Gloucestershire Care Services NHS
NHS Trust

Agenda

Agenda

Trust Board – Part 1
Tuesday, 19 May 2015
9.30am – 1.45pm

Guildhall, 23 Eastgate Street, Gloucester, GL1 1NS

Agenda No.	Item.	Outcome	Ref No.	Presenter	
1.	Patient Story - Gloucestershire Voices	For information	01/0515		09.30am
Standing Items					
2.	Welcome and Apologies	To receive	02/0515	Chair	10.30am
3.	Confirmation the meeting is quorate	To note	03/0515	Chair	
4.	Declaration of Interests	To receive	04/0515	Chair	
5.	Minutes of the Meeting held on 17 March 2015	To approve	05/0515	Chair	
6.	Matters Arising (Action Log)	To note	06/0515	Chair	
7.	Forward Agenda Planner review	To approve	07/0515	Chair	
8.	Questions from the Public	For discussion	08/0515	Chair	
9.	Chair's Report	To receive	09/0515	Chair	
10.	Chief Executive's Report	To receive	10/0515	Chief Executive	
11.	Chief Operating Officer's Report	To receive	11/0515	Chief Operating Officer	
Governance, Quality and Safety					
12.	Board Assurance Framework – Corporate Risks	To discuss	12/0515	Chief Executive Officer & Head of Corporate Planning	11.00am
13.	Quality and Performance Committee Update	To note	13/0515	Director of Nursing and Quality	11.15am
14.	Quality and Performance Report	To discuss	14/0515	Director of Nursing and Quality, Chief Operating Officer	11.25am
15.	Annual Mortality Report	To receive	15/0515	Medical Director	12.00pm
		Lunch			**12.15pm**
Strategic Items					
16.	Receipt of annual accounts	Verbal update see item 19	16/0515	Director of Finance	12.25pm
17..	Complaints Policy	To discuss and approve	17/0515	Director of Nursing and Quality,	12.35pm
18.	Duty of Candour Policy and Implementation Plan (Presentation by Clinical and Quality Team)	To discuss and approve	18/0515	Director of Nursing and Quality	12.45pm
Corporate					

19..	Finance Report	To discuss and approve	19/0515	Director of Finance	1.05pm
Items for Information Only					
20.	Workforce & OD Committee update – minutes 13 April 2015	To note	20/0515	Chair of HR&OD	1.20pm
21.	CQC Inspection Programme Board Update – minutes from 2nd and 30th April 2015	To note	21/0515	Director of Nursing and Quality	1.25pm
22..	Annual Governance Statement	To note	22/0515	Chief Executive	1.35pm
23.	Any other Business	To note	23/0515	Chair	
24.	Date of Next Public Meeting Tuesday, 21 July 2015 Cirencester Football Club				

GLOUCESTERSHIRE CARE SERVICES
NHS TRUST BOARD

Minutes of the Meeting held on Tuesday, 17th March 2015 at The Pavilion, Hatherley Lane, Cheltenham, Gloucestershire, GL51 6PN

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

Ref	Minute	Action
TB 027/15	**Patient Story presentation – Healthwatch** The Chair explained that the use of patient stories at Board and Committee level is increasingly seen as a positive way of reducing the "ward to Board" gap, by regularly connecting the organisation's core business with its most senior leaders. The Chair introduced Claire Feehily (CF) and Barbara Piranty (BP) from HealthWatch. CF and BP were invited to share their presentation, which outlined the role of HealthWatch within Gloucestershire. CF and BP also fed back findings and feedback from service users related to our Trust and had some helpful comments on the approach to complaints. The Chair conveyed her thanks to HealthWatch and **Noted** the presentation.	

TB 028/15	**Agenda Item 2: Welcome and apologies** The Chair welcomed the Board and members of the public to the meeting. There were no apologies.	
TB 029/15	**Agenda Item 3: Declarations of Interest** Members were asked to declare any updates from their original declaration of interests and to declare interests at the time of any concerned agenda item. The Chair declared that she has been appointed as a Governor at Hartpury College. No other interests were declared.	
TB 030/15	**Agenda Item 4: Minutes of the Meeting held 25 November 2014** The minutes of the Board meeting held on 20th January 2015 were **Received** and **Approved** as an accurate record, subject to some minor amendments.	
TB 031/15	**Agenda item 5: Matters Arising (Action Log)** The following matters were **Discussed** and **Noted**: TB110/14 – CIP Report to be received at the May Board. CLOSED TB110/14 – Approval of budgets – to be taken to Part 2 Private Board meeting. CLOSED TB006/15 – Medical Revalidation Report. CLOSED TB006/15 – BAF to be discussed at Part 2 Private Board meeting. CLOSED TB011/15 – Board to receive regular ALAMAC updates within the COO report. CLOSED	
TB 032/15	**Agenda item 6 – Forward Agenda Planner review** The Forward Planner was discussed and approved with minor changes as listed below: (1) Learning Disability Report to come to the July Board (2) Complaints Policy to come to the May Board (3) Annual Governance Statement to come to the May	**EF** **EF** **JB**

	Board (4) Report of Quality Strategy Metrics to come to July Board (5) CQC report once published to come to Board (6) The strategies to be added to the Forward Planner and mapped to the Terms of Reference	**JB** **JB** **JB**
TB 033/15	**Agenda Item 7: Questions from the public** There were no public questions submitted prior to the Board meeting. Bren McInerney (BM) (public representative) did not have a question but wanted to share his assessment of the Trust's Engagement Framework. The Chair acknowledged the comments and thanked BM for his time.	
TB 034/15	**Agenda item 8: Chair's Report** The Chair presented her report and brought to the attention of the Board the following: <u>Tewkesbury Community Hospital Opening</u> The Trust held a successful and enjoyable opening ceremony and welcomed Her Royal Highness, The Princess Royal to Tewkesbury Community Hospital on Wednesday 28 January 2015. The Chair thanked colleagues and guests who organised and attended the event. <u>Working with our Partners</u> The Chair attended a scheduled quarterly meeting with Claire Feehily, Chair of HealthWatch Gloucestershire on Tuesday 10 March 2015. The Chair and CEO continue to meet with Leaders and Chief Executives of the District and Borough Councils, and have made visits to Gloucester, Forest, Tewkesbury, Cheltenham and Stroud. <u>NED Recruitment</u> The Trust is currently recruiting two Non-Executive Director roles. One will have a clinical background and the other a HR/legal/business development background. The Trust plans to make the appointments by the end of April 2015. The Board **Received** the Chair's Report.	

TB 035/15	**Agenda item 9: Chief Executive's Report** The CEO presented his report which outlined key national, local and Trust issues and developments. In particular, he commented on: <u>"Understanding You" events</u> A total of 50 "Understanding You" events are taking place held at a variety of locations across the Trust. These events are part of a strategy for increasing communication with colleagues. The CEO agreed to keep the Board informed of developments following the events. <u>Freedom to Speak Up</u> Results from the recently published 2014 NHS Staff Survey reported that 64% of Trust colleagues agreed that they would feel secure raising concerns about unsafe clinical practice, compared to the average score of 72% for community trusts. The CEO reported that he will be addressing this concern through future "Understanding You" and Listening into Action events, and will keep the Board informed of any developments. <u>Leadership Meeting on WebEx</u> In February the Trust's Leadership Meeting was held on the online WebEx platform which has proved successful. The Trust will be further exploring this format of engagement for future meetings. <u>Pharmacy Contract</u> The CEO announced that Lloyds Pharmacy has won the recently tendered pharmacy contract for Community Hospitals. The Board **Received** the report.	**PJ** **PJ**
TB 036/15	**Agenda item 10: Chief Operating Officer's report** The COO presented his report which outlined key local and Trust issues and developments. In particular, he commented on: <u>Winter Pressures</u> The COO extended his congratulations to all appropriate teams and particularly to Susan Field, Director of Service Transformation for managing the winter pressures. DJ asked that a meeting be arranged so that lessons learned could be used to build a plan for dealing with these pressures during winter 2015. IB requested that winter planning should be	**DJ** **JB**

	discussed at a Board Development session later in the year. <u>Recruitment and Retention</u> Nurse recruitment continues to be a key priority for the Trust. Whilst some progress has been made in attracting new colleagues, significant challenges remain, in particular in recruiting Band 6 Nurses for Community Nursing and Band 5 Staff Nurses for Community Hospital inpatient units. No items of further assurance were requested. The Board **Received** the report.	
TB 037/15	**Agenda item 11: Quality & Clinical Governance Committee update** The Chair of the Quality and Clinical Governance Committee (SM) presented the following points in the report: The Quality and Performance Report was presented to the Committee and each of the aspects of safe, caring, effective, responsive and well-led were debated in some depth. Reports were received in respect of: • Unscheduled Care Governance Report • Preparedness for the Chief Inspector of Hospitals Visit • Service User Experience Report • Community Hospital Dependency Review • DN Services Report • Revised Governance Framework for Social Care • Infection Control Annual Report • Equality Annual Report • CQC Review of Children in Care Additionally, the Committee Chair stated that further work to update the Trust's Complaints Policy had been completed and the Board will be asked to ratify the policy in May 2015. No items of further assurance were requested. The Board **Noted** the update and acknowledged the points raised by the Committee.	

TB 038/15	**Agenda item 12: Quality and Performance Report** The report was presented to ensure the Board remained up-to-date with the Trust's performance in light of national requirements and local developments. The Director of Quality and Nursing outlined the following: <u>Safe</u> • The Trust reported 22 SIRIs year-to-date of which 41% related to falls. • Performance against the 95% threshold for harm-free care was 94.6% in January 2015. <u>Caring</u> • The Friends and Family Test reporting had been expanded in January 2015 to cover all services. Response rates are low for the services that began collecting data in January, but show increases into February as the process becomes embedded. • It was noted that there was an issue in respect of the quality of food at the North Cotswold Community Hospital. EF advised the Board that an action plan had been put in place to address the issue and improvements will be reported to the next Board meeting. <u>Effective</u> • It was noted that the Staff Flu Vaccination Programme resulted in 42.5% of staff vaccinated, an increase from 38.6% in 2013/14. • A survey to colleagues in January 2015 to capture information on those who received a vaccination by a route other than Working Well or a peer vaccinator was completed by 474 colleagues. <u>Responsive</u> • It was reported that there was some improvement against local and national targets, but this continues to be monitored. There was concern that the Trust's results for Adult Social Care Key Indicators were consistently poor. The Director of Service Delivery advised that a percentage of the poor performance figures were as a result of technical issues encountered by colleagues with the system.	**EF**

	Well-Led • The Trust reported that it is currently performing well against its data quality targets. • The Staff Friends and Family Test are positive in terms of colleagues recommending the Trust as a place for treatment. • Sickness absence levels, mandatory training rates and appraisals continue to under-perform. • The programme of patient experience visits and peer reviews has been revised in preparation for the Chief Inspector of Hospitals visits. The Board **Discussed** and **Noted** the report.	
TB 039/15	**Agenda item 13: Medical Revalidation Report** The Medical Revalidation Report was presented to the Board by the Interim Medical Director. The Board **Received** the report.	
TB 040/15	**Agenda item 14: Performance & Resources Committee update** Following the recent meeting, the Chair of the Performance and Resources Committee highlighted the following points: • Work had been progressed in respect of the Trust's Cost Improvement Programme for 2015/16. • Minutes of the meeting held on 16 December 2014 were attached to the report for information. No items of further assurance were requested. The Board **Noted** the update and acknowledged the points raised by the Committee.	
TB 041/15	**Agenda item 15: Finance Report** The Director of Finance presented the Finance Report and advised the Board on the year to date actual and forecast full year out-turn position for the Trust at month 10, and also provided and update regarding financial risks and priorities.	

	The following items were brought to the Board's attention: • The Trust has planned a full year surplus of £1.5m • Capital is now forecast to be £1.8m lower than planned due to delays in two projects, namely, Community of Interest Network Replacement and Gloucester City Premises Consolidation. • QiPP is expected to deliver £1m less than budget. • CQUIN is expected to deliver in full. • CIP schemes are now forecast to deliver £2.5m in year and £3.4m recurrently. Work is ongoing to mitigate the shortfall in CIP and to ensure that the plan surplus is delivered. The Board **Discussed** and **Approved** the report.	
TB 042/15	**Agenda item 16: Human Resources and Organisational Development Committee update** Following the recent meeting, the Director of Human Resources presented an update report on the meeting held on the 16th February 2015 and the approved minutes of the meeting held on 19th December 2014. Additionally, the Director of Human Resources stated that the recent staff survey had highlighted some areas of concern in respect of peer group support. Further investigation will be conducted and the Committee and Board will be kept informed. No items of further assurance were requested. The Board **Noted** the update and acknowledged the points raised by the Committee.	**TR**
TB 043/15	**Agenda item 17: Any other Business** No other business was requested for discussion. The Chair thanked everyone for attending the meeting. The meeting was closed by the Chair.	

	Agenda Item 26: Date of Next Public Meeting It was **Agreed** that the next meeting of the Board be held on Tuesday, 19th May 2015, at 9:30am at The Guildhall, 23 Eastgate Street, Gloucester, GL1 1NS.	

Chair's Signature ……..

Date ……

Gloucestershire Care Services NHS Trust Board Action Log

Minute Reference	Action Agreed	Lead Exec	Update for May 2015	Proposed Close Date	Status
Gloucestershire Care Services NHS Trust Board Action Log					
TB110/14	CIP Report to come to March meeting	Chief Operating Officer	Contained within COO report	Mar-15	Closed
	Complaint policy to be ratifired	Director of Nursing & Quality	On Agenda May 2015	May-15	Open
	Approval of budgets	Director of Finance	Defferd to May part 2 agenda	May-15	Open
	Rapid-response roll-out report	Director of Service Transformation	On agenda May 2015 - Included in COO repo	May-15	Open
	SystmOne update report	Director of Finance	On agenda May 2015- Included in COO repo	May-15	Open
	receipt of Annual accounts	Director of Finance	On agenda - May 2015 Board	May-15	Open
TB006/15	Medical Revalidation Report	Medical Director		Mar-15	Closed
	Annual Mortality Report	Medical Director	On Agenda - May 2015 Board	May-15	Open
	Membership Strategy	Director of Corporate Governance and Public Affairs		Jan-16	Open
	Corporate Risk Register	Director of Corporate Governance and Public Affairs			Closed
	IBP and Long Term Financial model	Director of Finance		Jul-15	Open
	Board to receive regular ALAMAC updates within the COO report	Chief Operating Officer	Contained within COO report	Mar-15	Closed
	Recent guidelines provided tools to calculate the "contact time" spent with patients and provides an opportunity to move away from a pure focus on numbers. EF/SF to discuss	Director of Nursing & Quality/Director of Service Transformation		Mar-15	Closed
	IB asked for length of stay information to be added to future Safer Staffing reports	Director of Nursing & Quality/Deputy Director of Nursing		Mar-15	Closed

Board Part 1 2014/15						
Month	**19 May 2015**	**21 July 2015**	**22 September 2015**	**24 November 2015**	**26 January 2016**	**22 March 2016**
Venue:	Guildhall	Cirencester FC	Chequers - Not Stroud	TEWKESBURY TOWN HALL?	EJC	Churchdown NOT Stroud Hospital
Standard Items						
	Welcome and apologies	Welcome and apologies	Welcome and apologies	Welcome and apologies	Welcome and apologies	Welcome and apologies
	Patient Story - Gloucestershire Voices	Patient Story - Gloucestershire Deaf Association	Carers Gloucestershire and Prestbury Carers' Group	Patient Story - GlosCats - Transgender Community	Patient Story - TBC	Patient Story - TBC
	Confirmation that the meeting is quorate	Confirmation that the meeting is quorate	Confirmation that the meeting is quorate	Confirmation that the meeting is quorate	Confirmation that the meeting is quorate	Confirmation that the meeting is quorate
	Declaration of interests	Declaration of interests	Declaration of interests	Declaration of interests	Declaration of interests	Declaration of interests
	Minutes of previous meeting	Minutes of previous meeting	Minutes of previous meeting	Minutes of previous meeting	Minutes of previous meeting	Minutes of previous meeting
	Matters arising action log	Matters arising action log	Matters arising action log	Matters arising action log	Matters arising action log	Matters arising action log
	Forward planner	Forward planner	Forward planner	Forward planner	Forward planner	Forward planner
	Questions from the public	Questions from the public	Questions from the public	Questions from the public	Questions from the public	Questions from the public
	Chair's Report	Chair's Report	Chair's Report	Chair's Report	Chair's Report	Chair's Report
	Chief Executive's Report (to include FT Programme Board update)	Chief Executive's Report (to include Understanding You Events update)	Chief Executive's Report (to include FT Programme Board update)	Chief Executive's Report	Chief Executive's Report (to include FT Programme Board update)	Chief Executive's Report
	Chief Operating Officer's Report	Chief Operating Officer's Report	Chief Operating Officer's Report	Chief Operating Officer's Report	Chief Operating Officer's Report	Chief Operating Officer's Report
Governance, Quality & Safety						
	Board Assurance Framework - Corporate Risks JBr	Board Assurance Framework - Corporate Risks JBr	Board Assurance Framework - Corporate Risks JBr	Board Assurance Framework - Corporate Risks JBr	Board Assurance Framework - Corporate Risks JBr	Board Assurance Framework - Corporate Risks JBr
	Quality and Performance Report - EF	Quality, Finance and Performance Report - EF	Quality, Finance and Performance Report - EF	Quality, Finance and Performance Report - EF	Quality, Finance and Performance Report - EF	Quality, Finance and Performance Report - EF
	Quality and Performance Committee Update (???? Minutes and update from 8 May Meeting)	Quality and Performance Committee Update (8 May Minutes and update from 18 June Meeting)	Quality and Performance Committee Update (18 June Minutes and update from ?? August Meeting)	Quality and Performance Committee Update (?? August Minutes and update from 22 October Meeting)	Quality and Performance Committee Update (22 October Minutes and update from 17 December Meeting)	Quality and Performance Committee Update (17 December Minutes and update from 25 February Meeting)
	Workforce and OD Committee Update (??? Minutes and update from 13 April Meeting)	Finance Committee Update (24 April Minutes and update from 13 July Meeting)	Finance Committee Update (13 July Minutes and update from 2 Sept Meeting)	Finance Committee Update (2 Sept Minutes and update from 3 Nov Meeting)	Finance Committee Update (3 Nov Minutes and update from 11 January Meeting)	Finance Committee Update (11 January Minutes and update from 7 March Meeting)
	Annual Mortality Reporting - JB	Learning Disability Steering Group Report - EF				
	ICT Steering Group report.	Workforce and OD Committee Update (13 April Minutes and update from 1 June	Workforce and OD Committee Update (1 June Minutes and update from 10 August	Workforce and OD Committee Update (10 August Minutes and update from 19 October	Workforce and OD Committee Update (19 October Minutes and update from 14	Workforce and OD Committee Update (14 December Minutes and update from
	Social Care Governance Framework - SF					
Strategy						
	Quality Strategy Metrics Report - RB			Information Governance Strategy (sign-off) (JBr)		Membership Strategy (sign-off) (JBr)
Corporate						
	Finance Report (GH)	Finance Report (GH)	Finance Report (GH)	Finance Report (GH)	Finance Report (GH)	Finance Report (GH)
	Finance Committee Update (??? Minutes and update from 24 April Meeting)					
	Audit and Assurance Committee Update (??? Minutes and update from 13 May Meeting)					
	Receipt of annual accounts (GH)	SystmOne update report (GH)				
	CQC Inspection Programme Board Update and Minutes (2 and 30 April)					
Information						
	Charitable Funds Committee Update (??? Minutes and update from 24 April Meeting)	Charitable Funds Committee Update (24 April Minutes and update from 14 July Meeting)		Charitable Funds Committee Update (14 July Minutes and update from 11 November Meeting)		Charitable Funds Committee Update (11 November Minutes and update from 17 February Meeting)
	Annual Governance Statement	Audit and Assurance Committee Update (13 May Minutes)		Audit and Assurance Committee Update (23 Sept Minutes and update from 18 November	Audit and Assurance Committee Update (18 November Minutes)	Register of Declaration
	Complaints Policy - EF	Register of Seals			Register & Commercial Sponorship	Register of Seals
	Any other business	Any other business	Any other business	Any other business	Any other business	Any other business
	Date of next meeting	Date of next meeting	Date of next meeting	Date of next meeting	Date of next meeting	Date of next meeting

Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: 19 May 2015
Location: Guildhall, Gloucester

Agenda item 9: Chair's report

Board Developments

It gives me great pleasure to announce that we have appointed two new Designate Non-Executive Directors (NEDs) to the board. Jan Marriott and Ian Dreelan are joining us with Jan's full appointment as a NED to be considered this month by the Trust Development Authority's Appointments Committee. Jan is the Independent Chair of the Gloucestershire Mental Health and Wellbeing Partnership Board, Independent Co-Chair of Gloucestershire Learning Disability Partnership Board and Vice Chair of the Community Hospitals Association and has had significant senior nursing and other healthcare experience. Having had a sixteen year career in the Army where he held the rank of Lieutenant Colonel, Ian is a Human Rights Advisor for a global charity, a member of the Independent Agriculture Appeals Panel and Assistant Coroner for Birmingham and Solihull. I would like to welcome them both and am sure that their expertise can help guide the board as we continue to seek improvements to our services over the coming year.

In the light of these new appointments, as well as our revised standing orders, I have reviewed the NED portfolios and responsibilities and these are shown in the attached chart. You will see that I have nominated Rob Graves as Vice Chair and Sue Mead to continue for a further term in her role as Senior Independent Director. I would invite the Board to ratify these nominations. I would like to thank Joanna Scott her valuable support in the role of Vice Chair over the last two years.

I can also announce that I have been reappointed as chair of the trust by the TDA to serve a further term.

The board held a regular strategy session on Tuesday, April 14, where HR Director Tina Ricketts and Head of Communications Mark Lambert gave a presentation on the NHS 'Draw the Line' guidance on raising concerns at work. In addition, Rosalind Ashcroft from legal firm DAC Beachcroft LLP gave an overview on the Care Act.

Following a competitive process culminating in interviews of shortlisted candidates, we have appointed Sheila Damon to undertake a programme of board development work with us. Sheila is a very well respected facilitator with a formidable pedigree. She is due to start in July and her work with us is likely to extend over several months.

Working with our partners

Together with our Chief Operating Officer, I attended the Health and Care Overview and Scrutiny Committee meeting on Tuesday, May 12. The agenda included items on re-commissioning of domiciliary care and drug and alcohol services, as well as a presentation on commissioning of primary care.

I would like to thank Rob Graves for representing me whilst I was on holiday at Gloucestershire Strategic Forum and at NHS Providers' National meeting of chairs and CEOs.

On Wednesday May 6 I attended the Board of Trustees meeting of NHS Providers. Taking place as it did on the day before the election, the meeting concentrated on how NHSP intends to position itself to build relationships with and influence the new government, in order to make the provider voice understood.

I visited Claire Mould, the CEO of Open House, a third sector organisation in Stroud which works with vulnerable and homeless young people. I saw some of their very impressive services and hope we can develop a greater partnership in the future. She is also chair of the VCS Alliance, the major grouping of voluntary organisations active in the County. We have now made clear links with VSCA through our engagement team.

Together with our CEO, I visited Peter Steele, CEO of the Independence Trust. We learned about the breadth of services provided by them and discussed a number of areas where we might develop closer partnership in the future.

I met informally with the other NHS Chairs to discuss matters of common interest. Our previous proposal for three facilitated 'Five Year View' sessions is now coming to fruition, with Jon Hale appointed as facilitator and dates now set for late Summer. All local Trusts will be invited to send four board members (including Chair and the CEO). Gloucestershire County Council has also been invited to participate.

Chief Executive Paul Jennings and I met with Jane Barrie, chair, and Derek Sprague, director, from Health Education South West. HEE in the South West has a £330m budget with which it trains and develops NHS staff. They are visiting a wide number of NHS Trusts in the region to gain an understanding of our priorities in this areas.

Engaging with our colleagues

I have been pleased, along with other Non-Executive Directors (NEDs), to meet a number of our colleagues through the 'Understanding You' events, of which more than 50 were held across the county. I personally led sessions at Tewkesbury hospital, Tewkesbury Council, Gloucestershire Royal Hospital, Sandford House, in Cheltenham, and Stonehouse Clinic. I have been impressed with the high level of

engagement and openness shown by our colleagues, with up to 45 people being present at some of these sessions.

The NEDs and I have been part of the teams undertaking unannounced quality visits across the Trust. I have undertaken visits to Lydney and Cirencester hospitals. This series of 18 visits has been led by a core clinical team, and supported by Executive colleagues, Healthwatch, commissioners and PWC. I would particularly like to thank our external partners for their generosity in giving us their time to ensure an independent view. Our announced NED quality visits are also continuing and can be seen in the quality and performance report.

Listening to Patients' Stories at Board Meetings

Colleagues at 2gether NHS Foundation Trust have prepared a guide to ensure that service user stories presented to their board are managed well, to ensure users feel safe and listened to and to gain maximum learning for the organisation. The Chair of 2gether has very kindly allowed us to make use of this guide which is attached to this report for information. As we are commencing a series of stories to our board presented directly by people who use our services, this guide will be particularly useful for us. I believe that hearing directly from patients, service users and carers will act as a powerful reminder of the impact our work can have and provide additional impetus to our efforts to provide the very best services possible to those we serve.

APPENDIX 1

Non-Executive Director (NED) Proposed Portfolios

NED	LOCALITY / SERVICES CHAMPION	BOARD / COMMITTEE LEAD	FORUM LEAD	COMMITTEE / FORUM MEMBERSHIP	CHAMPION / OTHER LEAD
Ingrid Barker (Chair)		Board Board Development Board Retreat Board Strategic Sessions Remuneration Committee FT Programme Board Your Care Your Opinion		* *The Chair is not a regular member of Committees, but reserves the right to attend. The Chair does not attend Audit Committee.* Finance Committee Charitable Funds Quality and Performance Workforce and OD	NHS constitution champion
Robert Graves (Vice-Chair)	Cotswold	Finance Committee		Board Remuneration Committee Audit and Assurance Charitable Funds FT Programme Board	Health and Safety Whistleblowing Procurement Technology
Richard Cryer	Forest Tewkesbury	Audit and Assurance	Learning Disabilities Partnership Board	Board Remuneration Committee Finance Committee Workforce and OD	Learning Disabilities
Ian Dreelan (designate)	Cheltenham			Board Remuneration Committee Audit and Assurance Finance Committee Quality and Performance	Complaints/litigation
Jan Marriott (designate)	Gloucester			Board Remuneration Committee Audit and Assurance Quality and Performance Workforce and OD	Duty of Candour
Sue Mead (Senior Independent Director)	Children's Services	Quality and Assurance		Board Remuneration Committee Audit and Assurance Finance Committee	Equality and Diversity Children's Champion
Joanna Scott	Stroud		Communications and Engagement Steering Group	Board Remuneration Committee Audit and Assurance Charitable Funds Workforce and OD Your Care Your Opinion	Dementia NED quality visits
Nicola Strother Smith	County-wide Services	Workforce and OD Charitable Funds		Board Remuneration Committee Audit and Assurance Quality and Performance	Caldicott Emergency planning / urgent care

Appendix 2
GCS Trust Board
19th May 2015

2gether
Making life better

2gether
NHS Foundation Trust

Listening to Patients' Stories at the Trust Board Meeting

Standards for a best practice process

Issue date: January 2015

Section 1 Background

1.1 The Department of Health have reinforced that listening to the views of people who use services is essential. Valuable lessons and service improvements can be gained from taking positive steps to respond to feedback thus ensuring that the quality of service provision continues to improve. No Health without Mental Health Strategic Vision and Implementation Plan[1] supports this view.

1.2 Understanding the experiences of people who use services is of critical importance and new ways of understanding are being established. For example, a new, web-based project has been launched to collect and share the experiences of people who experience mental health difficulties. More information is available from 'A Day in the Life' https://dyianthelifemh.org.uk/.

1.3 Listening to and responding appropriately to comments, concerns and complaints and being proactive about the development of inclusive, quality services is of great significance and importance to [2]gether. In recent years [2]gether's Service User Charter and Carers Charter have been developed collaboratively as key documents to deliver upon our values. This work is underpinned by the NHS Constitution and more locally through [2]gether's Service Experience Strategy (2013)[2].

1.4 The Trust has a rigorous approach to listening to feedback from patients and carers from many sources. These are analysed through a triangulation process and presented for scrutiny through the Trust's formal governance processes on a quarterly basis.

1.5 In May 2013 the Trust Board took the decision to introduce patient stories at the start of each Trust Board as an additional way of hearing directly from patients and their carers and to act as a platform on which to base subsequent discussion about Trust business during the meeting.

1.6 Narratives have been heard from individuals from many aspects of the Trust's services. Sources for identifying people who are willing to share their stories include: clinical services; serious incident reviews, complaints and concerns, incident forms or via experts by experience roles.

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[1] Closing the gap: Priorities for essential change in mental health (2014) www.gov.uk/dh

[2] http://www.2gether.nhs.uk/files/Service%20Expereince%20Strategy%20%202013.pdf

Section 2 Purpose of Patient Stories at Board Meetings

Inviting a patient story at each Board meeting is regarded as best practice[3] because it:

- Serves as a powerful reminder to organisational leaders of the impact on the lives of service users and their families of shortfalls in clinical quality, patient safety and patient experience.

- Enables stories of recovering and hope to be shared in a public setting. This is important to tackle stigma, is a powerful way of developing a culture of hope and of challenging myths about mental illness.

- Offers the opportunity for Board members to connect at an emotional level with service users and/or their relatives and to understand the whole patient journey.

- Connects leaders with front line staff and gives opportunity to consider the impact of organisational design or Trust activity on those involved in receiving care.

- Improves understanding of the impact of successful/unsuccessful care on the wider emotional, social, occupational, economic and safety aspects experienced by individual service users.

- Gives insight into the working of whole health and social care systems in relation to patient and family care.

- Helps build a culture of understanding and empathy.

- Develops additional understanding about how the Trust can improve on different aspects of care and service delivery.

- Publicly demonstrates that [2]gether is open and transparent in public meetings, and illustrates that the Board want to hear about and learn from the real experiences of people using services.

Section 3 Focus and process of selection of patient stories

3.1 A systematic approach to the identification, delivery and follow up of patient stories should be followed (Appendix 1).

3.2 Patients' stories should be selected to facilitate the learning of the Board and underpin its input into the Aggregated Learning and Continuous Quality Improvement process. As far as possible, stories should be selected that

[3] www.patientsafetyfirst.nhs.uk

reflect the main aims of the Trust's Quality Strategy: Personalised Care; Safe Care; Effective Care.

3.3 Written, informed consent must be sought for the story to be shared at the Public Board (Appendix 2)

3.4 A checklist is available for Board members to use during the presentation, to facilitate reflection about the Patient Story being heard (Appendix 3) and to document proposals for follow up action (Appendix 4).

Appendix 1

Process for arranging Patient Stories at the Board

Step	Task	Responsibility	Approx. Timescale
1	Establish subject areas to be considered over a 6 month period	Executive Team	Half yearly
2	Review sources of Patient Stories (e.g. PALS, Complaints, Experts by Expereince, Locality Directors etc.)	Director for E&I	8 weeks before
3	Ensure that informed confirm that consent is in place	Director for E&I	7 weeks before
4	Discuss process with patient/carer, including whether to present the story in person or to have someone narrate it	Director for E&I	5 weeks before
5	Arrange for the agenda item to be at the start of the Trust board meeting (wherever possible)	Director for E&I	4 weeks before
5	Provide a briefing note to the Board covering the issues of concern.	Director for E&I	2 weeks before
6	Make arrangements for the service user or carer to attend Board meeting including transport, expenses, support during the presentation and support after the presentation	Director for E&I and Board Secretary	2 weeks before
7	Presentation of story at Public Board (30 minutes on agenda)	Director for E&I	Board Meeting
8	During the Public Board meeting, agree any required actions, action holders and timescales.	Director for E&I	Board Meeting
9	Provide the Chair with information to enable a note of thanks to be provided by the Trust Chair.	Director for E&I	Immediately after the Board meeting.
9	Facilitate a debrief conversation during the Closed Board session and agree any further actions.	Director for E&I	Board Meeting
10	Facilitate debrief from participant and provide feedback to service user/family confirming any actions agreed at the Board meeting	Director for E&I	2 days after Board meeting
11	Follow up after one month to ensure that service user/carer is satisfied with the outcome and that the expereince has not caused harm to the individual.	Director for E&I	1 month after Board meeting

Appendix 2

PATIENT STORY CONSENT FORM

I …… (full name) give permission for the details of my experience to be shared as a patient story with [2]gether Trust staff for the purposes of learning and raising awareness.

I understand my experience may be used in one or all of the following forums and wish my experience to be/not to be* anonymised (*delete as appropriate).

External Meetings
Public Board of Directors' Meeting

Internal Meetings
Ward/Departmental Meeting
Other – please specify
……

I wish to personally read out my experience	Yes/No
I wish to record my experience	Yes/No
I would prefer a member of staff to record my experience	Yes/No
I wish to be made aware of when my experience will be used	Yes/No
I wish to be invited to the meeting where my experience will be presented	Yes/No

Please be advised that the Press may be in attendance at our Public Board of Directors' Meetings and are entitled to report on the contents of the meeting, which may include a reference to your experience.

I understand that the details of my experience will be shared in the strictest of confidence adhering to the Trust's Confidentiality Policy.

…… ……
(*Signed*) **(*Print Name*)**

…… ……
(*Date*) **(*Contact Telephone Number*)**

For Office Use Only:

Patient/Relative informed of date: ……
Confirm invited to attend: Y/N Date invite sent: ……..
Used at which meeting(s): Trust Board Meeting / Ward/Departmental Meeting /
Other – please specify: ……..

Appendix 3

Listening to Patient Story Checklist for Board Members

Preparation	Prompts	Comments
What does this story add to our understanding of the quality of our services?	• How does this story relate to the information contained in our quality or performance reports? • What does this story tell us about progress towards our quality improvement goals? • What additional information does the Board require to help it make sense to the story/put it in context?	
What does this story reveal about our staff?	• What does it suggest about morale and organisational culture? • What does it reveal about the context in which clinicians work? • What does it reveal about staff attitutes to harm / recovery?	
What actions need to be taken as a result of what we have heard?	• What needs to be done immediately to make things right for the patient and prevent a recurrence for other patients? • What implications does it have for the Trust's Clinical Service Strategy or Quality Strategy?	
How did we do in hearing this story?	• Did we give enough time to this term? • Were we sufficiently prepared? • What could we have done differently?	
Does this story raise any learning needs for Trust Board?	• What additional support do Board members need in hearing patient stories? • Do Board members wish to find out more about the processes for examining failures (e.g. significant event analysis, root cause analysis)? • Has the story evoked anxieties that members wish to talk through outside of the meeting?	

Appendix 4

Patient Story Template for Board member's commentry

Date:
Narrative:
Any immediate actions to be taken: (anything that is a risk to the service user's safety and comfort)

Received by email: 12 May 2015

Dear all,

Secretary of State for Health Jeremy Hunt MP has written a message to all staff, saying “I am humbled to be re-appointed Health Secretary, not least because of the enormous responsibility for hundreds of thousands of doctors, nurses and other NHS staff who are working incredibly hard right now and under enormous pressure”.

Click here to read the full message about the priorities for health and social care.
Link-
https://www.gov.uk/government/news/health-secretary-jeremy-hunt-on-his-reappointment

We would be grateful if you could disseminate this as widely as possible among staff and feel free to share a link on websites, social media and other channels you use.

External Communications
NHS England

Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: 19 May 2015
Location: Guildhall, 23 Eastgate Street, Gloucester, GL1 1NS

Agenda item 10: Chief Executive's Report

As a relatively young organisation, we are still in the early stages of embedding our vision, values and corporate culture into the Trust so that they inform every one of us in our work.

I am leading a number of inter-related projects aimed at developing that corporate culture, to empower colleagues across the Trust to make positive changes which improve the care we offer to the people of Gloucestershire.

Through March and April Executive Directors and the Chair presented more than 50 'Understanding You' engagement events at sites across the county, which allowed colleagues to examine and discuss their concerns, needs and ideas for improvements to our organisation.

Key themes to emerge from those events were:

- **Integration**: A feeling that health services are not joined up nor linked with social care as well as they could be
- **Technology**: lack of proper equipment, or it not working, issues with mobile working, or systems not being used to their full potential
- **SystmOne**: Uncertainty over how it will interface with other clinical systems, how it will link to social care, and the deployment of this in the community hospitals
- **Communication**: A feeling of over-reliance on email and insufficient face-to-face contact leading to poor communication within teams. Poor visibility of senior management
- **Culture**: A combination of the above factors leading to feelings of disempowerment, reduced morale and engagement

We will be taking these themes into the six Big Conversation events, being held as part of the second year of the Listening into Action programme. Four of these have already taken place with the final two due on Wednesday, May 20 at Forest of Dean Golf Club and Friday, May 29 at Dowty's Sports and Social Club in Gloucester.

Listening into Action

As mentioned in the last board report, the Listening into Action (LiA) programme is now being led by Sonia Pearcey, Lead Nurse for Sexual Health who has been seconded into the role for 12 months.

The first year saw us introduce the methodology of Listening into Action into the Trust. This year is needs to be embedded as a culture within the organisation so that colleagues across the Trust become the drivers of change and improvement.

As mentioned in the previous section, the last of our six 'Big Conversation' events will be on Friday, May 29. Four days later, on June 2, we will be holding our Leadership Conference where colleagues who have completed a service improvement project through Listening into Action, Leading for Quality Care or an NHS Leadership programme such as the Mary Seacole programme will come together to showcase their change programmes to encourage others to take on the programmes or develop one of their own.

This event is designed to take the ethos of the LiA 'Pass it On' event, held last November, and broaden it so that colleagues have the benefit to learn from, and be inspired by, all the learning happening across the Trust. We also have a number of guest speakers coming to the day, and I hope everyone will leave with new ideas and motivation for improving their individual service areas.

Medical Director update

Medical Director Dr Jo Bayley is set to leave the Trust at the end of May and I would like to place on record my thanks for her contribution to the board since joining us in April 2012.

The recruitment process for a new Medical Director is underway and I am looking forward to interviewing some outstanding candidates in the coming weeks.

Dr Mike Roberts, currently Medical Lead helping the Trust prepare for CQC inspections, will remain in that role until June and will then act as Interim Medical Director until a replacement has been appointed.

Preparations for our Care Quality Commission (CQC) inspection

At the beginning of May our Corporate Planning team sent out a 'Don't Panic!' message across the Trust and this is something I want to wholeheartedly endorse.

Naturally, we are eager to receive positive feedback from the CQC for the care we provide across all our services and it is understandable that there will be some anxiety as the inspections, starting on Monday, June 22, draw closer.

One of my roles is to maintain an overview and a sense of perspective as we head into this process. I believe we have great colleagues providing excellent care across a large geographical area. We are also a young, developing organisation and we are still building processes and relationships between our teams, and with our many stakeholders, at a time of substantial transformation within the NHS.

We are not going to perfect, but equally there is no reason for alarm. I am confident that the skill, care and professionalism shown every day will be clear, as will the ongoing work to strengthen our leadership and organisation.

Workforce Race Equality Standard

From April 1, 2015 all NHS Trusts are required to report on a series of metrics designed to give an indication of race equality amongst their workforce. The Workforce Race Equality Standard (WRES) has been mandated under the 2015-16 Standard Contract in response to clear evidence that BME people have poorer access to NHS jobs, poorer prospects once they're in NHS jobs, are more likely to undergo performance management, and are more likely to experience bullying and discrimination than their white colleagues. There is also strong evidence that unfair treatment of BME staff adversely affects patient outcomes and experiences.

There are nine metrics the Trust has to report against, covering the ethnic composition of our workforce (with a particular focus on senior positions), recruitment, access to training, and staff survey responses. The first publication date is July 1, 2015. Data published in our January 2015 equality annual report suggests that – in common with the NHS nationally – BME staff in our Trust fare less well than their white colleagues in securing employment and in their employment experiences.

The Trust will be setting up an Equality Governance Group to oversee the implementation of the WRES and the Equality Delivery System (EDS2 – also a mandatory requirement under the 2015-16 Standard Contract). The group will lead work to analyse and understand the underlying causes of any inequalities, and to take action to redress any issues.

NHS England Business Plan 2015/16

NHS England has published its business plan for 2015/16, summarising its goals for the year ahead. Ten priorities are identified, including improving care and access to cancer treatment and mental health and dementia services, and transforming care for people with learning disabilities. More information is available on the NHS England website (www.england.nhs.uk)

NHS Investigations into Jimmy Savile and the Kate Lampard Lessons Learnt Report

David Flory wrote to all CEOs of NHS Trusts in March highlighting the publication on the February 26, 2015, of a further 16 NHS investigation reports as well as the overarching Lessons Learnt Report authored by Kate Lampard.

The Secretary of State accepted in principle 13 of the recommendations set out in that report. Although not accepting recommendation 6 on Disclosure and Barring checks (DBS), Trust were urged to review their processes for DBS checks for volunteers, including enhanced DBS checks where volunteers may work closely with children.

Across GCS we have ensured we have considered how the lessons from the Inquiries may inform Trust policy, processes and training in the trust and has been a key topic on our Leadership Team agenda.

The Board is asked to consider the submission (Appendix A) which sets out Trust actions against the recommendations to ensure lessons learnt are embedded.

New Director of Delivery & Development (South) at the Trust Development Authority (TDA)

Anne Eden has written to the Trust to introduce herself as the new Director of Delivery & Development (South) at the TDA. Anne has spent nine years as CEO at Buckinghamshire Healthcare and will be visiting trusts across the South West, South Central and South East areas in the coming months. We look forward to meeting her in due course.

Appendix A: REPORT ON TRUST PROGRESS IN RESPONSE TO KATE LAMPARD'S LESSONS LEARNT REPORT

NAME OF TRUST:	Gloucestershire Care Services NHS Trust

Recommendation	Issue identified	Planned Action	Progress to date	Due for completion
I. All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors.	To ensure no risks to the safety and security of service users and colleagues arising from visits to the Trust by approved or invited visitors such as VIPs, Celebrities or Media Representatives	To develop a VIP Policy for the Trust and associated Procedure	Director of Corporate Planning	June 2015
II. All NHS trusts should review their voluntary services arrangements and ensure that: • They are fit for purpose; • Volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and, • All voluntary services managers have development opportunities and are properly supported.	Restricted capacity within the Trust to support development opportunities for voluntary services managers	Updated Volunteers Policy was ratified by the Workforce & OD Committee in April 2015 Volunteer co-ordinator in place to oversee recruitment	Director of Human Resources	June 2015
III. All NHS hospital staff and volunteers should be required to undergo formal refresher training in safeguarding at the appropriate level at least every three years.	Need to ensure that all trust volunteers undergo safeguarding training every three year	• Volunteer coordinator in place to ensure this is planned into induction and update sessions for all volunteers • Records to be maintained and reporting via the Quality Report	Director of Nursing & Quality/Director of Human Resources	June 2015
IV. All NHS Hospital trusts should undertake regular reviews of: • Their safeguarding resources, structures and processes	Assurance required of the understanding of	Ensure all actions from the CQC inspection of safeguarding are complete	Director of Nursing	Complete

(including their training programmes); and, • The behaviours and responsiveness of management and staff in relation to safeguarding issues. • to ensure that their arrangements are robust and operate as effectively as possible.	safeguarding issues and colleagues understanding of where to go for advise	Undertake an assessment of the organisations safety culture Include safeguarding questions within quality visit tool template to assess understanding and identify learning needs Benchmark GCS safeguarding services against similar Trusts	&Quality	June 2015 Complete June 2015
V. All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers. Director of Human Resources	The Trust no longer undertakes a three year rolling programme of DBS checks. However all staff are required to sign an annual declaration as part of their appraisal. Not all volunteers engaged through other organisations such as league of friends have DBS clearance	The Trust has contacted all volunteers to inform them of this requirement and has set up drop in sessions to facilitate the completion of DBS forms	Director of Human Resources	Complete June 2015
VI. All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.	To update the Trust's Internet and Email Policies to include access to blogs, twitter and other social media	Complete a review and update of the Trust's Internet and Email Policies	Director of Corporate Governance/ Director of Finance	June 2015

VII. All NHS hospital trusts should ensure that arrangements and processed for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.	Agency staff are booked by local budget holders with no central monitoring in place	Establishment control process to be developed to ensure central management of agency staff & consultants	Director of Human Resources	Jue 2015
VIII. NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.		Recruitment, checking and general employment practices managed centrally Training undertaken is recorded on ESR	Director of Nursing & Quality/Director of Human Resources	Complete
IX. NHS hospital trusts and their associated charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect this.	All VIPs are expected to sign a Media Indemnity Agreement and a Confidentiality Agreement before commencing a visit to the Trust. This will therefore mitigate risk and reputation.	Agreements are currently in development	Director of Corporate Governance/ Director of Finance	June 2015
I confirm that this Trust Board has reviewed the full recommendations in Kate Lampard's lessons learnt report: SIGNED: DATE: CE NAME:				

Return to Natalie Dixon, Senior Policy Advisor, NHS TDA – Natalie.Dixon7@nhs.net

Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: 19 May 2015
Location: The Guildhall, Gloucester

Agenda item 11: Chief Operating Officer's Report

This report is intended to provide an executive summary of key operational projects, and any associated issues, across the Trust.

1. Adult Social Care

Positive out turns for 2014-15 show the total number of referrals for adult social care up16% from 30,016 to 34,683. Service users in receipt of residential or nursing care fell 17% from a peak of 2,812 in April 2014 to 2,345 by March 2015, while Telecare support has risen steadily from 1,737 users in March 2013, to 2,061 in March 2014 to 2,457 by March 2015.

However, ongoing financial pressures in delivering adult social care have led Gloucestershire County Council to begin a restructure of the management and delivery of these services as the new financial year commences.

Discussions are underway with the county council, and our ICT colleagues with regards to management structures and working arrangements. The county council has indicated its continued commitment to working collaboratively to provide integrated health and social care for people in the community.

The county council's preference appears to be to manage social care staff under a new head of adult social care post, with a wider professional leadership role. It also plans to increase the number of professional team leaders, with one post for each locality and one taking on a county-wide role. A more detailed examination of the structure options being looked at is included as a Part 2 paper for this Board Meeting.

In the meantime, work continues on key projects for the coming year, including:

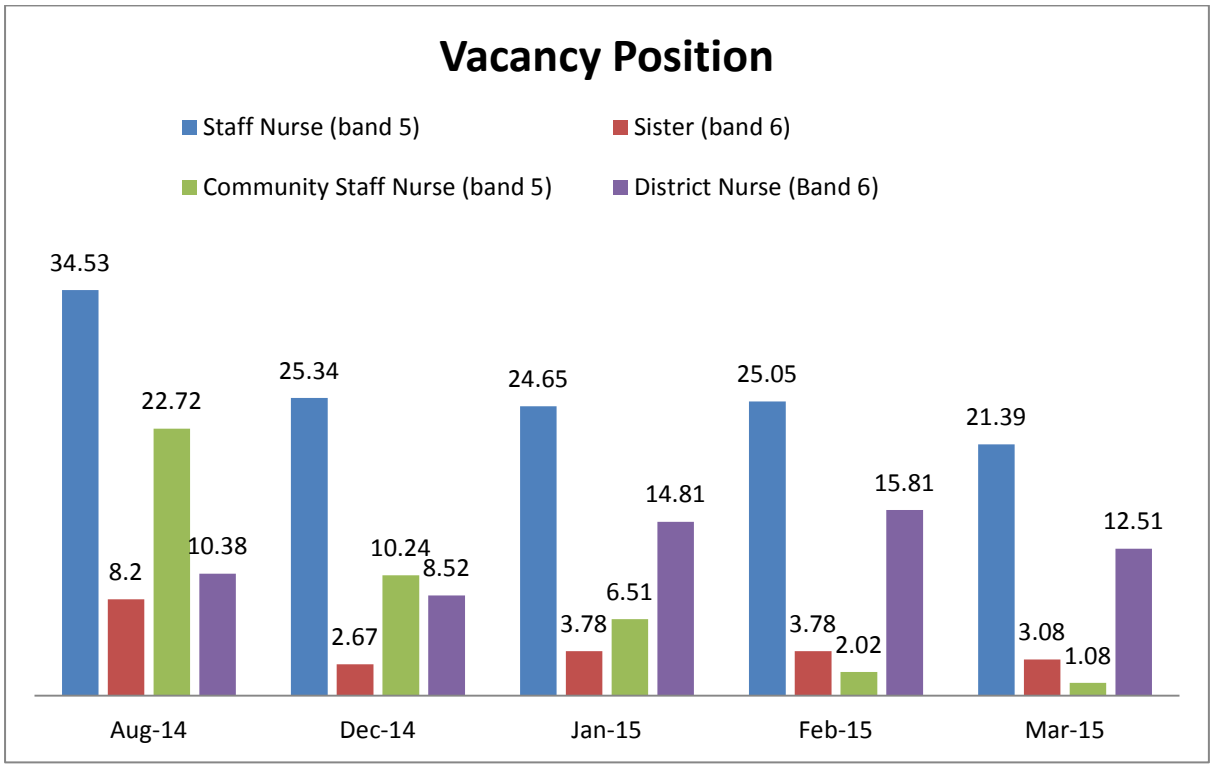
- Reassessments
- Reducing care home admissions and positive risk taking
- Increasing Direct Payments and recouping unused contingencies
- Referral Centres and managing demand
- Developing community assets
- Reablement and telecare
- Reducing short term packages spend (QSPs)
- Performance and finance reporting

2. Human Resources

2.1. Recruitment and retention

The Trust's recruitment and retention initiative which started in July 2014 has seen a reduction in overall qualified nursing vacancies of 37.77 whole time equivalents (WTE) which represents a 49% reduction.

The graph below shows the changing position of vacancies for the period August 1, 2014, to March 31, 2015. It shows that good progress has been made with regard to band 5 community nurses but that challenges remain with band 6 District Nurses and band 5 Staff Nurses.



Source: Finance and ESR

A further online recruitment campaign commenced on Monday, April 20, running for five weeks. Early analysis shows a significant rise in page views of our recruitment section of the website. The recruitment campaign is being reinforced by weekly 'Meet the Matron' editorial in the Gloucester Echo, which started on Wednesday, April 22.

Stands have been booked at the Royal College of Nursing (RCN) Recruitment Fairs in Birmingham on July 2 and 3 and London on September 10 and 11, 2015. The Communications Team is working closely with HR to design the promotional material.

2.2. Sickness compliance

The 12 month rolling average sickness absence rate for the Trust is 4.92% (data to end January 2015); the nationally set target is 3%. The latest figures released by the Health and Social Care Information Centre give a national average of 4.24%.

A range of tools and workshops is being developed across the Trust, particularly aimed at providing support and training for line managers to address sickness absence.

2.3. Appraisal completion rates

The Trust has an appraisal process which should ensure that all colleagues have an annual performance review with their line manager at which performance is reviewed, objectives are set and a performance development plan is agreed which identifies education, training and development needs.

As of February 2015, the proportion of staff with an up to date appraisal was 71.03%. The trajectory target is 80% by June 30, 2015, rising to 95% by March 31, 2016.

Actions to support improved performance include an audit by HR, review of guidance notes, appraisal training and new core objectives for line managers and a nurse revalidation policy launched by the nursing and quality directorate.

3. Cost Improvement Programme Schemes (CIPS)

The draft CIP scheme was presented at the March Performance and Resources Committee meeting and is now waiting formal approval by the Finance Committee.

The 2015-16 CIP programme encompasses 13 initiatives. Quality Impact Assessments will be undertaken on all CIP initiatives where a service change is planned. To date, QIAs have been completed for the following projects:

- Stock management;
- E-rostering; and the
- MI Reporting Tool (OBIE).

The QIAs were reviewed by the Clinical Senate on April 24 and subsequently approved by the Director of Nursing and Quality and the Medical Director.

The Clinical Senate in June will receive further QiAs including:

- Digital Dictation; and
- Patient Call System

Further QIAs will be undertaken as part of the Programme Planning process, as initiatives are developed and put forward for approval. Regular reviews will occur for projects that occur over long durations to ensure service quality is not compromised

during implementation. Individual QiAs will be completed for all posts that may be deleted, as they are identified under the system re-engineering CiP.

The programmes, their delivery risk rating and planned financial impact are summarised in the following table:

Project Title	Programme Delivery Risk	Planned Financial Impact
E-Rostering	Low	Medium
Patient Call Systems	Low	Low
Digital Dictation	Medium	Medium
SystmOne Review	Medium/High	Medium/High
MI Reporting tool (OBIE)	Low	Low
Managing non-frontline staff costs	High	High
Contracts and Procurement	Medium	Medium
Contracts and Procurement: Stock Management	Medium	Medium
Infrastructure Management: Estates Strategy	Low/Medium	Medium
Infrastructure Management: IT Strategy	Low	Low
Decontamination	Low	Low
Smart Working	Low	Low
NHS Contracts	Medium/High	Medium/High

Communications are planned and underway to help colleagues understand the importance of managing costs, and stakeholder analysis is underway to ensure that messages are targeted appropriately.

4. Commissioning for Quality and Innovation (CQUIN) and the Quality, Innovation, Productivity and Prevention programme (QIPP)

CQUIN

The Trust has completed its 2014-15 CQUIN activities with a submission of a Quarter 4 report to Gloucestershire Clinical Commissioning Group (GCCG). There are no apparent risks associated with this as all milestones were met. The Trust awaits formal feedback from the commissioners.

For the 2015-16 CQUIN programme negotiations with the GCCG have progressed well and the Trust is on track to formally sign these off. Key themes for CQUINs this year include:

- Positive Risk Taking
- Managing Acute Kidney Injuries
- Urgent Care and Community Hospitals
- Managing Delirium
- Young People's Transition into Adult services
- Frailty Screening

There are agreed activity milestones within each CQUIN and although not a CQUIN there will continue to be a robust monitoring approach with the Safety Thermometer activities during 2015-16 aligned to the CQUIN work stream.

QIPP
Negotiations with the GCCG have been progressing well. The themes for this year's QIPP are focussed around service improvement and development and have been negotiated to include agreed milestones throughout the year. QIPP themes include:

- Integrated Community Teams (ICTs) including Community Nursing
- Integrated Discharge Teams (IDTs)
- Single Point of Clinical Access (SPCA)
- MSK Pathways
- Community Hospitals including Minor Injury and Illness Units (MiIUs)
- Complex Leg Ulcer Services developments
- Reablement

The approximate value of the 2015-16 CQUIN and QIPP programmes equates to £1.9m and £3.9m respectively. There will continue to be proactive monitoring and risk management arrangements in place which will be overseen by the Quality Steering Group chaired by the Director of Service Transformation. Engagement with operational services remains good.

5. Community Hospitals

During April the Trust, in agreement with partners, commenced a de-escalation plan of its additional beds within the community hospitals. This approach broadly included:

- A phased approach at Stroud General Hospital. Princess Anne Ward has now reverted back to its original state and this has enabled GHFT to utilise more fully its theatre activity at Stroud General Hospital, which has reduced over the past 4 months because of these escalation beds.
- The Forest of Dean and Cirencester Hospitals closure of the additional beds has been completed.

As part of these de-escalation plans the Trust notified Healthwatch, the relevant League of Friends, colleagues and the CQC - all have been aware of these additional beds and the risks associated with them.

6. Tender process for Public Health Services

In April 2016 a number of contracts for lifestyle behaviours currently commissioned through Gloucestershire County Council come to an end. The county council commissions a range of services to address individual lifestyle issues – such as stopping smoking. As these contracts end simultaneously there will be an opportunity for the county council to review how these services are delivered.

The primary focus will be on four unhealthy behaviours: poor diet, physical inactivity, smoking and alcohol misuse. The county council's review will look at cost-effectiveness, ease of access, prevention and the potential for integration of different lifestyle services, as well as the use of self-care and community assets in meeting healthy lifestyle goals.

The services due for renewal which we provide are Stop Smoking, Health Improvement and Oral Health Promotion. Additional contracts coming up for tender include NHS Health Checks, Weight Management Services, Community Health Trainers and Breastfeeding support which are currently worth approximately £1.45m in total.

Where integrated health improvement contracts have come up for tender in other parts of the country there has been significant interest from competitive private providers, such as Virgin and Solutions for Health, and we have to anticipate similar interest in Gloucestershire.

The Trust is consulting with key stakeholders to explore the potential for more collaborative working, prior to working up a full business case and procurement strategy, due for completion this month.

7. Smoking Cessation target hit

The Trust's Stop Smoking Service achieved all their targets for 2014/15 eight weeks earlier than planned. This has been a considerable task but the team have worked tirelessly to support 2,340 people to stop smoking in Gloucestershire over the last year. This brings the numbers to a total of 43,195 people that have stopped smoking successfully since the service commenced in 2001. Our thanks must go to all our partners and colleagues for their unwavering support over the last year.

8. Chlamydia Screening Rates

The Trust has reported to Commissioners that it is unlikely to deliver the required positive Chlamydia screen set for 2014/15 and a refreshed action plan has been drafted.

Included in the action plan is an emphasis on service redesign. To support this work the service lead participated in a WebEx with Public Health England and has had a series of focus groups with young people who are our targeted audience for the service.

Ongoing work will also see improved targeting of prevention and screening messages for 19-24 year olds. We are exploring the options for doing this geographically (targeting places this audience tends to meet), by tapping into shared interest (such as sport) and electronically (targeting popular social media channels).

The Trust is exploring greater opportunities for partnership working with GPs, youth services and the Armed Forces at Imjin Barracks.

9. Homeless Healthcare Team

The owners of the Vaughan Centre, in Southgate Street, Gloucester, has given the Trust notice that the building has been sold and requested that our Homeless Healthcare Team leave the premises by the end of July.

The estates team is working with the county council and other organisations to look for premises which are suitable for the team and appropriate for delivery of services to this client group. We are also developing contingency plans should we need to vacate the Vaughan Centre prior to having permanent premises arranged.

The team is continuing to provide GP and nurse-led clinics, podiatry and tissue viability services and a blood borne virus clinic from the Vaughan Centre, as well as outreach work at various sites across the city.

10. New Pharmacy Contract

As of 1 May 2015, the Trust entered into a new three-year contract with Lloyds Pharmacy for the provision of pharmacy services across the Trust. The service contract is worth £0.5m per year and we anticipate purchasing approximately £3m in drugs each year, taking the total contract value to circa £10.5m.

11. Health Visiting

The Trust has demonstrated significant success in delivering the Health Visitor Call to Action 2011-2015 programme. In February we reached our target, with a workforce of 128.13 WTE Health Visitors against the year-end programme target of 127.32. Our anticipated year end WTE workforce is 131.19.

NHS England has agreed to fund this over recruitment up to the end of September 2015, which is the point at which the transfer of funding for health visiting will move to the county council. At this point it is confirmed that the resources transferred to the local authority excludes the over recruitment, and this will be operationally managed to ensure we do not create a financial risk for the Trust.

To acknowledge this achievement a celebration event was held on the 26 March 2015, an opportunity to thank colleagues both within and outside of the organisation who have worked diligently on this over the last four years.

The celebration event also provided a venue to showcase the 15 service improvement programmes underway, demonstrating achievement in not only expanding the numbers of health visitors but also in strengthening and modernising the delivery of health visiting services to help ensure that children and families have a positive start in life.

12. CQC

As part of the Trusts preparation for the June 2015 CQC inspection, and to provide continued assurances around patient safety and clinical quality issues, operational teams continue their work with colleagues around the 5 CQC Quality domains. Part

of this work has included high levels of attendance from operational teams at the Understanding You events that have taken place across the County.

Contributions

Many thanks to the following for helping compile this report:

- Candace Plouffe, Director of Service Delivery
- Susan Field, Director of Service Transformation
- Tina Ricketts, Director of Human Resources
- Matt Blackman, Communications Specialist

Gloucestershire Care Services NHS
NHS Trust

Board Assurance Framework - Corporate Risk Register

Ref: 12/0515

Board Assurance Framework - Corporate Risk Register

19 May 2015

The Board is asked to:

Note the high-level operational risks and provide steer where appropriate in respect of action / remedial plans

Executive summary:

This part of the Board Assurance Framework (BAF) provides oversight of the Trust's most significant operational risks as determined by colleagues across the organisation. It reflects position as of the end of April 2015.

Identify which strategic objective(s) this paper supports:

1.	Achieve the best possible outcomes for our service users through high quality care.	X
2.	Understand the needs and views of the service users, carers and families so 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

Rod Brown, Head of Corporate Planning

11 May 2015

Sponsored by Paul Jennings, Chief Executive

11 May 2015

Please complete the Equality Checklist over….

Please select one of the following options:

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

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

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

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

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

Gloucestershire Care Services NHS
NHS Trust

Board Assurance Framework:

Corporate Risk Register (v0.3)

APRIL 2015

Overview

This part of the Board Assurance Framework (BAF) describes the Corporate Risk Register as at the end of April 2015.

It therefore serves to detail the **most significant operational risks** faced by the Trust as identified by staff at all levels across the organisation and validated by senior managers.

Please note that the Trust's **strategic risks** are detailed in a separate document.

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1. Definitions

The risk scoring mechanism in this BAF uses the descriptions provided by the NHS National Patient Safety Agency. These are shown below:

1.1 Description of consequence

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of service users, staff or public (physical or psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident Impacts on a small number of service users	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of service user care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects Impacts on a large number of service users
Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for service user safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major safety implications if findings are not acted on	Non-compliance with national standards with significant risk to service users if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of service user safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss with risk of claim remote	Loss of 0.1-0.25% of budget Claim less than £10,000	Loss of 0.25-0.5% of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5-1.0% of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1% of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/ business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

1.2 Description of likelihood

	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

2. Corporate Risk Register (operational risks)

2.1 Categories

This section of the BAF details the most significant risks faced by the Trust as identified by staff across the organisation. To this end, it reflects Risk Registers that are held at local level and that detail risks in relation to the following services:

a) scheduled care (to include integrated community teams, countywide / specialist services and children's and young people's services);

b) unscheduled care (to include community hospitals and urgent care services);

c) the Nursing and Quality directorate (including clinical governance, medicines, safeguarding and infection control);

d) human resources (including workforce);

e) corporate governance (including information governance and legal services);

f) IM&T (including clinical systems);

g) financial management;

h) transformation and change;

i) Foundation Trust programme.

2.2 At a glance

Risks rated 12+ on all local Risk Registers as of the end of April 2015 are:

Area	Ref	Risk	New risk
Scheduled care to include integrated community teams, countywide / specialist services and children's and young people's services	SD1-ICT	Community nurse staffing pressures	
	SD2-ICT	Loss of base for Homeless Healthcare Team	
	SD3-ICT	Occupational Therapist and Physiotherapist vacancies	
	SD4-SXH	Inability to achieve Chlamydia screening target	
	SD5- CWS	Increasing demand for specialist services	
	SD6- CWS	Tendering of the integrated healthy lifestyle service	
	SD7-CWS	Unclear governance, accountability and reporting for Medical Devices	
	SD9- CWS	Lack of a Decontamination Lead	
	SD10- CWS	Management vacancies in countywide services	
	SD11-ICT	Observations not being taken prior to IV Therapy administration	X
	SD12-ICT	Ability to meet demand for care home reassessments	X
Unscheduled care to include community hospitals and urgent care services	ST1-CH	Staffing shortfalls in inpatient units	
	ST4-CH	Removal of the PAS in all Community Hospital sites	
	ST5-CH	Rising trend of reported falls at Community Hospitals	
	ST6-RR	Increased demand for overnight community service - nursing and rapid response	
	ST8-MIiU	Recruitment and retention in MIiUs	X
	ST9-MIiU	Migration of out-of-hours work to MIiUs	X
	ST10-MIiU	MIiU's ability to deliver services consistently across the county	X
	ST11-RR	Rapid response service's ability to deliver the trajectory of activity set out in contract	X
	ST12-EPPR	Trust resilience in providing effective information about capacity, demand and flows	X
Nursing and Quality Team	NQ1	The Trust's low rate of incident reporting may result in missed learning opportunities	
	NQ2	The Trust's low rate of formal complaints may lead to poor service user experience	

Human Resources	HR1-414	No robust understanding of contingent workforce demand and supply issues	
	HR2-433	Vacancy information is not escalated to senior managers on a timely basis	
	HR3-409	High number of nursing vacancies	
	HR4-413	Lack of a joint workforce plan across health and social care	
	HR5-404	Current sickness absence rate above NHS average and benchmark group	
Corporate Governance	CG1	There are some gaps and inconsistencies in record-keeping, meaning that the Trust is not always able to refute allegations of clinical negligence	
IM&T	IT1	Poor service delivery from countywide IT service provider	
	IT2	Service user status alerts are not displayed on the mobile working module	
	IT3	Removal of PAS system	
	IT4	Social workers, mental health workers, GP's may not be able to enter onto SystmOne	X
	IT5	Agency staff may not be able to update SystmOne despite having access	X
Transformation and Change	TC1	Ability of the External Care programme to deliver to target	
	TC2	Ability to deliver £2.8m of cost savings as set out in CIP Plan	X
	TC3	Ability to deliver full £3.9m of agreed QIPP schemes	X
	TC4	Ability to deliver multiple milestones across a number of schemes alongside BAU	X
FT programme	FT1	Inability to identify required targets or cost savings across a five year period	

Risks reduced in the previous period and therefore no longer on the Corporate Risk Register:

- SD8-CWS - waiting times for MSKCAT services
- ST2-CH - impact on service user privacy and dignity due to open escalation beds
- ST3-CH - Tewkesbury Community Hospital call bells
- ST7-RR - inability to maintain quality out-of-hours medical service during transition to SWAST

2.3 In detail

a) Scheduled Care

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
SD1-ICT	08 July 2014	Community nurse staffing pressures	Current staffing shortfalls in a number of localities (Tewks, Cots, Glos), particularly in band 6 leadership roles, impact on the leadership and support of the community nurses. This has put undue pressure on the remaining staff potentially leading to increased sickness absence and/or more staff leaving. Potential impact on ability to maintain current levels of activity	Controls and actions are described in a detailed District Nursing action plan. Reviewed regularly at the Quality and Performance Board and with commissioners	Consistent communication with both clinical staff and GPs to provide confidence that work is underway to address ongoing issues	4	4	**16**	Candace Plouffe / Margy Fowler / Dawn Porter / relevant community manager	Reviewing workload to identify tasks that community nurses are doing that can be stopped or could be performed by practice nurses. In Tewkesbury, arranged temporary support from a B6 and B5. In Cotswolds, targeted recruitment continues, bank staff being used and nurses from South ICT District Nurse teams supporting. Updates shared with GPs *Update: A proposal has been submitted to the CCG so as to train current community staff nurses to be able to move into district nurse roles*	3	4	**12**	30 April 2015

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
SD2-ICT	01 August 2014	Base for Homeless Healthcare Team	The Homeless Healthcare team face homelessness themselves as the charity hosting the service (GEAR) respond to financial pressures by selling their building for redevelopment	Viewing possible alternate sites in central Gloucester and flagging up with Estates team	Uncertain whether Estates team has full understanding of the complexity in rehousing this service. Notice to quit has been received for 31 July 2015	4	4	**16**	Melanie Getgood	Estates has identified potential accommodation in Gloucester, and is in the process of securing a contract	3	4	**12**	30 April 2015
SD3-ICT	26 March 2015	Occupational Therapist and Physio-therapist vacancies	Recent resignations from both Band 5 OTs and Physios who are moving to Band 6 positions both within and outside the organisation have put Gloucester ICT under slight pressure as the recruitment process may impact on the waiting list	Reviewing all cases pre-allocation to re-align existing allocated cases that require further work to staff	Lack of Robust Action plan similar to the nursing plan to address ongoing retention issues	4	3	**12**	Margy Fowler / Dawn Porter / relevant community manager	Work underway with HR to map current staffing levels for therapy in ICTs. Professional Heads of OT and PT have detailed current workforce in ICT and alignment to community hospitals which creates perception that there are more resources than are available. The Prof Head working with PTLs to temporarily realign workforce to ensure equitable coverage *Update; The Trust has made a number of successful appointments into vacancies, but will continue to monitor*	4	3	**12**	30 April 2015

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
SD4-SXH	26 June 2014	Chlamydia screening target	There is a risk that the service will not achieve the Chlamydia screening target	Meetings with Public Health Commissioners to review progress and agree a way forward. Performance and action plan being monitored by Quality and Performance Committee	Uncertainty on whether population in County is such that achieving higher target is possible	5	3	**15**	Elaine Watson / Rona McDonald	The action plan has been refreshed. A series of young people engagement sessions is informing service redesign. A two year trajectory negotiated with Commissioners	4	3	**12**	30 April 2015
SD5-CWS	09 July 2014	Increasing demand for specialist services and lack of clinical governance support	Demand for service is increasing beyond the original business case especially for IV therapy nurses, Tissue Viability and Home Oxygen Services, leaving services and service users at risk	Specialist services clinicians doing extra bank work to meet demand where they have reduced capacity. Team is recording capacity issues both in their teams and supporting teams e.g. DN. Links have been made with Rapid Response and unscheduled care. Service specifications and issues have been discussed with the Trust Executive, Board and Commissioners. Medical lead for GHT writing governance paper. Meeting with Governance lead to highlight issues and find solution to reduce governance risk to service	Funding for all services from block contract and therefore inability to recruit as required to meet demand No feedback from clinical governance lead	5	3	**15**	Andrea Darby	Wound management business case in situ. DN recruitment and ambulatory care initiatives to positively impact on service. Discussion on new ways of working to meet demands (i.e. integrated diabetes service)	5	3	**15**	30 April 2015

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
SD6 - CWS	10 February 2015	Integrated healthy lifestyle tender	The Trust has been service noticed that the Health Improvement Function of the business is due to be tendered by the County Council commissioners	The Trust has attended early engagement sessions and has fed back to its Senior Management	Initial sessions seem to indicate that County Council is looking for greater involvement of third sector providers in provision of this type of service	5	4	**20**	James Curtis	Tender project committee put together, including Commercial Manager, Service Transformation reps and service reps Links have been made with third sector providers who may want to submit a collaborative bid	5	4	**20**	20 April 2015
SD7- CWS	20 February 2015	Medical devices	There is unclear governance accountability and reporting for Medical Devices into the Quality and Performance Committee. There is no recognised Medical Devices Lead with clear role and responsibilities.	Medical Devices Group in place currently chaired by Chris Boden/Mark Parsons	Unclear accountability at senior level	4	4	**16**	Chris Boden	A proposal drafted by the Director of Nursing and Quality will be going to the Executive Team to resolve the issue	4	4	**16**	30 April 2015

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
SD9 - CWS	20 February 2015	Decontam-ination	The Trust requires a recognised Decontamination Lead (as per MRHA guidelines) with appropriate qualifications and experience	Decontamination issues reported at Infection Control and Prevention Committee	No clear direction decided yet by Executive in terms of overall lead for this area, continues to be shared across Clinical Development and Quality and Operations	4	4	**16**	Chris Boden	A proposal drafted by the Director of Nursing and Quality will be going to the Executive Team to resolve the issue	4	4	**16**	30 April 2015
SD10 - CWS	25 March 2015	Management staffing	There are a number of vacancies in senior management posts within Sexual Health services, including the service manager. This has led to the clinical director and band 7 nurses taking on additional management duties, which has made it difficult for them to complete their usual clinic based work	Impact of vacancy being monitored by Countywide Service Manager and Director of Service Delivery. Regular contact with SH Clinical Director to monitor workload for senior clinicians in the service	Uncertainty of length of time until senior staff team fully established.	4	4	**16**	Elaine Watson	Interviews in March did not lead to appointment. Re-advertised post. CD offered additional hours to provide clinical leadership. Senior clinicians who have been on sick leave have returned, so more support available.	4	4	**16**	30 April 2015

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
SD11-ICT	24 Nov 2014	Clinical Intervention	Reported that some District Nurses are not undertaking basic observations prior to administering IV Therapy.	On-going training to District Nurses by IV Therapy team to ensure they know the importance of basic observations prior to administration. Highlight to Managers in ICTs the importance of providing the correct equipment for IV administration	Time required to ensure nursing workforce is both competent and capable in this intervention	4	3	**12**	Theresa Cuthbert	Audit to be carried out to understand extent of issue and ascertain reason why observations are not being done prior to IV Therapy. Professional Head of Community Nursing to ensure included in Training Needs Analysis and Action plan. Potential move of this type of intervention into clinic based settings as part of ambulatory care.	4	3	**12**	23 April 2015
SD12-ICT	26 March 2015	Care home re-assessments	Inability to meet demand for volume of Care Home reassessments within a year, both in and out of County. This results in increasing number and length of overdue assessments	Staff reassessing the most overdue cases as a priority Staff have been utilising a proportionate based assessment rather than full assessment where appropriate	Capacity modelling to consider impact of Care Act on assessments required for this year	4	4	**16**	Melanie Getgood	Review of resource required to complete a full assessment as per the Care Act on all open service users. Gap analysis of shortfall in resources as current staffing level is 2.6 wte. Proposal of non-recurrent funding required to increase resource for 15/16 to be drafted	4	4	**16**	30 April 2015

b) Unscheduled Care

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
ST1-CH	08 July 2014	Community Hospital staffing levels	Staffing shortfalls in inpatient units exacerbated by the open escalation beds. Insufficient numbers of bank nurses to fill the gaps leading to increased use of agency staff which increases cost, decreases quality and continuity of care, and puts extra pressure on substantive staff	Continue to recruit to fill vacancies including targeting recruitment through local media. Proactive booking of bank and agency to ensure shifts are filled. Register risk dialogue with commissioners.	Less accountability of agency staff	4	4	**16**	All Community Hospital Managers	Substantive staff picking up clinical shifts to cover (not sustainable). Introduction of rotational posts linked to preceptorship programme and development of competency framework	4	4	**16**	23 April 2015
ST4-CH	01 February 2015	Removal of the PAS in all Community Hospital sites	The removal of the integrated PAS system will commence in May 2015, resulting in information not necessarily being available ***Refer also to risk IT3 below***	SystmOne Development Board planned training and resource allocation. Admin colleagues identified. SystmOne risk register. Ongoing learning from previous deployments.	TBC	4	3	**12**	All Community Hospital Managers	PAS working group set up re interdependencies with GHFT. Support team identified. Robust deployment plan in place.	4	4	**16**	23 April 2015

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
ST5-CH	01 January 2015	Rising trend of reported falls	Safety Thermometer (ST) reporting has seen overall improvement, however there is a rising trend in injurious and non-injurious falls	Local Community Hospital action plans. ST validation process in place. Incident reporting. RCA approach to all injurious falls.	Single rooms lead to higher incidence of falls	4	3	**12**	All Community Hospital Managers	Site inpatients at higher risk of falls nearer the nurses station. All inpatients to have an MDT falls risk assessment. Pharmacy review of medications. Ensure staff complete falls e-learning. Raise staff awareness in prevention of falls. All bank and agency staff to be made aware of risk. Safe staffing levels must be adhered to. Implement and monitor the falls prevention action plan	4	3	**12**	23 April 2015

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
ST6-RR	1 January 2015	Appropriate referral and admission criteria into unscheduled care service	Increased demand for overnight community service - nursing and rapid response	Routine review of demand. Internal shift review. Securing GCCG funding for additional rapid response staff	TBC	3	4	**12**	Helen Hodgson	Review of demand ongoing. Shift pattern proposal discussed at Execs on 8 Jan 15. Engagement with staff side and community team commenced. Recruitment on urgent care lead completed. Further negotiation for overnight resilience being trialled with GCCG.	3	4	**12**	23 April 2015
ST8-MIiU	22 April 2015	Safe staffing levels in MIiUs	Risk to recruitment and retention in MIiUs	Develop integrated workforce to enhance flexibility. Improved efficiencies to utilising staff i.e. charting of service users with complex needs. Enhance bank skill set. Undertake training needs analysis and develop urgent care competency framework.	TBC	4	3	**12**	Helen Hodgson	Additional bank staff recruited. Competency framework for urgent care practitioners finalised and being implemented. Minor illness training underway	4	3	**12**	22 April 2015
ST9-MIiU	22 April 2015	Migration of out-of-hours work to MIiUs	The new out-of-hours provider may potentially transfer out-of-hours cases to MIiUs	Codes for reporting added to patient first. Local operating procedures in place. Incident reporting.	TBC	4	3	**12**	Helen Hodgson	Capacity Manager escalation process. Dashboard for monitoring purposes.	4	3	**12**	22 April 2015

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
ST10-MIiU	22 April 2015	MIiU's ability to deliver services consistently across the county	MIiU staff require mentorship and training to support increase in referrals for illness management. The level of service currently being delivered is inconsistent across the county	Review of DOS Profile. Reiterated communication to MIiUs. Capacity and Service Improvement Manager in post to support MIiUs.	TBC	4	3	**12**	Helen Hodgson	Training needs analysed. Portfolio competency based training. Review MIiU handbook. Programme of work to monitor effectiveness	4	3	**12**	22 April 2015
ST11-RR	22 April 2015	Rapid response service	Rapid response service's ability to deliver the trajectory of activity set out in contract. Aspire to see 998 service users per annum, target is 1,300	Performance data and monitoring. GP communication. Pathway integration	TBC	4	3	**12**	Helen Hodgson	Re-communicate to Stroud GP about the rapid response team and the service they provide. Review access pathway through SPCA. Develop integrated work with ICTs	4	3	**12**	22 April 2015
ST12-EPPR	22 April 2015	Capacity and demand	Trust resilience in providing up to date, effective information about capacity, demand and service user flows 24/7, 365 days a year	Alamac team. Alamac dashboards. IT and Information. Medworxx (when introduced). On call arrangements	TBC	4	3	**12**	Helen Hodgson	Alamac roles to include managerial staff. IT support to input data. Head of Community Hospitals working with Matrons on Medically Stable list. Renew Trust on call arrangements. Capacity tools in development	4	3	**12**	22 April 2015

c) Nursing and Quality Directorate

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
NQ1	01 March 2015	Incident Governance	The Trust's low rate of incident reporting may result in missed learning opportunities from safety incidents leading to an increase of safety incidents up to and including moderate harm	• Incident reporting system • Incident Reporting Policy • Quality Team • Incident reporting is a standing item on in the Scheduled Care Governance Forums and Community Hospital, Urgent Care and Capacity Group	• The user-interface of the Trust's datix system may have become an obstacle due it being cumbersome • Reliable incident governance through the governance structures • Limited detailed scrutiny of incidents at service level	5	3	**15**	Christopher Brooks-Daw	• Approach to incident governance reviewed with improvement actions underway that include new incident policy and redesign of user interface with Datix incident module • Re-launch new approach to incident governance being rolled out in Q1 2015/16 • To support more accurate determination of the level of harm, the roll-out will have a renewed focus on the use of risk ratings when reporting and reviewing incidents across our services	4	3	**12**	30 April 2015

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
NQ2	01 March 2015	Service User Experience	The Trust's low rate (when compared to other similar organisations) of formal complaints may result in missed learning opportunities leading to poor service user experience	• Quality Team oversight and scrutiny, with integrated approach to understanding complaints in the wider context of incidents, concerns, etc • Weekly Quality Team scrutiny report using RAG rating of complaints and concerns. • Reporting through Quality and Performance Report • Governance Structure with Quality and Performance Committee oversight	• Limited assurance of embedded learning from across the Trust • Integrated approach to understanding and considering complaints alongside other information that tells us about service experience.	4	3	**12**	Christopher Brooks-Daw	New approach to reporting on complaints alongside other information that tell us about complaints is being roll-out in April 2015 (the Understanding You Report). This will include a renewed focus on considering learning at the point of service delivery as well as organisationally. New Complaints Policy being launched in April 2015.	4	3	**12**	30 April 2015

d) Human Resources

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
HR1-414	01 June 2014	Contingent workforce strategy	Further understanding of contingent workforce demand and supply issues is required. Centralised bank function not being utilised effectively	Monitoring of budgets and agency spend.	TBC	4	3	**12**	Tina Ricketts	Developing the strategy and operational policies. Review of centralised bank function – detailed project plan in place	4	3	**12**	30 April 2015
HR2-433	01 June 2014	Early alert systems re staffing levels	Information about vacancy rates is not escalated to senior managers on a timely basis. Disconnect between CIP savings and demand modelling. E-rostering system not being utilised effectively	Electronic Staff Records provides in-post information on staff. Monitoring and reporting of staffing levels within Community Hospitals	TBC	4	3	**12**	Kieth Dayment	Review of E-rostering system. Audit undertaken by PwC. Roll out of the E-rostering system across hospitals. Wards now complete with only routine monitoring required	4	3	**12**	30 April 2015
HR3-409	10 May 2013	Nurse recruitment and retention	There are a high number of nursing vacancies: for example, the number of vacancies for Band 6 community nurses has increased since August 2014	Weekly vacancy monitoring and reporting to Workforce Steering Group and Workforce and OD Committee	TBC	4	4	**16**	Sarah Curtis	Centralised recruitment. Dedicated post to lead on nurse recruitment. Preceptorship programme. Return to practice programmes. Nurse recruitment open days. Exit interview analysis. Detailed Work Programme monitored through Workforce Steering Group	4	4	**16**	30 April 2015

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
HR4-413	01 June 2014	Workforce planning across health & social care	A lack of a joint workforce plan across health and social care may impact on ensuring the Trust has the right staff with the right skills in the right place at the right time. Lack of workforce information available for social care	Monitoring of turnover rates and analysis of staff leaving Joint workforce plan has now been developed	TBC	4	3	**12**	Kieth Dayment	Joint workforce plan needs to be implemented	4	3	**12**	30 April 2015
HR5-404	10 May 2013	Sickness absence rates	Current sickness absence rate above NHS average and benchmark group	Monthly reports to managers	TBC	3	4	**12**	Sarah Curtis	Recruitment of Band 5 HR Attendance Management Advisor to support line managers in managing short term sickness Absence management workshops for managers. Detailed action plan to improve rates monitored through the Workforce and OD Committee. Review of policy and production of management toolkit and guidance	3	4	**12**	30 April 2015

e) Corporate Governance

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
CG1	04 March 2015	Lack of clear evidence of practice	There are some gaps and inconsistencies in record-keeping, meaning that the Trust is not always providing care based on the most up to date information: additionally, the Trust may then not be able to refute allegations of clinical negligence	Clinical policies Clinical record keeping policy Clinical governance policies	Due to some instances of poor record-keeping, the Trust is not always able to present counter arguments to clinical negligence claims, resulting in costs and damages	4	4	**16**	Jason Brown	Work is on-going to update all clinical and clinical governance policies A training programme will be carried out to confirm that colleagues have read and understood amendments to the processes	4	4	**16**	30 April 2015

f) IM&T

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
IT1	1 January 2015	Poor service delivery from the Countywide IT Service (CITS) provider	The Trust receives a poor level of service in terms of support for IT systems and IT enabled transformation projects	A service improvement programme is currently being put together by CITS based on the service metrics that the Trust has put forward	Performance is not at the required standard per the existing contract. Project delays are not reported as "red" issues in CITS project management reporting	3	4	**12**	Glyn Howells	Metrics have been passed to CITS that will form the basis of the improvement plan for all Trusts in the IT partnership. These will be further discussed at the partnership board before completion by the end of April	3	4	**12**	30 April 2015
IT2	1 May 2014	Service user status alerts	SystmOne service user status alerts are not displayed on the disconnected working module used by mobile workers	Staff must review the live system before leaving on appointments	Due to workload and capacity, there is chance that staff may miss necessary alerts	4	5	**20**	Bernie Wood	Glyn Howells is writing to TPP's Clinical Director for immediate resolution	4	5	**20**	30 April 2015
IT3	3 Nov 2014	Removal of PAS system	The Hospitals Trust PAS system is due for replacement in the next 12-18 months alongside the Trust introducing SystmOne in community hospitals. Due to these two system changes, a number of activities that occurred on one system will now work across two	Both of these new hospital trust system project groups are aware of this and the SystmOne community hospitals project group are aware of this with a sub group being set up led operationally to identify and resolve possible issues	Not all clinical activities are mapped, leaving a risk that as part of the system's replacement, a clinical function will be missed	4	4	**16**	Kevin Gannaway -Pitts	26 Jan 2015 - PAS Group meeting, PAS Action Plan developed and assigned to owners. 23 Feb 2015 - Action plan in place, meeting with GHT 24 Feb to establish GHT ownership. 23 Mar 2015 - Engagement taken place with GHT (SSCG) formed. Action plan updated with GHT ownership	4	4	**16**	23 March 2015

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
IT4	23 April 2015	Data entry by stakeholders	Risk that social workers, mental health workers, GP's may not be able to enter details onto SystmOne	Manual logins for those not captured – social workers will be trained with each Community Hospital (5 in Cirencester)	TBC	4	3	**12**	Susan Field	n/a	4	3	**12**	23 April 2015
IT5	23 April 2015	Data entry by agency staff	Agency staff may not be able to update SystmOne despite having access	Issue guides and engage with agency providers - contract terms need to be checked to ensure that agency staff enter data on the clinical record, in whatever form is required	TBC	4	3	**12**	Susan Field	n/a	4	3	**12**	23 April 2015

g) Financial management

There are currently no risks rated 12+ on the finance risk register

h) Transformation and Change

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
TC1	11 Dec 2014	External Care	Ability of the External Care programme to deliver to target	External care delivery programme with dedicated workstreams, reports to the External Care Programme Board. Dedicated Senior Manager and support to oversee this programme, regular meeting of an External Care management committee. Dedicated performance support to this programme Work plan in place with operational teams to shift to a new way of working to be able to deliver savings required	Current IT systems are not able to accurately forecast savings and demonstrate budgetary control. Manual systems have been put in place impacting on operational teams	5	4	**20**	D Porter / M Fowler	Performance in External Care delivery for 14/15 is showing trends which indicate that achievements are being made against the delivery plan	4	4	**16**	23 April 2015

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
TC2	1 April 2015	CIP	Ability to deliver £2.8m of cost savings as set out in CIP Plan	Robust project structure and governance framework to ensure continual monitoring and reporting with clear escalation pathway. Financial targets agreed at the outset between operations and finance. A clear communications plan to ensure that staff understand the importance of managing cost and its direct link to quality improvement	Delay in planning for 2015/16 programme Lack of clear evidence-based intelligence/ operational modelling upon which to build CIP plans and determine associated targets	4	4	**16**	Duncan Jordan	Clear CIP workplan is now in place overseen by a CIP Steering Group	4	4	**16**	22 April 2015
TC3	1 April 2015	QIPP	Ability to deliver full £3.9m of agreed QIPP schemes	Robust project structure and governance framework to ensure continual monitoring and reporting with clear escalation pathway	Challenges in milestone negotiations with GCCG, resulting in delays with delivery of programme	4	4	**16**	Susan Field	Continued focus on QIPP negotiations to mitigate risk as much as we are able, given that we have signed a variation stipulating the total funding and risk share split. Setting up the Quality Steering Group to monitor delivery	4	4	**16**	22 April 2015

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
TC4	1 April 2015	QIPP	Ability to deliver multiple milestones across a number of schemes, alongside BAU as well as CQC inspection and continued roll-out of SystmOne (especially in community hospitals)	The Trust's transformation and change work programme has been developed to explicitly identify the level of work across the multiple T&C programmes, including CIP, QIPP, and CQUIN, as well as additional requirements such as CQC and SystmOne. This should support Executives to prioritise work and ongoing negotiations with GCCG	Contract signed and financial risk limits the Trust's ability to prioritise work programme deliverables across any of the three major change programmes (CIP, QIPP & CQUIN) Limited financial leeway (£100k forecast surplus) to employ additional resource to support delivery of schemes	3	4	**12**	Susan Field	The Trust work programme developed and updated to identify quantum of work and to support decisions re priorities and how these will be resourced.	3	4	**12**	22 April 2015

i) Foundation Trust programme

Ref	Date opened	Title/ Theme	Description	Controls in place	Gaps in controls	Initial risk			Manager	Progress (Action Plan Summary)	Current risk			Review date
						Likelihood	Consequence	Risk Score			Likelihood	Consequence	Risk Score	
FT1	11 Sept 2014	Un-sustainable future projections	There is risk that the Trust's Integrated Business Plan (IBP) and Long-Term Financial Model (LTFM) will not be able to identify required targets or cost savings across a five year period: in particular, inability to identify £20million CIP efficiencies	The IBP and LTFM are being developed with oversight of the TDA. The Trust is also working more closely with the CCG so as to ensure that plans align, and that opportunities for cost efficiencies are recognised and realised	The annual commissioning intentions of the CCG remain unclear, and there is lack of clarity over long-term ambitions	3	4	**12**	Rod Brown	The Trust's current and projected financial position suggests that costs savings are not being achieved, which may lead to financial instability	4	4	**16**	30 April 2015

Gloucestershire Care Services NHS
NHS Trust

[Name of Paper]

Ref: 13/0515

Quality and Performance Committee Report

19th May 2015

Objective:

To provide the Board with a summary of the key issues and actions arising from the meeting of the Quality and Performance Committee Governance held on 8th May 2015.

The Board is asked to:

To receive the report and the approved minutes of the Quality and Clinical Governance Committee held on the 26th February 2015 meeting for information and assurance.

To receive the approved minutes of the Performance and Resources Committee held on 17th February 2015 together with the minutes of the extraordinary meetings of the Performance and Resources Committee held on 16th March 2015.

Sue Mead, Quality and Performance Committee, Chair

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

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

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

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

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

Quality and Performance Committee Report

1. Introduction

This report provides a summary of the key issues and actions arising from the meeting of the Quality and Performance Committee meeting held on 8th May 2015. This was the first meeting of the new Committee bringing together the key aspects of quality and performance

The approved minutes of the 26th February 2015 meeting together with the approved minutes of the Performance and Resources Committee held on 17th February 2015 and the extraordinary meeting of the Performance and Resources Committee held on 16th March 2015 are attached for information.

2. Quality Matters

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

- The Director of Nursing and Quality stated that over the reporting period the Trust achieved 88.8% of all applicable national NHS targets and 80.8% of local targets which is a positive position compared with the December 2014 report.
- The Committee welcomed the improvement to the FFT response rate. This has been extended across all GCS services since January 2015. In February 2,367 responses were received through a range of modes of collection including face to face interview, SMS messaging, comment cards and on line survey. 96.5% of respondents stated they were likely or extremely likely to recommend our services.
- Safety thermometer: the Committee noted the positive position in relation to harm free care. 100% of teams completed reports with the average performance achieving 95% There were still evidence of unexplained variation across sites but also recognition of the balance between old and new harms. No pattern or trend in new harm reporting has been identified.
- The Quality Visit programme has been enhanced using a modified version of an accreditation tool developed by Salford Royal Hospital. Teams have included NED colleagues and members of Healthwatch providing valuable preparation for our CQC inspection.

2. Complaints Policy

The Committee received the final draft of the Complaints Policy which incorporated the feedback received at the February meeting. The final draft document makes reference to the important Board oversight of complaints as a recommended by Clwyd. Additionally GCS will be actively involving our NED colleagues in this oversight and are establishing a quarterly review meeting.

The Committee approved the policy to be presented at Board for ratification and asked that the implementation plan come back to the next meeting in order to monitor progress. The Committee will also consider the draft Terms of Reference of the oversight group at its June meeting.

3. Duty of Candour Policy

The Director of Nursing and Quality presented the Duty of Candour Policy following which the Quality and Safety Manager (Unscheduled Care) presented the implementation plan and provided the Committee members with examples of the literature that will be available for colleagues.

The Duty of Candour was a recommendation from Francis following the Mid Staffordshire Enquiry and is embedded within the CQC Fundamental Standards of care and the NHS Contract. It encompasses the ten principles of Being Open and this policy will replace the Trust's Being Open policy once ratified.

The Committee expressed concern that there some delay in addressing this issue and raising awareness of the Duty of Candour at the front line but were pleased to support the policy to be presented to Board for ratification. The Committee requested that a progress report on the implementation plan be brought to the June meeting of the Committee.

4. Falls Report

Julie Ellery, Matron Tewkesbury Hospitals presented a comprehensive report on the actions that Community Hospitals are undertaking to reduce the risk of falls and to minimise the harm from falls when they do occur. A range of interventions are in place and will be evaluated, these include actively involving families and carers, use of alternative therapies and activities as well as interventions such as seating alarms. There was also discussion regarding the impact of single room accommodation in the new hospitals s and how this may be addressed.

It was noted a retrospective reclassification of falls resulting in harm as part of the revision of incident reporting system and aligning categories with national definitions has improved our performance when measured against similar organisations.

Discussion took place as to whether zero falls could ever be achievable; the Committee agreed that this would not be achievable however continued emphasis on reporting and the reduction in those falls resulting in harm is a priority.

5. Corporate Risk Register

The risk register was presented to the Committee by the Head of Corporate Planning and members agree that very positive progress had been made in the development of this critical document. The Committee will receive this at each meeting and key risks with inform future agendas and the forward planner.

6. Appraisals and Mandatory Training

The Director of Huma Resources presented a report to the Committee setting out performance in relation to appraisal and mandatory training.

The Committee were disappointed at the slow progress being made with mandatory training and the deteriorating position of appraisal completion. The Committee noted the trajectories set out to improve this position.

The work to enable reporting of other aspects of mandatory training was noted and the Committee look forward to receiving assurance in relation to safeguarding training in future Quality Reports.

7. Staff Survey

The Director of Human Resources presented the results of the staff survey with particular reference to those aspects that may have an impact on service user experience. It was noted that the full survey had been presented to the HR and OD Committee who will oversee the implementation of the action plan.

The Committee noted the disappointing results in some areas and the actions in place. The Director of Human Resources will keep the Committee informed of progress.

Other reports presented to the Committee

- Quality Account - progress towards development and publication

8. Conclusions and recommendations

The Board is asked to:

- **Note** this report

- **Receive** the approved minutes of 26th February 2015 meeting for information and assurance

- **Receive** the approved minutes of the Performance and Resources Committee held on 17th February 2015 together with the minutes of the extraordinary meetings of the Performance and Resources Committee held on 16th March 2015.

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

Gloucestershire Care Services NHS Trust

Minutes of the Quality and Clinical Governance Committee DRAFT

26th February 2015

Present:

Sue Mead (SM) Non-Executive Director
Liz Fenton (LF) Director of Nursing and Quality
Mike Roberts (MR) Interim Medical Director
Ingrid Barker (IB) Trust Chair
Nicola Strother Smith (NSS) Non-Executive Director
Duncan Jordan (DJ) Chief Operating Officer
Tina Ricketts (TR) Director of Human Resources
Candace Plouffe (CP) Director of Service Delivery
Sue Field (SF) Director of Service Transformation
Jason Brown (JB) Director of Corporate Governance and Public Affairs
Christine Thomas (CT) Minute Taker

In attendance:

Paul Jennings (PJ) CEO
Rod Brown (RB) Head of Corporate Planning

Item	Minute	Action
1.	**Welcome and Apologies** The Chair welcomed the representatives from the Trust Development Authority. Apologies were **Received** from Richard Cryer, Deborah Greig, Christopher Brookes Daw, Lucy Lea, Helen Chrystal.	
2.	**Minutes of the meeting held on 11th December 2014** The minutes of the meeting held on 11th December 2014 were **Received** and **Approved** as an accurate record subject to minor amendments.	JB
3.	**Matters arising (action log)** The following matters were Discussed and Noted: Item reference QC&G 89/14 - closed Item reference QC&G 64/14 - closed Item reference QC&G 66/14 – closed Item reference QC&G 72/14 - closed Item reference QC&G 73/14 - closed Item reference QC&G 86/14 - closed Item reference QC&G 89/14 – closed	

	Item reference QC&G 104/14 – closed Item reference QC&G 105/14 - closed Item reference QC&G 112/14 - closed Item reference QC&G 113/14 – include in the Forward Planner Item reference QC&G 117/14 - closed	JB
4.	**Forward agenda planner** The Forward Planner was discussed and approved with minor changes.	JB
5.	**Understanding You – an approach to customer service** The CEO and RB introduced the Understanding You – an approach to customer service report to the Committee. RB stated that the purpose of the report was twofold, namely to articulate how by moving towards a more customer services focused approach, the Trust will be better placed to listen to, and learn from, the voice of local service users, carers and families. Secondly, the report aims to update the Committee on proposals for a more integrated service user experience report that reflects and represents the Trust's customer service philosophy. The CEO assured the Committee that the report is not about rewriting the Engagement Framework and Communications and Engagement Strategy. The Committee was asked to approve the proposed customer services approach. IB stated her support for the report, subject to minor process changes particularly in respect to naming conventions and the proposed rebranding of the Engagement Framework. RB reaffirmed that the Engagement Framework will not be rebranded. JS stated her support for the report; however felt that the paper lacked emphasis on integration. It was also stated that a programme of work, KPIs and clear timelines should also be included within the report. TR stated that instilling the messages of the core values framework should also be included within the programme of work. The Committee **Discussed** and **Approved** the Understanding You – an approach to customer service report subject to minor changes.	RB RB
6.	**Revised complaints policy** The Director of Nursing and Quality presented the revised complaints policy and commented that the policy sets the approach that the Trust will take to listening to and learning from those that use the Trust services. It was stated that the policy will align to the core values framework and duty of candour, safeguarding processes and that an	LF

	implementation plan will be developed to support the policy. IB stated that where there maybe recurrent concerns raised about a similar issue and that the policy should be clear about how the Trust will collate and address any emerging themes. Additionally, IB stated that service users should be given clear guidance about how to make a complaint, and this should be evident within the policy. Discussion took place as to how NED oversight of complaints may be incorporated into the process. It was agreed a discussion would take place outside Committee. TR commented that a Quality and Equality Impact Assessment should be completed for the policy. The Committee **Discussed** and **Approved** the revised complaints policy subject to the proposed changes highlighted above.	LF LF LF
7.	**Quality and Performance Report** The Director of Nursing and Quality introduced the quality and performance report and commented on the Trust's performance in relation to the national and local care quality indicators. It was explained that the report was set out in a format to enable effective triangulation of the key aspects of quality that may be used to consider safety, care, responsiveness, effectiveness and leadership of the services. The Director of Nursing and Quality stated that over the period reported the Trust achieved 80% of all applicable national NHS targets and 74.1% of local targets which is a decline on the position reported in November 2014. **<u>Safe</u>** The Director of Nursing and Quality highlighted that in respect of the harm free care threshold the Trust reported 93.8% in December 2015 against the national target of 95%. The Trust also reported 17 SIRI's year to date, of which 47% related to falls, slips and trips. Focus remains on the key areas of falls and pressure ulcers looking at those patients who experienced harm and working across the health community to further reduce this risk. SF indicated that the position for February was positive in respect of meeting the 95% threshold. This had been achieved through focussed support to clinical teams and robust validation of the data. In respect of pressure ulcers, there is a current focus on "thinking heels" with learning events with teams and guidance on prevention of skin damage to heels. SF suggested that a report is brought to the next Committee on how the Trust plans to address the 5% differential in respect of the	SF

	Safety Thermometer, and how as a Trust we will be approaching this. The Director of Nursing and Quality provided an update on the issue in respect of falls reporting in an inpatient setting. It was stated that the falls policy is being revised and will include a clear definition which will link to the reporting within the incident management system. A review of the system underpinned by additional support in clinical areas is being undertaken. SF stated that an action plan has been developed by Julie Goodenough (Head of Community Hospitals) which includes the development of a falls prevention policy, sharing best practice and learning of Matrons, positive risk taking and understanding, patient anxiety and agitation level monitoring and standardisation of falls alert signage in line with NICE guidance. In respect of medicine management, it was reported that there were 36 completed audits that followed the NHS Protect Medicines Security Self-Assessment Checklist conducted between August and September 2014. The results of the audits will be reported to the service governance groups. The Committee asked for a detailed report at the next meeting. **Caring** The Director of Nursing and Quality reported that the Trust is not achieving the requisite response rates for the Friends and Family Test (FFT) for the Minor Injury Units and teams are being reminded of the importance of asking for feedback and learning shared from units achieving positive response rates. The Trust has achieved 29% response rate for inpatient wards against a target of 30% in December 2014 which was well received by the Committee. The Committee reported their concerns with the FFT figures at Stroud Community Hospital, and asked for a detailed report at the next meeting. **Effective** The Director of Nursing and Quality reported that staff flu vaccinations resulted in 42.5% of staff vaccinated, and increased from the 38.6% in 2013/14. It was reported that the Trust continues to review NICE guidance and quality standards published after May 2010. The Committee requested a detailed report for the next meeting in respect of quality standards review and implementation. **Responsive** It was reported that the updated action plans for MSKCAT and Podiatry have been reviewed with commissioners. It was also reported that there are two social care indicators currently rated red, which are of particular priority for the Trust and Adult Social Care Commissioners.	MR SF LF

	CP reported that in respect of Chlamydia Screening, the service have a number of actions in place to increase the number of positive screens. It was additionally reported that the Commissioner has asked for a business case to further improve service delivery. CP also reported that in respect of Adult Speech and Language Therapy, the service is struggling to fill vacancies, which has an impact upon capacity. An action plan will be developed by the end of February 2015. CP reported that the adult social care and rapid response key indicators improved in December 2014, this was acknowledged by the Committee. **<u>Well-Led</u>** The Director of Human Resources reported that the sickness absence levels, mandatory training rates and appraisals continue to under-perform. The Chair asked for a detailed report particularly in respect of appraisals and sickness absence for the next meeting. The Committee **Discussed** and **Noted** the report.	CP CP TR
8.	**Unscheduled Care Report** The Director of Service Transformation presented the unscheduled care report which highlighted the actions that have or are planned to be taken to address specific risks. Key risks reported were in respect of capacity and patient flow during winter and pressure ulcers. It was also reported that the Trust is maintaining a quality Out of Hours service during the transition to SWAST. Additionally, SF reported that the Rapid Response Service has now gone live in South Cotswolds. The Committee **Discussed** and **Noted** the report.	
9.	**Scheduled Care Report** The Director of Service Delivery presented the scheduled care report which highlighted the actions underway to mitigate the risks identified to clinical/professional care within the scheduled care services. The Committee **Discussed** and **Noted** the report.	
10.	**Annual Committee Statement** The Chair presented the Annual Committee Statement to the Committee which was **Received** and **Noted** subject to minor	LF

	changes.	
11.	**Diabetes Service – In depth review** CP reported that there has been an in-depth review of services for patients with Diabetes, to gain an understanding of the breadth and depth of services provided to this cohort of patients and how well these services are interlinked to create a seamless care pathway. CB stated that the review has allowed the organisation to confirm the quality of services provided, and sets the future direction of service development for the organisation to help improve the outcomes for patients with diabetes. Within the assurance given in the report, the Committee noted the work on the diabetes review, the actions undertaken and future action plans in development. The Chair requested that a task and finish group should be established to ensure the delivery of the planned actions. The Committee **Discussed** and **Noted** the report.	CP
12.	**Annual Mortality Report** The Medical Director introduced the template for the Annual Mortality Report, and asked the Committee to note the proposed system for analysis and improvement. The Chair requested that a procedure for the management of mortality should be developed and presented to the next Committee. The Committee **Received** and **Approved** the template report.	MR MR
13.	**Medical Revalidation Report** The Medical Director highlighted to the Committee the work in progress to ensure that a robust process is in place for professional validation and revalidation of all Doctors providing medical services for the Trust. The Committee **Discussed** and **Noted** the report.	
14.	**Governance for Chief Inspector of Hospitals visit** LF presented an overview of the governance arrangements for those senior Trust committees which have direct responsibility for supporting preparations for the Chief Inspections of Hospitals assessment in June 2015. IB requested that the minutes of the CQC Programme Board meeting should be brought to the Committee for information. The Committee **Discussed** and **Noted** the report.	LF

15.	**Estates and Facilities Report** MP presented an update on the status of current compliance in a number of areas facilitated by estates, safety, security and the facilities team. The Committee was asked to note that all Trust freehold properties currently have a planned preventative maintenance schedule. Additionally, the Committee was asked to note the PLACE assessment improvements. The Committee **Discussed** and **Noted** the report.	
16.	**Quality Account 2014/15** RB presented the Quality Account update to the Committee, which highlighted progress towards production of the report. The Committee **Noted** the update.	
17.	**Items for information** The subgroup reports in respect of (1) Infection Control Committee (2) Clinical Senate Report (3) Unscheduled Care Governance Meeting (4) Scheduled Care Governance Meeting was **Noted** by the Committee.	
18.	**Any Other Business** LF informed the Committee of the Safeguarding Board review of particular cases, which had concluded today. No other business was requested for discussion. The Chair thanked everyone for attending the meeting. The meeting was closed by the Chair.	
19.	**Date of the next meeting** It was agreed that the next meeting of the Committee be held on Thursday 16th April 2015, Boardroom, Edward Jenner Court, Gloucester.	

GLOUCESTERSHIRE CARE SERVICES NHS TRUST
PERFORMANCE AND RESOURCES COMMITTEE

Minutes of the Meeting held on Tuesday, 17 February 2015 at 2.00pm in the Boardroom, Edward Jenner Court

Present:

Members:

Richard Cryer (RC)	Non-Executive Director (Committee Chair)
Ingrid Barker (IB)	Trust Chair
Duncan Jordan (DJ)	Chief Operating Officer
Glyn Howells (GH)	Director of Finance
Rob Graves (RG)	Non-Executive Director
Tina Ricketts (TR)	Director of HR

In Attendance:

Sue Field (SF)	Director of Service Transformation
Stuart Bird (SB)	Deputy Director of Finance
Candace Plouffe (CP)	Director of Service Delivery
Kate Calvert (KC)	Head of Programme Transformation & Change
Caroline Holmes (CH)	Head of External Care
Lee Charlton (LC)	IM&T Clinical Systems & Change Manager (Item 15 only)

Secretariat:

Bev Samuels (BS)	Executive Assistant

Apologies:

Paul Jennings (PJ)	Chief Executive
Jason Brown (JB)	Director of Corporate Governance & Public Affairs
Matthew O'Reilly (MO)	Head of Performance & Information
Bernie Wood (BW)	Head of Information Management & Technology

Item	Detail	Action
P&R 001/15	**Agenda Item 1: Apologies** Apologies were noted from, Paul Jennings, Jason Brown, Matthew O'Reilly, Bernie Wood.	
P&R 002/15	**Agenda Item 2: Minutes of 16 December 2014 meeting** The Committee **RECEIVED** the unconfirmed minutes of the 16 December. There were some amendments noted, these were: 102/14 – A one off meeting of the Chairs as requested by the HOSC committee meeting was convened and chaired by Dr Helen Miller. The group met to agree a joint statement by GCS, GHFT, GCCG and GCC following the media statement by GHFT. 102/14 – PJ updated the Committee on the outcome of meetings between	

	the Trust and GCCG, the meeting agreed in principle to support the assumptions under the 5 year plan. An update to the Trust Board outlining the position as regards the current state of play with the GCCG was arranged. 103/14 – 6. Change 'bill' to 'invoice'. "The Trust is beginning to invoice GHFT based on actual activity (including high cost consumables)". 105/14 – Penultimate paragraph removed. 106/14 – add the words "in aggregate" (only 86.5% in aggregate in community hospitals). Action – SF/MO 108/14 – GCC's original panel savings target of £2.3m was calculated at a gross level, the actual net saving will be £1.5m which leaves a further £800k cost pressure against this savings programme. 111/14 – change extra Trust Board to an extra meeting of the Trust Board members. Subject to the above amendments these minutes were approved by the Committee. **Resolution: The Committee RECEIVED and APPROVED the minutes of the 16 December subject to the above amendments.**	
P&R 003/15	**Agenda Item 3: Matters Arising** The Committee reviewed the Action Log. Action 70 – Reopened – Progress towards moving GHFT outpatient clinic to activity based billing and charging for high cost consumables used in outpatient clinics. Action 72 – Deleted, duplicate entry Action 73 – Committee requested a report to the next meeting which identifies the Trust's surplus capacity and available opportunities to increase income. Action 74 – Closed Action 77 – Update – PWC appointed to undertake the internal audit. Contact made with GCC Finance Assistant Director, Mark Spilsbury, regarding arranging a meeting to discuss the external care financial control mechanisms. GCC best practice internal audit process has begun. The Trust is in agreement with the Terms of Reference. **Resolution: The Committee APPROVED the updates and the closure of Actions 72 and 74 and the reopening of Action 70.**	
P&R 004/15	**Agenda Item 4: Review of Forward Agenda Plan** The Committee noted the proposed partial merger between the Performance and Resources Committee and the Quality and Clinical Governance Committee and identified the need to provide a forward plan to ensure items are not overlooked when the agendas are re-allocated. **Resolution: The Committee NOTED the proposed partial merger of the Performance and Resources Committee and the Quality and Clinical Governance Committee and the likely impact on agendas.**	JB

P&R 005/15	**Agenda Item 5: Chief Operating Officer's Report** DJ presented the Report. This report provides a contextual overview for the Committee on some of the headline performance matters. Nurse Recruitment continues to be a key priority for the Trust. Whilst some progress has been made in attracting new staff significant challenges remain in particular in recruiting Band 6 Nurses for Community Nursing and Band 5 Staff Nurses for Community Hospital inpatient units. Through the HR&OD committee a report is to be produced which captures staff movement, retirement, promotions, bank and leavers and starters, an age profile review will also be captured. The rationale behind over recruiting to certain nursing vacancies to ensure staffing levels was discussed. Committee advised that good progress had been made with the implementation of e-rostering to facilitate automated daily monitoring of staffing levels. Three test sites - Stroud, Dilke and Lydney Community Hospitals are now all paperless and utilise e-rostering. E-rostering has just been introduced to Cirencester. Committee advised that consultant, Marianne Thompson, will have her contract extended on a Fixed Term basis to continue her work on E-Rostering. **Resolution: The Committee NOTED the report.**	
P&R 006/15	**Agenda Item 6: External Care Update Report** CH presented the External Care Programme update for 2014-15 and highlighted some developments: • New commitment movement reports. These now highlight all movements each month and require LMs to explain the movements; • Quick Support Plans have been brought into the daily panels which now run all day so that urgent support plans can be signed off within the panel process. • Organisational and workforce development planning to address the cultural and behavioural issues identified earlier in the year. • Continuation of the new workstreams around placements and existing workstreams to reduce the overspend. • Commencing the planning process for 2015-16 including staff and commissioner engagement. Quick Support Plans have now been included in the panel process. Only those with a total value of £200 or less are agreed outside panel. A large number of service user records are being checked to identify any service users without a commitment but a service in place. This process will take approximately 4 weeks. Committee advised of the additional pressures being experienced through the panel spends process, this is backed up by the recording of 800 more referrals in January 2015 than were recorded in January 2014. Priority areas to address: • Reduce reablement contact time	

	• High sickness levels across reablement colleagues • Access to additional domiciliary care placements • Planning the continued development and expansion of reablement, telecare and the referral centres to manage demand and introduce a wider variety of preventative services whilst fully understanding the full year effect of 2014-15 schemes and rolling these forward into 2015-16 • Review data and available benchmarking information. Target performance and financial outliers. • Complete 400 reassessments before the end of March. • Further analysis required to align with the budget - categories of activities, volume and price and budgeted amounts. Committee informed of mobile working delays which has had an impact in meeting targets. The Committee advised that Denise Hunt has joined the programme team as Programme Manager with effect from 2 February 2015 and will be working closely with Caroline Holmes. The Chair requested assurance that initiatives were in place to deliver on the priority areas identified and close the current gaps. The Chair requested: • further work on the financial model for this programme • identifying the achievable levels of spend • A demonstration of achievement • A consolidation of the current position • Outline of progress made **Resolution: The Committee NOTED the content of the update and continued risks to GCS and will monitor closely going forward.**	CH
P&R 007/15	**Agenda Item 7: Finance Performance Report** SB presented the Finance Performance Report. Committee was advised of both the year to date and full year forecast out-turn positions for GCS at Month 9 and highlighted risks and plans to mitigate them. The Trust is entering the final year of its initial three year contract with the CCG on 1st April. All major planning principles have been agreed with the CCG Chief Finance Officer (CFO) to ensure consistent planning assumptions and these are now being negotiated into the Contract Variation. On 29th January, the Monitor Board announced that the proposed pricing methodology for 2015/6 had been challenged by Foundation Trusts. This means that additional steps need to take place before inflation and efficiency figures in the contracts can be finalised. The Trust has agreed with the CCG CFO to continue to Contract Variation under the existing assumptions and then to vary in the impact of any revised pricing changes as and when they are issued. This will allow us to proceed through annual planning and budgeting with minimal delay. The impact of any change in pricing will be bought to the Board's attention through the Finance Report.	

	Within GCS, services are now commissioned and funded by a number of different commissioning organisations. Funding from Gloucestershire CCG and NHS England is now in place and contractually agreed. Funding for services being provided for Gloucestershire County Council (mainly public health related) are agreed but are yet to be varied into the contract. The CCG is making payments on account to prevent cash flow issues and there has been no impact on services. The Chair thanked GH and finance colleagues for the effective manner in which these negotiations with the CCG were undertaken. GCS will proceed with the contract adopting last year as a basis, any variance once known will be factored in. SB tabled a cashflow forecast table for information. Committee advised that creditor accrual duplications have been found and a review to resolve is currently underway. **Resolution: The Committee NOTED the report and contract negotiations undertaken.**	
P&R 07.2/15	**Agenda Item 7.2 Capital Schemes – approvals and progress review** SB briefly updated the Committee on Capital Expenditure Update. Committee is asked to note the current position and implications for the Trust. To date, the Trust has spent £1.62m of the planned £6.4m in 2014/15. Latest estimates indicate a total in year spend of £4.6m due to project slippage on the replacement Community of Interest (COIN) network which is being procured in collaboration with GHNHSFT and 2GNHSFT and delays in identifying a suitable property in Gloucester for planned service changes. The TDA have agreed to defer £0.8m of 2014/15 planned spend into 2015/16. Committee were reassured that Estates management is in good order. The committee were also advised of the Information Management & Technology (IM&T) Steering Group who are tasked with ensuring spends against capital receive Operational colleague agreement before final decisions are made. This is an operational and not financial led agreement. **Resolution: The Committee NOTED the contents of the report.**	
P&R 007.3/15	**Agenda Item 7.3: Business Development Tracker** SB presented the Business Development Tracker. The Committee received an update on ongoing service change discussions with commissioners and other providers. The Committee is advised of additional income potential for the Trust if unused capacity can be identified and sold to other providers or additional work can be secured from existing commissioners. A plan for future use of Cirencester Theatre is to be identified following	

	commissioner decision to give notice to current customer (UKSH) who provide GCS with approx. £800k of income per year for using our theatre. The Trust has been approached by GHFT wishing to use the theatre. An analysis by site on theatre usage, income and costs is to be made available. Information relating to the available hours by site is to be produced and appended to a future report to the Committee. Processes for moving to activity based billing on GHNHSFT outpatient clinics (including charging for high cost consumables) to go live on a phased basis from 1 April 2015. Income budget rebasing underway as part of 2015/16 budget round. New proposal submitted to CCG around lower limb (leg ulcer) service to be provided through specialist nursing. Potential gross annual value approx. £700k. Prime Minister's Challenge Fund – is a GP led opportunity to increase local primary care capacity. The Trust was asked to support separate bids that propose different operating models. The GPs expect to hear the outcome of their bids by the end of March. **Resolution: The Committee NOTED the report**.	SB SB
P&R 008/15	**Agenda Item 8: Quality and Performance Report** DJ and GH presented the Contract Performance Report. Over the period reported in the paper the Trust achieved 80.0% of all applicable National NHS targets (28 out of a total of 35) and a 74.1% of local targets (20 out of 27). The committee is asked to note that the report specifically focusses on contract performance, detailed Quality performance issues are reported to the Quality and Clinical Governance Committee. The Committee was asked to note that improvement plans were already in place to address the MSKCAT target concerns. The Friends and Family test targets are also now moving in the right direction. The Committee was also asked to note the steady progress that is being made on Harm Free Care. **Resolution: The Committee NOTED the report and the steady progress that is being made.**	
P&R 009/15	**Agenda Item 9 Transformation and Change Report** DJ presented the Transformation and Change Report. The Committee was provided with an update on the current Cost Improvement Programme 2014/15 and discussed the progress with the three schemes for 2015/16. *Cost Improvement Programme (CIPs)* – the Committee were advised that the	

	Trust could achieve the 2014/15 in year £2.5m forecast for its CIPs programme with the use of a managed vacancy factor and accounting adjustments. Analysis is still on-going to determine the Trust's position against the full year £3.4m CIP target. The Committee requested a special meeting to discuss CIPs for 2014/15 and 2015/16. A special meeting of the Performance and Resources Committee is to be scheduled to take place in March ahead of the next Trust Board meeting. Update to be presented to Board. *Quality, Innovation, Productivity and Prevention (QIPP)* – the Trust achieved 70% of agreed milestones to the value of £1.19m as at 31 December 2014 (Quarter Three). A risk forecast for the delivery against milestones is currently £160k. It has been proposed that this is offset by the work undertaken by the Trust in relation to the Rehabilitation Review. The Committee were advised that the Activity Risk Share component of the QIPP Schedule is currently at £844k and also advised that there is now a total risk of £1.04m, the QIPP RAG rating is RED. The Committee is asked to note the challenges with this year's QIPP Schedule, the majority of which has been beyond the Trust's control. The Trust is currently in active negotiations to mitigate this level of risk. Negotiations for 2015/16 have begun with GCCG. *Commissioning for Quality and Innovation (CQUIN)* – The Committee were advised of GCCG confusion with data submitted for CQUIN 1 in relation to 'falls'. Additional information has now been provided and no financial penalty should be incurred. **Resolution: The Committee NOTED the report and AGREED to a special meeting of this Committee taking place in March 2015.**	DJ/KC
P&R 010/15	**Agenda Item 10: Community Nursing Update** CP presented an update on Community Nursing. The Committee were updated on the continued robust work being undertaken in line with the district nursing action plan to address the band 5/6 recruitment issues. CP advised the Committee that a more detailed report will be presented to the Quality and Clinical Governance Meeting. **Resolution: The Committee NOTED the report and NOTE that a detailed report will be presented to the Quality and Clinical Governance Committee.**	CP
P&R 011/15	**Agenda Item 11: Benchmarking – referencing costs** SB presented the Benchmarking – referencing costs update report. Committee were advised that some of the figures supplied as part of the benchmarking group submission were incorrect and needed to be resubmitted. SB to ensure the correct numbers and data is submitted to ensure future benchmarking analysis presents the right view of the Trust. A more robust process to be put in place to resolve this problem.	

	Resolution: The Committee NOTED that correct numbers and data to be resubmitted. The Committee noted the plans to introduce a more robust system.	SB
P&R 012/15	**Agenda Item 12: Transition of OOH Service Report** SF presented the Transition of OOH Service report. The Committee were updated on the activity being undertaken to transition the Out of Hours service to SWAST on 1 April 2015. The Committee were updated on the key risks and issues identified and the costs associated with this transition project. All identified risks have been shared with the CCG and added to the risk register. The Trust continues to be part of the 3-way engagement – GCS, CCG and SWAST. The Committee is asked to note that SWAST participation was usually by teleconference with key SWAST personnel not always present at these meetings. Staff engagement sessions across the county have now taken place and SWAST will shortly commence 1:1 meetings with staff. The Trust and SWAST are working closely on the TUPE list and ensuring that staff are briefed on the service model. The Committee was asked to note concerns around TUPE and the potential for a legal claim against SWAST if staff engagement is not correctly handled. In readiness for the handover of services the Trust has ensured staff rotas have been populated up to 31 March 2015. **Resolution: The Committee NOTED and RECEIVED the report and the actions taken.**	
P&R 013/15	**Agenda Item 13: Urgent Care Discharge Report** SF presented a verbal update to the Committee. The Committee were advised that pressures have been high in recent months and as a result the Trust has an additional 16 beds open in Stroud and the Forest of Dean to help with the pressures currently being experienced by GHFT. A risk to the Trust is resilience in staffing - ensuring there are adequate staff - bank or agency available to cover the required shifts. The knock on effect has been an increase in the length of stays. Committee advised that planning meetings with commissioners across both health and social care have already started to take place to share learning from the current experiences. SF/H Hodgson will meet to discuss how the Trust can best use the information currently being received through the Alamac system. The Chair noted the Trust's contribution to the discharge pressures and the professionalism of staff involved. **Resolution: The Committee NOTED the verbal update.**	SF/HH
P&R 014/15	**Agenda Item 14: Chlamydia Performance Report**	

	CP presented the Chlamydia performance report. The Committee was provided with an update on the performance issues relating to Chlamydia Screening and the detailed recovery action plan. The Committee was asked to note that the Commissioners have been informed and a meeting has been set to discuss the likelihood that the recovery of performance is not achievable before year end. There are plans in place to review the whole service model of chlamydia screening, with a view to consider shared care of partner notification with primary care. **Resolution: The Committee NOTED the report and recovery plan and the actions being taken to improve performance.**	
P&R 015/15	**Agenda Item 15: SystmOne Update Report** GH presented the SystmOne Update report. The Committee was provided with a further update on the progress of the SystmOne deployments and actions taken against the lessons learnt. The Committee is asked to note the successful deployment to all Children's and Child Health services where 450 staff went live on the same day – 9 December 2014 including successful migration of children's electronic data from the legacy system to SystmOne. Project Initiation documents (PIDs) have been signed for the deployment of SystmOne to Community Hospitals and MIUs. The first hospital to go live will be Cirencester Hospital and MIU in May 2015, the remaining 6 community hospitals will be deployed between June and December 2015. The project will continue to be monitored via the fortnightly meetings. **Resolution: The Committee NOTED the report.**	
P&R 016/15	**Agenda Item 16: Long Term Financial Model (LTFM) Assumptions and Budget** GH updated the Committee on changes to the planned submission dates of the Trust's Integrated Business Plan (IBP) and LTFM). **Resolution: The Committee NOTED the LTFM item.**	
P&R 017.1/15	**Agenda Item 17.1: Information Technology Strategy Dashboard** LC presented the item and updated the Committee. LC confirmed that M Lambert – Head of Communications and Engagement - will provide an update to the Trust Board on the strategy. The Committee were advised of the need to ensure increased IT skill levels of future employees. The mobile working and other information technology led initiatives will be reliant on staff having the required skills to use IT equipment. **Resolution: The Committee NOTED the item.**	

P&R 017.2/15	**Agenda Item 17.2: Information and Performance Management Strategy Dashboard** Item deferred to the next meeting of Performance and Resources Committee. **Resolution: The Committee NOTED that this item will be deferred to the special meeting in March 2015.**	
P&R 017.3/15	**Agenda Item 17.3: Estates Strategy Dashboard** Item deferred to the next meeting of Performance and Resources Committee. **Resolution: The Committee NOTED that this item will be deferred to the special meeting in March 2015.**	
P&R 018/15	**Any Other Business** • GH updated the Committee on Tewkesbury Hospital. It has come to light that there are issues with some of the completion reports presented by Seddon. GH has formally written to the Chairman of Seddon to request attendance at an emergency meeting on 19 February 2014. Concerns still unresolved regarding the concrete/screed flooring material and the water ingress problems that have arisen as a result. The TDA have been made aware the current situation. The Chair noted the very good quality of committee papers presented at today's meeting. Meeting concluded at 4.35pm.	
P&R 019/15	**Date of Next Meeting** Tuesday 16 March 2015 in the Boardroom at Edward Jenner Court, Gloucester.	

Chair's signature……

Date……

GLOUCESTERSHIRE CARE SERVICES NHS TRUST
SPECIAL PERFORMANCE AND RESOURCES COMMITTEE

Minutes of the Meeting held on Monday 16th March 2015 at 10am in the Boardroom, Edward Jenner Court

Present:

Members:

Richard Cryer (RC)	Non-Executive Director (Committee Chair)
Rob Graves (RG)	Non-Executive Director
Duncan Jordan (DJ)	Chief Operating Officer
Tina Ricketts (TR)	Director of HR

In Attendance:

Stuart Bird (SB)	Deputy Director of Finance
Matthew O'Reilly (MO)	Head of Performance & Information
Kate Calvert (KC)	Head of Programme Transformation & Change

Secretariat:

Jenny Goode (JG)	Executive Assistant

Apologies:

Paul Jennings (PJ)	Chief Executive
Glyn Howells (GH)	Director of Finance
Jason Brown (JB)	Director of Corporate Governance & Public Affairs
Susan Field (SF)	Director of Service Transformation
Candace Plouffe (CP)	Director of Service Delivery

Item	Detail	Action
P&R 020/15	**Agenda Item 1: Apologies** Apologies were received from: Paul Jennings, Glyn Howells, Jason Brown, Susan Field and Candace Plouffe.	
P&R 021/15	**Agenda Item 2: Introduction and reason for meeting:** The Chair welcomed everyone to the meeting and explained that this would be the last meeting of Performance and Resources Committee in its present format with the new Quality and Performance Committee taking its place. The main purpose of this meeting was to discuss Cost Improvement Programme (CIP) schemes, looking at both the outturn for 2014/15 and the plan for 2015/16.	

P&R 022/15	**Agenda Item 3: Transformation and Change report** The Committee received an update on: • The forecast full-year impact position on the 2014/15 CIP; • Managing vacancies; • Lessons learned from this year's Programme and actions taken; and • CIP planning 2015/16 Following discussion, the Committee: a) NOTED the delivery report on the programme for 2014/15, including the full-year financial position; b) NOTED the challenges of achieving a significant cost saving without reducing permanent staffing levels across the organisation; c) NOTED the lessons learned from 2014/15 and subsequent actions taken; d) CONSIDERED THE draft transitional Cost Improvement Programme (CIP) for 2015/16 that encompasses a longer term view and planned transformational service change.	
P&R 023/15	**Agenda Item 4: Strategy Dashboard** The Committee RECEIVED and NOTED the reports.	
P&R 024/15	**Agenda Item 6: Any Other Business** No other business was requested for discussion. The Chair thanked Stuart Bird, Kate Calvert and Matthew O'Reilly for their contributions to the meeting. The meeting was closed by the Chair at 11.45am.	
P&R 025/15	Date of next meeting of Quality and Performance Committee:	

Chair's signature…….

Date…….

GLOUCESTERSHIRE CARE SERVICES NHS TRUST
SPECIAL PERFORMANCE AND RESOURCES COMMITTEE

Minutes of the Meeting held on Monday 16th March 2015 at 10am in the Boardroom, Edward Jenner Court

Part 2

Present:

Members:

Richard Cryer (RC)	Non-Executive Director (Committee Chair)
Rob Graves (RG)	Non-Executive Director
Duncan Jordan (DJ)	Chief Operating Officer
Tina Ricketts (TR)	Director of HR

In Attendance:

Stuart Bird (SB)	Deputy Director of Finance
Matthew O'Reilly (MO)	Head of Performance & Information
Kate Calvert (KC)	Head of Programme Transformation & Change

Secretariat:

Jenny Goode (JG)	Executive Assistant

Apologies:

Paul Jennings (PJ)	Chief Executive
Glyn Howells (GH)	Director of Finance
Jason Brown (JB)	Director of Corporate Governance & Public Affairs
Susan Field (SF)	Director of Service Transformation
Candace Plouffe (CP)	Director of Service Delivery

Item	Detail	Action
P&R 026/15	Agenda Item 1: Budget approval SB updated the Committee on the report due to be discussed by the Trust Board on 17th March 2015 regarding contracting for 2015/16 and the impact on budget setting. The Committee NOTED the report and agreed that the Chair should give an update to the Trust Board on 17th March 2015.	

Chair's signature……

Date……

Gloucestershire Care Services NHS
NHS Trust

Quality and Performance

Ref: 14/0515

Quality and Performance
May 19th 2015

The Board is asked to:

- Note the position at the end of March 2105 and the year-end outturn for 2014/15
- Note the positive impact of actions undertaken to improve patient safety as measured by the Safety Thermometer
- Note the overall improvement in performance against local and national targets in month and the action in place where remediation is required
- Support the plans to further develop the report for 2015/16 and incorporate financial reporting to more effectively triangulate the metrics

Executive summary:

The integrated quality and performance report, which is driven by the organisation's priority to deliver safe and effective care, has been developed to provide the Trust Board and its sub committees with assurance that quality is being carefully monitored and that improvement measures are being identified and implemented where necessary. It also enables the Trust to demonstrate its commitment to encouraging a culture of continuous learning, improvement and accountability to patients, communities, the commissioners of its services and other key stakeholders.

For 2015/16 this report will be further developed to provide robust assurance through triangulation of data by incorporating the financial reporting alongside the quality and performance metrics.

Infection Prevention and Control

There were four cases of Clostridium Difficile infection reported in March, one occurring in Cirencester Community Hospital and three in Dilke Memorial Hospital. This brings the total number of cases in 2014/15 to 17 against a tolerance level of 21. To date 8 cases have been agreed by the CCG as unavoidable in GCS care and outcome of further appeals are awaited. The focus for 2015/16 will be on the actions resulting from the RCAs in cases avoidable in our care.

Harm Free Care

The Trust achieved 95% harm free care in March 2015 bringing the year end average to 92.6% a considerable improved on the March 2014 outturn of 89.6%. the focus remains on reducing the risk of falls in our Community Hospitals and on the prevention of pressure ulcers.

Pharmacy Service

As a result of a competitive tendering process Lloyds Pharmacy will provide pharmacy services for the Trust with effect from May 1st. This arrangement ensures equity of provision across our hospital sites and an enhanced service to other teams. Robust key performance indicators have been agreed with the new provider which will detail drug usage and ordering frequency by all sites and services. This information will be shared monthly with Heads of Service and will be reviewed by the Medicines Management committee. This will strengthen governance of medicine usage across the organisation.

Friends and Family Test

The Friends and Family test has been extended in quarter four to cover all services. Response rates are low for the services that recently began collecting data in January but showing increases as the process becomes embedded. In March, 1,695 service users responded. This is a total of 7% of the 37,150 service users in contact with services during March

In March 2015, the Trust is reporting 85.7% compliance with national health targets and 77.8% compliance with local health targets on year to date basis: this is an improvement from with the position reported in February 2015.

MSKCAT

Waiting times remain above trajectory for those requiring routine appointments which has an impact on referral to treatment targets. This aligns to strategic risk 003 and the actions in place to address under performance include:

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

Podiatry

Referral to treatment times sustained performance in March. Aligning to strategic risk 003 the actions in place are as for MSKCAT. Service Lead has also undertaken review of clinic rotas and appointment schedules to maximise available capacity.

Social Care

There are two social care indicators currently rated red, which are of particular priority for the Trust and Adult Social Care Commissioners (see page 51). Performance in relation to permanent admissions to Care Homes continues to show a positive trend.

Incident governance

The potential under reporting of incidents is highlighted as a strategic risk (Ref 001) and actions are in place to reduce this risk. The most recent report from the NRLS shows the Trust has improved when compared to similar organisations. The newly built incident report system together with additional support and training will further enhance reporting, understanding and learning.

Identify which strategic objective(s) this paper supports:

1.	Achieve the best possible outcomes for our service users through high quality care.	**x**
2.	Understand the needs and views of the service users, carers and families so 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**

Matthew O'Reilly, Head of Performance and Liz Fenton, Director of Nursing and Quality

Sponsored by Liz Fenton, Director of Nursing and Quality
May 12th 2015

Please complete the Equality Checklist over….

Please select one of the following options:

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

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

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

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

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

Gloucestershire Care Services NHS
NHS Trust

Quality and Performance Report

19th May 2015

Understanding you

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Executive Summary

Gloucestershire Care Services NHS Trust is committed to providing high quality care to the communities that it serves and ensuring the highest standards of patient care and patient safety. We strive to make improvements in the quality of the care that we provide, at the same time as ensuring that it is clinically effective, person focused and safe. This enables us to evidence achievement of the quality goal set out in the Clinical and Professional Care Strategy; to deliver safe, compassionate and considerate care which ensures services users remain safe from avoidable harm.

The integrated quality and performance report, which is driven by the delivery of safe and effective care, has been developed to provide the Trust Board and its sub committees with assurance that quality is being carefully monitored and that improvement measures are being identified and implemented where necessary. It also enables the Trust to demonstrate its commitment to encouraging a culture of continuous improvement and accountability to patients, communities , the commissioners of its services and other key stakeholders.

Harm Free Care	**March 2015**	**2014/15 outturn**
% of teams submitting data	**100%**	**98.6%**
% of patients harm free	95%	92.6%
Number of patients harm free	989/1,041	11,834/12,783

Infection Prevention and Control

There were four cases of Clostridium Difficile infection reported in March, one occurring in Cirencester Community Hospital and three in Dilke Memorial Hospital. This brings the total number of cases in 2014/15 to 17 against a tolerance level of 21. To date 8 cases have been agreed by the CCG as unavoidable in GCS care and outcome of further appeals are awaited. The focus for 2015/16 will be on the actions resulting from the RCAs in cases avoidable in our care.

GCS recorded uptake of the influenza vaccination among staff of 42.5% in 2014/15. This is an increase of 3.9% on the performance for 2013/14 of 38.6%.

MSKCAT

Waiting times remain above trajectory for those requiring routine appointments which has an impact on referral to treatment targets. This aligns to strategic risk 003 and the actions in place to address under performance include:

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

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Incident governance

The potential under reporting of incidents is highlighted as a strategic risk (Ref 001) and actions are in place to reduce this risk. The most recent report from the NRLS shows the Trust has improved compared to similar organisations. The newly built incident report system together with additional support and training will further enhance reporting, understanding and learning.

Quality overview - health performance against indicators (March YTD)

	March cumulative year-to-date (with comparators to January)							February cumulative year-to-date			Average year-to-date		
	Red		Amber		Green		Total	Red	Amber	Green	Red	Amber	Green
National	3 8.8%	↑	2 5.9%	↓	29 85.3%	↔	34	2 5.9%	3 8.8%	29 85.3%	2 5.7%	3 8.6%	30 85.7%
Local	4 14.8%	↔	4 14.8%	↑	19 70.4%	↓	27	4 14.8%	3 11.1%	20 74.1%	5 18.5%	1 3.7%	21 77.8%
Total	7 11.5%	↑	6 9.8%	↔	48 78.7%	↓	61	6 9.8%	6 9.8%	49 80.3%	7 11.3%	4 6.5%	51 82.3%

National indicators

Red	Safety Thermometer - harm free care	Page 12
	Children in Year 6 with Height and Weight recorded	Page 48
	MIU FFT response rate	Page 48
Amber	MIU unplanned reattendance rate within 7 days	Page 48
	Face to Face Consultation in PCC (Urgent to be seen within 2 hours)	Page 48

Local indicators

Red	MSKCAT service - wait time for routine patients	Page 49
	MSKCAT service - wait time for urgent patients	Page 49
	MSKCAT service - referral to treatment	Page 49
	Chlamydia Screening - number of positive screens	Page 49
Amber	Bone Health Service – referral to treatment	Page 49
	Speech and Language Therapy (Adult) – referral to treatment	Page 49
	Podiatry Service – referral to treatment	Page 49
	Stop Smoking Service	Page 49

Quality overview - health performance against indicators (in-month March 2015)

	March 2015			
	Red	Amber	Green	Total
National	3 8.8%	2 5.9%	29 85.3%	34
Local	5 18.5%	4 14.8%	18 66.7%	27
Total	8 13.1%	6 9.8%	47 77.0%	61

National indicators		
Red	C Diff Post 48 hour infections	Page 50
	MIU FFT response rate	Page 48
	Children in Year 6 with Height and Weight Recorded	Page 48
Amber	MIU Unplanned re-attendance rate	Page 48
	Face to Face Consultation in PCC (Urgent)	Page 48

Local indicators		
Red	MSKCAT service - wait time for routine patients	Page 49
	Chlamydia Screening - number of positive screens	Page 49
	Speech and Language Therapy (Adult) – referral to treatment	Page 49
	SPCA % of calls abandoned	Page 50
	Psychosexual medicine RTT	Page 50
Amber	MSKCAT Service – referral to treatment	Page 49
	Stop smoking service	Page 49
	% of calls resolved with agreed pathway	Page 50
	% of terminations carried out within 9 weeks and 6 days	Page 50

SAFE

Safe - key points

- The Trust has reported 27 SIRIs throughout 2014/15 of which 33% relate to slips, trips and falls *(see page 11).*

- Falls within an inpatient setting continue to be of concern with our rate of injurious falls per 1,000 bed days considerably higher than our comparators. A detailed action plan is being developed by the Matrons that will be presented to the Quality and Performance Committee in May that sets out plans to reduce this risk to patients (see page 15). Falls resulting in no harm accounted for 72% of the incidents reported.

- Performance against the 95% threshold for harm-free care was 95% in March 2015 (see page 12). Of the 1,041 patients surveyed there were 13 new harms, 9 within the Community Hospital setting and 3 with the Community teams.

- Although the Trust's performance regarding pressure ulcers is impacting upon the harm-free care total, it is noted that there have been twelve acquired Grade 3/4 pressure ulcers this year. The Trust compares favourably with other community trusts (see page 16).

- The Trust has seen an increase in outbreaks of 30% when compared to previous years, this mirrors the pattern across the region. The Countywide Healthcare Acquired Infection Group will undertake a review to ensure learning is in place to minimise the risk and impact in 2015/16.

Incidents by category of harm

Category of harm	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	2014-15 outturn	2013-14 outturn
No Harm	167	173	158	212	156	207	170	192	175	183	204	204	**2,201 65%**	**2,405**
Minor: Injury requiring minor intervention	95	101	70	94	67	97	81	72	67	81	68	62	**955 28%**	**1,118**
Moderate: Injury requiring professional intervention	44	31	40	44	27	2	3	2	7	5	2	9	**216 6%**	**456**
Major – Injury leading to long-term incapacity	**0**	**5**	**2**	**1**	**1**	**0**	**0**	**0**	**0**	**1**	**0**	0	**10 0%**	**17**
Death	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0	**2 0%**	**1**
Total	**306**	**310**	**271**	**352**	**251**	**306**	**254**	**266**	**249**	**270**	**274**	**275**	**3,384**	**3,997**

Benchmarking		
Number of incidents (GCS)	**131.6 per 1,000 WTE staff**	**April -March 2015**
Number of incidents (Aspirant Community Foundation Trust Group)	**184.2 per 1,000 WTE staff**	**September – February 2015**

As you will note in the moderate harm category, there is an apparent significant reduction in moderate incidents from September 2014 onwards. These figures reflect a look-back review of the severity ratings to ensure that they accurately reflect national guidance and harm definitions. The incidents rated as moderate harm were generally over-rated and therefore the severity ratings were reduced to no harm or minor harm. The same look-back approach will be applied to April 2014 to August 2014, which will also include reviewing those incidents categorised as “major” and “death”.

Incidents by type (top 10 only)

Gloucestershire Care Services NHS

Category of harm /Type of incident (top 10 categories)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	2014-15 outturn	2013-14 outturn
Slip, Trip or Fall (Patient)	91	74	63	86	80	79	69	95	81	86	80	70	954	**1130**
Medication or drug error	22	26	12	21	14	20	21	15	16	23	20	18	228	**401**
Staffing issues	12	18	11	27	12	17	18	15	9	6	15	14	174	**145**
Treatment or procedure problem	12	13	16	19	10	18	13	9	6	8	11	12	147	**158**
Pressure Ulcer	24	18	15	9	2	4	9	6	12	17	13	13	142	**211**
Medical device or equipment	6	15	15	11	6	9	6	7	6	6	6	13	106	**123**
Verbal/written abuse	7	19	12	9	9	9	5	7	6	7	7	7	104	**90**
Communication between staff, teams and departments	10	12	18	14	6	10	7	6	2	2	3	11	101	**133**
Hit by/against object	9	8	8	10	10	8	7	6	9	7	8	6	96	**120**
Property	12	6	7	13	8	10	3	4	4	5	6	4	82	**104**
Total (All)	**306**	**310**	**271**	**352**	**251**	**306**	**254**	**266**	**249**	**270**	**274**	**275**	**3,384**	**3,997**

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

There have been 13 RIDDOR reportable incidents this year to date. 9 were staff incidents, 2 were patient incidents and 2 affected members of the public. These are reviewed by the Health & Safety Committee.

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

Clinical Alert System (CAS)

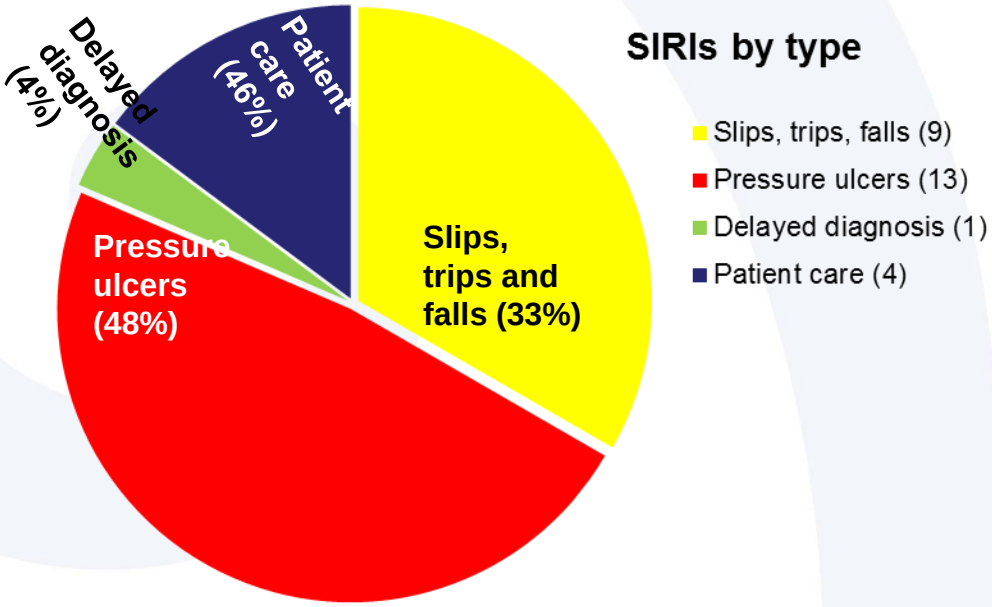
In 2014-15, the Trust has had two overdue CAS alerts due to technical errors

SIRIs / Never Events

SIRIs	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	2014-15 outturn
Inpatients	1	4	1	2	0	1	1	0	0	2	0	0	**12**
Community	1	0	0	0	1	0	1	2	2	2	1	5	**15**
MIU	0	0	0	0	0	0	0	0	0	0	1	0	**0**
Total	**2**	**4**	**1**	**2**	**1**	**1**	**2**	**2**	**2**	**4**	**2**	**5**	**27**

SIRIs
The learning from SIRIs has resulted in:
- Revision of the falls risk assessment process
- Alignment of the falls alerts in practice used to NICE guidance
- Review of the Braden Tool to ensure assessment captures all risks of pressure damage

No Never Events have been reported in 2014-15.

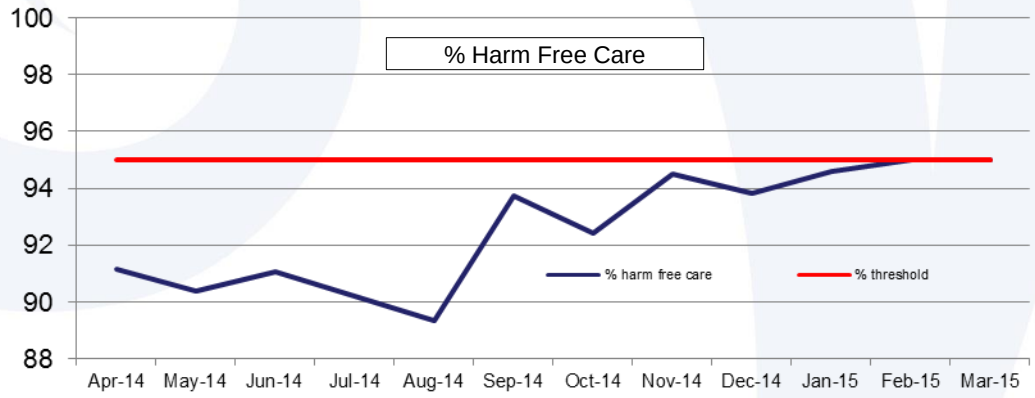


Benchmarking	
New SIRIs (GCS)	**2.3 average per month, April- March 2015**
New SIRIs (Aspirant Community Foundation Trust Group)	**4.3 average per month, September – February 2015**

Harm-free care / Safety Thermometer

Total	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	2014-15 outturn	2013-14 outturn
No of service users surveyed	1,120	1,153	1,009	1,059	1,078	1,084	1,036	1,059	1,018	1,044	1,089	1,041	12,790	**13,175**
No of service users with harm free care	1,021	1,042	919	955	963	1,016	957	1,001	955	988	1,035	989	11,841	**11,806**
% harm free care	**91.2%**	**90.4%**	**91.1%**	**90.2%**	**89.2%**	**93.7%**	**92.4%**	**94.5%**	**93.8%**	**94.6%**	**95.0%**	**95.0%**	**92.6%**	**89.6%**
% Completeness of Submission	**94.7%**	**97.3%**	**100.0%**	**95.5%**	**98.6%**	**98.6%**	**100%**	**100%**	**100%**	**98.6%**	**100%**	**100%**	**98.6%**	**97.4%**

Total	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD	2013-14 outturn
New Harms	48	40	27	32	35	11	29	7	10	7	11	13	**270**	**666**
Old Harms	51	71	63	72	80	57	50	51	55	51	43	38	**682**	**703**
Patients who experienced Harm	**99**	**111**	**90**	**104**	**115**	**68**	**79**	**58**	**65**	**56**	**54**	**51**	**950**	**1,369**



- 100% of teams submitted survey data in March
- Achievement of 95.0% harm free with variation of 70% - 100% across teams
- Focus remains on the key areas of falls and pressure ulcers looking at those patients who experienced harm and working across the health community to further reduce this risk

Harm-free care / Safety Thermometer March 2015

Safety Thermometer data from March 2015 census, showing variations between new and old harms, and between Community Hospital wards and Community teams by Locality. Variations will be investigated by Head of Community Hospitals and Locality Managers

Site	Ward	Harm Free Care %	No of new Harms	No of Old Harms	Total Harms	No of Patients
LYD	Lydney	90.0%	1	1	2	2
SGH	Princess Anne	80.0%	1	1	2	2
DLK	Dilke	86.7%	2	2	4	4
CIR	Coln	100.0%	0	0	0	0
NCH	North Cotswold	90.0%	1	1	2	2
VLH	Peak View	78.6%	0	3	3	3
CIR	Windrush	89.5%	1	1	2	2
SGH	Cashes Green	70.6%	3	2	5	5
SGH	Jubilee	100.0%	0	0	0	0
TWK	Abbey View	83.3%	0	3	3	3
All Hospitals		87.7%	9	14	23	23

9 new Harms in Community Hospitals:

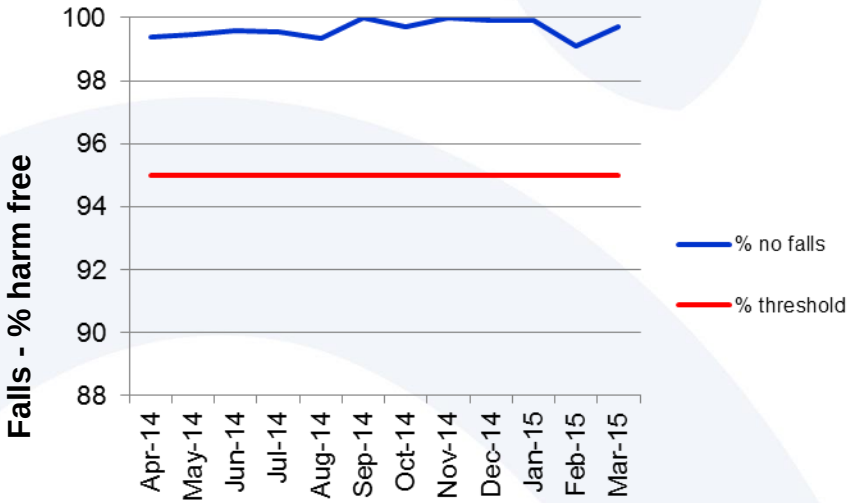
- 3 Falls resulting in Low Harm
- 1 Acquired Pressure Ulcer (Grade 2)
- 5 Patients with Urinary Tract Infections

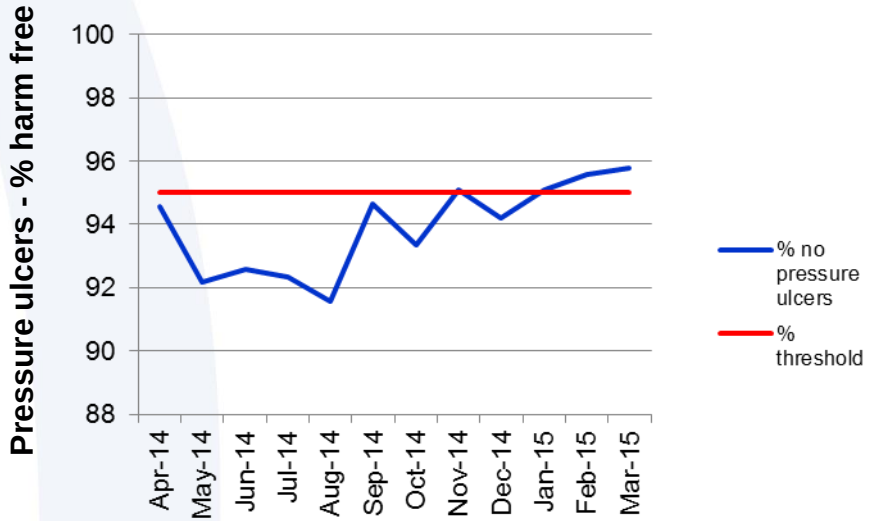
Community	Harm Free Care %	No of new Harms	No of Old Harms	Total Harms	No of Patients
Cotswold	94.1%	0	6	6	6
Forest	97.8%	1	2	3	3
Cheltenham	99.0%	0	2	2	2
Gloucester	93.3%	1	6	7	7
Stroud	98.8%	0	2	2	2
Tewkesbury	93.8%	1	4	5	5
All Localities	96.8%	**3**	**22**	**25**	**25**

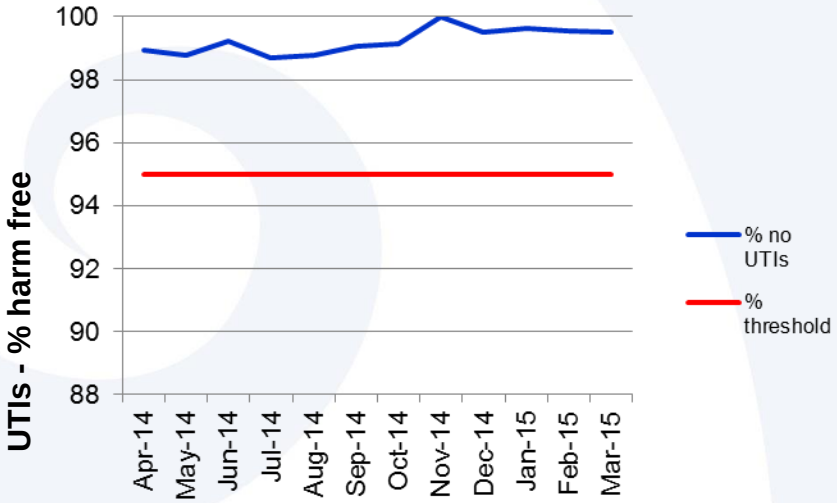
3 new Harms in Communities:

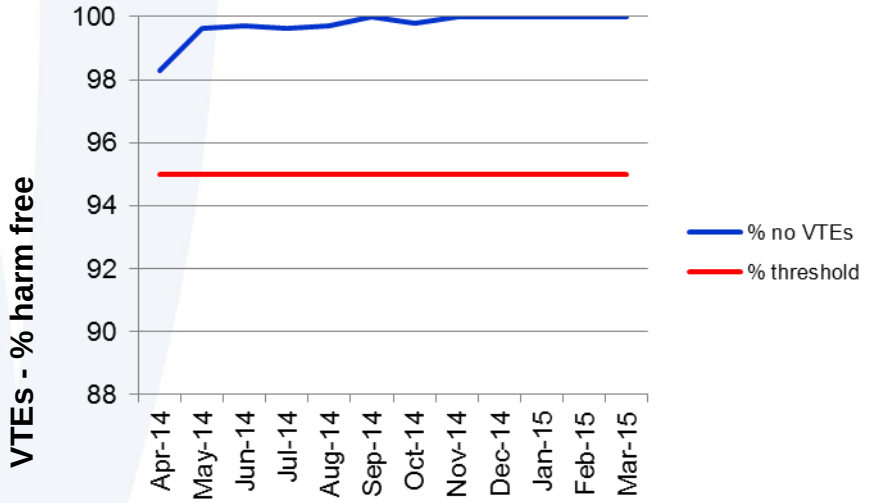
- 3 Acquired Pressure Ulcers (2 Grade 2 and 1 Grade 3)

Harm-free care by type / Safety Thermometer







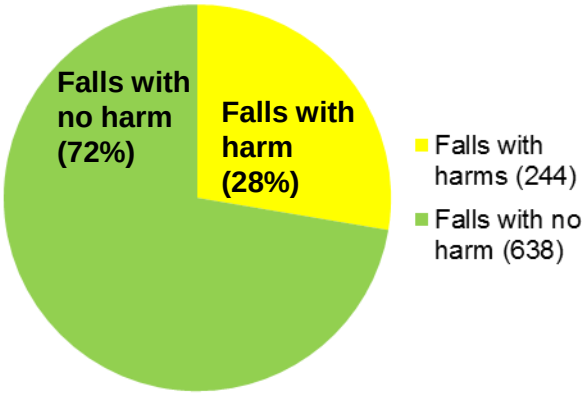


VTE risk assessment:
Performance for 2014/15 showed 98% VTE risk assessments were completed against a target of 95%

Falls in an inpatient setting

Hospital	Total Falls				Falls with harm			
	2014/15 Total		2013/14 Total		2014/15 Year to Date		2013/14 Total	
	No of falls	Falls per 1,000 bed days	No of falls	Falls per 1,000 bed days	No of Falls with harm	Falls with harm per 1,000 bed days	No of Falls with harm	Falls with harm per 1,000 bed days
The Vale	157	22.7	146	20.9	34	4.9	88	12.6
North Cotswolds	138	18.5	141	18.8	44	5.9	60	8
Tewkesbury	117	16.8	95	12.9	26	3.7	37	5
Cirencester	214	12.5	264	12.9	65	3.8	139	6.8
Lydney	85	11.3	82	11.8	24	3.2	55	7.9
Dilke	74	9.0	87	9.3	23	2.8	102	6.9
Stroud General	97	7.8	191	13	28	2.2	51	5.5
TOTAL	**882**	**13.2**	**1,006**	**13.7**	**244**	**3.7**	**532**	**7.2**

Result of falls (year-to-date)



Actions undertaken:

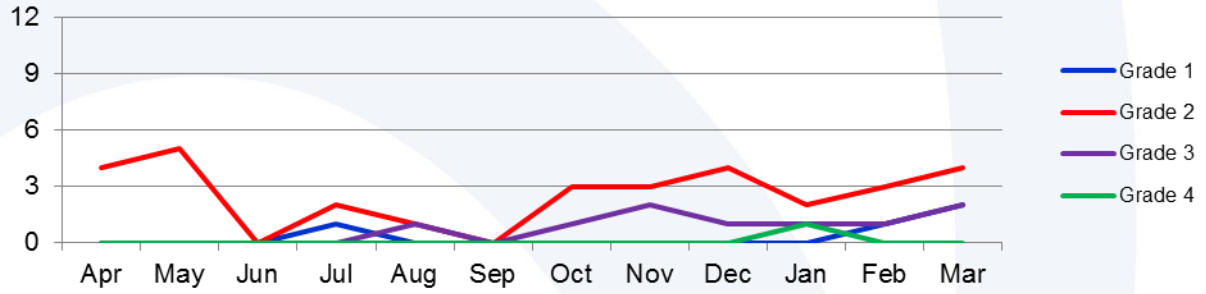
- Review of the Falls Prevention Policy
- Development of an action plan focussed on sharing best practice and learning by Matrons
- Standardisation of falls alert signage in line with NICE guidance

Benchmarking	
Falls with harm per 1,000 inpatient occupied bed days (GCS)	**3.7 average per month, April- March 2015**
Falls with harm per 1,000 inpatient occupied bed days(Aspirant Community Foundation Trust Group)	**2.4 average per month, September to February 2015**

The Quality and Performance Committee commissioned a deep dive into this aspect of patient safety which was presented in May 2015.
Throughout 2015/16 GCS will also be addressing the important aspect of positive risk taking through the CQUIN work programme.

Pressure ulcers

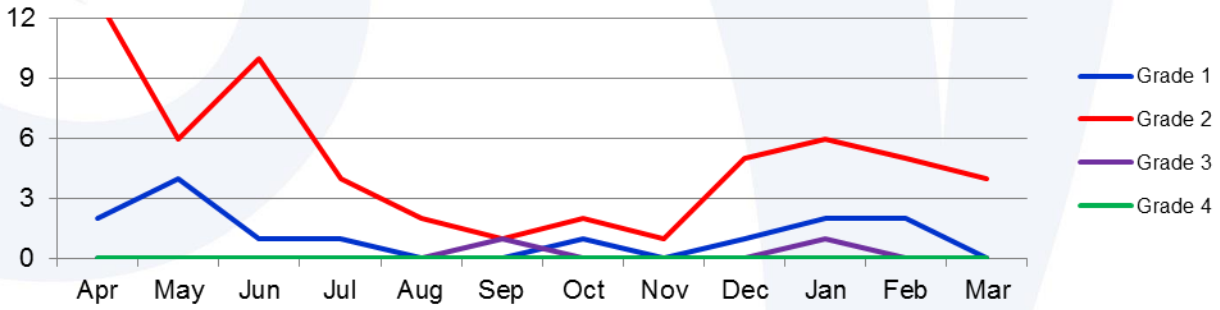
Community acquired	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	2014-15 outturn
Grade 1	0	0	0	1	0	0	0	0	0	0	1	2	4
Grade 2	4	5	0	2	1	0	3	3	4	2	3	4	31
Grade 3	0	0	0	0	1	0	1	2	1	1	1	2	9
Grade 4	0	0	0	0	0	0	0	0	0	1	0	0	1



Actions undertaken:

- Focus on heel blisters (grade 2) with use of hydofilm dressing as preventative measure
- Learning events with teams following avoidable damage

Hospital acquired	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	2014-15 outturn
Grade 1	2	4	1	1	0	0	1	0	1	2	2	0	14
Grade 2	13	6	10	4	2	1	2	1	5	6	5	4	59
Grade 3	0	0	0	0	0	1	0	0	0	1	0	0	2
Grade 4	0	0	0	0	0	0	0	0	0	0	0	0	0



Benchmarking	
New Grade 2, 3 & 4 pressure ulcers (GCS)	**8.4 average per month, April - March 2015**
New Grade 2, 3 & 4 pressure ulcers (Aspirant Community Foundation Trusts)	**13.8 average per month, September – February 2015**

Safeguarding (Quarterly Report)

Total	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	2014-15 outturn	2013-14 outturn
Adult safeguarding alerts raised by GCS	13	10	19	17	10	8	16	23	18	39	39	35	**247**	**176**
Total county adult safeguarding alerts	289	326	299	344	285	337	352	330	294	336	362	295	**3,853**	**4,008**
GCS adult safeguarding investigations*	3	5	7	11	6	6	5	8	14	11	19	17	**112**	**n/a**
Total county adult safeguarding investigations	30	31	34	29	33	27	18	37	33	36	47	42	**397**	**n/a**
Number of new Children's Serious Case Reviews	1	0	0	1	0	0	0	1	1	0	0	0	**4**	**n/a**
Number of new Adult's Serious Case Reviews	Data collection to be established													**n/a**
Number of children subject to a Child Protection Plan	428	391	408	403	416	426	419	426	453	450	424	428	**428**	**n/a**

*Breakdown of adult safeguarding enquiries (2014/15)					
Client group		**Type of concern**		**Outcome of investigation**	
Learning Disabilities	11	Neglect	33	On-going	29
Dementia	44	Physical injury	41	Substantiated	13
Physical Disability	48	Sexual	4	No further action	70
Mental Health	2	Financial	28		
Other Vulnerable	7	Psychological	11		
		Institutional	0		

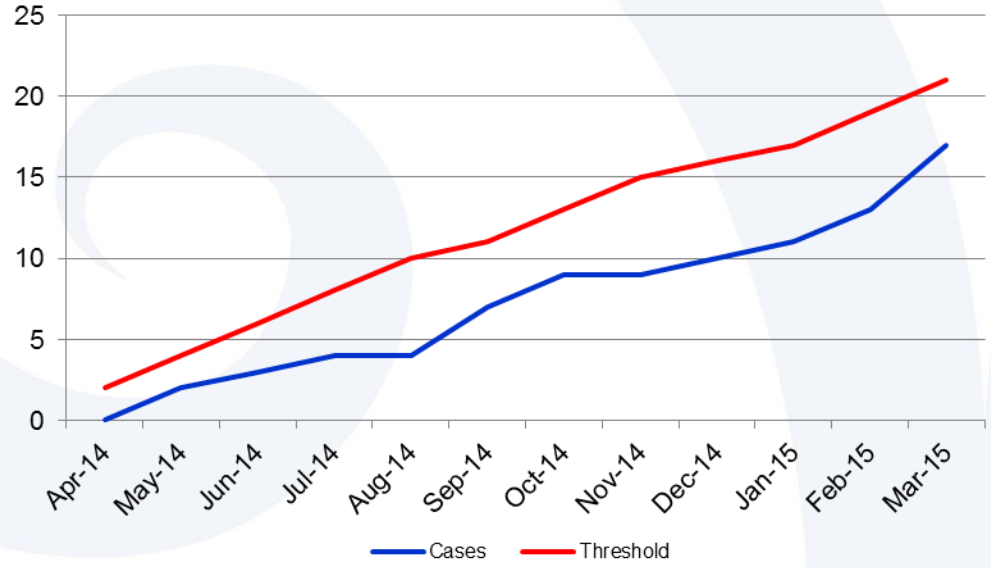
Published Adult Serious Case Reviews March 2015

- The sexual and financial abuse of adults within a supported living home (adults) had a range of learning relating to how we listen to the concerns, or communicate with people who have mental health or Learning Disabilities, and the need to treat all contacts with healthy suspicion.
- Death of individual in care home (adult) highlighted the need to listen to those who know the person best and to be vigilant to the early warning signs that may indicate a change in the physical condition of a person

Infection control

Infections	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	2014-15 outturn
MSSA	0	0	0	0	0	0	0	0	0	0	0	0	0
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0
E. Coli	0	0	1	0	0	0	0	0	0	0	0	0	1
CPE	0	0	0	0	0	0	0	0	0	0	0	0	0
C diff	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**2014-15 outturn**
Actual	0	2	1	1	0	3	2	0	1	1	2	4	17
Threshold	2	2	2	2	2	1	2	2	1	1	2	2	21
Variance	-2	0	-1	-1	-2	2	0	-2	0	0	0	2	-4
Unavoidable cases in GCS care	0	2	1	0	0	3	2						8

Incidence of C. Diff



Hand hygiene observation audits including the 'Bare below the Elbows' initiative for February evidenced an average of 90% compliance

Outbreaks	2014/15	2013/14
Number of outbreaks	16	11
Confirmed Norovirus	11	10
Patients affected	133	64
Lost bed days	252	220

Medicines management

Medication incidents	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Outturn
2014-15	22	26	12	21	14	21	27	16	15	23	20	18	**235**
2013-14	29	26	39	65	46	26	36	39	36	49	55	27	**473**

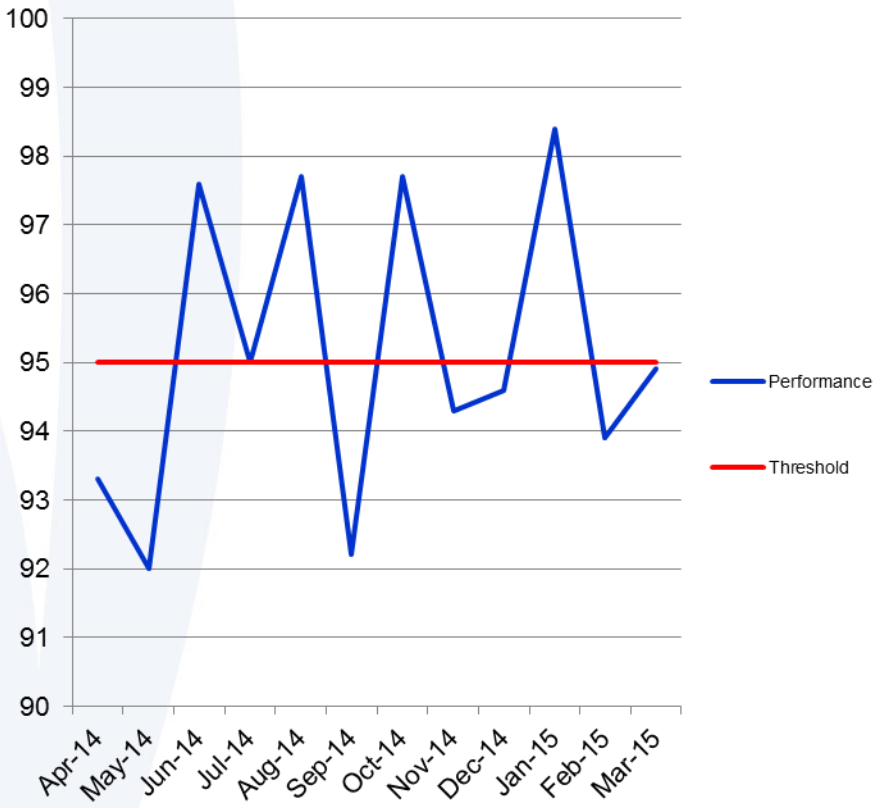
Medication incidents by sub-category	Number
Omitted or delayed administration	73
Medication administered in error/incorrectly	56
Controlled drugs issue	42
Medication prescribed incorrectly/in error	13
Medication dispensed incorrectly	12
Storage issue	9
Illegible or unclear information	9
Medication missing	9
Information to patient wrong or omitted	5
Failure to follow-up or monitor	3
Discharge or transfer without TTOs	2
Prescribed with known allergy	2
Total	**235**

Controlled Drug Issues (42)

9 incidents involved staff training/error

- 9 incidents related to incorrect or omitted entries in the CD register
- 6 incidents were unaccounted losses
- 5 incidents related to incorrect counting or measuring of CDs
- 4 incidents involved incorrect storage (not following policy)
- 3 incidents involved a GP
- 3 incidents involved District Nurses
- 3 incidents involve incorrect administration

HAPPI (Hospital Antibiotic Prudent Prescribing Indicator) audits



Development of Pharmacy Services

- As a result of a competitive tendering process Lloyds Pharmacy will be the new provider for pharmacy services. This new contract will come into effect from 1st May 2015.

- All community hospital wards and Minor Injury Units (MIUs) have been visited by the new provider and will be receiving written standard operating procedures detailing the process for ordering and receiving of medication.

- Additional support is being given to the HIV service to ensure a smooth transition and access to medication by their client group.

- An exit plan has been drafted for agreement with the current provider to support a smooth transition and handover.

- Robust key performance indicators have been agreed with the new provider which will detail drug usage and ordering frequency by all sites and services. This information will be shared monthly with Heads of Service and will be reviewed by the Medicines Management committee. This will strengthen governance of medicine usage across the organisation.

- The new contract for the first time will provide an equitable service across all of our Community Hospitals and strengthen support to Community based services.

Service user transfers*

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

		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	2014-15 Outturn	2013-14 outturn
All Admissions	**23:00-05:59**	153	11	19	19	16	12	10	11	13	19	20	29	**195**	**153**
	%	3.40%	3.29%	5.38%	5.35%	4.66%	3.76%	3.31%	3.55%	4.25%	5.51%	5.92%	9.76%	**4.98%**	**3.40%**
Direct Admission	**23:00-05:59**	74	3	8	7	5	6	7	7	6	10	5	8	**78**	**74**
	%	4.10%	2.52%	7.02%	5.26%	5.38%	5.45%	7.14%	8.64%	6.52%	9.43%	5.62%	9.52%	**6.49%**	**4.10%**
Transfer	**23:00-05:59**	79	8	11	12	11	6	3	4	7	9	15	21	**117**	**79**
	%	2.90%	3.72%	4.60%	5.41%	4.40%	2.87%	1.47%	1.75%	3.27%	3.77%	6.02%	9.86%	**4.31%**	**2.90%**

Transfer From	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	2014-15 Outturn	2013-14 outturn
Transfer from GRH	7	3	8	7	3	3	1	5	4	6	13	5	**65**	**47**
Transfer from CGH	1	5	3	4	3	0	3	2	4	3	7	2	**37**	**24**
Transfer from other	0	1	1	0	0	0	0	0	1	6	0	2	**11**	**4**
Internal transfer	0	2	0	0	0	0	0	0	0	0	1	1	**4**	**4**
Total	**8**	**11**	**12**	**11**	**6**	**3**	**4**	**7**	**9**	**15**	**21**	**10**	**117**	**79**

Working with GHNHSFT and Arriva, the Trust is undertaking an audit of all transfers that result in an admission (after 21:00) to understand at what point in the transfer delays are occurring. The October audit suggested the delays are often (but not always) due to the patient having to wait several hours for the arrival of the ambulance to transport then to the community hospital. The audit is continuing, reviewing the late transfers in the three months from November 2014 to January 2015. Data is awaited from GHNHSFT In October and November, one in two of these transfers occurred at the weekend. This proportion had fallen to one in four in December 2014 and January 2015.

Safer staffing – March 2015

Hospital	Ward	Day		Night		Bed Occupancy
		Average fill rate RNC	Average fill rate HCA	Average fill rate RNC	Average fill rate HCA	
Cirencester	Coln Ward	95.9%	102.3%	98.4%	98.4%	98.5%
	Stratton Ward	103.3%	47.5%	103.3%	96.7%	99.5%
	Windrush Ward	87.1%	107.4%	103.2%	100.0%	99.5%
Dilke Memorial	The Ward	100.0%	95.9%	97.8%	121.0%	90.1%
Lydney and District	The Ward	98.9%	98.2%	100.0%	98.9%	92.7%
North Cotswolds	NCH Ward	95.7%	96.3%	98.4%	100.0%	96.0%
Stroud General	Cashes Green Ward	100.5%	121.6%	103.2%	136.8%	96.5%
	Jubilee Ward	101.6%	99.1%	100.0%	100.0%	96.8%
Tewkesbury Community	Abbey View Ward	81.7%	113.8%	101.6%	101.6%	98.1%
Vale Community	Peak View	101.1%	94.5%	100.0%	100.0%	97.7%
TOTAL		96.0%	99.9%	100.3%	105.8%	95.8%

Hospital	Ward	Bank Staff	Agency Staff
Cirencester	Coln Ward	10.2%	21.6%
	Stratton Ward	6.1%	10.1%
	Windrush Ward	10.6%	21.1%
Dilke Memorial	The Ward	12.4%	29.9%
Lydney and District	The Ward	14.1%	22.5%
North Cotswolds	NCH Ward	12.9%	15.1%
Stroud General	Cashes Green Ward	7.7%	40.4%
	Jubilee Ward	14.2%	32.9%
Tewkesbury Community	Abbey View Ward	5.1%	12.8%
Vale Community	Peak View	17.4%	14.3%
TOTAL		11.4%	23.5%

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

- Cashes Green – Additional HCAs utilised due to patients requiring 1:1 care
- Stratton Ward – Work is currently underway to align the reporting onto the national system to reflect the change in staffing requirements for Thames Ward (previously Stratton). Planned staffing levels require 1 HCA (2 previously) as a result of the bed reconfiguration.

Safer staffing – February 2015

Hospital	Ward	Day		Night		Bed Occupancy
		Average fill rate RNC	Average fill rate HCA	Average fill rate RNC	Average fill rate HCA	
Cirencester	Coln Ward	87.9%	109.2%	98.2%	100.0%	98.1%
	Windrush Ward	82.7%	105.6%	100.0%	98.2%	99.8%
Dilke Memorial	The Ward	97.8%	115.0%	94.0%	151.8%	95.8%
Lydney and District	The Ward	98.8%	100.0%	100.0%	100.0%	95.7%
North Cotswolds	NCH Ward	95.2%	108.2%	100.0%	100.0%	95.8%
Stroud General	Cashes Green Ward	99.4%	111.6%	101.8%	114.3%	98.1%
	Jubilee Ward	100.0%	98.0%	96.4%	100.0%	97.5%
Tewkesbury Community	Abbey View Ward	85.1%	113.8%	101.8%	101.8%	99.3%
Vale Community	Peak View	99.4%	97.4%	101.8%	107.1%	97.1%
TOTAL		**93.8%**	**106.7%**	**99.1%**	**107.7%**	**97.4%**

Hospital	Ward	Bank Staff	Agency Staff
Cirencester	Coln Ward	11.9%	15.5%
	Windrush Ward	7.7%	12.9%
Dilke Memorial	The Ward	11.5%	36.4%
Lydney and District	The Ward	12.9%	26.3%
North Cotswolds	NCH Ward	14.0%	13.0%
Stroud General	Cashes Green Ward	10.9%	25.7%
	Jubilee Ward	16.4%	26.1%
Tewkesbury Community	Abbey View Ward	2.9%	13.1%
Vale Community	Peak View	17.5%	12.6%
TOTAL		**11.7%**	**21.0%**

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

•Dilke Memorial - Additional HCAs utilised due to patients requiring 1:1 care

CARING

Caring - key points

- The Trust is committed to providing care in an environment that protects privacy and dignity. This is supported by providing care in a single sex environment. No breaches were reported during the period April 2014 to March 2015.

- The Friends and Family test reporting has been expanded since January 2015 to cover all services. Response rates are low for the services that began collecting data in January but showing increases as the process becomes embedded. In March, 1,695 service users responded. This is a total of 7% of the 37,150 service users in contact with services during March.

- The national guidance changes the user satisfaction score to % Extremely Likely / Likely from the Net Promoter score previously reported. Therefore we will no longer report on Net Promoter scores.

- Minor Injury Units performance declined to 18% response rate in March (target 20%). Year to date performance now 19%. Teams are reminded of the need to ask for feedback and to share learning between units identifying best practice. The North Cotswolds Hospital achieved a 42% response rate.

- Inpatient wards overall achieved 49% response rate in March, with all wards above the 30% target. Since December 1st 2014, inpatients are offered the option of a face to face discussion as an alternative to the postal questionnaire.

#hello my name is…

- GCS along with a number of Listening into Action Trusts launched the "*Hello my name is*…" campaign on February 2nd 2015.

- Launched through the social media by Dr Kate Granger, the campaign is focussed on making their initial personal contact with a service user and staff introducing themselves by name, making personal connection essential to deliver care with compassion.

Measuring how we do:

- We will ask service users and their families as part of our experience survey, "*did colleagues introduce themselves by name*"? This information will be reported monthly and will be made available at service level.

	% of Responses		
Comment	**December 2014**	**February 2015**	**March 2015**
Yes, Definitely	83.4%	92.5%	91.2%
to some extent	10.6%	4.2%	5.7%
no / can't say	6.0%	3.3%	2.6%
Number of Responses	**386**	**1,274**	**1,324**

Friends and Family Test – Community Health March 2015

The tables below show the Friends and Family test data collected across all services during March 2015. This has expanded the coverage of the collection beyond Inpatient wards and Minor Injury units. The national guidance also changes the user satisfaction score to % Extremely Likely / Likely from the Net Promoter score previously in place.

Response rates are expected to increases as processes become embedded.

Number of Unique Patients accessing Services During the Month	Number of responses received via each mode of collection								
	SMS / Text / Smartphone app	Electronic tablet/kiosk	Paper / Postcard in care / at discharge	Paper survey sent to home	Telephone survey	Online survey	Other	Total responses	Response rate
37,150	135	9	1,293	82	0	176	0	**1,695**	7.2%

Service area	Total responses in each category for Community Health						Total responses	Response rate	% Extremely Likely / Likely
	Extremely Likely	Likely	Neither likely nor unlikely	Unlikely	Extremely Unlikely	Don't Know			
Community Inpatients	106	35	5	2	1	1	**150**	46.0%	94.0%
Community Nursing	46	14	1	1	2	0	**64**	0.9%	93.8%
Rehab & Therapy Services	189	71	6	4	1	3	**274**	3.3%	94.9%
Specialist Services	193	34	2	5	6	1	**241**	8.1%	94.2%
Children & Family Services	44	14	1	1	0	1	**61**	0.7%	95.1%
Community Healthcare Other	741	146	7	3	10	1	**908**	10.0%	97.7%
Total	**1,319**	**314**	**22**	**16**	**20**	**7**	**1,698**	4.6%	**96.2%**

'Community Healthcare Other' includes Minor Illness and Injury Units, Out of Hours, Homeless Healthcare as per guidance.

Friends and Family Test - Inpatient Units response rates

Responses	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	2014/15 Outturn	Target
Cirencester	56%	43%	65%	24%	36%	22%	31%	29%	27%	42%	45%	54%	35%	30%
Stroud	74%	74%	65%	66%	17%	32%	20%	29%	35%	44%	65%	65%	39%	
Tewkesbury	39%	39%	57%	23%	57%	29%	47%	38%	35%	35%	50%	35%	35%	
The Vale	27%	28%	55%	47%	19%	37%	27%	33%	33%	33%	32%	46%	32%	
North Cots	45%	31%	40%	30%	16%	41%	25%	28%	47%	56%	53%	40%	34%	
Dilke	33%	39%	55%	63%	13%	0%	14%	27%	11%	34%	35%	54%	32%	
Lydney	57%	54%	57%	30%	17%	28%	22%	18%	15%	44%	67%	26%	33%	
Response rate	**49%**	**47%**	**58%**	**39%**	**26%**	**29%**	**27%**	**29%**	**28%**	**41%**	**52%**	**49%**	**40%**	
Responses	**172**	**167**	**205**	**140**	**50**	**60**	**52**	**77**	**98**	**127**	**142**	**150**		
Sample Size	**349**	**359**	**354**	**356**	**193**	**206**	**190**	**266**	**345**	**311**	**271**	**309**		

•In December wards reverted back to the previous method of surveying patients before discharge from hospital. The impact of this is seen from January 2015.

Friends and Family Test – Minor Injury Units response rates

Responses	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	2014/15 Outturn	Target
Cirencester	15%	14%	16%	24%	28%	21%	24%	21%	16%	29%	29%	22%	21%	20%
Stroud	13%	10%	4%	11%	19%	14%	11%	17%	17%	15%	32%	16%	17%	
Tewkesbury	2%	19%	36%	14%	8%	22%	10%	22%	19%	37%	48%	14%	20%	
The Vale	30%	17%	17%	20%	27%	24%	23%	32%	30%	36%	29%	17%	23%	
North Cots	11%	17%	15%	13%	16%	18%	6%	20%	34%	48%	38%	42%	22%	
Dilke	30%	20%	21%	18%	20%	18%	16%	15%	12%	19%	31%	19%	20%	
Lydney	39%	34%	14%	14%	11%	13%	9%	6%	6%	32%	20%	7%	19%	
Response rate	**18%**	**17%**	**15%**	**17%**	**20%**	**18%**	**15%**	**19%**	**18%**	**28%**	**32%**	**18%**	**19%**	
Responses	**1,100**	**1,100**	**998**	**1,147**	**1,121**	**1,090**	**841**	**952**	**962**	**1,173**	**1,266**	**897**		
Attendances	**6,117**	**6,348**	**6,486**	**6,810**	**5,756**	**6,042**	**5,606**	**5,146**	**5,430**	**4,231**	**3,996**	**4,899**		

• Patients are provided with a copy of the FFT questionnaire whilst visiting the MIU and are asked to complete and return it in the comments box before leaving the premises. The completed forms are posted to Co-Metrica on a weekly basis by GCS. Learning to be shared between units.

Inpatient survey – Core questions (Cumulative)

Description	Tewkesbury	Stroud Cashes Green	Stroud Jubilee	The Vale	Dilke	Lydney	Cirencester Coln	Cirencester Windrush	North Cotswold	Trust Total
Q.4451 Did you have confidence and trust in the staff examining or treating you?	9.5	9.2	9.5	9.7	9.4	9.4	9.3	9.4	9.4	9.5
Q.4452 Were you involved as much as you wanted to be in decisions about your care and treatment?	8.2	6.5	8.7	8.5	7.5	7.8	7.5	7.2	7.9	7.8
Q.4454 Overall, did you feel you were treated with respect and dignity?	9.9	9.2	9.3	9.8	9.6	9.5	9.4	9.5	9.5	9.6
Q.4455 Overall experience of this service.	8.2	8.1	8.5	8.7	8.4	8.7	7.6	7.7	7.9	8.3
Q.4614 Did the staff caring for you introduce themselves?	8.8	8.4	8.9	9.7	9.2	9.0	8.8	8.6	8.8	9.0
Number of Patients Surveyed	**83**	**205**	**109**	**93**	**67**	**83**	**196**	**125**	**108**	**1082**

Patients are given the Friends and Family Test questionnaire to complete before discharge from hospital. This can be completed by the patient alone or with the help from a carer/family member or a hospital volunteer. CoMetrica collate the results and provide weekly comments reports to service leads as well as monthly reports on the results achieved.

Scores are an average score (maximum 10).

Q.4452: Discharge audit to take place during 2015/16. Patient engagement will be incorporated within the audit and any actions plans that follow.

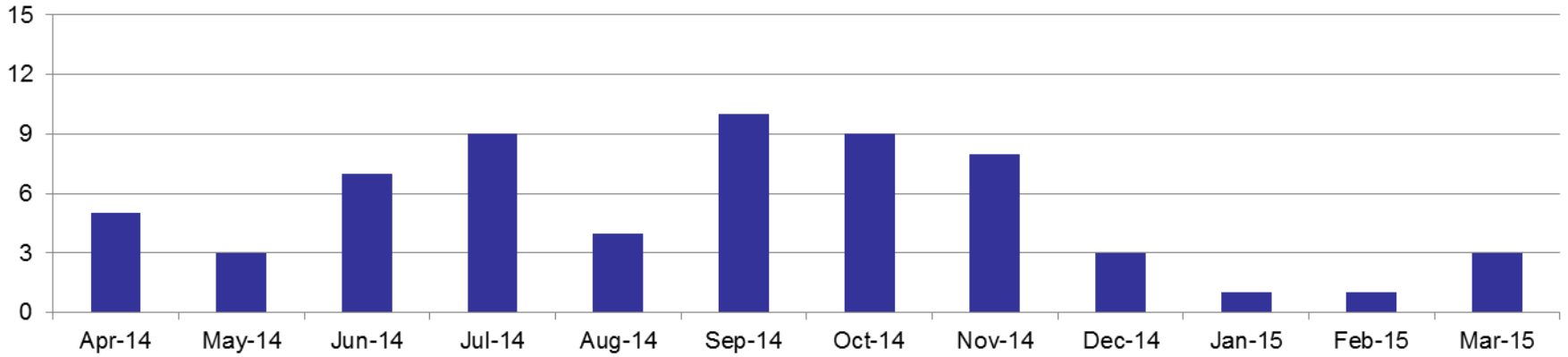
Inpatient survey – Experience questions (Cumulative)

Description	Tewkesbury	Stroud Cashes Green	Stroud Jubilee	The Vale	Dilke	Lydney	Cirencester Coln	Cirencester Windrush	North Cotswold	Trust Total
Q.4453 In your opinion, was the area clean?	10.0	9.5	9.8	9.9	9.8	9.9	9.6	9.6	9.8	9.8
Q.4461 How would you rate the hospital food?	7.6	7.5	8.3	8.3	8.4	7.6	7.1	7.0	6.5	7.7
Q.4462 Were you ever bothered by noise at night from hospital staff?	8.1	7.1	8.2	8.8	8.3	9.0	7.5	7.2	9.0	8.2
Q.4463 Were there enough nurses on duty to care for you in hospital?	7.8	7.4	8.6	7.6	5.5	8.0	6.6	7.9	7.6	7.6
Q.4464 Did staff take your family or home situation into account when planning your discharge?	8.3	8.4	9.3	8.8	7.9	8.6	8.8	8.5	8.6	8.6
Q.4465 How many minutes after you used the call button did it take before you got the help you needed?	5.6	5.6	6.4	5.0	5.5	5.9	5.3	5.1	5.0	5.6
Number of Patients Surveyed	**83**	**205**	**109**	**93**	**67**	**83**	**196**	**125**	**108**	**1082**

Scores are an average score (maximum 10).

Complaints

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD	2013-14
Number of complaints	**5**	**3**	**7**	**9**	**4**	**10**	**9**	**8**	**3**	**1**	**1**	**3**	**63**	**78**

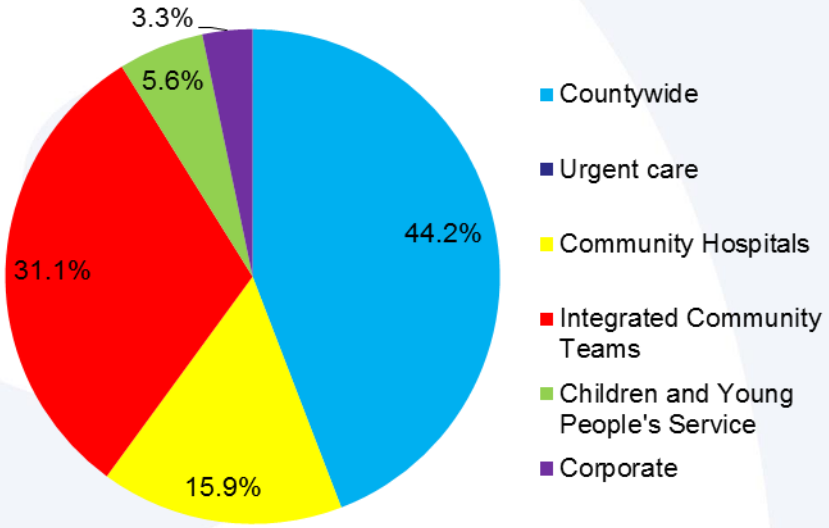


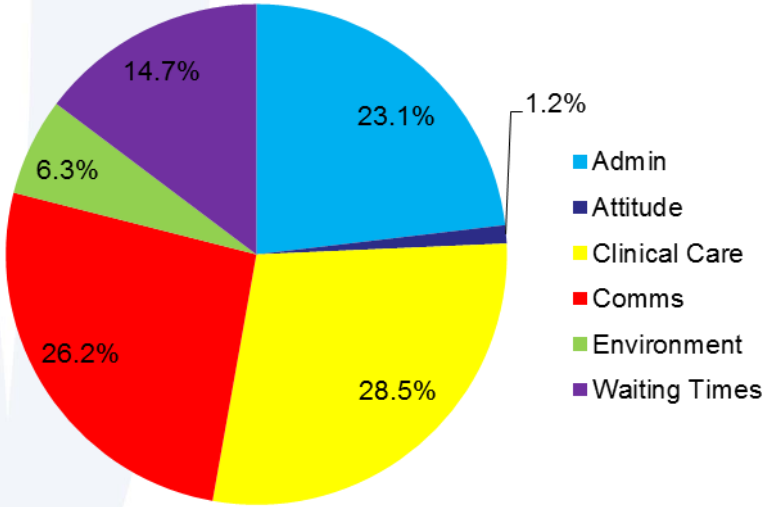
Response Time	April - March 2014-15	
	Number of responses	% of responses
Target time within agreed timescale	53	84.2%
Over the agreed timescale by 1-3 days	5	7.9%
Over the agreed timescale in excess of 4 days	5	7.9%
Awaiting investigation	0	n/a
Total	**63**	**100%**

Benchmarking	
Complaints per 1,000 WTE staff (GCS)	**2.5 average per month, April - March 15**
Complaints per 1,000 WTE staff (Aspirant Community Foundation Trust Group)	**4.9 average per month, September – February 15**

Concerns (cumulative)

Concerns	Admin	Attitude	Clinical Care	Comms	Environ	Waiting Times	2014/15 YTD Total
Countywide	68	0	43	44	7	27	189
Urgent Care	0	0	0	0	0	0	0
Community Hospitals	5	3	23	16	16	5	68
Integrated Community Teams	12	2	49	38	4	28	133
Children & Young People's Service	6	0	7	10	0	1	24
Corporate	8	0	0	4	0	2	14
Total	**99**	**5**	**122**	**112**	**27**	**63**	**428**





The Trust complaints policy is being revised. This aims to set out our approach to listening and learning from service users. Themes, trends and learning will be presented as part of the "Understanding You" Report that will go to Quality and Performance Committee.

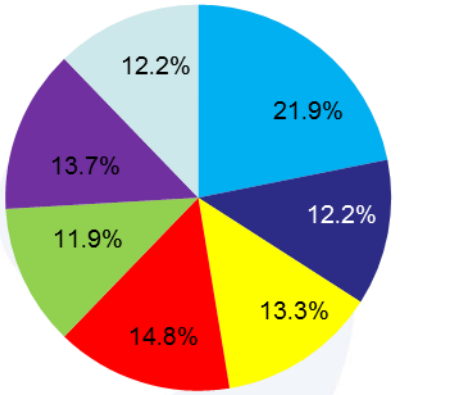
Mortality Reviews: Community Hospitals

Gloucestershire Care Services NHS Trust

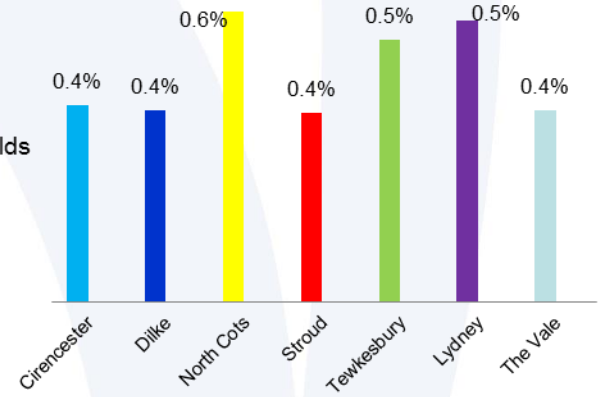
Number of Discharges from Community Hospital where discharge reason is as a result of death

Hospital Site	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	2014/15 Outturn	2013/14 Outturn
Cirencester	4	4	4	2	7	7	9	3	3	8	6	2	59	80
Stroud	3	6	2	2	2	2	2	3	7	3	4	4	40	52
North Cotswolds	2	6	2	4	2	1	4	3	4	2	5	1	36	32
Lydney	1	4	1	2	4	2	2	4	7	5	1	4	37	47
Dilke	6	5	2	3	2	2	3	0	4	2	3	1	33	47
The Vale	3	3	2	1	1	2	2	2	7	5	2	3	33	34
Tewkesbury	2	2	4	4	1	0	2	4	3	4	1	5	32	31
Total	**21**	**30**	**17**	**18**	**19**	**16**	**24**	**19**	**35**	**29**	**22**	**20**	**270**	**323**

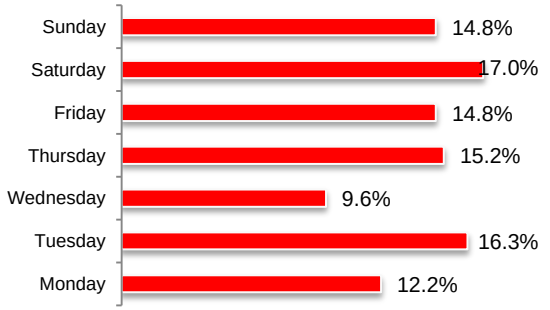
Number of deaths per Community Hospital (%)



Number of Deaths as % of Occupied Bed Days per Hospital



Number of Deaths (%) per Weekday



A new electronic mortality reporting system is being introduced into Community Hospitals to standardise data collection, capture more data for analysis and help identify learning points to improve quality of care. This will be 'live' from 2nd March 2015.

Learning to date shows a need to:

- Improve the recording and review of resuscitation status
- Improve the recording of conversations with the patient and their family
- Improve the legibility of recording in the medical record

Annual report will be provided to Board in May 2015

EFFECTIVE

Effective - key points

- The quality snapshot dashboard (page 37) provides an ‘at a glance’ picture of a number of quality metrics for the month and the movement since the last report. This provides a valuable tool to use as part of Matron’s Walkabouts and Peer Review Visits. A similar dashboard is being developed for Community Services (page 38). The Director of Nursing and Quality and the Head of Community Hospitals are developing further metrics to enhance this overview.

- The Staff Flu Vaccinations Programme resulted in 42.5% of staff vaccinated, and increase from the 38.6% in 2013/14.

- A survey was sent to all staff during January to capture information on staff who received a vaccination by a route other than Working Well or a peer vaccinator and to ask staff for feedback on this year’s campaign and ideas to improve future campaigns. 474 colleagues completed the survey.

- Key points from survey included 164 comments/suggestions to improve the campaign. The themes identified issues with delivery model and ideas for improvement which will be used to inform the plans for winter 2015/16.

Effective – Staff Flu Vaccination Programme

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

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

	October YTD	November YTD	December YTD	January YTD	Target	2013/14
%	13.6%	31.5%	38.9%	42.5%	75%	38.6%
Number of staff	282	655	807	883	2,077	807

Future plans:

- GCS Flu lead to meet with Working Well to discuss programme for 2015/16
- Increase number of Peer Vaccinators for 2015/16
- Develop a Public Health campaign to be promoted during September 2015 to ensure staff have accurate and correct information about the benefit of flu vaccination
- Flu vaccine ordered in February 2015 anticipating an increased uptake in the 2015/16 programme

Gloucestershire Care Services NHS
NHS Trust

Quality Snapshot – Community Hospital Inpatient Care March 2015

Hospital site	Inpatient wards	FFT response rate	FFT number of responses	% of respondents 'extremely likely' or 'likely' to recommend service	Complaints	Number of cases of C.Diff	Safety thermometer harm free care	Number of patients who fell					Number of patients with acquired pressure ulcers		Safer staffing fill rate (aggregated)		Shortfall of 8 Hours or 25% of RN hours on the shift	Previous Month Sickness (FTE at start of month)		Appraisal %		Movement against Previous Month
								No Harm	Minor	Moderate	Major	Death	Grade 1& 2	Grade 3 & 4	RNC	HCA		RNC	HCA	RNC	HCA	
SGH	Cashes Green	65%	17	94.1%	0	0	71%	3	1	0	0	0	0	0	101.2%	125.0%	7	3.0% (11.79)	7.5% (15.20)	100.0%	94.7%	↑
SGH	Jubilee	64%	14	100.0%	0	0	100%	0	1	0	0	0	0	0	101.1%	99.3%	1	0.0% (8.20)	6.4% (10.85)	61.0%	70.5%	↑
NCH	North Cotswold	40%	14	85.7%	0	0	90%	8	2	0	0	0	0	0	96.4%	97.1%	10	6.9% (13.63)	19.4% (14.63)	65.5%	49.1%	↑
VLH	Peak View	46%	17	100.0%	0	0	79%	7	1	0	0	0	0	0	100.8%	95.7%	2	3.4% (13.96)	11.0% (15.05)	81.5%	79.9%	↔
DLK	Dilke	54%	22	90.9%	0	3	87%	6	0	0	0	0	1	0	99.4%	99.8%	0	3.7% (15.59)	4.8% (15.36)	92.4%	85.7%	↓
TWK	Abbey View	35%	9	100.0%	0	0	83%	6	2	0	0	0	2	0	86.7%	111.1%	28	4.0% (16.84)	6.6% (16.55)	100.0%	89.1%	↑
LYD	Lydney	26%	11	90.9%	0	0	90%	8	0	0	0	0	0	0	99.2%	98.4%	5	7.4% (13.80)	20.6% (15.92)	75.4%	80.0%	↓
CIR	Coln	54%	19	89.5%	0	0	100%	8	1	0	0	0	1	0	96.5%	101.4%	6	1.4% (15.57)	10.3% (13.23)	94.9%	80.4%	↑
CIR	Windrush	58%	14	92.9%	0	1	90%	3	2	0	0	0	0	0	91.1%	105.7%	0	0.0% (10.55)	2.2% (15.42)	72.0%	74.5%	↔
CIR	Stratton Ward	38%	3	100.0%	0	0	100%	2	0	0	0	0	0	0	103.3%	57.3%	0	0.0% (4.27)	0.0% (2.53)	43.8%	78.9%	↑

Quality Snapshot - Community Teams March 2015

Locality	Safety thermometer harm free care	Number of patients with acquired pressure ulcers				Previous Month Sickness (FTE at start of month)	Appraisal %	Complaints	Movement against Previous Month
		Grade 1	Grade 2	Grade 3	Grade 4				
Cheltenham	99.0%	1	0	0	0	6.49% (72.6)	89.68%	0	⟷
Cotswold	94.1%	0	0	0	0	4.78% (75.3)	91.75%	0	↓
Forest	97.8%	1	1	0	0	4.30% (61.6)	85.31%	0	⟷
Gloucester	93.3%	0	1	1	0	4.41% (89.7)	96.92%	0	↓
Stroud	98.8%	0	1	0	0	5.47% (89.5)	91.48%	0	⟷
Tewkesbury	93.8%	0	0	1	0	5.23% (57.5)	100.10 %	0	↑

PwC Internal Audit – Clinical Record Keeping

Background

- Reports received by the Integrated Governance Committee in 2012-13 raised queries around the consistency and quality of clinical record keeping within the Trust. Questions were also raised on the robustness of the record keeping audit process in place to deliver continued improvements in this area, ensuring both organisational and professional record keeping standards are met.

- Recognising that there may be many reasons for poor record keeping, the Trust commissioned an internal audit on the robustness of the Trust's audit of record keeping. PricewaterhouseCoopers (PwC) undertook the review in March 2013 and reported their findings to the Trust which was tasked with agreeing a response and drafting an action plan.

- PwC revisited the Trust in January 2014 to follow through the recommendations of their report (delivered in August 2013). A report was published in May 2014. In March 2015 the Trust provided PwC with a report on progress relating to open actions (pages 40-41).

- All outstanding actions have been completed and the evidence will be validated by PwC. Further audit will be planned for 2016/17 with revised terms of reference to take account of the introduction of electronic patient records (SystmOne).

PwC Internal Audit – Clinical Record Keeping (March 2015)

Finding	Risk		Update
1. Compliance with the clinical record keeping policy – operating effectiveness	MEDIUM	Failure to comply with the policy could ultimately lead to deterioration in the levels of care given to GCS's patients, through a poor standard of clinical records being completed and maintained.	In March 2015 Gloucestershire Care Services NHS Trust and Gloucestershire County Council ratified their first joint health and social care policy on record keeping. Guidance on the conduct of record keeping audits is available on the clinical audit pages on the Trust's intranet. The clinical audit team has developed an audit tool which reflects the requirements of the record keeping policy. Services review and add specific professional requirements. **Assessment: Recommendations fully implemented.**
2. The timing of action plans – operating effectiveness	MEDIUM	The action plans need to be prepared in a timely manner. If not it will result, in services and localities will routinely failing the audit and will not develop their record keeping technique.	The Trust's CQUIN record keeping tracker spreadsheets detail: the expected audits to be undertaken, the lead clinicians, dates, status updates, methodology, action plans and progress against action plans, requirement to re-audit for failing items, and overall RAG ratings. They enable prompt follow-up where progress appears to be stalling. A link to the final audit report and action plan is included. **Assessment: Fully implemented.**

PwC Internal Audit – Clinical Record Keeping (March 2015)

Finding	Risk		Update
3. Segregation of duties – control design	LOW	By completing audits on their own records may result in a lack of independent judgement being expressed	The Trust's record keeping policy includes the expectation that elements of record keeping audit will include peer review and states that "audit reports should evidence the level of peer review used". Additional scrutiny is provided from the Nursing and Quality Directorate who randomly sample records on a regular basis. **Assessment: Fully implemented.**
4. Selection of sample sizes – operating effectiveness	LOW	It is also necessary to ensure that audits are being conducted efficiently, to an appropriate sample size to avoid unnecessary costs to the organisation.	The revised record keeping policy directs service audit leads to consult the clinical audit team regarding the choice of appropriate sample. Audit sample size is included on the tracker spreadsheets and in all audit reports. **Assessment: Fully implemented.**
5. Aggregation of audit results and action plans – control design	LOW	Services and localities could be failing to act in accordance with GCS's policy, and this could impact on the level of care given to patients through poor clinical record keeping practice.	The tracker spreadsheets, created within the Nursing and Quality Directorate to track progress and outcomes of the year's programme of record keeping audit across Trust services, have provided oversight at Trust level. **Assessment: Fully implemented.**

National Audit of Intermediate Care 2014

Gloucestershire Care Services NHS Trust

Audit lead	Margy Fowler, Locality manager
Date of audit	May - August 2014
Audit size:	National audit of 472 services delivered by 124 provider organisations. GCS took part in two out of four elements: home based intermediate care and reablement. (The trust found it difficult to align actual service delivery models with the audit categories).

Audit report (published Nov 14)

Patient experience of intermediate care

100 service users in each service were asked to complete Patient Reported Experience Measure (PREM) questionnaires.

Response rate	National	GCS
Home based intermediate care	21%	13%
Reablement	23%	30%

National results showed a very high level of satisfaction. The proportion of service users who felt they were treated with dignity and respect was over 89%. A question on whether service users felt less anxious since having the service saw over three quarters of service users agree, suggesting services are having a positive impact on mental health.

Areas for improvement at a national level were: communication with service users about their care, timing of visits, shortage of staff resulting in rushed visits and communication with family members.

Local scores reinforced some of the nationally reported areas for improvement, with below national average returns on many questions, though sample numbers were small and findings need to be treated with caution.

Since the audit, significant service redesign work has taken place to more closely align reablement to service user needs. Within the ICT framework, the trust now has three reablement pathways: recovery, rehabilitation and social reablement.

Organisational audit: key findings

Reablement service	National	GCS
Waiting time from referral to assessment (days)	5.3	2.5
Length of stay (days)	32.7	30.5
Mean no. of contact hours per service user	36.0	22.0

Since the national audit the service redesign has contributed to an increase in reablement worker face to face contact time from 32% in September 2014 to 42% in November and this percentage continues to rise.

Dependency and outcomes in intermediate care

National data suggested the vast majority of people experienced a positive outcome; 92% of service users in home based care maintained or improved their level of functioning across a range of everyday activities.

There is no comparative data for GCS within the national audit but data on dependency is collected locally; 65% of service users show a reduction in needs . One of the objectives of the PROMs and PREMs pilot running in Gloucester is to seek to measure changes in health related quality of life (using EQ5D) and changes in social-care related quality of life (using ASCOT) for the individual service user following a programme of reablement.

National Audit of Intermediate Care 2014
Agreed actions

Access to mental health services

A project is already underway in the Stroud and Berkeley Vale areas working with CCG, GCC, 2gther Trust and other partners to seek to improve patient experience around wider access to related provision including mental health services. A “test and learn” phase is scheduled to conclude in October 2015 and it is hoped that this will lead to countywide implementation of new ways of working.

Better understanding of outcomes for service users

A pilot is currently running in Gloucester locality with service users at a bed based reablement unit (Great Western Court) and with service users receiving reablement at home to evaluate a more comprehensive questionnaire of both PREMs and PROMs for use in reablement. The objective of this pilot is to assess a survey for response rates, operational impact and for its ability to deliver informative results. It is hoped that this could provide us with measures of both patient experience and the effectiveness of reablement that can inform continual improvements in service user outcomes.

Improved patient and service user engagement via Friends and Family Test

The FFT question has recently been introduced across the ICTs. In the light of the relatively low response rate to the national audit we intend to raise the profile of this survey within the teams. With good response levels we will have reliable data to feedback to colleagues and to inform discussion around how to improve patient experience.

Effective : Trust compliance with NICE guidance

published May 10 to March 15

Type of guidance	Not Assessed	Not Implemented	Partially Implemented - Moderate Concern	Partially Implemented - Minimal Concern	Fully Implemented	Not Applicable
NICE Guidance	38	0	3	16	25	437

Where partial compliance is declared, a clinical lead has been identified to review the guidance and consider actions required. This is monitored by the Clinical Senate who can escalate specific concerns to Quality and Performance Committee or Contract Quality Review Group.

Effective – NICE Quality standards

Trust compliance with NICE Quality Standards published June 2010 to March 2015

Type of guidance	Not Assessed	Not Implemented	Partially Implemented - Moderate Concern	Partially Implemented - Minimal Concern	Fully Implemented	Not Applicable
Quality Standards	31	1 (QS6 Diabetes)	1 (QS19 Bacterial meningitis and meningococcal septicaemia in children and young people)	1 (QS064 Feverish illness in children under 5 yrs)	8	42

- A compliance rating is declared for each Quality Statement within each Quality Standard.
- A “non-assessed” overall rating will apply where one or more statements remain unassessed. A “not implemented” overall rating will apply where one or more statements are considered not implemented.
- Clinical leads are identified to review each piece of guidance under the leadership of the Medical Director.
- A full report related to progress to implementation and requirements under newly published guidance is submitted to each Clinical Senate meeting.

RESPONSIVE

Responsive - key points

- In March 2015, the Trust is reporting 85.7% compliance with national health targets and 77.8% compliance with local health targets on year to date basis: this is an improvement from with the position reported in February 2015

- Details of actions in respect of areas of under-performance are included *(see pages 48 to 50)*

- Meetings held with Commissioners to review and update progress with MSKCAT and Podiatry on fortnightly basis. Referral to treatment within 8 weeks achieved in March for Podiatry and MSKCAT, however significant under-performance continues for MSKCAT target routine wait should not exceed 4 weeks

- There are two social care indicators currently rated red, which are of particular priority for the Trust and Adult Social Care Commissioners (see page 51) . Performance in relation to permanent admissions to Care Homes continues to show a positive trend.

- Health Visitor Call to Action target of 127.32 Health Visitors in post by end of March was achieved (131.19 in post). A celebration event was held in March 2015 to recognise the achievement of the Health Visiting workforce.

Performance exceptions – Year-to-date National

Indicator	YTD RAG	Performance	Actions	Projected date of remedy
Safety Thermometer - harm free care		Performance in March was 95.0% (target of 95%); year to date performance 92.6%	Focus remains on clinically reviewing all reported 'harms' to validate in comparison to data on SystmOne and DATIX. Work ongoing across health community to reduce risk of falls and pressure ulcers	In-month target achieved since February 2015
Children in Year 6 with Height and Weight recorded		Year to date performance to end of March 88.9% compared to trajectory of 95%	Under performance due to missing data that has not loaded into SystmOne. This is being investigated to determine the reason and resolution. The performance has also been impacted by reduced clinical capacity during December due to staff being released for SystmOne training. Original trajectory did not take account of SystmOne roll-out and will be reviewed accordingly	June 2015
Friends and Family Test response rate – Minor Injury Units		Year to date performance 19% compared to target of 20%	Performance declined in March to 18% following two months where achievement in excess of target. Staff are reminded to ask patients to return the completed questionnaire in a timely manner.	April 2015
MIU unplanned reattendance rate within 7 days		Year to date performance 5.4% compared to target of less than 5%. Performance of 5.6% in March 2015	Professional Lead for Urgent Care to investigate known issues identifying actions to include MSS Patient First recording system issues and primary care appointment availability	Transition to SystmOne from May 2015 to resolve MSS Patient First issue
Face to Face Consultation in Primary Care Centres (urgent to be seen within 2 hours)		Year to date performance 93% compared to target of 95%. Performance of 90% in March 2015	Year to date performance remains behind target primarily due to demand on service in previous months. Service ceases to be provided by the Trust from 1st April 2015	Service ceases to be provided by the Trust from 1st April 2015

Performance exceptions – Year-to-date Local

Indicator	YTD RAG	Performance	Actions	Project date of remedy
MSKCAT service - wait time for routine patients		Performance in March was 42% for routine and 100% for urgent patients against 95% targets. Year to date performance remains rated red	Actions include: • Monitoring of activity recorded on SystmOne (data quality) • Daily review of urgent patient waiting list • Agreement to over-recruit • Fortnightly performance report to be provided from Service Lead to CCG • MSKCAT, MSK, Podiatry to be reviewed as one service area to ensure that changes in any of the component parts do not cause instability	Urgent target achieved since September 2014. Routine to achieve 95% target by end of May 2015
MSKCAT service - wait time for urgent patients				
MSKCAT service - referral to treatment within 8 weeks		Performance in March was 96% (target 95%) ahead of trajectory, year-to-date performance 80%		March 2015
Chlamydia Screening - number of positive screens		Performance to end of March February behind target by 415 positive screens, (1,014 positive screens recorded compared to target of 1,429)	The service had actions in place to attempt to increase number of positive screens, however these were not successful. Action plan in place to demonstrate positive screens achievable in 2015/16. Key component based on feedback from focus group with 19-24 year olds, targeted work specific to 19-24 year olds, develop use of social media. Lessons learnt and good practice identified from other organisations	Target will not be achieved in 2014/15
Podiatry Service - referral to treatment within 8 weeks		Performance in March was 99% (target 95%), however year-to-date performance 90%	The actions itemised above for the MSKCAT service apply equally to the podiatry service. In addition, the service lead has undertaken a review of clinic rotas on SystmOne to maximise appointments available	In-month performance achieved February 2015
Bone Health Service - referral to treatment within 8 weeks		Performance in March was 100% (target 95%), however year to date performance is 93%	The target has now been achieved for 8 consecutive months	Performance on target since August 2014
Adult Speech & Language Therapy - referral to treatment within 8 weeks		Performance in March improved to 87% (target 95%), year to date performance 92%	Service has struggled to fill vacancies which has impacted upon capacity. Staff are moved between locations to cover outpatient work where possible. Service action plan to include review of structure and skill-mixing to mitigate recruitment difficulties	To be confirmed
Stop Smoking – number of smokers successfully quitting		Performance to end of March 2,301 compared to target of 2,332	The current under-performance is due to the lag-time in reporting and the target is expected to be achieved following receipt of further data.	May 2015

Performance exceptions – In month – National (in addition to those already referenced)

Indicator	Month RAG	Performance	Actions	Project date of remedy
C. Diff post 48 hour infections		4 cases reported in March compared to trajectory of 2 cases. Year to date performance remains ahead of trajectory (17 cases compared to trajectory of 21)	4 cases were reported in March 2015, all following transfer from Acute Trust, in each case symptoms developed after the post 48 hour period. Each case to be fully investigated and learning shared	April 2015

Performance exceptions – In month – Local (in addition to those already referenced)

Indicator	Month RAG	Performance	Actions	Project date of remedy
Psychosexual Medicine referral to treatments within 8 weeks		In month performance of 80% (target 95%); year to date performance 98%	The target was missed by one patient. The patient's appointment had to be rearranged following doctor unavailability. The only available appointment was outside of the 8 weeks period	April 2015
Single Point of Clinical Access (% of calls abandoned)		In month performance of 7.5% (target <5%); year to date performance 4.3%	The target was not achieved due to demand. There were 2,839 calls received in March, 195 were abandoned	TBC - In-month performance related to demand
Single Point of Clinical Access (% of calls resolved with agreed pathway within 20 minutes)		In month performance of 93.5% (target 95%); year to date performance 95.5%	The target was not achieved due to demand. There were a total of 98 calls resolved that had an agreed pathway but outside of the 20 minute target. The under-performance of 1.5% is equivalent to 22 calls resolved but outside of the 20 minute target	TBC - In-month performance related to demand
% of terminations carried out within 9 weeks and 6 days of gestation		In month performance of 78% (target 80%); year to date performance 84%	The 80% target was missed by two patients due to patient choice where appointments within the timeframe were not accepted	April 2015

Adult Social Care Key Indicators

Gloucestershire Care Services NHS
NHS Trust

Target description	2013/14 Outturn	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-14	Feb-14	Mar-14	Target 2014/15
% service users who have been asked at initial assessment whether they have a carer		98.4%	98.3%	98.4%	98.3%	98.4%	98.3%	98.5%	98.5%	98.6%	98.4%	98.5%	TBC	100.0%
Permanent admissions aged 65+ to residential and nursing care homes per 100,000 population	885.87	865.37	853.41	830.34	794.31	770.22	766.89	746.95	733.66	740.3	723.69	709.56	681.3	Smaller is better 731.90
% service users who have had a full re-assessment of their needs within the last 12 months	80.8%	89.5%	88.7%	88.3%	87.4%	86.1%	84.2%	82.5%	80.6%	79.1%	77.2%	75.0%	71.9%	80.0%

- **% service users who have been asked if they have a carer** - performance has been very steady over the year, only fluctuating by between 98.3-98.5% each month. Performance is close to target of 100%, but consistently below it. Data for March 2015 is currently being reviewed.
- **Permanent admissions aged 65+ to residential and nursing care homes per 100,000 population –** performance continues to steadily improve.
- **% service users who have had a full re-assessment of their needs within the last 12 months-** performance remains below target and worse than last year. Community Service SU cohort is performing well at 85.2% but Care Homes (Countywide) is much lower at 58% achievement. Work is underway to address the shortfall.

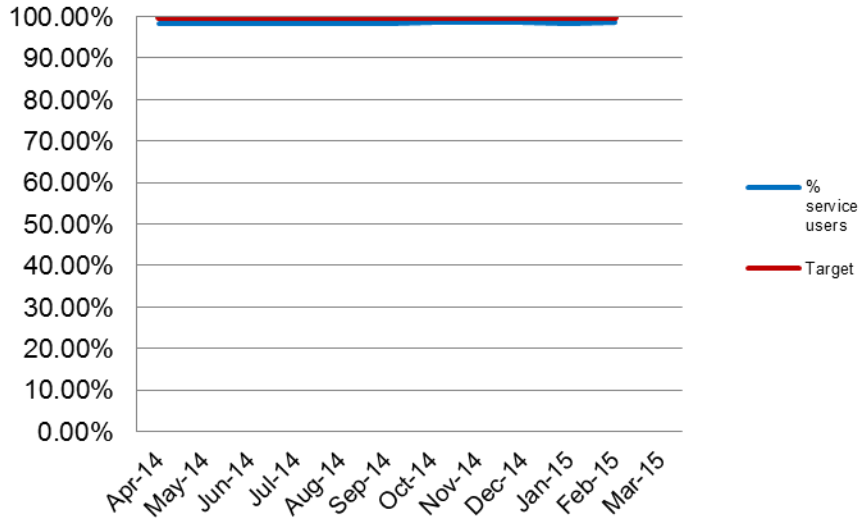
The above 3 indicators are those that have been agreed between the Trust and Gloucestershire County Council as highest priority

The target for Permanent admissions aged 65+ to residential and nursing care homes per 100,000 population has been achieved since January 2015

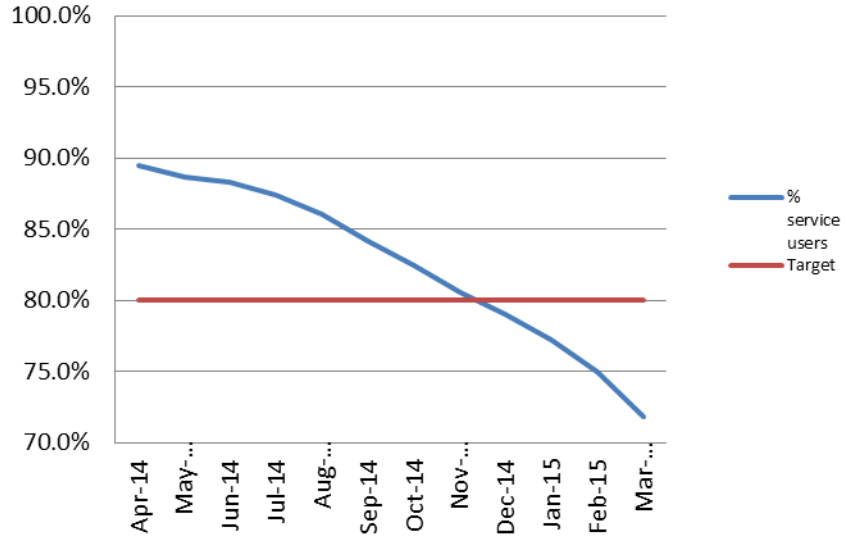
Adult Social Care Key Indicators

Gloucestershire Care Services NHS
NHS Trust

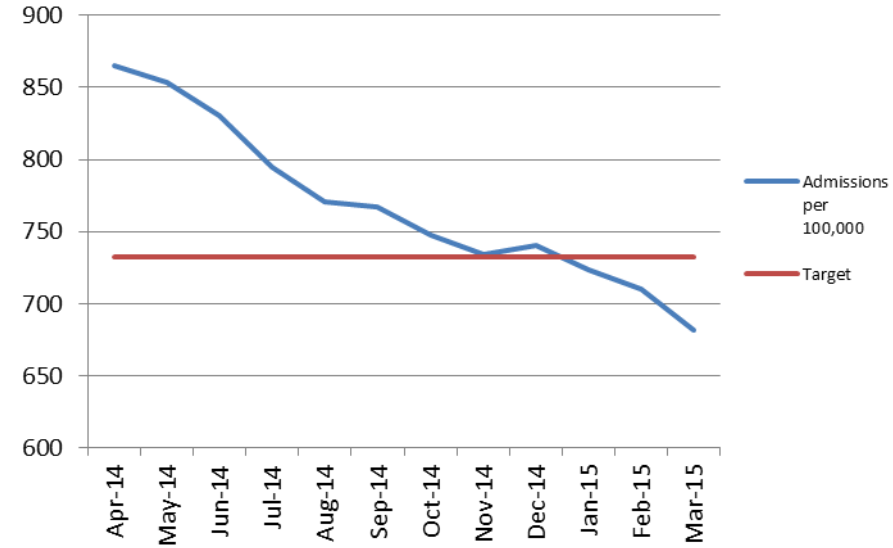
% service users who have been asked (within the last 12 months) whether they have a carer



% service users who have had a full re-assessment of their needs within the last 12 months



Permanent admissions aged 65+ to residential and nursing care homes per 100,000 population



Rapid Response - Key Indicators

Indicator	Target	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
Number of referrals		70	91	105	97	80	88	134	127	174	167	131	117	**1,381**
% of patients with assessment initiated within 1 hour	95%					88.0%	92.8%	92.5%	92.7%	96.3%	96.8%	88.5%	91.5%	**92.4%**
% of patients referred from SPCA who have an agreed patient led care plan in place	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**
% of patients where the direct referrer reports that rapid response intervention avoids hospital admission		80.0%	76.5%	73.2%	70.7%	62.5%	80.0%	83.3%	89.4%	82.5%	89.3%	97.7%	98.3%	**82.0%**
Number of referrals where the direct referrer reports that rapid response intervention avoids a hospital admission		56	70	77	69	50	70	112	114	144	149	128	115	**1154**

Rapid response referrals:

- Cotswold locality roll-out commenced in February 2015.
- Increase in % of patients where the direct referrer reports that rapid response intervention avoids hospital admission
- 100% of patients referred from SPCA have an agreed patient led care plan in place

WELL-LED

Well-led - key points

- The Trust is currently performing well against its data quality targets i.e. in respect of the validity of 45 data indicators that are submitted to the Secondary Uses Services (SUS), Trust performance is 99.2% against a target of 96% *(not referenced elsewhere)* based on the latest data available from the Health and Social Care Information Centre (HSCIC) (April 2014 to January 2015)

- The Staff Friends and Family Test is positive in terms of colleagues recommending the Trust as a place for treatment: however, there is opportunity to improve the Trust's recommendation as a place to work *(see page 56)*

- The Trust is currently employing more staff than planned *(see page 57)*

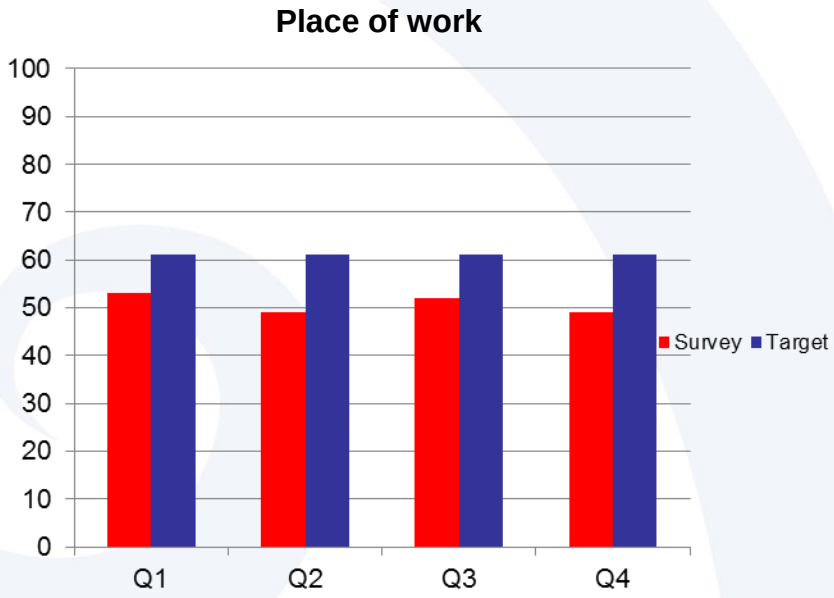
- Sickness absence levels, mandatory training rates and appraisals continue to under-perform *(see page 58)*

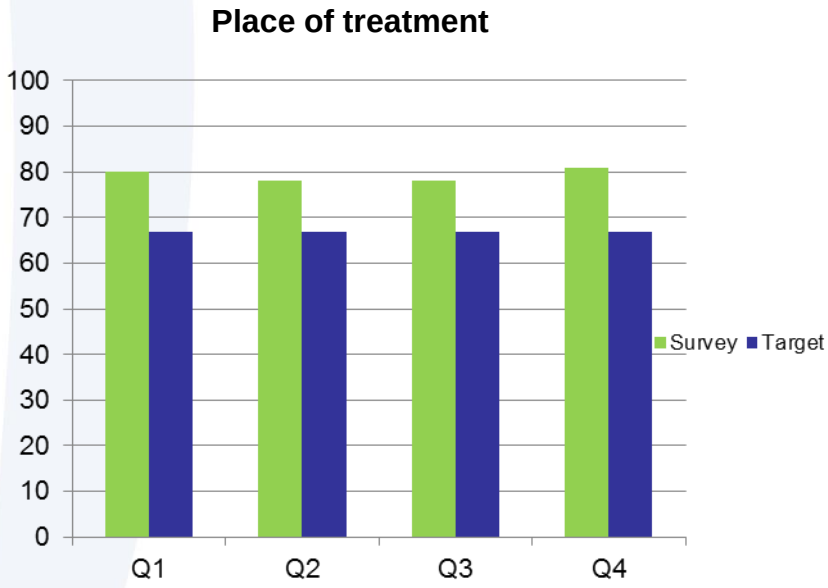
- A revised programme of Quality visits is in place using the Salford Accreditation and Assessment tool. We are being supported in the programme by Non Executive Director colleagues and members of Healthwatch Gloucestershire.

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

Staff Friends and Family Test

	Q1	Q2	Q3	Q4
Percentage of staff who would recommend the Trust as a place of work	**53%**	**49%**	**52%**	**49%**
Percentage of staff who would recommend the Trust as a place to receive treatment	**80%**	**78%**	**78%**	**81%**





Full analysis of the data is being undertaken. Report to Workforce & OD Committee.

Workforce numbers

	Monthly Actual Staff in Post (WTE)	Planned Staff in Post (month) WTE	Vacancy Rate (%) (variance against plan)	Monthly Actual Spend (£000s)	Annual Plan Spend (month) £000s
Total workforce	2,312.79	2,137.88	8.18%	£6,691	£6,819
- Temporary workforce	180.21	106.91	Not Required	£806	£87
- Bank	63.30	64.49	Not Required	£183	£30
- Agency staff	116.91	42.42	Not Required	£623	£57
Substantive WTE	2,132.58	2,030.97	5.00%	£5,885	£6,731
- Non-medical - clinical staff	1,884.00	1,764.34	6.78%	£5,049	£5,906
- Non-medical - non-clinical staff	220.44	232.80	-5.31%	£621	£600
- Medical and dental staff	28.15	33.83	-16.80%	£215	£225

Non-medical – non-clinical staff vacancy rate of -5.31% compared to plan lies mainly with Administration and Estates cohort of staff
**Medical and dental staff - vacancy rate of -16.80% compared to plan is largely within Dental and Sexual Health services

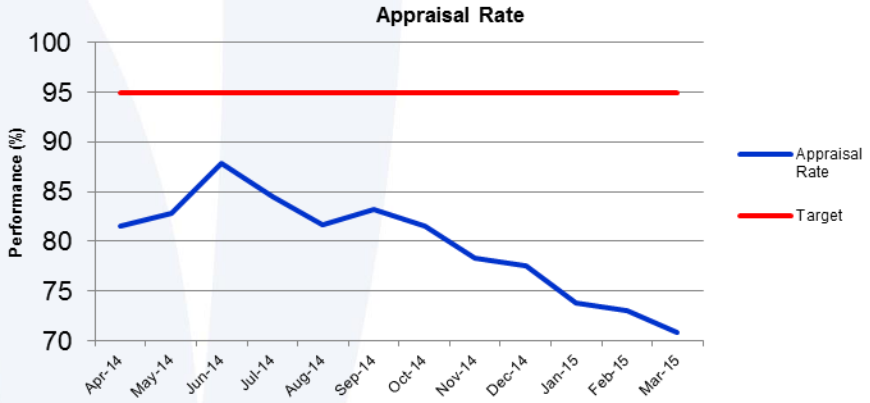
Staff Group	Funded Established – All Staff	In Post – All Staff	Difference	Starting April (WTE)	Starting May (WTE)	Appointed but with a Future Start Date (WTE)	Balance of Vacancies
Corporate Total	**261.37**	**268.52**	**7.15**	**10.93**	**0.00**	**5.73**	**23.82**
Service Delivery – ICTs	488.22	447.44	-40.78	5.60	2.60	8.40	-24.18
Service Delivery – Children	368.24	362.50	-5.74	1.30	0.0	5.91	1.47
Service Delivery – Countywide	401.92	353.36	-48.56	6.88	0.10	2.80	-38.78
Service Delivery – Other	62.71	55.78	-6.93	0.0	0.0	9.00	2.07
Service Transformation – Community Hospitals	572.68	513.64	-59.04	10.71	0.00	18.80	-29.53
Service Transformation – Other	102.62	131.35	28.73	1.80	1.13	2.42	34.08
Operational Services Total	**1996.39**	**1864.06**	**-132.33**	**26.29**	**3.83**	**47.33**	**-54.88**
Total	**2257.76**	**2132.58**	**-125.18**	**37.22**	**3.83**	**53.06**	**-31.06**

Sickness absence / mandatory training / appraisals

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Target
Sickness absence average % rolling rate - 12 months	4.35	4.39	4.45	4.55	4.59	4.59	4.69	4.73	4.80	4.92	4.89	4.85	**3.00**
Sickness absence % rate (1 month only)	4.88	4.48	4.88	5.43	4.94	4.34	5.17	4.83	5.15	5.35	4.54	4.11	**3.00**

Mandatory training course	Target	Health performance
Infection Control	95%	**79.83%**
Health & Safety	95%	**79.83%**
Conflict Resolution	95%	**72.69%**
Equality & Diversity	95%	**72.93%**
Information Governance	95%	**61.58%**
Fire Safety	95%	**60.03%**

Appraisal rate	Target	Performance
March	95%	70.91%



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

Non-Executive Directors (NED) Quality Visit Schedule (2015)

Date	Who	Service	Location	Status	Feedback From Visit
19th February	Nicola Strother Smith (Sally King, Respiratory Physio)	Pulmonary Rehabilitation	The Health and Well-Being Suite, Marina Court, Tewkesbury	Visit completed	• All of the patients indicated that their general wellbeing had improved with their attendance at the classes. • Concern regarding waiting time to join the class. • Question regarding what level of training staff have with dealing with distressed patients.
4th March	Nicola Strother Smith Matrons	Community Hospital	Tewkesbury Hospital	Visit Completed	Available in Separate Report
5th March	Ingrid Barker Angela Hemus	Immunisation and Vaccination Services	Lakers School, Forest of Dean	Visit Completed	• Impressed by the efficiency and kindness shown by the team. • Feedback sought from almost half of the girls; all said that the information provided was very clear

Gloucestershire Care Services NHS
NHS Trust

Non-Executive Directors (NED) Quality Visit Schedule (2015)

Date	Who	Service	Location	Status	Feedback From Visit
5th March	Joanna Scott (Sue Trigg Clinical Nurse Specialist)	Bone Health Waiting Room	Gloucestershire Royal Hospital	Visit Completed	• The clinic was small with only five appointments, of which three did not attend. • No specific waiting area and therefore not possible to talk to patients before their appointment • NED observed (with consent) two of the consultations.

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NHS Trust

Non-Executive Directors (NED) Quality Visit Schedule (2015)

Date	Who	Service	Location	Status	Feedback from Visit
16th March	Richard Cryer Matrons	Community Hospital	Cirencester Hospital	NED to join Head of Community Hospitals' walkabouts	All visits were very positive and encouraging. Positive feedback from patients on quality of care and environment (particularly in the new hospitals). Some areas found that need addressing were documentation, out of date signage and concern around high levels of bank and agency staff and the impact of this on patient care.
18th March	Matrons	Community Hospital	Lydney Hospital	NED to join Head of Community Hospitals' walkabouts	
18th March	Matrons	Community Hospital	Dilke Hospital	NED to join Head of Community Hospitals' walkabouts	
27th March	Rob Graves Matrons	Community Hospital	North Cotswolds Hospital	NED to join Head of Community Hospitals' walkabouts	
31st March	Nicola Strother Smith Matrons	Community Hospital	Vale Hospital	NED to join Head of Community Hospitals' walkabouts	
31st March	Nicola Strother Smith Matrons	Community Hospital	Stroud General Hospital	NED to join Head of Community Hospitals' walkabouts	

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Non-Executive Directors (NED) Quality Visit Schedule (2015)

Date	Who	Service	Location	Status
16th April	Sue Mead Stacey Rees and Kim Morris	Children's Physiotherapy Service	Stroud	Visit completed
30th April	Richard Cryer James Curtis	Stop Smoking Service	Gloucester	Visit confirmed
14th May	Ingrid Barker Liz Bromwell	Public Health Nursing Service	Cheltenham	Visit confirmed
21st May	Nicola Strother-Smith Community nursing team	Community Nursing Service (ICT)	This will agreed nearer to the date	Visit agreed, awaiting decision on location
3rd June	Sue Mead Community nursing team	Community Nursing Service (ICT)	This will agreed nearer to the date	Visit agreed, awaiting decision on location
4th June	Joanna Scott Sarah Nicholson	Adult MSK Physiotherapy Service	Stroud	Visit confirmed
9th June	Ingrid Barker Community nursing team	Community Nursing Service (ICT)	This will agreed nearer to the date	Visit agreed, awaiting decision on location
1st July	Rob Graves Community nursing team	Community Nursing Service (ICT)	This will agreed nearer to the date	Visit agreed, awaiting decision on location
5th July	TBC Caroline Halford	Children's Continence Service	TBC	Awaiting confirmation from Service Lead

Gloucestershire Care Services NHS
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Non-Executive Directors (NED) Quality Visit Schedule (2015)

Date	Who	Service	Location	Status
9th July	Richard Cryer Debbie Gray	Integrated Discharge Team	Cheltenham General Hospital	Visit confirmed
14th September	Sue Mead Lee Harrison	Children's Community Service	Cheltenham	Visit confirmed
5th November	Richard Cryer Sue Watts	Dental Service	Redwood House, Stroud	Visit confirmed
26th November	Ingrid Barker Sue Watts	Parkinson's/MND	Location depending on date available	Visit confirmed

Change Request Log

Number	Who	Description of change	Page Number	Report Change applied to
1	Workforce Team	Change of format of Operational Services contained within template	48	25th February 2015
2	Director of Nursing	Safety Thermometer snapshot added showing patients with old and new harms within Hospital and Community Settings	12	25th February 2015
3	Director of Nursing	Removed Safer Staffing Alert Level table and incorporated into Quality Snapshot	34	25th February 2015
4	Director of Nursing	Inclusion of Medicine Management – ward /department medicine security checklist	20	25th February 2015
5	Director of Nursing	Inclusion of "*hello my name is*…" campaign narrative	26	25th February 2015
6	Head of Performance and Information	Friends and Family Test pages revised to reflect revised National reporting requirements	27-29	17th March 2015
7	Director of Nursing	Non-Executive Directors Quality visit schedule reformatted to show all future visits scheduled including those to be confirmed	54-55	17th March 2015
8	Director of Nursing	Mortality reviews table updated to include data for 2013/14 to allow comparison with 2014/15	34	17th March 2015
9	Head of Performance and Information	Inpatient survey expanded to show Core questions and Experience questions	30-31	17th March 2015

Page numbers refer to page number within the specific report identified that report change applied to

Change Request Log

Number	Who	Description of change	Page Number	Report Change applied to
10	Workforce Team	Change of format of Operational Services and data items contained within template	51	17th March 2015
11	Head of Performance and Information	Introduction of 'word cloud' provided by CoMetrica to provide visual illustration of Friends and Family Test feedback received in January	28	17th March 2015
12	Interim Deputy Director of Nursing	Falls in inpatient setting terminology change from injurious falls to falls with harm, and non-injurious falls to falls with no harm	14	17th March 2015
13	Director of Finance	Charts added to illustrate Mortality reviews as % of Occupied Bed Days per Hospital site and also % of Mortality reviews per Day of the week	33	8th May 2015
14	Director of Finance	Graphical representations of Key Adult Social Care Indicators	53	8th May 2015
15	Director of Nursing and Quality	Addition of details of Internal Audit – Clinical Record Keeping	39-41	8th May 2015
16	Director of Nursing and Quality	Details on National Audit of Intermediate Care benchmarking completed May to August 2014	42-43	8th May 2015
17	Director of Nursing and Quality	Executive Summary added	3	8th May 2015
19	Director of Nursing and Quality	NED Quality Visit schedule expanded to include feedback from visit	60-63	8th May 2015
20	Head of Workforce Transformation	Appraisal and Mandatory Training targets adjusted to 95%	59	8th May 2015

Page numbers refer to page number within the specific report identified that report change applied to

Gloucestershire Care Services NHS
NHS Trust

Annual Mortality report

Ref: 15/0515

Annual Mortality Report

19 May 2015

The Board is asked to:

Note the high-level operational risks and provide steer where appropriate in respect of action / remedial plans

Executive summary:

The purpose of the annual mortality report to Board is to provide the board with:

- Data about mortality in community hospitals
- Assurance about the system used to monitor and scrutinise mortality in community hospitals
- Assurance about quality improvement in end of life care.

Identify which strategic objective(s) this paper supports:

1.	Achieve the best possible outcomes for our service users through high quality care.	
2.	Understand the needs and views of the service users, carers and families so 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.	

Joanna Bayley, Medical Director

13 May 2015

Please complete the Equality Checklist over….

Please select one of the following options:

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

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

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

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

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

Annual Mortality Report 2014-15

Section One: Introduction

This is the annual mortality report produced by Gloucestershire Care Services NHS Trust. It is the first report of this type to come to Board, following the development of a new system of data analysis and organisational learning in 2014. Previously, the mortality data considered by the Board were entirely derived from the Patient Administration System [PAS]; the new system provides greater detail and embeds learning about end of life care throughout the Trust.

The primary purpose of mortality reporting is to identify trends in mortality rates that may indicate that patients are receiving poorer quality care than in services with lower mortality rates. A secondary benefit of a robust system of mortality reporting is to scrutinise end of life care in general and to drive quality improvement by sharing learning across the Trust.

The purpose of the annual mortality report to Board is to provide the Board with:

- Data about mortality in community hospitals
- Assurance about the system used to monitor and scrutinise mortality in community hospitals
- Assurance about quality improvement in end of life care.

The mortality reporting system focuses on expected deaths. Unexpected deaths continue to be reported and investigated as Serious Incidents Requiring Investigation. However, learning from any unexpected death and subsequent investigation will be disseminated using the mortality reporting system.

Definitions

Expected Death – an expected death is one which is in which death is the anticipated or likely outcome of the episode of care, either because of the patient's clinical condition or, more rarely, because the patient has declined treatment.

Unexpected Death – an unexpected death is a death that was not anticipated as a result of the patient's clinical condition or that has occurred as a result of the clinical condition, but sooner than had been anticipated.

Duties

The Medical Director has overall Trust responsibility for ensuring that deaths within Community Hospitals are monitored, reviewed and any actions required identified and acted upon.

The Medical Director is the appointed Chair of the Trust's Mortality Group, which provides assurance to the Clinical Senate on patient safety, clinical effectiveness and user experience by monitoring and reviewing mortality-related issues

Section Two: Mortality reporting in community hospitals

Mortality reporting in community hospitals differs from reporting in acute trusts in two important respects: the lack of national benchmarking data for comparison purposes and the small numbers of deaths involved.

In 2013, Sir Bruce Keogh identified fourteen acute trusts that had been persistent outliers in mortality rates[1]. The mortality rates of all acute trusts had been compared using two indices, the HSMR Hospital Standardised Mortality Ratio [HSMR] and Summary Hospital-level Mortality indicator [SHMI]. An expected death rate for each acute trust was derived from these data, which took into account factors such as the type of surgery undertaken by each trust and patient demographics. No such benchmarking indices exist for community hospitals at present. It is therefore not possible for GCSNHST to compare its mortality rate with a national benchmark.

The small number of patients in each GCSNHST hospital, and therefore the small numbers of deaths, also create difficulties in data interpretation. Variations in death rates, particularly in the short-term, are unlikely to have statistical significance, as there is a high likelihood that they are due to chance. As an example, a hospital with 22 beds might have six deaths in July and twelve deaths in August simply as a result of chance factors such as a different clinical caseload from month to month and not due to any variation in the quality of care (though it would be impossible to exclude genuine variation in the quality of care, simply by reviewing the figures). In contrast, in a hospital with 222 beds, a 100% variation in mortality would be likely to indicate genuine variation in quality of care.

The degree of variation as an artefact of the small numbers of death can be seen in Figure 1, which shows the variation in deaths per month by community hospital. Although the plotted trends in death rates appear to show large variation, the differences in absolute numbers are small and likely to represent chance variation in caseload.

[1] Professor Sir Bruce Keogh. Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. NHS England 16 July 2013

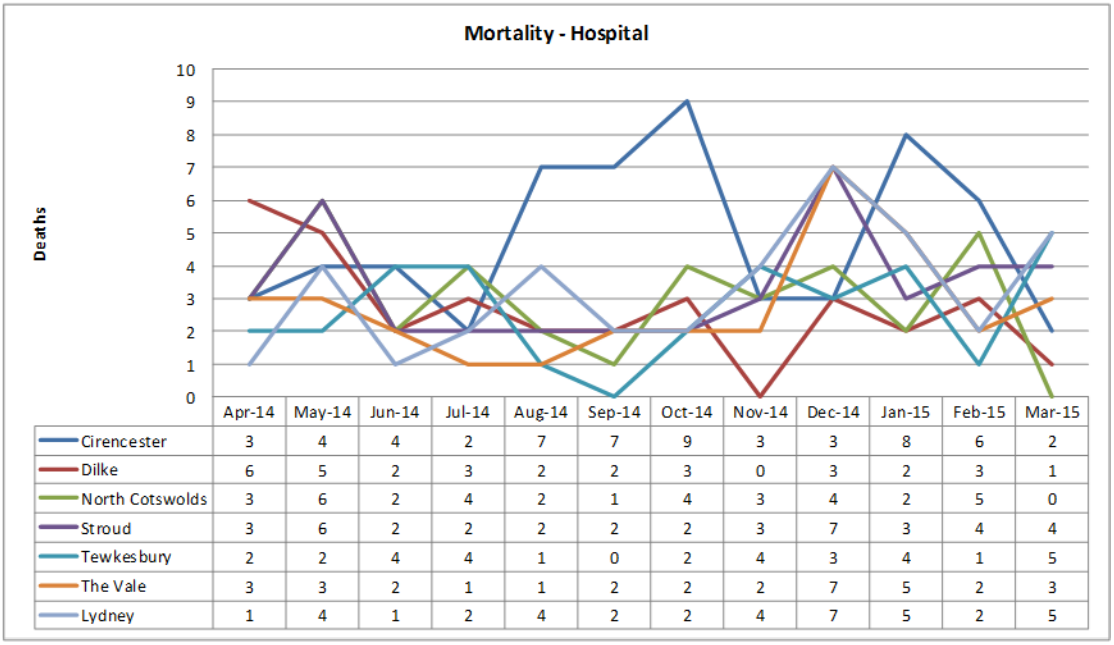
Figure 1: Deaths per month by community hospital.

Gloucestershire Care Services NHS Trust

Mortality - Hospital

April 2014 - March 2015

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	2014/15
Cirencester	3	4	4	2	7	7	9	3	3	8	6	2	58
Dilke	6	5	2	3	2	2	3	0	3	2	3	1	32
North Cotswolds	3	6	2	4	2	1	4	3	4	2	5	0	36
Lydney	1	4	1	2	4	2	2	4	7	5	2	5	39
Stroud	3	6	2	2	2	2	2	3	7	3	4	4	40
Tewkesbury	2	2	4	4	1	0	2	4	3	4	1	5	32
The Vale	3	3	2	1	1	2	2	2	7	5	2	3	33
Total	21	30	17	18	19	16	24	19	34	29	23	20	270



The absence of national benchmarking and the small size of GCSNHST hospitals mean mortality rates *per se* provide less assurance about quality of care than would be the case for larger and acute hospitals. Greater assurance is provided by the scrutiny of each death by a multi-disciplinary team; this is the system that GCSNHST has now adopted.

Section Three: Development of the current reporting process

In early 2014, the Medical Director (JB) developed a new system for mortality reporting in community hospitals. An electronic form was completed after each death by the ward and submitted to a database, to which the Medical Director had access. This allowed the Medical Director to review deaths as they occurred. A Mortality Reporting Group [MRG] was created, chaired by the Medical Director, reporting to the Clinical Senate, with the remit to:

- Review all mortality data and trends
- Scrutinise all deaths that had been that had been the subject of a concern or complaint
- Identify & disseminate learning from all unexpected deaths (as an adjunct to the SIRI process)

- Perform a detailed analysis of a random sample of deaths to ensure that initial reporting had been accurate and also to identify learning points from the end of life care given.

As well as reporting to the Quality and Performance Group via the Clinical Senate, the Mortality Reporting Group would also submit an annual report to the Trust Board. This new system was approved by the Deputy Medical Director of the Trust Development Authority, who asked permission to share the system with other community trusts as an example of good practice.

During 2014, the Deputy Medical Director (SS), reporting to the Interim Medical Director (MR), refined the reporting process. The key refinements were:

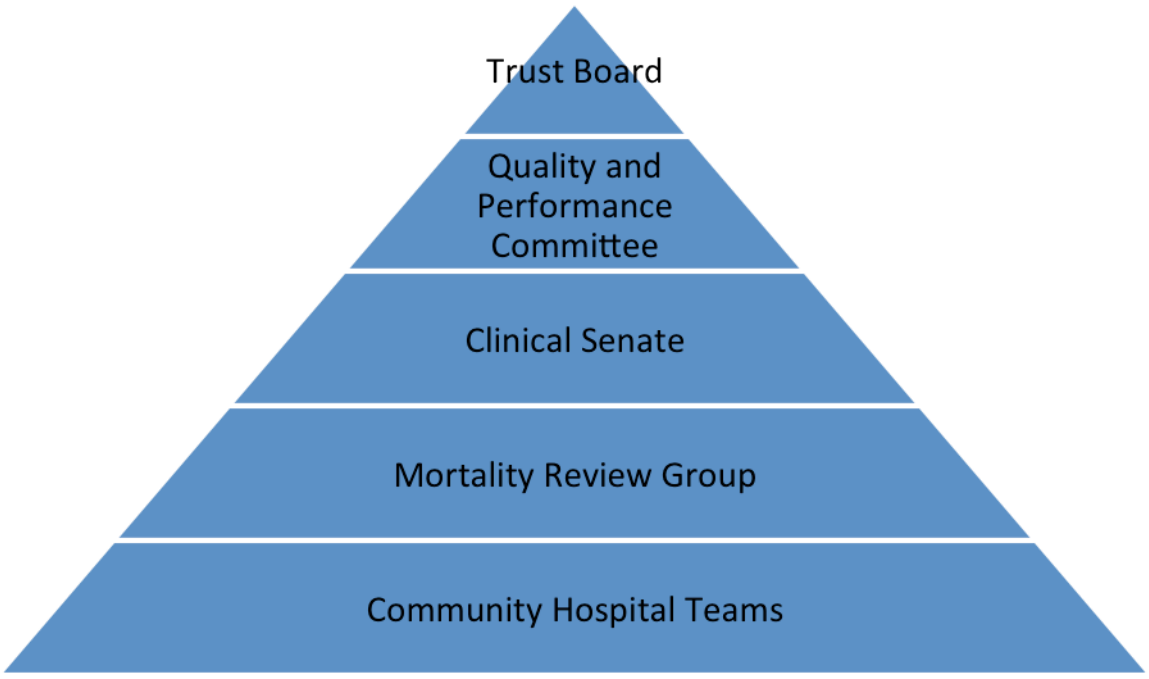
- A greatly enhanced system for data collection, known as MIDAS, which allows more information to be collected and, once SystmOne has been introduced to the community hospitals, will allow mortality reports to be populated directly from the electronic patient record. MIDAS also supports the generation of detailed discharge summaries for GPs.

- The mortality report is now compiled by both a doctor and nurse (rather than a nurse alone). This allows a greater range of clinical information to be captured and also guards against inaccuracy in reports, whether inadvertent or deliberate.

- All deaths will now be reviewed by the monthly clinical governance meetings at each community hospital. These are minuted meetings, chaired by the hospital matron, who will then report the findings to the Mortality Review Group. This allows greater scrutiny of each death and also allows all clinicians who have cared for the patient to be involved in the review and learning process.

The new reporting structure is shown as figure 2.

Figure 2: mortality reporting structure



Section Four: Mortality Data 2014-2015

Prior to the introduction of the new reporting system over the course of 2014, mortality data was solely captured by PAS. PAS collects demographic data, but no narrative information about a death. The PAS data do however provide assurance that there has been no increase in the mortality rates of the community hospitals. Mortality as a proportion of total discharges was 7% in 2014-15, compared to 7.3% in 2013-14. The new reporting system facilitates the capture of more detail around deaths as a percentage of discharge [figure 3] and will allow closer monitoring of trends.

Figure 3: Deaths as a percentage of total discharges

Gloucestershire Care Services NHS Trust

Mortality - Death On Discharge Percentage

April 2014 - March 2015

		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	2014/15
Cirencester	Deaths	3	4	4	2	7	7	9	3	3	8	6	2	58
	Discharges	84	66	82	83	68	82	79	72	76	63	62	60	877
	% Deaths	3.6%	6.1%	4.9%	2.4%	10.3%	8.5%	11.4%	4.2%	3.9%	12.7%	9.7%	3.3%	6.6%
Dilke	Deaths	6	5	2	3	2	2	3	0	3	2	3	1	32
	Discharges	46	51	40	39	37	37	43	41	45	41	31	41	492
	% Deaths	13.0%	9.8%	5.0%	7.7%	5.4%	5.4%	7.0%	0.0%	6.7%	4.9%	9.7%	2.4%	6.5%
Lydney	Deaths	1	4	1	2	4	2	2	4	7	5	2	5	39
	Discharges	29	39	37	40	30	39	34	34	39	33	40	44	438
	% Deaths	3.4%	10.3%	2.7%	5.0%	13.3%	5.1%	5.9%	11.8%	17.9%	15.2%	5.0%	11.4%	8.9%
North Cotswolds	Deaths	3	6	2	4	2	1	4	3	4	2	5	0	36
	Discharges	40	45	42	46	44	40	42	48	38	35	31	35	486
	% Deaths	7.5%	13.3%	4.8%	8.7%	4.5%	2.5%	9.5%	6.3%	10.5%	5.7%	16.1%	0.0%	7.4%
Stroud	Deaths	3	6	2	2	2	2	2	3	7	3	4	4	40
	Discharges	53	72	61	56	54	58	39	46	56	81	65	64	705
	% Deaths	5.7%	8.3%	3.3%	3.6%	3.7%	3.4%	5.1%	6.5%	12.5%	3.7%	6.2%	6.3%	5.7%
Tewkesbury	Deaths	2	2	4	4	1	0	2	4	3	4	1	5	32
	Discharges	32	28	42	42	35	21	22	34	31	26	23	26	362
	% Deaths	6.3%	7.1%	9.5%	9.5%	2.9%	0.0%	9.1%	11.8%	9.7%	15.4%	4.3%	19.2%	8.8%
The Vale	Deaths	3	3	2	1	1	2	2	2	7	5	2	3	33
	Discharges	40	54	47	47	35	38	31	35	47	37	32	38	481
	% Deaths	7.5%	5.6%	4.3%	2.1%	2.9%	5.3%	6.5%	8.6%	14.9%	13.5%	6.3%	7.9%	7.3%
Total	Deaths	21	30	17	18	19	16	24	19	34	29	23	20	270
	Discharges	324	355	351	353	303	315	290	310	332	316	284	308	3841
	% Deaths	6.5%	8.5%	4.8%	5.1%	6.3%	5.1%	8.3%	6.1%	10.2%	9.2%	8.1%	6.5%	7.0%

Comparison of the PAS mortality data for 2013-14 and 2014-15 indicates that most trends in mortality are stable [table 1].

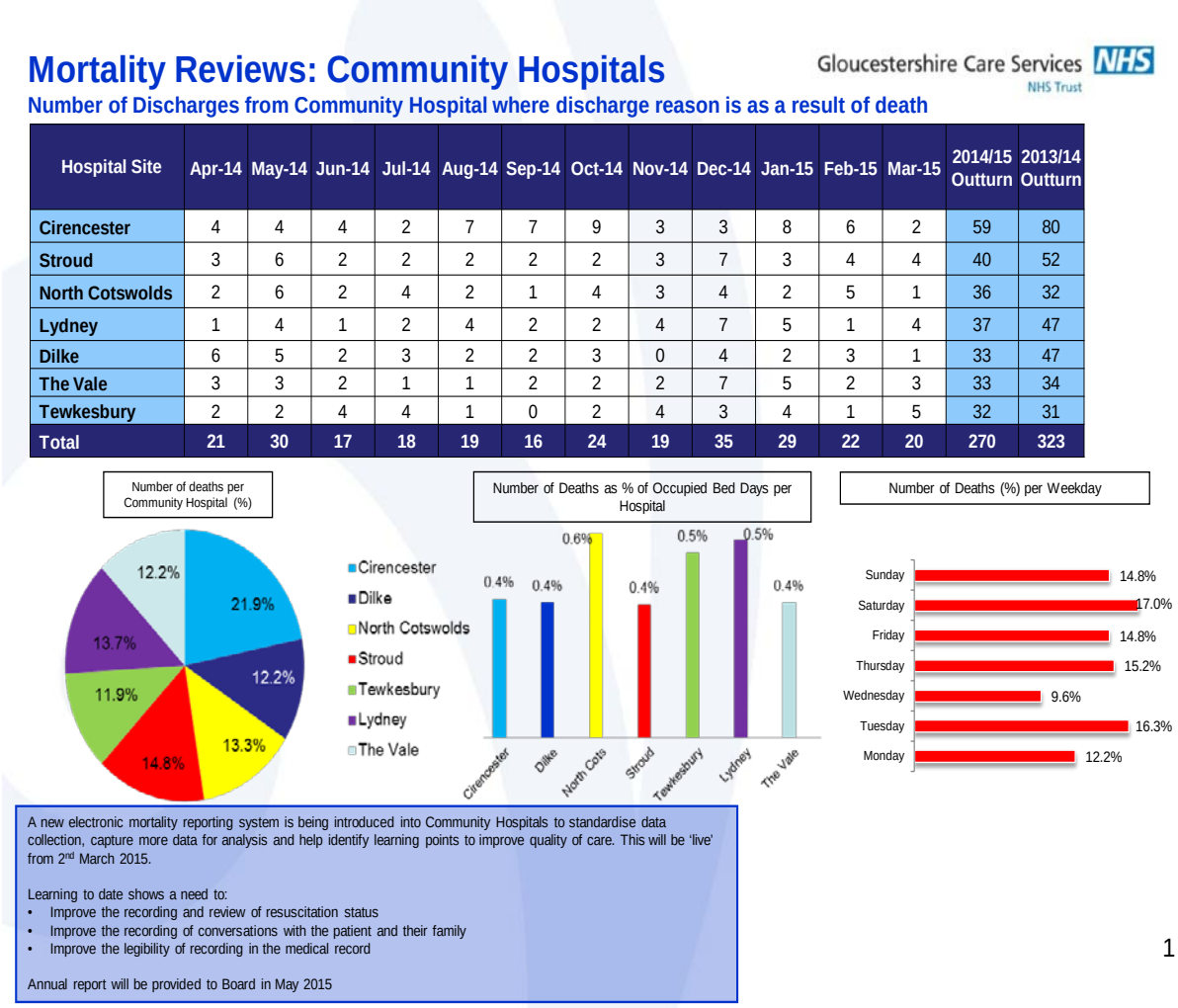
Table 1: Comparison of PAS mortality data 2013-14 and 2014-15

INDICATOR	2014-2015	2013-2014
Total deaths in CHs (number)	270	322
Range of deaths as a percentage of total discharge (%)	5-9	5-10
AVLOS for patients who died (number)	14	16

A difference identified by the PAS data was that most deaths (62%) occurred in patients over the age of 80 years in 2014-15, whereas most deaths in 2013-2014 occurred in patients aged 19-64 years. Due to the small numbers involved, it is likely that this variation is the result of chance differences in caseload, but the Mortality Review Group will monitor this trend.

Saturday had the highest average number of deaths in 2014-15, but next two most common days on which patients died were Tuesday and Thursday, rather than on a Sunday. This is reassuring as it would tend to suggest that the greater number of deaths on a Saturday is the result of chance, rather than any variation in the quality of care at weekends. However, again, the Mortality Review Group will monitor the trend. As well as the MRG reporting, mortality information is included in the Quality and Performance Group report [figure 4].

Figure 4: Illustration of Mortality Information in the Quality & Performance Report



Mortality Reviews: Community Hospitals

Gloucestershire Care Services NHS Trust

Number of Discharges from Community Hospital where discharge reason is as a result of death

Hospital Site	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	2014/15 Outturn	2013/14 Outturn
Cirencester	4	4	4	2	7	7	9	3	3	8	6	2	59	80
Stroud	3	6	2	2	2	2	2	3	7	3	4	4	40	52
North Cotswolds	2	6	2	4	2	1	4	3	4	2	5	1	36	32
Lydney	1	4	1	2	4	2	2	4	7	5	1	4	37	47
Dilke	6	5	2	3	2	2	3	0	4	2	3	1	33	47
The Vale	3	3	2	1	1	2	2	2	7	5	2	3	33	34
Tewkesbury	2	2	4	4	1	0	2	4	3	4	1	5	32	31
Total	21	30	17	18	19	16	24	19	35	29	22	20	270	323

A new electronic mortality reporting system is being introduced into Community Hospitals to standardise data collection, capture more data for analysis and help identify learning points to improve quality of care. This will be 'live' from 2nd March 2015.

Learning to date shows a need to:
- Improve the recording and review of resuscitation status
- Improve the recording of conversations with the patient and their family
- Improve the legibility of recording in the medical record

Annual report will be provided to Board in May 2015

1

Section Five: Quality Improvement of End of Life Care

As outlined in Section 3, the clinical governance meetings at each community hospital will review each death and identify learning points which will then be disseminated by the Mortality Reporting Group. The entire episode of end of life care is reviewed to identify good practice and areas where improvement is needed. The review process at community hospital level is intentionally a narrative one, rather than being driven by hard data collection, both to ensure that all learning points are captured and because of the limitations of numerical data analysis when small numbers are involved. However, the review process is complemented by MIDAS, which captures hard data. Findings from both are considered by the MRG.

Although the community hospital reviews involve a narrative process, prompt questions have been developed to ensure that no important aspect of end of life care is overlooked. These prompts include:

1. Whether the patient is identified as being on an end of life pathway at the clinically appropriate point.

2. Whether discussion about the patient's preferences for end of life care take place with the patient and family at the appropriate time.

3. Whether a Do Not Allow Cardio-Pulmonary Resuscitation [DNACPR] decision is documented at the clinically appropriate time and after discussion with the patient or his/her advocate.

4. General standards of record-keeping.

Initial reviews have established that discussions about end of life care and DNACPR usually occur at the clinically appropriate time, but that documentation of them is inconsistent. This has been fed back to the hospital clinicians and the MRG will monitor progress. The introduction of the electronic patient record will assist in monitoring documentation standards.

In summary, a new system for mortality reporting was developed and refined over the course of 2014, with approval from the Trust Development Authority. The new system aims to provide greater assurance about end of life care and mortality than is possible by numerical analysis alone. Because of the limitations of numerical analysis, the new system is intentionally narrative and qualitative in part, but is complemented by a comprehensive data collection system, MIDAS. As well as providing greater assurance to the Trust Board, the new system will drive organisational learning and quality improvement for all end of life patients.

Gloucestershire Care Services NHS
NHS Trust

Complaints Policy

Ref: 17/0515

Trust Board

Complaints Policy May 2015

Objective:

This revised policy sets the approach that Gloucestershire Care Services NHS Trust will take to listening to and learning from those that use our services.

The purpose of the Complaints Policy is to set out how the Gloucestershire Care Services NHS Trust (GCSNHST) acknowledges and implements the National Health Service Complaints Regulations, and demonstrates how as an organisation will listen and responds to the views of the people that use its services.

The Board is asked to:

The Board is asked to ratify this policy and approve for use throughout the organisation replacing the previous version.

Executive summary:

This policy sets out how as an organisation the trust will:

- Seek to resolve matters brought to our attention rapidly empowering clinicians to seek local resolution where possible
- Ensure we facilitate a process by which those that use our services understand how to make a complaint and we have a process that makes it easy for concerns and complaints to be raised
- Be open and transparent, acknowledging when things go wrong and saying sorry.
- Ensure that it meets the requirements of Duty of Candour
- Ensure that we take the learning from concerns and complaints and use this to improve the quality of the services we provide
- Take a “You said, We did” approach to informing the public of the changes we make as a result of feedback including complaints
- Support our colleagues to investigate complaints through a process that is fair, open and transparent
- Ensure that people are not treated differently as a result of raising a concern or making a complaint

Implementation Plan (to commence immediately post ratification):

Action	Present position	Start date	Completion date	Lead
The Service Experience team will roll out a launch and training programme for all staff to ensure staff are fully aware and understand the new policy	The Service Experience Team has established relationships across the services, including attendance at team and governance meetings. The approach in the new policy has already been discussed will team awaiting its ratification. Training around the complaints policy will link into the training for Duty of Candour that is already in place.	May 20th 2015	30th June 2015	Quality and Safety Mangers (Nicky Goodwin and Claire Powell)
The Service Experience team will attend staff events i.e. Leadership Event (June 2015) to promote the complaints policy with leaflets and feedback forms available for staff and will also be an opportunity for staff and managers to discuss the process more fully	As above, Service Experience team is underway in this area, with discussions about improvements in how we manage feedback received by patients being a regular occurrence.	June 2nd 2015	Ongoing	Quality and Safety Mangers (Nicky Goodwin and Claire Powell)
A section will be included in Team Brief and on the Trust intranet to advertise the new policy, with details of how to find about training and guidance		Next available Team Brief publication	June 2015	Quality and Safety Mangers (Nicky Goodwin and Claire Powell)
Information relating to Service User Experience in the Corporate Induction Handbook will be updated to reflect the new policy.	The present Corporate Induction Handbook has been reviewed and discussed with HR and will be updated immediately post ratification	May 2015	30th May 2015	Quality and Safety Mangers (Nicky Goodwin and Claire Powell)
The approach to complaints and concerns will be presented at the Scheduled Care Governance Forum and Community Hospitals, Urgent Care and Capacity group	We have discussed the new complaints policies alongside how we are improving incident governance and duty of candour. This will be further achieved by the new complaints policy being discussed in the June 2015 governance forums.	June 2015	June 2015	Quality and Safety Mangers (Nicky Goodwin and Claire Powell)

The policy will be made available on the Trust's Intranet		Immediately post ratification	22nd May2015	Quality and Safety Mangers (Nicky Goodwin and Claire Powell)
Information on how to make a complaint will be updated to reflect the new policy, including availability of information leaflet.	Information on how to contact us about experience of our services is already available on the Trust website. This will be updated to reflect the new policy.	Already in place	30th May 2015	Quality and Safety Mangers (Nicky Goodwin and Claire Powell)
New leaflets and posters have been developed and will be displayed at all of the Trust sites	The leaflets have been developed in consultation with our colleagues and are ready to launch with the policy.	Immediately post ratification	May 30th 2015	Quality and Safety Mangers (Nicky Goodwin and Claire Powell)
Support, guidance and monitoring of the policy.	The Quality Team is and will remain responsible for the ongoing effectiveness of the complaints policy. This will be achieved through close working with our colleagues across the services and monitoring and scrutiny of the nature of the contacts to ensure that themes and trends are identified and learned from. We will also work closely with our service user representatives e.g. Gloucestershire Healthwatch, to ensure that the complaints and concerns processes are effective and accessible.	Already in place	Ongoing Review of policy in May 2016	Quality and Safety Mangers (Nicky Goodwin and Claire Powell)

Identify which strategic objective(s) this paper supports:

"Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work"

Identify the key operational and strategic risks that result from the impact of the issues discussed in the paper:

Re NQ2: The Trust's low rate (when compared to other similar organisations) of formal complaints may result in missed learning opportunities leading to poor service user experience

Elizabeth Fenton
May 2015

Please complete the Equality Checklist over….

Please select one of the following options:

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

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

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

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

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

Gloucestershire Care Services NHS
NHS Trust

COMPLAINTS POLICY and PROCEDURE

Document reference:	
Version:	
Ratified by:	**Quality and Clinical Governance Committee**
Date ratified:	
Originator/author:	**Deputy Director of Nursing (Interim)**
Responsible committee/individual:	**Quality and Clinical Governance Committee/Liz Fenton, Director of Nursing and Quality**
Executive lead:	**Director of Nursing and Quality/Medical Director**
Date issued:	
Review date:	

THIS IS A CONTROLLED DOCUMENT

Whilst this document may be printed, the electronic version maintained on the Gloucestershire Care Services NHS Trust intranet is the controlled copy. Any printed copies of this document are not controlled. It is the responsibility of every individual to ensure that they are working to the most current version of this document.

DOCUMENT CONTROL SHEET

Purpose of document:	To provide guidance on the organisational responsibilities for the Complaints Policy

Dissemination:	Will take place through governance meetings supported by awareness sessions held within clinical teams. The policy will also be made available via the Trust intranet and to the public on the Trust website
Scope:	All colleagues, clinical and non-clinical, particularly anyone involved in concerns and complaints e.g. Clinicians, locality managers, Matrons and Ward Sisters/Charge Nurses, Serious Incident Investigators, Chief Executive and Directors, Quality/Service Experience team, Legal Department and Risk Management Department, Clinical Governance Managers,
Review:	Three years or sooner if there are any changes to the Complaints Regulations or Procedure
This document supports:	National Health Service Complaints Regulations (2009), governance frameworks
Key related documents:	Duty of Candour policy, incident and serious incident reporting policies
Equality and diversity:	This policy has been subjected to a Quality and Equality Impact review. This concluded that the policy will not negatively impact upon the quality of health and social care services provided by the Trust.
Quality:	This policy has been subjected to a Quality and Equality Impact review. This concluded that the policy will not negatively impact upon the quality of health and social care services provided by the Trust.
Consultation:	Members of the Quality and Performance Committee Trust Board Equality & Diversity Manager Healthwatch Gloucestershire
Financial implications:	There are no financial implications in relation to the policies

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

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Abbreviations

Abbreviation	Full Description
GCSNHST	Gloucestershire Care Services NHS Trust

1. Introduction

This policy is mainly concerned with the management of concerns and complaints, however the Trust recognises that all types of feedback (which include complaints, concerns, compliments, suggestions etc.) must be managed appropriately and listened to in order to develop services.

2. Purpose

2.1 The purpose of the Complaints Policy is to set out how the Gloucestershire Care Services NHS Trust (GCSNHST) acknowledges and implements the National Health Service Complaints Regulations (2009) and the Local Authority Social Services Complaints Regulations (2009) as GCSNHST manage some Gloucestershire County Council (GCC), along with demonstrating how it will listen and responds to the views of the people that use its services.

2.2 The aims of this policy are to:

- Ensure that the Trust's desire to listen to and learn from feedback is enacted.
- Fulfil the need to implement a complaints management procedure that is easy to understand and simple to use, whilst giving the Trust robust assurance, that complaints are effectively managed and lessons can be learnt.
- Support colleagues to conduct investigations which are thorough, fair, responsive, and open.
- Demonstrate how the Trust will learn from complaints and use them to improve services.
- Ensure that the Trust's complaints service is accessible to everyone.
- Show that the Trust will respect individuals' rights to confidentiality.
- Ensure the Trust Board is informed when considering and improving the quality of services.
- Satisfy the complainant by conducting a thorough investigation and providing a full explanation.
- Ensure that people are not treated differently as a result of making a complaint or raising a concern.
- Give clear guidance in differentiating between a complaint, a concern and a comment.

2.3 People need to be able to raise concerns and make complaints easily and safely, without fear that doing so might affect future care. We recognise that some people might find it harder, or be more worried about raising concerns and making complaints. They might also find it harder to follow and engage with the complaints management process. These include:

- People who use our services regularly;
- People with learning disabilities, hearing loss, sight loss, communication difficulties and other disabilities;
- People who do not speak and/ or read English (well);
- People who are new to the NHS;
- People who are more likely to face, or fear, prejudice from the NHS, including transgender people, Gypsies and Travellers, lesbians, gay men and bisexual people, and people from BME communities.

As a result, in implementing this policy, we will need to ensure we encourage people from all parts of our community to 'talk to us'. We will also:

- Train staff who manage complaints on the needs of people with certain disabilities and on use of our translation and interpreting services.
- Ensure there is a range of ways people can access the process (including face-to-face, phone, text, and online), and that people can decide the best format for us to communicate with them through the management of a concern or complaint.
- Encourage and enable people to use advocates, community representatives and third parties to help them raise concerns and make complaints, especially where they need help or support to do so.
- Promote access to translation and interpreting services.

3. Definitions

Although in everyday language, terms such as 'complaint' and 'concern' may be interchangeable, for clarity in management and understanding it is essential that we define each for the use of this policy. It is equally important that the person raising the issue understands our distinctions as they may believe that by raising a "concern" they are making a complaint, or vice versa:

- A ***concern*** is an expression of dissatisfaction requiring an oral or written response, which can be given as soon as possible after being raised.
- A ***complaint*** is an expression of dissatisfaction requiring a written response.
- A ***comment*** is an expression of views which may or may not require a response.
- A ***compliment*** is an expression of appreciation and/or recognition.
- A **suggestion** is an idea for service development, and may or may not require a response.

4. Roles and Responsibilities

Gloucestershire Care Services NHS Trust (GCSNHST) aims to take all reasonable steps to ensure the safety and independence of the people that use its services to make their own decisions about their care and treatment.

Additionally, **GCSNHST** will ensure that;

- All colleagues have access to up to date evidence based policy documents.
- Appropriate training and updates are provided.
- Access to appropriate equipment that complies with safety and maintenance requirements is provided.

Specific roles and responsibilities:

Managers and Heads of Service will ensure that:

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

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

they;

- Practice within their level of competency and within the scope of their professional bodies where appropriate.
- Read and adhere to GCSNHST policy.
- Identify any areas for skill update or training required.
- Participate in the appraisal process.
- Ensure that all care and consent complies with the Mental Capacity Act (2007).

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

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

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

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

The Scheduled and Unscheduled Care Management Team: should discuss complaints/responses each month in their Clinical Governance meetings. They should discuss themes across their areas of responsibility and identify the learning from complaints.

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

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

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

If discrepancies arise during the investigation, then advice should be sought from the Director of Nursing or Medical Director. Any colleague who is investigating or dealing with complaints should possess the necessary skills to undertake this role.

5. Policy Guidelines

5.1 Special Cases

- Where it has been identified that the person who is the subject of the complaint is a vulnerable adult or there are concerns around capacity, advice should be sought from the Service Experience Team and or Safeguarding Lead/Name Nurse.

- This policy does not apply when a complaint relates to a serious incident requiring investigation (SIRI) as defined in the Serious Incident Reporting Policy.

- This policy will not normally apply to complaints where a letter of claim has been received. In these cases the complaint file will normally be closed on confirmation from the Legal Service Team that a letter of claim has been received. It may though still be necessary to investigate concerns raised under this policy concurrently with a legal claim and advice should be sought from the Service Experience Team and Legal Services Team in this situation.

5.2 Under the Government's guidance on the implementation of the NHS Complaints Procedure, there are two stages for dealing with complaints:

- Stage 1 - Local Resolution (meaning local to an organisation or part thereof)
- Stage 2 - Parliamentary and Health Service Ombudsman.

Complaints may be made about any matter reasonably connected with the exercise of the functions of the Trust, including any matter reasonably connected with:

- Its provision of care or any other services.
- The function of commissioning health care or other services under an NHS contract or making arrangements for the provision of such care or other services with an independent provider or an NHS Foundation Trust.

Matters excluded from consideration under the arrangements are:

- A complaint made by an NHS body, which relates to the exercise of its functions by the Trust.
- A complaint made by a primary care provider which relates either to the exercise of its functions by the Trust or to the contract or arrangements under which it provides primary care services.
- A complaint made by an independent provider or an NHS foundation trust about any matter relating to arrangements made by the Trust with that independent provider or NHS foundation trust.
- A complaint made by an employee of the Trust about any matter relating to his or her contract of employment.
- A complaint which is being or has been investigated by the Ombudsman.

- A complaint arising out of the Trust's alleged failure to comply with a data subject request under the Data Protection Act 1998 or a request for information under the Freedom of Information Act 2000.
- A complaint about which the complainant has stated in writing that he or she intends to take legal proceedings
- A complaint about which the Trust is taking or is proposing to take disciplinary proceedings in relation to the substance of the complaint against a person who is the subject of the complaint.

5.3 Who can Provide Feedback?

Complaints may be made by:

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

A complaint may be made by a representative acting on behalf of a person that has used our services or any person who is affected by or likely to be affected by the action, omission or decision of the Trust, where that person:

- Has died.
- Is a child who cannot demonstrate **Fraser competence.**
- Is unable by reason of physical or mental incapacity to make the complaint themselves.
- Has requested a representative to act on his/her behalf and given consent for this.
- Is a Member of Parliament acting on behalf of their constituents.

Where the person affected has died or is unable to raise concerns themselves, the representative must be a relative or other person who, has a sufficient interest in their welfare and is a suitable person to act as representative. This decision will be reached by the Service Experience Team with advice from the Director of Nursing**/**Medical Director as appropriate

The Service Experience Team is responsible for determining whether the complainant has 'sufficient interest' in the deceased or incapable person's welfare to be suitable to act as a representative. The need to respect the confidentiality of the patient is a guiding principle.

If in any case the Team is of the opinion that a representative does not have a sufficient interest in the person's welfare or is unsuitable to act as a representative, that person is to be notified of this in writing and the reasons for the decision are to be provided.

In the case of a child, the representative must be a parent, guardian or other adult person who has care of the child and where the child is in the care of a local authority or a voluntary organisation, the representative must be a person authorised by the local authority or the voluntary organisation.

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

5.4 **Ways to Make a Complaint – see also 5.11**

If a patient is worried or unhappy about any aspect of their care or treatment they should bring this to the attention of the doctor, ward manager, health

professional involved with their care, so that immediate action can be taken to try to resolve the concerns immediately.

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

The Service Experience Team aim to provide a quick and helpful resolution to any complaint. The Team can be contacted by visiting their office based at the Trust Headquarters, Edward Jenner Court on the first floor, via email to

YourExperience@glos-care.nhs.uk; via telephone on 0300 421 8313 or in writing to:

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

The service operates from 9am until 5pm, Monday to Friday.

One of the team will then contact the complainant to ensure we understand the concerns correctly and the outcome which would give a satisfactory resolution to the matter. Once this has bene confirmed the Service Experience Team will confirm that an investigation will be carried out. We aim to carry out a thorough investigation and provide a full response within 25 working days. If the investigation cannot be completed within this timeframe, the Service Experience Team will inform the complainant of the reasons for the delay and negotiate and agree a revised timeframe.

5.5 Confidentiality & Consent

Some types of feedback will be made and responded to in the public domain, for example through the website NHS Choices; however the general principle is that all feedback should be confidential, unless consent is given for it to be disclosed.

The information about a complaint and all the people involved is strictly confidential, and will only be disclosed to those with a demonstrable need to know.

Complaint records will be kept separate from health records, subject to the need to record information which is strictly relevant to a person's health in their health records.

Correspondence about complaints will not be included in a person's health records. Informal discussions about concerns can be documented in the clinical records.

5.5.1 Consent

It is not necessary to obtain the person's explicit consent to use personal information when investigating a complaint as the person has implied their consent by asking the Trust to investigate the matter. However, it is good practice to explain that information from health records, including records held on SystmOne, may need to be disclosed to those involved.

Where a complaint is **made on behalf of an existing or former person that has used our service, consent must be obtained from that person** to disclose personal health information and the results of any investigation in order to uphold the duty of confidentiality. The complainant will be asked to return a consent form usually within seven days. A longer time scale may be agreed to if deemed appropriate.

If, once consent has been requested, there is a delay in obtaining consent that will impact on the timeframe in which we may review and respond, the date the final response is due will be recalculated and the complainant advised accordingly.

5.6 **Complaints Made on Behalf of Others**

Where a complaint is made on behalf of an existing or former person that has used our services who has not authorised the complainant to act on their behalf, care must be taken not to disclose personal health information without the explicit consent of that person.

If the person has died or is unable to act for him/her the next-of-kin may be able to provide consent for the complaint to be investigated and details released. In these circumstances, the Trust will respect any known wishes that had been expressed by the said person.

Where a complaint is made involving a child who is not Fraser competent, the Trust will ensure that those making a complaint or being communicated with have parental responsibility

Where a complaint has been made on behalf of a person that has used our services by a Member of Parliament (MP) it will be assumed that implied consent has been given by that person. If however, the complaint relates to a third party, consent will need to be obtained from that person prior to the release of personal information. An example of this would be if someone asks the MP to complain on behalf of their family member; in this case, consent would need to be sought from that family member.

Where it is known that the complaint involves a vulnerable adult or vulnerable child, the Executive Lead (Director of Nursing and Quality) for child safeguarding and vulnerable adults will be informed.

5.7 **Fraser (formerly Gillick) Competence**

Fraser (formerly Gillick) competences state that a child below the age of 16 can consent for their own medical treatment if they demonstrate sufficient understanding. This principle is adopted within the complaints process and therefore, there is no minimum age for a young person to raise concerns about the care that they have received. The young person will be offered support, facilitated by the Service Experience Team, and signposted to any additional resources such as Gloucestershire HealthWatch if required.

5.8 **Confidential Marking**

All correspondence/letters regarding the complaint will be marked 'private and confidential'. All internal e-mails regarding the complaint must be marked 'confidential' and where possible should not contain person identifiable information in the email heading. Where possible the email contents should also be anonymised.

By ensuring that all complaints are dealt with in the strictest confidence, the scope for people and their, relatives and/or carers being treated differently as a result of the complaint will be minimised.

5.9 **Time Limits**

Normally a complaint should be made within twelve months of the date on which the matter which is the subject of the complaint occurred or within twelve months of the date on which the matter which is the subject of the complaint came to the notice of the complainant.

Where a complaint is made after these times, the Trust may decide to investigate if they are of the opinion that the complainant had good reason for not making the complaint within that period and it is still possible to investigate the complaint effectively and efficiently.

Those who wish to complain should be encouraged to do so as soon as possible after an event so that the investigation can be most effective.

In any case where the Service Experience Team decides not to investigate a complaint on the grounds that it was not made within the time limit, the complainant will be informed in writing with further guidance if necessary. The complainant can ask the Parliamentary Ombudsman to consider their complaint.

In accordance with the Department of Health Records Management Code of Practice and GCSNHST's Health Records Policy, complaint files will be kept for eight years.

Complaint files about babies and children where there is the possibility of future legal proceedings are kept until their 25th birthday. If the baby or child has died, the complaint file is kept for eight years.

5.10 **Management Process**

When a complaint is made, the Trust aims to resolve the issue as quickly and as fully as possible, by putting things right if they have gone wrong, and developing learning for the future.

A flow chart showing the entire process is attached as Appendix 1.

When raising an issue, the person doing so may not understand our processes and therefore it is essential to help to clarify with them what they can do. For example, whereas some people may be familiar and comfortable with raising a complaint, others may not understand the differences in terms and approaches.

When considering something that has been raised, it is essential to consider the severity of what is being described. There are likely to be times where someone may express a "concern" and by doing so they think that they are complaining; however unless we recognise this and clarify we may not treat

the issue in the appropriate way. Therefore, you should refer to the "triage" section below.

5.11 **"Talk to us"**

The Trust places great importance on resolution as near to the issue and as soon as possible after it is raised.

The objective of "Talk to us" is to achieve resolution by listening and responding. This might involve doing something immediately, for example swapping a plate of food that is not hot enough.

Service-users and relatives should be encouraged to raise concerns or make complaints as soon as possible and directly to the colleagues involved or to the manager of the ward/team/department. At the outset, this may be raised as an issue and colleagues should listen and aim to understand and offer support to determine the best course of action.

The issue should be addressed constructively and where possible will be dealt with immediately. The person will be cared for sensitively and in an open and constructive manner. If the colleague approached is unable to deal with the issue, they should promptly refer this to the most senior person on duty at the time i.e. Matron, Senior Sister/Charge Nurse, Matron, Deputy or General Manager, Head of Locality, Head of Service, Community Manager or Professional Team Leader.

Where it is not possible to deal with the issue immediately, or if it requires a fuller investigation or the person wishes to address their concerns to somebody not involved, they should be referred to the Service Experience Team, who will assist them further.

Whether the issue is being dealt with locally or in partnership with the Service Experience Team, the person raising it should be given a name and telephone number of a key contact in relation to the issue.

Issues resolved 'on the spot' are normally less serious and do not need to be formally recorded, although good practice would be for all issues to be recorded to capture themes. Actions resulting or any learning should be discussed in the next available team meeting and documented in the minutes of that meeting.

We have developed support material available from the Service Experience Team; examples can be seen in Appendix 2.

5.12 **Lost Property**

Where appropriate, it is the responsibility of the team that provided care to look for any lost property associated with a complaint and any reimbursements or ex-gratia payments will be at the discretion of the Trust following discussion with the Legal Services team.

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

If an issue could not be resolved on the spot or if the person makes a complaint, the first step is for it to be triaged by the Service Experience team.

The receiving Team member will read or listen to the person raising the issue and rate its level of 'seriousness' according to the matrix in Appendix 4. They

will also try to understand what the person raising the issue would like to happen as a result and the resolution they are hoping for.

They may need to telephone and speak to the person to ascertain this information.

It is important to manage expectations at this stage and advise complainants if the Trust cannot give the desired outcome – for example, financial compensation cannot be given as a result of a complaint investigation.

When "Triaging" the issue, it is important to be mindful that the person raising the issue may have a different understanding of the terminology used in the NHS. For example, if they "raise a concern" or "bring something to our attention" they may think that they are complaining, or vice versa.

Within all complaints literature and during the triage process, people will be advised of independent advocacy services which can help them raise concerns, such as HealthWatch & SEAP.

Following "Triage", the issue should be categorised as either a complaint or a concern. However, the level of severity should be considered when deciding on the resulting actions. For example, there may be occasions where the person raising the issue does not want it to be dealt with as a complaint but the issue itself represents a potentially serious event that should be investigated.

At this point there are two possible routes to manage resolution. Depending on the issues raised, its seriousness and possible resolution, it could be treated as a 'concern' or a 'complaint'.

5.13.1 **Concerns**

Concerns may fall into two categories. The first relate to issues that can effectively be addressed "on the spot". An example might be a concern in relation to parking, or a cleaning issue in a public space where the resolution is to do something – e.g. arrange for a cleaner to undertake an additional clean of a public toilet.

The Local Authority Social Services and National Health Service Complaint Regulations 2009 s8(1)(c) excludes this type of feedback from being recorded as a 'complaint'. However the Trust recognises that recording such events supports learning and helps to develop services.

Unlike "on the spot" issues, all other 'concerns' will be formally logged and will be reported. Actions taken will be recorded to support learning and avoid recurrence.

Some concerns may highlight a potentially serious issue (such as an adverse incident) and these must be reviewed. In such cases, actions to take may include but are not limited to:

- Check to see if an incident was reported about the issue
- Check to see if there are any legal concerns relating to the issue
- If it represents an unreported incident, remedial action should be taken to address this; such as contacting the team/service/department to ensure that it is reported as an incident.
- Consider conducting an investigation.

- The Service Experience Team will contact and speak with the manager of the area to highlight the issue
- Identify learning and report on accordingly.

5.13.2 **Complaints**

The Service Experience Team are the central team responsible for complaints.

'Complaints' are likely to be received in writing, but not exclusively, and are subject to the same triage process noted previously and demonstrated in Appendix 1.

Where a complainant wishes to make a complaint and receive a response electronically, patient confidentiality is a guiding principle. Where anyone's personal information is to be disclosed electronically, consent must be received in writing.

When formal letters of complaints are received by the Chief Executive's office, they will be date stamped and passed to the Service Experience Team immediately, who will deal with them on behalf of the Chief Executive.

All complaints will be logged onto the complaint management system and will be acknowledged in writing by the Service Experience Team. The team aims to do this on the day of receipt, but in any case no later than within three working days.

The acknowledgment will includes information about the right to ask for an independent review if the complainant is not fully satisfied with the Trust's response.

The complaint leaflet which includes this information is set out at Appendix 3.

The complaint will be sent by the Service Experience Team (via e-mail) to the appropriate directorate complaints lead(s) to start the investigation. Some complaints may involve more than one directorate; in this case the Quality Team in discussion with the relevant Director/s involved appoint a joint investigating officer who will be responsible for ensuring the complaint is fully investigated.

5.13.3 **Concerns, Complaints and Incidents**

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

For Concerns or Complaints that are rated as Moderate, High or Extreme (please refer to Appendix 4) following Triage, consideration should be given as to whether or not it is a Serious Incident Requiring Investigation (SIRI). If it is determined that a SIRI has occurred, the case will be taken forward under the Serious Incident Reporting Policy and investigated formally with the complainant being made aware.

The complainant will be kept informed of the status of the investigation and will be offered a meeting to discuss the outcome of the investigation with the investigator and the Service Experience Team.

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

5.14 **Record Keeping and Responding**

Full records of the complaint investigation should be kept by the investigating officer. These notes should include a record of discussions with colleagues and the support offered. Guidance on writing and collecting information can be found at Appendix 5.

The Trust has a standard 25 working day response time for complaints, depending on the level of seriousness identified during the triage process. All complaint responses are signed off by the Chief Executive (or their nominated deputy) before being sent.

All investigations (unless an extension has been granted) should be completed by day 15, to allow five working days for sign off.

The investigating officer is responsible for ensuring that the report:

- Addresses all the issues raised.
- Is accurate.
- Gives a full and honest explanation.
- Provides an apology (or apologies) if appropriate.
- Explains the actions that have been/will be taken to improve the situation (action plans can be included where appropriate).
- Is factually based and provides an objective opinion.

The investigating officer should send the draft response and all paperwork to the relevant Director and Service Experience Team no later than by the end of day 15.

By completing the investigation by day 15, the Service Experience Team, Directors and Chief Executive will have several days in which to review the response and seek further clarification and ensure the letter is signed and mailed within the agreed timeframe.

If the Chief Executive is unavailable, then their nominated deputy will assume responsibility to sign the response letter.

Although most ‘complaints’ will be responded to in writing, the Trust will use the most effective method of communication and will aim to match the communication preferences of the person making the complaint.

A complete documentary record of the handling and consideration of each complaint is kept by the Service Experience Team and is kept separate from health records.

The Team will ensure that all information relevant to the investigation of the complaint is recorded and kept in the case files and is available without unnecessary delay to the Parliamentary and Health Service Ombudsman if requested.

5.18 **Extending the Investigation Period**

Although the investigation and draft response should be completed within 15 working days, the Trust acknowledges that some complaints may require longer to thoroughly conclude the investigation and provide a full response.

If a longer response time is required due to the complexity of the complaint or if a meeting with the complainant within this timescale cannot be achieved, the directorate can ask the Service Experience Team to negotiate an extension of up to 20 working days (giving a maximum of 40 working days) with the complainant.

If this is necessary, the appropriate Service Experience Team will contact the complainant to discuss and agree an extension, unless it would be more appropriate for the Investigating Officer to do this.

5.19 **Informing the Complainant of the Trust's Review Process**

All final responses letters will inform the complainant that if they have any outstanding or further concerns, or feel that the complaint has not been satisfactorily resolved, they may contact the Service Experience Team for further information. It will also advise of details of the Trust's review process (please refer to section 5.21) and how to refer the complaint to the Parliamentary and Health Service Ombudsman.

5.20 **Learning from Complaints**

As a learning organisation, the Trust is committed to learning from complaints and taking action where an investigation has identified a need to alter practice.

The respective Director (Transformation/Scheduled Care) is responsible for ensuring any action plans resulting from the complaint investigation are implemented within the agreed timescale with actions being included in their respective governance meetings.

Progress on action plans will be recorded through the Directorate Governance Forums.

The Service experience Team will ensure that the Trust maintains an overview in considering and identifying trends and themes. These themes will be considered and reported alongside other areas that inform us on what it is like for people to use our services, including incidents, claims and external reports.

When considering trends in complaints, repeating subjects and issues will be identified, with the respective Director (Transformation/Scheduled Care) being notified and assurance sort on actions where required.

5.21 **Investigation Review**

Although GCSNHST uses a quality approach to the investigation of complaints, there will be occasions when it may not be possible to resolve a complaint to the satisfaction of the complainant during the initial investigation.

In these cases, the reasons for continuing dissatisfaction should be discussed with the Service Experience Team. If particular questions have not been fully answered the complaint could be sent back to the directorate, or if a review is needed then the Service Experience Team will acknowledge the review request and will arrange for the complaint file to be sent to an appropriate senior manager, usually the Director of the Service or nominated deputy.

The review will consider if the appropriate process was followed and if the outcome of the complaint was sufficient. The review officer will have 20

working days to consider the review and draw up a formal response letter which will then be sent to the Chief Executive for signature.

If the complainant remains dissatisfied with the response, they may request a review by the Parliamentary and Health Service Ombudsman.

5.22 **Parliamentary and Health Service Ombudsman**

The Service Experience Team will be the single point of contact for the Parliamentary and Health Service Ombudsman (PHSO). The Service Experience Team will manage all requests and will ensure deadlines are met. The team will arrange any conciliatory/ex-gratia payments recommended by the PHSO and agreed by the Trust. Any such payments would be at a cost to the relevant directorate.

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

Action plans should be drawn up and signed off by the appropriate directorate within two months. This then gives a further month for consideration by the Director of Nursing and Quality who will provide 'sign off' on behalf of the Trust. The process of signing off and sending will be facilitated by the Service Experience Team, who will also advise if these timescales alter. Oversight of the action plans will be maintained by the Directorate Governance Forum

5.23 **Independent Advice**

All complainants have access to information about independent help, guidance or support service when making a complaint. This information is available from the Service Experience Team, and is included in the complaints leaflet and publicised on the Trust's website.

5.24 **Legal Implications**

If the complainant has instigated formal legal action the complaints procedure should only continue if it would not compromise or prejudice a concurrent legal investigation. This is at the discretion of the Service Experience Team and the Legal Services team with the complainant and person identified in the complaint being advised appropriately in writing.

Colleagues should offer apologies and not be concerned that this is in anyway an admission of negligence.

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

5.25 **Support for Colleagues Involved in a Complaint**

As well as supporting complainants, the Trust must also ensure that it supports those colleagues involved in a complaint investigation and will provide information on support systems for those distressed by complaints/incidents e.g. counselling, stress management, mentoring. Colleagues will be supported by their line manager and also by the Service Experience Team and additional support is available through Care First.

5.26 **General Feedback and Compliments**

Along with complaints, the Service Experience team will also maintain a record of feedback left and compliments given. These will be included in relevant reports to give a balanced picture. All formal compliments should be passed to the Service Experience Team for logging, and where applicable, acknowledged.

5.27 **Serious Allegations and Disciplinary Investigations**

The complaints procedure is not intended to be used for the investigating of employee disciplinary issues. The purpose of the complaints procedure is to thoroughly investigate complaints with the aim of satisfying complainants, whilst being fair to our colleagues.

However, complainants may identify information about serious conduct matters and the Trust may feel it appropriate to consider disciplinary investigation at any point during the complaints procedure. Consideration as to whether or not disciplinary action is warranted is a separate matter for the Trust.

The information gathered during a complaint investigation may be made available for a disciplinary investigation, although the consideration of disciplinary action is separate from the complaints procedure. The Trust has a duty to maintain confidentiality and must not share information regarding action against colleagues with the complainant other than that Human Resources Policies have been followed.

Where a complaint indicates the need for a referral to the disciplinary procedure, one of the professional regulatory bodies or agency such as the Police, the investigation under the complaints procedure will only take place if it does not compromise or prejudice the concurrent investigation. Where necessary other Trust-wide policies and procedures may need to be applied and could preclude compliance with this policy.

5.28 **Grievances**

Grievances raised by colleagues are handled separately. The Trust has local procedures for handling colleague concerns about health care issues, and established grievance and openness procedures. Colleagues can only use the Trust complaints procedure if their complaint relates to their own health care or if they are acting on behalf of a third party. In both situations they are acting as a patient or member of the public and not as a trust employee.

5.29 **Complaints Brought by Members of Parliament (MP) on Behalf of Constituents**

MPs in receipt of complaints about health services from members within their constituency often address personal letters to the Chairman or Chief Executive. These are acted upon in the same way as any other letter of complaint, recorded centrally and passed to the Service Experience Team to facilitate an investigation and responded to formally within the recommended time scales.

Letters from MPs on behalf of members of their constituency will automatically assume consent for the release of personal information, provided the constituent is the person involved. If the constituent is raising an issue about another person, consent will be required from the person the

concern/issue/complaint relates to before any confidential information can be disclosed to the MP.

5.30 **Fraud and Corruption**

Any complaint which concerns allegations of possible fraud or corruption is passed immediately to the Local Fraud Team.

5.31 **Oversight of Complaints – Clwyd Hart**

There is a recommendation for Board-led scrutiny of complaints. This is achieved through the Quality and Performance Report and Understanding You Report which are submitted to Quality and Performance Committee bi-monthly with the Quality and Performance Report being considered by Trust Board on the alternate month.

Further scrutiny will be achieved in a quarterly Complaints Review Meeting co-ordinated by the Quality Team with NED involvement.

5.32 **Evaluation of the Complaints Process**

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

5.33 **Complaints about Services Provided by Other Agencies**

If the Trust receives a complaint that is solely concerned with areas dealt with by another health body or by a body outside the NHS, the Service Experience Team will inform the complainant and forward the complaint to the correct body, with the permission of the complainant. If there are any doubts over which body is responsible for handling the complaint, this must be resolved before the complaint is dispatched.

Where the Trust receives a complaint which is mainly concerned with services provided by the Trust, but includes issues regarding an external agency, the Service Experience Team will forward a copy of the complaint as appropriate to the external agency for investigation and a response. The Service Experience Team will incorporate the response from the external agency into the Trust's final response. Where a complaint involves more than one NHS provider or one or more other bodies such as a local authority i.e. Integrated Care Teams (ICTs) and GCC and the complainant has requested a joint response, a discussion and agreement will take place between the Service Experience Lead and the organisations involved to agree who will "lead" on the complaint and who will provide the complainant with a joint response on behalf of all of the organisations involved. In these cases, the "lead" organisation will obtain reports from all of the organisations involved to include in the joint response requested. The Trust and local authorities will ensure that all matters of concern are addressed.

Complaints which require 'Independent Review' under the NHS Complaints Procedure and also involve either Social Services or fall within the remit of the Care Quality Commission (relating to patients who are or have been detained under the Mental Health Act), remain subject to both the NHS and the local

authority or Care Quality Commission procedures. The Trust will advise complainants of what matters fall under which procedure.

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

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

5.35 **Access to Health Records**

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

The Access to Health Records Act 1990 (AHRA) provides a small cohort of individuals with a statutory right to apply for access to information contained within a deceased person's health record.

The Department of Health accepts that the duty of confidentiality continues beyond death and this is reflected in their guidance. The AHRA defines these individuals as 'the patient's personal representative and any person who may have a claim arising out of the patient's death. (A personal representative is the executor or administrator of the deceased person's estate). Therefore individuals other than the personal representatives, who have a legal right of access under the AHRA, must establish a claim arising from a patient's death. Further guidance on a case-by-case basis can be sought from the Trust's Legal Services Department.

5.36 **Recording Complaint Meetings**

Where a complainant wishes to make a recording of a complaint meeting, a formal request must be made in writing to the Service Experience Team or the Investigating Manager in advance of the meeting in order that the consent of all parties may be sought. All parties must consent to the recording being made before the request will be agreed.

A copy of the recording will be sent with a covering letter outlining the key responses to the concerns raised. It needs to be made clear to the complainant (and their representatives) that the minutes will not be transcribed.

The Service Experience Team will arrange for any minutes of meetings to be taken and typed up. The complainant (and their representative) will to be informed that a summary of the discussions that took place will be sent, covering the key aspects of the complaint, and not a verbatim transcript.

5.37 **Media Interest**

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

5.38 **Procedure for Handling Unreasonably Persistent Complainants**

5.38.1 **Definition of an Unreasonably Persistent Complainant**

Complainants (and, or anyone acting on their behalf) may be deemed to be unreasonably persistent complainants where previous or current contact with them shows that they meet one or more of the following criteria:

a) The complainant persists in pursuing a complaint where the Trust's complaints procedure has been fully and properly implemented and exhausted.
b) The complainant continually raises new issues or seeks to prolong contact by continually raising further concerns or questions upon receipt of a response or whilst the complaint is being investigated (care must be taken not to discard new issues which emerge as a result of the investigation or the response. These might need to be addressed as either reviews of previous complaints or separate complaints). Independent advice services could be called upon to assist in such circumstances, ensuring that new and legitimate issues are answered.
c) Despite the best endeavour of colleagues to confirm and answer the complainant's concerns and, where appropriate, involving Independent Advice Services, the complainant does not accept the response and/or where the concerns identified are not within the remit of the Trust.
d) In the course of addressing a registered complaint, the complainant has had an excessive number of contacts with the Trust, which have placed unreasonable demands on colleagues. A contact may be in person or by telephone, email, letter or fax. Discretion must be used in determining the precise number of "excessive contacts" applicable under this section, using judgement based on the specific circumstances of each individual case.
e) The complainant has harassed or been personally abusive or verbally aggressive on more than one occasion towards colleagues dealing with their complaint or their families or associates. Colleagues must recognise that complainants may sometimes act out of character at times of stress, anxiety, or distress and should make reasonable allowances for this.
f) The complainant is known to have recorded meetings, face-to-face or telephone conversations without the prior knowledge and consent of other parties involved and used these recordings without prior permission.
g) The complainant has focussed on a matter to an extent which is out of proportion to its significance and continues to focus on this point. It is recognised that determining what is justified can be subjective and careful judgement must be used in applying this criterion.
h) The complainant displays unreasonable demands or patient/complainant expectations and fails to accept that these may be unreasonable (e.g. insist on responses to complaints or enquiries being provided more urgently than is reasonable or normal recognised practice).
i) The complainant has threatened or used actual physical violence towards colleagues or their families or associates at any time.
j) The complainant has sent indecent or offensive items to trust employees or their families or associates in the post, or has hand-delivered indecent or offensive items to staff or their families or associates at any time.

5.38.2 **Options for Dealing with Unreasonably Persistent Complaints**

Where complainants have been identified as unreasonably persistent in accordance with the above criteria, the Chief Executive (or nominated deputy) will determine what action to take. The Chief Executive (or nominated deputy) will implement such action and will notify complainants in writing of the reasons why they have been classified as unreasonably persistent complainants and the action to be taken. This notification may be copied for the information of others already involved in the complaint, e.g. GPs, Independent advice services and Members of Parliament. A record must be kept for future reference, in the complaint file of the reasons why a complainant has been classified as unreasonably persistent. This will not form part of their own or their family's medical notes.

The Chief Executive (or nominated deputy) may decide to deal with complainants in one or more of the following ways:

i. Try to resolve matters, before invoking this procedure by drawing up a signed 'agreement' with the complainant (if appropriate, involving the relevant advocate in a two-way agreement) which sets out a code of behaviour for the parties involved if the Trust is to continue processing the complaint. If these terms are contravened, consideration would then be given to implementing other action as indicated in this section.
ii. Once it is clear that the complainant meets any **one** of the criteria above, it may be appropriate to inform them in writing that they may be classified as an unreasonably persistent complainant, copy this procedure to them, and advise them to take account of the criteria in any further dealings with the Trust. In some cases it may be appropriate, at this point, to suggest that the complainant seeks advice in processing their complaint, e.g. through Independent Complaint Advocacy Services.
iii. Decline contact with the complainant either in person, by telephone, by email, by fax, by letter or any combination of these, provided that one form of contact is maintained or alternatively to restrict contact to liaison through a third party.
iv. If colleagues are to withdraw from a telephone conversation with a complainant it may be helpful for them to have an agreed statement available to be used at such times.
v. Notify the complainant in writing that the Chief Executive has responded fully to the points raised and has tried to resolve the complaint, but there is nothing more to add and continuing contact on the matter will serve no useful purpose. The complainant should also be notified that the correspondence is at an end and that further letters received will be acknowledged but not answered. They should be informed of their right to appeal and of their right to go to the Ombudsman.
vi. Enforce the Trust's Managing Challenging Individuals and Violence Prevention Policy (Ref 16).

5.38.3**Withdrawing 'Unreasonably Persistent' Status**

Once complainants have been determined 'unreasonably persistent' there needs to be a mechanism for withdrawing this status. For example:

(i) The complainant subsequently demonstrates a more reasonable approach.

(ii) If the complainant submits a further complaint for which the normal complaints procedures would appear appropriate.

Colleagues should previously have used discretion in recommending unreasonably persistent status at the outset and discretion should similarly be used in recommending that this status be withdrawn when appropriate. Discussion will be held with the Chief Executive (or nominated deputy) and subject to their approval normal contact with the complainant and application of the Trust's Complaints Procedure will then be resumed.

If any colleague does not feel they have the necessary skills to investigate and deal with complaints, they should discuss this in the first instance with their line manager and training arrangements should be made through the appraisal system and the professional development plan.

6. Consultation

Identify any extended consultation particular where this has involved service users, carers or stakeholders

7. Implementation

7.1 The Quality Team will lead on implementation across.

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

7.3 Information on who to contact for access to the policy from outside the organisation is available on GCS website.

7.4 Leaflets and posters will be displayed at all of the Trust sites

7.5 The Service Experience team will roll out a launch and training programme for all staff to ensure staff are fully aware and understand the new policy and what is expected of staff

8. Audit

Monitoring compliance with the timeliness of response will be continuous and reported through the monthly Quality report.

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

9. Equality Impact

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

10. Quality Impact

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

11. Financial Risk/Impact

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

12. Review

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

13. References, Bibliography, Acknowledgements and Regulatory Position

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

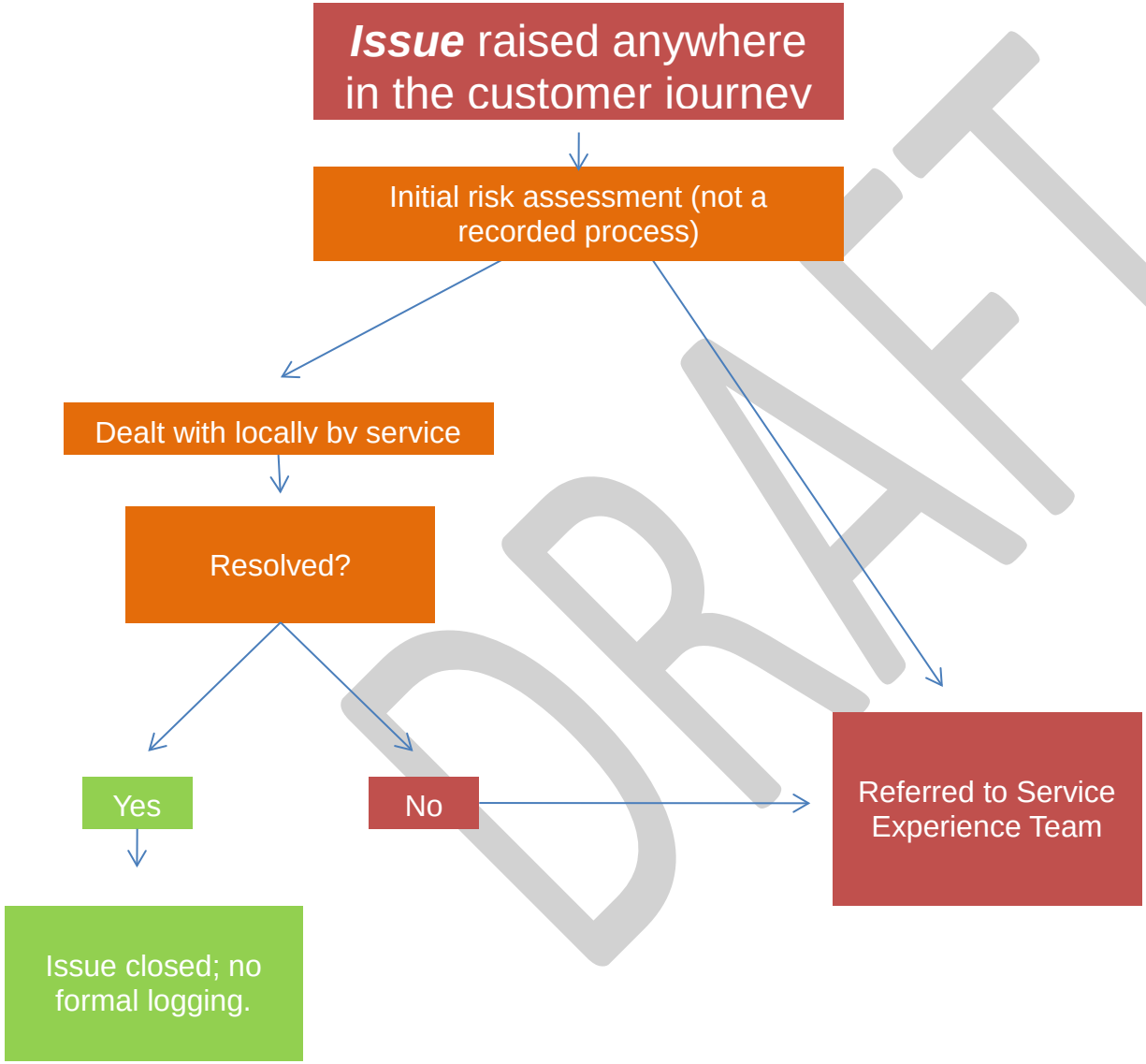
  Duty of Candour - Being Open is a fundamental process affecting integrated governance throughout the Trust. The Duty of Candour Policy is integrated with the incident, Serious Incident and Complaints processes and governance framework. Being Open is part of the “fair blame” culture which is striven for in the NHS. This culture is fundamental to learning from mistakes.

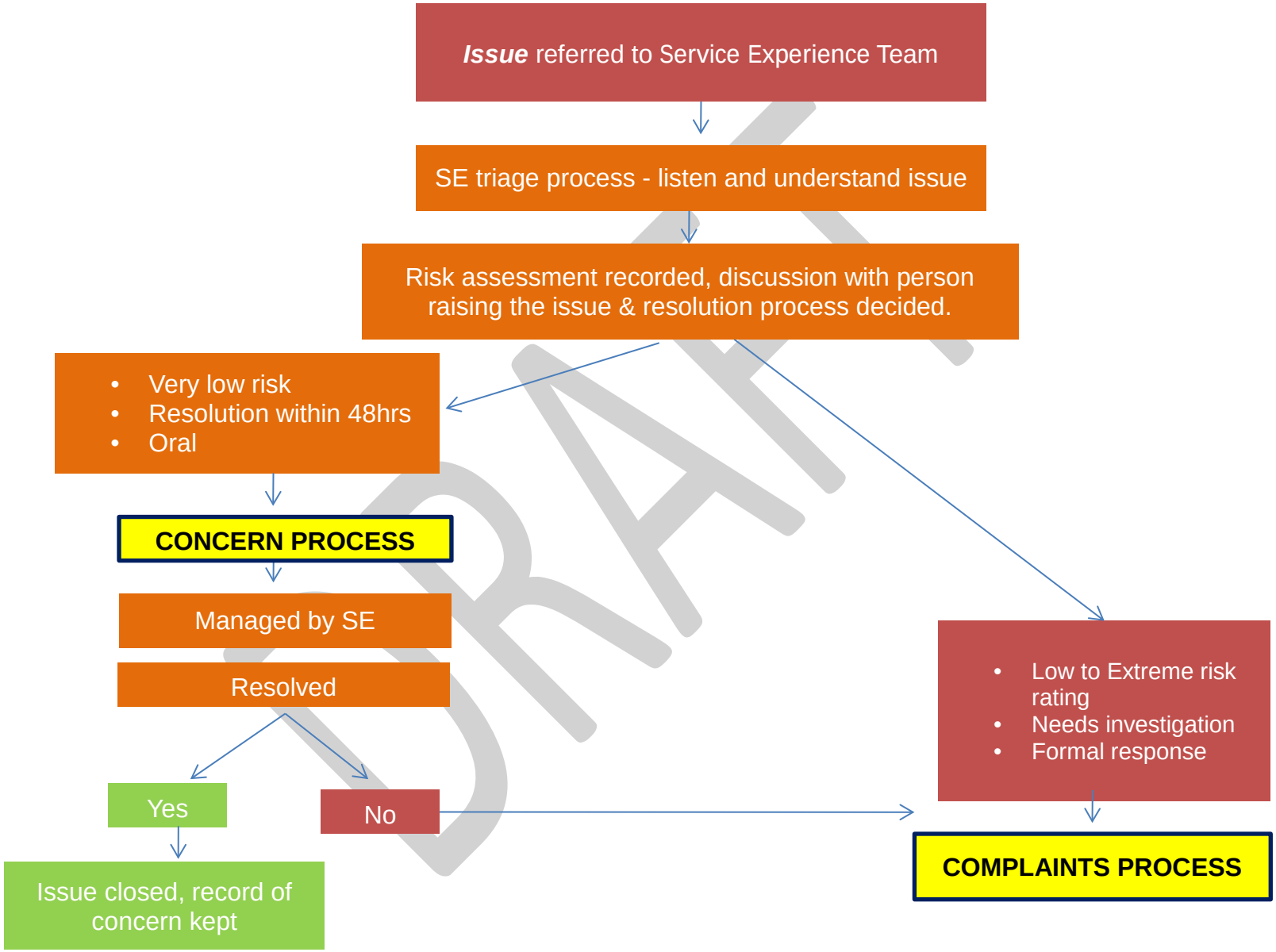
  Duty of Candour is a statutory duty requiring NHS organisations to ensure that patients/families are informed of medical errors causing moderate, severe harm or death and provided with support. This includes receiving an apology, and offering a local resolution meeting as appropriate, and the investigation findings and actions to prevent recurrence are shared.

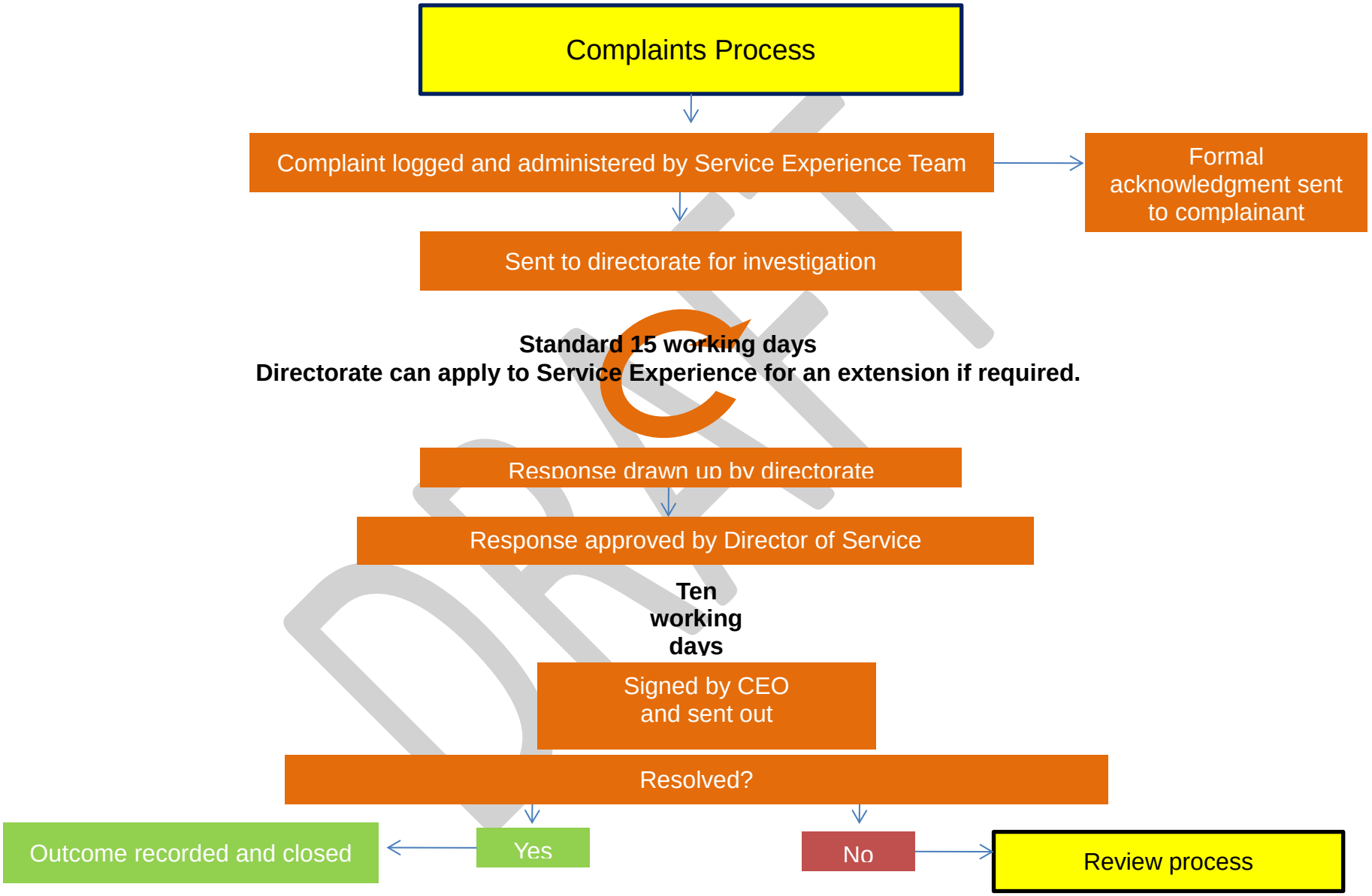
  Please refer to the Duty of Candour Policy on how to manage this process

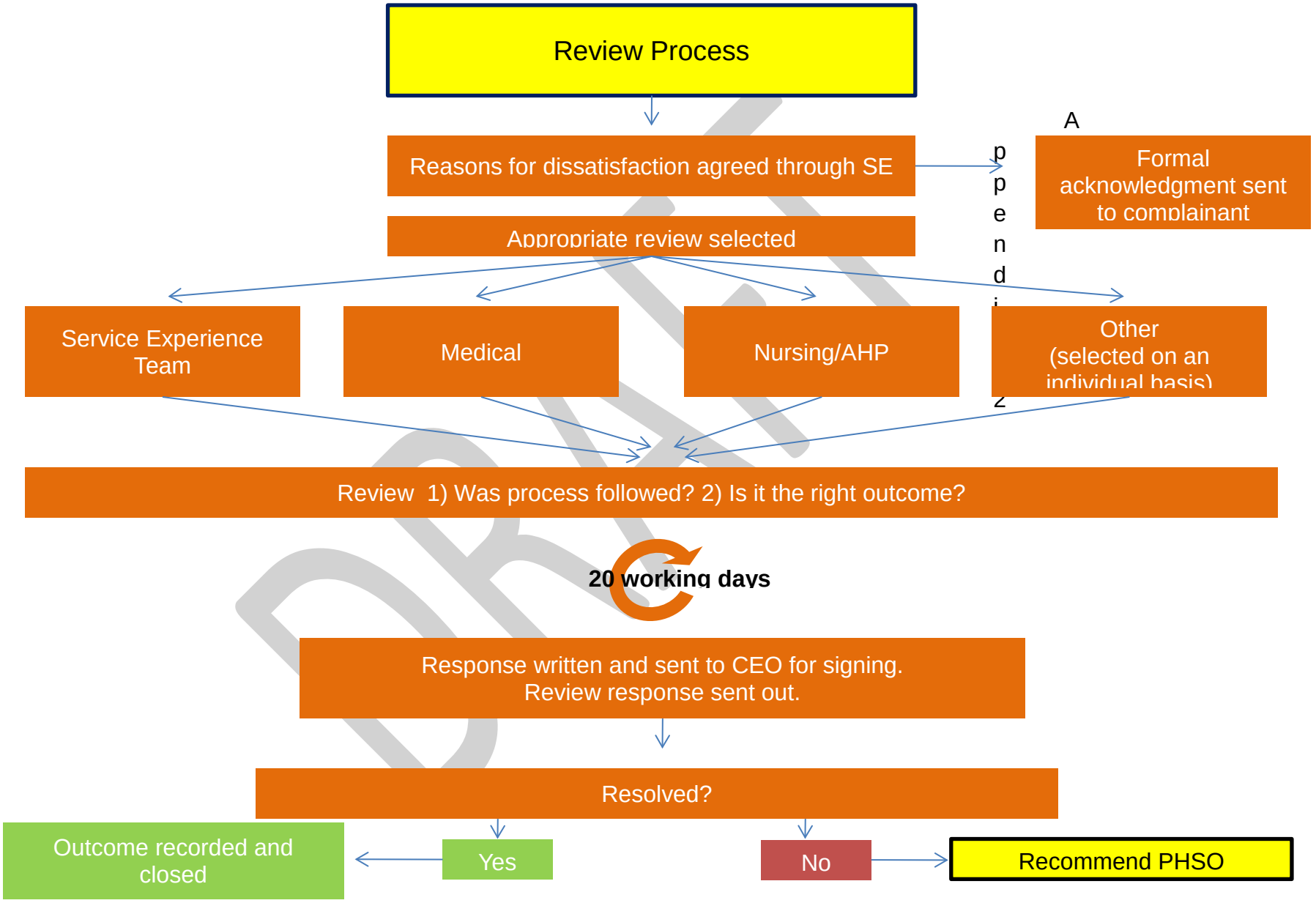
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- The Care Quality Commission inspections rely on information based on sound data.
- The Data Protection Act 1998 requires that personal data is processed in accordance with the Data Protection Principles.
- The Freedom of Information Act 2000 requires organisations to make some documents publicly available.
- The Access to Health Records Act 1990.

Appendix 1




Issue referred to Service Experience Team
SE triage process - listen and understand issue
Risk assessment recorded, discussion with person raising the issue & resolution process decided.
• Very low risk
• Resolution within 48hrs
• Oral
CONCERN PROCESS
Managed by SE
Resolved
Yes
No
Issue closed, record of concern kept
• Low to Extreme risk rating
• Needs investigation
• Formal response
COMPLAINTS PROCESS


Complaints Process
Complaint logged and administered by Service Experience Team
Formal acknowledgment sent to complainant
Sent to directorate for investigation
Standard 15 working days
Directorate can apply to Service Experience for an extension if required.
Response drawn up by directorate
Response approved by Director of Service
Ten working days
Signed by CEO and sent out
Resolved?
Yes
Outcome recorded and closed
No
Review process


Review Process
Reasons for dissatisfaction agreed through SE
A
Formal acknowledgment sent to complainant
Appropriate review selected
Service Experience Team
Medical
Nursing/AHP
Other (selected on an individual basis)
Review 1) Was process followed? 2) Is it the right outcome?
20 working days
Response written and sent to CEO for signing.
Review response sent out.
Resolved?
Outcome recorded and closed
Yes
No
Recommend PHSO


Your Experience Counts
Your feedback is very important to us and we welcome your comments to help us improve the service we provide.
Please complete the details inside and place in the comments box, give it to a member of staff, or post it back to the freepost address given. Thank you.
Alternatively, please contact the Service Experience Team on 0300 421 8313, email at yourexperience@glos-care.nhs.uk or visit our website at www.glos-care.nhs.uk.
Print Date: April 2015 LT201 www.glos-care.nhs.uk
Your Experience Counts
Gloucestershire Care Services NHS Trust
FREEPOST RSKC-CSKU-KRZX
Unit 1010, Pioneer Avenue
Gloucester Business Park
Brockworth
Gloucester
GL3 4AW
Gloucestershire Care Services NHS Trust
Your Experience Counts
Tell us about your experiences with us
Understanding you
Parliamentary and Health Service Ombudsman (PHSO)
The PHSO is independent from the NHS and the Government. The PHSO is responsible for reviewing formal complaints about the NHS in England that have not been resolved by the NHS organisation or the practitioner e.g. GP. You have the right to contact the PHSO if you are not happy with the outcome of your complaint.
You can contact the Parliamentary and Health Service Ombudsman for further information:
The Parliamentary and Health Service Ombudsman for England
Address: 11th Floor, Millbank Tower, London SW1P 4QP
Telephone: 0345 015 4033
Email: phso.enquiries@ombudsman.org.uk
Website: www.ombudsman.org.uk
SEAP NHS Advocacy Service
Address: PO Box 375, Hastings, TN34 9RU
Telephone: 0330 343 5710
Fax: 01424 204687
Email: gloucestershire@seap.org.uk
Website: www.seap.org.uk
Healthwatch
They represent public views on health and social care services.
Address: Healthwatch Gloucestershire, Community House, 15 College Green, Gloucester, GL1 2LZ
Telephone: 0800 652 5193 or 01452 504989
Website: www.healthwatchgloucestershire.co.uk
How to contact the service experience team
Service Experience Team
Address: Gloucestershire Care Services NHS Trust, Freepost RSKC-CSKU-KRZX, Edward Jenner Court, 1010 Pioneer Avenue, Gloucester Business Park, Gloucester, GL3 4AW
Telephone: 0300 421 8313
Email: yourexperience@glos-care.nhs.uk
Website: www.glos-care.nhs.uk
This leaflet can also be supplied in braille, audio format, PDF, large print, easy read and other languages on request.
Print Date: April 2015 LT200 www.glos-care.nhs.uk
Gloucestershire Care Services NHS Trust
Your Experience Counts
How do I give feedback or make a complaint?
Understanding you
Moisten Here
Service:
Location:
Date:
Whether you want to describe our staff or facilities, your care or that of a relative, please tell us your experiences here:
Moisten Here
Moisten Here
Please place the completed card in the comments box or give it to a member of staff. Or you can post it back to the freepost address on the back of this card. Thank you.
Name:
Address:
Postcode:
Telephone:
Email:
You do not have to fill in contact details if you don't want to, but it will help us to be able to respond to you and will not be shared with any other organisation or third party. Your comments will be dealt with in confidence.
About you: Male Female
Age: 16-24 25-34 35-44 45-54 55-64 65-74 75+
Do you consider yourself to have a disability?
Yes No
Ethnic Group:
White British
Other White Background
Mixed Background
Black Background
Asian Background
Other Ethnic Group:
Are you:
A patient
Visitor
Carer/family member
Member of staff
Other
We value your views and opinions and we use your feedback to improve the community health and adult social services we provide across Gloucestershire. You can contact our service experience team if you have any comments, compliments, complaints or concerns that you want to share. We aim to respond as quickly as possible to all feedback we receive.
Duty of Candour
Duty of Candour is a statutory duty which requires NHS organisations to ensure that patients and their families are informed of medical errors which cause moderate or severe harm, or death. This includes making an apology and offering a resolution meeting as appropriate.
Service Experience Team
This team provides a confidential service to help patients, their families and carers, to find answers to questions or concerns regarding the care or treatment they receive from all NHS services. The service experience team can help with obtaining information, advice or support if needed and, to help deal with any questions or concerns about any NHS services within Gloucestershire.
The contact details for the team are included on the back of this leaflet. You can also give us feedback by completing one of our feedback forms. Forms are available at all our sites, or you can ask a member of staff.
How to raise a concern
The first thing to do if you are worried or unhappy about any aspect of your care or treatment is to bring this to the attention of the doctor, ward manager, or health professional involved with your care, so that immediate action can be taken as they will want to help you and will try to resolve your concerns immediately.
If your concerns cannot be resolved informally, then let us know as soon as possible.
How will we resolve your complaint?
Contacting our Service Experience Team is the first stage of the formal NHS complaints procedure known as local resolution. We aim to provide a quick and helpful resolution to any complaint.
You can contact the Service Experience Team by telephone, in writing, by email or through our website. One of the team will contact you to make sure the Trust understands what you are complaining about and what outcome would make you feel you had a satisfactory resolution to the matter.
Once this has been confirmed, the Service Experience Lead will arrange for an investigation to be carried out.
Under the NHS complaints procedure, we can only investigate your complaint if it is made:
- Within 12 months of the event;
- Within 12 months of you realising you have something to complain about.
How long will this take?
You will be contacted within 3 working days of your complaint, and a full response with the outcome of the investigation will be sent to you within 25 working days.
If a full investigation cannot take place within that timescale, you will receive a letter explaining why there will be a delay and you will be kept updated on the progress of your complaint.
We will do our best to answer every issue which you raise in your complaint in an open and honest manner and we will inform you of any lessons learned and appropriate action taken to improve our service as a result of your complaint.
SEAP (Support, Empower, Advocate, Promote) NHS Complaints Advocacy Service
If you need independent help or advice regarding a complaint about an NHS service you may find it helpful to contact the NHS Complaints Advocacy Service. This service is free and confidential.
SEAP will:
- Offer independent help and support at all stages of a complaint
- Remain impartial
- Provide an integrated service to anyone receiving care provided or commissioned by the NHS
If you are not satisfied
When the investigation has been completed by the Trust, the Chief Executive will write to you, explaining the outcomes and what the Trust has done to resolve the matter. If you are not satisfied with the outcome of your complaint, please let us know why and we will do our best to resolve any outstanding issues. You can also contact the Parliamentary and Health Service Ombudsman and the details are included on the back of this leaflet.

Appendix 3

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

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

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

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

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

Step Three - Categorise the risk

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

Appendix 4

Guidelines for colleagues writing statements for complaint investigations

1 Introduction

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

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

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

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

2 General Principles

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

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

3 Format

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

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

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

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

3.5 Read your statement, date and sign it.

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

Equality Analysis

Plan/ policy name:	Complaints Policy

Plan/ policy author:	Christopher Brooks-Daw
Author job title:	Interim Deputy Director of Nursing
Plan/ policy sponsor:	Liz Fenton
Sponsor job title:	Director of Nursing and Quality
Date of Assessment:	23/03/2015

Q1: What are the aims of the plan/ policy (in brief)?

- Seek to resolve matters brought to our attention rapidly, empowering clinicians to seek local resolution where possible
- Ensure we facilitate a process by which those that use our services understand how to make a complaint and we have a process that makes it easy for concerns and complaint to be raised
- Be open and transparent, acknowledging when things go wrong and saying sorry.
- Ensure that we take the learning from concerns and complaints and use this to improve the quality of the services we provide
- Take a “You said, We did” approach to informing the public of the changes we make as a result of feedback including complaints
- Support our colleagues to investigate complaints through a process that is fair, open and transparent
- Ensure that people are not treated differently as a result of raising a concern or making a complaint

Q2: What will change (in brief)?

There will be a stronger focus on how Gloucestershire Care Services NHS Trust will take to listening to and learning from those that use our services.

Q2: Who will be affected?

Colleagues		Service users	
Carers		Community as a whole	

Q4: More specifically, will any of the following groups of people be affected by these changes?

These are groups of people who may face inequalities in health, healthcare or employment because of their personal characteristics or circumstances. You should

consider staff and service users in this analysis. The list is not exhaustive, and you may wish to add groups relevant to your plan/ policy at the end.

	Group	Definitely	Maybe	Unlikely	Not affected
Age	Older people	x			
	Working age adults		x		
	Children generally		x		
	Children in care		x		
	Adolescents in transition	x			
Disability	People with mobility issues	x			
	People with hearing impairments	x			
	People with visual impairments	x			
	People with learning disabilities	x			
	People with mental ill-health	x			
	People with dementia	x			
	People with long-term conditions	x			
Gender identity	Transgender people		x		
M/CP[1]	People who are married/ in a civil partnership				x
P/M[2]	Pregnant women		x		
	Women who are breastfeeding		x		
	Pregnant teenagers and teenage mums		x		
Race	People who are not 'White British'		x		
	Gypsies & Travellers	x			
	People who don't have English as a first language	x			
	'Newly arrived' people	x			

[1] Marriage/ Civil Partnership
[2] Pregnancy/ maternity

	Group	Definitely	Maybe	Unlikely	Not affected
	(including migrant workers)				
	Asylum seekers & refugees	x			
Religion/ Belief	People of faith		x		
	People of no faith		x		
Sex	Women		x		
	Men		x		
Sexual orientation	Gay men	x			
	Bisexual men/ women	x			
	Lesbians	x			
Other vulnerable groups	People living in poverty	x			
	People with limited access to transport living in rural areas	x			
	Homeless people	x			
	Sex workers	x			
	People who abuse substances	x			
	People in the military and veterans	x			
	Offenders	x			
	People in care homes/nursing homes	x			

Q5: Will the changes improve or worsen the access, outcomes or experiences of the people you have identified above?

Characteristic	Improve/ worsen/ Neither	Please expand:
Age		Older people: there is a risk that older people may be less able to access the complaints procedure if it is only available online, as older people are less likely than younger people to have access to – or feel confident in – digital technology. Under the policy, there is a wide range of ways in which people can access the complaints process, including face-to-face, written, telephone and online methods. Adolescents in transition: there is evidence across the NHS that adolescents in transition can feel vulnerable to – or worried about – poor transitions in care. As such, they are a group who may have greater need of the complaints process. While we do not have evidence that this is an issue in this Trust (based on past complaints), we need to be mindful that this is a group of people who need to be able to raise concerns easily and safely. Working age men and women: need to be able to access the complaints process to fit in with working hours.
Disability		People with disabilities need particular attention with regards to our complaints process. Firstly, they are likely to be more frequent users of our services and have more complex needs. As a result, there is a greater risk of things going wrong. Secondly, people with certain disabilities are likely to find it hard to access mainstream services and procedures, including complaints procedures. In particular, people with communication difficulties, hearing loss, sight loss, physical disabilities, learning disabilities. These disabilities make it harder for people to access complaints procedures and harder to follow and engage with the process.

Gender identity		Transgender people face – or fear – prejudice in society, including in their interactions with public services. In addition, they have extra or different needs, particularly during intimate care and inpatient care. They may be more likely to have poorer experiences of care, so have greater need of an easy and safe complaints procedure. Through our complaints procedures, we will treat everyone with respect and dignity and as an individual. The principles set out under 'disability' above should enable good access and experiences for transgender people.
Marriage/ Civil Partnership	N/A	
Pregnancy/ maternity		Mothers of young babies and breastfeeding mothers will have greater contact with our services at a challenging point in their lives. They may therefore be more likely to want to raise concerns. However, we need to recognise that they may have lower confidence, time and energy to do so. Teenage mums may have the added challenge of facing or fearing prejudice. The principles set out under 'disability' above should enable good access and experiences for pregnant women and new mothers. In publicising the complaints policy, we need to ensure that we send messages of inclusiveness, i.e. showing that we welcome comments, concerns and complaints from everyone, no matter who they are.

Race		People from non-White British communities – especially 'newly arrived' in the UK – may have a poorer understanding of services they can access and how to do this. This will also apply to the complaints process. Some communities face – or fear – prejudice from the NHS. This includes non-white people and Gypsy and Traveller communities. Communication is critical to make the complaints procedure accessible to communities who don't speak or read English (well). The principles set out under 'disability' above should enable good access and experiences for all our communities. The complaints process needs to pay particular attention to:
Religion		People of faith may need flexibility in appointment times during the complaints process to fit in with religious observances.
Sex		Women are more likely to have the main responsibility for childcare, so need greater flexibility in appointment times during the complaints process to fit in with childcare responsibilities.
Sexual orientation		Research shows that lesbian, gay and bisexual people are more likely to face – or fear – prejudice in their interactions with the NHS. In publicising the complaints policy, we need to ensure that we send messages of inclusiveness, i.e. showing that we welcome comments, concerns and complaints from everyone, no matter who they are.
Deprivation/ poverty		People living in poverty are likely to have lower levels of confidence in being able to raise concerns and make complaints. They may also have lower levels of literacy. As well as the guidelines set out above under 'disability', we particularly need to consider the following for people living in poverty:

Rurality		People living in rural areas – especially where there is limited access to transport – may find it harder to access services, which could be a cause for raising concerns or complaints. As well as the guidelines set out above under 'disability', it will be important to publicise opportunities to raise concerns and make complaints to this audience.

Q6: How will we personalise the service/ function to meet individual needs?

Please describe how we will:

1. Identify if someone has extra/ different needs
2. Share this information with others who need to know
3. Adapt the service to ensure they have the same high quality outcomes/ experiences as everyone else

(or state why this is not relevant):

Q6: Who are you involving in the development of this plan/ policy, and how?

Lucy Lea
Quality and Clinical Governance Committee

Q7: What – if any – Human Rights implications do you consider your plan/ policy to have[3]?

Easy access to complaints procedures is a fundamental human right.
Right to a fair trial, right not to be discriminated against as a result of raising a concern or complaint.
Consider:

1. **Fairness**: access to services and work opportunities; appeals processes; application of employment processes; access to complaints procedures;
2. **Respect**: right to respect for family and private life, home and correspondence; right to freedom of thought, conscience and religion; right to peaceful enjoyment of possessions;
3. **Equality**: right not to be treated unfavourably on the basis of personal characteristics; equal chances to develop one's full potential;
4. **Dignity**: right not to be tortured or treated in an inhuman or degrading way; protection of privacy; compassion in care

Autonomy: the right to liberty; the right to make one's own decisions (e.g.

[3] See guidance for a list of potential Human Rights implications in healthcare.

about care, treatment); promoting independence

Q7: Sign off and assurances

I, the project/ policy sponsor, am assured that the changes we are making take into account our responsibilities under s.149 of the Equality Act 2010 to have due regard to the need to:

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Signed:	
Name:	**Liz Fenton**
Job title:	**Director of Nursing and Quality**

Gloucestershire Care Services NHS
NHS Trust

Duty of Candour

Ref: 18/0515

Duty of Candour Policy
May 19th 2015

The Board is asked to:

Approve the policy and implementation plan

Executive summary:

The Care Quality Commission's Fundamental Standard's set out the standards below which care must never fall. One of the fundamental standards is the Duty of Candour, this requires providers of care to be open and transparent about treatment and care and should something go wrong to tell service users what has happened, provide support and apologies. Additionally, this has been made a requirement of the NHS Standard Contract.

This report summarises the requirements of the regulation and the key areas of improvement along with the proposed policy to ensure full compliance with the regulation.

Identify which strategic objective(s) this paper supports:

1.	**Achieve the best possible outcomes for our service users through high quality care.**	✓
2.	**Understand the needs and views of the service users, carers and families so 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.**	

Elizabeth Fenton, Director of Quality and Nursing

May 2015

Please complete the Equality Checklist over….

Please select one of the following options:

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

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

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

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

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

Gloucestershire Care Services NHS
NHS Trust

1. Introduction

The Trust is currently subject to the following:

A. A contractual duty of candour (service standard 35 of the NHS Standard Contract).

B. Legal duties under the CQC Regulations (requirement to notify the CQC of the death of a service user or of allegations of patient injury or abuse; obligation on every NHS Trust to send to the CQC, if requested, a summary of complaints and responses.

C. Legal duties under the Health and Safety Executive's reporting requirements (Reportable Injuries Diseases and Dangerous Occurrences or RIDDOR)

D. Disclosure through legal proceedings (HM Coroner, criminal and civil legal proceedings)

E. Individual colleagues are also bound by professional obligations, including the General Medical Council, Nursing and Midwifery Council and Healthcare Professionals Committee, which each have explicit requirements in their professional codes of candour if a patient suffers harm.

F. The Trust must also have due regard to the NHS Constitution and its commitment to candour when mistakes happen; the National Patient Safety Agency (NHS England) and the NHS Litigation Authority Guidelines in respect of Duty of Candour.

2. Duty of Candour Legislative Requirements

The Care Act 2014 was given Royal Assent on 14th May 2014 and placed a specific duty on the Government to include a statutory duty of candour on providers registered with the Care Quality Commission (CQC), with continuing compliance overseen by the CQC.

The duty of candour applies to any unintended or unexpected incident that occurs in respect of a service user during the provision of services that results in moderate or severe harm or death.

The regulation states that providers are required:

- To act in an open and transparent way with service users and their representatives, as regards to care and treatment.

- As soon as reasonably practicable after becoming aware of a notifiable incident, to:

    - Notify the service user (or someone lawfully acting on their behalf) that the incident has occurred. This notification must include an apology and must be in person by a representative of the health service body.

    - Provide a truthful account of all facts known as at the date of the notification.

    - Provide all information directly relevant to the incident.

    - Advise and if possible agree with the service user what further enquiries are appropriate.

    - Provide reasonable support to the service user.

    - Follow the personal notification with a written notification informing the service user of the original notification, enquiries undertaken and the results of any further enquiries along with an apology.

    - Keep a written record of all meetings and correspondence with the service user.

    - If a service user doesn't want to correspond or meet with the Trust, keep a record of attempts to contact and/or speak to them.

3. How is the Trust complying with the regulation

   The Trust has the following governance processes in place surrounding the Duty of Candour:

   - All incidents are reported on the risk and incident management system Datix, the system alerts the Quality Team of incidents reported that meet the Duty of Candour threshold.

   - Incidents resulting in harm are investigated using a root cause analysis approach with most moderate/significant harm incidents declared as serious incidents requiring investigation, ensuring robust central oversight and action.

   - Colleagues throughout the Trust uphold the ten principles of Being Open

- Training was commissioned by an external provider to support thirty Being Open Champions

- Documentation relating to incidents that reach the threshold is logged onto the Datix system providing a clear audit trail

- The attached implementation plan provides further assurance on the actions that the Trust will complete during the next 2 months to ensure compliance with the Duty of Candour.

BEING OPEN AND DUTY OF CANDOUR POLICY

Document Type	Clinical Governance Policy
Unique Identifier	TBC
Document Purpose	To ensure the infrastructure is in place to support openness between healthcare professionals and service users/families following an incident, complaint or claim.
Document Author	Director of Quality and Nursing
Target Audience	All colleagues who provide care to service users and carers
Responsible Group	Quality and Performance Committee
Date Ratified	
Expiry Date	

Accessibility

Interpreting and Translation services are provided by Capita for Gloucestershire Care Services NHS Trust, including:

- Face to face interpreting;
- Instant telephone interpreting;
- Document translation; and
- British Sign Language interpreting

Please refer to intranet page: http://nww.hacw.nhs.uk/a-z/services/translation-services/ for full details of the service, how to book and associated costs.

Training and Development

Gloucestershire Care Services NHS Trust recognises the importance of ensuring that its workforce has every opportunity to access relevant training. The Trust is committed to the provision of training and development opportunities that are in support of service needs and meet responsibilities for the provision of mandatory and statutory training.

All employees of the Trust are required to attend the mandatory and statutory training that is relevant to their role and to ensure they meet their own continuous professional development.

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Executive Summary

Every healthcare professional must be open and honest with patients. Every NHS Trust, since November 2014, has a statutory Duty of Candour.

Candour is defined by Robert Francis as: 'The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made'.

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

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

The requirements of the Duty of Candour are as follows:

As soon as reasonably practicable after becoming aware that a patient safety incident has occurred that falls into the moderate harm or more serious categories the healthcare professional must—

(a) notify the 'relevant person' (this is usually the patient but may in some circumstances be the relative, carer or advocate) that the incident has occurred and;

(b) provide reasonable support to the relevant person in relation to the incident.

The notification must:

(a) be given in person by one or more members of staff;

(b) provide an account of all the facts known about the incident to date;

(c) advise the relevant person what further enquiries into the incident will be undertaken;

(d) include an apology and/or a sincere expression of regret, and;

(e) be recorded in writing in the notes.

This notification must be followed up in writing to the relevant person.

The member of staff should be clear in the first meeting that the facts may not yet have been established, tell the relevant person only what is known and believe to be true, and answer any questions honestly and as fully as they can.

The aim of the Duty is to ensure that patients are told when harm occurs as a result of the care they receive. Where the degree of harm is not yet clear but may fall into the moderate or above categories, then the relevant person must be notified.

1. Introduction

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

Subsequently the CQC issued a guidance document addressing the Duty of Candour: http://www.cqc.org.uk/sites/default/files/20141120_doc_fppf_final_nhs_provider_guidance_v1-0.pdf

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

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

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

It is broadly acknowledged that healthcare treatment is not risk free. Patients, families and carers usually understand this, and want to know not only that every effort has been made to put things right, but every effort is made to prevent similar incidents happening again to somebody else**.** A critical test for patients' trust in our organisation is how we respond when things go wrong. Openness is comparatively easy when all is well, but can be far more challenging in cases of actual or possible harm.

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

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

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

2. Definitions

The 'Duty of Candour' requirements reinforce the 'being open' principles by placing more emphasis on organisational responsibility. While the Duty applies to organisations, not individuals, it is clear that individual NHS staff must cooperate with it to ensure the Duty is met.

2.1 Duty of Candour

Candour is defined in The Francis report:

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

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

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

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

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

The notification to be given must:

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

This notification must be followed up in writing.

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

2.2 Being Open

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

2.3 Patient Safety Incident

A patient safety incident is defined as **'**Any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS-funded healthcare" *(Seven Steps to Patient Safety, NPSA 2003).*

2.4 Serious Incident

Serious incidents requiring investigation are defined in the NHS England (2015) Serious Incident Framework. This replaces NPSA's 2010 National Framework for Reporting and Learning from Serious Incidents Requiring Investigation and NHS England's Serious Incident Framework (2013).

A serious incident is an incident that occurred during NHS funded healthcare which resulted in one or more of the following;

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

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

2.5 Notifiable Incident

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

Notifiable Safety Incident

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

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

(b) severe harm, moderate harm or prolonged psychological harm to the service user;

"prolonged psychological harm" means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days."

Sir David Dalton and Professor Norman Williams at paragraph 52 of their review of the threshold for the duty of candour 'Building a Culture of Candour' (2013) comment:

"We do, however, understand that recognition of a patient safety incident that leads to harm is not necessarily straightforward. Indeed, the majority of harm that occurs is not a simple case of one error leading to obvious identifiable harm. Most harm is a consequence of multiple instances of sub-optimal care that are not necessarily obvious to those involved in the delivery of care. It is therefore vital that the enforcement of the duty of candour is, as we have said, proportionate, and is sensitive to the realities of healthcare."

Essentially therefore, in the regulations the judgement as to whether an incident is notifiable is down to the opinion of the healthcare professional. Any decision made regarding notification by the healthcare professional must be clearly documented in the clinical notes, demonstrating clear rationale for decisions made.

Example Scenario – A Fall

There will be many cases where a patient reports harm that may or may not have occurred because of an error or mistake in the treatment they received. A patient with dementia may fall on the ward for example sustaining injuries that require a moderate increase in treatment. Everything may have been done appropriately to care for that individual and the fall may simply be an accident. However, the incident is almost certainly going to be something that you would want to discuss with the 'relevant person' be that the patient or a relative.

It is possible that a review of the incident reveals that more could have been done to prevent the fall - in which case the incident becomes a notifiable patient safety incident and the statutory Duty of Candour applies.

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

It should be remembered that the whole point of the Duty is to ensure that patients are told when harm occurs as a result of the care they receive. Where the degree of harm is not yet clear but may fall into the moderate or above categories, then the relevant person must be informed. It also may not be clear whether the incident or harm was as a result of the care the patient received. If, after using professional judgement, there is uncertainty about whether the incident is notifiable then the patient should be fully informed of the facts, and should be kept informed until the conclusion of the episode.

Any decisions made, and the outcome of the decisions, must be recorded in the notes.

2.6 Relevant Person

The regulations use the term of the "relevant person" when describing the person who will be informed of an incident in the Duty of Candour process. This may be the service user or patient, or the person acting on their behalf. The term "relevant person" is therefore used throughout this Trust policy.

Relevant Person

The regulations states that the "relevant person" means the service user or, in the following circumstances, a person lawfully acting on their behalf—

(a) on the death of the service user,

(b) where the service user is under 16 and not competent to make a decision in relation to their care or treatment, or

(c) where the service user is 16 or over and lacks capacity (as determined in accordance with sections 2 and 3 of the 2005 Act) in relation to the matter.

2.7 Level of Harm

Level of Harm

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

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

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

Moderate harm" means—

(a) harm that requires a moderate increase in treatment, and

(b) significant, but not permanent, harm;

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

Grade 3 and 4 pressure ulcers constitute a large proportion of incidents in the Trust that may be classed as moderate and severe harm incidents, using the NHSE guidance.. Consideration needs to be given to these as to whether they would also be notifiable incidents.

Example Scenario – Pressure Ulcer

A multi-disciplinary team are caring for a patient who develops a Grade 3 pressure ulcer. This, in line with Trust policy, is reported as an incident on Datix and may be declared as a Serious Incident, depending on the circumstances and contributory factors. As a grade 3 or 4 pressure ulcer may require a moderate increase in treatment and moderate or severe harm respectively will be experienced by the patient, this incident will almost certainly invoke the Duty of Candour. A notification meeting therefore takes place with the relevant person.

Subsequently the Root Cause Analysis investigation reveals that everything was put in place by the clinical team to help prevent the pressure ulcer – healthcare staff had evaluated the patient's clinical condition and pressure ulcer risk factors. The team had planned and implemented interventions and had regularly evaluated the impact of the interventions. All care and treatment had been appropriately recorded in the patient's notes.

The incident was therefore unintended and unavoidable. The relevant person should still be informed of the outcome of the investigation and should receive a full explanation of the facts.

3. Scope

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

The Being Open principles (Appendix 1) and ethical duty of openness applies to all incidents and any failure in care or treatment. The Duty of Candour applies to incidents whereby moderate harm, severe harm or death has occurred.

There will be exceptions to implementing the Duty of Candour; there must be very sound reasons, which must be clearly recorded, for not having the Duty of Candour principles applied.

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

<u>The potential implications of not implementing the Duty of Candour requirements</u>

As the Duty of Candour is a statutory requirement, non-compliance is a criminal offence.

Commissioners can withhold the cost of the episode of care or implement a fine of £10,000 if the cost is not known. In addition, they can do any/all of the following:

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

The CQC in their guidance relating to the Duty of Candour explain the approach they will be taking to assess whether a provider is complying with the new regulation. The CQC's key lines of enquiry will be:

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

<u>Incidents that are later uncovered or that have occurred within the care of another provider</u>

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

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

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

4. Aim

Conversations between patients, families and staff about risk and the potential for harm are essential for fostering a culture of candour, both as a means of preparing patients should something happen, and in encouraging clinicians and healthcare staff to do the right thing when errors occur.

The principle of this policy is to reinforce a 'conversation of equals' between people who use our services and staff who provide the services. Having a candid conversation when something goes wrong might not be so difficult if it is part of an on-going clinical relationship, in which issues of risk and consent are clearly discussed with the patient from the outset.

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

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

The following paragraph is taken from the Dalton and Williams review of the thresholds for the Duty of Candour:

"The obligations and challenges of candour serve to remind us that for all its technological advances, healthcare is a deeply human business. Systems and processes are necessary supports to good, compassionate care, but they can never serve as its substitute. It follows from this that making a reality of candour is a matter of hearts and minds more than it is a matter of systems and processes, important as they can be. A compliance-focused approach will fail. If organisations do not start from the simple recognition that candour is the right thing to do, systems and processes can only serve to structure a regulatory conversation about compliance.

The commitment to candour has to be about values and it has to be rooted in genuine engagement of staff, building on their own professional duties and their personal commitment to their patients".

5. Responsibilities

5.1 Trust Board

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

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

5.2 Chief Executive

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

5.3 Executive Directors and Senior Management Team

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

5.4 The Clinical Senate

The Clinical Senate is chaired by the Director of Nursing & Quality) and the Medical Director, . The Senate will review all Serious Incident investigation Root Cause Analysis (RCA) reports to ensure the quality of the investigation is of a high standard, and that associated action plans are comprehensive. The group will monitor Route Cause Analysis reports to determine whether the principles of Being Open and the Duty of Candour have been followed appropriately in each case.

5.5 Professional Bodies and Trade Union organisations

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

5.6 The Director of Nursing & Quality and the Medical Director

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

5.7 Line Managers' Responsibility

It is the responsibility of all Trust managers to support employees to comply with this policy and to ensure members of their teams are aware of this duty.

5.8 Employee Responsibility

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

- General Chiropractic Council
- General Dental Council
- General Medical Council
- General Optical Council
- General Osteopathic Council
- General Pharmaceutical Council
- Nursing and Midwifery Council
- Pharmaceutical Services of Northern Ireland

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

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

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

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

5.9 Investigating Officer

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

5.10 Senior Clinician

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

5.11 Notifying the Relevant Person

In making a decision about who is most appropriate colleague to lead on the notification discussion and apology, the member of staff's seniority, relationship to the person using the service, and experience should all be considered. Issues of consent and confidentiality and will determine who will lead on the discussions with the relevant person.

Children and Young People

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

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

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

6. Training

All new employees of the Trust are made aware of the 'Being Open' process and Duty of Candour as part of the the induction programme.

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

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

A Quick Reference Guide to the Being Open principles and the Duty of Candour is contained in appendix 1 and 2.

7. Support and Advice for Staff

It is very rare for staff in healthcare to go to work with the intention of causing harm or failing to do the right thing. While we do all we can to minimise risks, it will never be possible to eliminate them fully. It should be acknowledged from the outset that many 'human factors' can increase the risk of incidents occurring such as:

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

It is uncommon for any single action or 'failure' to be wholly responsible. The focus following an incident should always be on learning and prevention rather than individual blame.

Involvement in an incident and particularly a serious incident can have profound consequences on colleagues who may experience a range of reactions. The high personal and professional standards of most clinicians and other staff may make them particularly vulnerable to these experiences. Different individuals will have differing responses to the same incident and support should always therefore be tailored to the individual. The Human Resources team is able to advise on resources available in the Trust, but the support of close team members and managers is invaluable for the staff involved, and for taking forward learning from the event.

- The initial level of support is provided by line managers for employees involved in a patient safety incident.

- The second level of support is provided by appropriate Senior Managers and may include guidance from professional leads. Further escalation may be required depending on the severity of the incident.
- A further level of support is provided by the Executive Directors who participate in the 24 hour on call rotas.

Learning from serious events in the Trust has taught us that that practitioners or teams who work in isolated services or have lone working practices may be more likely to need support. These staff also need to be able to assure their Line Managers and the Trust that they are acting in an open and candid manner with patients.

8. Being Open and Duty of Candour Processes

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

A summary of the stages involved in this process is provided in Appendix 2 together with a flow chart in Appendix 3.

Stage One

Incident Identification and Reporting

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

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

Incident	Action
No harm *(including prevented patient safety incidents)*	o Patients are not usually contacted or involved in investigations and these types of incidents are **outside** the scope of the *Duty of Candour*. Openness remains best practice, but there is no requirement to follow the Duty of Candour processes.
Low harm	o Unless there are specific indications or the patient requests it, the communication, investigation and

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

All incidents must be reported onto Datix (refer to the Trust's Incident Governance Policy). The incident report must be completed as soon as possible after the incident has been discovered, and always within 48 hours of detecting the incident. For all moderate and greater harm incidents, Datix will (from May 2015) prompt the person reporting the incident whether the Duty of Candour has been applied in the incident.

Stage Two

Being Open

There are a set of principles for being open (Appendix 1) that colleagues should refer to when communicating with the relevant person following an incident in which the patient/service user was harmed.

Mental Capacity

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

Confidentiality

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

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

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

The Relevant Person Cannot be Contacted or Declines to Have Further Information

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

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

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

Stage Three

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

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

Apology

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

Guidance from the NHS Litigation Authority (2009) states:

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

liability. In addition, it is not our policy to dispute any payment, under any scheme, solely on the grounds of such an apology."

Clarity of Communication

The individual communication needs of the relevant person, for example, linguistic or cultural needs, learning disabilities, or sensory impairments must be considered and taken into full account before any discussion takes place. This involves consideration of circumstances that can include a patient requiring additional support, such as an independent patient advisor or a translator.

The relevant person should be fully informed of the issues surrounding the patient safety incident and its consequences in a face to face meeting.

The facts that are known should be explained. When talking to the relevant person about the incident colleagues must use clear, straightforward language and be honest with responses to any questions that are raised.

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

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

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

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

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

Information on likely short and long-term effects of the incident (if known) should be shared.

An offer of practical and emotional support should be made to the relevant person.

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

Stage Four

The Investigation

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

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

The actions above should be followed by a letter to the patient/relatives with an offer of a meeting, if this is appropriate. This should be written by the most appropriate person. This

may be before the conclusion of the investigation. An example template letter is provided in Appendix 4.

The letter should advise the patient of the independent advocacy service available to support and assist them.

The Investigating Officer will keep the relevant Lead and the person who is overseeing the Duty of Candour process up to date on progress with the investigation.

Stage Five

Communication with the Relevant Person – the Notification Meeting

A meeting with the relevant person should be arranged as soon as possible after the incident has happened to notify them of the incident. This meeting should always take place within 10 working days of the incident being discovered.

It may be appropriate for more than one member of staff to meet with the relevant person for support or for additional information.

At the meeting the nominated member of staff should follow the procedure below.

- If known, explain what went wrong and where possible, why it went wrong;
- Inform the patient and/or relative(s) and others what steps are being/will be taken to prevent the incident recurring;
- Offer an apology:
- Provide opportunity for the patient and/or relatives and others to ask any questions;
- Agree with the patient and/or relatives and others any future meetings as appropriate;
- Suggest any sources of additional support and counselling and provide written information if appropriate.
- Inform the relevant person that they will receive a written summary of the incident and that they will be, if they wish, be informed of progress with the investigation. The relevant person will also receive a copy of the final investigation report.

Wherever possible a named contact should be provided who the relevant person can speak to regarding the incident. This can be a manager in the clinical team or another member of staff who has the skills and knowledge to undertaken this role. It is vitally important that whoever is named as the contact is made aware of this, agrees to the role and is furnished with all of the information they may need to ensure clear and honest communication takes place.

The senior manager/clinician for the service should be informed of the outcome of any meeting.

The communication and outcome of the notification must be clearly recorded in the clinical notes by the person who has informed the patient/family.

A letter should then be written to the relevant person setting out what was explained at the notification meeting. The letter should be drafted immediately after the notification meeting and forwarded to the Serviceslead for approval prior to sending out. The letter must contain all the information that was provided at the initial notification meeting.

The regulations state that the notification given must be followed by a written notification given or sent to the relevant person containing—

(a) the information provided,

(b) details of any enquiries to be undertaken,

(c) the results of any further enquiries into the incident, and

(d) an apology.

Any Duty of Candour letters arising out of the notification meeting must be signed off by the Service Lead and a copy kept in the clinical notes. A copy will additionally be stored on the Datix system to provide a robust audit trail.

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

Stage Six

Investigation Closure and Learning

Where a SIRI investigation has been conducted,, the report will be presented to the Clinical Senate This will include details of how the Duty of Candour has been implemented.

Once the incident is signed off for closure, a letter should be sent to the relevant person together with the anonymised investigation report and action plan. The supporting letter should provide information in the event that the individual wishes to pursue legal action against the Trust.
If the SIRI Report is not available within the usual time frame for closure, a letter should be sent to the relevant person to provide an explanation as to when they can expect to be provided with additional details. This letter should clarify the information previously provided, reiterate key points, and record action points and future deadlines. This letter should also provide information in the event that the individual wishes to pursue legal action against the Trust.

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

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

9. Documentation

All correspondence should be held in accordance with Trust's Records Management Policy.

With specific relation to the Being Open/Duty of Candour the clinical records must:

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

10. Performance/Disciplinary Issues

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

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

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

This will particularly be the case in matters where safeguarding issues are identified.

The appropriate professional body (GMC/NMC etc.) may also need to be notified.

11. Monitoring the Policy

Monitoring implementation will be undertaken by the Clinical Senateby them agreeing the closure of incident reports. The outcome of this will be reported to the Quality and Performance Committee and Trust Board.

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

12. Associated Documents/References

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 No. 2936 PART 3SECTION 2 Regulation 20 http://www.legislation.gov.uk/uksi/2014/2936/regulation/20/made
The Francis Enquiry http://www.midstaffspublicinquiry.com/
A promise to learn – a commitment to act: Improving the Safety of Patients in England, Berwick and the National Advisory Group on the Safety of Patients in England, 2013, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf.
Building a culture of candour - A review of the threshold for the duty of candour and of the incentives for care organisations to be candid http://www.rcseng.ac.uk/policy/documents/CandourreviewFinal.pdf
Human Factors in Healthcare – National Quality Board 2013 http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/Intervention-support/Human+Factors+How-to+Guide+v1.2.pdf
NPSA – Being Open resources: http://www.nrls.npsa.nhs.uk/resources/?entryid45=65077
Mental Capacity Act 2005 – Code of Practice http://www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act
Fraser Guidelines http://www.fpa.org.uk/factsheets/under-16s-consent-confidentiality
General Medical Council, Good medical Practice, 2006 www.gmc-uk.org/guidance/good_medical_practice/index.asp
National Patient Safety Agency, Seven Steps to Patient Safety, April 2004 http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/
NHS Litigation Authority, Litigation Circular No. 02/02 Apologies and Explanations, 11 February 2002 www.nhsla.com
NHS Litigation Authority – Saying Sorry: 2013 - http://www.nhsla.com/Claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf
CQC Provider Guidance http://www.cqc.org.uk/sites/default/files/20141120_doc_fppf_final_nhs_provider_guidance_v1-0.pdf

APPENDIX 1

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

1. Principle of Acknowledgement

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

2. Principles of Truthfulness, Timeliness and Clarity of Communication

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

3. Principle of an Apology

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

4. Principle of Recognising Patient and Carer Expectations

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

5. Principle of Professional Support

The Trust has set out to create an environment in which all employees are encouraged to report patient safety events. Employees should feel supported throughout the patient safety event investigation process; they too may have been traumatised by the event. Resources available are referred to within the respective Trust policies, to ensure a robust and consistent approach to patient safety event investigation. Where there are concerns about the practice of individual employee the Trust's Human Resources department must be contacted for advice. Where there is reason to believe an employee has committed a

punitive or criminal act, the Trust will take steps to preserve its position and advise the employee at an early stage to enable them to obtain separate legal advice and/or representation. Employees should be encouraged to seek support from relevant professional bodies. Where appropriate, a referral will also be made to the Independent Safeguarding Authority.

6. Principle of Risk Management and Systems Improvement

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

7. Principles of Multi-Disciplinary Responsibility

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

8. **Principles of Clinical Governance**

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

9. **Principle of Confidentiality**

Details of a patient safety incidents should at all times be considered confidential. The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the patient. The Trust will anonymise any incident it publishes but still seek the agreement of those involved.
Where it is not practicable or an individual refuses consent to disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the patient safety event have statutory powers for obtaining information. Communications with parties outside of those involved in the investigation will be on a strictly need to know basis. Where possible, it is good practice to inform the patient, their family and carers about who will be involved in the investigations before it takes place, and give them the opportunity to raise any objections.

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

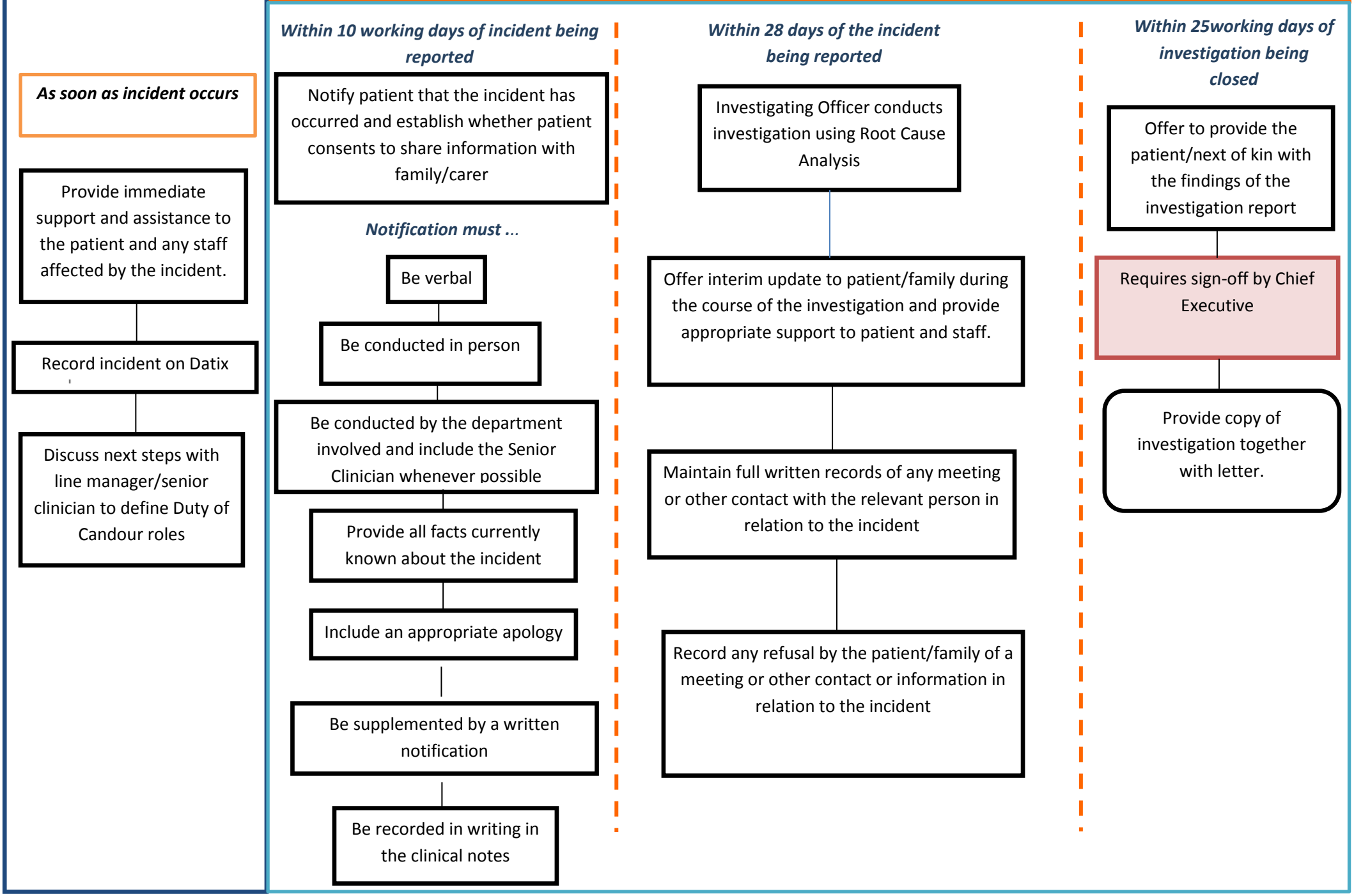
10. Principle of Continuity of Care

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

APPENDIX 2

Brief Summary of the Stages in the Duty of Candour Process

Requirement under Duty of Candour	Responsible Person/Department	Timeframe
For incidents where moderate harm, serious harm or death has occurred, the relevant person must be informed.	Senior clinician for episode of care during which the incident occurred. The Clinical/Operational Manager should be made aware and if appropriate, involved.	As soon as possible after the incident has been detected and reported but always within 10 working days of the incident
Initial notification of incident must be verbal (face-to-face, where possible) unless the relevant person declines notification or cannot be contacted in person. Sincere expression of regret or sorrow must be provided verbally. This must be recorded in the notes.	Senior clinician for episode of care during which the incident occurred. The Clinical/Operational Manager should be made aware and if appropriate, involved.	As above.
Step-by-step explanation of the known facts must be offered to the relevant person.	As above	As above
Written notification to the relevant person. The written notification should outline the facts discussed at the notification meeting and include a sincere expression of regret or sorrow.	As above. All letters must be approved by the Service Lead or their nominated deputy.	As above (template letter available for guidance only – all letters must be personalised and tailored to the individual needs of the person receiving the letter).
Maintain full written documentation of any meetings. If meetings are offered but declined this must be recorded	As above. All follow-up letters to patients/ relatives to be approved for release by the Service Lead or their nominated deputy.	
Share incident investigation report (including action plans) with an accompanying letter.	Investigating Officer or other nominated person. Letter to be approved by Service Lead and signed off by the Chief Executive or their nominated deputy.	As soon as reasonably practicable but always within 25 working days of report being signed off as complete and incident closed by the Clinical Senate


As soon as incident occurs
Provide immediate support and assistance to the patient and any staff affected by the incident.
Record incident on Datix
Discuss next steps with line manager/senior clinician to define Duty of Candour roles
Within 10 working days of incident being reported
Notify patient that the incident has occurred and establish whether patient consents to share information with family/carer
Notification must …
Be verbal
Be conducted in person
Be conducted by the department involved and include the Senior Clinician whenever possible
Provide all facts currently known about the incident
Include an appropriate apology
Be supplemented by a written notification
Be recorded in writing in the clinical notes
Within 28 days of the incident being reported
Investigating Officer conducts investigation using Root Cause Analysis
Offer interim update to patient/family during the course of the investigation and provide appropriate support to patient and staff.
Maintain full written records of any meeting or other contact with the relevant person in relation to the incident
Record any refusal by the patient/family of a meeting or other contact or information in relation to the incident
Within 25working days of investigation being closed
Offer to provide the patient/next of kin with the findings of the investigation report
Requires sign-off by Chief Executive
Provide copy of investigation together with letter.

Guidance letter template for initial communication letter in accordance with requirements of Duty of Candour.

NB This is provided purely for guidance. All letters must be personalised and tailored to the individual needs of the person receiving the letter.

Dear Mrs/Mrs xxxxxxxxxxx

I am writing to express my sincere regret that (you/your relative XXXXX) has been involved in an incident whereby ……(describe event here). As a Trust we are committed to being open with patients and carers when events such as these occur so that we gain a shared understanding of what happened, and what we can do to prevent such an incident occurring again in the future.

An investigation is already underway to try and establish the cause of the incident. If you would like to meet with a member of staff to discuss this, please let me know within the next two weeks, and we will arrange a mutually convenient time and place to meet.

There is an independent advocacy service available to support and assist you in this who can be contacted on XXXXXXX.

Staff member XXXXX is acting as your lead contact for the duration of the investigation. They can be contacted by email on xxxxxxxxxxxxxxx or on telephone number xxxxx xxxxxxx

Yours sincerely

The Duty of Candour (Regulation 20 – The Health and Social Care Act (Regulated Activities) Regulations 2014

Board Assurance: Implementation Plan

The requirement

A health service body i.e. NHS Trusts, NHS Foundation Trusts, must act in an open and transparent way in relation to care and treatment provided to patients. As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, a health service body must notify the relevant person and provide reasonable support to him or her in relation to the incident. The relevant person is the service user or a person acting on his or her behalf if the service user is dead or under 16 years or lacks capacity.

Notification must comply with specific requirements: it must be given in person, provide an account which is true as to the facts the health service body knows about the incident, advise what further enquiries into the incident are considered appropriate, apologise and record all of these matters in a written record which must be kept by the health service body. Notification must be followed by written notification.

The sanction

It is a criminal offence to fail to provide notification of a notifiable safety incident and/or comply with the specific requirements of notification. On conviction a health service body would be liable to a potential fine of £2,500.

Achieving compliance

The Trust must ensure they have systems in place to capture notifiable safety incidents and processes for notification to and support for relevant persons.

The concept of a notifiable safety incident is crucial. The Regulations define such an incident as one where any unintended or unexpected incident occurs in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a healthcare professional, could or appears to have resulted in death, severe or moderate harm, or prolonged psychological harm.

The Trust must take account of the following key points in training colleagues on the duty of candour.

Duty	Description	Action	Target Completion Date and Lead
Context	Make sure that colleagues understand that the duty sits alongside existing professional responsibilities. Managers and clinical colleagues need to be aware of the GMC's Good Medical Practice and existing policies and procedures such a Raising Concerns, Being Open and Serious Incidents policies. As the Williams/Dalton report "Building a Culture of Candour" said it is "vital that candour is understood in context by staff and by board members as an integral part of a culture of safety".	Duty of Candour Policy presented to Board (May 2015) Being Open Champion programme (Complete) Assessment of understanding through Quality Visits Duty of Candour Training/Awareness Programme Incidents Policy Duty of Candour Awareness Materials to include the 10 principles of Being Open	Director of Nursing and Quality Head of Communications
Roles	Colleagues have to understand their own obligations and the roles of those around	Raising Concerns Policy – update and send to JNCF in May 2015	Director of Human Resources

	them in relation to the duty. They have to be able to raise concerns where they think the duty has not been complied with by others and they need to understand their role in keeping the organisation compliant.	Job Descriptions – duty statement Terms and Conditions of Employment – duty statement	
Involve the Board	As the obligation rests with the organisation it is important that Board members are aware and kept informed about the duty and how it is being discharged. The focus of the Board should be on ensuring that systems are in place to deliver compliance. The Board should have periodic reports about how the duty is being met and the sort of events that are being reported.	Ratification by the Board of the Duty of Candour Policy Quality and Performance Report to include a compliance section evidencing compliance	Director of Nursing and Quality
Identifying a relevant incident	Ensure that colleagues understand when the duty arises and how to identify when the harm threshold has been reached.	Duty of Candour Identification Awareness Guidance Rebuild of Datix to include a duty of candour alert (complete) Resources and information available on the Trust intranet Awareness Materials in respect of Moderate/Significant Harm Identification	Director of Nursing and Quality Head of Communications
Reporting arrangements	Take colleagues through the organisational reporting requirements where the duty	Incident Policy	Director of Nursing and

	applies. It is in the interests of the Trust and service users that colleagues promote the reporting of incidents.	Datix to include prompts to ensure timely communication Root cause analysis for serious incidents have a section on duty of candour and is also linked to the action plan Awareness Materials in respect of Duty of Candour	Quality Head of Communications
Support	Make clear the ways in which colleagues can receive support in complying with the duty and raising concerns once they identify a problem.	Care First – free counselling support Duty of Candour Guardian	Director of Human Resources CEO
Communication	An essential part of training on the duty should include how to communicate with service users once the duty has arisen and, specifically, how to apologise in a meaningful way. An apology requires an expression of sorrow or regret – it does not require an admission or fault.	Duty of Candour Communications Guidelines and Standard Letter Templates Information for colleagues to be developed including for use at induction	Director of Nursing and Quality Head of Communications
Consequences	It is important that colleagues understand the consequences of not complying with the duty. Colleagues need to know how non-compliance could affect the Trust and how it could lead to disciplinary	Disciplinary Policy and Procedures – summary of proceedings and guidance on conduct linked to the duty Root Cause Analysis Training	Director of Human Resources Director of

	proceedings/professional conduct issues from them personally. It is also important to emphasise that the Trust will look at the underlying causes of service user safety concerns e.g. by root cause analysis, significant event audit, to ensure that the focus is not exclusively on the last individual to provide care.	Datix Training to include an element on the Duty of Candour	Nursing and Quality
Investigations	It is important to review how investigations are currently carried out to ensure that further training to meet the duty of candour is provided if required.	Incident Reporting Annual Audit	Director of Nursing and Quality

Gloucestershire Care Services NHS
NHS Trust

The Duty of Candour

What does this mean to you and your service users?

In order to promote transparency within NHS organisations and increase service user confidence in the delivery of care, the Government has introduced **statutory regulations** relating to **Duty of Candour**. The aim of these regulations is to ensure that providers of healthcare are open and honest with service users when things go wrong with their care and treatment.

How can you ensure that you comply with the Duty of Candour?

1. Where a service user may have been harmed, or had the potential to be harmed, it is your duty to inform and discuss with your manager
2. Tell service users in a timely manner when incidents have occurred
3. Report the incident and actual level of harm on Datix (our incident reporting system). Doing so informs others, and allows the Trust to investigate and put measures in place to reduce the risk of future harm

More information about the Duty of Candour is in our Trust leaflet **'Duty of Candour and what it means to service users'** and the Trust Duty of Candour Policy.

Understanding You

What happens if the Trust fails to meet the standards required for the Duty of Candour?

Each failure to notify and report incidents in accordance with the Trust policy may result in our commissioners withholding the cost of the episode of care or implementing a fine of £10,000 if the cost is not known.

In addition, they can do any/all of the following:

- Send a report to the Care Quality Commission
- Require that the Chief Executive sends an apology and an explanation of the breach to the service user/relatives
- Publish details of the breach on the Trust website

Print Date: May 2015 IG7 www.glos-care.nhs.uk

Gloucestershire Care Services NHS
NHS Trust

Information for Colleagues

Duty of Candour and what it means to service users

Understanding You

What is Duty of Candour?

Candour means frankness, openness and honesty

Every health professional must be open and honest with service users. The Duty of Candour statutory regulations are in place to ensure that providers of healthcare are open and honest with service users when things go wrong with their care and treatment.

To meet the requirements of the regulations, when a safety incident occurs to which Duty of Candour applies, Gloucestershire Care Services NHS Trust must:

- Make sure it has an open and honest culture across and at all levels
- Tell service users in a timely manner when such incidents have occurred
- Provide in writing a truthful account of the incident and an explanation about the enquiries and investigations that the Trust will carry out
- Offer an apology in writing and record in the care record
- Provide reasonable support to the person after the incident.

The regulations apply to the service user themselves and, in certain situations, to people acting on their behalf, for example when something happens to a child - or to a person over the age of 16 - who lacks the capacity to make decisions about their care.

The Duty of Candour was one of the recommendations made by Robert Francis to help ensure that NHS organisations are open and honest about their actions and that incidents are properly reported - and ensures that service users are also told about them.

How can you ensure that you comply with Duty of Candour?

1. Where a service user may have been harmed, or had the potential to be harmed, it is your duty to inform and discuss with your line manager.
2. Tell service users in a timely manner when incidents have occurred.
3. Report the incident and actual level of harm on Datix (our incident reporting system). Doing so informs others, and allows the Trust to investigate and put measures in place to reduce the risk of future harm.

What we do to ensure that Duty of Candour takes place

For incidents that have led to moderate harm or severe harm and death:

1. We ensure service users and family are supported to deal with the consequences and have a named contact identified for the incident.
2. We ensure that the service user/family/service user representative is informed within 10 working days of an incident being identified to which Duty of Candour applies.
3. We ensure that the initial notification should be face-to-face and this is accompanied with an offer of a written notification.
4. We ensure an apology is provided and documented in the service user notes.
5. We ensure that a step-by-step explanation is offered as soon as possible pending the investigation.
6. We ensure full written documentation of all meetings are kept with the service user/family and filed in Datix for future reference.
7. We ensure full written documentation is kept of all staff interviews and meetings about the incident and filed in the incident/complaint account in Datix.
8. We ensure the final investigation is shared with the service user/family/service user representative.
9. The Trust's adherence to Duty of Candour will be monitored by the commissioners as part of our regular Quality Contract monitoring processes.

Gloucestershire Care Services NHS
NHS Trust

Finance Paper

Ref: 19/0515

This report is for Publication

Trust Board

Finance Paper

May 19th 2015

Objective:

To update the Board on the final full year figures for financial year 2014/15 and the budget position for 2015-16.

The Committee is asked to:

Note the contents of the paper

Executive summary:

The Trust achieved its 2014-15 plan in respect of Income and Expenditure performance and Capital Expenditure. The Trust closed the year with a cash balance of £2.8m.

Budget for 2015-16 remains as approved at the last Board meeting but with an additional cost pressure resulting from the depreciation charge on revalued asset being offset by additional CIP savings required of £650k.

Glyn Howells, Director of Finance
19/05/2015

☒	This paper requires no equality impact assessment as it does not propose changes to how people receive services or our colleagues' working lives.

Gloucestershire Care Services NHS
NHS Trust

Finance Report

GCS Board

19th May 2015

Understanding You

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Introduction

- It is intended that from Financial Year 2015-16 that the Quality Report will include Finance reporting, this report has been prepared in the same format so that Board can see how this will look and provide feedback.
- Overall, the Trust has achieved the planned financial outturn of £1.5m surplus in line with plan; spent £3.9m against the adjusted capital expenditure target of £4.0m and had a year end cash balance of £2.8m.
- Looking forward, the Trust has submitted a plan with income of £106.5m, a surplus of £0.1m which includes the delivery of:
  - QIPP £3.9m
  - CQUIN £1.9m
  - CIP £3.15m (this has increased due to the impact of depreciation on revalued assets which is discussed on page 4)

Income and Expenditure

- The Trust achieved income of £2.9m more than plan including £2.0 CQUIN and £3.9m QIPP. The increase over plan was due to higher than plan spend on the rollout of the Rapid Response teams which the CCG has funded at cost until a business case is approved.

- Costs were broadly in line with plan other than three main areas:
  - Additional costs incurred against rapid response rollout which were recovered from the commissioner (£2.0m)
  - Higher agency spend which was offset by releases in reserves (£3.5m)
  - Additional depreciation charges as a result of assets being revalued at the previous year end. This was offset by some non recurrent accounting adjustments including the capitalisation of IT equipment and moving a level of stock onto the balance sheet. This creates a recurrent cost pressure which means that CIPs for the 2015-16 plan have needed to be increased to £3,150k).
- Overall the Trust achieved its planned surplus of £1.5m

£000s

	Actual	Plan	Variance
Income	(114,130)	(111,167)	2,963
Pay	82,003	79,279	(2,724)
Non-Pay	30,619	30,388	(231)
Total Cost	112,622	109,667	(2,955)
(Surplus) / Deficit	**(1,508)**	**(1,500)**	**8**

Capital Expenditure

Gloucestershire Care Services NHS Trust

- The Trust spent £3,864k against the adjusted plan (agreed with the TDA) target of £4,000k. Of note is the acquisition and development of the Milsom Street Clinic which will open for services in June 2015 and provides a Trust owned centre in Cheltenham for our Sexual Health services which were previously housed in GHFT sites and also will provide a Cheltenham base for a newly commissioned lower limb service.
- The planned receipt for disposal of land relates to the site that the "old" Tewkesbury hospital occupied. This is being sold to provide a site for a large GP development. Delays in completing the re-levelling of the site, post demolition, resulted in this sale slipping into 2015-16. This is expected to complete in the next month.

			£000s
	Actual	**Plan**	**Variance**
Backlog Maintenance Programme	0	256	256
Premises and Plant refurbishments 2014/15	1,725	1,765	40
Premises and Plant refurbishments 2016 Onwards	0	0	0
Medical - Equipment	310	530	220
Community Health System	0	500	500
IM & T	832	1,795	963
Furniture and Fittings | 10 yr Items		53	53
New property for countywide services	997	1,500	503
Receipt for disposal of Land		**(600)**	**(600)**
Reduction in capital agreed with TDA		**(1,800)**	**(1,800)**
Total Capital Spend	**3,864**	**4,000**	**136**

Cash Position

- The Trust closed the year on a cash balance of £2,812k this was £2,529k worse than plan due to late agreement in Month 12 amounts to be invoiced with the CCG. This was in accruals at month end but has since been paid. Cash balance as at the end of April was £9.8m after paying April salaries.

2015-16

Gloucestershire Care Services NHS Trust

Budget

- The budget for 2015-16 remains as approved at the previous Board Meeting with a slight change reflecting the impact of the additional £650k of depreciation on revalued assets. The impact of this caused our recurrent deficit to move from £353k to £1,003k, this has been countered by an additional CIP scheme of £650k to be delivered in year to offset this. This additional scheme is the revaluation of all of our assets by a commercial land agent to assess the revaluation element of our asset values and put a true realisable value on our asset base. Performance against this CIP will be reported monthly alongside the other CIP schemes.

- This budget include the delivery of £1,944k CQUIN, £3.9m QIPP and (allowing for the additional scheme mentioned above) of £3,150k.

	£000s
2015-16	**Budget**
Income	(106,479)
Pay	79,250
Non-Pay	27,129
Total Cost	106,379
(Surplus) / Deficit	**(100)**
Capital Expenditure	5,850
Closing Cash Balance	5,485

Contracts

- GCS has agreed and signed contracts in place for all commissioned services with the following exceptions:
  - The level of inflation / cost saving needed on the base contract for services provided to the local authority
  - Health Visitor funding from 1st October when responsibility transfers to the local authority.

  These are both being discussed at a meeting with the local authority on Monday 18th May and an update will be given at Board.

HR & OD Committee Annual Statement 2014/15

This Annual Statement is a report on the activities and accomplishments of the HR & OD Committee for the reporting period 1st April 2014 to 31st March 2015, together with anticipated developments during the next twelve months. The statement is therefore intended to provide the Trust Board and other interested parties and stakeholders with information about the past work of the Committee and its future direction. Of significance to this Committee is the consideration of how as a Trust we are achieving our strategic objective to:

Support individuals and teams to develop the skills, confidence and ambition to deliver our vision.

The overall aim of the Committee is to provide the Board with assurance in respect of all aspects of workforce strategy, planning and organisational development, in order that the organisation may be able to achieve exemplar clinical and professional outcomes and experiences for local service users and Trust colleagues. The Committee has particular responsibility for making significant contribution towards the realisation of a supporting and learning organisational culture that promotes the Trust's CORE values of being Caring, Open, Responsible and Effective.

1. Organisational Development Strategy - Progress in 2014/15

There are a number of key performance indicators that can be used to monitor the effectiveness of the OD strategy. A dashboard has been developed to monitor progress for 2015/16 and this was shared with the Board in March 2015.

The following NHS staff survey results confirm that steady progress has been made during 2014/15 but that further improvement is required as the Trust benchmarks slightly below the national average for Community Trusts in a number of areas:

- The overall staff engagement score for the Trust has improved from 3.71 in 2013 to 3.73 in 2014 (the higher score the better out of a total score of 5). The national 2014 average for Community Trust is 3.75
- Staff job satisfaction has improved from 3.57 in 2013 to 3.64 in 2014 (the higher score the better out of a total score of 5). The national 2014 average for Community Trust is 3.67
- Staff recommending the Trust as a place to work or receive treatment remained at 3.61 (the higher score the better out of a total score of 5). The national 2014 average for Community Trust is 3.66
- Staff motivation at work has improved from 3.87 in 2013 to 3.89 in 2014 (the higher score the better out of a total score of 5) and is above the national 2014 average for Community Trust which is 3.87

The following pulse check results confirm that the Listening into Action Programme has had a positive impact on the culture of the organisation. Improvement was seen across all questions which were asked at the launch of the programme in February 2014 and again in December 2014:. Examples being:

- I feel happy and supported in my team/department/ service – improved from 42% to 58.25%
- Our organisational culture encourages me to contribute to changes that affect my team/ department/ service - improved from 28.29% to 45.75%
- I feel valued for the contribution I make and the work that I do - improved from 31.94% to 45.52%
- I would recommend our Trust to my friends and family – improved from 45.35% to 56.25%

Listed in the table below are the key accomplishments achieved and/or overseen by the Committee in 2014/15. These show clear alignment to the existing Terms of Reference and are intended to demonstrate how these achievements have fulfilled delegated responsibilities; in particular the Committee's focus on the priority organisational development activities:

Table 1: Organisational Development Strategy Key achievements

OD Strategy Quality Goal	Key Achievements in 2014/15
To embed the Trust's core values across the organisation, ensuring that these are reflected in behaviours, and are used to inform and support the growth of the Trust's culture.	The development of a staff engagement plan following feedback from a number of workshops and engagement events held across the Trust. The development of a staff behaviour framework linked to the Trust's Core Values. The development and implementation of a new corporate induction programme which incorporates the Trust's vision, values and strategic objectives. The development, and embedding, of the ambition of the strapline "Understanding You" to support the Trust's visual identity.
To maintain a supportive and learning culture, that emphasises the importance of team working to achieve common goals, and then shares the results of actions so as to improve future performance and outcomes.	The implementation of year one of the Listening into Action Programme which has seen improvement in all 15 areas of the pulse check. The development of service plans across the Trust which includes clarity on the aims of the service and the outcomes they plan to achieve. The development and launch of a trust wide performance management framework. The development of competency frameworks for Community Nursing, Health Visiting, Reablement and Social work. The undertaking of a skills audit for Community Nursing. The development and implementation of a Clinical Strategy including the establishment of a Clinical Senate and Clinical &

OD Strategy Quality Goal	Key Achievements in 2014/15
	Professional Leadership structure.
To increase the capacity and capability of leadership across the Trust, encouraging corresponding behaviours in colleagues.	The development and implementation of a comprehensive Board Development Programme. A programmed approach to NHS Change Day in 2014 which included Executive Team participation. The launch of the Leading for Quality Care programme for 96 participants. The release of 28 colleagues to participate in national NHS Leadership Academy programmes. The establishment of the monthly GCS Leadership meeting chaired by the Chief Executive Officer. A network of action learning sets established within the Trust (supported through the Leading for Quality Care programme).
To support, encourage and motivate colleagues, and elicit their direct involvement with, and positive contribution to, all relevant Trust planning and decision-making.	A staff award scheme held in May 2014 with categories based on the Trust's core values. The review of staff engagement activities for effectiveness which helped inform the staff engagement plan. Meet the Chair & Chief Executive events held on a quarterly basis. Understanding You events planned for March & April 2015. Annual General Meeting held in October 2014 with an open invitation to colleagues.
To ensure that the Trust responsibly promotes Human Rights, challenges all discrimination and ensures appropriate equity in service delivery and employment .	Equality impact assessment template updated and combined with the quality impact assessment. Equality reports published in January 2014 and 2015. Equality objectives published in April 2014. Equality Steering Group established to take forward the equality objectives.

2. Organisational Development Strategy Priorities for 2015/16

Table 2: The Committee has identified the following priorities for 2015/16

OD Strategy Quality Goal	Actions carried forward to 2015/16	Additional Priority Actions for 2015/16
To embed the Trust's core values across the organisation, ensuring that these are reflected in behaviours, and are used to inform and support the growth of the Trust's culture.	Booklet to be developed to provide a summary of the Trust's key strategies. Recruitment and Selection Policy to be updated to embed the Core Values Framework and to support values based recruitment. Recruitment & Selection workshops to be held for recruiting managers. Job description template to be updated to include core values framework.	Embed the CORE Values Framework in key organisational policies, procedures and practices. Further develop coaching cards to support the roll-out of the framework. Test updated documentation & processes in five teams. Revise documentation according to feedback. Launch CORE Values Framework to all colleagues by way of a booklet and covering letter. Link CORE Values Framework to Pay Progression Policy and appraisals.
To maintain a supportive and learning culture, that emphasises the importance of team working to achieve common goals, and then shares the results of actions so as to improve future performance and outcomes.	Colleagues involved in the development of service plans. Team objectives and scorecards in place for all teams/services. Review all service specifications as part of the business planning cycle.	Launch Year Two of the Listening into Action Programme – "the year of tough love". Link LIA initiatives with OD/cultural change. Ensure further saturation of LIA across the organisation by supporting more teams to make change and by holding further pass it on events. Further embed the Team Development Framework across the Trust through service development and operational planning cycles.
To increase the capacity and capability of leadership across the Trust, encouraging corresponding behaviours in colleagues.	Create a library of competency frameworks for all staff groups/services. Develop action plan to improve the quality and completion rates of appraisals and mandatory training.	Undertake a Trust wide management capability and capacity review and submit a report to Workforce & OD Committee with recommendations. Undertake skills audit and training needs analysis for all staff groups against the NHS Leadership Competency Framework.

OD Strategy Quality Goal	Actions carried forward to 2015/16	Additional Priority Actions for 2015/16
	Develop and implement a Talent Management Policy.	Develop leadership and management development programme based on skills gap.
To support, encourage and motivate colleagues, and elicit their direct involvement with, and positive contribution to, all relevant Trust planning and decision-making.	Review Organisational Change Policy and Process.	Develop Staff Engagement Plan for 2015/16 based on the findings of the review of engagement activities.

3. Workforce Development Strategy – Progress in 2014/15

There are a number of key performance indicators that can be used to monitor the effectiveness of the Workforce strategy. A dashboard has been developed to monitor progress for 2015/16 and this was shared with the Board in March 2015.

The workforce scorecard as at 1st March 2015 shows that performance has deteriorated in the following areas since 1st April 2014 and these will remain a priority for 2015/16:

- Sickness absence has increased from 4.28% to 4.92%
- Turnover has increased from 11.71% to 14.65%
- Appraisal completion rates has decreased from 80% to 73%
- Health and Safety mandatory training compliance rates (which incorporates infection control) have decreased slightly from 88% to 86%

The scorecard shows that improvements have been made in the following mandatory training areas:

- Fire safety compliance has increased from 57% to 63%
- Equality and diversity compliance has increased from 50% to 77%
- Information Governance compliance has increased from 25% to 68%
- Conflict resolution compliance has increased from 66% to 77%

Listed in the table overleaf are the key accomplishments achieved and/or overseen by the Committee in 2014-15. These show clear alignment to the existing Terms of Reference and are intended to demonstrate how these achievements have fulfilled delegated responsibilities; in particular the Committee's focus on the priority workforce risks:

Table 3: Workforce Development strategy – key achievements

Workforce Strategy Quality Goal	Achievements
To ensure improved workforce planning so as to make optimum use of the Trust's most valuable resource.	Annual service planning cycle undertaken and overseen by the Transformation and Change Team. Development of an organisational level workforce plan (based on the Trust's long term financial model). Development and implementation of a Performance Management Strategy. Implementation of the e-rostering system in three test sites. Plan in place to implement the system across all Community Hospitals and Integrated Community Teams by March 2016.
To improve recruitment processes so as to enable the Trust to attract and retain a strong and stable workforce.	All aspects of the recruitment process reviewed with the length of time taken from recruitment requisition to start date reduced by 17 days. Action plan developed to maintain the Two Ticks and Mindful employer accreditations. Procedure for managing leavers updated to include guidance for managers. Workforce scorecard updated to include analysis of the reasons for leaving.
To ensure that the Trust provides appropriate support and development for all colleagues, empowering them to reach their full potential, whilst representing the Trust's values and helping achieve the organisations strategic objectives.	New corporate induction programme. New clinical induction programme. New preceptorship programme. 10 students supported through the Return to Practice programme. Rollout of management skills workshops.
To deliver robust governance systems that effectively support the Trust's workforce.	Improved workforce information provided through updated dashboards and scorecards. Audit of safer recruitment practices undertaken.
To encourage colleagues to remain healthy, so that they are best able to provide high quality services.	Dedicated resource in HR identified to support managers with sickness absence cases. Attendance management workshops held with managers. Capital funding obtained to purchase an on-line case management system and resource centre for

Workforce Strategy Quality Goal	Achievements
	managers.
To further develop the trusts HR function, so as to provide responsive, accurate and streamlined services that benefit the organisation's operations.	Independent review of the HR Directorate undertaken resulting in the restructuring of the service around transactional, operational and transformational HR functions.

4. Workforce Strategy Priorities for 2015/16

A comprehensive review of the workforce was undertaken in June 2014 which helped inform the priorities for the strategy and implementation plan. As a reminder the following hotspots and priorities were identified:

Table 4: Hotspots and Priorities for September 2014 to March 2016

Hotspot	Priorities for September 2014 to March 2016
Limited workforce information for GCC staff.	Joint workforce plan to be developed and implemented.
Contingent workforce plan.	Contingent workforce plan to be developed and linked to service plans and the overall Trust workforce plan. Review and rollout of the of the e-rostering system across the Trust. Bank Administration IT system to be determined (i.e. is the E-rostering module fit for purpose).
74% of Nursing Staff aged 40 or over.	HR Policies to be reviewed to support ageing workforce. i.e. Flexible Retirement. Staff incentives and benefits to be reviewed to support ageing workforce. Career progression/succession planning framework to be developed and implemented.
60% of workforce on part-time contracts.	Cost and benefits review to be undertaken of part-time workers to inform future policy.
Sickness Absence rate above target rate of 3%.	Review of current Occupational Health Services. Review of Employee Assistance Programme. Development of on-line toolkit for managers.

Hotspot	Priorities for September 2014 to March 2016
	Sickness absence KPI's to be incorporated in objectives for managers.
26% of total sickness absence calendar days lost due to stress/ anxiety/ depression.	Development and implementation of a healthy workforce plan. Review of Stress Management Policy. Stress Management workshops for Managers. Development of fact sheets for managers and staff.
Ethnicity of workforce not representative of local community.	Recruitment & Selection Policy and Procedure to be reviewed.
Time taken from advert to start date.	Implementation of electronic DBS checks. Review of recruitment process – i.e. central recruitment rather than one advert per vacancy.
Hard to recruit roles – Qualified Nursing & Allied Health Professionals.	Recruitment & Selection Policy and Procedure to be reviewed. Career progression/ succession planning framework to be developed and implemented.
Mandatory Training Rates below target rate of 95%.	Training and education function within the Trust to be reviewed (currently split by clinical & non-clinical). Mandatory Training KPI's to be incorporated in objectives for managers and individuals. Mandatory Training matrix to be reviewed.
Appraisal completion rate below target of 95%.	Appraisal completion rate KPI to be incorporated in objectives for managers and individuals. Review of appraisal process/e-appraisal. Review of competency frameworks. Further revision of Pay Progression Policy.

A further review of hotspots will be undertaken by the Committee in June 2015 through the annual workforce report.

Signed by: Nicola Strother Smith, Committee Chair

Dated: April 2015

Gloucestershire Care Services NHS
NHS Trust

Workforce & OD Committee

Ref: 20/0515

This report is for Publication

Workforce & Organisational Development Committee Report

19th May 2015

Objective:

The objective of this report is to provide the Board with an overview of the key agenda items considered by the Workforce & OD Committee at its meeting held on 13th April 2015.

The Board is asked to:

- Note the actions being taken to mitigate the key workforce and organisational development risks

Executive summary:

In order to seek assurance regarding the key workforce and organisational development risks, the agenda items considered by the Workforce & OD Committee at its April meeting were:

- Nurse recruitment and retention update
- Workforce Strategy Review – summary of achievements in 2014/15 and priorities for 2015/16
- Organisational Development Strategy Review – summary of achievements in 2014/15 and priorities for 2015/16
- Staff Engagement Plan for 2015/16
- Listening into Action Review – summary of achievements in 2014/15 and priorities for 2015/16

Whilst some progress has been made in attracting new staff to the Trust significant challenges remain, particularly with regard to Band 6 Nurses into Community Nursing posts and Band 5 Staff Nurses into Community Hospital inpatient unit roles. Positively the number of nurses leaving has reduced since January 2015 however turnover rates are closely monitored to identify trends and/or hotspots.

The workforce scorecard shows that performance has deteriorated with regard to sickness absence, mandatory training compliance and appraisal completion rates since 1st April 2014 and these will remain a priority for 2015/16.

The NHS staff survey results for 2014 confirm that steady progress has been made against the Organisational Development Strategy during 2014/15 but that further improvement is required as the overall results are slightly below the national average for Community Trusts.

A summary of the progress made against each of the strategies and priorities for 2015/16 can be seen in the Committee's Annual Statement in appendix one.

The Committee has requested regular "deep dive" reports to be submitted on workforce hotspots. At its June meeting the Committee will review the "deep dive" into appraisal rates and sickness absence.

Nicola Strother Smith

Please select one of the following options:

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

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

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

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

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

Workforce & Organisational Development Committee Report

1.0 Introduction

As a reminder to the Board, the high impact risks (scoring 12 or above) as detailed in the corporate risk register are:

Reference	Risk Title/ Theme	Current Risk Rating
SD1-ICT	Community Nursing staffing pressures	12
SD3-ICT	Occupational Therapist & Physiotherapist vacancies	12
SD10-CWS	Senior Management vacancies with Sexual Health Services	16
ST1-CH	Community Hospital Staffing Levels	16
HR1- 414	Contingent workforce strategy	12
HR2- 433	Early alert system re-staffing levels	15
HR3 - 409	Nurse recruitment and retention	16
HR4 - 413	Workforce plan across health and social care	12
HR5 - 404	Sickness absence rates	12

In order to seek assurance regarding these risks the key agenda items considered by the Workforce & OD Committee at its April meeting were:

- Nurse recruitment and retention update
- Workforce Strategy Review – summary of achievements in 2014/15 and priorities for 2015/16
- Organisational Development Strategy Review – summary of achievements in 2014/15 and priorities for 2015/16
- Staff Engagement Plan for 2015/16
- Listening into Action Review – summary of achievements in 2014/15 and priorities for 2015/16

2.0 Nurse Recruitment & Retention Update

Nurse recruitment continues to be a key priority for the Trust. Whilst some progress has been made in attracting new staff significant challenges remain, particularly in recruiting Band 6 Nurses into Community Nursing posts and Band 5 Staff Nurses into Community Hospital inpatient unit roles.

For the period of August 2014 to the end of February 2015, targeted recruitment activity resulted in 116 offers being made to qualified nurses, whilst 19 of the offers were subsequently declined. Of the total offers made, 29% of candidates were already known to the Trust (i.e. the appointments were internal promotions and transfers or in the large proportion of cases appointment to substantive posts from bank positions).

The effect of this is that in Community Nursing, for the same period, across both band 5 and 6 posts there has been a 46% reduction in vacancies and for Community Hospital the reduction has been less but positively still 33%. However, when looking at the roles in isolation Band 6 Community Nurses vacancies have increased for this period and there has been no significant impact on Band 5 Staff Nurse posts in Community Hospitals.

Whilst the overall vacancy rate has reduced, retention continues to be an issue with 47 qualified nurses leaving the Trust in the same period. Positively the number of nurses leaving has reduced since January 2015.

The Committee reviewed an action log which detailed the actions that are being taken to reduce the above risks and to highlight progress against the five quality goals:

1. Recruit to Establishment Levels
2. Reduce Nurse Turnover
3. Reduce Agency Spend
4. Improve time taken to recruit
5. Reduce Sickness Absence Levels

3.0 Workforce Strategy Review – summary of achievements in 2014/15 and priorities for 2015/16

The workforce scorecard shows that performance has deteriorated in the following areas since 1st April 2014 and these will remain a priority for 2015/16:

Sickness absence has increased from 4.28% to 4.92%
Turnover has increased from 11.71% to 14.65%
Appraisal completion rates has decreased from 80% to 73%
Health & Safety mandatory training compliance rates (which incorporates infection control) have decreased slightly from 88% to 86%

However improvements have been made in the following mandatory training areas:

Fire safety compliance has increased from 57% to 63%
Equality & diversity compliance has increased from 50% to 77%
Information Governance compliance has increased from 25% to 68%
Conflict resolution compliance has increased from 66% to 77%

A summary of the progress against the strategy in 2014/15 and priorities for 2015/16 can be seen in the Committee's Annual Statement in appendix one**.**

4.0 Organisational Development Strategy Review

The NHS staff survey results for 2014 confirm that steady progress has been made against the Organisational Development Strategy during 2014/15 but that further improvement is required as the Trust benchmarks slightly below the national average for Community Trusts.

- The overall staff engagement score for the Trust has improved from 3.71 in 2013 to 3.73 in 2014 (the higher score the better out of a total score of 5). The national 2014 average for Community Trust is 3.75
- Staff job satisfaction has improved from 3.57 in 2013 to 3.64 in 2014 (the higher score the better out of a total score of 5). The national 2014 average for Community Trust is 3.67
- Staff recommending the Trust as a place to work or receive treatment remained at 3.61 (the higher score the better out of a total score of 5). The national 2014 average for Community Trust is 3.66
- Staff motivation at work has improved from 3.87 in 2013 to 3.89 in 2014 (the higher score the better out of a total score of 5) and is above the national 2014 average for Community Trust which is 3.87

A summary of the progress against the strategy in 2014/15 and priorities for 2015/16 can be seen in the Committee's Annual Statement in **appendix one.**

5.0 Staff Engagement Plan

The Head of Corporate Planning presented a draft staff engagement plan to the committee, which included the following planned activities for 2015/16:

- Celebrating You Awards
- Ensuring the new intranet site supports a more engaged workforce
- Testing and rolling out the Core Values Framework
- Increasing the use of social media across the organisation as a communication channel
- Reviewing how team meetings are delivered to ensure they can become truly supportive, engaging and two-way
- Implementing the Team Development Framework across the Trust
- Holding a series of staff focus groups throughout the year on key topics and issues
- Review the effectiveness of Staff Forums
- Hosting a "Leadership Conference" in June to celebrate the work that over 350 colleagues have completed this year, and to share learning and best practice across the Trust, encouraging other colleagues to be more involved in their service area
- Increase visibility of executive team across the organisation
- Supporting the development of 'The Pulse', a leadership electronic portal where colleagues can share best practice and host discussion groups

- Understanding you staff engagement events
- Create and continue to support a network of communications and engagement champions across the organisation
- Explore the opportunities to undertake a programme of regular surveys by text message
- Annual General Meeting (AGM)
- Service Change Consultation
- Foundation Trust consultation

6.0 Listening into Action Review – summary of achievements in 2014/15 and priorities for 2015/16

The latest pulse check results confirm that the Listening into Action Programme has had a positive impact on the culture of the organisation. Improvement was seen across all questions which were asked in February 2014 at the launch of the programme and again in December 2014. Examples being:

- I feel happy and supported in my team/department/ service – improved from 42% to 58.25%
- Our organisational culture encourages me to contribute to changes that affect my team/ department/ service - improved from 28.29% to 45.75%
- I feel valued for the contribution I make and the work that I do - improved from 31.94% to 45.52%
- I would recommend our Trust to my friends and family – improved from 45.35% to 56.25%

Although there was a fundamental shift in all areas there is significant room for improvement (SRFI) in the two worst performing areas, which were consistent with the staff survey results. These two areas will be the priority for year two of the programme:

Q4:Day-to-day issues and frustrations that get in our way are quickly identified	15.26%(P1)	29.01 %(P2)	+13.75%	*70.99% (SRFI)*
Q10: Communication between senior management and staff is effective	17.87%(P1)	26.65%(P2)	+8.78%	*73.35% (SRFI)*

The plans for year two of the programme include:

- Continuing to focus on quality, patient experience “enabling and unblocking”
- A ‘refreshed’ sponsor group – ‘grass roots’ approach

- Further ‘Pulse Check’ to compare baseline results
- The year of “tough love”
- ‘Call to Action’10 pioneering clinical teams, enabling our people schemes and further ‘Quick Win’ ideas
- 6 Big Conversations, themed from the ‘Understanding You’ events
- A further ‘Pass it on’ event

Minutes of the CQC Inspection Programme Board

Meeting held 30 April 2015

Present:

Paul Jennings (PJ), Chief Executive (Chair)
Glyn Howells (GH), Director of Finance
Sue Mead (SM), Non-Executive Director
Liz Fenton (LF), Director of Nursing and Quality
Jason Brown (JB), Director of Corporate Governance and Public Affairs
Candace Plouffe (CP), Director of Service Delivery
Tina Ricketts (TR), Director of Human Resources
Rod Brown (RB), Head of Corporate Planning

In attendance: Louise Simons (LS) Minute Taker

Item	Minute	Action
1.	**Welcome and Apologies** The Chair welcomed everyone Apologies **received** from Duncan Jordan, Chief Operating Officer, Susan Field, Director of Service Transformation, Dr. Jo Bayley, Medical Director and Dr. Mike Roberts, Interim Medical Director.	
2.	**Minutes of the previous meeting** Subject to minor amends, the minutes of the meeting held 2 April 2015 were **approved.** **PJ agreed that no risk register would be required due to the Issues Log at item 6 covering this area.**	
3.	**Project Plan** RB discussed the project plan in detail, to whit the following issues were raised and addressed: • it was noted that the CQC planning meeting had been rescheduled to 11 May from 12 May; • the weekly planning calls with the CQC are to be added to the plan: these are attended by LF and RB; • the CQC enquiries regarding consultant-led beds and inpatient units were noted (ref 4.5 and 4.6 on the project plan); • it was noted that PwC had now confirmed the attendance of Kate Beaumont on the Unannounced Quality Assessment of Stroud Hospital on 12 May;	RB

	• in respect of the Day 0 presentation, PJ noted that Mark Lambert had been asked to provide designs and concepts; • in terms of feedback from the Unannounced Quality Assessments, PJ suggested that LF's team should support Jules Roberts in addressing key areas of concern, albeit with clear recognition that not all areas identified as requiring improvement will be rectified within the timescales; • PJ raised concerns that much of the workload within the plan was attributed to RB: PJ and RB to discuss outside of the Programme Board meeting .	PJ/ML LF/RB/JR PJ/RB
4.	**PwC Internal Audit ToR** The Terms of Reference for the PwC internal audit in preparation for the CQC inspection, was provided to the Programme Board for **information and was noted** LF asked for confirmation that Kate Beaumont would not have access to patient records or notes during her mock inspection: RB to confirm this with PwC. It was noted that the combined results from the PwC visit, and the interrogation of Trust data, would be available for initial review on 22 May.	RB
5.	**Unannounced Quality Assessments** RB provided the most up-to-date schedule of Unannounced Quality Assessments. LF confirmed that the Infection Control lead for the TDA would be visiting the Trust on 20 May	
6.	**Issues Log** PJ requested that the most recent version of the Issues Log be uploaded to BoardPad In terms of those issues previously discussed at the Executive Meeting on 23 April, PJ to speak with Bev Samuels who captured all the actions: these then to be circulated to colleagues PJ asked for an outline of the process following each Unannounced Quality Assessment. RB confirmed that verbal feedback was given on the day of the Assessment to the senior member of the team on duty. Written feedback would subsequently be provided, copied also to the Head of Service, with a request to complete an action plan within 2 weeks. Members agreed that they did not want to receive sight of actions arising from visits: rather, they wanted to wait for each service's action plan (these to be shared at future Programme Board meetings)	LS PJ/BS RB

	SM asked if any overall themes were emerging from the visits: RB confirmed that most services were demonstrating safe, effective, responsive and caring, but that well-led was a challenge, particularly in terms of staff not understanding Trust-wide strategy, plans or governance structures. GH noted that some of the issues regarding colleagues' lack of understanding of support services could be easily rectified and agreed to speak to the Communications Team to arrange some simple messaging around who staff should contact if they have an issue with IT, estates etc.	RB GH
7.	**Any Other Business** LF noted that the Quality Summit for GHT was now scheduled for 18 June. PJ reported that staff are feeling increasingly anxious about the upcoming visit, and some reassurance is needed. RB to address this through the CQC Office global emails	RB
8.	**Next Meeting** 14 May 2015 in the Boardroom, EJC	

Notes of the meeting on 11 May (*updated*)

CQC attendees: Bernadette Hanay (BH), Amanda Eddington (AE), Carl Beech (CB)

Trust attendees: Liz Fenton (LF), Candace Plouffe (CP), Annie MacCallum (AM), Rod Brown (RB)

Introductions were made and BH explained that she would be handing over to AE who would be the Lead Inspector for the Trust. The purpose of the meeting was to support planning for the forthcoming inspection, complementing the weekly conference calls.

Inspection Teams

BH confirmed that the following teams would be on-site for the inspection:

- In patients — 3 teams visiting all the community hospitals (3 on Wednesday, 3 on Thursday and 1 on Friday)
- Theatres — A specialist advisor in relation to theatre who will be mindful of the GCS/GHT interface
- Urgent care — 1 team looking at 4 MIIUs only, with possible fifth or revisit
- Comm adults — 2 teams focused largely on DNS and specialist nursing
- CYP — 2 teams (will incorporate end of life): will include health visitors, school nurses, specialist nurses etc
- End of Life — 1 team across hospitals and community
- Sexual Health — 1 team
- Dentistry — 1 or 2 teams (TBC)

Actions:

- Provide a theatre list for the 24-26 June (RB)
- Provide analysis of MIIU activity: preparing breakdown of April (RB / SF)
- Provide up-to-date schematic of locality teams (CP)
- Provide telephone contacts for community-based service users who are happy to provide feedback to the CQC (CP)

- Provide details of adult community appointments where service users have given consent to CQC attending during 24-26 June (CP)

- Confirm preferred specialist services (suggested as homeless healthcare, IV Therapy, Diabetes, Heart Failure and Respiratory)

- Provide activity for CYP services for 24-26 June (including clinics and homes) (RB)

- Provide details of CYP community appointments where consent has been given to CQC attending during 24-26 June (CP)

Board Interviews

These are to be proposed to the CQC as follows:

- Tuesday 16 June — Glyn Howells at 10.00am

- Thursday 25 June — Jason Brown at 8.30am
  Mike Roberts at 9.45am
  Susan Field at 11.00am
  Liz Fenton at 12.30pm
  Tina Ricketts at 3.00pm
  Duncan Jordan at 4.15pm

- Friday 26 June — Liz Fenton at 8.00am
  Paul Jennings at 9.00am
  Sue Mead at 10.00am
  Ingrid Barker at 11.00am
  NED focus group (excl Ingrid) 12.00pm

- Thursday 2 July — Candace Plouffe at 1.00pm

1-2-1 staff interviews

Need to propose a list of other staff to be interviewed to include leads for:

- Complaints
- PALS
- Clinical governance
- Safeguarding
- Tissue viability
- Infection control

Focus Groups

Looking at approximately 13-14 across the county – these will be open to all staff but the CQC may choose to subdivide

Actions:

- Provide proposals for sites of focus groups (all 7 community hospitals either 9-10am or 3-4pm plus 2 EJC and others TBC)
- Provide list of team meetings weeks commencing 8 and 15 June which the CQC may choose to attend (RB)
- Propose Leadership Meeting (18 June)

Minutes of the CQC Inspection Programme Board

Meeting held 2 April 2015

Present:

Glyn Howells (GH), Director of Finance (Chair)
Sue Mead (SM), Non-Executive Director
Liz Fenton (LF), Director of Nursing and Quality
Mike Roberts (MR), Interim Medical Director
Duncan Jordan (DJ), Chief Operating Officer
Candace Plouffe (CP), Director of Service Delivery
Rod Brown (RB), Head of Corporate Planning
Louise Simons (LS) Minute Taker

In attendance: Louise Simons (LS), Kay Searle (KS), Minute Takers

Item	Minute	Action
1.	**Welcome and Apologies** It was noted that in the absence of Paul Jennings (PJ), GH would chair. The Chair welcomed everyone Other than PJ, apologies were received from Tina Ricketts (TR), Jason Brown (JB) and Sue Field (SF)	
2.	**Introduction – Key dates and timelines** LF provided an overview of the dates / timeline, namely: • 12 May - visit by the CQC Lead Inspector to inform planning of the community services visits *(since changed to 11 May)* • 20 May - TDA Infection Control Lead visiting Trust • 26 May - draft data pack to be shared with the Trust • 5 June - final data pack published • 23 June - Day Zero - inspection team in the county for training/ planning • 24-26 June - announced inspections • 27 June - 13 July - unannounced visits • 12 August - inspection report to be presented to the national panel	

	• 20 August - report to be received by the Trust to check for factual accuracy • 20 Aug - 4 September - appointment with the CQC Lead Inspector to discuss factual accuracy (date TBC) • 21 September - Quality Summit • 22 September - report published on CQC website / Trust Board meeting LF then described her meeting with Mary Cridge, the CQC Lead Inspector, attended also by PJ. LF confirmed that Day Zero was 23 June – this is the date upon which the Trust must give its 30 minute opening presentation. LF also confirmed that there would be approx. 30/35 inspectors who will be onsite from early morning on 24 June to lunchtime on the 26 June. LF and RB stressed that the Inspectors could still turn up announced for up to 2 weeks following the inspection, taking us up to 13th July. RB was asked to include this message in a future communication from the CQC Office email address. LF confirmed that the Quality Summit to be held on 21 September will be in two parts, hosted by the CQC and the TDA respectively. The final report will then be published on 22 September (which is the same day as the Trust Board meeting). RB explained that a control room had been planned for the Inspectors' use at EJC. Similarly, that rooms had been reserved at locations across the Trust. GH asked that discussions with IT about wifi access in these rooms be brought forward so as to allow sufficient time for planning and preparation. There was discussion about leave allowances over the period of the inspection. However, RB explained that should a Team Manager be on leave whilst the inspection is taking place, then their deputy would need to be fully briefed. RB also confirmed that key staff (i.e. the performance and information team) had been asked not to take leave over the weeks 15 and 22 June.	RB RB
3.	**Project Plan** RB discussed the project plan at length. There was focused discussion around response to formal data requests – GH noted that RB should be given flex within his diary to allow time for scrutiny and assessment of returns. Due to PwC suggesting that they could not support the mock inspections, DJ suggested looking for alternatives. RB was asked to liaise with Mark Parsons for a programme of works.	RB RB
4.	**Staff Engagement**	

	Understanding You Events - RB explained that KS was currently collating feedback from all the Understanding You events across the county. Opinion was that the Executive Team needed to have oversight of this feedback, in order to ensure that adequate response was being cascaded to attendees, so as not to disillusion staff or discourage them from attending or contributing to future events. This to be added as an agenda item to next the Executive Meeting Leadership workshops – these workshops, that were requested for Band 7s in the ICTs and Community Hospitals, are now forming part of the Leadership Conference being held at Cheltenham Chase Hotel on 2 June.	RB
5.	**Unannounced Quality Assessments** RB provided the most up-to-date schedule of Unannounced Quality Assessments. RB confirmed that Healthwatch Board Members were now to attend all 7 community hospital visits, and that the TDA would attend at least 2 visits. It was requested that all Executive Directors be added to the list of attendees. RB explained that an adapted version of the Salford Model was going to be used by the core clinical team at each assessment (tailored by setting), and that an adapted version of the 15 Step Challenge would be used by guests. RB confirmed that he was working on the documentation, and that individual invitations would go out to teams in advance of each visit.	RB RB
6.	**Formal requests** RB confirmed that he was currently finalising the information returns for Mary Cridge and the main CQC team, both of which were due for submission on 7 April.	RB
7.	**Key Risks & Issues** Estates – there are currently 21 issues to be addressed: Mark Parsons has set up a separate log to manage these. Policies – it was agreed that not all policies should be updated, only those that are critical / overdue. Baseline audits – these are to be shared with the relevant clinical teams ahead of each unannounced quality visit.	RB
9.	**Any Other Business** • GH asked that a CQC Risk Register be established • Members asked that an additional meeting be set up before the next planning meeting on 14 May	RB RB
10.	**Next Meeting**	

	Since confirmed as 30 April 2015 at 4.30 pm	

Gloucestershire Care Services NHS
NHS Trust

Annual Governance Statement

Ref: 22/0515

Annual Governance Statement

19 May 2015

The Board is asked to:

Note the Annual Governance Statement (AGS).

Executive summary:

This draft of the AGS was submitted to the TDA on 23 April 2015 as required.

It will henceforth be included within the Annual Report and Accounts, and will be sent by the Trust auditors to the Department of Health on 5 June.

Identify which strategic objective(s) this paper supports:

1.	Achieve the best possible outcomes for our service users through high quality care.	
2.	Understand the needs and views of the service users, carers and families so 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.	X

Rod Brown, Head of Corporate Planning

11 May 2015

Sponsored by Paul Jennings, Chief Executive

11 May 2015

Please complete the Equality Checklist over….

Please select one of the following options:

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

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

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

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

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

Gloucestershire Care Services NHS
NHS Trust

ANNUAL GOVERNANCE STATEMENT

2014-15

Annual Governance Statement 2014-15

Version control	
Version:	0.1
Ratified by:	All Executive and Non-Executive Directors
Date ratified:	23 April 2015
Originator/author:	Rod Brown, Head of Corporate Planning
Owner:	Paul Jennings, Chief Executive
Executive lead:	Jason Brown, Director of Corporate Governance
Date issued:	23 April 2015 (first draft issued to the NHS Trust Development Authority)

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1. Scope of Responsibility

As Chief Executive of Gloucestershire Care Services NHS Trust ("the Trust"), I hereby affirm my belief that this organisation ably and routinely demonstrates its clear commitment to the principles and practices of corporate governance, and that this commitment is evidential both in our outcomes and this Annual Governance Statement. I also assert that this Trust's activities in all areas of governance, be it corporate governance, clinical governance, financial governance or information governance, are undertaken fully in accord with our organisational values of Caring, Open, Responsible and Effective.

Moreover, I recognise that as Accountable Officer, I have ultimate responsibility for ensuring that the Trust maintains a robust system of governance and internal control that facilitates achievement of our organisational vision and strategic objectives. I also acknowledge that I have personal responsibility for safeguarding public funds and optimising the use of organisational assets: thus, I am committed to ensuring that the Trust is administered by the most economical and prudent means possible, and that all resources are applied with maximum efficiency. As best example of this efficiency, I would note that as at the end of the financial year 2014-15, the Trust remains financially sustainable, returning a surplus of £1.5million in line with our forecast plan, despite the financial challenges and constraints that are clearly apparent across the national health and social care landscape.

I additionally recognise my personal responsibilities for overseeing the achievement of quality standards across this organisation, not only throughout all aspects of provided care, but also within the support functions that serve to enable the Trust's health and social care services. To this end, I would claim that overall, this Trust delivers excellent standards of care across the whole of Gloucestershire, demonstrated as example, by our achievement of the Safety Thermometer standard for achieving harm-free care in February and March 2015, and our consistently low rates of infections. I therefore welcome the opportunity to showcase this excellence as part of the assessment by the Chief Inspector of Hospitals that is scheduled for June 2015.

Finally, I confirm my compliance with all requirements and obligations as determined within the Accountable Officer Memorandum, and reflected within the Trust's Standing Orders, Scheme of Reservation, Scheme of Delegation of Powers, and Standing Financial Instructions. This includes being accountable through the NHS Accounting Officer to Parliament for the stewardship of the Trust's resources, and for ensuring that all Trust managers have a clear view of their personal and team objectives, and are duly provided with the means and information to assess their achievements in relation to those responsibilities.

In summary therefore, I trust that this Annual Governance Statement attests the significant successes that the Trust has achieved in 2014-15, whilst also recognising the work necessary to achieve future quality improvement.

Chief Executive Signature: Date:

2. Board / Corporate Governance

2.1 Responsibilities of the Board

The Terms of Reference for the Trust Board made clear its responsibilities for 2014-15. These responsibilities encompassed:

- governing the organisation effectively, and maintaining public and stakeholder confidence in the Trust's continued quality and sustainability;
- managing, and continuously appraising, the strategic development, integrated governance and on-going financial and operational performance of the Trust in line with all prevailing mandatory and statutory guidelines;
- ensuring the delivery of safe, effective, high quality health and social care services at all times, that are wholly responsive and accessible to the public, and that have been shaped both directly and indirectly by service user experience and opinion;
- overseeing investment in appropriate resources that deliver optimal health and social care outcomes, and enable public money to be spent in a way that is both efficient and effective;
- upholding the values of the Trust and the NHS Constitution.

More specifically, the Terms of Reference charged the Trust Board with responsibility for:

- **providing leadership**: in particular, this included responsibility for formulating the overarching direction for the Trust, ratifying all documented strategies, and shaping a positive culture for the Board and Trust as a whole;
- **ensuring quality**: this required the Board to receive the monthly Quality and Performance Report for comment and/or direction, and validate that no programme of transformational change or other variation to process or activity, would result in negative impact upon the quality of provided care;
- **maintaining control**: this included responsibility for ensuring that financial probity and effective financial controls were in place, and scrutinising the Board Assurance Framework (BAF) to advise upon all strategic and operational risks;
- **introducing innovations**: as such, the Board was responsible for ratifying all business development opportunities recommended by the Performance and Resources Committee, and approving all business cases that required capital investment, ensuring that these would minimise financial and clinical risk, and increase service effectiveness and efficiency;

- **promoting integrity**: this required the Board members to set the standard for the Trust, act in accordance with the CORE values of the organisation, and observe the seven Nolan Principles, namely selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

Prior to the start of the financial year 2014-15, the Trust updated its Standing Orders, Scheme of Reservation, Scheme of Delegation of Powers and Standing Financial Instructions. Together, these documents articulated how the Trust would seek to fulfil and discharge its statutory functions throughout the year, and how these functions would be directed and managed by the Trust Board.

2.2 Board changes

In 2014-15, there were a number of changes at Board level as detailed below. These changes were undertaken with the full support of the NHS Trust Development Authority ("TDA").

- **Duncan Jordan, Chief Operating Officer**
  Duncan joined the Trust in April 2014 on secondment from Gloucestershire County Council, where he previously held the role of Group Director and Chief Operating Officer. Duncan's role within the Trust gives him responsibility for all front-line services delivered by the organisation, and leadership of an extensive programme of change.

  Duncan's appointment prompted additional changes in the titles and portfolios of two other Trust Directors, namely:

  - Candace Plouffe, previously Director of Operations - Countywide, Children's and Young People's Services, became Director of Service Delivery with responsibility for the management of all scheduled care activity i.e. that supported by the Trust's Integrated Community Teams, Countywide and Specialist Services as well as Children and Young People's Services;

  - Susan Field, previously Director of Operations - Adult Services, became Director of Service Transformation with responsibility for the management of all unscheduled care activity i.e. that supported by the Trust's community hospitals and urgent care services: Susan is also responsible for managing the Transformation and Change Team;

- **Elizabeth Fenton, Director of Nursing and Quality**
  In April 2014, Elizabeth's job title changed from Director of Nursing to Director of Nursing and Quality.

- **Tina Ricketts, Director of Human Resources**
  In April 2014, Tina's job title changed from Head of HR to Director of HR.

- **Richard Cryer, Non-Executive Director**
  Richard joined the Board in April 2014, having previously served as Director of Finance at the University of London between 2006 and his retirement at the end of 2012.

- **Dr Joanna Bayley, Medical Director**
  In June 2014, Dr Joanna Bayley took up a ten-month secondment with the NHS Leadership Academy as one of just 35 clinicians from across the UK who was selected to join the NHS Fast Track Executive Programme.

- **Dr Michael Roberts, Interim Medical Director**
  In Dr Joanna Bayley's absence, Dr Michael Roberts joined the Board in July 2014. Michael had previously worked as a GP in Gloucestershire for 25 years, and had also held a number of leadership positions across the county, including Clinical Lead, interim Medical Director, Chair of the Gloucester City Executive, and representative for the Gloucestershire LMC.

- **Jason Brown, Director of Corporate Governance**
  Jason joined the Board in May 2014, having previously 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, as well as adult and children's social care in England. Jason had also worked nationally on behalf of both the Department of Health supporting confidential enquiries, and the Health and Social Care Information Centre.

- **Simeon Foreman, Board Secretary**
  In June 2014, Simeon stood down as Board Secretary to pursue new opportunities elsewhere: upon his departure, the statutory responsibilities of Board Secretary passed to Jason Brown.

- **Christopher Creswick, Non-Executive Director**
  Christopher retired from his post in January 2015.

2.3 Board attendance

The table below provides details of Executive and Non-Executive Directors' attendance at the Trust Board throughout 2014-15. This illustrates that the total attendance of available members was 94% across the year: this represents a 6% increase in attendance compared to 2013-14.

	2014				2015		
	20 May	**15 July**	**16 Sept**	**25 Nov**	**20 Jan**	**17 Mar**	
Voting Members							
Ingrid Barker, Chair	✔	✔	✔	✔	✔	✔	100%
Paul Jennings, CEO	✔	✔	✔	✔	✔	✔	100%
Robert Graves, NED	X	✔	✔	✔	✔	✔	83%
Richard Cryer, NED	✔	✔	✔	✔	✔	✔	100%
Joanna Scott, NED	✔	✔	✔	✔	✔	✔	100%
Susan Mead, NED	✔	✔	✔	✔	✔	✔	100%
Nicola Strother Smith, NED	✔	✔	✔	✔	✔	✔	100%
Christopher Creswick, NED	✔	✔	✔	✔	✔		100%
Glyn Howells, Director of Finance	✔	✔	✔	✔	✔	✔	100%
Elizabeth Fenton, Director of Nursing and Quality	✔	✔	✔	X	X	✔	66%
Dr Joanna Bayley, Medical Director	✔						100%
Dr Michael Roberts, Interim Medical Director			✔	✔	✔	✔	100%
Non-Voting Members							
Duncan Jordan, Chief Operating Officer	✔	✔	✔	✔	✔	✔	100%
Susan Field, Director of Service Transformation	X	✔	✔	✔	✔	✔	83%
Tina Ricketts, Director of HR	✔	✔	✔	✔	✔	✔	100%
Candace Plouffe, Director of Service Delivery	✔	✔	X	✔	✔	✔	83%
Simeon Foreman, Board Secretary	X						0%
Jason Brown, Director of Corporate Governance	✔	✔	✔	✔	✔	✔	100%

2.4 Board effectiveness and evaluation

Following the Trust Board meeting in March 2015, Board members took opportunity to reflect upon successes and achievements, measured against the Board responsibilities as detailed in section 2.1 above. In summary, this Board effectiveness evaluation concluded as follows:

	Assessment of 2014-15	Development opportunities
How effectively has the Trust Board fulfilled its responsibilities as prescribed in its terms of reference?	• There was clear development and greater stability of the Board in 2014-15 • The Board faced up to a number of considerable challenges to the Trust, and addressed these effectively • There was good scrutiny and improved reporting of key issues with firm focus on performance, quality and safety • Governance structures supporting the Trust Board were suitably strengthened	• Increase visibility of service user experience / opinion • Ensure more alignment to risk, and make risks the impetus for papers / agenda • Undertake full appraisal of new initiatives or service transformations • Increase debate on key clinical issues • Reflect on assessments from the NHS Trust Development Authority and other external agencies
What were the Board's biggest achievements in 2014-15? What could have been done better?	• There were a number of detailed and productive discussions regarding the Trust's strategic direction • Some critical service user safety issues saw performance improvement as a consequence of Board focus • Similarly, there were improvements in staff engagement, satisfaction and motivation as directed by Board • The Board saw improved service user / service delivery stories at beginning of sessions	• Further enhance the Board Development programme • Ensure better focus upon the Cost Improvement Programme (CIP) • Understand challenges in achieving key national performance targets • Increase scrutiny of HR hotspots • Build better relationships with local commissioners
Does the Trust have the right balance of skills around the Boardroom? Where are the gaps?	• There was an appropriate skills balance within the Executive Directors' team: in particular, this was strengthened by the appointment of the Chief Operating Officer • Strong assembly of Non-Executive Directors, all with clear backgrounds	• Additional clinical Non-Executive Director input would be beneficial • Similarly additional Non-Executive Director expertise in respect of the HR/OD agenda

	Assessment of 2014-15	Development opportunities
What style of leadership does the Board use? How successful is the Board in promoting this style of leadership across the Trust?	• The Board adopted a democratic, collaborative and inclusive approach, championed by the Chair • Board members committed to leading by example, and aimed to build a Trust culture of open engagement, empowerment and involvement • There was clear acceptance of accountability and responsibility as appropriate	• Less focus on reassurance, and increased emphasis upon assurance at Board • Opportunity for a more outward-facing approach so as to ensure wider horizon scanning, leading to clear direction setting for the Trust • Greater visibility of Executives around the Trust so that all staff have opportunity to interact
How do colleagues, service users, the public and other stakeholders perceive the Board? Is the Trust doing enough to listen to their views? Is the Trust doing enough to inform others about its work?	• In 2014-15, the Board updated the way it heard service user / service delivery stories, and this will evolve further in 2015-16 • Service user experience was included in the Board Quality and Performance Report albeit not comprehensively • The Trust developed an Engagement Framework with the support of stakeholders, to stimulate improved dialogue • Attendance at Board by the public was very limited: equally, few staff attend • The Annual General Meeting was well attended and received by public and partners • Much work was undertaken in 2014-15 to raise the Trust profile with partner agencies	• Extend coverage of service user experience within Board reporting • Provide clear evidence to the Board and other stakeholders of examples of where service change has been informed by service user feedback • Promote Board meetings more widely so as to encourage increased attendance by a range of stakeholders • Improve communications and engagement with key stakeholders, in particular, local GPs
Does the Board agenda adequately reflect the things that the Trust needs to give attention to? Are there sufficient opportunities for Board members to influence the agenda?	• In 2014-15, the Board discussed the Forward Plan at each meeting giving opportunity for all members to contribute • Non-Executive Directors also had opportunity via the NED meetings and one-to-one discussions with the Chair to influence future agendas • The new Board format whereby NEDs presented summaries of sub-committees brought better balance to the Boardroom	• Increase the level of discussion held at public Board rather than in private • Increase the level of discussion in respect of risk and risk mitigations • Action the agreed plan to hold regular Board planning meetings between the Chair, Chief Executive and Director of Corporate Governance

	Assessment of 2014-15	Development opportunities
Are the Trust's governance structures effective? Do Committees provide sufficient assurances to the Board? Should the Board be reviewing certain information that is currently delegated to its Committees?	• At the end of 2013-14, it was agreed that Board subcommittees which were established in April 2013, should operate for a further year prior to assessment: this time has now passed and analysis has been undertaken, resulting in a revised governance structure for 2015-16 • The introduction of Committee reviews of progress against strategy and operational risk registers were welcome • The revised format of the Board whereby summaries of subcommittees were presented, provided suitable assurances	• Embed the revised Board sub-Committee governance structure, ensuring that there is absolute clarity of remit, role and responsibilities so as to avoid any potential duplications or omissions: equally, ensure that membership of these subcommittees is appropriate so as not to overburden Executive and Non-Executive Directors
Does the Trust know enough about the quality of care delivered to service users and their carers and relatives?	• Compared to concerns raised in 2013-14, the Trust Board felt more assured that it understood where quality care was being delivered in Gloucestershire, and equally where there were opportunities for improvement: in particular, the Quality and Performance Report significantly improved • Benchmarking data was increasingly available to compare Trust performance against other similar Trusts	• Increase the number of quality visits by Executive and Non-Executive Directors to service users' homes • Build upon recent improvements in Friends and Family Test response rates • Continue to increase the triangulation of information in Board reporting • Routinely receive and act upon Healthwatch feedback
Does the Trust meet the needs of its most vulnerable service users, and does the Board have sufficient assurances that they are safe from harm and receiving high-quality care?	• The Trust continued to monitor how best to meet the needs of all people for whom it cares and mitigate against any unforeseen consequences of change (thus, for example, the increase in single inpatient rooms has led to higher numbers of falls in community hospitals) • The Trust Board was assured of significant improvements in work with people with dementia	• Greater support is needed for people with learning disabilities as insufficient progress was made in 2014-15 by the Learning Disabilities Steering Group • The eQuality Impact Assessment tool needs further strengthening so as to provide appropriate assurance in respect of service developments

2.5 Compliance with the UK Corporate Governance Code

In March 2015, the Trust undertook self-assessment against the main principles of The *UK Corporate Governance Code* (Financial Reporting Council, September 2012). A summary of this assessment is as follows:

CODE REQUIREMENT	RAG	TRUST RESPONSE
LEADERSHIP		
Every Trust should be headed by an effective Board which is collectively responsible for the long-term success of the organisation		The Trust Board has very clear Terms of Reference which establish its remit, duties and responsibilities (see summary at 2.1 above). Moreover, these responsibilities are reiterated within the organisation's Standing Orders. Throughout 2014-15, the Trust continued to update and maintain its Board composition matrix which it routinely used to assess members' skills, talent and capabilities so as to inform their annual objectives and personal development plans, and thereby ensure a high-performing Board. In 2014-15, the Trust also assessed and ensured its absolute compliance with the requirements of the Fit and Proper Persons Test (Regulation 5 of the Health and Social Care Act 2008 (Regulation of Regulated Activities) (Amendment) Regulations 2014).
There should be a clear division of responsibilities at the head of the Trust between the running of the Board and the executive responsibility for the running of the Trust's business. No one individual should have unfettered powers of decision		There is clear demarcation between the responsibilities of the Chair and the Chief Executive, which is articulated in their respective job descriptions and enforced within the Trust's Standing Orders. Thus, the Chair is pivotal in creating the conditions for Board and for ensuring the effective contribution of all individuals, whilst the Chief Executive is responsible for leading and managing the Executive Directors.
The Chair is responsible for leadership of the Board and ensuring its effectiveness on all aspects of its role		The Chair is paramount in setting the tone, style and agenda for the Board, taking into account, the concerns of the Executive and Non-Executive Directors. Supported by the Director of Corporate Governance, the Chair also ensures that the Board receives accurate, timely and clear information on all relevant issues, enabling Board members to make sound judgements and decisions, and monitor the Trust's performance. Additionally, the Chair encourages active engagement and constructive challenge by all Board members.

As part of their role as members of a unitary Board, Non-Executive Directors should constructively challenge and help develop proposals on strategy		Throughout 2014-15, the Trust's Non-Executive Directors made crucial contribution to the development of Trust strategy and policy. This was directed through Trust Board, Board Development sessions, Board sub-Committees, and where appropriate, one-to-one engagement with Executive Directors and other senior Trust colleagues. The Chair meets formally on a monthly basis with the Non-Executive Directors, independent of the Trust's Executive Directors, to debate pertinent issues. In September 2014, led by the Senior Independent Director, the Non-Executive Directors undertook a detailed appraisal of the Trust Chair.
EFFECTIVENESS		
The Board and its committees should have the appropriate balance of skills, experience, independence and knowledge to enable them to discharge their respective duties and responsibilities effectively		Throughout 2014-15, the Trust Board was actively supported by a number of Committees and other key forums as illustrated in section 2.6 below. The Terms of Reference for these groups sought to ensure an appropriate balance of attending Executive and Non-Executive Directors supported by other Trust colleagues. At the start of each Board meeting, the Chair ascertains whether there are any changes to the Declarations of Interest already formally lodged by each Executive and Non-Executive Director. Any such change would be formally recorded by the Director of Corporate Governance, and used to determine the independence of the associated individual. Throughout 2014-15, Non-Executive Directors represented over 50% voting members of the Board.
There should be a formal, rigorous and transparent procedure for the appointment of new directors to the Board		The Trust observes a formal process for the appointment of Executives which explores each prospective candidate's competencies, attributes, knowledge and experience linked to the corresponding role. Moreover, the TDA's input on key positions has always been sought, and TDA representatives have participated in relevant recruitment exercises. Overall, the recruitment process for Board Directors is overseen by the Remuneration and Terms of Service Committee so as to ensure transparency, openness and accountability.
All directors should be able to allocate sufficient time to the Trust to discharge their responsibilities effectively		The Chair and all Non-Executive Directors are made formally aware at appointment, the time commitment expected of them. In 2014-15, all individuals made contributions well in excess of these requirements, demonstrating their commitment to their roles.

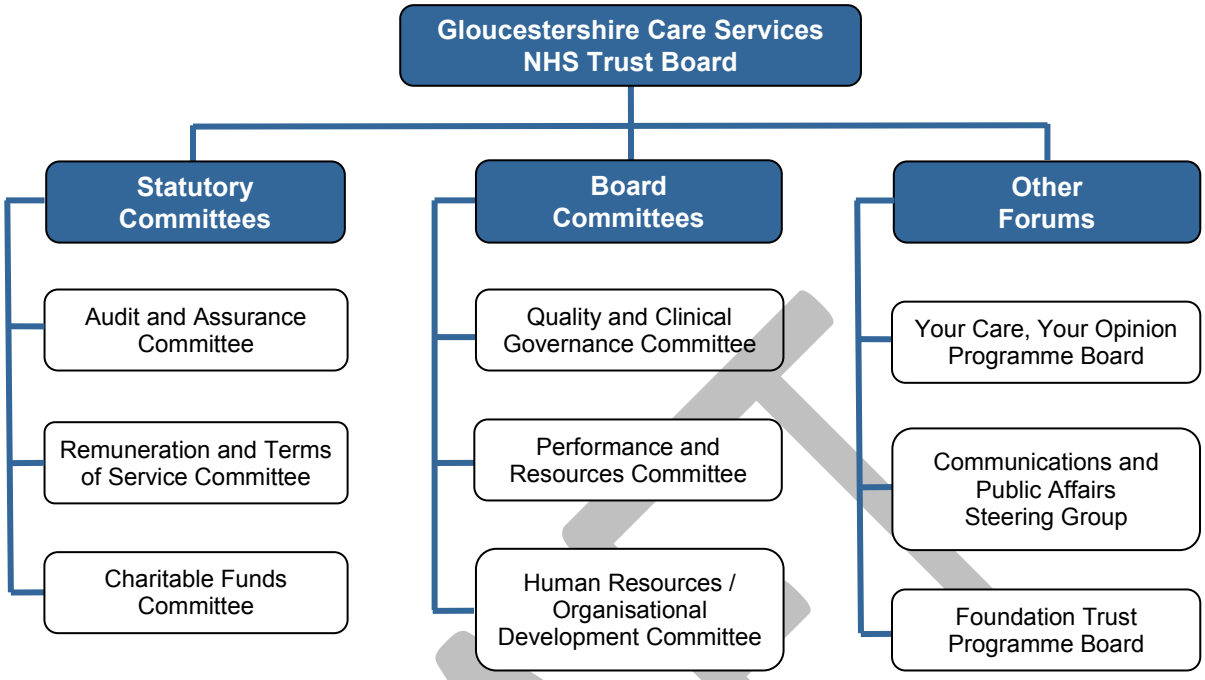
All directors should receive induction on joining the Board and should regularly update and refresh their skills and knowledge		The Trust maintains a clear induction programme so as to provide appropriate support to new Executive and Non-Executive Directors. This is complemented by an induction manual which provides a wealth of information materials. The Directors' personal development plans identify how they are expected to update and refresh their skills: moreover, all Directors are actively encouraged to attend both local and national conferences.
The Board should be supplied in a timely manner with information in a form and of a quality appropriate to enable it to discharge its duties		In 2014-15, the Trust's Director of Corporate Governance ensured that through the Chair, all Executives and Non-Executive Directors received the necessary information and reports appropriate to their individual roles and responsibilities. The Director of Corporate Governance was also responsible for advising the Trust Board, via the Chair, of all relevant governance matters.
The Board should undertake a formal and rigorous annual evaluation of its performance and that of its committees and individual directors		Both at the start of 2014-15, and also at the end of the financial year, the Board undertook formal assessment of its performance and that of its Committees (see also sections 2.4 above and 2.7 below). The results of the 2013-14 Board self-assessment were included within the Trust's 2013-14 Annual Report and Accounts. Throughout 2014-15, both the Trust Board as a whole, and also the Board's Executive Directors, have benefited from external assessment of their individual and collective skills and performance.
All directors should be submitted for re-election at regular intervals, subject to continued satisfactory performance	n/a	This principle is not relevant to NHS Trusts
ACCOUNTABILITY		
The Board should present a fair, balanced and understandable assessment of the Trust's position and prospects		Via the Annual Report and Accounts which was issued in June 2014, the Trust made clear its position and prospects. This document was approved as a true reflection of the Trust's financial status by the Chief Executive as Accountable Officer and the Director of Finance, and was additionally validated and endorsed by the organisation's External Auditors. Moreover, at each Board, a Finance Report is presented that identifies the Trust's most up-to-date position.

The Board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. The Board should maintain sound risk management and internal control systems		In March 2015, the Trust Board received and debated the Board Assurance Framework, which identified the most salient strategic risks aligned to the organisation's strategic objectives as proposed by the Executive and Non-Executive Directors. As a result of this first draft, Executive Directors were charged with refining the document further, and bringing it to the Board Development session in April 2015 for final ratification. Thereafter, the Board Assurance Framework will become a living document to be routinely reviewed and revised by both the Audit and Assurance Committee and the Trust Board.
The Board should establish formal and transparent arrangements for considering how it should apply the corporate reporting, risk management and internal control principles and for maintaining an appropriate relationship with the company's auditors		In 2014-15, these arrangements and responsibilities were clearly and formally delegated to the Trust's Audit and Assurance Committee, which is open to all of the organisation's Non-Executive Directors. The key roles of this Committee are described in section 2.6 below. It is noted in particular however, that the Audit and Assurance Committee was responsible in June 2014, for approving the organisation's draft Annual Report and Accounts on behalf of the Trust Board. Additionally, the Audit and Assurance Committee maintained overview of the Trust's whistleblowing policy and activity throughout 2014-15. Moreover, the Audit and Assurance Committee was responsible for overseeing the work of both internal and external audit: this included responsibility for considering the major findings of all internal and external audit work (and management response), and ensuring suitable coordination between the auditors to optimise audit response.
REMUNERATION		
Levels of remuneration should be sufficient to attract, retain and motivate directors of the quality required to run the Trust successfully, but no more than is necessary for this purpose. A significant proportion of executive directors' remuneration should be structured so as to link rewards to corporate and individual performance		In 2014-15, scrutiny of remuneration for the Trust's Very Senior Managers was delegated to the Remuneration and Terms of Service Committee. Thus, this Committee agreed individual Directors' remuneration arrangements including their salaries, benefits and allowances, giving due regard to the policies and recommendations of the Department of Health and the NHS Trust Development Authority, and adhering to all relevant laws, codes and regulations.

There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration		In determining the remuneration, allowances and other terms and conditions of office for the organisation's Very Senior Managers, the Trust's Remuneration and Terms of Service Committee acted wholly in accord with the requirements of the NHS Codes of Conduct and Accountability, the Higgs report, and the Trust's Standing Financial Instructions. It is noted that the Committee's membership comprised the Trust's Non-Executive Directors only, thereby ensuring that no Director was directly involved with discussion regarding their own remuneration.
RELATIONSHIPS WITH STAKEHOLDERS		
There should be a dialogue with stakeholders based on the mutual understanding of objectives. The Board as a whole has responsibility for ensuring that a satisfactory dialogue with stakeholders takes place		Throughout 2014-15, the Trust held regular on-going dialogue with all professional stakeholders: thus, for example, the Trust met with its Commissioners formally on a regular basis as part of the Contract Monitoring Board, and was an active participant in all relevant cross-organisational committees including the Gloucestershire Strategic Forum (attended by senior Trust representatives including the Chair and Chief Executive), and the Joining Up Your Care Group which sought to identify ways in which provider and commissioner organisations could jointly fulfil the vision of the Gloucestershire Strategic Forum. Additionally, there were regular meetings with local MPs, the Health and Care Overview and Scrutiny Committee and local elected members. Service users, carers, families, community representative groups and the local Gloucestershire public were consulted as part of a number of events, including the Your Care, Your Opinion Programme Board, and its larger consultative sub-group.
The Board should use the AGM to communicate with stakeholders and to encourage their participation		In October 2014, the Trust hosted its inaugural Annual General Meeting. The event was widely attended by both staff and external stakeholders including the public and representatives from provider and commissioner organisations. Presentations were given by a number of the Board members, and questions were received from those in attendance. The AGM was well received, and plans are already underway to stage a similar event in October 2015.

2.6 Committee structure

In 2014-15, the Trust's Committee structure was as per the schematic below:



The main Committees, and those that are the primary focus of this Annual Governance Statement, are the six Statutory and Board Committees. To this end, it is noted that their key responsibilities were as follows:

- the Audit and Assurance Committee was responsible for providing an independent and objective review of the Trust's financial systems, financial information, financial governance and compliance in accordance with all relevant laws, guidance and regulations governing the NHS. It was also delegated responsibility for overseeing the Trust's corporate governance functions, and thus assured an effective system of governance, risk management and internal control, which covered the whole of the Trust's activities, and supported achievement of the Trust's strategic objectives;

- the Remuneration and Terms of Service Committee was responsible for overseeing the appointment, remuneration, allowances and other terms and conditions of office of the Trust's Very Senior Managers (VSMs);

- the Charitable Funds Committee was responsible for advising the Corporate Trustee on all matters relating to charitable funds, and for decision-making on fund allocations in order to provide appropriate benefit to Gloucestershire service users and Trust colleagues;

- the Quality and Clinical Governance Committee was responsible for providing clear assurance on all issues pertaining to clinical and professional care, clinical governance systems, clinical risk management, and all prevailing regulatory standards related to quality and safety;

- the Performance and Resources Committee was responsible for reviewing the fiscal and service delivery activities of the Trust, agreeing and monitoring action plans where remedial steps were necessary to improve performance. The Committee was additionally responsible for making recommendations in respect of business development opportunities and business cases that required capital investment;

- the Human Resources / Organisational Development (HR/OD) Committee was responsible for overseeing workforce strategy, planning and organisational development, in order that the Trust could achieve exemplar clinical and professional outcomes and best experiences for local service users and Trust colleagues.

Each of these Committees reported directly to the Trust Board, provided a mechanism for escalation of risks and other issues, and ensured that the Trust Board had a clear and overarching role in assurance and performance monitoring.

2.7 Annual Committee Statements

As part of their delegated responsibility, relevant Board Committees were required to identify the key highlights of their performance in 2014-15, and provide these by means of a formalised statement to the Board. These statements also included a look forward to planning actions and developments in 2015-16: however, for the purposes of this Annual Governance Statement, it is deemed appropriate to include the past year's review only, namely:

Audit and Assurance Committee	Routinely reviewed financial reports including analysis of the service provided by SBS (the Shared Business Support service), standing orders and waivers, budget holders' cost centre status, debtors and write-offs, special payments and "Better Payment Practice" performance
	Reviewed the Trust's estate (both freehold and leasehold) in regard to compliance with building regulations and requirements
	Received reports from the Local Counter Fraud Team and reviewed activity including all cases under investigation: also received updates about incidence of whistleblowing
	Approved the internal audit plan, reviewed all issued reports, considered all major findings and requested supplementary work where appropriate
	Reviewed the external audit plan and was assured that the necessary liaison between the finance team and internal / external audit was in place in order to ensure that statutory obligations were met

Charitable Funds	Supported people from across the county at their time of need, crisis or illness, aided by the generous donations and legacies of local people
	Provided food hampers for vulnerable service users in the community and commenced planning with local food bank organisations in respect of emergency food parcel distribution
	Sponsored the improvement of signage throughout various sites in Gloucestershire, enabling the public to navigate through the system more easily
	Approved grants in order to make a real difference to service users, carers and staff, particularly in respect of support of specialist clinical studies and research
	Commenced work to rebrand the Charitable Funds' identity and to reshape its proposition in association with the Charities Commission
Quality and Clinical Governance Committee	Strengthened the levels of challenge and assurance in relation to the delivery of safe care and reduction in harm, with a particular focus upon Harm Free Care (Safety Thermometer) as well as safe and suitable staffing across hospital and community nursing services
	Provided assurance to the Trust Board that incidents were robustly investigated and that learning was shared across the organisation
	Maximised opportunities to hear the voice of the service user, their families and carers
	Strengthened and refined reporting structures to support challenge in relation to all aspects of care quality at Executive and Committee level
	Improved the breadth and depth of information available by which to judge quality, ensuring appropriate triangulation of information on costs, activity, outcomes and service user views, and improved use of benchmarking and trend analysis

Performance and Resources Committee	Reviewed the performance of health and social care services
	Reviewed the performance and financial impacts of the Cost Improvement Programme (CIP), the Quality, Innovation, Productivity and Prevention (QIPP) programme and the Commissioning for Quality and Innovation (CQUIN) programme
	Reviewed progress against the External Care programme for adult social care
	Reviewed the Trust's financial performance including the capital programme
	Provided initial scrutiny of the budget for 2015-16
HR/OD Committee	Oversaw continued implementation of the Organisational Development Strategy in order to perpetuate a supportive and learning culture across the Trust: this resulted in an improvement in all areas of the NHS Staff Survey compared to 2013-14
	Requested and received assurance in respect of plans for staff engagement
	Oversaw continued implementation of the Workforce Strategy in order to improve workforce planning and processes
	Requested and received improved workforce information through updated dashboards and scorecards
	Received, approved and monitored remedial action plans in respect of deterioration in workforce metrics (sickness absence, turnover, mandatory training rates etc)

2.8 Board Governance Assurance Framework

Throughout 2014-15, the Trust continued to monitor its on-going compliance with all requirements of the Board Governance Assurance Framework. This resulted in a programme of work which saw significant improvements in the Trust's performance against the Framework's criteria, specifically in respect of (i) Board evaluation, development and learning, given the Trust's commitment to increased internal and external assessment of Executive and Non-Executive Directors' strengths and capabilities, and (ii) Board insight and foresight, which has improved, in part due to improved information reporting as evidenced by Board members' responses in section 2.4 above. Notwithstanding, the Trust aims to achieve further improvement in 2015-16.

3. Quality / Clinical Governance

3.1 Quality Governance Assurance Framework

Throughout 2014-15, the Trust regularly re-assessed its position against the ten criteria of the Quality Governance Assurance Framework. Initially, these reviews suggested a continued decrease in overall scores, moving the Trust towards the required target of 4. However, a more formalised reappraisal in December 2014, informed by external authorities including representatives of the NHS Trust Development Authority and Monitor who identified the need for greater triangulation in Trust responses, suggested to the Trust Board that a more cautious and conservative stance should be taken. Although this therefore yielded a higher score, implying a worsening position, this reflection did enable the Trust to more clearly identify those areas in which quality improvements were required, and to attribute corresponding remedial plans.

As a result, and since the time of the reassessment, work has been targeted at key areas, namely:

- ratification of the overarching Quality Strategy by Board in January 2015, and on-going monitoring of performance against identified goals, aligned to the organisation's strategic objectives and Quality Account priorities;

- implementation of improved risk management processes resulting in the presentation of a full Board Assurance Framework in March 2015, now designed as a live document to be updated and reviewed at every subsequent Board meeting;

- development of a Core Values Framework so that colleagues across the Trust can easily recognise their personal responsibilities for adhering to the Trust values and associated behaviours;

- agreement to a Team Performance Framework which sets the standard for performance management within each operational service delivery team across the Trust;

- publication of the Trust's Engagement Framework which details a variety of methodologies and approaches by which the organisation will realise its commitment to improved two-way dialogue with local service users, carers and families, as well as the wider Gloucestershire community;

- development of an Internal Engagement Implementation Plan which specifies the activities to be undertaken in 2015-16 in order to improve communications with colleagues, and thus ensure their active involvement in Trust decision-making.

The Trust is now confident that it can more reliably undertake renewed assessment of compliance, and that the results will evidence the significant progress made.

3.2 Quality Account

In June 2014, the Trust published its first Quality Account. This public-facing document summarised the organisation's quality achievements in 2013-14, and looked forward to service delivery activities in the coming year which would ensure continuous improvement and achieve quality outcomes for local people. Thus, the quality goals which were identified for 2014-15 were:

- to reduce the number of service users who fall in community hospitals or who acquire a pressure ulcer;
- to improve the experiences of service users, carers and families within community hospitals;
- to further develop and enhance Integrated Community Teams;
- to improve active two-way engagement with service users, carers and families;
- to ensure that staffing levels are maintained as appropriate to the needs of service users.

Progress and performance against these goals has been continuously monitored throughout the year via a dedicated dashboard which has been regularly presented at the Quality and Clinical Governance Committee.

The Trust's second Quality Account will be published in June 2015: this aims to build upon the successes of the previous year in order to further develop the delivery of safe, effective, caring, responsible and well-led care services.

3.3 Clinical audit

At the beginning of 2014-15, service managers and commissioners agreed a programme of clinical audit to enable them to improve the effectiveness of service, reduce prevailing risks, and improve the experiences of service users, carers and families. A number of these audits are described below:

- **children's speech and language therapy**: this audit identified that one in six service referrals did not actually require therapy and were discharged after initial assessment. As a result, the Trust introduced a telephone triage service which has subsequently ensured appropriate service referrals only. This has been supported by the publication of additional referral advice for parents, health visitors and schools on the Trust's website;
- **children's occupational therapy:** sling clinics were introduced to special schools in 2013 in order to provide guidance in respect of the moving and handling of children who need hoisting. This audit demonstrated the benefit for parents of regular contact with therapists, and the need to make slings more readily available by holding them as stock items;

- **podiatry:** in response to an increasing number of referrals for domiciliary podiatry, an audit was undertaken to review whether all staff were assessing service users against the same criteria, thereby ensuring equity of provision. The audit identified disparity of assessment, and has since led to the establishment of a telephone triage service for all new referrals;

- **Integrated Discharge Team:** the IDT supports service users in local acute and community hospitals who require healing time, but who cannot return home due to physical or environmental issues. An audit looked at the opportunities for securing placements to Non Weight Bearing Beds (NWBB) in care homes, and concluded that NWBBs were both a cost-effective and safe alternative to people remaining in hospital. As a result, a revised management process enabled more prompt discharge of service users;

- **Diabetes**: an audit of Diabetes, Food and You, a new programme designed to provide dietary education to people with type 2 diabetes, showed a significant improvement in attendance rates compared to the previous education programme, and an improvement in diabetes control for the majority of those who attended;

- **Pulmonary Rehabilitation**: an audit of outcomes achieved by people attending the pulmonary rehabilitation programme was undertaken in 2014, so as to better support service users in future;

- **Dementia**: a monthly audit of dementia case finding and care planning was undertaken in 2014-15 throughout all community hospitals and community nursing teams in order to ensure continued prompt identification of memory loss, with referral for onward investigation and appropriate care planning;

- **Record-keeping**: a programme of record-keeping audits in 2014-15 enabled the Trust to address areas of weaker performance, especially important in the move from paper documentation to electronic data capture.

Additionally during 2014-15, the Trust participated in all four national clinical audits relevant to the services provided by the organisation. These were:

- the Sentinel Stroke National Audit Programme (SSNAP), which aims to review information from a service user's initial admission to six month follow-up through all subsequent care settings;

- the National Audit of Intermediate Care, which allows the Trust to benchmark its home-based rehabilitation and reablement services with equivalent services delivered by other providers;

- the National Chronic Obstructive Pulmonary Disease audit, which will continue into 2015-16; and

- the National Diabetes Foot Care audit, for which data collection also continues into 2015-16.

3.4 Clinical governance

During 2014-15, the Trust made significant progress in its clinical governance performance. This included:

- greater focus on the need to provide harm-free care and optimum service user safety. Success in this initiative was measured by the use of the Safety Thermometer, which accounts for incidence of pressure ulcers, falls, urinary tract infections (UTIs) and venous thromboembolism (VTEs): this showed that in both February and March 2015, the Trust achieved the 95% target for harm-free care as required nationally. Notwithstanding, the Trust is not complacent in this matter, and will continue to undertake further work in 2015-16 so as to ensure no harm to any of its service users;

- revision of incident management processes, given that barriers to incident reporting were identified by the Trust: moreover, additional support and training was provided to frontline clinical teams in order that they could fully understood the need for, and benefit of, robust reporting so as to enable continuous quality improvement;

- achievement of the C difficile target, in that only 17 cases of infection were recorded in year against a commissioner agreed threshold of 21;

- launch of the "Hello, my name is" campaign within the Trust, based on the national initiative to ensure that staff adequately introduce themselves to service users, carers and families, and thus improve care experiences;

- update of the Trust's Complaints Policy and process, supported by education and training so that it is easier for service users, carers and families to understand how to lodge a complaint should they wish to do so;

- initiation of bi-annual service user dependency audits as a tool by which to review staffing levels across the Trust;

- implementation of the Friends and Family Test across all Trust services and locations;

- management of response to the 27 Serious Incidents Requiring Investigation (SIRIs) that occurred in 2014-15, which were as follows:

SIRI Type	Number	Actions
Pressure ulcer	12 (NB 10 were determined to be unavoidable)	Learning from the investigations included improvements in the use of wound care charts; better assessment, planning, implementation and evaluation of care; earlier identification of service users at higher risk with clear plans of management; and timely reporting of incidents in order to foster continual improvement

Hip fracture following fall	9	An action plan developed from the recommendations of all falls investigations is currently being implemented by the Head of Community Hospitals. This plan includes the roll-out of a new falls risk assessment which encompasses the NICE Falls Pathway and introduces “safety huddles” at all community hospitals
Possible delay in transfer to acute Trust	2	Investigations recommended that: staff ensure the correct provision of drugs appropriate for use at ward level; the introduction of standard operating procedures for handover to the Night Sister in order to ensure that wards and MIU responsibilities can be managed safely and that communication is effective; the development of a written process for signing out drugs from the emergency cupboard to include a running total of drugs taken or left after each attendance in order to mitigate the risk of human error
Potentially incorrect management of VAC therapy leading to harm to a service user	2	At the time of writing, this investigation is ongoing. The report will be reviewed by a panel independent to the service in order to consider the recommendations and findings. The service user is being kept informed, and an apology has been made both verbally and in writing
Mistaken reuse of a needle during a Human papilloma virus (HPV) immunisation clinic	1	At the time of writing, this investigation is ongoing. Immediate actions include close working with the young people and families involved in order to offer support and apologies
Administration of incorrect drug	1	At the time of writing, this investigation is ongoing. Immediate actions include review of staff competencies, and being open with the service user and family, apologising both verbally and in writing

4. Financial Governance

Throughout 2014-15, the Trust continued to monitor its on-going compliance with the Financial Governance component of the Board Governance Assurance Framework. The actions resulting from this review provided direction on the Trust's in-year priorities in respect of financial management, supported by the recommendations of the financial systems audit (see section 7.1 below) and the priority goals identified in the Trust's Financial Management Strategy which was ratified by the Board in January 2015. Thus, the principle control mechanisms that were introduced or enhanced in 2014-15 were as follows:

- the Trust's emerging Long Term Financial Model, which built upon projections previously made at the time of the Trust's authorisation in 2013, and which will be finalised in 2015-16;

- the organisation's Financial Management Strategy which sought to further develop the Trust's financial management systems, and thereby enable the organisation to maintain financial sustainability whilst continuing to deliver high quality care. To this end, the Strategy identified a number of priority goals to:

    - ensure that relevant financial management activities demonstrate clear engagement with commissioners, colleagues and other stakeholders as appropriate, so as to increase understanding of, contribution to, and recognition for, financial decision-making: this includes requirement for the Trust to promote an environment in which queries relating to finance can be discussed openly and honestly;

    - maintain stringent financial planning processes, regulated by strong governance and accountability arrangements, in order that appropriate scrutiny is afforded in advance of all spending: this requires the production of clear, credible and realistic financial plans which are thoroughly evaluated via the Trust's established committee structure;

    - implement effective financial controls across all relevant parts of the organisation: this includes responsibility for developing robust mechanisms and systems to ensure efficient cash management and capital spend processes, and safeguard against fraud and corruption;

    - maintain effective purchasing practices in order to reduce expenditure, facilitate the delivery of high quality care, provide support to budget holders, and enable the Trust to benefit from best value: this requires the Trust to develop a more consistent and systematic procurement service, and create closer working with service budget holders and clinical staff;

    - ensure that the Trust's responsibilities and obligations under all forms of enforceable agreement, are appropriately recognised, documented and managed;

- scrutinise and challenge all proposed business developments so as to validate that they are financially robust and sustainable, ethically sound, and represent appropriate use of financial resource;

- ensure that all Trust financial modelling and performance analysis is based upon the most accurate, timely, relevant and complete information and intelligence;

- the Trust's Cost Improvement Programme (CIP), which regulated the specific transformational changes designed to release cost-efficiencies in-year, and which utilised eQuality Impact Assessments to ensure no detrimental impact upon service provisions or service users.

  Although this programme under-achieved in its target of £6.4million efficiency savings in 2014-15 by only reaching a total of £3.4million, this was countered by the publication of reference costs which unequivocally demonstrated that at 96.6%, the Trust was already working at greater efficiency than other comparable community Trusts;

- plans for the Trust to comply fully with the recommendations of the Better Procurement, Better Value, Better Care programme, and in particular, the requirement to ensure the implementation of GS1 coding where appropriate;

- the Trust's Standing Financial Instructions, which provided details on how the resources of the organisation were to be managed within an agreed governance framework. These included an emphasis on budgetary management, and ensured that service developments were implemented with appropriate financial controls. Financial governance arrangements were further supported by both internal and external audit, in order to secure the economic, efficient and effective use of all resources that were at the Trust's disposal;

- the Finance Report, which was presented at each Trust Board in order to provide relevant financial information to allow Board members to discharge their duties effectively (NB it is noted that in months when the Trust Board did not convene, the Finance Report was presented at the Performance and Resources Committee for information and guidance);

- the internal and external audit reviews and reports (see section 7.1 below);

- the Audit and Assurance Committee, which in 2014-15, provided scrutiny of financial reporting and financial controls (see sections 2.6 and 2.7 above).

In summary, weaknesses that were identified by the above processes as being within the Trust's remit related to deficiencies in working practices between the Trust and the Shared Business Support service which undertakes much of the Trust's financial administration. Thus, there were no significant inadequacies within the Trust's own internal practices, nor in its use of public resources.

5. The Internal Control System

5.1 Purpose of the internal control system

The role of the Trust's internal control system is to provide a formal and consistent basis for the identification, evaluation and prioritisation of all risks to the Trust's quality, operations, effectiveness and sustainability, in order to gain assurance that these are properly controlled, managed and/or mitigated, and thereby ensure safe and effective care. This includes both operational risks (both clinical and non-clinical) as well as strategic risks.

It is noted however that the internal control system is designed to manage all prevailing risks to a reasonable level only: thus, the Trust recognises the impracticality of aiming to completely eliminate all risks to the organisation's capacity and/or capability to fulfil its vision, values and strategic objectives.

In summary, the Trust's internal control system is based on an on-going process that serves to:

- identify and prioritise all operational and strategic risks;
- evaluate the likelihood and impact of those risks being realised;
- manage all identified risks efficiently, effectively and economically, and within agreed tolerances;
- ensure a measurable reduction in the detrimental impact of risk upon the quality of health and social care services provided across Gloucestershire, thereby improving service user safety and experience;
- enable decisions of the Trust to be taken with full consideration and awareness of the risk environment.

This system of internal control is designed to sit within an integrated governance framework, whereby salient risks are aligned to the key domains of corporate governance, clinical and quality governance, information governance, financial governance and research governance. By contextualising risks via this approach, the Trust not only enables its systems to work together holistically, but it also helps ensure that the Trust's services continue to be safe, caring, responsive, effective and well-led.

In the 2013-14 Annual Governance Statement, the Trust recognised that it needed to commit further time and focus towards ensuring that this internal control system became fully embedded across the organisation, so as to move from a strategic and aspirational model to daily practice. In 2014-15, this ambition has been realised, although the Trust would concede that significant progress was made in the latter half of the year only. Notwithstanding, there are now clear risk reporting and governance structures in place, which will be improved further in the coming year.

5.2 Leadership of the internal control system

The Trust recognises that clear leadership in the area of risk management is critical to the establishment and maintenance of a robust internal control system as articulated above. The Trust is therefore committed to ensuring that the organisation encompasses the necessary skills, expertise, controls and resources to provide this leadership.

The Trust's Risk Management Strategy (initially ratified by the Trust Board in March 2014) details the organisation's overall responsibility for ensuring the effective management of all risks that may otherwise impact detrimentally upon the quality of provided care across Gloucestershire. Furthermore, the Strategy identifies that specific personal accountabilities are delegated on behalf of the Chief Executive as follows:

- the Trust's Executive and Non-Executive Directors maintain shared responsibility for the oversight of strategic risks (see section 5.3.1 below), and for ensuring that adequate responses, actions and/or mitigations are in place and monitored via the Board Assurance Framework (NB management of the Board Assurance Framework which captures strategic risks is the responsibility of the Director of Corporate Governance);

- the Director of Corporate Governance maintains overarching responsibility for the oversight of all operational (non-clinical) risks, and for ensuring that suitable and effective corporate risk management processes are in place;

- the Director of Nursing and Quality maintains overarching responsibility for the oversight of all operational (clinical) risks, and for ensuring that suitable and effective clinical risk management processes are in place;

- the owner of each operational risk (clinical and non-clinical) is one of the Trust's Executive Directors, with assigned ownership relative to each Executive's individual areas of expertise;

- the lead for each operational (clinical and non-clinical) risk is a nominated colleague of suitable authority within the Trust who is responsible for practically managing the necessary actions that arise from each identified risk.

Leadership in respect of risk is also provided through the Trust's Board Committee structure, wherein all Board Committees are chaired by Non-Executive Directors and attended by appropriate Executive Directors and senior Trust managers (see also section 2.6 above). Thus, the Terms of Reference for each of these Committees makes clear its responsibility for identifying all operational risks as appropriate to the respective Committee's remit, enacting all mitigations as may be relevant, and/or making suitable recommendations to the Trust Board in respect of the management of risks that are outside the particular Committee's sphere of influence.

5.3 Risk prevention and management

5.3.1 Strategic risks

Responsibility for the oversight and management of strategic risks is allocated to the Trust's Executive Directors. This includes responsibility for identifying all strategic risks, evaluating these risks, and ensuring that adequate responses, actions and/or mitigations are in place and monitored.

The Trust classifies strategic risks as those risks which, as a result of inadequacies in the operation of controls or insufficient assurances, may threaten or impede achievement of the Trust's strategic objectives.

To support understanding and facilitate mitigation of these risks, the Trust is committed to the maintenance of an active Board Assurance Framework which documents all strategic risks. Additionally, the Board Assurance Framework identifies the most significant operational risks that require the input and direction of the Board (these risks are detailed in section 5.3.2 below).

The Board Assurance Framework also provides structured assurances about where risks are being managed, and ensures that objectives are being delivered to time and budget. This allows the Board to determine how to make the most efficient use of resources, and address the associated issues in order to improve the quality and safety of provided care.

The Board Assurance Framework is evaluated by the Trust Board every two months. This includes review, assessment and update of the Board Assurance Framework's content as appropriate. The evaluation also serves to provide assurance of the effectiveness of the controls and actions that have been implemented in order to manage or mitigate the identified strategic and high-level operational risks.

The Board Assurance Framework is also evaluated annually by the Audit and Assurance Committee in order to ensure its consistent use to inform risk-based Board decision-making.

At the end of March 2015, the principle strategic risks recorded in the Board Assurance Framework, were as follows:

Strategic Objective	Strategic risk
Achieve the best possible outcomes for service users through high quality care	Under-reporting of incidents may compromise service user safety
	Lack of robust risk management processes may restrict the Trust's ability to respond quickly and effectively to concerns about care quality
	Continued increases in demand for services may restrict the Trust's flexibility and capacity to provide services in other settings, and in particular, may limit aspirations to deliver greater preventative interventions

Strategic Objective	Strategic risk
Understand the needs and view of our service users, carers and families so that their opinions inform every aspect of our work	Inconsistent engagement practices with service users, families and carers may result in the public's voice not being heard or used to inform Trust decision-making
Provide innovative community services that deliver health and social care together	The under-defined service delivery model for Integrated Community Teams (ICTs) may prevent the Trust from undertaking effective planning for one of its most critical services
	Threats to the delivery of integrated services with Gloucestershire County Council may prevent an effective joined-up approach to health and social care
Work as a valued partner in local communities and across health and social care	A variable relationship with the Gloucestershire Clinical Commissioning Group which is more operational than strategic, may limit the Trust's planning and potentially undermine its long-term sustainability
	Unclear relationships with local partner organisations may reduce the potential for effective system-wide planning and service delivery
Support individuals and teams to develop the skills, confidence and ambition to develop our vision	Failure to develop a learning and supportive culture that engages, inspires and motivates colleagues, may impact upon the Trust's recruitment and retention, and its ability to deliver the highest standards of care quality
	Lack of assurance that colleagues have the clinical skills and managerial competencies to create a workforce with the necessary knowledge and expertise to deliver best care
	Inability of the Trust to recruit and retain staff with the right skills may be detrimental impact upon the quality of provided care
	The lack of robust formalised succession planning may lead to Board instability should senior staff leave or become unavailable for any extended period
	The Trust's financial management processes and structures do not consistently provide budget managers and senior management with the financial information needed to address all relevant issues
Manage public resources wisely to ensure local services remain sustainable and accessible	Failure to deliver a successful CIP, CQUIN and QIPP programme
	Ability to operate against a small planned surplus
	Inability to maintain independence as a NHS provider may threaten the future provision of community health and social services across Gloucestershire
	A breakdown in internal control / governance systems may lead to reputational loss and long-term sustainability

5.3.2 Operational risks

All Trust colleagues have explicit responsibility for identifying operational risks relevant to their service, team and/or working environment. These risks may be apparent as a result of colleagues' observations, or they may require the triangulation of information from a range of sources including all internal or external evaluations (see section 5.4 below).

A range of tools and resources are maintained to support colleagues in the identification, assessment and escalation of these risks, including a comprehensive portfolio of fully documented risk management policies and other control documents that are readily available via the Trust intranet.

An essential element of the risk management process employed by the Trust is the Corporate Risk Register. This systematically gathers together all service delivery, team and project risk registers in order to portray the total extent of operational (clinical and non-clinical) risks across the Trust. The Corporate Risk Register is then used to inform operational management, and is subject to regular review and monitoring as part of the Trust's governance arrangements, in particular via the Scheduled Care Governance Forum and the Community Hospitals, Urgent Care and Capacity Group, which in 2014-15, both reported to the Quality and Clinical Governance Committee.

It is also noted that the Trust maintains a standardised process by which all operational risks are effectively analysed, evaluated, managed and mitigated. This process includes the nomination of a relevant lead and Executive owner for each risk as described in section 5.2 above. It also enables each identified risk to be evaluated so as to determine the risk score, based upon the comparative likelihood and consequence of that risk's occurrence. Thereafter, the Trust ensures that:

- risks that are attributed a 4-10 risk rating are subject to regular review at local level via the relevant Trust forum;
- risks that are attributed a 12-14 risk rating have a formal action plan developed, and are monitored and reviewed every 6 months;
- risks that are attributed a 15+ risk rating have actions identified to be implemented within a minimum of 3 months and audited until under control.

As a result of Trust processes, the following significant operational risks were identified as at the end of March 2015:

Domain	Risk	Mitigations
Scheduled care to include integrated community teams, countywide / specialist services and children's and young people's services	The Homeless Healthcare team may no longer have a base of operation as the charity hosting the service is having to respond to financial pressures by selling its building for redevelopment	Working to source an alternative inner city location. Potential has already been identified to rent additional space from a building already used in part by the Trust
	County Council commissioners have tendered the Health Improvement Service and there is risk that this business may therefore be lost	The Trust is working towards its response to the tender application
	There is unclear governance, accountability and reporting for Medical Devices into the Quality and Performance Committee. There is no recognised Medical Devices Lead with clear role and responsibilities	This issue has been raised at the Clinical Senate. There is on-going discussion between the Director of Nursing and Quality and the Director of Service Delivery in order to resolve
	The Trust requires a recognised Decontamination Lead (as per MRHA guidelines) with appropriate qualifications and experience	Discussions are on-going to agree a Decontamination Lead. Dental services and Endoscopy are currently challenged to demonstrate full compliance with standards although both services have an agreed action plan
	There are a number of vacancies in senior management posts within Sexual Health services, including the service manager. This has led to senior colleagues taking on additional management duties, which has made it difficult for them to complete their usual clinic based work	Interviews are being held at the end of March 2015, although as any new member of staff will take time until settled in post, continued support from colleagues will be needed

Unscheduled care to include community hospitals and urgent care services	Staffing shortfalls in inpatient units are exacerbated by the escalation beds that remain open. There are insufficient numbers of bank nurses to fill the gaps leading to increased use of agency nurses which increases cost, decreases quality and continuity of care, and puts extra pressure on substantive staff	Substantive staff are currently covering clinical shifts, although this is not sustainable. The introduction of rotational posts linked to the preceptorship programme and competency frameworks, will alleviate. There is also a centralised recruitment campaign, headed by a dedicated lead on nurse recruitment
	The removal of the integrated Patient Administration System by Gloucestershire Hospitals NHS Foundation Trust will commence in May 2015, resulting in information not necessarily being available electronically to Trust colleagues	A working group has been set up in collaboration with the local acute Trust, and a robust deployment plan is in place
Corporate governance	There are some gaps and inconsistencies in record-keeping, meaning that the Trust is not always providing care based on the most up-to-date information: additionally, the Trust may then not be able to refute allegations of clinical negligence	Work is on-going to update all clinical and clinical governance policies. A training programme will be carried out to confirm that colleagues have read and understood amendments to the processes
Transformation and Change	Non delivery of the External Care programme may result in continued overspend by the County Council and loss of confidence in the Trust to maintain responsibility for this area of work	All performance in relation to External Care for 2014-15 is showing trends which would indicate achievement of the savings plan
Foundation Trust programme	There is risk that the Trust's Integrated Business Plan and Long-Term Financial Model will not be able to identify required cost savings across a five year period	The Trust's current and projected financial position suggests that costs savings are not being achieved, which may lead to financial instability

In determining the above operational risks, the Trust utilises the scoring mechanism (based upon a calculation of likelihood versus consequence) as well as the corresponding definitions, provided by the NHS National Patient Safety Agency. As such, all operational risks are reviewed in terms of their actual or potential impact upon:

- the safety of service users, staff or the public (including both physical or psychological harm);
- the quality of Trust services (which may be measured by complaints or audit);
- human resources / organisational development (to include considerations of staffing levels and competencies);
- the Trust's statutory duty or the result of inspections;
- business objectives or projects;
- the Trust's finances including claims;
- disruption or interruption to Trust services;
- the local environment.

5.3.3 Training and learning

To support staff in their understanding of operational risk identification and management, the Trust is committed to delivering a range of training programmes. Thus currently, all colleagues joining the Trust receive training in risk management as part of their mandatory induction. As additional support, colleagues are directed to the Trust's portfolio of risk management policies, including the Risk Assessment and Management Policy, the Incident Reporting and Management Policy and the Serious Incident Management Policy.

In 2015-16, the Trust will continue to disseminate learning from its risk experiences, including learning from how risks occurred, how they were identified, mitigated, and resolved or accepted within agreed tolerance levels.

Moreover, it is noted that the Trust has recently identified 24 Risk Champions across all operational delivery areas and support services in order that colleagues within frontline and back office teams can help raise the profile and understanding of risk management across the Trust. This network will now support the Trust's risk management processes which seek to ensure that:

- where an identified risk is deemed to be pertinent or applicable to staff across the Trust, the Champions will oversee the escalation of all transferable learning to all relevant teams so as to prevent or reduce the likelihood of the same or similar risk occurring;

- all changes to practice that result from risk learning, are effectively communicated to the Trust's professional partners and other stakeholders in order to evidence the organisation's integrity and commitment to continuous quality improvement;

- formal analyses in respect of operational (clinical and non-clinical) risks will be routinely shared with relevant Committees in order to facilitate the identification of trends, and enable proactive measures to be taken to reduce the potential of repeated risks occurring in future.

5.4 Internal and external sources of assurance

The assurances used in 2014-15 in order to validate the effectiveness of the Trust's internal controls, were derived from a range of internal and external sources as shown below (NB these lists are indicative only and not exhaustive):

- **Internal assurance, including:**
  - internal audit reports and Head of Internal Audit opinion;
  - local performance scorecards;
  - the Quality and Performance Report (includes benchmarking);
  - Quality Visits by the Executive and Non-Executive Directors;
  - Matron-led peer reviews
  - the Finance Report;
  - local counter fraud reviews;
  - clinical and care audit reports;
  - Friends and Family Test;
  - local service user satisfaction surveys / site specific surveys;
  - Serious Incident Requiring Investigation (SIRI) reviews;
  - incident reviews;
  - the Quality Account;
  - Annual Report of the Director of Infection Control;
  - Cost Improvement Programmes reviews;
  - the Safety Thermometer;
  - Mortality Tool;
  - Report on Controlled Drug Incidents;
  - health and safety reviews;
  - sickness absence / mandatory training rates / appraisals completion.

- **External assurance, including:**
  - Care Quality Commission reports;
  - Audit Commission reports;
  - NICE guidance;
  - compliments and complaints;
  - safeguarding reviews (adults or children's) that are initiated by Gloucestershire County Council;
  - external audit and annual letter;
  - Health and Safety Executive reviews;
  - National Confidential Enquiries into Patient Outcome and Death (NCEPOD);
  - Rule 43 Reports;
  - national audits;
  - peer reviews;
  - Information Governance Toolkit submissions;
  - NHS Protect reports;
  - Patient-Led Assessment of the Care Environment (PLACE) inspections;
  - national staff surveys;
  - NHS Trust Development Authority returns;
  - Department of Health returns;
  - Information Centre for Health and Social Care returns;
  - Secondary Uses Service (SUS) submissions.

An example of external assurance was the Review of Health Services for Children Looked After and Safeguarding in Gloucestershire that was published by the Care Quality Commission (CQC) in July 2014. This multi-agency assessment provided five clear recommendations, of which the following were pertinent to the Trust:

- ensure that appropriately trained individuals undertake health assessments and implement a robust monitoring system to ensure consistently good quality of health assessments for looked after children and young people who are living in placements either in or out of county;

- ensure that care leavers receive good quality health information, advice and guidance, and are provided with a full summary of their healthcare history in a format suitable to their needs;

- develop and implement robust monitoring systems for the safeguarding responsibilities of all independent contractors.

To address these recommendations, a detailed action implementation plan was developed for monitoring by appropriate committees within the Trust, and to provide assurance to the Board.

5.5 Deterrents to fraud

The Trust is committed to observing General Condition 6 of the NHS Standard Contract which sets out the clauses relating to counter fraud. Of particular note in 2014-15:

- the Trust obtained its counter fraud, bribery and corruption service from the Gloucestershire Local Counter Fraud Service (GLCFS) which provided regular updates on activity to the Audit and Assurance Committee;

- the organisation undertook a fraud risk assessment in April 2014 using the Self-Review Tool provided by NHS Protect;

- as a result of the Self-Review, the Trust drew up a comprehensive action plan, comprising a full range of activity to follow on from that undertaken in 2013-14 covering four areas, namely (i) Strategic Governance, (ii) Inform and Involve, (iii) Prevent and Deter, and (iv) Hold to Account;

- the Trust reviewed its counter fraud, bribery and corruption policy to ensure compliance with legislation;

- in August 2014, the Trust was visited by the Quality and Assurance Team from NHS Protect who undertook an assessment of the Trust's counter fraud arrangements and activities relating to the Prevent and Deter standards. As a result of the progress the Trust had made to strengthen procedures within two of the standards which had previously rated "red" in the 2013-14 Self-Review Tool and "amber" in 2014-15, the assessors uplifted both to "green", giving the Trust an overall "green" rating for Prevent and Deter;

- the GLCFS delivered fraud awareness presentations as part of induction and at departmental meetings, and used newspaper articles of successful prosecutions as a deterrent to would-be fraudsters;

- the Trust adopted a robust response to anyone found to have committed fraud and ensured all appropriate sanctions were considered, including prosecution, internal and professional disciplinary action, and financial recovery. Outcomes from investigations included two criminal prosecutions (one guilty plea with a sentence of 120 hours community service; one case withdrawn as the subject had left the country), in addition to three resignations and one written warning following internal disciplinary action. £13,169.89 was recovered.

5.6 Information Governance breaches

The Trust maintains robust processes to identify all possible and actual risks to robust information governance, and thus, the occurrence of any incident which may threaten the safety, security, confidentiality, integrity, availability or accessibility of any person-identifiable or other confidential information held under the Trust's guardianship, whether such information relates to the Trust's service users, employees or business critical matters.

Throughout 2014-15, the Trust used the Datix system to report and monitor all such information governance incidents. However, it is noted that in year, there were no serious information governance breaches that required internal investigation or escalation to the Information Commissioner.

The principle success of 2014-15 in terms of information governance was the achievement of Level 2 compliance with the requirements of the Information Governance Toolkit. The Trust now plans to aim for Level 3 compliance in those areas where this is practical and achievable.

5.7 Future risks

Whilst the individual risk registers in operation across the Trust already anticipate some future risks, additional potential concerns are held within the organisation's SWOT analysis, which is routinely reviewed at Board. These additional risks / threats include:

- potential disinvestment from Commissioners which, if too significant, could undermine the Trust's continue financial sustainability;
- increased competition from other providers both from within Gloucestershire and outside;
- an ageing clinical workforce profile which could, in the medium- to long-term, impact upon staffing numbers and therefore the ability to deliver commissioned care;
- pressures on services due to national and local requirements for increased 7 day working practices without corresponding financial investment;
- increasing health inequalities between the least and most disadvantaged in Gloucestershire society.

The Trust will continue to monitor all these possible eventualities as part of its routine evaluation of its SWOT, and transfer to the Board Assurance Framework as risks when appropriate.

6. Other Controls

6.1 Public and stakeholder involvement

The Trust is committed to partnership working with all local professional stakeholders including the Gloucestershire Clinical Commissioning Group, Gloucestershire County Council, Gloucestershire Hospitals NHS Foundation Trust, 2gether NHS Foundation Trust and South Western Ambulance Service NHS Foundation Trust. Equally, the Trust works closely with a range of organisations from the voluntary sector including Sue Ryder, Carers Gloucestershire, the Gloucestershire Deaf Association etc.

Moreover, the Trust actively seeks service user involvement and feedback, not only through formal surveys and consultations, but also proactively through the established Your Care, Your Opinion Programme Board which is attended by a range of public and service user representatives including Healthwatch Gloucestershire and the Learning Disability Partnership Board.

The most visible public event in 2014-15 was the Trust's first Annual General Meeting (AGM) which was held in October 2014. This welcomed over 200 members of the public, professional partners and staff, and celebrated the work of the Trust with a large-scale interactive exhibition.

6.2 Equality, Diversity and Human Rights

The Trust maintains dedicated processes and controls so as to gain assurance that the organisation complies appropriately with all relevant equalities and human rights legislation and regulations. These controls include:

- the publication of an Equality Annual Report in January 2015 to demonstrate how the Trust meets the Public Sector Equality Duties under the Equality Act 2010;
- equalities objectives and detailed implementation plans to address priorities identified both within the Equality Annual Report and as evidenced by the Trust's communities and colleagues;
- the use of detailed eQuality Impact Assessments (eQIAs) to support policy creation and revision, and all service change initiatives;
- an Equality and Human Rights Policy which sets out the responsibilities of all colleagues, and which is available on the Trust's internet and intranet;
- a reporting line into the Quality and Clinical Governance Committee in order to provide assurance that equality and human rights considerations are embedded throughout the Trust;
- mandatory Equality, Diversity and Human Rights training that is made available for all Trust colleagues.

6.3 NHS Pension Scheme

As an employer whose workforce is entitled to membership of the NHS Pension Scheme, the Trust maintains necessary control measures to ensure that all obligations contained within the Scheme's regulations, are fully embedded in policy and procedure. These control measures include formal process to verify that deductions from salary, as well as employer's contributions and payments into the Scheme, are made in accordance with the Scheme's rules, and that members' records are updated accurately in accordance with the timescales detailed within the regulations and associated guidance.

The Trust also offers the NEST pension scheme to staff who do not qualify for the NHS pension scheme.

6.4 Corporate Social Responsibility

As part of its Corporate Social Responsibility (CSR) policy, which recognises that the Trust has an explicit responsibility to act as a Good Corporate Citizen, the Trust is wholly committed to reducing its environmental impact whilst contributing positively to local communities. Key achievements in 2014-15 have included the following:

- reduced carbon footprint from building energy use by 2%;
- reduced water consumption across Trust sites by 5%;
- refurbished Thames Ward, Cirencester Hospital and added LED lighting;
- installed smart LED lighting at the Trust's head office;
- implemented an inverter project to reduce the energy consumption of air handling at Cirencester Hospital by 50%;
- promoted active healthy lifestyles with a cycling event and the provision of 9 pool bikes for use by school nurses for appointments, and office staff for meetings;
- increased the use of Webex for meetings across the Trust to reduce unnecessary travel across the county;
- encouraged volunteers to plant an additional 500 trees across Trust sites in order to increase physical activity and reduce carbon emissions;
- refreshed and re-launched the Trust's Charitable Funds so as to increase the awareness and understanding of ways in which the Trust can help some of the most vulnerable service users in Gloucestershire.

7. Trust performance

7.1 Internal audit results

In 2014-15, seven internal audits were conducted in respect of key aspects of the Trust's control system i.e. performance reporting, clinical systems, payroll, staffing escalation, staff overpayment, core financial systems and corporate governance (NB an additional audit on External Care spend commenced in March 2015, but will not report until later in the year). The risks and issues highlighted by these audits are shown below, together with details of the Trust's mitigating actions.

Subject of audit	Level of risk	Identified risks	Trust mitigation	Current level of risk
Performance Reporting System (quarter 1)	Medium	There is no defined control framework for managing and controlling changes to system configurations	A process is currently being embedded to ensure a control framework is introduced. To date, the evolution of Essbase (the Trust's financial reporting tool) has been developmental; however the need for this framework is crucial as this continues	Low
		There is currently no requirement for teams performing data validation to confirm the number of records corrected, the root causes of the data problems, or retain any evidence of their activity	A process has now been established to ensure validation of load data. This formalises the checks that currently take place and establishes a documented procedure to provide an audit trail and ensure consistency	Low
	Low	There is not a consistent process of access authorisation to ensure that user access is reviewed on a periodic basis and therefore that access remains commensurate with job roles and responsibilities	An authorisation process has been fully established and embedded	Good practice
		Formal training is not regularly provided to users who require technical skills and knowledge as part of their job role	This will be embedded into the Essbase System Manager role. The need for more complex, technical training for key individuals will also be reviewed. Moreover, all users of the Trust's new business intelligence reporting tool (OBIF) will have full system training	Low

Subject of audit	Level of risk	Identified risks	Trust mitigation	Current level of risk
Clinical System Project Management (quarter 1)	High	There is no clear documentation which outlines how non-financial benefits will be measured	The Trust is currently developing a document to outline non-financial benefits and how they will be measured. The Trust will also be implementing a mechanism for monitoring and reporting	Medium
	Medium	The Trust would benefit from a review of the project scope against deliverables to ensure that the project is still in alignment and 'scope creep' has not occurred	The Trust continues to review the project scope to ensure that it is still in alignment with the needs of the Trust	Good practice
	Low	The project organisational structure chart is out of date	The Trust has updated the organisational, reporting and governance structure, so that the project configuration is appropriate	Good practice
		Stakeholders were originally defined within the Project Initiation Document: however, there is no clear stakeholder engagement strategy, plan or responsible role. As such, their expectations and needs may not be met	The Trust has mapped all stakeholders, and has clear processes and governance arrangements to ensure that all relevant internal and external parties are involved and engaged via participation in forums, routine communications etc	Low
		There may be an opportunity for key members of the project team, such as the Senior Project Manager, to undertake formal project management training	The Senior Project Manager is suitably qualified and has clear documented objectives	Good practice
	Opportunities for further review	Risk and opportunities management could be reviewed to provide assurance of the quality and effectiveness of the risk processes	Risk management processes have been significantly improved with reporting and review through established governance arrangements, and robust escalation procedures to alert senior colleagues of any salient concerns	
		A more detailed audit may enhance project outcomes and provide control operating effectiveness assurance to the Project Board	This opportunity will be reviewed as the project continues	

Subject of audit	Level of risk	Identified risks	Trust mitigation	Current level of risk
Payroll Review (quarter 2)	High	Employees are able to submit duplicate or inaccurate timesheets which could result in an overpayment to the employee	Staff will receive training on fraud awareness, and will be reminded of the importance of diligently reviewing time sheets. Analysis is already being undertaken of payroll each month to highlight the largest variances for further review. It is noted that the introduction of e-rostering will eliminate the potential for duplication	Medium
	Medium	There is no list of authorised signatories to determine whether or not an authorisation is appropriate and legitimate	The Trust will maintain a list of authorised signatories. All amendment forms will be agreed by an authorised signatory before processing	Medium
		In respect of starters, leavers and amendments, forms are not always provided in good time to the Workforce team or are appropriately dated	All starters, leavers and amendment forms will be authorised and dated in good time. Line managers will be held to account where this process is not followed	Medium
	Low	The Trust's leavers' process has existed since January 2012, and as such, may not meet the needs of the Trust	The Trust has reviewed and updated its procedures, and ratified these through agreed governance structures	Good practice
		It is possible for members of the Trust's Workforce team to amend their own payroll details within the payroll system	To reduce risk, the payroll team sends records to SBS for authorisation: once completed, analysis is forwarded to the Director of Finance highlighting variances from the previous month to enable further validation	Low
		The log which records and tracks errors made by SBS is not reviewed or approved by senior members of Trust staff	The query log will be periodically reviewed by the ESR Systems Manager, who will escalate necessary issues to senior management	Low
		The Trust does not review final payment calculations to ensure that these have been made correctly	The Workforce team will check the accuracy and completeness of a sample of pay information each month	Low
	Advisory	There are no KPIs for processing new joiners or leavers	Reporting, KPIs and metrics are now included in workforce reports	Good practice

Subject of audit	Level of risk	Identified risks	Trust mitigation	Current level of risk
Staffing Escalation (quarter 2)	Medium	There is limited sharing of information between central support service teams, with budget holders regularly receiving duplicate requests for information from teams	A formal feedback loop will be established to ensure relevant central functions receive appropriate information from monthly finance and performance review meetings with service managers: this will form part of the new formalised finance governance guidelines	Medium
		Cost Improvement Plans (CIPs) should include guidance and support on implementation to enable budget holders to get a better understanding of how they can achieve savings within their teams	CIP training (together with CQUINs and QUIPPs) will be provided where a need is identified	Medium
		Quality and equality impact assessments are not completed by budget holders before any changes are made to establishment	The Trust will ensure that each operational plan is supported by a workforce plan and subject to an eQuality Impact Assessment	Medium
		Budget holders do not always ensure that the HR team is provided with timely leaver information to ensure that final payroll calculations can be met and overpayments avoided	All leavers information will be authorised and dated in good time. Line managers will be held to account where this process is not followed	Medium
		Workforce planning changes are not clearly communicated to teams and there is not sufficient collaboration with budget holders during development	When relevant, workshops for service leads will be held to provide guidance and instruction on the development of workforce plans in line with both operational and strategic organisational goals	Medium
		There appears to be a lack of clarity around the need to either hold open or recruit staff to vacant posts	The quality of feedback provided for rejected requests has been enhanced with more detailed explanations provided	Good practice
		Budget holders should raise concerns regarding staffing levels into Datix and to line managers on a daily basis if required	There is greater understanding and escalation of staffing risks: this needs to be an on-going focus to reinforce its importance	Low

Subject of audit	Finding *(NB not risk rated)*	Trust actions
Staff Overpayment (quarter 2)	The Trust's leavers' process has existed since January 2012, and as such, may not meet the needs of the Trust	The Trust has reviewed and updated its procedures, and ratified these through agreed governance structures
	Upon someone leaving the employ of the Trust, it is the line manager's responsibility to email the workforce team. The Workforce team should then check that this person has been removed from the payroll system	All starters, leavers and amendment forms will be authorised and dated in good time. Line managers will be held to account where this process is not followed
	Budget holders' review of monthly budget reports should identify if costs in relation to a leaver, are still being processed inappropriately	Budget holders are reminded of the need to fully interrogate their budgets to ensure that all pay and non-pay costs incurred within their budgeted responsibility, are appropriate
	Payslips are distributed to employees at their work address. If more than one month's payslip is sent to a directorate, the budget holder should become aware that an overpayment may have been made to an ex-employee	Budget holders are reminded to check payslips upon receipt. Moreover, staff should be reminded not to send payslips to employee's home addresses unless given appropriate authorisation to do so
	Should an overpayment occur, there should be a process to systematically communicate this back to the budget holder	The Workforce team will liaise with budget holders in the event of an overpayment to ensure that all relevant parties are aware of the issue
	There is evidence that the Trust has previously advised SBS that a member of staff was being paid through the incorrect annual fee rate, but that the responsible officer in SBS was unavailable, so a colleague acted on their behalf but missed the Trust instruction	The Trust will seek assurance from SBS that should responsible officers within SBS be unable to fully undertake their duties, an appropriate officer will be assigned
	SBS send follow up letters to client employees if overpayments are made. However, it is not standard practice for SBS to inform clients, such as the Trust, if an overpayment is made to a client's employee	The Trust should liaise with SBS to agree monetary amount above which all correspondences related to overpayment are discussed with the Trust before issue. This recommendation could be expanded to include all staff members on the red list

Subject of audit	Level of risk	Identified risks	Trust mitigation	Current level of risk
Core Financial Systems (quarter 3)	Medium	There is currently no control in place to confirm the completeness of the list of journals which have been printed and stored in paper files for review	The Trust has implemented a formal monthly review to reconcile the list of journals posted into the ledger with those in the paper files. This review will be retained in case any further investigation is required	Good practice
		The procurement process requires multiple quotes to be obtained for certain purchases. These are not retained on a shared drive leaving management unable to establish when a Procurement Waiver Form should be signed by the Director of Finance	Quotes obtained for purchases will be retained on a shared drive. These will be reviewed centrally to identify cases where a Procurement Waiver is required	Medium
	Low	The Trust does not maintain a Signatory List of the finance staff who review documents and journals	The Trust will maintain a signatory list of all members of staff who may authorise journals or review information received by SBS. This list will be used to confirm that authorising signatories are appropriate	Low
	Advisory	There are no reports provided and no monitoring of the performance SBS against contract KPI's	Monitoring of SBS against contract KPIs is undertaken on a weekly basis	Good practice
Subject of audit	**Level of risk**	**Identified risks**	**Trust mitigation**	**Current level of risk**
Corporate Governance (quarter 4)	Medium	The Information Governance team structure and cost is not in line with other Trusts who scored highly on the Toolkit	The Trust is currently reviewing structures for Information Governance support, with a view to delivering the most efficient and cost-effective service	Medium
	Low	The job descriptions for Information Governance roles require review, ensuring that there are no duplicate tasks, and there is clear definition of the responsibilities for each role	Job descriptions have now been reviewed supported by the HR team in order to ensure that there is clarity of purpose, role, remit and responsibility	Good practice

7.2 TDA Accountability Framework indicators 2014-15

For 2014-15, the Trust's performance against the relevant indicators within the TDA Accountability Framework was as follows TO BE COMPLETED MONDAY:

Metric		Trust Performance 2014-15	Target (where applicable)	RAG
Caring	Inpatient scores from Friends and Family Test*		+60	
	A&E scores from Friends and Family Test*		+46	
	Complaints		n/a	n/a
	Inpatient Survey: Q68 Overall I had a very poor/good experience?		n/a	n/a
	Mixed sex accommodation breaches	0	0	
Well-Led	Inpatients response rate from Friends and Family Test	40%	30%	
	A&E response rate from Friends and Family Test	19%	20%	
	Data quality of Trust returns to the HSCIC	99.2%	96%	
	NHS Staff Survey: Percentage of staff who would recommend the Trust as a place of work	52%	61%	
	NHS Staff Survey: Percentage of staff who would recommend the Trust as a place to receive treatment	68%	67%	
	Trust turnover rate		n/a	n/a
	Trust level total sickness rate		n/a	n/a
	Total Trust vacancy rate		n/a	n/a
	Temporary costs and overtime as % total paybill		n/a	n/a
	Percentage of staff with annual appraisal		n/a	n/a

Effective	Emergency re-admissions within 30 days	10.7%	n/a	n/a
Safe	C. diff (variance from plan)	17	21	
	MRSA	0	0	
	Never Event incidence		0	
	Medication errors causing serious harm		0	
	Percentage of Harm Free Care	92.6%	95%	
	Proportion of patients risk assessed for VTE	98.2%	95%	
	Serious Incidents	27	0	
	Patient safety events that are harmful		0	
	Overdue CAS alerts	2	0	
Responsive	Number of diagnostic tests waiting longer than 6 weeks	0%	1%	
	A&E 4 hour waiting time (all types)	99.82%	95%	
	A&E 12 hour trolley waits	0	0	
	Urgent ops cancelled for second time	0%	0%	
	Proportion of patients not treated within 28 days of last minute cancellation	0%	0%	
	Delayed transfers of care		7.5%	

**These two measures ceased reporting nationally in January 2015, and were replaced by a calculation of the percentage of people responding who were either "Likely" or "Extremely Likely" to recommend the Trust to friends and family: results for the three months to March 2015 showed 91% in respect of inpatient settings and 97.9% in respect of A&E (or Minor Injury Unit) settings.*

8. Review of Effectiveness

As Accountable Officer, I have ultimate responsibility for reviewing the effectiveness of the Trust's Board/corporate governance, quality/clinical governance, financial governance and internal control systems. My review of 2014-15 however is informed by the contribution and perspective of the Trust's Executive and Non-Executive Directors, as well as senior managers, who each have individual responsibility for contributing to the maintenance and quality of these functions.

In developing this Annual Governance Statement, I have also drawn upon the wealth of information that has been reported to the Trust Board and/or its Committees over the past twelve months, together with self-assessments, peer and external reviews. Additionally, my assessment is underpinned by the work of both the internal and external auditors in their various reports.

Finally, I have been advised on the implications of my review by the Trust Board and its appropriate Committees, and would note that a plan to address all identified weaknesses, and thereby ensure continuous quality improvement, is already in place.

To this end, I would note that the following actions have been highlighted as requiring additional focus in 2015-16:

- *reflect upon the feedback received by the NHS Trust Development Authority as well as other independent assessors, in order to strengthen Board and subcommittee practices;*

- *validate that the implemented improvements to incident reporting processes are successfully encouraging colleagues to highlight areas of concern so that corresponding quality improvements can be made;*

- *maintain the momentum in building improved risk management processes and practices that have already resulted in the development of a detailed Board Assurance Framework;*

- *ensure consistent use of a more robust eQuality Impact Assessment tool so as to understand the potential consequence of service change upon all stakeholders and populations, especially those who are most seldom seen and seldom heard.*

Notwithstanding, in light of the information within this Annual Governance Statement, I conclude that the Trust has a sound system of governance practice and internal control that with the above adjustments, will facilitate achievement of the organisation's vision, values and strategic objectives within the coming years.

Chief Executive Signature:
Date: