Gloucestershire Care Services NHS
NHS Trust

Meeting of
Gloucestershire Care Services
NHS Trust Board

Papers for Meeting to be held at
9.30am on Tuesday, 20th May 2014 at
Hesters Way Community Resource Centre,
Cassin Drive, Cheltenham, GL51 7SU

GLOUCESTERSHIRE CARE SERVICES NHS TRUST BOARD

Meeting to be held on Tuesday 20th May 2014 at Hesters Way Community Resource Centre, Cassin Drive, Cheltenham, GL51 7SU

AGENDA (PART 1)

Iten		Presenter	Timing
1.	**Apologies**	Chair	10.00
2.	**Declaration of Interests**	Chair	
3.	**Minutes of the Meeting held on 11 March 2014**	Chair	
4.	**Matters Arising (Action Log)**	Chair	10:10
5.	**Questions from the Public** *Questions relating to items on the agenda only should be provided in advance to the Board Secretary by 12noon on Monday 19 May 2014*	Chair	
6.	**Chair's Report**	Chair	10.15
7.	**Chief Executive's Report**	Chief Executive	10.20
8.	**Chief Operating Officer's Report**	Chief Operating Officer	10.25
Governance, Quality and Safety			
9.	**Quality & Performance Report**	Director of Finance / Director of Nursing & Quality	10.30
10.	**Hard Truths Response: National Quality Board Report**	Director of Nursing & Quality	10.45
Refreshment/Comfort Break – 11.00			
Service Delivery and Performance			
11.	**Staff Survey Report and Results**	Director of HR	11.15
12.	**Finance Report**	Director of Finance	11.30

Ratification of Strategies			
13.	**Health, Safety & Security Strategy**	Director of Finance	11.45
Information			
14.	**Quality & Clinical Governance Committee update (and approved IGQC Minutes from 20 February 2014)**	Chair of Q&CG	11.50
15.	**Performance & Resources Committee update (and approved Minutes from 13 February 2014)**	Chair of P&R	
16.	**Audit & Assurance Committee update (and approved Minutes from 17 December)**	Chair of A&A	
17.	**Any Other Business**	Chair	
18.	**Date of Next Public Meeting** *Tuesday, 15 July at the Corinium Stadium, Kingshill Lane, Cirencester, GL7 1HS*		

To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential matters of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1 (2) Public Bodies (admission to Meetings) Act 1960]

GLOUCESTERSHIRE CARE SERVICES
NHS TRUST BOARD

Minutes of the Meeting held on Tuesday, 11 March 2014 in the Coopers & Malvern Training Rooms, Edward Jenner Court

Voting Board Members	
Ingrid Barker (IB)	Chair
Joanna Scott (JS)	Non-Executive Director, Vice Chair
Paul Jennings (PJ)	Chief Executive
Rob Graves (RG)	Non-Executive Director
David Harwood (DH)	Non-Executive Director
Sue Mead (SM)	Non-Executive Director
Chris Creswick (CC)	Non-Executive Director
Liz Fenton (EF)	Director of Nursing
Glyn Howells (GH)	Director of Finance/Deputy Chief Executive
Jo Bayley (JB)	Medical Director
Board Attendees (Non-Voting)	
Caroline Holmes (CH)	Locality Manager, Cheltenham & Cotswolds, deputising for Susan Field, Director of Adult Services
Andrew Hall (AH)	Director (Project Development and Strategy)
Candace Plouffe (CP)	Director of Countywide and CYP Services
Tina Ricketts (TR)	Director of Human Resources
Tony Hicks (TH)	Councillor, Gloucestershire County Council
Duncan Jordan (DJ)	Chief Operating Officer, Gloucestershire County Council
In Attendance	
Jason Brown (JBR)	In lieu of the Board Secretary
Ruth Darling (RD)	Communications Manager
Jill Rowell (JR)	Minute Taker

Members of the public/observers
Three members of staff and one member of the public attended the meeting.

Ref	Minute	Action
	Sexual Health Service - 'Patient Story' presentation IB welcomed Sally Snowden (SS), Matron, and Andrew de Burgh Thomas (ABT), Consultant, from the Sexual Health Service. SS and ABT gave an overview of recent progress made by the service, which currently comprises 3 consultants and 100 staff.	

	This presentation demonstrated that service user demand has increased markedly over the past four years, significantly increasing pressure on the service. To alleviate corresponding budget pressures, various schemes have been trialled, including a home delivery drug service for HIV service users. The service also performs approximately 40 terminations each week. A paper by Dr Mary Pillai, Consultant, detailing a new termination model that has been piloted by the service, has recently been published in the British Medical Journal. A question posed by a member of the public in respect of the progress made by the service in implementing recent NICE guidance within cultural communities was acknowledged, and will be responded to outside the meeting. SS and ABT were thanked by IB for a very encouraging presentation on a highly regarded service.	**CP/SS**
TB 20/14	**Agenda Item 1: Apologies** Apologies were recorded for Susan Field, Director of Adult Services, and Simeon Foreman, Board Secretary.	
TB 21/14	**Agenda Item 2: Declarations of Interest** There were no changes to the declarations of interest recorded.	
TB 22/14	**Agenda Item 3: Minutes of the Meeting held on 21 January 2014** The Board received the minutes of the previous Board meeting held on 21 January. Subject to a few minor amendments, the minutes were **APPROVED**.	**JBR**
TB 23/14	**Agenda Item 4: Matters arising (Action Log)** The Board reviewed the Action Log, and noted where actions could now be closed. Where items could not be closed, the Board received a progress update, and these updates will be shown in the Log at the next Board meeting. **The Board NOTED the updates to the Action Log.**	**JBR**
TB 24/14	**Agenda Item 5: Questions from the Public** There were no public questions submitted prior to the Board.	

TB 25/14	**Agenda Item 6: Chair's Report** IB presented the Chair's Report, focusing the Board's attention on the following areas: • <u>Gloucestershire Strategic Forum</u> A draft response to the CCG's Joining Up Your Care strategy has been prepared on behalf of the Trust, and is included as an Appendix to the Chief Executive's Report (see agenda item 7). • <u>Changes to Board membership</u> A warm welcome was extended to DJ who will be joining the Trust on secondment from 1 April, to take up the position of Chief Operating Officer. The Board recognised DH's resignation, and thanked him for all his hard work during his time in office. The Board wished him success for his business venture in Spain. The Board also acknowledged that AH was shortly taking up a new post as Deputy Chief Operating Officer on behalf of Derby Hospitals NHS Foundation Trust. • <u>National Procurement Initiative</u> It was noted that all Trusts have recently been contacted by the TDA with regard to a national initiative for savings through better procurement, for which a NED is asked to take particular interest. The Board was asked to approve Rob Graves' nomination for this role. **The Board NOTED the report and APPROVED Rob Graves' nomination as champion for procurement.**	
TB 26/14	**Agenda Item 7. Chief Executive's Report** PJ presented the Chief Executive's Report, and noted: • <u>Flooding Incidents</u> The recent flooding crisis was well managed by the Trust, and gratitude was extended to all staff. • <u>Getting Mrs Foster Home week</u> The efforts of staff during the week's countywide approach to expedite the journey of patients through services were highly commended, and there are plans for a follow-up shortly.	

	• <u>Joining Up Your Care in Gloucestershire</u> The Trust has submitted a supportive statement to the CCG with regard to this Strategy. • <u>Listening into Action (LiA)</u> Claire Powell, LiA Co-ordinator, provided an update on progress to date, describing how the Trust had embarked upon LiA in January 2014 as one of a cohort of six organisations. The purpose of LiA is to introduce a fundamental shift in the Trust's culture, and enable staff's voices to be heard, so that corresponding remedial actions can be taken where appropriate. To start the process, 1,343 Trust colleagues had completed the Pulse Check questionnaire, and the resultant data provided a baseline of staff opinion: this included evidence that 60% staff consider that the Trust delivers high quality care to its service users. 31 March sees the first of a series of 'Big Conversation' meetings, hosted by PJ, which will give staff more direct opportunity to engage with, and influence, the approach. Feedback from each event will be given to staff within 24 hours. • <u>NHS Change Day</u> On 3 March, staff had been given the opportunity to shadow colleagues in frontline services: following learning from this experience, 42 pledges for improvement had been made by staff, which are available to view on the intranet. A reciprocal event that will enable frontline staff to work in Edward Jenner Court for a day is being reviewed. The Director of HR extended thanks to the NHS graduate trainees who had co-ordinated the Trust's participation in NHS Change Day. **The Board NOTED the report.**	
TB 27/14	**Agenda Item 8: Quality Report** EF presented the Quality Report and drew attention to a number of items: • the Annual Statement of Compliance for ensuring single sex accommodation in community hospitals was presented for approval. The Board **APPROVED** the Statement, subject to a minor amendment of wording to clarify that decisions are taken in consultation with the service user and their family;	**EF**

	• the Trust's response to the Clywd/Hart report prepared by AH was discussed in depth. Assurance was given that the Trust handles complaints in an effective manner via the Service Experience Team. However, the Board **RECOMMENDED** that some additional information be added to the reporting of complaints in order to denote the Trust Lead for each complaint, and highlight where scrutiny is delegated to the Quality and Clinical Governance Committee. It was also noted that although social care complaints are included within the Trust's reports, the management of these complaints is the responsibility of the County Council; • the Board was asked to note the two Serious Incidents Requiring Investigation (SIRIs) that are currently underway. It was noted that once complete, the investigation reports will be presented at the Quality and Clinical Governance Committee; • EF reported that she had met with the TDA Quality Lead, which had provided an invaluable insight into how Clostridium Difficile infection reporting will be managed in future. It was also noted that the TDA has taken away the Trust's infection control policy for review. **The Board NOTED the content of the Quality Report.**	**AH**
TB 28/14	**Agenda Item 9: Learning Disabilities Action Plan** This plan, presented by EF, forms part of the Clinical and Professional Strategy Implementation Plan, and will serve to monitor progress on actions agreed at a multi-agency workshop chaired by IB in December 2013. The Board discussed the plan, including funding options, and noted the adult focussed approach. In summing up, IB considered it a matter of duty and pride for the Trust to achieve the best possible service for people in Gloucestershire with learning disabilities. **On that basis, the Board:** • **ENDORSED the implementation plan, subject to input being sought from GCC and Children's Services;** • **NOTED the invitation from the LD Partnership Board and DELEGATED responsibility to the Executive Team to identify a nominee from the Trust;** • **NOTED the funding issues associated and RECOMMENDED the available options are explored.**	**EF** **EF** **EF**

TB 29/14	**Agenda Item 10: Service User Experience Report** AH presented the Service User Experience Report which had previously been submitted to February's Integrated Governance and Quality Committee meeting. **The Board noted the content of the report and RECOMMENDED that it would be enhanced by better quality analysis of information.**	**AH**
TB 30/14	**Agenda Item 11: Quality and Performance Report** Matthew O'Reilly (MOR), Head of Information and Performance, and Diana Morgan (DM), Information Analyst, were welcomed to the Board for this agenda item. In summary, IB commended the excellent performance across the Trust. GH however asked the Board to be aware of a potential dip in performance during the roll out of SystmOne training, when staff capacity will be reduced by 10%. GH then presented the Quality and Performance Report in detail, and briefed the Board on a number of key indicators, namely: <u>Post 48 hour C.Diff infections in community hospitals</u> Confirmation of a case in March has taken the Trust to 19 reported infections against a tolerance of 18. Notwithstanding, the formula for the calculation of future tolerance levels issued by NHS England, suggests that the Trust's target for next year will be 21. <u>Chlamydia Screening</u> The number of positive screens recorded by the Trust in January was 73, which was 9 below the target: however, year-to-date performance remains ahead of target. <u>HPV Immunisation</u> The "no consent" rate has fallen to 4.7% and the Trust has a realistic chance of achieving the 90% immunisation target set for the academic year. <u>Call to Action (Health Visitors)</u> The Trust remains behind target by 2 WTE Health Visitors. However, the Trust has 40 trainee Health Visitors undergoing training at the present time, who are expected to qualify next year.	

	Psychosexual Medicine The necessary service redesign is almost complete, and 100% performance target is expected to be achieved in February. Falls in Community Hospitals The number of falls reported in January was within the monthly tolerance of 80: however, year-to-date performance exceeds the tolerance of 865. The classification of a fall as applied by Datix is currently being reviewed by the Head of Clinical Governance as a result of discussion at a Contract Quality Board meeting, as the Trust may be over-reporting. Pressure Ulcers An improvement in performance was observed in January. An investigation into the consistency of reporting by the Trust in comparison with peer organisations has been undertaken by the Tissue Viability Team. The learning from this review and further training will now be actioned. The Chair of the Quality and Clinical Governance proposed that the Committee should commission a deep dive review of the issue. Baby Friendly Initiative Level 2 The Trust achieved Level 2 accreditation in February and will strive to attain Level 3 in 2015. Social Care The Trust is working with GCC colleagues to improve access to data and increase corresponding levels of understanding. The issues impacting on the delivery of Reablement were discussed in depth. The Board was informed that a working group has been established, to include PJ and DJ, to evaluate the service, and that a paper on the group's recommendations will be presented at the next Board meeting in May. Friends and Family Test The FFT response rate improved in February to 17%. Workforce The Board was asked to note improvements in sickness levels and appraisal reporting. MOR was **REQUESTED** that the 'Never Event' reported by the Trust's out of hours' dental clinic be included on the dashboard. **The Board NOTED the content of the Report**.	**EF** **EF** **DJ** **MOR**

TB 31/14	**Agenda Item 12: Finance Report** GH presented the Report, and updated the Board on the elements of risk for the Trust, particularly around the delivery of CQUINs. GH advised that the Trust is still in discussion with the contractor regarding issues identified with the new build at Tewkesbury Hospital. The opening balance sheet for the Trust has now been finalised: however, property revaluations are still to be resolved. **The Board NOTED the content of the Report and the current position and implications for the Trust.**	**GH**
TB 32/14	**Agenda Item 13: Update on 2014/15 CIPs** GH presented a report on the Trust's Cost Improvement Programme that identifies a target of £7.3m for 2014/15. The Leadership Group is focussed on delivering CIPs and understands the level of change that must be achieved. Internal Audit has undertaken a review of CIPs and will present a report to the next Audit and Assurance Committee. **The Board took ASSURANCE from the content of the report. However, the Board also RECOMMENDED that the Performance and Resources Committee undertakes a deep dive of the CIPs and routinely monitors them.**	**GH** **DJ**
TB 33/14	**Agenda Item 14: IT Strategy** The IT Strategy was presented by GH for ratification. It was noted that all costs relating to this Strategy will be contained within the detailed implementation plan will subsequently be monitored by the Performance and Resources Committee. **The Board ACCEPTED the Strategy on the understanding that the implementation plan will explore all necessary financial implications.**	**GH**
TB 34/14	**Agenda Item 15: Risk Management Strategy** The Risk Management Strategy was presented by JBR for ratification. **The Board APPROVED the Strategy.**	

TB 35/14	**Agenda Item 16: Clinical and Professional Care Strategy** EF presented the Clinical and Professional Care Strategy for ratification. **Subject to two minor amendments, the Strategy was APPROVED by the Board.**	**EF**
TB 36/14	**Agenda Item 17: Communications and Engagement Strategy** AH presented the Communications and Engagement Strategy for ratification, and paid tribute to Ruth Darling and Rod Brown for their contribution. **The Board ACCEPTED the Strategy on the understanding that the implementation plan will explore all necessary financial implications.**	**AH**
TB 37/14	**Agenda Item 18: Estates Strategy** GH presented the Estates Strategy for ratification. The Board was asked to note the strategy was less defined than similar documents, as the Trust's stance on estates remains subject to the influence of other projects. **The Board APPROVED the Strategy.** **Also, on behalf of the Board, EF thanked Rod Brown and JBR for the huge amount of work they have undertaken in producing the Trust's suite of strategies.**	
TB 38/14	**Agenda Item 19: Integrated Governance & Quality Committee update (Parts 1 & 2)** SM, as Chair of the IGQ Committee, presented the report of the meeting held on 20 February, and the approved minutes from the meeting held on 9 January. The Board was advised that the imminent appointment of a Director of Corporate Governance and Public Affairs will impact on the management of risk within the Trust, which the IGQ Chair had raised as a concern. As the Board meeting scheduled for 25 March had been cancelled, the Board **RECOMMENDED** that approval of the Equality Objectives was delegated to the Trust Chair. **The Board RECEIVED and NOTED the report and approved minutes.**	**TR/IB**

TB 39/14	**Agenda Item 20: Performance and Resources Committee update** DH, as Chair of the Performance and Resources Committee, presented the report of the meeting held on 13 February, and the approved minutes from the meeting held on 10 December 2013. GH reported that the Trust had served notice to Gloucestershire Hospitals NHS Foundation Trust (GHT) for the provision of Estates services, and that six members of the GHT estates team will be TUPED to the Trust. **The Board RECEIVED and NOTED the report and approved minutes.**	
TB 40/14	**Agenda Item 21: Learning Objectives and Board Development Forward Plan** JBR presented the Board Development Learning Objectives and Forward Plan to the Board. **The Board APPROVED the Forward Plan and RECOMMENDED that comments and topics of interest are emailed to JBR or IB.**	**ALL**
TB 41/14	**Agenda Item 22: Any Other Business** IB took opportunity to again thank DH for his service to the Trust. DH responded by thanking the Board for their patience with him over the past 2½ years, and noted his belief that the Trust has a bright future.	
TB 42/14	**Agenda Item 23: Date of Next Meeting** 9.30am - 4.00pm on Tuesday, 20 May 2014 at Hesters Way Community Resource Centre, Cheltenham.	

Chair's Signature ……..

Date ……..……

Gloucestershire Care Services NHS Trust Board Action Log

Minute Reference	Action Agreed	Lead Exec	Update for 20 May 2014	Proposed Close Date	Status
Actions Carried forward from Gloucestershire Care Services Operational Board					
6/11/12 – item 8.11	Operational Board agreed that a detailed study on stress within the organisation should be progressed. It subsequently agreed that an employee health and wellbeing plan should be incorporated within the HR Strategy	Head of HR	Employee Health and Wellbeing Plan scheduled to be considered by Board in July. **However this will now be taken forward by the HR and OD Programme Board, with the aim of a draft HR Strategy to be submitted to the board in March 2014.** Further action through HR/OD Programme Board	Mar-14	Closed
TB43/13	Further to IiP Assessment report the Board agreed funding to progress undertaking the "top up" assessment and the Health and Wellbeing Framework	Head of HR	Progressing led by the Head of HR and overseen by HR and OD Programme Board. **TR advised IiP progress report will be considered by the HR/OD Programme Board in Jan 14 with an update being provided to the Board in March 14.** Further action through HR/OD Programme Board	Mar-14	Closed
TB62/13	Board to review the progress of the Organisational Development Plan in January 2014	Head of HR	The Organisational Development Plan will be developed once the OD Strategy has been approved by the Board. **The draft OD Strategy is scheduled to be submitted to the December Board.** OD Plan and easy read version of OD Strategy to be taken to OD & HR Programme Board in January and brought to a future Board meeting **Further action through HR/OD Programme Board**	Mar-14	Closed
TB63/13	The Board requested more detail included in the Clinical and Professional Care Strategy for submission in November 2013	Foundation Trust Programme Managers	***FT Programme Managers to add.*** *Strategy to be presented to December Board.* ***For January 2014 Board Timing has slipped – final draft to IGQC in February and to Board in March***	Mar-14	Closed
TB88/13	Board approved work be progressed to address identified cost pressures being offset by underspends.	Director of Finance	Issue of accruals totalling £6M generated by SBS requires unravelling by Management Accountants. **Tidying up under/overspend position**	Mar-14	Closed
TB76/13	Further work required to develop a quality dashboard drawing data from initiatives that can be measured and quantified and presented to October's IG&QC	Director of Nursing	Development of quality reporting to be reviewed in the context of the Government's response to Francis and reported to IGQC in December **New form of reporting to April IGQC meeting and then to Board in May. The new style report and future actions with be presented to May Board**	May-14	Open
TB125/13	Present report on Charitable funds available and its uses for staff to Execs team and report to Board	Director of Finance	Report coming to July Board and will be of interest to League of Friends' Chairs	Aug-14	Open
Gloucestershire Care Services NHS Trust Board Action Log					
TB25/14	Report to be prepared and presented to the Board in July on responding the needs of people with Learning Disabilities	Chair		Jul-14	Open

Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: 20 May 2014
Location: Hesters Way Community Resources Centre, Cheltenham

Agenda item 6: Chair's Report

Board membership changes

I am delighted to welcome Non-Executive Director Richard Cryer to the Board. Richard was Director of Finance at the University of London between 2006 and his retirement at the end of 2012. He is Treasurer and a Trustee of Hereford learning disabilities charity Aspire Living and a member of the Finance Committee of national learning disability charity Mencap. He is also a governor of Worcester College of Technology and a member of the audit committee of the Institution of Civil Engineers.

I am delighted also to welcome Jason Brown to the Board in the new role of Director of Corporate Governance and Public Affairs. Jason has worked within the NHS for the past 22 years, providing corporate, strategic and operational management for a range of acute, community and mental health providers. Jason has also worked nationally on behalf of both the Department of Health and the Health and Social Care Information Centre. Jason has worked for Gloucestershire Care Services since December 2012, helping to prepare the Trust for its pending Foundation Trust application.

I would additionally like to use today's Board as an opportunity to seek Board approval for my recommendation that Non-Executive Director Susan Mead be nominated as the Trust's Senior Independent Director (SID). As SID, Susan would continue to perform her regular duties as a NED. However, she would additionally be available to all Directors should they have any concerns which cannot be resolved through contact with me or the Chief Executive. I would also note that this role will expand in responsibilities, once we are a Foundation Trust and have members and governors.

Dialogue with our stakeholders

Involving the people we serve in our thinking and development continues to be a very high priority and I would highlight the following activities since the last Board:

- We were represented at the first public Board meeting of Healthwatch, which was held on 25 March. I have also had a briefing meeting with the Healthwatch Chair, which our CEO attended.

- With Non-Executive Chris Creswick, I attended a joint meeting with Gloucestershire Hospital's Trust Chair, NED and executive colleagues to review ongoing progress in relation to our joint urgent care agenda.

- We hosted a successful 'Board to Board' seminar at Sandford Education Centre on 21 March, focusing on partnership working and welcoming keynote speaker Professor Jon Glasby from the University of Birmingham for his presentation 'Breaking down the Berlin Wall'. The seminar was well-attended by Chairs, Chief Executives, Directors and Councillors from Gloucestershire's health and social care community. Professor Glasby facilitated the seminar, which resulted in open discussion on how to enhance effective partnership working.

- A number of NED meetings have been held at Trust sites, providing an informal opportunity to meet colleagues: for example, within our integrated community teams at Gloucester (Quayside) and Stroud (Beeches Green). These provide a valuable opportunity to further NED knowledge and understanding of services, their issues and opportunities.

- Since the last Board, I have visited a number of services, including a diabetic clinic in Cheltenham and also the social work team based within Gloucester Royal Hospital to learn more about our integrated discharge services.

- Together with executive colleagues, I regularly attend the Health and Care Overview and Scrutiny Committee. At its most recent meeting, we were pleased to discuss various aspects of our performance and service development including Integrated Community Teams and our performance over the winter period.

- To support national Nutrition and Hydration Week (17-21 March) and the importance of good nutritional care, I was pleased to have lunch with patients at Cirencester Hospital as part of a 'Come Dine with Me' event. Tewkesbury Community Hospital hosted a similar lunch, attended by the Trust's Director of Service Transformation Susan Field. Hannah Gorf from Stroud District Council and retired Tewkesbury GP Andrew Crowther were amongst the guests attending the events.

- As part of this year's NHS Sustainability Day (27 March), I attended an event in the grounds of Cirencester Hospital, which brought together children and volunteers to promote the benefits of sustainability and highlight the work being done across the Trust. This was one of three events across the Trust, and offered a chance to reflect on our

contribution to a sustainable healthcare service, whether by reducing power consumption by turning off monitors and computers, through recycling and reducing waste or by cycling and walking.

- The focus for Your Care, Your Opinion (YCYO) since our last Board was an engagement event (1 April) which brought together a wide range of individuals, community groups and partner organisations. An invitation was extended to members of the public who have expressed an interest in becoming involved in the Trust, and I am pleased that a number of local people came along to join the debate. In total, more than 50 people attended the event at Gloucester Rugby Club and a number of organisations joined us for the first time, including the Deaf Association, which subsequently asked to join the YCYO Programme Board. Discussions centred on the Trust's five-year business plan and three key themes: community hospitals, urgent care and integrated community teams. There was also a presentation and discussion of the Trust's understanding of quality and our equality objectives, with the opportunity to feed back on the key themes.

- The Chief Executive and I continue to participate fully in the Gloucestershire Strategic Forum, an important meeting of senior health and social care figures in the county. At the last meeting, discussion centred on the Better Care Fund.

- I held a one-to-one meeting with Gloucestershire County Councillor Kathy Williams, cabinet lead for a number of areas of significance to GCS such as long-term conditions and safeguarding, to offer her a briefing on GCS and its services. An initial meeting between the CEO, the Chief Operating Officer and myself, with key Cabinet members and their executive counterparts, has also taken place and it is hoped this will form the basis for on-going dialogue and briefings.

Engaging with our Trust Colleagues

A range of initiatives are taking place to ensure meaningful engagement of our colleagues across the Trust. As Chair, I have been involved in the following:

- As part of Listening into Action, I and Non-Executive Director Rob Graves attended a 'Big Staff Conversation' event in Cheltenham (2 April) and Moreton-in-Marsh respectively (31 March) respectively.

- I was delighted to attend a Trust showcase event on 22 April where the first group to complete the Royal College of Nursing's Leading for Quality Care Programme presented their service improvement projects.

Twelve projects were presented, all of the highest standard, and now all of the participants will be sponsored by a member of the management team to ensure they have the support to put their ideas into practice. Also attending were Directors Duncan Jordan, Liz Fenton and Candace Plouffe, Non-Executive Director Chris Creswick and also Marion Andrews-Evans, quality lead from NHS Gloucestershire Clinical Commissioning Group.

National networks

The Trust continues to play its part on the national stage, particularly through the Foundation Trust Network of which I am a board member and the Aspiring Community Foundation Trust Network

Appendices

Appendix 1: NED Portfolios

Gloucestershire Care Services NHS
NHS Trust

NON–EXECUTIVE DIRECTOR (NED) PORTFOLIOS

NED	LOCALITY /SERVICES CHAMPION	BOARD / COMMITTEE LEAD	FORUM LEAD	COMMITTEE / FORUM MEMBERSHIP	FUNCTIONAL INTEREST	OTHER
Ingrid Barker (Chair)		• Board • Remuneration and Terms of Service Committee	• Your Care, Your Opinion Programme Board • Foundation Trust Programme Board	• Quality and Clinical Governance Committee • Performance and Resources Committee • Communications and Public Affairs Steering Group	Board Development	• NHS Constitution Champion
Joanna Scott (Vice Chair)	Gloucester & Stroud		• Communications and Public Affairs Steering Group	• Remuneration and Terms of Service Committee • Audit and Assurance Committee • Your Care, Your Opinion Programme Board	Communications and Engagement	• Dignity Champion
Robert Graves	Cheltenham & Cotswold	• Audit and Assurance Committee		• Remuneration and Terms of Service Committee • Performance and Resources Committee • Foundation Trust Programme Board	Finance, Information and Audit	• Health and Safety • Whistleblowing • Procurement • Technology Champion
Susan Mead	Children and Young People (CYP) Services	• Quality and Clinical Governance Committee		• Remuneration and Terms of Service Committee • Audit and Assurance Committee • Charitable Funds Committee	Clinical Governance and Social Care	• Senior Independent Director • Equality and Diversity Champion
Chris Creswick	Urgent Care	• Human Resources / Organisational Development Committee		• Remuneration and Terms of Service Committee • Audit and Assurance Committee • Performance and Resources Committee	HR and OD Development	• Staff Council • Emergency Planning
Richard Cryer	Forest & Tewkesbury	• Performance and Resources Committee		• Remuneration and Terms of Service Committee • Audit and Assurance Committee • Quality and Clinical Governance Committee	Finance, Business Development and Marketing	• Learning Disabilities Champion
Nicola Strother-Smith (Designate)	Countywide Services	• Charitable Funds Committee		• Remuneration and Terms of Service Committee • Quality and Clinical Governance Committee • Human Resources / Organisational Development Committee	Quality and Safety	• Caldicott Champion • Older Peoples' Champion • Dementia Champion

Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: 20 May 2014
Location: Hesters Way Community Resource Centre, Cheltenham

Agenda item 7: Chief Executive's Report

1. Listening into Action (LiA) update

Launched by the Trust in January 2014, Listening into Action is a new way of listening to the views of staff, and using what they say to make our Trust a better place for our service users, and a better place to work. It is a tried and tested approach within the NHS, that now uses the insight and learning from 100s of NHS Trusts and 100,000s of staff and leaders.

Listening into Action is led by me personally, with the support of a sponsor group of ten colleagues (mainly clinicians). As LiA Co-ordinator Claire Powell reported at our last meeting, the results of February's 'Pulse Check' survey - a short survey of 15 questions sent to all colleagues – drew a response of 1,339. The results highlighted a range of issues, which were put forward for consideration and response.

During late March and early April, five Staff Conversations have been held at different sites in the county, involving more than 300 colleagues from across the Trust. These were lively, interactive events, that encouraged people to share their frustrations on the barriers to effective working, their ideas for 'Quick Wins' and ways we can improve multi-disciplinary working. All the feedback from colleagues has been collated, themed and shared across the Trust, and provides a rich source of ideas with which we will move forward.

The next stage in the Listening into Action journey - planned for early summer 2014 - encourages colleagues to volunteer to join the first ten teams. These teams will be supported to deliver measurable results within 20 weeks to improve the quality and experience of care for service users. Colleagues will also start delivering some of the 'Quick Wins' that were identified as part of the Staff Conversations. A 'Pass it on' event will be held in Autumn 2014 to showcase stories and successes, and inspire others to adopt the Listening into Action approach. In February 2015, the 'Pulse Check' survey will be repeated to find out how colleagues feel about the changes, both personally and in terms of the quality of care that they deliver.

Our progress in this journey will be reported in my next report to Board.

2. Celebrating You Awards 2014

Nominations have opened for our Celebrating You Awards, which celebrate outstanding individuals and teams who work across community health and adult social care on behalf of the Trust to care for local people. The judging panel will be the Chair, Ingrid Barker, Non-Executive Director Chris Creswick and myself. The awards are being promoted widely within the Trust. Nominations close Friday, 6 June 2014, and the presentations will take place during the daytime of Wednesday, 25 June 2014 at three different Trust sites across the county.

3. CQC visit to Southgate Moorings

Southgate Moorings, based in the city of Gloucester, provides NHS dental care for people in Gloucestershire who are unable to access treatment from a general dental practitioner. The Care Quality Commission carried out an inspection of Southgate Moorings on 26 March 2014, in response to information provided by the Trust relating to an incident at the dental clinic.

In its report published 23 April 2014, the CQC found that the dental services at Southgate Moorings are meeting all standards in regards to: consent to care and treatment; care and welfare of people who use services; assessing and monitoring the quality of service provision; complaints.

4. GCCG notice of termination for Out of Hours Services

The Trust has received formal notice of termination for 'Out of Hours Services for Urgent and Unscheduled Advice and Care for Gloucestershire Patients' from Gloucestershire Clinical Commissioning Group. The contract will terminate on 31 March 2015. We are currently in the process of responding to the Pre Qualification Questionnaire (deadline for submission 15 May 2014). The successful bidder will be awarded a new contract which will be effective from 1 April 2015.

5. GCS notice of termination for Pharmacy Services for Community Hospitals

The Trust has issued formal notice of termination to Gloucestershire Hospitals NHS Foundation Trust (GHFT) to provide pharmacy services for the Trust's community hospitals. The notice includes all drug provision and clinical pharmacy services to the Trust's community hospitals and community services (but excludes supply of HIV drugs).

As there is no current Service Level Agreement relating to pharmacy, GCS will be working in partnership with GHFT to agree a notice period that ensures current pharmacy services are maintained until a formal procurement process has been completed.

6. CQC fee structure update

In March, the Care Quality Commission (CQC) announced its fee structure for 2014/15. All services registered with CQC are required under the Health and Social Care Act 2008 to pay fees to cover the cost of registration and inspection. The fees scheme reflects government policy which requires CQC to recover the costs of regulation from providers and has been approved by the Secretary of State of Health.

In summary, there will be:

- No increase for providers of dental services, as the sector is at 100% cost recovery
- A 1.5% increase for providers of adult social care services, as the sector is at 85% cost recovery, and
- 2.5% for all other types of providers

During 2013/14, CQC fees for the Trust were £55,000.

The CQC will carry out a public consultation in autumn 2014 to consider the next set of changes to the fees scheme for 2015/16.

7. CQC consultation – New approach to regulating, inspecting and rating community health services

Following on from its publication in December 2013 of 'A fresh start', the CQC has launched a formal consultation (April 2014), inviting feedback on proposals for a revised approach to regulating, inspecting and rating community health services.

Services that fall within the community healthcare sector include the following:

- District nursing, community matron and specialist community nursing services
- Health visiting, school nursing services and community children's services
- Intermediate care
- Community rehabilitation and reablement services
- Hospital at home services
- End of life care delivered at home
- Inpatient and day-case services in community hospitals.

The CQC began testing the new approach in five community health service providers between January and March 2014, and is incorporating the learning and experience from these inspections into a second wave of trial inspections between April and September 2014.

The CQC will use the feedback from this consultation to further shape its approach to regulating, inspecting and rating community health services. The

Trust will be submitting an organisational response to the consultation, which closes on 4 June 2014 (Reference www.cqc.org.uk).

8. NHS England update - Hard Truths: The Journey to Putting Patients First

NHS England issued national guidance (31 March 2014) on the delivery of the Hard Truths commitments associated with publishing staffing data regarding care staff. The commitments in this first phase, which focus on all inpatient areas, are to publish nursing and care staffing data from April 2014 and, at the latest, by end June 2014 in the following ways:

- A Board report describing the staffing capacity and capability, following an establishment review, using evidence-based tools where possible. To be presented to the Board every six months.

  Action: A report is being presented at Board today to begin the process of reporting publicly on planned staffing. Nursing staffing capacity and capability for community hospitals have been established, using evidenced-based acuity tools (undertaken most recently in March 2014) together with the professional body recommendations and the professional judgement of matrons and ward sisters. The next report to Board is due September 2014.

- Information about the care staff deployed for each shift compared to what has been planned and this is to be displayed at ward level.

  Action: Information boards are at the front of each community hospital ward displaying planned versus actual staffing levels

- A Board report containing details of planned and actual staffing on a shift-by-shift basis at ward level for the previous month. To be presented to the Board every month.

  Action: The Trust has trialled a bespoke web-based solution at Cirencester Hospital and this is now being rolled out across all community hospitals. The web-based solution gives visibility of staffing levels compared to planned establishment and this will be reported by month to board (two months data at each meeting). The first full reports will be available from June 2014 and will be shared with the Board in July 2014. The reports will be uploaded via the unify system to NHS choices using the national reporting template.

- The monthly report must also be published on the Trust's website, and Trusts will be expected to link or upload the report to the relevant hospital(s) webpage on NHS Choices.

  Action: The monthly report on staffing information will also be published on the Trust website, and to the relevant hospital webpage on NHS Choices.

9. Department of Health (DoH) guidance following Cheshire West case

The Department of Health issued guidance (31 March 2014) following Cheshire West. This case concerned the living arrangements of three adults without capacity to consent to their residence and care arrangements. The question was whether the arrangements amounted to a Deprivation of Liberty (DOL). The DoH guidance focuses on reducing the use of restrictive practices in healthcare settings and describes a list of “suggested actions” to be taken. The guidance has been shared with senior colleagues across the Trust and we will continue to ensure it is embedded in relevant practice.

Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: 20 May 2014
Location: Hesters Way Community Resource Centre, Cheltenham

Agenda item 8: Chief Operating Officer's Report

1. On 1 April 2014, I was delighted to join the Trust on secondment as Chief Operating Officer. My first weeks in post have focused on fact-finding and getting to know colleagues and their roles across both adult and children and young people services. In particular, during April and May, I visited colleagues at five community hospitals (Stroud, Dilke, Lydney, Vale and Tewkesbury) to learn more about their services, and to have informal discussions around the issues and opportunities being identified by frontline staff. Further visits to community hospitals and other clinical and integrated community team sites are scheduled for May and June. In addition, I have held a number of one-to-one meetings with key external stakeholders, including Mary Hutton (Accountable Officer, Gloucestershire Clinical Commissioning Group), Frank Harsent (Chief Executive, Gloucestershire Hospitals NHS Foundation Trust) and Sean Clee (Chief Executive, 2gether NHS Foundation Trust).

2. Since joining the Trust, I have also been reviewing responsibilities and structures within the operations directorate, and these will be announced to colleagues shortly.

3. I was pleased to attend the Staff Conversation event held in Cirencester (4 April 2014) as part of Listening into Action to hear the feedback and ideas from colleagues on the issues that get in the way of day-to-day practice and their thoughts and views on possible solutions that will improve the way we provide health and adult social care.

4. With a number of other Board members, I was delighted to attend the showcase event on 22 April hosted by the first group of colleagues to complete the Royal College of Nursing's Leading for Quality Programme.

5. At the NICE annual conference this month (13-14 May 2014), I will be a keynote speaker for an interactive session titled 'Moving forwards in public health: Bridging the gap between NICE, Public Health England, and local government'.

Gloucestershire Care Services NHS Trust Board

Title:	**Quality and Performance Report March 2014**	**20 May 2014**
Agenda Item:	**9**	
Purpose of Paper:	The purpose of this paper is to provide assurance to the Board of the Trust's performance against local and national key quality indicators. This is provided in a format that aims to enable triangulation of the key aspects of care quality; those being safety, care, responsiveness, effectiveness and leadership. Providing a year end position for the reporting period April 2013 – March 2014 this paper notes the position for the Trust and the actions and monitoring that is in place to support continuous quality improvement.	
Key Points:	In 2013-14 the Trust achieved 93.8% of all applicable national NHS targets and a total of 81.1% of all GCS, local and national targets. Over the same period the Trust achieved 75% of all national targets that relate to the services we deliver on behalf of the Gloucestershire County Council and 64% of all local and national targets.	
Options and decisions required	The Board is asked to: • Note the position at the end of the reporting period 1st April 2013 – 31st March 2014 • Note the actions in place to ensure continuous improvement with a focus on the key domains of care quality • Endorse the next steps for further development of the quality report	
Fit with strategic objectives	1. Achieve the best possible outcomes for our service users through high quality care	x
	2. Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	X
	3. Provide innovative community services that deliver health and social care together	X
	4. Work as a valued partner in local communities and across health and social care	x

	5. Support individuals and teams to develop the skills, confidence and ambition to deliver our vision	x
	6. Manage public resources wisely to ensure local services remain sustainable and accessible	x

Next steps/future actions	The quality reporting process will continue to be developed ensuring that all aspects of quality are captured in a timely manner and where it is available benchmarking and service user feedback will be utilised in order that as a Trust we can assess how we are doing.		
Author name and title	The Nursing and Quality Team Matthew O'Reilly Head of Performance	**Director Name and Title**	Liz Fenton Director of Nursing and Quality

Gloucestershire Care Services NHS
NHS Trust

Quality & Performance Report

March 2014

Understanding You

Executive Summary

This report provides the Board with a summary of the quality and performance across the Trust throughout 2013/14. The report themed across the domains of quality against which care providers are assessed; safe, caring, responsive, effective and well led, in the spirit of being open highlights positive achievements and where we need to focus our quality improvement activity in the coming year.

The table below shows the number of targets reported within the main sections of the Health scorecard and the year to date RAG rating in comparison between national and locally commissioned targets (GCCG) and GCS internal targets developed for continual development.

Target	Red	Amber	Green	Total
National	1	1	30	32
Local	4	1	31	36
Total	5	2	61	68

Red	Amber	Green	Total
3.1%	3.1%	93.8%	100.0%
11.1%	2.8%	86.1%	100.0%
7.4%	2.9%	89.7%	100.0%

The table below shows the number of targets reported within the main sections of the Adult Social Care scorecard and the year to date RAG rating in comparison between national and locally commissioned targets (GCC).

Target	Red	Amber	Green	Total
National	1	0	3	4
Local	4	1	8	13
Total	5	1	11	17

Red	Amber	Green	Total
25.0%	0.0%	75.0%	100.0%
30.8%	7.7%	61.5%	100.0%
29.4%	5.9%	64.7%	100.0%

The health performance and scorecards are reported to the CCG Contract Board and the Adult Social Care scorecard to the GCC – GCS SLA group on a monthly basis for scrutiny and challenge.

Next steps in developing the reporting

This report will be further developed over the first quarter of 2014/15 in order to ensure that comprehensive reporting at team, locality and organisational level. The table below shows the areas for development and inclusion within future reports.

Developing the Quality Reporting for GCS

CQC five pillars of quality services	Areas for reporting
Safe	Safety thermometer coverage and harm free care by harm and by service line, VTE risk assessment, MEWS, , medication errors by level of harm, data breaches, CAS/NRLS reporting, safeguarding adults and children ie SCR, RIDDOR/HSE reported incidents, incidents effecting staff
Effective	Clinical audit programme, NICE, policy development plan, CQUINs by scheme, research participation, CQC non-compliance, performance notices, quality account objectives by topic, SUS data, essential care indicators ie – falls assessment, obs recorded, TV assessments, nutritional assessment, medicines management, PROMs, flu vac rates, balanced scorecards by locality/service in rotation
Caring	Service user engagement, “you said, we did”, 6Cs implementation plan, PLACE, mixed sex breaches, Clinical and professional care strategy implementation plan, service user stories, GCS in the media
Responsive	Complaints , FFT and net promoter score,, risk register and actions, staff survey and actions, LiA, , service redesign ,ethnicity coding, litigation, press coverage, health watch feedback, HV trajectory
Well led	Implementation of clinical and professional care objectives, essential to role training, NMPs in place, WTE funded nursing posts, vacancies, % of agency spent of temporary staff budget, temporary staff, agreed establishments and methodology used to agree this, shifts below establishment (inc. bank and agency) sickness absence, appraisal rates, turnover, average length of time to recruit advert to offer, GSAB/GSCB attendance rate,

Safe

1.1 Incidents Overview (April 2013 – March 2014)

An incident is any event which has given rise to actual harm, injury or to damage/loss of property (Ref: NHS Executive).
This definition includes patient or client injury, fire, theft, vandalism, assault and employee accident. It also includes incidents resulting from negligent acts, deliberate or unforeseen.

The tables below show Trust figures for the period from April 2013 - March 2014 as compared to 2012 - 2013

Incident by Type	Total 2012-13	Total 2013-14	Number of incidents in 2013-2014 where harm to patients has been considered to have a long term impact
Incident at Point of Care Delivery (Clinical Incident)	1270	1298	4
Communication	261	216	0
Confidentiality, data and information governance	159	164	0
Discharge, Transfer, Admission, Appointment	262	179	0
Estates, Staffing, Infrastructure	323	326	0
Fire Incident	35	28	0
Personal Accident (Patient/Staff)	1603	1469	0
Security Incident	190	230	0
Violence, Abuse or Harassment	190	189	0
Vehicle Incident	31	27	_
Waste Environmental Incident	36	53	_
Prevent Referral	0	0	_

Incident by Type	Top 3 Categories	Total
Incident at Point of Care Delivery (Clinical Incident)	Medication or drug error	360
	Pressure sore	173
	Treatment or procedure problem	176
Estates, Staffing, Infrastructure	Estates problem/issue	90
	Hotel / domestic services issue	39
	Staffing issues	147
Personal Accident	Hit by/against object	119
	Slip, Trip or Fall (Patient)	1098
	Slip, Trip or Fall (Staff / visitor)	54

The table below shows the number of incidents per month and the rate per 1,000 WTEs. This allows comparison with data collected by the ACFT Benchmarking group. The average reported by the ACFT group for the period April to January 2014 was161 incidents per 1,000 WTE.

Incidents	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	2013/14 Monthly Average
WTE Budgeted Staff	2,116	2,125	2,126	2,122	2,114	2,116	2,156	2,169	2,147	2,150	2,150	2,150	2,135
Total Number of Incidents	358	337	361	424	393	409	394	381	307	343	325	327	367
Number of incidents per 1,000 WTE budgeted staff	169.2	158.6	169.8	199.8	185.9	193.3	182.7	175.7	143.0	159.6	151.2	152.1	171.7

1.2 Serious Incidents

Serious Incidents in 2013/14	10

A serious incident is

- An accident when a patient, member of staff (including those working in the community), or a member of the public (including contractors) suffers serious injury, major permanent harm or unexpected death (or the risk of death or serious injury) on either premises where healthcare is provided, or whilst in receipt of health care, or
- Any event where actions of health staff are likely to cause significant public concern.
- Any event that might seriously impact upon the delivery of services and/or which is likely to produce significant legal, media or other interest and which, if not properly managed, may result in loss of the Trust's reputation or assets.
- Damage or loss to property by fire, flood, theft or negligent, deliberate or unforeseen act.

Serious Incident Type	**Number**
Pressure Ulcer	5
Unexpected Death	1
Attempted patient suicide	1
Dentistry ('never event')	1
Missed diagnosis at a Minor Injuries Unit	1
Staff Assault	1
Total (year to date)	**10**

Across the Trust, 50 percent of all serious incidents relate to the development of pressure ulcers either in a patients' home or within an in-patient setting. As part of our quality drive to reduce the incidence of pressure ulcers, all acquired grade 3 and 4 pressure ulcers are treated as serious incidents requiring investigation. Clinical staff have worked consistently hard to ensure that these incidents are identified and appropriate care and treatment plans are in place. Effectiveness of these measures is monitored through the CQUIN scheme and quality indicator reporting.

New SIRI (attributable to provider) - average number per month	
Gloucestershire Care Services NHS Trust (April – March)	0.8
Aspirant Community Foundation Trust Benchmark (April – January)	0.0
Aspirant Community Foundation Trust Average (April – January)	3.1

1.3 Never events

'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. During the period 2013-2014, the Trust reported one 'never event' which related to 'wrong site surgery' within the dental surgery. This has been the subject of a full, independent, and has resulted in the following changes in practice:

The definition of wrong site surgery is:
A surgical intervention performed on the wrong site (for example wrong knee, wrong eye, wrong patient, wrong limb or wrong organ); the incident is detected at any time after the start of the operation and the patient requires further surgery on the correct site, and or may have complications following the wrong surgery. In this case the wrong tooth was extracted.

This incident has been subject to root cause analysis and has been examined by an independent investigator. All learning has been shared to prevent reoccurrence.

1.4 Understanding and learning from our incidents

Slips, trips and falls are the highest number of recorded incidents, which is due to the relatively high proportion of elderly and rehabilitation patients cared for within our services. Significant work has been undertaken across all services to reduce the risk of falls whilst continuing to ensure robust reporting. A falls project has concentrated on targeting care at the high risk patient and the use of specialised equipment designed to alert staff to the movement of patients at risk of falls. This work has been supported and monitored throughout the year through the CQUIN schemes and through other care indicators.

1.5 Incidents that occur at the point of care delivery

Further interrogation of these incidents show that many of the incidents reported under this category are incidents relating to the development of pressure ulcers. Improvements have been made to training programmes and awareness and there has been ongoing development of the care bundle (SSKIN). The CQUIN scheme has significantly raised awareness of the need to report this type of incident and reporting figures have risen throughout the year as a consequence.

1.6 Medication incidents

The majority of incidents in this category relate to issues at the point that medication is or should be administered. Many incidents recorded report that medication has not been administered at the time it is due. The Medicines Management Committee maintains an oversight of medications-related incidents in order to identify any themes. The Committee works closely with services to identify lessons that can be learned.

1.7 Safety Thermometer: Harm Free Care

The table below shows the results of data collected via the NHS Safety Thermometer. NHS Safety Thermometer is a tool for measuring, monitoring and analysing patient harms and 'harm free' care.

Harm free care is defined as a patient not having any of the four harms reported via the Safety Thermometer (Catheters and urinary tract infections (UTI), Venous Thromboembolism (VTE), Falls or Pressure Ulcers) that are either acquired, or inherited on the census day.

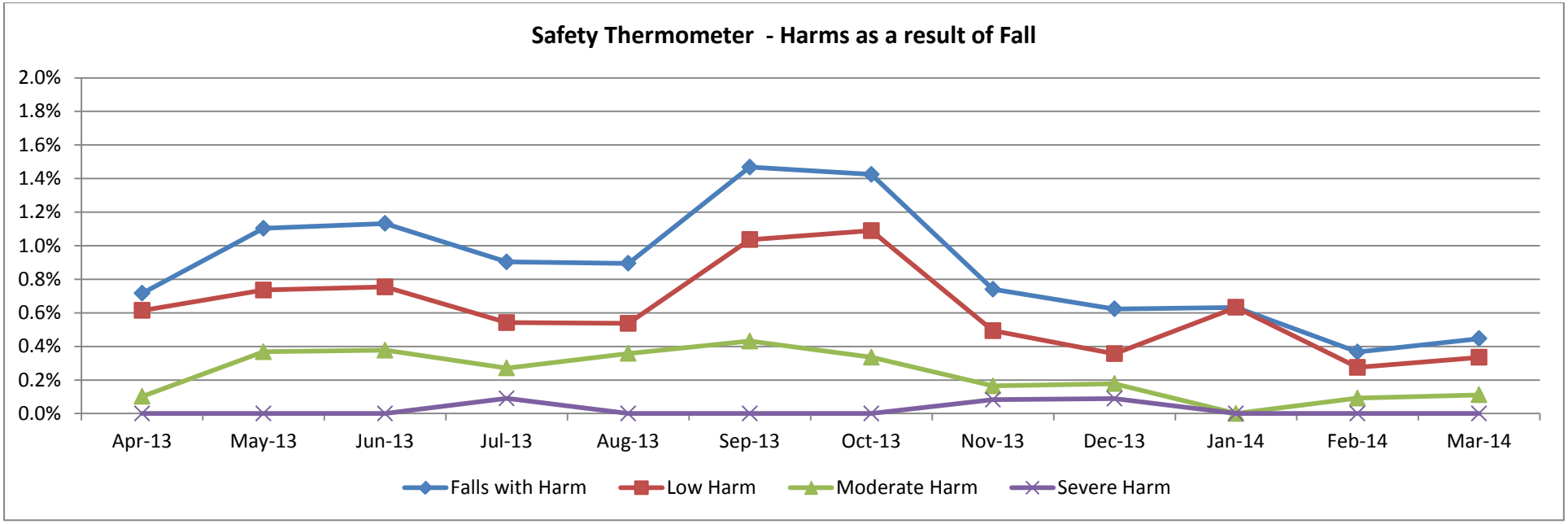
GCS is required to survey patients on a monthly census date and complete a submission of data to the Health and Social Care Information Centre each month covering patients in an inpatient setting and community setting.

Safety Thermometer Harm Free Care	
Gloucestershire Care Services NHS Trust (April – March)	89.6%
Aspirant Community Foundation Trust Benchmark (April – January)	92.0%
Aspirant Community Foundation Trust Average (April – January)	89.1%

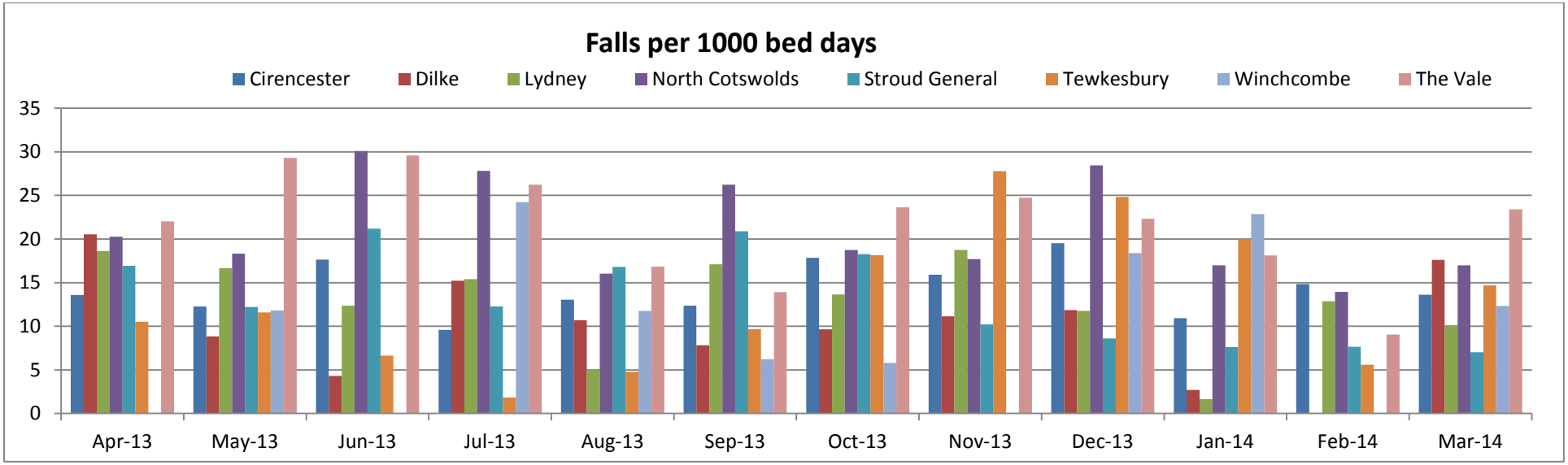
1.8 Safety Thermometer - Falls

The Trust Safety Thermometer data indicated a sharp rise in September and October of falls that resulted in harm to patients. This is shown in the chart overleaf.

Falls are unfortunately a common scenario for older people in hospital. The falls NICE guidelines (National Institute for Health and Care Excellence), June 2013, state that people aged 65 and over have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. The average age of our inpatients is 82.



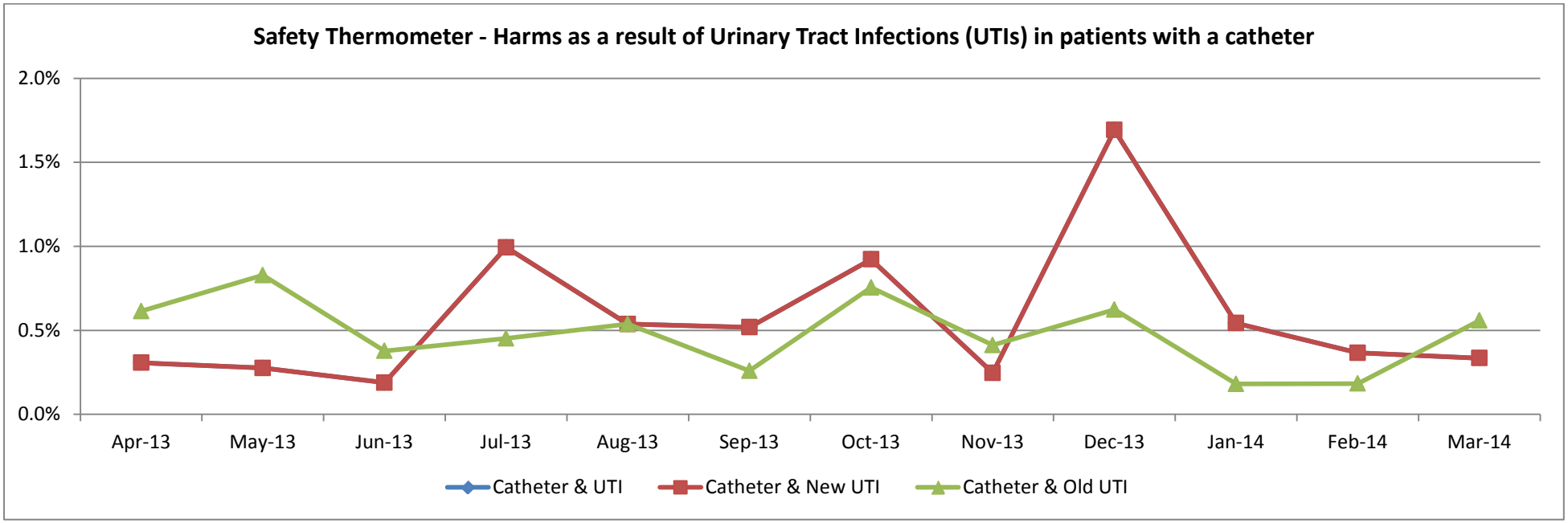
The Safety Thermometer data is cross-referenced with the incidents reported on Datix and reported as falls per 1000 bed days.



The increase in falls at Tewkesbury Hospital appear to relate to the move to single room accommodation in October 2013. The number of falls has subsequently declined as ways of working adjusted to the new environment and falls prevention measure put in place.

Similarly the number of falls at The Vale Hospital was seen to peak in June but is since declined as a focused falls project was implemented by the Matron. It is currently difficult to ascertain whether subsequent peaks relate to increased activity or acuity but data will continue to be gathered and analysed

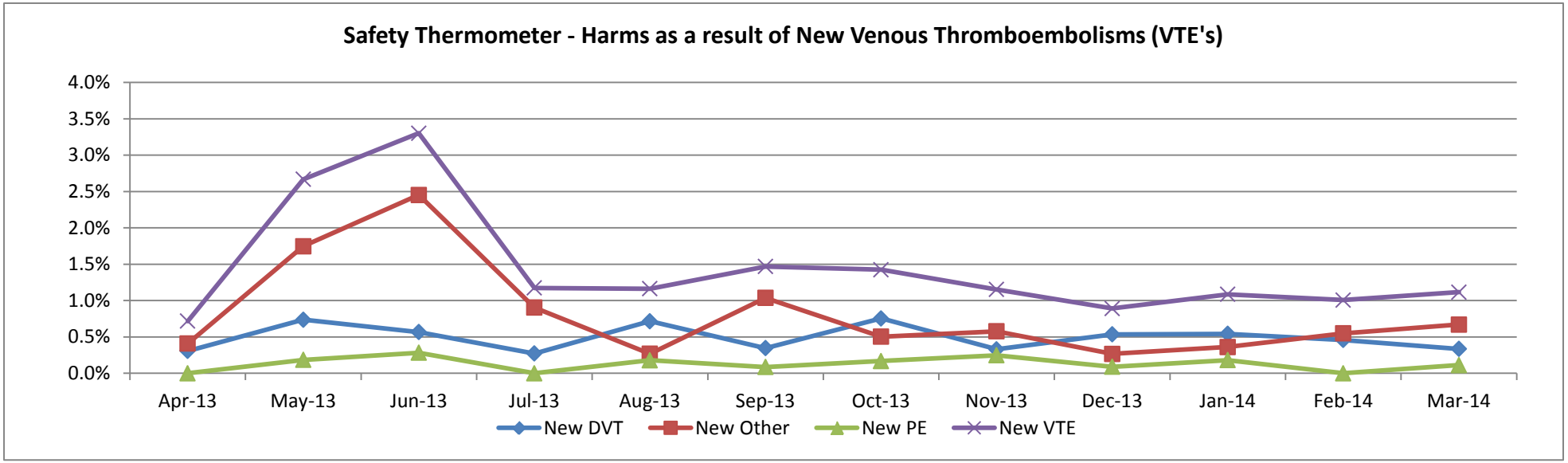
1.9 Safety Thermometer - Urinary Tract Infections (UTIs) in patients with a catheter



One of the most common sites for infection is the urinary tract, and they are most often caused by placement or presence of a catheter. Approximately 20% of all hospital acquired infections are from the urinary tract. For the purpose of the Safety Thermometer data a Urinary Tract Infection is defined as a service user who is being treated with an appropriate antibiotic. If this treatment started whilst in the care of the team reporting on the safety thermometer then this is considered a new UTI.

As can be seen from the data above over the past year the GCS number of new UTI's is consistently less than 1%, with the spike in December likely to be due to inaccurate reporting. Changes to reporting due to commence in April 2014 will allow the greater scrutiny of information prior to national submission which will help resolve this.

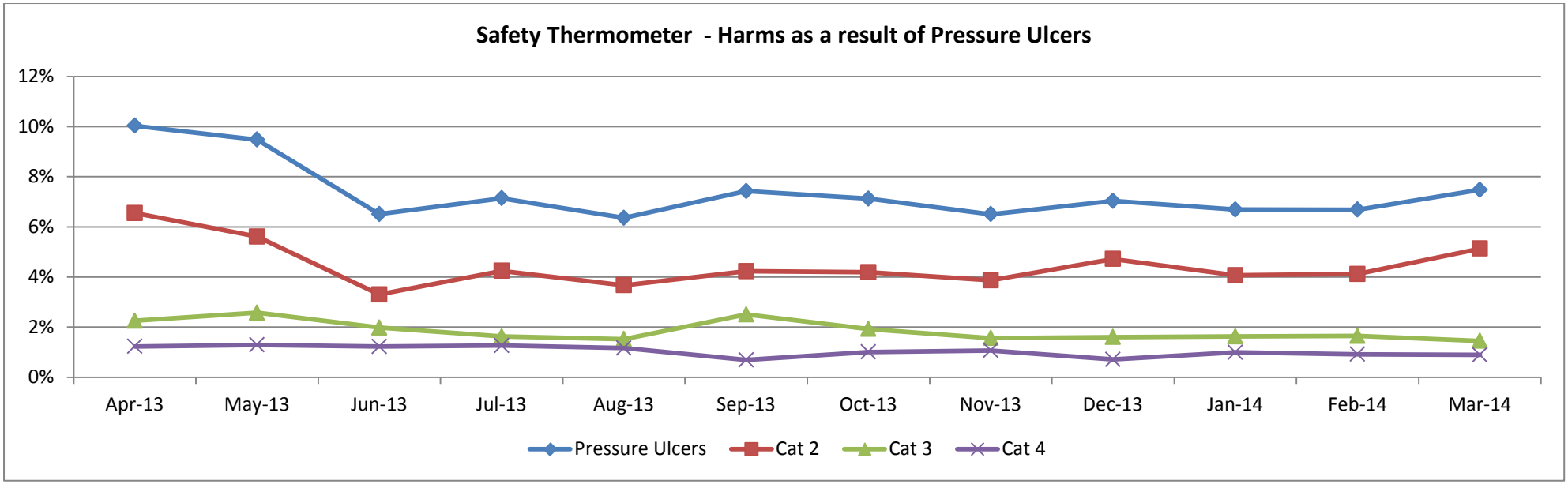
1.10 Safety Thermometer - New Venous Thromboembolisms (VTE's)



Venous Thromboembolisms (blood clot) recorded within the Safety Thermometer may be due to a deep vein thrombosis (DVT) in the leg, or in the lungs (PE). Other sites for thromboembolisms are very rare, but can be recorded on the safety thermometer as other. The definition of 'new' VTE is when a service user has a VTE diagnosed and treatment commenced whilst in the care of the team submitting the safety thermometer return.

As can be seen from the data above it is likely that some of the data reporting has been inaccurate over the past year; in particular the spike seen at the beginning of 2013. The continued reporting of new 'other harm' is also likely to be inaccurate, with colleagues not fully understanding the criteria for being a new incident. Work is underway to review the data and to investigate individual service users reported with new VTE harm to ensure greater understanding and accuracy.

1.11 Safety Thermometer - Pressure Ulcers



This report provides an overview of the actions taken to date to reduce the number of acquired pressure ulcers and to improve the quality of the data collected on pressure ulcers

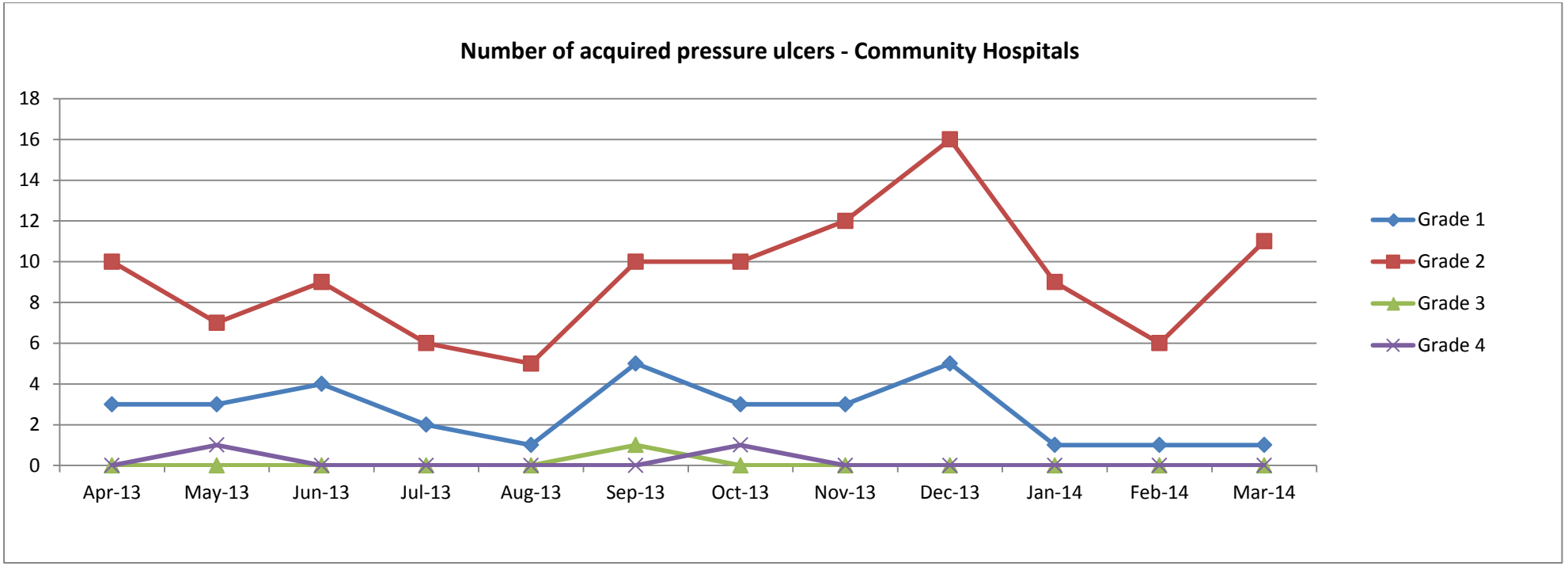
The Safety Thermometer (Harm Free Care 2011) was introduced to enable nationwide benchmarking, and forms a point prevalence audit, monitored through data collection undertaken on a monthly “census” date.
Since September 2013 all pressure ulcers (grade 1 – 4) are reported through Datix, and therefore is a more accurate method of monitoring. Prior to this community nurses reported via a paper system

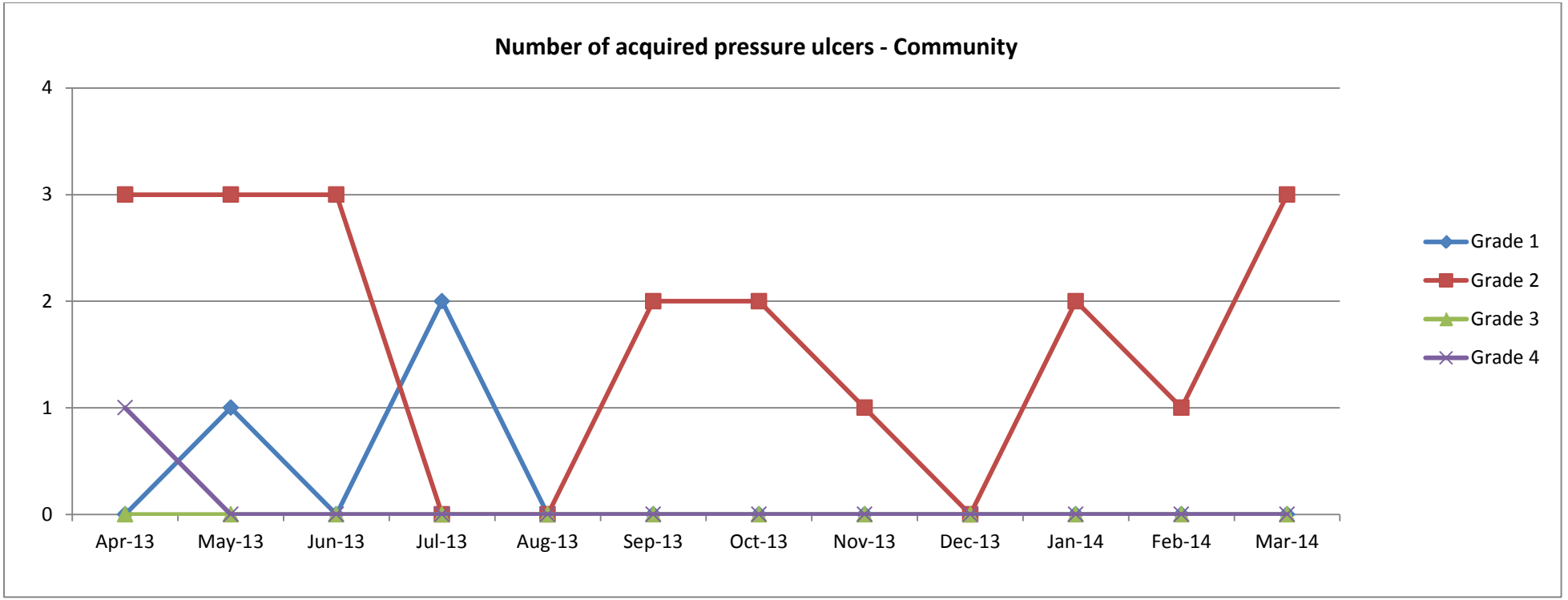
All pressure ulcers reported on Datix are reviewed by the Named Nurse Safeguarding (Adults), and the majority have telephone follow up as a minimum.
All patients with a grade 3 and 4 ulcer both acquired (new) and inherited (old) are reviewed by the Tissue Viability Team and have a safeguarding alert raised and an investigation conducted to identify root cause.

Inherited Ulcers are reported back to the relevant organisation for investigation.

Acquired grade 3 and 4 ulcers are reported on STEIS and have as a minimum an initial RCA completed. These are treated as serious incidents reporting investigation and in 2014/15 we will look to regard these incidents in Community Hospital as local never events.

The following charts show number of acquired pressure ulcers split between Community Hospitals and Community by grade of ulcer.





The peak of grade 1 and 2 pressure ulcers in November and December 2013 was investigated. No common themes or causes were identified.

There is a robust investigation process in place to establish whether a pressure ulcer is acquired or inherited. From April pressure ulcers will be reported further as avoidable and unavoidable.

Aspirant Community Foundation Trust Benchmarking

New Grade 2, 3 and 4 avoidable Pressure Ulcers whilst under the care of the provider (average)

New Grade 2, 3 and 4 Pressure Ulcers acquired (attributable to provider) - average number per month	
Gloucestershire Care Services NHS Trust (April – March)	11.5
Aspirant Community Foundation Trust Benchmark (April – January)	15.2

Of note this year

Following on from playing a lead role in the development of the Safeguarding and Pressure Ulcer Policy and associated reporting structure, GCS has won an award from the Community Hospital Association in recognition of this work, and has been asked to provide a poster display at a Patient Safety Conference in Bristol later this year.

Negotiation has taken place with our commissioners to enable GCS NHST to move to the reporting criteria of avoidable and unavoidable pressure ulcers in line with national safety thermometer data. This will commence from April 2014 but will be supported by the same rigorous investigation process described above.

1.12 Community Hospital focus on falls: Julie Ellery, Matron Tewkesbury Hospital

In our Community Hospital wards, our multidisciplinary teams are working to reduce the falls risk to patients and preventing falls. We also aim to reduce the number of overall falls, develop a training programme for staff focusing on falls prevention and bone health and reduce severe harm from falls, therefore reducing mortality, morbidity, length of stay in hospital and associated healthcare/complications and cost.

When a patient is admitted to hospital a multidisciplinary risk assessment is completed which promotes an individualised care plan detailing actions to be taken to maximise falls prevention. This includes all aspects of care such as the environment, (flooring, lighting, furniture), individual patient risks such as cognitive impairment, continence problems, falls history, footwear, health and balance problems and their vision. The majority are assessed as being at medium or high risk of falling on admission.

Staff explain the risks of falls to the patient when possible and discuss risks with family members/carers to enhance their understanding and participating in risk reduction as appropriate. For example this may be about how to use the nurse call bell system or explaining individual risk factors and the steps taken to reduce risks during a hospital stay. In some cases it may be necessary to ask a family member/carer to spend more time on the ward, settling a patient or the ward providing one to one care if a patient is at high risk of falls.

- A falls policy is in place which is evidence based to ensure that all staff are working to the same standard across the organisation.
- A falls training package has been identified for all multidisciplinary staff who work in inpatient areas.
- Hands on training for staff will take place facilitated by senior clinicians. This training is available to all staff and in 2014/2015 it will be launched to a wider audience of staff, for example MIU staff/district nurses, who will benefit from the programme.
- The number of patient falls is collated on a monthly basis and this information is shared with teams. The evidence shows that the number of patient falls has risen
- The majority of falls result in minimal harm
- The number of reported incidents suggest a good reporting culture

The average length of stay for community hospital patient has reduced during 2013/14 when compared to the 2012/13 outturn, therefore the throughput of patients has increased this has a potential impact on the number of falls. Performance in March 2014 was rated amber as above the target of 15.3 days (95th percentile).

	2012/13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	2013/14 Outturn
Average Length of Stay 95th Percentile	15.8	15.5	15.1	15.4	14.8	14.0	15.3	14.1	14.7	13.7	15.4	13.1	15.5	14.5
Total Average Length of Stay	18.1	17.6	17.2	17.7	16.6	15.9	17.4	15.8	16.2	15.6	17.3	15.9	17.3	16.7

There are three community hospitals that now have all single rooms (Tewkesbury, North Cotswolds and The Vale.) This has posed new challenges for staff and the need to develop new ways of working in order to maintain patient safety.

Trials of new ways of working to support patients are in place and include open visiting, walk round handovers and the introduction of Telecare. Telecare is equipment such as door sensors, fall pendants, pressure mats for beds and chairs all linked to a pager that can alert staff to patient movements.

Community Hospital staffing and skill mix has been reviewed and there will be an increase in registered nurses on all wards to meet the needs of the patients. In addition to this one to one nursing is requested and put in place for patients that are assessed as needing that level of care.

It is also estimated that up to 30% of people over 65 suffer from some degree of dehydration. This is because thirst lessens with age and persistent dehydration can lead to complications such as urinary infections, pressure ulcers, dizziness leading to falls, confusion and constipation, to name but a few.

Raising awareness of the problems and consequences of dehydration amongst the elderly and vulnerable groups we care for has been a focus in the Clinical Quality Team. A hydration workbook has been developed to educate and assist healthcare professionals in recognising, treating and evaluating patients who may be suffering from dehydration.

This year all wards were able to request additional equipment to prevent or reduce the risk of falls through a central system, in order to enhance patient safety. For example a patient who is assessed at risk of falls and likely to get up and walk without help could have a pressure mat placed under their cushion. When the patient stands an alarm will sound alerting help immediately. It could also be set with a voice recording from a relative/carer asking them to sit down acting as a prompt.

Patient boards have been introduced this year enabling rapid identification of care needs to maintain safety. The board is placed by a patients' bed and displays their name alongside different symbols which are individualised to quickly identify specific needs. All of these measures are put in place following consultation with the patient/family or carers as appropriate and with their consent.

1.13 Safeguarding Adults

Adult safeguarding alerts and referrals continue to rise in line with both the county and national picture. The GCS 4.4% alert rate of the county total is comparable with the other health organisations in the county. This is regarded as a positive development by the GCC Safeguarding team as it evidences that colleagues are thinking "safeguarding" as core in care.

1/4/2013 – 31/3/2014	Alerts
GCS NHST	176
Countywide Total	4,008

Gloucestershire Care Services (GCS) remains committed to playing a full and active role in the multi-agency Safeguarding Adults agenda, having representation at Board, Management Committee and sub groups. Linked to this the GCS Safeguarding Group with both health and social care membership has continued to meet regularly, providing a forum for information sharing, discussion about incidents and the focus for audit and review.

GCS took part in the Gloucestershire County Council peer review in 2013. Outcomes from both this and the 1st Annual Self-Assessment audit have framed the activity of the GCS Safeguarding group; increased participation in training, embedding safeguarding responsibilities in both job descriptions and policy documents.

Training

Since January 2014 the Named Nurse for Safeguarding Adults and the Named Nurse for Safeguarding Children provide a joint presentation on the Trust induction programme to deliver safeguarding awareness training to all new starters with Gloucestershire Care Services NHS Trust.

All employees have access to a range of training appropriate to role; this meets the requirements described within the countywide training and education strategy.
688 colleagues have attended safeguarding training during 2013/14, as detailed below.

E learning		Face to Face	
Safeguarding	191	Foundation (joint adult and children day)	146
Mental Capacity Act (MCA)	206	Safeguarding level 2	14
Deprivation of Liberty (DoLS)	121	MCA for practitioners	10

1.14 Infection Prevention and Control – Sam Lonnen, Head Nurse Infection Prevention and Control

MRSA 2013/14
Within this reporting period the Trust have had no cases of MRSA bacteraemia that have been associated with Gloucestershire Care Services NHS Trust.

Clostridium difficile Target for 2013/14
A new incidence of Clostridium difficile is defined as an initial sample which is reported as positive with no previous history diagnosis of Clostridium difficile or a positive result from a sample taken in the previous 28 days.

The Clostridium difficile countywide limit figure for this financial year is 162. The GCSNHST post 72 hour limit figure for this financial year is 18 compared to 24 in the previous year. There have been 19 cases diagnosed as post 72 hour infections and a root cause analysis has been carried out on each individual case. Key findings include multiple antibiotic courses over a short period of time and the use of proton pump inhibitors that have now been understood to influence and provide a predisposition to develop the infection. Prescribing patterns are the key focus of the development working across all providers in the country.

Hospital	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Total**
Dilke	2	0	1	0	0	1	0	1	0	0	0	0	**5**
Cirencester	1	0	1	0	0	0	0	0	0	1	1	0	**4**
Lydney	0	0	2	0	1	0	0	0	0	0	0	0	**3**
Stroud General	0	0	2	0	0	1	0	0	0	0	0	0	**3**
North Cotswolds	1	1	0	0	0	0	0	0	0	0	0	0	**2**
Tewkesbury	0	1	0	0	0	0	0	0	0	0	0	0	**1**
The Vale	0	0	0	0	0	0	0	0	0	0	0	1	**1**
Total	**4**	2	**6**	0	1	**2**	0	1	0	1	1	1	**19**
Target	1	2	1	**2**	**2**	**1**	**2**	**1**	**1**	**1**	**2**	**2**	**18**

Number of Clostridium difficile cases and rate per 1,000 occupied bed days comparing 2012/13 and 2013/14:

Hospital	2012/13 Number of cases	2012/13 rate per 1,000 bed days	2013/14 Number of cases	2013/14 rate per 1,000 bed days
Dilke	2	0.2	5	0.5
Cirencester	2	0.1	4	0.2
Lydney	2	0.3	3	0.4
Stroud General	3	0.2	3	0.2
North Cotswolds	4	0.5	2	0.3
Tewkesbury	3	0.2	1	0.1
The Vale	0	0	1	0.1
Total	**16**	**0.2**	**19**	**0.3**

What we have learned

Due to the number of Clostridium difficile cases across GCSNHST a Clostridium difficile action plan was drafted in July 2013 to address issues found in the RCA process, to raise awareness of contributory factors and to educate and update staff in the care of the patient with Clostridium difficile. This action plan is reviewed every 6-8 weeks and is coupled with a Gap Analysis on the PHE document – Revised Guidelines for the management of C. difficile (May 2013). There is only one outstanding action left to date and that is the formation of a Multidisciplinary Review Group and this is currently being organised in partnership GHNHSFT and GCCG who have agreed fund the resources required.

E. coli Blood Cultures

There have been no E. coli positive blood cultures so far this financial year and a total of 4 were reported in 2012/13.

Outbreaks

Since the 1st April 2013 there have been 11 outbreaks, ten identified Norovirus as the causative organism. This compared to 18 outbreaks with 13 with a confirmed Norovirus as the cause in 2012/13. The management and patient care in an outbreak situation has improved over the past 12 months as practices have been adapted to more effectively deal with the situation.

	2012/2013	2013/2014
No. of patients affected	199	135
Bed days lost	497	220

Influenza

There have been no patients reported as having a confirmed diagnosis of influenza whilst in the care of Gloucestershire care Services NHS Trust at the time of this report so far.

Hand Hygiene

The 2012 Staff Survey indicated a reduction in the number of staff who reported that they 'Always have access hand hygiene materials' with a percentage score of 63% as opposed to 64% from the previous survey. Investigation as to why there had been a reduction in staff being able to access hand hygiene materials such as hand sanitizer or detergent/biocide wipes it was found that some ICT staff did not have a ready supply of such items. Meetings with locality leads have taken place and I can now report that thanks to these locality leads and their understanding of what is required there is now an availability of the necessary items to ensure hand hygiene compliance as the policy dictates.

Observational hand hygiene audits are undertaken monthly and the tool used tests compliance with both the '5 Moments for Hand Hygiene' and 'Bare Below the Elbows' initiative.

The Hand Hygiene observation audits have so far this year been comparable with previous years with a year to date average score of 94% for the organisation. From January 2014 Podiatry and Dentistry Services will be providing monthly audit results.

Infection Control Audits Programme

The current infection control audit tool includes elements of the Infection Prevention Society's Quality Improvement Tool (QIT) as well as pertinent elements of the Infection Control Nurses Association Community Infection Control 2005 audit tool. Audit scores have improved with higher scores achieved in the Patient Care Environment element as care is provided in new and refurbished units, outpatient departments and hospitals which have rooms with en suite facilities. The elements of the infection control audit that focus on staff awareness of process and procedure and patient safety have performed well and shown improvements across the organisation with the total average score for the previous year's elements scoring 91% compared to a 92% average score for 2013-2014.

Adenosine Triphosphate (ATP) bioluminescence Testing continues to improve

The ATP monitoring system can detect organic matter that remains on a surface or item of equipment after cleaning. While the testing units pass mark is 2000 GCSNHST have halved this figure so reducing the pass mark to 1000. If an ATP swab is between 1000 and 2000 then a caution is issued and the item/environment is re-cleaned and tested again. This process of re-cleaning is duplicated in the rare event that an item or the environment ATP score is above 2000. The ATP scores across the organisation continue to be outstanding over the period 2013/14 to date and are a clear indication of how the process of cleaning and cleaning schedules/frequencies are working. ATP results are available for each site using the hyperlink below.

https://nww.gloscareservices.nhs.uk/hotel_services/Web%20Pages/ATP%20Results.aspx

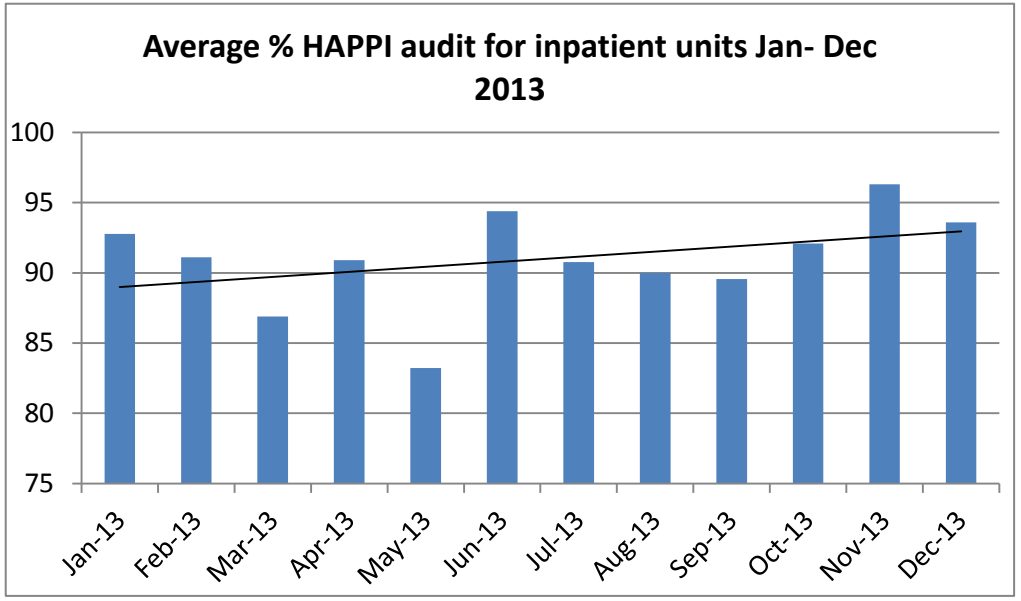
Table to show correlation between positive C. difficile cases, hand hygiene and ATP scores between April 2013 and March 2014

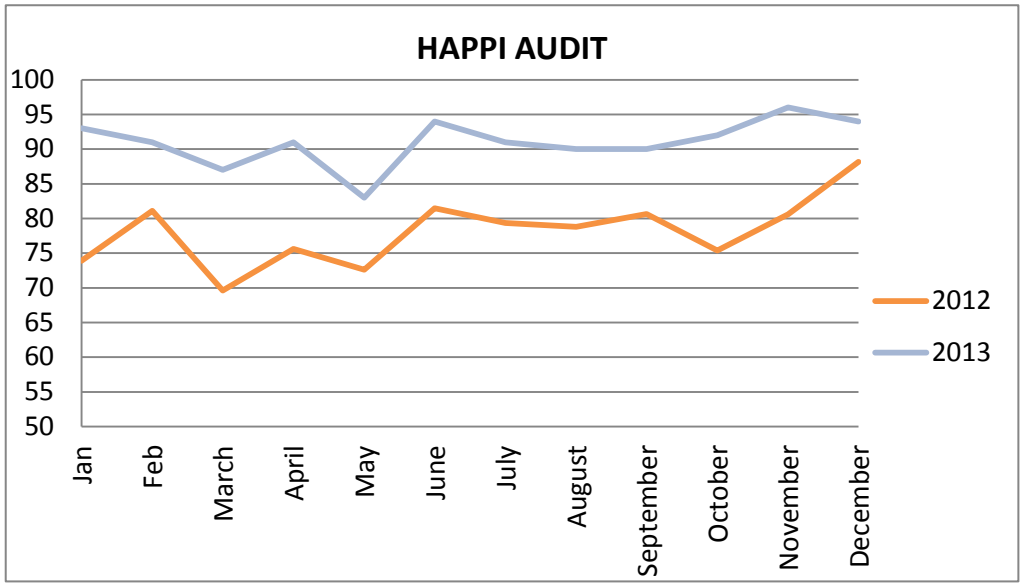
HOSPITAL	WARD	MONTH	OHHA	ATP
Cirencester	Stratton	June	100%	1 fail
Cirencester	Windrush	N/A	N/A	N/A
Cirencester	Coln	April	100%	1 fail
Cirencester	Coln	Jan	100%	Pass
Stroud	Cashes	N/A	N/A	N/A
Stroud	Jubilee	June	90%	Pass
Stroud	Jubilee	June	90%	Pass
Lydney	-	June	100%	1 fail
Lydney	-	June	100%	1 fail
Lydney	-	August	100%	2 fails
Dilke	-	April	100%	Pass
Dilke	-	April	100%	Pass
Dilke	-	June	100%	Pass
Dilke	-	June	100%	Pass
Dilke	-	September	100%	Pass
Dilke	-	November	100%	1 fail
Dilke	-	March	100%	N/A
Tewkesbury	-	May	100%	Pass
North Cotswold	-	April	100%	N/A
North Cotswold	-	May	100%	N/A
Vale	-	February	90%	Pass

1.15 Medicines Management: Laura Bucknell, Head of Medicines Management

Antimicrobial Stewardship (AMS)

- Monthly HAPPI (Hospital Antibiotic Prudent Prescribing Indicator) audit of medication charts on inpatient units to check
- Allergy status completed, dated and signed
- Indication for antibiotic is recorded in the drug chart
- Review or end date is recorded on the drug chart
- The antibiotic prescribed is in line with the local formulary or on the advice of a microbiologist
- The route of administration is appropriate
- The results are reported on the locality dashboard and to the Medicines Management Committee and the Infection Control and Contamination Committee
- Any areas of non-compliance are fed back to the prescriber by the matron or the out of hours medical lead (if the prescribing was initiated by and OOH doctor)





These figures have now been collected for 2 years and graph 2 shows considerable improvement in performance across the Trust

Medicines Management Committee

This membership and terms of reference of this group have been reviewed to meet the requirements of the Trust Development Authority (TDA).The group is tasked among many other things, with monitoring the organisation's progress towards full compliance with the TDAs medicines optimisation framework.

Medications Safety Thermometer

The organisation will be piloting the medications safety thermometer over the next couple of months. This is a national tool developed by a

steering group led by Dr David Cousins (Head of Patient Safety for Safe Medication Practice and Medical Devices, NHS England)

The medication safety thermometer has built on learning from the NHS Safety thermometer and has incorporated the same key design principles – data is collected wherever the patient is across the health economy and is collected as part of routine care
The medication safety thermometer follows a process in order to measure medication error, triggers of potential harm from critical medicines and actual harm from medication errors. The process requires the collection of data relating to the previous 24 hours. The purpose being to identify errors in the administration of medicines, focussing on:

- the reconciliation of medicines
- number of regular medicines
- total medicine admissions
- the number of critical medicines omissions

Data collection should take place on100% of patients on one day each month.

Transdermal Patch Application Record

The use of the transdermal route to administer medication, particularly pain relief, had increased markedly in recent years. The CQC 'Safer Management of Controlled Drugs Annual Report 2011' recommended that controlled drug accountable officers should ensure that suitable systems are in place to ensure the safe and effective use of transdermal fentanyl patches. This was due to nationally a high number of incidents related to fentanyl (transdermal) patches over the period 2007-2011. To support staff and minimise the risk to patients a GCS Transdermal Patch Application record has been developed which will be introduced in April/May of this year

1.16 Transfer of patients between hospital wards.

In March 2013, Sir Bruce Keogh wrote to all Trusts raising concerns about the transfer of patients between wards between the hours of 11pm and 6am. Such movement, where there is not clear clinical need, will have a detrimental impact on the individual patient and onto patients within that ward area.

Table 1 shows the total of direct admissions and transfers into GCS in patient care for the year to date.

		Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	2013/14
All Admissions	**23:00 - 05:59**	**18**	**10**	**11**	**9**	**9**	**10**	**11**	**8**	**21**	**18**	**14**	**14**	**153**
	23:00 - 05:59 %	**4.6%**	**2.6%**	**3.2%**	**2.3%**	**2.4%**	**2.7%**	**2.6%**	**2.1%**	**5.5%**	**4.6%**	**3.8%**	**3.9%**	**3.4%**
Direct Admission	23:00 - 05:59	12	6	7	3	5	8	6	2	9	6	5	5	74
	23:00 - 05:59 %	9.4%	3.7%	5.4%	1.6%	3.2%	5.7%	3.6%	1.3%	6.1%	3.8%	3.5%	3.9%	4.1%
Transfer	23:00 - 05:59	6	4	4	6	4	2	5	6	12	12	9	9	79
	23:00 - 05:59 %	2.3%	1.8%	1.9%	2.9%	1.8%	0.9%	2.0%	2.7%	5.2%	5.2%	3.9%	4.0%	2.9%

Table 2 provides high level detail of the 79 transfers, a further analysis of these cases is being undertaken.

Reason for Admission / Transfer	**Number of patients**
Transfer from GRH	35
Transfer from CGH	30
Transfer from Out of County Hospital	10
GRH for tests	2
CGH for tests	1
Transfer from Great Western Court	1
Grand Total	**79**

1.17 Mortality Surveillance Dr Joanna Bayley, Medical Director

The electronic reporting form has been in use since the beginning of 2014 and appears to be working well, useful data is being received and no one has reported any difficulty using the system since early "teething" problems were eliminated.

We held the first mortality review meeting as part of the Clinical Senate in April. A review of all SIRIs, complaints or concerns about deaths were reviewed but there were none for consideration on this occasion. The review looked at care through a case not review for a randomly chosen selection of patients who were cared for at the end of their life in North Cotswold, Lydney, Stroud and Cirencester Hospitals. We meeting reviewed all aspects of their End of Life (EOL), including the actual death. I am pleased to report that, in each case, we found evidence of excellent care, including:

- Recognition of the need for the use of an EOL pathway at the appropriate time and good documentation of this
- Good palliative care including use of syringe drivers and care of pressure areas
- Early involvement of AHPs and a multi-disciplinary approach
- Documentation of thorough discussions with patients (where possible) and families about wishes and expectations
- Documentation of a DNACPR decision once clinically appropriate
- Datix reporting of pressure ulcers noted at admission (from home)
- Generally good nurse record-keeping.

There were no areas of concern noted in our review. The standard of documentation by doctors was not as consistent as by nurses: in some cases it was excellent, in other cases adequate, but not to a point of being unsafe. The integrated notes were easy to read and mapped the patient's care well. Feedback from the review was provided to the Hospital Matrons for sharing with their teams.

We will consider randomly chosen cases from Tewkesbury, the Dilke and The Vale Hospitals at our next meeting, as well as all deaths about which there has been a SIRI, concern or complaint.

The Senate was very pleased (though not surprised) to find evidence of such excellent EOL care, reflecting the hard work and skill of the community hospital staff.

Caring

2.1 Patient/User/Carer Experience

The Friends and Family Test (FFT) was implemented on inpatient wards and in Minor Illness and Injury Units (MIU) from 1st April 2013.

The overall required response rate across all wards and MIUs is 15% and the aim is to achieve and improve this score during each month of reporting.

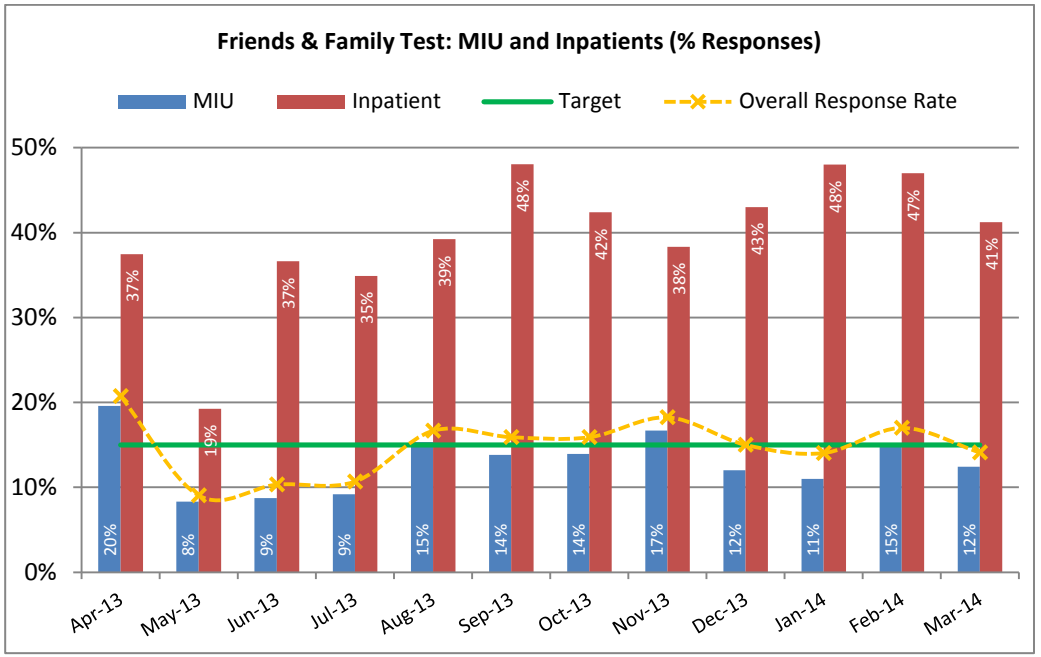
The 'Net Promoter Score' is presented as a number score (between +100 and -100). The score overall has remained high throughout 2013/14, with MIUs typically receiving a higher score than inpatient wards.

The next steps is to ensure that actions are developed and are taken forward, monitored and reported on through a 'You said, we did' approach, displaying posters in ward areas and MIU settings

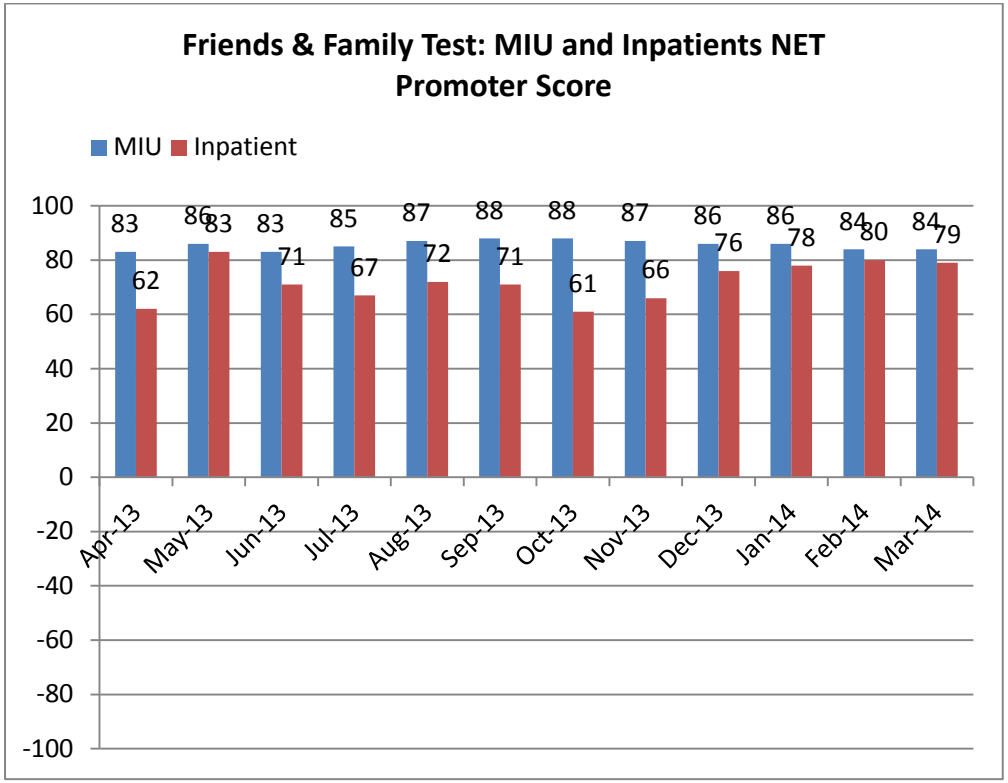
From April 2014 the Trust is to roll-out the Friends and Family Test to all community services. The roll-out will see a number of methods being piloted to ensure the best possible response rate within different services.

The table below shows that even though the Trust has achieved the minimum target of 15%, this is behind the average rate reported by Aspirant Community Foundation trust benchmarking group.

Friends and Family Test - Response Rate	
Gloucestershire Care Services NHS Trust (April – March)	15.0%
Aspirant Community Foundation Trust Average (April – January)	25.2%



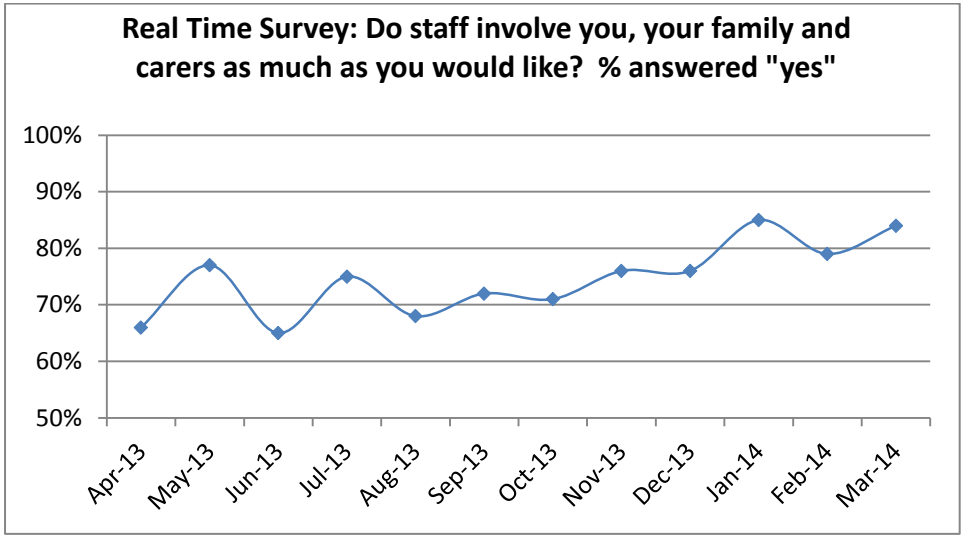
The net promoter score for each setting (MIU and Inpatient unit) is shown in the chart below.

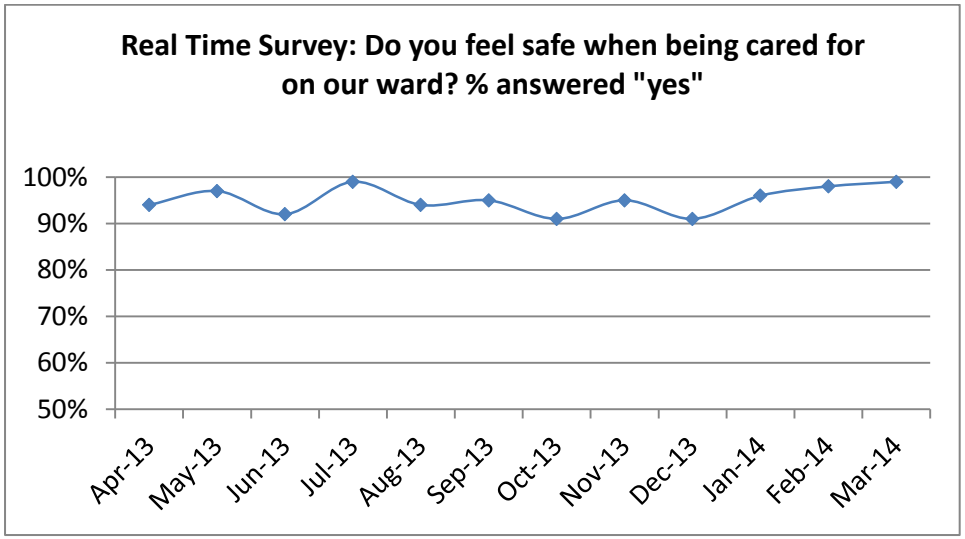


The table below shows that Net promoter score achieved by the Trust is ahead of the average rate reported by Aspirant Community Foundation trust benchmarking group.

Friends and Family Test - Net Promoter Score	
Gloucestershire Care Services NHS Trust (April – March)	83.0
Aspirant Community Foundation Trust Benchmark	75.0
Aspirant Community Foundation Trust Average (April – January)	79.5

2.2 Inpatient Real time survey





A RAG rating is used to score the survey results as follows:
Green: 90%>
Amber: 80-90
Red: <80%

The continuous inpatient survey has been running on all inpatient wards for two years and is reported on a monthly basis.

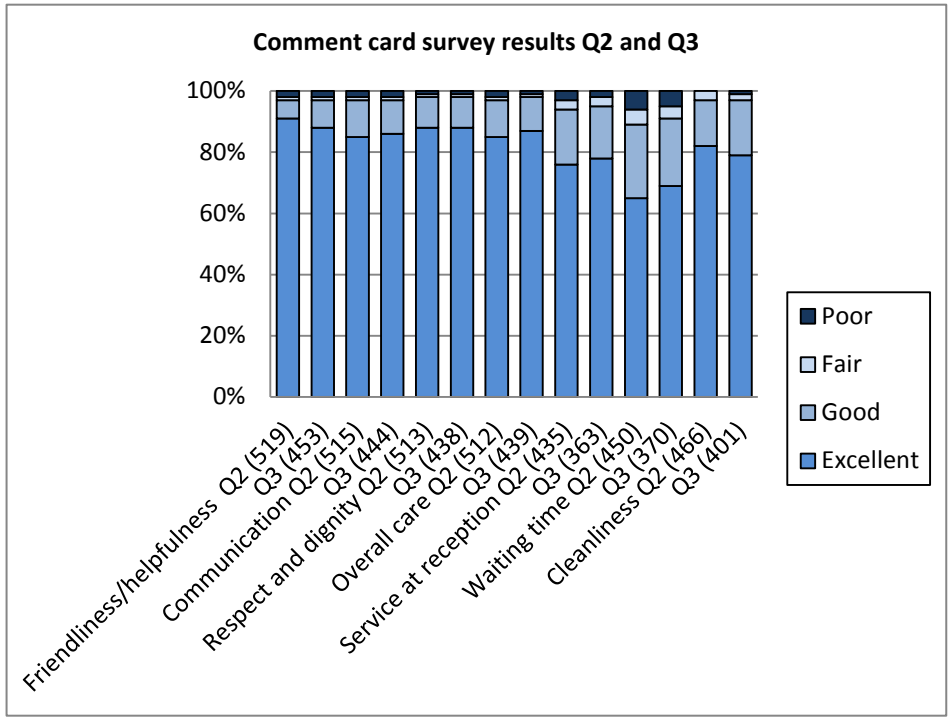
The survey results have shown an overall improvement in most questions throughout the year, although there is some differences between wards.

Some hospitals perform consistently better than others, with North Cotswolds, Lydney and Dilke hospitals generally displaying the most positive results. Stroud and Cirencester hospitals have lagged behind, although improving over recent months. A targeted action plan at Stroud showed very positive improvement in both response rate and results in January 2014.

The Matrons are responsible for agreeing, implementing and monitoring local action plans which are reported through the CQUIN structure.

2.3 Comment cards

The new comment cards were introduced in July 2013



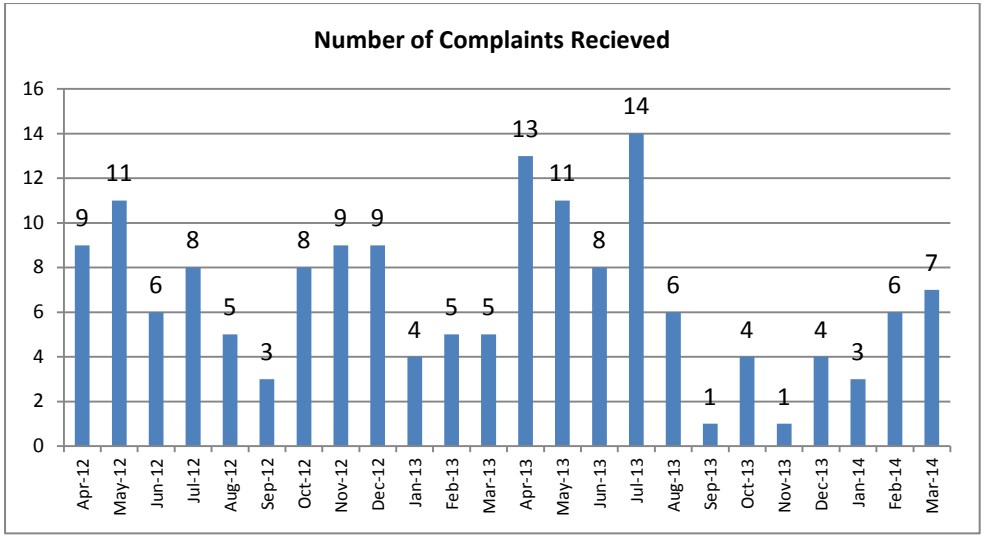
2.4 Service specific survey

The Trust runs a programme of annual surveys in most services; during 2013/14 the numbers of surveys carried out are shown below. Service specific surveys are designed, managed and reported centrally, with local survey leads responsible for distribution, actions from results and monitoring

Type of survey	Surveys completed (or still running)		Surveys outstanding
Across county	6	Outpatient, District nursing, OOH, Reablement, Dental service, Sexual health	0
Hospital specific		Cirencester and Stroud endoscopy unit	0
Specialist service	11	Wheelchair Service, Pregnancy Advisory Clinic, Diabetes Team, DESMOND programme, Heart Failure Service, Parkinson Specialist Nurse, Bone Health Service, Community IV Therapy, Respiratory Service, Speech and Language Therapy, Cardiac Rehabilitation Phase 3, Stroke Coordinator, Occupational Therapist Palliative Care	1 (Telecare)
CYP	9	Children in care, Immunisation Team, School Nurses, Newborn Hearing Screening Service, Children's Complex Care Team, Children's Community Nursing, Health Visitors, Children's physiotherapy, Children's occupational therapy	1 (Children's speech and language therapy)
On-going	1	Podiatry services via PROMS	

2.5 Complaints

The graph shows number of complaints across the Trust from April 2012 to March 2014.



Coroner's Inquests

There are currently 14 outstanding Coroner's inquest cases which name the Trust or its predecessor organisation:

- 5 are forthcoming, 2 of which have dates for inquests;
- 9 are pending which may or may not proceed to inquest.

Three earlier cases have recently been completed with the verdicts of: (i) natural causes, (ii) service user suffered from co-morbidities and died from the effects of pressure sores, and (iii) suicide.

Litigation Claims

As of the end of quarter 3, there are:

- 2 settled cases (2012/13);
- 3 pending cases (2011/12, 2012/13 and 2013/14 respectively).

Number of complaints responded to within 25 days target during quarter 3 was 100%

Benchmarking comparison

Complaints per 1,000 WTE	
Gloucestershire Care Services NHS Trust (April – March)	3.0
Aspirant Community Foundation Trust Benchmark	4.8
Aspirant Community Foundation Trust Average (April – January)	4.8

2.6 Concerns

The table below shows the number of concerns raised across the Trust from April 2013 to March 2014. These have been grouped into a range of categories to enable comparison. This shows that Communications / Telecommunications and Clinical Care account for 60.4% of all concerns raised.

Category of Concern	Number of Concerns	Percentage of Concerns
Communications / Telecommunications	100	31.0%
Clinical Care	95	29.4%
Waiting Times / Access	44	13.6%
Administration / Health records	44	13.6%
Environment	10	3.1%
Discharge Arrangements	8	2.5%
Behaviour / Attitude	8	2.5%
Confidentiality, Privacy and Dignity	5	1.5%
Aids and Appliances	5	1.5%
Parking	3	0.9%
Transport	1	0.3%
Total	323	100.0%

Effective

3.1 Audit programme 2014-15

One of the goals of the Trust's audit and effectiveness strategy is to have a "*schedule of mandatory and proactive audits prior to the start of each financial year, with capacity for in-year additional reflective and reactive audits*". Each locality/ business unit has been asked to propose topics for inclusion in the Trust's programme of audit for 2014-15. They were to sign these off at their clinical governance meeting in March for submission to the Quality and Safety Governance Forum in April and then to this committee for final ratification.

This programme of Trust audit will be complemented by participation in the following **national audits** which are to collect data in 2014-15 and are relevant to the services the Trust provides:

- Sentinel Stroke National Audit Programme (SSNAP)
    - 2013 saw the extension to community services of this rolling audit, which captures the care and treatment given to all patients admitted with a stroke to an acute hospital.
    - Current GCS participation from the Early Supported Discharge team and Stroke specialist nursing. Community hospitals have yet to participate. First report with data from community services awaited.

- National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme

    - Pulmonary rehabilitation audit: Nov 14 – Apr 15: Data collection.

- Parkinson's disease (National Parkinson's Audit)
    - Details awaited

- National Audit of Intermediate Care
    - Expressions of interest to be submitted by 28 Feb 14
    - Subscription audit (Cost £1,000; to be met by commissioners)

Participation and findings from these audits are required to be reported in the Trust's Quality Account.

The Clinical Audit Network Forum (membership drawn from audit leads from providers, convened and chaired by the CCG) is looking to discuss provider audit plans at their next meeting in May, and also to regularly review executive summaries and action plans from Trust participation in national audits.

The Trust's Heart Failure Team are working with the National Heart Failure audit to explore the potential of extending the scope of the current acute-focussed national audit to include data from community-based specialist services. The Heart Failure Team are in a position to do this because of their robust database populated with patient data developed over a number of years.

3.2 Audit programme 2013-14

Progress against the 2013-14 audit programme is captured on Excel workbooks and should be reviewed at service /locality clinical governance meetings together with completed audit reports and progress on audit action plans. There is work to do to see this well embedded in all areas.

The annual clinical audit report for 2013-14 will document Trust audit activity with details of all projects known to the clinical audit team. The table below outlines the number of clinical/care audits supported by the clinical audit team by locality /business unit this year**.** It is important to note that:

- The number of audits supported by team does not equate necessarily to the total number of audits undertaken. Audits are sometimes undertaken without the involvement of the clinical audit team.
- Projects vary by:
    - number of criteria
    - size and structure of the service undertaking the audit (varying from one team to 60)

Locality	**Current/ underway:**	**Completed in 2013-14**
Gloucester and Stroud *	2	78 **
Forest and Tewkesbury *	4	117 **
Cheltenham and Cotswold *	2	79 **
Urgent and capacity care	8	8
County wide inc specialist services	28	24
CYPS	8	9
Total	**52**	**315**

Key:
* *Most audits run across localities, reporting by locality/hospital and, where relevant, team. Where this is the case each participating site/locality has been counted separately, reflecting the individual nature of the results and action plan.*
** *CQUIN reaudits and other reaudits have been counted as separate projects.*

3.3 Internal audit record keeping review

The internal auditors, PwC, returned in January 2014 and met with Rosemary Clifford to follow up their report published in August and review the Trust's progress against the agreed actions. A draft report was delivered by PwC in March.

Guidance on the revised record keeping audit process has been uploaded to the Trust intranet and a tracker spreadsheet developed for all services to use to outline their progress through the audit cycle. The record keeping policy was revised in January 2014 and will be revised again in April 2014 to reflect health and social care requirements

3.4 HealthAssure: clinical audit module

HealthAssure, the on-line board assurance and governance tool purchased to track compliance with NICE guidance, CQC and NHSLA standards will also incorporate a clinical audit module. Work is underway with the software developers to configure it to the Trust's requirements. All audit projects will be registered on the database. It has the facility for uploading of completed audit reports and presentations.

3.5 NICE guidance issued in 2013-14

NICE has continued to issue guidance throughout this year. Currently recently issued guidance is reviewed by the Quality and Safety Governance Forum on a bi-monthly basis and allocated to one or more clinicians to undertake a baseline compliance assessment. The results of these assessments are reported back to a subsequent meeting of the Forum. The results of these assessments are reported below. Where partial compliance is declared an action plan is agreed. Once completed the compliance status is updated.

Type of guidance	Number issued	Number applicable to Trust	Compliance declared			Yet to be fully assessed
			Full	Partial	Non-compliant	
Clinical guideline	20	10	2	1	0	7
Diagnostics guidance	4	0	-	-	-	-
Medical Technologies guidance	3	0	-	-	-	-
Interventional Procedures guidance	40	0	-	-	-	-
Public Health guidance	7	5	2	1	0	2
Technology Appraisals	29	1	1	-	-	-
Total	**100**	**16**	**5**	**2**	**0**	**9**

3.6 NICE Quality Standards

Quality Standards (QS) are a synthesis of guidance recommendations, largely from that produced by NICE, but also from other sources evidence sources accredited by NHS Evidence. Eventually there will be in excess of 150 Quality standards.

In that Quality Standards can cover pathways of care from prevention, through diagnosis to treatment and end of life care (if applicable) delivery will be dependent on contributions made by a number of organisations/agencies. Any one provider may only be commissioned to deliver services against part of that pathway. As a community services provider many of the statements in Quality standards do not apply to the Trust. There may also be standards where the Trust is commissioned to provide care for part of one of the standard.

Over the past three and a half years 57 Quality Standards have been published, 28 of them being deemed applicable to the Trust. With a number of assessments outstanding, there is work to do to across the Trust to better understand our compliance position against the standards published to date.

3.7 NICE Assure

NICE Assure is a module within the Trust's new HealthAssure software which will track and report on compliance. The software will herald a change in the way the Trust provides evidence of implementation of NICE guidance, with allocated leads to attach and enter evidence and monitor the progress of action plans.

Locality clinical governance meetings will review recently issued guidance, decide on its applicability to the services currently provided and allocate appropriate clinicians to review implementation and report on compliance. Self-assessments should be discussed and signed-off at subsequent locality clinical governance meetings.

Compliance with all NICE guidance judged applicable to the locality will be reported on a regular basis via the use of dashboards and reports. Trust level compliance will be reported on a regular basis to this committee.

Work is underway to configure the software to the Trust's requirements and to train staff across all localities.

3.8 Early Warning Trigger Tool

All in-patient areas within GCS Community Hospitals carry out a monthly “temperature check” using a nationally validated early warning scoring system (QuEST). With weighted scoring against some key quality indicators including staff vacancies, appraisal completion and sickness absence the tool is designed to give early warning of potential risk to enable early intervention aimed at supporting staff and maintaining standards of care.

In March, all wards were rated as green, with the exception of Cashes Green (Stroud General Hospital) which was rated amber with a score of 10 (the same as the previous month).

Early warning trigger tool scores (March 2014):

Site	Ward	Score
Stroud General	Cashes Green	10
Stroud General	Jubilee	7
North Cotswold	North Cotswold	6
The Vale	The Vale	5
Cirencester	Windrush	4
Dilke	Dilke	3
Tewkesbury	Abbeyview	2
Cirencester	Coln	0
Cirencester	Stratton	0
Lydney	Lydney	0

Actions include:

Cashes Green Ward was rated amber due to a cumulative score based on a number of indicators.

This will be reviewed in conjunction with the Nursing and Quality Directorate. The scoring matrix and escalation levels are shown overleaf for reference.

Early Warning Trigger Tool scoring matrix:

Score	PROPOSED ACTIONS
22 - 24	As below plus: Inform Director of Opertaions and Director of Nursing Consider ward closure
18 – 22	As below plus: Stop all admissions to the unit Inform locality Manager of the situation
13 – 17	As below plus: Formally involve Hospital Matron Agree staffing requirements for shift and the following 24hour period Identify staffs that are able to work additional shifts. If unable to get additional staff then look to obtain bank/agency staff. Inform the Single Point of Clinical Access and advise them of ward based pressures and ensure any new admissions/transfers reflect ward pressures. All transfers/admissions to be discussed directly with the Hospital Matron/Deputy
8 – 12	As below plus: Review hospital wide skill mix and consider re-deployment of staff between wards/units and departments Ward Sister/Charge Nurse to undertake formal risk assessment.
3 – 7	As below plus: Score to be formally validated by Ward Sister/Charge Nurse or deputy if not available Ensure all ward based patient risk assessments completed and actions in place as per agreed care plan
2 or below	Continue to monitor situation on a shift by shift basis

RESPONSIVE

Performance against National and Local targets is included within the scorecard that accompanies this report. The indicators rated red or amber that have not been referenced within the previous sections of this report are detailed below.

National Targets – Amber

4.1 Call to Action (Health Visitors)
At the end of 2013/14 GCS was behind the trajectory developed in the local monitoring plan with NHS England Area Team (NHSE AT) for increase in numbers of health visitors. The number in post was 101.29 WTE compared to target of 106.0 WTE.

This is due to the difficulty the Trust has had with recruiting trained Health Visitors in 2013/14, even though there has been an ongoing recruitment campaign. This has further highlighted the need for training Health Visitors rather than trying to recruit.

The position for 2014/15 shows GCS expecting to be significantly ahead of target due to 40 trainee Health Visitors that are currently in a training programme.

National Targets – In-month Amber
The following indicators recorded performance that was rated amber for March 2014 but overall outturn performance remained rated green.

4.2 Face to Face Consultations in Primary Care Centre for those assessed as an Urgent case to be seen within 2 hours
The target for consultations for those assessed as Urgent within the Primary Care Centres is that 95% of patients should be seen within 2 Hours. Performance in March 2014 was 93% and rated amber. 2013/14 outturn performance remained ahead of target at 96% (target 95%). This is due to NHS111booking appointments outside of, or very close to the 2 hour timeframe.

There are numerous incidences' where Harmoni 111 have booked in appointments with 15 minutes or less, of the 2 hour urgent time frame remaining. In some cases there has been less than 5 minutes in which to book the patient in at reception and for the patient to be seen by the clinician. It is likely that earlier appointments were available. Datix completed for investigation by Harmoni 111.
The table below shows the number of patients breaching the target and length of time by which the target was missed.

Distance from achieving target	Number of patients
Missed by up to 10 minutes	19
Missed by 11 - 20 minutes	12
Missed by 21 - 60 minutes	19
Over 60 minutes	5
Over 120 minutes	2
Total	**57**

Actions include:

- Review of booking process with NHS111 as in many cases the patients were booked into appointment slots with very little time remaining to see the patients.
- An action plan will be developed and agreed with NHS111 to reduce this risk of this occurring again.

4.3 Chlamydia Screening

The Department of Health Public Health Outcomes Framework (2013-2016) includes an indicator to assess progress in controlling Chlamydia in sexually active young adults. The revised diagnosis indicator recommends a level of achievement for local areas to work towards: *at least 2,300 chlamydia diagnoses per 100,000 15-24 year olds*. This reflects both coverage and the proportion testing positive at all sites, including Genito-Urinary Medicine (GUM) as well as those made outside of GUM in core services.

The rationale for this is that a substantial proportion of young adults (15 – 24 years old) become infected with Chlamydia each year and as many of these infections will be asymptomatic, a large proportion of cases remain undetected. However, Chlamydia infection can be easily diagnosed and treated.

The target for number of positive Chlamydia screens to be delivered in March was 79, however only 76 positive screens were recorded and therefore in month performance is rated amber. 2013/14 outturn performance was ahead of target and rated green.

Actions taken include:

Sexual Health service to continue to screen patients attending clinic and to identify at risk patients and follow-up partners of those patients that are tested as positive.

Local Targets – Red

4.4 Sexual Health – Psychosexual Medicine

Gloucestershire Care Services is required to achieve the Operating Standard of 95% of patients referred to the Psychosexual Medicine service receiving treatment within 8 weeks of referral.

Performance for patients treated in March 2014 was 100% and rated green for the second consecutive month and is expected to continue to attain target following changes implemented in recent months in triage and administration. 2013/14 outturn was 83% and rated red.

Local Targets – In-month Red

4.5 Referral to Treatment – Bone Health Service
Gloucestershire Care Services is required to achieve the Operating Standard of 95% of patients referred to the Bone Health service receiving treatment within 8 weeks of referral.

Performance for patients treated in March 2014 was 70% and rated red. 2013/14 outturn was 95% and rated green.

This resulted in 21 patients waiting in excess of 8 weeks in March (total of 69 new patients seen and treated during the month).

The reason for this was due to capacity issues within the service and analysis of the patients breaching is shown below.

	Wait Band (weeks)							
Reason for breach	9-10	10-11	11-12	12-13	13-14	14-15	15-16	Total
Clinics Full - patient booked to next available clinic	3	2	3	4	5	1	1	19
Patients diverted from other clinic	2	0	0	0	0	0	0	2

Actions include:
Additional clinics have been established in Stroud. Further review of administrative processes using SystmOne to ensure booking processes ensure appointments are allocated in order of priority.

Performance team to work with service to monitor progress and ensure that patients are prioritised based on referral date and to review capacity and demand.

Local Targets – Amber

4.6 Single Point of Clinical Access (SPCA) Abandoned Calls
Percentage of calls abandoned was 3.9% in March 2014 (compared to a target of less than 5%) and in month performance is rated green. This equated to 96 calls that were abandoned out of 2,466 calls received in March 2014.

2013/14 outturn performance improved further from 5.3% (year to date to February) to 5.2% (2013/14 outturn) and was rated amber. The target was missed by 42 calls not answered out of a total of 28,283 calls handled.

Actions include:
In November 2013 a number of telephony system changes were implemented. Performance has been rated green since this implementation and is expected to continue to be on target.

Local Targets – In-month Amber

4.7 Direct Admissions to Community Hospitals
Performance for the percentage of direct admissions to Community Hospitals in March was rated amber at 47% compared to target of 50% (based on the 2012/13 outturn). 2013/14 outturn was on target at 50% and rated green.

The table below shows the performance at each Hospital:

Hospital	% of Direct Admissions
Cirencester	59.6%
North Cotswold	58.3%
Lydney	50.0%
The Vale	45.7%
Tewkesbury	37.9%
Stroud	34.0%
Dilke	32.6%
Winchcombe	25.0%
Total	47.3%

Actions include:
Community Hospital Matrons to check that ring-fencing of beds for direct admissions continues where this has been in place. Single Point of Clinical Access and Integrated Discharge Teams to continue to identify patients for early discharge from Acute Hospital (those discharged from Acute Hospital within 48 hours of admission can be counted as Direct Admissions). It is noted that there was a 4% reduction in March compared to February of patients that were Direct admissions but transferred to Community Hospital from Acute Hospital within 48 hours of original admission.

Adult Social Care
The format of the scorecard accompanying this report now shows one page with all of the key indicators that are 'RAG' rated. The remaining indicators that are used for operational management of service delivery are reported to each Business Unit but not included within the accompanying scorecard.The basis of the following narrative is the indicators that are 'RAG' rated only.

There has been difficulty with accessing data, however a secure daily copy of data from the GCC to the GCS data warehouse is now operational. There is now a need for a period of development to set-up reporting to provide support to operational teams.

There has been significant improvement from the dedicated resource within the GCS Performance and Information Team.

National Targets – Red

4.8 Service users receiving self-directed support as direct payments
Performance in March 2014 showed 24.5% of service users receiving self-directed support as direct payments, compared to target of 27.0% which is rated as red.

Actions include:
Provision of weekly monitoring reports to teams and review of those service users receiving self-directed support but not as direct payment.

Additional reports to be developed to identify service users who have been offered a direct payment but have actively declined (for comparison purposes).

Local Targets – Red

4.9 Reassessments (SC330, 340 and SC350)
The number of service users that are overdue Community Service and FAST reassessments at the end of March remains rated red as shown in the table below.

	Universal Services SC340	Community Services SC330
Target	0	48
Actual	99	544
Variance	99	496

There is also a decrease in the number of reassessments (SC350) recorded as completed when comparing performance for the period January 2014 to March 2014 to be behind that for the same period in the previous year.

This is summarised in the table below.

Indicator	January 2013 - March 2013 (average)	January 2014 - March 2014 (average)	Variance
Reassessments completed	537	518	19

Support plans completed (SC210) also show a reduction when comparing January 2014 to March 2014 (556) with the plans completed compared to same period in 2012/13 (783).

Actions include:

Planning
Performance and Information Team will provide support to Operational Teams with improving activity planning.

Data
There appears to be a gap in the process regarding completing the Reassessment on ERIC. A report has been sent to all Clerical Leads, requesting a data validation exercise to review the open cases.

Regarding indicator SC330, there continue to be delays in being able to complete a case from initial allocation, to the visit itself and the recording on ERIC and eventual closure of that reassessment process.

Agreement has been reached by GCS and GCC that the face to face visit undertaken to reassess the Service user, should be counted as the review having taken place, which should give a more accurate picture of the remaining backlog, than awaiting the closure and de-allocation of a case before it is counted.

Performance teams are checking whether this data can be extracted easily from ERIC but initial discussions are that it is not possible as the actual review meeting is not recorded in ERIC. The only measurable point in the process is the Support Plan sign-off and indicative budget generation

4.10 Care Home Reviews outstanding (SC510)
There has been a decrease in the number of service users overdue a care home review in March to 322 from 348 in February. This is rated red as the target in March has reduced to 141.

Actions include:
There is a continued downward trend against the trajectory. The number of care home reviews outstanding is significantly below March 2013 when there were 532 reviews outstanding. However the number of outstanding reviews has not reduced in line with the trajectory.

4.11 FACE overview assessments open longer than 28 days
Indicator SC170 shows performance for FACE overview assessments open longer than 28 days to have increased considerably in the period January 2014 to March 2014, compared to that same period in 2012/13.

This is rated red and performance is shown in the table below.

The number of FACE overview assessments open longer than 28 days has increased significantly (shown below):

Indicator	January 2013 - March 2013 (average)	January 2014 - March 2014 (average)	Variance
FACE overview assessments open longer than 28 days	390	699	309

Actions include:
Outstanding assessments to continue to be prioritised to reduce those open longer than 28 days and according to need (urgency).

4.12 Ongoing development
Further work is ongoing to support the operational management and reporting process and this includes the following:

- Working with GCC data and performance team to facilitate understanding of the full daily data warehouse data extract to enable more efficient reporting processes to be established to support the operational teams.

- A review of the current scorecard metrics to ensure that this meets operational requirements in terms of content and presentation.

4.13 External Care

- There are a number of work streams split into those with actual savings against them and those that will enable those savings. For each work stream there is information collected which summarises what is included, who the leads are, impacts, risks etc. The lead officers have a deadline to have headline figures/plans in place by next the end of the first week of April, and a final plan completed by the end of April.

- Performance monitoring is being developed to support this programme utilising the daily copy of data received by the GCS Performance and Information team.

4.14 Challenge and Support Peer Review

The 'Challenge and Support Visits' are a new innovative way to provide assurance to our stakeholders that the' Essential Standards of Quality and Safety' are embedded in the day to day work of our staff when providing care.
The programme of visits for 'Challenge and Support Peer Review' has now been rolled out. Each month, every hospital will focus on one or two designated CQC outcomes linked with current local training or national initiatives. Each month every hospital will examine their PCA for that outcome, look at current evidence and raise awareness amongst staff. Every month, one visit will take place led by a Matron and a more junior colleague. They will assess the CQC outcome which was focused on the previous month. They will feedback findings to the Matron of the host hospital who will develop an action plan which will be presented at their locality meeting. This meeting will then monitor the action plan and sign off. The action plan will be shared at the Quality and Safety Meeting and the Matrons meeting. Assurance or concerns can then be escalated to IGQC or Board as necessary.

Alongside the need to obtain assurance, is the desire to achieve enthusiasm and understanding of the CQC aims and principles. Collective commitment and engagement of staff is of the highest importance. To meet this aim the junior colleague will spend time with the Matron prior to the unannounced visit understanding CQC Standards and adherence to outcomes within their own hospital. Following the visit they will then feedback their assessment at the next hospital/ward meeting and through a structured feedback process will share with their colleagues good practice and identify practice to be improved and why.

All assessments will focus on whether the services are effective, well led, safe, caring and responsive. The aim will be to assess care given to children and families, at end of life care, coordinated care for those with complex and multiple needs, the provision of universal services which focus on improving health, the prevention of inappropriate admissions, the partnership with other care providers, the provision of acute services in community settings. This focus will develop as the year progresses

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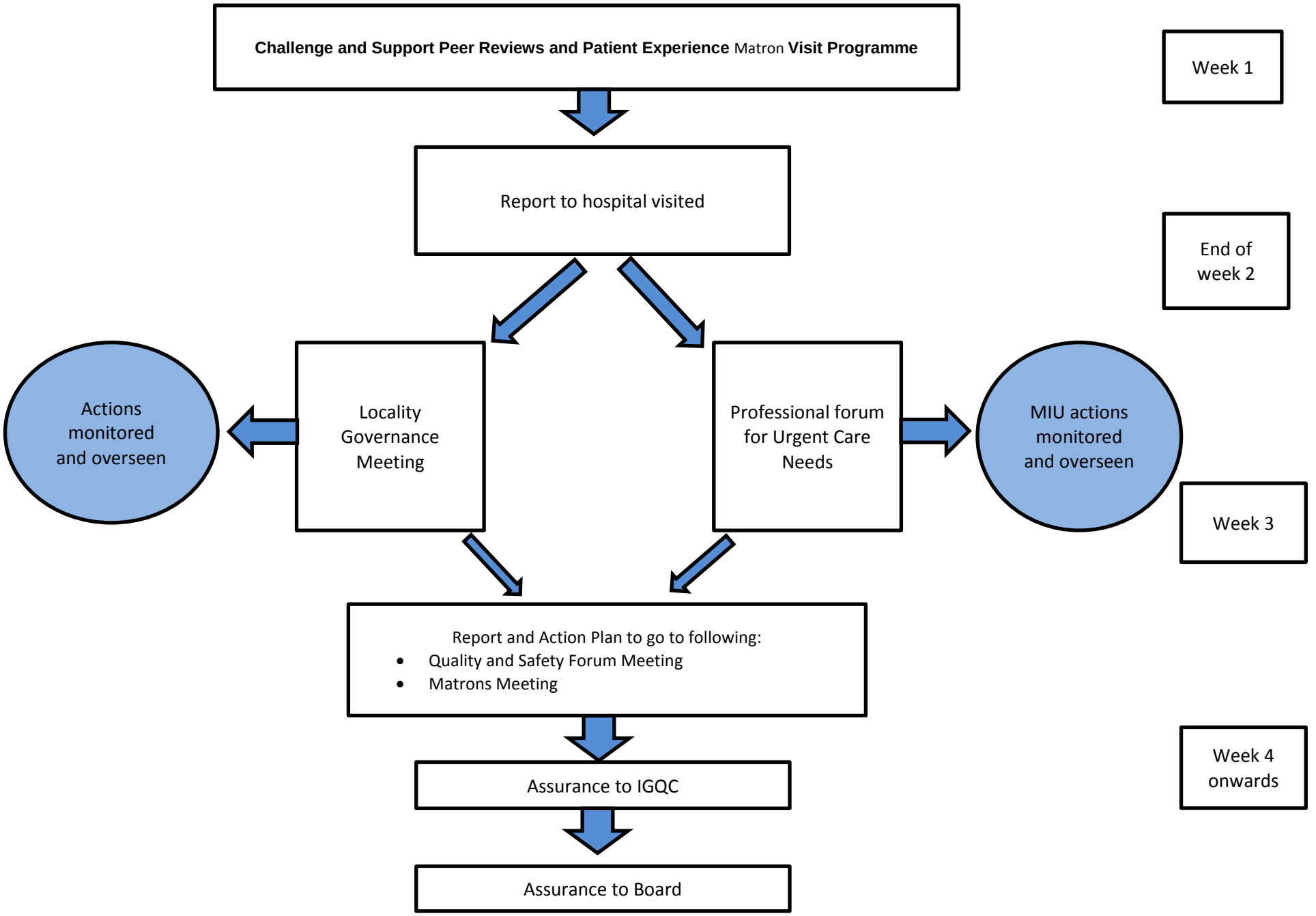

Challenge and Support Peer Reviews and Patient Experience Matron Visit Programme
Week 1
Report to hospital visited
End of week 2
Actions monitored and overseen
Locality Governance Meeting
Professional forum for Urgent Care Needs
MIU actions monitored and overseen
Week 3
Report and Action Plan to go to following:
Quality and Safety Forum Meeting
Matrons Meeting
Assurance to IGQC
Week 4 onwards
Assurance to Board

Challenging Support Schedule

Month	Matron/ Assessor	CQC Outcome Reviewed	Site/Hospital	Actions resulting
March	Linda Edwards	Outcome 17: Complaints Outcome 21: Records	The Dilke Hospital Ward and MIU	• To increase knowledge amongst staff relating to integrated records. • To increase staff awareness of principles of confidentiality relating Patient information. • To ensure that all service users will be able to provide feedback relating to their visit/stay. • To ensure that all staff are aware of action plans formulated following complaint investigation.
April	Jane Evans	Outcome 5: Meeting nutritional needs	Stroud General Hospital Wards and Theatre	Action plan awaited
May	Julie Ellery	Outcome 11: Safety, availability and suitability of equipment		
June	Michelle Slater	Outcome 8: Cleanliness and infection control		
July	Jane Evans	Outcome 9: Management of medicines		
Aug	Mandy Hampton	Outcome 4: Care and welfare of people who use services		
Sept	Linda Edwards	Outcome 12: Requirements relating to workers Outcome 13: Staffing Outcome 14: Supporting workers		
Oct	Julie Ellery	Outcome 16: Assessing and monitoring the quality of service provision		
Nov	Mandy Hampton	Outcome 7: Safeguarding people who use services from abuse		
Dec	To be confirmed	Outcome 1: Respecting and involving people who use services		
Jan	To be confirmed	Outcome 6: Cooperating with other providers		

Non-Executive Directors Quality Visit Schedule – Patient Experience Assessment Visit

Date	Time	Who?	Site/Service		Location	Actions Resulting
April 2nd	10-1pm	Chris Creswick Melanie Rogers	Diabetes	Community Diabetes Service Chris Creswick attended a clinic of 3 patients and accompanied a cardiac specialist nurse on a home visit.	Matson Lane Surgery	
April 24th	10-1pm	Ingrid Barker Melanie Rogers	Cirencester	Hospital Visit	Hospital	
May 7th	1-4pm	Nicola Strother Smith Sarah Warne	Wheelchair Service (1.30-4.30pm)	Patients to be approached by receptionist to establish consent to speak to NED re: experience Lisa Martin – 01242 713900	Clinic on Village Road	
May 14th	1-4pm	Ingrid Barker Sarah Warne	Tewkesbury Hosp	Hospital Visit	Hospital	
May 21th	10-1pm	Ingrid Barker Melanie Rogers	Homeless Health Care Service	Patients to be approached by receptionist to establish consent to speak to NED re: experience Gayle Clay – 01452 521898	Vaughan House	
May 21st	10-1pm	Chris Creswick Alison Reddock	Stroud General Hosp	Hospital Visit	Hospital	
June 10th	2-5pm	Joanna Scott Sarah Warne	Dental Service Waiting Room	Patients to be approached by receptionist to establish consent to speak to NED re experience	TBC in May	
June 19th	1-4pm 2-5pm	Ingrid Barker Barbara Lees	Reablement	Patients to be approached by receptionist to establish consent to speak to NED re experience	TBC in May	
June 30th	1-4pm	Sue Mead Melanie Rogers (Jane Daggatt)	Podiatry Service Waiting Room	Patients to be approached by receptionist to establish consent to speak to NED re experience	St Pauls Medical Centre Swindon Road Cheltenham	
July 16th	10-1pm	Rob Graves (Andrea Darby Clinical Nurse Specialist)	IV Therapy	Patients will be informed prior to ensure consent	TBC in June	

July 31st	10-1pm	Ingrid Barker (Suzy Hughes Clinical Nurse Specialist)	Heart Failure	Patients will be informed prior to ensure consent	TBC in June	
August 13th	1-4pm	Nicola Strother Smith (Sally King, Respiratory Physio)	Pulmonary Rehabilitation	Patients will be informed prior to ensure consent	TBC in July	
September 5th	10-1pm	Chris Creswick TBC	Leg Ulcer Clinic In waiting room	Patients to be approached by receptionist to establish consent to speak to NED re experience	Dilke Hospital	
September 9th	1-4pm	Joanna Scott TBC	ARU Tewkesbury	Patients to be approached by receptionist to establish consent to speak to NED re experience	Tewkesbury Hospital	
September 29th	10-1pm	Sue Mead (Debbie Gray, Capacity Community Services Manager)	SPCA	Debbie Gray	EJC	
October 8th	1-4pm	Rob Graves (Pamela Stevenson Clinical Nurse Specialist)	Cardiac Rehabilitation	Patients will be informed prior to ensure consent	Oxstalls Gym	
October 30th	10-1pm	Ingrid Barker TBC	Children's Speech and Language Service	Regular clinic 9-3.30 Patients to be approached by receptionist to establish consent to speak to NED re experience	TBC in September	
November 12th	1-4pm	Nicola Strother Smith TBC	Children's OT	Quedgeley Wed AM clinic Patients to be approached by receptionist to establish consent to speak to NED re experience	TBC in October	
November 26th	10-1pm	Sue Mead TBC	Immunisation and Vaccination Services	Angela Hemus x8206 Patients to be approached by receptionist to establish consent to speak to NED re experience	TBC in October	
November 26th	10-1pm	Ingrid Barker TBC	Physiotherapy and Early Supported Discharge Team (Cheltenham and Tewkesbury)	Prestbury Centre in Cheltenham Patients to be approached by receptionist to establish consent to speak to NED re experience	TBC in October	

December 3rd	1-4pm	Chris Creswick (Sue Trigg Clinical nurse Specialist)	Bone Health Waiting Room	Patients to be approached by receptionist to establish consent to speak to NED re experience	TBC in November	
December 19th	10-1	Rob Graves (Sue Watts, Clinical Nurse Specialist)	Parkinson's/MND	Patients will be informed prior to ensure consent	TBC in November	
January 29th	10-1	Joanna Scott TBC	Dilke Hospital	Hospital Visit	Hospital	

Well Led

5.1 Workforce

Key workforce indicators are included within the performance scorecard and reviewed at each Locality Board. Locality Managers and their leads are being actively supported by the Workforce team and HR Business Partners with the provision of more detailed information to help the Boards with the management of performance within their localities.

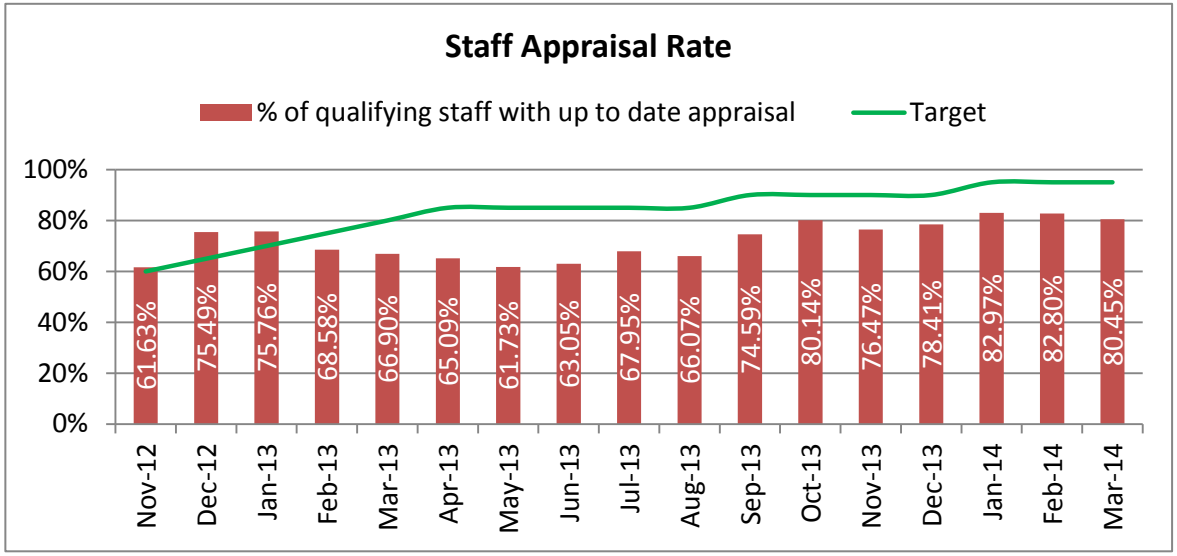
The key indicators, targets and current performance are summarised in the table below.

Indicator	Target	Performance
Sickness absence	3.0%	4.28%
Mandatory Training - Fire / Health & Safety	90%	92.81%
Mandatory Training - Equality & Diversity	90%	74.47%
Mandatory Training - Information Governance	90%	67.69%
Mandatory Training - Conflict Resolution	90%	68.47%
Appraisal completion	95%	80.45%
Turnover rate	7-17%	11.71%

Sickness absence levels have increased slightly to 4.28% (from 4.22%) for rolling 12 months to March. This is rated as red compared to the target of 3%. However, this compares favourably with the benchmark data provided by the Aspirant Community Foundation Trusts Network (ACFTN) which shows an average rate of 4.83% (year to date average data to January combining short-term and long-term sickness data).

In month performance for March was 4.61% compared to 3.97% in February.

Appraisal completion rates decreased slightly in March to 80.45% from 82.80% in February. This continues to compare favourably with the ACFTN rate of 76.39% (January), however remains rated as red compared to the current target of 95%.



All line managers have been provided with a report for their team / service highlighting colleagues whose appraisal is overdue, or due by the end of April to support ensuring that the appraisal is scheduled and completed as a priority This is in addition to the regular monthly appraisal completion reports. This action has been a particular focus for the Trust for the last few months and whilst completion rates have improved in the last six months the percentage has remained consistently around 80%.

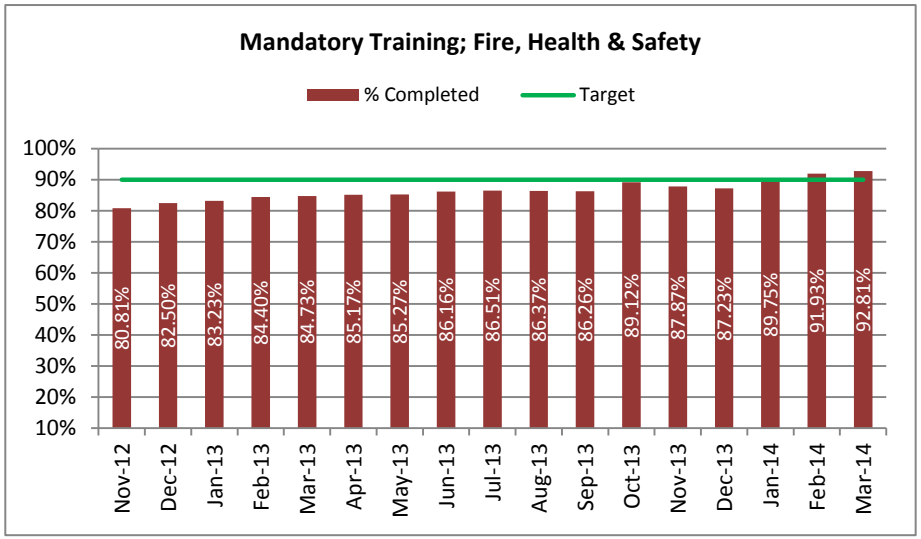
Historically a large proportion of appraisals were carried out at the end of the financial year and therefore there are a number due in March which is presenting some challenges for line managers. All teams were asked to provide assurance that 90% completion would be achieved by the end of April 2014 which has been managed through Locality Boards.

At the time of writing this report this data is not yet available so will be tabled at the Board Meeting, however initial indications are that whilst there are areas of good practice some services / teams have not achieved the target which is affecting the overall Trust completion rate. Furthermore managers continue to express concern that their local records do not match that recorded Electronic Staff Record (ESR), which is used to prepare all analysis. The Board report presented in November 2013 updated action taken to address this concern and provided an update on the data cleansing exercise undertaken in September and October 2013 which failed to highlight any issues based on information provided by managers.

Despite this work this concern remains to some and therefore any line managers who have expressed concern that the records for their team are incorrect were asked requested to provide a copy of their local records to their dedicated HR Business Partner who committed to personally checking the accuracy of the ESR record. To date however no local records have been received.

Work will continue with line managers whose team and or service performance is below target. In addition the Human Resources and Training team will continue to support managers with specific advice and guidance relating to conducting appraisals and managing the introduction of the Pay Progression Policy (recognising the need to transition from historical appraisal date to the employees incremental date in order to adhere to the requirement of the employee having an up to date appraisal).

All of the mandatory training programmes are rated red, with the exception of the Fire and Health and Safety training which is rated green at 92.81% compared to target of 90%. GCS performance for this element of mandatory training continues to compare favourably against the ACFTN average rate of 82.3% (January data) for the Fire and Health and Safety mandatory training only.


Mandatory Training; Fire, Health & Safety
% Completed
Target
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
80.81%
82.50%
83.23%
84.40%
84.73%
85.17%
85.27%
86.16%
86.51%
86.37%
86.26%
89.12%
87.87%
87.23%
89.75%
91.93%
92.81%
Nov-12
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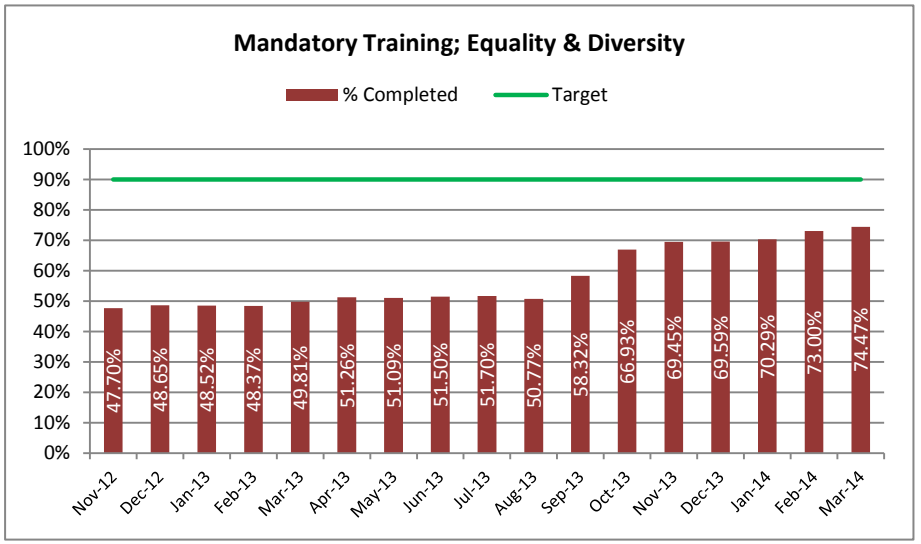
Mar-14


Mandatory Training; Equality & Diversity
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Target
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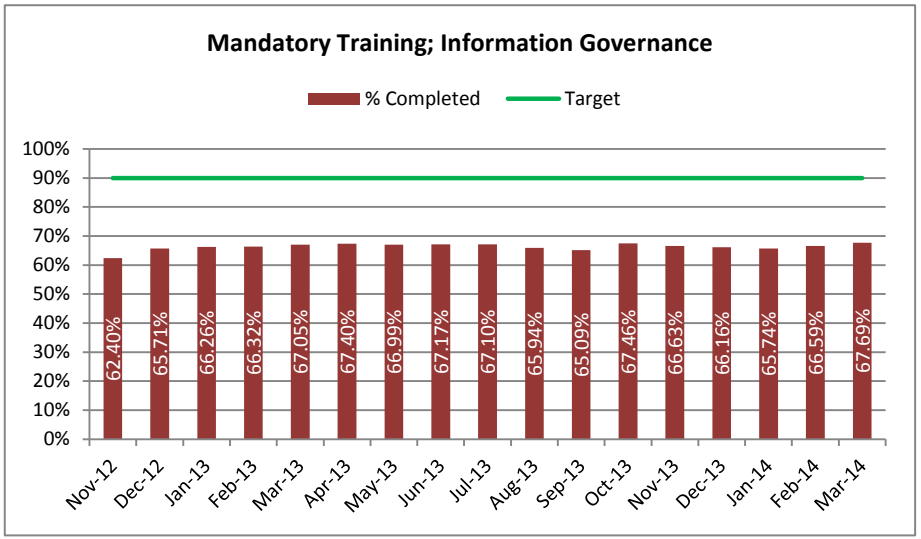
Mandatory Training; Information Governance
% Completed
Target
100%
90%
80%
70%
60%
50%
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30%
20%
10%
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62.40%
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66.26%
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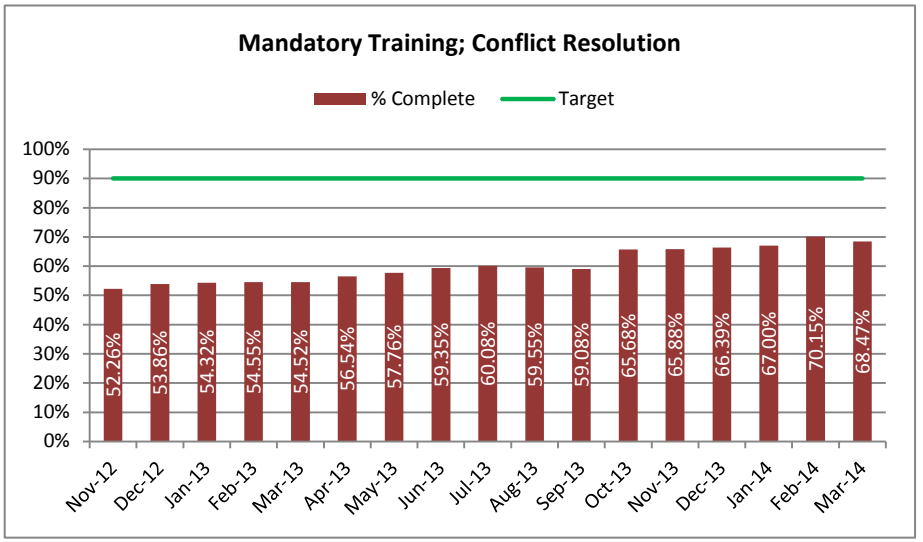
Mandatory Training; Conflict Resolution
% Complete
Target
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90%
80%
70%
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52.26%
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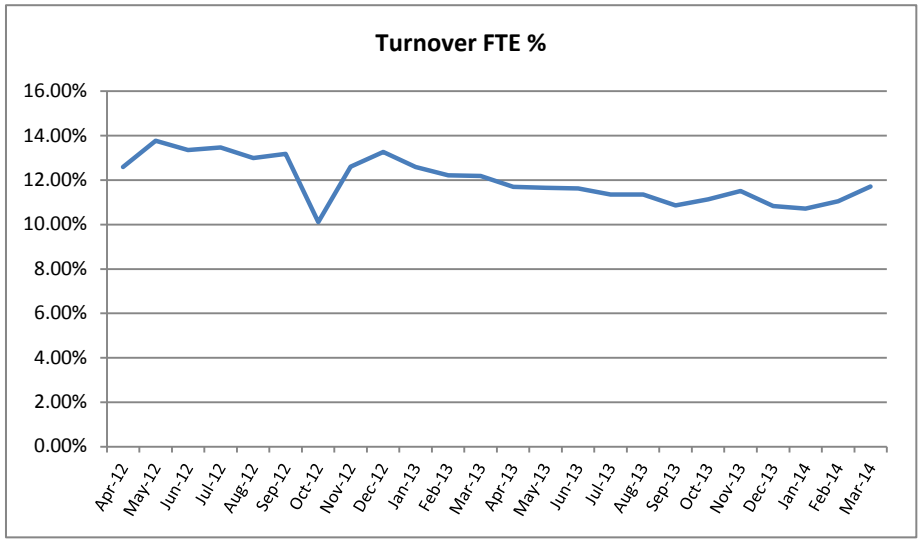
The staff turnover rate of 11.71% in March remains higher than the ACFTN average of 9.02% (combining planned and unplanned turnover year to date average data to January). However, performance is within the benchmark target range of 7-17% and therefore rated green.



5.2 Listening in Action Update

In January 2014 GCS started out on their Listening into Action journey along with 5 other NHS organisations from across the country. The focus of Listening into Action is to fundamentally shift how we work and lead, putting staff-who know the most-at the centre of the change. The Listening into Action framework focuses on 3 dimensions of change:

- Quality & Safety
- Patient experience
- Working together

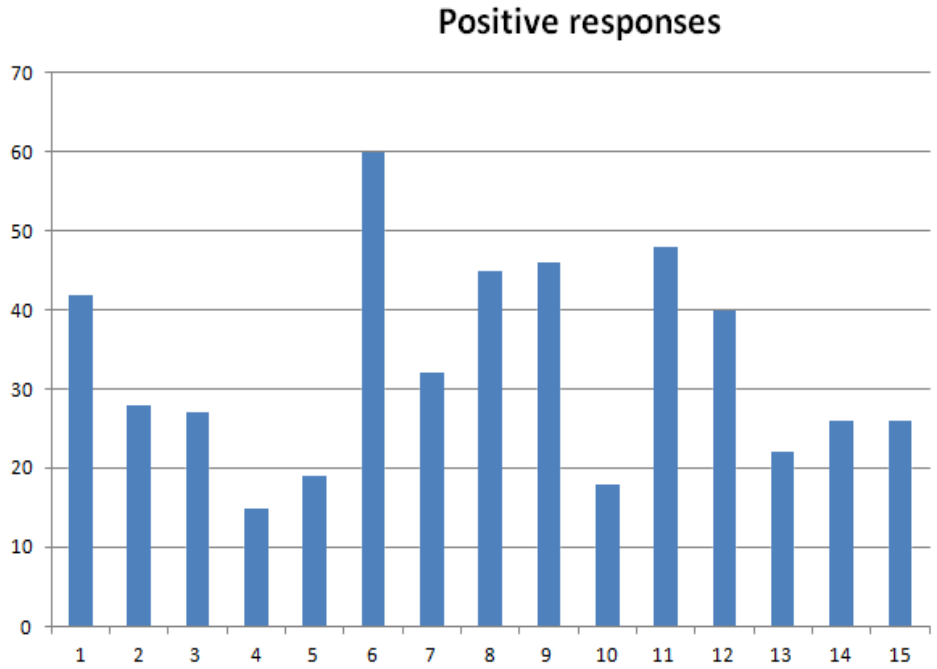
Listening into Action is about engaging all the right people to deliver better outcomes for our patients, staff and the organisation. It gives teams 'permission' to get on and make positive changes happen with managers supporting them and helping to unblock the way.

Committing to a new way of working

In December 2013 the Board approved GCS adopting the Listening into Action (LiA) approach. A sponsor group was formed made up of 12 staff members across health & social care that are instrumental in empowering staff to make changes and help to unblock the way if issues arise. A Listening into Action lead was also appointed. In early January communication was sent out to staff across health & social care introducing the LiA lead and to launch the concept.

Engaging our staff around what matters

As part of the engagement process members of the senior leadership team were asked to complete a 'Journey Scorecard' which illustrated how ready they felt the organisation was for change. In conjunction with this the 'Pulse Check' survey was distributed to approximately 3,600 staff across health & social care. This mini survey focused on 15 questions, after 3 weeks 1343 (around 40%) responses were collated and the results communicated to staff (see attachment).
Five Big Conversations will be hosted by the CEO during the first2 weeks of April; these events will bring together a rich mix of staff from across all levels and roles in order to understand what really matters to staff.
Following these events rapid feedback will be given in order to maintain momentum and some 'Quick Wins' will be identified and implemented by staff.



Following these events the organisation will move from **LISTENING into ACTION** and ten teams will be identified to pioneer adoption of LiA and deliver a piece of work in 20 weeks. This approach will then snowball, with staff accepting LiA as a new of working. Later on in the year a 'pass it on event' will be held where successes and learning will be shared.
We asked, you said.

	Statement	Positive Response
1	I feel happy and supported working in my team/department/service	**42%**
2	Our organisational culture encourages me to contribute to changes that affect my team/department/service	**28%**
3	Managers and leaders seek my views about how we can improve our services	**27%**
4	Day-to-day issues and frustrations that get in our way are quickly identified and resolved	**15%**
5	I feel that our organisation communicates clearly with staff about its priorities and goals	**19%**
6	I believe we are providing high quality services to our patients/service users	**60%**
7	I feel valued for the contribution I make and the work I do	**32%**
8	I would recommend our Trust to my family and friends	**45%**
9	I understand how my role contributes to the wider organisational vision	**46%**
10	Communication between senior management and staff is effective	**18%**
11	I feel that the quality and safety of patient care is our organisation's top priority	**48%**
12	I feel able to prioritise patient care over other work	**40%**
13	Our organisational structures and processes support and enable me to do my job well	**22%**
14	Our work environment, facilities and systems enable me to do my job well	**26%**
15	This organisation supports me to develop and grow in my role	**26%**

5.3 Activity Monitoring
This scorecard includes a summary of activity compared to plan for all of the services provided by the Trust.

The activity schedule within the scorecard is for the period April to March 2014 and shows activity compared to plan for services provided by the Trust grouped into services areas rather than at service level.

This shows overall activity to be 16.13% above plan, which represents an additional 192,922 patient contacts above planned activity. However, it is acknowledged that there is a lag of data entry in some service areas. If data recorded for the period April to January 2014 is compared to plan then there is a variance of 16.8% above plan.

5.4 Data Quality
The scorecard includes indicators to illustrate a number of data quality measures that are monitored on a monthly basis in comparison to national average performance for admitted patient data and Minor Injury Units data that are flowed to the Secondary Uses Service.

- Valid ethnic code recorded
- Valid NHS number recorded
- GP Practice code recorded

The performance and information team run a number of data validation checks on a regular basis to highlight missing data items and ensure validation occurs prior to submission, including feedback of any errors or missing data to Clinicians and Clinical Systems Team.

Current performance for these indicators shows GCS performance to be ahead of the national average for data submitted to SUS.

There are currently issues with the coverage of ethnic code recorded on SystmOne. To date this has not been fully populated.

The Directors of Service Transformation and Operations have written to staff to highlight the need to capture this data to meet equality and diversity obligations, one of which is to ensure positive use of ethnicity information. This mandates the requirement to collect this data and is accompanied by a ‘quick guide’ that explains what to ask and how to record the data on SystmOne.

Progress will be monitored on an ongoing basis to ensure compliance with this.

Gloucestershire Care Services NHS Trust

Adults Social Care Operational & Performance Management Scorecard. County Totals

ADULT SOCIAL CARE INDICATORS		Measure method	Lead		2012/2013 Dec	Jan	Feb	Mar	2013/2014 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Variance	M12 YTD	Average for Last 3 Months Average 2012/2013	Average 2013/2014	Variance
NATIONAL INDICATORS (Gloucestershire Summary)																									
ASCOF 1C Part 1	Percentage of service users receiving self-directed support	Percentage	Sue Field	Target	70.0%	73.3%	76.7%	80.0%	80.3%	80.7%	81.0%	81.3%	81.7%	82.0%	82.7%	83.0%	83.3%	83.5%	83.7%	84.0%					
				Actual	79.4%	79.5%	80.0%	80.9%	82.4%	80.9%	81.7%	82.7%	82.8%	83.4%	79.1%	79.5%	84.0%	84.8%	85.7%	87.4%	5.6%	82.8%	80.1%	86.0%	5.8%
ASCOF 1C Part 2	Percentage of service users receiving self-directed support as Direct Payments	Percentage	Sue Field	Target	13.7%	13.8%	14.0%	14.1%	26.0%	26.1%	26.2%	26.3%	26.4%	26.5%	26.6%	26.6%	26.7%	26.8%	26.9%	27.0%					
				Actual	26.1%	26.1%	25.9%	26.0%	25.7%	25.1%	24.3%	24.1%	23.9%	24.2%	23.8%	23.4%	24.8%	24.7%	24.9%	24.5%	-1.3%	24.4%	26.0%	24.7%	-1.3%
ASCOF 2A Part 1	Admissions to residential & nursing care, per 100,000 population (Age 18-64)	Rolling 12-Month Average	Sue Field	Target																					
				Actual	48	51	52	49	45	45	48	47	48	48	43	38	35	35	31	29	-44	492	51	32	-19
ASCOF 2A Part 2	Admissions to residential & nursing care, per 100,000 population (Age 65+)	Rolling 12-Month Average	Sue Field	Target																					
				Actual	951	949	963	984	990	1017	1035	1033	1008	932	969	950	923	897	721	686	256	11161	965	768	-197
ASCOF 2B	Achieving independence for older people through reablement	Percentage	Sue Field	Target				87.5%																	
				Actual				71.5%	ANNUAL SURVEY																
ASCOF 2C Pt 1	Delayed transfers of care	In Month	Sue Field	Target					*10*	*10*	*10*	*10*	*10*	*10*	*10*	*10*	*10*	*10*	*10*	*10*					
				Actual	8	7	7	6	*6*	*6*	*6*	*6*	*6*	*6*	*6*	*6*	*6*	*6*	*6*	-	*-31*	*58*	7	*4*	-3
ASCOF 2C Pt 2	Delayed transfers of care from hospital attributable to adult social care	In Month	Sue Field	Target					*4*	*4*	*4*	*4*	*4*	*4*	*4*	*4*	*4*	*4*	*4*	*4*					
				Actual	4	3	3	3	*3*	*3*	*3*	*2*	*2*	*2*	*2*	*2*	*2*	*2*	*2*	-	*-17*	*25*	3	*2*	-1
LOCAL INDICATORS																									
	Referral Centre																								
SC010	Referrals	In Month	Sue Field	Actual	657	1909	1823	2227	2369	2295	2250	2836	2450	2557	2682	2585	2282	3012	2652	2778		30748	No data for 2012/13	2814	
SC055	Referrals (priority within 2 hours)	In Month	Sue Field	Actual	25	85	163	243	286	307	341	457	399	408	273	206	177	224	174	155		3407		184	
SC056	Percentage of referrals (priority within 2 hours)	Percentage	Sue Field	Actual	3.8%	4.5%	8.9%	10.9%	12.1%	13.4%	15.2%	16.1%	16.3%	16.0%	10.2%	8.0%	7.8%	7.4%	6.6%	5.6%		11.1%		6.5%	
	Reablement																								
SC061	Community & Bed based reablement starting in month	In Month	Sue Field	Actual	267	336	267	332	359	375	344	383	355	336	303	338	293	327	325	313	305	4051	312	322	10
SC062	Community reablement starting in month	In Month	Sue Field	Actual	236	295	241	295	321	330	308	342	305	290	263	290	257	290	287	266	220	3549	277	281	4
SC102	Community reablement completing after 6 weeks	In Month	Sue Field	Actual	83	142	85	90	94	112	102	84	77	66	73	72	48	57	58	54	-129	897	106	56	-49
	FACE overview assessments																								
SC170	Open longer than 28 days	Snapshot	Sue Field	Actual	488	391	368	410	400	463	467	391	425	377	379	356	851	993	544	560	150	560	390	699	309
SC181	Completed within 28 days	In Month	Sue Field	Actual	553	651	642	593	611	718	615	690	648	694	678	559	1059	1163	1072	947	1369	9454	629	1061	432
	Support Plans																								
SC210	Support plans completed	In Month	Sue Field	Actual	739	778	737	834	747	1127	934	994	1077	780	787	738	642	599	553	516	695	9494	783	556	-227
	Personal budgets																								
SC240	Service users eligible for personal budgets	Snapshot	Sue Field	Actual	2929	2828	2648	2539	2547	2570	2546	2608	2614	2656	2705	2841	2642	2644	2646	2545	6	2545	2672	2612	-60
SC250	Service users with personal budgets	Snapshot	Sue Field	Actual	2076	2099	2071	2070	2110	2120	2106	2105	2141	2200	2175	2297	2249	2248	2271	2229	159	2229	2080	2249	169
	Reassessments																								
SC330	Service users overdue a community service reassessment	Snapshot	Sue Field	Target					579	607	635	663	691	599	507	412	324	232	140	48				140	
				Actual	525	562	608	492	552	555	547	537	505	452	451	540	513	470	426	544	-496	544	554	480	-74
SC340	Service users overdue a FAST reassessment	Snapshot	Sue Field	Target					1255	1153	1051	949	847	745	643	408	120	60	20	0				27	
				Actual	1143	1219	1268	1205	1133	1076	997	978	842	703	718	407	165	125	84	99	-99	99	1231	103	-1128
SC350	Reassessments completed	In Month	Sue Field	Actual	515	575	591	446	532	563	503	511	491	545	611	543	525	533	570	451	-379	6378	537	518	-19
	Carers																								
SC410	Percentage of carers accepting the offer of assessment	Percentage	Sue Field	Actual	87.7%	88.7%	90.8%	91.6%	91.4%	92.4%	88.3%	90.5%	92.2%	92.5%	93.3%	92.9%	92.2%	92.9%	91.2%	93.8%	3.2%	92.0%	90.4%	92.6%	2.3%
	Safeguarding																								
SC425	New safeguarding alerts	In Month	Sue Field	Actual				94	117	157	179	159	180	224	265	247				0		1528			
SC430	New safeguarding referrals	In Month	Sue Field	Actual	39	37	35	46	73	77	96	75	84	87	107	81	76	84	69	63	472	972	39	72	33
SC440	Safeguarding referrals completed	In Month	Sue Field	Actual	29	55	42	49	44	68	70	84	64	58	107	115	81	75	56	54	431	876	49	62	13
SC450	Safeguarding referrals substantiated	In Month	Sue Field	Actual	12	15	12	5	11	7	11	13	19	19	22	26	15	11	7	13	32	174	11	10	0

ADULT SOCIAL CARE COUNTYWIDE SERVICES 2013/14		Measure Method	Lead		2012/2013 Dec	Jan	Feb	Mar	2013/2014 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Variance	M12 YTD	Average 2012/2013	Average 2013/2014	Variance
	Care Home Reviews																								
SC510	Reviews outstanding	Snapshot	Sue Field	Target					549	541	533	525	477	429	381	333	285	237	189	141		141		189	189
				Actual	545	567	597	532	517	535	492	492	466	463	456	521	372	358	348	322	181	322	565	343	-223

Gloucestershire Care Services NHS Trust Board

Title:	**Hard Truths Commitments Regarding the Publishing of Staffing Data**	**20 May 2014**
Agenda Item:	**10**	
Purpose of Paper:	The purpose of this paper is to provide assurance to the people of Gloucestershire and the Board that the Trust has taken all necessary actions to ensure implementation of the recommendations made within the "Hard Truths" document and that there are processes in place to monitor ongoing our compliance.	
Key Points:	• Together with the Hospital Matrons the Director of Nursing and Quality has agreed staffing levels for each inpatient ward across the Trust • Ward budgets have been increased to fund staffing at those levels • There is a process in place to monitor the number of staff on duty on a shift by shift basis • Acuity audits will be undertaken at least every six months and staffing reviewed as a result. This work will be aligned to that of the Community Hospital Programme Board	
Options and decisions required	The Board is asked to: • Endorse the staffing establishments assessed as suitable to meet the care needs within our Community Hospitals through recognising the role of Senior Nurse in ensuring that this is reviewed on a shift by shift basis • Note the level of compliance with expectations at Phase 1 of implementation and the actions to ensure GCS has the principles fully embedded • Agree to receive monthly workforce information from June 2014 that includes staffing metrics as part of the Quality and Performance reporting process • Agree to receive a six monthly update on inpatient staffing capacity and capability in September 2014 and others as aligned to national timescales	
Fit with strategic objectives	1. Achieve the best possible outcomes for our service users through high quality care	X
	2. Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	X

	3. Provide innovative community services that deliver health and social care together	X
	4. Work as a valued partner in local communities and across health and social care	
	5. Support individuals and teams to develop the skills, confidence and ambition to deliver our vision	X
	6. Manage public resources wisely to ensure local services remain sustainable and accessible	X

Next steps/future actions	An action plan has been developed that ensures GCS are able to evidence full compliance within our hospital wards with the requirements set out within Hard Truths documents. Assurance will be provided via the Performance and Resources Committee and to Board of that compliance at least bi-monthly. Acuity assessments will be undertaken and nursing establishments reviewed based on the findings at least every six months.		
Author name and title	**Liz Fenton** **Director of Nursing and Quality** **Community Hospital Matrons**	**Director Name and Title**	**Liz Fenton** **Director of Nursing and Quality**

Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: 20 May 2014
Location: Hesters Way Community Resource Centre, Cheltenham

Agenda Item 10: Hard Truths Commitments Regarding the Publishing of Staffing Data

1. Purpose

The purpose of this paper is to provide assurance to the people of Gloucestershire and the Trust Board, that GCS has taken all necessary actions to ensure implementation of the recommendations made within the document "Hard Truths; the journey to putting patient first" (Department of Health 2014) and that there are processes in place to monitor ongoing our compliance.

2. Recommendations

The Board is asked to:

- Endorse the staffing establishments assessed as appropriate to meet the care needs within our Community Hospitals
- Note the level of compliance with expectations at Phase 1 of implementation and the actions to ensure GCS has the principles fully embedded
- Agree to receive monthly workforce information from June 2014 that includes staffing metrics as part of the Quality and Performance reporting process
- Agree to receive a six monthly update on inpatient staffing capacity and capability in September 2014 and others as aligned to national timescales

3. Background

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

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

- Providers to take an active role in securing staff in line with their workforce requirements.

Following the publication of the NQB document the government made a number of commitments in "Hard Truths: the Journey to Putting Patients First" published in January 2014. This document, endorsed by Jane Cummings, Chief Nursing Officer and Professor Sir Mike Richards, Chief Inspector of Hospitals, sets out a number of nationally mandated milestones to be achieved by all Trusts, within the first phase of implementation, which is focussed on inpatient care. Annex 1 shows the responsibilities at Board and individual level for the implementation of these requirements and job titles have been adjusted to reflect titles within GCS.

4. GCS compliance with the expectations

Expectation 1: Board takes full responsibility for the staffing capacity and capability

The Trust Board will receive regular reports (at least six monthly) at an open Board meeting and this paper begins that process of reporting of the planned staffing for all Community Hospital wards. Further work will be required to include other departments and services and will be aligned to the national timeframes and publication of staffing recommendations and guidelines.

Across all inpatient areas planned nurse staffing levels have been reviewed to ensure that appropriate skill and grade mix has been taken into account when setting establishments. This ensures that suitable expertise and capability is available to deliver and support the care of our patients as well as providing appropriate supervision to our valuable unregistered workforce. Additional to nurse staffing, but critical to the provision of care, are the roles of Allied Healthcare Professionals (OT, Physiotherapy and Social Work) within our multi professional ward teams.

In the first quarter of 2014 – 15 a training needs analysis will be undertaken and used to inform the education programme for the coming year which will focus on developmental needs at an individual professional level as well as service development needs.

An electronic system has been implemented across the Trust that will ensure staffing information, for all our wards, is visible on a shift by shift basis allowing action to be taken where there are staffing concerns whilst minimising the data input required which would take nursing staff away from clinical duties. This information will be collated monthly and reported to Board at each meeting highlighting where there may have been exceptions and the action taken to mitigate any potential risks.

Compliance with expectation 1 in all Trust inpatient settings	

Expectation 2: Processes are in place to enable staffing to be met on a shift by shift basis

Ensuing safe and suitable staffing to meet service needs is a core responsibility for operational staff on a day to day basis. The Matrons supported by Locality Managers

currently manage well any staffing concerns on the wards, however, the escalation processes that they use are not formally documented and these need to be developed. The development of this document is being led by the Chief Operating Officer and will be in place by June 2014.

The development of the Trust's Temporary Staffing Bureau is supporting the operational teams with staffing requirements through both planned and reactive deployment of bank staff to meet clinical and care need. Regular recruitment of staff to the Bank Service has been enhanced with the commencement of weekly interviews to build this valuable pool of staff and consideration is currently being given as to the development of a peripatetic team.

In setting establishment levels for our wards, GCS are clear that the day to day authority for ensuring suitable staffing rests with the Ward Sisters/Charge Nurses and the Matron who are empowered to use their professional judgement and expertise to be flexible in the application, for example, increasing the establishment to provide one to one care for a patient who is highly dependent. Decisions will be made based on care needs, acuity and occupancy levels.

Compliance with expectation 2 in all Trust inpatient settings	

<u>Expectation 3: Evidence based tools are used to inform nursing staffing capacity and capability</u>

Following the publication of "Safe staffing for older people wards" (RCN, 2012) the Trust undertook a baseline review of nurse staffing levels on all inpatients wards. This work was informed by an acuity audit, collecting information over a period of one month, through the application of the Keith Hurst acuity tools (University of Leeds) for elderly medicine and rehabilitation (apportioned according to HRG code).

Working together with their Ward Sisters/Charge Nurses, the Hospital Matrons reviewed this information, together with professional body recommendations and professional judgment, to define the staffing establishments required by ward throughout the 24 hour period. This work provided evidence of the care needs of those within our care and the recommended staffing establishment and skills mix.

A process of external validation of these requirements was commissioned by NHS Gloucestershire PCT and was undertaken in 2013.

An additional £2million of investment for ward staffing was secured as a result of this work to enable the recruitment of additional registered nurses and care staff to bring the funded establishments in line with those recommended establishments. That recruitment is still underway and represents a key challenge to the Trust given the national concern regarding shortages of registered nursing staff.

Additional acuity assessments have been undertaken across all wards in November 2013 and March 2014 using an audit tool agreed with the GCCG and this information will be used to inform the work of the Community Hospital Programme Board throughout 2014 and ongoing review of establishments. This tool assesses the

appropriateness of care at an individual level being provided within a Community Hospital setting. This next phase, informed by the revised service specification for inpatient care, will consider the wider care needs and the roles of the therapists and generic support roles within that multi professional team.

It is anticipated that national guidance will be published that will define the tools for use to support the establishment review required in September 2014.

The revised ward staffing levels set a Registered Nurse to patient ratio of 1:8 during the day and 1:10.2 overnight, the critical role of the Health Care Assistant brings the total WTE to patient ratio of 1:6.These figures are based on the anticipated needs with 100% bed occupancy. This is a significant increase in our nursing levels from previous establishments and colleagues are providing positive feedback as to the benefits despite there being some posts still to be recruited to. The impact of this investment will be measured using staff and service user experience and key care quality indicators.

Careful consideration was given to the numbers of RNs on duty throughout the night to provide effective care. Risk assessment undertaken by the Matrons considered that any potential risk is mitigated by the revised staff rotas that will be implemented in May 2014 which extend the late shift ensuring more staff to provide care in the evening. This also considers the care needs of the client group overnight.

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

Key- RN:HCA

Compliance with expectation 3 in all Trust inpatient settings	

<u>Expectation 4: leaders foster a culture of professionalism and responsiveness where staff feel able to raise concerns</u>

The Clinical and Professional Care Strategy is underpinned by the 6Cs and an emphasis on service user centred care delivered with compassion. The Trust can evidence a number of examples where concerns have been raised and appropriate support and action has been taken by leaders in a timely manner.

The Trust policy “It’s OK to ask why” is in place and use, though infrequent, is monitored by the Quality and Clinical Governance Committee and reported on at least annually to the Trust Board.

In order to ensure that we are working as a Trust to embed this culture that empowers colleagues, recognises the skills and knowledge of our clinical and care teams, supports the raising of concerns and has a zero tolerance approach to poor care, throughout 2014/15 we will be participating in the Listening into Action Programme and Board will receive regular reports.

Compliance with expectation 4 in all Trust inpatient settings	

Expectation 5: a multi-professional approach is taken when setting nurse staffing establishments

The NQB expects that Director of Nursing leads the review of nurse staffing requirements and actively involves ward staff but that roles of the Medical Director, Chief Operating Officer, Director of Finance, Human Resources and Service Delivery are critical in this work. This recognises the interdependencies between staffing and other aspects of the organisations functions. Papers shared with the Board should be as a result of team work and reflect an agreed position.

Within GCS there has been a multi-professional approach involving Matrons and Ward Sisters in agreeing staffing levels. This is reflected in the work led by the Director of Nursing and Quality in agreeing inpatient staffing levels and this work will be championed in the future by a small group led by the Chief Operating Officer together with the Directors of Human Resources and Nursing and Quality. This group is established as a sub-group of the Performance and Resources Committee who will approve the terms of reference for this at their next meeting.

Compliance with expectation 5 in all Trust inpatient settings	

Expectation 6: Nurses and care staff have sufficient time to fulfil responsibilities that are in addition to their caring duties.

Our revised inpatient staffing levels includes an absence factor which allows time for training, which includes statutory and mandatory training, as well as continuous professional development requirements. A review of mandatory education programmes and introduction of a variety of methods of learning sets a more flexible approach to achieving this which in turn is expected to reduce the impact on the ward teams.

All Senior Sister/Charge Nurse (Band 7) roles are supervisory and these roles are supported by Sister/Charge Nurses at Band 6.

Compliance with expectation 6 in all Trust inpatient settings	

Expectation 7: Boards receive monthly updates on workforce information and staffing capacity and capability is discussed at a public board meeting at least every six months on the basis of a full nursing and midwifery establishment review

This paper begins the process of reporting publicly on planned staffing. This work has been supported by the Performance Team who have developed a bespoke web based solution to cover all wards. The use of a web based solution allows ward staff to capture data for early, late and night shifts against prepopulated staffing numbers within the application. This data will be used to build the monthly reports required and support onward reporting. The first full reports will be shared with the Board in July 2014.

The application uses an active directory login, which provides an audit of staff that have accessed and populated data. The design replicates the boards displayed in each ward that displays publicly the planned and actual staff numbers and visitors on duty for each shift (Appendix 1).

The Quality Report is also being revised to include a number of workforce metrics that are being developed by the Director of Human Resources and provide valuable triangulation of the data available.

Compliance with expectation 7 in all Trust inpatient settings	

Expectation 8: NHS providers clearly display information about the nurse and care staff present on each shift

Each ward displays a board that sets out the number of patients on the ward on that day, the level of staffing that should be on duty (RN and HCA) and those actually on duty, shift by shift. Review of theses boards to ensure accuracy will be included as part of the monthly Peer Review process and Senior Nurse visits.

There has been a national drive to ensure that there is a Named Consultant and Named Nurse detailed above every bed. Due to the nurse led nature of our services the Director of Nursing and Quality has had discussions regarding our ability to demonstrate compliance with this key drive with both GCCG and the NTDA. It is recognised that this was set out as an acute trust measure and does not directly translate to a community hospital setting. It has therefore been agreed that within GCS the name of the senior nurse responsible for the ward be displayed above the bed and this is in place. This provides a named contact for families should they have concerns or questions that they would wish to discuss, in addition to the colleagues that are available on the ward at each shift who can ensure questions and concerns are addressed promptly and can be the route for contact with professionals including Doctors .

Compliance with expectation 8 in all Trust in patient settings	

Expectation 9: providers of NHS services take an active role in securing staffing in line with their workforce requirements

The Trust provides information on workforce to the LETB to inform the commissioning of pre-registration placements. We work in partnership with Higher Education Establishments to recruit to values and support a number of pre-registration students throughout our services.

The Director of Human Resources oversees the development of the annual workforce plan which is signed off by the Medical Director and Director of Nursing and Quality

.

5. Further actions required

	Action	Lead	By when
1	Implementation of the NTDA mandated workforce assessment tool	Director of Human Resources	May 2014
2	Escalation policy and procedure to be developed for ward teams to escalate staffing issues and concerns	Chief Operating Officer	June 2014
3	Staffing to reflect nationally agreed evidence based model across all services	Director of Nursing and Quality	Determined by national timescales
4	Monthly reporting of workforce data to include capacity metrics	Director of Human Resources	June 2014
5	Regular reporting through the Performance and Resources Committee	Chief Operating Officer	Bi monthly
6	Six monthly reporting on staffing capacity and capability including other teams and services within national timescales	Director of Nursing and Quality	September 2014
7	Development of innovative processes that includes recruiting to Trust values that makes GCS an employer of choice	Director of Human Resources	June 2014
8	Publication of staffing information on the GCS website and on NHS Choices	Head of Communications	June 2014

6 Legal Implications

The Trust has a duty of care to both our service users and our colleagues and are required by the Care Quality Commission to ensure safe and suitable staffing that enables us to evidence that our services are safe, caring, effective, responsive and well led.

7 Risk Implications

The issue of the availability of the required numbers of registered nurses is a key risk. This is being mitigated by the work led by the Director of Human Resources to develop innovative and responsive recruitment practices that will attract applications

to GCS. This will be supported by the work currently in place to develop and empower colleagues which it is suggested will support retention and attract the best staff to the Trust.

8 Equality and Quality Implications

This programme of work provides assurance that we are supporting the delivery of high quality care by ensuring safe and suitable staffing. The evidence base suggests strong links between the levels of staffing, morale and patient outcomes.

9 Consultation and Communication including Public Involvement

The ward staffing establishments were developed through a consultative process that actively involved senior nurses, operational leaders and colleagues from Finance, HR and Performance.

Prepared by: Liz Fenton; Director of Nursing and Quality together with the Matrons of the Community Hospitals across Gloucestershire

Presented by: Liz Fenton; Director of Nursing and Quality

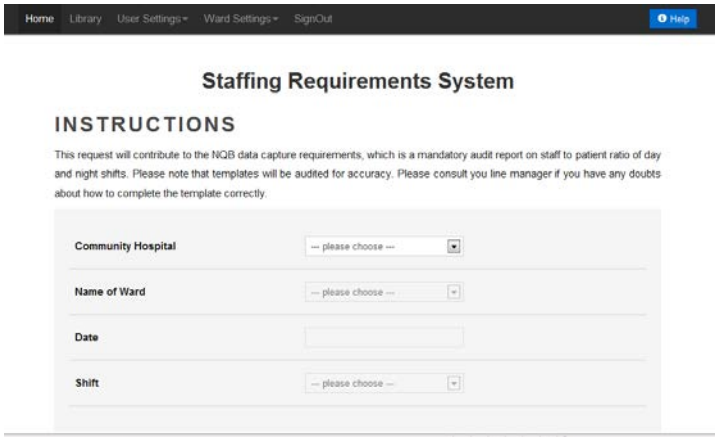
Appendices:

- Appendix 1: GCS Staffing Tool
- Appendix 2: Support of responsibilities as set out in the NQB guidance (job titles adjusted to fit with the Trust roles)

GCS Staffing Tool

The functionality of the solution developed by the Performance Team provides the following:

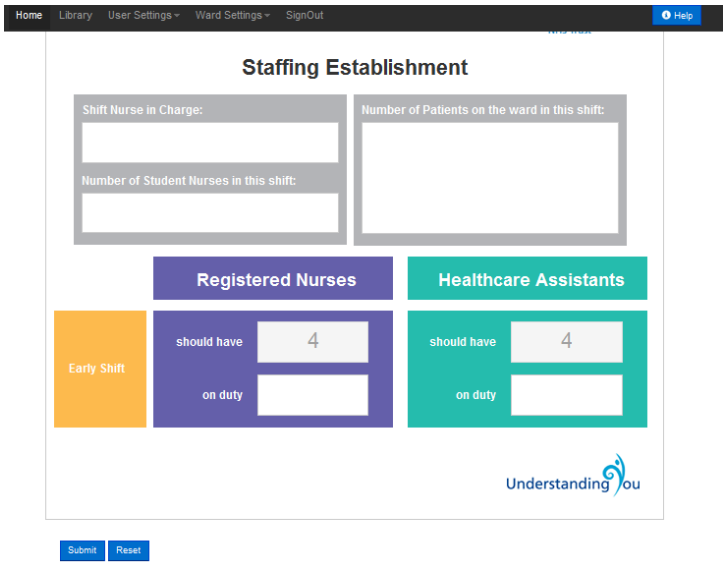
Home page:



This page is for users to populate the data by choosing using the drop down options for:

- Community Hospitals
- Name of Ward
- Date
- Shift (Early, Late, Night shift)

Example of the view following selection of the early shift:



Staff are required to complete the following:

- Staff Nurse in Charge
- Number of Student Nurses on the shift
- Number of patients on the ward during the shift.
- Registered Nurses on duty.
- Healthcare Assistants on duty

Note: this is completed at the end of a shift and following handover to the oncoming shift.

Appendix 2

NON-EXECUTIVE DIRECTORS OF THE BOARD

- Ensure there are robust systems and processes in place across the organisation to make informed and accurate decisions concerning workforce planning and provision
- Review data on workforce, quality of care and patient safety on a regular basis and hold
- Executive Directors to account for ensuring that the right staff are in place to provide high quality care to patients
- Ensure that decisions being taken at a board level, such as implementing cost improvement plans, have sufficiently considered and taken account of impacts on staffing capacity and capability and key quality and outcomes measures
- Understand the principles which should be followed in workforce planning, and seek assurance that these are being followed in the organisation

CHIEF EXECUTIVE

- Ensure that the organisation has the right number of staff with the required knowledge and skills to provide safe and effective patient care
- Ensure that there is an agreed nursing and midwifery establishment for all clinical areas
- Ensure there are robust systems and processes in place across the organisation to make informed and accurate decisions concerning workforce planning and provision
- Ensure that appropriate escalation policies are in place and action is taken when staffing falls below that expected
- Ensure workforce plans are clinically and financially viable, and that they inform education commissioning process in place through the Local Education and Training Board (LETB) and Health Education England (HEE)
- Ensure that the Executive Team have SMART objectives (specific, measurable, achievable, realistic, timely) aligned to staffing and that these are reviewed and performance tracked regularly

EXECUTIVE BOARD MEMBERS

- Report to the Board on nursing, midwifery and care staffing capacity and capability, highlighting concerns and making recommendations where necessary. Workforce data should be triangulated with data on quality of care
- Where staffing capacity and capability is insufficient to provide safe care to patients and cannot be restored, undertake a full risk assessment and consider the suspension of services and closure of wards in conjunction with the Directors of Operations, Chief Executive and Commissioners
- Foster a culture of openness and honesty amongst staff, supported by nursing and midwifery leaders, where staff feel able to raise concerns, and concerns are acted upon

DIRECTOR OF NURSING

- Develop the nursing and midwifery leadership team to ensure that they understand the principles of workforce planning and can use evidence based tools informed by their professional judgement to develop workforce plans and make staffing decisions on a day to day basis
- Assure the Board that there are nursing and midwifery workforce plans in place for all patient care areas/pathways
- On a monthly basis, report workforce information to the Board on expected vs actual staff in post on a shift-to-shift, together with information on key quality and outcome measures
- Ensure there is an uplift in planned establishments to allow for planned and unplanned leave and ensure absence is managed effectively
- Ensure there are staff recruitment and retention strategies in place, and regularly review the effectiveness of these
- Ensure that there are systems and processes in place to capture accurate data on establishment, staffing levels and skill mix, to inform decisions on workforce planning

DIRECTOR OF HUMAN RESOURCES

- Ensure that human resources support and policies are available to secure sufficient staffing capacity and capability to provide high quality care to patients
- Ensure that there are systems and processes in place to capture accurate data on establishment, staffing levels and skill mix, staff movements, training and turnover to inform decisions on workforce planning
- Develop and implement policies that support all staff working within areas of competence
- Develop and implement a strategic recruitment plan to provide the required resources and fill current and future vacancies
- Ensure there are staff recruitment and retention strategies in place, and regularly review the effectiveness of these
- Ensure that there are systems and processes in place to capture accurate data on establishment, staffing levels and skill mix, to inform decisions on workforce planning

CHIEF OPERATING OFFICER

- Ensure that the management of the organisation supports delivery of the workforce plan and there is sufficient staffing capacity and capability to provide high quality care to patients
- Ensuring that there are systems and processes in place to capture accurate data on quality of care, patient pathways and volume to inform decisions on workforce planning
- Ensure there are staff recruitment and retention strategies in place, and regularly review the effectiveness of these
- Ensure there are staff recruitment and retention strategies in place, and regularly review the effectiveness of these

DIRECTOR OF FINANCE

- Ensure that finance decisions which could have an impact on staff capacity, capability and patient outcomes are taken with consideration of staffing and workforce planning implications, and that these are reflected in any advice provided for decision to the Board, linking proposals to patient outcomes and quality

NURSE LEADERS (Matrons)

- Review and approve rosters submitted from wards
- Reallocate staff and authorise the use of temporary staffing solutions if necessary and where required
- Continuously review and monitor nursing, midwifery and care staffing capacity and capability across areas of responsibility
- Produce data / information to inform the Board and management of the organisation, and to inform workforce planning
- Hold Service Managers to account for having appropriate staffing capacity and capability on a shift to shift basis, and following escalation procedures where necessary

SISTER/CHARGE NURSE/TEAM LEADER

- Produce and manage safe and efficient staff rosters
- Measure quality of care and outcomes achieved for patients and the capacity and capability of staff on a ward-to-ward basis
- Respond in a timely manner to unplanned changes in staffing, changing patient acuity / dependency or numbers, including the request for and use of temporary staffing where nursing/midwifery shortages are identified
- Escalate concerns to line manager where staffing capacity and capability are inadequate to meet patient needs
- Understand the evidence based methodology used to determine the nursing and/or midwifery staffing in your area of responsibility

OTHER HEALTH & CARE STAFF

- Complete data returns where requested about the staffing in your workplace to inform workforce planning decisions
- Participate in discussions and decisions regarding staffing in your clinical area
- Understand the agreed staffing capacity and capability are for your clinical area on a shift by shift basis
- Raise concerns regarding staffing and/or the quality of clinical care within your organisation when they arise

How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability (National Quality Board, 2013)

Gloucestershire Care Services NHS
NHS Trust

Gloucestershire Care Services NHS Trust Board

Title:	**Staff Survey Results Report**	**Date:** 20th May 2014
Agenda Item:	**11**	
Purpose of Paper:	The purpose of this paper is to share with the Trust Board the 2013 national NHS staff survey results for Gloucestershire Care Services NHS Trust and specifically to give an overview of our results compared to other Community Trusts. Furthermore, it provides a progress report of the Listening into Action Programme and outlines how improvements against the staff survey will be supported and linked to this programme.	
Key Points:	This paper provides the Board with details of the national NHS survey results for Gloucestershire Care Services NHS Trust compared to other Community Trusts within England and details how the organisation will monitor its progress against the findings.	
Options and decisions required	Board members are asked to note the content of this report with specific regard to how staff views are being considered and how local action planning and the Listening into Action programme will be used to improve staff experiences during 2014/15.	
Fit with strategic objectives	Objective 1 – To secure, develop and deliver innovative high quality community- based services meeting the needs of users	x
	Objective 2 – To integrate health and social care services	x
	Objective 3 – To develop and strengthen partnerships with our communities	x
	Objective 4 – To support, develop and involve our staff	x
	Objective 5 – To strengthen our excellent reputation	x
	Objective 6 - To deliver our contract commitments and provide value for money	x
Next steps/future actions	Actions to improve staff experience will be monitored through the HR & OD Committee.	

Author Name and title	Sarah Curtis HR Business Partner	**Director Name and Title**	Tina Ricketts Director of HR

Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: Tuesday 20th May 2014
Location: Hesters Way Community Resource Centre, Cheltenham

Agenda item 11: Staff Survey Report

1. Purpose

The purpose of this paper is to share with the Trust Board the 2013 national NHS staff survey results for Gloucestershire Care Services NHS Trust and specifically to give an overview of our results compared to other Community Trusts.

Furthermore, it provides a progress report of the Listening into Action Programme and outlines how improvements against the staff survey will be supported and linked to this programme.

2. Recommendations

Board members are asked to note the content of this report with specific regard to how staff views are being considered and how local action planning and the Listening into Action programme will be used to improve staff experiences during 2014/15.

3. Background

Gloucestershire Care Services NHS Trust took part in the 2013 national NHS staff survey for the first time since the Trust was established on 22nd March 2013.

The survey was conducted by Quality Health on behalf of the organisation and took place during the period October to December 2013. Survey questionnaires were randomly distributed to 790 eligible members of staff in accordance with the survey sample national guidance. 444 staff responded which equated to a return rate of 56%. The survey was anonymous and results cannot be attributed to individuals.

The national results were published in February 2014 and as in previous years the report focuses on 38 key areas (known as 'Key Findings') under the headings of the NHS Constitution along with additional themes (staff satisfaction, quality and diversity). The key findings are summary scores for groups of questions which, when taken together, give more information about each area of interest.

This year the Trust also invited responses from a sample of social care staff, and whilst these results are not included in the national NHS report the Trust has been provided with a Trust specific report that gives responses to each question which includes those from social care colleagues.

The Staff Friends and Family test questions are also included in the national survey questions. The introduction of the new staff friends and family test in April 2014 will allow the Trust to compare results for these questions

throughout the year, in addition to the staff survey being undertaken each year in Quarter 3. A copy of the national results report is included at Appendix one.

4. Key Findings and Actions

Gloucestershire Care Services NHS Trust results for 2013

Figure 1 below highlights the five key findings for which Gloucestershire Care Services NHS Trust compares most favourably with other Community Trusts in England.

Figure 1 - TOP FIVE RANKING SCORES

		Trust score 2013	2013 Average for community Trusts
KF11	Percentage of staff suffering work-related stress in the last 12 months	39%	43%
KF28	Percentage of staff experiencing discrimination at work in the last 12 months	7%	8%
KF12	Percentage of staff saying hand washing materials are always available	59%	57%
KF5	Percentage of staff working extra hours	70%	71%
KF24	Staff recommendation of the trust as a place to work or receive treatment *(score between 1 and 5 with the higher the score the better)*	3.61	3.59

Figure 2 below highlights the five key findings for which Gloucestershire Care Services NHS Trust compares least favourably with other Community Trusts in England.

Figure 2 - BOTTOM FIVE RANKING SCORES

		Trust score 2013	2013 Average for community Trusts
KF18	Percentage of staff experience harassment, bullying or abuse from patients, relatives or the public in the last 12 months	33%	27%
KF26	Percentage of staff having equality and diversity training in the last 12 months	44%	66%
KF16	Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	13%	9%
KF15	Fairness and effectiveness of incident reporting procedures *(score between 1 and 5 with the higher the score the better)*	3.45	3.53

KF8	Percentage of staff having well-structured appraisals in the last 12 months	33%	37%

In response to the above findings (specifically KF26) the Board is asked to note that at the time of the survey colleagues are only asked to undertake equality and diversity training every three years (as a mandatory training requirement in accordance with national guidance) it is therefore likely that many staff will not have been required to complete this training within the last 12 months. Furthermore, it is likely that many staff will have undertaken some form of equality and diversity training as part of their role, for example the learning disability training, however colleagues may not consider this as 'equality and diversity' training when answering the survey question.

It should be noted that as a result of the staff survey findings, the Equality Steering Group have now agreed to amend the frequency of this mandatory training to annually with immediate effect.

FURTHER AREAS FOR IMPROVEMENT

Figure 3 below highlights a number of other areas where staff experience could be improved, compared to the average of other Community Trusts.

Figure 3

		Trust score 2013	2013 Average for community Trusts
KF3	Work pressure felt by staff *(score 1 to 5 with the lower the score the better)*	3.16	3.13
KF4	Effective team working *(score 1 to 5 with the higher the score the better)*	3.76	3.80
KF6	Percentage of staff receiving job-relevant, learning or development in last 12 months	81%	83%
KF7	Percentage of staff appraised in the last 12 months	82%	87%
KF21	Percentage of staff reporting good communication between senior management and staff	24%	29%
KF22	Percentage of staff able to contribute towards improvements at work	68%	69%
KF23	Staff job satisfaction *(score 1 to 5 with the higher the score the better)*	3.57	3.60

STAFF FRIENDS AND FAMILY TEST

Figure 4 below provides the results for the trust in response to these questions, it shows that that colleague's views on the trust as a place to work and receive treatment is positive compared to the average results for Community Trusts.

Figure 4

		Trust in 2013	Average for community trusts
Q12c	I would recommend my organisation as a place to work	56	54
Q12d	If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	69	66

The new arrangements for Staff Friends and Family test will commence this month with all staff being invited to answer these questions on a quarterly basis. The Trust will be able to compare results throughout the year with staff receiving a further opportunity as part of the national survey during quarter 3.

KEY FINDINGS FOR DIFFERENT OCCUPATIONAL GROUPS

Figure 5 below provides for five key findings the results based on the different staff groups. This is a useful tool and will support the Trust in ensuring that it tailors approaches where necessary to specific groups of staff and seeks to learn best practice where colleagues experience is higher in some staff groups compared to others. Care should be taken however not to over interpret the findings if scores differ slightly as there may be a small number of respondents in the subgroups.

		Adult Nurses	**Other Nurses**	**Care Health Assistants**	**Medical /Dental**	**Occupational Therapists**	**Physiotherapists**	**Allied Other Health Professionals**	**Other scientific & Technical**	**and Admin Clerical**	**/ Maintenance Ancillary**
	Number of Respondents	68	77	48	17	32	35	25	14	60	22
KF3	Work pressure felt by *staff (score 1 to 5 with the lower the score the better)*	3.21	3.44	2.94	2.84	3.42	3.50	3.21	2.79	2.89	3.21
KF6	Percentage of staff receiving job relevant training, learning or development in the last 12 months	75	88	84	75	87	88	79	77	70	47
KF7	Percentage of staff appraised in the last 12 months	83	82	77	94	80	100	88	86	83	64
KF21	Percentage of staff reporting good communication between senior management and staff	22	18	28	24	16	31	13	14	22	14
KF22	Percentage of staff able to contribute towards improvements at work	74	66	63	65	69	71	72	64	72	27

It should be noted that due to the low number of respondents, no scores are shown for other occupational groups such as general management and corporate services.

The full analysis of the key findings can be found at pages 19 and 20 of Appendix 1 along with the key findings reported for different business units / directorates at pages 21 and 22.

Implementation and Review of Progress

The HR and OD Programme Board received a briefing on the 2013 staff survey results in January 2014 and managers have been asked to share the results with their teams, as a priority, through team meetings and to identify and progress local action plans.

It is recognised that there are a number of areas (as detailed in Figure 2 and Figure 3) where action needs to be taken in respect of improving colleagues' views and perceptions of their experience working for the Trust. It is intended to drive change and improvement of the staff survey results through the Trust's OD Strategy, specifically the Listening into Action Programme.

Board members were provided with an updated of the Listening into Action Programme in March 2014 following the Pulse Check survey completed in February 2014. In respect of recent progress made with this Programme, five 'Listening into Action Big Conversation' events were held in March and April. Individual invitations were sent to 400 staff with over 300 attending. Staff were selected at random, whilst attention was given to ensure that there was a good representation of staff from across the organisation. These 'conversations' were led by Paul Jennings, Chief Executive Officer and supported by members of the Listening into Action sponsor Group. Colleagues were invited to talk about three things, the frustrations and barriers that get in the way of their day to day work, what they would stop doing or fix tomorrow if they could and ways we can improve multi-disciplinary working across the Trust.

Over 3,400 pieces of feedback were taken from these events which have been recorded and broken down into nine themes.

1. Working smarter
2. Cross-team working
3. Time to do my job
4. Engaging leadership
5. Shared Vision
6. Valuing Colleagues
7. Getting the basics right
8. Communication
9. Understanding You

The next phase is to identify 'quick wins' after which the Trust will be identifying the 'First 10' pioneering teams/services to effect change in their own areas. They will receive coaching and support from the sponsor group to ensure that they feel empowered and engaged in creating and making change. The stories of the 'First 10' teams will be used to share good practice and inspire other teams as part of embedding change in practice. This will be supported by a 'pass it on event' to take place in Autumn 2014.

Conclusion
Much of the feedback received from the Big Conversations links closely to the staff survey findings, for example communication between senior management and staff and being able to contribute towards improvements at work. Going forward it is envisaged that the next phases of the Listening to Action programme will support improvement in the required areas, supported by local action planning and that the Trust will see improvements in the next survey that will take place towards the end of 2014.

6 Financial implications
Costs of implementing the Listening into Action Programme are detailed in the OD Strategy Implementation Plan.

7 Implementation and Review of Progress
The Board will be kept informed of the progress through the HR and OD Committee and through the Listening into Action Programme.

8 Legal Implications
None identified.

9 Risk Implications
None identified.

10 Implications for Health Inequalities
Not applicable.

11 Implications for Equalities (Black and Other Minority Ethnic / Disability / Age Issues)
Any implications (and subsequent actions) for equalities have been noted within this report.

12 Consultation and Communication including Public Involvement
Not applicable.

13 Links to:
The Trust's Organisational Development Strategy.

Prepared by: **Sarah Curtis, HR Business Partner**

Presented by: **Tina Ricketts, Director of HR**

Appendices:

Appendix 1: National Results Report

2013 National NHS staff survey

Results from Thle Gloucestershire Care Services National Health Service Trust

Table of Contents

1. Introduction to this report

This report presents the findings of the 2013 national NHS staff survey conducted in Thle Gloucestershire Care Services National Health Service Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3 to 6 of this report, the findings of the questionnaire have been summarised and presented in the form of 28 Key Findings.

These sections of the report have been structured around 4 of the seven pledges to staff in the NHS Constitution which was published in March 2013 (http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution) plus two additional themes:

- Staff Pledge 1: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.

- Staff Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

- Staff Pledge 3: To provide support and opportunities for staff to maintain their health, well-being and safety.

- Staff Pledge 4: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

- Additional theme: Staff satisfaction

- Additional theme: Equality and diversity

Please note that the NHS pledges were amended in 2013, however the report has been structured around 4 of the pledges which have been maintained since 2009. For more information regarding this please see the “Making Sense of Your Staff Survey Data” document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

Responses to the individual survey questions can be found in Appendix 3 of this report, along with details of which survey questions were used to calculate the Key Findings.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q12a - 12d and the weighted score for Key Finding 24. The percentages for Q12a – Q12d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

The Q12d score is related to CQUIN payments for Acute trusts participating in the National NHS Staff Survey. 2013/2014 guidance on CQUIN payments can be found via the following link https://www.supply2health.nhs.uk/eContracts/Documents/cquin-guidance.pdf.

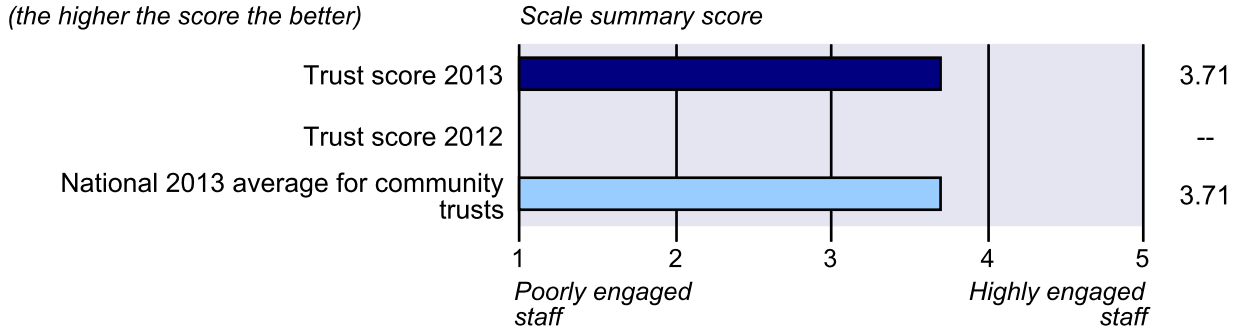
Q12a, Q12c and Q12d feed into Key Finding 24 “Staff recommendation of the trust as a place to work or receive treatment”.

		Your Trust in 2013	Average (median) for community trusts
Q12a	"Care of patients / service users is my organisation's top priority"	62	64
Q12b	"My organisation acts on concerns raised by patients / service users"	67	71
Q12c	"I would recommend my organisation as a place to work"	56	54
Q12d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	69	66
KF24.	Staff recommendation of the trust as a place to work or receive treatment (Q12a, 12c-d)	3.60	3.59

2. Overall indicator of staff engagement for Thle Gloucestershire Care Services National Health Service Trust

The figure below shows how Thle Gloucestershire Care Services National Health Service Trust compares with other community trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.71 was average when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 22, 24 and 25. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 22); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 24); and the extent to which they feel motivated and engaged with their work (Key Finding 25).

The table below shows how Thle Gloucestershire Care Services National Health Service Trust compares with other community trusts on each of the sub-dimensions of staff engagement, and whether there has been a change since the 2012 survey.

	Change since 2012 survey	Ranking, compared with all community trusts
OVERALL STAFF ENGAGEMENT	--	• Average
KF22. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	--	! Below (worse than) average
KF24. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the Trust's top priority, would recommend their Trust to others as a place to work, and would be happy with the standard of care provided by the Trust if a friend or relative needed treatment.)*	--	• Average
KF25. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	--	• Average

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

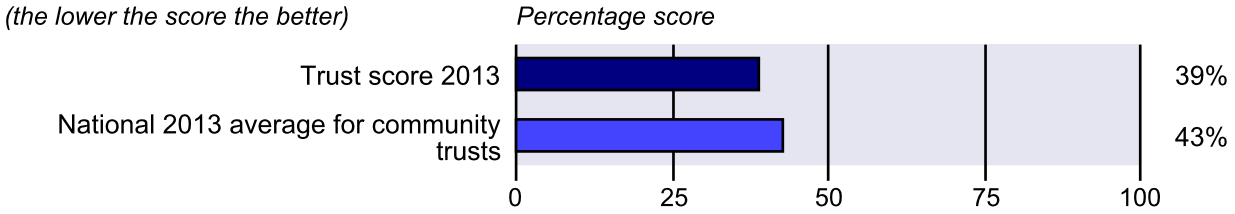
3. Summary of 2013 Key Findings for Thle Gloucestershire Care Services National Health Service Trust

3.1 Top and Bottom Ranking Scores

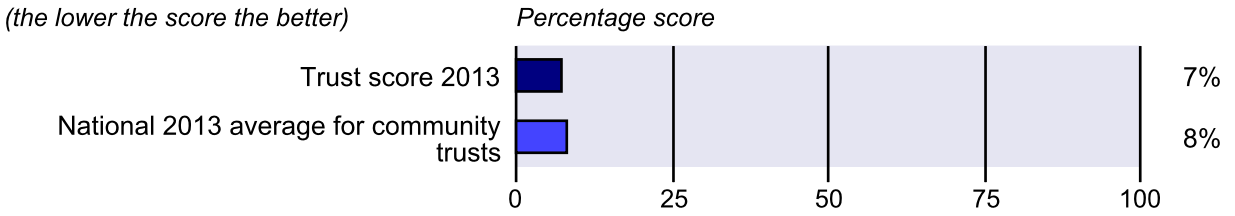
This page highlights the five Key Findings for which Thle Gloucestershire Care Services National Health Service Trust compares most favourably with other community trusts in England.

TOP FIVE RANKING SCORES

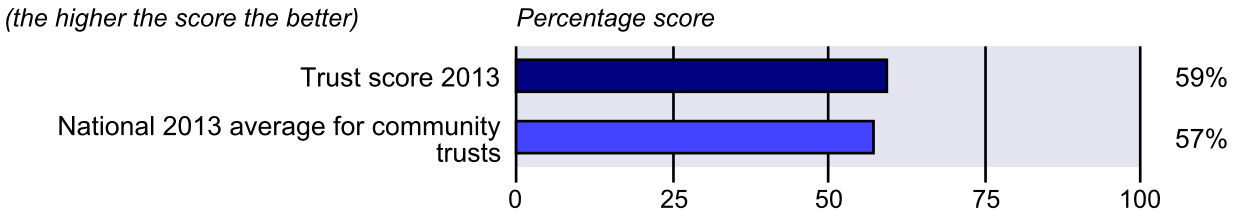
✓KF11. Percentage of staff suffering work-related stress in last 12 months



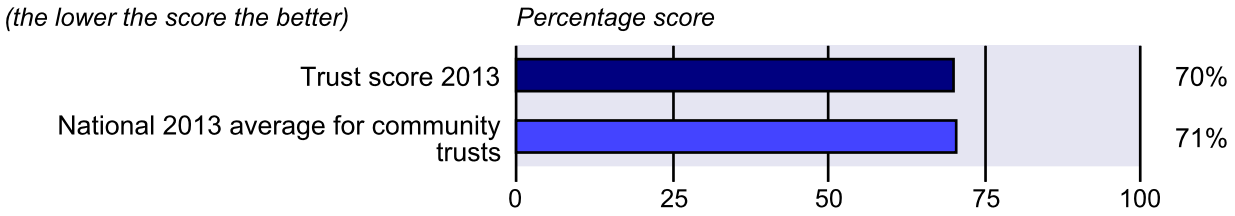
✓KF28. Percentage of staff experiencing discrimination at work in last 12 months



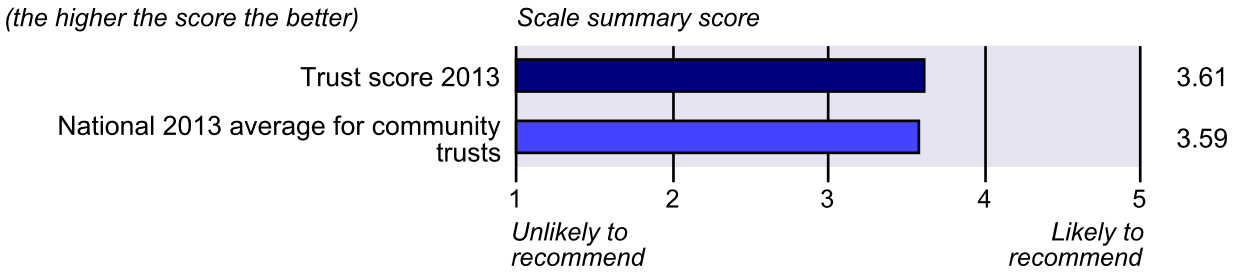
✓KF12. Percentage of staff saying hand washing materials are always available



✓KF5. Percentage of staff working extra hours



✓KF24. Staff recommendation of the trust as a place to work or receive treatment



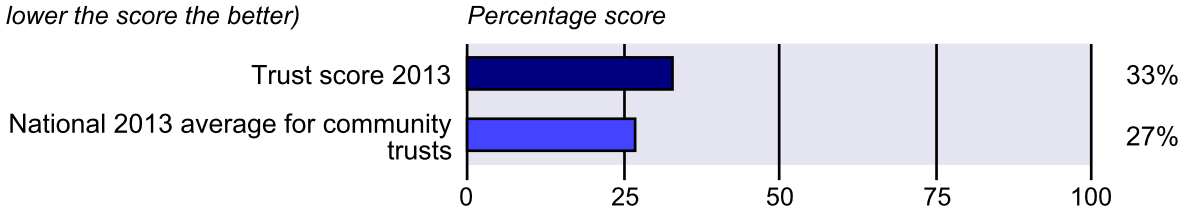
For each of the 28 Key Findings, the community trusts in England were placed in order from 1 (the top ranking score) to 20 (the bottom ranking score). Thle Gloucestershire Care Services National Health Service Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the five Key Findings for which Thle Gloucestershire Care Services National Health Service Trust compares least favourably with other community trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

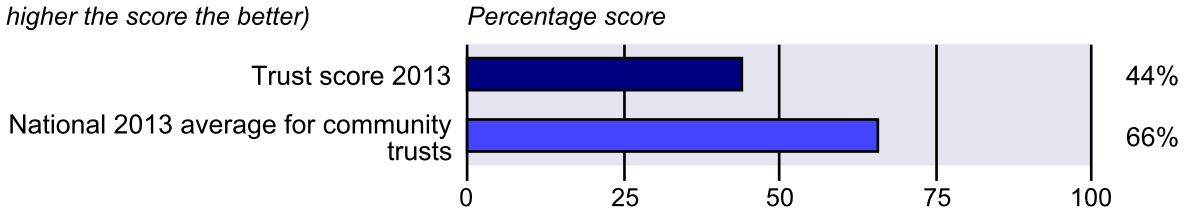
! KF18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



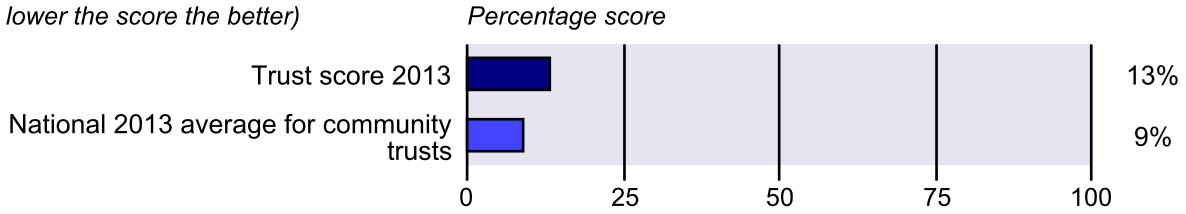
! KF26. Percentage of staff having equality and diversity training in last 12 months

(the higher the score the better)



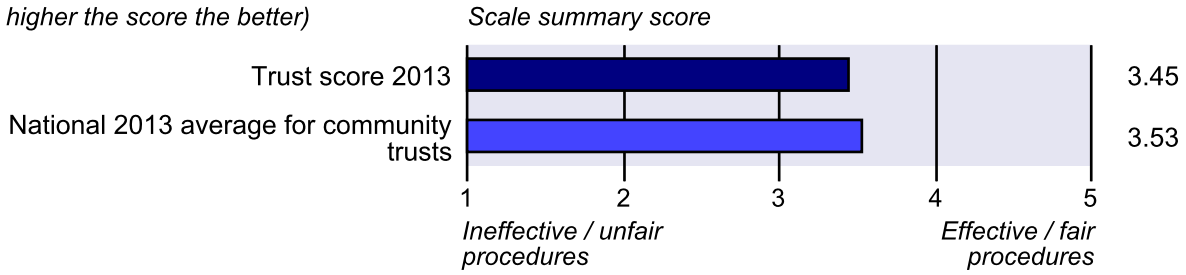
! KF16. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



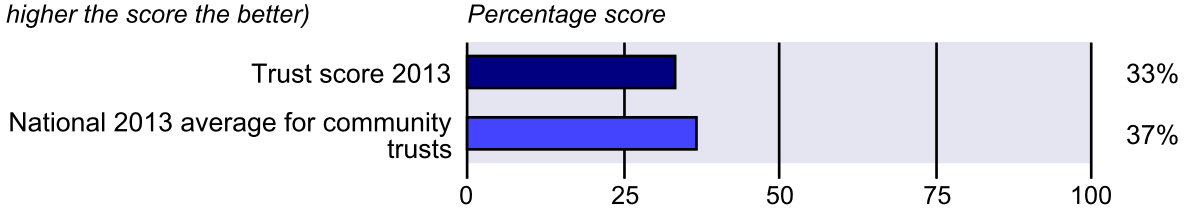
! KF15. Fairness and effectiveness of incident reporting procedures

(the higher the score the better)



! KF8. Percentage of staff having well structured appraisals in last 12 months

(the higher the score the better)



For each of the 28 Key Findings, the community trusts in England were placed in order from 1 (the top ranking score) to 20 (the bottom ranking score). Thle Gloucestershire Care Services National Health Service Trust's five lowest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 20. Further details about this can be found in the document ***Making sense of your staff survey data***.

3.2. Summary of all Key Findings for Thle Gloucestershire Care Services National Health Service Trust

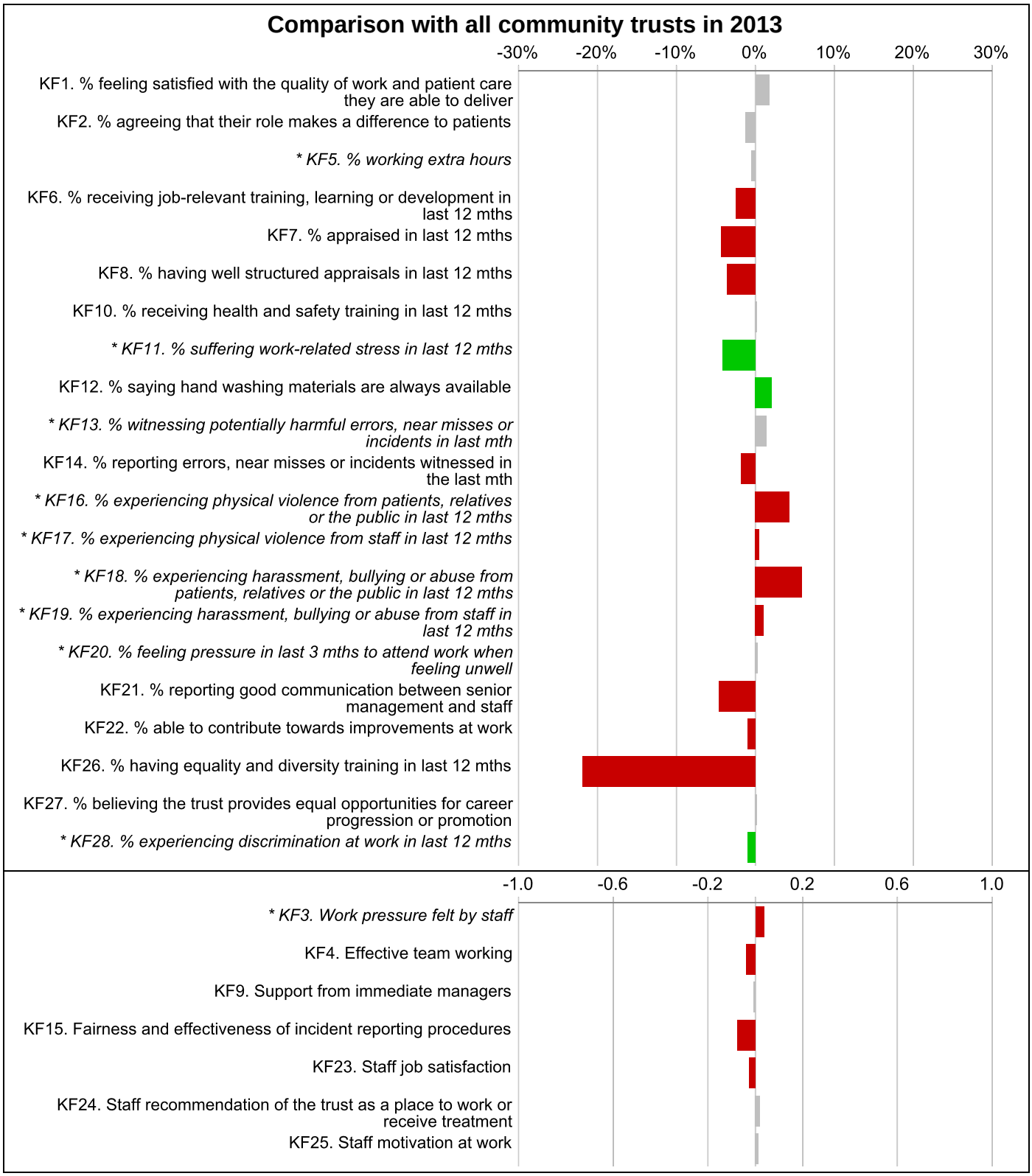
KEY

Green = Positive finding, e.g. better than average.

Red = Negative finding, e.g. worse than avearge.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterix and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for Thle Gloucestershire Care Services National Health Service Trust

KEY

✓ Green = Positive finding, e.g. better than average, better than 2012.

! Red = Negative finding, e.g. worse than average, worse than 2012.

'Change since 2012 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2012 survey.

-- Because of changes to the format of the survey questions this year, comparisons with the 2012 score are not possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterix and in *italics*, the lower the score the better.

	Change since 2012 survey	Ranking, compared with all community trusts in 2013
STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.		
KF1. % feeling satisfied with the quality of work and patient care they are able to deliver	--	• Average
KF2. % agreeing that their role makes a difference to patients	--	• Average
* *KF3. Work pressure felt by staff*	--	! Above (worse than) average
KF4. Effective team working	--	! Below (worse than) average
* *KF5. % working extra hours*	--	• Average
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.		
KF6. % receiving job-relevant training, learning or development in last 12 mths	--	! Below (worse than) average
KF7. % appraised in last 12 mths	--	! Below (worse than) average
KF8. % having well structured appraisals in last 12 mths	--	! Below (worse than) average
KF9. Support from immediate managers	--	• Average
STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.		
Occupational health and safety		
KF10. % receiving health and safety training in last 12 mths	--	• Average
* *KF11. % suffering work-related stress in last 12 mths*	--	✓ Below (better than) average
Infection control and hygiene		
KF12. % saying hand washing materials are always available	--	✓ Above (better than) average
Errors and incidents		
* *KF13. % witnessing potentially harmful errors, near misses or incidents in last mth*	--	• Average
KF14. % reporting errors, near misses or incidents witnessed in the last mth	--	! Below (worse than) average
KF15. Fairness and effectiveness of incident reporting procedures	--	! Below (worse than) average

3.3. Summary of all Key Findings for Thle Gloucestershire Care Services National Health Service Trust (cont)

	Change since 2012 survey	Ranking, compared with all community trusts in 2013
Violence and harassment		
* *KF16. % experiencing physical violence from patients, relatives or the public in last 12 mths*	--	! Above (worse than) average
* *KF17. % experiencing physical violence from staff in last 12 mths*	--	! Above (worse than) average
* *KF18. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	--	! Above (worse than) average
* *KF19. % experiencing harassment, bullying or abuse from staff in last 12 mths*	--	! Above (worse than) average
Health and well-being		
* *KF20. % feeling pressure in last 3 mths to attend work when feeling unwell*	--	• Average
STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.		
KF21. % reporting good communication between senior management and staff	--	! Below (worse than) average
KF22. % able to contribute towards improvements at work	--	! Below (worse than) average
ADDITIONAL THEME: Staff satisfaction		
KF23. Staff job satisfaction	--	! Below (worse than) average
KF24. Staff recommendation of the trust as a place to work or receive treatment	--	• Average
KF25. Staff motivation at work	--	• Average
ADDITIONAL THEME: Equality and diversity		
KF26. % having equality and diversity training in last 12 mths	--	! Below (worse than) average
KF27. % believing the trust provides equal opportunities for career progression or promotion	--	• Average
* *KF28. % experiencing discrimination at work in last 12 mths*	--	✓ Below (better than) average

4. Key Findings for Thle Gloucestershire Care Services National Health Service Trust

444 staff at Thle Gloucestershire Care Services National Health Service Trust took part in this survey. This is a response rate of 56%[1] which is above average for community trusts in England.

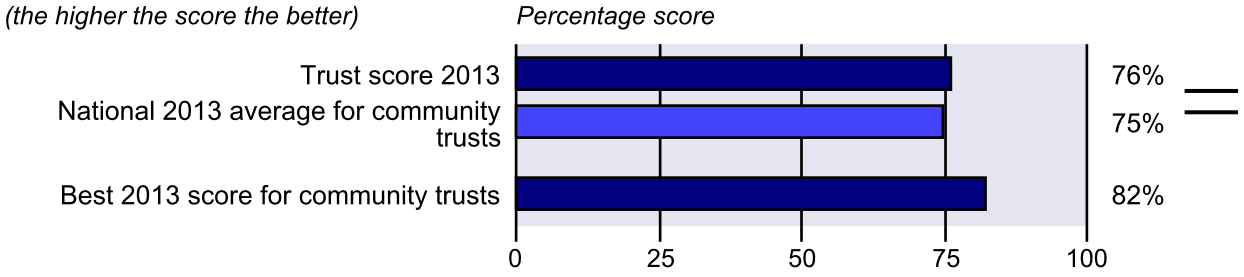
This section presents each of the 28 Key Findings, using data from the trust's 2013 survey, and compares these to other community trusts in England and to the trust's performance in the 2012 survey. The findings are arranged under six headings – the four staff pledges from the NHS Constitution, and the two additional themes of staff satisfaction and equality and diversity.

Positive findings are indicated with a green arrow (e.g. where the trust is better than average). Negative findings are highlighted with a red arrow (e.g. where the trust's score is worse than average). An equals sign indicates that there has been no change.

STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.

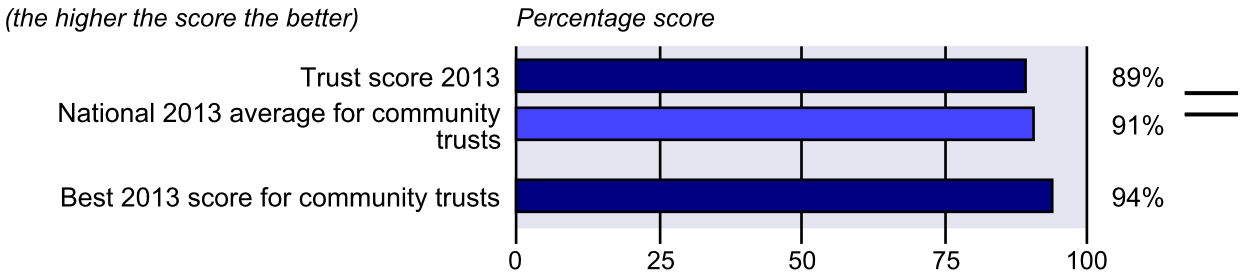
KEY FINDING 1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver

(the higher the score the better)



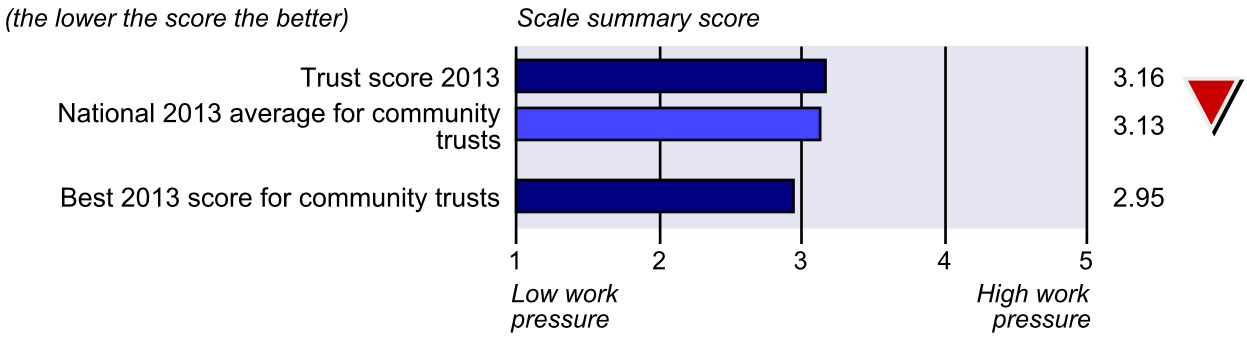
KEY FINDING 2. Percentage of staff agreeing that their role makes a difference to patients

(the higher the score the better)



KEY FINDING 3. Work pressure felt by staff

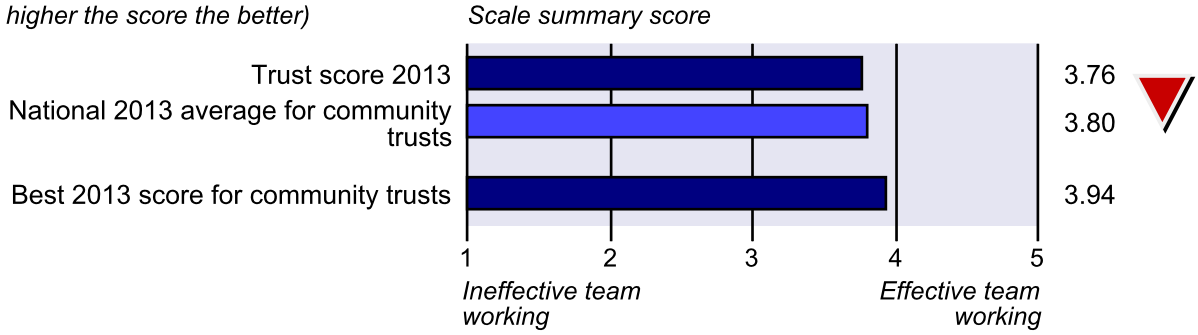
(the lower the score the better)



[1]At the time of sampling, 2444 staff were eligible to receive the survey. Questionnaires were sent to a random sample of 790 staff. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

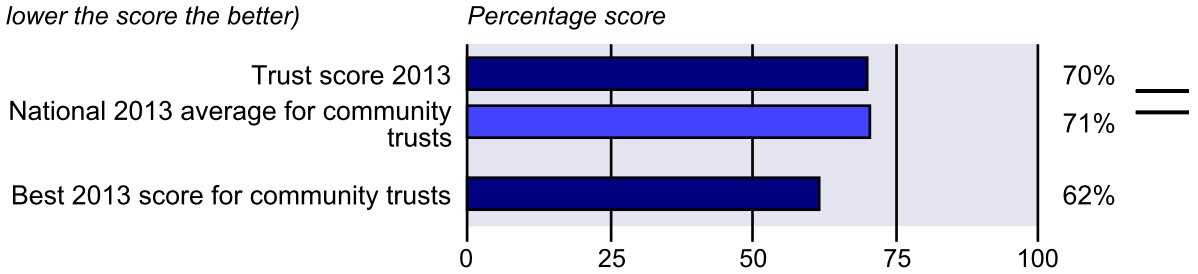
KEY FINDING 4. Effective team working

(the higher the score the better)



KEY FINDING 5. Percentage of staff working extra hours

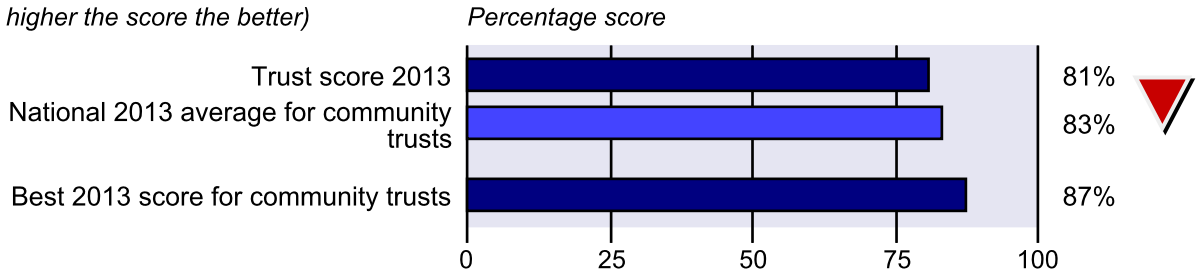
(the lower the score the better)



STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

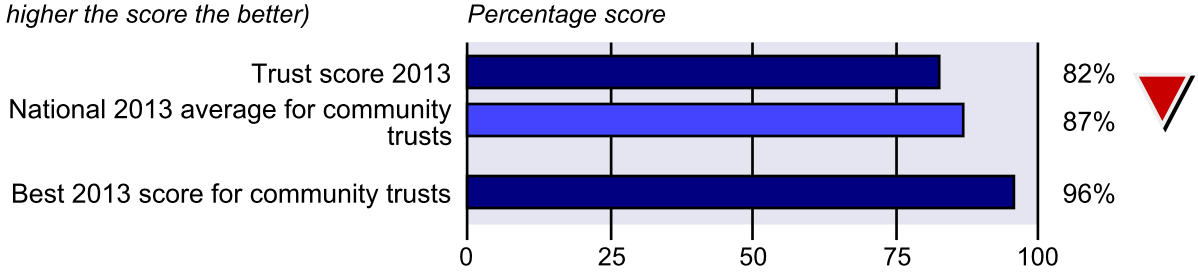
KEY FINDING 6. Percentage of staff receiving job-relevant training, learning or development in last 12 months

(the higher the score the better)



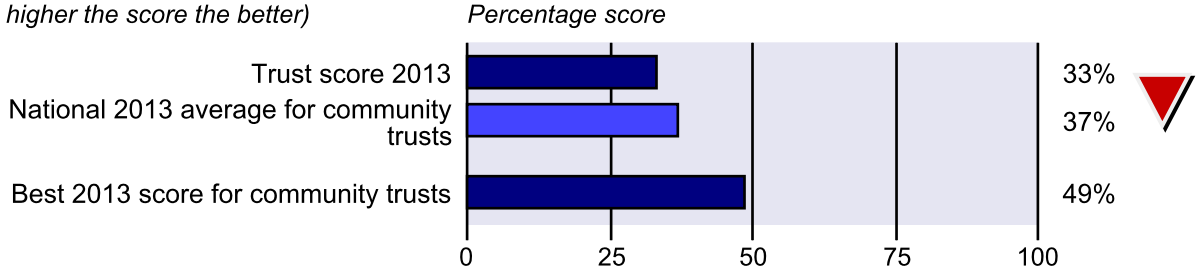
KEY FINDING 7. Percentage of staff appraised in last 12 months

(the higher the score the better)



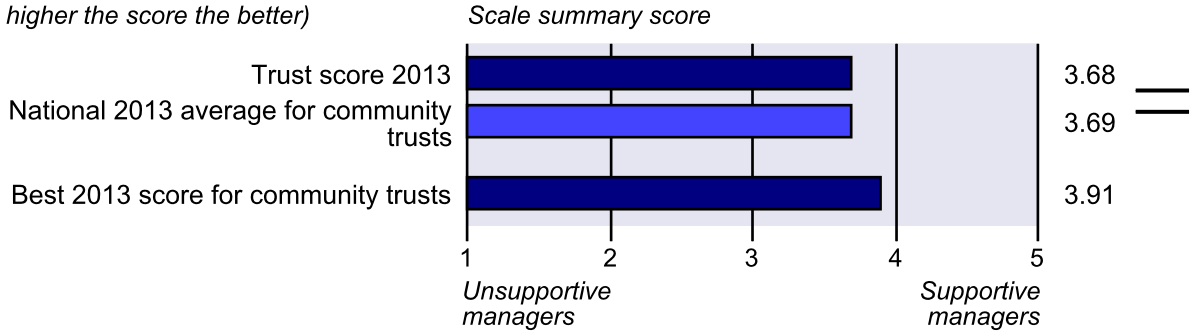
KEY FINDING 8. Percentage of staff having well structured appraisals in last 12 months

(the higher the score the better)



KEY FINDING 9. Support from immediate managers

(the higher the score the better)

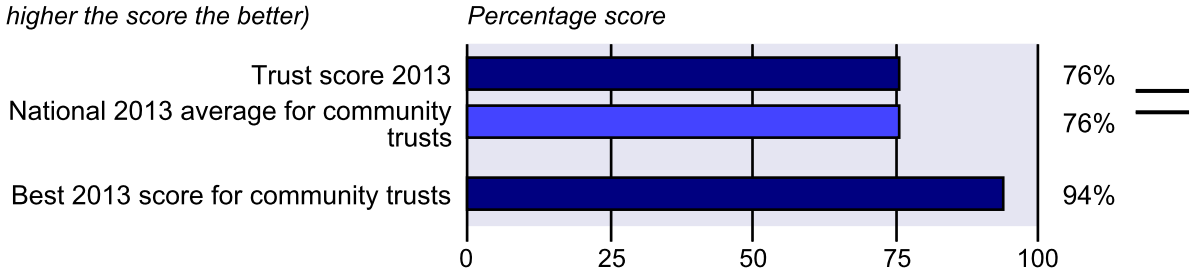


STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.

Occupational health and safety

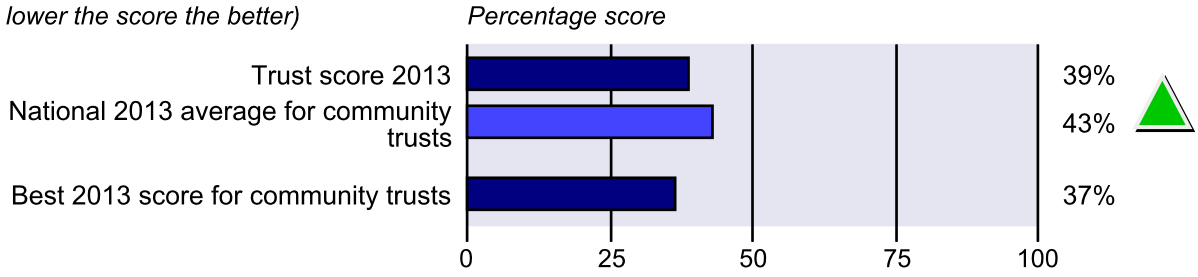
KEY FINDING 10. Percentage of staff receiving health and safety training in last 12 months

(the higher the score the better)



KEY FINDING 11. Percentage of staff suffering work-related stress in last 12 months

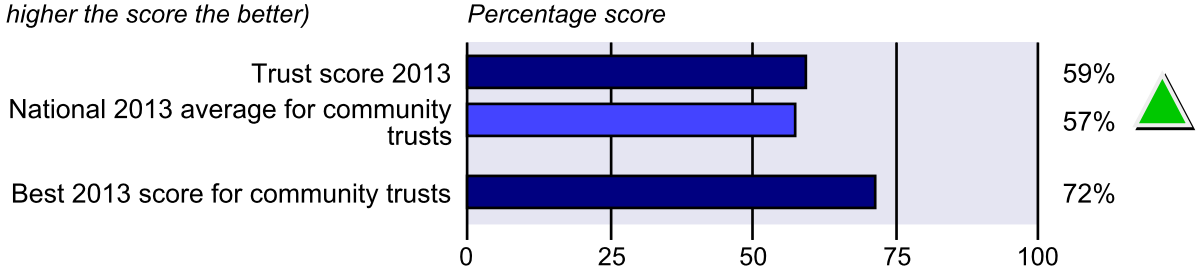
(the lower the score the better)



Infection control and hygiene

KEY FINDING 12. Percentage of staff saying hand washing materials are always available

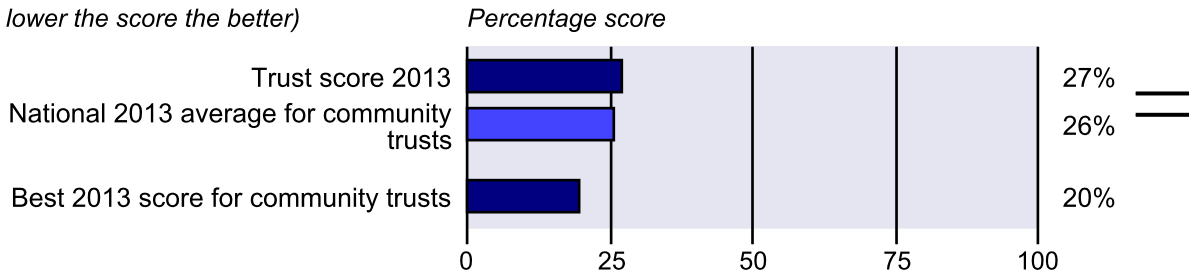
(the higher the score the better)



Errors and incidents

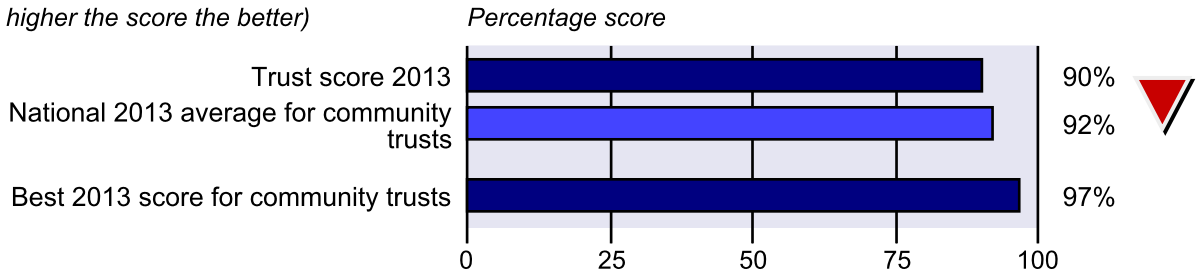
KEY FINDING 13. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



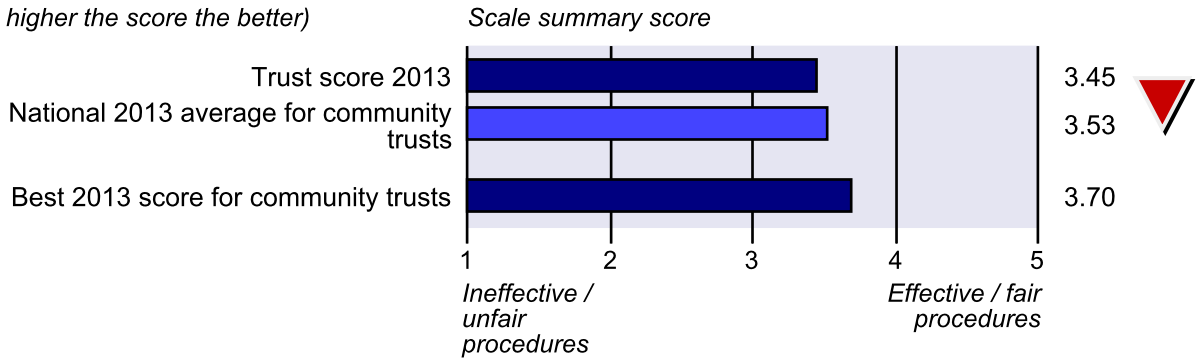
KEY FINDING 14. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



KEY FINDING 15. Fairness and effectiveness of incident reporting procedures

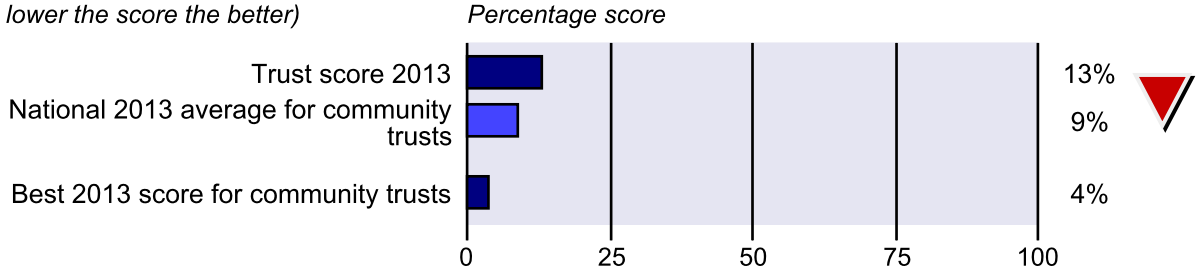
(the higher the score the better)



Violence and harassment

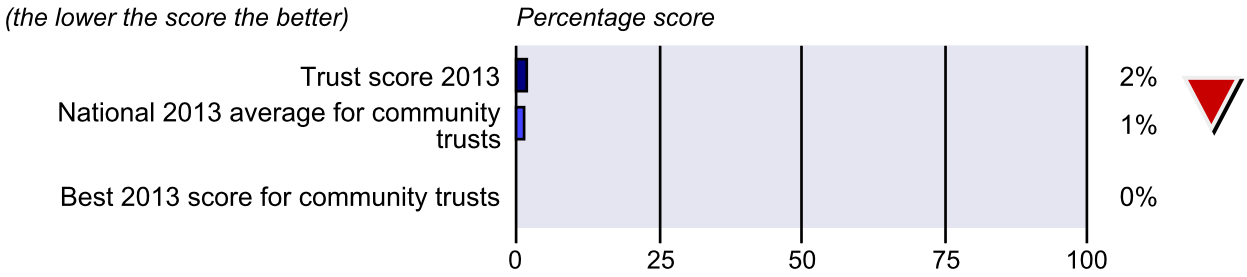
KEY FINDING 16. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



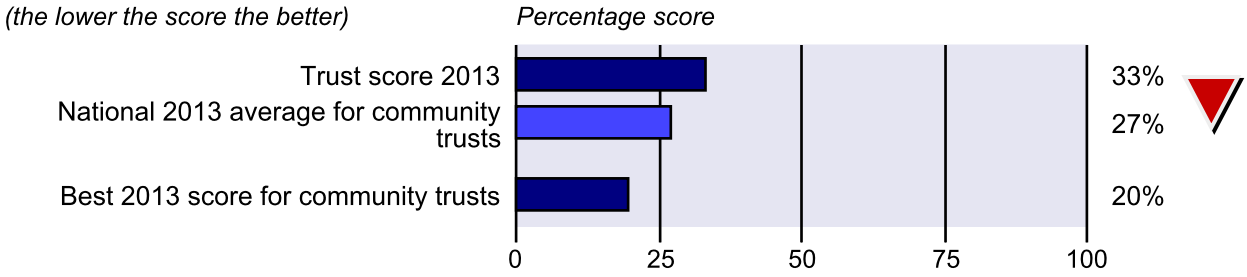
KEY FINDING 17. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



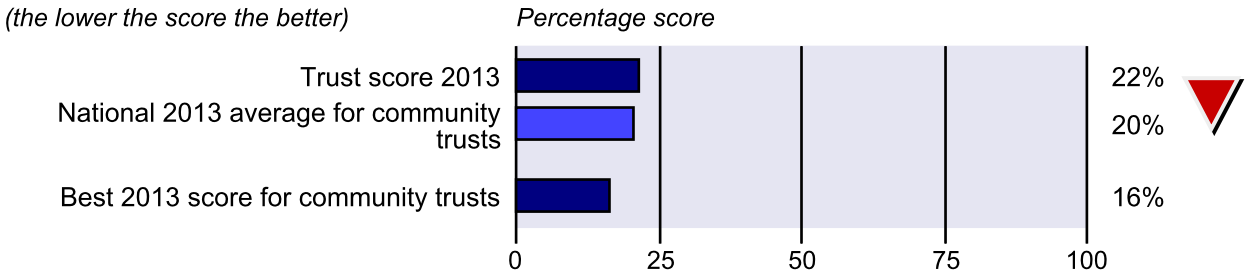
KEY FINDING 18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



KEY FINDING 19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

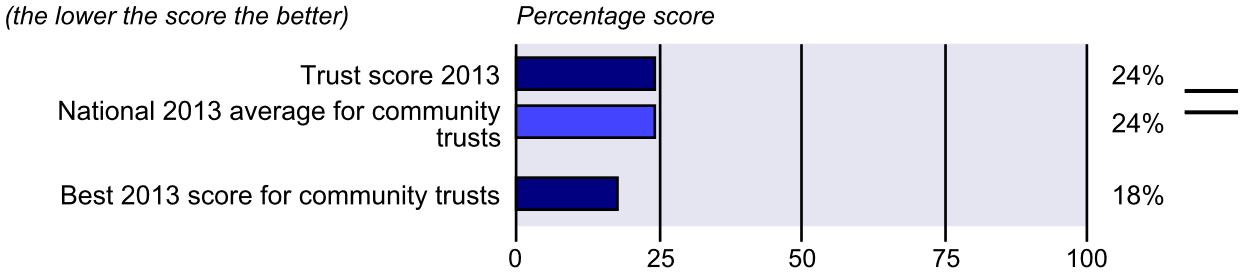
(the lower the score the better)



Health and well-being

KEY FINDING 20. Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell

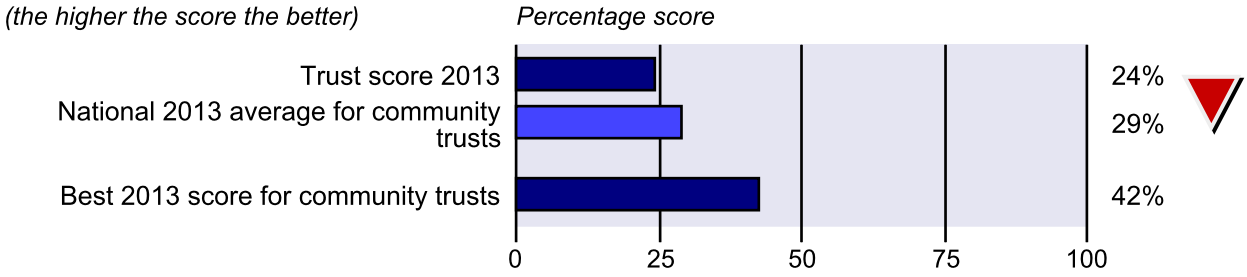
(the lower the score the better)



STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.

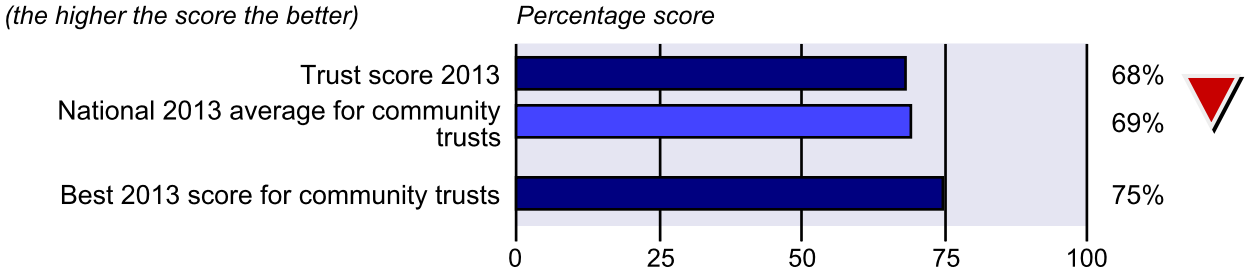
KEY FINDING 21. Percentage of staff reporting good communication between senior management and staff

(the higher the score the better)



KEY FINDING 22. Percentage of staff able to contribute towards improvements at work

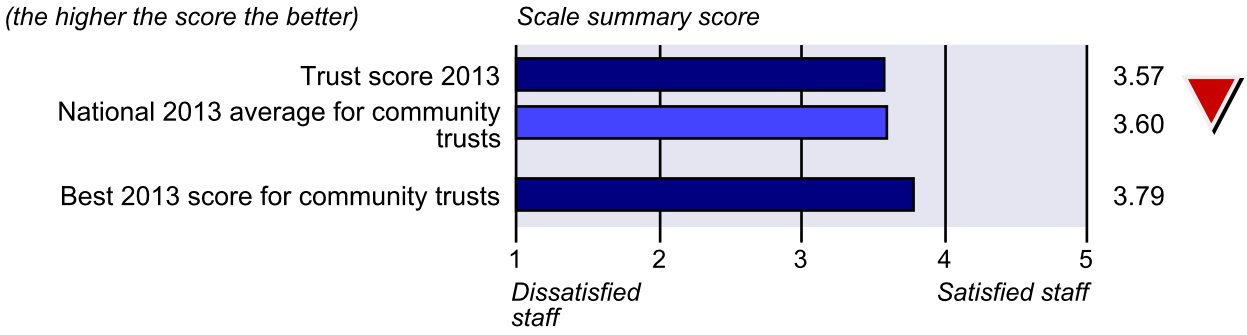
(the higher the score the better)



ADDITIONAL THEME: Staff satisfaction

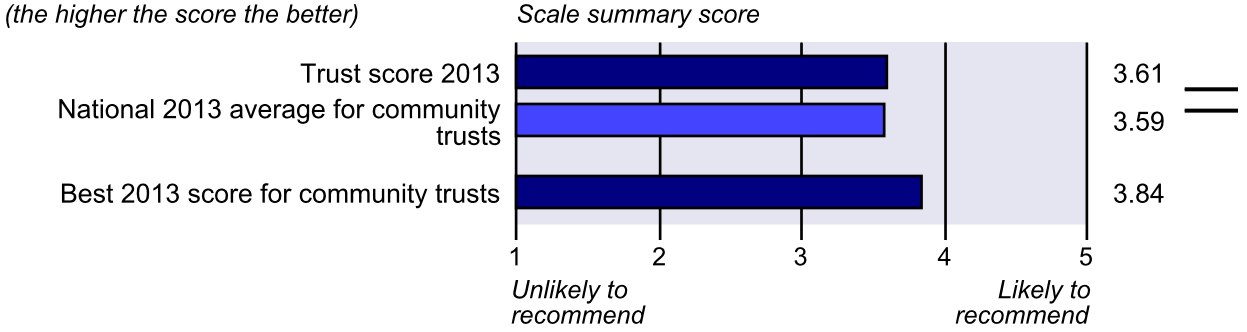
KEY FINDING 23. Staff job satisfaction

(the higher the score the better)



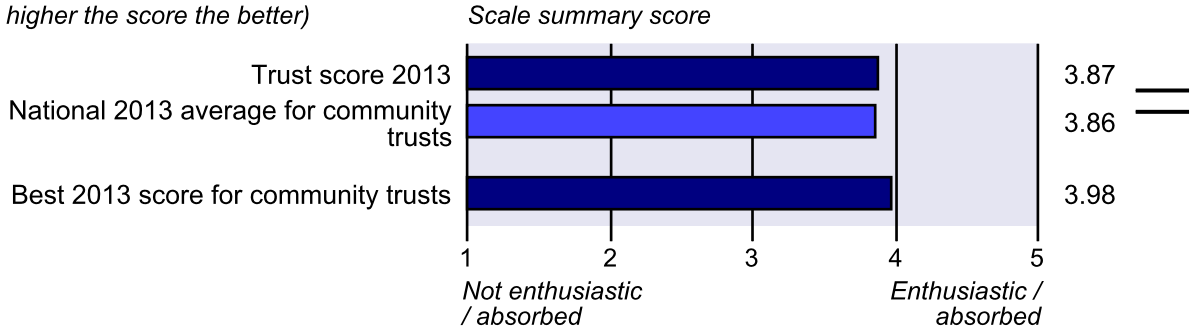
KEY FINDING 24. Staff recommendation of the trust as a place to work or receive treatment

(the higher the score the better)



KEY FINDING 25. Staff motivation at work

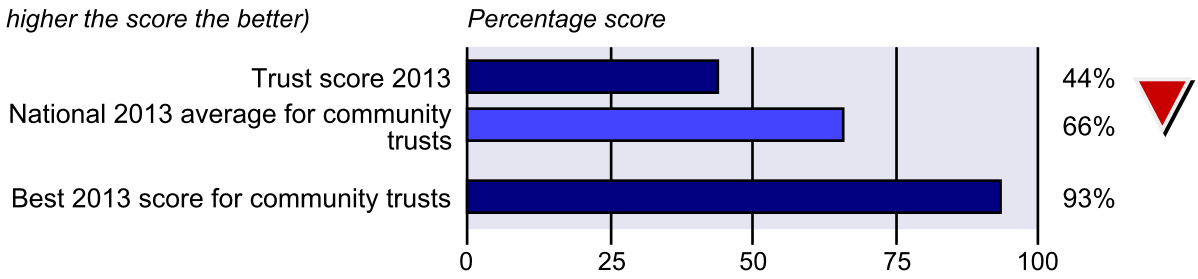
(the higher the score the better)



ADDITIONAL THEME: Equality and diversity

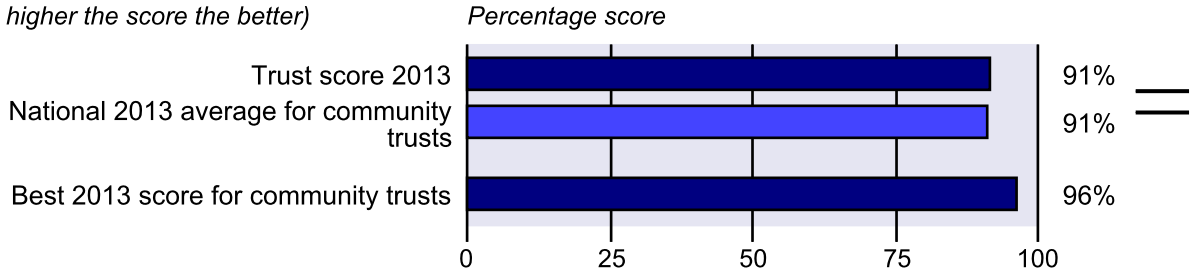
KEY FINDING 26. Percentage of staff having equality and diversity training in last 12 months

(the higher the score the better)



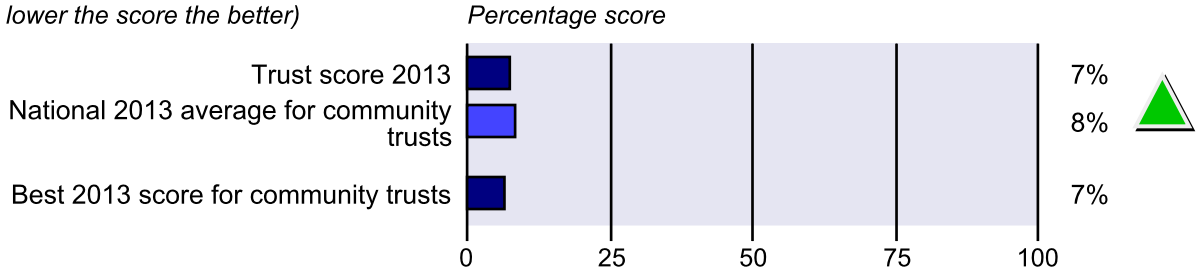
KEY FINDING 27. Percentage of staff believing the trust provides equal opportunities for career progression or promotion

(the higher the score the better)



KEY FINDING 28. Percentage of staff experiencing discrimination at work in last 12 months

(the lower the score the better)



5. Key Findings by work group characteristics

Tables 5.1 to 5.4 show the Key Findings at Thle Gloucestershire Care Services National Health Service Trust broken down by work group characteristics: occupational groups, departments, staff groups and full time/part time staff.

Technical notes:

- As in previous years, there are two types of Key Finding:
    - percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions
    - scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5
- For most of the Key Findings presented in tables 5.1 to 5.4, the higher the score the better. However, there are some Key Findings for which a high score would represent a negative result. For these Key Findings, marked with an asterix and shown in italics, the lower the score the better.
- Care should be taken not to over interpret the findings if scores differ slightly. For example, if for 'KF8. % having well structured appraisals in last 12 months' staff in Group A score 45%, and staff in Group B score 40%, it may appear that a higher proportion of staff in Group A have had well structured appraisals than staff in Group B. However, because of small numbers in these sub-groups, it is probably not statistically significant. A more sensible interpretation would be that, on average, similar proportions of staff in Group A and B have well structured appraisals.
- Please note that, unlike the overall Trust scores, data in this section are not weighted.
- Please also note that all percentage scores are shown to the nearest 1%. This means scores of less than 0.5% are displayed as 0%.
- In order to preserve anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

Table 5.1: Key Findings for different occupational groups

	Adult / General Nurses	Other Registered Nurses	Nursing / Healthcare Assistants	Medical / Dental	Occupational Therapy	Physiotherapy	Other Allied Health Professionals	Other Scientific & Technical	Admin & Clerical	Maintenance / Ancillary
STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.										
KF1. % feeling satisfied with the quality of work and patient care they are able to deliver	70	68	91	88	61	71	68	100	87	54
KF2. % agreeing that their role makes a difference to patients	85	93	94	88	84	100	96	100	84	81
* *KF3. Work pressure felt by staff*	3.21	3.44	2.94	2.84	3.42	3.50	3.21	2.79	2.87	3.21
KF4. Effective team working	3.64	3.98	3.65	3.75	3.86	3.89	3.62	3.69	3.65	3.13
* *KF5. % working extra hours*	79	88	59	59	68	77	75	71	59	43
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.										
KF6. % receiving job-relevant training, learning or development in last 12 mths	75	88	84	75	87	88	79	77	70	47
KF7. % appraised in last 12 mths	83	82	77	94	80	100	88	86	83	64
KF8. % having well structured appraisals in last 12 mths	40	32	30	31	30	41	24	36	32	18
KF9. Support from immediate managers	3.76	3.65	3.81	3.94	3.64	3.89	3.14	3.74	3.65	3.14
STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.										
Occupational health and safety										
KF10. % receiving health and safety training in last 12 mths	84	80	83	82	84	86	84	71	61	50
* *KF11. % suffering work-related stress in last 12 mths*	47	49	17	41	47	32	38	29	31	20
Infection control and hygiene										
KF12. % saying hand washing materials are always available	72	47	69	82	47	46	40	71	63	82
Errors and incidents										
* *KF13. % witnessing potentially harmful errors, near misses or incidents in last mth*	36	38	25	29	45	23	21	29	18	9
KF14. % reporting errors, near misses or incidents witnessed in the last mth	100	93	83	-	86	-	-	-	82	-
KF15. Fairness and effectiveness of incident reporting procedures	3.47	3.32	3.57	3.52	3.36	3.52	3.41	3.55	3.51	3.32
Number of respondents	68	77	48	17	32	35	25	14	60	22

Due to low numbers of respondents, no scores are shown for the following occupational groups: Mental Health Nurses, General Management, Central Functions / Corporate Services, Social Care Staff, Public Health / Health Improvement and Commissioning Staff.

Table 5.1: Key Findings for different occupational groups (cont)

	Adult / General Nurses	Other Registered Nurses	Nursing / Healthcare Assistants	Medical / Dental	Occupational Therapy	Physiotherapy	Other Allied Health Professionals	Other Scientific & Technical	Admin & Clerical	Maintenance / Ancillary
Violence and harassment										
* *KF16. % experiencing physical violence from patients, relatives or the public in last 12 mths*	30	8	38	12	3	9	20	7	2	5
* *KF17. % experiencing physical violence from staff in last 12 mths*	6	1	4	0	0	3	0	0	0	5
* *KF18. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	44	45	36	47	23	23	44	21	35	18
* *KF19. % experiencing harassment, bullying or abuse from staff in last 12 mths*	30	26	7	41	17	11	20	21	17	29
Health and well-being										
* *KF20. % feeling pressure in last 3 mths to attend work when feeling unwell*	25	21	36	35	31	21	35	15	24	24
STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.										
KF21. % reporting good communication between senior management and staff	22	18	28	24	16	31	13	14	22	14
KF22. % able to contribute towards improvements at work	74	66	63	65	69	71	72	64	72	27
ADDITIONAL THEME: Staff satisfaction										
KF23. Staff job satisfaction	3.46	3.53	3.67	3.65	3.40	3.74	3.54	3.51	3.63	3.23
KF24. Staff recommendation of the trust as a place to work or receive treatment	3.65	3.33	3.84	4.14	3.08	3.37	3.56	3.90	3.75	3.73
KF25. Staff motivation at work	3.88	3.90	4.05	3.73	3.78	3.93	3.95	3.90	3.81	3.97
ADDITIONAL THEME: Equality and diversity										
KF26. % having equality and diversity training in last 12 mths	53	33	62	47	55	35	32	36	33	11
KF27. % believing the trust provides equal opportunities for career progression or promotion	95	84	88	83	90	100	91	-	92	-
* *KF28. % experiencing discrimination at work in last 12 mths*	9	5	2	18	10	3	20	0	8	14
Overall staff engagement	3.77	3.61	3.79	3.80	3.50	3.68	3.76	3.78	3.73	3.65
Number of respondents	68	77	48	17	32	35	25	14	60	22

Due to low numbers of respondents, no scores are shown for the following occupational groups: Mental Health Nurses, General Management, Central Functions / Corporate Services, Social Care Staff, Public Health / Health Improvement and Commissioning Staff.

Table 5.2: Key Findings for different departments

	Cheltenham and Cotswold	Children, Family & Young People	Corporate	Countywide	Forest and Tewkesbury	Gloucester and Stroud	Unscheduled Care and Capacity
STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.							
KF1. % feeling satisfied with the quality of work and patient care they are able to deliver	71	54	73	91	87	69	91
KF2. % agreeing that their role makes a difference to patients	94	85	81	96	89	90	91
* *KF3. Work pressure felt by staff*	3.36	3.47	3.12	2.87	3.10	3.29	2.92
KF4. Effective team working	3.62	3.90	3.60	3.99	3.70	3.54	3.92
* *KF5. % working extra hours*	78	73	66	64	68	69	70
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.							
KF6. % receiving job-relevant training, learning or development in last 12 mths	81	94	68	86	77	77	77
KF7. % appraised in last 12 mths	76	83	75	93	81	81	84
KF8. % having well structured appraisals in last 12 mths	34	28	26	37	25	33	60
KF9. Support from immediate managers	3.70	3.50	3.56	3.86	3.88	3.58	3.63
STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.							
Occupational health and safety							
KF10. % receiving health and safety training in last 12 mths	83	76	62	79	72	77	81
* *KF11. % suffering work-related stress in last 12 mths*	42	48	33	27	30	49	28
Infection control and hygiene							
KF12. % saying hand washing materials are always available	57	35	73	65	62	63	56
Errors and incidents							
* *KF13. % witnessing potentially harmful errors, near misses or incidents in last mth*	30	16	21	23	40	33	41
KF14. % reporting errors, near misses or incidents witnessed in the last mth	74	-	-	94	97	91	83
KF15. Fairness and effectiveness of incident reporting procedures	3.46	3.36	3.40	3.58	3.45	3.43	3.46
Number of respondents	67	66	48	75	72	73	32

Please note that the departments classification was provided by Thle Gloucestershire Care Services National Health Service Trust

Table 5.2: Key Findings for different departments (cont)

	Cheltenham and Cotswold	Children, Family & Young People	Corporate	Countywide	Forest and Tewkesbury	Gloucester and Stroud	Unscheduled Care and Capacity
Violence and harassment							
* *KF16. % experiencing physical violence from patients, relatives or the public in last 12 mths*	22	6	4	7	26	21	6
* *KF17. % experiencing physical violence from staff in last 12 mths*	3	0	2	1	3	3	0
* *KF18. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	32	28	17	44	40	44	25
* *KF19. % experiencing harassment, bullying or abuse from staff in last 12 mths*	24	14	26	26	16	23	16
Health and well-being							
* *KF20. % feeling pressure in last 3 mths to attend work when feeling unwell*	25	17	19	31	27	32	18
STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.							
KF21. % reporting good communication between senior management and staff	28	15	27	23	25	19	22
KF22. % able to contribute towards improvements at work	69	71	56	68	68	67	66
ADDITIONAL THEME: Staff satisfaction							
KF23. Staff job satisfaction	3.51	3.52	3.50	3.70	3.63	3.51	3.58
KF24. Staff recommendation of the trust as a place to work or receive treatment	3.52	3.41	3.78	3.80	3.67	3.47	3.55
KF25. Staff motivation at work	3.87	3.85	3.82	3.89	4.06	3.84	3.84
ADDITIONAL THEME: Equality and diversity							
KF26. % having equality and diversity training in last 12 mths	42	25	39	42	43	49	61
KF27. % believing the trust provides equal opportunities for career progression or promotion	90	84	93	88	98	92	95
* *KF28. % experiencing discrimination at work in last 12 mths*	6	8	13	13	4	3	6
Overall staff engagement	3.64	3.62	3.72	3.80	3.81	3.65	3.65
Number of respondents	67	66	48	75	72	73	32

Please note that the departments classification was provided by Thle Gloucestershire Care Services National Health Service Trust

Table 5.3: Key Findings for different staff groups

	Administration & Estates Staff	Allied Health Professional	Health Care Assistants & Support Staff	Nursing, Midwifery & Health Visiting Staff
STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.				
KF1. % feeling satisfied with the quality of work and patient care they are able to deliver	85	72	61	76
KF2. % agreeing that their role makes a difference to patients	84	93	82	91
* *KF3. Work pressure felt by staff*	2.96	3.29	3.12	3.21
KF4. Effective team working	3.76	3.81	3.08	3.79
* *KF5. % working extra hours*	63	69	46	76
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.				
KF6. % receiving job-relevant training, learning or development in last 12 mths	74	84	60	84
KF7. % appraised in last 12 mths	84	91	59	80
KF8. % having well structured appraisals in last 12 mths	33	33	15	35
KF9. Support from immediate managers	3.68	3.69	3.11	3.73
STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.				
Occupational health and safety				
KF10. % receiving health and safety training in last 12 mths	60	86	54	81
* *KF11. % suffering work-related stress in last 12 mths*	36	39	28	40
Infection control and hygiene				
KF12. % saying hand washing materials are always available	58	50	81	59
Errors and incidents				
* *KF13. % witnessing potentially harmful errors, near misses or incidents in last mth*	16	28	22	34
KF14. % reporting errors, near misses or incidents witnessed in the last mth	86	87	-	93
KF15. Fairness and effectiveness of incident reporting procedures	3.47	3.49	3.32	3.42
Number of respondents	86	110	27	211

Please note that the staff groups classification was provided by Thle Gloucestershire Care Services National Health Service Trust

Table 5.3: Key Findings for different staff groups (cont)

	Administration & Estates Staff	Allied Health Professional	Health Care Assistants & Support Staff	Nursing, Midwifery & Health Visiting Staff
Violence and harassment				
* *KF16. % experiencing physical violence from patients, relatives or the public in last 12 mths*	2	10	7	22
* *KF17. % experiencing physical violence from staff in last 12 mths*	0	1	4	3
* *KF18. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	26	28	22	42
* *KF19. % experiencing harassment, bullying or abuse from staff in last 12 mths*	20	16	35	23
Health and well-being				
* *KF20. % feeling pressure in last 3 mths to attend work when feeling unwell*	21	28	27	25
STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.				
KF21. % reporting good communication between senior management and staff	28	20	15	23
KF22. % able to contribute towards improvements at work	74	72	26	68
ADDITIONAL THEME: Staff satisfaction				
KF23. Staff job satisfaction	3.66	3.60	3.17	3.54
KF24. Staff recommendation of the trust as a place to work or receive treatment	3.73	3.44	3.73	3.58
KF25. Staff motivation at work	3.79	3.86	3.89	3.94
ADDITIONAL THEME: Equality and diversity				
KF26. % having equality and diversity training in last 12 mths	41	42	13	46
KF27. % believing the trust provides equal opportunities for career progression or promotion	94	96	85	89
* *KF28. % experiencing discrimination at work in last 12 mths*	7	8	15	6
Overall staff engagement	3.74	3.67	3.57	3.72
Number of respondents	86	110	27	211

Please note that the staff groups classification was provided by Thle Gloucestershire Care Services National Health Service Trust

Table 5.4: Key Findings for different work groups

	Full time / part time[a]	
	Full time	Part time
STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.		
KF1. % feeling satisfied with the quality of work and patient care they are able to deliver	76	77
KF2. % agreeing that their role makes a difference to patients	90	90
* *KF3. Work pressure felt by staff*	3.25	3.06
KF4. Effective team working	3.81	3.69
* *KF5. % working extra hours*	75	63
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.		
KF6. % receiving job-relevant training, learning or development in last 12 mths	84	77
KF7. % appraised in last 12 mths	81	84
KF8. % having well structured appraisals in last 12 mths	34	32
KF9. Support from immediate managers	3.74	3.63
STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.		
Occupational health and safety		
KF10. % receiving health and safety training in last 12 mths	77	75
* *KF11. % suffering work-related stress in last 12 mths*	44	32
Infection control and hygiene		
KF12. % saying hand washing materials are always available	55	63
Errors and incidents		
* *KF13. % witnessing potentially harmful errors, near misses or incidents in last mth*	35	19
KF14. % reporting errors, near misses or incidents witnessed in the last mth	90	89
KF15. Fairness and effectiveness of incident reporting procedures	3.46	3.45
Number of respondents	248	189

[a] Full time is defined as staff contracted to work 30 hours or more a week

Table 5.4: Key Findings for different work groups (cont)

	Full time / part time[a]	
	Full time	Part time
Violence and harassment		
* *KF16. % experiencing physical violence from patients, relatives or the public in last 12 mths*	15	12
* *KF17. % experiencing physical violence from staff in last 12 mths*	3	1
* *KF18. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	39	28
* *KF19. % experiencing harassment, bullying or abuse from staff in last 12 mths*	23	19
Health and well-being		
* *KF20. % feeling pressure in last 3 mths to attend work when feeling unwell*	28	22
STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.		
KF21. % reporting good communication between senior management and staff	27	19
KF22. % able to contribute towards improvements at work	76	57
ADDITIONAL THEME: Staff satisfaction		
KF23. Staff job satisfaction	3.60	3.53
KF24. Staff recommendation of the trust as a place to work or receive treatment	3.62	3.56
KF25. Staff motivation at work	3.90	3.87
ADDITIONAL THEME: Equality and diversity		
KF26. % having equality and diversity training in last 12 mths	43	41
KF27. % believing the trust provides equal opportunities for career progression or promotion	90	93
* *KF28. % experiencing discrimination at work in last 12 mths*	9	5
Overall staff engagement	3.76	3.65
Number of respondents	248	189

[a] Full time is defined as staff contracted to work 30 hours or more a week

6. Key Findings by demographic groups

Tables 6.1 and 6.2 show the Key Findings at Thle Gloucestershire Care Services National Health Service Trust broken down by different demographic groups: age group, gender and disability.

Technical notes:

- As in previous years, there are two types of Key Finding:
    - percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions
    - scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5
- For most of the Key Findings presented in tables 6.1 and 6.2, the higher the score the better. However, there are some Key Findings for which a high score would represent a negative result. For these Key Findings, marked with an asterix and shown in italics, the lower the score the better.
- Care should be taken not to over interpret the findings if scores differ slightly. For example, if for 'KF8. % having well structured appraisals in last 12 months' staff in Group A score 45%, and staff in Group B score 40%, it may appear that a higher proportion of staff in Group A have had well structured appraisals than staff in Group B. However, because of small numbers in these sub-groups, it is probably not statistically significant. A more sensible interpretation would be that, on average, similar proportions of staff in Group A and B have well structured appraisals.
- Please note that, unlike the overall Trust scores, data in this section are not weighted.
- Please also note that all percentage scores are shown to the nearest 1%. This means scores of less than 0.5% are displayed as 0%.
- In order to preserve anonymity of individual staff, a score is replaced with a dash if the demographic group in question contributed fewer than 11 responses to that score.

Table 6.1: Key Findings for different age groups

	Age group			
	Age 16-30	Age 31-40	Age 41-50	Age 51+
STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.				
KF1. % feeling satisfied with the quality of work and patient care they are able to deliver	82	71	73	79
KF2. % agreeing that their role makes a difference to patients	92	92	90	89
* *KF3. Work pressure felt by staff*	3.12	3.32	3.18	3.14
KF4. Effective team working	3.87	3.80	3.67	3.77
* *KF5. % working extra hours*	66	72	70	70
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.				
KF6. % receiving job-relevant training, learning or development in last 12 mths	90	87	80	77
KF7. % appraised in last 12 mths	78	83	81	85
KF8. % having well structured appraisals in last 12 mths	42	32	32	33
KF9. Support from immediate managers	3.79	3.76	3.64	3.66
STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.				
Occupational health and safety				
KF10. % receiving health and safety training in last 12 mths	81	73	74	78
* *KF11. % suffering work-related stress in last 12 mths*	40	37	40	38
Infection control and hygiene				
KF12. % saying hand washing materials are always available	51	59	59	61
Errors and incidents				
* *KF13. % witnessing potentially harmful errors, near misses or incidents in last mth*	34	30	27	27
KF14. % reporting errors, near misses or incidents witnessed in the last mth	94	89	85	92
KF15. Fairness and effectiveness of incident reporting procedures	3.59	3.41	3.44	3.44
Number of respondents	53	64	128	192

Table 6.1: Key Findings for different age groups (cont)

	Age group			
	Age 16-30	Age 31-40	Age 41-50	Age 51+
Violence and harassment				
* *KF16. % experiencing physical violence from patients, relatives or the public in last 12 mths*	13	16	15	13
* *KF17. % experiencing physical violence from staff in last 12 mths*	2	2	1	3
* *KF18. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	36	33	29	38
* *KF19. % experiencing harassment, bullying or abuse from staff in last 12 mths*	19	24	24	20
Health and well-being				
* *KF20. % feeling pressure in last 3 mths to attend work when feeling unwell*	26	34	23	24
STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.				
KF21. % reporting good communication between senior management and staff	34	17	25	21
KF22. % able to contribute towards improvements at work	74	66	71	66
ADDITIONAL THEME: Staff satisfaction				
KF23. Staff job satisfaction	3.72	3.56	3.54	3.55
KF24. Staff recommendation of the trust as a place to work or receive treatment	3.82	3.52	3.60	3.56
KF25. Staff motivation at work	3.83	3.78	3.92	3.93
ADDITIONAL THEME: Equality and diversity				
KF26. % having equality and diversity training in last 12 mths	58	48	39	39
KF27. % believing the trust provides equal opportunities for career progression or promotion	100	96	88	88
* *KF28. % experiencing discrimination at work in last 12 mths*	11	5	10	6
Overall staff engagement	3.81	3.65	3.71	3.70
Number of respondents	53	64	128	192

Table 6.2: Key Findings for other demographic groups

	Gender		Disability	
	Men	Women	Disabled	Not disabled
STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.				
KF1. % feeling satisfied with the quality of work and patient care they are able to deliver	88	76	68	78
KF2. % agreeing that their role makes a difference to patients	89	90	85	91
* *KF3. Work pressure felt by staff*	3.06	3.17	3.20	3.16
KF4. Effective team working	3.88	3.77	3.55	3.80
* *KF5. % working extra hours*	55	71	63	71
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.				
KF6. % receiving job-relevant training, learning or development in last 12 mths	77	82	75	82
KF7. % appraised in last 12 mths	83	83	73	86
KF8. % having well structured appraisals in last 12 mths	38	33	27	35
KF9. Support from immediate managers	3.79	3.68	3.47	3.73
STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.				
Occupational health and safety				
KF10. % receiving health and safety training in last 12 mths	75	77	66	78
* *KF11. % suffering work-related stress in last 12 mths*	29	38	58	34
Infection control and hygiene				
KF12. % saying hand washing materials are always available	62	59	62	59
Errors and incidents				
* *KF13. % witnessing potentially harmful errors, near misses or incidents in last mth*	17	29	35	27
KF14. % reporting errors, near misses or incidents witnessed in the last mth	-	89	88	90
KF15. Fairness and effectiveness of incident reporting procedures	3.50	3.45	3.44	3.46
Number of respondents	29	397	74	352

In order to preserve anonymity of individual staff, scores are not shown if there are fewer than 11 respondents. This means that no analysis by ethnic background is shown.

Table 6.2: Key Findings for other demographic groups (cont)

	Gender		Disability	
	Men	Women	Disabled	Not disabled
Violence and harassment				
* *KF16. % experiencing physical violence from patients, relatives or the public in last 12 mths*	3	15	12	15
* *KF17. % experiencing physical violence from staff in last 12 mths*	0	2	3	2
* *KF18. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	28	34	50	31
* *KF19. % experiencing harassment, bullying or abuse from staff in last 12 mths*	17	21	35	19
Health and well-being				
* *KF20. % feeling pressure in last 3 mths to attend work when feeling unwell*	18	26	40	21
STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.				
KF21. % reporting good communication between senior management and staff	24	23	22	23
KF22. % able to contribute towards improvements at work	79	68	58	70
ADDITIONAL THEME: Staff satisfaction				
KF23. Staff job satisfaction	3.76	3.56	3.44	3.60
KF24. Staff recommendation of the trust as a place to work or receive treatment	3.93	3.59	3.59	3.62
KF25. Staff motivation at work	4.03	3.88	3.80	3.91
ADDITIONAL THEME: Equality and diversity				
KF26. % having equality and diversity training in last 12 mths	43	42	36	43
KF27. % believing the trust provides equal opportunities for career progression or promotion	95	91	91	92
* *KF28. % experiencing discrimination at work in last 12 mths*	4	8	10	7
Overall staff engagement	3.93	3.70	3.63	3.74
Number of respondents	29	397	74	352

In order to preserve anonymity of individual staff, scores are not shown if there are fewer than 11 respondents. This means that no analysis by ethnic background is shown.

7. Work and demographic profile of the survey respondents

The occupational group of the staff survey respondents is shown in table 7.1, other work characteristics are shown in table 7.2, and demographic characteristics are shown in table 7.3.

Table 7.1: Occupational group of respondents

Occupational group	Number questionnaires returned	Percentage of survey respondents
Nurses, Midwives and Nursing Assistants		
Registered Nurses - Adult / General	68	16%
Registered Nurses - Mental Health	1	0%
Registered Nurses - Children	5	1%
Health Visitors	21	5%
Registered Nurses - District / Community	41	9%
Other Registered Nurses	10	2%
Nursing auxiliary / Nursing assistant / Healthcare assistant	48	11%
Medical and Dental		
Medical / Dental - Consultant	1	0%
Medical / Dental - Other	16	4%
Allied Health Professionals		
Clinical Psychology	1	0%
Occupational Therapy	32	7%
Physiotherapy	35	8%
Other qualified Allied Health Professionals	24	6%
Support to Allied Health Professionals	10	2%
Scientific and Technical / Healthcare Scientists		
Support to Scientific and Technical / Healthcare Scientists	4	1%
Social Care Staff		
Social care managers	1	0%
Social care support staff	2	0%
Other groups		
Registered nurses	10	2%
Nursing auxiliary / Nursing assistant / Healthcare assistant	48	11%
Allied Health Professionals	24	6%
Scientific and Technical / Healthcare Scientists	10	2%
Public Health / Health Improvement	10	2%
Commissioning managers / support staff	1	0%
Admin and Clerical	60	14%
Central Functions / Corporate Services	9	2%
Maintenance / Ancillary	22	5%
General Management	4	1%
Other	7	2%
Did not specify	11	

Sums of percentages may add up to more than 100% due to rounding, and do not include 'did not specify' responses

Table 7.2: Work characteristics of respondents

	Number questionnaires returned	Percentage of survey respondents
Full time / part time		
Full time	248	57%
Part time	189	43%
Did not specify	7	
Length of time in organisation		
Less than a year	30	7%
Between 1 to 2 years	40	9%
Between 3 to 5 years	87	20%
Between 6 to 10 years	88	20%
Between 11 to 15 years	74	17%
Over 15 years	119	27%
Did not specify	6	

Sums of percentages may add up to more than 100% due to rounding, and do not include 'did not specify' responses

Table 7.3: Demographic characteristics of respondents

	Number questionnaires returned	Percentage of survey respondents
Age group		
Between 16 and 30	53	12%
Between 31 and 40	64	15%
Between 41 and 50	128	29%
51 and over	192	44%
Did not specify	7	
Gender		
Male	29	7%
Female	397	93%
Did not specify	18	
Ethnic background		
White	429	98%
Black and minority ethnic	7	2%
Did not specify	8	
Disability		
Disabled	74	17%
Not disabled	352	83%
Did not specify	18	

Sums of percentages may add up to more than 100% due to rounding, and do not include 'did not specify' responses

Appendix 1

Key Findings for Thle Gloucestershire Care Services National Health Service Trust benchmarked against other community trusts

Technical notes:

- The first column in table A1 shows the trust's scores for each of the Key Findings. The same data are displayed in section 3 and 4 of this report.

- The second column in table A1 shows the 95% confidence intervals around the trust's scores for each of the Key Findings.

- The third column in table A1 shows the average (median) score for each of the Key Findings for community trusts. The same data are displayed in section 3 and 4 of this report.

- The fourth and fifth columns in table A1 show the thresholds for below and above average scores for each of the Key Findings for community trusts. The data are used to describe comparisons with other trusts as displayed in section 3 and 4 of this report.

- The sixth column in table A1 shows the lowest score attained for each of the Key Findings by an community trust.

- The seventh column in table A1 shows the highest score attained for each of the Key Findings by an community trust.

- For most of the Key Findings presented in table A1, the higher the score the better. However, there are some Key Findings for which a high score would represent a negative score. For these Key Findings, marked with an asterix and shown in italics, the lower the score the better.

- Please note that the data presented in table A1 are rounded to the nearest whole number for percentage scores and to two decimal places for scale summary scores.

Table A1: Key Findings for Thle Gloucestershire Care Services National Health Service Trust benchmarked against other community trusts

	Your trust		National scores for community trusts				
	Trust score	95% Confidence Interval	Median score	Threshold for below average	Threshold for above average	Lowest score attained	Highest score attained
Response rate	56	-	53	49	55	38	62
STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.							
KF1. % feeling satisfied with the quality of work and patient care they are able to deliver	76	[72, 81]	75	73	77	66	82
KF2. % agreeing that their role makes a difference to patients	89	[86, 93]	91	89	92	88	94
* *KF3. Work pressure felt by staff*	3.16	[3.09, 3.24]	3.13	3.08	3.15	2.95	3.32
KF4. Effective team working	3.76	[3.67, 3.85]	3.80	3.77	3.81	3.75	3.94
* *KF5. % working extra hours*	70	[66, 74]	71	68	73	62	79
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.							
KF6. % receiving job-relevant training, learning or development in last 12 mths	81	[77, 85]	83	82	84	77	87
KF7. % appraised in last 12 mths	82	[79, 86]	87	83	90	79	96
KF8. % having well structured appraisals in last 12 mths	33	[29, 38]	37	35	40	29	49
KF9. Support from immediate managers	3.68	[3.60, 3.77]	3.69	3.68	3.74	3.53	3.91
STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.							
Occupational health and safety							
KF10. % receiving health and safety training in last 12 mths	76	[72, 80]	76	72	81	59	94
* *KF11. % suffering work-related stress in last 12 mths*	39	[34, 43]	43	40	45	37	51
Infection control and hygiene							
KF12. % saying hand washing materials are always available	59	[55, 64]	57	52	59	41	72
Errors and incidents							
* *KF13. % witnessing potentially harmful errors, near misses or incidents in last mth*	27	[23, 31]	26	24	27	20	33
KF14. % reporting errors, near misses or incidents witnessed in the last mth	90	[85, 95]	92	91	92	88	97
KF15. Fairness and effectiveness of incident reporting procedures	3.45	[3.40, 3.50]	3.53	3.50	3.57	3.45	3.70

Table A1: Key Findings for Thle Gloucestershire Care Services National Health Service Trust benchmarked against other community trusts (cont)

	Your trust		National scores for community trusts				
	Trust score	95% Confidence Interval	Median score	Threshold for below average	Threshold for above average	Lowest score attained	Highest score attained
Violence and harassment							
* *KF16. % experiencing physical violence from patients, relatives or the public in last 12 mths*	13	[10, 16]	9	7	11	4	15
* *KF17. % experiencing physical violence from staff in last 12 mths*	2	[1, 3]	1	1	2	0	2
* *KF18. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	33	[29, 37]	27	24	28	20	33
* *KF19. % experiencing harassment, bullying or abuse from staff in last 12 mths*	22	[18, 26]	20	18	21	16	25
Health and well-being							
* *KF20. % feeling pressure in last 3 mths to attend work when feeling unwell*	24	[20, 29]	24	23	26	18	32
STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.							
KF21. % reporting good communication between senior management and staff	24	[20, 28]	29	26	32	21	42
KF22. % able to contribute towards improvements at work	68	[64, 73]	69	68	71	64	75
ADDITIONAL THEME: Staff satisfaction							
KF23. Staff job satisfaction	3.57	[3.51, 3.64]	3.60	3.58	3.62	3.50	3.79
KF24. Staff recommendation of the trust as a place to work or receive treatment	3.61	[3.54, 3.68]	3.59	3.55	3.63	3.47	3.84
KF25. Staff motivation at work	3.87	[3.81, 3.94]	3.86	3.84	3.90	3.69	3.98
ADDITIONAL THEME: Equality and diversity							
KF26. % having equality and diversity training in last 12 mths	44	[39, 49]	66	59	74	44	93
KF27. % believing the trust provides equal opportunities for career progression or promotion	91	[88, 95]	91	89	92	85	96
* *KF28. % experiencing discrimination at work in last 12 mths*	7	[5, 10]	8	8	9	7	16

Appendix 2

Changes to the Key Findings since the 2012 staff survey

The trust was only recently formed and did not participate in the 2012 survey.

Appendix 3

Data tables: 2013 Key Findings and the responses to all survey questions

For each of the 28 Key Findings (Table A3.1) and each individual survey question in the core version of the questionnaire (Table A3.2), this appendix presents your trust's 2013 survey response, the average (median) 2013 response for community trusts, and your trust's 2012 survey response (where applicable).

In Table A3.1, the question numbers used to calculate the 28 Key Findings are also listed in the first column.

In Table A3.2, the responses to the survey questions are presented in the order that they appear within the core version of the 2013 questionnaire.

Technical notes:

- In certain cases a dash (-) appears in the 'Your Trust in 2012' column in Tables A3.1 or A3.2. This is because of changes to the format of survey questions or the calculation of the Key Findings so comparisons with the 2012 score are not possible.

- In certain cases a dash (-) appears in Tables A3.1 or A3.2. This is in order to preserve anonymity of individual staff, where there were fewer than 11 responses to a survey question or Key Finding.

- Please note that the figures reported in tables A3.1 and A3.2 are un-weighted, and, as a consequence there may be some slight differences between these figures and the figures reported in sections 3 and 4 and Appendix 2 of this report, which are weighted according to the occupational group profile of a typical community trust.

- More details about the calculation of Key Findings and the weighting of data can be found in the document ***Making sense of your staff survey data***, which can be downloaded from: www.nhsstaffsurveys.com

Table A3.1: Key Findings for Thle Gloucestershire Care Services National Health Service Trust benchmarked against other community trusts

	Question number(s)	Your Trust in 2013	Average (median) for community trusts
STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.			
KF1. % feeling satisfied with the quality of work and patient care they are able to deliver	Q6d, 9a, 9c	76	75
KF2. % agreeing that their role makes a difference to patients	Q9b	90	91
* *KF3. Work pressure felt by staff*	Q7e-g	3.17	3.12
KF4. Effective team working	Q4a-d	3.75	3.80
* *KF5. % working extra hours*	Q25b-c	70	71
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.			
KF6. % receiving job-relevant training, learning or development in last 12 mths	Q1a-g, 2a-c	81	83
KF7. % appraised in last 12 mths	Q3a	82	87
KF8. % having well structured appraisals in last 12 mths	Q3a-d	33	37
KF9. Support from immediate managers	Q10a-e	3.67	3.70
STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.			
Occupational health and safety			
KF10. % receiving health and safety training in last 12 mths	Q1a	76	77
* *KF11. % suffering work-related stress in last 12 mths*	Q16	38	43
Infection control and hygiene			
KF12. % saying hand washing materials are always available	Q13a-b	59	57
Errors and incidents			
* *KF13. % witnessing potentially harmful errors, near misses or incidents in last mth*	Q17a, 17b	28	25
KF14. % reporting errors, near misses or incidents witnessed in the last mth	Q17a-b, 17c	90	92
KF15. Fairness and effectiveness of incident reporting procedures	Q18a-g	3.45	3.53

Table A3.1: Key Findings for Thle Gloucestershire Care Services National Health Service Trust benchmarked against other community trusts (cont)

	Question number(s)	Your Trust in 2013	Average (median) for community trusts
Violence and harassment			
* *KF16. % experiencing physical violence from patients, relatives or the public in last 12 mths*	Q20a	14	9
* *KF17. % experiencing physical violence from staff in last 12 mths*	Q20b	2	1
* *KF18. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	Q21a	34	27
* *KF19. % experiencing harassment, bullying or abuse from staff in last 12 mths*	Q21b	21	20
Health and well-being			
* *KF20. % feeling pressure in last 3 mths to attend work when feeling unwell*	Q15a-c	25	24
STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.			
KF21. % reporting good communication between senior management and staff	Q11a-d	23	29
KF22. % able to contribute towards improvements at work	Q7a, 7b, 7d	67	69
ADDITIONAL THEME: Staff satisfaction			
KF23. Staff job satisfaction	Q8a-g	3.56	3.60
KF24. Staff recommendation of the trust as a place to work or receive treatment	Q12a, 12c-d	3.60	3.59
KF25. Staff motivation at work	Q5a-c	3.89	3.86
ADDITIONAL THEME: Equality and diversity			
KF26. % having equality and diversity training in last 12 mths	Q1b	42	66
KF27. % believing the trust provides equal opportunities for career progression or promotion	Q22	91	91
* *KF28. % experiencing discrimination at work in last 12 mths*	Q23a-b	8	8

Table A3.2: Survey questions benchmarked against other community trusts

		Your Trust in 2013	Average (median) for community trusts
	Areas of training, learning and development		
	% having received training, learning or development in the following areas in the last 12 months:		
Q1a	Health and safety training	76	77
Q1b	Equality and diversity training	42	66
Q1c	How to prevent or handle violence and aggression to staff, patients / service users	34	39
Q1d	Infection control (e.g. guidance on hand-washing, MRSA, waste management, disposal of sharps / needles)	71	78
Q1e	How to handle confidential information about patients / service users	68	84
Q1f	How to deliver a good patient / service user experience	35	45
Q1g	Any other job-relevant training, learning or development	78	81
	Job-relevant training, learning and development		
	% who had received training, learning and development in the last 12 months (YES to any part of Q1a-g) agreeing / strongly agreeing that:		
Q2a	It has helped me to do my job more effectively	69	69
Q2b	It has helped me stay up-to-date with professional requirements	73	78
Q2c	It has helped me to deliver a better patient / service user experience	63	67
	Appraisals		
Q3a	% saying they had received an appraisal or performance development review in the last 12 months	82	87
	If (YES to Q3a) had received an appraisal or performance development review in the last 12 months:		
Q3b	% saying their appraisal or development review had helped them to improve how they do their job	51	51
Q3c	% saying their appraisal or development review had helped them agree clear objectives for their work	77	78
Q3d	% saying their appraisal or development review had made them feel their work was valued by the organisation	61	61
Q3e	% saying their appraisal or development review had identified training, learning or development needs	78	75
	If (YES to Q3a) had received an appraisal or performance development review AND (YES to Q3e) training, learning or development needs identified as part of their appraisal or development review:		
Q3f	% saying their manager supported them to receive training, learning or development	87	88
	Team-based working		
Q4a	% working in a team	97	97
	If (YES to Q4a) they work in a team:		
Q4b	% agreeing / strongly agreeing team members have a set of shared objectives	76	77
Q4c	% agreeing / strongly agreeing team members often meet to discuss the team's effectiveness	65	68
Q4d	% agreeing / strongly agreeing the team members have to communicate closely with each other to achieve the team's objectives	77	79
	Staff motivation at work		
	% saying often or always to the following statements:		
Q5a	"I look forward to going to work"	53	52
Q5b	"I am enthusiastic about my job"	70	68
Q5c	"Time passes quickly when I am working"	80	79

		Your Trust in 2013	Average (median) for community trusts
	Job design		
	% agreeing / strongly agreeing with the following statements:		
Q6a	"I have clear, planned goals and objectives for my job"	70	72
Q6b	"I always know what my work responsibilities are"	79	81
Q6c	"I am trusted to do my job"	89	89
Q6d	"I am able to do my job to a standard I am personally pleased with"	75	75
	Opportunities to develop potential at work		
	% agreeing / strongly agreeing with the following statements:		
Q7a	"There are frequent opportunities for me to show initiative in my role"	68	69
Q7b	"I am able to make suggestions to improve the work of my team / department"	75	76
Q7c	"I am involved in deciding on changes introduced that affect my work area / team / department"	52	54
Q7d	"I am able to make improvements happen in my area of work"	54	57
Q7e	"I am unable to meet all the conflicting demands on my time at work"	50	48
Q7f	"I have adequate materials, supplies and equipment to do my work"	55	56
Q7g	"There are enough staff at this organisation for me to do my job properly"	29	27
	Staff job satisfaction		
	% satisfied or very satisfied with the following aspects of their job:		
Q8a	"The recognition I get for good work"	49	50
Q8b	"The support I get from my immediate manager"	64	66
Q8c	"The freedom I have to choose my own method of working"	63	67
Q8d	"The support I get from my work colleagues"	84	81
Q8e	"The amount of responsibility I am given"	76	74
Q8f	"The opportunities I have to use my skills"	71	69
Q8g	"The extent to which my organisation values my work"	32	38
Q8h	"My level of pay"	34	41
	Contribution to patient care		
	% agreeing / strongly agreeing with the following statements:		
Q9a	"I am satisfied with the quality of care I give to patients / service users"	83	83
Q9b	"I feel that my role makes a difference to patients / service users"	90	91
Q9c	"I am able to deliver the patient care I aspire to"	66	64

		Your Trust in 2013	Average (median) for community trusts
	Your managers		
	% agreeing / strongly agreeing with the following statements:		
Q10a	"My immediate manager encourages those who work for her/him to work as a team"	71	72
Q10b	"My immediate manager can be counted on to help me with a difficult task at work"	68	69
Q10c	"My immediate manager gives me clear feedback on my work"	52	58
Q10d	"My immediate manager asks for my opinion before making decisions that affect my work"	53	53
Q10e	"My immediate manager is supportive in a personal crisis"	72	73
Q11a	"I know who the senior managers are here"	81	84
Q11b	"Communication between senior management and staff is effective"	28	35
Q11c	"Senior managers here try to involve staff in important decisions"	28	29
Q11d	"Senior managers act on staff feedback"	22	28
Q11e	"Senior managers where I work are committed to patient care"	49	52
	Your organisation		
	% agreeing / strongly agreeing with the following statements:		
Q12a	"Care of patients / service users is my organisation's top priority"	62	64
Q12b	"My organisation acts on concerns raised by patients / service users"	67	71
Q12c	"I would recommend my organisation as a place to work"	56	54
Q12d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	69	66
	Availability of hand washing materials		
	% saying hot water, soap and paper towels, or alcohol rubs are available for staff:		
Q13a	Always	63	63
Q13a	Most of the time	26	26
Q13a	Sometimes	8	7
Q13a	Never	0	0
Q13a	Don't know	2	3
	% saying hot water, soap and paper towels, or alcohol rubs are available for patients / service users:		
Q13b	Always	54	53
Q13b	Most of the time	22	23
Q13b	Sometimes	7	6
Q13b	Never	1	1
Q13b	Don't know	16	17
	Health and well-being		
	% agreeing / strongly agreeing with the following statements:		
Q14a	"In general, my job is good for my health"	42	42
Q14b	"My immediate manager takes a positive interest in my health and well-being"	57	58
Q14c	"My organisation takes positive action on health and well-being"	36	44
	Health and well-being		
Q15a	% saying in the last three months they had gone to work despite not feeling well enough to perform their duties:	72	68
	(If YES to Q15a): % saying they...		
Q15b	...had felt pressure from their manager to come to work	26	27
Q15c	...had felt pressure from their colleagues to come to work	21	22
Q15d	...had put themselves under pressure to come to work	93	94

		Your Trust in 2013	Average (median) for community trusts
Q16	% saying they have have felt unwell in the last 12 months as a result of work related stress:	38	43
	Witnessing and reporting errors, near misses and incidents		
Q17a	% witnessing errors, near misses or incidents in the last month that could have hurt staff	17	15
Q17b	% witnessing errors, near misses or incidents in the last month that could have hurt patients / service users	24	22
Q17c	(If YES to Q17a or YES to Q17b): % saying the last time they witnessed an error, near miss or incident that could have hurt staff or patients / service users, either they or a colleague had reported it	93	95
	Fairness and effectiveness of procedures for reporting errors, near misses or incidents		
	% agreeing / strongly agreeing with the following statements:		
Q18a	"My organisation treats staff who are involved in an error, near miss or incident fairly"	46	48
Q18b	"My organisation encourages us to report errors, near misses or incidents"	87	89
Q18c	"My organisation treats reports of errors, near misses or incidents confidentially"	68	65
Q18d	"My organisation blames or punishes people who are involved in errors, near misses or incidents"	7	10
Q18e	"When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again"	53	61
Q18f	"We are informed about errors, near misses and incidents that happen in the organisation"	32	40
Q18g	"We are given feedback about changes made in response to reported errors, near misses and incidents"	30	40
	Raising concerns at work		
Q19a	% saying if they were concerned about fraud, malpractice or wrongdoing they would know how to report it	91	94
Q19b	% saying they would feel safe in raising their concern	71	72
Q19c	% saying they would feel confident that the organisation would address their concern	53	54
	Experiencing and reporting physical violence at work		
	% experiencing physical violence at work from patients / service users, their relatives or other members of the public in last 12 months...		
Q20a	Never	86	91
Q20a	1 to 2 times	10	7
Q20a	3 to 5 times	3	1
Q20a	6 to 10 times	1	0
Q20a	More than 10 times	0	0
	% experiencing physical violence at work from managers / team leaders or other colleagues in last 12 months...		
Q20b	Never	98	99
Q20b	1 to 2 times	2	1
Q20b	3 to 5 times	0	0
Q20b	6 to 10 times	0	0
Q20b	More than 10 times	0	0
Q20c	(If YES to Q20a or YES to Q20b): % saying the last time they experienced an incident of physical violence, either they or a colleague had reported it	82	74

		Your Trust in 2013	Average (median) for community trusts
	Experiencing and reporting harassment, bullying and abuse at work		
	% experiencing harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public in last 12 months...		
Q21a	Never	66	73
Q21a	1 to 2 times	25	18
Q21a	3 to 5 times	6	4
Q21a	6 to 10 times	2	1
Q21a	More than 10 times	1	2
	% experiencing harassment, bullying or abuse at work from managers / team leaders or other colleagues in last 12 months...		
Q21b	Never	79	80
Q21b	1 to 2 times	14	14
Q21b	3 to 5 times	4	4
Q21b	6 to 10 times	1	1
Q21b	More than 10 times	3	2
Q21c	(If YES to Q21a or YES to Q21b): % saying the last time they experienced an incident of harassment, bullying or abuse, either they or a colleague had reported it	47	50
	Equal opportunities		
Q22	% saying the organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age	91	91
	Discrimination		
Q23a	% saying they had experienced discrimination from patients / service users, their relatives or other members of the public in the last 12 months	3	3
Q23b	% saying they had experienced discrimination from their manager / team leader or other colleagues in the last 12 months	5	6
	% saying they had experienced discrimination on the grounds of:		
Q23c	Ethnic background	0	1
Q23c	Gender	2	1
Q23c	Religion	0	0
Q23c	Sexual orientation	1	0
Q23c	Disability	1	1
Q23c	Age	2	2
Q23c	Other reason(s)	3	3
	BACKGROUND DETAILS		
	Gender		
Q24a	Male	7	11
Q24a	Female	93	89
	Age group		
Q24b	Between 16 and 30	12	10
Q24b	Between 31 and 40	15	16
Q24b	Between 41 and 50	29	29
Q24b	51 and over	44	43
Q25a	% working part time	43	29
Q25b	% working additional PAID hours	26	22
Q25c	% working additional UNPAID hours	60	61

		Your Trust in 2013	Average (median) for community trusts
	Ethnic background		
Q26	White	98	96
Q26	Mixed	0	1
Q26	Asian / Asian British	1	2
Q26	Black / Black British	0	1
Q26	Chinese	0	0
Q26	Other	0	0
	Sexuality		
Q27	Heterosexual (straight)	93	91
Q27	Gay Man	0	1
Q27	Gay Woman (lesbian)	1	1
Q27	Bisexual	0	0
Q27	Other	0	0
Q27	Preferred not to say	5	7
	Religion		
Q28	No religion	31	25
Q28	Christian	62	61
Q28	Buddhist	0	0
Q28	Hindu	0	0
Q28	Jewish	0	0
Q28	Muslim	0	0
Q28	Sikh	0	0
Q28	Other	1	1
Q28	Preferred not to say	6	6
	Disability		
Q29a	% saying they have a long-standing illness, health problem or disability	17	17
Q29b	(If YES to Q29a and if adjustments felt necessary): % saying their employer has made adequate adjustment(s) to enable them to carry out their work	79	74
	Contact with patients		
Q30	% saying they have face-to-face contact with patients / service users as part of their job	93	88
	Length of time at the organisation (or its predecessors)		
Q31	Less than 1 year	7	6
Q31	1 to 2 years	9	9
Q31	3 to 5 years	20	20
Q31	6 to 10 years	20	21
Q31	11 to 15 years	17	17
Q31	More than 15 years	27	24

		Your Trust in 2013	Average (median) for community trusts
	Occupational group		
Q32	Emergency Care Practitioner	0	0
Q32	Paramedic	0	0
Q32	Emergency Care Assistant	0	0
Q32	Ambulance Technician	0	0
Q32	Ambulance Control Staff	0	0
Q32	Patient Transport Service	0	0
Q32	Registered Nurses and Midwives	34	32
Q32	Nursing or Healthcare Assistants	11	7
Q32	Medical and Dental	4	4
Q32	Allied Health Professionals	24	23
Q32	Scientific and Technical / Healthcare Scientists	1	1
Q32	Social Care staff	1	0
Q32	Public Health / Health Improvement	2	1
Q32	Commissioning staff	0	0
Q32	Admin and Clerical	14	16
Q32	Central Functions / Corporate Services	2	5
Q32	Maintenance / Ancillary	5	3
Q32	General Management	1	2
Q32	Other	2	1

Appendix 4

Other NHS staff survey 2013 documentation

This report is one of several ways in which we present the results of the 2013 national NHS staff survey:

1) A separate summary report of the main 2013 survey results for Thle Gloucestershire Care Services National Health Service Trust can be downloaded from: www.nhsstaffsurveys.com. The summary report is a shorter version of this feedback report, which may be useful for wider circulation within the trust.

2) A national briefing document, describing the national Key Findings from the 2013 survey and making comparisons with previous years, will be available from www.nhsstaffsurveys.com in March 2013.

3) The document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com. This includes details about the calculation of Key Findings and the data weighting method used.

4) A series of detailed spreadsheets are available on request from www.nhsstaffsurveys.com. In these detailed spreadsheets you can find:
    - responses of staff in your trust to every core survey question
    - responses in every trust in England
    - the average responses for each major trust type (e.g. all acute trusts, all ambulance trusts)
    - the average trust responses within each strategic health authority
    - the average responses for each major occupational and demographic group within the major trust types

Gloucestershire Care Services NHS
NHS Trust

Gloucestershire Care Services NHS Trust Board

Title:	**Finance Report**	**20th May 2014**
Agenda Item:	**12**	
Purpose of Paper:	To advise the Board on the final full year out-turn position for 2013/14; to provide updates regarding financial risks and priorities and to give bridge to the two year plan submitted to the TDA and the initial modelling for the LTFM.	
Key Points:	For Health budgets, the Trust delivered the planned full year surplus of £2m. There was a shortfall of circa £1m against the £4.0m of in year savings from CIP schemes which was made up through non recurrent savings and added to the CIP target for 2014/15. QIPP was finalised with commissioners with a risk share to GCS of £375k compared to the £3.9m in the original budget. Out of a target of over £2m, CQUIN schemes in 2013/14 delivered just £31k less than full achievement after agreement was reached with our collaborative commissioners. Opening balances were agreed with DH, NHSE and TDA and have been journalled into GCS' accounts during February 2014. Some of the inherited shortfall in funding for depreciation and capital charges on the asset base has now been funded by commissioners as £1m has been added into recurrent funding from 1 April 2014.	
Options and decisions required	The Board is asked to note the position and implications for the Trust.	
Fit with strategic objectives	1. Achieve the best possible outcomes for our service users through high quality care	
	2. Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	
	3. Provide innovative community services that deliver health and social care together	
	4. Work as a valued partner in local communities and across health and social care	X

	5. Support individuals and teams to develop the skills, confidence and ambition to deliver our vision		
	6. Manage public resources wisely to ensure local services remain sustainable and accessible		X
Next steps/future actions	• Finalise audit and related annual report • Agree final details of 2014/15 CIP, CQUIN and QIPP schemes • Formalise all 2013/14 changes into contract with CCG • Agree contracts for 2014/15 with key commissioners; CCG, GCC, NHSE and GHNHSFT • Continue work to confirm property arrangements (rents and % occupancy by property) with NHS Property Services		
Author name and title	Stuart Bird Deputy Director of Finance	**Director Name and Title**	Glyn Howells Director of Finance

Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: 20 May 2014
Location: Hesters Way Community Resource Centre, Cheltenham

Agenda item 12: Finance Report

1. Purpose
To advise the Board of the final (subject to audit) out-turn for the Trust in financial year 2013/14 and bridge between this and the original plan for the year as submitted to the TDA in early 2013.

2. Recommendations
The Board is asked to note the performance of the Trust and to be aware of the risk and opportunities within the plan for 2014/15 and beyond.

3. Background
GCS is now fully operational as a separate trust and agreed its opening balance sheet in early 2014.

The plans for 2013/4 were challenging with £750k of QIPP income to be earned, £2.1m of CQUIN income and £4.0m of CIP savings required to deliver the budgeted surplus of £2m. Final (unaudited) figures for the Trust show the budgeted surplus has been achieved. This is a significant achievement for the Trust in its first year as a separate entity.

In addition to management of its own financial position GCS also has responsibility for approximately £74m of spend made through Gloucestershire County Council (GCC). For 2013/14 the budgets were approximately £17m of spend on reablement and social workers working within the Integrated Community Teams and £57m of external care spend with care homes and domiciliary care agencies.

4. Discussion of Issues
The main issues that the Trust faced from the financial perspective in 2013/14 were:

1. Managing the risks and opportunities to enable delivery of the planned surplus.
2. Getting contractual agreement with commissioners on a number of key areas:
    a. QIPP (including headroom)
    b. CQUIN
    c. Staffing for inpatient wards
    d. Approval for Integrated Community Team development
3. Delivering against health cost improvement plans (CIP) and GCC Meeting the Challenge (MtC).
4. Addressing the current overspend on external care reported in GCC
5. Managing the Trust's cash position.

5. Key Findings and Actions

Historical Financial Performance

GCS closed financial year 2013/14 having achieved its budgeted £2m surplus. Performance is shown in more detail in the table below.

GCS Final OutTurn 2013/14 (subject to audit)	Actual Full Year	Budget Full Year	Actual v Budget Full Year
Cheltenham & Cotswold	(11,268)	(10,499)	(769)
Gloucester & Stroud	(11,336)	(10,437)	(898)
Forest & Tewkesbury	(10,883)	(9,700)	(1,183)
Unscheduled Care	311	(30)	341
Specialist Nursing	163	14	149
Adult Services	**(33,013)**	**(30,652)**	**(2,361)**
Children, Family & Young People	79	(23)	103
Countywide	404	0	404
Children & Countywide Services	**483**	**(23)**	**506**
Clinical Quality & Development	215	0	215
Estates, Facilities & Hotel Services	(4,836)	(4,551)	(285)
Central Income	38,080	36,807	1,272
Total Operations	**929**	**1,581**	**(652)**
Corporate	(4,004)	332	(4,335)
Corporate Projects	(912)	(2,006)	1,094
Recharges	(470)	0	(470)
Savings	(48)	2,109	(2,157)
Reserves	1,509	(16)	1,526
Unallocated	6	0	6
Total Overheads	**(3,918)**	**419**	**(4,337)**
Total Trust	**(2,989)**	**2,000**	**(4,989)**
Adjustments to get to normailised position			
Add back: Impairments on Tewkesbury new build	2,636		2,636
Add back: Impairment on old Tewkesbury hospital	3,209		3,209
Less: Legacy gains included in position	(650)		(650)
Less: Provision reduction taken to reserves	(32)		(32)
Less: Doations received to buy assets	(319)		(319)
Add back: depreciation suffered on donated assets	154		154
Adjusted Result	**2,010**	**2,000**	**10**

The high level items to note within the 2013/14 outcome are as follows:

1. CIP delivered was £1m less than budget
2. QIPP under-delivery was only £375k against a target of £3.9m. This was a significant risk throughout 2013/14 and represents a good outcome for the Trust
3. CQUINs were achieved with the exception of £31k against the dementia CQUIN that was flagged as a risk in previous reports
4. The depreciation and capital charges budget that was transferred to GCS is £1.6m less than the anticipated recurrent value. Additional funding has been agreed from 1 April 2014 which leaves a £600k recurrent pressure

5. GCS benefitted by £2.8m in 2013/14 from the waiver of the requirement to pay capital charges on its assets. This was a one off benefit which all Trusts receive in their first year of operation

As well as managing the Trust against its agreed plan for 2013/14 a significant amount of work has also been completed recently to calculate and propose plans and budgets for 2014/15 and 2015/16. These plans include anticipated service changes and are currently with TDA for review.

Budget Monitoring

Performance against budget is tracked and reported against individual localities and cost centres. Budget monitoring reports are now generated from ESSBASE each month with "books" of management accounting information produced for the operational directors and locality managers. All reports are being cascaded down through the organisation so budget holders and their managers will receive consistent performance to date and full year forecast out-turn positions.

For the executive team, as well as their own area detail, a Trust summary is now being produced including headcount and worked whole time equivalent (WTE) information and a quarterly summary of performance.

Work continues to net off historical cost pressures and underspends to provide ever more accurate achievable budgets for budget holders to work to. The work is expected to be complete by the end of the financial year to enable clarity in end of year reporting and to help with 2014/15 budget setting.

Performance in Achieving Cost Improvement Plans

For 2013/14 the CIP target was £4.7m of recurrent savings of which £4.0m was required to be delivered in year to enable delivery of the planned £2m surplus. Final figures for 2013/14 show that £3m was delivered in year.

CIP plans for 2014/15 have been planned and developed in conjunction with operational and strategic planning. The overall savings target for 2014/15 has been increased to include recovery of the slippage in the 2013/14 savings programmes.

QIPP

The final QIPP payment was agreed as £3.525m compared to a target of £3.9m. Significant operational and performance effort went into the delivery of this income – this effort is now focused on getting agreement of the 2014/5 schemes which are making good progress.

CQUIN

The £100k of risk identified on two in year CQUIN schemes (dementia assessment and falls) was managed very effectively by the operational teams during the last two months of 2013/4. Recovery plans reduced the impact to £31k on the dementia CQUIN and ensured full achievement of the falls CQUIN. A significant operational and performance effort has been spent in

trying to get agreement of the 2014/5 schemes which has made good progress.

New Business

The request from the CCG that the Trust expand the level of the services in Integrated Community Teams that was referred to in the previous finance report has now been confirmed in writing. Detailed plans are being drawn up within the Trust and once all recruitment trajectories have been finalised a variation to the contract will be drawn up. In 2013/14 the Trust received £600k of funding non recurrently with current plans showing the potential for £3.9m of recurrent income when the rollout is complete.

Capital Spend

As a new Trust, GCS had to establish a capital regime (as when part of the PCT all capital accounting was managed on its behalf). A capital approval group has been established with both operations directors present with Heads of IT and Estates to ensure that capital is spent in areas that the operations see as priorities.

Capital spend for 2013/14 was in line with plan with the exception of an agreed underspend of £1.5m that the TDA has agreed can roll over into the next year.

The additional public dividend capital that was approved prior to GCS coming into creation to cover the final costs of the Tewkesbury Hospital has now been received in the sum of £1.7m.

6. Financial implications

For 2013/4 GCS closed the financial year having achieved its budgeted £2m surplus, which is summarised in Appendix 1.

For 2014/5, GCS has submitted a two year annual plan in line with the Board approved plan. The main items within this plan are:

1. Income inflation on most contracts of 2.2%
2. CIP requirement on most contracts of 4%
3. Funded demographic growth of £700k from the CCG
4. Funded increase in inpatient staffing of £1.9m
5. Unfunded increase in inpatient staffing £700k of which £500k falls through as a reduction in surplus
6. Non recurrent funding of Child health and community system of £800k
7. CIP requirement of £6.4m
8. Reserves created of £1m recurrent, £1m non recurrent

7. Implementation and Review of Progress

The two year plan has been submitted as above, work is now starting on developing a five year CIP programme alongside a long term financial model

(LTFM) to support the development of an Integrated Business Plan by the end of June.

Quality impact assessments and Equality Impact Assessments are needed as a matter of urgency on all CIP and QIPP schemes being started in 2014/15.

8. Legal Implications

None

9. Risk Implications

a) Sign off of annual report and accounts still to be received from auditors
b) Delivery of 2014/15 CIP schemes in year
c) Agreement of recharges to/from GHNSHFT for 2014/15 based on agreed service specs and up to date costings
d) Reputational risk associated with external care overspend on GCC budgets

All of these items will remain on the risk register throughout the year and will be regularly reported to the Board to ensure that they are managed appropriately and that their impact is minimised as early in the year as possible.

10. Implications for Health Inequalities

Equality Impact Assessments are needed as a matter of urgency on all CIP and QIPP schemes being started in 2014/5.

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

See above

12. Consultation and Communication including Public Involvement

None

13. Links to:

Objectives 5 and 6.

Prepared by: **Stuart Bird, Deputy Director of Finance**

Presented by: **Glyn Howells, Director of Finance**

Appendices

Appendix 1 High level variance to plan 2013/14

App: 1

Gloucestershire Care Services Highlevel Variance to Plan 2013/14 - Final **£000s**

V15 **13/05/2014**

	Recurrent			Non-Recurrent			Total			
	Income	Cost	Surplus / (Deficit)	Income	Cost	Surplus / (Deficit)	Income	Cost	Surplus / (Deficit)	
Reserves included in Annual Plan		*1,000*			*1,000*			*2,000*		
Annual Plan	**100,879**	**100,353**	**526**	**2,467**	**993**	**1,474**	**103,346**	**101,346**	**2,000**	
1 QIPP risk share			0	(375)		(375)	(375)	0	(375)	
2 CIPs under delivery		2,000	(2,000)			0	0	2,000	(2,000)	
3 CIP offset non recurrently (move rec MVF)		(1,000)	1,000			0	0	(1,000)	1,000	
4 Missing non CCG CQUIN			0	0		0	0	0	0	
5 Under delivery on dementia CQUIN			0	(31)		(31)	(31)	0	(31)	
6 Inpatient staffing agreed funding			0	600	1,000	(400)	600	1,000	(400)	
Inpatient staffing (£470k TBC)			0	470		470	470	0	470	Added in the £470k as now agreed
7 ICT Enhancements			0	600	700	(100)	600	700	(100)	
8 Contribution to community and child health system			0	400	400	0	400	400	0	
9 In year changes (see finance report)	2,475	2,475	0			0	2,475	2,475	0	
10 Additional depreciation charge		1,810	(1,810)			0	0	1,810	(1,810)	
11 Removal of PDC			0		(2,800)	2,800	0	(2,800)	2,800	
12 Use of PDC funds for 1 time projects			0		1,550	(1,550)	0	1,550	(1,550)	Was £1,250
13 Agency Useage			0		1,300	(1,300)	0	1,300	(1,300)	Was £1,000
14 Propco holiday			0		(400)	400	0	(400)	400	
15 Additional Dep'n funding	1,000		1,000	(400)		(400)	600	0	600	
16 Tewkesbury Hospital penalty			0			0	0	0	0	Not in position (was £300k non rec income)
17 Stroud project			0		600	(600)	0	600	(600)	Was £500k
18 Release of reserves		(1,000)	1,000		(1,000)	1,000	0	(2,000)	2,000	
19 Addition funding for agency inpatient premium			0	350		350	350	0	350	New
20 Additional funding for out of county HIV drugs			0	285		285	285	0	285	New
21 Additional income for Glos HIV drugs				206		206	206	0	206	New
22 New born hearing screening income				65		65	65	0	65	New
Current Position	**104,354**	**104,638**	**(284)**	**4,637**	**2,343**	**2,294**	**108,991**	**106,981**	**2,010**	
Reserves included in current postion		***0***			***0***			***0***		

App: 2

Gloucestershire Care Services Plan 2014/15 - Final **£000s**

V15 **13/05/2014**

	Recurrent			Non-Recurrent			Total		
	Income	Cost	Surplus / (Deficit)	Income	Cost	Surplus / (Deficit)	Income	Cost	Surplus / (Deficit)
Reserves included in 2013/14 Out-turn		*0*						*0*	
2013/14 Out-turn	**104,354**	**104,638**	**(284)**				**104,354**	**104,638**	**(284)**
1 Income Inflation (2.2%)	2,000		2,000			0	2,000	0	2,000
2 CIP Requirement (4%)	(3,403)		(3,403)			0	(3,403)	0	(3,403)
3 Pay inflation (1.5%)		1,099	(1,099)			0	0	1,099	(1,099)
4 Non pay inflation (5% of £10m)		500	(500)			0	0	500	(500)
5 Demographic Growth now agreed with CCG	700		700			0	700	0	700
6 CCG Savings targets (Medical Model @ Ciren and 2 week wait)	(1,000)	(900)	(100)			0	(1,000)	(900)	(100)
7 CQUIN - income (2.5%)			0	2,281		2,281	2,281	0	2,281
8 Inpatient staffing - GCS		700	(700)			0	0	700	(700)
Inpatient staffing - CCG	1,900	1,900	0			0	1,900	1,900	0
9 Close Stratton Ward	(700)	(700)	0			0	(700)	(700)	0
10 ICT Enhancements (£3.9m full year)			0	2,000	2,000	0	2,000	2,000	0
11 Reserve against CQUIN / QIPP			0				0	0	0
12 Contribution to community and child health system			0	800	800	0	800	800	0
13 Difference on ICT funding		0	0			0	0	0	0
14 Investment in management (comms and operational management)		600	(600)			0	0	600	(600)
15 CIP Cost savings required		(6,400)	6,400			0	0	(6,400)	6,400
16 FT Program Costs			0		500	(500)	0	500	(500)
17 ISO Costs			0		250	(250)	0	250	(250)
18 LIA			0		100	(100)	0	100	(100)
19 New business (ambulatory care)	2,500	2,250	250			0	2,500	2,250	250
20 Inpatient agency			0		500	(500)	0	500	(500)
21 Defering costs from 2013/4		200	(200)		100	(100)	0	300	(300)
22 Contingency		1,010	(1,010)		1,000	(1,000)	0	2,010	(2,010)
Proposed 2014/15	**106,351**	**104,897**	**1,454**	**5,081**	**5,250**	**(169)**	**111,432**	**110,147**	**1,285**
Reserves included in current postion		***1,010***			***1,000***			***2,010***	

Gloucestershire Care Services Year 2 Plan 2015/16 - Final **£000s**

V15 **13/05/2014**

	Recurrent			Non-Recurrent			Total		
	Income	Cost	Surplus / (Deficit)	Income	Cost	Surplus / (Deficit)	Income	Cost	Surplus / (Deficit)
Reserves included in 2013/14 Out-turn		*1,010*						*1010*	
2014/15 Out-turn	**106,351**	**104,897**	**1,454**				**106,351**	**104,897**	**1,454**
1 Income Inflation (2.7%)	2,871		2,871			0	2,871	0	2,871
2 CIP Requirement (4.5%)	(4,786)		(4,786)			0	(4,786)	0	(4,786)
3 Pay inflation (1.5%)		1,101	(1,101)			0	0	1,101	(1,101)
4 Non pay inflation (3%)		944	(944)			0	0	944	(944)
5 Demographic Growth Not yet agreed with CCG)	700		700			0	700	0	700
6 CCG Savings targets (£2m p.a.)	(2,000)	(1,500)	(500)			0	(2,000)	(1,500)	(500)
7 CQUIN - income (2.5%)			0	2,659		2,659	2,659	0	2,659
8 Reserve against CQUIN (55%)			0			0	0	0	0
9 ICT Enhancements (£3.9m full year)	3,900	3,900	0			0	3,900	3,900	0
10 CIP Cost savings required		(4,150)	4,150			0	0	(4,150)	4,150
11 FT Program Costs			0		1,000	(1,000)	0	1,000	(1,000)
12 LIA			0		100	(100)	0	100	(100)
13 New business (ambulatory care)	2,600	2,350	250			0	2,600	2,350	250
14 Contingency		422	(422)		1,429	(1,429)	0	1,851	(1,851)
15 Pension additional cost (0.7% of £75m pay)		525	(525)			0	0	525	(525)
Proposed 2015/6	**109,637**	**108,489**	**1,147**	**2,659**	**2,529**	**130**	**112,295**	**111,018**	**1,277**
Reserves included in current postion		***1,010***			***1,429***			***2,439***	

Gloucestershire Care Services NHS Trust Board

Title:	Health, Safety and Security Strategy (v0.11)		20 May 2014
Agenda Item:	13		
Purpose of Paper:	To seek the Board's support for the Health, Safety and Security Strategy in its current form.		
Key Points:	This Strategy has previously been presented and discussed at the Integrated Governance and Quality Committee on 20 February 2014, and the Performance and Resources Committee on 15 April 2014. As a result of both meetings, amends have been made. Please note that costs relating to the priorities and actions recommended by this Strategy will be identified within the accompanying implementation plan.		
Options and decisions required	The Board is asked to approve and ratify the Health, Safety and Security Strategy for adoption by the Trust.		
Fit with strategic objectives	1. Achieve the best possible outcomes for our service users through high quality care		x
	2. Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work		x
	3. Provide innovative community services that deliver health and social care together		x
	4. Work as a valued partner in local communities and across health and social care		x
	5. Support individuals and teams to develop the skills, confidence and ambition to deliver our vision		x
	6. Manage public resources wisely to ensure local services remain sustainable and accessible		x
Next steps/future actions	A detailed implementation plan will be developed, that will subsequently be monitored by the Performance and Resources Committee.		
Author name and title	Rod Brown, FT Programme Manager	**Director Name and Title**	Glyn Howells, Director of Finance

Gloucestershire Care Services NHS
NHS Trust

HEALTH, SAFETY & SECURITY STRATEGY

2014-19

To maintain robust health, safety and security systems in all locations wherein the Trust provides health and social care services, in order to ensure the protection of service users and colleagues

Version control	
Document reference:	TB17
Version:	0.12
Ratified by:	Trust Board
Date ratified:	
Originator/author:	Max Boyce, Local Security Management Specialist Adrian Warren, Safety and Corporate Facilities Manager Mark Parsons, Head of Estates, Safety, Security and Facilities Rod Brown, FT Programme Manager
Owner:	Mark Parsons, Head of Estates, Safety, Security and Facilities
Executive lead:	Glyn Howells, Director of Finance
Date issued:	
Review date:	

Contents

Appendices

Please note that this Health, Safety and Security Strategy supports both health and social care colleagues managed by Gloucestershire Care Services NHS Trust.

However, with respect to the risk and incident management processes advocated by this Strategy, social care colleagues are advised to refer to Gloucestershire County Council's Risk Management Policy Statement and Strategy.

Notwithstanding, early within the lifecycle of this Health, Safety and Security Strategy, it is the intention that networks and resources will be shared across the two partner organisations, enabling this Strategy to become relevant to the whole workforce.

0. Executive Summary

This Strategy serves to confirm the commitment of Gloucestershire Care Services NHS Trust ("the Trust") to maintain the health, safety and security of all Trust colleagues, service users, carers, as well as visitors to the Trust. It also seeks to ensure the protection of all buildings, systems, property and other assets owned and/or operated by the Trust, and deliver continuous improvement where appropriate. To achieve these goals, this Strategy seeks to:

- ensure that service users, carers and visitors, as well as colleagues, benefit from safety and security whilst under the care of the Trust, irrespective of environment or setting. Thus, the Trust will be proactive in promoting best practice across the organisation, and will conduct regular inspections, audits and risk assessments in all Trust locations so as to identify weaknesses or failures in practice that could create risk to a person's health, safety or security. Moreover, should an incident occur, it requires the Trust to thoroughly investigate its cause and impact, and develop a corresponding action plan;

- provide the best levels of security for all assets, both tangible and intangible, so as to ensure the protection of all equipment, information and resources. To this end, the Trust will seek to safeguard against loss, theft, damage or other malicious attack on Trust equipment, Trust or service user property or Trust information resources. This aligns to the ambitions of the organisation's Information Governance Strategy and IT Strategy;

- maintain robust governance processes to facilitate the effective management of all health, safety and security matters, including clear responsibilities for leadership. This requires Trust colleagues to recognise their personal responsibilities to contribute to the maintenance of a safe and secure working environment, and abide by best practice. It also requires the development of a complete set of health, safety and security policies, adherence to reporting and data capture procedures, and empowerment of Trust forums to track and monitor actions and progress;

- involve stakeholders in appropriate decision-making regarding health, safety and security, enabling resultant actions to be truly reflective of local need and requirements: this is in line with the Trust's objective to be an excellent partner in the health and social care community;

- ensure that lessons learnt from health, safety and security incidents are used to improve future service delivery

This Strategy therefore seeks to outline the Trust's aspirations and direction of travel in respect of health, safety and security over the next 5 years in order to ensure the best possible protection of people and assets. The accompanying implementation plan will detail the practical actions that will be taken in the period 2014-19 to fulfil these aspirations.

1. Introduction

1.1 This Health, Safety and Security Strategy serves to confirm the commitment of Gloucestershire Care Services NHS Trust ("the Trust") to:

- maintain the safety and security of all service users, carers, and members of the wider Gloucestershire public who visit any of the Trust's facilities;
- maintain the safety and security of all Trust colleagues (this includes permanent employees as well as "*persons not in (the Trust's) employment who may be affected*" as defined by the Health and Safety at Work Act 1974, section 3.1. This therefore includes contractors, sub-contractors, students, volunteers etc who undertake duties on behalf of the Trust. It also includes employees of Gloucestershire County Council who are managed by the Trust as part of its Integrated Community Teams);
- ensure the protection of all buildings, systems, property and other assets owned and/or operated by the Trust;
- achieve continuous improvement in the delivery of health, safety and security services where appropriate and practical.

1.2 In making this commitment, the Trust recognises not only its legal responsibilities, but also its ethical and professional duties, to ensure robust systems that will enable the provision of safe and secure working environments. To this end, the Trust aims to:

- ensure a proactive, consistent approach to the development and adoption of best practice procedures in respect of health, safety and security;
- publish a comprehensive portfolio of health, safety and security policies, supported by appropriate guidance and support documentation;
- routinely evaluate the relative protection of all the Trust's working environments by means of inspections, audits and risk assessments in order to recognise and respond to all opportunities for sustainable improvements in health, safety and security arrangements.

1.3 The resultant benefits of this approach will be to:

- minimise the number of colleagues suffering an injury in the workplace as a result of moving and handling, a slip, trip or fall etc, which may result in a loss of working days and/or a claim being made against the Trust;
- minimise the number of service users, carers or visitors suffering an injury in any of the Trust's buildings;
- mitigate the number of colleagues suffering abuse of any description, including injury as a result of a violent or aggressive act;
- provide clarity in the reporting of crime or anti-social behaviour;
- respond to the national legal frameworks which serve to provide the Trust with the necessary assurance that requisite standards are being met.

2. Scope

2.1 The following are all included within the scope of this Health, Safety and Security Strategy:

- all colleagues who are employed or otherwise contracted or managed by the Trust (see section 1.1 above), whether such colleagues are working in any of the organisation's facilities, or whether they are engaged on business on behalf of the Trust in some other setting;
- all service users, carers, visitors to the Trust, and other members of the Gloucestershire public as appropriate;
- all buildings, facilities, settings and environments in which the Trust provides its health and social care services: this includes those premises that are owned or leased by the Trust (refer to the Trust's Estates Strategy), as well as, when appropriate, service users' homes and other care environments in which the Trust provides care services such as residential and nursing homes, schools etc;
- all assets and resources that are owned or otherwise managed or governed by the Trust including:
    - tangible assets such as the Trust's IT or clinical equipment, drugs and other medicines, or service user property that is under the guardianship of the Trust whilst service users are resident in a community hospital;
    - intangible assets such as intellectual property and the personal information that is held by the Trust about the organisation's service users or colleagues (NB to this extent, this Health, Safety and Security Strategy aligns to the Trust's Information Governance Strategy).

2.2 The Trust recognises that health, safety and security matters not only involve and affect those individuals within the Trust's Estates, Safety, Security and Facilities team, but that these are fundamental issues that have clear responsibilities and implications for all colleagues.

Thus, this Strategy serves to encourage all colleagues across the Trust to demonstrate care and concern for the safety and protection of all people, assets and resources, thereby ensuring the provision of a high quality service to the Gloucestershire community. Indeed, under sections 7 and 8 of the Health and Safety at Work etc. Act 1974, everyone who works for the Trust has personal responsibility to perform their duties in such a way that they do not create unnecessary risk to themselves or others who may be affected by their acts or omissions.

2.3 It is noted that considerations of counterfraud activity are not included within this Strategy, but are within the Trust's Financial Management Strategy.

3. Ambition and Objectives

3.1 The ambition of this Health, Safety and Security Strategy is "*To maintain robust health, safety and security systems in all locations wherein the Trust provides health and social care services, in order to ensure the protection of service users and colleagues".*

This aligns to the Trust's overarching vision which is "*To be the service people rely on to understand them and organise their care around their lives*", given that both intentions share a clear service user focus.

3.2 This five year Health, Safety and Security Strategy seeks to ensure that by 2019, the following objectives have been achieved, linked to the Trust's overarching strategic objectives:

Health, Safety and Security Strategy Objectives	Trust Strategic Objectives
• Ensuring that all service users receive the care they need in environments that provide the highest possible levels of health, safety and security • Continuing to improve the quality of health, safety and security arrangements within all the Trust's care services	Achieve the best possible outcomes for our service users through high quality care
• Engaging with service users and their representatives, as well as local stakeholder groups, to ensure that health, safety and security concerns are managed and reviewed • Responding promptly to service user comments, feedback and assessments	Understand the needs and views of service users, carers and families so their opinions inform every aspect of our work
• Developing integrated partnership working and sharing best practice in order to ensure that safe and secure environments are maintained with partner organisations	Provide innovative community services that deliver health and social care together

• Maintaining strong links with NHS Protect and all relevant national and local forums in order to remain advised of emerging health, safety and security management standards and best practice that will benefit the Trust • Benchmarking against similar organisations so as to recognise any additional opportunities for improvement in health, safety and security practices	Work as a valued partner in local communities and across health and social care
• Ensuring strong organisational awareness of health, safety and security via the provision of specialist support, training, guidance and communications • Supporting colleagues to embed appropriate health, safety and security standards into daily working practice	Support individuals and teams to develop the skills, confidence and ambition to deliver our vision
• Ensuring that the Trust's health, safety and security management meets all legislative and contractual requirements, and provides a solid foundation for additional contracts that may be considered • Maintaining and/or improving prevailing compliance levels through robust monitoring, management and audit • Integrating health, safety and security management in all areas of estates and asset management	Manage public resources wisely to ensure local services remain sustainable and accessible

4. National Context

4.1. The Trust has a legal responsibility and duty of care under all prevailing health and safety legislation, and in particular the *Health and Safety at Work etc. Act 1974,* to ensure optimum protection within all relevant working environments. Moreover, the need to ensure compliance with the Act is enshrined in the contracts of all Trust colleagues.

Equally, the Trust has responsibility to abide by all supporting guidance including the *Regulatory Reform (Fire Safety) Order* (2005), the *Control of Asbestos Regulations* (2012), the *Control of Legionella Bacteria in Water Systems (*1991) and the *Control of Substances Hazardous to Health Regulations* (2002).

4.2 The NHS Litigation Authority (NHSLA) provides a series of risk management standards including considerations for a safe environment. However, at the time of writing this Strategy, these standards and the associated assessment processes, are subject to review and update.

4.3 Within the Care Quality Commission (CQC) Outcomes Framework, Outcome 10 relates to the safety and suitability of premises, and as such, requires the Trust to care for people in safe, accessible buildings that support their health and welfare.

4.4 In 2012, revisions to the *Health and Social Care Act* changed responsibilities for property ownership. Thus, the Trust now has landlord responsibility for a number of its properties, as serves as a tenant elsewhere. Security arrangements are now included in the Standard Commissioning Contract.

4.5 Nationally, NHS Protect leads on identifying and tackling crime across the NHS. Its aim is to protect colleagues and resources from activities that would otherwise undermine their effectiveness and ability to meet the needs of service users and professionals, and provides leadership in tackling crime.

4.6 *Creating a Pro Security Culture* (NHS Counter Fraud and Security Management Service, 2005) provides clear guidance as how to best to mitigate security risks. Moreover, the document suggests that a pro security culture is derived from an acceptance of responsibility from all colleagues, service users, visitors to the Trust and members of the public. For further information, refer to Appendix 2 below.

4.7 The *Prevent Strategy* (Crown 2011) is a cross-Government policy that forms one of the four strands of CONTEST – the Government's counter terrorism strategy. The NHS is regarded as critical to the support and delivery of this strategy, and thus local commissioners will be seeking regular assurance on implementation from the Trust, thereby ensuring that all elements are fully embedded in everyday safeguarding activity, including training. For further detail on the Trust's commitment to robust safeguarding processes, refer to the organisation's Clinical and Professional Care Strategy.

5. Local Context

5.1 The Trust has a developed a systematic approach to health and safety management that involves the on-going testing and measurement of relevant services and systems in order to ensure their compliance and provide assurance, ultimately to the Trust Board.

Responsibility for overseeing this approach has been assigned to the Health, Safety and Security Committee which in turn, reports to the Performance and Resources Committee.

5.2 In support of its security management approach, the Trust has assessed its crime profile which identifies the organisation's local risks. At the time of writing, the current profile confirms the Trust as a Category One organisation (as defined by *Standards for Providers 2013/14: Fraud, Bribery and Corruption*, NHS Protect, 2013) i.e. the Trust is an organisation which has:

- high-value NHS contracts;
- a high number of colleagues;
- high-value NHS assets; and
- large numbers of service user interactions.

This definition therefore informs the level of security standards that must be met through completion of the NHS Protect Security Standards for Providers, in order that the Trust may most effectively combat crime, and safeguard its service users, colleagues and assets across all community settings within Gloucestershire.

5.3 The Gloucestershire Clinical Commissioning Group ("CCG") as the Trust's principal commissioner, is clear in its expectations of the organisation's health, safety and security arrangements. These expectations are expressed broadly in documents describing their five year focus.

Specifically, the CCG requires the Trust to conduct routine assessments where significant risks are identified to health, safety or security, and thereafter, determine clear plans for changing service provision and/or the environments in which care is provided.

Commissioners additionally require the completion of an annual Assurance Statement in relation to the security management arrangements and standards observed by the Trust.

5.4 There is clear synergy between the Trust's health, safety and security protocols and those encapsulated within the organisation's risk management processes. To this end, it is noted that this Strategy complements the guidance within the Trust's Risk Management Strategy and all supporting documentation including the Risk Assessment and Management Policy, the Incident Reporting and Management Policy, the Serious Incident Management Policy, the Complaints Policy etc.

6. Quality Goals

6.1 In order to ensure that this Health, Safety and Security Strategy maintains optimum focus upon achieving quality outcomes, the following goals have been identified:

- to ensure that service users, carers and visitors, as well as colleagues, benefit from safety and security whilst under the care of the Trust, irrespective of environment or setting;
- to provide the best levels of security for all assets, both tangible and intangible, so as to ensure the protection of all equipment, information and resources;
- to maintain robust governance processes to facilitate the effective management of all health, safety and security matters, including clear responsibilities for leadership;
- to involve stakeholders in appropriate decision-making regarding health, safety and security, enabling resultant actions to be truly reflective of local need and requirements;
- to ensure that lessons learnt from health, safety and security incidents are used to improve future service delivery.

7. Priorities and Actions

This section identifies the priority actions, mapped against the Strategy's quality goals. Further details regarding each of these priorities will be itemised within the Strategy's implementation plan, progress against which will be monitored on a regular basis by the Health, Safety and Security Committee and the Performance and Resources Committee.

7.1 To ensure that service users, carers and visitors, as well as colleagues, benefit from safety and security whilst under the care of the Trust, irrespective of environment or setting

Threats to people's health, safety and security within the setting of a community hospital or clinic can stem from a range of hazards including slips, trips and falls, clinical risks, exposure to dangerous substances, fire, physical or verbal assault etc. Additionally, colleagues who travel offsite in order to provide care within service users' homes, schools or nursing or residential homes, can also face dangers as a result of lone working, occupational driving etc. In order to minimise the dangers of all these threats, the Trust will seek to ensure the following actions:

7.1.1 The Trust will be proactive in its endeavours to ensure that best practice in health, safety and security is promoted and observed across the organisation, and that all colleagues are fully aware of national standards and guidance, including those given in section 4 above. This will include requirement for the Trust to conduct regular safety awareness campaigns in order to increase colleagues' understanding of salient health, safety and security issues.

7.1.2 Regular, unprompted health, safety and security inspections will be conducted across all Trust locations and premises in order to identify weaknesses or failures in systems, operations or practices that could create risk to any individual's health, safety and security. In most circumstances, local managers will be responsible for leading this process, and for dealing with any nonconformities or discrepancies that are identified by these inspections, with escalation to appropriate senior colleagues as necessary.

7.1.3 In addition to the inspections referenced in section 7.1.2 above, the Trust will also abide by a regular cycle of proactive health, safety and security audits of Trust premises in line with the organisation's Audit and Effectiveness Strategy. All such audits will be clearly led, and upon completion, will be escalated across the Trust as required. Audits will be followed up initially at local level in order to provide assurance that actions have been implemented.

Where necessary, and principally in response to newly identified health, safety or security risks, an appropriate schedule of reactive audits will also be undertaken.

7.1.4 Whether as a result of the inspections referenced in section 7.1.2 above or the audits referenced in section 7.1.3 above, or else as a result of regular working practice, health, safety and security risk assessments will be conducted in all Trust settings. This is in line with local commissioning requirements (see section 5.3 above). These risk assessments will help to eliminate potential or actual hazards, reduce risks to the health, safety and security of colleagues and service users, enable continuous improvement in health and safety management, and identify necessary change to Trust policies and procedures.

Additionally and where appropriate, action plans will be developed in respect of high-risk concerns that are identified by these assessments, in line with the guidance within the Trust's Risk Management Strategy.

7.1.5 All relevant colleagues across the Trust will be obligated to observe a systematic and robust process to receive, disseminate and respond accordingly to all medical alerts which serve to identify pertinent concerns in respect of service user safety, as well as important public health messages and other critical safety information. This is directly in line with Outcome 4 of the *Essential Standards of Quality and Safety* (Care Quality Commission, 2010) which identifies the particular need to "*ensure that patient safety alerts, rapid response reports and patient safety recommendations issued by the National Patient Safety Agency (NPSA) and which require action, are acted upon within required timescales*".

In particular, this requires the Trust to ensure that responsibility for the oversight and management of the Central Alerting System (CAS) is embedded within the organisation's clinical governance function, supported by colleagues across the Trust as appropriate.

7.1.6 Where appropriate, Trust colleagues will be empowered with the skills and knowledge to manage service users who threaten violence. Moreover, the Trust will continually assess the potential use of innovative solutions to manage the risk of violence to colleagues. In particular, the Trust will give consideration to the support that is necessary to protect all lone workers (NB the Trust's lone workers are the focus of a case study in this respect – see overleaf). Notwithstanding, should any untoward incidence of violence occur, the Trust will seek robust sanctions and redress against perpetrators where appropriate, through liaison with criminal justice departments or via civil proceedings.

Conversely, the Trust maintains a robust approach to safeguarding for both adults and children, so as to provide the best possible protection against the potential of harm or abuse: this is detailed in the Trust's Clinical and Professional Care Strategy.

Case Study: Lone Workers

The development of the Trust's Integrated Community Teams (ICTs), which unite community nurses, physiotherapists, occupational therapists, reablement staff and social workers in single mobile teams and which, at time of writing, are moving towards provision of services in the community seven days per week, has highlighted the need for the Trust to strengthen its focus upon lone workers. As a result, the Trust has established a Lone Worker Review Group, which has acknowledged the following key risks to colleagues who regularly work in isolation, whether in service users' homes or alone in Trust buildings:

- alcohol and drug use by service users and members of the public with whom lone workers come into contact, which can make their behaviour unpredictable;
- late evening/early morning work when there is perceived higher risk of violence;
- the emotional state of some service users and carers which can result in confrontational or aggressive behaviour, and verbal or physical abuse.

Such risks can lead to colleagues experiencing stress, anxiety, fear and depression, which impacts upon staff retention and recruitment, sick leave, turnover and productivity. As a result, the Trust is committed to:

- improving training and information, so that all health and social care colleagues can better understand how to (i) use risk assessments to help identify a problem situation, and agree what actions to take including withdrawal from that situation, (ii) use conflict resolution or defusing techniques, (iii) be aware of surroundings and inter-personal relationships;
- excellent communication between colleagues, and with external organisations and professional bodies where appropriate, so that (i) lone workers' movements are known at all times, (ii) colleagues' experiences and concerns are shared appropriately using an agreed warning system, (iii) all incidents are suitably reported, (iv) there is clear management support so that colleagues may be empowered to refuse service delivery where appropriate;
- providing appropriate support equipment including mobile phones or other communication devices, and ensuring suitable working environments that include, for example, panic alarms and CCTV in Trust facilities;
- appropriate job design using a risk-based approach whereby working practices that engender specific concerns about colleagues' health, safety or security, are addressed by, for example, using alternate treatment locations or double teams.

Specific priorities and actions resulting from this commitment include (i) ensuring that the links between the Trust's Lone Worker Policy and the model risk assessment are clearer and better understood by all health and social care colleagues, (ii) on-going review of all lone worker incidents by the Health, Safety and Security Committee so as to ensure that lessons learned are incorporated into working practice, and (iii) embedding an effective buddy system.

7.1.7 Should an incident or near miss occur, a robust process will be followed to investigate cause and impact. The Trust will also provide support to all affected individuals whether colleagues or service users, and identify opportunities to improve systems or training so as to minimise the potential for such an incident to reoccur.

Where appropriate, such investigations will observe the protocols detailed within the Trust's Incident Reporting and Management Policy and the Serious Incident Management Policy. Equally, such investigations will necessitate triangulation of data from a range of sources so as to enhance knowledge of the nature and scale of incidents. Investigations will also require the development of bespoke action plans in response to areas identified at high risk.

Specifically, the Trust will observe robust procedures, in association with the Director of Nursing, to investigate all RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) incidents, in order to review all injuries that may arise from work-related accidents that may result in, for example:

- the death of a person;
- injuries to colleagues which result in their incapacitation for more than 7 days;
- injuries to non-workers which result in them being taken directly to hospital for treatment etc.

7.1.8 The Trust recognises its responsibilities to staff for whom driving forms an essential part of their role. Risks to such staff in respect of occupational driving will therefore be thoroughly assessed, and suitable control measures implemented where practical.

7.2 <u>To provide the best levels of security for all assets, both tangible and intangible, so as to ensure the protection of all equipment, information and resources</u>

The Trust has explicit responsibility to ensure that it maintains robust and suitable processes to ensure adequate protection against (i) the loss of, the theft of, or damage to, Trust equipment, private property or materials in store, (ii) the theft of and from, or damage to, Trust motor vehicles, and (iii) the unauthorised access to, and/or use of, any of the Trust's information resources, including:

- personal information relating to colleagues, service users or others;
- Trust owned or licenced information (i.e. intellectual property);
- any commercially sensitive or restricted information.

To this end, the Trust will ensure the following actions:

7.2.1 All colleagues across the Trust will be required to remain mindful of potential security threats: to this end, should anyone identify a weakness or vulnerability to the continued physical or electronic security of any of the Trust's assets or resources, they will be required to conduct a risk assessment and then follow the guidance contained within the Risk Assessment and Management Policy. This will help to develop a culture of responsibility across the Trust, and will serve to encourage a shared sense of ownership towards the protection of Trust assets.

7.2.2 Similar to the guidance in section 7.1, aimed at ensuring the security of individuals, the Trust will also observe a systematic process of proactive inspections, audits and risk assessments in order to validate and ensure the security of its assets.

7.2.3 The Trust will make every effort to maintain the physical security of its premises. This requires adherence to a strict identification procedure in order to verify the appropriateness of any individual to access Trust locations. In particular, locations in which servers and other critical IT equipment are stored, will be rigorously safeguarded against the threat of theft, vandalism and other forms of malicious damage: thus, access to these secure areas will be strictly controlled and kept out-of-bounds to visitors and unauthorised colleagues.

7.2.4 In order to maintain overview of all Trust assets, the organisation will ensure that all tangible assets owned and/or operated by the Trust, whether static (i.e. desktop PC's) or portable (i.e. the laptops used by all members of the Trust's Integrated Community Teams) will be appropriately security marked and asset tagged (refer to the Trust's Asset Control Policy). Furthermore, an accurate and up-to-date list of all asset tagged equipment and its respective operators/users will be maintained as an integral part of the organisation's asset register.

7.2.5 The Trust will routinely explore all options to embrace technology in the pursuit of asset protection. Thereafter, any emerging technologies that are identified as having the potential to offer tangible benefit to the Trust, will be subject to rigorous scrutiny so as to evaluate their perceived effectiveness, viability, sustainability and cost-efficiency prior to recommendation for use, which will be addressed via the Performance and Resources Committee.

7.2.6 The Trust is wholly committed to protecting the confidentiality, integrity and availability of all information that it holds. To this end, the Trust will observe robust Information Governance standards, protocols and procedures - for further information, refer to the Trust's Information Governance Strategy and supporting guidance.

7.2.7 The Trust is equally committed to ensuring the integrity and availability of its electronic systems, both clinical and non-clinical, and maintains agreed processes to realise this commitment - for further information, refer to the Trust's IT Strategy.

7.2.8 The Trust will investigate all incidents that involve theft, attempted theft or damage to the organisation's property and assets, making recommendations to reduce the future risk, and addressing these through the Performance and Resources Committee.

7.2.9 The Trust will observe formal processes to enable effective response to all national alerts issued by NHS Protect.

7.3 <u>To maintain robust governance processes to facilitate the effective management of all health, safety and security matters, including clear responsibilities for leadership</u>

The Trust has agreed a set of core values that will underpin all governance arrangements in respect of the management of health, safety and security across the Trust. These values are ascribed as follows:

- Caring: health, safety and security procedures must seek to extend the best possible protection, and provide the most compassionate service, to colleagues, service users, carers, and visitors to any of the Trust's facilities;

- Open: colleagues, service users, carers and visitors must have formal opportunity, via a variety of channels, to raise any concerns that they may have regarding health, safety and security;

- Responsible: everyone within the Trust shares accountability for health, safety and security, and Trust leaders in particular, have unequivocal duty to ensure that all issues that are raised in respect of potential or actual weaknesses or vulnerabilities within Trust systems, are addressed with due urgency;

- Effective: management arrangements for health, safety and security must be evaluated by their successes which achieve measureable reduction in risks and incidents.

To enable the Trust to abide by these principles, the following actions will be observed:

7.3.1 All Trust colleagues must recognise their personal responsibilities to contribute to the maintenance of a safe and secure working environment. These responsibilities will be included in colleagues' job descriptions which are linked to Service Development Plans (see the Trust's Organisational Development Strategy).

Moreover, individual accountabilities will be itemised within relevant health, safety and security policies (see section 7.3.2 below) and supporting guidance documentation. In particular, these documents will highlight the responsibilities of the Trust's nominated leads including the LSMS and the Trust's Estates, Safety, Security and Facilities team.

7.3.2 The Trust will develop and publish a comprehensive and consistent set of health, safety and security policies and procedures, which will enable colleagues to clearly understand the best practice that they must consistently apply in order to keep themselves, service users, carers and visitors, as safe, secure and healthy as possible.

These policies and all other Trust control documents will be reviewed on a regular basis, and amended and updated accordingly in order to reflect changes within the internal and external environment, and all corresponding security risks.

7.3.3 All hazards, incidents and near misses will be reported and assessed as necessary. In order to ensure a systematic approach, the Trust will need to:

- actively maintain an appropriate array of electronic risk registers that together, will enable all risks to on-going health, safety and security to be recorded, reported and escalated;
- make risk assessment and incident reporting forms readily available to colleagues via the Trust intranet;
- ensure that formal action plans are developed where appropriate, and specifically in response to risk assessments and incident investigations, these to be monitored by the relevant Trust forum;
- provide information to service users, carers, visitors and the wider public so that they know how they know how they may report any concerns to their health, safety and security.

7.3.4 The Trust will maintain a number of key forums in which issues relating to health, safety and security are addressed. These include the Health, Safety and Security Committee, and the Performance and Resources Committee. Robust Terms of Reference will regulate the activities of these forums, which will include:

- responsibility for the oversight of an annual work plan and Assurance Statement that will detail specific security management actions to be undertaken in year, based on identified gaps in the Trust's compliance with its health, safety and security control documentation (NB this annual plan will be extrapolated from the five year implementation plan that supports this Strategy);

- responsibility for the review of the Trust's annual organisational crime risk profile that will identify principle risks in relation to crime, prior to the document's submission to NHS Protect;

- responsibility for endorsing the output of the security standards self-review tool (SRT) which provides assurance to NHS Protect, NHS England and the Department of Health that the Trust has carried out a full self-assessment against its contractual obligations;

- responsibility for the monitoring of corrective actions instigated as a result of health, safety or security inspections, audits, risk assessments and action plans;

- responsibility for performance monitoring health, safety and security activity at all levels of the organisation.

7.3.5 The Trust will provide appropriate instruction, training and supervision to all relevant colleagues across the Trust in respect of health, safety and security. This will include:

- comprehensive introduction to health, safety and security as part of the mandatory induction training package that will be available to all new Trust colleagues;

- mandatory training on how colleagues may best manage hazards and emergency evacuations: this includes training on appropriate response to fire and fire precautions, lockdown processes to deal with emergencies on large sites, risk assessment and management etc;

- training in how colleagues may best apply and maintain safe systems of work;

- provision of mandatory Conflict Resolution Training (CRT) and consideration of emerging best practice that will enable colleagues to best understand how to de-escalate potentially violent, abusive or aggressive acts (see also section 7.1.6 above);

- professional development for those within the Trust who are responsible for leading in health, safety and security. This will require, for example, the LSMS to undertake all necessary NHS Protect training and development updates.

Moreover, the Trust recognises that all training programmes and content needs to remain flexible, so that it can adapt to emerging requirements and changes in local and national risk profiles.

7.4 To involve stakeholders in appropriate decision-making regarding health, safety and security, enabling resultant actions to be truly reflective of local need and requirements

In line with its commitment to be an excellent partner in the health and social care community, the Trust will seek to ensure good communications with all relevant internal and external stakeholders. This includes the following actions:

7.4.1 As part of the investigation of all health, safety and security incidents, the relevant Trust lead will be responsible for liaising with the Non-Executive Director who has specific nominated authority for security.

There is also responsibility to inform all relevant Trust Executives and forums (as detailed in section 7.3.4 above) to keep them apprised of any significant risks to the continued health and well-being of Trust colleagues, service users, carers, visitors or the wider Gloucestershire public.

7.4.2 The Trust will work with all relevant professional stakeholders across Gloucestershire in order to exchange information, advice and best practice. This will include, for example, all other local NHS organisations who should be apprised of any prevailing themes or trends in local crime or risks, as well as other partner agencies such as the Gloucestershire police.

7.4.3 The Trust will ensure that its nominated representatives attend pertinent conferences and other engagements, so as to understand changes in the environment or national thinking.

Thus, for example, the LSMS will be required to attend the quarterly NHS Protect South West Region security management meetings in order to receive best practice updates in respect of health, safety and security.

7.4.4 There will be active engagements with all staff groups across the Trust, so as to help the development and promotion of initiatives to improve the health and wellbeing of colleagues. In particular, this engagement will actively involve the traditionally hard-to-reach staff groups, such as volunteers, night workers etc.

For further information, refer to the Trust's Workforce Strategy.

7.5 <u>To ensure that lessons learnt from health, safety and security incidents are used to improve future service delivery</u>

As referenced in section 7.1.6 above, the Trust will be responsible for thoroughly investigating all health, safety and security related incidents in order to identify high-risk concerns and trends, and to ensure the effective and robust management / mitigation of these risks. The outputs of these investigations will need to be shared as appropriate across the organisation, so as to help raise awareness, prevent similar incidents from reoccurring, and thus improve the quality of the Trust's health and social care services.

To this end, the following actions will be followed:

7.5.1 The Trust will ensure that all relevant learning and outcomes from investigations will be systematically reported back to relevant authorities so that this learning can be subsequently incorporated within updates of policies and procedures, and reflected within the Trust's training programmes (see section 7.3.5 above).

7.5.2 All investigation outcomes, lessons learnt, root cause analyses etc will be recorded on the Trust's electronic risk management database, and will be formally presented to the appropriate forums as detailed in section 7.3.4 above.

7.5.3 There will be a formal process whereby investigation outputs will be shared with the Trust's communications function, so that information can be escalated across the Trust, thereby raising colleagues' awareness of salient issues and risks.

The Trust will also communicate both internally and externally, all successful prosecutions of offenders, thereby demonstrating the organisation's on-going commitment to tackling crime.

8. Quality Measures

8.1 Each of the quality goals as identified in section 6 above, will be supported by a series of performance measures as detailed below, to be reported to, and monitored by the Health, Safety and Security Committee and the Performance and Resources Committee on a routine basis:

Quality Goal	Quality Measure
To ensure that service users, carers and visitors, as well as colleagues, benefit from safety and security whilst under the care of the Trust, irrespective of environment or setting	• Reduction in the number of incidents relating to slips and trips recorded on Trust premises • Mitigate the number of physical or verbal assaults upon Trust colleagues • Increase in the application of safety awareness campaigns across the Trust • Where appropriate, ensure that risk assessments are conducted following relevant health, safety and security inspections or audits • 100% received and relevant medical alerts cascaded appropriately across the Trust • Robust investigations / action plans in respect of all reported incidents and near misses
To provide the best levels of security for all assets, both tangible and intangible, so as to ensure the protection of all equipment, information and resources	• Reduction in the number of reported thefts across the Trust • Mitigate incidents of malicious damage to Trust property or assets • Maintenance of a comprehensive and up-to-date asset register • Annual security review of all Trust locations and premises • Robust investigations / action plans in respect of 100% reported thefts or incidents of crime • Effective response to 100% national alerts issued by NHS Protect

To maintain robust governance processes to facilitate the effective management of all health, safety and security matters, including clear responsibilities for leadership	• Development of an annual work plan to respond to identified gaps in the Trust's health, safety and security control documentation • Development of the Trust's annual organisational crime risk profile • Development of an annual Assurance Statement for commissioners • Use of the security standards self-review tool (SRT) to review Trust performance against contractual obligations • Induction and mandatory training in health, safety and security provided to all Trust colleagues
To involve stakeholders in appropriate decision-making regarding health, safety and security, enabling resultant actions to be truly reflective of local need and requirements	• Evidence of partnership working with other local NHS organisations in order to share information about local crimes or emerging risks to health, safety and security • Evidence of engagement with relevant authorities and partner agencies such as the Gloucestershire police, to inform the Trust's health, safety and security activities • Increase in the number of activities designed to improve the health and well-being of Trust colleagues
To ensure that lessons learnt from health, safety and security incidents are used to improve future service delivery	• Evidence of the update of health, safety and security policies and supporting guidance following Trust investigations • Evidence that trends and lessons are appropriately shared with the relevant Trust forum • Benchmark trends against other NHS provider organisations

9. Accountabilities and Assurances

9.1 Trust Board

The Board is responsible for the delivery of safe, effective health and social care, and for ensuring that resources are used efficiently. This includes responsibility for overseeing the application of robust systems to ensure that the organisation's estate is safe and secure, and that also all colleagues, service users, visitors and members of the public, are kept free from harm.

9.2 Chief Executive

The Chief Executive is the Trust's Accountable Officer, and thus has overall responsibility for ensuring exemplar health, safety and security practices that enable the delivery of the highest quality care services.

9.3 Performance and Resources Committee

This Committee has responsibility for ensuring the Trust's compliance with core health, safety and security standards, national practice and mandatory guidance including that issued by the Health and Safety Executive. The Committee is supported by the Health, Safety and Security Committee, which monitors the effectiveness of local policies, procedures and training.

9.4 Director of Finance

The Director of Finance is the Trust Executive with personal responsibility for the delivery of health, safety and security standards. The Director of Finance also acts as the Security Management Director (SMD), overseeing security management at a strategic level. The SMD supports the Local Security Management Specialist (see section 9.6 below) to fulfil their role, and aids the Board in its commitment to the security of people and assets.

9.5 Head of Estates, Safety, Security and Facilities

The Head of Estates, Safety, Security and Facilities is responsible for all matters of health and safety, and for ensuring that security is a primary consideration in any contracted works, new builds or change to the estates portfolio. The role also provides day-to-day management of the LSMS.

9.6 Local Security Management Specialist (LSMS)

The LSMS is responsible for adhering to the NHS Protect Code of Professional Conduct, and for providing assurance that requisite security management requirements as outlined in this Strategy, are fulfilled.

9.7 All Trust colleagues

All colleagues across the organisation have responsibilities for health, safety and security. This includes explicit obligation to perform their duties in such a way that they do not create unnecessary risk to themselves or others.

10. Enabling and Supporting Strategies

10.1 This Health, Safety and Security Strategy complements the following additional strategy documents maintained by the Trust:

- the Quality Strategy, which seeks to champion a whole-system approach so as to ensure that consideration of quality becomes fundamental to every decision and action taken by the Trust;
- the Risk Management Strategy, which serves to identify the framework and aspirations that will support the effective management of both strategic and operational risks (both clinical and non-clinical) across the Trust;
- the Audit and Effectiveness Strategy, which strives to ensure a robust approach to the auditing of the Trust's clinical and social care practices, so that the organisation is fully assured of the quality of its care functions, and understands how improvements can be made where necessary, in order to increase the continued effectiveness of Trust services;
- the Information Governance Strategy that specifies the Trust's plans to achieve compliance with all requisite information governance standards, and thereby ensure that the information that is maintained by the organisation is complete, safe, secure, accurate, timely and reliable;
- the IT Strategy, which seeks to ensure that information technology is used as an aid to empower Trust colleagues to provide service users with the best possible care, and provide steer for a reliable, effective IT infrastructure that employs a diverse range of technologies to improve communications both within the Trust and across the whole of the local health and social care system;
- the Business Continuity Strategy, which seeks to outline the Trust's strategic approach to continuing its most critical services in light of a major incident, including the unavailability of the organisation's systems and networks;
- the Estates Strategy, which seeks to ensure that all users of the Trust's facilities receive the best experience the Trust is able to provide, offering safety, privacy and dignity, whilst respecting the need to match commissioned services, quality and environmental sustainability with cost-effectiveness.

10.2 This Health, Safety and Security Strategy is directly supported by the Health, Safety and Security Implementation Plan, which will clarify the actions to be undertaken by the Trust within the period 2014-19 in order to fulfil the ambitions of this Strategy.

11. References

Control of Substances Hazardous to Health Regulations (2002)
http://www.hse.gov.uk/coshh/
http://adlib.everysite.co.uk/adlib/defra/content.aspx?id=18274

Disability Discrimination Act (2005)
http://www.legislation.gov.uk/ukpga/2005/13/notes/contents

The Control of Legionella Bacteria in Water Systems (1991)
http://www.hse.gov.uk/consult/condocs/cd258.htm

Control of Asbestos Regulations (2012)
http://www.legislation.gov.uk/uksi/2012/632/contents/made

Fire Regulatory Reform (Fire Safety) Order (2005)
http://www.legislation.gov.uk/uksi/2005/1541/contents/made

Essential Standards of Quality and Safety (Care Quality Commission, 2010)

Health & Safety at Work etc Act 1974 (Health & Safety Executive, 2013)

Secretary of States Directions on NHS Security Management Measures (NHS Protect, 2012)

Management of Health & Safety at Work Regulations 1999 (Health & Safety Executive, 2013)

Occupiers Liability Act 1957 (Crown, 2013)

Police and Criminal Evidence Act (Home Office, 1984)

Children's Act (Home Office, 1989)

Creating a Pro Security Culture (NHS Counter Fraud and Security Management Service, 2005)

The 2013/14 Security Management Standards for Providers (NHS Protect, 2013)

NHS Standard Contract 2013/14 (NHS Commissioning Board, 2013)

Appendix 1: Consultation

This Health, Safety and Security Strategy has been presented to the following groups and Committees so as to ensure appropriate senior support, prior to its escalation to the Trust Board in May 2014 for ratification:

Consultation Group	Date of Meeting
Integrated Governance and Quality Committee (named the Quality and Clinical Governance Committee from 1 April 2014)	20 February 2014
Health, Safety and Security Committee (email circulation)	March 2014
Performance and Resources Committee	15 April 2014
Trust Board	20 May 2014

Appendix 2: Creating a Pro Security Culture

The guidance document, *Creating a Pro Security Culture* (NHS Counter Fraud and Security Management Service, 2005), advises that the development of a pro security culture is integral to all strands of security management work, as it underpins all applications to mitigate security risks. A pro security culture amongst colleagues, service users, visitors and members of the public will be derived from an acceptance of responsibility from all.

The conclusion of this approach will be to achieve a safe and secure environment. The Trust recognises however, that this can only be achieved by the application of the processes outlined within this Health, Safety and Security Strategy as well as all associated policies and board level engagement.

Specially, the guidance makes clear recommendations in respect of:

a) Strategic Governance

- The Trust will ensure that a member of the Board is responsible for overseeing and providing strategic management and support for all health, safety and security management work within the organisation
- The Trust will employ a Local Security Management Specialist (LSMS) to undertake security management work, and has appointed a competent person to cover health and safety
- Sufficient resources and investment are allocated to security management in line with the identified security risks. Compliance with the security standards will be reported annually.

b) Inform and Involve

- The Trust will use risk assessments as a basis for identifying risk in relation to protecting colleagues, service users, premises, property and assets. The risk assessments will inform and develop security policies and systems that will be communicated to the organisation via internal communications and face to face briefing
- Effective communication between the LSMS and internal and external stakeholders will identify risk and the measured response required
- The Trust will participate in any national or local publicity initiatives to raise security awareness
- Colleagues will receive information regarding security measures through induction or bespoke training and how to report security incidents

c) Prevent and Deter Crime in the Organisation

- The Trust will utilise robust security controls to prevent or discourage those tempted to commit crime on the organisation's premises or whilst employed by the organisation
- A programme of Conflict Resolution Training in line with national guidance to prevent violence and aggression towards colleagues, will be delivered to all frontline staff
- The Trust will learn from reported incidents which, in turn, will assist in the development of policy and guidance
- Security management will be an integral element of new build or refurbishment projects with management of access being a key component
- A clear process of asset management will be in place to maintain protection and control of Trust assets
- The Trust will provide colleagues and service users with secure facilities for their personal belongings
- In the event of an increased security threat, the Trust will have the ability to increase security resources in line with the threat, and implement clear lockdown arrangements

d) Hold to Account

- Through the LSMS, the Trust will be committed to applying necessary sanctions against any person found committing crime against the organisation by thorough, timely investigation and where necessary in partnership with the police and other crime prevention agencies.
- Where appropriate, successful prosecutions will be publicised.
- Where necessary, the Trust will recover financial losses.

Gloucestershire Care Services NHS Trust Board

Title:	**Quality and Clinical Governance Committee Report**		**20 May 2014**
Agenda Item:	**14**		
Purpose of Paper:	To provide the Board with a summary of the key issues and actions arising from the meeting of the Quality and Clinical Governance Committee, previously the Integrated Governance and Quality Committee held on 10th April 2014.		
Key Points:	The report sets out the key points discussed and the approved minutes of the meeting held on 20th February 2014 are attached for information.		
Options and decisions required	The Board is asked to receive the report and the approved minutes of 20th February 2014 meeting for information and assurance.		
Fit with strategic objectives	1. Achieve the best possible outcomes for our service users through high quality care		X
	2. Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work		X
	3. Provide innovative community services that deliver health and social care together		X
	4. Work as a valued partner in local communities and across health and social care		X
	5. Support individuals and teams to develop the skills, confidence and ambition to deliver our vision		X
	6. Manage public resources wisely to ensure local services remain sustainable and accessible		X
Next steps/future actions	The approved minutes from the Quality and Clinical Governance Committee of April 2014 will be presented to Board at the next meeting.		
Author name and title	**Liz Fenton** **Director of Nursing and Quality**	**Director Name and Title**	**Sue Mead** **Non-Executive Director and Chair of QCGC**

Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: 20 May 2014
Location: Hesters Way Community Resource Centre, Cheltenham

Agenda Item 14: Quality & Clinical Governance Committee update

1. Introduction

This report provides a summary of the key issues and actions arising from the meeting of the Integrated Governance and Quality Committee meeting held on 10th April 2014. The approved minutes of 20th February 2014 meeting are attached for information.

2. Implementation Plan

The Committee received a first draft of the implementation plan for the Clinical and Professional Care Strategy. It was recognised that there was much work to do to sharpen the priorities and to determine milestones, costs and metric measures. The June meeting is to see an enhanced version of the plan.

3. Quality Reporting

The Committee received the first iteration of the new style Quality Report. This is a developing report and is based on the key questions posed by the Care Quality Commission when assessing the quality of care; are services safe, caring, responsive, effective and well led?

The Committee noted the progress made and recognised that this style of reporting enabled greater triangulation of key quality indicators underpinned where possible by benchmarking. The Committee highlighted some gaps in the reporting at present and endorsed the planned next steps in further developing this report. The Committee approved that this be presented to the Board meeting to be held in May.

A focus on pressure ulcers formed part of this report and was underpinned by a presentation provided by Sarah Warne (Named Nurse, Safeguarding) and Lucy Woodhouse (Senior Tissue Viability Nurse). This very informative presentation provided the group with valuable insight into the work to reduce the risk to those within our care by providing education, support and expert advice to our health and social care teams. This is supported by information provided to patients and their carers as to how they may care for their skin.

4. Review and Management of Risk

The critical importance of effective review and management of organisation risk was discussed. The Trust is currently moving to an electronic risk register which will provide better oversight and ensure a greater level of consistency in both risk scoring and reporting. The priority of this work was emphasised and discussion took place

about the potential need to provide further training across the Trust to ensure a good understanding of the processes. The risk management strategy implementation plan will highlight how risk management will be managed/delivered over the next five years.

The Committee will oversee the clinical risks which will be reported to the group at each meeting from June 2014.

5. Care for those with Dementia, their families and carers.

Mandy Hampton, Matron of the Forest of Dean Hospitals, who has led the quality improvement work associated with the care of those with dementia and their families across the Trust, presented a paper to the Committee on this important topic. This has included taking on the Trust lead role for the associated CQUIN schemes for the last two years.

Matron presented the work undertaken over that period and the Committee commended the quality improvements that have resulted. A number of recommendations were made within the paper and Susan Field (Director of Service Transformation) committed to support Mandy in ensuring that the appropriate colleagues be involved to take this work forward.

6. Annual Statement

The Committee approved, subject to some amendments, the Annual Statement from the Committee to Trust Board for 2013-14. This will be presented by the Chair to the May Board.

7. Conclusions and Recommendations

The Board is asked to:

- **Note** this report
- **Receive** the approved minutes of 20th February 2014 meeting for information and assurance

Report prepared by: **Liz Fenton, Director of Nursing and Quality**

Report Presented by: **Sue Mead, Chair, Quality & Clinical Governance Committee**

GLOUCESTERSHIRE CARE SERVICES NHS TRUST

INTEGRATED GOVERNANCE AND QUALITY COMMITTEE

Minutes of the Meeting held on Thursday 20 February 2014

Voting Committee Members	
Sue Mead (SM)	Non-Executive Director
Joanna Scott (JS)	Non- Executive Director
Nicola Strother Smith (NSS)	Non- Executive Director
Elizabeth Fenton (EF)	Director of Nursing
Jo Bayley (JB)	Medical Director
Glyn Howells (GH)	Director of Finance
Committee Attendees (Non-Voting)	
Ingrid Barker (IB)	Trust Chair
Candace Plouffe (CP)	Director of Countywide and Children & Young Peoples Services
Tina Ricketts (TR)	Head of HR
Susan Field (SF)	Director of Adult Services
Louise Foster (LF)	Joint Clinical Director – Dental (Countywide representative)
Melanie Rogers (MR)	Head of Clinical Governance
Amanda Harris (AmH)	Information Governance and Risk Manager
Deborah Greig (DG)	Head of Social Care
Rod Brown (RB)	FT Programme Manager
Laura Grainger (LG)	NHS Graduate Management Trainee
Jon Flett (JF)	NHS Graduate Management Trainee
In Attendance	
Jason Brown (JBR)	In lieu of the Board Secretary
Jill Rowell (JR)	Minute Taker

Ref	Minute	Action
01/14	**Agenda Item 1: Apologies** Apologies were received from: Simeon Foreman, Andrew Hall, Mark Parsons, Diana Gould and Jackie Jenkins. The Chair welcomed the Trust's two NHS Graduate Management Trainees to the meeting and invited Committee members to introduce themselves to them.	

02/14	**Agenda Item 2: Declaration of Interests** There were no declarations noted at the meeting.	
03/14	**Agenda Item 3: Minutes of the meeting held on 9 January 2014** The Chair considered the wording at item 93/13 (Management of Policies Policy Review) was ambiguous and did not reflect the groups recollection of the discussions and agreed actions. The Director of Nursing and the Board Secretary were requested to amend the minute outside the meeting. Subject to two more minor amendments the minutes were **APPROVED** as an accurate record.	**EF/JBR** **JR**
04/14	**Agenda Item 4: Matters arising and action log** The Action Log was reviewed by the Committee and the following updates given for the items that were not closed or featured on this meeting's agenda: ***(IG&Q 76/13)*** – the Committee's revised Terms of Reference will be presented to April meeting ***(IG&Q 77/13)*** – the Policy on Policies will be taken to Exec Team for review and comment before presentation to Board. ***(IG&Q 78/13 & 94/13)*** – the Head of Clinical Governance is leading on the quality and safety visit programme and a schedule of two visits per months, starting on 12 March, has been drawn up. Feedback on the visits will be incorporated into the Quality Report. ***(IG&Q 80/13)*** – the Information Governance & Risk Manager advised rolling out the risk training had been delayed to March / April. ***(IG&Q 92/13)*** – the Committee's comments regarding the Annual Governance Statement have been taken on board and the document will be presented to the Audit & Assurance Committee on 19 March. ***(IG&Q 98/13)*** – the Board Secretary reported the Board Assurance Framework and the Risk Register will be overseen and scrutinised by the Audit and Assurance Committee with effect from 19 March and will be the focus of April Board Development session. ***(IG&Q 103/13)*** – the Board Secretary advised laptops have been	**JBR** **JBR** **MR** **JBR**

	ordered for the NEDs in a move towards paperless meetings in the future. The Committee **RECEIVED** the Action Log and **NOTED** the updates. ***(IG&Q 94/13) Clinical Governance Structure*** The Chair introduced the new clinical governance structure to the Committee, and explained that a robust governance framework is essential throughout the Trust to provide assurance that processes for the governance of quality care are embedded throughout the organisation. She expressed that a yearly review of the structure would be undertaken by the Committee, and will be scheduled within the Committee Forward Plan. IB stated that the Terms of Reference should clarify service user experience accountability and, in particular, reference other Committees and/or Programme Boards that have a responsibility for service user experience to ensure clarity of boundaries. The Committee **NOTED** and **ENDORSED** the report.	**JBR**
05/14	**Agenda Item 5: Clinical and Professional Care Strategy** RB presented the strategy to the Committee. The Committee was asked to approve the current draft of the document, ahead of its presentation to the Trust Board on 11 March for final ratification. RB highlighted the key themes and goals of the strategy to the Committee. RB also stated that a detailed implementation plan will be developed to support this strategy, which will therefore be monitored by the Committee. The Committee suggested several changes to the strategy to include: • Clarification of the costs for implementation of key components of the strategy, • Understanding of the ownership and engagement to achieve the key milestones, • Reference to waiting times, staffing levels and continuity of care, • Clarification on the triangulation of the strategy with other Trust strategies, • Confirmation that the strategy aligns with commissioning intentions, • Links to be understood with the QIPP agenda,	

	• Clarity in respect of links to service user experience, • Emphasis on responding promptly and robustly to incidents including safeguarding, • Referencing links to the learning disability agenda particularly in respect of external advocacy, • Ensuring quality measures include a realistic metric. The Committee agreed to approve the strategy. The Committee **APPROVED** the strategy on the understanding that the proposed changes will be incorporated before the strategy is presented to the Trust Board on 11 March 2014.	**EF**
06/14	**Agenda Item 6: Health, Safety and Security Strategy** RB presented the strategy to the Committee. The Committee was asked to approve the current draft of the document, ahead of its presentation to the Trust Board on 25 March for final ratification *(this meeting was subsequently cancelled and the item deferred to Board meeting on 20 May).* RB reported the strategy confirms the commitment of the Trust to maintain the health, safety and security of all Trust colleagues, service users, carers as well as visitors to the Trust. The strategy outlines the aspirations and direction of travel over the next five years. SF stated that the obligations to colleagues should be made clearer, i.e. supporting colleagues, etc. TR stated that the language within the strategy will be amended to reflect a supportive environment. IB suggested that the strategy should be more explicit about other colleagues, i.e. lone workers, mobile workers, provision of torches, alarms, etc. Subject to the **RECOMMENDED** amendments, the Committee **APPROVED** the Strategy which will be presented to the Trust Board on 25 March 2014	**TR**
07/14	**Agenda Item 7: Risk Management Strategy** RB presented the strategy to the Committee. The Committee was asked to approve the current draft of the document, ahead of its presentation to the Trust Board on 11 March for final ratification. RB stated that the strategy represents an update of the Trust's Risk Management Strategy, formally approved by the Trust Board in July 2013.	

	The new version of the strategy emphasises quality goals and the identification of five year priorities and actions. It was agreed that a Board summary of priority tasks to be implemented will be discussed at the next Board. The Committee **APPROVED** the Strategy which will be presented at the Trust Board 11 March 2014	**RB**
08/14	**Agenda Item 8: Equality Objectives** TR reported that the first Equalities Steering Group meeting that took place 29 January 2014 identified the key objectives for the group. The Committee was asked to approve the objectives. SF stated that the Committee should explore how to link the Trust's CQUIN programme to the objectives of the Equalities Steering Group. TR to bring an update report and objectives in June 2014. The Committee **NOTED** the report.	**TR**
09/14	**Agenda Item 9: Safe and Suitable Staffing Gap Analysis** EF presented on behalf of Liz Jarvis (Deputy Director of Nursing) an overview, summary and gap analysis of the expectations resulting from the recently published National Quality Board guidance "How to ensure the right people, with the right skills are in the right place at the right time". The document was developed by the Chief Nursing Officer for England in conjunction with the National Quality Board and sets out ten expectations for NHS Trust Providers to deliver. The national time frame for delivering against the guidance was reported by EF. IB stated that the Board would like assurance that the levels of nursing are appropriate for delivering effective services. EF informed the group that LJ will look to work with the matrons to identify how the Trust can implement the work in the timeline stated. TR asked whether a sub-group/task and finish group should be established, namely a "Safe Staffing Group". The Committee agreed with the development of a task and finish group to lead this piece of work. The Committee requested assurance of non-compliance should be reported to the next meeting. EF will report back in June on	**EF**

	progress made. The Committee **NOTED** the report.	
10/14	**Agenda Item 10: Quality Account** EF asked the Committee to endorse the plans to develop the annual Quality Account, which will complement the work of the Clinical and Professional Care Strategy. It was proposed that the initial draft should be discussed at the next scheduled meeting of the Committee (10 April 2014), with the final version of the Quality Account being agreed by special arrangement with the Committee Chair and two Non-Executive Directors by the end of April 2014. The Committee **NOTED** the report	**EF/JRB**
11/14	**Agenda Item 11: Service User Experience Report** EF provided a brief overview of actions being taken to ensure that the Trust obtains feedback from service users, their carers and the public. The Trust is continuing to develop a comprehensive approach to securing feedback from service users etc. IB stated that the Trust should be much clearer about what it does with the results of service users' feedback, and the methods used to provide solutions to the feedback, particularly in respect of relaying how the Trust has approached concerns back to the public. The Chair suggested that the Trust should consider the need to develop and implement appropriate tools that will help support the analysis and understanding of service user experience. She stated that focus groups and other soft methods of engagement should be explored in order to gauge expectations, perceptions and understanding of service users' experiences. She also stated that where members of the public have a specific complaint, the Trust should work to provide and report solutions to the complaint, and capture the level of service user satisfaction. The Committee **NOTED** the report	**AH** **AH** **AH** **AH**
12/14	**Agenda Item 12: Safeguarding (Adult) Report** EF presented the annual report to the Committee for information.	

	The Chair asked that consideration be given as to how the IGQC may receive local information regarding aspects of adult and children's safeguarding. A local dashboard is being developed that will form part of the revised reporting process for April 2014. The Committee **RECEIVED** the report	**EF**
13/14	**Agenda Item 13: Child Death Review Report** EF presented the Child Death Review report. There were 44 child deaths reported last year. The Child Death Overview Panel met to discuss cases on five occasions and 33 cases were reviewed. The Committee **RECEIVED** the report.	
14/14	**Agenda Item 14: Quality Performance Framework for ICTs and Rapid Response Service** SF reported progress that has been made with regards to the implementation of the enhanced ICT services – Rapid Responses and High Intensity Service (which went live in Gloucester City on 22 January 2014). SF also highlighted some of the quality metrics that GCS have developed and agreed with the CCG. The Chair asked when the next report will be expected and SF stated that a rapid response operational report would be available for the next Committee. The Committee **NOTED** the report.	**SF**
15/14	**Agenda Item 15: Children's Community Nursing Service – Deep Dive** CP provided the Committee with a detailed report in respect of the performance of the Children's Community Nursing Service. The service offers home based clinical nursing care to children and young people. The report triangulates current information available from the following sources: (1) performance (2) workforce (3) finance (4) governance (5) patient experience	

	Seventeen incidents have been recorded on Datix since April 2013. The Committee **NOTED** the report.	
16/14	**Agenda Item 16: CQC Inspection of Stroud Hospital** EF presented the CQC inspection report of Stroud Hospital and the action plan developed as a result of the inspection. Overall, the report provided positive feedback especially in relation to the kindness of staff. However, there were some learning points to be reviewed and addressed to improve care provided to patients and their families. The Committee requested an update report in respect of the learning points and how they have been implemented and measured. The Committee **NOTED** the report.	**EF**
17/14	**Agenda Item 17: Patient Led Assessment of the Care Environment** GH informed the Committee of the Trust's response to the PLACE assessments that had been undertaken in a number of Trust's community hospitals, and provided an update on the actions required and achieved since the initial audits. The Committee **NOTED** the report.	
18/14	**Agenda Item 18: Countywide Interim End of Life Care Plan t** EF reported that, following the independent review of the Liverpool Care Pathway in July 2013 and the decision to phase out the pathway by July 2014, GCS has worked with partners across the county through an End of Life Care Strategic Steering Group to develop a countywide care plan document to support the delivery of excellent end of life care throughout the county. This will be reviewed, including feedback from staff and families, and in line with future national direction. The Committee **APPROVED** the Use of the care plan	
19/14	**Agenda Item 19: Health and Safety Group Update** TR provided an update on the key issues considered at the Health and Safety Committee meeting held on 6 February 2014. The Committee **NOTED** the report.	

20/14	**Agenda Item 20: Operational HR Policy Development** TR requested that the Committee note the amendments to the policies in her report and ratify the policies in order for the Trust to commence implementation. The Committee **NOTED** the amendments and **RATIFIED** the policies.	
21/14	**Any Other Business** **QIPP 2014-15** GH informed the Committee of the meeting with the CCG that is planned to develop the QIPP schemes and agreed schedules before the end of March 2014. There were no other items for the Committee's attention.	
22/14	**Matters for Board or other Committees** There were no matters for referral to the Board or other Committees.	
23/14	**Date of Next Meeting** Thursday, 10 April 2014 at 1.30pm in the Boardroom, Edward Jenner Court	

Chair's Signature **……..**

Date **……**

Gloucestershire Care Services NHS Trust Board

Title:	**Performance & Resources Committee Report**		**20 May 2014**
Agenda Item:	**15**		
Purpose of Paper:	To provide the Board with a summary of the key issues and actions arising from the meeting of the Performance & Resources Committee held on 15th April 2014		
Key Points:	The Committee approved the minutes of the meeting held on 13th February 2014. Other key points discussed at the meeting are outlined in the report.		
Options and decisions required	The Board is asked to **NOTE** the report and the approved minutes for information and assurance.		
Fit with strategic objectives	1. Achieve the best possible outcomes for our service users through high quality care		
	2. Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work		
	3. Provide innovative community services that deliver health and social care together		
	4. Work as a valued partner in local communities and across health and social care		
	5. Support individuals and teams to develop the skills, confidence and ambition to deliver our vision		
	6. Manage public resources wisely to ensure local services remain sustainable and accessible		
Next steps/future actions	The Committee has agreed a forward programme which will be reviewed on an on-going basis.		
Author name and title	**Glyn Howells** **Director of Finance**	**Director Name and Title**	**Richard Cryer** **Non-Executive Director**

Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: 20th May 2014
Location: Hesters Way Community Resource Centre, Cheltenham

Agenda item 15: Performance & Resources Committee update

1. Introduction

This report provides a summary of the key issues and actions arising from the meeting of the Performance & Resources Committee held on 15th April 2014. The approved minutes of the meeting held on 13th February 2014 are attached for information.

This was the first meeting where Richard Cryer was chairing and Duncan Jordan (COO) was the executive lead and so Glyn Howells (DoF) led the meeting to ensure continuity with previous committee meetings.

2. Health, Safety and Security Strategy

The Committee received a presentation and overview of the strategy in the form of edited highlights which included amendments made following review by the Quality and Clinical Governance Committee.

The strategy was discussed in depth and the Committee approved the strategy subject to minor amendments. The strategy with these amendments is to be reviewed at the Board Meeting on 20th May 2014.

3. IT Strategy Implementation Plan

The Head of IT, Developments and Operations (BW) presented the IT Strategy Implementation Plan as a work in progress

4. Estates Strategy Implementation Plan

The Head of Estates, Safety, Security and Facilities (MP) presented a work in progress Estates Strategy Implementation Plan to the Committee and stated that the final version will be presented at the next meeting.

5. Quality & Performance Report

The Quality & Performance Report was presented to the Committee by the Head of Performance & Information and focus was given to the high profile issues, namely:

- Number of post 48 hour – C.Diff Infections in Community Hospitals

- Sexual health – Psychosexual Medicine
- Number of acquired pressure ulcers
- A number of indicators in Adult Social Care

The committee noted the content of the report and the action plans to address under—performance

6. Finance Performance Report

The Director of Finance presented the report and gave a brief overview to the Committee. He advised the Trust had achieved a £2M surplus and would need to deliver £6.4M CIP in 2014/15.

The Committee **RECEIVED** the report, **NOTED** the urgency and **SUPPORTED** the CIP initiatives.

7. Capital Schemes

The Director of Finance (GH) presented the Capital Scheme Report and provided the Committee with a brief update.

8. Business Development Tracker

The Director of Finance presented the Business Development Tracker Report and advised that a formal business development process is in place.

9. Committee Terms of Reference

The Terms of Reference were received, and the Committee was requested to forward their comments to the Interim Board Secretary

10. Committee Annual Statement for Trust Board

The Committee's Annual Statement for Trust Board was received and the Committee was requested to forward their comments to the Interim Board Secretary.

11. Contract with Independent Health Group (IHG)

The Director of Finance presented the Independent Health Group Contract Report to the Committee for approval.

The Committee discussed and debated the procedures IHG wish to perform at GCS' community hospitals and the associated cost implications and risks to the Trust.

Resolution: The Committee NOTED the content of the contract and REQUESTED feedback on the questions raised.

12. Conclusion and Recommendations

The Board is asked to:

- **NOTE** this report
- **RECEIVE** the approved minutes of 13th February 2014.

Prepared by: **Glyn Howells, Director of Finance**

Presented by: **Richard Cryer, Chair, Performance & Resources Committee**

Appendices

Appendix 1: Approved minutes of the Performance and Resources Committee on 13th February 2014

GLOUCESTERSHIRE CARE SERVICES NHS TRUST
PERFORMANCE AND RESOURCES COMMITTEE

Minutes of the Meeting held on Thursday, 13 February 2014 at 2.00pm in the Boardroom, Edward Jenner Court

Present:

Members:

David Harwood (DH)	Non-Executive Director (Committee Chair)
Rob Graves (RG)	Non-Executive Director
Paul Jennings (PJ)	Chief Executive
Stuart Bird (SB)	Deputy Director of Finance (deputising for Glyn Howells, Director of Finance)

In Attendance

Johanna Bogle (JoB)	Financial Accountant
Bernie Wood (BW)	Head of IT Developments and Operations
Matthew O'Reilly (MO)	Head of Performance & Information
Mark Parsons (MP)	Head of Estates, Safety, Security and Facilities
Rod Brown (RB)	Foundation Trust (FT) Programme Manager (for agenda items 11, 12 and 13)
Jason Brown (JB)	Interim Board Secretary
Jill Rowell (JR)	Board Administrator

Item	Detail	Action
P&R 01/14	**Agenda Item 1: Apologies** Apologies were noted from Ingrid Barker, Trust Chair, Chris Creswick, NED and Glyn Howells, Director of Finance.	
P&R 02/14	**Agenda Item 2: Declaration of Interests** There were no changes to the declarations previously recorded.	
P&R 03/14	**Agenda Item 3: Minutes of 10 December 2013 meeting** The Minutes were reviewed and, subject to a minor amendment, agreed as an accurate record. These will now be signed off by the Chair. **Resolution: The Minutes were NOTED and APPROVED.**	**JB**
P&R 04/14	**Agenda Item 4: Matters Arising** The Committee reviewed the Action Log and agreed to close items	

	33, 36 and 39. Update on actions were provided as follows and will be recorded on the action log for future meetings; Action 29 – Monthly expenditure column will be included in the papers for the next meeting in April. Action 34 – A trial of electronic board paper package is a work in progress and an update will be brought to April's meeting. Action 36 – the TDA agreed the money GCS had identified to purchase new premises for Dental service can be carried over to next year's budget as an appropriate property could not be found. Action closed. Action 39 – Safeguarding paper will go to next week's IGQC meeting (20 February). Action closed. Actions 40 – Update on suggestions received with regard to the layout of the Quality & Performance report to remain open until April's meeting. Action 41 – an update on information on workforce outliers requested by the Committee remain open until April's meeting. Action 42 – on 10 December the Board did not have sufficient time to review in depth all agenda items and authority was delegated to the Performance & Resources Committee, sitting later the same day, to scrutinise and review the Quality & Performance and Finance reports. The minutes of the meeting reflect the Committee noted the reports and endorsed the actions that have been put in place in order to address those areas of performance falling below target. **Resolution: The Committee APPROVED the updates and closure of actions.**	**GH** **JB** **GH** **GH**
P&R 05/14	**Agenda Item 5: Review of Forward Agenda Plan** The Interim Board Secretary introduced the Plan, which he advised is for review together with the Committee's Terms of Reference, and has a meeting later in the month with the Trust Chair (IB) to formalise agenda items for 2014-15. A raft of strategies will be monitored on a regular basis by the Committee and the inclusion of a review of the Cost Improvement Plans as a recurring agenda item was recommended. **Resolution: The Committee NOTED the Forward Agenda Plan and the RECOMMENDATION made.** The Chair requested a reordering of the agenda to accommodate strategy presentations ahead of other business.	**JB**

P&R 06/14	**Agenda Item 11: IT Strategy** The FT Programme Manager (RB) presented an overview, in the form of edited highlights, of the three strategies submitted to the Committee for approval. RB was congratulated on the usefulness of the bullet pointed presentation. The IT strategy was discussed in depth and the Committee recommended a budget statement section be included before presentation to the Board for approval. **Resolution: The Committee NOTED the update on the IT Strategy and, subject to the RECOMMENDED amendment, was approved for escalation to the Board.**	**RB**
P&R 07/14	**Agenda Item 12: Estates Strategy** The Estates Strategy was discussed by the Committee and it was recommended RB add reference to maximising the use of the estate and include a budget statement section before escalation to the Board for approval. **Resolution: The Committee NOTED the update on the Estates Strategy and, subject to the RECOMMENDED amendments, was approved for escalation to the Board.**	**RB**
P&R 08/14	**Agenda Item 13. Communications and Engagement Strategy** The Communications and Engagement Strategy was discussed by the Committee. It recommended some of the language within the document which carries implied negativity be reviewed and a budget statement section included before presentation to the Board for approval. **Resolution: The Committee NOTED the update on the Communications and Engagement Strategy and, subject to the RECOMMENDED amendments, was approved for escalation to the Board.** **BW and RB left the meeting at this juncture.**	**RB**
P&R 09/14	**Agenda Item 6: Quality & Performance Report** The Quality & Performance Report was presented to the Committee by the Head of Performance & Information (MO) and focus was given to the high profile issues. <u>Number of post 48 hour – Clostridium Difficile Infections in Community Hospitals</u> The Trust remains ahead of trajectory for its target number of C.diff	

	infections in Community Hospitals, despite performance in the last six months showing a pattern of incidence within tolerance. The Deputy Director of Nursing is undertaking a piece of work with the assistance of Kent Community Health NHS Trust, who report a much lower C.diff infection rate per 1000 bed days than GCS, to understand where improvements can be made. <u>HPV Immunisation</u> The HPV immunisation programme, involving a series of three injections, remains behind target despite an improvement in this year's no consent rate. Children's Service leads are looking at ways of working with GPs to improve the rate further and address the drop in number of girls opting to be immunised at their GP surgery. <u>Sexual Health – Psychosexual Medicine</u> Psychosexual Medicine remains red rated, however, a triage process is in place and patients currently waiting to access the service have been allocated appointments or are in the process of making an appointment. Commissioners have recently met to review a proposed service model. <u>Reduction in Total Number of Falls in Community Hospitals</u> The number of falls reported is above the national tolerance rate and the Committee particularly noted the increase in those occurring in the Trust's new community hospitals with single bed units. <u>Number of acquired Pressure Ulcers</u> All pressure ulcers are being reviewed to identify themes and take forward actions. <u>Social Care</u> A number of targets remain red and MO highlighted a lack of progress in efforts to improve them. Significant issues identified are poor reporting and recording and poor quality of data produced by ERIC system. The Chief Executive recommended simple measures are taken to address the issues, for example reviewing all reports the Trust provides to Social Care and identifying what the key operational issues are. <u>Workforce</u> The rate for number of staff undertaking mandatory training remains static and the onus lies with line managers to raise staff awareness. **Resolution: The Committee NOTED the report and RECCOMMENDED the Director of Nursing is invited to attend a future meeting to give an overview on the falls pathway and provide comparisons around number of incidences occurring in single bed units to those in wards.**	

P&R 10/14	**Agenda Item 7: Finance Performance Report** The Deputy Director of Finance presented the report, giving both the year to date and full year forecast out-turn positions for the Trust, and tabled two appendices; 2013/14 Forecast and GCS agency pay costs 2013/14. He gave a brief overview on the main financial issues that the Trust faces, including the high monthly cost associated with the use of agency staff. The Chief Executive advised the Safe and Suitable Staff gap analysis undertaken by the Trust had identified staffing issues at some units and these are being addressed. **Resolution: The Committee RECEIVED the papers and NOTED the position and implications for the Trust.**	
P&R 11/14	**Agenda Item 8: Progress on Social Care performance/external care/reablement** The Deputy Director of Finance presented as read the External Care update on behalf of the Director of Adult Services. He informed the Committee a performance meeting was taking place tomorrow. **Resolution: The Committee NOTED the report.**	
P&R 12/14	**Agenda Item 9: ICT Development** The Deputy Director of Finance presented as read the ICT services report on behalf of the Director of Adult Services. He informed the Committee the Rapid Response and High Intensity Services went live in Gloucester on 22 January and at a recent ICT meeting, attended and minuted by the CCG, progress was made with regard to determining how these services would be financed when rolled out in other parts of the county. **Resolution: The Committee NOTED the report.**	
P&R 13/14	**Agenda Item 10: Urgent Care Action Plan Update** The Deputy Director Finance presented as read the Urgent Care Strategic Plan update on behalf of the Director of Adult Services. **Resolution: The Committee NOTED the report and RECOMMENDED it be reviewed and amended to include key purposes and an action plan.**	**SF**
P&R 14/14	**Agenda Item 14: Cost Improvement Plans (CIPs) update** The Deputy Director of Finance tabled a spreadsheet giving data on GCS' 2014/15 CIP schemes, totalling £6m, and advised the Trust is	

	ahead of where it was last year. The Chief Executive has implemented new budget holder management group meetings involving Band 7 and 8A managers to ensure their engagement with the schemes. Even if in budget, managers have been requested to scrutinise their respective budgets for any efficiency failings. A programme of visits by Sam Mongon and Alston Owens, from the Project Management team, to help Service Leads progress this action is underway. The Head of Estates, Safety, Security and Facilities brought to the Committee's attention that identifying and achieving savings for those services recently re-aligned was a little more challenging. **Resolution: The Committee RECEIVED and NOTED the tabled document.**	
P&R 15/14	**Agenda Item 15: Capital Schemes – approvals and progress review** The Trust's Financial Accountant presented the Capital Schemes update report and reiterated the key points. Agreement has been reached with the TDA to revise GCS' planned capital spend from £6.7m to £5m, due to their delay in confirming what additional Public Dividend Capital cash the Trust could request this year. The Department of Health has released another set of forms for GCS to complete to agree a £9m shortfall identified in fixed assets received when Gloucestershire PCT ceased to exist. **Resolution: The Committee RECEIVED the papers and NOTED the position and implications for the Trust.**	
P&R 16/14	**Agenda Item 16: Business Development Tracker** The Deputy Director of Finance tabled a paper and briefed the Committee on the business opportunities listed. The Trust has commissioned the services of Bevan Brittan to produce a standardised contract for external providers use. **Resolution: The Committee RECEIVED the document and NOTED the contents.**	
P&R 17/14	**2014/15 Committee Dates** **Resolution: The Committee RECEIVED and NOTED the meeting schedule.**	
P&R 18/14	**Any Other Business** The Chair of the Audit Committee (RG) expressed his appreciation to the Deputy Director of Finance and the Head of Performance and Information for the quality of analysis provided to the Performance & Resources Committee.	

P&R 19/14	**Matters for Board or other Sub-committees** Escalation of the IT, Estates and the Communications and Engagement strategies to the Board for approval.
P&R 20/14	**Date of Next Meeting** **Tuesday, 15 April 2014 at 2.00pm in the Boardroom, Edward Jenner Court**

Gloucestershire Care Services NHS Trust Board

Title:	**Audit and Assurance Committee Report**		**20th May 2014**
Agenda Item:	**16**		
Purpose of Paper:	To provide the Board with a summary of the key issues and actions arising from the meeting of the Audit and Assurance Committee (AAC) held on 19th March 2014.		
Key Points:	The Committee approved the minutes of the meeting held on 17th December 2013. Other key points discussed at the December meeting are outlined in the report.		
Options and decisions required	The Board is asked to **RECEIVE** the report and the approved September minutes for information and assurance.		
Fit with strategic objectives	1. Achieve the best possible outcomes for our service users through high quality care		
	2. Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work		
	3. Provide innovative community services that deliver health and social care together		
	4. Work as a valued partner in local communities and across health and social care		
	5. Support individuals and teams to develop the skills, confidence and ambition to deliver our vision		
	6. Manage public resources wisely to ensure local services remain sustainable and accessible		
Next steps/future actions	The Committee has agreed a forward programme which will be reviewed on an on-going basis.		
Author name and title	**Glyn Howells** **Director of Finance**	**Committee Chair**	**Rob Graves** **Non-Executive Director**

Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: 20th May 2014
Location: Hesters Way Community Resource Centre, Cheltenham

Agenda item 16: Report of the Audit and Assurance Committee

1. Introduction

This report provides a summary of the meeting of the Audit and Assurance Committee held on 19th March 2014. The approved minutes of the 17th December 2013 meeting are attached for information.

2. Key Issues

2.1 External Audit

The External Auditors presented a Progress report and technical update on the Trust's reporting mechanisms and gave an overview on the findings. The Director of Finance reported that the Trust's opening balance has now been agreed.

2.2 Internal Audit

The Committee **RECEIVED** three reports from the Internal Auditors and three more were tabled.

DH Publication Greater risk, wider responsibilities
A survey on the challenges identified for NHS Audit Committees, was provided to the Committee for information purposes.

Annual Report 2013/14
The Committee considered the wording used within the report was harsh. LP advised she needed to understand the Trust's action plans and once clarified a revised draft Annual Report would be circulated

2.3 Counter Fraud

The Director of Finance presented the Annual Report of the Counter Fraud Service 2013-14.

2.4 Asset Disposal Assurance

The Internal Auditors have been requested to undertake a review of the Trust's processes regarding the disposal of PCs and the information stored on them.

2.5 Board Statements

The Interim Board Secretary presented five Board Statements, developed in line with the National Board Code of Governance, for the Trust's adoption and to be referenced in GCS' 2013/14 Annual Report and Accounts.

2.6 Annual Governance Statement

The Interim Board Secretary presented the Annual Governance Statement, which adheres to an NHS Trust template and is in line with legislation, and tabled the Trust's Corporate Governance Framework.

2.7 Annual Corporate Governance Statement

The Interim Board Secretary presented the Annual Corporate Governance Statement. To ensure GCS complies with the conditions of the NHS Provider Licence and moves towards compliance with the Annual Governance Statement, he advised work will commence in April

2.8 Caldicott 1: Audit Report

The Interim Board Secretary presented the Audit Report detailing the Trust's compliance with Caldicott 1, a requirement of the Information Governance Toolkit.

2.9 Annual Committee Statement

The Chair reported the Annual Committee Statement will be completed in light of today's discussion and circulated to members for comment.

2.10 Update on Board Assurance Framework

The Interim Board Secretary tabled two documents for the Committee's attention:

- Board Assurance Framework Flow Chart
- Quality Strategy cycle diagram

2.11 Schemes of reservation and delegation of powers

The Interim Board Secretary advised NHS Trusts are required to demonstrate the existence of comprehensive corporate governance arrangements in accordance with legislation. The Scheme of Reservation and the Scheme of Delegation of Powers
The Director of Finance reported training programmes will be rolled out in April to make the Trust's procedures for managing risk more robust.

2.12 Other standing items

Comprehensive reviews of Budget Holders' cost centres, Debtors and Write-offs, Losses and Special Payments and Better Payment Practice were conducted. No new significant issues were identified.

3. Recommendations

The Board is asked to:

- **NOTE** this report
- **RECEIVE** the approved minutes of the 17th December 2013 meeting

Report prepared by: Glyn Howells, Director of Finance

Report Presented by: Robert Graves, Committee Chair

Appendices:

Appendix 1: Approved Minutes of the Audit and Assurance Committee held on 17th December 2013

GLOUCESTERSHIRE CARE SERVICES NHS TRUST
AUDIT AND ASSURANCE COMMITTEE

Minutes of Meeting held on 17 December 2013
in the Boardroom, Edward Jenner Court

Present:	Robert Graves - Chair (RG)	Non-Executive Director
	David Harwood (DH)	Non-Executive Director
	Sue Mead (SM)	Non-Executive Director
In attendance:	Stuart Bird (SB)	Deputy Director of Finance
	Johanna Bogle (JB)	Financial Accountant
	Sallie Cheung (SCh)	Local Counter Fraud Specialist
	Simeon Foreman (SAF)	Board Secretary
	Lynn Pamment (LP)	Internal Audit, Pricewaterhouse Coopers
	Paul Dalton (PD)	Internal Audit, Pricewaterhouse Coopers
	Duncan Laird (DL)	External Audit, KPMG
Secretariat	Jill Rowell (JR)	Governance Project Support Officer
Apologies:	Jon Brown (JBr)	External Audit, KPMG

Ref	Minute	Action
A&A 51/13	**Agenda item 1. Apologies** The Chair welcomed colleagues to the Meeting and apologies from Jon Brown, KPMG External Auditor, were recorded.	
A&A 52/13	**Agenda item 2. Declarations of Interest** There were no declarations of interest noted.	
A&A 53/13	**Agenda item 3. Minutes of the previous meetings held on 17th September 2013** The Committee **RECEIVED** the unconfirmed minutes of the meeting held on 17th September 2013. **Resolution: Subject to a few minor amendments the Committee APPROVED the minutes of 17th September.**	
A&A 54/13	**Agenda item 4. Action Log and Matters Arising** The Committee **REVIEWED** the action log and the following amendments were noted. **Resolution: The Committee NOTED the updates on the action log**	

and closed actions.

Minute Reference	Action Agreed	Lead Exec	Update for 19 March 2014
34. 19/9/12 – item 8	**IT Strategy** IT Strategy to June's meeting	Glyn Howells	Long standing request to see a diagrammatic picture of all key systems not just clinical (ie this should include areas such as accounting, HR, payroll etc) and how they fit together **Carry over to March 2014 meeting**
AA16/13	Minutes - 25 March 2013 Committee proposed that a summary version of the Scheme of Delegation be prepared	Stuart Bird	Outstanding issue for Head of Finance to prepare Carry forward to March 2014 meeting
AA18/13	Forward Agenda Plan Include self-assessment of the Committee on the forward agenda plan for September	Board Secretary	Postponed until December
AA24/13	Property Update The Committee requested a further report in September	Glyn Howells / Mark Parsons	Estates portfolio to be presented in December
AA36/13	Made changes and re-issue forward agenda to Committee	Board Secretary	Forward Agenda to be presented to every other meeting
AA38/13	Head of Finance requested QIPP income be included on the risk map	Board Secretary/ Internal and External Auditors	Actioned by Auditors
AA38/13	Set dates for interim audit of accounts and report them to December meeting	Deputy Director of Finance	At December meeting identify early Jan 2014 date for interim audit
AA39/13	Requested a review of clinical record keeping by Internal Audit in the near future	Paul Dalton/Board Secretary	On forward agenda plan for June 2014
AA39/13	Internal Audit requested more involvement from Clinical Audit regarding inconsistencies in	Board Secretary	

	clinical record keeping procedures		
AA40/13	Concern the number of days support the Counter Fraud Service provide to GCS is not sufficient. Head of Finance to bring to attention of Director of Finance to discuss with LCFS.	Deputy Director of Finance	
AA40/13	Head of Finance to gain understanding of scale of problem with regard to overseas visitors paying for pregnancy terminations, etc and follow up with Director of Finance.	Deputy Director of Finance	Carry forward to March meeting
AA40/13	Committee requested future Counter Fraud reports be anonymised and the minutes of the meetings drafted to protect confidentiality.	Sallie Cheung	Actioned
AA43/13	Requested budget holders' cost centre data is presented to reflect an individual can be a holder of multiple budgets.	Deputy Director of Finance	Actioned but further refinement to report required, carry forward to March
AA46/13	Requested inclusion of a graphical representation of data in the better payment practice performance report.	Deputy Director of Finance/ Financial Accountant	Actioned
AA50/13	Ensure matters for Board and other Committees are actioned.	Board Secretary	Actioned

Resolution: The Committee NOTED the updates on the action log and closed actions.

A&A 55/13

<u>Agenda item 5. External Audit Reports</u>

DL, KPMG External Auditor, presented a progress report and technical update on GCS, which had been discussed at the earlier pre-meeting of

	NEDs and internal and external auditors, and advised national issues had impacted on the data being available for the Trust's end of year balances. The Director of Finance briefed the Committee on how the split of the PCT's assets and property, particularly with regard to land owned at Tewkesbury, had impacted on GCS. Properties, such as health centres, have been given to PropCo to manage who are now seeking to charge the Trust rent for using them. GCS' budget for said properties ceased on their transfer to PropCo. The Department of Health's Legacy Team is attempting to work through the issue, however, GCS understand NHS England consider it too difficult to split the assets. Providing year-end balance is a requirement for GCS, as stipulated by the TDA, and the Director of Finance will comply but the report submitted will be subject to significant caveats. He advised the Committee should recognise there may be additional splits of assets in the future and that he has an introductory meeting with Jennifer Howells, NHS England on 30 December. **Resolution: The Committee NOTED the report and RECOMMENDED a letter is drafted, for posting early January, to alert the TDA to the situation faced by the Trust and that the opening balance submission will be a 'best estimate'.** The Chair invited Sallie Cheung, Local Counter Fraud Specialist (LCS) to present her item at this juncture.	**GH**
A&A 56/13	**<u>Agenda item 7. Counter Fraud Report</u>** The LCS introduced the report and advised, after review of the Action Plan, the number of days the Counter Fraud service was contracted to GCS had been reduced to 112 and, if required, will be reviewed again next year. The standards within the Action Plan are now RAG rated and she briefed the Committee on the two amber ones. Since the last report the service has received 28 referrals, however only one has resulted in a full investigation. As recommended by the Committee, the LCS advised that all Counter Fraud reports and case updates have been anonymised to respect confidentiality. With regard to cases of overpayment of salary, the Director of Finance advised recovering money overpaid is still a problem area for the Trust, due in part to antiquated processes. SCh reported Gloucestershire's Counter Fraud Service's work around identifying overseas patient payments had been shortlisted for an award and she was delighted to advise the Committee they had won. On behalf of the Trust, the Chair congratulated her on the team's achievement. SCh left the meeting. **Resolution: The Committee RECOMMENDED the overpayment of salaries issue is reviewed at the Committee's meeting in March. The Committee NOTED the report, updated action plan and attachments.**	**LCS/GH**
A&A 57/13	**<u>Agenda item 6. Internal Audit Reports</u>** The Committee **RECEIVED** three reports from the Internal Auditors and	

	LP presented the Progress Report. She advised the Budgetary Control report remains outstanding and if pushed back further will reach a point of diminishing return. The Cost Improvement Plan work has been rescheduled and will now be undertaken in Quarter 4. The audit of the disposal process for Trust computer hard drives was raised by the Director of Finance, further to a fine incurred by another Trust for inappropriate disposal. PD introduced the Staff Appraisal audit and reported the findings rated it a medium risk, identifying some staff had not had appraisals or their objectives captured. However, for staff who had had them set it would be useful to revisit their objectives more than once during the year. The NHS appraisal process was debated and consideration given to whether it was fit for purpose across the Trust. PD reported the Corporate Record Keeping audit findings had identified the area as high risk within the Trust. He briefed the Committee on the risks, with the most serious considered the Trust's lack of formal processes for the disposal of corporate records. The Board Secretary is lead for this item and is working to resolve the issues with the Information Manager, in association with the Information Governance Toolkit. The report's findings and the internal auditors' follow up report on the identified high risk, for completion by the end of March 2014,will be referred to the Integrated Governance and Quality Committee for its opinion. **Resolution: The Committee RECOMMENDED:** **Director and Deputy Director of Finance look into what needs to be done to close down the Budgetary Control report** **Board Secretary liaise with the Internal Auditors regarding disposal of hard drives** **NHS staff appraisal process be reviewed by the HR & OD Committee and suggestions presented to the Committee** **The Committee NOTED the findings in the Corporate Record Keeping and Staff Appraisal reports and RECEIVED the Progress report.**	**GH/SB** **SAF/LP** **SAF**
A&A 58/13	**<u>Agenda item 8. Audit Action Log</u>** The Board Secretary advised the log has been compiled from information received during his time in post and will be circulated to Committee members after the meeting.	
A&A 59/13	**<u>Agenda item 9. Draft Annual Governance Statement (AGS)</u>** The Board Secretary presented the draft AGS and, advising the document has replaced the Internal Control Procedure, driven by the Foundation Trust application process. He welcomed the Committee's comments and will continue to work with the Auditors to develop the draft	

	AGS. **Resolution: The Committee RECEIVED the draft AGS and agreed it is the right direction of travel and RECOMMENDED:** • **the Committee work with the Internal Auditors to highlight issues and work through resolutions** • **the final draft be reviewed and approved by the Committee, before being presented to the Trust Board for sign off**	
A&A 60/13	**Agenda item 10. IT update** The Director of Finance understood what the Committee Chair was asking to see when he had requested a diagram of how the Trust's IT systems interfaced, in particular Systm1 (TPP), and will present one to the next meeting. The Head of IT Development & Operations will be invited to attend this meeting to provide background information to the diagram. **Resolution: The Committee NOTED the update.**	**GH**
A&A 61/13	**Agenda item 11. Property update** The Director of Finance reported the Property Strategy will be presented to Board in March 2014. The Trust's property portfolio is being managed by the Head of Estates (Security, Safety & Facilities) with the assistance of a project officer. However, the Trust recognises the shared Estates service, based at Gloucestershire Royal Hospital, cannot provide the level of support it requires and the facility should be brought in house. The Chair requested a summary of the property portfolio is made available to inform how GCS' resources are deployed. **Resolution: The Committee NOTED the Property update and the Committee Chair and Director of Finance will progress the property portfolio issue.**	**RG/GH**
A&A 62/13	**Agenda item 12. GCC – internal audit** The Director of Finance advised that the GCC internal audit report on the Spot Purchase of Domiciliary Care Provision had been forwarded to him by the Director of Adult Services (DAS). She deemed the Committee should have sight of the report as a number of GCC work for the Trust in the Reablement service. The Committee acknowledged the Reablement and Telecare Delivery Group (RTDG) referred to in the report is no longer active and its remit is now provided by the Integrated Community Teams (ICTs). The Chair thanked the DAS for bringing this report to the Committee's attention. **Resolution: The Committee RECOMMENDED the DAS liaise with GCC's Audit Committee to determine anything pertinent before**	**SAF/SF**

	preparing a draft response for the attention of the Integrated Governance and Quality Committee, and copying in this Committee.	
A&A 63/13	**Agenda item 13. GCS NHS Trust Opening Balance Confirmation** The Director of Finance reported information to inform the Trust's opening balance was not available at this time.	
A&A 64/13	**Agenda item 14. Review of Budget Holders' Cost Centres** The Committee **RECEIVED** the report presented by the Deputy Director of Finance. The focus of current staff is on devoting time and effort to monitoring the budget holders' cost centres. Current staffing level precludes the team from looking into the effectiveness and efficiency of budgets, benchmarking and extending productivity. The Director of Finance advised a suite of reports produced by the ESSBASE system from Datix information will shortly be available. **Resolution: The Committee REQUESTED enhancements to the report including the addition of trend data.**	**SB**
A&A 65/13	**Agenda item 15. Update of Debtors and Write Offs** The Financial Accountant presented the report and brought to the Committee's attention the four main NHS debtors with a combined overdue debt of £1.1m. A meeting between the CCG and its collaborative partners on 25 November had failed to resolve the delay of £715k CQUIN payments to the Trust. **Resolution: The Committee NOTED the update on debtors and write offs.**	
A&A 66/13	**Agenda item 16. Losses and Specialist Payments Register** The Committee **RECEIVED** the report, now a cumulative record, which was presented by the Director of Finance (DoF). Forms for all reported losses are submitted to the Financial Accountant, in the first instance, passed to the DoF for approval and declared at year end. **Resolution: The Committee NOTED the current position.**	
A&A 67/13	**Agenda item 17. Better Payment Practice Code(BPPC) Performance** The Committee **RECEIVED** the report and were appraised of the current situation by the Director of Finance. He advised the Trust's poor BPPC performance reflects lack of control with suppliers and is an ongoing issue the organisation is experiencing which has evolved since contracted to use SBS. The system is expensive and fundamentally flawed, however, the Trust is doing its best to work with it. The Deputy Director of Finance is drafting a paper for the Execs Team Meeting in January with regard to moving away from SBS, as soon as the Trust's contract with them allows. **Resolution: The Committee NOTED the update and the current**	

	position.	
A&A 68/13	**<u>Agenda item 18. Waiver of Standing Orders</u>** The Financial Accountant presented the waiver form log and asked the Committee to note the last four items, which were new. The Committee discussed the larger waivers and advised, under the Delegation of Authority, the Director of Finance had been given authority to sign off waivers up to £25k and the Chief Executive on items up to £50k. The Chair proposed the current process be reviewed to ensure the Audit & Assurance Committee has advance warning of waivers, rather than viewing them retrospectively, with those over £250k requiring approval from the Director of Finance. The majority of waivers relate to capital items and a meeting is held regularly to review them. **Resolution: The Committee APPROVED the waivers of standing orders but RECOMMENDED the process be reviewed as proposed.**	**SB/SAF**
A&A 69/13	**<u>Agenda item 19. SBS Performance</u>** The Committee considered this matter had been reviewed adequately under Agenda Item Agenda item 17 - Better Payment Practice Code (BPPC) Performance.	
A&A 70/13	**<u>Agenda item 20. Proposed new constitutional requirements for NHS Trusts and Clinical Commissioning Groups from the Department of Health</u>** A consultation paper and questionnaire on new constitutional requirements for NHS organisations has been received by the Director of Finance. The Board Secretary will complete the questionnaire on behalf of the Trust and the Committee was asked to review and consider the questions posed. The Committee considered question 5 (*Do you agree an audit committee should potentially be able to include independent members, who are not members of the governing board?).* **Resolution: The Committee RECOMMENDED the Board Secretary draft a response for the Chair to approve and note at question 5 the Trust's Audit Committee co-opts in particular non-voting expertise to attend meetings as required.**	**SAF**
A&A 71/13	**<u>Agenda item 21. Meeting dates to March 2015</u>** The Board Secretary presented the 2014-2015 meeting schedule for the Committee's consideration.	
A&A 72/13	**<u>Agenda item 22. Any other business</u>** There were no items for the Committee's attention.	

A&A 73/13	**<u>Agenda item 23. Matters for Board and other Committees</u>** • Chair of the Committee and Director of Finance to progress the property portfolio issues • Corporate Recording Keeping report and follow up report referred to Integrated Governance & Quality Committee for opinion • HR OD Committee review the NHS staff appraisal process and feedback to the Committee • Director of Adult Services to draft response to the GCC internal audit report for the attention of the Integrated Governance and Quality Committee, copying in this Committee	**RG/GH** **SAF** **SAF** **SAF**
	Date of next meeting: The next meeting will take place at 11.00am on Wednesday, 19 March 2014 in the Boardroom.	

Chair's signature ……..

Date ……..