Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 22 March 2016

Agenda Item:	19
Agenda Ref:	19/0316
Author:	Susan Field, Director of Nursing, Michael Richardson, Deputy Director of Nursing
Presented By:	Paul Jennings, Chief Executive Officer
Sponsor:	Paul Jennings, Chief Executive Officer

Subject:	Complaints Policy, Duty of Candour and Parliamentary and Health Service Ombudsman (PHSO) process

This report is provided for: ☐ Discussion ☐ Decision ☒ Approval ☐ Assurance ☐ Information

Executive Summary:

These two polices were initially ratified by the Trust Board May 2015. Following implementation of the policies it became apparent that improvements could be made in terms of:

- Simplifying processes and that this include any associated documentation
- Ensuring consistency across both clinical and non-clinical areas
- Further clarification of roles and responsibilities

The Complaints Oversight Group (COG) is a sub-committee of the Quality and Performance Committee, and is led by the Chief Executive and a Non-Executive Director colleague and has the remit to review significant complaints and serious incidents; to extrapolate Trust wide themes and learning in order to improve practice and to detect early indicators for change.

The COG has also overseen the review of the Complaints and Duty of Candour policies and procedures

Complaints policy – Changes include:

- Shortening of policy
- The introduction of 'action cards' at the beginning of the policy
- A specific action card for responding to the Parliamentary and Health Service Ombudsman (PHSO) requests pertaining to specific complaints
- The introduction of easier to read complaints leaflets which are shorter and more succinct.

Duty of Candour Policy – Changes include:

- Shortening of Policy
- Action card at the beginning of the policy, with an emphasis on support being provided by the quality and safety team
- Change in Duty of Candour pathway – all letters to be signed by Chief Executive
- Removal of Duty of Candour template letter
- Introducing a closer alignment to the recently appointed post - Ambassador of Cultural Change

Recommendations:

The Board is asked to: Approve the two policies and leaflets.

Considerations:
Quality implications: Oversight from the COG enhances the Trusts assurance arrangements with regards to the complaints and Duty of Candour process.
Human Resources implications: No new implications identified
Equalities implications: The new leaflets provide an easier narrative for translation and interpretation pruposes.
Financial implications: No new implications specifically identified
Does this paper link to any risks in the corporate risk register: Yes – the relatively lower number of formal complaints received in to the Trust compared to comparator Trusts
Does this paper link to any complaints, concerns or legal claims *By policy and process and not specific cases.*

Which Trust strategic objective(s) does this paper Progress (P) or Challenge (C)?	**P or C**
Achieve the best possible outcomes for our service users through high quality care	P
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	P
Actively engage with health and social care partners as well as local communities, in order to deliver seamless, innovative services across Gloucestershire	P
Support individuals and teams to develop the skills, confidence and ambition to deliver our vision	P
Manage public resources wisely to ensure local services remain sustainable and accessible	P

Which Trust value(s) does this paper Progress (P) or Challenge (C)?	**P or C**
Caring	P
Open	P
Responsible	P
Effective	P

Reviewed by (Sponsor):	Paul Jennings, Chief Executive Officer

Date:	14 March 2016

Where in the Trust has this been discussed before, e.g. Committee, Programme Board, Group?
Trust Board May 2015, Complaints Oversight Group November 2015, January 2016 Quality and Performance Committee, 3rd March 2016

Explanation of acronyms used:
COG – Complaints and Oversight Group DoC – Duty of Candour RCA – Root Cause Analysis SIRI – Serious Incident Requiring Investigation PHSO – Parliamentary and Health Service Ombudsman

AGENDA ITEM: 19.1

Gloucestershire Care Services NHS
NHS Trust

COMPLAINTS POLICY and PROCEDURE

Document reference:	
Version:	**1**
Ratified by:	**Gloucestershire Care Services NHS Trust Board**
Date ratified:	
Originator/author:	**Patient Experience Lead, Quality and Safety Manager**
Responsible committee/individual:	**Quality and Performance Committee Complaints Overview Group**
Executive lead:	**Director of Nursing**
Date issued:	
Review date:	

PLEASE NOTE

The electronic version maintained on the Gloucestershire Care Services NHS Trust intranet is the controlled copy. If printed copies are used it is the responsibility of every individual to ensure that they are working to the most current version of this document.

DOCUMENT CONTROL SHEET

Purpose of document:	To provide guidance on the organisational responsibilities for the Complaints Policy
Dissemination:	Will take place through governance meetings supported by awareness sessions held within clinical teams. The policy will also be made available via the Trust intranet and to the public on the Trust website
Scope:	All colleagues, clinical and non-clinical, particularly anyone involved in concerns and complaints e.g. Clinicians, locality managers, Matrons and Ward Sisters/Charge Nurses, Serious Incident Investigators, Chief Executive and Directors, Quality/Service Experience team, Legal Department and Risk Management Department, Clinical Governance Managers,
Review:	Three years or sooner if there are any changes to the Complaints Regulations or Procedure
This document supports:	All relevant governance documents, standards and legislation are embedded within the document
Key related documents:	All any related Trust policies or other control documents are referenced within the document
Equality and diversity:	This policy has been subjected to a Quality and Equality Impact review. This concluded that the policy will not negatively impact upon the quality of health and social care services provided by the Trust.
Quality:	This policy has been subjected to a Quality and Equality Impact review. This concluded that the policy will not negatively impact upon the quality of health and social care services provided by the Trust.
Consultation:	Members of the Quality and Performance Committee Trust Board Equality & Diversity Manager Healthwatch Gloucestershire
Financial implications:	There are no financial implications in relation to the policies

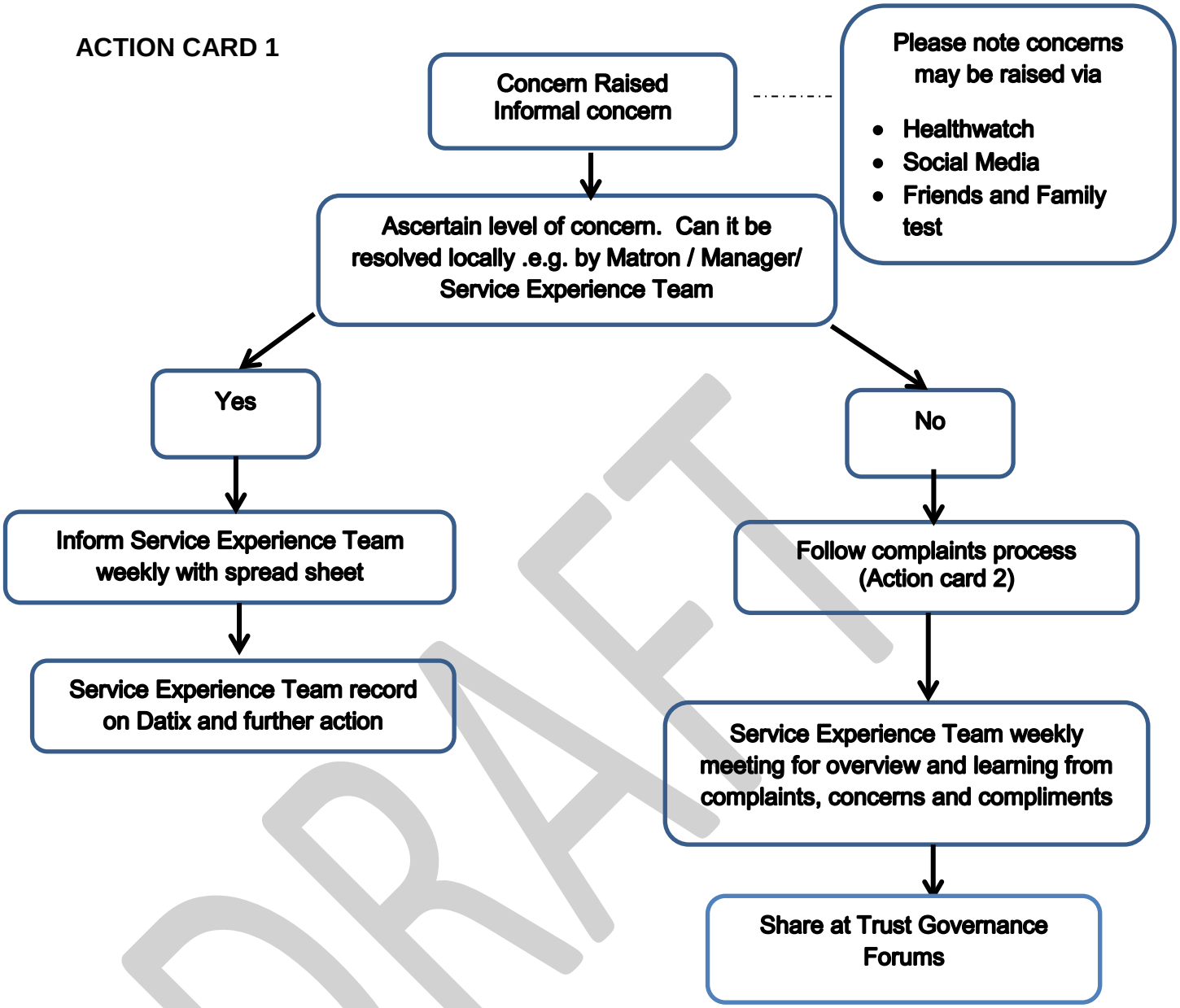
Version Control Information	
Summary of Key Changes	**Previous Version Archive Date**

Contents:

Abbreviations

Abbreviation	Full Description
GCSNHST	Gloucestershire Care Services NHS Trust
ICO	Information Commissioners Office
SIRI	Serious incident requiring investigation
PHSO	Parliamentary and Health Service Ombudsman
CQC	Care Quality Commission
TDA	Trust Development Authority
MP	Member of Parliament
NED	Non-Executive Director
COG	Complaints Oversight Group
CG	Clinical Governance

ACTION CARD 1

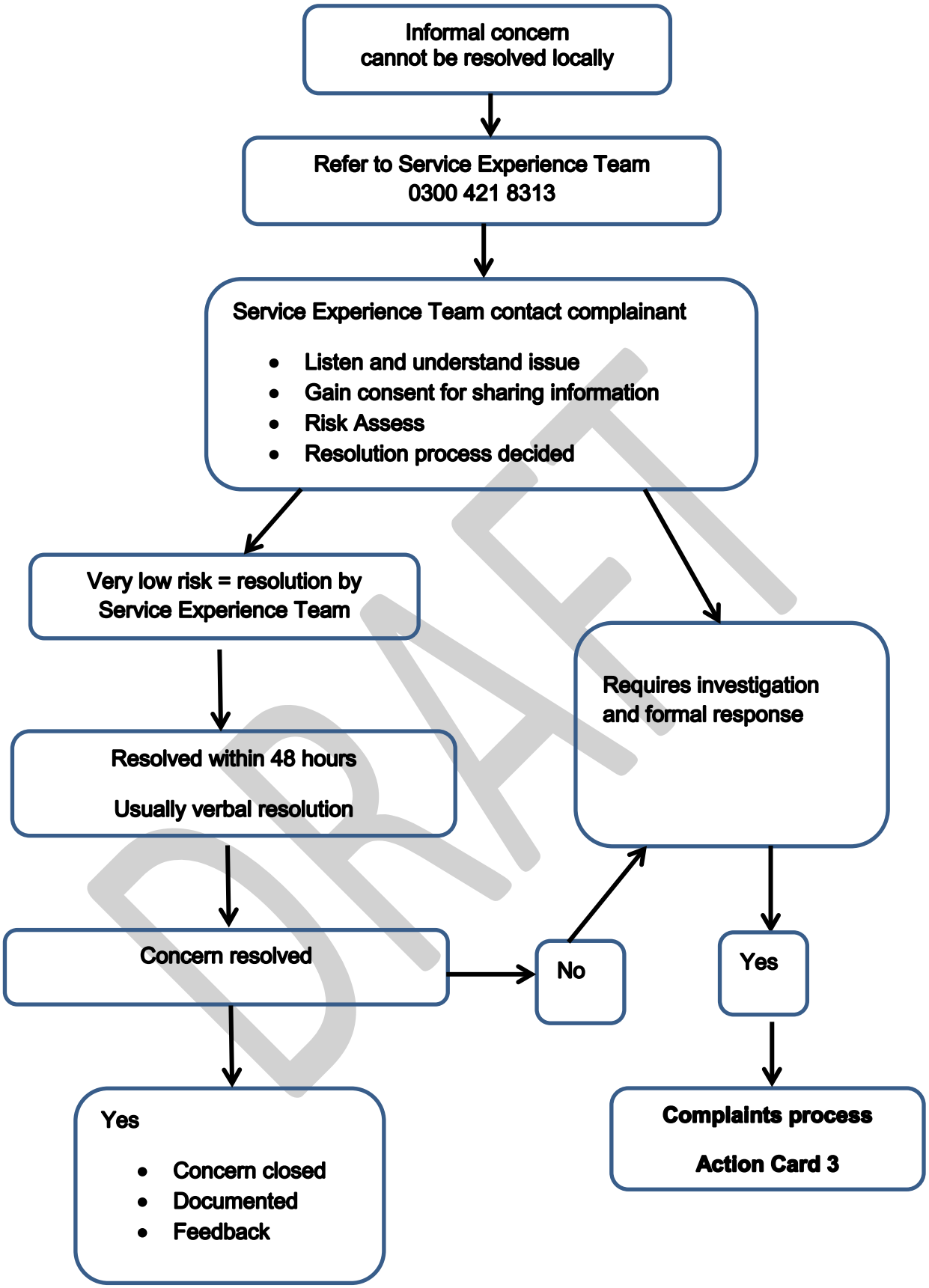


Things to consider when deciding if an issue can be resolved locally or needs other input:

- What is nature of issue?
- What is the expectation of the person bringing the issue to your attention?
- What is their expect outcome?
- Having considered these, can you quickly and easily resolve the issue satisfactorily?
- Do you need to seek advice from your manager or team member?

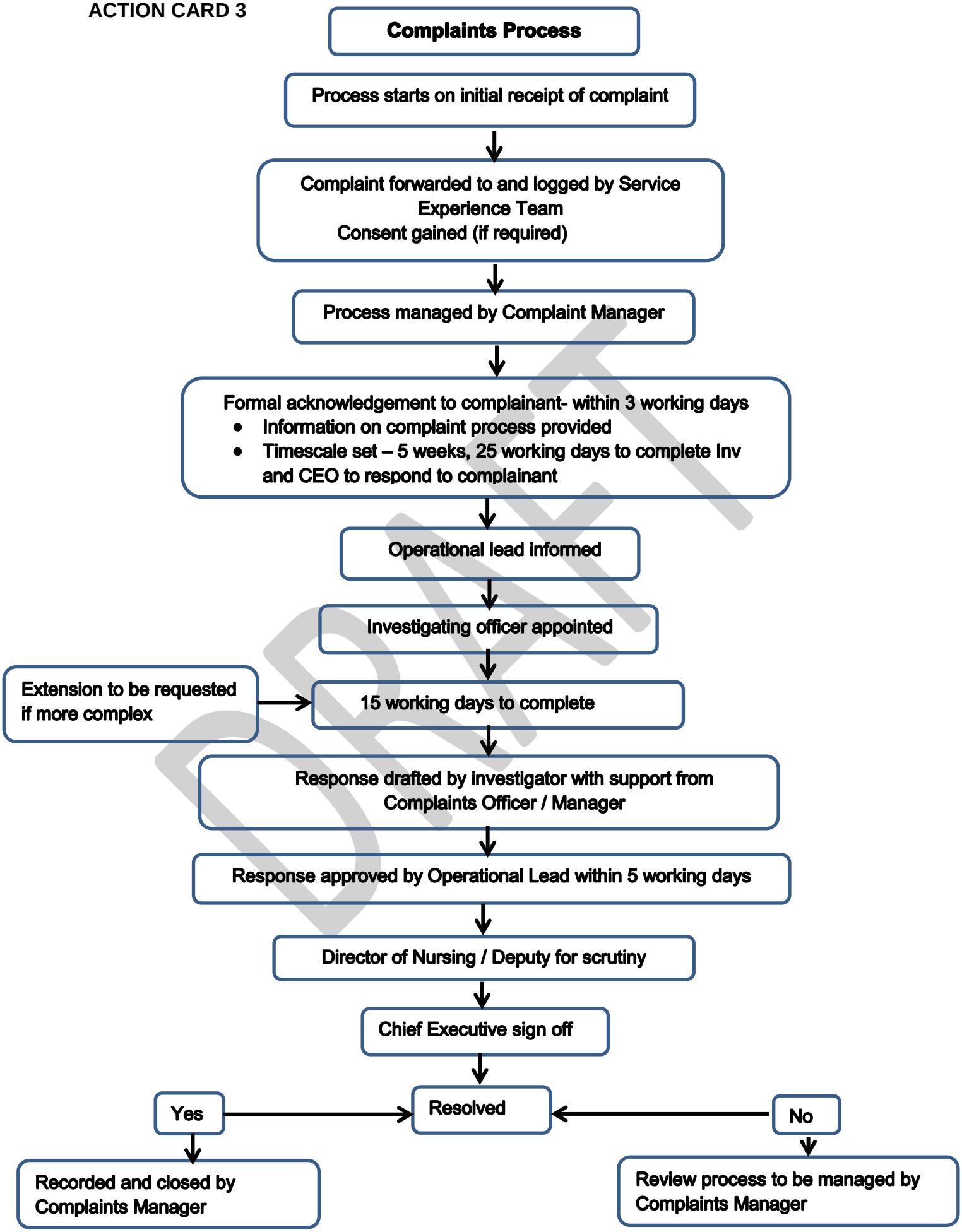
January 2016

ACTION CARD 2



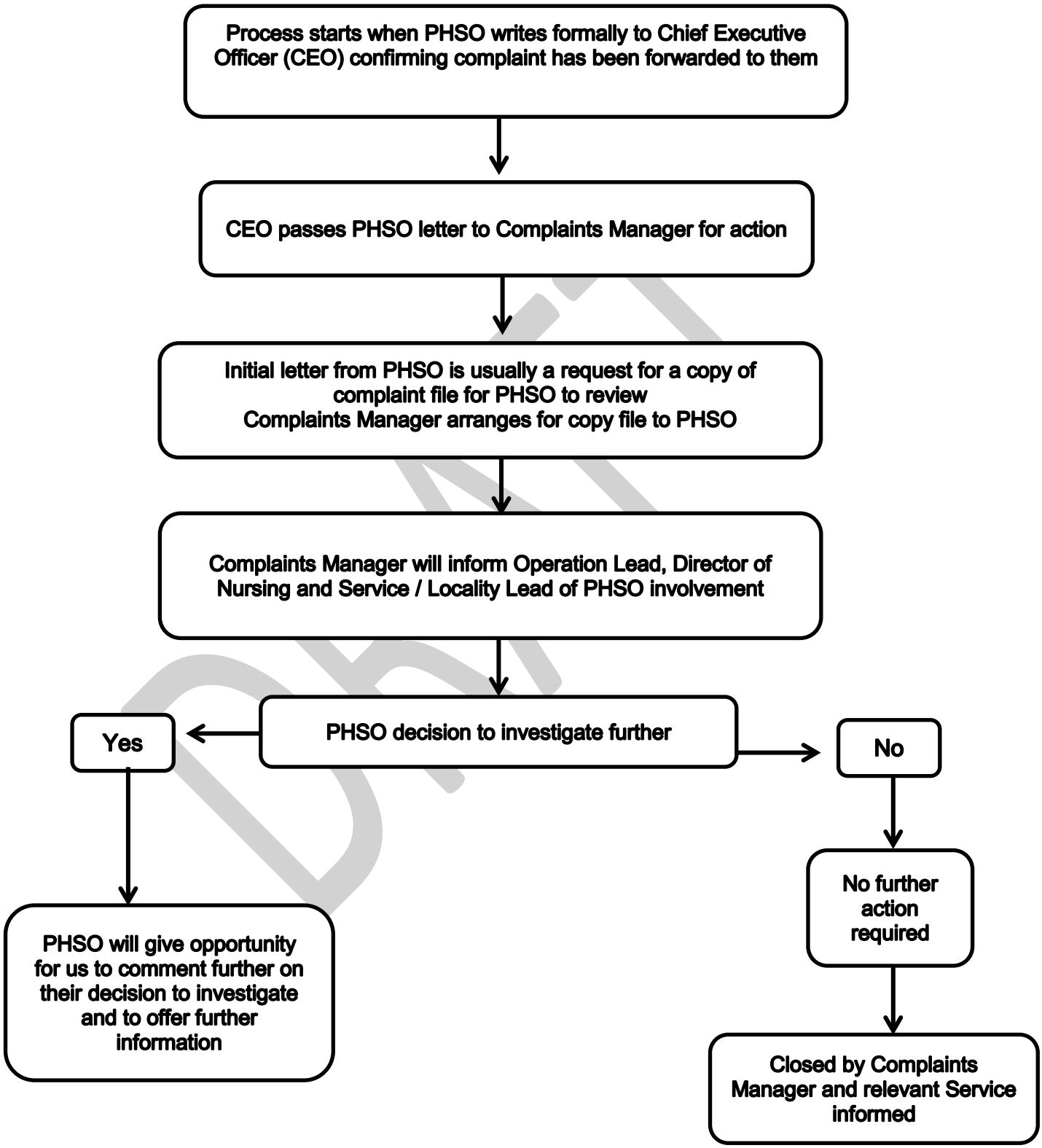
January 2016

ACTION CARD 3



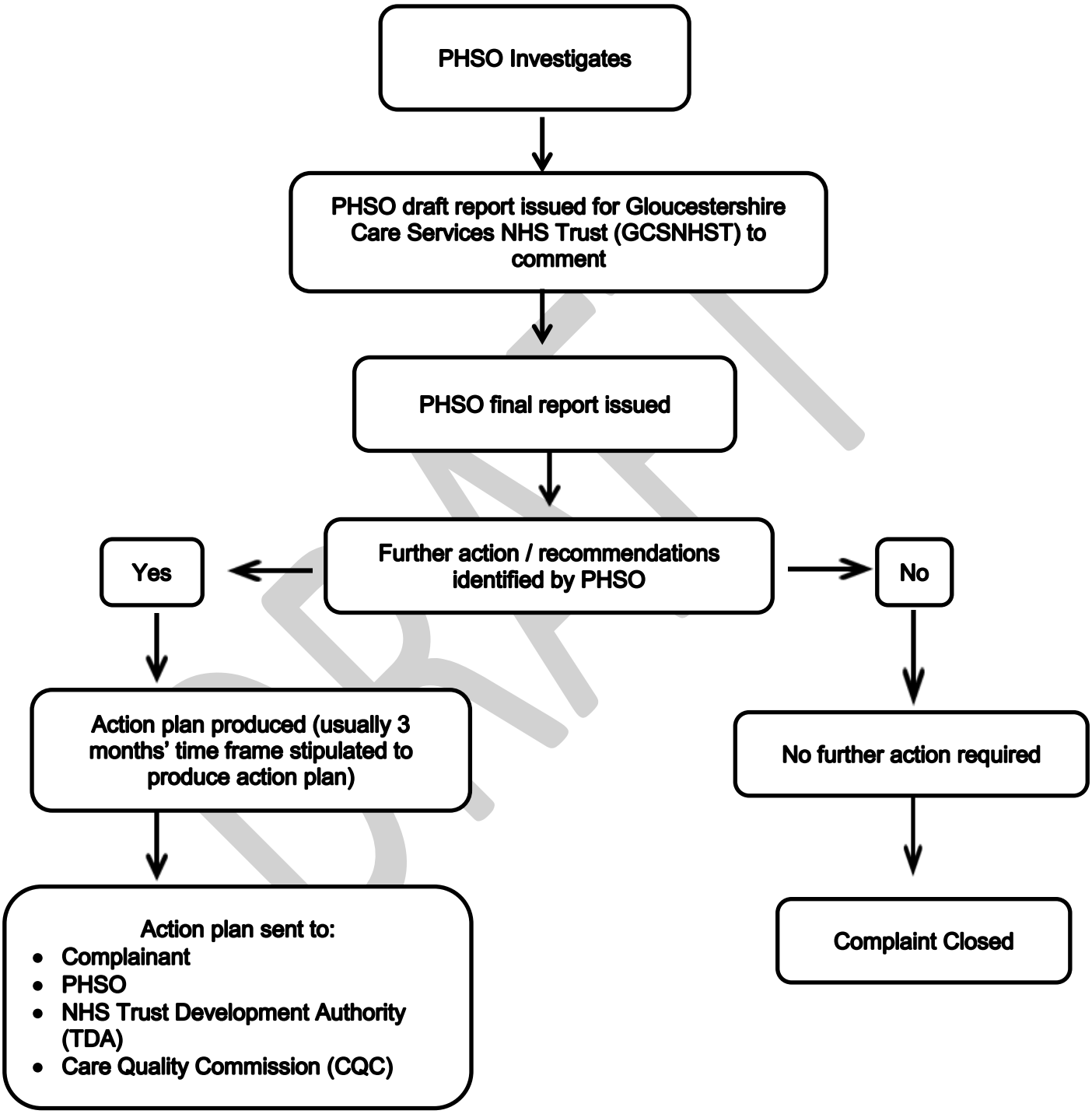
ACTION CARD 4

Parliamentary and Health Service Ombudsman (PHSO) Process January 2016



January 2016

ACTION CARD 5



1 Introduction

1.1 This document outlines our commitment to dealing with complaints and concerns about the services provided by Gloucestershire Care Services NHS Trust (GCSNHST). This also provides information about how we manage, respond to and learn from complaints and concerns made about our services.

1.2 The Trust recognises that all types of feedback including complaints, concerns, compliments, and suggestions must be managed appropriately and listened to in order to develop services, ensure high quality care and service user satisfaction

1.3 For guidance with complaints process please refer to Action Cards found at the front of this policy

2 Purpose

2.1 GCSNHST is committed to high quality care for all as a core principal of our vision and values. This includes the opportunity for any service user, their family, carers, or members of the public, to seek advice, raise concerns or make a complaint, about any of the services provided, or policies and procedures it has developed and implemented.

We are therefore very committed to ensuring that the complaints process is fair to all parties i.e. both complainants and colleagues. When dealing with complaints we aim to adhere to GCSNHST's organisation principles and follow the 'Good Practice Standards for NHS Complaints Handling' (Sept 2013) outlined by the Patients Association:

- Openness and Transparency - well publicised, accessible information and processes, and understood by all those involved in a complaint.
- Evidence based complainant led investigations and responses. This will include providing a consistent approach to the management and investigation of complaints.
- Logical and rational in our approach.
- Sympathetically respond to complaints and concerns in appropriate time frames.
- Provide opportunities for people to offer feedback on the quality of service provided.
- Provide complainants with support and guidance throughout the complaints process.
- Provide a level of detail appropriate to the seriousness of the complaint.
- Identify the causes of complaints and to take action to prevent recurrences.
- Ensure that the care of complainants is not adversely affected as a result of making a complaint.
- Support colleagues to conduct investigations which are thorough, fair, responsive, and open.
- Demonstrate how the Trust will learn from complaints and use them to improve services.
- Ensure that the Trust's complaints service is accessible to everyone.
- Show that the Trust will respect individuals' rights to confidentiality..

- Ensure the Trust Board is informed when considering and improving the quality of services.
- Ensure that people are not treated differently as a result of making a complaint or raising a concern.
- Give clear guidance in differentiating between a complaint, a concern and a comment.
- Ensure that GCSNHST meets its legal obligations.
- Act as a key tool in ensuring the good reputation of GCSNHST.

2.2 The complaints system also incorporates the Parliamentary and Health Service Ombudsman Principles of Good Complaints Handling (2009) and the NHS Constitution which includes a number of patient rights relating to complaints. In summary, these include patients' rights to:

- Have their complaint acknowledged and properly investigated.
- Discuss the manner in which the complaint is to be handled and know the period in which the complaint response is likely to be sent.
- To be kept informed of the progress and to know the outcome including an explanation of the conclusions and confirmation that any action needed has been taken on.
- Take a complaint about data protection breaches to the independent Information Commissioners Office (ICO) if not satisfied with the way the NHS has dealt with this.
- Make a claim for judicial review if the patient thinks that they have been directly affected by an unlawful act or decision of an NHS body.
- Receive appropriate redress if the patient has been harmed by medical negligence.

3 Definition

3.1 *A **complaint or concern** is an expression of dissatisfaction about an act, omission or decision of GCSNHST, either verbal or written, and whether justified or not, which requires a response and/or redress.*
A ***comment*** is an expression of views which may or may not require a response.
A **suggestion** is an idea for service development, and may or may not require a response.
A ***compliment*** is an expression of appreciation and/or recognition.

3.2 The Service Experience Team is responsible for ensuring that there is an advice line Telephone number: **0300 421 8313** is available for people that use our services, their carers and families and for administering the complaints process, ensuring thorough replies are provided to the complainant.

3.3 The complaints leaflet give guidance on accessing information in other languages, audio format, braille and easy read format to ensure equity.

3.4 The Service Experience Team will ensure that reporting and learning from complaints and concerns is discussed and scrutinised in GCSNHST's governance structures. This will be achieved in numerous ways, including standalone reports, period reporting to the committee framework and ad-hoc reports as required. This reporting will consider the wider evidence available, including but not limited to incidents, external reports and claims.

4 Roles and Responsibilities

4.1 The National Health Service Complaints Regulations 2009 includes statutory responsibilities for senior management. .

The Chief Executive: is accountable for ensuring effective management of complaints across the Trust. All formal responses will be signed by the Chief Executive (or by their nominated deputy).

The Responsible Officer: will be informed of any complaint regarding conduct or delivery of clinical care of doctors and dentists.

The Director of Nursing: has delegated responsibility for ensuring effective management of complaint handling across the Trust.

The Chief Operating Officer: is responsible for ensuring the investigation is carried out in line with this policy and for ensuring that all actions identified are implemented. They will have an overview of the complaints process and are accountable for ensuring their governance arrangements support learning and openness.

Ensuring complaints/responses each month are discussed in their Clinical Governance meetings. They should discuss themes across their areas of responsibility and identify the learning from complaints.

Managers, Matrons, Team Managers and Team Leaders should ensure that anonymised complaints and the quarterly and annual complaints reports are discussed at the departmental and/or Clinical Governance meetings (whichever they feel is most appropriate) to ensure remedial actions are taken to address recurring themes.

The Service Experience Team: is responsible for ensuring that there is an advice line available for people that use our services, their carers and families and for administering the complaints process, ensuring thorough replies are provided to the complainant.

The Service Experience Team will ensure that reporting and learning from complaints and concerns is discussed and scrutinised at GCSNHST's governance forums. This will be achieved in numerous ways, including standalone reports, period reporting to the committee framework and ad-hoc reports as required. This reporting will consider the wider evidence available, including but not limited to incidents, external reports and claims.

4.2 **Managers and Heads of Service** will ensure that:

- All colleagues are aware of, and have access to policy documents.
- All colleagues access training and development as appropriate to individual colleague needs.
- All colleagues participate in the appraisal process, including the review of competencies.

Employees (including bank, agency and locum colleagues) must ensure that they:

- Practice within their level of competency and within the scope of their professional bodies where appropriate.
- Read and adhere to GCSNHST policy.
- Identify any areas for skill update or training required.
- Participate in the appraisal process.
- Ensure that all care and consent complies with the Mental Capacity Act (2005).

- Individuals should have knowledge of complaints/concerns etc within their clinical area and learning gained from this.

5. Policy Details

5.1 Who can Provide Feedback?

A complaint may be made by the person who is affected by the action, or it may be made by a person acting on behalf of a patient in any case where that person:

- **is a child;** (typically up to the age of 16 years old)
  In the case of a child, the representative must be satisfied that there are reasonable grounds for the complaint being made by the representative instead of the child, and the representative is making the complaint in the best interests of the child.
- **has died;**
  In the case of a person who has died, the complainant must be the personal representative of the deceased. GCSNHST needs to be satisfied that the complainant is the personal representative and can demonstrate that the responsible party has been affected, or is likely to be affected, by the action, omission or decision of GCSNHST.
- **has physical or mental incapacity**;
  In the case of a person who is unable by reason of physical capacity, or lacks capacity within the meaning of the Mental Capacity Act 2005, to make the complaint themselves, GCSNHST needs to be satisfied that the complaint is being made in the best interests of the person on whose behalf the complaint is made and the complainant can demonstrate that the responsible part has been affected, or is likely to be affected, by the action, omission or decision of GCSNHST.
- **has given consent to a third party acting on their behalf;**
  In the case of a third party pursuing a complaint on behalf of the person affected we will request the following information:
  - Name and address of the person making the complaint;
  - Name and either date of birth or address of the affected person; and
  - Contact details of the affected person so that we can contact them for confirmation that they consent to the third party acting on their behalf.

  This will be documented in the complaint file and confirmation will be issued to both the person making the complaint and the person affected.

  Or has delegated authority to do so, for example in the form of a registered Power of Attorney which must cover health affairs.
- Is a Member of Parliament (MP), acting on behalf of and by instruction from a constituent.

If the Patient Experience Lead is of the opinion that a representative does or did not have sufficient interest in the person's welfare, is not acting in their best interests, we will notify that person in writing stating the reasons.

Complaints may be made by:

- A person that has used our services
- The carer (including but not only family members) of a person that has used our services, with the said person's consent.

General feedback, including comments, concerns and compliments can be received from anyone.

5.2 **Complaints that cannot be dealt with under this policy**

- A complaint made by any NHS organisation or private or independent provider or responsible body.
- A complaint made by an employee about any matter relating to their employment.
- A complaint, the subject matter of which has previously been investigated under these or previous NHS Regulations.
- A complaint which is made orally and resolved to the complainant's satisfaction no later than the next working day.
- A complaint which is being or has been investigated by the Ombudsman.
- A complaint arising out of an NHS body's alleged failure to comply with a request for information under the Freedom of Information Act 2000.
- A complaint which relates to any scheme established under Section 10 (superannuation of persons engaged in health services) or Section 24 (compensation for loss of office) of the Superannuation Act 1972 or to the administration of those schemes.
- A complainant has stated in writing intent to take legal proceedings in relation to the substance of the complaint where it will prejudice the proceedings.
- GCSNHST has been notified that criminal proceedings have been commenced in relation to the substance of the complaint where it will prejudice the proceedings.

5.3 **How to Complain**

5.3.1 If a patient is worried or unhappy about any aspect of their care or treatment they should bring this to the attention of the doctor, ward manager, health professional involved with their care, so that immediate action can be taken to try to resolve the concerns immediately.

Although the Trust advocates that all colleagues should be able to help those wishing to provide feedback, if the concern cannot be resolved informally then the Service Experience Team is the central team responsible for handling concerns and complaints and they can arrange for a thorough investigation to be carried out.

The Service Experience Team aim to provide a quick and helpful resolution to any complaint. The Team can be contacted by visiting their office based at the Trust Headquarters, Edward Jenner Court on the first floor, via email to YourExperience@glos-care.nhs.uk; via telephone on **0300 421 8313** or in writing to:

The Service Experience Team
Edward Jenner Court
1010 Pioneer Avenue
Gloucester Business Park
Brockworth
Gloucester
Gloucestershire GL3 4AW

The service operates from 9am until 5pm, Monday to Friday.
An answer machine service is available outside of these hours

Information regarding how to complain is made available: In GCSNHST's 'How do I give feedback or make a complaint' leaflet and on *Gloucestershire Care Services NHS Trust's internet website*

One of the team will then contact the complainant to ensure we understand the concerns correctly and the outcome which would give a satisfactory resolution to the

matter. The Service Experience Team will confirm that an investigation will be carried out. We aim to carry out a thorough investigation and provide a full response within 25 working days. If the investigation cannot be completed within this timeframe, the Service Experience Team will inform the complainant of the reasons for the delay and negotiate and agree a revised timeframe.

5.4 **Timescales for making a complaint**

5.4.1 Complaints can be made twelve months from the date on which the matter that is the subject of the complaint came to the notice of the complainant.

If there are good reasons for not having made the complaint within the above timeframe and, **if it is still possible to investigate the complaint effectively and fairly,** GCSNHST may decide to still consider the complaint, for example, longer periods of complaint timescales may apply to specific clinical areas.

5.5 **GCSNHST complaint's process**

5.5.1 All complaints will be acknowledged no later than three working days after the complaint is received (the acknowledgement will be made either by telephone, email or letter) and an offer will be made, as appropriate, to discuss with the complainant the following:

- An action plan for handling the complaint.
- Timescales for responding.
- The complainants' expectations and desired outcome.
- Information relating to the provider of independent advocacy services in their geographical area.
- Consent for GCSNHST to handle the complaint in the event that the complaint requires input or investigation from parties or organisations outside of GCSNHST.
- Where appropriate outline the complainant's rights as set out by the NHS Constitution.

The complainant can expect that:

- They will be kept up to date with the progress of their complaint.
  - Their complaint will be investigated by specially trained members colleagues and, where appropriate, they will receive an explanation based on facts.
- They can expect to receive a quality response with assurance that action has been taken to prevent a recurrence.
- To be informed of any learning.
- A remedy will be made where appropriate.

GCNHST's response to a complainant will be wherever possible be provided using the complainant's preferred method of communication (email correspondence will only be responded to by email when the complainant has expressly requested this as their method of communication and security measures will be implemented in line with office policy to protect personal information sent via email).

On receipt of the investigation report, a response to the complaint will be prepared and the Chief Executive will include information on the next stages of the complaints procedure should the complainant wish to take matters further.

5.6 **Joint Working with Other Organisations**

5.6.1 Where the complaint involves more than one organisation or provider GCSNHST will adhere to the duty to cooperate. Discussions will take place between the organisations concerned and the most appropriate person to take the lead in coordinating the complaint and communicating with the complainant.

Permission will be sought from the complainant before sharing or forwarding a

complaint to another organisation/provider.

As soon as it is reasonably possible after completing the investigation, and within the timescale agreed with the complainant, GCSNHST will send a formal response in writing to the complainant which will be signed by the Chief Executive or delegated deputy.

The response will include:

- An explanation of how the complaint has been considered.
- An apology if appropriate
- An explanation based on facts.
- Whether the complaint in full or in part is upheld.
- The conclusions reached in relation to the complaint including any remedial action that the organisation considers to be appropriate.
- Confirmation that the organisation is satisfied any action has been or will be actioned.
- Where possible, we will respond to people about any lessons learnt.
- Information and contact details of the Parliamentary and Health Service Ombudsman as the next stage of the NHS complaints process.

A key consideration is to make arrangements flexible; treating each case according to its individual nature with a focus on satisfactory outcomes, organisational learning and those lessons should lead to service improvement.

5.7 **Confidentiality**

5.7.1 Complaints will be handled in the strictest of confidence in accordance with the GCSNHST Confidentiality Policy, and will be kept separately from patient medical records. Informal discussions about concerns may be documented in the health care records. Care will be taken that information should only be disclosed to those who have a demonstrable need to have access to it.

Suitable arrangements are in place for the handling of patient identifiable data to meet the compliance of the Data Protection Act (1998) and other legal obligations such as the Human Rights Act 1998 and the common law duty of confidentiality. The Caldicott Report sets out a number of general principles that health and social care organisations should use when reviewing its use of patient or client information.

The designated Caldicott Guardian is responsible for ensuring that confidentiality is maintained.

Confidentiality will be maintained in such a way that only managers and colleagues who are leading the investigation know the contents of the case. Anyone disclosing information to others who are not directly involved in this may be dealt with under disciplinary procedures.

5.8 **Exceptions to the Policy**

5.8.1 It is recognised that there may be circumstances in which information disclosure is in the best interests for the patient, or the protection, safety or wellbeing of a child or vulnerable adult. In these circumstances, a complaint will be escalated as necessary in line with NHS England and GCSNHST Safeguarding policies and procedures.

Any allegations of fraud of financial misconduct should be referred to the National Fraud Reporting line at NHS Protect. Full details of the methods for reporting are on their website: https://www.reportnhsfraud.nhs.uk/

Since April 2013, individual local authorities have a statutory duty to commission independent advocacy services to provide support for people making, or thinking of making, a complaint about their NHS care or treatment. Arrangements will vary

between local authority areas. Complainants will be advised to contact the Service Experience Team or local authority for information about how this service is provided in their area.

5.9 **Consent**

5.9.1 There is an expectation that when capturing consent for the use and sharing of information, that the patient has made an informed decision and clearly understands the processing and potential sharing of their information. Colleagues must also understand the expectations of confidentiality that the information is provided under.

Information will not be disclosed to third parties unless the complainant or appropriate authorised party who has provided the information has given consent to the disclosure of that information, or it is required under legislation.

5.10 **Triage: Deciding what action to take when receiving a complaint or concern**

5.10.1 If an issue cannot be resolved on the spot or when the person makes a complaint, the first step is for it to be triaged by the Service Experience team and rate its level of 'seriousness'.

Following "Triage", the issue will be categorised as either a complaint or a concern. The level of severity should also be rated when deciding on what subsequent action(s). For example, there may be occasions where the person raising the issue does not want it to be dealt with as a complaint but the issue itself represents a potentially serious event that should be investigated.

For Concerns or Complaints that are rated as Moderate, High or Extreme following Triage, consideration should be given as to whether or not it is a Serious Incident Requiring Investigation (SIRI). If it is determined that a SIRI has occurred, the case will be taken forward under the Serious Incident Reporting Policy and investigated formally with the complainant being made aware.

When a concern or complaint is received, it is also important to consider whether it relates to an incident. If it represents a possible incident that was not previously reported, a discussion may take place between the Service Experience Team and the Risk Manager about whether an Incident needs to be reported.

The complainant will be kept appropriately informed of the status of the investigation and will be offered a meeting to discuss the outcome of the investigation with the investigator and/or Lead for the Service and the Patient Experience Lead.

If the complaint relates to an incident which resulted in moderate or greater harm, the requirements of Duty of Candour must be met.

5.11 **Parliamentary and Health Service Ombudsman**

5.11.1 If a complainant remains dissatisfied with the handling of the complaint by GCSNHST, they can ask the Parliamentary and Health Service Ombudsman (PHSO) to review the complaint.

The PHSO may investigate a complaint where, for example:

- A complainant is not satisfied with the result of the investigation undertaken by NHS organisation.
- The complainant is not happy with the response from NHS organisation and does not feel that their concerns have been resolved.
- The NHS organisation has decided not to investigate a complaint on the grounds that it was not made within the required time limit.

GCSNHST will provide the complainant adequate information on how to contact the PHSO when issuing the formal written response.

When informed that a complainant has approached the PHSO, GCSNHST will

cooperate fully with the PHSO and provide all information that has been requested in relation with the complaint investigation. The relevant director will be informed that a request for investigation has been made so that colleagues involved can be informed as well.

GCSNHST can also refer a complaint to the Parliamentary Health Service Ombudsman for a final decision.

The Service Experience Team will be the single point of contact for the Parliamentary and Health Service Ombudsman (PHSO). The Service Experience Team will manage all requests and will ensure deadlines are met.

Any action plans requested by the PHSO are the responsibility of Head of Service who will be held accountable for their creation and quality. In most cases, the PHSO gives three months for an action plan to be created and sent back to itself, Monitor, the Care Quality Commission (CQC) and TDA.

5.12 **Record keeping**

5.12.1 Keeping clear and accurate records of complaints is important and these should be retained for a period of ten years. Please refer to GCSNHST records management policy for further information.

5.13 **Grievances**

5.13.1 Grievances raised by colleagues are handled separately. The Trust has local procedures for handling colleague concerns about health care issues, and established grievance and openness procedures.

5.14 **Complaints Brought by Members of representatives eg Members of Parliament (MP) on Behalf of Constituents**

5.14.1 Letters of complaints received from elected representatives on behalf of their constituents are managed in the same way as any other letter of complaint, recorded centrally and passed to the Service Experience Team to facilitate an investigation and responded to formally within the recommended time scales.

Letters of complaint from elected representatives stating that s/he has the constituent's consent or instruction to make the complaint may be accepted without further resort to seeking consent from that constituent. If the constituent is raising an issue about another person, consent will be required from the person the concern/issue/complaint relates to before any confidential information can be disclosed to the elected representative.
The communication with the elected representative will still adhere to GCSNHST's policy on confidentiality, for instance, with respect to third part information.

5.15.1 **Guidance for dealing with persistent and unreasonable contact**

This guidance covers all contacts, enquiries and complainants. It is intended for use as a last resort and after all reasonable measures have been taken to try and resolve a complaint within the Gloucestershire Care Services NHS Trust Complaints Policy.
Persistent contact may be as a result of individuals having genuine issues and it is therefore important to ensure that this process is fair and the complainant's interests have been taken into consideration.

5.15.2 **Purpose of the guidance**

To assist the organisation to identify when a person is persistent or unreasonable, setting out the action to be taken.

Definition of persistent and unreasonable complainants

There is no one single feature of unreasonable behaviour. Examples of behaviour may include those who:

- Persist in pursuing a complaint when the procedures have been fully and properly implemented and exhausted.
- Do not clearly identify the precise issues that they wish to be investigated, despite reasonable efforts by colleagues, and where appropriate, the relevant independent advocacy services could assist to help them specify their complaint.
- Continually make unreasonable or excessive demands in terms of process and fail to accept that these may be unreasonable e.g. insist on responses to complaints being provided more urgently than is reasonable or is recognised practice.
- Continue to focus on a 'trivial' matter to an extent that it is out of proportion to its significance. It is recognised that defining 'trivial' is subjective and careful judgment must be applied and recorded.
- Change the substance of a complaint or seek to prolong contact by continually raising further issues in relation to the original complaint. Care must be taken not to discard new issues that are significantly different from the original issue. Each issue of concern may need to be addressed separately.
- Consume a disproportionate amount of time and resources.
- Threaten or use actual physical violence towards colleagues.
- Have harassed or been personally abusive or verbally aggressive on more than one occasion (this may include written abuse e.g. emails).
- Repeatedly focus on conspiracy theories and/or will not accept documented evidence as being factual.
- Make excessive telephone calls or send excessive numbers of emails or letters to colleagues.

Actions prior to designating a persons' contact as unreasonable or persistent
It is important to ensure that the details of a complaint are not lost because of the presentation of that complaint. There are a number of considerations to bear in mind when considering imposing restrictions upon a complainant.
These may include:

- Ensuring the persons case is being, or has been dealt with appropriately, and that reasonable actions will follow, or have followed, the final response.
- Confidence that the person has been kept up to date and that communication has been adequate with the complainant prior to them becoming unreasonable or persistent.
- Checking that new or significant concerns are not being raised, that requires consideration as a separate case.
- Applying criteria with care, fairness and due consideration for the client's circumstances – bearing in mind that physical or mental health conditions may explain difficult behaviour. This should include the impact of bereavement, loss or significant/sudden changes to the complainant's lifestyle, quality of life or life expectancy.
- Considering the proportionality and appropriateness of the proposed restriction in comparison with the behaviour, and the impact upon colleagues.
- Ensuring that the complainant has been advised of the existence of the policy and has been warned about, and given a chance to amend their behaviour.

Consideration should also be given as to whether any further action can be taken prior to designating the persons' contact as unreasonable or persistent.

This might include:

- Raising the issue with a Director with no previous involvement, in order to give an

independent view.

- Where no meeting with a colleague has been held, consider offering this at a local level as a means to dispel misunderstandings (only appropriate where risks have been assessed).
- Where multiple departments are being contacted by the complainant, consider a strategy to agree a cross-departmental approach.
- Consider whether the assistance of an advocate may be helpful.
- Consider the use of ground rules for continuing contact with the complainant.

Ground rules may include:-

- Time limits on telephone conversations and contacts.
- Restricting the number of calls that will be taken or agreeing a timetable for contacting the service.
- Requiring contact to be made with a named colleage and agreeing when this should be.
- Requiring contact via a third party e.g. advocate.
- Limiting the complainant to one mode of contact.
- Informing the complainant of a reasonable timescale to respond to correspondence.
- Informing the complainant that future correspondence will be read and placed on file, but not acknowledged.
- Advising that the organisation does not deal with calls or correspondence that is abusive, threatening or contains allegations that lack substantive evidence. Request that the complainant provides an acceptable version of the correspondence or make contact with a third party to continue communication with the organisation.
- Ask the complainant to enter into an agreement about their conduct.
- Advise that irrelevant documentation will be returned in the first instance and (in extreme cases) in future may be destroyed.
- Adopting a 'zero tolerance' policy. This could include a standard communication line, for example: "The NHS operates a zero tolerance policy, and safety of colleagues is paramount at all times. Colleagues have a right to care for others without fear of being attacked either physically or verbally."

Process for managing unreasonable or persistent behaviour

Where a persons' contact has been identified as unreasonable or persistent, the decision to declare them as such is made jointly by the Patient Experience Lead and the Director/Deputy of Nursing.

The Patient Experience Lead will write to the complainant, informing them that either:

- Their complaint is being investigated and a response will be prepared and issued as soon as possible within the timescales agreed.
- That repeated calls regarding the complaint in question are not acceptable and will be terminated, or;
- Their complaint has been responded to as fully as possible and there is nothing to be added.
- That any further correspondence will not be acknowledged.

All appropriate colleagues should be informed of the decision so that there is a consistent and coordinated approach across the organisation.

If the declared complainant raises any new issues then they should be dealt with in the usual way.

Review of the persistent status should take place at six monthly intervals.

Urgent or extreme cases or unreasonable or persistent behaviour

In urgent or extreme cases, adopt safeguarding and zero tolerance policies and procedures. Discuss the case with the appropriate Director to develop an action plan that may include the use of emergency services in some circumstances. In these circumstances, carry out a review of the case at the first opportunity after the event.

Record keeping

Ensure that adequate records are kept of all contact with unreasonable and persistent contact.

Consideration should be given as to whether the organisation should take further action, such as reporting the matter to the police, taking legal action, or using the risk management or health and safety procedures to follow up such an event in respect of the impact upon colleagues.

6. Consultation

6.1 Service Clinical Governance
6.2 Policy Group
6.3 Clinical Forum Group
6.4 Quality and Performance Committee

7. Resources

7.1 An investigation may identify that care has fallen below the expected standard and in such cases there may be a risk of litigation and the costs of the NHSLA in handling a legal claim

8. Training

8.1 **To be confirmed**

9. Implementation

9.1 Monthly report sent to Head of Service highlighting new and revised policies

9.2 The policy will be communicated to colleagues via line managers following the approved process.

9.3 The policy will be made available on the organisations Intranet and it will also be highlighted in team meetings.

9.4 Information on who to contact for access to the policy from outside the organisation is available on the Internet. Details how the document is to be rolled out and maintained within the Trust

9.5 Line mangers must ensure all colleagues are aware of and understand policies and procedures

10. Audit

10.1 **Oversight of Complaints – Clwyd Hart**

There is a recommendation for Board-led scrutiny of complaints. This is achieved through the Quality and Performance Report and Understanding You Report which are submitted to Quality and Performance Committee bi-monthly with the Quality and Performance Report being considered by Trust Board on the alternate month.
Further scrutiny will be achieved in a quarterly Complaints Oversight Group co-ordinated by the Quality Team with NED involvement.
Monitoring compliance with the timeliness of response will be continuous and reported through the monthly Quality report.

GCSNHST will demonstrate how we use feedback to learn and improve. An annual

report will be produced for the GCSNHST Board, which will detail:

- Numbers of complaints received.
- Numbers of complaints received considered to be based on solid evidence or good reasons (complaints upheld).
- Issues and key themes that the complaints have raised.
- Lessons learnt.
- Actions taken, or being taken, to improve services as a result of the complaints made.
- Number of cases which GCSNHST have been advised are being considered or referred to the Parliamentary and Health Service Ombudsman.
- Equality impact data.
- Include reporting on praise and other feedback and how that information has been shared.

10.2 **Quality Assurance**

GCSNHST will monitor both the effectiveness of the complaints process, and how complaints information is being used to improve services and delivery of care. Specifically, the Quality Team including the Service Experience Team will provide a system to:

- Disseminate learning from complaints across the relevant parts of the organisation.
- Include the use of complaints procedures as a measure of performance and quality.
- Use complaints information to contribute to service planning.

10.3 **Evaluation of the Complaints Process**

The Trust's Complaints process is evaluated by the Patients Association. All complainants receive a Patient's Association Survey form 10 weeks after their complaint has been completed. The results of the surveys are evaluated by the Patient's Association and reported to the Trust on a monthly basis. These results will form part of our regular reporting.

10.4 **Complaints about the Data Protection Act 1998 and the Freedom of Information Act 2000**

The Trust may consult the Information Commissioner's Office (ICO) about complaints arising out of an alleged failure to comply with a data subject access request under the Data Protection Act 1998 and with requests made under the Freedom of Information Act 2000.

10.5 **Access to Health Records**

Complainants may request access to or copies of their medical records under the Data Protection Act 1998. They can access their own medical records, or a child's medical records (if they are a parent or guardian). Access to Health Records Act 1990 may also be relevant if requests are made for information about deceased persons. The Quality team will advise complainants about the Trust's Access to Medical Records Policy and who to contact regarding their request. Further information is available from the Department of Health.

10.6 **Media Interest**

Colleagues are advised to refer any media interest in a complaint to the Trust's Communications team. The Trust's Head of Communications is to be briefed where any complainant expresses their intention to contact the media.

10.7 **Procedure for Handling Unreasonably Persistent Complainants**

Complainants (and, or anyone acting on their behalf) may be deemed to be unreasonably persistent complainants where previous or current contact with them shows that they are being unreasonable such as:

a) The complainant persists in pursuing a complaint where the Trust's complaints procedure has been fully and properly implemented and exhausted.
b) The complainant continually raises new issues or seeks to prolong contact by continually raising further concerns or questions upon receipt of a response or whilst the complaint is being investigated.

11. Equality Impact

11.1 This policy has been subjected to a Quality and Equality Impact review. This concluded that this policy will not create any adverse effect or discrimination on any individual or particular group.

12. Quality Impact

12.1 This policy has been subjected to a Quality and Equality Impact review. This concluded that the policy will not negatively impact upon the quality of health and social care services provided by the Trust

13. Review

13.1 This policy will be reviewed three years from the date of ratification or sooner should legislation or best practice advice alter

14. References, Bibliography, Acknowledgements and Regulatory Position

- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Please refer to the Duty of Candour Policy (Regulation 20 Health and Social Care Act 2008) and GCSNHST Policy duty of Candour 2015 on how to manage this process

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- The Care Quality Commission inspections rely on information based on sound data.
- The Data Protection Act 1998 requires that personal data is processed in accordance with the Data Protection Principles.
- The Freedom of Information Act 2000 requires organisations to make some documents publicly available.
- The Access to Health Records Act 1990.
- Mental Capacity Act 2005
- Parliamentary and Health Service Ombudsman Principles of Good Complaints Handling (2009)
- Good Practice Standards for NHS Complaints handling (Sept 2013)

Appendix 1

Seriousness Matrix, from the DH guide 'Listening, Responding Improving'

Step One - **Decide on the 'Seriousness'**

Seriousness	Description
Low	Unsatisfactory service or experience not directly related to patient care. No impact or risk to provision of patient care. OR Unsatisfactory service or experience related to patient care, usually a single resolvable issue. Minimal impact and relative minimal risk to the provision of patient care or the service. No real risk of litigation.
Medium	Service or patient experience below reasonable expectations in several ways, but not causing lasting problems. Has potential to impact on service provision. Some potential for litigation.
High	Significant issues regarding standards, quality of patient care and safeguarding of or denial of rights. Complaints with clear quality assurance or risk management issues that may cause lasting problems for the organisation, and so require investigation. Possibility of litigation and adverse local publicity. OR Serious issues that may cause long-term damage to an individual, such as grossly substandard care, professional misconduct or death. Will require immediate and in-depth investigation. May involve serious safety issues. A high probability of litigation and strong possibility of adverse national publicity.

Step Two - How likely is it to re-occur?

Likelihood	Description
Rare	Isolated or 'one off'
Unlikely	Rare – unusual but may have happened before
Possible	Happens from time to time – not frequently or regularly
Likely	Will probably occur several times a year
Almost Certain	Recurring and frequent, predictable

Step Three - Categorise the risk

Seriousness	Likelihood of Recurrence				
	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
LOW	LOW	LOW	LOW	MODERATE	MODERATE
MEDIUM	LOW	MODERATE	HIGH	HIGH	EXTREME
HIGH	MODERATE	HIGH	HIGH	EXTREME	EXTREME

Appendix 2

Guidelines for colleagues writing statements for complaint investigations

1 Introduction

1.1 Any member of the Trust directly involved will be asked to provide statements in connection with investigations into complaints.

1.2 Colleagues asked to provide statements will be supported in this process by the Investigating Manager, their line manager and operational manager. Further advice can be obtained from the Service Experience Team.

1.3 The Service Experience Team is responsible for ensuring that appropriate patient consent for the release of personal information is obtained.

1.4 A copy of any statement that is given is kept in the complainants' complaint file, and may be passed on if the complainant requests an Independent or Health Service Ombudsman's Review of their complaint.

2 General Principles

2.1 Written statements should be:
Written in ink or typed
Legible and concise
Factual, accurate and relevant

2.2 Avoid abbreviations. Explain any technical words, phrases or procedures and avoid jargon.

3 Format

3.1 Title
The title should indicate the date, place and time of the incident complained about.

3.2 Opening paragraph State your present:
Name
Post in the Trust
How you can be contacted most easily
(If different from above, give the following information as it applied when the events under investigation occurred)
Name
Address
Post in the Trust
How long you had been in post
How you can be contacted most easily

3.3 Narrative of events
Provide a narrative of the events, keeping to the facts.
In date and time order state:
When and what you did and why

3.4 Where relevant, identify your contributions to clinical notes, adding explanations if you feel there is any ambiguity.

3.5 Read your statement, date and sign it.

3.6 Give the statement to your line manager, keep a copy for yourself.

Gloucestershire Care Services NHS
NHS Trust

Making a complaint

We value your experiences and opinions and use feedback to improve our services.

If you have a complaint or comment please fill in one of our comment cards or contact our Service Experience Team on:

0300 421 8313
yourexperience@glos-care.nhs.uk

If you require help making a complaint, the NHS provides an independent service which can talk to you about your options.

This service is called SEAP and can be contacted at:

0330 343 5710
gloucestershire@seap.org.uk
www.seap.org.uk

Further steps

If you make a complaint, our Chief Executive will write to you to inform you of the outcome and the actions being taken by our Trust.

Understanding You

This leaflet can be supplied in braille, audio format, pdf, large print, easy read and other languages on request.

Print date: Oct 2015

www.glos-care.nhs.uk

Gloucestershire Care Services NHS
NHS Trust

Use this comment card to tell us your experiences

We value your views and opinions and use your feedback to improve our services.

If you have a comment please fill in this comment cards or contact our Service Experience Team on:

0300 421 8313
yourexperience@glos-care.nhs.uk

Please fill this in

Whether you have a compliment for a staff member or team, observation about how your care could have been improved or a complaint about how you have been treated, we want to hear about it.

Please complete the details inside and place in the comments box, give to a member of staff, or fix with the glue strip and post back to us.

Understanding You

Moisten here

Service:

Location:

Date:

My comments:

Moisten here

Moisten here

Would you like to be contacted to discuss your feedback? ❑ Yes ❑ No

Name:

Address:

Postcode:

Telephone:

Email:

Are you:

	A patient		Staff
	Carer family member		Visitor
	Other		

Your Experience Counts
Gloucestershire Care Services
Freepost address
etc

AGENDA ITEM: 19.3

BEING OPEN AND DUTY OF CANDOUR POLICY

Document reference:	
Version:	
Ratified by:	Gloucestershire Care Services NHS Trust Board
Date ratified:	
Originator/author:	Complaints Lead, Quality and Safety Manager
Responsible committee/individual:	Quality and Performance Committee
Executive lead:	Director of Nursing
Date issued:	
Review date:	

DOCUMENT CONTROL SHEET

Purpose of document:	To ensure the infrastructure is in place to support openness between healthcare professionals and service users/families following an incident, complaint or claim.
Dissemination:	Implementation of the policy is embedded within the document
Scope:	All colleagues who provide care to service users and carers
Review:	3 years or before if changes required
This document supports:	Any relevant governance documents, standards and legislation are embedded within the document
Key related documents:	All related Trust policies or other control documents are embedded within the document
Equality and diversity:	An Equality Impact Assessment has been completed
Quality:	A Quality Impact Assessment has been completed
Consultation:	Consultation of this policy will be found within the document
Financial implications:	*Reference any financial implications of implementing the document*

Version Control Information	
Summary of Key Changes	**Previous Version Archive Date**

CONTENTS

Abbreviations

Abbreviation	Full Description
GCSNHST	Gloucestershire Care Services NHS Trust
CQC	Care Quality Commission
RCA	Root Cause Analysis
IO	Investigating Officer

Action Card 1

Duty of Candour Action Card

1. Incident occurs – Report on Datix immediately
   - Ensure patient is safe
   - Document clearly in patient record
   - Inform senior clinician/line manager

2. In cases of Moderate / Severe Harm / Death, Duty of Candour applies
   - Discuss with Quality and Safety Team
   - Spoken apology give as soon as possible by Senior Clinician and documented

3. Operational Lead appoints investigator to undertake quick RCA (Root Cause Analysis) to be completed within 72 hours and sent electronically to Performance and Clinical Effectiveness (PACE) directorate

4. Patient receives a written apology within 10 days of incident
   - Letter written by Matron / Senior Clinician with support from Quality & Safety Team and signed by Chief Executive Officer
   - If incident is a SIRI / Complaint is handled through SIRI/ complaints process

5. Record communication on S1 / Datix "Being Open – Duty of Candour" – Date, time, persons involved, issues, apology, plan for further communication

6. Maintain contact, as agreed with patient / family if incident is SIRI / Complaint in line with GCS Complaints policy

7. Ensure that all Duty of Candour cases/SIRIs/complaints have action plans and are shared for learning at relevant Clinical Governance groups.
Wider learning across Trust communicated via monthly quality and Safety report

1. Introduction

Gloucestershire Care Services NHS Trust (the Trust) wants to make this duty a reality for people who come into contact with our services. We want to ensure there is clear, strong organisational support for colleagues to follow their responsibilities in being open and honest with patients and their families/carers. This policy is a reinforcement of our development of a wider culture of safety, learning and improvement.

1.1 Regulation 20 of The Health and Social Care Act 2008 (Regulated Activity) Regulations 2014, introducing the statutory Duty of Candour for the NHS, came into force on 27th November 2014. The introduction of Regulation 20 is a direct response to recommendation 181 of the Francis Inquiry report into Mid Colleaguesordshire NHS Foundation Trust, which recommended that a statutory Duty of Candour be imposed on healthcare providers. The regulations can be found here http://www.legislation.gov.uk/uksi/2014/2936/regulation/20/made

Subsequently the CQC issued a guidance document addressing the Duty of Candour:

http://www.cqc.org.uk/sites/default/files/20141120_doc_fppf_final_nhs_provider_guidancev1-_0.pdf

The intention of this regulation is to ensure that providers are open and transparent with people in relation to care and treatment, and specifically when things go wrong with care and treatment, and that they provide people with reasonable support, truthful information and an apology.

2. Purpose

2.1 Clinicians already have an ethical Duty of Candour under their professional registration to tell patients about errors and mistakes. This policy builds on individual professional duty and places an obligation on the organisation - not just individual healthcare professionals - to be open with patients when harm has been caused.

The impact and consequences of mistakes or errors can affect everyone involved and this policy aims to ensure there is unequivocal, sustained support for colleagues in reporting incidents and in being open.

GCSNHST's approach to Candour underpins a commitment to providing high quality care, understanding and sharing the truths about harm at an organisational as well as an individual level, and learning from them. It is about our organisational values being rooted in genuine engagement of colleagues, our clinical leadership building on professional accountability, and on every member of colleagues's personal commitment to the safety of patients.

Local Trust "Freedom to Speak Up Guardians" was a recommendation by Sir Robert Francis QC 'Freedom to Speak Up Review' (2015). The Trust's Ambassador for Cultural Change incorporates the Guardian role and such a role can make a huge contribution to developing trust within an organisation and improving the culture and the way cases [of raising concerns] are handled.

The processes contained within this policy reflect those set out in Regulation 20 and in the associated CQC guidance.

2.2 Conversations between patients, families and colleagues about risk and the

potential for harm are essential for fostering a culture of Candour, both as a means of preparing patients should something happen, and in encouraging clinicians and healthcare colleagues to do the right thing when errors occur.

This policy underpins the Trust's values and aims to ensure:

- The patient's right to openness from the Trust is clearly understood by all colleagues;
- That this right is integrated into the everyday business of the Trust;
- The Trust learns from mistakes with full transparency and openness;
- Patients and their families and carers can trust us to share information with them in an open and collaborative way;
- The Trust works in partnership with others to protect patients;
- Trust colleagues ensure appropriate support is offered to the patient/families/carers/ and colleagues and;
- Line managers understand an individual or team may well require support during and after an incident. Support for employees is available from Care First and Occupational Health Service and the Human Resources Department in the Trust.

3. Definitions

3.1 Duty of Candour (as defined in The Francis report):

"The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made."

Unlike the existing professional and ethical duty which applies to all circumstances where a patient is harmed when something goes wrong, the statutory Duty of Candour only applies to incidents where a patient suffered unintended harm resulting in moderate or severe harm or death or prolonged psychological harm (Table 1 – page 10 provides harm definitions).

The requirements of the Duty of Candour as set out by the regulations are as follows.

As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must:

(a) notify the relevant person that the incident has occurred
(b) provide reasonable support to the relevant person in relation to the incident, including when giving such notification.

The notification to be given must:

(a) be given in person by one or more representatives of the health service body,
(b) provide an account, which to the best of the health service body's knowledge is true, of all the facts the health service body knows about the incident as at the date of the notification,
(c) advise the relevant person what further enquiries into the incident the health service body believes are appropriate,
(d) include an apology, and
(e) be recorded in a written record which is kept securely by the health service body.

This notification must be followed up in writing.

Patients should always be informed when adverse incidents occur in line with being open, but the emphasis for the Duty of Candour is on incidents that result in moderate harm, severe harm or death (see Action Card).

3.2 Being Open

Being open was described by the National Patient Safety Agency in 2009 as 'discussing patient safety incidents promptly, fully and compassionately' adding that this 'can help patient and professionals to cope better with the after effects'. The Being Open principles are contained in Appendix 1.

3.3 Patient Safety Incident

A patient safety incident is defined as **'**Any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS-funded healthcare.

3.4 Serious Incident

A serious incidents requiring investigation is defined in the NHS England (2015) Serious Incident Framework and is an incident that occurred during NHS funded healthcare which resulted in one or more of the following;

- Unexpected or avoidable death or severe harm of one or more patients, colleagues or members of the public;
- A never event - all never events are defined as serious incidents although not all never events necessarily result in severe harm or death;
- A scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;
- Allegations, or incidents, of physical abuse and sexual assault or abuse;
- Loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.

Further guidance in relation to Serious Incidents is available in the Trust's Incident Governance Policy. It is important to note that a Serious Incident is not necessarily the same as a Duty of Candour notifiable incident, although there will be some cases where a serious incident is also a notifiable incident.

3.5 Notifiable Incident

This is an incident that needs to be notified to the patient and/or their carer/family under the Duty of Candour. A notifiable incident and a serious incident are not necessarily one and the same; however all notifiable incidents will be investigated using Root Cause Analysis methodology. The nature of the incident will determine the scope of the investigation and this should be discussed with the Quality and Safety Manager.

Notifiable Safety Incident

The regulations state that a "notifiable safety incident" means "any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in—

(a) the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or

(b) severe harm, moderate harm or prolonged psychological harm to the service user; "prolonged psychological harm" means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days."

In the regulations the judgment as to whether an incident is notifiable is decided by the healthcare professional. Any decision made regarding notification by the healthcare professional must be clearly documented in the clinical notes demonstrating clear rationale for decisions made.

3.6 Determination of whether a notifiable incident has occurred

It is a matter of judgment from a healthcare professional that needs to be exercised on a case by case basis to determine whether a notifiable incident has occurred. What may or may not appear to be an incident at the outset may look very different once more information comes to light, and may therefore mean an incident becomes notifiable under the Duty of Candour.

Once an incident has been reported via the Trust's Incident Reporting system (Datix) and moderate or severe harm has been caused by this organisation, the incident is reviewed by the Clinical Safety Improvement Lead, Quality & Safety Manager and the Duty of Candour Lead to confirm that the incident is notifiable under the Duty of Candour. The Duty of Candour Lead will the contact the Service involved to provide Duty of Candour advice and support.

3.7 Relevant Person

The Relevant Person is the person who will be informed of an incident in the Duty of Candour process. This may be the service user or patient or the person acting on their behalf.

(a) on the death of the service user,
(b) where the service user is under 16 and not competent to make a decision in relation to their care or treatment, or
(c) where the service user is 16 or over and lacks capacity (as determined in accordance with sections 2 and 3 of the 2005 Act) in relation to the matter.

3.8 Level of Harm

The regulations state that the Duty of Candour applies to incidents as follows:

a) the **death** of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or
b) **severe** harm, moderate harm or prolonged psychological harm to the service user; "prolonged psychological harm" means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;

Moderate Harm is defined as:

a) harm that requires a moderate increase in treatment, and
b) significant, but not permanent, harm;

"moderate increase in treatment" means an unplanned return to surgery, an unplanned re- admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care);

4. Roles and Responsibilities

4.1 This policy applies to all colleagues including permanent and temporary colleagues employed by the Trust, students, bank and locum colleagues, contracted colleagues and volunteers. Every healthcare professional in the Trust must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress.

The Being Open principles and ethical duty of openness applies to all incidents and any failure in care or treatment. The Duty of Candour applies to incidents whereby moderate harm, severe harm or death has occurred.

There will be exceptions to implementing the Duty of Candour; there must be very sound reasons, which must be clearly recorded, for not having the Duty of Candour principles applied. These cases must be discussed with the Quality Team for advice.

4.2 Trust Board

The Board fully endorses the principles of Being Open and actively promotes an open, honest and fair culture. The Trust Board will seek assurances that the principles and processes set out in this policy work effectively to support the commitment to implementing the Duty of Candour.

Employees involved in patient safety incidents in which a patient has been harmed can be traumatised by the event. The Board ensures that systems are in place to provide support to employees in these circumstances.

4.3 Chief Executive

The Chief Executive is ultimately responsible for the process of managing and responding to the Being Open/Duty of Candour process and for the delegation of this role as required.

4.4 Executive Director and Senior Management Team

The Executive Directors and Senior Management Team are responsible for actively supporting the Chief Executive with being open and the Duty of Candour principles and process.

4.5 The Clinical Reference Group

The Clinical Reference Group is chaired by the Director of Nursing and the Medical Director. The Clinical Reference Group will review all Serious Incident investigation Root Cause Analysis (RCA) reports to ensure the quality of the investigation is of a high standard, and that associated action plans are comprehensive. The group will monitor Root Cause Analysis reports to determine whether the principles of Being Open and the Duty of Candour have been followed appropriately in each case. The Complaints Overview Group will review and monitor these incidents and provide information other groups.

4.6 Professional Bodies and Trade Union Organisations

The above bodies accept the responsibility of working with the Trust on issues with the shared intention of investigating and learning from incidents. Trade Unions can play a vital role in representing employees in individual matters and supporting them through difficult and stressful situations.

4.7 The Director of Nursing and the Medical Director

The Director of Nursing and the Medical Director are jointly responsible for ensuring the effective implementation of the Being Open and the Duty of Candour is reported to the Quality and Performance Committee and Trust Board.

4.8 Quality Team

Quality & Safety Manager, Clinical Safety Improvement Lead and Duty of Candour Lead receive all incidents where moderate or severe harm has been caused by this Trust to establish whether it is a Duty of Candour case

4.9 Ambassador for Cultural Change

The Freedom to Speak Up Guardian component of the role will complement all other channels by which colleagues can raise concerns, and will provide confidential support and advice to individuals raising concerns regarding safety, quality or wrongdoing, ensuring that there are no repercussions for the person

who in good faith drew attention to it.

4.10 Line Managers' Responsibility

It is the responsibility of all Trust managers to support employees to comply with this policy and to ensure members of their teams are aware of this duty. It is the line manager's responsibility to liaise with the Quality Team.

4.11 Employee Responsibility

All employees must comply with their relevant professional code. A joint statement on Candour has been issued by the following professional healthcare regulators:

- General Chiropractic Council
- General Dental Council
- General Medical Council
- General Optical Council
- General Osteopathic Council
- General Pharmaceutical Council
- Nursing and Midwifery Council
- Health and Care Professions Council
- College of Paramedics

All employees have a contractual duty and must understand their responsibility for being open and demonstrate the principles of being open in their work.

All employees who become aware of an incident or near miss having occurred must follow the Trust Incident Reporting Policy and apply the principles of Being Open and the Duty of Candour throughout these processes.

All employees dealing with patients or relatives should abide by the Trust's complaints process and advise who patients or carers should write to if they wish to formalise a complaint.

Employees who are concerned about the non-reporting or concealment of incidents, or about on-going practices which present a risk to patient safety, must raise their concerns either through established governance routes or through the Trust's 'Raising Concerns at work' policy.

4.12 Investigating Officer

An Investigating Officer will have received training in undertaking Root Cause Analysis (RCA) and will be able to demonstrate competence with this skill. The Investigating Officer could be the point of contact throughout an investigation between the patient, the family and the Trust if it is agreed that this is most appropriate approach. This communication role can be undertaken by another person such as the lead clinician or senior manager if this is more appropriate, but whoever the contact is must be recorded in the clinical notes and the RCA documentation.

4.13 Senior Clinician

The most senior clinician in partnership with the Quality and Safety Manager will determine whether the incident is notifiable. Advice can be obtained from Senior Managers, the Deputy Director of Nursing or the Quality Team.

4.14 Notifying the Relevant Person

In making a decision about who is most appropriate colleague to lead on the notification discussion and apology, the member of colleagues's seniority, relationship to the person using the service, and experience should all be

considered. Issues of consent and confidentiality and will determine who will lead on the discussions with the relevant person.

4.15 Children and Young People

Young people are owed the same duties of care and confidentiality as adults. Confidentiality may only be broken when the health, safety or welfare of the young person, or others, would otherwise be at grave risk.

Where a child or young person is judged to have the mental capacity and the emotional maturity to understand the information provided (refer to the Fraser guidelines http://www.fpa.org.uk/factsheets/under-16s-consent-confidentiality), then he/she should be involved directly in the Duty of Candour process following a notifiable patient safety incident.

Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents alone or in the presence of the child. In these instances the parents' or legal guardian's views on the issue should be sought. More information can be found in the Trust Consent to Treatment policy.

5. Policy Details

5.1 Being Open and Duty of Candour Process

Most clinicians will find themselves in the difficult position of having to discuss harm or potential harm with a patient at some time in their career. The following guidance provides a framework for colleagues to work to. It is recognised however that many scenarios do not always follow predetermined processes, and colleagues must use their own professional judgement in deciding, for example, when is the right time to talk to patients and families/carers. There is no substitute for clinical and professional expertise and compassionate care.

5.1.1 Stage One

Incident Identification and Reporting

Firstly any actions that can be taken immediately to reduce the risk of harm to the patient must be implemented.

The initial facts of the incident should be established and an assessment of the level of harm that has happened to the patient as a result of the incident (see table below) should be undertaken. When considering the level of harm, it is essential to report on actual harm (not potential).

Incident	Action
No harm *(including prevented patient safety incidents)*	• Patients are not usually contacted or involved in investigations and these types of incidents are **outside** the scope of the *Duty of Candour*. Openness remains best practice, but there is no requirement to follow the Duty of Candour

Low harm	• Unless there are specific indications or the patient requests it, the communication, investigation and analysis, and the implementation of changes will occur at local service delivery level with the participation of those directly involved in the incident. • Communication should take the form of an open discussion between the colleagues providing the patient's care and the patient and/or their carers. • Reporting to the operational managers will occur through standard incident reporting and will be analysed centrally to detect high frequency events. • Review will occur through aggregated trend data and local investigation. • Where the trend data indicates a pattern of related events, further investigation and analysis may be needed. • Openness remains best practice, but there is no requirement to follow the Duty of Candour processes for • incidents that result in this level of harm.
Moderate harm **Severe harm or death**	<u>The *Duty of Candour* policy is implemented.</u> • It may be necessary to inform the relevant Senior Operational Manager. For Never Events senior manager must be informed immediately and for serious incidents, the Quality & Safety Team and Duty of Candour Lead will also need to be contacted as quickly as possible to ensure everyone who needs to know is informed. The Trust operates within openness principles with our commissioners and regulators, and we will inform these organisations of the

All incidents must be reported onto Datix (refer to the Trust's Incident Governance Policy). The incident report must be completed as soon as possible after the incident has been discovered, and always within 48 hours of detecting the incident. For all moderate and greater harm incidents, Datix prompts the handler reporting the incident whether the Duty of Candour has been applied in the incident.

5.1.2 Stage 1

Being Open

There are a set of principles for being open that colleagues should refer to when communicating with the relevant person following an incident in which the patient/service user was harmed.

Mental Capacity

Where the patient or service user is assessed as not having the capacity to make a decision in relation to their care or treatment, or where the patient / service user is under 16 and deemed not to have the necessary competency, then the most appropriate relevant person should be notified of the incident.

Confidentiality

Details of a patient's care and treatment should at all times be considered confidential. Where the Duty of Candour would include providing confidential information to family or carers, then the consent of the individual concerned should be sought prior to disclosing information. This consent or denial of consent to share should be recorded in the clinical notes and subsequent RCA documentation.

Communication with parties outside of the clinical team should be on a strictly need-to-know basis and, where practicable, records should be anonymised.

Further advice is available in the Trust's Consent to Treatment Policy and Code of Conduct for Employees in Respect of Confidentiality.

If the Relevant Person Cannot be Contacted or Declines to Have Further Information

If, after discussion, the patient says they do not want more information, then the possible consequences must be explained to them. It should be made clear that they can change their mind and have more information at any time.

All Duty of Candour conversations must be recorded in the notes including instances when the patient has declined the offer of further information.

Where a relevant person cannot be contacted, a clear written record must be kept of the attempts made to contact or speak to the relevant person. This should evidence that every reasonable effort was made to contact the person by stating how many attempts were made, who by and when.

5.1.3 Stage Three

The initial 'Being Open'/Duty of Candour communications will vary according to the individual needs of the relevant person, the severity grading of the incident, clinical outcome and family circumstances for each specific event. The most senior clinician on the clinical shift should coordinate this initial communication, ensuring that the relevant person receives clear, unambiguous explanation of the event and the next steps to be taken. It is also vital that colleagues involved in the incident receive appropriate support from the outset.

The following is intended as broad advice as it is recognised that the vast majority of clinical colleagues have extensive, highly tuned communication skills.

Apology

Where a patient safety incident has caused harm, an apology must be offered to the relevant person – a sincere expression of sorrow or regret for any possible harm and distress Caused as soon as possible.

Guidance from the NHS Litigation Authority (2009) states:

"It is both natural and desirable for clinicians who have provided treatment which produces an adverse result, for whatever reason, to sympathise with the patient or the patient's relatives; to express sorrow or regret at the outcome; and to apologise for shortcomings in treatment. It is most important to patients that they or their relatives receive a meaningful apology. We encourage this, and stress that apologies do not constitute an admission of liability. In addition, it is not our policy to dispute any payment, under any scheme, solely on the grounds of such an apology."

Clarity of Communication

The individual communication needs of the relevant person, for example, linguistic or cultural needs, learning disabilities, or sensory impairments must be considered and taken into full account before any discussion takes place. This involves consideration of circumstances

that can include a patient requiring additional support, such as an independent patient advisor or a translator.

The relevant person should be fully informed of the issues surrounding the patient safety incident and its consequences in a face to face meeting where possible.
The facts that are known should be explained. When talking to the relevant person about the incident colleagues must use clear, straightforward language and be honest with responses to any questions that are raised.

The relevant person should be informed that an incident review will be carried out and more information will become available as this progresses.

It should be made clear to the relevant person that new facts may emerge as the incident review proceeds.

The relevant person's understanding of what happened should be established from the outset, as well as any questions they may have.

There should be consideration and formal noting of the relevant person's views and concerns, and demonstration that these have been heard and taken seriously.

An explanation should be given about what will happen next in terms of the long term treatment plan for the patient as well as the incident review findings.

Information on likely short and long-term effects of the incident (if known) should be shared. An offer of practical and emotional support should be made to the relevant person.

Patients, family and/or carers might be anxious, angry and frustrated, even when the discussion is conducted appropriately. It is essential that colleagues are not drawn into speculation, attribution of blame, denial of responsibility or the provision of conflicting information.

5.1.4 Stage Four
The Investigation

For Serious Incidents involving Duty of Candour, the Investigating Officer (IO) will undertake the RCA as set out in the Trust's Incident Governance Policy. The IO will meet with the employee(s) directly involved in the incident to establish the facts.

Where an incident is notifiable but does not meet the criteria for a Serious Incident, then an RCA must be undertaken.

The actions above should be followed by a letter within 10 working days from the Service involved to the patient/relatives with an offer of a meeting, if this is appropriate. The letter should be sent from a Senior member of colleagues and includes their contact details as the contact lead for the duration of the investigation.

The Investigating Officer will keep the relevant Quality Safety Lead and Duty of Candour Lead fully informed on progress with the investigation.

5.1.5 Stage Five
Communication with the Relevant Person – the Notification Meeting

A meeting with the relevant person should be arranged as soon as possible after the incident has happened by the Investigating Officer and

supported by the Duty of Candor Lead to notify them of the incident. This meeting should always take place within 10 working days of the incident being discovered.

At the meeting the Investigating Officer will follow the procedure below:

- If known, explain what went wrong and where possible, why it went wrong;
- Inform the patient and/or relative(s) and others what steps are being/will be taken to prevent the incident recurring;
- Offer an apology:
- Provide opportunity for the patient and/or relatives and others to ask any questions;
- Agree with the patient and/or relatives and others any future meetings as appropriate;
- Suggest any sources of additional support and counselling and provide written information if appropriate.
- Inform the relevant person that a further meeting will be arranged on completion of the investigation to share the outcome, findings and recommendations. This will be followed by a letter from the Chief executive summarising the outcome, findings and recommendations.

All Duty of Candour letters will be signed off by the relevant Director and a copy retained on the Datix system to provide a robust audit trail.

If, for whatever reason, the patient cannot be contacted in person or declines to speak to anyone from the Trust in relation to the incident, then the above processes do not apply but a written record must be kept of the attempts made to contact or to speak to the relevant person.

5.1.6 Stage Six
Investigation Closure and Learning

Where a SIRI investigation has been conducted, where Duty of Candour applies, the report will be presented to the Clinical Reference Group.

All learning from the incidents must be cascaded via the Directorate Governance meetings, Quality and Performance Committee and Team Brief. This information will be relayed to Trust Board through the Quality and Performance Report.

The outcome of reports must also be shared with any other healthcare organisation or relevant stakeholder as appropriate to optimise learning from the incident.

5.2 Implications of non-complinace of the Duty of Candour requirements

As the Duty of Candour is a statutory requirement, non-compliance is a criminal offence. Commissioners can withhold the cost of the episode of care or implement a fine of £10,000 if the cost is not known. In addition, they can do any/all of the following:

- Inform the CQC
- Require that the Chief Executive send an apology and an explanation of the breach to the patient/relatives
- Publish details of the breach on the Trust web-site.

The CQC will assess whether a provider is complying with the new regulation. The CQC's key lines of enquiry will be:

1. Are lessons learned and improvements made when things go wrong?
2. Are people who use services told when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result?
3. How does the leadership and culture reflect the vision and values encourage openness and transparency and promote good quality care?
4. Does the culture encourage candour, openness and honesty?

5.3 Incidents that are later uncovered or that have occurred within the care of another provider

On occasions, an incident that happened some time ago may be discovered. The incident should be reported in the usual way on Datix, and agreement reached by the senior clinician and the Quality and Safety Manager as to the most appropriate action to take. A delay in discovering an incident does not mean the Duty of Candour does not apply.

The processes however may require additional consideration so that the patient is informed of the incident with care to avoid unexpected shock or distress.

Incidents that are discovered which relate to care delivered by another provider will be reported to a senior manager in that organisation, and to the commissioning body. That organisation is then responsible for implementing the Duty of Candour. The Trust will work in partnership with other providers to ensure the Duty of Candour applies as a care economy wide, patient-centered policy.

This policy deals with the information and methods of sharing of information with the relevant person. Patients and those close to them will vary in how much information they want, and when they want it. Some people will want as much detail as possible, including details of rare risks, to those who ask health professionals to make decisions for them. There will always be an element of professional judgement in determining what information should be given. However, the presumption must be that the relevant person wishes to be well informed about the risks and benefits of the various options. Where the relevant person makes clear that they do not wish to be given this level of information, this should be documented.

Incidents that are later uncovered or that have occurred within the care of another provider

On occasion, an incident that happened some time ago may be discovered. The incident should be reported in the usual way on Datix, and agreement reached by the senior clinician and the Quality and Safety Manager as to the most appropriate action to take. A delay in discovering an incident does not mean the Duty of Candour does not apply.

The processes however may require additional consideration in order that the patient is informed of the incident with care to avoid unexpected shock or distress.

Incidents that are discovered that relate to care delivered by another provider will be reported to a senior manager in that organisation, and to the commissioning body. That organisation is then responsible for implementing the Duty of Candour. The Trust will work in partnership with other providers to ensure the Duty of Candour applies as a care economy wide, patient-centered policy.

5.4 Documentation

All correspondence should be held in accordance with Trust's Records Management Policy. With specific relation to the Being Open/Duty of Candour the clinical records must:

- Record the sharing of any facts that are known and agreed with the relevant person;
- Record how it has been agreed that the relevant person will be kept informed of the progress and results of that investigation;
- Record, where appropriate, a full apology to the patient and their family/carers;
- Record any explanation given of the likely short and long-term effects of the incident;
- Contain copies of any letters sent to the relevant person;
- Record an offer of appropriate practical and emotional support.

5.5 Performance Disciplinary Issues

As previously described, the Trust will strive to identify the underlying causes of patient safety incidents (i.e. systems failures or latent conditions) through RCA processes. The incident decision tree http://www.ahrq.gov/downloads/pub/advances/vol4/meadows.pdf supports this process and provides a straightforward guidance tool to support a fair and just approach to patient safety incidents. The tool aims to support clinicians and managers in understanding when safety incidents should be attributed to systemic or organisational issues, as well as identifying the occasions when there may be individual culpability for an incident.

The purpose of the tool is to support building a just and fair safety culture that moves away from inappropriately blaming individual colleagues for safety incidents when these are more often the result a combination of human, organisational, technological and system factors.

Where concerns are identified about the performance of colleagues, the Trust's Human Resources policies will be invoked.

This will particularly be the case in matters where safeguarding issues are identified. The appropriate professional body (GMC/NMC/ etc.) may also need to be notified.

6. Consultation

- Complaints Oversight Group
- Clinical Policy Group
- Clinical Reference Group
- Quality and Performance Committee

7. Resources

Colleagues trained to undertake RCA

8. Training

8.1 As part of the Trust's induction programme, all new employees of the Trust are made aware of the 'Being Open' process and Duty of Candour.

All Investigating Officers should receive RCA training before undertaking an investigation. The Duty of Candour processes form part of this training.

Awareness of the Being Open principles will be promoted to all through Team Brief, information leaflets and existing Quality Governance structures.

8.2 Support and Advice for Colleagues

Colleagues in healthcare rarely intend to cause harm or fail to do the right thing.

While risks can be minimised, it will never be possible to eliminate them fully and many 'human factors' can increase the risk of incidents occurring such as:

- Workload
- Distractions
- Physical environment
- Physical demands
- Device/product design.

and the Trust is committed on the learning and prevention of incidents and not to apportioning blame on colleagues.

Involvement in an incident and particularly a serious incident can have profound consequences on colleagues who may experience a range of reactions and support is available from Line Management, Senior Managers, Human Resources and Care First.

9. Implementation

9.1 The policy will be communicated to colleagues via line managers following the approved process.

9.2 The policy will be made available on the organisation's Intranet and it will also be highlighted in team meetings.

9.3 Information on who to contact for access to the policy from outside the organisation is available on the Internet. Details how the document is to be rolled out and maintained within the Trust.

10. Audit

10.1 The Clinical Reference Group is responsible for the agreeing sign off and closure of the incident report and once completed, the outcome of this will be reported to the Quality and Performance Committee and Trust Board.

A questionnaire will be developed to gain feedback from colleagues who have been involved in Duty of Candour incidents in order to establish what extra support and resources need to be put in place to provide support throughout the process.

11. Equality Impact

11.1 This policy has been subject to a Quality and Equality Impact review. This concluded that this policy will not create any adverse effect or discrimination on any individual or particular group. Confirms the results of an Equality Impact Assessment .

12. Quality Impact

12.1 This policy has been subject to a Quality and Equality Impact review. This concluded that the policy will not negatively impact upon the quality of health and social care services provided by the Trust. Confirms the results of a Quality Impact Assessment .

13. Review

3 years or before if changes required

14. References, Bibliography and Acknowledgements

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 No. 2936 PART 3SECTION 2 Regulation 20 http://www.legislation.gov.uk/uksi/2014/2936/regulation/20/made

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A promise to learn – a commitment to act: Improving the Safety of Patients in England, Berwick and the National Advisory Group on the Safety of Patients in England, 2013, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Ber wick_Report.pdf.

Building a culture of candour - A review of the threshold for the duty of candour and of the incentives for care organisations to be candid http://www.rcseng.ac.uk/policy/documents/CandourreviewFinal.pdf

Human Factors in Healthcare – National Quality Board 2013 http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/Intervention-support/Human+Factors+How-to+Guide+v1.2.pdf

NPSA – Being Open resources: http://www.nrls.npsa.nhs.uk/resources/?entryid45=65077

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NHS Litigation Authority, Litigation Circular No. 02/02 Apologies and Explanations, 11 February 2002 www.nhsla.com

NHS Litigation Authority – Saying Sorry: 2013 - http://www.nhsla.com/Claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf

CQC Provider Guidance http://www.cqc.org.uk/sites/default/files/20141120_doc_fppf_final_nhs_provider_guidance_v1-0.pdf

Appendix 1

The 10 Principles of Being Open - *Being open* involves apologising when something has gone wrong, being open about what has happened, how and why it may have happened, and keeping the patient and their family informed as part of any subsequent review.

1. Principle of Acknowledgement

All patient safety events should be acknowledged and reported as soon as they are identified. In cases where the patient, their family and carers inform healthcare employees that something has happened, their concerns must be taken seriously and should be treated with compassion and understanding by all employees. Denial of a person's concerns or defensiveness will make future open and honest communication more difficult.

2. Principles of Truthfulness, Timeliness and Clarity of Communication

Information about a patient safety incident must be given in a truthful and open manner by an appropriately nominated person. Communication should be timely, informing the patient, their family and carers what has happened as soon as is practicable, based solely on the facts known at that time. It will be explained that new information may emerge as the event investigation takes place. Patients, their families and carers and appointed advocates should receive clear, unambiguous information and be given a single point of contact for any questions or requests they may have.

3. Principle of an Apology

Patients, their families and carers should receive a meaningful apology - one that is a sincere expression of sorrow or regret for the harm that has resulted from a patient safety event or that the experience was poor. Both verbal and written apologies should be offered. **Saying sorry is not an admission of liability and it is the right thing to do.** Verbal apologies are essential because they allow face to face contact, where this is possible or requested. A written apology, which clearly states the organisation is sorry for the suffering and distress resulting from the patient safety event, should also be given.

4. Principle of Recognising Patient and Carer Expectations

Patients, their families and carers can reasonably expect to be fully informed of the issues surrounding a patient safety incident, and its consequences, in a face to face meeting with representatives from the organisation and/or in accordance with the local resolution process where a complaint is at issue. They should be treated sympathetically, with respect and consideration. Confidentiality must be maintained at all times. Patients, their families and carers should also be provided with support in a manner to meet their needs. This may involve an independent advocate or an interpreter. Information enabling to other relevant support groups will be given as soon as possible and as appropriate.

5. Principle of Professional Support

The Trust has set out to create an environment in which all employees are encouraged to report patient safety events. Employees should feel supported throughout the patient safety event investigation process; they too may have been traumatised by the event. Resources available are referred to within the respective Trust policies, to ensure a robust and consistent approach to patient safety event investigation. Where there are concerns about the practice of individual employee the Trust's Human Resources department must be contacted for advice. Where there is reason to believe an employee has committed a punitive or criminal act, the Trust will take steps to preserve its position and advise the employee at an early stage to enable them to obtain separate legal advice and/or representation. Employees should be encouraged to seek support from relevant professional bodies. Where appropriate, a referral will also be made to the Independent Safeguarding Authority.

6. Principle of Risk Management and Systems Improvement

Root Cause Analysis (RCA) or similar techniques should be used to uncover the underlying causes of patient safety events. Investigations at any identified level will however focus on improving systems of care, which will be reviewed for their effectiveness. *Being open* is integrated into patient safety incident reporting and risk management policies and processes.

7. Principles of Multi-Disciplinary Responsibility

Being open applies to all employees who have key roles in patient care. This ensures that the *Being open* process is consistent with the philosophy that patient safety incidents usually result from system failures and rarely from actions of an individual. To ensure multi-disciplinary involvement in the *Being open* process, it is important to identify clinical and managerial leaders who will support this across the health and care agencies that may be involved. Both senior managers and senior clinicians will be asked to participate in the patient safety incident investigation and clinical risk management as set out in the respective Trust policies and practice guidance.

8. Principles of Clinical Governance

Being open involves the support of patient safety and quality improvement through the Trust's clinical governance framework, in which patient safety incidents are investigated and analysed, to identify what can be done to prevent their recurrence. It is a system of accountability to ensure that these changes are implemented and their effectiveness reviewed. Findings are disseminated to employees so they can learn from patient safety incidents. Audits are an integral process, to monitor the implementation and effects of changes in practice following a patient safety incident.

9. **Principle of Confidentiality**

Details of a patient safety incidents should at all times be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the patient. The Trust will anonymise any incident it publishes but still seek the agreement of those involved.

Where it is not practicable or an individual refuses consent to disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the patient safety event have statutory powers for obtaining information. Communications with parties outside of those involved in the investigation will be on a strictly need to know basis. Where possible, it is good practice to inform the patient, their family and carers about who will be involved in the investigations before it takes place, and give them the opportunity to raise any objections.

Consent and duty to inform for incidents involving patients in Offender Health will be dealt with in accordance with the normal prison protocol.

10. Principle of Continuity of Care

Patients will continue to receive all usual treatment and continue to be treated with respect and compassion.

Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 22 March 2016

Agenda Item:	20 (Part 1)
Agenda Ref:	20/0316
Author:	Rod Brown, Head of Planning, Compliance and Partnerships
Presented By:	Glyn Howells, Director of Finance
Sponsor:	Glyn Howells, Director of Finance

Subject:	One year operational plan

This report is provided for: ☐ Discussion ☐ Decision ☐ Approval ☒ Assurance ☒ Information

Executive Summary:

The attached document is a summary of the submission made to the NHS Trust Development Authority (TDA) on 8 February 2016 in line with the latest Planning Round timetable. Positive feedback has been received by the Trust in respect of this plan, ahead of an updated submission being required by 11 April 2016.

Recommendations:

The Board is asked to:

Note the submission

Considerations:

Quality implications:

Implicit in the attached document

Human Resources implications:

Implicit in the attached document

Equalities implications:

Implicit in the attached document

Financial implications:

Implicit in the attached document

Does this paper link to any risks in the corporate risk register:

No

Does this paper link to any complaints, concerns or legal claims

No

Which Trust strategic objective(s) does this paper Progress (P) or Challenge (C)?	P or C
Achieve the best possible outcomes for our service users through high quality care	P
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	P
Actively engage with health and social care partners as well as local communities, in order to deliver seamless, innovative services across Gloucestershire	P
Support individuals and teams to develop the skills, confidence and ambition to deliver our vision	P
Manage public resources wisely to ensure local services remain sustainable and accessible	P

Which Trust value(s) does this paper Progress (P) or Challenge (C)?	P or C
Caring	P
Open	P
Responsible	P
Effective	P

Reviewed by (Sponsor):	Glyn Howells, Director of Finance

Date:	11 March 2016

Where in the Trust has this been discussed before, e.g. Committee, Programme Board, Group?
This plan was discussed extensively with the Executive Team prior to submission

Explanation of acronyms used:

Contributors to this paper include:
Rod Brown, Head of Planning, Compliance and Partnerships

2016-17 operational plan (first draft submission)

1. Introduction

Within the financial year 2016-17, Gloucestershire Care Services NHS Trust ("the Trust") plans to build upon its position as an organisation which is:

- financially sound, having returned a £1.0million operational surplus in 2015-16 and achieved its fiscal stretch targets despite rising demand;
- operationally effective, reporting 85.7% year-to-date compliance with all prevailing national targets;
- continuously improving the quality and safety of provided care.

These successes are recognised by the NHS Trust Development Authority ("TDA") in its monthly Escalation and Assurance Framework, which throughout 2015-16, consistently rated the Trust as "green" on quality, and which currently rates the organisation as "amber" on financial performance.

Additionally in 2016-17, the Trust will continue to play a lead role in the strategic development of Gloucestershire health and care services. Already, the Trust is an effective contributor to countywide discussions on future models of sustainability and transformation, as evidenced by its involvement with the Gloucestershire Strategic Forum and joint provider / commissioner initiatives such as Joining Up Your Care and Joining Up Your Information.

Notwithstanding, and despite the Trust's tangible commitment to working in partnership with both local NHS and voluntary care organisations, the Trust also maintains its own set of five-year service development aspirations, foundations for which will be established in 2016-17.

1.1 Five Year Service Developments

1.1.1 To ensure that new community services delivery models are designed to consistently deliver best outcomes for local populations, and address identified need within care pathways

In 2016-17, this will be realised by the introduction of, for example, new community-based models for lower limb wound care, continence and cancer survivorship, as well as improvements in the delivery of end-of-life care. Also in-year, the Trust will be seeking to better understand its capacity to respond to acuity and demand, which will serve to underpin future care models.

1.1.2 To develop and implement a robust long-term model of demand in the Forest of Dean in order to address the current and future health and social care needs of local people

In 2016-17, the Trust in collaboration with the Gloucestershire Clinical Commissioning Group ("GCCG") will undertake a period of statutory consultation with the Forest of Dean population in order to assess and agree a series of options for the future delivery of health and social care services in the locality. These options will be derived not only from extensive data modelling and needs assessment, but also from public opinion elicited as part of a nine month engagement exercise, September 2015 to May 2016.

1.1.3 To increase levels of integrated working with particular focus upon operational synergies with other local providers as well as voluntary and support organisations

In 2016-17, the Trust will further develop its Integrated Community Teams ("ICTs"). These already represent excellent joint working between the Trust's healthcare services and social care services provided by Gloucestershire County Council. Additionally, ICTs will be developing integrated pathways with 2gether NHS Foundation Trust, in order to provide relevant service users with easier access to mental health services as part of their overall care.

1.1.4 To encourage colleagues to undertake improved collaborative working with primary care so as to ensure a more seamless service user experience

The Trust will further explore opportunities to better integrate its services with primary care providers, whether this be through reorganising ICTs around developing GP clusters, providing facilities and support services for GPs, or entering into more formal GP partnership contracting arrangements.

1.1.5 To ensure that resources are allocated appropriately and efficiently across the system, and that payment models reflect clinical need / delivery

The Trust believes that its block contract with the GCCG lacks transparency and disincentivises increases in community activity, which negatively impacts upon transformation and quality. As a result, the Trust will explore new contract forms to reward integrated working, and to ensure that funding reflects service user flows. The Trust will also contribute to a pilot for developing community currencies with Monitor and NHS England. Additionally in 2016-17, the Trust is looking to maximise the utilisation of its estates - including investment in a single site in Gloucester - though there is recognition that any significant reconfigurations will not realise financial return in-year.

By fulfilling these aspirations, the Trust will be helping to close the three gaps identified within the Five Year Forward View. However, examples of additional planned contributions in 2016-17 are as follows:

1.2.1 Closing the health and wellbeing gap

- As part of its commitment to increase focus upon self-management with the direct involvement of service users, the Trust is working towards embracing the philosophy of co-production, and so is actively engaging local people as part of its service redesign processes, especially where self-care will become part of a revised pathway. The Trust is also working more closely with the voluntary care sector to ensure that local people are able to access the necessary range of support services when undertaking self-care.

- The Trust is currently exploring with its commissioners, how personal health budgets can be used, initially for the benefit of services users with continuing healthcare needs, but subsequently also for people with long-term conditions and the chronically unwell.

- The Trust is committed to a range of initiatives to improve the health of its workforce including encouraging exercise, developing a stress and resilience training course for staff, and holding health awareness days.

1.2.2 Closing the care and quality gap

- In 2016-17, the Trust will play a critical role in the development of a new model of care across Gloucestershire, based upon the concept of a Locality Care Organisation. This work is being undertaken with all other local NHS providers as well as health and social care commissioners. Equally, the Trust is actively involved with the local devolution bid, ensuring that local health and social care services are appropriately represented.

- In 2016-17, the Trust will be appointing two Clinical Pathway Leads to assume strategic leadership for high-quality dementia and end-of-life care respectively. These leads will be responsible for developing person-centred, evidence-based practice, and for ensuring more consistent service delivery performance across the Trust and its partners.

- Following a Care Quality Commission (CQC) Chief Inspector of Hospital's assessment in June 2015, the Trust will continue to monitor the progress of identified improvement programmes through its Quality Improvement Plan (QIP). The majority of actions are scheduled to be completed by May 2016.

- In order to support on-going work aimed at ensuring an open, learning and safety culture, the Trust has newly appointed an Ambassador for Cultural Change: the postholder will now act as the independent advisor and guardian on all matters relating to workplace concerns, and will play a key role in promoting a culture of transparency and service user safety.

- The Trust will be developing plans to ensure that by 2020, services are paper-free at the point of care. As such, the Trust is working closely with the local Commissioning Support Unit on the Digital Roadmap, illustrating the organisation's commitment to sustainability.

1.2.3 Closing the finance and efficiency gap

- In 2016-17, the Trust will extend its use of a fully-integrated business intelligence reporting system. This will provide colleagues with the necessary level of data granularity to be able to highlight variations in the type and level of services provided by similar community teams in different parts of the county, leading to more standardised and consistent practice / delivery models and creating cost efficiencies.

- The Trust will focus on workforce arrangements in community hospital inpatient wards and Minor Injuries and Illness Units (MIiUs) in order to identify efficiencies, whilst maintaining absolute quality and safety. For example, on inpatient wards, the Trust will be seeking to utilise staffing models which provide greater flexibility than the 1:8 model in circumstances where alternative staffing numbers are clinically approved: this will also help reduce the Trust's reliance upon agency staff. In MIiUs, the Trust will be introducing Band 5 staff in place of healthcare assistants thereby addressing CQC concerns, whilst also working with GCCG to review MIiU opening hours in order to ensure that the Trust continues to provide value-for-money throughout all hours of operation.

2. Approach to activity planning

In order to forecast the anticipated levels of demand and activity for community services in 2016-17, the Trust has applied the following assumptions:

- based upon ONS projections, overall countywide demographic growth is estimated at 0.3% for children and young people's services, and 0.8% for all other services: however, the Trust is currently evaluating whether these rates of population increase adequately reflect changing service user demand;

- occupancy rates, length of stay and rates of transfers in respect of community hospital inpatient wards is anticipated to remain unchanged from 2015-16: however it is noted that in the previous 12 months, demand resulted in overall inpatient occupancy rates of an average 96.4% across the seven community hospitals, whereas in line with CQC and GCCG recommendations regarding service user safety and care quality, the Trust aspires to reduce bed occupancy to 85-90% by means of increased service provision within community-based settings;

- an increase in MIiU attendances of approximately 6.6% is anticipated as a result of acute Trusts being encouraged to reduce their A&E attendances by redirecting service users to more appropriate settings;

- an increase in the number of day cases being provided by the Trust is expected, as in 2015-16, a lack of staffing resources within the sexual health service resulted in some service users being referred to the British Pregnancy Advisory Service: this matter has since been resolved;

- an increase in activity within the Trust's specialist nursing services as a result of new business such as the lower limb wound care service;

- an increase in activity within the ICTs as a result of, for example, additional staffing input and introduction of new models of care including the continence service.

It is also noted that in 2016-17:

- the Trust will be reviewing its health improvement activities which may be impacted by a tender of the service by the GCCG;

- minimal impact is expected on Trust activity as a result of changes in border arrangements between England and Wales as of April 2016, as this will simply represent a change in commissioner from the Aneurin Bevan Health Board to the GCCG.

The results of these assumptions are shown in the table below:

	2014-2015	2015-2016	2016-2017
Inpatients	3,993	3,373	3,393
Day cases	1,432	1,353	1,461
Outpatients	1,782	3,212	4,789
Urgent care (MIiUs, Integrated Discharge Teams, SPCA)	103,380	107,148	110,259
ICTs	417,757	575,659	619,109
Countywide services	245,173	253,891	256,395
Specialist services	60,099	73,561	88,979
Children and young people's services	260,058	327,574	330,728

Other issues impacting the Trust's activity planning are as follows:

- the Trust has benefitted from significant learning gleaned during winter 2014-15. In particular, the Alamac system is now being used to provide daily evidence of activity across the local healthcare system, and has led to informed provider / commissioner discussions based upon transparency and clear recognition of risk. As such, Alamac has considerably helped towards managing unplanned changes in demand across Gloucestershire;
- in order to provide additional system resilience for winter, in December 2015, the Trust opened an additional 12 escalation beds, 8 in Cirencester and 4 in the Forest of Dean. These will continue to be available until such time that the local healthcare system agrees that there is no further need;
- the Trust has newly appointed to the Head of Capacity: the postholder will provide continued leadership in respect of capacity management, and will work with clinical leads to develop organisational service resilience and capability in order to respond effectively to demand and service user flow;
- Trust representatives attended the demand and capacity workshops held by the TDA in January 2016. Whilst no dedicated tools were made available for community providers at this time, the Trust is now engaged in dialogue with the TDA to support the future development of such resources (NB the Trust also continues to work towards implementation of Medworxx which will enable more appropriate referrals to community inpatient wards);
- over 2015-16, the Trust has continued to roll-out its SystmOne clinical information system: this is now being used across the majority of services, including all community-based teams, community hospitals, children's services, the Single Point of Clinical Access (SPCA), rapid response and the Integrated Discharge Team. The data gathered by SystmOne will be of significant benefit in activity planning, as it records details of every clinical intervention and provides simple summary data for management;
- in terms of working with the independent sector, the Trust is currently introducing social prescribing, enabling referrals to be made by providers across the care sector to local voluntary care and support organisations where these may be of clear benefit to service users: whilst this may ultimately help reduce people's over-reliance upon health and care services, the effects are yet to be fully quantified and realised.

In summary however, the Trust can confirm that it believes its resources and capacity are sufficient to manage the above levels of demand in 2016-17.

3. Approach to quality planning

3.1 Approach to quality improvement

Quality improvement within the Trust is led by Susan Field, Director of Nursing and Mike Roberts, Medical Director. Whilst the Trust Board is ultimately responsible for ensuring the delivery of safe, effective, high-quality health and social care services, practical responsibility for assuring the Board on all issues pertaining to clinical and professional care, clinical governance systems, clinical risk management, and all regulatory standards related to quality and safety, is delegated to the Quality and Performance Committee. This Committee is supported by a number of key sub-groups including the Clinical Reference Group - additional committees are currently under review as part of an on-going organisational restructure.

It is noted that the Trust's annual quality priorities are decided from a combination of the following:

- alignment to the Trust's strategic objectives, which articulate the organisation's overarching commitment to providing high-quality, accessible and sustainable community services;
- alignment to the Trust's five year service development aspirations, detailed in section 1.1 above;
- alignment to quality goals which are detailed across the range of Trust strategies, identifying the discipline-specific aspirations that contribute towards the fulfilment of the organisation's strategic objectives (i.e. the goals within the Clinical and Professional Care Strategy which demonstrate how the Trust seeks to remain a leading provider of community-based care that offers optimum quality, safety and effectiveness, and enables every person in Gloucestershire to experience a positive journey and outcome);
- alignment to the Gloucestershire Clinical Commissioning Group's commissioning intentions as identified in the Joining Up Your Care strategy;
- response to local or national imperatives (for example, one of the Trust's quality priorities for 2016-17 relates to improving care for people with learning disabilities, which is one of the national "Must Do's");
- response to independent Trust reviews or audits, including serious incident (SIRI) investigations, recommendations from CQC inspections, Healthwatch reports etc;
- response to trended data, for example, an increase in complaints or incidents about a specific service, or else a decrease in performance against local or national benchmarks or indicators;
- response to feedback from service users, carers, families and the wider public across Gloucestershire.

Evaluation of the above has resulted in the identification of five quality priorities for 2016-17 to be detailed in the Trust's forthcoming Quality Account. These are shown below, aligned to the Trust's wider priorities / service developments:

Trust strategic objectives	5 year service developments	Clinical and Professional Care Strategy 2014-19 quality goals	Quality Account priorities 2016-17	CQC domain
Achieve the best possible outcomes for our service users through high quality care	Ensure that new community services delivery models are designed to consistently deliver best outcomes for local populations, and address identified need within care pathways	• Deliver compassionate and considerate care which ensures that service users remain safe from avoidable harm • Determine that local health and social care services adopt a person-centred approach, and are wholly effective and efficient	Ensure that local people with learning disabilities benefit from enhanced community services, enabling them to have a positive experience of care and receive support and treatment within a safe environment	Safe
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	Develop and implement a robust long-term model of demand in the Forest of Dean in order to address the current and future health and social care needs of local people	• Inform and involve service users, their carers and families so that they are confident and have the best possible experience during their care	Continue to improve our active two-way community engagement in order to ensure that the public's voice can directly influence service design, and to enable us to fully understand local people's extra or different needs	Responsive
Actively engage in partnerships with other health and social care providers in order to deliver seamless services	Increase levels of integrated working with particular focus upon operational synergies with other local providers as well as voluntary and support organisations	• Achieve excellence in integrated health and social care, and develop appropriate strategic partnerships with local professional stakeholders	Embed a positive risk-taking approach within the Integrated Community Teams and community hospitals, enabling care to be solution-focused and service user-led	Caring
Value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision	Encourage colleagues to undertake improved collaborative working with primary care so as to ensure a more seamless service user experience	• Help the development of a supportive and learning culture that is clinically-led, that will strengthen leadership across the Trust, and that will enable delivery of improved services and outcomes	Upskill colleagues to adopt a Gold Standards Framework approach to end-of-life care which requires increased partnership working with local GPs, and gives local people greater opportunity to die in their place of choice	Effective
Manage public resources wisely to ensure local services remain sustainable and accessible	Ensure that resources are allocated appropriately and efficiently across the system, and that payment models reflect clinical need / delivery	• Ensure an able, flexible workforce that can meet new challenges and opportunities, and that is supported by exemplar standards in education, training and research	Increase services in the community for people with continence issues, promoting awareness and self-care where appropriate, and delivering more support outside of hospital	Well-led

The Trust uses a formalised project management methodology to ensure that these quality priorities are fully understood, owned, actioned and embedded across the organisation - moreover, the Trust is committed to the *Listening into Action* approach whereby quality initiatives which are to the benefit of service users, carers and families, are escalated and enacted within a 20 week period.

In addition to the five priorities detailed above, the Trust also undertakes quality improvements as part of its CQUIN and QIPP programmes (2016-17 schemes are currently under negotiation with the GCCG). The Trust has also developed a formal response to the Sign Up To Safety campaign, and will be maintaining a detailed implementation plan to govern its actions.

Currently, the three biggest risks to quality and safety, as identified within the Trust's Board Assurance Framework, are as follows:

Risk	**Mitigation**
Inability to negotiate necessary changes to the operational model for MIiUs which may threaten on-going service user safety	On-going discussions with the GCCG both directly, and as part of the CQC Oversight Group, chaired by the TDA
Inability to recruit and retain staff with the right skills which may have detrimental impact upon the quality of provided care	Recruitment and selection processes are being reviewed to identify opportunities for improvement in speed and efficiency: additionally, the Trust is using a range of recruitment opportunities including university open days. To help improve retention, the Trust is currently developing its preceptorship scheme
Inability to provide assurance that colleagues have the clinical skills and managerial competencies to create a workforce with the necessary knowledge and expertise to deliver best care	The Trust is currently reviewing all its mandatory and essential-to-role training to ensure that content is comprehensive and appropriate: simultaneously, the Trust is updating its systems so as to ensure that colleagues' training is fully captured and able to be reported

Furthermore, in order to ensure that the Trust remains well-led in terms of quality, the organisation is appointing to key some posts as part of the Director of Nursing's Professional and Clinical Effectiveness directorate: these include a Head of Clinical Governance and Effectiveness, a Clinical Pathways Lead for end-of-life care, and a Clinical Pathways Lead for dementia care (see also section 1.2.2 above). Moreover, the Trust has recently appointed a Head of Professional Practice who will enhance the organisation's education and learning agendas for both clinical and non-clinical colleagues.

It is also noted that the Trust now reports compliance with the *Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients* (Academy of Medical Royal Colleges, 2014) in that the Responsible Clinician for the duration of an inpatient's stay is the Community Hospital Matron, whilst the Named Nurse is recognised as being the shift lead.

3.2 Seven day services

In terms of urgent care, the Trust already provides 7-day access to MIiUs and rapid response services across Gloucestershire. With respect to these services' integration with out-of-hours, in 2015-16, responsibility for out-of-hours care transferred to the South Western Ambulance Service NHS Foundation Trust (SWAST). The Trust now regularly attends service governance meetings with SWAST to ensure improved communication and partnership, and is also working closely with the GCCG in order to ensure the delivery of agreed support to MIiUs by SWAST.

In terms of the extension of the Trust's specialist services to 7-day working, the Trust is currently working with Gloucestershire Hospitals NHS Foundation Trust focusing initially upon respiratory services, but also considering IV therapy.

3.3 Quality impact assessment process

The Trust utilises a Quality Equality Impact Assessment (QEIA) tool to evaluate the likely and actual effect of change upon the quality, safety, effectiveness and experience of provided care services, and to demonstrate an evidence-based approach to its decision-making in respect of all change initiatives, particularly those prompted by Cost Improvement Programme (CIP) schemes. The tool is one recommended for use by the TDA, and was originally developed by the Northern, Eastern and Western Devon Clinical Commissioning Group.

QEIAs are an essential part of any business case / CIP plan that is proposed to the Trust's Transformation and Change Programme Group (NB this group is currently under review as part of the Trust's restructure as referenced in section 3.1 above). Endorsed QEIAs are then escalated to the Clinical Reference Group for sanction by the Director of Nursing and Medical Director. Thereafter, change programmes remain subject to on-going assessment and scrutiny, which includes a review of the QEIA within 3-6 months so as to validate the initial thinking, identify any concerns and enable future learning and planning.

3.4 Triangulation of data

The Board currently receives triangulated information via the monthly Quality and Performance Report. This includes ward-by-ward analysis of experience data (Friends and Family Test, complaints) alongside safety information (falls, pressure ulcers) and HR statistics (fill rates, appraisals) in order to identify trends or concerns. Similar information is provided for community-based teams which gives analysis per locality in respect of safety and HR data.

To ensure greater depth of reporting - and to make data available in as near real-time as possible - the Trust is developing its business intelligence reporting system as referenced in section 1.2.3 above. The first phase of rollout is already complete, giving analysis of inpatient services and MIiUs in respect of activity, safety and finance. The second phase due in 2016-17 will extend the range of information to include workforce and service user experience data: and will roll out the information to all community-based services including ICTs. Further phases will follow thereafter.

To improve benchmarking as further support for data analysis, the Trust actively contributes to the Community Indicators Project led by the TDA, relevant NHS Benchmarking projects, and also serves as lead for the Aspirant Foundation Trusts Benchmarking Group, part of Community First.

4. Approach to workforce planning

The Trust recognises that a workforce empowered with the right skills and capabilities, is fundamental to achieving the necessary step change in quality care delivery. To this end, the Trust is committed to effectively planning the ways in which it utilises its colleagues, so as to determine the most efficient staffing levels and mix, and thereby ensure the best outcomes for service users, carers and families across Gloucestershire.

As such, workforce planning within the Trust is conducted using both:

- top-down workforce planning, which uses approved methodologies such the National Workforce Assurance Tool, in order to ensure that the necessary links are established and understood between workforce data, activity information, quality and safety outcomes, and financial plans. This triangulated approach also means that the Trust is best able to make informed decisions about its workforce, can continuously improve its workforce monitoring and planning systems, and can effectively analyse workforce configuration impacts on increased productivity, quality and safety;

- bottom-up workforce planning, which involves colleagues from across the Trust (predominantly, frontline and clinical colleagues including all Heads of Service) in order to identify the specific workforce needs of each service given both its current activity and forecast demand, and also to explore the skill mix that is necessary and appropriate in order to produce the most effective delivery model. The result of this approach is a detailed local workforce profile linked to service budget lines, that specifically shows the numbers and grades of staff needed both now and in the future, in order to ensure delivery of the highest quality of care to local service users.

These two approaches are subsequently reconciled by the Director of Human Resources, and brought to the attention of the Trust Board via the organisation's Workforce and Organisational Development Committee, which in turn, is advised and supported by a number of sub-committees including the Workforce and Organisational Development Steering Group, the Agency Usage Group and the Workforce Education Development Group.

In undertaking workforce planning, there is also recognition that within the Trust's Clinical and Professional Care Strategy (the implementation of which is overseen by the Quality and Performance Committee), there are three quality goals and associated tasks/actions which relate to workforce (this can be seen in the table in section 3 above). For this reason, both the Director of Nursing and the Director of Human Resources are active members of the Workforce and Organisational Development Committee, as well as the Quality and Performance Committee, in order to ensure consistency and shared accountability. It is also noted that the Agency Usage Group is chaired by the Director of Nursing so as to ensure that care quality and key workforce issues are intrinsically coordinated. Moreover, it is noted that a number of key appointments within the Trust, notably the organisation's new Head of Professional Practice, reports jointly to the Director of Nursing and the Director of Human Resources.

As a result of the above approaches to planning, the Trust is anticipating a number of staff reconfigurations in 2016-17 (NB it is noted that the Trust does not currently expect any of the posts proposed for removal from the organisational structure to require redundancy, but in line with the methodology adopted over the past two years, will instead utilise a combination of natural staff turnover together with a plan to reallocate identified at-risk employees into suitable vacant alternatives elsewhere within the Trust). In summary, the proposed reconfigurations are:

- a reduction of 64 whole-time equivalent (WTE) posts as a result of Cost Improvement Programme schemes: these to be identified from the following staff groups:
    - 36 WTE nursing posts: these will, in part, be identified by a relaxation of the current 1:8 staffing model in community hospitals which has created a 70% / 30% split of qualified and unqualified staff respectively, and which will instead introduce a clinically-approved model which comprises 60% qualified and 40% unqualified colleagues;
    - 15 WTE allied healthcare professional posts: these will, in part, be identified by removal of posts from areas where the Trust recognises high-reference costs, and will require a redesign of service delivery principles to, for example, reduce the number of home visits and substitute with telephone contacts where appropriate;
    - 13 WTE administration and clerical posts: these will be identified primarily as a result of the Trust's increased use of technologies / new ways of working;
- a reduction of 15 WTE posts as a result of the withdrawal of Gloucestershire County Council from a number of joint-funded schemes: these posts to be identified from the following staff groups:
    - 8 WTE allied healthcare professional managerial posts from the Integrated Community Teams;
    - 7 WTE administration and clerical posts;
- an increase of 5 WTE nursing posts as a result of new business: it is expected that these services will be provided from existing Trust locations (ostensibly, the Trust's seven community hospitals), and therefore aligns to the organisational ambition to make better use of its estates resource as described in section 1.2.3 above;
- an increase of 20 WTE posts (10 nursing and 10 allied healthcare professional posts) as a result of new services to be commissioned from the GCCG (see also section 1.1.1 above);
- an increase of 15 WTE nursing posts and 15 WTE allied healthcare professional posts as a result of further planned development and expansion of the ICTs (see section 1.1.3 above): this will also include the embedding of the rapid response service within the ICTs.

There may additionally be some changes in the staffing of the Trust's health improvement services as a result of the forthcoming tender by GCCG: however, as noted in section 2 above, these changes are unknown and unquantified at this stage.

Thus, the results of the above reconfigurations are summarised in the table below:

	Staff Groups			
	Nursing	**AHP**	**A&C**	**Total**
Impact of 2016-17 CIPs	(36)	(15)	(13)	**(64)**
Reduction in posts joint-funded with the Council	0	(8)	(7)	**(15)**
New business	5	0	0	**5**
New commissioned services	10	10	0	**20**
ICT enhancement	15	15	0	**30**
Forecast staff movement in 2016-17	**(6)**	**2**	**(20)**	**(24)**

To inform its workforce planning, the Trust would additionally note the following activities:

- throughout 2015-16, the Trust has reported significant successes by means of ensuring greater control on agency spend in line with national directives. This stringency will continue in 2016-17, aided by the proposed relaxation of the 1:8 staffing model in community hospitals which will ensure better use of salaried and bank colleagues rather than relying upon agency staff;

- e-rostering is now available within all of the Trust's community hospitals and countywide / specialist services, and is currently being implemented across the ICTs. Additionally, before the end of March 2016, the Trust aims to have e-rostering available to all staff within sexual health, dentistry and support services – however, there is recognition that the system will not be fully embedded and operational before September 2016. This will then allow all colleagues to see management information on shift patterns (including preferred shift patterns of individual colleagues), together with data relating to staff's annual leave, sickness absence and skill mix. It will also help identify the movement of staff between the organisation's locations. As such, e-rostering will enable the Trust's line managers to quickly create bespoke rotas that can effectively fulfil service user demand;

- whenever any change in service design or staffing configuration is proposed as a result of workforce planning, the Trust ensures the corresponding development of a Quality Equality Impact Assessment (see section 3.3). This serves to ensure that no mooted change will have negative impact upon any population group within the local community, or create further deterioration in prevailing health inequalities.

These QEIAs are escalated through the Transformation and Change Programme Board and the Clinical Reference Group as described in section 3.3 above, and are subject to routine review. Additionally, it is noted that in all cases, the Trust provides clear documented rationale to colleagues explaining the reasoning and benefits behind the change, supported by the evidence of the QEIA, thereby ensuring appropriate staff engagement with change practice;

- the Workforce Education Development Group is now established, supporting and embracing relevant initiatives from Health Education England and the Academic Health Science Network. In terms of workforce development, the Trust is currently engaged in the following:

    - establishing career pathways for staff enabling them to see how they may progress over-time from Band 2 to become a qualified nurse: in this way, the Trust seeks to nurture and encourage professional development within its existing staff cohort;

    - working with other local provider organisations to create consistent apprentice opportunities across Gloucestershire;

    - developing more accessible education programmes for local students rather than looking out-of-county, in line with the philosophy of devolution as supported by the Trust;

- as described in section 3.4 above, workforce data is fundamental to the future development of the Trust's business intelligence reporting system. Thus in 2016-17, real-time data and performance analysis will include staff information, triangulated against quality, experience and finance data, in order to provide colleagues with robust overview and understanding of the Trust's activities. Moreover, this analysis, in tandem with the more granular-level data being captured through the Trust's SystmOne clinical information system, will better inform workforce planning, and provide an opportunity to remodel workforce deployment based upon changes in demand across the day, week or year;

- there are now robust systems in place to capture workforce risks from all areas of the Trust. These are reported through locally-held risk registers so as to ensure bottom-up reporting, and are presented at the Workforce and Organisational Development Committee. Workforce risks are also collated into the Corporate Risk Register, thereby ensuring that the Trust Board is suitably informed and assured that all necessary and appropriate mitigating actions are being progressed.

5. Approach to financial planning

5.1 Financial forecasts and modelling

In developing its financial plans for 2016-17, the Trust has sought appropriate input from operational, information management and workforce colleagues so as to ensure consistency and transparency.

This has resulted in the following assumptions that underpin the Trust's financial forecast:

- the Trust is expected to exit 2015-16 with a £1.0million operational surplus as forecast, enhanced by an additional £1.5million from the Department of Health in respect of a capital-to-revenue transfer scheme;

- in 2016-17, the Trust will be receiving £0.4million in return for its commitment to sustainability and transformation funding principles;

- to accommodate the projected 0.3%-0.8% demographic growth which is detailed in section 2 above, the Trust has agreed an additional £0.6million income from commissioners in 2016-17;

- the Trust has set itself an ambitious CIP target of £4million for 2016-17. Although national guidance would suggest that CIP should be reduced to 2% of Trust income for 2016-17 - which would have otherwise resulted in a target of £1.5million once ring-fenced services have been excluded - an additional £2.5million has been added to the organisation's CIP target. This is to cover cost pressures arising from ensuring the resilience of small-scale services, as well as funding for agency staff on a recurrent basis within agreed limits;

- the Trust will be aiming for a 2016-17 CQUIN target of £1.8million, although the details of the corresponding schemes are yet to be negotiated and agreed with the GCCG;

- income inflation has been set at 3.1% which includes the pension cost increase for 2016-17;

- as noted in section 4 above, it is estimated that in 2016-17, 15 WTE posts will be removed from Trust structures as a result of reduced funding from Gloucestershire County Council: however, there will remain cost pressure upon the Trust of £0.3million;

- the result of the above modelling is that the Trust will exit 2016-17 with a surplus of £1.1million of which £0.4million is recurrent.

It is anticipated that the above factors will have no detrimental impact upon the Trust's forecast financial risk ratings.

The above is summarised in the table below:

	2015-16 (£000s)	2016-17 (£000s)
Income	111.4	111.3
Pay costs	80.3	81.3
Non-pay costs	28.6	28.9
Surplus	2.5*	1.1

*Includes the additional £1.5m Department of Health funding

5.2 Efficiency savings for 2016-17

Cost Improvement Programme

The Trust is currently working toward the following CIP programme for 2016-17:

	Income (£000s)	Pay (£000s)	Non-Pay (£000s)
CIP total	350	2,650	1,000
	4,000		

As noted within section 3.3 above, all CIP schemes will be supported by a detailed and robust Quality Equality Impact Assessment in order to validate the impact of change processes upon the Trust's services, service users and colleagues.

Agency rules

As noted in section 3 above, in order to ensure oversight of the Trust's compliance with the rules on agency staff, the Trust has already established an Agency Usage Group.

Work overseen and assured by this group within 2015-16 included the following:

- ensured the robustness of a revised inpatient staffing model as validation for the proposed relaxation of the previous 1:8 staff: service user ratio (this work included the re-alignment of bed numbers on some wards in order to make more efficient use of available staffing);

- provided regular and timely data on staff, as well as bank and agency use, across the community hospitals, at ward level, day by day, with more detailed ad hoc analysis when necessary;

- recruited 45 new healthcare assistants for the community hospitals, thereby resulting in less reliance upon agency staff;

- re-negotiated agency rates with approved agencies, and moved away from organisations not on an authorised framework.

As a result of these activities, the Trust identified approximately £0.5million reduction in agency costs up to the end of December 2015.

In 2016-17, the Group aims to oversee the following activities:

- to routinely monitor the Trust's agency spend against a trajectory that will open at £0.2million per month in April 2016 and decrease to £0.14million by March 2017;

- to evaluate implementation of the revised ward staffing ratios so as to assure no quantifiable detrimental impact upon service user quality, safety or experience;

- to investigate opportunities to introduce incentives as a means of encouraging an increased number of staff to use bank arrangements as opposed to agency;

- to ensure that agency usage is assessed and controlled across all of the Trust's services, including ICTs, children and young people's services and countywide services.

Procurement

In 2016-17, the Trust aims to build upon the processes and procedures that it has introduced so as to ensure optimum control over procurement practices. In particular, this includes a challenge to the organisation to more diligently use purchase orders as a way of managing spend.

The Trust also remains fully committed to ensuring that it pays only the best price for its equipment and supplies.

5.3 Capital planning

In 2016-17, the Trust is planning for the following capital spend in 2016-17:

	Total (£000s)	Q1 (£000s)	Q2 (£000s)	Q3 (£000s)	Q4 (£000s)
Consolidation of estates across Gloucester into a single owned site at Hatherley Road in order to make optimum use of resources in line with the aspirations detailed in section 1.1.5 above	**2,000**	-	1,000	1,000	-
Replacement of IT (rolling programme of hardware upgrades)	**500**	125	125	125	125
Replacement of IT WAN / LAN (necessary upgrade of N3 connection across the county)	**500**	300	200	-	-
Building compliance primarily in order to meet standards prescribed by the CQC (see section 1.2.2 above)	**1,000**	250	250	250	250
Building reconfiguration: this will be in respect of redesigning MIiUs / urgent care centres in light of the national requirement to improve access (see section 3.2 above)	**500**	125	125	125	125
Further development of SystmOne so as to ensure the ability to undertake e-prescribing as identified under the Digital Roadmap (see section 1.2.2 above)	**500**	125	125	125	125
Total	**5,000**	**925**	**1,825**	**1,625**	**625**

6. Link to the emerging Sustainability and Transformation Plan

At the time of writing this draft of the Operational Plan, the Trust is still in the early stages of dialogue with other stakeholders with regard to the Sustainability and Transformation Plan (STP).

As already stated in section 1 above, both the Trust and its partner organisations are committed to ensuring a seamless and consistent model of care for Gloucestershire, and this ambition will become evident as the STP is developed over the coming months.

February 2016

Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 22 March 2016

Agenda Item:	21
Agenda Ref:	21/0316
Author:	Glyn Howells, Director of Finance
Presented By:	Glyn Howells, Director of Finance
Sponsor:	Glyn Howells, Director of Finance

Subject:	Budget Approval

This report is provided for: ☐ Discussion ☐ Decision ☒ Approval ☒ Assurance ☐ Information

Executive Summary:

The draft annual plan was submitted based on estimated outturn for 2015/16 and estimated contractual position. Other than minor changes this has been encapsulated in the draft contract extension that GCS will sign with the CCG.

Individual budget holders have been through budgets, establishment, changes and cost pressures which were then summarised to the executive team for them to approve the principle of budgeting Pay at actual increment point and vacancies at bottom of pay band; and also to approve which identified budget pressures to relieve.

Individual budget holders will have their budgets and the bridge from previous year communicated out to them for the start of 2016/17 financial year and be invited to meeting to sign off their budgets, get a refresher on the scheme of delegation and be taken through the CIP processes for the year.

Total Trust budget for the year in line with annual plan is:

£m	2015/16	2016/17
Income	111.4	111.3
Pay	80.3	81.3
Non-Pay	28.6	28.9
Operational Surplus	**2.5**	**1.1**

Recommendations:

The Board is asked to: ***note*** *the process followed in setting the annual budget and to* ***approve*** *the attached budgets*

Considerations:

Quality implications: individual CIP schemes will be subject to QEIAs.
Human Resources implications: As laid out in the annual plan
Equalities implications:None
Financial implications: As detailed in the report
Does this paper link to any risks in the corporate risk register: None
Does this paper link to any complaints, concerns or legal claims None

Which Trust strategic objective(s) does this paper Progress (P) or Challenge (C)?	**P or C**
Achieve the best possible outcomes for our service users through high quality care	
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	
Actively engage with health and social care partners as well as local communities, in order to deliver seamless, innovative services across Gloucestershire	
Support individuals and teams to develop the skills, confidence and ambition to deliver our vision	P
Manage public resources wisely to ensure local services remain sustainable and accessible	P

Which Trust value(s) does this paper Progress (P) or Challenge (C)?	**P or C**
Caring	
Open	P
Responsible	P
Effective	P

Reviewed by (Sponsor):	Glyn Howells, Director of Finance

Date:	14 March 2016

Where in the Trust has this been discussed before, e.g. Committee, Programme Board, Group?
Annual plan which informs this has been through Finance Committee and Part 2 Board meetings.

Explanation of acronyms used:

Contributors to this paper include:
Johanna Bogle and Stuart Bird

Gloucestershire Care Services NHS Trust
Trust Public Board Meeting – 22 March 2016

AGENDA ITEM 21.1: BUDGET APPROVAL

1. Purpose
To update the Board on the processes followed in setting the budget and gain Board approval of final budgets.

2. Recommendations
The board is asked to approve the budgets for both income & expenditure and capital spend.

3. Background
The Trust was required to submit a draft annual plan in early February based on likely out-turn and expected contracting arrangement with commissioners. This was submitted following detailed review of assumptions at Finance Committee and Part 2 Board.

Separately, discussion have been ongoing with the 50 budget holders in the Trust regarding their likely outturn; changes in their service specification or delivery and cost pressures etc..

The bottom up budgeting process has then been aligned with the top down planning to produce a revised set of budgets that reflects internal cost pressures and changes and external changes in contracting arrangements.

4. Discussion of Issues
The Trust is now very close to signing a one year extension to its original 3 year contract with the clinical commissioning group. The contractual agreement that will be signed is very close to the annual planning assumptions that informed the first version of the annual plan. There is more clarity about the scale and remit of the public health reductions but other than that the assumptions have been validated by the contracting round.

The Finance team have been in discussion with all budget holders and the following steps gone through:

a) All Cost centres distributed with current WTE budgets for validation, with names in post where possible.
    a. Costed at scale-points for in post and bottom of scale for vacancies;
b) Budget holders met with to go through staffing and potential changes for next year (cost pressures, CIP targets, cleaning up of coding and budgets)
c) Communications sent by email outlining process, deadlines and expected outcomes on:

    a. 30/11/2015
    b. 15/12/2015
    c. 12/01/2016

d. Communication sent out on 23/02/2016 for updates on the process and requests for feedback where the approach being suggested not work
e. Communication due out following exec approval of pay budgeting principle and approval for cost pressures relief.

5. Financial implications

The Trust is budgeting income and expenditure (split between pay and non pay) as laid out below:

£m	2015/16	2016/17
Income	111.4	111.3
Pay	80.3	81.3
Non-Pay	28.6	28.9
Operational Surplus	**2.5**	**1.1**

n.b. 2015/16 include £1.5m capital to revenue transfer.

To deliver this the Trust will need to make £4.0m of CIP savings in line with the draft CIP plan discussed at Finance Committee.

In addition the Trust is budgeting to spend £5m on a capital programme which again has been reviewed at Finance Committee and Part 2 Board and includes rolling £1.5m from financial year 2015/16. All capital schemes will be self-funded (no expectation of DH funding).

All budget holders will have their budgets sent out to them at the end of March with a bridge from this years out-turn; they will all then be invited to one of two meetings where they will:

a) Go through bridge from prior year
b) Signoff receipt and understanding of their budgets
c) Be taken through this year's CIP schemes
d) Be taken through the revised scheme of delegation
e) Have any queries answered re: finance
f) Be offered the chance to feedback on this year's budgeting process for improvement for next year.

6. Implications for Equalities (Black and Other Minority Ethnic/Disability/Age Issues)

None

7. Consultation and Communication including Public Involvement

None

8. Links to:

Strategic objectives 5.

Appendix 1: Bridge between 2015/16 recurrent outturn and 2016/17 budgets.

Prepared by: **Glyn Howells – Director of Finance**
Presented by: **Glyn Howells– Director of Finance**

Budget Approval - Appendix 1						
All values in £000's						
			LTFM starting point	*Proposed Recurrent Changes 2016/17*	*Total Proposed Recurrent 2016/17*	*Proposed Non-Recurrent 2016/17*	*Total Budget proosed 2016/17*
Income		ICTs	2,630	***657***	***3,287***	***0***	***3,287***
Income		CYPS	749	***0***	***749***	***0***	***749***
Income		Capacity	2,192	***18***	***2,210***	***0***	***2,210***
Income		Countywide	3,312	***(1,037)***	***2,275***	***0***	***2,275***
Income		Community Hospitals	1,296	***1***	***1,297***	***0***	***1,297***
Income		Estates and Hotel Services	215	***1***	***216***	***0***	***216***
Income		Scheduled Care Mgt	0	***0***	***0***	***0***	***0***
Income		Nursing and Quality	248	***0***	***248***	***0***	***248***
Income		Medical Director	0	***0***	***0***	***0***	***0***
Income		Cap'l Charges & Depreciation	113	***0***	***113***	***0***	***113***
Income		Reserves	0	***0***	***0***	***0***	***0***
		Corporate Summary	95,656	***2,738***	***98,394***	***2,700***	***101,094***
Income			***106,410***	***2,378***	***108,788***	***2,700***	***111,488***
Pay		ICTs	18,449	***100***	***18,548***	***0***	***18,548***
Pay		CYPS	12,376	***332***	***12,708***	***0***	***12,708***
Pay		Capacity	4,846	***107***	***4,953***	***0***	***4,953***
Pay		Countywide	14,116	***(272)***	***13,844***	***0***	***13,844***
Pay		Community Hospitals	19,099	***448***	***19,546***	***0***	***19,546***
Pay		Estates and Hotel Services	3,696	***82***	***3,778***	***0***	***3,778***
Pay		Scheduled Care Mgt	147	***(38)***	***109***	***0***	***109***
Pay		Nursing and Quality	1,841	***173***	***2,013***	***0***	***2,013***
Pay		Medical Director	91	***25***	***115***	***0***	***115***
Pay		Cap'l Charges & Depreciation	0	***0***	***0***	***0***	***0***
Pay		Reserves	0	***418***	***418***	***1,000***	***1,418***
		Corporate Summary	3,957	***(194)***	***3,763***	***750***	***4,513***
Pay			***78,618***	***1,179***	***79,797***	***1,750***	***81,547***
Non-Pay		ICTs	1,684	***317***	***2,001***	***0***	***2,001***
Non-Pay		CYPS	808	***(26)***	***782***	***0***	***782***
Non-Pay		Capacity	774	***(100)***	***674***	***0***	***674***
Non-Pay		Countywide	6,747	***25***	***6,772***	***0***	***6,772***
Non-Pay		Community Hospitals	8,825	***277***	***9,102***	***0***	***9,102***
Non-Pay		Estates and Hotel Services	2,492	***225***	***2,717***	***0***	***2,717***
Non-Pay		Scheduled Care Mgt	0	***(1)***	***(1)***	***0***	***(1)***
Non-Pay		Nursing and Quality	1,369	***45***	***1,414***	***0***	***1,414***
Non-Pay		Medical Director	0	***1***	***1***	***0***	***1***
Non-Pay		Cap'l Charges & Depreciation	1,446	***270***	***1,716***	***0***	***1,716***
Non-Pay		Reserves	0	***56***	***56***	***0***	***56***
		Corporate Summary	3,932	***(588)***	***3,343***	***250***	***3,593***
Non-Pay			***28,077***	***500***	***28,577***	***250***	***28,827***
Surplus / (Deficit)			***(285)***	***699***	***414***	***700***	***1,114***
		Income / (Expenditure) Movements and Budgets per Directorate					
		ICTs	(17,504)	241	(17,263)	0	(17,263)
		CYPS	(12,436)	(305)	(12,741)	0	(12,741)
		Capacity	(3,429)	11	(3,418)	0	(3,418)
		Countywide	(17,551)	(790)	(18,340)	0	(18,340)
		Community Hospitals	(26,627)	(724)	(27,351)	0	(27,351)
		Estates and Hotel Services	(5,973)	(306)	(6,279)	0	(6,279)
		Scheduled Care Mgt	(147)	39	(108)	0	(108)
		Nursing and Quality	(2,961)	(218)	(3,179)	0	(3,179)
		Medical Director	(91)	(25)	(116)	0	(116)
		Cap'l Charges & Depreciation	(1,333)	(270)	(1,603)	0	(1,603)
		Reserves	0	(475)	(475)	(1,000)	(1,475)
		Corporate Summary	87,767	3,520	91,287	1,700	92,987
			(285)	**699**	**414**	**700**	**1,114**

Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 26th March 2016

Agenda Item:	22
Agenda Ref:	22/0316
Author:	Glyn Howells – Director of Finance
Presented By:	Nicola Strother Smith, Non-Executive Director
Sponsor:	Nicola Strother Smith, Non-Executive Director

Subject:	Charitable Funds Committee Report

This report is provided for: ☐ Discussion ☐ Decision ☐ Approval ☒ Assurance ☐ Information

Executive Summary:

The Trust Board are asked to received assurance that the following items were **APPROVED** by the Charitable Funds Committee:

- The 19th October 2015 Committee meeting minutes (appendix 1)
- The Annual Report and Accounts (appendix 2)
- A revised Committee Forward Planner
- An interim investment strategy

The Trust Board are asked to receive assurance that the following items were **NOTED** by the Charitable Funds Committee:

- An analysis of the history on donations and legacies to understand likely future funding
- The approved and rejected application for Charitable funds (there were none large enough to require Committee approval)
- An update from the Brokenborough sub-committee on progress and next steps
- The review of the risk register

Recommendations:
The Board is asked to: The Board is asked to receive the report, the approved minutes of the Charitable Funds Committee held on 19th October 2015 and the submitted annual report and accounts.

Considerations:
Quality implications: N/A
Human Resources implications: N/A
Equalities implications: N/A
Financial implications: N/A
Does this paper link to any risks in the corporate risk register: No
Does this paper link to any complaints, concerns or legal claims No

Which Trust strategic objective(s) does this paper Progress (P) or Challenge (C)?	**P or C**
Achieve the best possible outcomes for our service users through high quality care	P
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	P
Actively engage with health and social care partners as well as local communities, in order to deliver seamless, innovative services across Gloucestershire	P
Support individuals and teams to develop the skills, confidence and ambition to deliver our vision	P
Manage public resources wisely to ensure local services remain sustainable and accessible	P

Which Trust value(s) does this paper Progress (P) or Challenge (C)?	**P or C**
Caring	P
Open	P
Responsible	P
Effective	P

Reviewed by (Sponsor):

Date:	

Where in the Trust has this been discussed before, e.g. Committee, Programme Board, Group?

Explanation of acronyms used:

Contributors to this paper include:

CHARITABLE FUNDS COMMITTEE MARCH 2016 REPORT

Introduction

This report provides an executive summary of the key issues and subsequent actions arising from the Charitable Funds Committee meeting held on 19th January 2016. The minutes of the 19th October meeting were approved and can be seen in Appendix 1. It is the following issues that the Committee Chair and Finance Director would like to draw to the Trust Board's attention:

Current Funds, Donation and Legacies.

The Committee had asked for some historical analysis of the rates of donations and legacies. Analysis was presented which showed that donation had been dropping over the last 3 years but had been masked by one or two large legacies; historically the legacies have been effectively keeping the fund topped up and the change that has started depleting the funds has been the drive to get the funds being used which has increased over the last 2 years.

The Director of Finance sought approval to contact Great Western Hospital to ask them to fund the 50% of fees to date on getting Brokenborough legal resolution which was given.

The Heads of Estate and Comms are to visit other Trust's to understand what they do to generate donations and will feed back at the next committee to advise on whether to invest in resource to try to increase donations.

Use of Funds

The Head of Estates took the Committee through the detail of how funds had been used.

The Committee debated what funding the Charity should make towards "cultural change events" such as staff celebration and sharing learning events. The Director of HR undertook to do some research and draft a report for the Committee to review.

Other than the note above the Committee supported the approvals and rejections made by the executive members since the last Committee.

Legacy at Brokenborough

The Committee received an update from the Brokenborough joint sub-committee with GWH. The loose tenancy arrangement on the land has now been formally wiaived by the tenant and progress is being made with procurement to select a developer to work up a proposal for the development of the land. This appointment is expected before the end of the financial year.

Risk Register

The Committee reviewed the risk register and thanked the Head of estates for preparing this.

Annual Report and Accounts.

The Committee reviewed the draft annual report and accounts and made some minor amendments then approved them for submission. It was noted that the Trust's auditors KPMG had audited the accounts and raised no concerns. These are aatached at Appendix 2.

Terms of Reference

The Committee reviewed some amendments to the terms of reference (TOR); requested some changes and asked that these be circulated in advance of the next Committee meeting. Once these are approved by the Committee they will be included in the annual update of Committee TOR that are taken through Audit and Assurance Committee prior to being approved at Board.

Definitions of Funds

The Committee debated the current definitions of the funds and felt that drop in donations may be due to breaking the link between a geographical fund and the person making the donation (e.g. A hospital or a community team feels more real to someone making a donation than a nebulous Countywide fund). The executives were asked to look at potentially reinstating the locality based funds that had previously been in place.

Investment Strategy

The Director of Finance presented a draft investment strategy to operate until funds increase above a year's expected spend. The Committee approved the interim investment strategy and asked that it be reviewed once we have an idea of when funds are likely to increase above a year's expected spend.

Report prepared by: Glyn Howells, Finance Director
Report Presented by: Nicola Strother Smith, Chair, Charitable Funds Committee and Non- Executive Director

Appendix 1: Approved minutes of Charitable Funds Committee meeting: 19th October 2015

Appendix 1

Gloucestershire Care Services NHS
NHS Trust

Minutes of the Charitable Funds Committee

Boardroom, Edward Jenner Court

Monday 19th October 2015 – 1.00pm – 3.00pm

Committee Members present:

Nicola Strother Smith (NSS) – Non-Executive Director (Chair)
Rob Graves (RG) – Non-Executive Director
Glyn Howells (GH) – Director of Finance
Tina Ricketts (TR) – Director of HR
Susan Field (SF) – Director of Nursing

In attendance:

Mark Parsons (MP) – Head of Estates
Amruta Hiremath (AH) – Head of Financial Accounts
Jenny Goode (JAG) (Executive Assistant - minute taker)

Item	Minute	Action
CFC 34/15	**1. Welcome and Apologies** The Chair welcomed the Director of Nursing to the meeting and congratulated her on the appointment to post. The Chair also welcomed Amruta Hiremath, Head of Financial Accounts, to her first meeting of the committee.	
CFC 35/15	**2. Confirmation that the meeting is quorate** The meeting was confirmed as quorate by the Chair. Following a discussion about Membership of the Committee it was agreed that The Director of Finance will bring revised Terms of Reference to the next meeting of the Committee on 19th January 2016 to reflect recent changes in management responsibilities.	Director of Finance
CFC 36/15	**3. Declarations of Interests** Members were asked to declare any updates from their original declaration of interests and to declare interests at the time of any concerned agenda item. No updates or interests were declared.	
CFC 37/15	**4. Minutes of the meeting held on 14th July 2015** The minutes of the meeting held on 14th July 2015 were **Received** and **Approved** as an accurate record subject to the	

	following comment: CFC 26/15 – following a query from Rob Graves regarding the >£10k rule for bids requiring committee approval, the Director of Finance agreed that the limit be adjusted to >£5k. The Director of Nursing confirmed that as far as operational teams are concerned, they already work to this limit.	Director of Finance
CFC 38/15	**5. Matters Arising and Action Log** The following matters were **Discussed** and **Noted:** CFC 44/14 – Glos Arthritis Trust – reassigned to Director of Finance CFC 46/14 – Guidance on Charitable Funds Spend – item superseded and now closed. CFC 53/14 – complete; action closed. CFC 57/14 – complete; action closed CFC 9/15 – complete; action closed CFC 11/15 – complete; action closed CFC 12/15 – complete; action closed CFC 13/15 – complete; action closed CFC 20/15 – complete; action closed CFC 22/15 – complete; actions closed CFC 23/15 – Amendment to action: funds will be merged into seven groups and not six. Action complete; actions closed CFC 24/15: Legacy Gifts – Head of Estates to circulate spreadsheet showing history of legacy gifts to all members of the Committee. Fundraising campaigns that do not conflict with LoF. The Committee agreed that there is a need to revisit six or seven funds and review the purpose for each fund. Following this staff can be advised how they access these funds. Head of Estates to bring back proposal to next meeting, CFC 25/15 – spreadsheet showing quarterly receipts for donations received over the last two years to be circulated to members of committee.	Head of Estates Head of Estates Director of Finance

	CFC 26/15 – Bids requiring committee approval: Health visiting – part funding – Head of Estates will circulate papers to Committee members before next meeting to be held on 19th January 2016. "Recognition Fund" – to be discussed under item "Charitable Funds Application Guide" on this agenda. CFC 27/15 – complete; action closed CFC 28/15: a) Meeting held – action complete b) Internal Communications Plan – item deferred to 19th January 2016 CFC 29/15 – complete; action closed CFC 31/15 – Director of Finance met with NSS/RG. Draft accounts to be approved at 19th January 2016 meeting. Director of Finance to circulate prior to meeting. KPMG will audit in time for accounts to be filed at end of January 2016 – Director of Finance to check date.	Head of Estates Head of Communications Director of Finance
CFC 39/15	**6. Forward Planner** The Forward Planner was **Discussed** and **Approved** subject to the following amendments/comments: **19th January 2016:** Trust Deed Report – Director of Finance to query with Head of Corporate Governance whether this is a statutory requirement. Rob Graves queried whether the organisation should be considering an investment strategy and it was agreed that this will be an item for discussion at the next meeting on 19th January 2016. Director of Finance to discuss further with the Head of Financial Accounts and report back with a proposal to the next meeting. **13th July 2016:** Annual Report Following a query raised by the Director of Nursing, the Committee **Agreed** that the Risk Register should appear on the Forward Plan for each meeting. The Chair invited the meeting to suggest items that should be included on the Risk Register and the following were put forward:	Director of Finance JG Director of Finance / Head of Financial Accounts JG

	• Cash-flow • Absence of an investment strategy • Reduction in legacies and donations • Relationship with League of Friends • Inappropriate delay in using restricted funds • Lack of clarity for Trust colleagues in how to access funds • Whether or not we have clarified what is legitimately spent through funds • Lack of clarity and decision and reputational issues Any further ideas/thoughts to be sent to the Director of Finance. In order to progress this, it was agreed that a monthly meeting is arranged involving the Director of Finance, the Director of Nursing, the Director of HR, the Head of Estates and the Head of Financial Accounts. This meeting to be held in between Charitable Funds Committee meetings.	All Director of Finance
CFC 40/15	**7. Current Funds, legacy gifts and donations** The Chair welcomed the Head of Financial Accounts, Amruta Hiremath, to the meeting. The Head of Financial Accounts thanked the Chair and explained that she had only recently been appointed to post, but plans to produce a more comprehensive report for future meetings. She highlighted the following points from her report: • 45 funds now consolidated into 11 funds • Donations are reducing significantly in terms of numbers • New column "commitments" has been included in the summary of fund balances to show where approval has been granted, but funds not yet paid out and AH will include more detail in this column in future report The following issues were subsequently raised and discussed by the Committee: In order to analyse expenditure, should we show what funds are actually spent on and also the location it relates to, i.e. hospital, community area, so that we can see a pattern over time. Consolidation of Charitable Fund spreadsheet: remove pence and round up to nearest pound.	Head of Financial Accounts Head of Financial Accounts Head of Financial Accounts

	Need to provide guidance around when staff can access Charitable funds for training. Restricted Funds: Director of Finance to report back to the next committee on 19th January 2016 on the following matters: • Brokenborough – figure shown is land value not cash value and Rob Graves asked that this is made clear • Rowcroft • Children's Palliative OT – discuss with Janet Mills • R J Page – investigate restrictions relating to this fund.	Director of Finance Director of Finance
CFC 41/15	**8. Bids requiring Committee approval and LoF / Giving to Glos Activity** The Head of Estates presented his report to the Committee and the following issues were discussed: The Director of Nursing queried why the request for Optometry Services in Forest Hospitals was rejected when other requests for equipment had been approved. The Head of Estates explained they need to consider whether any ongoing costs are associated with requests received. The Director of Nursing queried why an application has been approved for a bid for Tracheostomy training aids. The Director of Finance explained that the Head of Service had sanctioned the request. It was agreed that in future applications will be discussed at monthly meetings involving Executive team members. The Chair commented that it was useful to see a summary of expenditure. Rob Graves said that we want to encourage people to come forward with ideas and in order for them to do this we need to ensure there is clarity about the process. It was agreed that the Director of Nursing will be a counter-signature on applications for Charitable Funds. **Bids**: **Dr. Simon Opher – bid for £10k for setting up allotments at Vale Hospital**	Director of Finance Director of Finance

	The Head of Estates updated the Committee on this Bid. He confirmed that indemnities would be in place and occupancy arrangements would be arranged. The Head of Estates was asked to clarify whether Dr Opher is acting alone with this bid request, or part of a group. The Head of Estates to update the Committee once this has been clarified. The Director of Nursing queried whether local schools will be involved, but the Director of HR raised an issue around governance / liability. Following the above discussions, the Committee **agreed** to **approve** the application with the caveat that the necessary governance arrangements are in place. **Paul Jennings – bid for £17,088 for celebration event** The Chair asked that any future bids of a similar nature are approved before events take place. The Director of Finance explained that this request relates to trying to reinforce cultural change in the organisation and celebrating people taking ownership of their roles. He stressed that this is not core NHS business. Rob Graves said that he found it very hard to distinguish from any other form of sharing best practice in the organisation. He also said that there is a need to be careful in that you are not setting precedence by approving this request. Following discussion the committee **agreed** to **approve** the bid, but asked that any future requests are put to the Committee in advance of the event taking place and requested that this is shared with colleagues.	Head of Estates Director of Finance
CFC 42/15	**9. Minutes of Brokenborough Sub-Committee held on 19th August 2015** The Minutes were taken as read.	
CFC 43/15	**10. Brokenborough – use of funds** The Director of Finance briefed the committee on various matters since the Brokenborough sub-committee had taken place: The Land Agent has approached the Farmer, but now feels there is a conflict of interest. The Head of Estates will follow this up.	

	Procurement process will soon be under way. There is a need to show what investment will be made in Cirencester and Fairford. The Director of Finance will put together ideas for discussion at Board Summit being held at the beginning of December. The Director of Finance to arrange a meeting with various organisations re. Cirencester and Fairford configuration. The Committee thanked the Director of Finance for the verbal update and requested feedback at the next meeting scheduled for 19th January 2016.	Director of Finance Director of Finance Director of Finance
CFC 44/15	**11. Charitable Funds Application Guide** The Head of Estates presented his report to the meeting. The following comments were made: • GCS logo to be inserted on the Guidance document • Timescale for response to be included on email acknowledgement • Remove names from the process chart and include job titles only • Head of Estates to revise application form and include Director of Nursing as counter-signature • Health and Safety to be incorporated Subject to the above comments and suggested changes, the Committee **approved** the forms/process.	Head of Estates
CFC 45/15	**12. Internal Communications Plan** Deferred for discussion at 19th January 2016 meeting	Head of Communications and Marketing
CFC 46/15	**13. Any Other Business**	
a)	The Director of Finance explained that bids are coming together for the Marketplace in Cirencester and said that we need to clarify what we are trying to achieve there in order to get consistency.	
	There were no further AOB items.	
	The Chair thanked everyone for attending the meeting and the meeting was closed by the Chair at 3.05p.m.	
	Date/time of next meeting:	

	The next meeting is scheduled to be held on Tuesday 19th January 2016 at 10a.m. and will be held in the Boardroom at Edward Jenner Court.	

Committee Chair ……

Date: ……

Gloucestershire Care Services NHS
NHS Trust

Trustee's Annual Report for Gloucestershire Care Services NHS Trust charities for the year ended 31 March 2015

Gloucestershire Care Services NHS Trust Charities Annual Report

Trustee's Annual Report for Gloucestershire Care Services NHS Trust Charities for the year ending 31 March 2015

1 Foreword

The Corporate Trustee presents the Charitable Funds Annual Report together with the audited financial statements for the year ended 31 March 2015.

The Charity's Annual Report and Accounts for the year ended 31 March 2015 have been prepared by the Corporate Trustee in accordance with the Charities Act 2011, and the Charities (Accounts and Reports) Regulations 2005. The Charity's Accounts and Report include all the separately established funds from which Gloucestershire Care Services NHS Trust is the beneficiary.
The Charitable Funds are registered with the Charity Commission (registration number 1096480) in accordance with the Charities Act 2011.

1.1 Reference and Administrative details

The group Charity 'Gloucestershire Care Services NHS Trust Charities', registered charity number 1096480, was registered on 8 May 2003. The group Charity has one active charity linked to it being Brokenborough Fund.

Charitable Funds received by the Charity are accepted, held and administered as funds and property held on trust for purposes relating to the Health Service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990, and these funds are held on trust by the Corporate Body.

The charity operates in accordance with the terms set out in the declaration of trust dated 8 April 2003, as amended by the supplemental deed date 28 June 2007.

1.2 Trustees

The following full members of the Trust Board are the named Trustees of the charitable fund and have served during the year.

Ingrid Barker – Chair

Paul Jennings - Chief Executive Officer

Glyn Howells – Director of Finance

Liz Fenton – Director of Nursing and Quality

Mike Roberts – Interim Medical Director

Jason Brown – Director of Corporate Governance and Public Affairs (Board Secretary)

Joanna Scott – Non Executive Director

Robert Graves – Non Executive Director

Richard Cryer – Non Executive Director

Sue Mead – Non Executive Director

Nicola Strother Smith – Non Executive Director

Chris Creswick – Non Executive Director

1.3 Charitable Funds Advice to the Board

Gloucestershire Care Services NHS Trust is the Corporate Trustee of Gloucestershire Care Services NHS Trust Charitable Fund. Only full members of the Trust Board can be Trustees.

Gloucestershire Care Services NHS Trust is the main beneficiary of the Charity and is a related party by virtue of being the Corporate Trustee. By working in partnership with the Trust the Charitable Funds are used to best effect. When deciding upon the best use of the Charitable Funds, the Corporate Trustee takes into consideration the main activities, objectives, strategies and plans of the proposed beneficiary.

1.4 Principal Office

Gloucestershire Care Services NHS Trust
Edward Jenner Court
1010 Pioneer Avenue
Brockworth
Gloucester
GL3 4AW

1.5 Principal Professional Advisers

Bankers
Citibank N.A
London Branch
Canary Wharf
London
E14 5LB

Royal Bank of Scotland Group plc
1 Redheughs Avenue
Edinburgh
EH12 9JN

Auditors
KPMG LLP
100 Temple Street
Bristol
BS1 6AG

Solicitors
Field FisherWaterhouse LLP
35 Vine Street
London
EC3N 2AA

2 Structure, Governance and Management

The Charity's unrestricted fund was established using the model declaration of trust. The restricted funds were separately registered under the group Charity. All funds held at the date of registration either formed part of the unrestricted or restricted funds. Subsequent donations and gifts received by the Charity that are attributable to the original funds have been added to those fund balances within the existing charity.

The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objects of each fund and by designating funds; in this way the Trustee is able to respect the wishes of the donors, to benefit patient care and advance the good health and welfare of patients and staff. The charitable funds available to spend are held within the fund categories described in note 10 of the accounts.

Executive members of the Board are subject to recruitment by the NHS Trust Board. Core membership of the Charitable Funds Committee consists of the Chair of the Trustees, a Non-Executive Director appointed by the Trust Board; the Director of Finance and; one other Non-Executive Director. Members of the Trust Board and the Charitable Funds Committee are not individual Trustees under Charity Law, but act as agents on behalf of the Corporate Trustee.

The Trust undertakes induction training for newly appointed members of the Trust Board and Charitable Funds Committee. The induction involves a presentation and a pack of information which includes: copies of the governing documents of the charities; a copy of the latest Annual Report and Accounts; Policies and Procedures, and; the Charity Commission document 'The Essential Trustee: What you need to know'.

The Charitable Funds Committee is responsible for the overall management of the Charitable Funds. The Committee is required to:

a Support the Board in its duty to ensure the Trust has the systems to effectively manage Charitable Funds.

b Ensure the audit processes performed by both external and internal audit in the area of Charitable Funds effectively deal with the traditional requirements of:

- True and accurate accounting records;
- Safeguarding of assets;
- Compliance with appropriate accounting policies, standards and Charity Law;
- Detection of fraud and irregularities.

c Recommend additional policies and procedures to the Board to comply with statutory changes.

d Review annual financial statements and trustees report prior to submission to the Board.

e Consider any other matters relating to charitable funds referred to it by the Board.

f Receive advice from representatives of the other beneficiaries as to how their funds should be expended.

The accounting records and the day-to-day administration of the funds are dealt with by the Finance Department located at Edward Jenner Court, 1010 Pioneer Avenue, Gloucester Business Park, Gloucester, GL3 4AW.

3 Risk Management

The amount of funds held in respect of charitable funds is considered too small to support an investment portfolio. The Trustee does not consider there to be any major risks associated with the charitable funds due to the nature of the charitable activities undertaken. Funds spent during the year will be no more than the balance held.

No transaction can be approved without a signatory of either the Director of Finance or the Director of Corporate Governance and Public Affairs. Plans to spend over £5,000 must be presented to the next Trustee's meeting for approval.

The Trust provides accounting facilities for the funds. The financial position of any fund can be known at any time, as each fund has a unique code which is debited or credited at the time of a transaction. Transactions are processed through the ledger system. Any balance owing to or from the fund is transferred between the Trust Fund Account and Gloucestershire Care Services NHS Trust's bank account during the financial year.

4 Reserves Policy

The charity aims to expend all funds received within two years of receipt, except where funds are being saved for a specific purpose. Fund balances earn interest during the year from Nat West Bank PLC and Citibank.

5 Objectives and Strategy for the Public Benefit

The core vision of the charity is to enhance the care and treatment of service users accessing NHS services within Gloucestershire Care Services NHS Trust, by raising funds to support high priority areas which are beyond the scope of government funding.

The charity's core objectives are:

- Develop key messages to better connect with the communities served in Gloucestershire to increase awareness of the charity and the ways in which donors can support the Trust.
- Provide support, guidance and encouragement for colleagues to access funds for projects that align to the vision of the charity.
- Deliver practical improvements to the service user environment.
- Encourage new and existing supporters to engage with the charity using a range of media including email, the post, website and telephone.
- Develop a supporter care programme by including an annual thank you event that details the impact that supporters have made over the year.
- Invest in new charity signage, information leaflets, posters and donor collection boxes across key sites. This will lead to an increase in awareness of the charity and may generate enquiries from potential donors.
- Work with grant applicants to ensure that applications clearly demonstrate service user benefit and congruence with Trust policies and plans.

This is an ambitious vision and set of objectives, which the charity will achieve by:

- Generating income through a variety of means;
- Supporting Trust colleagues development to enable them to provide excellent clinical and service user centred care;
- Improving the quality of service user care and experience;
- Effectively managing charitable funds available;
- Improving environments for service users, carers and the Trust colleagues;
- Approving grants which will make a real difference, particularly in respect of support for specialist clinical study and/or research that has the potential to impact on the treatment and well-being of service users and carers.

6 Achievements and performance

The charity is proud to support people from across the county at their time of need, crisis or illness, and is able to provide this help as a result of the generous donations and legacies of local people, organisations and the wider community, and also through the inspirational fundraising activities of NHS colleagues and other organisations and individuals.

Over the years thousands of people have benefited from the kindness of others, with every penny being spent in accordance with the wishes of benefactors. Examples of some of the good causes the charity has sponsored include:

- Study days for clinical staff to enable them to deliver the most up-to-date care practices and to further develop their knowledge and skills, above and beyond that which is currently funded by the NHS.
- Annual subscription membership to the Community Hospital Association.
- Arts in Health – North Cotwolds
- Early discharge stroke equipment and supplies

- Bariatric equipment and furniture
- Specialist furniture
- Christmas gifts for inpatients within the Trust's Community Hospitals
- Toys for the Children's Ward
- Plaques for staff memorials
- Improved signage at various sites throughout the organisation

7 Financial Review

The net assets of the charitable fund as at 31 March 2015 were £286,000 (2014: £358,000). Overall net assets have decreased by 20 percent in the year. In this financial year legacy income and donations dropped by 81 and 67 percent respectively. This was partially compensated by an increase in League of Friends donations by 31 percent. There was a corresponding increase in League of Friends expenditure of 31 percent leading to an overall increase in expenditure of 60 percent as compared to last year. In this financial year £46,000 (2014: £6,000) was spent on patient and staff welfare activities.

The income for the year was £154,000 (2014: £200,000), which included:

- Legacies of £9,000 (2014: £47,000)
- Donations of £14,000 (2014: £43,000)
- Investment income of £1,000 (2014: £1,000)
- Just giving fundraising of £1,000 (2014: £2,000)
- Grants of £0 (2014: £9,000)
- Donations from the League of Friends of £128,000 (2014: £98,000)

Expenditure for the year totalled £226,000 (2014: £142,000), which included:

- Expenditure on charitable activities of £79,000 (2014: £36,000)
- Governance costs of £19,000 (2014: £8,000)
- Expenditure arising from charitable activities relating to League of Friends donations £128,000 (2014: £98,000)

Service users and Gloucestershire Care Services NHS Trust colleagues have benefited greatly from the generosity of family, friends, colleagues and the wider community who have made donations to the charitable fund. Further information about the particular funds can be obtained in the first instance from the charity website www.givingtoglos.org.uk.

Approved on behalf of the Corporate Trustees

Signed: Nicola M. Strother Smith

Date 19.01.2016

Statement of Trustees' responsibilities in respect of the Trustees' Annual Report and the Financial Statements

Under the trust deed of the charity and charity law, the trustees are responsible for preparing the Trustees' Annual Report and the financial statements in accordance with applicable law and regulations.

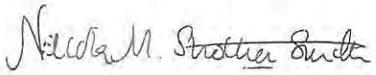
The financial statements are required by law to give a true and fair view of the state of affairs of the charity and of the excess of expenditure over income for that period.

In preparing these financial statements, generally accepted accounting practice entails that the trustees:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable UK Accounting Standards and the Statement of Recommended Practice have been followed, subject to any material departures disclosed and explained in the financial statements;
- state whether the financial statements comply with the trust deed [and rules], subject to any material departures disclosed and explained in the financial statements;] and
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The trustees are required to act in accordance with the trust deed of the charity, within the framework of trust law. They are responsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the charity at that time, and to enable the trustees to ensure that, where any statements of accounts are prepared by them under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision. They have general responsibility for taking such steps as are reasonably open to them to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

The accounts for 2014-15 and the report thereon is approved on behalf of the Corporate Trustee, by members of the Charitable Funds Sub Committee under delegated authority from the Board of Directors on 19 January 2016.

Signed: 

Date: 19.01.2016

Signed 

Date: 19.01.2016

Independent Auditors Report to the Trustees of Gloucestershire Care Services NHS Trust Charitable Fund for the year ended 31 March 2015.

We have audited the financial statements of Gloucestershire Care Services NHS Trust Charities for the year ended 31 March 2015 set out on pages 9 to 16. The financial reporting framework that has been applied in their preparation is applicable law and UK Accounting Standards (UK Generally Accepted Accounting Practice).

This report is made solely to the charity's trustees as a body, in accordance with section 145 of the Charities Act 2011 (or its predecessors) and regulations made under section 154 of that Act. Our audit work has been undertaken so that we might state to the charity's trustees 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 charity and its trustees as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of trustees and auditor

As explained more fully in the Statement of Trustees' Responsibilities set out on page 6 the trustees are responsible for the preparation of financial statements which give a true and fair view.

We have been appointed as auditor under section 145 of the Charities Act 2011 (or its predecessors) and report in accordance with regulations made under section 154 of that Act. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

A description of the scope of an audit of financial statements is provided on the Financial Reporting Council's website at www.frc.org.uk/auditscopeukprivate.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the charity's affairs as at 31 March 2015 and of its incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with UK Generally Accepted Accounting Practice; and
- have been properly prepared in accordance with the requirements of the Charities Act 2011.

Matters on which we are required to report by exception
We have nothing to report in respect of the following matters where the Charities Act 2011 requires us to report to you if, in our opinion:

- the information given in the Trustees' Annual Report is inconsistent in any material respect with the financial statements; or
- the charity has not kept sufficient accounting records; or
- the financial statements are not in agreement with the accounting records; or
- we have not received all the information and explanations we require for our audit.

Jonathan Brown

Jonathan Brown
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
100 Temple Street
Bristol
BS1 6AG

27 January 2016

KPMG LLP is eligible to act as an auditor in terms of section 1212 of the Companies Act 2006

Gloucestershire Care Services NHS Trust Charities
Statement of Financial Activities for the Year Ending 31 March 2015

	Note	Unrestricted Funds £000's	Restricted Funds £000's	**Total Funds 2015 £000's**	Total Funds 2014 £000's
Incoming Resources from Generated Funds					
Voluntary Income		21	3	**24**	90
Investment Income		1	-	**1**	1
Activities for Generating Funds		1	-	**1**	2
Total		23	3	**26**	93
Other Incoming Resources		128	-	**128**	107
Total Incoming Resources	3	151	3	**154**	200
Resources Expended					
Cost of Charitable Activities		46	21	**67**	36
Other Resources Expended		140	-	**140**	98
Total Direct Charitable Expenditure	4	186	21	**207**	134
Governance Costs		5	14	**19**	8
Total Resources Expended		191	35	**226**	142
Net Movement on Funds		(40)	(32)	**(72)**	58
Total Funds Brought Forward		320	38	**358**	300
Total Funds carried forward	10	280	6	**286**	358

Gloucestershire Care Services NHS Trust Charities
Balance Sheet as at the 31 March 2015

	Note	Unrestricted Funds	Restricted Funds	**Total Funds 2015**	Total Funds 2014
		£000's	£000's	**£000's**	£000's
Fixed Assets					
Tangible Assets	7	150	-	**150**	150
Current Assets					
Debtors	8	34	-	**34**	48
Cash in Hand and at Bank		195	39	**234**	224
Total Current Assets		229	39	**268**	272
Creditors: Amounts falling due within one year	9	99	33	**132**	64
Net Current Assets		130	6	**136**	208
Total Net Assets		280	6	**286**	358
Unrestricted Income Funds		280	-	**280**	320
Restricted Income Funds		-	6	**6**	38
Capital in perpetuity		-	-	**-**	-
Total Funds of the Charity	10	280	6	**286**	358

Notes on pages 11 to 16 form part of these accounts

Signed:

Name: Glyn Howells, Director of Finance

Date: 19.01.2016

1 Accounting Policies

a Basis of Preparation

These accounts have been prepared on a going concern basis under the historic cost convention, with the exception of investments which are included at market value, as deemed appropriate by the Trustees. The financial statements have been prepared in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice (SORP 2005) issued in March 2005 and applicable UK Accounting Standards and the Charities Act 2011. The charity qualifies as a small charity and accordingly the charity is exempt from the requirement (as set out in Financial Reporting Standard 1) to prepare a cash flow statement.

b Funds Structure

Restricted Funds are funds, which are to be used in accordance with specific restrictions imposed by the donor.

Unrestricted Funds comprise those funds, which the Trustee is free to use for any purpose in furtherance of the charitable objects.

c Incoming Resources

All incoming resources are included in full in the Statement of Financial Activities as soon as the following three factors can be met:

- Entitlement – arises when a particular resource is receivable or the charity's right becomes legally enforceable;
- Certainty – when there is reasonable certainty that these incoming resources will be received;
- Measurable – when the monetary value of the incoming resources can be measured with sufficient reliability.

d Incoming Resources from Legacies

Legacies are accounted for as incoming resources once the receipt of the legacy becomes reasonably certain. This will be once confirmation has been received from the representatives of the estate that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled.

e Resources Expended

The funds held on trust accounts are prepared in accordance with the accruals concept. All expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party.

f Irrecoverable VAT

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

g Allocation of overhead and support costs

These are accounted for on an accruals basis and are recharges of appropriate proportions of the Gloucestershire NHS Finance Share Service calculated on the basis of staff time. These are apportioned to Charitable Activities and Governance Costs.

i Cost of Charitable Activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the Charity. These costs comprise an apportionment of overhead and support costs.

j Governance costs

Governance costs comprise all costs incurred in the governance of the Charity. These costs include audit charges together with an apportionment of Committee members recharged pay costs (as per note g).

k Tangible fixed assets

Tangible fixed assets are stated at cost, net of depreciation and any provision for impairment. Depreciation is provided on all tangible fixed assets other than freehold land.

m Tax position

Gloucestershire Care Services NHS Trust Charitable Fund is considered to pass the tests set out in Paragraph 1 Schedule 6 Finance Act 2010 and therefore it meets the definition of a charitable trust for UK income tax purposes. Accordingly, the charity is potentially exempt from taxation in respect of income or capital gains received within categories covered by Part 10 Income Tax Act 2007 or Section 256 of the Taxation of Chargeable Gains Act 1992, to the extent that such income or gains are applied exclusively to charitable purposes.

2 Related Party Transactions

During the year none of the members of the NHS Bodies Boards of Directors or key management staff or person(s) related to them have undertaken any material transactions with or been beneficiaries of the Charity. Neither the Corporate Trustee nor any members of the NHS Bodies have received honoraria, emoluments or expenses, and have not purchased Trustee indemnity insurance.

3 Analysis of Incoming Resources

	Unrestricted Funds £000's	Restricted Funds £000's	**Total 2015 £000's**	Total 2014 £000's
Voluntary Income				
Donations	11	3	**14**	43
Legacies	9	-	**9**	47
Miscellaneous Income	1		**1**	
Total	21	3	**24**	90
Investment Income				
Bank Interest	1	-	**1**	1
Total	1	-	**1**	1
Activities for Generating Funds				
Just Giving Fundraising	1	-	**1**	2
Total	1	-	**1**	2
Incoming Resources from Charitable Activities				
League of Friends Donations	-	128	**128**	98
Grants	-	-	**-**	9
Total	-	128	**128**	107

4 Analysis of Resources Expended

	Activities Undertaken £000's	Support Costs £000's	**Total 2015 £000's**	Total 2014 £000's
Staff admin costs	-	12	**12**	8
Medical and surgical equipment	71	-	**71**	53
Training and course fees	1	-	**1**	1
Furniture and fittings	68	-	**68**	48
Computer software	-	2	**2**	9
Patient welfare and amenities	36	-	**36**	5
Staff welfare and amenities	10	-	**10**	6
Other	-	7	**7**	4
Total	186	21	**207**	134

The analysis above represents expenditure of items purchased by both trust charitable funds and league of friends' donated monies
Support costs were allocated against all unrestricted funds, based on their final balance as a proportion of the total funds held.

5 Auditor's Remuneration

The Auditor's remuneration was £4,000 in 2014-15 (£3,000 in 2013-14) and related solely to the Audits in both financial years, no other work was undertaken.

6 Staff Costs

	Total 2015 £000's	Total 2014 £000's
Gross wages, salaries and benefits in kind	**10**	7
Employer's National Insurance costs	**2**	1
Pension costs	**-**	-
Balance carried forward	**12**	8
Average number of staff	**0.2**	**0.2**

The analysis above represents amounts charged to the Charity for staff employed by the NHS Trust. All staff are on standard NHS terms and conditions and are contracted to work with the NHS Trust. There were no staff costs incurred in 2012/13 as the administration of the charity was outsourced to a shared service provider.

7 Tangible Fixed Assets

	Total 2015 £000's	Total 2014 £000's
Balance brought forward	**150**	150
Balance carried forward	**150**	150
Net Book Value 2014	**150**	150

The only fixed asset included in the accounts is for land which is not depreciated. Land at Brokenborough has been referred to legal professionals to transfer ownership back to Gloucestershire Care Services Charitable Funds due to PCT Closures incorrectly allocating this asset to a different NHS Body.

8 Debtors

	Total 2015 £000's	Total 2014 £000's
Trade debtors	**34**	48
Total	**34**	48

9 Creditors

	Total 2015 £000's	Total 2014 £000's
Accruals	**60**	12
Other creditors	**72**	52
Total	**132**	64

Other creditors represents monies owed at the year-end by the Charity to a related party Gloucestershire Care Services NHS Trust, for costs incurred by the NHS Trust on behalf of the Charity in the furtherance of the Charity's objects.

10 Analysis of Charitable Funds

Types of fund held:

- Permanent endowment funds (PE);
- Expendable endowment funds (EE); and
- Restricted income funds, including special trusts of the charity (R).

Fund Name	Type PE, EE or R	Purpose and Restrictions
Childrens Palliative Care	R	Childrens Care Only
Aging Well	R	Elderly Project
Brokenborough	R	Brokenborough Land
J Page	R	Fairford Hospital
Rowcroft Medical Centre	R	Rowcroft Medical

Significant Balances on Restricted and Unrestricted Funds

Fund Name	Adjusted Balance As at 31/03/2014 £000's	Incoming Resources £000's	Resources Expended £000's	**Fund C'fwd As at 31/03/2015 £000's**
Cirencester General Staff Purposes	48	11	-	**59**
North Cotswold General Purposes	24	-	(2)	**22**
Children's palliative OT	14	-	-	**14**
Vale Hospital	12	-	(2)	**10**
J.Page Fund	7	-	-	**7**
George Moore General Purposes	8	-	(1)	**7**
Forest Hospitals General Purpose	2	3	(2)	**3**
Coln Ward Staff	3	-	-	**3**
Stratton Ward	3	-	-	**3**
Art in Health	5	-	-	**5**
Fairford General Purpose	3	-	-	**3**
ESD Stroke Team	2	2	(2)	**2**
North Cotswold General Staff Welfare	2	-	-	**2**
Tewkesbury General Purpose	1	3	(2)	**2**
Diagnostic Suite Moreton	2	-	-	**2**
Other	72	7	(87)	**(8)**
Total	**208**	**26**	**(98)**	**136**
League of Friends donations	-	128	(128)	-
Fixed asset fund	150	-	-	150
Total as per SOFA	**358**	**154**	**(226)**	**286**

Charity Commission has approved consolidation of the above unrestricted funds into six unrestricted funds from the Financial year 2015-16.

Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 22nd March 2016

Agenda Item:	23
Agenda Ref:	23/0316
Author:	Glyn Howells – Director of Finance
Presented By:	Richard Cryer – Non-Executive Director
Sponsor:	Richard Cryer – Non-Executive Director

Subject:	Audit and Assurance Committee Report

This report is provided for: ☐ Discussion ☐ Decision ☐ Approval ☒ Assurance ☐ Information

Executive Summary:

The Trust Board are asked to received assurance that the following items were **APPROVED** by the Audit and Assurance Committee:

- The 18th November 2015 Committee meeting minutes (attached)
- A revised Committee Forward Planner

The Trust Board are asked to receive assurance that the following items were **NOTED** by the Audit and Assurance Committee. The Audit and Assurance Committee:

- Reviewed the Internal Audit Plan and the closure of management actions noted in issued reports;
- Reviewed the External Audit Plan and received confirmation of the materiality that will be used during the audit;
- Received an update from Counter Fraud on performance against the annual planned activity and the reactive investigations;
- Reviewed the position on Debtors and Creditors and received explanation of the balances;
- Reviewed the draft Risk Management policy and gave feedback to be incorporated alongside results from the soon to start Internal Audit of this area. The updated policy is to be brought back to Committee at a later date.
- Discussed the Risk Appetite of the Trust and how to document and use this in practice. Feedback was given on the two draft items which are to be amalgamated and bought back to Committee.

Recommendations:
: The Board is asked to receive the report and the approved minutes of the Audit and Assurance Committee held on 18th November 2015.

Considerations:
Quality implications: N/A
Human Resources implications: N/A
Equalities implications: N/A
Financial implications: N/A
Does this paper link to any risks in the corporate risk register: No
Does this paper link to any complaints, concerns or legal claims No

Which Trust strategic objective(s) does this paper Progress (P) or Challenge (C)?	**P or C**
Achieve the best possible outcomes for our service users through high quality care	
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	
Actively engage with health and social care partners as well as local communities, in order to deliver seamless, innovative services across Gloucestershire	
Support individuals and teams to develop the skills, confidence and ambition to deliver our vision	
Manage public resources wisely to ensure local services remain sustainable and accessible	P

Which Trust value(s) does this paper Progress (P) or Challenge (C)?	**P or C**
Caring	
Open	P
Responsible	P
Effective	P

Reviewed by (Sponsor):	

Date:	

Where in the Trust has this been discussed before, e.g. Committee, Programme Board, Group?

Explanation of acronyms used:

Contributors to this paper include:

AUDIT AND ASSURANCE COMMITTEE JANUARY 2016 REPORT

INTRODUCTION

This report provides an executive summary of the key issues and subsequent actions arising from the Audit and Assurance Committee meeting held on 27th January 2016. The minutes of the 18th November 2015 meeting were approved and can be seen in Appendix 1, and the Forward Planner was reviewed and amended abased on discussions.

The Committee Chair and Director of Finance would like to draw to the Trust Board's attention to the following:

Internal Audit Update.

The Committee was assured that the audits were being completed in line with the plan; good progress is being made in clearing open items from issued reports and a draft plan for next year's audits was presented and discussed.

A final plan is to come back to the next meeting.

External Audit Update

The external auditors updated The Committee on some minor changes in the scope of the audit work to be completed. They confirmed that audit materiality was being calculated as in previous years and for GCS would be £2m with any adjustments greater than £1.5m being reported to the Committee.

The dates of audit work were discussed and the Director of Finance gave the commitment to the auditors that there would not be a repeat of the delays experienced last year in getting statutory accounts to the auditors for their review.

The Auditors comfirmed that they had been involved in discussions around the DTZ revaluation of property assets and the accounting for income from DH to support the capital to revenue transfers and did not forsee any problems with these entries in the accounts during the audit.

Counter Fraud Update

The Head of Counterfraud gave an update on investigation (both completed and ongoing) and also gave an update on performance against the annual plan. Sallie Cheung confirmed that she was retiring from the NHS and that this was her last audit committee meeting for GCS – the Chair thanked her for her support and tenacity in the work undertaken by the team under her leadership. (Post meeting note – Lee Sheridan has been appointed replacement Head of Counterfraud).

Review of Debtors and Creditors

The Deputy Director of Finance took the Committee through an analysis of debtors and creditors. He identified that there are 4 significant debtors to the Trust:

1. Gloucestershire Hospitals NHS FT (GHFT)
2. Gloucestershire County Council (GCC)
3. NHS Property Services Ltd (Propco)
4. Gloucestershire Clinical Commissioning Group. (GCCG)

For GHFT the Board is fully aware of the cause for delays in payments; for GCC, work had just been completed which will see this balance reducing significantly in the next 2-3 weeks; the non-payment of invoices by Propco relates to services provided more than 2 years ago and has been escalated to a national level; the debts outstanding from GCCG are no all cleared. Other than the above 4 debtors, the remainder of money owed are relatively small and in terms of creditors; other than a large creditor to GHFT the balances are small and get paid out promptly.

Risk assessment and Management Policy.

The Director of Finance explained that this was a document created by the previous Trust secretary shortly before leaving and had come to committee as there was nothing on file documenting the Trust's approach. However, the Committee was asked to note the policy as a draft for comment rather than approve it as all risk management documentation and processes were being updated.

Risk Appetite

The Committee discussed two draft statements of risk appetite; Duncan Laird asked how they would be used in practice to inform decision making. GH was tasked to take the two documents away and attempt to merge the best parts of each. This was to come back to the Committee for approval at the next meeting.

Report prepared by: Glyn Howells, Director of Finance
Report Presented by: Richard Cryer, Chair of Committee and Non- Executive Director

Appendix 1: Approved minutes of Audit and Assurance Committee meeting: 18th November 2015

Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 22 March 2016

Agenda Item:	24
Agenda Ref:	24/0316
Author:	Louise Simons, Assistant Trust Secretary
Presented By:	Glyn Howells, Director of Finance
Sponsor:	Glyn Howells, Director of Finance

Subject:	Register of Declaration of Interest

This report is provided for: ☐ Discussion ☐ Decision ☐ Approval ☐ Assurance ☒ Information

Executive Summary:

1. Summary
All Board members are required to comply with the policy on the Code of Business Conduct, and declare their interests. This information will be updated on the website and referenced in the annual report.

2. Publication Under Freedom of Information Act
This paper has been made available under the Freedom of Information Act 2000

Recommendations:

The Board is asked to:

- Note and check the information listed as their personal declaration and should any updates or amendments be required to liaise with the Assistant Trust Secretary.
- Receive for information

Considerations:

Quality implications: None

Human Resources implications:None

Equalities implications:None

Financial implications: n/a

Does this paper link to any risks in the corporate risk register:

Does this paper link to any complaints, concerns or legal claims None

Which Trust strategic objective(s) does this paper Progress (P) or Challenge (C)?	P or C
Achieve the best possible outcomes for our service users through high quality care	
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	
Actively engage with health and social care partners as well as local communities, in order to deliver seamless, innovative services across Gloucestershire	C
Support individuals and teams to develop the skills, confidence and ambition to deliver our vision	
Manage public resources wisely to ensure local services remain sustainable and accessible	P

Which Trust value(s) does this paper Progress (P) or Challenge (C)?	P or C
Caring	
Open	P
Responsible	P
Effective	P

Reviewed by (Sponsor):	Glyn Howells, Director of Finance

Date:	14 March 2016

Where in the Trust has this been discussed before, e.g. Committee, Programme Board, Group?

Explanation of acronyms used:

Contributors to this paper include:

Gloucestershire Care Services NHS
NHS Trust

DECLARATION OF INTERESTS FRAMEWORK - January 2016 - January 2017

		Ingrid Barker	Paul Jennings	Glyn Howells	Duncan Jordan	Richard Cryer	Robert Graves	Susan Mead	Ian Dreelan	Joanna Scott	Nicola Strother Smith	Jan Marriott	Mike Roberts	Tina Ricketts	Candace Plouffe	Susan Field
GOVERNANCE	Declaration of Interests Proforma	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
	Declaration of Interest signed by Board Members	✔	✔	✔	✔	✔	✔	✔	Pending	✔	✔	✔	✔	✔	✔	✔
	Declarations reviewed at Board Meeting - Jan 2016	✔	✔	✔	✔	✔	✔	✔	Pending	✔	✔	✔	✔	✔	✔	✔
MATERIAL INTERESTS	Directorships, including non executive directorships, held in private companies or public limited companies, (with the exception of those of dormant companies).	Board member and Trustee of NHS Providers. Governor Trustee of Hartpury College (Corporation)	Director of Colouring in Consulting Ltd Trustee Extra care Charitable Trust Trustee and Chair Welcome Well Being CIC	Non-Exec position on Health Education England South West Quality Committee		Trustee for: • Action for Children • Aspire Living						Jan Marriott Associates Ltd (Director)		Board Member of NHS Leadership Academy, South West		
	Ownership, part ownership of private companies, businesses or consultancies, likely or possibly seeking to do business with Gloucestershire Care Services NHS Trust, or likely to be considered a potential trading partner with Gloucestershire Care Services NHS Trust.															
	Majority or controlling share holdings in organisations likely or possibly seeking to do business with Gloucestershire Care Services NHS Trust															
	Any connection with an organisation, entity, or company, considering entering into or having entered into, a financial arrangement with the Gloucestershire Care Services NHS Trust, including but not limited to, lenders or banks.	Husband is the Pro-Vice Chancellor of Nottingham Trent University.			On secondment from GCC until the end of March 2016.							Gloucestershire Learning Disability Partnership Board (Gloucester County Council). Independent Chair - Gloucestershire Mental Health Wellbeing Partnership Board (Glos CCG). Gloucestershire Physical Disability and Sensory Impairment Board (Glos CC and CCG).	GP Partner - Rosebank Surgery, Gloucester			
	A position of authority in a charity or voluntary organisation in the field of health and social care services.									Chairman of the Wiggly Worm Charity, Gloucestershire		Gloucestershire Learning Disability Partnership Board (Gloucester County Council). Independent Chair - Gloucestershire Mental Health Wellbeing Partnership Board (Glos CCG). Gloucestershire Physical Disability and Sensory Impairment Board (Glos CC and CCG).			Active Gloucestershire	
	Any connection with a voluntary or other organisation contracting for, or commissioning NHS services.													Chair of South West NHS Graduate Management Trainee Steering Group		
	Research funding / grants that may be received by an individual or their department															
	Interests in pooled funds that are under separate management															
CONFLICTS	Direct financial interest															
	Indirect financial interest															
	Non-financial personal interest															
	Conflicts of loyalty															

AGENDA ITEM 25

ANY OTHER BUSINESS