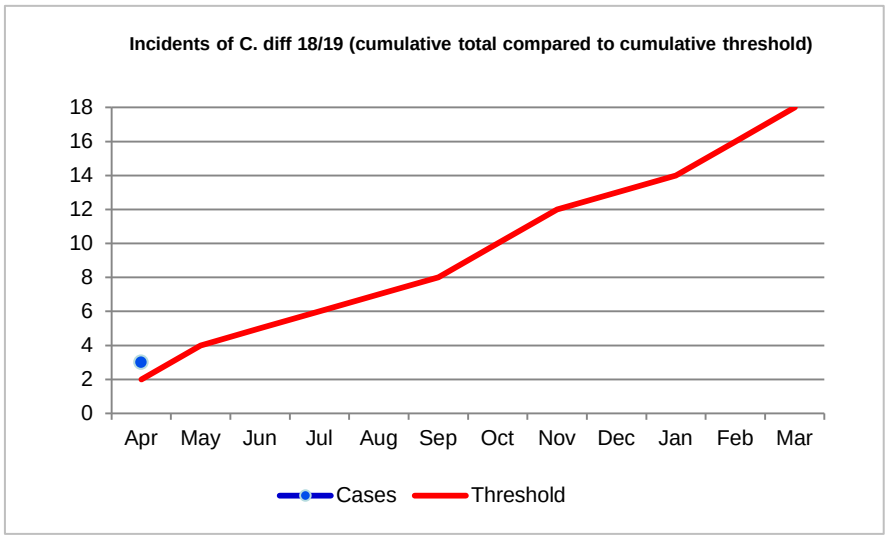
NHS Gloucestershire Care Services NHS Trust

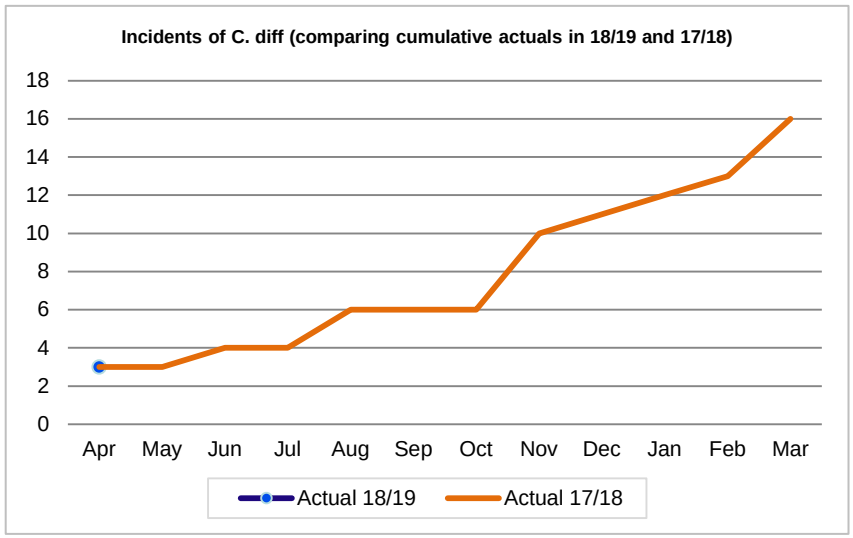
Infection Control

CQC DOMAIN - ARE SERVICES SAFE?

		Target Type	Performance Target	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?
14	Number of post 48 hour Clostridium difficile Infections	N – R L – C	*2	16	3												3	Y
19	VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	95.0%	87.9%												87.9%	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												3
Avoidable cases in GCS care	1	0												0
Unavoidable cases in GCS care	15	3												3
Norovirus Outbreaks	9	0												0





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

EXCEPTION REPORT | ARE SERVICES SAFE?

Gloucestershire Care Services NHS Trust

• Additional information related to performance	What actions have been taken to improve performance?
There were three C.Diff cases to report for April 2018: 1. One patient was transferred from GHFT to Vale Hospital and was treated with intravenous antibiotics and prescribed aperients. This case is considered to have been **unavoidable**. 2. One patient had spent a considerable amount of time in hospital prior to a transfer to Jubilee Ward at Stroud with a range of complexities and transferred back to GHFT. This case is considered to have been **unavoidable**. 3. One patient was transferred to Tewkesbury Hospital from GHFT. A course of antibiotics for a urinary tract infection resulted in them becoming symptomatic. This case is considered to have been **unavoidable**.	• Predisposing factors mean this positive case was hard to avoid, especially as there is no record of colonisation. • The use of Co-Amoxiclav again in this case supports further investigation into the association of this antibiotic and infection. • Education around obtaining a suitable sample at the earliest opportunity has been reinforced.
Norovirus There have been no confirmed Norovirus outbreaks to report, however there has been one potential outbreak at Lydney Hospital. No bed days were lost as a result of this outbreak and no identifiable organism isolated from the samples obtained. **Influenza** There were also two influenza outbreaks in April 2018 both at Stroud Hospital.	• Colleagues at Lydney Hospital responded well with the correct barrier procedures put into place and policy followed. Facilities staff also organised enhanced cleaning and a timely Deep Clean was undertaken. • The good practice and infection prevention and control measures implemented resulted in a limited number of cases and swift return to normality post a Deep Clean.
VTE Risk Assessment • Performance was 87.9% in April compared to 95.0% in March and an outturn figure of 95.0%. Target is 95.0% 24 out of 198 patients did not have a VTE Risk Assessment completed.	• An audit was carried out of those records that do not show that a VTE Assessment was carried out. This has highlighted that in some cases the patients concerned were not under care of the Trust for a long enough duration after admission for the assessment to be carried out before they were transferred back to GHFT. Work is underway with the Matrons to ensure recording of VTE Assessments is improved for future admissions.

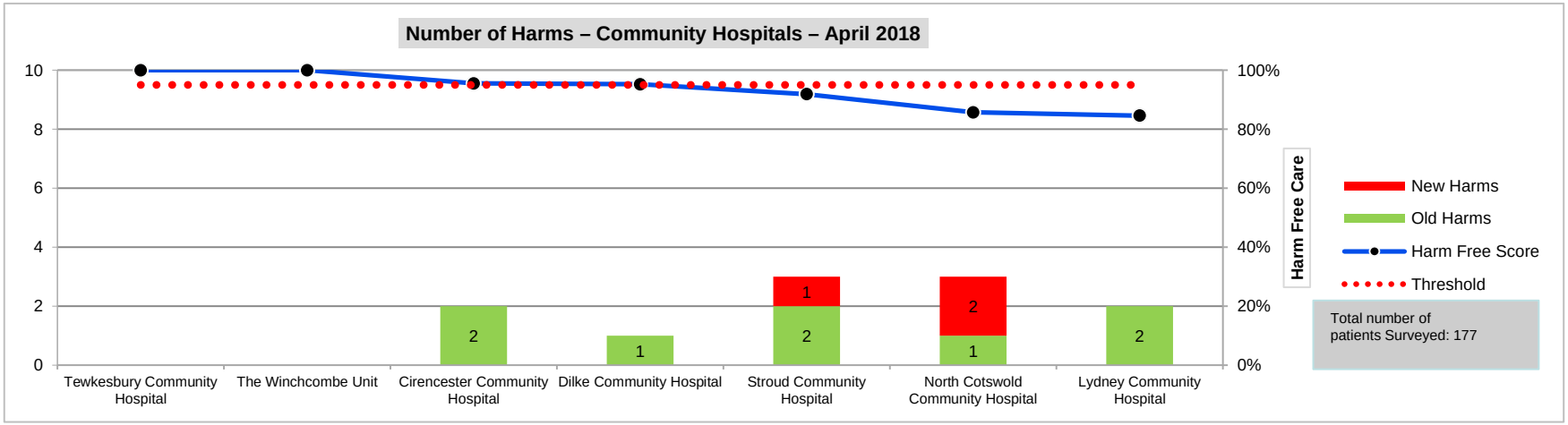
EXCEPTION REPORT | ARE SERVICES SAFE?

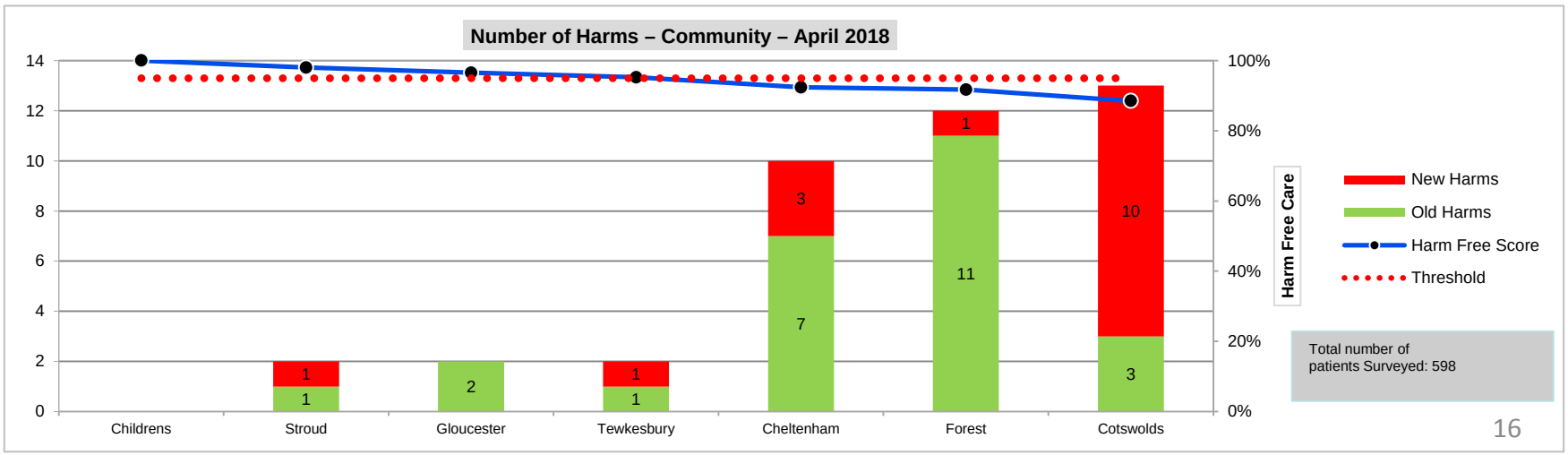
Safety Thermometer (Page 1 of 2)

NHS Gloucestershire Care Services NHS Trust

CQC DOMAIN - ARE SERVICES SAFE?

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

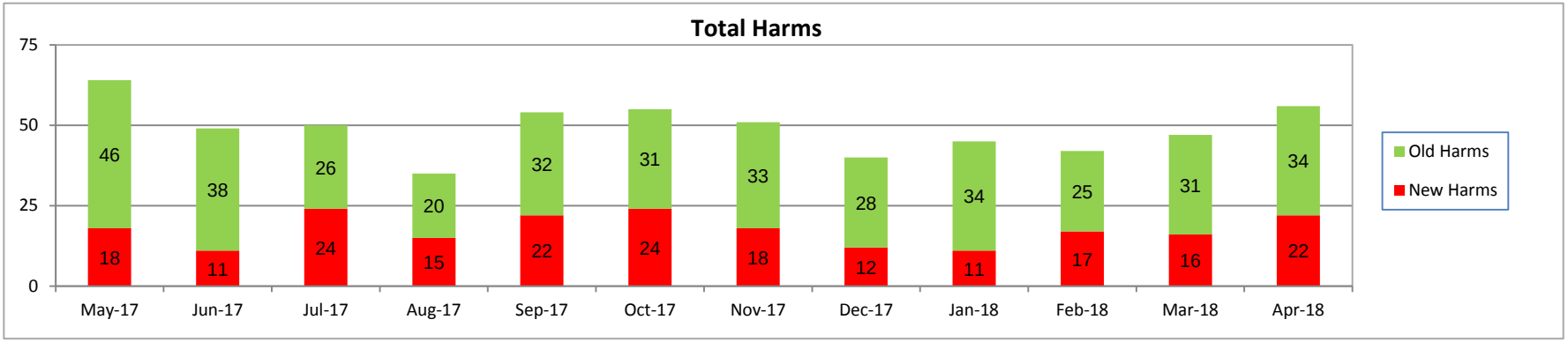




EXCEPTION REPORT | ARE SERVICES SAFE?

NHS Gloucestershire Care Services NHS Trust

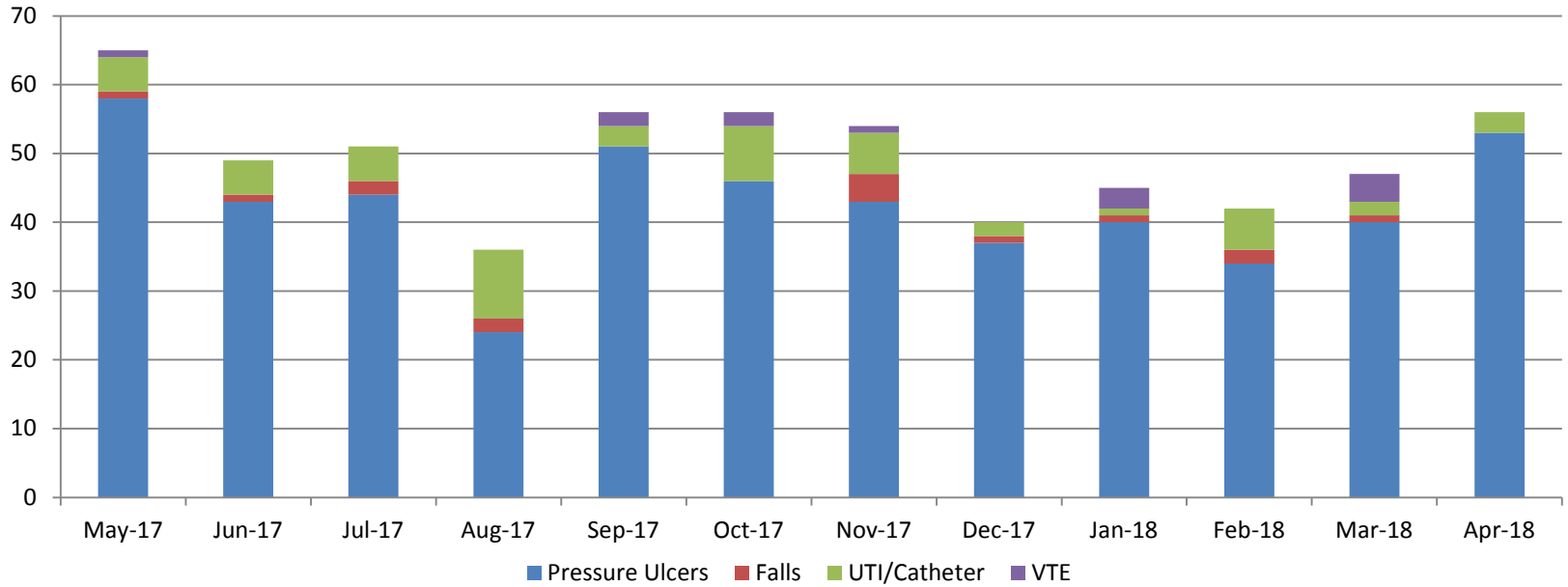
Safety Thermometer (Page 2 of 2)



Additional information related to performance	What actions have been taken to improve performance?
Safety Thermometer: • 775 patient episodes of care were surveyed for the April Safety Thermometer census, out of which 719 patients' care was harm free. The Trust's Harm Free Care score was therefore 92.8% in April, below the target of 95%. Based on new harms only, Harm Free Care in March was **97.2%**. • The Community Hospital is inpatient harm free care performance was 91.5% in April. Based on new harms only, the inpatient performance was 96.6% in April. • Community Nursing harm free care performance was 93.1% in April. Based on new harms only, Community Nursing harm free care was 97.3% in April. • 56 harms were reported in April, of which 22 were new harms. In April, 2.8% of all patients surveyed had a new harm. In 207/18, 205 new harms were reported, representing 2.0% of all patients surveyed for safety thermometer in 2017/18.	• Achieving 95% percent harm free care overall continues to be a major challenge for the Trust, with this only being achieved in one month (August 2017). Locally it has been decided that the threshold for harm-free care for *new harms* should be set at 98% and we are not quite achieving this either. • Pressure ulcers are the main harms surveyed and in April there were no falls or VTEs detected on census day, The Quality Improvement Group for Pressure Ulcer Prevention continues it's work with focus on ensuring colleagues code Datix incidents correctly and harms on safety thermometer. In April 34 of the pressure ulcer harms were old and 22 were new. • An urgent Safety Thermometer extraordinary meeting is scheduled for 15th June 2018 to agree actions to turn this curve. **Risks** Reference – 562 Rating – 16

Benchmarking:
- The Trust reported 2.8% new harms in April which is above the national average of 2.1% (NHS Digital, January 2018).

Safety Thermometer Harms by type (May 2017 – April 2018)



	Pressure Ulcers	Falls	UTI/Catheter	VTE	Total Harms
May-17	58	1	5	1	**65**
Jun-17	43	1	5	0	**49**
Jul-17	44	2	5	0	**51**
Aug-17	24	2	10	0	**36**
Sep-17	51	0	3	2	**56**
Oct-17	46	0	8	2	**56**
Nov-17	43	4	6	1	**54**
Dec-17	37	1	2	0	**40**
Jan-18	40	1	1	3	**45**
Feb-18	34	2	6	0	**42**
Mar-18	40	1	2	4	**47**
Apr-18	53	0	3	0	**56**

EXCEPTION REPORT | ARE SERVICES EFFECTIVE?

NHS Gloucestershire Care Services NHS Trust

Community Hospitals

CQC DOMAIN - ARE SERVICES EFFECTIVE?

		Reporting Level	Target?	Threshold	2017/18 YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?
32	Average of 4 discharges per day (weekends) - Inpatients	L – C	Y	**4	3.1	2.6												2.6	Y
33	Average of 11 discharges per day (weekdays) - Inpatients	L – C	Y	**11	8.1	8.7												8.7	Y

Additional information related to performance

Bed Occupancy

92.0% - 94.0%
94.0% - 96.0%
>96.0%

Delayed Transfer of Care (DToC)

- In April, an average of 3 patients per day were experiencing a delay in their transfer of care. The number of bed days occupied by patients experiencing a delay was 76 (1.4%) of all bed days occupied across community hospitals. Target is <3.5%.
- Out of the 76 bed days occupied by patients experiencing a delay in April, NHS was responsible for 33 delay days (43.4%) and Social care for 43 delay days (56.6%).

Discharges per Weekday and Weekend Day

- 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.

What actions have been taken to improve performance?

- Discussions continue with Commissioners on the expected level of discharges per day to support patient flow.

Benchmarking

- The Trust is reporting an average of 26.3 days (Oct-17 to Apr-18) average length of stay compared to an average of 27.9 days in the NHS Benchmarking Network report.

EXCEPTION REPORT | ARE SERVICES RESPONSIVE?

NHS Gloucestershire Care Services NHS Trust

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2017/18 YTD	
Referral to Treatment																		
41	Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	84.4%	60.7%												60.7%	Y
45	ICT Physiotherapy - %Treated Within 8 Weeks	L - C	95%	85.0%	84.3%												84.3%	Y
46	Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	82.8%	77.4%												77.4%	Y
52	Sexual Health - % of terminations carried out within 9 weeks and 6 days of gestation	L - C	80%	77.4%	77.5%												77.5%	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%												84.6%	Y
59	Stroke ESD - Proportion of new patients assessed within 2 days of notification	L - C	95%	88.6%	83.3%												83.3%	Y
66	95% of priority 1 & 2 calls answered within 60 seconds after introductory message finishing	L - C	95%	90.5%	91.7%												91.7%	Y

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

		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
41	Speech and Language Therapy - % treated within 8 Weeks	95%	60.7%	37	24	92%	95.1%	58	3	41
45	ICT Physiotherapy	95%	84.3%	366	68	92%	97.9%	425	9	13
47	Occupational Therapy Services - % treated within 8 Weeks	95%	77.4%	335	98	92%	92.4%	400	33	20

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 60.7% in April compared to 41.9% in March (target is 95%). 24 out of 61 patients were seen outside the 8 week threshold. • Performance against the 18 week target was 95.1% (3 out of 61 patients seen outside the 18 week threshold)) • Profile of breaches in April (number and percentage): 8-9 wks 2 8.3% 9-10 wks 1 4.2% 10-18 wks 18 75.0% 18+ wks 3 12.5%	• As this is an integrated service, covering both acute and community, resource has been prioritised to support acute inpatient work which is impacting on community performance. • Discussion underway with Commissioners to clarify and quantify acute vs community resource and agreed plans when capacity is limited • Service is impacted by both clinical and non-clinical staffing issues. • A plan in place to address significant admin staffing issues, • Recruitment for qualified staff has been successful and there is some locum cover while new starters on-board
Adult ICT Physiotherapy (% treated within 8 weeks) • Performance was 84.3% in April, compared to 89.2% in March (target is 95%). 68 out of 434 patients were seen outside the 8 week threshold in March. • Performance against the 18 week target was 97.9% (425 of 434 patients seen) • Profile of breaches (number and percentage): 8-9 wks 22 31.0% 9-10 wks 6 8.5% 10-18 wks 34 47.9% 18+ wks 9 12.7%	• There is a continued focus on reducing average length of time on waiting list, which is now 5.3 weeks as the long wait patients have reduced. • Work underway to review SystmOne module as concerns remain that recording is not producing accurate reporting of actual performance
Adult ICT Occupational Therapy (% treated within 8 weeks) • Performance in April was 77.4% compared to 80.5% in February (target is 95%). 98 out of 433 patients were seen outside the 8 week threshold in March. • Performance against the 18 week target was 91.7% (400 out of 433 patients seen) • Profile of breaches (number and percentage): 8-9 wks 11 11.2% 9-10 wks 7 7.1% 10-18 wks 47 48.0% 18+ wks 33 33.7%	• Service now carrying significant vacancies, which are being held to support transition to new OT service model following the Commissioner review • The service is in discussion Commissioners regarding KPIs, as there is an expectation that performance will be impacted during the service transformation and implementation of a new service model. • In the interim there is a continued focus on reducing average length of time on waiting list, which is 7.0 weeks. • Work underway to review SystmOne module as concerns remain that recording is not producing accurate reporting of performance

EXCEPTION REPORT | ARE SERVICES RESPONSIVE?

Gloucestershire Care Services NHS Trust

Additional information related to performance	What actions have been taken to improve performance?
Sexual Health - % of terminations carried out within 9 weeks and 6 days of gestation • Performance was 77.5% in April compared to 72.7% in February. 18 out of 80 patients were seen outside the 9 weeks 6 days gestation threshold. • 99.4% of medical terminations this year have been provided within the 9 week 6 day target • 77.35% received a treatment/procedure within 9w6d (compared to 46.17% last year) and MTOPs, compared to surgical procedures, have increased from 46.2% last year to 57.9% this year (national average 60%)	• The issue is providing timely surgical terminations, which is due to not having sufficient suitably qualified staff. Recruitment to date has not been successful, and this is a recognised national issue. • The service does use alternative providers to support the provision of this service in a timely way.
MSKCAT Service - wait from referral for urgent patients to be seen not to exceed 2 weeks • Performance was 84.6% in April, compared to 100% in March (target is 95%). • This equates to 4 out of 26 patients were seen outside the 2 week threshold.	• Service is now green for 8 week RTT as per action plan (95.8%) and this is having a positive impact on the wait times for the urgent patients overall • Service started taking on new 'body parts' as part of MSK redesign and will commence direct booking by end of Q1, however this was done in a planned way which allowed performance to not be impacted
Stroke ESD (% of new patients assessed within 2 days of notification) • Performance in April was 83.3% compared to 71.4% in March (target is 95%. • 3 out of 18 patients were seen outside the 2 day target.	• Issues pre-April with changes in scorecard reporting led to drop in performance. Audits undertaken show this was a reporting issue • Work now underway to improve ESD S1 module but will not be live until July 2018 • Manual review of April data has updated initial position, and 83.3% is correct due to service capacity (saw 15 out of 18 patients within time). • As the service is only commissioned for a weekday offer, any patients referred on Friday afternoon will automatically breach the target of being assessed within 2 days

EXCEPTION REPORT | ARE SERVICES RESPONSIVE?

Gloucestershire Care Services NHS Trust

Additional information related to performance	What actions have been taken to improve performance?
95% of priority 1 & 2 calls answered within 60 seconds after introductory message finishing. • Performance was 91.7% in April, compared to 88.9% in March (target is 95%). 206 out of 2,477 Priority 1 & 2 calls were answered outside of the 60 second target. • Finished Significant improvement in KPI across the year , with 83.4% full year at end of 16/17 and 90.4% at end of 17/18	• Ongoing discussions with CCG re. relevance and appropriateness of KPI, particularly as now accepting telephone referrals for transfers from the acute to community beds, which is impacting on capacity

EXCEPTION REPORT | ARE SERVICES WELL LED?

Workforce / HR (Page 1 of 3)

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?
68	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place of work	N - R L - T	61%	53.3%														Y
69	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place to receive treatment	N - R L - T	67%	83.0%														
70	Mandatory Training	L - I	92%	82.6%	86.3%												86.3%	Y
71	% of Staff with completed Personal Development Reviews (Appraisal)	L - I	95%	79.9%	84.4%												84.4%	Y
71 a	% of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only	L - I	95%	N/A	87.4%												87.4%	Y
72	Sickness absence average % rolling rate - 12 months	L - I	<4%	4.6%	4.7%												4.7%	Y

Additional information related to performance	What actions have been taken to improve performance?
Staff FFT In Quarter 4 of 2017/18, 49% of staff would recommend the Trust as a place to work (target is 61%) and 85.0% 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. These plans will continue align to the wider OD agenda's. **Risks (Staff FFT)** Reference – 622 Rating – 12
Staff with completed Personal Development Reviews (PDRs) • **84.4%** of Personal Development Reviews were completed by the end of April 2018. For active assignments, this rises to **87.4%** in March. **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. • We are working with our operational and system colleagues looking at improvements to both the PDR paperwork and the system.
Sickness absence • The rolling 12 months performance was 4.7% to April, above target of 4.0%. **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.

EXCEPTION REPORT | ARE SERVICES WELL LED?

Workforce / HR – Mandatory Training (Page 2 of 3)

Gloucestershire Care Services NHS Trust

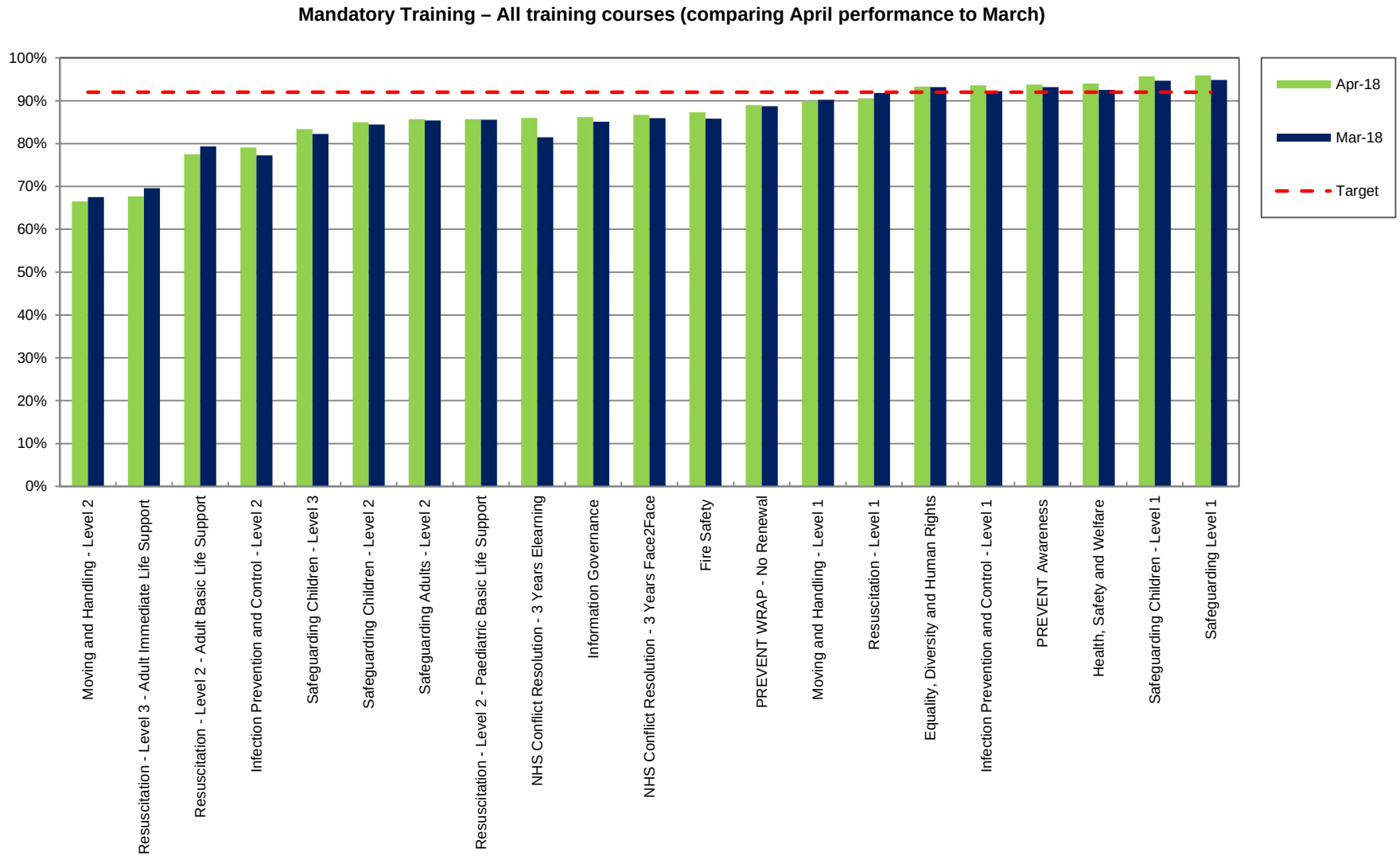
Additional information related to performance	What actions have been taken to improve performance?

Mandatory Training
 	
• Average April performance was 86.3% 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
 	
• 5 out of 20 measures have reduced in performance in April compared to March:
  • Moving and Handling - Level 2
  • Resuscitation - Level 3 - Adult Immediate Life Support
  • Resuscitation - Level 2 - Adult Basic Life Support
  • Moving and Handling - Level 1
  • Resuscitation - 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 and 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.

EXCEPTION REPORT | ARE SERVICES WELL LED?

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

NHS Gloucestershire Care Services NHS Trust



NHS Gloucestershire Care Services NHS Trust

Dashboard Key:

- Implemented for March report:

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

Trust Board

Date of Meeting: 7th June 2018

Report Title: Audit and Assurance Committee Update

Agenda reference Number	13/0618
Accountable Executive Director (AED)	Sandra Betney, Director of Finance
Presenter (if not AED)	Richard Cryer, Chair of Audit and Assurance Committee
Author(s)	Sandra Betney, Director of Finance
Board action required	To note
Previously considered by	

Executive Summary

This report provides assurance to the Trust Board that the Audit and Assurance Committee is discharging its responsibility for oversight of the Trust's independent and objective review of its financial systems, financial information and compliance with laws, guidance and regulations governing the NHS.

It confirms:

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

Recommendations:

The Board is asked to

(i) **NOTE** the contents of the Audit and Assurance Committee report.

Related Trust Objectives	1.2.4.5.
Risk Implications	No risks identified
Quality/Equality Impact Assessment Requirements/implications (QEIA)	No equality implications identified
Financial Implications	No finance implications identified
Legal/Regulatory Implications	Legal/Regulatory implications are clearly referenced in the report

Audit and Assurance Committee Update

1 Introduction and Purpose

The Audit and Assurance Committee met on the 10th and 23rd May 2018. Key Issues considered by the Committee were Internal Audit Annual Report, External Audit Report and GCS Annual Report and Accounts.

2. Internal Audit Reports

Members considered the Internal Audit Annual report, progress report and Audit Report on Cyber Vulnerability. The Trust in conjunction with Countywide IT Services (CITS) had requested an internal audit on Cyber Vulnerability across a range of infrastructure processes. The Committee noted the next steps planned.

The Committee noted the assurance from the Internal Auditors that the audit recommendations from the Audits through the year had been progressed well.

Internal Audit presented their Annual Report. The Opinion was the same level as in 2016/17 "Opinion – generally satisfactory with some improvements required".

3. External Audit Report

The External Auditors confirmed that it would provide an unqualified opinion on the Trust's Annual Accounts and that the Trust had complied with the Department of Health requirements in the preparation of its Annual Governance Statement. The External Auditor confirmed the adequacy of the Value for Money arrangements in place for securing economy, efficiency and effectiveness in the Trust's use of resources.

4. Annual Report and Accounts

The Committee considered in detail the final accounts 2017/18 which included year on year and performance against budget comparisons, bad debt provision and analysis and linked accounts, noting the opinion and feedback from the External Auditors. The Committee confirmed the Going Concern basis on which the Accounts were prepared

The Committee, on behalf of the Board, formally approved the accounts, duly signed by the Chair, CEO and Director of Finance, for submission to NHSI.

5. Self-Certification of License

The Committee noted that from April 2017 NHS Trusts were required to self-certify compliance with the observations set out in the NHS Provider Licence (which includes compliance with the Health and Social Care Legislation, have regard to the constitution and complied with governance required). The Committee considered the Self-certification information provided.

The Committee NOTED the self-certification requirements and APPROVED on behalf of the Board the Self-Certification.

6. Counter Fraud Report

The Committee reviewed and endorsed the Annual Counter Fraud Report for 2017/18 noting the assurance processes and the way the activity from 2017/18 would inform work planned in 2018/2019 activity

7. Committee Self-Assessment

The Committee, in line with the other Board Committees, undertook a self assessment to inform the Annual Report and the Review of Effectiveness. The Self-assessment confirmed the Committee's effectiveness and also identified potential to broaden its remit. This proposal will now be worked up for the Committee's consideration at its next meeting. The Committee was updated on consideration currently being given to a proposal to develop a Resources Committee, which would enable greater triangulation of the Finance and Workforce agendas. The Committee was supportive in principle of this proposal. {consideration on the implementation of this from 1 August is now ongoing}.

7. Conclusion

The Audit and Assurance Committee has reviewed a range of assurance reports from across Trust and has maintained an independent and objective review.

8. Recommendations

The Board is asked to

(i) **NOTE** the contents of the Audit and Assurance Committee report.

NHS
Gloucestershire
Care Services
NHS Trust

Trust Board

Date of Meeting: **7th June 2018**

Report Title: **Finance Committee Report**

Agenda reference Number	14/0618
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 24th April 2018. Key aspects considered included the Month 12 Finance Report; Final submission Operating Plan, 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.

A number of commercially sensitive items were also progressed.

2.1 Finance Report Month 12

The Committee was assured that at Month 12 the Trust was ahead of plan as had been advised previously. The Committee recognised the work that had taken place across the Trust to achieve the expected year end position.

The Committee expressed thanks to the Finance Team for the considerable effort made in finalising the year end accounts in such a timely manner.

2.2 CIP/QIPP/CQUIN Progress

The Committee discussed progress on the Cost Improvement Plan (CIP) and the achievement at quarter 4 CQUINS for 2018/19 were noted to be in line with 2017/18.

2.3 Cyber Security – 2017/18 Data Security and Protection Requirements

The Committee received a report detailing the requirements for organisations contracted to provide services under the NHS Standard Contract to comply with the 10 data security standards recommended by the National Data Guardian for Health & Care and the Trust's compliance against the standards.

The Committee recognised the work in place and ongoing to minimise the Trust's exposure to cyber-attack. The Committee **NOTED** the requirements and the GCS position against compliance against the 10 Cyber Security standards and the need to keep this issue under regular review.

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

3.1 Operating Plan – refresh submission

The Committee discussed in detail and approved for submission as per the delegated authority given by the Board meeting on March 29th 2018

4. Conclusion and recommendations

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

Trust Board

Date of Meeting: **7 June 2018**

Report Title: **Finance Report**

Agenda reference Number	15/0618
Accountable Executive Director (AED)	Sandra Betney
Presenter (if not AED)	Stuart Bird
Author(s)	Stuart Bird
Committee action required	To note
Previously considered by	n/a
Appendices	App 1 : Main M1 Finance Report

Executive Summary:

This report provides an overview of the Trust's financial position for Month 1 of 2018/19.

The report also confirms to the board that the 17/18 position has now been finalised and that unqualified accounts have been signed off by the auditors and submitted to NHSI. The final closing position for 17/18 was an NHS basis adjusted surplus of £5.563m (which included STF of £3.642m) compared to a plan and control total of £1.986m (which included £1.020m of STF)

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, Capital Resource Limit approved so far is £5.021m
- Cost Improvement Plan (CIP) target is £5.3m

- Agency spending cap is £2.232m

Month 1 (M1) performance is as follows:

- M1 surplus is £188k which is £2k better than plan and budget of £186k
- Capital spend to date is Nil.
- Cash at the end of Month 1 is £12.11m compared to plan of £14.22m. (capital spend is £65k below plan but 17/18 STF of £2.978m is still owed by DHSC in respect of 17/18)
- M1 agency spend is £134k compared to a plan figure of £186k

Single Operating Framework score was 1 throughout 17/18 and will be included from month 2 onwards when available from the NHSI submission template.

Recommendations:

The board is asked to note the content of the report and in particular the risks shown on the final page of the appendix.

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2018/19 Month 1 Finance Report

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Understanding You

Overview

Gloucestershire Care Services NHS Trust

- Month 1 surplus £2k above plan and budget at £188k. 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 £2.04m) Full year forecast is in line with the cap, Month 1 actual was £134k compared to a plan of £186k.
- Full year Cost Improvement Plan (CIP) target for the full year is £5.3m . The amount saved recurrently to the end of M1 is £168k compared with a plan of £865k. The amount removed from full year budgets in respect of CIP is £1.961m so far. The CIP steering grouping are working to firm up plans and ensure savings are delivered recurrently.
- Full year Income from Quality, Innovation, Productivity and Prevention (QIPP) schemes is forecast as the full amount available. Work is ongoing with the CCG to finalise all schemes and to clarify the details of the risk share element (currently £900k).
- 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 1 is £2.11m below plan at £12.11m
- Capital spend for the year is £Nil. Full year plan is £7.85m and the amount approved by NHSI at present (via the Capital Resource Limit setting process) is £5.021m.

Income and Expenditure

Gloucestershire Care Services NHS Trust

Month 1 performance is £2k above plan at £188 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	9,069	9,036	(33)	108,260
Other operating income exc PSF	1,048	115	128	13	1,380
Employee expenses	(78,529)	(6,479)	(6,460)	19	(77,750)
Operating expenses excluding employee expenses	(28,918)	(2,449)	(2,448)	1	(29,384)
PDC dividends payable/refundable	(1,666)	(150)	(150)	0	(1,800)
Surplus/(deficit) before impairments and transfers	**1,824**	**106**	**106**	**0**	**706**
Remove capital donations/grants I&E impact	97	10	10	0	120
Adjusted performance exc PSF	**1,921**	**116**	**116**	**0**	**826**
PSF	3,642	72	72	0	1,436
Adjusted performance inc PSF	**5,563**	**188**	**188**	**0**	**2,262**
Control Total	**1,986**		**186**		**2,238**

Understanding You

Balance Sheet

STATEMENT OF FINANCIAL POSITION (all figures £000)		Mar-18	April 2018 Actual			Mar-19
		Audited PY	Plan	Actual	Variance	Plan
Non-current assets	Intangible assets	1,000	1,000	1,000	0	1,000
	Property, plant and equipment: other	58,709	58,574	58,507	(67)	64,159
	Total non-current assets	**59,709**	**59,574**	**59,507**	**(67)**	**65,159**
Current assets	Inventories	228	228	228	0	228
	NHS receivables	4,817	1,000	5,725	4,725	1,000
	Non-NHS receivables	1,939	3,130	1,962	(1,168)	3,130
	Cash and cash equivalents:	12,354	14,224	12,110	(2,114)	10,438
	Total current assets	**19,338**	**18,582**	**20,025**	**1,443**	**14,796**
Current liabilities	Trade and other payables: capital	(1,533)	(500)	(200)	300	(500)
	Trade and other payables: non-capital	(8,283)	(8,211)	(9,952)	(1,741)	(8,211)
	Provisions	(160)	(138)	(132)	6	(138)
	Total current liabilities	**(9,976)**	**(8,849)**	**(10,284)**	**(1,435)**	**(8,849)**
Non-current liabilities	Borrowings	**(221)**	**(280)**	**(221)**	59	**(115)**
	Total net assets employed	**68,850**	**69,027**	**69,027**	**0**	**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)	(9,166)	(9,166)	0	(7,202)
	Total taxpayers' and others' equity	**68,850**	**69,027**	**69,027**	**0**	**70,991**

Capital and Cash

Gloucestershire Care Services NHS Trust

Capital schemes	2018/19	2019/20	2020/21	2021/22
	Plan	Plan	Plan	Plan
Gloucester base	3,400	0	0	0
Cheltenham Base	0	2,000	0	0
Forest of Dean	800	5,500	4,700	-1,500
Building refurbishment	2,250	750	1,250	1,250
IT replenishment	600	600	600	600
IT Network replacement	300	300	300	300
Corporate systems	0	0	0	0
Medical Equipment	500	200	200	200
Total	**7,850**	**9,350**	**7,050**	**850**

- Year to date spend for month 1 is Nil.
- Current level of spend approved is £5.021m
- Capital Expenditure Steering Group meets on 4 June 18 to agree prioritisation of spend within Capital resource Limit (CRL) set by NHSI and to identify any risks created around CIP delivery or STP collaboration.

Cash position at the end of Month 1 is a positive balance of £12.11m

- This is £2.1m lower than plan as STF for 17/18 of £2.978m hasn't been received yet from DHSC.

Understanding you

Cash Flow Summary

Gloucestershire Care Services NHS Trust

Statement of Cash Flow £000	ACTUAL YTD to Apr 2018		FORECAST 2018/19	
Cash and cash equivalents at start of period		**12,354**		**12,354**
Cash flows from operating activities				
Operating surplus/(deficit)	**178**		**2,142**	
Add back: Depreciation on donated assets	**10**		**104**	
Adjusted Operating surplus/(deficit) per I&E	**188**		**2,246**	
Add back: Depreciation on owned assets	191		2,296	
(Increase)/decrease in STF receivable	(72)		2,978	
(Increase)/decrease in inventories	0		0	
(Increase)/decrease in other NHS receivables	(836)		839	
(Increase)/decrease in non NHS other receivables	(23)		(1,191)	
Increase/(decrease) in provisions	(28)		(22)	
Increase/(decrease) in trade and other payables	1,669		(73)	
Increase/(decrease) in capital payables	(1,333)		(1,033)	
Net cash generated from / (used in) operations		**(244)**		**6,040**
Cash flows from investing activities				
Increase/(decrease) in Finance Lease Payables	0		(106)	
Purchase of property, plant and equipment	0		(7,850)	
Net cash generated used in investing activities		**0**		**(7,956)**
Cash and cash equivalents at end of period		**12,110**		**10,438**

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 1	Month 1 Change
Delivering required recurrent CIP	1,500	1,000	-500
Delivery of non rec savings in year to offest CIP phasing	1,000	0	-1,000
Delayed agreement of capital limit impacts STP and CIP work	0	585	585
Potential for unfunded elements of July pay award	600	600	0
Unbudgeted elements of 2G integration work	122	0	-122
VAT changes impacting recovery on Systm1	100	100	0
Delivering Milestone QIPP	1,500	1,500	0
QIPP risk share	900	900	0
Delivering CQUIN in line with plan	2,000	400	-1,600
Managing agency spend within cap	500	300	-200
Provivder Sustainability funding (formerly STF)	1,436	1,364	-72
Release of accruede expenditure	0	-200	-200
	9,658	**6,549**	**-2,837**

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Trust Board

Date of Meeting: 7th June2018

Report Title: Year End Governance Compliance Report

Agenda reference Number	16/0618
Reason for Being Heard in Confidential Session	N/A
Accountable Executive Director (AED)	Paul Roberts, Chief Executive Officer
Presenter (if not AED)	Gillian Steels, Trust Secretary
Author(s)	Gillian Steels, Trust Secretary
Board action required	To note
Previously considered by	None
Appendices	

Executive Summary:

This report provides the Board with assurance on compliance with statutory register maintenance relating to:

- Register of Declaration of Interests (Directors)
- Register of Declaration of Interests (all Budget Holders)
- Register of Fit and Proper Persons Test
- Register of Gifts and Commercial Sponsorship
- Register of Seals

Recommendations:

The Board is asked to:

1) **RECEIVE** this report.

2) **NOTE** that the registers detailed above are being held, maintained and updated as required in line with statutory requirements and good practice.

Related Trust Objectives	**1,5**
Risk Implications	No risks identified
Quality/Equality Impact Assessment (QEIA) Requirements/Implications	No equality implications identified
Financial Implications	No finance implications identified
Legal/Regulatory Implications	No legal or regulatory implications identified

Year End Governance Compliance Report

1 Introduction and Purpose

To provide the Board with assurance that statutory governance compliance is being maintained.

2 Register of Declaration of Interests

The NHS Code of Accountability requires Board members to declare interests which are relevant and material to the NHS Board of which they are a member.

It is also a requirement that budget holders declare any interests that they have which may conflict with the interests of the Trust itself.

The following registers have been updated for 2018/19

- Register of Declaration of Interests (Directors)
- Register of Declaration of Interests (all Budget Holders)

For Board Members the following processes are in place, equivalent processes are in place for staff if required.

- Declarations made during the course of Board meetings are recorded in the Trust Board minutes. Any changes in interests are declared at the next Board meeting following the change and recorded in the minutes of that meeting.
- Board members' directorships of companies likely or possibly seeking to do business with the NHS are signposted in the statutory Annual Report & Accounts.
- Conflicts which arise during the course of a meeting are be declared and if established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

Declarations of Interest have been completed by all Board Members and Budget holders in line with the revised statutory guidance on managing conflicts of interest, which came into force 1 June 2017 for NHS Trusts.

This register for Board members is available on the public website under the "our publications" section.

3. Register of Fit and Proper Person Test

Since 27 November 2014, all NHS bodies that are required to register with the Care Quality Commission (CQC) must consider the fit and proper person requirements when making appointments to director level positions. A person's continued fitness should be assessed as part of the existing appraisal process. Following further guidance from the CQC in March 2018 all Board members all have also completed an Enhanced Disclosure and Barring Service (DBS) check.

All Board members have completed the Fit and Proper Person Declaration for 2018/19.

4. Register of Gifts and Commercial Sponsorship

The revised guidance on Managing Conflicts of Interest in the NHS came into force on 1st June 2017 and there is also increased public scrutiny in this area with the Association of the British Pharmaceutical Industry publishing records of gifts and hospitality given by their members to NHS organisations and staff.

The Trust's Gifts and Commercial Sponsorship forms are completed, recorded on the register and then authorised (if suitable) by the Director of Nursing or Medical Director for all applications.

5. Register of Seals

The common Seal of the Trust is primarily used to seal legal documents such as transfers of land, lease agreements. The seal has been used 13 times in 2017/18 in line with the Standing Orders.

6. Conclusion and Recommendations

The Board is asked to:

1) **RECEIVE** this report.

2) **NOTE** that the registers detailed above are being held, maintained and updated as required in line with statutory requirements and good practice.

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Annual Report and Accounts 2017/18

Gloucestershire Care Services NHS Trust

Annual Report and Accounts 2017/18

Presented in accordance with the DH Group Manual for Accounts 2017/18

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Annual Report and Accounts 2017/18

About this document

This document fulfils the Annual Reporting requirements for NHS trusts.

Copies of this document are available from our website www.glos-care.nhs.uk, by email from TrustSecretary@glos-care.nhs.uk or by writing to Trust Secretary, Gloucestershire Care Services NHS Trust, Edward Jenner Court, 1010 Pioneer Avenue, Gloucestershire Business Park Brockworth, Gloucester, GL3 4AW.

If you would like this report in a different format, such as large print, or need it in a different language, please contact the Trust Secretary

Foreword

Welcome from the Chair

I am delighted to welcome you to this Annual Report and to introduce to you the achievements of Gloucestershire Care Services NHS Trust in a year that has been marked by some significant milestones.

Colleagues across the Trust are absolutely delighted that the Care Quality Commission confirmed our overall rating as Good, following inspections in January and February 2018. At our last inspection in 2015 we received a 'Requires Improvement' rating, so it is heartening that the efforts of my colleagues to make improvements and deliver safe, effective care have been acknowledged. Of course, we are restless for excellence, so our sights are now set on working towards Outstanding!

I am 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.

I would like to acknowledge the contribution of Katie Norton, our Chief Executive until April 2018, in achieving this assessment, reflecting her patient-centred approach to care and focus on achieving the best possible performance for our community. Her predecessor, Paul Jennings, also played a very significant role in leading us on this journey of improvement.

I would also like to formally record my thanks to Tina Ricketts Director of HR, who left to take up the role of Director of People and Culture with Worcestershire Acute Hospitals Trust in January 2018. Tina had been with the Trust since its inception following eight years with the Primary Care Trust. Her contribution to both the Trust and the wider Gloucestershire Health system is widely recognised

Our Trust vision is about "Understanding You' and this means understanding the whole person. In pursuit of this vision, we took a hugely important and exciting step this year in announcing plans to develop integrated services with ^{2}gether NHS Foundation Trust, with the intention of merging as a single Trust.

There is clear evidence of the interplay between mental and physical health. Life expectancy for people with long term mental health problems is 15 to 20 years shorter than for the general population and these early deaths are mostly due to physical health problems. People with long-term physical health conditions are three times as likely to have mental health problems and these in turn impact negatively on their physical health outcomes. People with two or more long-term physical health conditions are seven times more likely to experience depression.

Colleagues see and experience this reality every day in delivering care in people's homes and communities; so aligning community health and mental health services is a natural fit. It offers the prospect of more holistic care, improved co-ordination between clinicians, better pro-active care and simplified access to services – all of which will benefit the people we serve.

Foreword

In an organisation as large and complex as the NHS there is a huge amount of work to get through in order to realise these benefits. I took up the post of Joint Chair of both Trusts on 1st January to oversee the process, which involves not just merging the two organisations, but ensuring that we retain our focus on the needs of our service users and communities throughout. Accomplishing this will take more than work – it will require skill, insight, imagination, diplomacy, and courage.

To that end I am delighted to welcome Paul Roberts, who took up the 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 is exemplary and his passion for, and understanding of, the inter-relationships between the acute, community and mental health sectors will be invaluable as we move into this new chapter for our organisations.

Throughout the year our Trust has continued to build strong partnerships with those around us. This has included active participation in the Gloucestershire Strategic Partnership, the Health and Care Overview and Scrutiny Committee, The Health and Wellbeing Board and good partnerships with Healthwatch and the Police.

We have also worked hard to build our wider community networks and I am particularly proud of our partnership work with BAME communities in the county. This year saw the development of an Equalities App for our colleagues, co-produced by our diverse community partners, to help ensure the services we provide meet the needs of all our community members. It is a great resource which we have made available across the wider health and social care community.

I am usually reluctant to single out individuals for praise when we are so reliant on each other to achieve our goals. However, on this occasion I would like to mention Gayle Clay, who leads the homeless healthcare team. She was awarded a British Empire Medal in the New Year's Honours List for her championing of the care and rights of this disadvantaged – often invisible – group throughout her long NHS career. Gayle really exemplifies our Trust values in her caring approach and values-based leadership.

However, I know that every colleague, including our many volunteers and supporters from the Leagues of Friends, has a daily role to play in ensuring we meet the standards of the NHS Constitution on which our Trust is built. I would like to thank you all for your support.

Ingrid Barker, Chair

Performance Report

Chief Executive's Introduction

As the recently appointed Chief Executive of both Gloucestershire Care Services NHS Trust and 2gether NHS Foundation Trust I'm in the unique position of being able to objectively review the Trust's achievements over the last 12 months, while setting out my main priorities for 2018/19.

Since taking up my position, my overriding impression has been that high quality services and support are being provided in Gloucestershire Care Services, and in both Gloucestershire and Herefordshire by 2gether.

Both Trusts have a very strong track record, which is borne out in the case of Gloucestershire Care Services by the wide range of information, data and performance measures contained within this report.

But data only provides part of the story. I have made it my aim to meet as many colleagues and stakeholders as I possibly can in order to gain their impressions of the Trusts. By and large, what I have heard backs up my initial impression that these are organisations doing a very good job in sometimes challenging circumstances. They can only continue to do so due to the significant contribution of our colleagues, as well as our Board, service users, carers, volunteers, commissioners, partners and communities.

That isn't to say that we cannot do better – there will always be more we can and should do to support our communities more effectively. I know everyone within the organisations is committed to doing so.

This brings me to our plans to more formally join 2gether and Gloucestershire Care Services as a combined Trust. This will be a major focus of 2018/19, with the ultimate aim of providing a seamless service to support people of all ages with their health needs, whether that is physical health, mental health or a learning disability. Integrating our services will improve lives and health outcomes across our communities.

While integration is a priority, we will also be maintaining our attention to Gloucestershire Care Services' five strategic objectives:

- We will be recognised locally and nationally as an outstanding provider of community services, caring for people in their homes and local communities
- We will make sure the needs and views of service users, carers and families shape the way we plan and deliver care

Performance Report

- We will provide services in partnership with other providers so that people experience seamless care and support
- We will have an energised and enthusiastic workforce and each individual will feel valued and supported
- We will manage public resources effectively so that the services we provide are sustainable

Within our Quality Account we set out the Trust's achievements over the last year in patient quality and care, as well as the developments we have made in enhancing the services and support we provide. This includes:

- major work to reorganise Integrated Community Teams around GP clusters
- transforming services in public health for Children and Young People and Sexual Health
- implementing the new MSK Service Model with system partners
- progressing plans to modify facilities in the Forest of Dean
- enhancing our rapid response service to decrease admissions to acute services

This report also provides a full breakdown of financial performance, including:

- in 2017/18 the Trust ended the year meeting its financial plan and control total
- achieved an NHS basis adjusted surplus of £5.6million
- received income of just over £114.5million
- received Sustainability and Transformation Funding of £3.6million

Sustaining this strong financial position will be challenging in the year ahead, but we are focused on doing so in order to invest further in services.

I have already outlined our work to join Gloucestershire Care Service NHS Trust and ^{2}gether, but in the year ahead we will continue to work closely with others. This includes our voluntary and third sector partners, but also our partners within the Sustainability and Transformation Partnership in Gloucestershire and the local authority.

These are key networks, enabling health and social care organisations to plan services and delivery in the coming years, when we know demand will be ever increasing. We have a duty not only to meet that demand but to effectively improve the health and wellbeing of our communities.

Performance Report

I am delighted to have joined Gloucestershire Care Services as we embark upon an exciting year ahead. There will be many changes to come but we have a dedicated team of colleagues who all have one priority in mind – making life better for our communities.

Paul Roberts
Chief Executive

Performance Report

Joint work with 2gether NHS Foundation Trust

Last September, the Boards of 2gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust announced plans to work on proposals to integrate as a single organisation.

Since then, the two Trusts have appointed a Joint Chair, Ingrid Barker, who took up her position in January 2018. The Trusts have also recently appointed Paul Roberts as Joint Chief Executive, who started in his post in April 2018.

Shaun Clee, who was formerly Chief Executive of 2gether, and Katie Norton, Chief Executive of Gloucestershire Care Services, have now stepped down from their posts.

Both Shaun, who was Chief Executive for 2gether for 11 years, and Katie, who was in her role for 15 months, made significant and lasting contributions to healthcare in the county of Gloucestershire. The respective Boards have thanked them for their unswerving dedication to improving services, championing the rights and needs of patients, service users and carers and their leadership through many challenges and changes.

The Boards of each Trust have agreed to work towards formally joining, with the aim of:

- Providing opportunities for more seamless care provision
- Streamlining and simplifying how services work with GPs and acute hospitals
- Making more efficient use of care records and information
- Creating integrated pathways through community health, mental health and learning disability services
- Developing innovative services for our communities
- Sharing best practice and understanding to improve care
- Ensuring a focus on a single set of priorities
- Offering greater employment and career development opportunities

While the Trusts are working towards this, both will remain separate legal entities with independent Boards until a full business case is completed and the necessary approvals are received. Engagement with service users, patients, carers and staff of both Trusts will take place throughout.

Performance Report

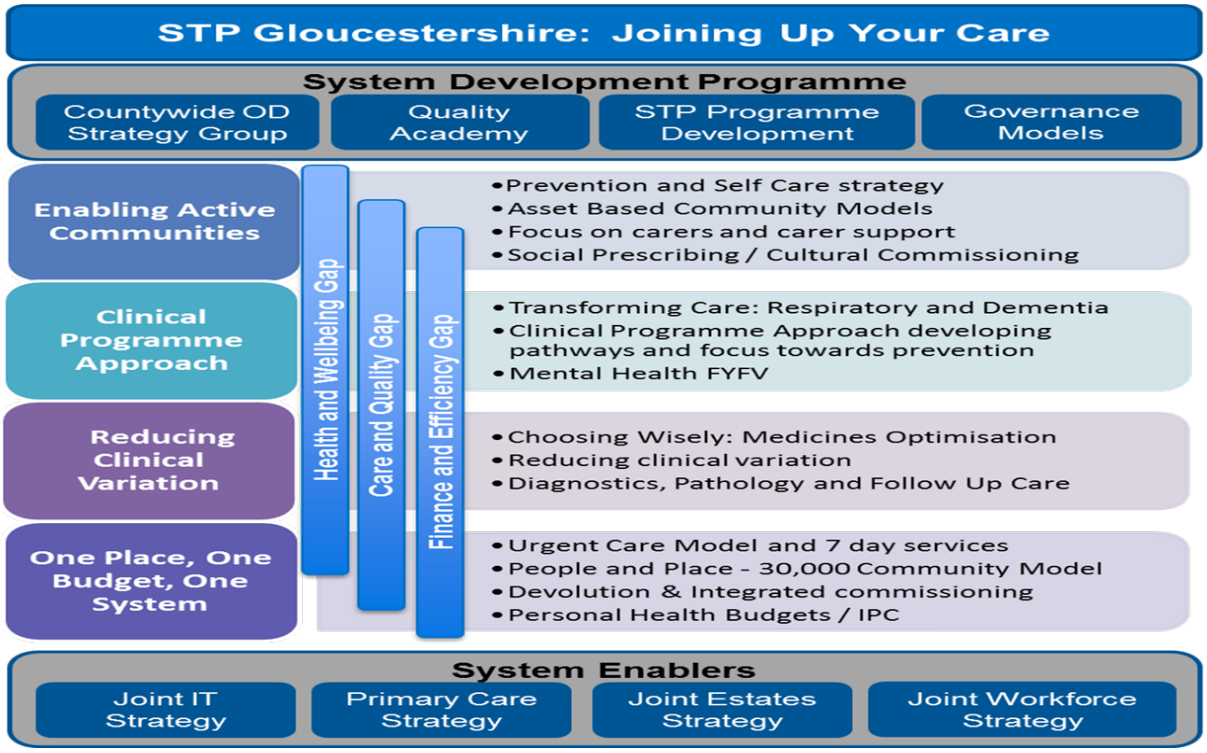
One Gloucestershire

As a Trust we are a key partner within the One Gloucestershire Sustainability and Transformation Partnership which has the following commitments at the heart of its work:

- We will invest in keeping people healthier for longer by enabling communities to support each other, and support self-care and prevention
- We will reduce variation in prescribing and services, cut waste, and fund interventions that can deliver the greatest health benefit for our population
- We will review the patients' care journey, to ensure that care is delivered efficiently and effectively, and when appropriate, closer to home
- We will join-up care around communities, creating 16 GP practice clusters delivering integrated care with community services to support physical and mental health needs
- We will have a clear joined-up approach to urgent care provision, so that people will know when and where to access urgent care, when they need it
- We will introduce urgent care centres and streamline assessment services when we are clear this will improve quality and safety, and reduce waiting times for our population
- We will have a 'one county' approach to IT, Estates, and other system enablers
- We will introduce countywide leadership, training, education and learning opportunities to support the shift to new roles and responsibilities for staff

Performance Report

We work together to achieve this through the mechanisms outlined below:



For more information on One Gloucestershire www.gloucestershirestp.net

Performance Report

Who we are and what we do

Who we are

Gloucestershire Care Services is the main provider of NHS community-based health and care services across Gloucestershire, caring for a population of around 635,000 people. We serve the entirety of Gloucestershire, made up of the large urban communities of Gloucester and Cheltenham, sitting within a largely rural community from the Forest of Dean to the Cotswolds.

To support the people of Gloucestershire, the Trust employs more than 2,700 staff including nursing, medical and dental staff, allied healthcare professionals, as well as support service, administrative and clerical workers.

The Trust's vision, which defines its overarching ambition, is "To be the service people rely on to understand them and organise their care around their lives". This is further emphasised by the Trust's strapline "Understanding You".

The Trust's CORE values are Caring, Open, Responsible and Effective.

Performance Report

What we do

Our main role is to support people's health needs in the most appropriate place in the community.

Our focus is on prevention and keeping people out of crisis so that they can receive the care and support they need at, or as close to, home as possible. To enable this to happen the Trust has made a strategic commitment to place based working. During 2017/18 the Trust helped to take this forward through the integrated locality boards which are a key element of the One Gloucestershire programme. In 2018/19 the Board is committed to further developing place based working.

Around 90% of all patient contact with the NHS happens in community or primary care settings (mostly GP services). So, whilst NHS community services may not always be as visible to the public as the larger acute hospitals, it is clear that they play a vital role in supporting many people with ongoing health problems. Community services are especially important in a county such as ours, covering diverse urban and rural areas, with increasing numbers of elderly people and others, including children and young people, with long-term health conditions.

We work in peoples' homes, community clinics, outpatient departments, community hospitals, schools and GP practices. We also provide in-reach services into acute hospitals, nursing and residential homes and social care settings.

We run the county's seven community hospitals, provide nursing, physiotherapy, reablement and adult social care in community settings, and run health visiting, school nursing and speech and language therapy services for children.

We also provide a number of specialist services including sexual health, heart failure, community dentistry, diabetes, intravenous therapy (IV), tissue viability and community equipment.

Performance Report

Our services during 2017/18 are set out below:

Adult Countywide and Specialist Services:

- Specialist Nursing
- Physiotherapy
- Occupational therapy
- Speech and language therapy
- Podiatry
- MSKCAT
- Independent Living
- Sexual Health
- Community Dental

Children and Young People's Services:

- Health visitors
- Physiotherapy
- Occupational therapy
- Speech and language therapy
- Community nurses
- Complex care team
- School nurses

Community Hospitals:

- Inpatient rehabilitation
- Semi-acute care beds
- Outpatient appointments
- X-ray facilities
- Minor Injury and Illness Units

Integrated Community Teams:

- Social workers and reablement workers from Gloucestershire County Council working with the Trust's physiotherapists, community nurses and occupational therapists
- Helping manage complex or long-term conditions at home
- Reducing unnecessary hospital admissions

These clinical and care services are supported by a range of corporate services, including finance, human resources, information and performance, IT, governance, estates, hotel services, risk management, communications, engagement and service user experience team.

Corporate Governance Report
Performance Report
Financial Performance

The Trust met all its financial targets in 2017/18, managing to maintain performance while delivering against a challenging cost improvement agenda.

Overall, in 2017/18 the Trust ended the year meeting its financial plan and control total, with an NHS basis adjusted surplus of £5.6m against an income of just over £114.5m. This incorporated a £2million NHS adjusted operational surplus as forecast*. This was enhanced by Sustainability and Transformation Funding of £3.6m from the Department of Health in respect of the Trust's active engagement in the Sustainability and Transformation Partnership activity. At the end of the financial year the Trust's cash balance was £12.3m.

The table below shows our sources of income and key areas of expenditure:

Source	2017/18	2017/18	2016/17	2016/17
	Income £m	%	Income £m	%
Gloucestershire Clinical Commissioning Group	92.8	81%	95.0	84%
NHS England	10.1	9%	5.5	5%
Gloucestershire Hospitals NHS Foundation Trust	5.8	5%	5.5	5%
Gloucestershire County Council	2.1	2%	2.2	2%
Other NHS Commissioners	1.5	1%	2.4	2%
Other	2.2	2%	1.9	2%

*Note the NHS adjusted surplus is calculated by taking the £5.8m deficit and adjusting for impairments and donated assets

Statement of Comprehensive Income

		Group		Trust	
		2017/18	2016/17	2017/18	2016/17
	Note	£000	£000	£000	£000
NHS Basis Financial Performance					
Total comprehensive income / (expense) for the period		(15,906)	6,041	(15,928)	6,074
Impairments Taken to Income and Expenditure Account		15,685	-	15,685	-
Impairments Taken to Revaluation Reserve		5,709	-	5,709	-
Revaluation Uplift Taken to Revaluation Reserve		-	(3,865)	-	(3,865)
Depreciation on donated assets		97	100	97	100
Adjusted Retained Surplus		**5,585**	**2,276**	**5,563**	**2,309**

Corporate Governance Report

Performance Report
Financial Performance

Service	**2017/18 Expenditure £m**	**2017/18 %**	2016/17 Expenditure £m	2016/17 %
Community Hospitals & MIIUs	24.4	20%	25.2	23%
ICTs	17.7	14%	18.7	17%
Countywide Services	15.1	12%	15.1	14%
Children and Young Peoples Services	12.2	10%	12.8	12%
Support Services	14.0	11%	13.1	12%
Sexual Health	6.5	5%	6.7	6%
Unscheduled Care	4.7	4%	5.0	4%
Nursing and Quality	2.7	2%	3.0	3%
Estates and Facilities	10.5	8%	10.2	9%
Other Operations	1.2	1%	0.8	1%
Total	**109.0**		**110.4**	

The Trust met its Cost Improvement Programme (CIP), achieving £6.6m efficiency savings in operational and support services of which £3.7m are recurrent savings. We have maintained our focus on Agency spending and remained within the Agency cap requirement at £2.04m.

Achievement of our financial plan has been delivered through concentration on ensuring efficiencies, delivering the Cost Improvement Plan and Capital Programme.

In 2017/18 the Trust's £3.3m capital spend was marginally below the revised plan of £3.5m agreed with NHS Improvement in January 2018. This included investment of over £1m in ward refurbishments and IT equipment alongside medical equipment purchases of almost £600k.

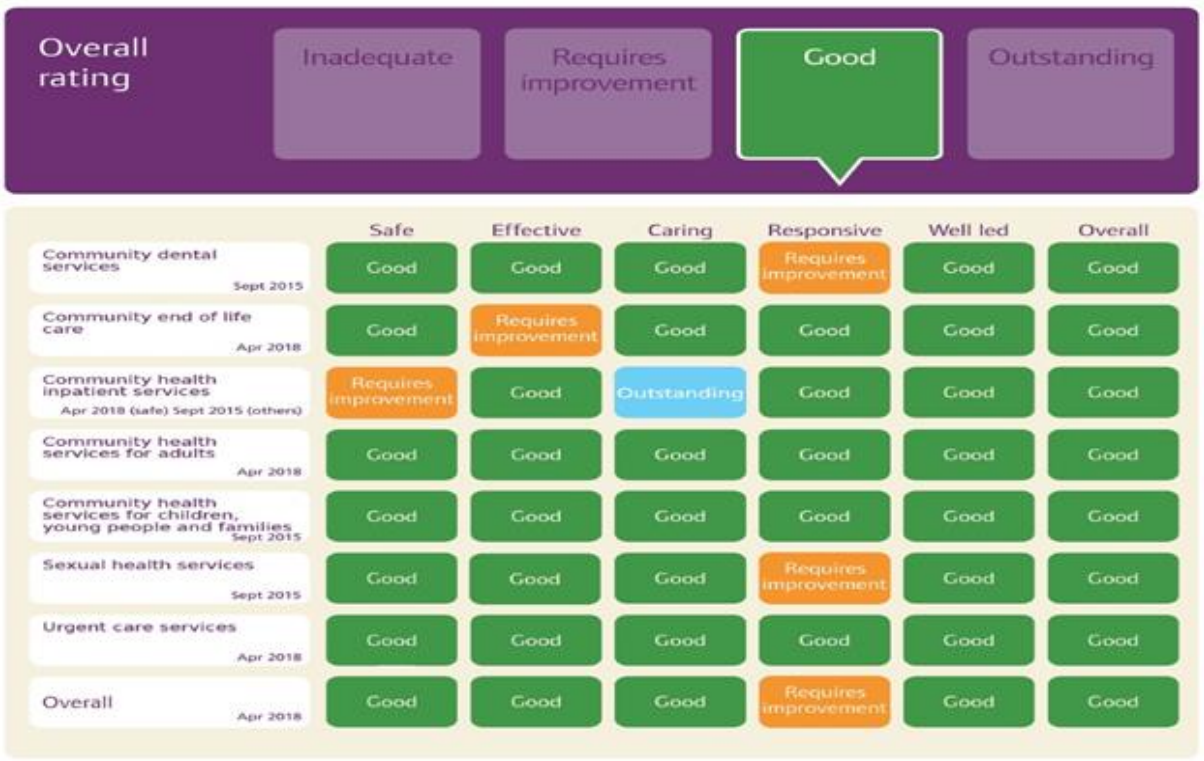
Performance Report

Care Quality Commission (CQC) Inspection – Spring 2018 Rated as GOOD.

The CQC assesses NHS organisations according to five separate criteria for its services: whether they are Safe, Effective, Caring, Responsive and Well-led. In each one it gives a rating of Outstanding, Good, Requires Improvement or Inadequate.

It also gives a Trust-wide rating for each of the five criteria as well as a single overall rating for the whole organisation, which includes an assessment of the Trust leadership.

A team of Inspectors from the Care Quality Commission, the independent regulator of health and care, undertook an inspection of the Trust in Spring 2018. They inspected many of the Trust's services, focusing on the seven Minor Injury and Illness Units, community services for adults and end of life care, as well as undertaking a review of the leadership of the Trust.
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.



	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

Performance Report

As part of our CQC inspection report we have a number of recommendations to progress, 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.
End of Life	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	No issues
Inpatients	Ensure nursing staff consistently follow systems to ensure that clinical equipment is regularly cleaned.

CQC Assessed the Trust well-led as good for a breadth of reasons including:

- The Trust had an experienced executive and non-executive director and senior leadership team with the skills, abilities, and commitment to lead the delivery of high-quality services.
- 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. They worked hard to ensure staff at all levels understood them in relation to their daily roles.
- The Trust strategy was directly linked to the vision and values of the trust, local sustainability and transformation plans and the joint work with local mental health foundation trust.
- The Trust involved clinicians, patients and groups from the local community in the development of the strategy and work with the local mental health trust.
- Non-executive directors visited all parts of the Trust on a three-monthly basis and fed back to the board to discuss issues staff faced and challenged directors appropriately.
- The Trust had a clear board assurance framework and structure for overseeing performance reports, quality and risk which enabled oversight of issues facing the service and it responded when issues in service where identified.
- 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.
- There was evidence of high levels of respect between staff and passionate and knowledgeable managers who motivated their staff and made them feel valued.
- Staff told CQC inspectors how their working lives had improved as a result of changes.

Performance Report

Areas where the CQC highlighted the Trust could improve were also identified and included:

- staff diversity and equality across the Trust and at board level
- training and development

The Trust will now put in place an action plan to share good practice and to improve areas highlighted as requiring improvement.

The full report is available on the CQC website.

Performance Report

Performance Analysis - Our Delivery Performance

Overall, in 2017/18 the Trust had over 1.2 million contacts with service users, which equates to over 3280 every day.

As an organisation we have a strong record of achievement in delivering our key objectives and targets and 2017/18 was no exception to this. We have fully achieved over 80% of national targets (5 out of 6 achieved, with the performance against the 6th target significantly improved since last year) and almost 70% of local targets were either fully achieved or significantly achieved.

	National Targets	Local Targets
Total Number of Targets	**6**	**40**
Achieved fully	5	22
Significantly achieved	0	5

Monitoring our activity and performance against a range of indicators – including national, contractual and local targets – is an important part of ensuring we deliver high quality services. Our performance in 2017/18 is set-out below, with the previous year's performance also provided. We are committed to building on this strong performance, and in particular driving improvement in those areas which are not yet achieving targeted levels. Some examples of the ongoing work and associated learning are summarised below.

CQC DOMAIN - ARE SERVICES CARING?

		Reporting Level	Threshold	2017/18	2016/17
1	Friends and Family Test Response Rate	N	15%	**8.3%**	4.3%
2	% of respondents indicating 'extremely likely' or 'likely' to recommend the service	L	95%	**94.2%**	95.2%

The Trust has put in place a revised Family and Friends Test process which has seen an improved response rate. The percentage rate response over the year has increased across the months and in the last quarter the average monthly response rate has reached 16%, above the National Target. The Trust will use the feedback provided to work to improve the percentage of respondents "extremely likely" or "likely" to recommend the service.

Performance Report

CQC DOMAIN - ARE SERVICES SAFE?

		Reporting Level	Threshold	2017/18	2016/17
3	Number of post 48 hour Clostridium Difficile Infections	L	18	**16**	13
4	Number of MRSA bacteraemia	L	0	**0**	1
		Reporting Level	**Threshold**	**2017/18**	2016/17
5	VTE Risk Assessment - % of inpatients with assessment completed	N	95%	**95.0%**	96.4%
6	Safety Thermometer - % Harm Free (New Harms only)	L	98%	**98.0%**	98.0%

The performance data demonstrates sustained good performance on national safety measures regarding Clostridium Difficile infections and MRSA bacteraemia.

The Safety Thermometer is a national safety initiative launched in 2012. It allows teams to measure harm and the proportion of patients that are “harm-free” from the four most common and preventable causes - pressure ulcers, patient falls, venous thromboembolisms (blood clots) and urinary infections associated with catheters. The audit is undertaken on a monthly basis in community and in-patient clinical areas. The “harm free” percentage includes both “old harms” (broadly harms which were present when a patient was admitted to care or were developing) and “new harms” – harms which develop when the patient is receiving care (this may be care being received in the home). The measure is used in both community trusts and acute trusts.

The Safety Thermometer % Harm Free (New Harms only) provides assurance on the Trust’s standards of safety but the Trust is committed to continuing to work to improve its Safety Thermometer - % Harm Free for 2018/19 and is in the process of launching a “turning the curve” campaign with clinical leaders to improve performance for the future. Reducing pressure ulcers, which is the highest number of new harms, will be carried forward for 2018/19 as a key quality priority.

Performance Report

CQC DOMAIN - ARE SERVICES EFFECTIVE?					
		Reporting Level	Threshold	2017/18	2016/17
Community Hospitals					
7	Bed Occupancy - Community Hospitals	L	92%	**96.7%**	98.5
8	Average of 4 discharges per day (weekends) - Inpatients	L	**4	**3.1**	3.9
9	Average of 11 discharges per day (weekdays) - Inpatients	L	**11	8.1	9.3
10	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	N	>99%	100.0%	100.0%

The bed occupancy rate has remained above target, the potential impact of this on patient care and colleagues' wellbeing is kept under ongoing review, and triangulation has indicated that these are not being compromised by over performance in this area which is supporting the wider health and social care system. Safe staffing levels reflect increased occupancy levels to support this.

Countywide the One Gloucestershire – Sustainability and Transformation Partnership is working to reduce this across the system in the longer term.

Average length of stay has reduced reflecting improved discharge planning and system working.

Average Number of Discharges from community hospitals, weekdays and weekends
The ability to discharge safely is constrained by the availability of other community based services such as reablement, independent domiciliary care and/or nursing and residential care. The Trust works with patients, families and health and social care partners to ensure effective patient discharge plans are in place before a patient is discharged to ensure their health and wellbeing in the longer term. The Trust's performance in these areas is 3.1 against target of 4 patients discharged at weekends and 8.1 against a target of 11 patients discharged per day on weekdays

The Trust continues to ensure that no patients wait more than 6 weeks from referral for a diagnostic test.

CQC DOMAIN - ARE SERVICES RESPONSIVE?					
		Reporting Level	Threshold	2017/18	2016/17
Minor Injuries and Illnesses Unit (MIIU)					
11	MIIU % seen and discharged within 4 Hours	N	95%	**99.3%**	99.6
12	Total time spent in MIIU less than 4 hours (95th percentile)	L	<4hrs	**2:53**	2:35
13	MIIU - Time to treatment in department (median)	L	<60 m	**00:26**	00:16
14	MIIU - Unplanned re-attendance rate within 7 days	L	<5%	**2.4%**	3.4%
15	MIIU - % of patients who left department without being seen	L	<5%	**2.2%**	1.6%

Performance within the Trust's Minor Injury and Illnesses Units continues to be strong against the range of targets.
The Trust continued to be well within the National Target threshold for % seen and discharged within 4 hours. A position maintained throughout the year despite the demands of winter pressures.

Performance Report

Referral to Treatment					
		Reporting Level	Threshold	2017/18	2016/17
16	Speech and Language Therapy - % treated within 8 Weeks	L	95%	**84.4%**	95.8%
17	Podiatry - % treated within 8 Weeks	L	95%	**92.8%**	94.3%
18	MSKCAT Service - % treated within 8 Weeks	L	95%	**57.1%**	85.8%
19	Adult Physiotherapy - % treated within 8 Weeks	L	95%	**89.6%**	91.8%
20	MSK Physiotherapy	L	95%	**90.7%**	93.1%
21	ICT Physiotherapy	L	95%	**85.0%**	87.7%
22	Occupational Therapy Services - % treated within 8 Weeks	L	95%	**82.8%**	91.3%
23	Diabetes Nursing - % treated within 8 Weeks	L	95%	**96.2%**	98.6%
24	Bone Health Service - % treated within 8 Weeks	L	95%	**99.5%**	99.7%
25	Contraception Service and Sexual Health- % treated within 8 Weeks	L	95%	**100.0%**	99.7%
26	HIV Service - % treated within 8 Weeks	L	95%	**100.0%**	100.0%
27	Psychosexual Service - % treated within 8 Weeks	L	95%	**100.0%**	100.0%
28	Sexual Health - % of terminations carried out within 9 weeks and 6 days of gestation	L	80%	**78.4%**	81.5%
29	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L	95%	**97.7%**	97.4%
30	Paediatric Physiotherapy - % treated within 8 Weeks	L	95%	**99.0%**	95.6%
31	Paediatric Occupational Therapy - % treated within 8 Weeks	L	95%	**96.6%**	96.8%
32	MSKCAT Service - % of referrals referred on to secondary care	L	<30%	**12.4%**	12.2%
33	MSKCAT Service - Patients referred to secondary care within 2 days of decision to refer onwards	L	100%	**100.0%**	100.0%
34	MSKCAT Service - wait from referral for urgent patients to be seen not to exceed 2 weeks	L	95%	**95.9%**	98.5%
35	Stroke ESD - Proportion of new patients assessed within 2 days of notification	L	95%	**88.6%**	**96.7%**
36	Stroke ESD - Proportion of patients discharged within 6 weeks	L	95%	**98.9%**	99.5%
37	New-born Hearing Screening Coverage	N	97%	**100.0%**	100.0%
38	New-born Hearing Screens completed by 5 weeks (community sites) - Well babies	N	97%	**99.9%**	99.5%
		Reporting Level	Threshold	2017/18	2016/17
39	SPCA % of calls abandoned	L	<5%	**2.7**	5.7%
40	95% of priority 1 & 2 calls answered within 60 seconds after introductory message finishing	L	95%	**90.5%**	83.4%
41	Rapid Response - Number of referrals	L	71 per week	**3,726**	2,993
Detailed action plans with improvement trajectory have been put in place where targets have not been achieved.					

Performance Report

Performance is now within agreed trajectory in MSKCAT Service (% treated within 8 weeks) and MSK Physiotherapy (% treated within 8 weeks) and work will continue to move to target.

In Adult Speech and Language Therapy and Adult ICT Physiotherapy (% treated within 8 weeks) staff shortages are being addressed through locum cover and a revised triage system has been put in place to ensure patient safety and prioritisation.

CQC DOMAIN - ARE SERVICES WELL LED?

		Reporting Level	Threshold	2017/18	2016/17
42	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place of work	L	61%	**53.8%**	51.8%
43	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place to receive treatment	L	67%	**83.0%**	80.3%
44	Mandatory Training	L	**92%	**82.6%**	77.8%
45	% of Staff with completed Personal Development Reviews (Appraisal)	L	95%	**79.9%**	75.0%
46	Sickness absence average % rolling rate - 12 months	L	<4%	**4.6%**	4.4%

The performance indicators 44 and 45 whilst below the target threshold indicate an improving picture which will continue to be built on during 2018/19 (Latest data for March 2018 shows performance of 86% for both these indicators for March 2018 demonstrating the significant improvements made). Work on indicator 46 is the subject of work throughout the organisation and monitored by the Board's Workforce and Organisational Delivery Committee.

Sickness absence is a priority for the Executive who are exploring a number of initiatives to reduce sickness absence rates. This includes policy review, HR workshops and HR support.

Key to Target Categories	
N	National measure/standard with target
L	Local Target

Performance Report

Quality and Sustainability

The Trust Quality Account provides a detailed overview of the work progressed in 2017/18 to improve quality. The Trust is also mindful of its role in supporting sustainability.

Quality

During 2017/18 we set quality priorities to improve performance in:

- Meeting the needs of service users in relation to pressure ulcers, equalities, dementia, falls and end of life care;
- improving health and well-being for colleagues

Progress against these is tracked in detail in our Quality Account, published separately on our website.

Sustainability

In 2017/18 the Trust maintained activity to support environmental sustainability with ongoing work to reduce water usage, energy consumption and waste to landfill.

The Trust has completed its programme of renewable energy at its community hospitals and now has in place solar photovoltaic panels at six out of seven of its community hospitals. These benefit the Trust financially through energy savings and the Feed in Tariff and ensure that all these hospitals have some of their energy demands supplied through renewable energy.

The Trust's newest hospitals in North Cotswolds, Vale and Tewkesbury were classified as BREEAM excellent reflecting the building of sustainability into their development.

The Trust's head office is based in an open plan model building, Edward Jenner Court. The building is air conditioned and controlled by a building management system and lighting is automated. The building management system has been optimised to minimise the run time of the air handling systems to reduce electricity consumption.

The Trust is in the third year of the implementation of its new waste policy which means more waste is recycled and less is sent for incineration. Recycling awareness is promoted through waste posters which are disseminated throughput and the dissemination of recycling bins.

The Trust has smart screens available in its main meeting rooms and supports staff to use technology such as laptops and mobile devices to reduce printing, for example through setting printers to double sided and black and white copying. The Trust has in place electronic health records management systems which also reduce printing requirements and use of paper. These measures together have contributed to a reduction of stationery costs by more than 60% over the last two years.

The Trust's Community Hospitals provide in- and out-patient services to enable patients to be seen closer to home, reducing travel and carbon emissions.

Performance Report

The Trust has in place schemes to promote green travel including car sharing schemes (10% of spaces at head office reserved for car sharing), use of a shuttle bus which helps reduce carbon emissions, bicycle use schemes for staff and provision of IT equipment to support mobile working to reduce unnecessary mileage. In 2017/18 the Trust reduced the number of miles travelled by staff by over 235,000 miles, a reduction of 9% against last year.

The Trust achieved Mindful Employer status in 2017/18 and has a range of initiatives in place including mindfulness training and health and hustle activities which encourage health and well-being. Over 160 staff take part in these activities, with numbers increasing regularly.

The Trust continues to increase its number of volunteers, with almost 400 volunteers now in place across the Trust supporting service users in a wide variety of ways.

Performance Report

Patient Experience

We are constantly looking at opportunities to improve the experience of service users and carers. We are pleased that over 94% of service users who responded to the Friends and Family Test would be likely or very likely to recommend our services, at a time when we have doubled the number of respondents to our surveys following a comprehensive review of our processes. During this process we revised the style of questionnaire and increased its service specificity to improve the quality of feedback to be integrated within ongoing service improvement development and service redesign, ensuring that the views of our service users drive our services and are at the heart of how we operate.

Friends and Family Test

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give your views after receiving care or treatment across the NHS. Our performance for 2017/18 can be seen in the tables below:

Service	2017/18	2016/17
MIIU Response "likely" or "very likely" to recommend	94.4%	95.9%
Inpatients Response "likely" or "very likely" to recommend	95.0%	96.4%
Children and Young Peoples Service "likely" or "very likely" to recommend	92.3%	96.7%
Integrated Community Teams "likely" or "very likely" to recommend	97.5%	97.4%
County Wide and Specialist Nursing "likely" or "very likely" to recommend	95.1%	94.4%
Capacity Service % "likely" or "very likely" to recommend	99.2%	96.2%
Overall Response "likely" or "very likely" to recommend	94.2%	95.2%

During the year the Trust reviewed its Family and Family Test processes to ensure consistency of use across services and to increase the number of responses. The revised processes have improved response levels and increased the ability of services to customize the surveys to the needs of service users and enable the feedback to be more swiftly feedback in to improve service.

The compliments and complaints we receive are another valuable source of feedback about our services that we use to support our improvement plans. We have procedures in place to ensure we manage any complaints in line with national policy and in line with the Duty of Candour.

Feedback Categories	**2017/18**	2016/17
Compliments	**924**	512
Complaints	**44**	73
Concerns	**391**	403

The significant increase in compliments provides assurance that service users understand the feedback processes and that the fall in number of complaints is not a cause for concern.

Performance Report

Supporting Colleagues

We want the Trust to be a great place to work for all colleagues and to support them to achieve their aspirations and goals. We know that everyone is working under increasing pressures and we want to do everything we can to help people manage their work life balance. We know this is an area where we have more to do and corporate and local action plans are being developed to ensure we achieve improvement in this important area during 2018/19

Staff Engagement

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 and wellbeing, training and development, health and safety and health and wellbeing.

The results of the survey, which took place between October and December 2017, were published nationally on 6th March 2018 and can be found here:

http://www.nhsstaffsurveys.com/Page/1073/Latest-Results/Community-Trusts/

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 that they are 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	GCS 2017	2017 National Average	GCS 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 in to 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 do believe that our Trust does provide equal opportunities for career progression and promotion.

Performance Report

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. It is also concerning to see the disparity in scores between the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public, compared to the national picture.

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 were fulsome in their praise for the welcome afforded by colleagues across the organisation 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 issues (such as challenged workforce supply, historic pay restraint) and local issues (including the proposed merger with 2gether NHS Trust and the uncertainty generated through the early stages of such a process) which have undoubtedly contributed to these results and need to be understood. Notwithstanding these however, it is far more important to focus on the actions we can take going forward which will promote the improvements in engagement that are required. Whilst the recommendations are based around 'action plans', the emphasis has to be less on highly detailed action plans than on fewer high impact actions. Determining what is (really) important and fixing these will be key.

As ever, it is likely that our colleagues and their managers will have the bulk of the solutions and we need to listen and respond to these once received.

Localised action plans supported by corporate led priorities are now being developed to support improved engagement.

Investors in People (IIP) accreditation

Since 1991, IIP has set the standard for better people management. IIP's internationally recognised accreditation is held by 14,000 organisations across the world. The Standard defines what it takes to lead, support and manage people well for sustainable results.

The Trust was assessed against the IIP framework in February 2017. The balance of evidence from the online assessments, face-to-face interviews, documentary evidence and observation produced a final outcome which confirmed that the Trust meets all of the requirements for accreditation as an Investor in People.

The report stated "This is a very significant achievement, especially in light of the government imposed cost reduction targets, and the size and spread of the Trust and the diversity of services it provides." It was also highlighted that "The Trust continues to work in line with its values and in this aspect practice is not only Advanced but very close to High Performing."

The Trust continues to work to ensure it maintains the ambitions and aspirations achieved within the standard.

Signed

Chief Executive 23rd May 2018

Corporate Governance Report

The Directors' Report 2017/18

The Trust's Board of Executive and Non-Executive Directors is responsible for overseeing the development of strategic direction and compliance with all governance, probity and assurance requirements.

Details of the Trust's Chair, Chief Executive, Executive Directors and Non-Executive Directors are set out later in the annex to the Governance Statement, together with information on membership of the Trust's Board and its sub-committees.

Compliance Statement

A register of Directors' interests for the Trust is maintained and is available on the Trust's website or by request from the Trust Secretariat by contacting **TrustSecretary@glos-care.nhs.uk.**

The Trust has undertaken the necessary action to evidence that each Director has stated that, as far as he/she is aware, there is no relevant audit information of which the Trust's Auditors are unaware and he/she has taken all the steps that he/she ought to have taken as a Director, in order to make themselves aware of any relevant audit information, and to establish that the Trust's Auditors are aware of that information.

Corporate Governance Report

Statement of Directors' Responsibilities in Respect of the Accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts;
- assess the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.[1]

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

23rd May 2018 Date.....Chief Executive - Paul Roberts

23rd May 2018 Date.....Finance Director – Sandra Betney

Corporate Governance Report

Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust.

The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum.

These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Paul Roberts

Signed.....Chief Executive

Date....23rd May 2013

Corporate Governance Report

Annual Governance Statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Gloucestershire Care Services NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Gloucestershire Care Services NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust has a risk management strategy, which makes it clear that managing risk is a key responsibility for the Trust and all staff employed by it. The Trust has in place a Risk Steering Group which reports to the Audit and Assurance Committee to support the risk management process. The Board receives regular reports that detail risk, financial, quality and performance issues and, where required, the action being taken to reduce identified high-level risks.

Full details of the Trust's approach to Risk Management is contained in the Trust's risk management strategy.

Guidance and training are provided to staff through specific risk management training, wider management training, policies and procedures, information on the Trust's intranet and feedback from audits, inspections and incidents. Included within all of this is sharing of good practice and learning from incidents. Information from a variety of sources is considered in a holistic manner to provide learning and inform changes to practice that would improve patient safety, and overall experience of using the Trust's services. During 2017/18 the Trust further developed its Risk Steering Group to promote integrated working and enable cross organisational review of risks and consideration of good practice learning.

Corporate Governance Report

The Risk and Control Framework

The risk management strategy sets out the key responsibilities for managing risk within the organisation, including the ways in which risk is identified, evaluated and controlled.

It identifies strategic and operational risk and how both should be identified, recorded and escalated and highlights the open and honest approach the Board expects with regard to risk. The Trust's risk assessment policy describes the process for standardised assessment of risk including assessment of likelihood and consequence. During 2017/18 the Trust further embedded the use of patient safety software, which was already in use for incident reporting, in its risk management processes; supporting consistency and increased timeliness of organisation wide oversight of risks.

The Board has identified the risks to the achievement of the Trust's objectives and determined the appropriate level of risk appetite. The nominated lead for each risk has identified and evaluated existing controls and sources of assurance that these controls operate effectively. Any gaps in controls have been identified and action plans put in place to strengthen controls where appropriate. The outcome of this process is articulated in the Board Assurance Framework (BAF) and this is presented to the Board for review and endorsement at each routine Board meeting. In line with the Trust's risk management strategy, risks rated 12 or above (8 where there is patient safety/clinical risk identified) are escalated to the Board through the Board's Committee structure. All corporate risks are reviewed regularly by identified Board sub-committees and an escalation process is in place, as outlined in the risk management strategy.

Risk is assessed at all levels in the organisation from individual members of staff within service areas to the Board. This ensures that both strategic and operational risks are identified and addressed.

The Trust has in place a BAF, which sets out the principal risks to delivery of the Trust's strategic objectives. Executive Directors review the risk register and enter strategic risks onto the corporate risk register. In addition, other corporate risks scoring 12 or above (8 where there is patient safety/clinical risk identified), that have been reviewed by the relevant sub-committee, are escalated in line with the Trust's escalations processes. The Executive Director with delegated responsibility for managing and monitoring each risk is clearly identified. The BAF identifies the key controls in place to manage each of the principal risks and explains how the Board is assured that those controls are in place and operating effectively. These include the monthly performance report, monthly finance report, minutes of the sub committees and assurances provided through the work of internal and external audit, the CQC and the NHS Resolution.

Specific areas of risk such as fraud, corruption and bribery are addressed through specific policies and procedures and regular reports made to the Board via the Audit and Assurance Committee.

Corporate Governance Report

At 31 March 2018 the Trust's major strategic risks and corresponding mitigations were:

Risk	Mitigation and Key Controls
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	Communication & Engagement Strategy and plan Relationships with Gloucestershire Strategic Forum, Health and Care Oversight and Scrutiny Committee, Health & Wellbeing Board, NHS Providers and Community First Network. Your care Your Opinion Engagement activities
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	Annual Operating Plan, Quality Priorities, Contractual Agreements and relationships. Place based model developments, One Place One Budget Sustainability and Transformation Partnership work. Strategic Intent work with ^{2}gether NHS Foundation Trust.
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.	Communication & Engagement Strategy and plan Celebration Awards and Events nationally and locally. Your Care Your Opinion Engagement Activities Involvement in wider Health care system key forums.
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.	Clinical Governance Framework and processes. Quality Improvement Priorities and improvement plans. Staff Development commitments. Research and Development Strategy development. Continuous Professional Development plans and investment.
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. **This is currently the highest risk on the Trust's Board Assurance Framework and is receiving Board focus**	Recruitment and Development Strategy and action plan. Continuous Professional Development plans and investment. Centralised bank and agency function Nursing Associate Programme Apprenticeship Programme Progression pathway developments Staff Engagement processes
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 optimally designed to meet the needs of service users and carers.	Friends and Family Test Processes. Learning Assurance Action Tracker processes. Your Care Your Opinion Engagement Activities Co-production developments

Corporate Governance Report

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.	Person focused initiatives, Positive Risk Taking, Policies to support patient focused decision making. Patient Activation Measures and Personalised Care Plans.
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.	Quality and Performance reporting. One Gloucestershire commitments Processes to develop Strategic Intent.
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.	Partnership work with One Gloucestershire Delivery Pathways Cluster working developments.
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.	Manager Toolkit Investors in People Freedom to speak up Guardian and other related mechanisms to raise concerns Communication and Engagement Strategy Core Colleague and Communication processes.
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.	Sickness absence monitoring Recruitment and Retention Strategy Working Well support Health and wellbeing initiatives
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	Refresh of Leadership Development Plan Manager Toolkit Leadership Development
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.	Estates Strategy Business Plan Review of IT Strategy Capital Plan
There is a risk that we do not lead on, and invest in, transformation to secure long term sustainability of services; resulting in inability to sustain quality and compromising year on year cost improvement.	Business Plan Cost Improvement Plan and delivery processes Quality Equality Impact Assessments Workforce planning
There is a risk we do not maintain robust internal controls and governance systems; resulting in potential financial and organisational instability.	Governance Framework Review and Monitoring Use of Resources review Monitoring Financial and Quality metrics for assurance.

Corporate Governance Report

At the end of the financial year 2017/18, the Trust reviewed all its Trust-wide risks and has updated the Board Assurance Framework to reflect developments in the external environment.

Compliance with NHS Provider Licence

NHS Trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements. Although NHS Trusts are exempt from needing a Provider Licence, directions from the Secretary of State require NHS Improvement (NHSI) to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. Consequently, all provider NHS Trusts must self-certify the following after the financial year-end:

• Condition G6(3) - the provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution

• Condition FT4(8) - the provider has complied with required governance arrangements

The Trust Board was required to approve the self-certification statements for 2016/17 before 31 May 2017 (Condition G6) and 30 June 2017 (Condition FT4).

The Trust complied with these requirements as is formally confirmed on its website and is on track to complete the required declarations for 2017/18.

Care Quality Commission (CQC)

The Trust is fully compliant with the registration requirements of the CQC and was rated as Good during the inspection in Spring 2018. The well-led review of the Trust's leadership confirmed the Trust's well-led rating as Good. The Trust ensures compliance with CQC registration requirements through its clinical governance processes which report to the Board's Quality and Performance Committee. Assurance in relation to CQC regulation requirements is led by the Executive Lead, Director of Nursing. Our new internal approach to review against the regulatory framework using the DATIX CQC module has enabled a much greater level of local understanding of regulatory requirements and compliance. This revised approach has greatly supported clinical areas in preparing for the full CQC inspection which took place in Spring 2018 and has given local teams an ongoing systematic method of measuring and testing their compliance with the regulatory framework. This included local assessment in relation to the well led framework which was confirmed by the CQC outcome.

The Trust learns from good practice through a range of mechanisms including national guidance / alerts, benchmarking, clinical supervision and reflective practice, individual and peer reviews, performance management, continuing professional development programmes, clinical audit and application of evidence-based practice and meeting risk management standards. Significant this year has been our work in developing a Mortality Review Group to take forward the requirements of the National Framework for Mortality

Corporate Governance Report

Data security risks: The Trust actively monitors and manages its information governance (IG) compliance through the IG assurance framework as stipulated in policy, reporting up to the Information Governance Steering Group (IGSG), which is chaired by the Senior Information Risk Owner (SIRO) and attended by key IG staff including the Caldicott Guardian and Head of IG. The IGSG monitors the Trust's compliance with the HSCIC IG Toolkit, approves the IG work plan that is developed year on year, reviews incidents where they occur and looks to recommend improvements to increase compliance.

The Trust has implemented a full range of technical and organisational measures in line with national best practice, has a suite of information governance (IG) related policies,procedures and guidance documents which are made available to all staff in a variety of ways and ensure staff are appropriately trained in IG. Communicating IG to Trust staff is an on-going and extremely important process in ensuring staff are aware of their responsibilities, as detailed in these documents. Where failings are found to occur investigations are carried out, lessons learnt and recommendations made and implemented where appropriate.

Risks have also been identified and mitigation put in place in respect of IT failures or IT risk, none are currently reported at 12 or above on our risk register or BAF, they include:

- Risk of Trust network failure.
- Unplanned disruption to services due to underinvestment in replacing/maintaining the virtual server infrastructure.
- Unauthorised access to network user account.

All risks continue to be managed and monitored as set out above.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality, Diversity and Human Rights Legislation

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. This includes compliance with our duties under the Equality Act 2010 by the annual publication of information relating to people who are our employees and those who are affected by our policies and practices, and by the publication of our equality objectives. In addition, this includes compliance with the annual publication of both our NHS Equality Delivery System 2 report and our NHS Workforce Race Equality Standard report.

Corporate Governance Report

Emergency Preparedness and Carbon Reduction Plans

The trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

I acknowledge the Accountable Officer's responsibilities as set out in the Accountable Officer Memorandum and my responsibilities contained therein for the propriety and regularity of public finances in the Trust, for the keeping of proper accounts, for prudent and economical administration, for the avoidance of waste and extravagance, and for the efficient and effective use of all the resources in my charge.

The Board has established arrangements to ensure it achieves economy, efficiency and effectiveness (or value for money) from the use of resources. The Trust manages its financial resources in accordance with an annual financial plan or budget and has developed a medium term financial plan in order to make informed strategic decisions about resource control and areas of investment and disinvestment.

The Director of Finance reports to the Board on actual performance against the financial plan and is accountable for variances in performance. The Board has also established a Finance Committee to review financial performance and scrutinise specific areas, with the objective of ensuring value for money and effectiveness.

The Board's Audit and Assurance Committee is responsible for reviewing the adequacy of the Trust's arrangements for achieving value for money from the use of resources. The committee receives reports from both internal and external auditors in this regard, and highlights areas of concern and proposed actions to the Board. The External Auditor's conclusions on the Board's arrangements for achieving value for money are referred to in their audit report on the Trust's 2017/18 financial statements.

For 2017/18, the Trust ended the year with a Single Oversight Framework segment of 1. We achieved this rating in a year where the cash releasing efficiency savings were set at a particularly challenging level and still invested in our estate, where we have completed considerable work on statutory standards and backlog maintenance and minor schemes to improve the service user environment and our IT infrastructure including mobile working equipment which will support our staff to deliver services and to generate future efficiencies. During 2017/18, we have used a range of methods to identify and deliver efficiency savings, including new business development, redesign of service user pathways and process improvements.

Corporate Governance Report

Information Governance Performance

There were 7 information personal data related incidents which required reporting to the Information Commissioner's office. The Trust co-operated fully in reporting and providing follow up information. In all 7 incidents the information commissioner has confirmed that no regulatory action will be taken, confirming the processes the Trust has in place to respond to an information personal data related incident.

The Trust has in place an Information Governance Steering Group which oversees compliance with the Information Governance Toolkit and implements improvement plans where required.

Fraud and Security Management

The Trust has in place arrangements to manage fraud and security. This includes the provision of Local Counter Fraud and Security Specialists. Annual work plans are formulated which are reported to the Audit and Assurance Committee. The NHS Protect standards, which are contained within the NHS Standard Contract, are used as benchmarks for performance. These are reported to the Audit and Assurance Committee and Commissioners as required.

Cyber Security

The Trust has in place processes, as required under the NHS Standard Contract, to comply with the 10 data security standards recommended by the National Data Guardian for Health & Care. This compliance is monitored at both management and Board level. The Trust treat Cyber Security as an issue requiring the highest vigilance.

Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and quality and performance committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Governance Framework of the Organisation

The Department of Health 2006 defined integrated governance as: "Systems, processes and behaviours by which Trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organisations."

Corporate Governance Report

The structures, systems, processes and behaviours NHS bodies are expected to have for ensuring good governance include:

- Standing Orders, Standing Financial Instructions, Reservation of Powers to the Board and Scheme of Delegation.
- Requirement for a statutory board, and requirements on the committees that support the board.
- How line managers operate, including codes of conduct and accountability.
- Business planning.
- Procedural guidance for staff.
- Risk register and assurance framework.
- Internal audit.
- Scrutiny by external assessors including the Care Quality Commission, external audit and NHS Improvement.

As Accountable Officer I can confirm that these structures, systems, processes and behaviours are reflected in the Trust's Governance Framework.

The Board Structure and Remit

Gloucestershire Care Services NHS Trust (GCS) is run by a unitary Board of Directors, with clear division of responsibilities between the Chair of the Board and the Chief Executive of the Trust, Non-Executive Directors and the Executive, including appropriate challenge on strategic development. The Board consists of the Chair, 6 Non-Executive Directors, and 5 voting Executive Directors. There is also one non-voting Directors (Interim Director of Human Resources and Organisational Development). Non-Executive Directors use the skills and experience gained from the private, public and voluntary sectors to help run the Trust, but do not have day-to-day managerial responsibilities within the Trust. Executive Directors are paid employees with clear areas of work responsibility within the Trust.

The Board regularly meets in public, and details of the board meetings, including the public papers are available at: www.glos-care.nhs.uk

The Board held 6 formal board meetings in 2017/18 and has met a further 12 times in private.

The Board is responsible for the leadership, management and governance of the organisation and setting the strategic direction and supporting the development of organisational culture. Its meetings cover comprehensive items on quality, finance and strategy. At each routine Board meeting held in public it considers the Board Assurance Framework, Quality and Finance.

The Board continually self-assesses its performance, evaluating its meetings and those of its committees at the conclusion of business. Further Board discussions have led to a board development programme supported by an external governance advisor. This has helped support effective integration of new Board members into Board working and supported a review of Committee roles and responsibilities to maintain focus. Internal Audit provided assurance on the governance processes in place.

Corporate Governance Report

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 (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 HR, who left the Trust in January 2018 to take up the role of Director of People and Culture with Worcestershire Acute Hospitals Trust.

We thank Katie Norton and Tina Ricketts for their contribution to our development.

Board Committees

The Board is supported in its work by a number of sub-committees which include:

- ***Audit and Assurance Committee***, chaired by Non-Executive Director, Richard Cryer
- ***Charitable Funds Committee***, chaired by Non-Executive Director, Nicola Strother Smith.
- ***Finance Committee***, chaired by Non-Executive Director, Graham Russell.
- ***Quality and Performance Committee***, chaired by Non-Executive Director, Susan Mead.
- ***Remuneration and Terms of Service Committee***, chaired by Trust Chair, Ingrid Barker.
- ***Workforce and Organisational Development Committee***, chaired by Non-Executive Director, Nicola Strother Smith.

Each of the sub-committees reported directly to the Trust Board and:

- Monitored risk relating to their area of responsibility, ensuring the Board had a clear overarching understanding of the risks;
- Provided regular summary reports to the Board on their work for assurance and performance purposes.

Executive Directors are responsible for maintaining effective systems of control on a day-to-day basis. A full governance rationale has been developed providing terms of reference and escalation processes for all sub-committees and the Board, together with standing items, which are in turn encapsulated into programmes of business for each sub-committee and for the Board.

The table shown at Annex 1 of this Governance Statement sets out attendance levels by Executive and Non-Executive Directors at Trust Board meetings and at all sub-committees of the Board.

Corporate Governance Report

In addition, the Trust Board is supported by the Your Care Your Opinion group which provides opportunities for two-way communication with service users and local communities. This enables the Board to benefit from the insight and experience of local people in the planning and delivery of services. During 2017/18 this has included sessions on the Board's developing Strategic Intent with [2]gether NHS Foundation Trust, Quality Dashboards and Communication.

Charitable Funds Committee - met three times during 2017/18

Gloucestershire Care Services NHS Trust is the corporate trustee for charitable funds. The Board, on behalf of the Trust, is responsible for the effective overall management of charitable funds. The role of the committee is to oversee the management, investment and disbursement of charitable funds, as delegated, within the regulations provided by the Charities Commission and to ensure compliance with the laws governing NHS charitable funds and the wishes of the donors. The charitable funds seek to provide benefit to local service users and Trust colleagues.

Remuneration and Terms of Service Committee **–** met nine times in 2017/18

The Committee is responsible for supporting the Board to ensure fairness, equity and consistency in remuneration practices on behalf of the Trust Board. The Committee oversaw the appointment processes for the Chief Executive Officer and the remuneration, allowances and other terms and conditions of office of the Trust's Very Senior Managers (VSM).

Audit and Assurance Committee – met five times in 2017/18

The Audit and Assurance Committee is constituted in accordance with the provisions of the NHS Audit Committee Handbook 2014.

The Committee is responsible for providing assurance to the Board that an effective system of integrated governance, risk management and internal control, is in place across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. It has also overseen the audit of the 2017/18 accounts.

As part of these processes the Committee reviewed all reports from completed internal audit assignments for the 2017/18 work plan, which had been agreed by the Committee at the start of the year. The following table summarises the outcomes from those assignments:

Corporate Governance Report

Internal Audits 2017-18	Report Classification	Progress
Finance	High Risk	*All recommendations implemented and closed*
HR	Medium Risk	All recommendations implemented and closed
Risk Management	Low Risk	All recommendations implemented and closed
Clinical Governance – Medicines Management	High Risk	6 recommendations implemented and closed, 1 in progress
IM&T -ITGC	Medium Risk	6 recommendations implemented and closed, 1 in progress
Information and Performance	Medium Risk	3 recommendations implemented and closed, 1 in progress
IM&T – Cybersecurity (Pen testing)	Medium Risk	2 recommendations –in progress

The Audit and Assurance Committee uses its Internal Audit programme to focus on areas of most benefit to receive independent scrutiny and actively targets Audits to learn and develop its processes and operation. Progress against recommendation actions is actively monitored by the Committee and the Internal Auditors have confirmed that actions are being completed within required timescales. Over the seven audits there were no critical findings and only 2 high level recommendations.

The Audit and Assurance Committee is also informed by the work of the External Auditors. The External Auditors undertake their audits on a risk based approach. The audit for 2017/18 focused on the following risks: fraud risk from income recognition, management override of controls, valuation of land and building assets, accuracy of NHS income. The audit has not identified any significant issues of concern.

The Audit Committee has not identified any significant issues in the year 2017/18.

Quality and Performance Committee – met 6 times during 2017-18

The Committee is responsible for providing clear assurance on all issues relating to clinical and professional care, clinical systems, clinical risk management and all prevailing regulatory standards relating to quality and safety. The Committee also reviews the Trust's service delivery activities and agrees and monitors action plans where remedial steps were considered necessary. During the year the Committee considered a range of key issues including clinical audit, safeguarding, end of life care, information governance, patient reported outcomes, research, incidents, complaints and performance.

Corporate Governance Report

Finance Committee **–** met six times during 2017-18
The Committee is responsible for providing detailed scrutiny of the Trust's finances, and agreeing and monitoring action plans where remedial plans are required to improve financial performance. The Committee is also responsible for advising the Board on business development opportunities and overseeing capital expenditure against the Trust's approved capital plan. In 2017/18 it supported the development of the business planning process and the review of the Estates Strategy.

Workforce and Organisational Development **Committee –** met four times during 2017/18

The Committee is responsible for providing clear assurance on all aspects of workforce strategy, planning and organisational development to support the Trust achieving exemplar clinical and professional outcomes and experiences for service users and Trust colleagues. It also has particular responsibility for the development of a supportive and learning organisational culture that promotes the Trust's CORE values of being Caring, Open, Responsible and Effective.

Performance

As Accountable Officer I can confirm that there are processes in place to ensure that the Board has oversight of key areas of performance to ensure that the Trust is meeting its statutory duties and functions.

Quality Performance

The Trust produces an annual Quality Account in line with Department of Health Guidance. This account looks back at performance in the last year and sets priorities for the following year. The Board approves the account prior to publication. Arrangements are in place via service delivery groups and trust wide groups to report quality and safety matters to the Quality and Performance Committee, which in turn reports to the Board. This includes progress against the priorities set out in the Quality Account.

Quality report priorities and core indicators reported in the quality and performance report have been an integral part of the routine governance processes over the year. Key indicators have been routinely reported to the Trust Board and the Quality and Performance Committee through the year, reflecting wider review and monitoring undertaken by the Trust. The quality and performance report has been developed this year following review by the Board. This has included regular reports being presented
to the Quality and Performance Committee and commissioners. Progress against quality and performance goals has been received at both the Quality and Performance Committee and the Board throughout the year.

The Trust has a Learning Assurance Framework to ensure incidents and serious incidents are followed up, thoroughly investigated and learnt from. In 2017/18 there were 26 serious incidents requiring investigation and 1 never incident.

The Trust has arrangements in place to manage Infection Prevention and Control and theSafeguarding of Children and Vulnerable Adults. These include external partnership arrangements with Local Authorities, Police and Gloucestershire Hospitals NHS Foundation Trust.

Corporate Governance Report

The Trust was inspected by the Care Quality Commission in January 2018 and was graded overall as “Good” (an improvement from the 2015 rating of “Requires improvement”), with ninety percent of areas graded as either “Good” or “Outstanding”. An Improvement Action Plan to take forward the areas identified for further improvement and to spread good practice has now been developed and will be implemented during 2018/19.

The Trust engages with service users through a range of forums and processes and continues to develop the contribution that volunteers make across our services.

Financial Performance

NHS Trusts are required to deliver statutory and other financial duties. For the year ended 31 March 2018, the Trust met these duties, as summarised below,

to break-even on Income and Expenditure in line with NHS guidance on our NHS adjusted surplus*
to maintain capital expenditure below a set limit

* Statement of Comprehensive Income

		Group		Trust	
		2017/18	2016/17	2017/18	2016/17
	Note	£000	£000	£000	£000
NHS Basis Financial Performance					
Total comprehensive income / (expense) for the period		(15,906)	6,041	(15,928)	6,074
Impairments Taken to Income and Expenditure Account		15,685	-	15,685	-
Impairments Taken to Revaluation Reserve		5,709	-	5,709	-
Revaluation Uplift Taken to Revaluation Reserve		-	(3,865)	-	(3,865)
Depreciation on donated assets		97	100	97	100
Adjusted Retained Surplus		**5,585**	**2,276**	**5,563**	**2,309**

Within this, the Trust faced significant challenge in delivering the efficiency programme for the year, with plans remaining under development throughout most of the year. However, the target was met by year-end, with non-recurrent measures replacing in-year shortfalls in recurrent initiatives where required. Whilst this area remains a significant challenge, the Trust's transformational approach to generate and implement efficiency measures has been further revised and strengthened to support delivery.

Checking the correct discharge of statutory functions is managed via the Trust risk management system. No areas of non-compliance have been identified. The Trust met its Agency cap which was set by NHS Improvement as a financial value of Agency Spend for the Year.

Corporate Governance Report

Data Quality Performance

The Trust has systems in place to verify data quality, including elective waiting time data. These include:

- Validation of data reports and results by service managers and systems users
- Planned internal audits of data by informatics staff.
- Electronic data validation e.g. missed mandatory fields and data out of permitted ranges.
- Performance data monitoring by Trust groups and committees and subsequent enquiries.
- Commissioner scrutiny of activity and quality data.
- User training on systems, e.g. clinical coding.

During 2017/18 the Trust revised its reporting processes to improve reporting efficiency. This improved the audit trail of reported information, but also revealed underlying data quality issues which are now being addressed.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework, and on the controls reviewed as part of the internal audit work.

The Head of Internal Audit's opinion is "Generally satisfactory with some improvements required" and highlighted that "The Trust has made progress in improving and strengthening its internal control environment during 2017/18. There has been a positive direction of travel in terms of the number and severity of issues noted in the course of our reviews." Action Plans are in place to take forward the required improvements.

Executive Managers within the organisation, who have responsibility for the development and maintenance of the system of internal control, provide me with assurance.

The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by clinical audits, the Trust's External Auditors Opinion, Care Quality Commission (CQC) and NHS Resolution. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board's subcommittees.

A plan to address weaknesses and ensure continuous improvements of the system is in place. The Board's role is to determine the overall strategic direction and to provide active leadership of the Trust within a framework of prudent and effective controls, which enables risk to be assessed and managed.

Conclusion

There has been no evidence presented to myself or the Board to suggest that at any time during 2017/18, the Trust has operated outside of its statutory authorities and duties. In relation to our reporting of the Trust's corporate governance arrangements, we have drawn from the best practice.

Corporate Governance Report

With the exception of the internal control issues that I have outlined in this statement, my review confirms that Gloucestershire Care Services NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

I confirm that no significant internal control issues have been identified.

Signed:

Paul Roberts
Chief Executive

23rd May 2018

Corporate Governance Report

Annex1

Modern Slavery Act 2015

Slavery and Human Trafficking Policy Statement

INTRODUCTION

At Gloucestershire Care Services NHS Trust we are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. This statement sets out actions taken by this Trust to understand all potential modern slavery and human trafficking risks and to implement effective systems and controls

ORGANISATION'S STRUCTURE

Gloucestershire Care Services NHS Trust provides community-based health and care services across Gloucestershire, caring for a population of around 635,000 people. We serve the entirety of Gloucestershire, made up of the large urban communities of Gloucester and Cheltenham, sitting within a largely rural community from the Forest of Dean to the Cotswolds. We have an income of over £100 million.

Our Trust has over 2,700 dedicated staff. Our main role is to support people's health needs in the most appropriate place in the community.

Our focus is on prevention and keeping people out of crisis so that they can receive the care and support they need at, or as close to home as possible.

OUR SUPPLY CHAINS

The Trust supply chain is predominantly service orientated with the majority of its supplier base within the United Kingdom (UK) with our extended supply chain linking into the wider European Economic Area (EAA). NHS Supply Chain is the Trusts largest goods provider and incorporates the principles of the Modern Slavery Act within its code of conduct and ensures these products comply.

OUR POLICIES ON SLAVERY AND HUMAN TRAFFICKING

We are fully aware of the responsibilities we have towards our service users, colleagues and local communities. We are guided by a strict set of ethical values in all of our business dealings and expect our suppliers (i.e. all companies we do business with) to adhere to these same principles. We have zero tolerance for slavery and human trafficking. Staff are expected to report concerns about slavery and human trafficking and management are expected to act upon them in accordance with our policies and procedures, such as the Adult Safeguarding Multi-Agency Policy and Procedures.

Corporate Governance Report

DUE DILIGENCE PROCESSES FOR SLAVERY AND HUMAN TRAFFICKING

To identify and mitigate the risks of modern slavery and human trafficking in our own business and our supply chain we:

- Are working towards the Department of Health (DoH) NHS Procurement & Commercial Standards, which requires a Corporate Social Responsibility (CSR) policy defining the procurement approach to sustainability, modern slavery and all other appropriate ethical standards and approaches.

- Undertake appropriate pre-employment checks on directly employed staff and access temporary staff only through the NHS Improvement approved frameworks ensuring suppliers comply with the same pre-employment checks.

- Uphold best practice and professional codes of conduct relating to procurement and supply.

- Contractual clauses are utilised to ensure that supplier supply chains are monitored and that there is zero tolerance of modern slavery within their supply chain.

- Where any such issues arise within the extended supply chain, the supplier shall act to remove these items from entering the Trust's extended supply chain and implement ethical sourcing programs and supply chain audits to prevent any repetition.

TRAINING

The Trust is planning to offer awareness sessions for staff regarding the recognition of modern day slavery and trafficking.

OUR EFFECTIVENESS IN COMBATING SLAVERY AND HUMAN TRAFFICKING

Further work is needed to identify how we measure how effective we have been in ensuring that slavery and human trafficking is not taking place in any part of our business or in our supply chain.

The Board of Director of Gloucestershire Care Services will review and update this statement on an annual basis.

This statement is also made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending March 2018.

Paul Roberts
Chief Executive Officer

Corporate Governance Report

Annex 2

Chief Executive's Statement – Bribery and tax evasion

Gloucestershire Care Services NHS Trust is committed to the highest standards of ethical conduct and integrity in our respective business activities. Transparent, fair conduct helps to foster deeper relationships of trust between the Trust and its partners. It is vital for our reputation and continued sustainability.

A bribe is a financial advantage or other reward that is offered to, given to, or received by an individual or company (whether directly or indirectly) to induce or influence that individual or company to perform public or corporate functions or duties improperly. Bribery and corruption has a detrimental impact on Trust business by undermining good governance. We benefit from carrying out our functions in a transparent and ethical way and thereby helping to ensure that there is honest, open and fair competition in the NHS. Where there is a level playing field, we can lead by example and deliver excellent services to our patients.

The Trust will not tolerate any form of bribery, whether direct or indirect, by or of its staff, agents or consultants or any persons or entities acting for it or on its behalf. We will not conduct business with service providers, agents or representatives that do not support the Trust's anti-bribery objectives. We reserve the right to terminate contractual arrangements with any third parties acting for or on behalf of the Trust with immediate effect where there is evidence that they have committed acts of bribery, or have engaged in tax evasion.

The board and senior management of the Trust are committed to implementing and enforcing effective systems throughout the organisation to detect and eliminate bribery in accordance with the Bribery Act 2010 and prevent tax evasion in accordance with the Criminal Finances Act 2017. The Trust employs a Local Counter Fraud Specialist who will investigate any allegations of fraud, bribery or corruption. Policies have been developed outlining our position on preventing bribery and fraud, promoting the highest standards of business conduct, and managing conflicts of interest. These policies apply to all employees(colleagues), as well as agency workers, consultants and contractors acting for or on behalf of the Trust. Employees and others acting for or on behalf of the Trust are strictly prohibited from making, soliciting or receiving any bribes or unauthorised payments, and from engaging in any form of tax evasion.

As part of its anti-bribery measures, the Trust is committed to transparent, proportionate, reasonable and bona fide hospitality and promotional expenditure. Such expenditure must only be offered or accepted in accordance with the procedures set out in the Trust's policies. A breach of Trust policy by an employee will be treated as grounds for disciplinary action, which may result in a finding of gross misconduct, and immediate dismissal. Employees and other individuals acting for the Trust should note that bribery is a criminal offence that may result in up to 10 years' imprisonment and/or an unlimited fine for the individual and an unlimited fine for the Trust. If an organisation is successfully prosecuted under the Criminal Finances Act it will face an unlimited fine and possible ancillary sanctions, such as being prohibited from bidding for public contracts.

Every employee and individual acting on behalf of the Trust is responsible for maintaining that Trust's reputation, conducting business honestly and professionally, and playing their part in helping to detect and eradicate bribery. All employees and others acting for, or on behalf of, the Trust are encouraged to report any suspected bribery in accordance with the procedures set out in either the relevant Whistleblowing (Freedom to Speak Up) policy and/or the relevant policy on Fraud, Bribery and Corruption. The Trust will support any individuals who make such a report, provided that it is made in good faith.

Paul Roberts
Chief Executive Officer

Corporate Governance Report

Annex 3 to Governance Statement

Attendance at Board meetings and Board sub-committees

The table below sets out meetings attended by each Board member during 2016/17.

Name	Position	Board *	Percentage Board Attendance	Audit & Assurance Committee	Charitable Funds Committee	Remuneration & Terms of Service Committee	Finance Committee	Quality and Performance Committee	Workforce and Organisational Development Committee	Date of any change
Ingrid Barker	Chair	6 (6)	100%	-	#2	9	#	#	#	-
Susan Mead	Non-Executive Director Senior Independent Director	6 (6)	100%	3	-	9	5	6	-	
Katie Norton	Chief Executive	5 (6)	83%	1`**	-	**	1	1	-	Ceased to be CEO 15/04/18
Sandra Betney	Deputy Chief Executive/Director of Finance	6 (6)	100%	***	2	-	6	1	-	
Richard Cryer	Non-Executive Director	4 (6)	67%	5	2	8	5	-	5	
Susan Field	Director of Nursing	6 (6)	100%	-	2	-	6	6	5	
Jan Marriott	Non-Executive Director	5 (6)	83%	5	-	5	-	6	4	
Dr Michael Roberts	Medical Director	4 (6)	66%	-	-	-	-	4	-	
Nick Relph	Non-Executive Director	5 (5)	100%	4		7	3	-	2	Appointed 15/06/17
Graham Russell	Non-Executive Director	6 (6)	100%	5	-	8	6	6	-	
Nicola Strother Smith	Non-Executive Director	5 (6)	83%	-	2	7	-	6	5	
Candace Plouffe	Chief Operating Officer	6 (6)	100%	-	-	-	6	6	4	
Tina Ricketts	Director of Human Resources (non-voting)	5 (5)	100%	-	3	-	-	4	5	Resigned 29/01/18
David Smith	Interim Director of Human Resources and Organisational Development (non-voting)	1 (1)	100%	-	-	-	1	1	-	Appointed 29/01/18

*Figures in brackets show total number of Board meetings members could have attended in year (meetings shown reflect meetings being held in public which were preceded by a confidential Board session). Additionally there were also a number of meetings to progress commercially sensitive items)
** attended meetings as required in role of Accountable Officer not as a member
*** attended by invitation as Director of Finance
# The Chair of the Board attends Board Committees on a rolling basis for assurance.

+ Paul Roberts commenced as CEO 16/4/18

Additionally Directors attended a range of development activities – both as a Board and individually - and attended a number of Private Board meetings

Remuneration and Staff Report

Policy for the remuneration of Directors

The Trust's remuneration policy for Executive Directors observes the Department of Health's Pay Framework for Very Senior Managers (VSMs) in Strategic and Special Health Authorities, Primary Care Trusts and Ambulance Trusts (NB although this document dated July 2013 now references organisational forms and bodies no longer in existence, this is the latest available version of the guidance). The Trust's future remuneration policy for Executive Directors will observe these guidelines or any replacement guidelines.

Accordingly, in 2017/18, the pay for the Trust's Chief Executives was in line with that proposed within the Pay Framework for Primary Care Trust (PCT) Chief Executives i.e. it was based on a local population of 0.5million to 1.0million people, weighted for age and deprivation.

Payments made to the Trust VSM Executive Directors were in line with the pay framework.

Changes were made to the following Trust VSM Executive Directors during the year to bring them in line with sector benchmarks:

- the Chief Operating Officer received a 6% increase in salary from 1st January 2018 to bring the salary in line with benchmark, this was confirmed by both the Trust's Remuneration and Terms of Service Committee and NHS Improvement
- the Director of HR received a 10% increase in salary from 1st April 2017 to bring the salary in line with benchmark, this was confirmed by both the Trust's Remuneration and Terms of Service Committee and NHS Improvement

In 2017/18 all Non-Executive Director payments were made in line with Department of Health guidelines.

Remuneration and Staff Report

Directors' Remuneration (Audited)

The table below shows details about director remuneration for 2017/18

		Salary (Bands to £5,000)	Expense payments (taxable) total to Nearest £1,000	Performance pay and Bonuses(bands of £5,000)	Long term performance Pay and bonuses (bands of £5,00) £000	All pension-related Benefits (bands of £2,500)	Total (bands of £5,000)	Note
Ingrid Barker	Chair	20-25*	3	-	-	-	20-25	
Susan Mead	Non-Executive Director Senior Independent Director	5-10	2	-	-	-	5-10	
Katie Norton	Chief Executive	140-145	3	-	-	112.5-115	260-265	
Sandra Betney	Deputy Chief Executive/Director of Finance	125-130	1	-	-	32.5-35	160-165	
Richard Cryer	Non-Executive Director	5-10	2	-	-	-	5-10	
Susan Field	Director of Nursing	95-100	2	-	-	0-2.5	95-100	
Jan Marriott	Non-Executive Director	5-10	2	-	-	-	5-10	
Dr Michael Roberts	Medical Director	45-50	1	-	-	15-17.5	65-70	
Graham Russell	Non-Executive Director	5-10	1	-	-	-	5-10	
Nicola Strother Smith	Non-Executive Director	5-10	1	-	-	-	5-10	
Candace Plouffe	Chief Operating Officer	95-100	0	-	-	27.5-30.0	125-130	
Tina Ricketts	Director of Human Resources (non-voting)	75-80	2	-	-	30-32.5	110-115	Resigned 29/01/18
David Smith	Interim Director of Human Resources & OD (non-voting)	15-20	0			0-2.5	15-20	Appointed 29/01/18
Nick Relph	Non-Executive Director	5-10	2				5-10	Appointed 15/06/18

* From 1st January 2018 Ingrid Barker was appointed Chair at both GCS Care Services and 2gether NHS Foundation Trust. The detailed remuneration reflects GCS Care Services element of Remuneration.

Remuneration and Staff Report

Directors' Remuneration (Audited)

The table below shows details about director remuneration for 2016/17

		Salary (Bands to £5,000)	Expense payments (taxable) total to Nearest £1,000	Performance pay and Bonuses(bands of £5,000)	Long term performance Pay and bonuses (bands of £5,00) £000	All pension-related Benefits (bands of £2,500)	Total (bands of £5,000)	Note
Ingrid Barker	Chair	20-25	1	-	-	-	20-25	-
Robert Graves	Non-Executive Director Vice Chair	5-10		-	-	-	5-10	Resigned 31/01/17
Susan Mead	Non-Executive Director Senior Independent Director	5-10	1	-	-	-	5-10	
Paul Jennings	Chief Executive	110-115	0	-	-	-	110-115	Retired 31/12/16
Katie Norton	Chief Executive	30-35	0	-	-	0-2.5	30-35	Ceased to be CEO 15/4/18
Glyn Howells	Deputy Chief Executive/Director of Finance	115-120	0	5-10	-	0-2.5	120-125	Resigned 31/03/17
Richard Cryer	Non-Executive Director	5-10	1	-	-	-	5-10	
Susan Field	Director of Nursing	95-100	0	-	-	35-37.5	130-135	
Jan Marriott	Non-Executive Director	5-10	1	-	-	-	5-10	
Dr Michael Roberts	Medical Director	45-50	0	-	-	15-17.5	60-65	
Graham Russell	Non-Executive Director	0-5	0	-	-	-	0-5	Appointed 01/08/16
Joanna Scott	Non-Executive Director	0-5	0	-	-	-	0-5	Resigned 31/07/16
Nicola Strother Smith	Non-Executive Director	5-10	1	-	-	-	5-10	
Candace Plouffe	Chief Operating Officer (non-voting)	95-100	0	-	-	62.5-65	160-165	
Tina Ricketts	Director of Human Resources (non-voting)	85-90	0	-	-	30-32.5	115-120	

Remuneration and Staff Report

Director Pension Contributions (Audited)

Pension Contributions for Executive Directors 2017-18.
Non-Executive Directors do not receive pensionable remuneration.

		Real increase in pension at Pension age (Bands of £2,500)	Real Increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March m 2017 (Bands of £5,00)	Lump Sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at April 2017 £000	Cash Equivalent Transfer Value at 31st March 2018 £000	Real increase in cash Equivalent Transfer Value £000	Employer's Contribution to stakeholder pension
Katie Norton	Chief Executive	5-7.5	15-17.5	33-40	105-110	550	663	113	0
Sandra Betney	Deputy Chief Executive/ Director of Finance	0-2.5	5-7.5	35-40	110-115	618	691	73	0
Susan Field	Director of Nursing	0-2.5	0-2.5	25-30	75-80	477	510	33	0
Dr Michael Roberts	Medical Director	0-2.5	2.5-5	10-15	30-35	222	248	26	0
Candace Plouffe	Chief Operating Officer	0-2.5	2.5-5.0	15-20	45-50	294	339	45	0
Tina Ricketts	Director of Human Resources (non-voting)	0-2.5	5-7.5	15-20	40-45	244	293	49	0
David Smith	Interim Director HR &OD	0-2.5	2.5-5	10-15	0	219	205	-14	0

Remuneration and Staff Report

Notes – Definitions used in Pensions Contributions Table above

- **Cash Equivalent Transfer Values:** a Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

  The pension figures shown in the table above relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries;
- **Real Increase CETV:** this reflects the increase in CETV effectively funded by the Trust. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Pay Multiples (Audited)

The Trust is required to disclose the relationship between the remuneration of its highest-paid Director and the median (average) remuneration of the organisation's workforce.

The midpoint of the banded remuneration of the highest paid Director in the Trust in the financial year 2017-18 was £143,942 (2016-7 142,499). This was 5 times (2016-17 5 times) the median remuneration of the workforce, which was £ 26,565 (2016-17, £26,302).

In 2017-18, no employees (2016-176, also no employees) received remuneration in excess of the highest-paid Director. Remuneration ranged from £10,132-£143,942 (2016/17 - £15,251 to £142,499).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

In respect of the above, it is noted that there were no significant changes to the remuneration of the workforce in 2017-18. In general, staff salaries were increased by 1% in April 2017 in line with government policy. Senior managers and Executive Directors however were excluded from these arrangements, so did not receive any corresponding increase during the year.

Remuneration and Staff Report

Staff Report (Audited)

Senior Managers' Analysis

The details of staff within the Trust at Agenda for Change Band 8A upwards (excluding Executive Directors) as at 31 March 2018, a number of whom are also providing clinical services, are shown below:

	2017/18		2016/17	
Banding	**WTE**	**Headcount**	**WTE**	**Headcount**
Band 8A	**54.9**	**60**	57.0	62
Band 8B	**21.8**	**22**	22.0	22
Band 8C	**9**	**9**	9.0	9
Band 8D	**4**	**4**	4.0	4
	89.7	**95**	**92.0**	**97**

Staff Numbers 2017-2018

The number of staff employed by the Trust in 2017/18 analysed by professional discipline (excluding staff on outward secondment) are shown below

	2017/18		2016/17	
Occupation	**WTE**	**Headcount**	**WTE**	**Headcount**
Administration & Estates Staff	**439.3**	**527**	424.0	507
Allied Health Professional	**468.1**	**595**	463.1	590
Ancillary Staff	**91.0**	**141**	89.8	137
Medical & Dental Staff	**26.1**	**40**	27.3	45
Nursing, Midwifery & Health Visiting Staff	**1068.8**	**1340**	1121.4	1393
Total	**2093.3**	**2643**	2125.7	2672

Remuneration and Staff Report

Staff costs

	Group						
					2017/18		2016/17
	Permanent		Other		Total		Total
	£000		£000		£000		£000
Salaries and wages	63,232		-		**63,232**		63,435
Social security costs	4,971		-		**4,971**		5,474
Apprenticeship levy	294		-		**294**		Not Applicable
Employer's contributions to NHS pensions	8,249		-		**8,249**		8,248
Pension cost - other	-		-		**-**		106
Temporary staff	Not Applicable		2,044		**2,044**		1,675
Total gross staff costs	**76,746**		**2,044**		**78,790**		**78,938**
Recoveries in respect of seconded staff	(261)		-		**(261)**		(278)
Total staff costs	**76,485**		**2,044**		**78,529**		**78,660**

Average number of employees (WTE basis)	Group						
					2017/18		2016/17
	Permanent		Other		Total		Total
	Number		Number		Number		Number
Medical and dental	26		-		**26**		27
Administration and estates	439		8		**447**		421
Healthcare assistants and other support staff	91		29		**120**		90
Nursing, midwifery and health visiting staff	1,069		40		**1,109**		1,117
Nursing, midwifery and health visiting learners	-		-		**-**		5
Scientific, therapeutic and technical staff	468		5		**473**		463
Other	-		-		**-**		3
Total average numbers	**2,093**		**82**		**2,175**		**2,126**

Remuneration and Staff Report

Staff Composition (Audited)

The gender composition of the Trust is as follows (headcount figures):

	Male		Female		
Role	**Number**	**Percent**	**Number**	**Percent**	**Total**
Board Members	5	42%	7	58%	12
Senior Managers	20	21%	75	79%	95
All Other Staff	230	10%	2388	90%	2565

Main changes in gender composition were:

- A decrease in female representation at Board from 67% in 2016/17 to 58% in 2017/18;
- A slight increase in female representation at senior management level from 78% in 2016/17 to 79% in 2017/18.

Trust Sickness Absence 2017 - 2018 (12 months to December 2017) Audited

Occupation	**12 month Sickness % Rate (12 months to Dec 2017)**
Administration & Estates Staff	3.76
Allied Health Professional	3.50
Health Care Assistants & Support Staff	5.32
Medical & Dental Staff	7.67
Nursing, Midwifery & Health Visiting Staff	5.19
Grand Total	**4.56**

Figures Converted by DHSC to Best Estimates of Required Data Items			**Statistics Published by NHS Digital from ESR Data Warehouse**	
Average FTE 2017	**Adjusted FTE days lost to Cabinet Office definitions**	**Average Sick Day per FTE**	**FTE-Days Available**	**FTE-Days Lost to Sickness Absence**
2,103	21,908	10.4	767,419	35,540

The increase in sickness was across all categories, except Nursing, Midwifery and Health visiting staff where there was a small reduction.

Remuneration and Staff Report

Staff policies on disabled employees

The Trust is fully committed to ensuring equal opportunities, and this is reflected by its accreditation by Investors in People, confirmed for a further three year period in March 2017. It is also evidenced by the Trust's continued application of its Equality and Human Rights Policy, as well as its Recruitment and Selection Policy and Procedure, which together demonstrate that the Trust gives full and fair consideration for applications for employment by disabled persons, namely:

- all recruitment uses the NHS Jobs system in order to ensure that personal details are removed for the shortlisting stage;
- advertising seeks to attract suitably qualified, skilled and experienced candidates from all sections of the community and the existing workforce;
- the Trust operates a Guaranteed Interview Scheme, so that people with disabilities are guaranteed an interview as long as they meet the minimum criteria: in recognition of this work, the Trust holds Two Ticks and Mindful Employer status;
- training has been developed to ensure that those responsible for making selection decisions do not discriminate, consciously or unconsciously, when making such decisions;
- where there is an identified need, the Trust takes positive action to try and encourage a diverse range of applicants.

Equally, all people are treated fairly when in employment with the Trust i.e.

- the Trust actively avoids practices that would put a disabled person at a disadvantage, compared to those who are not disabled;
- the Trust makes reasonable adjustments at work, such as removing or altering a physical feature, or providing a reasonable means of avoiding such a feature, where it would put a disabled person at a substantial disadvantage, compared to those who are not disabled;
- the Trust provides auxiliary aids where a disabled person would otherwise be put at a substantial disadvantage, compared to those who are not disabled;
- all employees, irrespective of disability status, have access to regular supervision, an annual review of their performance, and a personal development plan which identifies their training needs: moreover, the reasons for choosing certain employees for training is clear and based on sound judgments.

In terms of career progression, everyone who applies for a promotion within the Trust receives fair treatment and is considered solely on their ability to do the job. Furthermore, no applicant is placed at a disadvantage by requirements or conditions that are not essential for the performance of the job.

Remuneration and Staff Report

Equality Delivery System

In order to assure appropriate equity across its workforce, the Trust continued in 201718 to review its progress against the relevant components of the updated NHS Equality Delivery System (EDS2). In doing so, the Trust was encouraged to evaluate the impact of the nine criteria shown in the table below, upon groups of staff representing the nine protected characteristics outlined in the Equality Act 2010, namely age, sex, disability, sexual orientation, gender reassignment, marriage or civil partnership, pregnancy and maternity, race / ethnicity, or religion / belief.

A representative and supported workforce	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
	Training and development opportunities are taken up and positively evaluated by all staff
	When at work, staff are free from abuse, harassment, bullying and violence from any source
	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
	Staff report positive experiences of their membership of the workforce
Inclusive leadership	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed
	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

However, with the exception of the race/ethnicity which is described under the Workforce Race Equality Standard (WRES) below, the majority of Trust workforce information in 2017/18 was analysed at a more generalized level and therefore did not specifically assess outcomes upon people representing the nine protected characteristics. This was, in part, due to the fact that significant numbers of staff did not wish to disclose details of, for example, their disabilities, sexual orientation or religion, meaning that baseline data was not indicative of the workforce as a whole. The Trust continues to work to improve data reporting.

Remuneration and Staff Report

Workforce Race Equality Standard

Compliance with the national Workforce Race Equality Standard (WRES) was first introduced in the NHS Standard Contract 2015-16, in response to clear evidence of race inequality in the NHS, and a strong correlation between race equality amongst staff and the quality / safety of provided care.
WRES requires NHS organisations to report annually against nine indicators.

In August 2017 the Trust's submission was as follows:

Indicator	White colleagues	Black and Minority Ethnic (BME) colleagues
Percentage of Black and Minority Ethnic (BME) staff compared with the overall workforce		4.5% of the total workforce is from a BME background, split 3.8% non-clinical and 4.65% clinical
Relative likelihood of staff being appointed from shortlisting across all posts	2.29 times more likely to be appointed from shortlisting	-
Relative likelihood of staff entering the formal disciplinary process	-	1.67 times more likely to enter the formal disciplinary process
Relative likelihood of staff accessing non-mandatory training and Continuing Professional Development	1.04 times as likely to access non-mandatory training and CPD	
Percentage of staff experiencing harassment, bullying or abuse from service users, relatives or the public in last 12 months	32%	26%
Percentage of staff experiencing harassment, bullying or abuse from other staff in last 12 months	21%	13%
Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	89%	87%
In the last 12 months, percentage of staff who have experienced discrimination from a manager/team leader or other colleague	6%	7%
Percentage difference between the Trust's Board voting membership and its overall workforce	-4.5% given that none of the Trust's voting members is from a BME background	

Remuneration and Staff Report

The most significant findings from the above were as follows:

- the proportion of BME colleagues employed by the Trust in 2017 (4.5%) was largely comparable to the percentage of BME people in the Gloucestershire population (4.6%), although this is significantly lower than the proportion of BME people living in England as a whole (14.6%). Nevertheless, it is recognised that relatively few of these colleagues hold senior posts. As a result, the Trust is set to develop and embed talent management and career progression policies: equally, the Trust now advertises job vacancies not only upon the NHS Jobs website, but also within a range of targeted media and publications, such as the national website promoting Black History Month. The Trust is also working with other NHS organisations across the county to encourage community peers within local black and minority ethnic populations, to join a dedicated leadership programme with the aim of becoming Non-Executive Directors. During 2017/18 the Trust hosted its first member of the cohort and will take a further member during 2018/19;

- in response to the suggestion that people from BME backgrounds appeared to be disadvantaged by both appointment and disciplinary processes, the Trust continues to review sample cases so as to identify, and thereafter address, any underlying issues. These elements are incorporated within the Trust's Leadership Programme going forward;

- compared to 2016, there was a further marked decrease in 2017 in the percentage of BME staff who experienced harassment, bullying or abuse from both patients/public and colleagues;

- in 2017, there was a 10% decrease in the percentage of BME staff reporting discrimination at work from either their line manager or other colleague: as a result, however the experience of white colleagues has worsened by 4% in both previous reporting periods.

A further WRES data submission will be made in August 2018.

Expenditure on consultancy

In 2017/18 the Trust spent £157k on external consultancy from companies supporting specific projects around Estates, HR and Finance. This was because specific internal expertise did not exist to complete these projects.

Remuneration and Staff Report

Off payroll engagements

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	12
Of which, the number that have existed:	
for less than one year at the time of reporting	2
for between one and two years at the time of reporting	2
for between 2 and 3 years at the time of reporting	8
for between 3 and 4 years at the time of reporting	
for 4 or more years at the time of reporting	

Table 2: New Off-payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and March 2018, for more than £245 per day and that last for longer than six months

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	2
Of which...	
No. assessed as caught by IR35	2
No. assessed as not caught by IR35	
No. engaged directly (via PSC contracted to the entity) and are on the entity's payroll	
No. of engagements reassessed for consistency / assurance purposes during the year.	2
No. of engagements that saw a change to IR35 status following the consistency review	2

Table 3: Off-payroll board member/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

Number of off-payroll engagements of board members , and/or senior officers with significant financial responsibility, during the year (1)	0
Total no. of individuals on payroll and off-payroll that have been deemed "Board members", and/or senior officials, with significant financial responsibility", during the financial year. This figure must include both on payroll and off-payroll engagements. (2)	0

Remuneration and Staff Report

Exit Packages (Audited)

In 2017-18, 7 exit payments were paid totaling £29,549 as shown below.

	*Cost of compulsory redundancies		Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£s
Less than £10,000	-	-	7	29,549	-	-	-	-
£10,000-£25,000	-	-			-	-	-	-
£25,001-£50,000	-	-	-	-	-	-	-	-
£50,001-£100,000	-	-	-	-	-	-	-	-
£100,001-£150,000	-	-	-	-	-	-	-	-
£150,001- £200,000	-	-	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-	-	-
Totals	-	-	7	29,549	-	-	-	-

Redundancy and other departure costs were paid in accordance with the provisions of the Medical and Dental or Agenda for Change Schemes as appropriate. Exit costs are accounted for in full in the year of departure. In 2017-18, the Trust did not agree any early retirements, so there are no additional costs to be met. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

No non-contractual payments in lieu of notice were paid. No non-contractual severance payments were made following judicial mediation, and therefore none related to non-contractual payments in-lieu-of-notice.

No non-contractual payments were made to individuals where the payment value was more than 12 months of their annual salary.

Not included in the exit payments table are contractual payments made to the outgoing Chief Executive.

I hereby confirm that the above Accountability Report is a true and accurate representation of Trust activities in 2017/18.

Chief Executive
23 May 2018

Gloucestershire Care Services NHS Trust

Annual accounts for the year ended 31 March 2018

Statement of Comprehensive Income

		Group		Trust	
		2017/18	2016/17	2017/18	2016/17
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	109,889	109,995	109,889	109,995
Other operating income	4	4,710	2,899	4,656	2,629
Operating expenses	5, 7	(123,164)	(108,221)	(123,132)	(107,918)
Operating surplus/(deficit) from continuing operations		**(8,565)**	**4,673**	**(8,587)**	**4,706**
Finance income	10	34	16	34	16
PDC dividends payable		(1,666)	(2,513)	(1,666)	(2,513)
Net finance costs		**(1,632)**	**(2,497)**	**(1,632)**	**(2,497)**
Surplus / (deficit) for the year		**(10,197)**	**2,176**	**(10,219)**	**2,209**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	6	(5,709)	-	(5,709)	-
Revaluations	12	-	3,865	-	3,865
Total comprehensive income / (expense) for the period		**(15,906)**	**6,041**	**(15,928)**	**6,074**
NHS Basis Financial Performance					
Total comprehensive income / (expense) for the period		(15,906)	6,041	(15,928)	6,074
Impairments Taken to Income and Expenditure Account		15,685	-	15,685	-
Impairments Taken to Revaluation Reserve		5,709	-	5,709	-
Revaluation Uplift Taken to Revaluation Reserve		-	(3,865)	-	(3,865)
Depreciation on donated assets		97	100	97	100
Adjusted Retained Surplus		**5,585**	**2,276**	**5,563**	**2,309**

The notes on pages 74 to 111 form part of this account.

Statement of Financial Position

	Note	Group 31 March 2018 £000	Group 31 March 2017 £000	Trust 31 March 2018 £000	Trust 31 March 2017 £000
Non-current assets					
Intangible assets	11	1,000	1,581	1,000	1,581
Property, plant and equipment	12	58,859	80,521	58,709	80,371
Total non-current assets		**59,859**	**82,102**	**59,709**	**81,952**
Current assets					
Inventories	15	228	227	228	227
Trade and other receivables	16	6,762	7,010	6,756	6,928
Cash and cash equivalents	17	12,412	8,381	12,354	8,280
Total current assets		**19,402**	**15,618**	**19,338**	**15,435**
Current liabilities					
Trade and other payables	18	(9,563)	(11,492)	(9,545)	(11,333)
Borrowings	20	(148)	-	(148)	-
Provisions	22	(160)	(15)	(160)	(15)
Other liabilities	19	(123)	(211)	(123)	(211)
Total current liabilities		**(9,994)**	**(11,718)**	**(9,976)**	**(11,559)**
Total assets less current liabilities		**69,267**	**86,002**	**69,071**	**85,828**
Non-current liabilities					
Borrowings	20	(221)	-	(221)	-
Provisions	22	-	(1,050)	-	(1,050)
Total non-current liabilities		**(221)**	**(1,050)**	**(221)**	**(1,050)**
Total assets employed		**69,046**	**84,952**	**68,850**	**84,778**
Financed by					
Public dividend capital		79,982	79,982	79,982	79,982
Revaluation reserve		610	6,319	610	6,319
Other reserves		(2,398)	(2,398)	(2,398)	(2,398)
Income and expenditure reserve		(9,344)	875	(9,344)	875
Charitable fund reserves	14	196	174	-	-
Total taxpayers' equity		**69,046**	**84,952**	**68,850**	**84,778**

The notes on pages 74 to 111 form part of this account.
The financial statements on pages 67 to 111 were approved by the Board on the 23rd May 2018 and signed on its behalf by:

Name **Paul Roberts**
Position **Chief Executive**
Date **23rd May 2018**

Statement of Changes in Equity for the year ended 31 March 2018

Group	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**79,982**	**6,319**	**(2,398)**	**875**	**174**	**84,952**
Surplus/(deficit) for the year	-	-	-	(10,219)	22	**(10,197)**
Impairments	-	(5,709)	-	-	-	**(5,709)**
Taxpayers' and others' equity at 31 March 2018	**79,982**	**610**	**(2,398)**	**(9,344)**	**196**	**69,046**

Statement of Changes in Equity for the year ended 31 March 2017

Group	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**79,982**	**2,454**	**(2,398)**	**(1,334)**	**207**	**78,911**
Prior period adjustment	-	-	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2016	**79,982**	**2,454**	**(2,398)**	**(1,334)**	**207**	**78,911**
Surplus/(deficit) for the year	-	-	-	2,209	(33)	**2,176**
Revaluations	-	3,865	-	-	-	**3,865**
Taxpayers' and others' equity at 31 March 2017	**79,982**	**6,319**	**(2,398)**	**875**	**174**	**84,952**

Statement of Changes in Equity for the year ended 31 March 2018

Trust	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**79,982**	**6,319**	**(2,398)**	**875**	**84,778**
Surplus/(deficit) for the year	-	-	-	(10,219)	**(10,219)**
Impairments	-	(5,709)	-	-	**(5,709)**
Taxpayers' and others' equity at 31 March 2018	**79,982**	**610**	**(2,398)**	**(9,344)**	**68,850**

Statement of Changes in Equity for the year ended 31 March 2017

Trust	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**79,982**	**2,454**	**(2,398)**	**(1,334)**	**78,704**
Taxpayers' and others' equity at 1 April 2016	**79,982**	**2,454**	**(2,398)**	**(1,334)**	**78,704**
Surplus/(deficit) for the year	-	-	-	2,209	**2,209**
Revaluations	-	3,865	-	-	**3,865**
Taxpayers' and others' equity at 31 March 2017	**79,982**	**6,319**	**(2,398)**	**875**	**84,778**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves
Other reserves are shown in respect of donated assets included on the Trust balance sheet

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted and are managed by the fund trustees on an arms length basis to the affairs of the Trust.

Statement of Cash Flows

		Group		Trust	
		2017/18	2016/17	2017/18	2016/17
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus / (deficit)		(8,565)	4,673	(8,587)	4,706
Non-cash income and expense:					
Depreciation and amortisation	5.1	4,184	2,387	4,184	2,387
Net impairments	6	15,685	-	15,685	-
(Increase)/decrease in receivables and other assets		192	5,905	192	5,905
(Increase)/decrease in inventories		(1)	(2)	(1)	(2)
Increase/(decrease) in payables and other liabilities		(1,519)	(6,238)	(1,519)	(6,238)
Increase/(decrease) in provisions		(905)	1,042	(905)	1,042
Movements in charitable fund working capital		(65)	(34)		
Net cash flows from / (used in) operating activities		**9,006**	**7,733**	**9,049**	**7,800**
Cash flows from investing activities					
Interest received		34	-	34	-
Purchase of intangible assets		-	(576)	-	(576)
Purchase of PPE and investment property		(3,192)	(2,612)	(3,192)	(2,612)
Net cash flows from / (used in) investing activities		**(3,158)**	**(3,188)**	**(3,158)**	**(3,188)**
Cash flows from financing activities					
Capital element of finance lease rental payments		(74)	-	(74)	-
PDC dividend (paid) / refunded		(1,743)	(2,416)	(1,743)	(2,416)
Net cash flows from / (used in) financing activities		**(1,817)**	**(2,416)**	**(1,817)**	**(2,416)**
Increase / (decrease) in cash and cash equivalents		**4,031**	**2,129**	**4,074**	**2,196**
Cash and cash equivalents at 1 April - b/f		**8,381**	**6,280**	**8,280**	**6,112**
Unrealised gains / (losses) on foreign exchange		**-**	**(28)**	**-**	(28)
Cash and cash equivalents at 31 March	17	**12,412**	**8,381**	**12,354**	**8,280**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis.

Note 1.2 Critical judgements in applying accounting policies

There has been one significant judgement, apart from those involving estimations, that management has made in the process of applying the Trust accounting policies and has had a significant effect on the amounts recognised in the financial statements.

An updated Equivalent Modern Asset Valuation has been carried out during the year on the land and buildings owned by the Trust. This resulted in an impairment of £21,394k which is shown on the statement of comprehensive income and the Statement of Changes in Equity and is also explained fully in note 13.

Note 1.2.1 Sources of estimation uncertainty

Key areas of estimation uncertainty are detailed in note 1.2 above regarding judgements applied in the preparation of the accounts.

Note 1.3 Consolidation

NHS Charitable Fund

The Trust is the corporate Trustee to Gloucestershire Care Services NHS charitable fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund’s statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity’s assets, liabilities and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Retirement benefit costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes, the cost of to the NHS body of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Local Government Pension Scheme
Some employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the Trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Actuarial gains and losses are recognised in the general fund reported in the Statement of Changes in Taxpayers Equity.

National Employment Savings Trust
The Trust also offers a National Employment Savings Trust (NEST) pension scheme for employees who do not or cannot access the NHS pension scheme. The scheme is provided by NEST Corporation (www.nestpensions.org.uk) and the Trust contributes 1% of relevant salaries. The scheme is a defined contribution scheme.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has a cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.7.2 Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Freehold land, assets under construction or development and assets held for sale are not depreciated.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefit from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful lives.

At each financial year end the Trust checks whether there are any indications that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

A revaluation decrase that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Note 1.7.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions to complete the plan mean it is unlikely that the plan will be dropped or changed significantly.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 Useful Economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	5	87
Plant & machinery	5	15
Transport equipment	7	7
Information technology	3	10
Furniture & fittings	5	10

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust where the cost of the asset can be measured reliably, and where th cost is at least £5k.

Intangible assets acquired separately are initially recognised at cost.

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset. Expenditure on research is not capitalised, it is recognised as an operating expense in the period in which it is incurred.

Internally generated assets are recognised if and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it, and
- the ability to measure reliably, the expenditure attributable to the intangible asset during its development

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic life of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Software licences	5	10

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised as loans and receivablesor available-for-sale financial assets.

Financial liabilities are classified as other financial liabilities.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced.

Note 1.12 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.12.1 The Trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution (Formerly know as the NHS Litigation Authority or "NHSLA") operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is adminstratively responsibile for all clinical negligence cases the legal liability remains with the Trust. The total value of the clinical negligence provisions carried by the NHS Resolution on behalf of the Trust is disclosed in note 25.3

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any “excesses” payable in respect of particular claims are charged to operating expenses as and when they become due.

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in notes to the accounts where an inflow of economic benefits is probable. Contingent liabilities are not recognised, but are disclosed in the notes to the financial statements, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital

Public dividend capital represents taxpayers' equity in the Trust. At any time the Secretary of State can issue new PDC to, and require repayment of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying value amount of assets is calculated as a simple average of opening and closing relevant net assets.

Note 1.16 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

Note 1.18 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.19 Accounting Standards that have been issued but have not yet been adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

● IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted

● IFRS 15 Revenue from Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted

● IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

● IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.

● IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

Note 1.20 Pooled Budgets

The Trust has entered into a pooled budget with Gloucestershire Clinical Commissioning Group and

Gloucestershire County Council. Under the arrangement funds are pooled under S75 of the NHS Act 2006 for community activities.

The pool is hosted by Gloucestershire Clinical Commissioning Group (GCCG). Payments for services provided by the Trust are accounted for as income from GCCG. The Trust accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Note 2 Operating Segments

The Trust has determined that it has only one reportable segment. All services delivered by the Trust are as an NHS Community Services Provider and over 80% of income is earned through an over-riding block contract with NHS Gloucestershire Clinical Commissioning Group.

Note 3 Operating income from patient care activities (Group)

Note 3.1 Income from patient care activities (by nature)

	2017/18	2016/17
	£000	£000
Community services		
Community services income from CCGs and NHS England	100,478	96,181
Income from other sources (e.g. local authorities)	9,411	13,814
Total income from activities	**109,889**	**109,995**

Note 3.2 Income from patient care activities (by source)

	2017/18	2016/17
Income from patient care activities received from:	£000	£000
NHS England	6,644	3,907
Clinical commissioning groups	93,834	96,181
Department of Health and Social Care	126	-
Other NHS providers	6,207	5,932
Local authorities	2,071	2,356
Non-NHS: private patients	-	1
Non-NHS: overseas patients (chargeable to patient)	-	7
NHS injury scheme	257	333
Non NHS: other	750	1,278
Total income from activities	**109,889**	**109,995**

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18	2016/17
	£000	£000
Income recognised this year	-	7

Note 4 Other operating income (Group)

	2017/18	2016/17
	£000	£000
Research and development	22	-
Education and training	432	575
Charitable and other contributions to expenditure	-	2
Non-patient care services to other bodies	56	33
Sustainability and transformation fund income	3,642	1,596
Charitable fund incoming resources	54	270
Other income	504	423
Total other operating income	**4,710**	**2,899**

Note 5.1 Operating expenses (Group)

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	4,396	4,589
Purchase of healthcare from non-NHS and non-DHSC bodies	1,435	1,632
Purchase of social care	88	151
Staff and executive directors costs	78,529	78,660
Remuneration of non-executive directors	59	59
Supplies and services - clinical (excluding drugs costs)	3,767	3,428
Supplies and services - general	3,136	3,855
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	3,186	3,579
Consultancy costs	159	205
Establishment	228	729
Premises	4,110	4,265
Transport (including patient travel)	1,609	1,599
Depreciation on property, plant and equipment	3,603	2,061
Amortisation on intangible assets	581	326
Net impairments	15,685	-
Increase/(decrease) in provision for impairment of receivables	(155)	370
Audit fees payable to the external auditor		
audit services- statutory audit	39	63
other auditor remuneration (external auditor only)	3	3
Internal audit costs	40	68
Clinical negligence	286	260
Legal fees	206	53
Insurance	122	117
Education and training	578	479
Rentals under operating leases	1,433	1,358
Hospitality	4	2
Losses, ex gratia & special payments	3	3
Other	34	4
Total	**123,164**	**108,221**
Of which:		
Related to continuing operations	123,164	108,221
Related to discontinued operations	-	-

Note 5.2 Other auditor remuneration (Group)

	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the Trust	3	3
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**3**	**3**

Note 5.3 Limitation on auditor's liability (Group)

There is no limitation on auditor's liability for external audit work carried out for the financial years 2017/18 or 2016/17.

Note 6 Impairment of assets (Group)

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	15,685	-
Total net impairments charged to operating surplus / deficit	**15,685**	**-**
Impairments charged to the revaluation reserve	5,709	-
Total net impairments	**21,394**	**-**

The impairments charged in year all relate to the updated revaluation on Trust land and buildings.
The accounting entries made in respect of the revaluation are explained at note 13.

Note 7 Employee benefits (Group)

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	63,232	63,435
Social security costs	4,971	5,474
Apprenticeship levy	294	-
Employer's contributions to NHS pensions	8,249	8,248
Pension cost - other	-	106
Temporary staff (including agency)	2,044	1,675
Total gross staff costs	**78,790**	**78,938**
Recoveries in respect of seconded staff	(261)	(278)
Total staff costs	**78,529**	**78,660**
Of which		
Costs capitalised as part of assets	-	-

Note 7.1 Retirements due to ill-health (Group)

During 2017/18 there were no early retirements from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £0k (£0k in 2016/17).

Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the Government Financial Reporting Manual (FReM) requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

Note 9 Operating leases (Group)

Note 9.1 Gloucestershire Care Services NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Gloucestershire Care Services NHS Trust is the lessee.

Aside from the lease on the headquarters building at Edward Jenner Court (which are analysed below) the Trust has minimal other operating lease commitments.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	734	458
Contingent rents	699	900
Total	**1,433**	**1,358**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	833	734
- later than one year and not later than five years;	3,065	2,777
- later than five years.	4,735	4,435
Total	**8,633**	**7,946**
Future minimum sublease payments to be received	-	-

Note 10 Finance income (Group)

Finance income represents interest received on assets and investments in the period.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	34	16
Total	**34**	**16**

Note 11.1 Intangible assets - 2017/18

Group	Software licences	Internally generated information technology	Intangible assets under construction	Other (purchased)	Charitable fund intangible assets	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**-**	**1,945**	**-**	**-**	**-**	**1,945**
Transfers by absorption	-	-	-	-	**-**	**-**
Additions	-	-	-	-	**-**	**-**
Impairments	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	**-**
Valuation / gross cost at 31 March 2018	**-**	**1,945**	**-**	**-**	**-**	**1,945**
Amortisation at 1 April 2017 - brought forward	**-**	**364**	**-**	**-**	**-**	**364**
Transfers by absorption	-	-	-	-	-	**-**
Provided during the year	-	581	-	-	-	**581**
Impairments	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	**-**
Amortisation at 31 March 2018	**-**	**945**	**-**	**-**	**-**	**945**
Net book value at 31 March 2018	**-**	**1,000**	**-**	**-**	**-**	**1,000**
Net book value at 1 April 2017	**-**	**1,581**	**-**	**-**	**-**	**1,581**

Note 11.2 Intangible assets - 2016/17

Group	Software licences	Internally generated information technology	Intangible assets under construction	Other (purchased)	Charitable fund intangible assets	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**-**	**1,294**	**-**	**-**	**-**	**1,294**
Prior period adjustments	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2016	**-**	**1,294**	**-**	**-**	**-**	**1,294**
Transfers by absorption	-	-	-	-	-	**-**
Additions	-	651	-	-	-	**651**
Impairments	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	**-**
Valuation / gross cost at 31 March 2017	**-**	**1,945**	**-**	**-**	**-**	**1,945**
Amortisation at 1 April 2016 - as previously stated	**-**	**38**	**-**	**-**	**-**	**38**
Prior period adjustments	-	-	-	-	-	**-**
Amortisation at 1 April 2016	**-**	**38**	**-**	**-**	**-**	**38**
Transfers by absorption	-	-	-	-	-	**-**
Provided during the year	-	326	-	-	-	**326**
Impairments	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	**-**
Amortisation at 31 March 2017	**-**	**364**	**-**	**-**	**-**	**364**
Net book value at 31 March 2017	**-**	**1,581**	**-**	**-**	**-**	**1,581**
Net book value at 1 April 2016	**-**	**1,256**	**-**	**-**	**-**	**1,256**

Note 11.2 Intangible assets - 2017/18

Trust	Software licences	Internally generated information technology	Development expenditure	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**-**	**1,945**	**-**	**-**	**-**	**1,945**
Valuation / gross cost at 31 March 2018	**-**	**1,945**	**-**	**-**	**-**	**1,945**
Amortisation at 1 April 2017 - brought forward	**-**	**364**	**-**	**-**	**-**	**364**
Provided during the year	-	581	-	-	-	**581**
Amortisation at 31 March 2018	**-**	**945**	**-**	**-**	**-**	**945**
Net book value at 31 March 2018	**-**	**1,000**	**-**	**-**	**-**	**1,000**
Net book value at 1 April 2017	**-**	**1,581**	**-**	**-**	**-**	**1,581**

Note 11.3 Intangible assets - 2016/17

Trust	Software licences	Internally generated information technology	Development expenditure	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**-**	**1,294**	**-**	**-**	**-**	**1,294**
Valuation / gross cost at 1 April 2016	**-**	**1,294**	**-**	**-**	**-**	**1,294**
Additions	-	651	-	-	-	**651**
Valuation / gross cost at 31 March 2017	**-**	**1,945**	**-**	**-**	**-**	**1,945**
Amortisation at 1 April 2016 - as previously stated	**-**	**38**	**-**	**-**	**-**	**38**
Amortisation at 1 April 2016	**-**	**38**	**-**	**-**	**-**	**38**
Provided during the year	-	326	-	-	-	**326**
Amortisation at 31 March 2017	**-**	**364**	**-**	**-**	**-**	**364**
Net book value at 31 March 2017	**-**	**1,581**	**-**	**-**	**-**	**1,581**
Net book value at 1 April 2016	**-**	**1,256**	**-**	**-**	**-**	**1,256**

Note 12.1 Property, plant and equipment - 2017/18

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**11,799**	**70,524**	**-**	**1,441**	**5,607**	**160**	**4,896**	**1,474**	**150**	**96,051**
Transfers by absorption	-	-	-	-	-	-	-	-	-	**-**
Additions	-	424	-	1,726	279	-	790	116	-	**3,335**
Impairments	(5,034)	(16,360)	-	-	-	-	-	-	-	**(21,394)**
Revaluations	-	(11,153)	-	-	-	-	-	-	-	**(11,153)**
Reclassifications	(200)	66	241	(41)	(117)	-	(44)	95	-	**-**
Valuation/gross cost at 31 March 2018	**6,565**	**43,501**	**241**	**3,126**	**5,769**	**160**	**5,642**	**1,685**	**150**	**66,839**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**11,153**	**-**	**-**	**2,422**	**92**	**1,311**	**552**	**-**	**15,530**
Provided during the year	-	793	241	-	545	27	1,791	206	-	**3,603**
Revaluations	-	(11,153)	-	-	-	-	-	-	-	**(11,153)**
Accumulated depreciation at 31 March 2018	**-**	**793**	**241**	**-**	**2,967**	**119**	**3,102**	**758**	**-**	**7,980**
Net book value at 31 March 2018	**6,565**	**42,708**	**-**	**3,126**	**2,802**	**41**	**2,540**	**927**	**150**	**58,859**
Net book value at 1 April 2017	**11,799**	**59,371**	**-**	**1,441**	**3,185**	**68**	**3,585**	**922**	**150**	**80,521**

Note 12.2 Property, plant and equipment - 2016/17

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**11,799**	**65,733**	**-**	**2,293**	**5,109**	**160**	**3,056**	**1,080**	**150**	**89,380**
Valuation / gross cost at 1 April 2016	**11,799**	**65,733**	**-**	**2,293**	**5,109**	**160**	**3,056**	**1,080**	**150**	**89,380**
Additions	-	-	-	74	498	-	1,840	394	-	**2,806**
Revaluations	-	3,865	-	-	-	-	-	-	-	**3,865**
Reclassifications	-	926	-	(926)	-	-	-	-	-	**-**
Valuation/gross cost at 31 March 2017	**11,799**	**70,524**	**-**	**1,441**	**5,607**	**160**	**4,896**	**1,474**	**150**	**96,051**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**10,248**	**-**	**-**	**1,894**	**69**	**813**	**445**	**-**	**13,469**
Accumulated depreciation at 1 April 2016	**-**	**10,248**	**-**	**-**	**1,894**	**69**	**813**	**445**	**-**	**13,469**
Provided during the year	-	905	-	-	528	23	498	107	-	**2,061**
Accumulated depreciation at 31 March 2017	**-**	**11,153**	**-**	**-**	**2,422**	**92**	**1,311**	**552**	**-**	**15,530**
Net book value at 31 March 2017	**11,799**	**59,371**	**-**	**1,441**	**3,185**	**68**	**3,585**	**922**	**150**	**80,521**
Net book value at 1 April 2016	**11,799**	**55,485**	**-**	**2,293**	**3,215**	**91**	**2,243**	**635**	**150**	**75,911**

Note 12.3 Property, plant and equipment financing - 2017/18

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018										
Owned - purchased	6,565	41,686	-	3,126	2,635	41	2,193	927	150	**57,323**
Finance leased	-	-	-	-	-	-	347	-	-	**347**
Owned - donated	-	1,022	-	-	167	-	-	-	-	**1,189**
NBV total at 31 March 2018	**6,565**	**42,708**	**-**	**3,126**	**2,802**	**41**	**2,540**	**927**	**150**	**58,859**

Note 12.4 Property, plant and equipment financing - 2016/17

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017										
Owned - purchased	11,799	59,371	-	1,441	3,185	68	3,585	922	150	**80,521**
NBV total at 31 March 2017	**11,799**	**59,371**	**-**	**1,441**	**3,185**	**68**	**3,585**	**922**	**150**	**80,521**

Note 12.5 Property, plant and equipment - 2017/18

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**11,799**	**70,524**	**-**	**1,441**	**5,607**	**160**	**4,896**	**1,474**	**95,901**
Additions	-	424	-	1,726	279	-	790	116	**3,335**
Impairments	(5,034)	(16,360)	-	-	-	-	-	-	**(21,394)**
Revaluations	-	(11,153)	-	-	-	-	-	-	**(11,153)**
Reclassifications	(200)	66	241	(41)	(117)	-	(44)	95	**-**
Valuation/gross cost at 31 March 2018	**6,565**	**43,501**	**241**	**3,126**	**5,769**	**160**	**5,642**	**1,685**	**66,689**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**11,153**	**-**	**-**	**2,422**	**92**	**1,311**	**552**	**15,530**
Provided during the year	-	793	241	-	545	27	1,791	206	**3,603**
Revaluations	-	(11,153)	-	-	-	-	-	-	**(11,153)**
Accumulated depreciation at 31 March 2018	**-**	**793**	**241**	**-**	**2,967**	**119**	**3,102**	**758**	**7,980**
Net book value at 31 March 2018	**6,565**	**42,708**	**-**	**3,126**	**2,802**	**41**	**2,540**	**927**	**58,709**
Net book value at 1 April 2017	**11,799**	**59,371**	**-**	**1,441**	**3,185**	**68**	**3,585**	**922**	**80,371**

Note 12.6 Property, plant and equipment - 2016/17

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**11,799**	**65,733**	**-**	**2,293**	**5,109**	**160**	**3,056**	**1,080**	**89,230**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2016	**11,799**	**65,733**	**-**	**2,293**	**5,109**	**160**	**3,056**	**1,080**	**89,230**
Additions	-	-	-	74	498	-	1,840	394	**2,806**
Revaluations	-	3,865	-	-	-	-	-	-	**3,865**
Reclassifications	-	926	-	(926)	-	-	-	-	**-**
Valuation/gross cost at 31 March 2017	**11,799**	**70,524**	**-**	**1,441**	**5,607**	**160**	**4,896**	**1,474**	**95,901**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**10,248**	**-**	**-**	**1,894**	**69**	**813**	**445**	**13,469**
Accumulated depreciation at 1 April 2016	**-**	**10,248**	**-**	**-**	**1,894**	**69**	**813**	**445**	**13,469**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	905	-	-	528	23	498	107	**2,061**
Accumulated depreciation at 31 March 2017	**-**	**11,153**	**-**	**-**	**2,422**	**92**	**1,311**	**552**	**15,530**
Net book value at 31 March 2017	**11,799**	**59,371**	**-**	**1,441**	**3,185**	**68**	**3,585**	**922**	**80,371**
Net book value at 1 April 2016	**11,799**	**55,485**	**-**	**2,293**	**3,215**	**91**	**2,243**	**635**	**75,761**

Note 12.7 Property, plant and equipment financing - 2017/18

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	6,565	41,686	-	3,126	2,635	41	2,193	927	**57,173**
Finance leased	-	-	-	-	-	-	347	-	**347**
Owned - donated	-	1,022	-	-	167	-	-	-	**1,189**
NBV total at 31 March 2018	**6,565**	**42,708**	**-**	**3,126**	**2,802**	**41**	**2,540**	**927**	**58,709**

Note 12.8 Property, plant and equipment financing - 2016/17

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned - purchased	11,799	59,371	-	1,441	3,185	68	3,585	922	**80,371**
NBV total at 31 March 2017	**11,799**	**59,371**	**-**	**1,441**	**3,185**	**68**	**3,585**	**922**	**80,371**

Note 13 Revaluations of property, plant and equipment

The land and buildings owned by the Trust were revalued in year with an effective date of 1 April 2017
The modelling for the valuation was carried out by our advisors 'Psec' using assumptions agreed with the Trust management.
The valuation itelf was performed by the District Valuer's office.

All land and buildings continue to be valued on an equivalent modern asset basis as in previous years.
Because of changed assumptions regarding the size and scale of land and buildings required if services were redesigned there was a significant reduction in carrying values when the valuation was adopted.
The total impairment was £21,394k (land £5,034k and buildings £16,360k) of which £15,585k was taken to the income and expenditure accounts and the remaining £5,709k was taken to revaluation reserve.

Note 14 Analysis of charitable fund reserves

	31 March 2018 £000	31 March 2017 £000
Unrestricted funds:		
Unrestricted income funds	38	26
Restricted funds:		
Other restricted income funds	158	148
	196	**174**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the Trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the Trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 15 Inventories

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Consumables	228	227	228	227
Total inventories	**228**	**227**	**228**	**227**
of which:				
Held at fair value less costs to sell	-	-	-	-

Note 16.1 Trade receivables and other receivables

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Current				
Trade receivables	3,095	5,913	3,095	5,913
Accrued income	3,357	1,084	3,357	1,084
Provision for impaired receivables	(695)	(850)	(695)	(850)
Prepayments (non-PFI)	759	629	759	629
PDC dividend receivable	20	-	20	-
VAT receivable	187	152	187	152
Other receivables	33	-	33	-
NHS charitable funds: trade and other receivables	6	82	-	-
Total current trade and other receivables	**6,762**	**7,010**	**6,756**	**6,928**
Of which receivables from NHS and DHSC group bodies:				
Current	4,817	5,135	4,817	5,135
Non-current	-	-	-	-

Note 16.2 Provision for impairment of receivables

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
At 1 April as previously stated	**850**	**480**	**850**	**480**
At 1 April	**850**	**480**	**850**	**480**
Increase in provision	82	370	82	370
Amounts utilised	(237)	-	(237)	
At 31 March	**695**	**850**	**695**	**850**

Note 16.3 Credit quality of financial assets

Group	**31 March 2018**		**31 March 2017**	
	Trade and other receivables	**Investments & Other financial assets**	**Trade and other receivables**	**Investments & Other financial assets**
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
Over 180 days	695	-	850	-
Total	**695**	**-**	**850**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	5,029	-	5,340	-
30-60 Days	634	-	624	-
60-90 days	76	-	75	-
90- 180 days	78	-	77	-
Over 180 days	186	-	183	-
Total	**6,003**	**-**	**6,299**	**-**

Trust	**31 March 2018**		**31 March 2017**	
	Trade and other receivables	**Investments & Other financial assets**	**Trade and other receivables**	**Investments & Other financial assets**
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
Over 180 days	695	-	850	-
Total	**695**	**-**	**850**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	5,029	-	5,340	-
30-60 Days	634	-	624	-
60-90 days	76	-	75	-
90- 180 days	78	-	77	-
Over 180 days	186	-	183	-
Total	**6,003**	**-**	**6,299**	**-**

Note 17 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
At 1 April	**8,381**	**6,280**	**8,280**	**6,112**
Net change in year	4,031	2,101	4,074	2,168
At 31 March	**12,412**	**8,381**	**12,354**	**8,280**
Broken down into:				
Cash at commercial banks and in hand	2	2	2	2
Cash with the Government Banking Service	12,410	8,379	12,352	8,278
Total cash and cash equivalents	**12,412**	**8,381**	**12,354**	**8,280**

Note 18.1 Trade and other payables

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Current				
Trade payables	1,203	3,953	1,203	3,953
Capital payables	1,533	1,833	1,533	1,833
Accruals	4,358	3,153	4,358	3,153
Social security costs	793	784	793	784
Other taxes payable	530	499	530	499
PDC dividend payable	-	57	-	57
Other payables	1,128	1,054	1,128	1,054
NHS charitable funds: trade and other payables	18	159	-	-
Total current trade and other payables	**9,563**	**11,492**	**9,545**	**11,333**
Of which payables from NHS and DHSC group bodies:				
Current	1,104	4,829	1,104	4,829
Non-current	-	-	-	-

Note 18.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

Group and Trust	31 March 2018	31 March 2018	31 March 2017	31 March 2017
	£000	Number	£000	Number
- number of cases involved	-	-	-	1
- outstanding pension contributions	-	-	-	-

Note 19 Other liabilities

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Current				
Deferred income	123	211	123	211
Total other current liabilities	**123**	**211**	**123**	**211**

Note 20 Borrowings

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Current				
Obligations under finance leases	148	-	148	-
Total current borrowings	**148**	**-**	**148**	**-**
Non-current				
Obligations under finance leases	221	-	221	-
Total non-current borrowings	**221**	**-**	**221**	**-**

Note 21 Finance leases

as a lessee

Obligations under finance leases where the Trust is the lessee.

	Group		Trust	
	2018	2017	2018	2017
	£000	£000	£000	£000
Gross lease liabilities	**369**	**-**	**369**	**-**
of which liabilities are due:				
- not later than one year;	148	-	148	-
- later than one year and not later than five years;	221	-	221	-
- later than five years.	-	-		-
Finance charges allocated to future periods	-	-		-
Net lease liabilities	**369**	**-**	**369**	**-**
of which payable:				
- not later than one year;	148	-	148	-
- later than one year and not later than five years;	221	-	221	-

The only significant finance lease commitment for the Trust is for laptop computers used by clinical staff. This is a 3 year commitment ending September 2020.

Note 22.1 Provisions for liabilities and charges analysis (Group)

Group	Pensions - early departure costs	Legal claims	Redundancy	Other	Charitable fund provisions	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2017	**-**	**15**	**-**	**1,050**	**-**	**1,065**
Arising during the year	-	20	-	121	-	**141**
Utilised during the year	-	(26)	-	(290)	-	**(316)**
Reversed unused	-	(1)	-	(729)	-	**(730)**
At 31 March 2018	**-**	**8**	**-**	**152**	**-**	**160**
Expected timing of cash flows:						
- not later than one year;	-	8	-	152	-	**160**
Total	**-**	**8**	**-**	**152**	**-**	**160**

Note 22.2 Provisions for liabilities and charges analysis (Trust)

Trust	Pensions - early departure costs	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2017	**-**	**15**	**-**	**1,050**	**1,065**
Arising during the year	-	20	-	121	**141**
Utilised during the year	-	(26)	-	(290)	**(316)**
Reversed unused	-	(1)	-	(729)	**(730)**
At 31 March 2018	**-**	**8**	**-**	**152**	**160**
Expected timing of cash flows:					
- not later than one year;	-	8	-	152	**160**
Total	**-**	**8**	**-**	**152**	**160**

Note 22.3 Clinical negligence liabilities

At 31 March 2018, £1,047k was included in the provisions of NHS Resolution in respect of clinical negligence liabilities of the Trust (31 March 2017: £452k).

Note 23 Contingent assets and liabilities

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Value of contingent liabilities				
Redundancy	-	(45)	-	(45)
Gross value of contingent liabilities	**-**	**(45)**	**-**	**(45)**

Note 24 Pensions

Past and present employees are covered by the provisions of the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

Local Government Pension Scheme (LGPS)

As part of the S75 Integrated Services arrangements, the Trust employs staff who were TUPEd from Gloucestershire County Council. As part of the TUPE transfer, former local authority staff could elect to remain in the LGPS. The LGPS is a defined benefit statutory scheme administered by the County Council in accordance with the LGPS (Benefits, Membership and Contributions) Regulations 2007; the LGPS (Administration) Regulations 2008 and the LGPS (Transitional Provisions) Regulations 2008. It is contracted out of the State Second Pension.

During the financial period 1 April 2017 to 31 March 2018, the Trust's pension contributions totalled £85k and employees' contributions totaled £22k.

Key Assumptions in actuarial valuation of assets and liabilities	**31-Mar-18**	**31-Mar-17**
	%	%
Pension Increase Rate	2.40%	2.40%
Salary Increase Rate	2.70%	2.70%
Discount Rate	2.60%	2.50%

The fair value of employer assets of the whole fund as at 31 March 2017 is as shown below:

	31-Mar-18		**31-Mar-17**	
Assets	**£000s**	**%**	**£000s**	**%**
Equity Securities	1,447	18%	1,398	18%
Debt Securities	1,061	13%	1,026	13%
Private Equity	20	0%	20	0%
Real Estate	553	7%	535	7%
Investment Funds & Unit Trusts	4,722	60%	4,563	60%
Derivatives	6	0%	6	0%
Cash and Cash Equivalents	115	1%	111	1%
	7,924	**100%**	**7,658**	**100%**

The details of the Trust's share of assets and the net position as included in the accounts are as follows:

	Assets £000s	**Obligations £000s**	**Net liability £000s**
Fair Value of employer assets	7,658	-	7,658
Present value of funded liabilities	-	(7,605)	(7,605)
Opening position at 31 March 2017	**7,658**	**(7,605)**	**53**
Current service cost	-	(148)	(148)
Net interest			
Interest on plan assets	190	-	190
Interest cost on defined benefit obligation	-	(190)	(190)
Total defined benefit cost recognised in SOCI	*190*	*(190)*	-
Cashflow			
Participants contributions	22	(22)	-
Employer contributions	85	-	85
Benefits paid	(177)	177	-
Expected closing position	**7,778**	**(7,788)**	**(10)**
Remeasurements			
Change in financial assumptions	-	127	127
Returns on assets excluding amounts included in net interest	146	-	146
Remeasurements recognised in other comprehensive income	**146**	**127**	**273**
Fair value of employer assets	7,924	-	7,924
Present Value of funded liabilities	-	(7,661)	(7,661)
Closing position at 31 March 2018	**7,924**	**(7,661)**	**263**
In Year Movement	**266**	**(56)**	**210**

The in year increase in attributable net assets has not been reflected in the accounts of the Trust. The Trust elected at 31/3/16 not to show the value of any attributable surplus pension scheme assets on its balance sheet as there is no scenario where these would become the property of the Trust.

Note 25 Losses and special payments

Group and Trust	2017/18 Total number of cases Number	2017/18 Total value of cases £000	2016/17 Total number of cases Number	2016/17 Total value of cases £000
Special payments				
Ex-gratia payments	3	3	8	3
Total losses and special payments	**3**	**3**	**8**	**3**

Note 26 Related Parties

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff or parties related to any of them, has undertaken any material transactions with the Trust.

The Trust Chair, Ingrid Barker, is also Chair of 2Gether NHS Foundation Trust

The Department of Health and Social Care is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent.

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies.

As at 31 March 2018	Income	Expenditure	Receivables	Payables
Entity	£000	£000	£000	£000
NHS Gloucestersdhire CCG	92,849	-	184	-
Gloucestershire Hospitals NHS Foundation Trust	5,816	4,442	80	514
NHS England	10,200	4	3,541	-
Gloucestershire County Council	2,071	1,106	704	149
NHS Resolution (formerly NHS Litigation Authority)	-	367	-	-
HM Revenue and Customs	-	5,265	186	1,323
NHS Pensions Authority	-	8,249	-	1,122

As at 31 March 2017	Income	Expenditure	Receivables	Payables
Entity	£000	£000	£000	£000
NHS Gloucestersdhire CCG	95,016	-	362	-
Gloucestershire Hospitals NHS Foundation Trust	5,530	4,338	2797	2,689
NHS England	5,503	-	879	-
Gloucestershire County Council	2,208	904	32	57
NHS Resolution (formerly NHS Litigation Authority)	-	342	-	-
HM Revenue and Customs	-	5,474	-	1,650
NHS Pensions Authority	-	8,248	-	1,118

The Trust has also received revenue and capital payments from its' charitable funds, of which all trustees are also members of the Trust board.

Note 27 Events after the reporting date

No events have occurred since the balance sheet date that require adjustment or disclosure.

Note 28 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	20,746	25,375	18,199	22,139
Total non-NHS trade invoices paid within target	10,242	9,585	8,926	7,972
Percentage of non-NHS trade invoices paid within target	49.37%	37.77%	49.05%	36.01%
NHS Payables				
Total NHS trade invoices paid in the year	377	1,797	316	1,609
Total NHS trade invoices paid within target	105	425	75	365
Percentage of NHS trade invoices paid within target	27.85%	23.65%	23.73%	22.68%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

The Trust is working to monitor and to improve performance on this metric and has reported throughout the year to Audit Committee.

The figures shown above are for the whole financial year, if March 2018 only is considered the position improves to 66.89% of invoices paid in time by volume and 66.51% by value.

Note 29 External financing

The Trust is given an external financing limit against which it is permitted to underspend

	2017/18 £000	2016/17 £000
Finance leases taken out in year	369	-
External financing requirement	369	-
Under / (over) spend against EFL	(369)	-

Note 30 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	3,335	3,457
Charge against Capital Resource Limit	3,335	3,457
Capital Resource Limit	3,400	3,887
Under / (over) spend against CRL	65	430

Note 31 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	5,563
Breakeven duty financial performance surplus / (deficit)	5,563

	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000
Breakeven duty in-year financial performance	2,006	1,508	2,501	2,309	5,563
Breakeven duty cumulative position	2,006	3,514	6,015	8,324	13,887
Operating income	108,980	114,111	113,905	112,624	114,599
Cumulative breakeven position as a percentage of operating income	1.84%	3.08%	5.28%	7.39%	12.12%

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF GLOUCESTERSHIRE CARE SERVICES NHS TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Gloucestershire Care Services NHS Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2017/18. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2017/18.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 31 the directors are responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity . As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on Page 32 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 32, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Board of Directors of Gloucestershire Care Services NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Gloucestershire Care Services NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Rees Batley

Rees Batley for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE

24 May 2018

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)		Finance Strategy 2017 (every 3 years)		
	Estates Strategy **DUE 2018** (every 3 years)					
	Communication & Engagement Strategy 2017 (every 3 years, **DUE 2020**)					

Corporate						
Understanding You Report			x			x

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