Gloucestershire Care Services NHS
NHS Trust

Agenda

Agenda

Trust Board
Tuesday, 25 November 2014
9.30am – 4.00pm

Malvern & Coopers Room, Edward Jenner Court,
1010 Pioneer Avenue, Brockworth, Gloucester, GL3 4AW

Agenda No.	Item.	Outcome	Ref No.	Presenter
1.	Rapid Response Team	For information	14/B024	Helen Hodgson/Cathy Campbell
Refreshment Break				
2.	Apologies		14/B025	Chair
3.	Declaration of Interests	To receive	14/B026	Chair
4.	Minutes of the Meeting held on 16 September 2014	To approve	14/B027	Chair
5.	Matters Arising (Action Log)	To note	14/B028	Chair
6.	Forward Agenda Planner review	To approve	14/B029	Chair
7.	Questions from the Public All questions from the public should be received in advance	For discussion	14/B030	Chair
8.	Chair's Report	To receive	14/B031	Chair
9.	Chief Executive's Report	To receive	14/B032	Chief Executive
10.	Chief Operating Officer's Report	To receive	14/B033	Chief Operating Officer
11.	Media Analysis	To note	14/B034	Director of Corporate Governance and Public Affairs
Governance, Quality and Safety				
12.	Quality & Performance Report	To receive	14/B035	Medical Director
13.	Complaints Policy	To receive	14/B036	Medical Director
14.	Quality & Clinical Governance Committee update – minutes 13 Aug 2014	To note	14/B037	Chair of Q&CG
15.	HR Report and HR & OD Committee update - minutes 18 August 2014	To note	14/B038	Chair of HR & OD/Director of HR
16.	LiA Presentation – Pass it on	Presentation	14/B039	Listening into Action Lead Coordinator
Refreshment Break				
Service Delivery and Performance				
17.	Charitable Funds Committee update – minutes 19 August 2014	To note	14/B040	Chair of Charitable Funds

18.	Finance Report	To receive	14/B041	Director of Finance
19.	Annual Security Report	To receive	14/B042	Director of Finance
20.	Performance & Resources Committee update – minutes 2 Sept 2014	To note	14/B043	Chair of P&R
21.	Quality Impact Assessment	To receive	14/B044	Chief Operating Officer
22.	Audit & Assurance Committee update - minutes 4 June 2014	To note	14/B045	Chair of A&A
23.	SystmOne Paper – Community Hospitals and MIU	To approve	14/B046	Director of Finance
Ratification of Strategies				
24.	Information & Performance Management Strategy	To approve	14/B047	Director of Finance
Information				
25.	Any other Business	To note	14/B048	Chair
26.	Date of Next Public Meeting Tuesday, 20 January in Coopers/Malvern Training Rooms, Edward Jenner Court, Brockworth, GL3 4AW			

GLOUCESTERSHIRE CARE SERVICES
NHS TRUST BOARD

Minutes of the Meeting held on Tuesday, 16th September 2014 at Brockworth Community Centre, GL3 4ET

Voting Board Members	
Ingrid Barker (IB)	Chair
Joanna Scott (JS)	Non-Executive Director, Vice Chair
Paul Jennings (PJ)	Chief Executive
Robert Graves (RG)	Non-Executive Director
Richard Cryer (RC)	Non-Executive Director
Susan Mead (SM)	Non-Executive Director
Christopher Creswick (CC)	Non-Executive Director
Nicola Strother Smith (NSS)	Non-Executive Director
Glyn Howells (GH)	Director of Finance/Deputy Chief Executive
Elizabeth Fenton (EF)	Director of Nursing and Quality
Dr. Mike Roberts (MR)	Interim Medical Director
Board Attendees (Non-Voting)	
Duncan Jordan (DJ)	Chief Operating Officer
Jason Brown (JB)	Director of Corporate Governance & Public Affairs
Susan Field (SF)	Director of Service Transformation
Tina Ricketts (TR)	Director of Human Resources
In Attendance	
Jenny Goode	Minute Taker

Members of the public/observers
A number of staff attended the meeting.

Ref	Minute	Action
TB 82/14	**"Patient Story" presentation – Wheatridge Court** IB introduced the team from Wheatridge Court (namely Mike McEachern, Establishment Manager, James Ahern, Assistant Manager, Kim Jones, Assistant Manager and Lee Russell, Residential Support Worker), who described the services they provide for adults with physical disabilities including sensory loss. The team's presentation outlined the service's referral and admission process, care planning procedure, as well as the practical challenges faced by the team. Additionally, three case studies were highlighted. IB thanked the team for their excellent presentation, and commended the outstanding work at Wheatridge Court.	

TB 83/14	**Agenda Item 2: Apologies** Apologies were tendered by Candace Plouffe, Director of Service Delivery.	
TB 84/14	**Agenda Item 3: Declarations of Interest** There were no changes to the recorded declarations of interest.	
TB 85/14	**Agenda Item 4: Minutes of the Meeting held 15 July 2014** The Board received the minutes of the previous Board meeting held on 15 July 2014. A number of minor amendments were requested which will be made prior to IB signing the final draft for retention. **Subject to the agreed revisions and amendments, the minutes were APPROVED by the Board.**	
TB 86/14	**Agenda item 5: Matters Arising (Action Log)** The Board reviewed the Action Log and noted those actions that could now be closed. Where items could not be closed, the Board received a progress update, and updates will be shown at the next Board meeting. • **TB125/13** - the report on Charitable Funds will be circulated to Board members outside of the meeting, and the matter will be discussed at the next Board on 25 November. This action can then be closed. • **TB27/14** - EF advised that the Trust's Complaints Policy is being updated. EF will attend a future NEDs meeting to update on progress and a full report will be presented at the next Board. This action can then be closed. • **TB30/14** - included within this Agenda at item 15. This action can be closed. • **TB54/14** - included within this Agenda at item 14. This action can be closed. • **TB64/14** - included within this Agenda at item 16. This action can be closed. • **TB65/14** - closed as actions have been completed. • **TB70/14** - included within this Agenda at item 12. This action can be closed.	

	• **TB70/14.1** - included within this Agenda at item 15. This action can be closed. • **TB73/14** and **TB74/14** - closed as actions have been completed. • **TB75/14** –included within this Agenda at item 14. This action can be closed. **The Board NOTED the updates to the Action Log.**	
TB 87/14	**Agenda item 6 – Forward Agenda Planner review** GH confirmed that the Trust's five year Integrated Business Plan will be discussed under Part 2 of Board Agenda over the coming months until its completion and ratification. RC reported that a Social Values Strategy was in development. TR and JB to meet after the Board to discuss which Committee should receive and review this strategy going forward.	**TR/JB**
TB 88/14	**Agenda Item 7: Questions from the public** No questions had been received.	
TB 89/14	**Agenda item 8: Chair's Report** IB took the Chair's Report as read, and briefed members on other recent developments, which included the following: • **West of England Academic Health Science Network Leaders' Meeting (10 September)** - IB attended this meeting, and will prepare a briefing for Board; • **TDA Meeting** - IB recently attended a meeting in London with Sir Peter Carr (Chair of the NHS Trust Development Authority, "TDA") at which a number of issues were discussed including the Foundation Trust pipeline; • **Gloucester Community Hospital** - a formal letter has been received from Gloucester City Council about the possibility of a community hospital in Gloucester. A joint response is being prepared with the Gloucestershire Clinical Commissioning Group, which will be shared with Board members prior to release; • **2gether Trust Annual General Meeting (AGM)** - IB and EF attended the 2gether Trust AGM on 15 September. **The Board NOTED the report.**	**JB**

TB 90/14	**Agenda item 9: Chief Executive's Report** PJ presented the report and commented on the following: • **Interim Medical Director** - PJ formally welcomed MR to the Board, and noted his significant experience in the local GP community which will be an invaluable asset to the Trust; • **Out-of-Hours service** - the Trust is currently awaiting the Clinical Commissioning Group's decision on the tender for the Out-of-Hours service: this is expected in October; • **Leading for Quality Care** - by December, approx. 300 staff will have attended this leadership training programme; • **Listening Into Action** - consideration is being given to the viability and benefits of rolling Listening Into Action into year 2: this matter will be discussed again at a later Board; • **Savile Reports** - PJ noted key lessons from the recent enquiries into Jimmy Savile as being (i) the courage of the individuals to speak out, and (ii) the need for organisations to really listen to, and respect, what the public say. **The Board NOTED the report.**	
TB 91/14	**Agenda item 10: Chief Operating Officer's report** DJ presented the report and highlighted the following: • **Community Nursing Recruitment** - this remains high priority for the Trust, although as MR noted, recruitment is not just a local problem but a national issue. Four open days are being held in October to try and attract new nurses. PJ commented that the Trust also needs to work closer with Gloucestershire Hospitals Foundation Trust on shared recruitment challenges - TR and EF will follow up on this; • **External Care** - DJ recognised some slippage against planned budget, but noted that his team are looking at ways to improve this position; • **Serious Case Review –** DJ echoed the recent review, and commended Trust staff for their work and contributions. IB thanked DJ for an informative report and commented that it was a welcome addition to the Board. **The Board NOTED the report.**	

TB 92/14	**Agenda item 11: Media analysis** Rod Brown (acting as interim Head of Communications and Engagement) presented the report, explaining that it will refined in subsequent iterations dependant on Board feedback. To this end, the Board very much welcomed the report and the breadth of media it covered. JS and CC in particular asked for following reports to also include a scoring mechanism to show the impact of various media coverage, and how closely media reports represent the Trust's key messages. **The Board NOTED the report.**	
TB 93/14	**Agenda item 12: Quality and Performance Report** The report was taken as read, and the following issues were highlighted: • IB commented that the report's new format was welcome, and thanked Rod Brown for pulling it together; • clarity was sought over some of the presented data (i.e. the year-to-date figures for compliance with national and local targets): GH to investigate; • it was agreed that reporting parameters would be reviewed so that for future reports, data would be consistently presented at either ward, hospital or locality level; • it was requested that triangulated reporting also be included for community-based services; • RG felt that it would be useful for the Board and other receiving Committees to have operational managers in attendance to explain the detail: JB to discuss with IB; • the Board commended the improvement in the Patient-Led Assessment of the Care Environment (PLACE) scores; • Board members asked that future reports provide greater detail regarding indicators that are RAG rated either Amber or Red so as to clarify when precisely it is anticipated that these will become green; • NSS noted that a Quality Visit to the Wheelchair Centre had taken place on 22 July but had not been reported. **The Board NOTED the report.**	

TB 94/14	**Agenda item 13: Patient Experience Development Framework self-assessment** EF presented the Trust's self-assessment against the TDA framework, aimed at improving patient experience. EF emphasised that this report was a first-run assessment for the Board's information, and that the framework would continue to be reviewed going forward. Members felt that some of the scores were a little harsh, but recognised that this was an on-going piece of work. **The Board NOTED the self-assessment.**	
TB 95/14	**Agenda item 14: Finance report** GH presented the report to Board and gave a brief overview. The following comments were made: • following a discussion about workforce numbers, GH agreed to ask the Deputy Head of Finance to produce a report showing the number of whole-time equivalent (WTE) posts against plan and actual by month, and circulate this to Board members; • in response to a concern raised by RC, DJ responded that the current recruitment drive aimed at filling vacancies, should result in a significant reduction in the use of agency staff; • in terms of Cost Improvement efficiencies, DJ reassured the Board that additional opportunities are still being sought to identify further savings: IB requested that Board receive detail of this work at the next Board meeting; • IB commented that the Board needs to understand exactly how much risk the Trust faces with respect to potential non-delivery of CQUINs and QIPP: DJ to report at the next Board; • JB noted that the risks to delivery of both CQUINs and QIPP should be recorded by their respective owners on the Corporate Risk Register. IB agreed with this proposal. **The Board NOTED the report.**	**DJ** **DJ** **DJ / SF / CP**

TB 96/14	**Agenda item 15: Reablement Service Report** SF presented a service progress report which highlighted a number of performance and workforce issues. As a result, it was agreed that a workshop would be held with all key stakeholders to explore prevailing issues. **The Board NOTED the contents of the report and:** • **SUPPORTED progress of the action / milestone plan outlined in Appendix 1;** • **REQUESTED that a workshop be scheduled ASAP;** • **AGREED that further service reports be discussed at the Performance and Resources Committee**.	**SF**
TB 97/14	**Agenda item 16: Workforce Strategy** TR presented the Strategy to the Board for ratification. **The Board APPROVED and RATIFIED the Workforce Strategy for adoption by the Trust.**	
TB 98/14	**Agenda item 17: Business Continuity Strategy** SF presented the Strategy to the Board for ratification. In discussing the Strategy, the matter of Business Interruption insurance cover was discussed. JB reported that he had obtained quotations for this specific cover, but recommended that it was not cost-effective or good use of resources. Additionally, GH asked that when the implementation plan is developed, that trial runs be included: SF confirmed that such test exercises are already scheduled for October. **The Board APPROVED and RATIFIED the Business Continuity Strategy for adoption by the Trust.**	

TB 99/14	**Agenda item 18: Quality and Clinical Governance Committee Report and Minutes** A report of the Committee meeting held on 13 August, and the minutes of the meeting held on 12 June, were taken as read. However, SM as Chair of the Committee, drew the Board's attention to the continued need for Quality Impact Assessments in order to be routinely reassured that there is evidence of quality in practice. PJ raised the issue of District Nursing, and suggested that it would be helpful for the Board if the Quality and Clinical Governance Committee could discuss this matter. SM confirmed that this subject was due for discussion at the Committee in October. **The Board RECEIVED the report and APPROVED the minutes of the meeting held on 12 June**	
TB 100/14	**Agenda item 19: Performance and Resources Committee minutes** The minutes of the meeting held on 2 July were taken as read. However, DJ noted the need to clarify the sequence of reporting minutes to Board, as they are often quite out of date. JB to review. **The Board RECEIVED and APPROVED the minutes of the meeting held on 2 July**	
TB 101/14	**Agenda item 20: Audit and Assurance Committee minutes** The minutes of the meeting held on 14 May were taken as read. It was noted that a further meeting had been held in June. **The Board RECEIVED and APPROVED the minutes of the meeting held on 14 May**	
TB 102/14	**Agenda item 21: HR&OD Committee Update** A report of the Committee meeting held on 18 August, and the minutes of the meeting held on 19 June, were taken as read. TR also circulated a set of Coaching Cards around the Board for information. **The Board RECEIVED the report and APPROVED the minutes of the meeting held on 19 June**	

TB 103/14	**Agenda item 22: Charitable Funds** The minutes of the meeting held on 21 May were taken as read. Additionally, the following comments were made: • Executive responsibility for Charitable Funds has now transferred from the Director of Finance to the Director of Corporate Governance and Public Affairs; • NSS formally thanked GH and his team for their good work; • JB is now developing a Charitable Funds Strategy, and is working on branding and marketing: furthermore, he will liaise with the Leagues of Friends around the county (it was also noted that IB and NSS were also due to meet the League Chairs imminently); • GH updated on the land at Brokenbrough, confirming that there is no other valid legal claim to the property. The next Charitable Funds meeting will therefore seek to agree with the Great Western Hospital how our two organisations can work together to maximise value. **The Board RECEIVED and NOTED the update and APPROVED the minutes of the meeting held on 21 May**	
TB 104/14	**Agenda item 23: Any Other Business** • GH presented a Food Hygiene Report, explaining that the inspection carried out at Tewkesbury Hospital on 25 November 2013 had been a victim of unfortunate timing, and that the Executive Team had not been made aware of the visit or the subsequent rating. RG asked that a further inspection is carried out asap, and GH confirmed this had already been requested. The Board agreed that a future report should be discussed at the Quality and Clinical Governance Committee and subsequently, at the Audit and Assurance Committee. There being no further business, IB **closed** the meeting at 13:45.	

Chair's Signature ……..

Date ……..…….

Gloucestershire Care Services NHS Trust Board Action Log

Minute Reference	Action Agreed	Lead Exec	Update for 16 September 2014	Proposed Close Date	Status
Actions Carried forward from Gloucestershire Care Services Operational Board					
TB125/13	Present report on Charitable funds available and its uses for staff to Execs team and report to Board	Director of Finance	Report coming to September Board and will be of interest to League of Friends' Chairs. On Agenda	Sep-14	Open
TB27/14	Additional information denoting Trust lead for each complaint and highlighting where scrutiny is delegated to Q&CG Committee to be included in Trust's response to Clywd/Hart report.	Director of Nursing & Quality	Implementation Plan to July Board The complaints function transferred to Director of Nursing on 1st April. Review of Director of Strategy plan undertaken and a meeting arranged to discuss this within the NED forward plan. Update on progress to September's Board	Sep-14	Closed
TB30/14	Present report to May's Board from working party established to evaluate the Reablement service.	Chief Operating Officer	Report to Septembers meeting	Sep-14	Closed
TB54/14	Board recommended CIP schemes continue to be reported to and monitored by Performance & Resources Committee	Chief Operating Officer	CIP Schemes and Project Plans Report to September Board	Sep-14	Closed
TB64/14	The Chair of HR&OD (CC) identified an action from May's minutes had been omitted from the log and requested the Workforce Strategy paper is included on the forward planner as an agenda item for September's Board	Director of HR/Director of Corporate Governance & Public Affairs	On-agenda	Sep-14	Closed
TB65/14	The Board members suggested various items to be included on the Forward Agenda Planner	Director of Corporate Governance & Public Affairs			Closed
TB70/14	Level of harm breakdown requested. Analysis will be undertaken and included in the next report to Q&CG Committee (August 2014)	Director of Nursing & Quality		Sep-14	Closed
TB70/14.1	DJ to request Caroline Holmes investigates what is happening to clients no longer going into residential care and include findings in Reablement paper (TB30/14) for presentation to September Board	Chief Operating Officer		Sep-14	Closed
TB73/14	Amend attendance record for April 2013 to reflect Joanna Scott had not yet been appointed a NED and therefore not absent	Director of Corporate Governance & Public Affairs		Jul-14	Closed
TB74/14	RG to meet with TR to advise suggested amendments to Equality Objectives	Director of HR	Completed. Equality objectives amended and published on Trust website	Sep-14	Closed
TB75/14	Major piece of work to be undertaken and report produced on CIP schemes and mitigation of risk for September's meeting	Chief Operating Officer / Director of Finance		Sep-14	Closed
Gloucestershire Care Services NHS Trust Board Action Log					
TB87/14	TR & JB to decide which Committee should receive the Social Values Strategy going forward	Director of HR/Director of Corporate Governance & Public Affairs	HR & OD to receive the strategy	Nov-14	Open
TB89/14	A joint letter from GCS and GCCG to be compiled in response to GCC letter re a Community Hospital for Gloucester	Director of Corporate Governance & Public Affairs			Open
TB95/14	It was requested that the Board receive detailed CIP report at the next Board meeting	Chief Operating Officer		Nov-14	Open
TB95/14	The Board needs to understand exactly how much risk the Trust faces with respect to potential non-delivery of CQUINs and QUIPP. A report to come to the next Board meeting	Chief Operating Officer	Part 2 Agenda	Nov-14	Open

Minute Reference	Action Agreed	Lead Exec	Update for 16 September 2014	Proposed Close Date	Status
TB95/14	The risk to delivery of both CQUINs and QIPP to be recorded by the respective owners on the Corporate Risk Register	Chief Operating Officer/Director of Service Transformation/ Director of Service Delivery	Part 2 Agenda	Nov-14	Open
TB96/14	SF presented a service progress report which highlighted a number of performance and workforce issues. It was agreed that a workshop would be held to explore prevailing issues.	Director of Service Transformation		Nov-14	Open

Board Part 1 2014/15						
Month	**25 November 2014**	**20 January 2015**	**17 March 2015**	**19 May 2015**	**21 July 2015**	**22 September 2015**
Venue:	Coopers & Malvern Rooms, EJC	Boardroom - Patient Story Coopers & Malvern Rooms, EJC	Pavillion, Cheltenham			
Patient Story / Service Presentation	LD - (Simon Shorrick, Marc Pratt, Tim Heaven)	Turn Around Children's Service - (Michael Richardson)	COPD Team (Annie McCallum)	Healthwatch - Claire Feehily		
	Filming					
Standard Items						
	Apologies	Apologies	Apologies	Apologies	Apologies	Apologies
	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
	Actions arising from previous meetings	Actions arising from previous meetings	Actions arising from previous meetings	Actions arising from previous meetings	Actions arising from previous meetings	Actions arising from previous meetings
	Chair's Report	Chair's Report	Chair's Report	Chair's Report	Chair's Report	Chair's Report
	Chief Executive's Report	Chief Executive's Report	Chief Executive's Report	Chief Executive's Report	Chief Executive's Report	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
	Public Questions	Public Questions	Public Questions	Public Questions	Public Questions	Public Questions
	Forward Planner	Forward Planner	Forward Planner	Forward Planner	Forward Planner	Forward Planner
	Media analysis	Media analysis	Media analysis	Media analysis	Media analysis	Media analysis
Governance, Quality & Safety						
	Quality & Performance Report (EF/GH)	Quality & Performance Report (EF/GH)	Quality & Performance Report (EF/GH)	Quality & Performance Report (EF/GH)	Quality & Performance Report (EF/GH)	Quality & Performance Report (EF/GH)
	HR Report	Board Governance Assurance Framework				
	LiA Presentation - Pass it on (CP)	Medical Revalidation Report				
	Complaints Policy	Equality annual report (LL)				
Strategy						
		Social Values Strategy (TR) (sign off)				
		Information Governance Strategy (sign-off) (JBr)	Membership Strategy (sign-off) (JBr)			
	Performance & Information Strategy (sign-off) (GH)	Financial Management Strategy (sign-off) (GH)	Public Consultation Strategy (sign-off) (JBr)			
		Quality Strategy (Sign off) (EF)				
Service Delivery & Performance						
	Finance Report (GH)	Finance Report (GH)	Finance Report (GH)	Finance Report (GH)	Finance Report (GH)	Finance Report (GH)
	Annual Security Report	Mortality Reporting (MD)				
	SystmOne Community Hospitals and MIU					
	Quality Impact Assessment					
Communications						
Information						
	Sub-Committee minutes	Sub-Committee minutes	Sub-Committee minutes	Sub-Committee minutes	Sub-Committee minutes	Sub-Committee minutes
			Committees Annual Statement for March			
	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: 25 November 2014
Location: Edward Jenner Court, 1010 Pioneer Avenue, Brockworth, Gloucester, GL3 4AW

Agenda item 8: Chair's report

AGM

I would like to thank everyone who attended our Annual General Meeting, including all the visitors and colleagues who prepared and manned the stands. More than 215 people came to the exhibition at Kingsholm Stadium on Tuesday 14 October and around 70 were present for the formal AGM.

The afternoon proved to a wonderfully vibrant showcase for the Trust, demonstrating the range of services we provide, as well as an important opportunity for us to engage with the communities we serve. I am sure the event made a positive impression on those who attended and gives us a platform to build on as we look to engage more widely with the communities we serve in the coming year.

Board Developments

Since my last report, two board development sessions have taken place as we build towards developing our five year plan. At the most recent session we were joined by Sarah Boulton and Janice Smith, both from Capsticks, and are grateful for their facilitation and observations of our board, which will be shared with members for reflection and learning.

I am very sorry to announce the retirement of Chris Creswick as a Non-Executive Director. Chris was a Non-Executive Director of Gloucestershire Ambulance Trust 1993-96, Chairman of Gloucestershire Health Authority 1996-2002, Acting Chair of North Somerset PCT 2005-06, and Chairman of Weston Area Health NHS Trust 2007-13. He is Trustee and Chairman of Crossroads Care, Forest of Dean and Herefordshire, and a Trustee of the Independence Trust.

He joined us a year ago and has brought that great wealth of experience and insight to enhance our work as a board. We will be very sorry to lose him at the end of January. I am in discussion with the TDA about arrangements for recruitment of a NED to fill this forthcoming vacancy.

NED Activities

I am grateful to Sue Mead, our Senior Independent Director, who conducted a thorough review of the Chair's performance, using the Monitor tool, in September. The outcome has been reported to the TDA. Arrangements for NED appraisals are now in progress and will also be reported to the TDA.

Our non-executive directors visited the Vaughan Centre, the base for our homeless health care team, as part of their ongoing monthly visits to services. This was an instructive visit to a service for a disadvantaged community which traditionally suffers health inequalities. We have also had a special session led by Rod Brown, Head of Corporate Planning, to review progress in our development in line with the Quality Governance Assurance Framework.

<u>Engaging with our services</u>

- I was invited by two teams to undertake home visits to see their work in action and to discuss the service with patients. I went with a care support worker with the children's complex care team to visit a family caring for a very disabled small child at home, with the support of our team. The visit revealed how highly this service is valued and the extent of the compassion and skilled care delivered by our colleagues. The second visit was to the Integrated Community Team in Cheltenham where I went on two home visits with physiotherapists. Once again, the service is clearly very highly valued and it was impressive to see colleagues working with older people to maximise their independence following severe health difficulties.

- Richard Cryer, Nicola Strother Smith, Paul Jennings and myself were delighted to be invited to visit the Dilke hospital to see their work on providing a dementia friendly environment. Of particular interest was a quiet side room which patients can use which is furnished in a 'vintage' domestic style and with memory prompts such as newspapers from past decades. The hospital is to be congratulated on its approach which other community hospitals are also learning from as they too develop dementia friendly services.

- I was pleased to be able to meet with the newly appointed head of community nursing, Dawn Allen, and the recently appointed head of community Hospitals, Julie Goodenough, to discuss the future development of services and their roles in strengthening clinical leadership amongst our colleagues.

- I attended the Listening into Action ‘Pass it On’ event on Monday 3 November, covered in more detail in the Chief Executive’s report. I would like to note that both I and fellow non-executive director Richard Cryer were impressed with the inventiveness and enthusiasm of colleagues involved in this project.

Working with our partners

- The Chairs of the three Gloucestershire NHS provider Trusts have written to the chair of the Health and Wellbeing Board following a letter from Health Secretary Jeremy Hunt (appendix 1) which advised that providers be centrally involved in the board. We are currently formalising our response and I will report back to Board in due course.

- Duncan and I attended the Health and Care Overview and Scrutiny Committee meeting (HCOSC) where we heard a detailed presentation from NHS England's local area team on the commissioning of primary care in Gloucestershire and fielded questions on the temporary reduction in bed numbers at Stroud Community Hospital.

- I met with the CEO of Two Rivers Housing to explore our common interests and agendas. There are plans to follow up this visit as it is clear there is potential for us to work together.

- I met with the three other Trust chairs and we have agreed to hold a facilitated seminar to consider a joint response to the Five Year Forward View (by NHS England Chief Executive Simon Stevens) and its implications for Gloucestershire. That Forward View will be presented at this year's Foundation Trust Network National Conference in Liverpool which I will be attending with Paul Jennings and Joanna Scott.

- Paul and I had one of our regular four way meetings with the chair and chief operating officer of the Gloucestershire Clinical Commissioning Group to consider matters of joint interest on which the board has already been briefed.

- I held my regular quarterly meeting with Clair Feehily from Healthwatch where I shared our newly published engagement framework which details our plans to ensure that the voices of our service users, carers and communities inform every aspect of our work. As part of that engagement process the Trust is beginning a series of focus groups to sample opinion and stimulate discussion on service development.

National networking

- I have attended a range of one-to-one and group meetings with Trust Development Authority, including a meeting of Chairs from the South of England. We heard from Chris Day, Care Quality Commission (CQC) director of engagement, about the experience so far of the Chief Inspector of Hospitals' inspections and the approach being developed by the CQC to specific sectors, including community services.

- Rob Graves went to a Trust Development Authority (TDA) national meeting for audit chairs, giving a comprehensive overview of the current financial picture across the NHS, a review of the operation of the National Audit Office

and presentations by PwC on both the Well-Led Framework and transactions and mergers.

Appendix 1: Letter from Jeremy Hunt on October 7 entitled **Effective engagement between health and wellbeing boards and major providers**

Department of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000
Mb-sofs@dh.gsi.gov.uk

To: Chairs of Health and Wellbeing Boards

Cc: Chief Executives of NHS Trusts and NHS Foundation Trusts

- 7 OCT 2014

Dear colleagues,

Effective Engagement between health and Wellbeing Boards and Major Providers

As we move towards a modern, effective health and care system the importance of working together across local health and care economies only grows. Effective engagement between Health and Wellbeing Boards and the major providers who serve their communities is critical to our shared success.

The Better Care Fund (BCF) plans were submitted on 19 September following a great deal of hard work in local areas. These plans are built on the foundation of conversations taking place that have never happened before, and I do want to commend local areas for all their efforts to bring this about. However, it has become clear through this process that there are differences in the level of engagement between Boards and providers. The results of the National Consistent Assurance Review (NCAR) process for the BCF will be made available shortly, and we want to take steps now to ensure that all local areas will be working effectively together to lay strong foundations for the implementation of the BCF plans from April 2015.

The BCF, among other changes, will lead to a reduction in emergency admissions across England and a changing pattern of care with more being done in the community. This will have a significant impact on major NHS providers and so the BCF planning necessitates strong relationships, open conversations and new ways of working. Strong, constructive dialogue from all local partners involved in developing and delivering BCF plans will be crucial to success.

How this engagement works in practice will be different in each area. Where providers have been included as full members on boards, there have been clear advantages – for example full involvement and challenge throughout the process of developing and signing off BCF plans. Around two thirds of boards do not include local NHS providers, and I know that in many areas, this has been a considered

decision. In such cases there are some examples of engagement working well through secondary mechanisms such as partnership groups, provider forums and workshops convened to explore specific local issues.

However, there are cases where this engagement does not seem to have worked effectively and this is unacceptable. Boards and providers must be positively engaging in the local decision making process, and it is the responsibility of all parties to ensure that engagement is effective, timely and meaningful. I would therefore urge Boards that do not include providers to reconsider this position, or at the least to consider their current arrangements, and assure themselves that the right structures and relationships are in place.

Support is available to Boards and providers to support effective engagement, through the Health and Wellbeing System Improvement Programme (delivered by the Local Government Association with DH funding)
http://www.local.gov.uk/health-and-wellbeing-boards

I would welcome your feedback on the issues raised in this letter. In particular, further examples of where you believe engagement is working well and how this has been achieved; and suggestions for further support from system leaders that you think would be helpful.

Yours sincerely

Jeremy Hunt

JEREMY HUNT

Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: 16 September 2014
Location: Edward Jenner Court, 1010 Pioneer Avenue, Brockworth, Gloucester, GL3 4AW

Agenda item 9: Chief Executive's Report

Listening into Action update

On Monday 3 November over 100 colleagues attended the Listening into Action (LiA) Pass it On event to celebrate the achievements of our teams.

There were presentations by 13 teams, and the day focused on innovation and imagination in order to build on the momentum and enthusiasm for the programme as it flows through the organisation.

Highlights included a Wizard of Oz role play from the Children's Occupational Therapy Team, a live web-ex from the Healthy Lifestyles team and a rewritten version of Tony Christie's 'Is this the way to Amarillo' from the North Cotswolds team.

Feedback from the event was extremely positive as we prepare to move into a new phase of LiA, with a follow-up to the Pulse Check due, new members drawn into the sponsorship group and a new round of teams ready to pick up their own project ideas.

Foundation Trust (FT) status update

- The TDA is observing Board on 25 November (today) followed by subsequent observances at the Quality and Clinical Governance Committee, the Audit and Assurance Committee and the Performance and Resources Committee.
- In the coming weeks, there will be interviews with all voting Executive Directors, as well as with Ingrid as Chair, Sue Mead as Chair of the Quality and Clinical Governance Committee, and Rob Graves as Chair of the Audit and Assurance Committee
- Work is continuing to develop our Integrated Business Plan (IBP) with discussion at Board Development on 2 December to agree the principles of our planned service developments
- Also at Board Development on 2 December, there will be update and debate in respect of our status against the requirements of the Quality Governance Assurance Framework
- There has been delay in the official launch of the Well-Led module but we continue to prepare for evaluation against the current requirements

- It is noted that the pending Dalton Review is now not expected until December

Ebola preparedness

The Trust has taken a multi-disciplinary approach to resilience planning in the event of a case or suspected case of Viral Haemorrhagic Fever (ebola).

Actions have included:

- Internal walkthrough of a suspected ebola case
- Participation in a multi-agency walkthrough of a suspected ebola case, including colleagues from 2gether, South West Ambulance Services, Gloucestershire County Council, Gloucestershire Hospitals NHS Trust, Public Health England, NHS England, district and borough councils, Gloucestershire Airport, Arriva, Gloucestershire Fire and Rescue Service and Gloucestershire Constabulary
- Amended action cards and guidance for appropriate colleagues
- Site visits by the Infection Control team to identify appropriate isolation rooms
- Engagement of key individuals, such a Minor Injury Unit colleagues
- Programme of additional training to be completed by November 28
- Development of a communications plan
- Maintenance of robust reporting arrangements with commissioners

National Tripartite Meetings

I attended one of the national tripartite meetings on Friday 31 October which involved presentations from Simon Stevens (CEO, NHS England), Dr David Bennett (CEO, Monitor) and David Flory (CEO, Trust Development Authority).

The main theme was around the need for cross-organisational strategies and a more 'system wide' approach in the NHS if we are to meet the growing challenges faced by trusts across the country. There have been a series of these meetings which have involved chief executives from most NHS trusts and commissioning groups as a driver for greater co-operation.

7-day Services Vision Workshop

The Trust was invited to send a representative to the local 7-Day Services Vision Workshop, which is pulling together a system-wide strategy to improve weekend outcomes for patients in a clinically and financially sustainable way.

The meeting was on Monday 24 November and the board will be updated in due course.

Five-Year Forward View

NHS England's Chief Executive Simon Stevens has launched the Five Year Forward View.

The Five Year Forward View is a collaboration between six leading NHS groups including Monitor, Health Education England, the NHS Trust Development Authority, Public Health England, the Care Quality Commission and NHS England.

It represents the first time the NHS has set out a clear sense of direction for the way services need to change and improve.

It is available at: http://www.england.nhs.uk/ourwork/futurenhs/

NHS England (NHSE) revised Never Events Policy Framework

The Director of Patient Safety at NHSE, Dr Mike Durkin, has written to the Trust regarding the Never Events Policy Framework, which is under review.

The framework is designed to provide healthcare workers, clinicians, managers, boards and accountable officers with clarity around their responsibilities and on the principles of never events.

In particular, it is designed to be clear about what they are expected to do in terms of preventing never events and how they must respond to them if they should occur, including clarity around incident reporting.

The framework is being reviewed to address feedback from NHS providers and commissioners on a number of uncertainties around the existing Never Events Policy Framework, with a particular focus on:

- The purpose of never events and their criteria
- Definition of each type of never events
- The list of incidents that are considered to be never events
- The management of never events, including financial penalties
- Application of never events to the wider healthcare sector beyond
- secondary care

The consultation closed on 31 October 2014. Responses are being analysed with a view to publish the final revised Never Events Policy Framework by the end of the year, along with a summary of the consultation's findings.

Appointments

- Dr Stephen Dunn is leaving his role of Director of Delivery and Development at the TDA (South) to take up a new post as Chief Executive of West Suffolk NHS Foundation Trust.

Jim Lusby, Portfolio Director (South East) will be acting up for Dr Dunn in an interim capacity until permanent arrangements are finalised.

- Sue Frith, previously Head of National Investigation Services, has been appointed Managing Director of NHS Protect. NHS Protect leads on work to identify and tackle crime across the health service.

  Sue said: “The NHS landscape is not going to stop changing, and NHS Protect must deliver, adapt and improve our services in what we know will continue to be a challenging environment. My goal is to see that NHS Protect exceeds expectations in delivering a range of top quality services – from fraud investigation to security policy and guidance.

  “I hope that all who work at NHS Protect can continue to count on your support and collaboration to tackle crime. I will be making an extra effort to ensure communication with our stakeholders is the best it can be.

  “I will be listening to you as I look afresh at the services we deliver and where and how they can be strengthened. I really look forward to working with you all to protect the precious resources of our national health service, and help ensure NHS premises remain a safe and secure environment for all.”

Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: 25 November 2014
Location: Edward Jenner Court, 1010 Pioneer Avenue, Brockworth, Gloucester, GL3 4AW

Agenda item 10: Chief Operating Officer's report

Community Hospitals

Development Group

A joint community hospital development group that involves GPs, clinical leads and commissioners has developed a community facing work plan for community hospitals which includes:

- Revised and clearer admissions criteria
- Enhancing the skills and competencies of community hospital staff
- Greater out-patient and theatre activity nearer to the community
- Ongoing development of MIU services and signposting to them

The Trust is also continuing to work jointly with Gloucestershire Clinical Commissioning Group (GCCG) to plan developments and services at Cirencester Community Hospital

Stroud Community Hospital

The Trust has been in the unfortunate position of reducing bed availability for a short period of time at its Stroud Community Hospital. This was due to significant operational pressures around staff numbers and patient acuity.

The hospital had been operating at 38 beds, but as a result of the pressures we reduced to 22 beds on Thursday 9 October. Bed availability rose to 26 on Friday 17 October and to 30 over the weekend of 18-19 October. On the 17th November it rose to 32 and during December it will be back to 38. During this period an additional 3 beds have been provided at Lydney.

Stakeholders were informed of this decision and I responded to questions regarding the reduced bed numbers at a HCOSC meeting on Tuesday 11 November. There had been concerns, picked up in the media that the reduced numbers were contributing to delayed discharges at the acute trust. While I acknowledge that the reduced capacity at Stroud is not ideal and we are working hard to rectify it, the impact on the wider health system has at times been overstated.

Other community hospitals continue to operate as usual and will continue to support patient flows.

Recruitment and Retention

The Trust continues to focus on the recruitment and retention of staff to key posts. We successfully managed a series of Recruitment Fairs across the county which have been targeted at both community hospitals and community nursing roles. We anticipate that the outcomes of this work will start to show by late November acknowledging that the national picture of nurse shortages are beginning to impact on the Gloucestershire Health and Care Community. There is a report on this agenda that sets out the workforce strategy.

In addition, Gloucestershire Hospitals Foundation Trust also tried to secure some additional non-agency nursing capacity for GCS but to no avail.

Community Nursing

Gloucestershire Care Services continues to work jointly with GCCG to strengthen the Community nursing service as part of the Integrated Community Teams. Key areas of work include:

- Countywide Recruitment programme targeting both community staff and district nurses, with media campaigns and four open days held in September and October 2014
- Benchmarking of workforce and performance with comparative community organisations
- Training and skills analysis in community nursing, linked to review of community nursing practice to assess the effectiveness and quality of clinical care and to assess capacity to meet current service demands

The initial focus of this work has been on the community nursing service within the Cotswolds. It is proposed that this will widen to a countywide community nursing action plan, which will engage with all stakeholders on defining the vision and a sustainable model for community nursing in Gloucestershire.

Winter Pressures Planning

The Gloucestershire health and care community has been allocated £3.6m for Urgent Care resilience in 2014/15. There has been a well-publicised plan developed and financial allocations are being based on the outcome of stakeholder workshops and reviews of national best practice, with the aim of delivering maximum resilience this coming winter.

The plan is set out under the following headings:

- Self-Care and Prevention

- Pre-Hospital
- In Hospital
- Discharge and Out of Hospital

We will be receiving £350k for the Integrated Discharge Team (IDT), discussed further below. In addition, the Trust is responsible for the provision of a number of services that have crucial interdependencies with operational resilience and capacity planning (ORCP) schemes, which are described in more detail below.

- Self Care and Prevention

The Trust has not received specific funding from the ORCP for schemes in this priority group. However, the continued roll out of the Integrated Community Teams with an emphasis on embedding the living well principle is crucial in supporting this work. This is sometimes also referred to as phase 2 ICT which includes closer alignment with 2gether Mental Health Trust and is being tested across Stroud and Berkeley Vale.

There is also the roll out across GP practices of shared care plans for their top two per cent highest risk patients from within their practice population. The ICT response in supporting appropriate patients using a case managed approach will be critical to delivery.

- Clear and Simple Signposting to Appropriate Services

The Trust has not received specific funding from ORCP for this priority. However, the Directory of Service (DoS) with 111 detailing critical services is crucial and GCS is working with commissioners to ensure its services are appropriately reflected in the entries on the DoS.

- Avoiding Unnecessary Admission to Hospital

The Trust has received an additional £350k in funding for the Integrated Discharge Team (IDT) to provide additional support for both additional bed base and admission avoidance.

Some of this funding will be used to support the discharge of patients who have had a stroke as part of ongoing work to provide a seamless transition from acute to community services. This work will also be enhanced by the planned introduction (utilising ORCP funding) of an IT system (Almanac) that will support shared care plans across critical services referred to as priority one scene.

Critical services required to support this priority include the Single Point of Clinical Access (SPCA) and its use it by more general practitioners.

A continuing service development within this category is the roll-out of the rapid response service, which was introduced in Gloucester in January. This service went ‘live’ across the Tewkesbury locality on Wednesday 24 September and Forest of Dean locality on Wednesday 15 October in response to demand from commissioners and GPs who value the service highly.

The Trust is now working towards having a rapid response service across the Stroud locality.

- A system that works effectively together to discharge patients

The Trust has not received specific funding, but critical services that support this priority focus on the IDT schemes and the development of seven day working. Additional work streams that will support timely and appropriate discharge include the review of reablement services and external care and the revision of the Community Hospitals Admission Criteria. There is also a scheme in development that will test out seven-day dedicated Social Worker time to one ward at Gloucestershire Royal Hospital.

External Care

It is now six months since the External Care programme was approved by the Board, with the aims of reversing overspends from previous years and delivering a programme of service transformation. Overall, strong progress is being made in key areas and the trend data is very encouraging, but there is still a lot more work required.

The scale of the changes needed to deliver the service improvements are significant and as a result, progress at times has been slower than expected with proportionate delays to some of the savings being realised. However, the early forecasts for the full year savings effect are looking positive.

In October 2014 Gloucestershire County Council sought further assurance of the effectiveness of the programme and set an eight week window for additional changes to the reablement service aimed at reducing commitments. During October, commitments stabilised with a net reduction of £70k during the month. This compares with an increase of £1.4m during the same month in 2013.

Elements within the External Care programme are highlighted in the Operational Change section below and a comprehensive report is included later in the papers.

Strengthening our Workforce

In September 2014, GCC was awarded a £200k Southwest Regional grant to support workforce development. This funding is being used to target a number of areas to support integration, social work practice and leadership.

Plans for using this funding are being drafted, with areas to be addressed including:

- Competencies for social work staff
- Skills gaps
- Clarity over role and objectives
- Workforce profiling to ensure the right skill mix is in place going forward

- Funding to be used to maintain social work practitioner support to front line teams and also the External Care Programme
- One-to-one coaching and master classes for managers to support culture change plus a rapid development programme for sign off managers and assessors

An external team manager has been commissioned to help embed new ways of working at team and individual level and there will be a review of the processes and systems used within the teams to produce a set of recommendations which streamline processes and increase efficiencies.

This will form part of a wider workstream across GCC and GCS looking at productivity in preparation for the implementation of the Care Act in 2015.

Operational Change

The Trust has a number of ongoing workstreams focused on operational change, including:

- Mobile working – laptops

  As part of the plan to move towards mobile working, we will be testing laptops for ERIC users and other Gloucestershire County Council (GCC) staff within the Integrated Community Teams to enable teams to work more flexibly.

  There is also a proposal to use wireless GCC laptops (not 3G, but can be used in Wi-Fi areas) to support more flexible working for assessors. Once we know the number of devices available, the project team will be looking to establish how to distribute these.

- Referral Centres

  We have an aim to reach 50 per cent of all queries resolved within 24 hours. As the table below shows, there has been an improvement in the number of referrals being resolved within 24 hours in all localities since April. This means that many more people are receiving a quicker response rather than being put onto the pending list.

  To date, this equates to 6,231 service users.

	Total referrals	Resolved by referral centre and closed	Resolved by referral centre and closed (%)
April	2,538	950	37.4
May	2,667	1,010	37.7
June	2,474	1,001	36.4
July	2,682	1,102	41.1
August	2,396	984	41.1
September	2,647	1,184	44.7

This is as a result of closer co-ordination between the referral centres and ICTs. We recognise that localities must tailor to different local circumstances and will sometimes need to respond in different ways, but feel this collaborative approach will continue to yield benefits.

- Telecare

The programme of referral and assessment training sessions is underway with the first sessions starting on Monday 6 October. It is our intention that colleagues receive two days training on Telecare to familiarise themselves with equipment, shadow an expert and read through case studies. Refresher training sessions on equipment are now complete and we have received positive feedback from these.

There has been a further purchase of the Just Checking Telecare kits, bringing the total to 18 in the county. This equipment is able to identify the daily routine and patterns of behaviour and, in particular, to help assess patterns of movement overnight and the scale of risk during that time.

- Reablement

Robert Walker, previously the community manager for Gloucester, is leading a reablement transformation project, aimed at embedding a new care pathway.

Since Monday 20 October, teams have been following a new pathway with an initial four day period of intensive assessment (where telecare, financial benefits and rehab needs will be assessed). This is followed by two weeks of intensive *social reablement* led by reablement staff.

This type of reablement is not therapy led but focuses on building confidence and enabling people to return to normality for them and will include reablement outside of the home. Rehabilitation will also still be offered but this will be led by therapists and will compliment reablement.

Part of the rationale is that reablement has traditionally been difficult to access, while care home placements have been easier. The new pathway will allow a more thorough assessment of the needs of service users so that a decision can be made about their ongoing care requirements and where they can be met.

Short term overnight support is also in the process of being commissioned, and the project is being monitored via the Reablement and Domiciliary Care Board chaired by commissioners.

OOHs Contract

As announced by the GCCG on Monday 13 October this contract has been awarded to SWASTFT and is due to come into place in April 2015. As the incumbent provider Gloucestershire Care Services NHS Trust will, over the coming months, work with SWASTFT to ensure that there is safe transition of the service to the new provider and that its staff TUPE across accordingly. GCS will endeavour to operate a high quality service and "business as usual" during this period, but there are risks during such periods of change, not least the retention of staff to deliver the service.

Contributions

Many thanks to the following for helping compile this report:

- Candace Plouffe, Director of Service Delivery
- Susan Field, Director of Service Transformation
- Matt Blackman, Communications Specialist

Gloucestershire Care Services NHS
NHS Trust

Media Analysis

Ref: 14/B034

This report is for Publication

Gloucestershire Care Services NHS Trust Board

Media Analysis
30 October 2014

Objective:

To provide the Board with an overview of media and social media coverage regarding the Trust that was published in September and October 2014.

The Board is asked to:

Note the report for information only

Executive summary:

This is the second time that a media analysis has been presented at Board. To this end, it is recognised that this report is in early stages of development, and will continue to be refined in subsequent iterations.

The report currently highlights six categories of coverage, namely:

1. Articles from newspapers / journals:
    a) On-going and b) one-off)
2. Coverage on the NHS Choices website
3. Social media coverage
4. Mentions in local Board papers
5. Internet traffic statistics
6. Freedom of information requests

Jason Brown
30 October 2014

Please complete the Equality Checklist….

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.

1 Newspapers and media websites coverage

Media coverage is split between ongoing coverage which repeatedly focuses on a specific issue/story, and one-off coverage of an event or announcement.

a) On-going coverage

- **Future of medical cover at Cirencester Hospital**

Gloucestershire Clinical Commissioning Group has been leading on the issue. Media coverage has previously suggested that Cirencester Hospital faces an uncertain future. That theme continues, although the headline is less alarmist than prior coverage.

So far the Trust has declined to comment directly and left the matter in the hands of GCCG.

Councillor says 'gem' of hospital should be used more

A CALL has been made to secure the future of Cirencester Hospital after concerns were raised about the vital community facility facing a review.

Councillor Paul Hodgkinson made the call following a statement issued by the clinical commissioning group in Gloucestershire.

The group, which provides medical cover for the hospital, has launched a review into whether the hospital could be used more.

- **Smoking and e-cigarettes**

The local media devote regular coverage to issues surrounding stopping smoking and the use of e-cigarettes, often seeking opinion from members of our Stop Smoking service and positive coverage of its services.

Local coverage for the national Stoptober stop smoking campaign began in September.

The Smoker's Angel has opened in Westgate Street, Gloucester

Elaine Watson from the NHS Stop Smoking Service in Gloucestershire wants a change.

“There is limited evidence about the long-term health impacts,” she said. “We share the view of the British Medical Association that it is important to regulate the content to ensure they are a safe and effective way of cutting down or quitting.”

James Curtis, from the Healthy Lifestyles team, was interviewed by BBC Radio Gloucestershire on Friday, September 24, to promote this year’s Stoptober the campaign.


Gloucester Citizen

News Sport What's On Jobs Property Cars Directory Offers Notices

Inspirational Gloucester mum Karen Lumley boots 30 year smoking habit into touch

By The Citizen | Posted: September 30, 2014 By Max Webster, health reporter

Gloucester mum Karen Lumley was smoking 15 cigarettes for 30 years before quitting last year

The Citizen reported on one of the Trust's staff, Karen Lumley, who successfully gave up smoking – part of its Stoptober coverage.

Smoking costing south west councils more than £66 million a year in social care

So far in 2014, more than 3,300 smokers kicked the habit thanks to the Gloucestershire Stop Smoking Service. The Gloucester based service has a main office in Eastgate Street offering advice and incentives to help people quit. It has helped more than 30,000 people to quit smoking since its start in 2000.

Elaine Watson, from the service, said: "Our advisors are talking to people all the time – smokers who are just starting to think about quitting, or not really thinking about it at all, as well as those trying to give up."

- **Cirencester Hospital Car Park (Wilts and Glos Standard)**

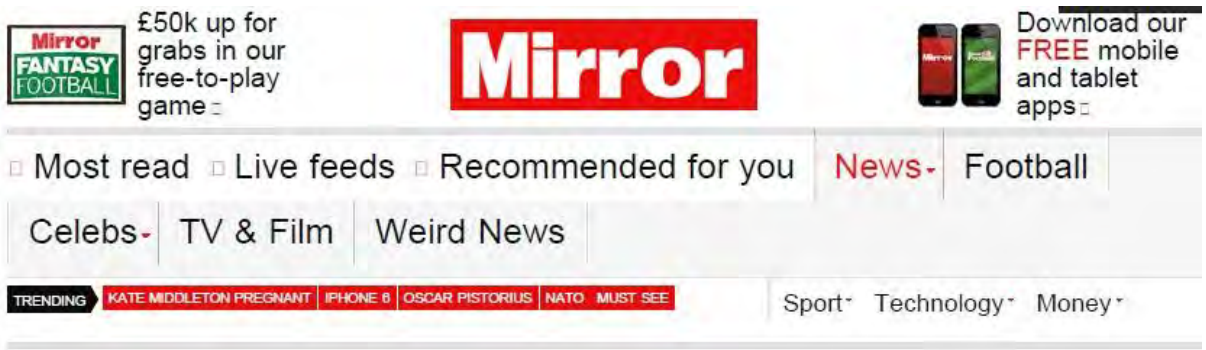
  "A decision on the future of a car park in Cirencester has been deferred to a later meeting after Cotswold District Council's planning committee decided it needed more information to make a decision."

1b) One-off coverage

- At the beginning of September there was brief, but extremely high profile, coverage of kitchen hygiene in hospitals following a national report by the Food Standard Agency.

  Tewkesbury Hospital received a score of two out of six due to relatively minor infractions, but the low score meant the hospital was included in national coverage which focused on the most serious breaches of hygiene.

  National newspaper coverage was predictably lurid, while the local articles were more measured.



News · UK News · Hospitals

Dead bugs and out-of-date meats among shocking finds in hospital kitchens

Mirror (Sep 6): Tewkesbury Community Hospital in Gloucestershire was blasted by inspectors for failing to use the correct sanitiser to clean surfaces and ensuring food handlers were wearing protective overclothing.

People (Sep 7): Tewkesbury Community Hospital in Gloucestershire was blasted by inspectors for failing to use the correct sanitiser to clean surfaces and ensuring food handlers were wearing protective overclothing…

Tewkesbury Hospital said the inspection happened a few weeks after its opening when there were a small number of teething issues.

Gloucestershire Echo (Sep 9): Tewkesbury Hospital received a disappointing report on its kitchen hygiene practices – just a few weeks after it opened.

Liz Fenton, Director of Nursing and Quality, is quoted at length, including: "The inspections are carried out annually and the next one is due this November. However, we have requested a further inspection as we don't wish to wait until November to evidence our usual high standard."

Tewkesbury's new hospital criticised over food standard failings

By RobinJenkins | Posted: September 07, 2014

Tewkesbury Community Hospital has been criticised by the Food Standards Agency.

However, later in the month Tewkesbury Hospital also received some positive coverage during its first birthday celebrations.


GLOUCESTERSHIRE ECHO

News | Sport | What's On | Jobs | Property | Cars | Directory | Xmas | Notices

Crime | Education | Business | Health | Politics | Blogs | Letters | Transport | Community

Teething problems solved as Tewkesbury Hospital turns one

By Robin Jenkins | Posted: October 10, 2014

Staff at Tewkesbury Community Hospital celebrate its first birthday.

Gloucestershire Echo (Oct 15): Matron Julie Ellery said: "My colleagues are proud to work at Tewkesbury Hospital. They are doing a brilliant job and being able to do a brilliant job in wonderful surroundings gives you a dignified and professional feeling."


GLOUCESTER Citizen

News | Sport | What's On | Jobs | Property | Cars | Directory | Offers | Notices

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Nursing shortages sees bed spaces slashed at Stroud General Hospital

By The Citizen | Posted: October 18, 2014

In October, Stroud Hospital was in the news having closed a number of beds because of a nursing shortage. Glosmedia, which produced the Citizen and Stroud Life, received the story from an external source and quoted the CCG, while the

Stroud News and Journal approached the comms team and used our information and quotes:

BEDS at Stroud General Hospital were cut temporarily by almost a half due to a shortage of nurses earlier this month.

The number of beds was reduced from 38 to 22, Gloucestershire Care Services NHS Trust has said.

In a statement issued on Monday, a Trust spokesman said the measure had been temporary and that bed numbers at the Trinity Road unit had now been increased.

They were reduced for nine days from Wednesday, October 8, but were increased to 26 on Friday and rose again over the weekend.

There are currently 30 beds available.

The AGM was given coverage on the Echo health page and a double page in the Gloucester Review:

News

NHS stages a get to know you show

Thursday, 16 October 2014

Infection control nurse Lisa McLean showed people how much care had must be taken with hand washing, using ultra-violet light

By Peter Hayward

A health showcase at Kingsholm Rugby Club this week gave a flavour of the huge range of services that are available to care for people in the community.

Gloucestershire Care Services NHS Trust put on a fascinating hands-on exhibition of its work prior to holding its annual general meeting.

This is the trust that manages community inpatient and outpatient services, public health nursing, community nursing and therapy services, and also takes care of adult social care services on behalf of Gloucestershire County Council.

Its services are delivered in people's own homes, community clinics, outpatient departments, community inpatient wards, schools and GP practices.

The trust also provides services into acute hospitals, nursing and residential homes and social care settings.

1b Other one-off coverage

- BBC Radio Gloucester: Five minute segment on Breakfast show about HIV – prevalence and attitudes towards HIV. Contribution by Rona Macdonald – HIV specialist at the Trust
- Hospitals clean but privacy below average (Echo) - report on Dilke and Lydney hospitals' results in the Assessments of the Care Environment reports
- Hospitals step up Norovirus Campaign as winter approaches (Citizen) – report on joint campaign, including quote from Liz Fenton, Director of Nursing
- Winter Bug warning (Heart FM, Bristol) – coverage of Norovirus Campaign on website and then radio interview with Liz Fenton
- Stroud Hospital's League of Friends AGM (Stroud News & Journal)
- Macmillan Coffee Morning at Cirencester Hospital (Wilts & Glos Standard)
- New Charter promises better mental health care for patients in Gloucestershire (Echo)
- Patients offered chance to have their say at first Gloucestershire Care Services Trust AGM
- Hospital gives out advice on facilities following complaint

Additional material in local papers included:

- Supporting our brilliant hospitals – Neil Carmichael column in the Glos Echo (Sep 2)

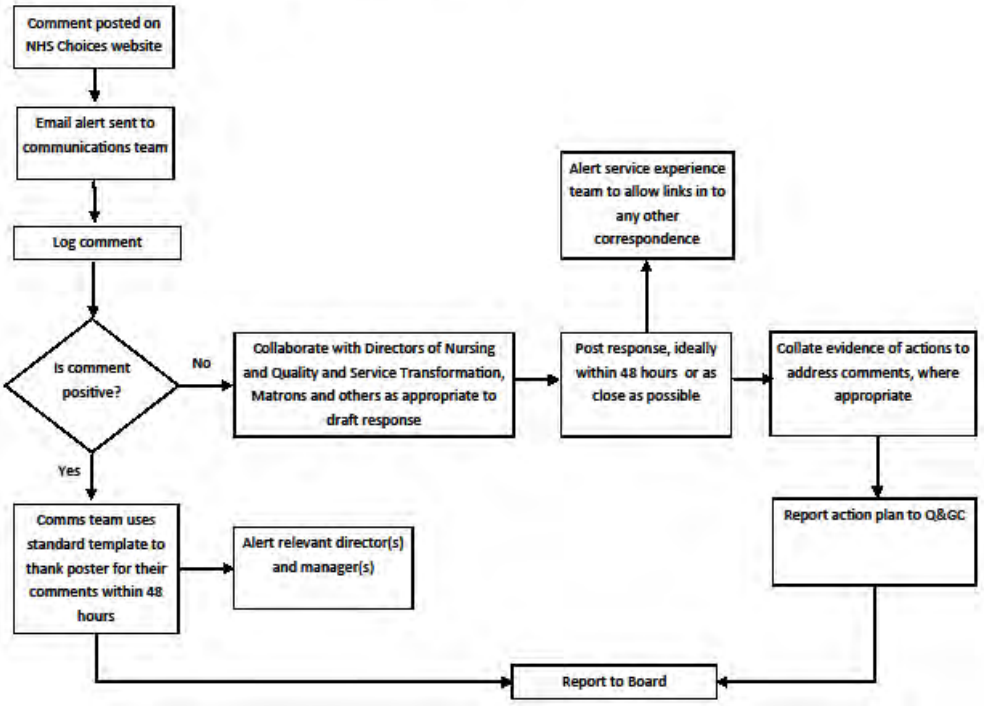
2 NHS Choices reviews

NHS Choices is one of the main vehicles for service users to leave feedback regarding the care they have received.

The Trust's Communications Team monitors this feedback regularly, and is able to issue a response to each comment. Where feedback is positive, this consists of a thank you message. Where feedback is negative, the team will liaise with the appropriate Director to collate an appropriate response. All feedback is shared with the relevant care staff and the service experience team.

A formal process map for consistent monitoring and responding to comments on NHS has been drafted and is included below.

Responding to NHS Choices comments: Process map



September feedback

Nine comments were posted on NHS Choices in September and October as below:

Date	Hospital	Department/area	Positive / negative / neutral (stars)	Additional comments/notes
Sep 15	Cirencester	Minor Injuries Unit	Positive (5)	Was well looked after with a broken wrist
Sep 23	Tewkesbury	Minor Injuries Unit	Negative (1)	Respondent said they waited three hours to see someone

				because of a throat problem before going to Cheltenham General and being dealt with in half an hour.
Sep 25	Tewkesbury	Minor Injuries Unit	Positive (5)	Respondent said staff went out of their way to help.
Sep 28	Tewkesbury	Minor Injuries Unit	Positive (5)	Respondent said they couldn't have asked for a better service. Seen within 5 minutes, given pain relief, x-ray and stitches to injury.

October feedback

Date	Hospital	Department/area	Positive / negative / neutral (stars)	Additional comments/notes
Oct 8	Cirencester	Minor Injuries Unit	Positive (4)	Parent said staff were professional, gentle and friendly when son needed an x-ray
Oct 9	Stroud	Occupational Therapy	Positive (5)	Friendly and welcoming. Bowbridge outpatients superb.
Oct 15	North Cotswold	In-patient ward	Positive (5)	All the staff were caring, kind,

				professional and supportive
Oct 20	Cirencester	Minor Injuries Unit	Positive (5)	Respondent said services could not be faulted after visiting with a viral infection
Oct 26	Vale	Minor Injuries Unit	Negative (1)	Respondent said booking in took too long and nurse who treated him was rude, insulting and dismissive.

3 Social Media

Twitter

	August 2014	September 2014	October 2014
Followers (month end)	532	574	598
Following (month end)	520	520	521
Tweets	3	5	6
Retweets	6	5	19

Themes covered byTwitter activity over September and October included the Stoptober challenge to stop smoking, nursing recruitment open days and the Trust's Annual General Meeting.

4 Board papers

The Trust has featured in the Board papers of the following stakeholders:

Gloucestershire Clinical Commissioning Group

Date	Agenda Item	Notes
September 25, 2014	Accountable Officers Report	ICT update
	Integrated Governance and Quality Committee	GHFT focusing on pressure ulcers – query whether GCS is doing the same

Gloucestershire Hospitals NHS Foundation Trust

Date	Agenda Item	Notes
September 26, 2014	Winter Plan 2014/15	The schemes that are in place to address the need for additional capacity are part of the Emergency Care Programme and the QIPP and include: - Ambulatory Emergency Care - Integrated Discharge Team - Older Peoples Assessment and Liaison Team - Hot Clinics - Integrated Community Teams - Community Hospital programme These schemes should save 10 admissions a day currently rising to 20 admissions a day in March 2015.
October 31, 2014	Chief Executive's Report	This report includes a progress update from the West of England Academic Health Science Network Board, which includes our joint sponsorship of a community services workstream.

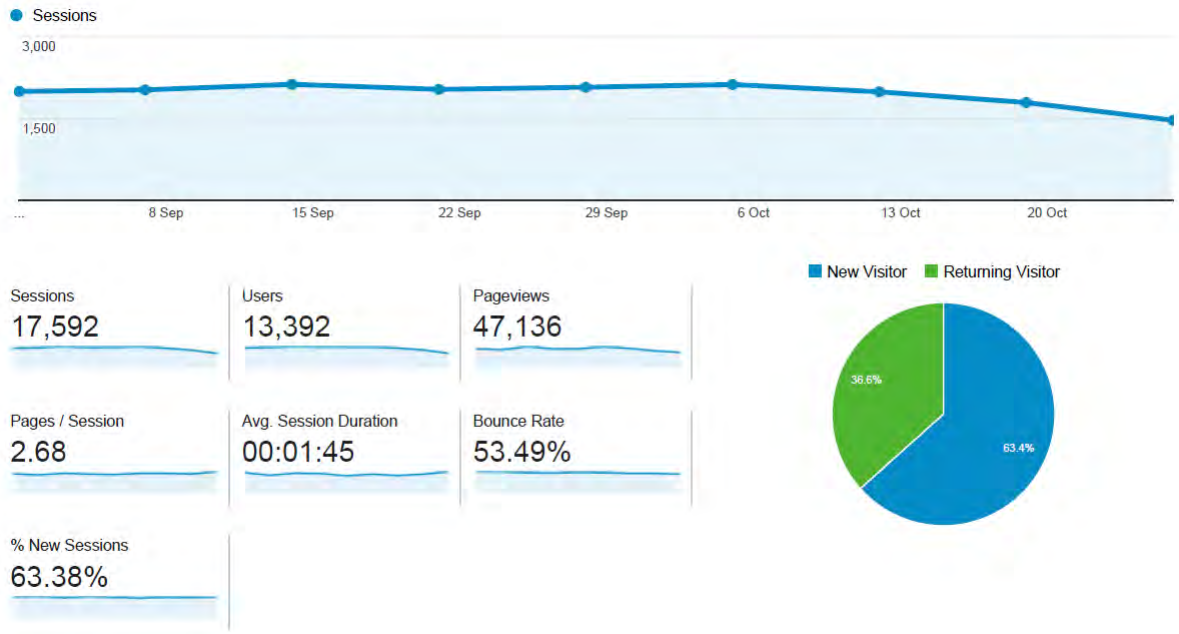
South West Ambulance Service

No mentions.

5 Internet traffic stats

The Trust uses Google Analytics – the full toolkit has the potential functionality to show us the full customer picture across any adverts, videos, websites and social tools, tablets and smartphones.

Audience Overview: 1 Sep 2014 - 31 Oct 2014



Bounce rate means a visitor clicked through our website, and only visited one page. They didn't browse around any - they viewed one page and left.

	Language	Sessions	% Sessions
1.	en-us	9,718	55.24%
2.	en-gb	7,634	43.39%
3.	en	83	0.47%
4.	pl	24	0.14%
5.	en_gb	14	0.08%
6.	it-it	10	0.06%
7.	pt-pt	8	0.05%
8.	de	7	0.04%
9.	pl-pl	7	0.04%
10.	es	6	0.03%

City	Acquisition			Behavior			Conversions		
	Sessions	% New Sessions	New Users	Bounce Rate	Pages / Session	Avg. Session Duration	Goal Conversion Rate	Goal Completions	Goal Value
	17,592 % of Total: 100.00% (17,592)	63.38% Site Avg: 63.38% (0.00%)	11,150 % of Total: 100.00% (11,150)	53.49% Site Avg: 53.49% (0.00%)	2.68 Site Avg: 2.68 (0.00%)	00:01:45 Site Avg: 00:01:45 (0.00%)	0.00% Site Avg: 0.00% (0.00%)	0 % of Total: 0.00% (0)	$0.00 % of Total: 0.00% ($0.00)
1. Gloucester	4,329 (24.61%)	51.81%	2,243 (20.12%)	50.01%	2.90	00:02:08	0.00%	0 (0.00%)	$0.00 (0.00%)
2. London	3,154 (17.93%)	62.14%	1,960 (17.58%)	55.33%	2.44	00:01:33	0.00%	0 (0.00%)	$0.00 (0.00%)
3. Cheltenham	2,234 (12.70%)	69.52%	1,553 (13.93%)	64.15%	2.34	00:01:27	0.00%	0 (0.00%)	$0.00 (0.00%)
4. Birmingham	554 (3.15%)	64.80%	359 (3.22%)	56.14%	2.50	00:01:29	0.00%	0 (0.00%)	$0.00 (0.00%)
5. Bristol	517 (2.94%)	60.15%	311 (2.79%)	50.87%	2.77	00:02:03	0.00%	0 (0.00%)	$0.00 (0.00%)
6. Stroud	407 (2.31%)	71.25%	290 (2.60%)	55.28%	2.83	00:01:44	0.00%	0 (0.00%)	$0.00 (0.00%)
7. Cirencester	266 (1.51%)	69.55%	185 (1.66%)	48.87%	3.22	00:01:46	0.00%	0 (0.00%)	$0.00 (0.00%)
8. Oxford	193 (1.10%)	71.50%	138 (1.24%)	44.56%	2.82	00:02:03	0.00%	0 (0.00%)	$0.00 (0.00%)
9. Worcester	171 (0.97%)	65.50%	112 (1.00%)	59.65%	2.78	00:01:40	0.00%	0 (0.00%)	$0.00 (0.00%)
10. Nottingham	157 (0.89%)	61.78%	97 (0.87%)	62.42%	2.96	00:01:45	0.00%	0 (0.00%)	$0.00 (0.00%)

Rows 1 - 10 of 909

Analytics – all website data – New vs Returning

User Type	Acquisition			Behavior			Conversions		
	Sessions	% New Sessions	New Users	Bounce Rate	Pages / Session	Avg. Session Duration	Goal Conversion Rate	Goal Completions	Goal Value
	17,592 % of Total: 100.00% (17,592)	63.38% Site Avg: 63.38% (0.00%)	11,150 % of Total: 100.00% (11,150)	53.49% Site Avg: 53.49% (0.00%)	2.68 Site Avg: 2.68 (0.00%)	00:01:45 Site Avg: 00:01:45 (0.00%)	0.00% Site Avg: 0.00% (0.00%)	0 % of Total: 0.00% (0)	$0.00 % of Total: 0.00% ($0.00)
1. New Visitor	11,150 (63.38%)	100.00%	11,150(100.00%)	54.19%	2.63	00:01:34	0.00%	0 (0.00%)	$0.00 (0.00%)
2. Returning Visitor	6,442 (36.62%)	0.00%	0 (0.00%)	52.28%	2.76	00:02:05	0.00%	0 (0.00%)	$0.00 (0.00%)

Rows 1 - 2 of 2

Session duration

Sessions
17,592
% of Total: 100.00% (17,592)

Pageviews
47,136
% of Total: 100.00% (47,136)

Session Duration	Sessions	Pageviews
0-10 seconds	10,144	11,005
11-30 seconds	1,488	4,045
31-60 seconds	1,418	4,768
61-180 seconds	2,186	10,175
181-600 seconds	1,530	9,975
601-1800 seconds	714	5,223
1801+ seconds	112	1,945

6 Freedom of information requests

Date	Service/Area	Request	Information provided	Additional comments/notes
Sep 2	Social Care	A list of providers of domiciliary care and contract information	Not applicable	This request was not applicable to GCS and therefore redirected
Sep 2	Estates / facilities	How much does the organisation charge for parking	Not applicable	GCS does not charge for parking
Sep 5	Performance and Information	Elective patient backlog – size, if this is subcontracted and who to	Partly responded	
Sep 8	Estates / Finance	Compulsory Purchase Orders	Not applicable	Information not held as no CPOs issued
Sep 15	Nursing and Quality	Nursing vacancies, Oversees recruitment and Agency costs	All information provided	Request from the RCN
Sep 19	Wheelchair	How many wheelchair users are equipped by GCS	Information provided	
Sep 17	Countywide	Agency AHPs on 01/09	Information provided	

Oct 02	Performance and Information	List of Clinical coders	Not applicable	Information not held
Oct 02	Operations	Out of area GP referrals refusals/restrictions	Not applicable	No restrictions would be held on record
Oct 03	Countywide	MSK referrals, waiting times, access pathways	Information provided	
Oct 13	IM&T	IM&T Provision questionnaire inc. a copy of the strategy	Information provided	
Oct 14	Countywide	Sexual Health patient communications	Information provided	
Oct 20	IM&T	IM&T infrastructure		Still open
Oct 24	Operations	Non-emergency patient transport providers	Not applicable	Information not held
Oct 28	Nursing and Quality	Nursing spend		Still open

NEW Media Monitoring tool for the Trust

For the past year the Trust had maintained a contract with CisionPoint to provide media monitoring. That contract ended in October 2014, and the Communications team evaluated a number of competing systems in the search for a provider.

A number of providers demonstrated high quality systems offering a range of media and social media analysis tools, and the Trust has chosen a new provider on the basis of the combination of the strength of its software and the user-friendliness of the interface. We are in the process of setting up the contract and we will share further information on the new tool in the next board report.

As part of the evaluation it became apparent that all the available packages provide substantially greater functionality than the team has hitherto made use of and the new contract should allow a more comprehensive overview of media coverage and social media reach moving forward.

Gloucestershire Care Services NHS
NHS Trust

Quality & Performance Report

Ref: 14/B035

This report is for Publication

Gloucestershire Care Services NHS Trust Board

Quality and Performance Report
25th November 2014

Objective:

This report is to provide information and assurance to The Gloucestershire Care Services NHS Trust Quality and Health and Social Care contract performance against nationally and locally commissioned targets.

The Board is asked to:

Note the contents of this paper, provided for information and assurance, with details of actions included.

Executive summary:

The report shows the Trust position as of September 2014 against key quality and performance indicators and is showing Green or Amber against targets on a year to date basis (April to September 2014) as follows:

National = 88.9% (32)
Local = 74.1% (27)

The report has been further developed in response to feedback to enable more effective triangulation of data and aims to “humanise” the picture given by talking in numbers of people rather than simply percentages.

Matthew O’Reilly/Liz Fenton
13th November 2014

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

25 November 2014

Understanding you

Contents

Key Matters

MSKCAT Services Waiting times remain above trajectory for those requiring routine appointments. Actions to undress under performance include:

- Review of recording on Systm1
- Recruitment above establishment to create capacity
- Provision of additional clinics

Podiatry Services Waiting times also remain above trajectory. The actions in place to address this are as for MSKCAT

District Nursing The service are experiencing challenges in recruitment in some areas. The issue in GCS mirrors that nationally with the shortage of registered nurses holding the specialist practitioner qualification. Recruitment has been particularly challenging within the Cotswold area. Actions including recruitment days and focussed advertising have attracted nurses. Additionally, a review of the rotas and shift patterns has commenced to ensure these meet care needs and support colleagues in their work life balance.

Community Hospitals Have found it challenging to recruit to staff nurse roles at Band 5. Participating in the recruitment days has attracted new nurses and the hospitals are supporting 7 return to practice nurses and 7 student nurses who have passed their finals and will take up substantive posts on receipt of their NMC registration

Quality overview - health performance against indicators (September YTD)

	September cumulative year-to-date (with comparators to August)							August cumulative year-to-date			Average year-to-date		
	Red		Amber		Green		Total	Red	Amber	Green	Red	Amber	Green
National	2 5.6%	↔	2 5.6%	↓	32 88.9%	↑	36	2 5.6%	4 11.1%	30 83.3%	2 5.6%	3 8.3%	31 86.1%
Local	7 25.9%	↑	0 0.0%	↓	20 74.1%	↔	27	5 19.2%	1 3.8%	20 76.9%	5 18.5%	1 3.7%	21 77.8%
Total	9 14.3%	↑	2 3.2%	↓	52 82.5%	↑	63	7 11.3%	5 8.1%	50 80.6%	7 11.1%	4 6.3%	52 82.5%

National indicators

Red	Safety Thermometer - harm free care	Page 11
	Friends and Family Test - MIU response rate	Page 26
Amber	MIU unplanned reattendance rate within 7 days	Page 39
	Newborn Bloodspot Screening - timeliness of result	Page 39

Local indicators

Red	Bone Health Service - referral to treatment	Page 40
	MSKCAT service - wait time for routine patients	Page 40
	MSKCAT service - wait time for urgent patients	Page 40
	MSKCAT service - referral to treatment	Page 40
	Chlamydia Screening - number of positive screens	Page 40
	Podiatry Service - referral to treatment	Page 40
	Stop Smoking Service - Number of smokers successfully quit	Page 40

Quality overview - health performance against indicators (September 2014)

	September 2014			
	Red	Amber	Green	Total
National	3 8.3%	2 5.6%	31 86.1%	36
Local	5 18.5%	0 0.0%	22 81.5%	27
Total	8 12.7%	2 3.2%	53 84.1%	63

National indicators	
Red	Safety Thermometer - harm free care
	Friends and Family Test - MIU response rate
	Number of post 48 hour Clostridium Difficile Infections in Community Hospitals
Amber	MIU unplanned reattendance rate within 7 days
	Completion of a valid NHS number field in Social Care data sets held by GCS

Local indicators	
Red	MSKCAT service - wait time for routine patients
	MSKCAT service - referral to treatment
	Chlamydia Screening - number of positive screens
	Podiatry Service - referral to treatment
	Stop Smoking Service - Number of smokers successfully quit

SAFE

Safe - key points

- The Trust has reported 12 SIRIs year-to-date of which 58% current SIRIs relate to slips, trips and falls *(see page 10)*

- Performance against the 95% threshold for harm-free care has increased in September to 93.7%. The Trust is now exceeding the 95% in all aspects with the exception of pressure ulcers *(see page 12)*

- The number of falls in an inpatient setting are lower than in 2013-14: similarly, the percentage of falls that are injurious have reduced however 55% falls in a community hospital are still classified as injurious *(see page 13)*

- Although the Trust's performance re: pressure ulcers is impacting upon the harm-free care totals, it is noted that there has been two acquired Grade 3/4 pressure ulcers this year: it is also noted that the Trust compares favourably with other community trusts *(see page 14)*

- The Trust is a very low reporter of incidents when compared with comparable Trust using NRLS data. Actions are in place to address this including a survey of colleagues to understand the barrier that may prevent reporting, discussions with the NRLS and other Trusts. An action plan will be presented to the QCGC.

- The Trust is currently 36% below the agreed tolerance for C diff *(see page 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	YTD	Forecast	2013-14 outturn
No injuries or harm	167	173	158	212	156	185							**1,051 58%**	**2,102**	**2,405**
Minimal harm: required extra observation or minor treatment	95	101	70	94	67	87							**514 28%**	**1,028**	**1,118**
Short term harm: required further treatment or procedure	44	31	40	44	27	52							**238 13%**	**476**	**456**
Severe, permanent or long-term harm	**0**	**5**	**2**	**1**	**1**	**1**							**10 1%**	**20**	**17**
Death	**0**	**0**	**1**	**1**	**0**	**0**							**2 0%**	**4**	**1**
Total	**306**	**310**	**271**	**352**	**251**	**329**							**1,819**	**3,638**	**3,997**

Benchmarking		
Number of incidents (GCS)	**143.5 per 1,000 WTE staff**	**April-September 2014**
Number of incidents (Aspirant Community Foundation Trust Group)	**182.5 per 1,000 WTE staff**	**March-August 2014**

Incidents by type (top 10 only)

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	YTD	Forecast	2013-14 outturn
Slip, trip or fall (patient)	91	74	63	86	80	80							474	948	1,130
Medication or drug error	22	26	12	21	14	21							116	232	401
Staffing issues	12	18	11	27	12	17							97	194	145
Treatment or procedure problem	12	13	16	19	10	16							86	188	158
Pressure ulcer	24	18	15	9	2	10							78	170	211
Staff communications	10	12	18	14	6	13							73	146	133
Verbal/written abuse	7	19	12	9	9	9							65	128	90
Medical device/equipment	6	15	15	11	6	8							61	122	123
Property	12	6	7	13	8	10							56	112	104
Hit by/against object	9	8	8	10	10	8							53	106	120
Total (All)	306	310	271	352	251	313							1,803	3,606	3,997

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

There have been 9 RIDDOR reportable incidents this year to date. 6 were staff incidents, 2 were patient incidents and 1 affected a member of the public. These are reviewed by the Health & Safety Committee.

RIDDOR Actions taken	Total
None required	4
Staff reminded to follow correct processes	3
Falls risk process reviewed	1
Staff to ensure access available	1
Total	9

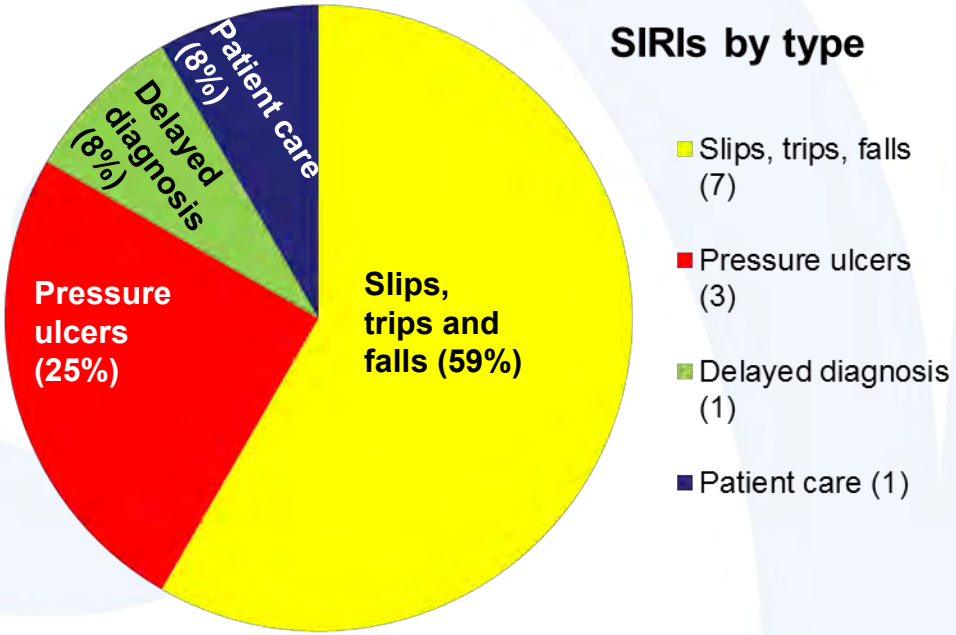
Clinical Alert System (CAS)

In 2014-15, the Trust has had one overdue CAS alert (June) which was due to a technical error

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	YTD
Inpatients	1	4	1	2	0	1							9
Community	1	0	0	0	1	0							2
MIU	0	0	0	1	0	0							1
Total	2	4	1	3	1	1							12

- There was one **SIRI** reported in September 2014 which related to a Grade 3 Pressure Ulcer at Stroud General Hospital. As a result of the RCA the following learning will be taken forward across the Trust. The Braden score must be recalculated before 'stepping down' a patient's mattress. If dressings are used for pressure ulcers, the ulcer site must be checked daily to assess for any deterioration.
- No Never Events have been reported in 2014-15



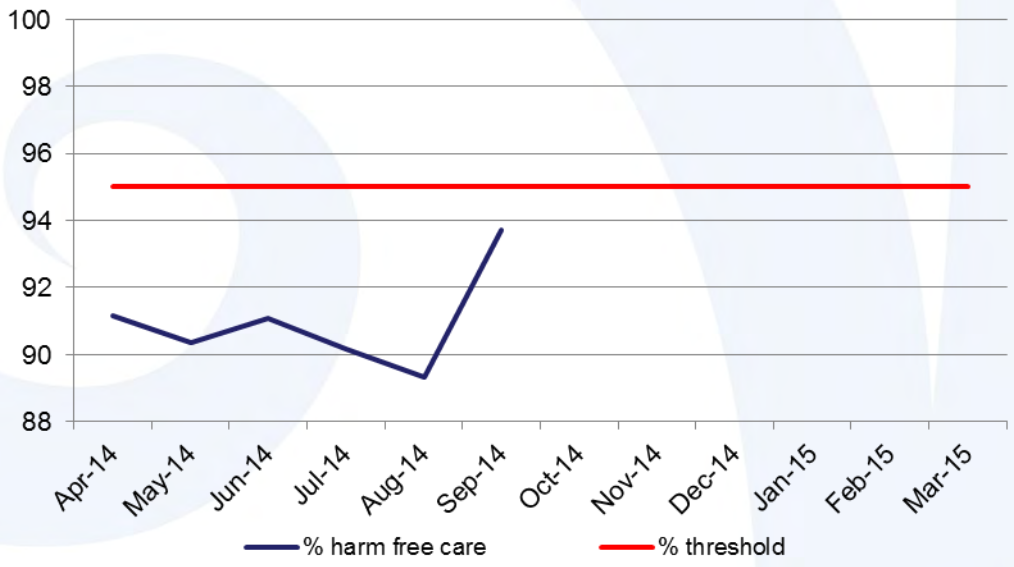
Benchmarking	
New SIRIs (GCS)	**2.0 average per month, April-September 2014**
New SIRIs (Aspirant Community Foundation Trust Group)	**3.0 average per month, April-August 2014**

Always Events

GCS is supporting the "Hello my name is.." campaign and makes the commitment that we will always introduce ourselves to patients, service users, their families and carers and will measure how well we are doing through our experience surveys.

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	YTD	2013-14 outturn
No of service users surveyed	1,120	1,153	1,009	1,059	1,078	1,084							6,503	13,006
No of service users with harm free care	1,021	1,042	919	955	963	1,016							5,916	11,760
% harm free care	91.2%	90.4%	91.1%	90.2%	89.2%	93.7%							91.0%	91.0%
% Completeness of Submission	94.7%	97.3%	100.0%	95.5%	98.6%	98.6%								97.4%



Actions

The census data for September shows improvement in our achievement to meet this threshold. The focus continues ensuring both a emphasis on improving safety as well as data quality.

September

- New data entry format to ensure data quality
- Establishment of the intranet site

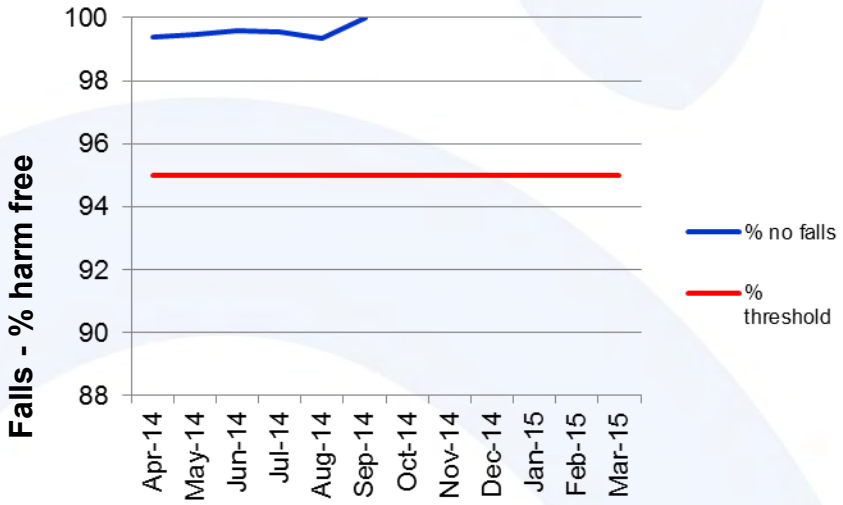
December

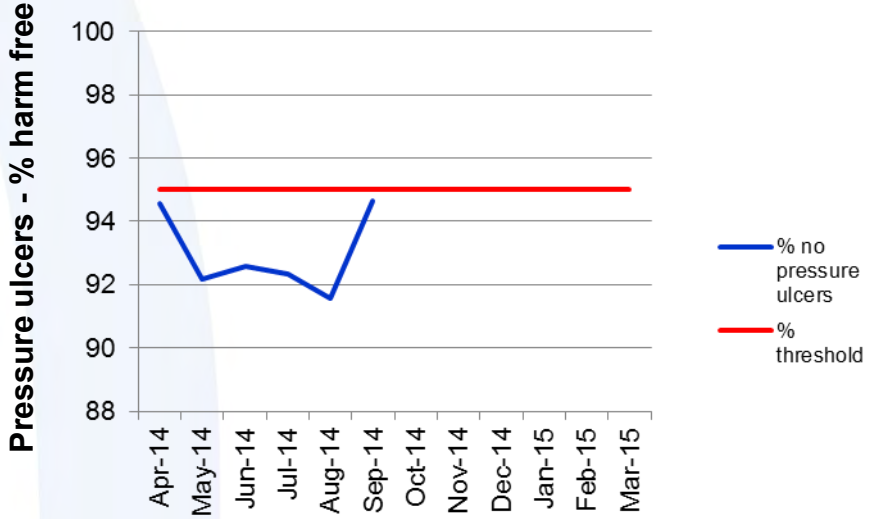
- Meetings with managers to communicate Trust reporting and addressing concerns

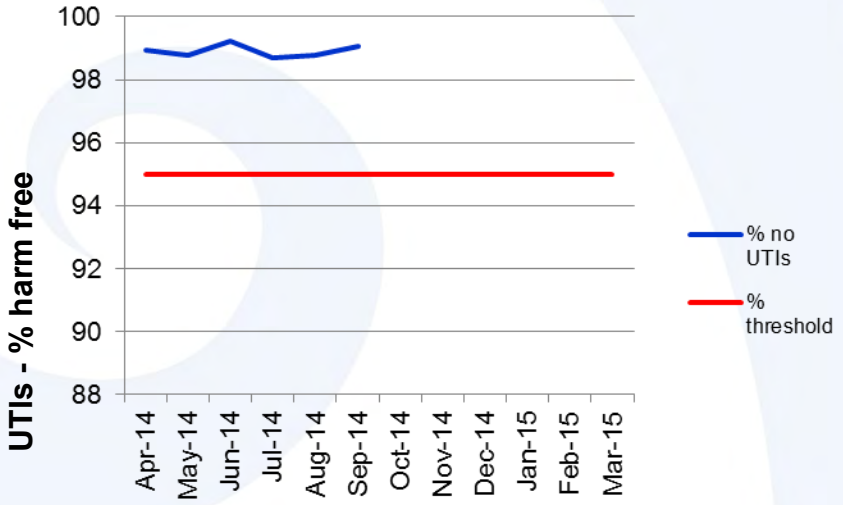
Ongoing

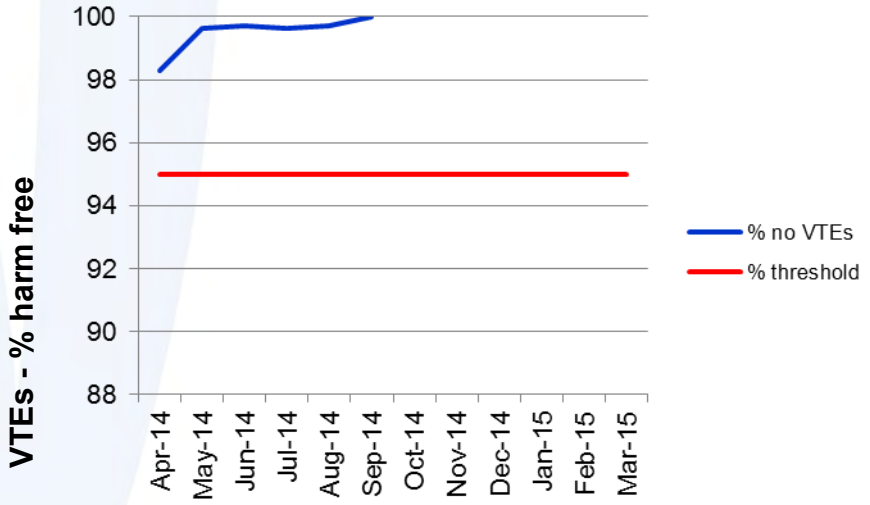
- Targeted focus on teams that are outstanding reports or where there are concerns with data entered
- Further training sessions where required
- Issue reminder e-mail to teams reporting ST

Harm-free care by type / Safety Thermometer









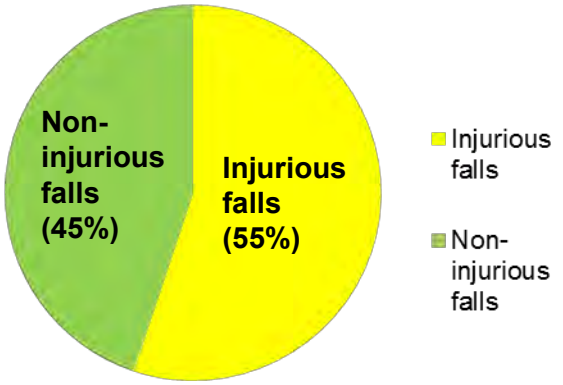
VTE risk assessment:
Performance in April to September showed 98.4% VTE risk assessments were completed against a target of 95%

Falls in an inpatient setting

Hospital	Total Falls				Injurious Falls			
	2014/15 Year to Date		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 injurious falls	Injurious falls per 1,000 bed days	No of injurious falls	Injurious falls per 1,000 bed days
The Vale	77	22.5	146	20.9	51	14.9	88	12.6
Tewkesbury	61	17.5	95	12.9	31	8.9	37	5.0
North Cotswolds	72	19.3	141	18.8	32	8.6	60	8.0
Cirencester	114	13.2	264	12.9	61	7.1	139	6.8
Lydney	32	9.3	82	11.8	19	5.5	55	7.9
Dilke	28	7.6	87	9.3	15	4.1	51	5.5
Stroud General	35	6.0	191	13.0	22	3.8	102	6.9
TOTAL	**419**	**13.0**	**1,006**	**13.7**	**231**	**7.2**	**532**	**7.2**

Benchmarking	
Injurious falls per 1,000 inpatient occupied bed days (GCS)	**7.2 average per month, April-September 14**
Injurious falls per 1,000 inpatient occupied bed days(Aspirant Community Foundation Trust Group)	**3.2 average per month, April-August 14**

Result of falls
(year-to-date)

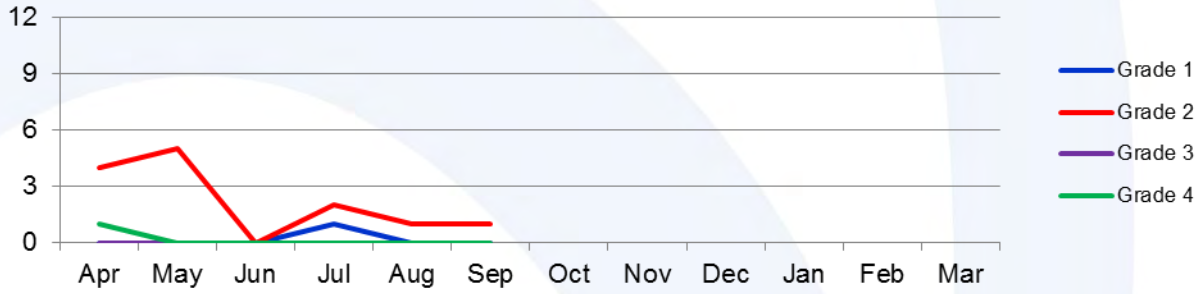


A best practice group focussing on falls prevention and minimising the risk of harm has been established led by the Director of Nursing and Quality. This group is benchmarking GCS against national best practice standards and is currently:

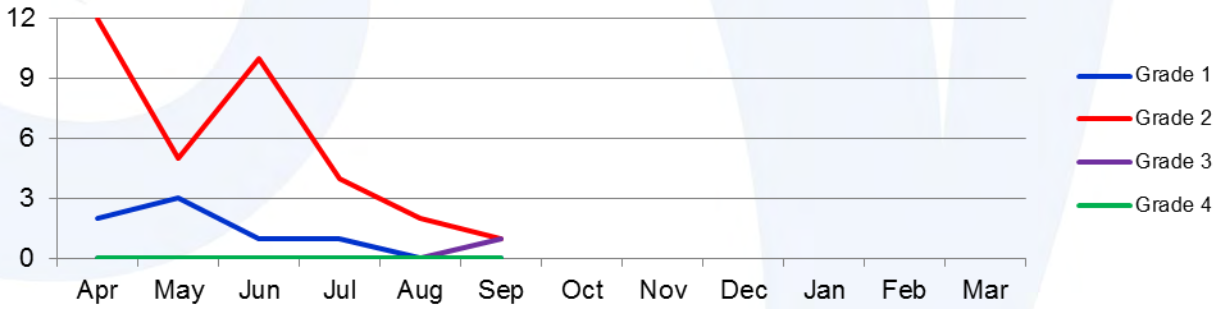
- Revising the falls policy
- Trialling revised documentation in the Forest of Dean hospitals
- Aligning falls alerts to NICE guidance
- Developing falls reduction plans by site
- Looking at pathways of care and communication across community and hospitals services

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	YTD
Grade 1	0	0	0	1	0	0							1
Grade 2	4	5	0	2	1	1							13
Grade 3	0	0	0	0	0	0							0
Grade 4	1	0	0	0	0	0							1



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	YTD
Grade 1	2	3	1	1	0	0							7
Grade 2	12	5	10	4	2	1							34
Grade 3	0	0	0	0	0	1							1
Grade 4	0	0	0	0	0	0							0



Benchmarking	
New Grade 2, 3 & 4 pressure ulcers (GCS)	**8.2 average per month, April-September 14**
New Grade 2, 3 & 4 pressure ulcers (Aspirant Community Foundation Trust Group)	**14.2 average per month, April-August 14**

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	YTD	2013-14 outturn
Adult safeguarding alerts raised by GCS	13	10	18	17	10	8							**76**	**176**
Total county adult safeguarding alerts	59	66	64	65	60	60							**370**	**4,008**
GCS adult safeguarding investigations*	3	5	6	11	3	4							**32**	**n/a**
Total county adult safeguarding investigations	27	30	30	28	29	24							**168**	**n/a**
Number of new children's Serious Case Reviews	1	0	0	1	0	2							**4**	**n/a**
Number of children subject to a Child Protection Plan	428	391	408	403	416	426								**n/a**
Number of children identified as 'cause for concern' during supervision	756	1,114	1,505	1,503	1,505	1,506								**n/a**

***Breakdown of adult safeguarding investigations (Q1 and Q2 2014/15)**

Client group		Type of concern		Outcome of investigation	
Learning disabilities	2	Neglect	11	On-going	14
Dementia	13	Physical injury	6	Substantiated	1
Physical disability	14	Sexual	2	No further action	15
Mental health	0	Financial	7		
Other vulnerable	2	Psychological	4		
		Institutional	0		

GCS participated in the Serious Case Review related to Abigail and her siblings published on August 20th 2014. In response to the learning from this review GCS has

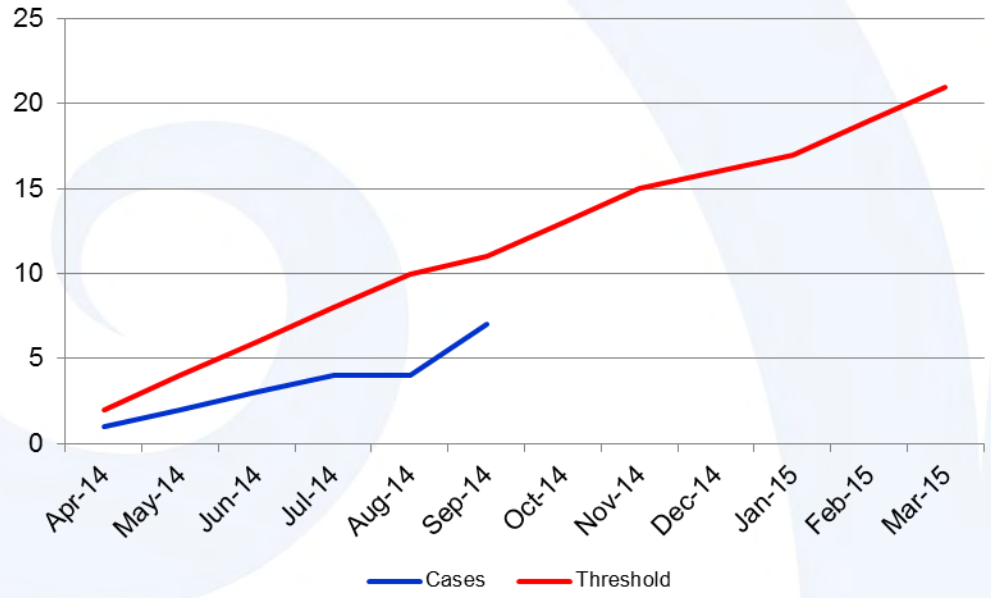
- Reinforced the use of the escalation policy
- With GSCB reviewed the training to professionals to support the recognition of neglect
- Re-emphasised the importance of hearing the voice of the child
- Reviewed our supervision policy to support practitioners

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	YTD
MSSA	0	0	0	0	0	0							0
MRSA	0	0	0	0	0	0							0
E. Coli	0	0	1	0	0	0							1
CPE	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	YTD
Actual	1	1	1	1	0	3							7
Threshold	2	2	2	2	2	1	2	2	1	1	2	2	11
Variance	-1	-1	-1	-1	-2	2							-4

Incidence of C. Diff



September 2014

Lydney Hospital (C diff)

Patient admitted from acute care, developed diarrhoea whilst at Lydney Hospital post 48 hours after admission

Abbeyview Ward, Tewkesbury (C diff)

Patient admitted from home sample taken post 48 hours after admission and then no further diarrhoea symptoms

Coln Ward, Cirencester (C diff)

Patient admitted from acute care, sample taken post 48 hours after admission, patient discharged home by the time result was available

Norovirus

GCS launched the annual campaign to raise awareness of the risks of Norovirus to those in our care and asking hospital visitors to help us keep patients safe. The campaign has included the use of posters, leaflets and press coverage including a radio interview

Hand hygiene observation audits for September evidenced an average of 93% compliance

Medicines management

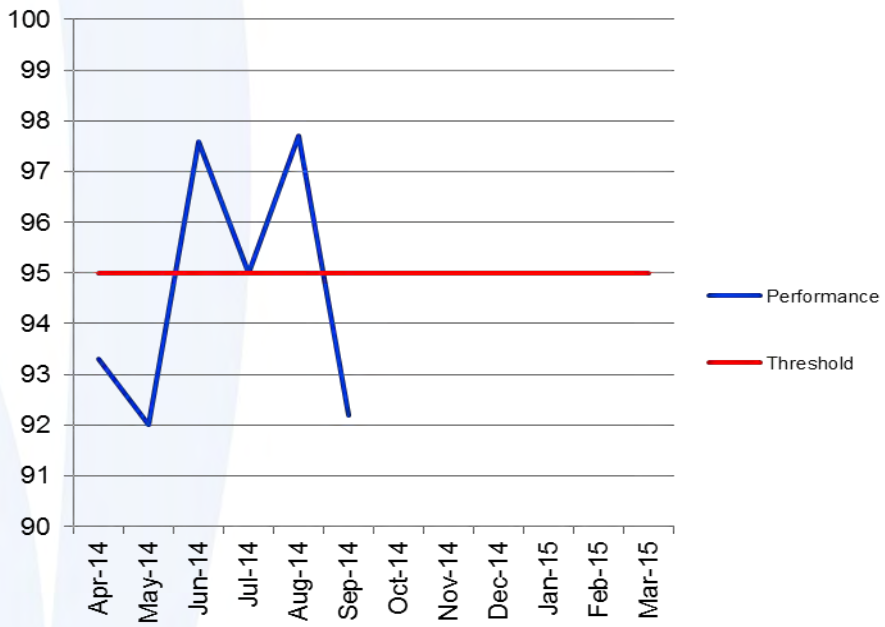
Medication incidents	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
2014-15	22	26	12	21	14	21							**116**
2013-14	29	26	39	65	46	26	36	39	36	49	55	27	**473**

Medication incidents by sub-category	Number
Omitted or delayed administration	44
Medication administered in error/incorrectly	25
Controlled drugs issue	16
Medication prescribed incorrectly/in error	12
Medication dispensed incorrectly	5
Illegible or unclear information	4
Medication missing	4
Storage issue	4
Information to patient wrong or omitted	2
Total	**116**

Controlled Drug Issues (16)

•4 incidents related to incorrect or omitted entries in the CD register
•4 incidents related to incorrect counting or measuring of CDs
•3 incidents were unaccounted losses
•2 incidents involved CDs being incorrectly stored
•2 incidents involved District Nurses
•1 incident involved a GP

HAPPI (Hospital Antibiotic Prudent Prescribing Indicator) audits



The decrease in September is due to no return from Dilke due to a change in pharmacy staff there. The Vale has also dropped due to there being only one patient on antibiotics on the day of the audit and 3 of the 5 criteria were not recorded for this patient.

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	YTD	Forecast	2013-14 outturn
All Admissions	**23:00-05:59**	11	19	19	16	11	10							**86**	**172**	**153**
	%	3.29%	5.38%	5.35%	4.65%	3.12%	3.31%							**4.29%**	**4.29%**	**3.40%**
Direct Admission	**23:00-05:59**	3	8	7	5	6	7							**36**	**72**	**74**
	%	2.52%	7.02%	5.26%	5.38%	5.17%	7.00%							**5.38%**	**5.38%**	**4.10%**
Transfer	**23:00-05:59**	8	11	12	11	5	3							**50**	**100**	**79**
	%	3.72%	4.60%	5.41%	4.38%	1.95%	1.49%							**3.74%**	**3.74%**	**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	YTD	Forecast	2013-14 outturn
Transfer from GRH	7	3	8	7	3	3							**31**	**62**	**47**
Transfer from CGH	1	5	3	4	2	0							**15**	**30**	**24**
Transfer from other	0	1	1	0	0	0							**2**	**4**	**4**
Internal transfer	0	2	0	0	0	0							**2**	**4**	**4**
Total	**8**	**11**	**12**	**11**	**5**	**3**							**50**	**100**	**79**

It is recognised that patient transfers that happen late at night are not good practice and can lead to patients being tired, distressed and confused and can have an impact on their recovery. Gloucestershire Care Services complete a datix incident report on each late transfer (after 21.00 hours) and are currently planning an audit with partner organisations to identify at what points in the transfer the delays have occurred and whether there are any common root causes that require further investigation

Safer staffing – September 2014

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	87.1%	111.4%	103.3%	105.0%	91.3%
	Windrush Ward	86.7%	104.3%	101.7%	93.3%	93.5%
Dilke Memorial	The Ward	99.4%	119.0%	103.2%	101.6%	88.9%
Lydney and District	The Ward	100.6%	95.7%	103.3%	98.3%	87.1%
North Cotswolds	NCH Ward	97.2%	96.2%	101.7%	103.3%	86.8%
Stroud General	Cashes Green Ward	68.9%	107.6%	100.0%	126.7%	94.0%
	Jubilee Ward	100.0%	107.6%	100.0%	126.7%	95.6%
Tewkesbury Community	Abbey View Ward	83.3%	95.2%	100.0%	100.0%	96.2%
Vale Community	Peak View	99.4%	92.9%	100.0%	100.0%	92.8%
TOTAL		90.9%	103.3%	101.5%	106.1%	91.3%

Hospital	Ward	Bank Staff	Agency Staff
Cirencester	Coln Ward	12.5%	17.1%
	Windrush Ward	5.3%	14.7%
Dilke Memorial	The Ward	6.8%	22.6%
Lydney and District	The Ward	3.7%	17.8%
North Cotswolds	NCH Ward	11.0%	10.4%
Stroud General	Cashes Green Ward	10.9%	23.9%
	Jubilee Ward	5.6%	31.8%
Tewkesbury Community	Abbey View Ward	1.3%	2.6%
Vale Community	Peak View	9.1%	181.4%
TOTAL		7.5%	17.8%

The Trust is currently re-auditing planned staffing levels in order to ensure that they continue to meet care needs. This data will be discussed at QCGC in December

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

- Cashes Green - Low fill rate due to increased vacancies and incidence of sickness and non availability of bank or agency RNs
- Cashes Green & Jubilee - Increase in HCAs due to the number of patients on the ward who required one to one supervision
- A review of the Stroud hospital position is being undertaken by the Head of Community Hospitals

Safer Staffing Alert Levels – September 2014

Hospital	Ward	Shortfall of 8 hours or 25% of RN hours on the shift	Staffing levels as planned	Staffing levels below plan but care needs met	Staffing levels increased to meet care need
Cirencester	Coln Ward	4	54	10	1
	Windrush Ward	7	48	13	1
Dilke Memorial	The Ward	0	45	5	20
Lydney and District	The Ward	0	60	9	0
North Cotswolds	NCH Ward	2	63	5	0
Stroud General	Cashes Green Ward	1	46	2	19
	Jubilee Ward	10	27	1	32
Tewkesbury Community	Abbey View Ward	7	50	11	1
Vale Community	Peak View	2	60	8	1
TOTAL		**33**	**453**	**64**	**75**

From the 9th September ward teams commenced recording based on clinical judgement the ability of staff per shift to meet the needs of those in their care. This enhances the data provided based on fill rate and bed occupancy with the clinical judgement by the teams as to their ability to meet care needs based on patient dependency for that shift.

In December 2014 the data captured will be further analysed in order to assign weighting scores to the alert levels and build a system of RAG rating.

Safer staffing – August 2014

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	83.1%	111.1%	100.0%	98.4%	91.1%
	Windrush Ward	82.8%	101.4%	98.4%	96.8%	98.1%
Dilke Memorial	The Ward	97.3%	107.4%	101.6%	103.1%	84.8%
Lydney and District	The Ward	98.9%	101.8%	100.0%	106.5%	89.8%
North Cotswolds	NCH Ward	98.4%	95.4%	100.0%	97.0%	88.3%
Stroud General	Cashes Green Ward	87.3%	105.9%	91.9%	125.8%	77.9%
	Jubilee Ward	100.0%	96.3%	100.0%	98.4%	93.3%
Tewkesbury Community	Abbey View Ward	78.0%	100.5%	100.0%	100.0%	94.2%
Vale Community	Peak View	99.5%	100.0%	100.0%	103.2%	90.3%
TOTAL		**91.1%**	**102.2%**	**99.1%**	**103.2%**	**89.7%**

The Trust is currently re-auditing planned staffing levels in order to ensure that they continue to meet care needs

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

- Abbeyview - Low fill rate due to increased incidence of sickness.
- Abbeyview - Patient dependency on the ward relatively low therefore staffing requirement reviewed and shifts covered by substantive or bank HCAs rather than using agency RNs. Band 7 available on the ward to provide clinical leadership and support
- Cashes Green - Increase in HCAs due to the number of patients on the ward who required one to one supervision which is over and above the staffing levels

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 to September 2014 *(not referenced elsewhere)*

- Minor Injuries Units are not achieving the requisite response rates for the Friends and Family Test and teams are reminded of the importance of asking for feedback. NB *it is noted that new national guidance is changing the ways in which FFT is reported in future (see pages 24 and 26)*

- The number of complaints received increased in September compared to previous month. The Trust is still receiving relatively low numbers compared to other community trusts and is looking at ways to encourage service users to "Talk to Us"*(see page 27)*

Gloucestershire Care Services NHS
NHS Trust

Friends and Family Test - Inpatient Units

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	Average	Target
Cirencester	56%	43%	65%	24%	36%	22%							41%	30%
Stroud	74%	74%	65%	66%	17%	32%							55%	
Tewkesbury	39%	39%	57%	23%	57%	29%							41%	
The Vale	27%	28%	55%	47%	19%	37%							35%	
North Cots	45%	31%	40%	30%	16%	41%							34%	
Dilke	33%	39%	55%	63%	13%	0%							34%	
Lydney	57%	54%	57%	30%	17%	28%							41%	
Average	47%	44%	56%	40%	25%	27%							40%	
Total responders	172	167	205	140	50	60								
Sample Size	349	359	354	356	193	206								

- Patients are sent a questionnaire together with a letter from the Director of Nursing one or two days after discharge asking them complete this either on paper (return envelope included) or by logging on to a website and submitting the survey online.
- CoMetrica is responsible for collating the results and provide weekly comments reports to service leads as well as monthly reports on the results achieved.
- In order to achieve the response rate it is essential that staff inform patients that they are likely to receive a questionnaire after discharge and encourage them to complete the questionnaire and return to CoMetrica.
- Stroud Hospital show a Net Promoter score of zero, which is calculated by subtracting the detractors from those extremely likely to recommend the service
- *Please note: Dilke score of 0% for September was due to no responses received back from patients*

Net promoter	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Average	Target
Cirencester	60	57	62	75	71	54							63	60+
Stroud	90	96	65	69	80	0							67	
Tewkesbury	92	92	96	100	75	50							84	
The Vale	36	87	92	91	83	82							79	
North Cots	79	100	100	54	100	69							84	
Dilke	80	79	65	72	100								66	
Lydney	100	76	95	92	25	89							80	
Total	76	83	83	76	74	62							76	

Inpatient survey – September 2014

Description	Tewkesbury	Stroud Cashes Green	Stroud Jubilee	Cirencester Coln	Cirencester Windrush	Vale	North Cotswold	Lydney
Q.4451 Did you have confidence and trust in the staff examining or treating you?	10.00	8.33	5.00	10.00	9.00	10.00	9.62	10.00
Q.4452 Were you involved as much as you wanted to be in decisions about your care and treatment?	7.50	6.67	0.00	8.13	9.00	8.18	8.08	7.50
Q.4453 In your opinion, was the area clean?	10.00	10.00	10.00	9.17	10.00	10.00	10.00	10.00
Q.4454 Overall, did you feel you were treated with respect and dignity?	9.17	8.33	7.50	10.00	10.00	10.00	10.00	10.00
Q.4455 Overall experience of this service.	7.53	7.91	6.70	8.19	8.04	9.16	7.75	8.55
Patients Surveyed	6	6	2	8	5	11	13	9

In addition to the Friends and Family question respondents to our in-patient survey are asked five questions about their experience of care whilst a patient in a community hospitals. The responses are presented as an average satisfaction score based on all responses received. The highest achievable score is 10.00

Friends and Family Test - Minor Injuries Units

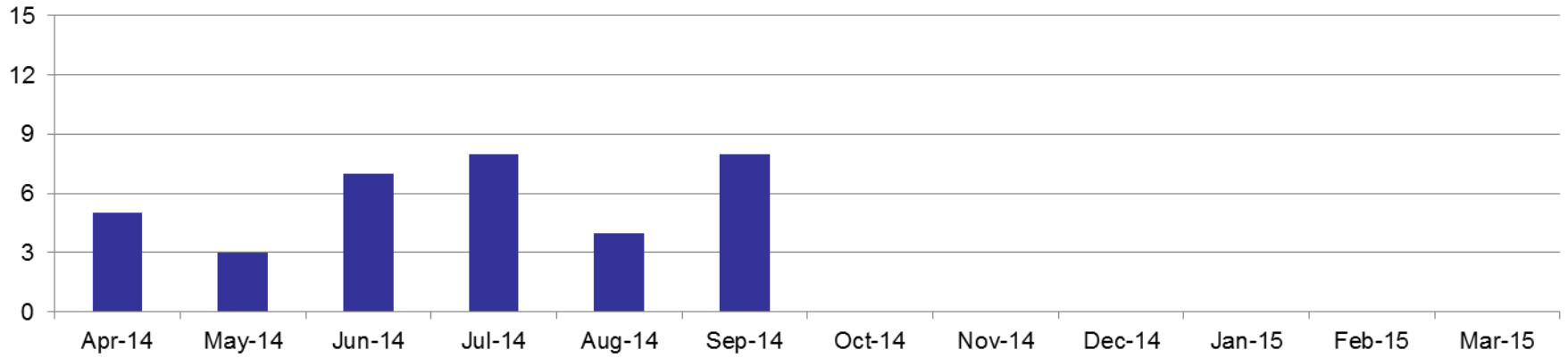
Responses	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Average	Target
Cirencester	15%	14%	16%	24%	28%	21%							19%	20%
Stroud	13%	10%	4%	11%	19%	14%							11%	
Tewkesbury	2%	19%	36%	14%	8%	22%							16%	
The Vale	30%	17%	17%	20%	27%	24%							22%	
North Cots	11%	17%	15%	13%	16%	18%							14%	
Dilke	30%	20%	21%	18%	20%	18%							22%	
Lydney	39%	34%	14%	14%	11%	13%							22%	
Average	20%	19%	18%	16%	18%	19%							18%	
Total responders	1100	1100	998	1147	1121	1090								
Attendances	6117	6348	6486	6810	5756	6042								

- Patients are provided with a copy of the FFT questionnaire whilst visiting the MIU and are asked to complete and put it in the comments box before leaving the premises. The completed forms are posted to CoMetrica on a weekly basis by GCS
- A further collection technique has been added by CoMetrica . Where mobile numbers are known, patients are sent a text message following their visit to MIU with a link to the questionnaire, providing them with an additional option to complete the questionnaire.
- CoMetrica is responsible for collating the results and provides weekly comments reports to service leads as well as monthly reports to GCS
- In order to achieve the response rate it is essential that the FFT is promoted by both admin and clinical staff and that posters and information as well as feedback about the survey is available in all units.

Net promoter	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Average	Target
Cirencester	85	78	77	78	85	85							81	46+
Stroud	80	70	87	66	65	65							74	
Tewkesbury	100	83	66	82	84	77							83	
The Vale	89	88	68	79	84	75							82	
North Cots	82	73	83	86	84	92							82	
Dilke	87	77	81	82	82	81							82	
Lydney	87	81	79	86	79	75							82	
Total	84	77	76	78	79	79							79	

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	8	4	8							35	78



Response Time	April - August 2014-15	
	Number of responses	% of responses
Target time within agreed timescale	28	84.8%
Over the agreed timescale by 1-3 days	2	6.1%
Over the agreed timescale in excess of 4 days	3	9.1%
Awaiting investigation	2	n/a
Total	35	100%

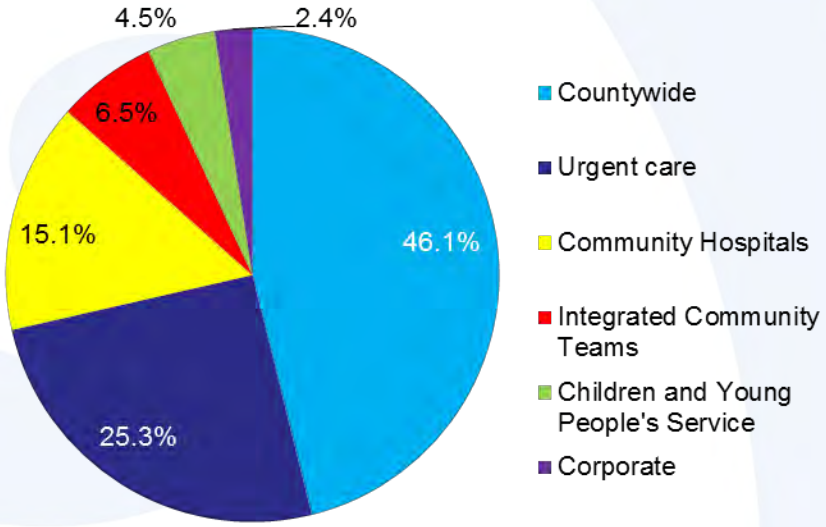
Benchmarking	
Complaints per 1,000 WTE staff (GCS)	**2.7 average per month, April-September 14**
Complaints per 1,000 WTE staff (Aspirant Community Foundation Trust Group)	**5.3 average per month, April-August 14**

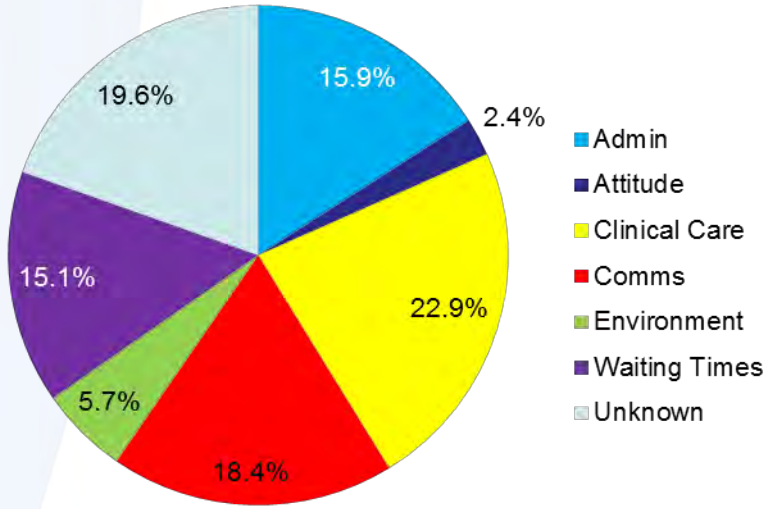
Formal complaints are dealt with by the Complaints Manager who works closely with the investigation officer to undertake a full investigation of the complaint. The complainant is informed of the process and a full investigation process should be undertaken within 25 working days. The service is expected to undertake any suggested actions as a result of the investigation process. Themes from complaints are collated into the quarterly patient experience report presented to QCGC.

Concerns

Concerns (year-to-date)	Admin	Attitude	Clinical Care	Comms	Environ	Waiting Times	Unknown	Total
Countywide	21	0	19	17	3	17	36	**113**
Urgent Care	5	3	21	13	2	12	6	**62**
Community Hospitals	2	3	9	8	9	1	5	**37**
Integrated Community Teams	1	0	4	5	0	6	0	**16**
Children & Young People's Service	5	0	3	2	0	0	1	**11**
Corporate	5	0	0	0	0	1	0	**6**
Total	**39**	**6**	**56**	**45**	**14**	**37**	**48**	**245**

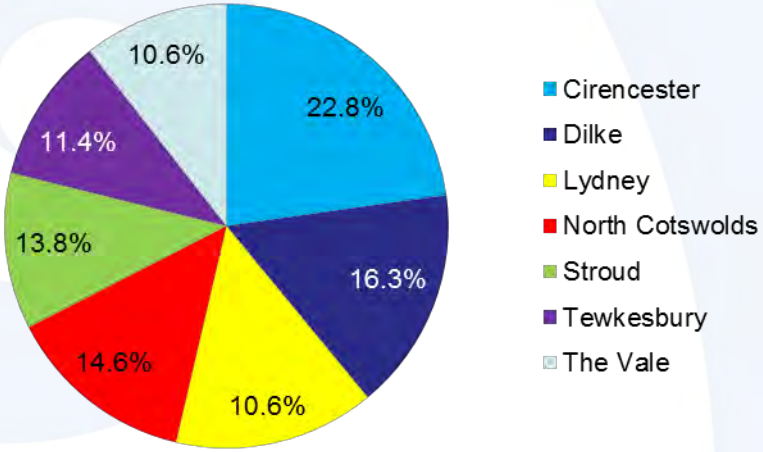
Concerns are dealt with by the service experience team in the first instance who then inform service leads of the issues raised. It is the responsibility of the service to investigate and they will usually engage directly with the service user. Once complete the service will inform the service experience team.





Mortality Reviews: Community Hospitals

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
Cirencester	4	4	4	2	7	7							**28**
Dilke	6	5	2	3	2	2							**20**
North Cotswolds	3	6	2	4	2	1							**18**
Stroud	3	6	2	2	2	2							**17**
Lydney	1	4	1	2	4	2							**14**
Tewkesbury	2	2	4	4	1	0							**13**
The Vale	3	4	2	1	1	2							**13**
Total	**22**	**31**	**17**	**18**	**19**	**16**							**123**



This table shows the mortality numbers at each community hospital for the year to date. The Medical Director leads the process for reviews of all deaths in our hospitals in order that we may continually improve the care we provide. 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
- This is being taken forward through education sessions with medical staff and the professional cabinet

EFFECTIVE

Effective - key points

- Following a review undertaken by the Matrons the Early Warning Trigger tool *(see Appendix 2)* has been replaced by the Quality Snapshot report *(see page 32)* this makes more visible the quality metrics used as a temperature check and therefore makes a more robust tool for matrons to use as part of their quality assurance processes

- Metrics to provide a similar temperature check within community based services *(see page 33)* is currently being developed

- The Clinical Senate took on the role in September to review all newly published NICE guidance, assess whether applicable to the trust, assign leads and monitor implementation

Gloucestershire Care Services NHS
NHS Trust

Quality Snapshot – Community Hospital Inpatient Care September 2014

Hospital site	Inpatient wards	FFT response rate	FFT number of responses	FFT net promoter score	Concerns	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)		Sickness % (Previous Month)		Appraisal %		Movement against Previous Month
								No harm	Minimal	Short-term	Severe	Death	Grade 1	Grade 2	Grade 3	Grade 4	RNC	HCA	RNC	HCA	RNC	HCA	
SGH	Cashes Green	32%	6	17	0	0	86%	1	1	0	0	0	0	0	0	0	76.7%	111.9%	1.3% (10.3)	1.2% (10.9)	100.0%	100.0%	↔
SGH	Jubilee	33%	2	-50	0	0	94%	2	1	2	0	0	0	0	1	0	100.0%	111.9%	4.8% (10.2)	6.1% (9.9)	100.0%	13.3%	↓
NCH	North Cotswold	41%	13	69	0	0	83%	4	5	0	0	0	0	0	0	0	98.3%	97.8%	4.5% (12.9)	3.4% (12.5)	89.5%	94.1%	↑
VLH	Peak View	37%	11	82	0	0	94%	7	7	1	0	0	0	1	0	0	99.6%	94.4%	7.8% (12.4)	12.0% (11.3)	94.1%	82.4%	↑
DLK	Dilke	0%	0	0	0	0	89%	3	1	0	0	0	0	0	0	0	100.4%	115.1%	12.4% (14.4)	0.0% (12.8)	95.0%	93.8%	↓
TWK	Abbey View	29%	6	50	0	1	100%	9	3	2	0	0	0	0	0	0	87.5%	96.3%	7.6% (15.6)	9.5% (16.5)	94.7%	95.0%	↓
LYD	Lydney	28%	9	89	0	1	100%	3	2	1	0	0	0	0	0	0	101.3%	96.3%	19.4% (11.7)	6.7% (13.7)	85.7%	94.4%	↑
CIR	Coln	24%	8	50	0	1	95%	7	4	1	0	0	0	0	0	0	90.3%	110.0%	13.3% (16.0)	15.9% (10.9)	71.4%	100.0%	↓
CIR	Windrush	19%	5	60	0	0	94%	5	2	0	0	0	0	0	0	0	90.4%	101.9%	5.9% (13.4)	10.9% (15.4)	53.9%	57.9%	↓

Please note Jubilee Ward FFT net promoter score only consisted of only 2 responses, 1 “Likely” (excluded from the calculation) and 1 “Neither likely nor unlikely”

Quality Snapshot - Community Teams September 2014

Locality	Safety thermometer harm free care	Number of patients with acquired pressure ulcers				Sickness % (Previous Month)	Appraisal %	Complaints	Movement against Previous Month
		Grade 1	Grade 2	Grade 3	Grade 4				
Cheltenham	96%	0	0	0	0	8.1% (46.8)	75.8%	0	↑
Cotswold	90%	0	0	0	0	6.5% (27.2)	88.6%	0	↔
Forest	97%	0	0	0	0	2.0% (37.7)	85.9%	0	↑
Gloucester	94%	0	0	0	0	7.8% (61.0)	82.2%	0	↔
Stroud	89%	0	1	0	0	2.5% (45.2)	84.8%	1	↔
Tewkesbury	96%	0	0	0	0	3.3% (30.5)	71.1%	0	↑

Effective – Best Practice Groups

- Best Practice Groups:
  - End of Life

- The End of Life Best Practice Group had its first meeting in September where members spent the session identifying what was positive in respect of current care provision and what they felt needed improvement. The group has a wide variety of members from professions representing many of our care settings. The group welcomed the prospect of an external review of End of Life Care provided by Gloucestershire Care Services to be conducted by Dr Susi Lund, Nurse Consultant in End of Life Care. The group agreed to reconvene after the review to agree key pieces of work to take forward. The report will be circulated to the group prior to their action planning meeting on 14th November 2014

  - Dementia

- There has been a positive response to the setting up of this group and the first meeting is planned for early November 2014. The meeting will focus on learning on the CQC Cracks in the Pathway document published this month, work looking at walking with a purpose and learning from the Dementia Friendly Environment work already undertaken in GCS

  - Falls *(see page 13)*
  - Deteriorating Patients

The Identifying the Deteriorating Patient best practice group has a wide variety of members from professions representing many of our care settings, initial meetings have taken place during September and October 2014 and there are currently two new pieces of work now being carried forward, there are

- an early warning score system and observation chart for children and young people attending Minor Injury and Illness Units (MIIU's) is currently being developed, this initiative will build upon the work carried out to implement an early warning score system and observation chart across Community Hospitals and the Rapid Response Service.
- a significant area of work is commencing to improve the identification and treatment of patients with suspected and confirmed episodes of sepsis, this will include and education and awareness programme for all clinical staff and different ways of working to assess and identify patients who may be showing clinical signs of sepsis. A detailed plan has been developed and proposals will be presented to relevant groups and leaders by the end of the year.

  - Medicines

- The focus of the first medicine management best practice group is insulin. An initial meeting has been held which was attended by colleagues from a range of care settings. The focus of the meeting was reviewing incidents and near misses relating to insulin, to identify any themes and trends. From this meeting a number of actions are being taken forward including the introduction of training package for all clinical staff which will address the gaps in knowledge identified from incident reports and provide assurance of a safe and competent workforce

Effective – NICE

Trust compliance with NICE guidance published May 2010 to August 2014

Type of guidance	Not Assessed	Not Implemented	Partially Implemented - Moderate Concern	Partially Implemented - Minimal Concern	Fully Implemented	Not Applicable
NICE Guidance	23	0	1	14	23	388

Trust compliance with NICE Quality Standards published June 2010-August 2014

Type of guidance	Not Assessed	Not Implemented	Partially Implemented - Moderate Concern	Partially Implemented - Minimal Concern	Fully Implemented	Not Applicable
Quality Standards	29	2	0	4	0	32

- The NICEASSURE application has now been configured to support the trust's ability to provide robust assurance of our compliance with NICE guidance.
- 100 colleagues have received training on this application
- Services are reviewing guidance that is applicable to their service to provide assurance at both service and trust wide level
- Although the trust was not established until 2013 it has been agreed to look back at guidance from May 2010. A further retrospective review will then commence for pre 2010 publications
- The process is being overseen by the Clinical Senate

Effective – Clinical Audit

Gloucestershire Care Services NHS
NHS Trust

Integrated care records (CQUIN 7)

Context: Mix of electronic and paper patient records we audited, with significant in-year changes for many services. Some established services have a long track record of auditing patient notes and have improved their recording through re-audit and ensuring all staff are clear what is required. Other services are newly formed, e.g. Rapid Response, and have had little time to demonstrate they have responded learning as a result of the audit.

- **Record keeping audits completed in the following services**:
- Community hospital In-patients, Rapid response, Integrated Discharge Team, Out of Hours, Minor Injury Units
- Integrated community teams: Physiotherapy; Community Nursing in Forest and Tewkesbury localities
- Sexual Health Services
- All 13 county wide specialist services (except Palliative Occupational Therapy)
- Children's community nursing

Overview of findings from Q1 and Q2 :

High compliance with records policy (over 90% in most audits) **was evidenced in the following areas**

- Best record keeping practice in relation to professional guidance
- Recording of goals, treatment planning, discharge
- Recording of information provided to service users
- Recording of significant events

Low compliance (below 90% in most audits) **was noted in the areas of**

- Recording of consent
- Recording of mental capacity

- **Reasons noted for low attainment:**
- Lack of connectivity when mobile working leading to staff not entering information
- Some information not transferred from written notes to SystmOne/ Care Plus
- Variability within teams in the approach to recording information on new platforms
- Some staff unclear as to what is expected in terms of assessment around mental capacity

- Action plans will now be produced by service that set out the steps required for improvement, this may include training. Findings will also be discussed at the Systm1 user group and re-audits will be scheduled to assess progress.

RESPONSIVE

Responsive - key points

- In September, the Trust is reporting 88.9% compliance with national health targets and 74.1% compliance with local health targets on year to date basis: this represents slight increase in national targets and a slight decrease in local targets from the August position: however, there are clear action/remedial plans in respect of all areas of under-performance *(see pages 39 and 40)*

- There are three social care indicators, currently RAG rated red, which are of particular priority for the Trust and our Adult Social Care Commissioners *(see page 41)*

Performance targets - National

Indicator	YTD RAG	Performance	Actions	Projected date of remedy
Friends and Family Test - MIU response rate		See page 26 for details		
Safety Thermometer - harm free care		See page 11 & 12 for details		
MIU unplanned reattendance rate within 7 days		Performance in September was 5.9% compared to target of less than 5%	MIU targets and performance are now routinely reviewed by the Professional Lead for Urgent Care and in monthly Clinical Governance meetings. Feedback is provided to the Head of Urgent Care	
Newborn Bloodspot Screening - timeliness of result		Performance in September was ahead of the target of 95% at 98.4%. Year to date performance is 93.9%	Year to date performance remains below target due to under performance in April and July due to laboratory issues at Southmead Hospital.	December 2014 (year to date)

Performance targets - Local

Indicator	YTD RAG	Performance	Actions	Project date of remedy
Bone Health Service - referral to treatment within 8 weeks		Performance in September was 100% compared to a target of 95%, however year to date performance currently stands at 87%	The team is continuing a range of remedial actions including providing extra clinics to reduce waiting times, staff working extra hours, recruitment to a new Band 6 Nurse and Team Administrator. There is also a proposal to commissioners that the team will not see fractured Neck of Femurs on acute wards until November to release potential 18% workload. The team are now back on track with the monthly RTT figure.	Performance has been on target since August 2014
MSKCAT service - wait time for routine patients		Performance in September was 22% for routine and 100% for urgent patients against 95% targets. Year to date performance remains rated red	Actions to address this under-performance include clarifying the classification of patients to urgent and routine after triage and how staff record on SystmOne, the service lead reviewing the lists of urgent patients daily as part of a data validation programme, and adding additional clinics following recruitment.	Urgent target achieved in September 2014. Routine TBC
MSKCAT service - wait time for urgent patients				
MSKCAT service - referral to treatment within 8 weeks		Performance for year to date was 72% against a target of 95%	Actions to address under-performance include additional capacity (over and above funded establishment) to clear backlog of referrals, ESP Clinicians to be taken off non-essential, non-clinical tasks, and a request to clinicians to volunteer for overtime	
Chlamydia Screening - number of positive screens		Performance in September is short by 236 positive screens, with 503 positive screens recorded compared to target of 739.	Attending the Cheltenham GP meeting to promote Chlamydia Screening. MIU Issue being addressed to try and motivate staff to obtain screens. Continuation of auditing own services. The Care Services team are running Locality meetings and update events across Gloucestershire throughout October, GPs, Children Centres Midwives, Schools, Health Visitors, School Nursing, Youth Service and Military are invited.	
Podiatry Service - referral to treatment within 8 weeks		Performance in September was 80% against a target of 95%	The actions itemised above for the MSKCAT service apply equally to the podiatry service	
Stop Smoking Service - Number of smokers successfully quit		Performance in September was 632 against a target of 860	There is a national and local downturn in the number of smokers quitting. The service relies heavily on GP referrals and negotiations are taking place with commissioners regarding the target. Training has been planned for frontline GCS staff as well as an increase in promotional activity.	

Adult Social Care Key Indicators

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 (within the last 12 months) whether they have a carer	75.1%	73.0%	68.9%	66.1%	69.6%	68.3%	64.5%							100.0%
Permanent admissions aged 65+ to residential and nursing care homes per 100,000 population	895.3	866.2	842.3	803.0	793.6	774.8	749.2							Smaller is better 731.90
% service users who have had a full re-assessment of their needs within the last 12 months	80.8%	79.3%	77.6%	76.2%	76.1%	74.2%	72.4%							80.0%

Notes

- **% service users who have been asked if they have a carer** - it is believed that the reported under-performance is attributable more to data quality rather than a significant drop in people with carers. This assumption is currently being explored and tested
- **Permanent admissions aged 65+ to residential and nursing care homes per 100,000 population** - the External Care Programme is launching a campaign in September to keep more people at home than going into care homes. This is reducing the number of permanent admissions, but not quickly enough.
- **% service users who have had a full re-assessment of their needs within the last 12 months** - The numbers of both assessments and reassessments are lower than last year, and it is the aim of the External Care Programme to agree productivity targets for all teams

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

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 routinely submitted to the Secondary Uses Services (SUS), Trust performance is 96.4% against a target of 96% *(not referenced elsewhere)* based on April to August 2014 data. September data has not yet been received from HSCIC

- 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 44)*

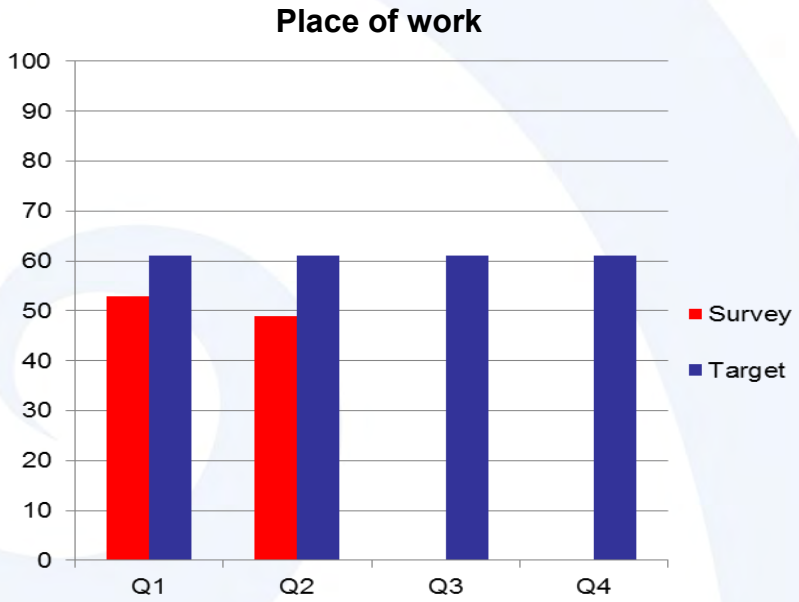
- The Trust is currently employing more staff than planned *(see page 45)* due to lower achieved C.I.P efficiency

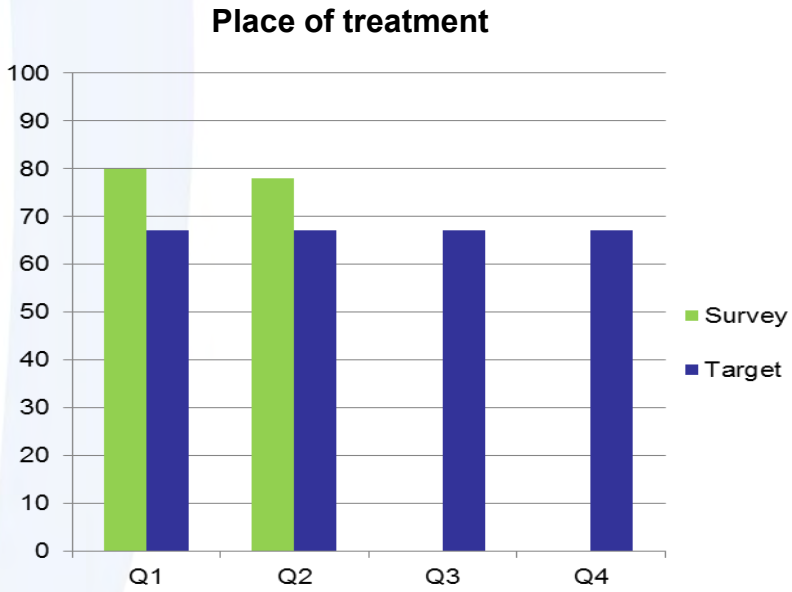
- Sickness absence levels, mandatory training rates and appraisals continue to under-perform *(see page 46)*

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%		
Percentage of staff who would recommend the Trust as a place to receive treatment	80%	78%		





Full analysis of the data is being undertaken. Report to Trust Board in November.

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	**2,209.32**	**2,165.93**	**2.00%**	**£6,533**	**£6,561**
- Temporary workforce	**119.70**	**106.92**	Not applicable	**£510**	**£97**
- Bank	69.88	64.49	Not applicable	£161	£30
- Agency staff	49.82	42.42	Not applicable	£349	£67
Substantive WTE	**2,089.62**	**2,059.02**	**1.49%**	**£6,023**	**£6,463**
- Non-medical - clinical staff	1,845.47	1,792.39	2.96%	£5,264	£5,632
- Non-medical - non-clinical staff	212.13	232.8	-8.88%	£541	£607
- Medical and dental staff	32.02	33.83	-5.34%	£218	£225

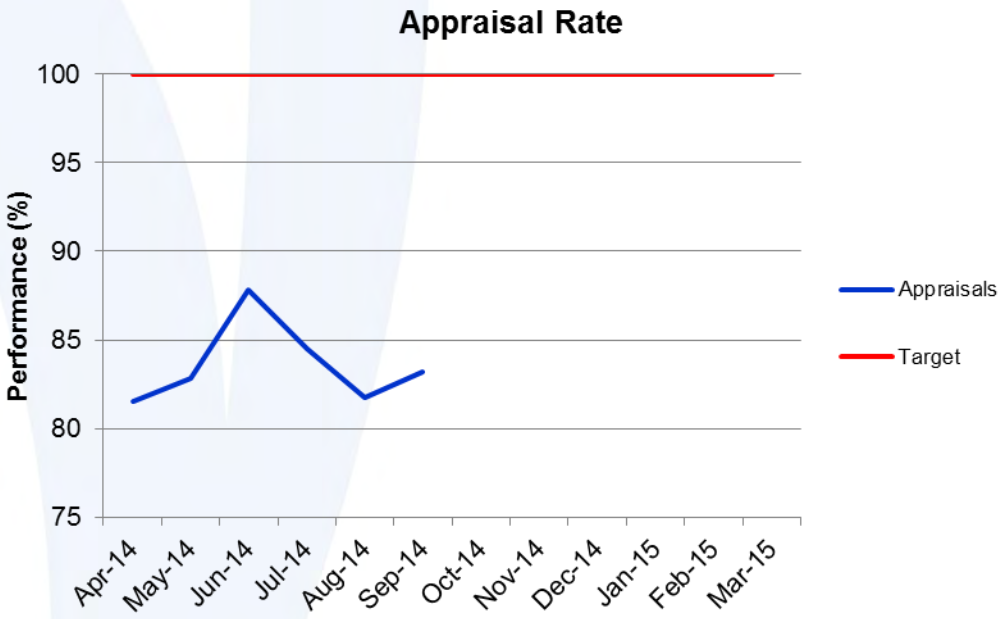
Staff Group	WTE (year-to-Sep)	Starters WTE (year-to-Sep)	Starters headcount (year-to-Sep)	Leavers WTE (year-to-Sep)	Leavers headcount (year-to-Sep)	Vacancy rates	Turnover WTE rates (year-to-Sep)
ICTs	440.73	69.12	78	54.07	75	TBC	12.61
Children, Family &Young People	369.15	44.35	59	36.55	49	TBC	11.47
Countywide	354.99	37.94	49	51.30	76	TBC	14.20
Community Hospitals	478.82	69.23	84	76.56	101	TBC	15.60
Support Services	338.02	71.08	81	53.99	64	TBC	16.65
Unscheduled Care & Capacity	107.91	37.56	42	13.62	23	TBC	14.96
Total	**2089.62**	**329.31**	**393**	**286.10**	**388**	**TBC**	**14.09**

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							**3.00**
Sickness absence % rate (1 month only)	4.88	4.48	4.88	5.43	4.94	4.34							**3.00**

Mandatory training course	Target	Health performance
Fire Safety	100%	**90.97%**
Infection Control	100%	**90.20%**
Health & Safety	100%	**90.20%**
Information Governance	100%	**82.07%**
Equality & Diversity	100%	**78.60%**
Conflict Resolution	100%	**78.09%**

Appraisal rate	Target	Performance
August	100%	83.18%



"Challenge and Support" peer review

August - CQC Outcome 2 & 4		
Is the service safe?	**Good**	This Peer Review which was led by Mandy Hampton, evaluating Tewkesbury Hospital against CQC Outcomes 2 (Consent to care and treatment) and 4 (Care and welfare of people who use the services). The review identified the following learning: • An emphasis needs to be placed on thorough completion of documentation • Day unit to revise procedures in gaining consent • Documentation in the ward and MIU areas to include evidence of consent obtained. • Clarity needed advocating team involvement in discharge process. • Interim Care Record for End of Life not being used by Medical staff • Access to documents on 'o' drive and IT competencies need to be reviewed and supported with additional training
Is the service effective?	**Good**	
Is the service caring?	**Good**	
Is the service responsive?	**Good**	
Is the service well led?	**Good**	

September - CQC Outcome 12, 13 & 14		
Is the service safe?	**Requires Improvement**	This Peer Review was led by Linda Edwards, evaluating Cirencester Hospital against CQC Outcomes 12 (Requirements relating to workers) Outcome 13 (Staffing) and Outcome 14 (Supporting workers). The review identified the following learning: • Issues around adequate training and competence for use of equipment for bank and agency staff • Safer staffing board needs to be clearly visible. • Minor Injuries Unit staff cover vacancies which demonstrated good teamwork. Work life balance for staff in the long term cover needs to be considered. • Training folder to be initiated on wards • Student Nurses have no formal induction in place, but this is planned. • There is an opportunity to formalise the arrangement for supervision and peer support to band 5's and 2's on the wards
Is the service effective?	**Requires Improvement**	
Is the service caring?	**Good**	
Is the service responsive?	**Good**	
Is the service well led?	**Good Outstanding - MIU**	

NED Quality Visits - Patient Experience Assessment (August/September)

Date	Who	Site/Service	Location
August		No visits in August	
29 September	Sue Mead	Single Point of Clinical Access (SPCA)	Edward Jenner Court

Clinical and Professional Care Strategy 2014-15 (Draft)

Quality Goal	Measure	RAG
To deliver compassionate, considerate care which ensures that service users remain safe from avoidable harm	Compliance with Safety Thermometer standards	
	90% care audits with pre-agreed deadlines completed within prescribed timescales	**TBC**
	Reduction in medicines incidents compared to 2013-14 baseline	
To determine that local care services adopt a person-centred approach, and are wholly effective and efficient	95% service users treated and discharged from Minor Injury Units within four hours	
	All health and social care services routinely evaluated against outcome measures	
	90% compliance with agreed CQUIN targets	**TBC**
To inform and involve service users, carers and families so that they have the best possible experience	Implementation of the Friends and Family Test across all locations in line with trajectory	
	90%+ service user overall satisfaction with their experience of care (*currently inpatient*)	
To develop a supportive and learning culture that is clinically-led, that will strengthen leadership across the Trust	Measured increase in the number of staff who are promoted internally	**TBC**
	Number of clinical staff who have had a team meeting, peer assessment, one-to-one meeting with their line manager and supervision session per month	**TBC**
To ensure an able workforce that can meet new challenges and is supported by education, training and research	Increase in the number of non-medical prescribers compared to 2013-14 baseline	**TBC**
	Number of clinical and professional care colleagues in post measured against plan	
To achieve excellence in integrated health and social care, and develop appropriate strategic partnerships	95% calls to the SPCA resolved with an agreed pathway within 20 minutes	
	Increase in the number of people setting a quit date for smoking, and increase in the number of people successfully quitting	

Quality Account

Priority	Measure	RAG
To reduce the number of service users who fall in our community hospitals or who acquire a pressure ulcer	Completion of the Safety Thermometer for 100% eligible service users	
	Reduction in the number of people who fell in community hospitals compared to 2013-14 baseline	
	Reduction in the number of people who acquired a pressure ulcer compared to 2013-14 baseline	
To improve the experiences of service users, carers and families within our community hospitals	Improvements in annual PLACE scores against 2013 baseline	
	95% compliance with hand hygiene observation audits	
	95%+ service user satisfaction score in respect of cleanliness of community hospitals	
	95%+ service user satisfaction score with respect and dignity at community hospitals	
To further develop and enhance our Integrated Community Teams	Implementation of the enhanced ICT model in line with the agreed timetable	**TBC**
	95% people referred to Rapid Response assessed within 1 hour	
	80% referrers report that the Rapid Response intervention avoids a hospital admission	
To improve our active two-way engagement with service users, carers and families	95%+ people reported as being “extremely likely” or “likely” to recommend our services	
	Completion of the agreed programme of service users surveys in line with trajectory	
	Minimum of two service development areas which are subject to scrutiny by public focus groups per quarter from quarter 3	**N/A**
To ensure that we maintain staffing levels as appropriate to the needs of service users	80-120% staffing across all community hospital sites in month	
	Monthly submission of Safer Staffing data to NHS England	

Hospital	Agency Use %
Cirencester Hospital	16.0%
Dilke Memorial Hospital	22.6%
Lydney and District Hospital	17.8%
North Cotswolds Hospital	10.4%
Stroud General Hospital	27.8%
Tewkesbury Community Hospital	2.6%
Vale Community Hospital	18.4%
	17.8%

Weekday	Agency Use %
Mon	17.5%
Tue	17.9%
Wed	16.0%
Thu	16.5%
Fri	19.2%
Sat	20.5%
Sun	17.2%
	17.8%

Gloucestershire Care Services NHS Trust

Safe Staffing Data - 1st September 2014 to 30th September 2014

Staff

HOSPITAL	WARD_NAME	Shift	Count of Shift	RNC Planned Staff	RNC Actual Staff	RNC Bank Staff	RNC Agency Staff	HCA Planned Staff	HCA Actual Staff	HCA Bank Staff	HCA Agency Staff	Planned Staff	Actual Staff	Bank Staff	Agency Staff	Staffing (Under)/Over	Bank %	Agency %	RNC Agency %	HCA Agency %
Cirencester Hospital	Coln Ward	Early	30	120	117	3	19	120	123	31	15	240	240	34	34	0	14%	14%	16%	12%
Cirencester Hospital	Coln Ward	Late	30	120	92	5	12	90	111	28	22	210	203	33	34	-7	16%	17%	13%	20%
Cirencester Hospital	Coln Ward	Night	30	60	62	0	7	60	63	4	22	120	125	4	29	5	3%	23%	11%	35%
Cirencester Hospital	Windrush Ward	Early	30	90	82	0	11	120	120	8	10	210	202	8	21	-8	4%	10%	13%	8%
Cirencester Hospital	Windrush Ward	Late	30	90	74	0	8	90	99	7	7	180	173	7	15	-7	4%	9%	11%	7%
Cirencester Hospital	Windrush Ward	Night	26	52	53	6	18	52	48	4	16	104	101	10	34	-3	10%	34%	34%	33%
Dilke Memorial Hospital	The Ward	Early	30	90	89	2	23	120	138	12	32	210	227	14	55	17	6%	24%	26%	23%
Dilke Memorial Hospital	The Ward	Late	30	90	90	1	26	90	112	11	31	180	202	12	57	22	6%	28%	29%	28%
Dilke Memorial Hospital	The Ward	Night	29	58	60	1	7	58	59	10	5	116	119	11	12	3	9%	10%	12%	8%
Lydney and District Hospital	The Ward	Early	29	87	88	0	21	116	111	4	7	203	199	4	28	-4	2%	14%	24%	6%
Lydney and District Hospital	The Ward	Late	29	87	87	0	21	87	83	5	10	174	170	5	31	-4	3%	18%	24%	12%
Lydney and District Hospital	The Ward	Night	30	60	62	2	16	60	59	7	12	120	121	9	28	1	7%	23%	26%	20%
North Cotswolds Hospital	NCH Ward	Early	29	87	85	6	7	116	111	12	6	203	196	18	13	-7	9%	7%	8%	5%
North Cotswolds Hospital	NCH Ward	Late	30	90	87	15	10	90	87	4	14	180	174	19	24	-6	11%	14%	11%	16%
North Cotswolds Hospital	NCH Ward	Night	27	54	55	3	13	54	56	13	0	108	111	16	13	3	14%	12%	24%	0%
Stroud General Hospital	Cashes Green Ward	Early	30	90	63	5	14	120	124	24	30	210	187	29	44	-23	16%	24%	22%	24%
Stroud General Hospital	Cashes Green Ward	Late	30	90	61	6	16	90	102	13	29	180	163	19	45	-17	12%	28%	26%	28%
Stroud General Hospital	Cashes Green Ward	Night	30	60	60	1	12	60	76	4	15	120	136	5	27	16	4%	20%	20%	20%
Stroud General Hospital	Jubilee Ward	Early	30	60	60	2	12	120	128	2	51	180	188	4	63	8	2%	34%	20%	40%
Stroud General Hospital	Jubilee Ward	Late	30	60	60	3	16	90	98	1	41	150	158	4	57	8	3%	36%	27%	42%
Stroud General Hospital	Jubilee Ward	Night	29	58	58	7	19	58	74	12	13	116	132	19	32	16	14%	24%	33%	18%
Tewkesbury Community Hospital	Abbey View Ward	Early	30	90	88	0	2	120	114	5	2	210	202	5	4	-8	2%	2%	2%	2%
Tewkesbury Community Hospital	Abbey View Ward	Late	30	90	62	0	3	90	86	1	1	180	148	1	4	-32	1%	3%	5%	1%
Tewkesbury Community Hospital	Abbey View Ward	Night	30	60	60	0	4	60	60	0	0	120	120	0	4	0	0%	3%	7%	0%
Vale Community Hospital	Peak View Ward	Early	30	90	89	5	11	120	115	13	12	210	204	18	23	-6	9%	11%	12%	10%
Vale Community Hospital	Peak View Ward	Late	30	90	90	0	24	90	80	7	12	180	170	7	36	-10	4%	21%	27%	15%
Vale Community Hospital	Peak View Ward	Night	30	60	60	0	21	60	60	20	11	120	120	20	32	0	17%	27%	35%	18%
Grand Total			**798**	**2133**	**1994**	**73**	**373**	**2401**	**2497**	**262**	**426**	**4534**	**4491**	**335**	**799**	**-43**	**7%**	**18%**	**19%**	**17%**

	All Hospitals	Early	268	804	761	23	120	1072	1084	111	165	1876	1845	134	285	**-31**	7%	15%	15.8%	15.2%	15.4%
		Late	269	807	703	30	136	807	858	77	167	1614	1561	107	303	**-53**	7%	19%	19.3%	19.5%	19.4%
		Night	261	522	530	20	117	522	555	74	94	1044	1085	94	211	**41**	9%	19%	22.1%	16.9%	19.4%
			798	**2133**	**1994**	**73**	**373**	**2401**	**2497**	**262**	**426**	**4534**	**4491**	**335**	**799**	**-43**	**7%**	**18%**	**18.7%**	**17.1%**	**17.8%**

** Please note some sites may not have submitted all shift returns yet

HOSPITAL	WARD_NAME		Count of Shift	RNC Planned Staff	RNC Actual Staff	RNC Bank Staff	RNC Agency Staff	HCA Planned Staff	HCA Actual Staff	HCA Bank Staff	HCA Agency Staff	Planned Staff	Actual Staff	Bank Staff	Agency Staff	Staffing (Under)/Over	Bank %	Agency %	RNC Agency %	HCA Agency %
Cirencester Hospital	Coln Ward		90	300	271	8	38	270	297	63	59	570	568	71	97	-2	12.5%	17.1%	14.0%	19.9%
Cirencester Hospital	Windrush Ward		86	232	209	6	37	262	267	19	33	494	476	25	70	-18	5.3%	14.7%	17.7%	12.4%
Dilke Memorial Hospital	The Ward		89	238	239	4	56	268	309	33	68	506	548	37	124	42	6.8%	22.6%	23.4%	22.0%
Lydney and District Hospital	The Ward		88	234	237	2	58	263	253	16	29	497	490	18	87	-7	3.7%	17.8%	24.5%	11.5%
North Cotswolds Hospital	NCH Ward		86	231	227	24	30	260	254	29	20	491	481	53	50	-10	11.0%	10.4%	13.2%	7.9%
Stroud General Hospital	Cashes Green Ward		90	240	184	12	42	270	302	41	74	510	486	53	116	-24	10.9%	23.9%	22.8%	24.5%
Stroud General Hospital	Jubilee Ward		89	178	178	12	47	268	300	15	105	446	478	27	152	32	5.6%	31.8%	26.4%	35.0%
Tewkesbury Community Hospital	Abbey View Ward		90	240	210	0	9	270	260	6	3	510	470	6	12	-40	1.3%	2.6%	4.3%	1.2%
Vale Community Hospital	Peak View Ward		90	240	239	5	56	270	255	40	35	510	494	45	91	-16	9.1%	18.4%	23.4%	13.7%
Grand Total			**798**	**2133**	**1994**	**73**	**373**	**2401**	**2497**	**262**	**426**	**4534**	**4491**	**335**	**799**	**-43**	**7.5%**	**17.8%**	**18.7%**	**17.1%**

Quality Effectiveness and safety Trigger Tool (QuEST) for Community Hospitals

		Month												
Site	Ward	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Total
Stroud General	Cashes Green	7	5	4	7	7	9							30
North Cots	North Cots	2		4		4	2							10
Stroud General	Jubilee	5	3	3	3	3	3							17
The Vale	The Vale	3	7	5	0	0	5							15
Dilke	Dilke	5	5	5	5	4	5							24
Tewkesbury	Abbeyview	1	4	1	3	2	2							11
Lydney	Lydney	0	0	0	0	0	0							0
Cirencester	Coln	0	1	2	1	0	5							4
Cirencester	Windrush	0	0	0	0	0	0							0
Cirencester	Stratton	0												0
	Average	2.3	2.78	2.67	2.11	2.22	3.44	0	0	0	0	0	0	11

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

Gloucestershire Care Services NHS
NHS Trust

Complaints Policy

Ref: 14/B036

This report is for Publication

Gloucestershire Care Services NHS Trust Board

Managing Concerns and Complaints Policy
25th November 2014

Objective:

Gloucestershire Care Services NHS Trust welcomes all feedback on the care and services we provide and are committed to making it as easy as possible for service users to talk to us, ensuring we listen to and learn from their experience with the specific aim of continuous organisational learning and subsequent improvement of care for our service users. We will work in partnership with our colleagues at Gloucestershire County Council where our services are integrated to ensure ease of access for the public, whilst ensuring both organisations meet the organisations requirements.

The Board is asked to:

Receive this policy and approve for use across all Trust Services

Executive summary:

The purpose of the Concerns and Complaints Policy is to set out how the Gloucestershire Care Services NHS Trust acknowledges and implements the National Health Service Complaints Regulations (2009), and takes into consideration the recommendations from the review of NHS Hospital Complaints System; Putting Patients Back in The Picture which was commissioned by the Department of Health, following the Francis Inquiry. The review, published on 28 October 2013, was co-chaired by the Rt. Hon. Ann Clwyd MP and Professor Tricia Hart.

The policy is intended to standardise the handling of concerns and complaints Trust-wide. The principles that underpin this purpose are:

- To increase people's confidence that their complaints will be taken seriously and that services will improve as a result of their experiences
- To have a flexible approach to resolving people's complaints, which includes effective support
- To provide a seamless approach to complaints investigations
- To ensure organisational openness and fairness when dealing with complaints
- To ensure an approach which is fair to people using and delivering services

- To place the emphasis on early and effective resolution of complaints
- To provide excellent local leadership and accountability that supports the resolution of complaints.

Liz Fenton
13th November 2014

Please complete the Equality Checklist….

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

Concerns and Complaints Policy

Document reference:	
Version:	**0.1**
Ratified by:	
Date ratified:	
Originator/author:	**Melanie Rogers, Interim Deputy Director of Nursing**
Responsible committee/individual:	**Quality and Clinical Governance Committee**
Executive lead:	**Liz Fenton, Director of Nursing and Quality**
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:	Section 1 of this document refers to the purpose of the document
Dissemination:	Section 7 of this document refers to dissemination of the document
Scope:	This policy applies across all Trust Services
Review:	This policy will be reviewed bi- annually or sooner should the need arise
This document supports:	
Key related documents:	
Equality and diversity:	*An Equality Impact Assessment will be completed*
Quality:	*A Quality Impact Assessment will be completed*
Consultation:	Legal Services Executive Team
Financial implications:	There will be no financial implications in implementing this policy

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

Contents:

Abbreviations

Abbreviation	Full Description
GCSNHST	Gloucestershire Care Services NHS Trust

1. Introduction

1.1 Gloucestershire Care Services NHS Trust welcomes all feedback with the specific aim of continuous organisational learning and subsequent improvement of care for our service users.

2. Purpose

2.1 The purpose of the Concerns and Complaints Policy is to set out how the Gloucestershire Care Services NHS Trust acknowledges and implements the National Health Service Complaints Regulations (2009), and takes into consideration the recommendations from the review of NHS Hospital Complaints System; Putting Patients Back in The Picture which was commissioned by the Department of Health, following the Francis Inquiry. The review, published on 28 October 2013, was co-chaired by the Rt. Hon. Ann Clwyd MP and Professor Tricia Hart.

2.2 The policy is intended to standardise the handling of concerns and complaints Trust-wide. The principles that underpin this purpose are:

- To increase people's confidence that their complaints will be taken seriously and that services will improve as a result of their experiences
- To have a flexible approach to resolving people's complaints, which includes effective support
- To provide a seamless approach to complaints investigations
- To ensure organisational openness and fairness when dealing with complaints
- To ensure an approach which is fair to people using and delivering services
- To place the emphasis on early and effective resolution of complaints
- To provide excellent local leadership and accountability that supports the resolution of complaints.

2.3 The policy is also underpinned by the regulations and requirements of Duty of Candour. These aim to ensure that providers are open and honest with patients when things go wrong with their care and treatment. To meet these requirements the Trust has to:

- Make sure that it has an open and honest culture across all levels of the organisation.
- Tell patients in a timely manner when particular incidents have occurred
- Provide in writing a truthful account of the incident and an explanation about the enquiries and investigations that they will carry out.
- Offer an apology in writing
- Provide reasonable support to the person after the incident

2.4 **Scope**

The policy will outline in a clear and concise manner for patients, relatives, carers and staff the process of raising and handling concerns and complaints regarding Trust services.

2.5 **Concerns and Complaints Policy Commitments**

The Concerns and Complaints Policy will be easy to understand and simple to use:

- The policy will be accessible to everyone
- Investigations will be thorough, fair, responsive, open and honest
- The Trust will listen to the complainant to understand the concerns and work with the patient to rectify the problem
- The Trust will learn from complaints and use them to improve the services for patients
- The Trust will answer complaints in a timely manner and in a timescale agreed at the outset of the investigation
- The Trust will respect an individual's rights to confidentiality
- Staff will respond positively to complaints and endeavour to resolve issues quickly
- The Trust aims to satisfy the complainant by conducting a thorough investigation and providing a full explanation
- The Trust will ensure that service users, their relatives / carers are not treated differently as a result of making a complaint. In instances where it is thought that a patient may have been treated differently as a result of a complaint being made this will be reported as an adverse event and managed in line with the Incident Management Policy and Serious Incident Reporting Policy.

These commitments are based on the recommendations following the Francis Inquiry (February 2013) and the review of NHS Hospital Complaints System, commissioned by the Department of Health (Clywd & Hart) and published on 28 October 2013.

3. Definitions of a Concern and a Formal Complaint

3.1 A concern or issue that may be locally resolved in a timely manner for the service user, patient, their family or carer.

A complaint may be any expression of dissatisfaction or where a concern has not been locally resolved. Any letter of concern addressed to the Chief Executive or Service Experience Team will be treated as a formal complaint.

4. Roles and Responsibilities

4.1 General Roles Responsibilities and Accountability

- The Chief Executive: is accountable for ensuring effective management of complaints across the Trust and all formal responses will be signed by the Chief Executive or by his/her designated deputy in their absence
- The Responsible Officer: will be informed of any complaint regarding the conduct or delivery of clinical care provided by medical staff
- The Director of Nursing and Quality: has delegated responsibility for ensuring the effective management of complaint handling across the Trust.
- The Director of Service Delivery and Director for Service Transformation: will have an overview of the complaints process and are accountable for the thorough investigation of complaints within their Operational Area. They are

responsible for ensuring the investigation is carried out in line with this policy and where action is identified this is implemented.

- The Scheduled and Unscheduled Care Management Teams: must ensure that they discuss complaints/responses each month as part of their team meetings and Clinical Governance meetings. They should discuss themes across their areas of responsibility and look for evidence of learning from complaints.
- The Service Experience Team: is responsible for ensuring that there is an advice line available for service users, their carers and families and for administering the complaints process, ensuring thorough replies are provided to the complainant. They are responsible for ensuring that Service User Experience data is available for teams. Through the Director of Nursing and Quality, they will also provide regular reports to the Quality and Clinical Governance Committee detailing concerns and complaint themes and trends, and the actions which have been taken to rectify problems, and improvements in the quality of the services provided by the Trust.

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

5. Policy Content

5.1 Talk to Us

Local Resolution of Concerns

The Trust is committed to encouraging feedback through inviting service users, their families and carers to 'Talk to Us'. The Trust wants to give assurance that any comment or issue raised will not adversely affect their care.

The *Talk to Us* approach encourages immediate action to resolve issues quickly and effectively without having to go through the NHS Complaints Procedure. Service Users and their families are encouraged to speak directly to the staff caring for them (or to the Matron, Team leader, or Manager if needed). They will also be able to speak to a Director of Service Delivery or Director of Service Transformation if they feel that the issue is serious or relates more generally to the service. In addition, patients or relatives who are unhappy with dealing with the service or ward or staff directly will be signposted to Service Experience Team who can liaise with colleagues to try and sort out issues quickly.

The *Talk to Us* approach is supported by leaflets and posters (Appendix 1) that replace the 4C's leaflets and posters leaflets and posters on the wards and around the Trust buildings.

The *Talk to Us* leaflet (Appendix 1), sets out the steps which explain how service users, their relatives, carers and visitors can raise concerns. As a first step it is preferable that the staff members caring directly for the service user resolve the issue or take on board feedback, Issues dealt with on the spot are resolved quickly and effectively. Appendix 2 illustrates a staff checklist to guide them through the process.

If the service user prefers to give feedback anonymously, the leaflet has a blank space provided for comments, compliments or observations. The leaflet highlights that any feedback given anonymously obviously cannot be responded to it explains that the issue raised will be investigated (and acted upon if appropriate).

Any *Talk to Us* feedback sent in by leaflet or by email will be logged by the Service Experience Team on the Datix database before being distributed to the relevant staff member for investigation and, where necessary, action. When the service user provides an address or email contact details, the investigating member of staff will respond directly to the service user with their findings or outline of any action as a result of the feedback. A copy of the response will be sent to the Service Experience Team for their records.

5.2 Formal Complaints

NHS Complaint Procedure

There are two stages for the management of complaints
(NHS Complaints Procedure, 2009):

Stage 1: Local Resolution
Stage 2: Parliamentary and Health Service Commissioner (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 health care or any other services.

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 employee of the Trust about any matter relating to his 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 intends to take legal advice.

5.2.1 Who may complain?

Complaints may be made by a service user, a patient, their nominated representative or any persons who are affected by or likely to be affected by the action, omission or decision of the Trust.

A complaint may be made by a representative acting on behalf of a service user, 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.

- Is unable by reason of physical or mental incapacity to make the complaint himself/herself.
- Who has requested the representative to act on his/her behalf and given consent for this.

Such a representative may be a friend or relative of the service user, a Member of Parliament acting on behalf of their constituent or Healthwatch/SEAP.

Where a service user or person affected has died or is incapable, the representative must be a relative or other person who, in the opinion of the Director of Nursing and Quality, had or has a sufficient interest in his/her welfare and is a suitable person to act as representative.

The Director of Nursing and Quality discusses with the Director of Corporate Affairs 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 Director of Nursing and Quality and Director of Corporate Affairs are of the opinion that a representative does not or did not have a sufficient interest in the person's welfare or is unsuitable to act as a representative, that person is notified of this in writing and given reasons for the decision.

If a complaint is instigated where the patient is deceased, in all cases the Director of Corporate Affairs should be contacted to establish whether the death is the subject of a Coroner's Inquest. If so the Director of Corporate Affairs will be obtaining statements for that purpose and when doing so the individual will be informed that the statement will be used to assist in the response to the complaint. If the complaint is subject to a coroner's inquest it will only be responded to after advice from the Director of Corporate Affairs.

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.

5.3 Confidentiality and consent

The information about complaints and all the people involved is strictly confidential and is only disclosed to those with a demonstrable need to know and /or a legal right to access those records under the Data Protection Act 1998.

Complaint records are kept separate from clinical records, subject to the need to record information which is strictly relevant to their health in the patient's clinical records.

Correspondence about complaints is not included in the patient's clinical records. Informal discussions about concerns can be documented in the clinical records.

Unless the complainant is not the patient it is not necessary to obtain the patient's express consent to use personal information when investigating a complaint. It is

good practice to explain that information from health records may need to be disclosed to those involved.

Where a complaint is made on behalf of an existing or former service user, consent must be obtained from the service user to disclose personal information and the results of any investigation in order to uphold the duty of confidentiality to the patient. The complainant is asked to return a Form of Authority to the Service Experience Team.

If the patient is deceased then the personal representative appointed under the will should give consent for the complainant to receive the personal health information (seek advice from the Director for Corporate Affairs).

If, once consent has been requested, there is a delay obtaining consent that affects the date on which the final response can be sent out, the complaint will be closed but re- opened upon receipt of the consent.

Where a complaint is made on behalf of an existing or former patient who has not authorised the complainant to act on their behalf, care must be taken not to disclose personal information without the service user's express consent.

Where a complaint is made on behalf of a patient by Healthwatch/SEAP, consent must be obtained if personal information is to be released so care must be taken not to disclose personal health information without the patient's express consent.

Where a complaint has been made on behalf of a service user by a Member of Parliament (MP) it will be assumed that implied consent has been given by that patient. If however, the complaint relates to a third party such as another service user, consent will need to be obtained from the service user prior to the release of personal information.

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

All letters regarding the complaint will be marked 'confidential'. All internal emails regarding the complaint must not contain patient identifiable information in the email heading, the email contents should be anonymised and any attachments should be password protected.

By ensuring that all complaints are dealt with in the strictest of confidence the likelihood for service user, relatives or carers being treated differently as a result of the complaint will be minimised.

5.4 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 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 Patient Experience Manager following discussions with the Director for Nursing and Quality may investigate it if they are of the opinion that the complainant had good reasons 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 Director of Nursing and Quality decides not to investigate a complaint on the grounds that it was not made within the time limit, the complainant is informed in writing with further guidance if necessary. The complainant can appeal in writing to the Chief Executive.

In accordance with the 'For the Record' guidance (Department of Health 1999/053), complaint files are kept for 10 years. Complaints files about babies and children (under the age of 18) 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 10 years.

5.5 Formal Complaint Process

Appendix 3 is a flowchart of the process.

A complaint may be made orally, in writing or electronically (NHS Complaints Regulations, 2009).

Staff's first responsibility on receipt of a complaint is to ensure that the patient's immediate health care needs are being met. This may require urgent action before any matters relating to the complaint are dealt with.

The Service Experience Team will be available to provide information to colleagues and complainants relating to how a service user can raise a concern or make a complaint and advice on the process.

When a formal complaint is received, a Director will initially phone the complainant within a working day to apologise and acknowledge the receipt of the complaint. They will then act as the complainants 'Critical Friend' throughout the process, giving the complainant their contact details and explaining that if they are not kept informed throughout the process or have concerns as to timeliness they can contact them directly for advice and support. It is important to note that this senior executive advocacy role will be open and non-judgemental, helping and signposting as appropriate in non-defensive manner. They will also ask the complainant if they are happy to receive a call from the Investigating Manager.

When formal letters of complaint are received by the Chief Executive's Office they will be date stamped and an acknowledgement letter from the Chief Executive or his designated Deputy will be prepared by the Service Experience Team who will then record the complaint, create a file and request that the Director of Service Delivery appoints an Manager. The Service Experience Team will prepare an acknowledgement letter indicating how the complaint will be processed. All formal

complaints will receive an acknowledgement within two working days with an offer of a meeting to either resolve or further explore the complaint.

The complexity and seriousness of the complaint will initially be assessed by the Director of Nursing and Quality and graded accordingly before a copy is sent by the Service Experience Team directly (via e-mail) to the Director of Service Delivery or Director of Service Transformation. This initial assessment is subject to change once the complaint has been fully investigated. The Director of Service Delivery or Director of Service Transformation will assess the complaint and either personally investigate or allocate an appropriate senior member of their team to undertake the investigation, ensuring a neutral unbiased approach. This person will be known as the Investigating Manager and will be supported by the Service Experience Team.

We will seek to resolve all complaints within 25 working days. However, it is recognised that there is variation in the level and complexity of complaints and some may require longer to conduct a thorough investigation, and to provide a full response. In these situations, a change to the 25 day timescale can be agreed between the Investigating Manager and the complainant at the outset and the response monitored against that agreed timescale. Before this is agreed, the Investigating Manager must inform the Service Experience Team of any proposed timescale beyond 25 days, which has to have authorisation from the Director of Nursing and Quality.

The Investigating Manager will also telephone the complainant to introduce themselves (with the complainants consent). During this conversation the Investigating Officer may wish to clarify any issues in the complaint. He or she can provide a point of contact should the complainant wish to raise any questions during the investigation.

Where the complaint has arisen from a serious incident or in the view of the Director of Nursing and Quality is sufficiently serious, it will be investigated in line with the Incident Management Policy and Serious Incident Reporting Policy with the appointment of an external investigator as appropriate.

Although the Director of Service Delivery or Director of Service Transformation may delegate aspects of the investigation as appropriate, they remain wholly responsible for the investigation and the response.

Where staff are directly involved in the complaint, statements will be taken at the time of the investigation as an accurate account of events. These statements will be submitted with the draft response by the Investigating Manager to the Service Experience Team (Appendix 4). Staff directly involved in the complaint should not investigate the complaint.

The Investigating Manager is responsible for producing a draft response in the form of a letter from the Chief Executive in conjunction with appropriate staff involved and must ensure that appropriate clinical input has been provided, where necessary. The response must ensure:

- That all the issues raised have been addressed.

- Accurate information.
- A full and honest explanation.
- Apology (apologies).
- Explain the actions that have/will be taken to improve the situation (action plans can be included where appropriate).
- Explain the monitoring arrangements to ensure actions will be implemented.

The Investigating Manager is responsible for ensuring that the draft response together with all supporting evidence, complaint investigation summary sheets and action plans are returned to the Director of Service Delivery or Director of Service Transformation and the Service Experience Team within the agreed timescale. He/she is also responsible for notifying the Service Experience Team of any change to the initial grading assessment.

The Service Experience Team will then review the complaint and the investigation to using the Complaint Investigation Summary (Appendix 5) and Audit Tool (Appendix 9) to ensure that it has been thorough and addresses all the issues raised by the complainant. This process will act as a quality check for the complaint investigation.

A complete documentary record of the handling and consideration of each complaint is kept by the Service Experience Team. Complaint records are kept separate from health records, subject to the need to record information which is strictly relevant to their health in the service user's health records. All records including supporting evidence from the Investigating Manager should be sent to the Patient Experience Manager with the draft response and included in the main complaints file for their records.

The Service Experience Team ensures 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 Health Service Ombudsman if requested.

All final responses 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. If the complainant still feels that the complaint has not been dealt with in full, it will be reviewed by the Director of Nursing.

The Director of Service Delivery or Director of Service Transformation are responsible for ensuring that all complaints are shared at the Scheduled Care Clinical Governance Forum and Unscheduled Care Clinical Governance Forum, and that action plans are implemented within the agreed timescale.

Progress on action plans are reported to the Service Experience Team and included in the quarterly 'Patient Experience' reports for review by the Quality and Clinical Governance Committee. Where agreed with the complainant, they should be kept informed on the progress of the actions by the Service Experience Team.

5.6 Learning from Complaints

All complaints and concerns offer an opportunity for the Trust to learn and improve. When the investigation of a complaint identifies that local changes in practice are required, the appropriate manager will ensure these are considered and implemented as soon as is practically possible.

All trends and themes that result from concerns and complaints are reported directly to the Trust and information shared regarding complaints made in relation to the provision of Social Care to Gloucestershire County Council and are reported through the patient experience reports to Scheduled and Unscheduled Care Governance Forums and to the Quality and Clinical Governance Committee. 'You Said, We Did' underpins the approach to reporting at local clinical governance meetings, Scheduled and Unscheduled Care Governance Forums and Patient Experience quarterly reports.

The Trust is committed to listening to the views of patients and the public about the care we provide and values the experiences of our patients. To understand and learn for the experience of our service users who make a complaint the Trust participates in the National Complainants Survey which is being co-ordinated by the Patients Association and the NHS Benchmarking Network.

5.7 Advocacy support

All complainants have access to information about Healthwatch or SEAP, depending on where they reside, who offers independent help, guidance or support when raising a concern or making a complaint. This information is available from Service Experience Team

5.8 Legal implications

If the complainant has either instigated formal legal action, or notified in writing that he or she intends to do so, the Complaints Procedure should be stopped, with the complainant and person identified in the complaint being advised appropriately in writing. The complainant should be advised to ask their legal representative to write to the Director for Corporate Affairs. If a complaint reveals a likelihood of legal action, the Patient Relations Team should inform the Director for Corporate Affairs and provide a complete copy of the file.

5.9 Serious allegations and disciplinary investigations

The Complaints Policy is concerned only with resolving complaints and not with investigating staff or regulation of conduct. The purpose of the complaints procedure is to thoroughly investigate complaints with the aim of satisfying complainants, whilst being fair to members of staff.

Where serious allegations regarding staff performance and behaviour arise through the complaints investigation, the Investigating Manager will refer the complaint back to the commissioning Director and they will then investigate and manage through the appropriate conduct policies.

The Trust has a duty to maintain staff confidentiality and must not share information regarding any action against staff with the complainant.

5.10 Staff grievances

Staff grievances are handled separately. The Trust has local procedures for handling staff concerns about health care issues and established grievance and openness procedures:

- The Grievance Policy and Procedure
- It is OK to ask Why

Staff may only use the NHS 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 member of staff.

5.11 Fraud and corruption

Any complaint concerning possible allegations of fraud and corruption is passed immediately to the Director of Finance.

5.12 Complaints about services involving other agencies

If the Trust receives a written complaint that is solely concerned with areas dealt with by another health body or by a body outside the NHS, the complaint is referred to the Service Experience Team. With the complainant's agreement, the Service Experience Team will then forward the complaint to the correct body. If there are any doubts over which body is responsible for handling the complaint, this is resolved before the complaint is dispatched. This is then recorded in writing.

Where a complaint involves more than one NHS provider or one or more other bodies, there will be full cooperation in seeking to resolve the complaint through each body's local complaints procedure. It will be agreed between them which organisation will take the lead on the final response and co- ordinate responses all organisations.

The Trust and Gloucestershire County Council work collaboratively to ensure that we address all matters of concern raised and that the process supports the requirements of each organisation's complaints policy and process and importantly seeks to share learning across organisational boundaries.

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 forwards a copy of the complaint as appropriate for investigation and a response. The Service Experience Team incorporates the response from the external agency into the Trust's final response.

Where the Trust makes arrangements for the provision of services with independent providers, it ensures that the independent providers have arrangements in place for the handling and consideration of complaints about any matter connected with its provision of services as if the NHS (Complaints) Regulations 2009 applied to it.

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

The Information Commissioner contacts the Data Controller regarding complaints arising out of an alleged failure to comply with a data subject request under the Data Protection Act 1998.

The Information Commissioner contacts the Freedom of Information Officer regarding complaints arising out of an alleged failure to comply with a data subject request under the Freedom of Information 2000.

The Trust consults the Information Commissioner about complaints arising out of an alleged failure to comply with a data subject request under the Data Protection Act 1998 and the Freedom of Information 2000.

Further information is available at http://www.informationcommissioner.gov.uk/

5.14 Media interest

Staff should refer any media interest in relation to the complaint to the Head of Communications. The Head of Communications is briefed where any complainant expresses their intention to contact the media or where there is potential for media interest or involvement by the Director of Nursing and Quality or Director of Corporate Governance.

5.15 Procedure for handling unreasonably persistent complainants

Definition of an unreasonably persistent (vexatious) 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 two or more of the criteria outlined on Appendix 6.

5.16 Options for dealing with unreasonably persistent complainants

Where complainants have been identified as unreasonably persistent in accordance with the above criteria, the Chief Executive (or appropriate deputy in his/her absence) will determine what action to take. The Chief Executive (or his/her 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. practitioners, conciliators, Healthwatch/SEAP, MPs. A record must be kept in the complainant's complaint file for future reference of the reasons why a complainant has been classified as unreasonably persistent. This will not form part of their health care record.

The Chief Executive (or his/her deputy) may decide to deal with such complaints in one of the following ways as found in Appendix 6.

5.17 Withdrawing 'unreasonably persistent' status

If a complainant has been determined as 'unreasonably persistent' there is an ongoing approach to constantly review this status. There is discretion for withdrawing this status if, for example, complainants subsequently demonstrate a more reasonable approach or if they submit a further complaint for which the normal complaints procedures would appear appropriate.

Staff 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 deputy). Subject to approval, normal contact with

the complainants and application of the Trust's Complaint Procedure will then be resumed.

6. Training

6.1 The Director for Service Delivery and Director for Service Transformation upon assigning an Investigating Manager should check that the member of staff has the necessary skills to investigate the complaint. If not, the Service Experience Team will provide informal complaints and customer care training to any individual member of staff or department as required.

The Complaints Investigation Summary can also be used as guidance for investigating Managers (Appendix 5).

The Service Experience Team will monitor the quality of investigations and complaint responses and will highlight additional training needs to the relevant Manager.

7. Dissemination Circulation

7.1 The policy will be communicated to staff via line managers following the approved process.

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 the Internet.

8. Monitoring of compliance and effectiveness

8.1 Compliance to this policy is monitored by the Service Experience Team and Director for Service Delivery and Director for Transformation

A secure electronic database is maintained for all patient feedback.

Records of concerns, complaints and compliments will be maintained for all contacts on the Datix electronic system along with the number and outcomes of Parliamentary and Health Service Ombudsman requests.

All complaint investigations will be audited by the Service Experience Team to ensure that complaints are acknowledged within two working days and are responded to within the timescale agreed at the outset (Appendix 8). The audit (Appendix 9) and an action plan will be reported quarterly in the Patient Experience Quarterly Report to the Quality and Clinical Governance Committee and by exception to The Director for Service Delivery and Director for Service Transformation

A quarterly patient experience report will be compiled. This will be presented to the Quality and Clinical governance Committee. These reports include the number of concerns and complaints received, response times and details of individual concerns and complaints.

9.0 References

Document title	Document Reference/Location
The Francis Inquiry Report 2013	http://www.midstaffspublicinquiry.com/report
A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture. Clywd and Hart. (2013)	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf
The National Health Service Complaints Regulations 2009	http://www.legislation.gov.uk/uksi/2009/309/contents/made
Data Protection Act 1998	http://www.legislation.gov.uk/ukpga/1998/29
Freedom of Information Act 2000	http://www.legislation.gov.uk/ukpga/2000/36/pdfs/ukpga_20000036_en.pdf
For the Record Guidance. Department of Health 1999/053	http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/
Introducing the Statutory Duty of Candour. A consultation on the proposals to introduce new CQC regulation. DOH, 2014.	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/295773/Duty_of_Candour_Consultation..pdf
Guidance for NHS bodies on the fit and proper person requirement for directors and the duty of candour. CQC 2014	http://www.cqc.org.uk/sites/default/files/20140725_nhs_fppr_and_doc_consultation_final.pdf

Bibliography

Document title	Document Reference/Location
Review into the Care and Quality of Treatment Provided by 14 Hospital Trusts in England. Keogh (2013)	http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf
A Promise to Learn– a commitment to act. Berwick (2013)	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf
Good Practice Standards for NHS Complaints Handling. Patients Association. (2013)	http://patients-association.com/Portals/0/Good%20Practice%20Standards%20for%20NHS%20Complaints%20Handling,%20Sept%202013.pdf
Health and Social Care Act 2012	http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

Parliamentary and Health Service Ombudsman. Listening and Learning.(2012)	http://www.ombudsman.org.uk/listening-and-learning-2012

Tell us more...

Use the space below for your comments, suggestions or compliments and post the leaflet in one of the suggestion boxes around the Trust or hand it to a member of staff. You do not need to give your name or contact details but if you would like us to respond to your feedback, please tell us how we may contact you.

Your name: _____

Your address/tel no/email:

NHS Choices
You can also give feedback about our services via NHS Choices. Visit www.nhs.uk/comment and choose the relevant hospital to give feedback about an experience in one of our community hospitals

Addresses to contact:

The Chief Executive
c/o the Service Experience Manager
Gloucestershire Care Services NHS Trust, Edward Jenner Court, 1010 Pioneer Avenue, Gloucester Business Park, Gloucester, GL3 4AW
Tel: 0300 421 8148

Service Experience Team
Edward Jenner Court, 1010 Pioneer Avenue, Gloucester Business Park, Gloucester, GL3 4AW
Tel: 0300 421 8313
Email: yourexperience@glos-care.nhs.uk

SEAP NHS Advocacy Service
PO Box 375, Hastings, TN34 9HU
Tel: 0330 440 9000
Fax: 01424 204687
Email: info@seap.org.uk
Website: www.seap.org.uk

Healthwatch
They represent public views on health and social care services.
Healthwatch Gloucestershire, Community House, 15 College Green, Gloucester, GL1 2LZ
Tel: 0800 652 5193 or 01452 504989
Website: www.healthwatchgloucestershire.co.uk

Our Values

Our values are centered around being:

- Caring
- Responsible
- Open
- Effective

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

Print Date: November 2014
www.glos-care.nhs.uk

Gloucestershire Care Services NHS
NHS Trust

Talk to Us

Understanding You

If you have a comment about the service provided by Gloucestershire Care Services (GCS) – whether positive or negative – please 'Talk to Us'! Your feedback is always welcome and can help us to improve the services we provide. There are different ways of getting your views heard in our Trust. This leaflet will help you choose the best way for you. Raising an issue or concern will not adversely affect your care and treatment.

Talk to Us

We prefer to sort out issues quickly and effectively at the time and place where you are receiving your care or treatment. If you have a query or concerns or would like to make a suggestion, please speak to a member of staff in the relevant area; this may be on a ward, in a clinic or when you are being treated at home.

If you prefer to talk to a senior member of staff, please ask to speak to a ward sister, matron or service lead.

Or, speak to the Service Experience Team

The Service Experience Team is a service that offers help and guidance in addressing and resolving issues by liaising with the relevant teams. This is a confidential service to help patients, their families and carers, to find answers to questions or concerns regarding the care or treatment they receive.

If you would like to make a Formal Complaint

If after speaking with staff or the Service Experience Team you feel that you have an issue that cannot be resolved informally or at a local level, please write to the Chief Executive, giving full details of the issue that you would like us to investigate.

The Complaints process

You will be contacted within two 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, we will contact you to explain why there will be a delay, agree a new timeframe and keep you updated on the progress of your complaint.

We will 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.

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

If you are not satisfied with the outcome of your complaint, you can contact the Parliamentary and Health Service Ombudsman.

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

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. You have the right to contact the PHSO if you are not happy with the outcome of your complaint.

If you would like the PHSO to review your complaint, you must contact them within two months of receiving a final formal written response from the Trust.

You can contact the Parliamentary and Health Service Ombudsman for further information:
The Parliamentary and Health Service Ombudsman for England
11th Floor, Millbank Tower, London SW1P 4QP
Tel: 0345 015 4033
Email: phso.enquiries@ombudsman.org.uk
Website: www.ombudsman.org.uk

Gloucestershire Care Services NHS
NHS Trust

Talk to us

Your feedback about your experiences is very important to us

Your views will help us improve the care we provide

- We prefer to sort out issues as they arise as often they can be dealt with quickly and efficiently. Please speak to a member of staff in the relevant area; this may be on a ward, in a clinic or when you are being treated at home.
- Pick up a 'Talk to Us' leaflet to find out the different ways of getting your views heard on our Trust or you can download one from our website www.glos-care.nhs.uk

www.glos-care.nhs.uk

Understanding You

Talk to Us – a short guide for staff

How to deal with a concern

- Try to resolve the problem 'on the spot'. Our approach to a person raising an issue should be honest and thorough, with the prime aim of resolving problems and satisfying their concerns.
- Explain to them that raising the issue *genuinely* will not adversely affect care or treatment.
- Offer them a copy of the leaflet called '*Talk to Us*'.
- If they ask to speak to someone else, refer them to your line manager. If they are not available, refer them to the Matron or Service Lead. Alternatively you offer to put them in contact with the Director of Service Delivery or Director for Service Transformation.
- If they are not happy speaking to a member of staff or they would like advice or support, contact the Service Experience Team on 0300 421 8313 (Mon-Fri office hours).

How to deal with a complaint

- If an issue cannot be resolved 'on the spot' or by the Service Experience Team, explain to them that they can escalate their concern, which will be investigated fully. Offer them a copy of the leaflet called '*Talk to Us'*.
- If a serious complaint arises outside of normal office hours, speak to the on-call manager.
- **Remember to be polite and non-judgemental and try not to take any complaint personally.**

Checklist

1	Try to resolve the problem straight away	
2	Offer them a copy of 'Talk to Us' leaflet.	
3	If you need support, speak to your line manager or other senior staff	
4	If they are still not happy, contact the Matron or Service Lead	
5	If they need support or advice, call the Service Experience Team on 0300 421 8313 in office hours or the on-call manger outside of normal office hours	
6	If they do not want to speak to ward staff or a manager, call the Service Experience Team on 0300 421 8313 in office hours or the on-call manger outside of normal office hours	
7	If the complainant is adamant that they want to make a formal complaint, offer them a copy of the *'Talk to Us' l*eaflet and explain they can get their concerns addressed	

Formal Complaint to Chief Executive

Written complaint received

Director to contact complainant within a working day

Service Experience Team

- Acknowledge receipt within **2 working days**
- Send to Director for Service Delivery or Director for Service Transformation to appoint an 'Investigating Manager'.
- Forward paperwork to Investigating Manager.

Investigating Manager (IM)

- Start and conclude the investigation promptly.
- Make contact with/telephone the complainant (suggesting meeting as appropriate).
- Conduct the investigation in a manner that is supportive to those involved and takes place in a blame free atmosphere.
- List every point of concern.
- Obtain and examine all relevant documentation
- Establish sequence of events and staff involved.
- Decide who to interview and who to ask for statements.
- Inform staff of the reasons for the investigation.
- Ask for written statements, giving timescales for completion.
- Interview staff involved, using open questions to gain facts.
- Ensure staff feel supported and are informed of support services available.
- Listen to and record responses in writing.
- Remain objective and keep an open mind.
- Analyse all the information logically.
- Make recommentations.
- Construct an action plan.
- Draft response with staff involved, keep staff informed of progress.

Can a response from the Chief Executive be sent in agreed timescale?

Yes

Written response from the Chief Executive sent. Service Experience Team sends copy of final response to IM for circulation to staff involved

No

Service Experience Team (SET) agrees an extension time with the complainant

Complainant satisfied

NO

Further investigation Further resolution meeting

Complainant satisfied

NO

Referred to Parliamentary and Health Service Ombudsman

YES

END

Appendix 4

Guidelines for staff writing statements for complaint investigations

1 Introduction

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

1.2 Staff 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 black 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.

3.4 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.

Investigation summary

When returning the draft complaint response letter to the Service Experience Team, the Investigating Manager must complete and return this pro forma to assure the Chief Executive that the following criteria have been met.

Complaint Reference Number: ☐ Investigating Manager: ☐

		Yes	No	N/A
1	Did you contact the complainant to hear more about the concerns and explain the process?			
2	Did you offer to meet with the complainant?			
3	Have you fully understood the nature of the complaint?			
4	Are you certain that each aspect of the complaint has been satisfactorily resolved?			
5	Has there been a full explanation and apology offered as appropriate?			
6	Has there been a full explanation of any changes, improvements and actions?			
7	If the complaint concerns a member of staff, have they been supported appropriately?			
8	If the complaint concerns a member of staff, have they seen the response?			
9	Where appropriate have statements been taken from staff concerned? (if they have these must be sent to Service Experience Team)			
10	If the complaint concerns a matter of clinical judgement, has the response been agreed by the clinician?			
11	Is there a clearly documented record of the events of Local Resolution?			
12	Do you feel that the Trust has done all that is practicable in the circumstances?			
13	Has your investigation file been sent to Service Experience Team for inclusion in the main complaint file?			
14.	**Will this complaint be taken to the appropriate Clinical Governance meeting – Yes/No** If 'Yes' please also advise the date of the Governance meeting (Please note - meeting minutes may be requested at a later date)			
	If you have answered NO to any of the questions, please explain why?			
15.	**Lessons Learnt / Action Plan**			

Unreasonably Persistent Complaint

A complainant may be considered unreasonably persistent if:

1) Persist in pursuing a complaint where the Trust's complaints procedure has been fully and properly implemented and exhausted.
2) Continually raise new issues or seek 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 separate complaints.) Healthwatch/SEAP could be called upon to assist in such circumstances, thus ensuring that new and legitimate issues are answered.
3) Despite the best endeavour of staff to confirm and answer the complainant's concerns and, where appropriate, involving Healthwatch/SEAP, the complainant will not accept the response and, or where the concerns identified are not within the remit of the Trust.
4) In the course of addressing a registered complaint, have had an excessive number of contacts with the Trust, which have placed unreasonable demands on staff. (A contact may be in person or by telephone, 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.)
5) Have harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with their complaint or their families or associates. (Staff must recognise that complainants may sometimes act out of character at times of stress, anxiety, or distress and should make reasonable allowances for this. Staff must document all incidents of harassment).
6) Are 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.
7) Focus on a matter to an extent which is out of proportion to its significance and continuing 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 criteria.)
8) Display unreasonable demands or patient/complainant expectations and fail 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).
9) Complainants (and or anyone acting on their behalf) may be deemed to be unreasonably persistent complainants where they have threatened or used actual physical violence towards staff or their families or associates at any time.
10) Complainants (and or anyone acting on their behalf) may be deemed to be unreasonably persistent complainants where they have sent indecent or offensive items to staff or their families or associates in the post, or if they hand deliver indecent or offensive items to staff or their families or associates at any time.
11) All such incidents must be documented on an incident form, and will in themselves be grounds to stop personal contact with the complainant and, or their representatives and thereafter the complaint may only be pursued through written communications

Options for managing an unreasonably persistent complainant

- Try to resolve matters, before invoking this procedure by drawing up a signed 'agreement' with the complainant (if appropriate, involving the relevant practitioner 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.
- Once it is clear that complainants meet any **one** of the criteria above, it may be appropriate to inform them in writing that they may be classified as unreasonably persistent complainants, 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 complainants seek advice in processing their complaint, e.g. through Healthwatch/SEAP.
- Decline contact with the complainants either in person, by telephone, 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.
- If staff 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.
- 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.
- Inform the complainants that in extreme circumstances the Trust reserves the right to pass unreasonable or unreasonably persistent complaints to the Trust's solicitors.
- Temporarily suspend all contact or investigation of a complaint whilst seeking legal advice or guidance.

Complaint Reference Number: Investigating Manager:

Please Include An Action Plan For This Complaint:

This form must be returned to Service Experience Team with the final response – if there are no actions resulting from the complaint please indicate this on the form.

Problem Identified	Action Needed	By Whom	By When	Review Date

Notes:

Draft responses sent to Service Experience Team must:

- Confirm and address all the issues raised.
- Contain an analysis of the allegations and concerns and an indication as to whether these are felt to be justified.
- Demonstrate that the investigation has been thorough.
- Contain information on action taken to redress identified substandard performance or opportunities noted for improving current practices.
- Contain information on the method of monitoring that remedial action has been effective, including scheduled review dates.

Any evidence that supports your investigation (i.e. copies of medical notes, statements from staff, nursing records, policies etc) must be sent with the draft response to the Service Experience Team office.

Key Quality Indicators for the effective management of complaints

	Criterion	Standard	Exceptions
1.	An acknowledgement is sent within 2 working days of receipt of complainant's letter	100%	None
2.	The acknowledgement letter includes: • Name of the Director it has been sent to • Telephone number of Service Experience Team for further queries • Expression of gratitude for drawing the matter to the Trust's attention • Number of days in which to expect a reply • Details of the Ombudsman	100%	None
3.	A response from the Chief Executive is sent within 25 working days or timescale agreed at the outset	90%	None
4.	Written statements are completed by all individuals involved in complaint	100%	None
5.	The draft response is shared with all the staff involved and is approved by the Investigating Manager prior to signing	100%	None
6.	The final response includes: • All the issues raised • An explanation of action taken • An apology where due	100%	None
7.	An action plan is drawn up to include timescales, assigned responsibility and review date	100%	None
8.	Each Service has 'complaints review' as a standing agenda item at their Clinical Governance meetings	100%	None
9.	Correspondence about the complaint is not included in the patients' medical records	100%	None
10.	Investigating Managers complete the complaint investigation summary and return to Service Experience Team with the draft letter	100%	None
11.	Investigating Managers return the investigation file to Service Experience Team once file is closed	100%	None

Key Performance Audit Tool

	Criterion	Standard	Exceptions	Y/N	Y/N	Y/N	Y/N	Y/N
1	An acknowledgement is sent within two working days of receipt of complainant's letter	100%	None					
2	The acknowledgement letter includes: • Name of the Director/Clinician it has been sent to • Telephone number of Service Experience Team for further queries • Expression of gratitude for drawing the matter to the Trust's attention • Number of days in which to expect a reply	100%	None					
3	A response from the Chief Executive is sent within 25 working days or the timescale agreed at the outset	90%	None					
4	Written statements are completed by all individuals involved in complaint	100%	None					
5	The draft response is shared with all the staff involved	100%	None					
6	The final response includes: • All the issues raised • An explanation of action taken • An apology where due	100%	None					
7	An action plan is drawn up to include: • Timescales • Assigned responsibility • Review date	100%	None					
8	Each Service has 'complaints review' as a standing agenda item at their Clinical Governance meetings	100%	None					
9	Correspondence about the complaint is not included in the patients' medical records	100%	None					
10	Investigating Managers complete the complaint investigation summary and return to Service Experience Team with the draft letter	100%	None					
11	Investigating Managers return the investigation file to Service Experience Team once file is closed	100%	None					

Gloucestershire Care Services NHS
NHS Trust

QCGC Chair's Report

Ref: 14/B037

This report is for Publication

Gloucestershire Care Services NHS Trust Board

Quality and Clinical Governance Committee Report
25th November 2014

Objective:

To provide the Board with a summary of the key issues and actions arising from the meeting of the Quality and Clinical Governance Committee Governance and Quality held on 16th October 2014.

The Board is asked to:

To receive the report and the approved minutes of the 13th August 2014 meeting for information and assurance

Executive summary:

The report sets out the key points discussed at the meeting of 16th October 2014 and highlights keys issues agreed for escalation to Board. The approved minutes of the meeting held on 13th August 2014 are attached for information

Liz Fenton, Director of Nursing and Quality
25th November 2014

Please complete the Equality Checklist over…

☒	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

Meeting of Gloucestershire Care Services NHS Trust Board

To be held on: November 25th 2014
Location: Malvern & Coopers Room, Edward Jenner Court, Brockworth

1. Introduction

This report provides a summary of the key issues and actions arising from the meeting of the Quality and Clinical Governance Committee meeting held on 16th October 2014. The approved minutes of the 13th August 2014 meeting are attached for information.

2. Quality Matters

The Quality Report was presented to the Committee and each of the aspects of quality; safe, caring, responsive, effective and well led were debated in some depth. The aspects presented for particular attention by the Committee where:

- Safety thermometer: While the August performance was disappointing, the Committee were advised of significant improvement in September towards achievement of the minimum of 95% harm free care. The focussed efforts taken to ensure full reporting across the Trust were noted as supporting this progress.
- Discussion took place regarding the complaints process and how as a Trust we enable service users and their families to provide feedback on their experience. The Trusts Complaint Policy is being revised together with the information leaflets. The Committee sought a detailed report on the reporting system and how it fitted together to order to gain assurance about its effectiveness.
- The validity of the Early Warning Trigger tool was discussed, this was a tool used widely across the South West region as part of a patient safety programme. However the new Quality Overview document within the quality report now sets out staff and patient experience measures alongside safety data and replaces the EWTT.

3. Quality Strategy

The development of the Quality Strategy was discussed by the Committee who made recommendations as to improve focus and ownership across the Trust. It was agreed that the overview of the strategy should sit with the QCGC who will monitor progress against the objectives.

The final draft of the document will be presented to the Committee in December ahead of final ratification by Board in January 2015.

4. PLACE report

The Head of Estates presented the report which set out the results from the reviews undertaken in May 2014. The Committee noted the marked improvement on the results from the previous year.

Actions plans by site have been developed as a result of the PLACE scores and the implementation is being overseen by the Hospital Matrons.

5. Working with the Pharmaceutical Industry Policy

The Head of Medicines Management presented this policy, informed by best practice guidance, to the Committee Quality. Following discussion the policy was approved subject to some minor amendments.

6. District Nursing Service

A presentation prepared jointly with GCCG was shared with the Committee. This set out the progress to date with recruitment of nurses with a particular focus having been on the teams within the Cotswold Locality.

The Committee noted the considerable work underway to support the service but requested assurance on the impact of nurse vacancies were having on patient safety and quality of care. This will be brought back to the meeting in December.

7. Other reports presented to the Committee

- Clinical Record Keeping
- Pressure Ulcers
- Controlled Drugs Accountable Officer Report
- Unscheduled Care Governance Report
- Annual Report Children in Care

8. Conclusions and Recommendations

The Board is asked to:

- **Note** this report

- **Receive** the approved minutes of 13th August 2014 meeting for information and assurance

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

GLOUCESTERSHIRE CARE SERVICES NHS TRUST

QUALITY & CLINICAL GOVERNANCE COMMITTEE

Minutes of the Meeting held on Wednesday 13 August 2014

Voting Committee Members	
Sue Mead (SM)	Non-Executive Director
Richard Cryer (RC)	Non- Executive Director
Elizabeth Fenton (EF)	Director of Nursing & Quality
Ingrid Barker (IB)	Trust Chair
Tina Ricketts (TR)	Director of HR
Jason Brown (JB)	Director of Corporate Governance and Public Affairs
Committee Attendees (Non-Voting)	
Louise Foster (LF)	Joint Clinical Director – Dental (Countywide representative)
Melanie Rogers (MR)	Head of Clinical Governance
Sue Field (SF)	Director of Service Transformation
In Attendance	
Chris Creswick (CC)	Non-Executive Director
Sarah Warne (SW)	Named Nurse Safeguarding Adults/Clinical Quality Manager
Geraint Bright (GB)	District Nurse
Rod Brown (RB)	Foundation Trust Programme Manager
Jane Evans (JE)	Matron - Cirencester and Fairford Hospitals
Kathy Cambell (KC)	Clinical Lead for Urgent Care – Rapid Response
Christine Thomas (CT)	Minute Taker

Ref	Minute	Action
57/14	**Agenda Item 1: Apologies** Apologies were received from: Duncan Jordan, Nicola Strother-Smith, Mike Roberts, San Sumathipala, & Candace Plouffe. The Chair opened the meeting and welcomed attendees.	
58/14	**Agenda Item 2: Minutes of the meeting held on 10 April 2014** The Committee reviewed the minutes of the last meeting. Amendments were agreed for items 44/14 and 48/14, and subject to these changes the minutes were **APPROVED** as an accurate record. Additionally, the following points were raised during the review of the minutes.	**CT**

	• In the Service User Experience Report (47/14) the Committee had recommended the Service User Experience Report come to the Committee every quarter. Discussion took place regarding the recently published TDA user experience tool and the requirement to use this tool to report to Board • Agenda item 5 (42/14) the Clinical and Professional Care Strategy – implementation plan. SM raised concern around the lack of clear matrix with which to assess progress regarding the implementation of this strategy. It was agreed that discussions happen outside the meeting to review the measures. • The Committee asked to understand the volume of people going through the Rapid Response Service, SF to bring this information to the Committee. EF asked whether this should be coming to this next Committee or to Performance & Resources, SM suggested it may be appropriate to come to both. • SM discussed the proposal to share user experience through complaints so as to enhance learning and it was suggested that users are approached to share their stories. This was seen as very positive though recognised this needed to be taken forward with sensitivity. SM asked if there was an update from item 44/14 which noted that there had been a grade four pressure ulcer in the community setting. SW advised that the main points of learning had been around positioning and nutrition. An action plan had been developed and was being implemented.	**SF** **SF**
59/14	**Agenda Item 3: Matters arising and action log** The Action Log was reviewed by the Committee and the following updates given for the items that were not closed or featured on this meeting's agenda: ***(Q&CG 41/14)*** – Equality and Diversity Manager to present an outline proposal of the Equality Annual Report in December 2014. No change – expected to Committee in December 2014. **(Q&CG 46/14)** – Comments around the Outcomes report on the Rapid Response service to be fed back to the Director of Transformation and an update report to be fed back to the Committee in Oct 14. No change – expected to Committee in October 2014. The Committee **RECEIVED** the Action Log and **NOTED** the update.	**JR**

60/14	**Agenda Item 4: Forward Agenda Planner** The Chair asked if a detailed report on waiting times should be included. It was decided that this was really for Performance & Resources Committee and that RC would pick this up. The Committee **RECEIVED** the Forward Agenda and **NOTED** the items.	
61/14 **61/14.1**	**Agenda Item 5: Quality & Performance Report** The Director of Nursing & Quality (EF) presented the Quality Report to the Committee. EF noted the reported overall achievements but it was unclear from the dashboard as to where this had originated as there did not appear to be any significant shifts in the figures. EF to check this with the Head of Performance & Information (MOR) and share with the Committee before the next Committee meeting. EF then went through the main report, the key areas raised were: **Safe:** • Safety thermometer was high on the agenda • Pressure ulcers were an area of focus. Currently achieving 95% harm free care in over 3 aspects however there needs to be a focus on those 5%. There remain some anomalies within the data. It was noted that some of these harms related to pressure ulcers which are inherited by the organisation and therefore the cross county work continues to be critical. • Following education and awareness we are evidencing a reduction in grade 3 and 4 pressure ulcers with the anticipated increase at grade 2 due to earlier detection. • There are a number of best practice groups being established focusing on specific aspects of patient safety to ensure we remain focussed these will include: falls, dementia, medication, deteriorating patient and end of life. There is CQUIN work that brings a strong focus on pressure ulcers. • There were 3 cases (post 72 hour) of C.difficile reported in quarter 1. Common patterns had emerged as to causes of this such as age, length of time in hospital and antibiotic prescribing. A full RCA using the new PHE tool has been conducted and these are discussed by the infection control and shared with the CCG. Medicines management – there was an increase in Datix reports regarding insulin investigation. The focus of the medicines management best practice group will focus on the work in this area as a priority. • The transfer of a patient overnight is showing an increase.	EF

61/14.2	SF will do a root cause analysis to look at this and inform the Committee • TR noted that there were issues around the visibility of staffing levels and the ability to escalate and action, there was particular reference to the current e rostering system. This would be picked up in a more detailed report in Human Resources & Organisational Development. • CC highlighted the importance of being able to triangulate all the data to provide "early warning". EF reported on some best practice models shared by the TDA and that she is currently working with MOR on a GCS report of this type. **Caring:** • IB asked that the safer staffing table on page 2 was risk rated. EF advised that the electronic reporting system is being built and will then be tested with the ward teams that enable this reporting. SF had proposed running the report in draft form while we consider how cumulative risk is judged. • An anomaly in planned hours at the Dilke Hospital had been noted and corrected. RC asked if they were happy that the hours for the other sites were correct as the day and night figures did not appear to tally. EF would go back and check to assure the Committee • IB noted that in the minor injury response rates for FFT reported % of responses, but not number of respondents and that this was important for them to analyse the figures properly. **Responsive:** • SM asked if they should discuss the implementation of SystmOne now or later. RC advised that a full report would come to the Performance & Resources Committee on the 2nd September. **Well Led:** • The performance of mandatory training figures were better than last time, but there was still much work to be done. TR advised that they hoped that the introduction of mandatory training sessions would help increase completion rates. One problem which was faced was that for 50% of colleagues there was no financial incentive to complete the training as they were already at the top of their pay band. It had been agreed that these people would be given a 1% increase in pay on completion of the training. EF discussed that it was important that people	**SF** **EF**

	were not penalised for not doing the training where we have recognised staffing pressures and are covering gaps in rotas as this would lead to lower staff morale. • TR advised that at the DTR the TDA proposed that mandatory training and appraisals targets should be set at 100%. The Committee **NOTED** the report and **ENDORSED** the next steps for further development of the report. The Chair agreed to move agenda item 7 forward	
62/14	**Agenda Item 7: Quality Governance Framework** The Foundation Trust Programme Manager (RB) presented the Quality Governance Framework presentation to the Committee. Quality governance serves to provide assurance that the Trust has suitable processes in place to reach required standards and best practice. There were 10 key questions that the Trust needed to answer to reach these standards and RB advised as to the thorough and robust evidence that was needed to support and answer these questions. It was requested that RB hold a separate meeting around the Quality Governance Framework for the Trust Chair and the NEDs. It was agreed that RB would organise this. The Committee **NOTED** the presentation RB left the room	**RB**
63/14	**Agenda Item 6: Community Nursing Service** The Chair advised that as they had, had quite an in-depth discussion around this at a recent NED meeting they were just looking for an update. EF expressed apologies from the Director of Service Delivery who was unable to make the meeting but she would give a verbal update to the Committee in her absence. It was identified that the key issues were in respect of staff experience. The focus to date has been predominately around the service in the North Cotswold and a number of steps have been undertaken or are in progress. These include: • A review of funding, agreed establishments and staff in post • A focus on recruiting to vacancy, the CIP plan has been deferred on the grounds of quality impact until we have better baseline data around work load and acuity.	

	• A review of exit interviews to look at why colleagues may have left • An equipment audit • Supporting the teams with consistency in bank and agency support where possible. • Recruitment of additional bank staff MR advised that the North Cotswolds were extremely stretched at the moment and they were also reviewing travel times as part of the case load management process as these could be quite long in rural areas. GB advised that they had been told to buy their own kit. SM raised that there were some urgent issues here and she would want more assurance around these problems. GB advised that nurses were feeling disempowered to do things and there were managers who were not managing properly and this was not helping the current problems. MR made the Committee aware that they were moving staff where they could and trying to use the same agency staff for longer periods of time though EF acknowledged that there was still more work that needed to be done. EF advised that an Interim Head of Community Nursing had been appointed whilst substantive recruitment was taking place and she would be focusing on supporting the teams, undertaking a training needs analysis and looking at supervision. SM asked for confirmation that safe patient care was the key focus. MR advised that this was being scrutinised daily by GCS, CCG and the Directors of Nursing & Quality and Service Delivery who were leading this for GCS. SM was happy that there was much day to day activity to support the team and it is now a case of moving that to a higher level of assurance. A summary of actions was in place and needed to be circulated out of committee, to provide further assurance. TR informed the Committee that PWC had been commissioned to look at root cause analysis and RC advised that this would also be scrutinised within the Performance & Resources Committee. The Committee **NOTED** the update and the further work needed to provide additional assurance.	**EF**
64/14	**Agenda Item 8: Corporate Risk Register** The Director of Corporate Governance and Public Affairs (JB)	

	presented an update on the Corporate Risk Register to the Committee and noted that this was Work in Progress. The Corporate Risk Register was now on Datix and this would integrate with all local Risk Registers to bring them together. The Corporate Risk Register still needed some work on it and the RAG ratings were not yet correct so further work would take place. SM agreed that this should be driving the work and priorities throughout the organisation. RC expressed concern that not every item had an owner and was not sure if this was being sorted. JB advised that they were following the TDAs template and this was not required to be shown, but they could add in. It was agreed that a session on this would be useful for the Trust Chair and the NEDs. SM expressed concern that Quality Impact Assessments (QIAs) had not yet been signed off. EF advised that the QIA for the three big schemes had been completed but not approved by the Director of Nursing as the risks of impact on quality are too great at this stage. IB expressed concern that there were currently £3m of CIPs not being delivered and the Boards not clearly sighted in this work. JB acknowledged this and recognised the importance of getting this on the board agenda. The Committee **NOTED** the risk registers and **ACKNOWLEDGED** the work to be done.	**JB**
65/14	**Agenda Item 9: NHS CCG CQC Inspection: Report and Action Plan** The Chair advised that she did not propose a discussion on the report, unless there were any questions. They would spend the time for discussion on the Action Plan and how they were going to monitor this. EF advised that the actions were to be completed together with the CCG. It was for the CCG to provide assurance to the CQC that these actions were completed. It was proposed that this come back to the Committee in December for an update. The Committee **NOTED** the content of the report and **REQUESTED** this come back to the Committee in December 2014.	**SW**
66/14	**Agenda Item 10: Quality Assurance Structure** The Head of Clinical Governance (MR) advised the Committee of the process undertaken to further develop the Quality	

	Assurance Structure since it last came to Committee and acknowledged that there had been some problems making this a joined-up process. TR noted that the Health & Safety Forum no longer reports to Q&CGC. JB to look into all terms of reference to understand where this now reports. SM suggested that the structure be implemented for 12 months and then a review is undertaken. This was agreed by the Committee. The Committee **APPROVED** the content on the basis that Health & Safety was added on and it came back to Committee in 12 months for a review. GB and CC left the meeting.	**JB**
67/14	**Agenda Item 11: Horizon Scanning** The Committee were asked to note that the NICE guidance relating to Inpatient Staffing had been recently published, but that this excludes Community Hospitals. Guidance may be factored into the NICE programme. The Clinical Audit and Compliance Manager (Rosemary Clifford) had provided assurance on how the management of NICE guidance and maintaining quality standards would be upheld throughout the Trust. The Committee **RECEIVED** and **NOTED** the paper on Management of NICE guidance and Quality standards: Trust procedure. The Chair agreed to move agenda item 17 and 16 forward	
68/14	**Agenda Item 17: Clinical Policy Approval Process** The Named Nurse Safeguarding Adults/Clinical Quality Manager (SW) presented the paper on the Clinical Policy Approval Process. The process for scrutiny and ratification of clinical policies is in place. It was agreed that in the future the list of new and revised policies would come to the Committee as opposed to each complete policy. JB stated that it would be good practice to focus on policies that are covered on the risk register and deemed a risk. The Committee **RECEIVED** and **NOTED** the document and agreed that a list of policies would come to the Committee.	
69/14	**Agenda Item 16: Patient Testimonial Presentation**	

	The Clinical Lead for Urgent Care – Rapid Respond (KC) presented a Patient Testimonial presentation to the Committee. The case study followed a service user who had been enabled to stay at home as opposed to going to hospital by using this service. The service user felt that he was happier by being able to stay at home and that he was more involved in the care he received. SM asked how typical this case study was. KC felt that on the whole most service users found Rapid Response care to be a more positive experience, the negatives were usually around what was not possible to do. JB asked who would have cared for the patient if the Rapid Response Team was not in place. KC confirmed this would be SWAST and therefore there was a possibility that they would be taken to hospital. SWAST did refer patients to them the difficulty could be ensuring these referrals were appropriate. KC offered to forward on an audio clip of the presentation to the Committee. The presentation was **RECEIVED** by the Committee thanked KC for presenting to them. KC left the meeting	
70/14	**Agenda Item 12: Falls within Community Hospitals** The Director of Service Transformation (SF) and The Matron for Cirencester and Fairford Hospitals (JE) presented on Falls within Community Hospitals. The purpose of the presentation was to inform the Committee on the consequences of falls. Falls in hospitals can cost the NHS between £2-3billion a year; this includes additional staffing needed and extra cost in medicines. The CQUIN for last year was to achieve an incremental reduction in falls and significant work around training, safety, more awareness that falls have happened and better reporting have all taken place. JE acknowledged that it was not just for staff that education was needed. Ensuring that Service Users also knew that it was ok to use the call bell for help was equally important. There has been a strong push on identifying when falls occur, such as at night with low lighting and less staff around. All 3 new hospitals with single rooms have seen an increase in falls. The Committee discussed the presentation and the pros and cons of some of the actions that are being, and have been, taken. The Committee felt that this was a really useful presentation. SF wanted this presentation to give the Committee assurance around falls and highlighted the places that falls have also been	

	seen: CQUIN Steering Group Quest Incident Reporting Scorecards SIRI The Presentation was **RECEIVED** by the Committee and they thanked SF and JE on a very useful presentation.	
71/14	**Agenda Item 13: Service User Experience report Q1** The Chair had some concerns as to why this report showed no complaints for Cheltenham and Children's. MR advised that unfortunately this was down to reporting and related to written complaints; we need to ensure we capture concerns addressed locally to ensure learning. TR noted that a complaint re attitude was showing as no action required and expressed concern that this was not correct and that some form of action should be taken to acknowledge. MR was not sure as to the detail around this complaint, but acknowledged that there should at least be some kind of reflection around these kinds of complaints. TR asked why there was not a 100% response rate within the 25 days to complainants and SF advised that this was often due to complexities of cases or slow response from hospitals for reports around the complaint. SM noted that waiting times were still an area of concern in some areas. The Committee **NOTED** the report and the work undertaken to compile this report.	
72/14	**Agenda Item 14: Service Transformation Portfolio Report** The Director of Service Transformation (SF) presented the report to the Committee. SF bought to the attention of the Committee that this workplan excluded Out of Hours and Community Hospitals and suggested that these were bought to the Committee in the future. The Committee **RECEIVED** the report and **NOTED** the work so far and agreed to take the Out of Hours and Community Hospital information at a later date.	**SF**
73/14	**Agenda Item 15: Quality of Reablement Services Report** The Director of Service Transformation (SF) presented the report	

	to the Committee. SM noted that she could not pick up quality and outcomes from this report, SF acknowledged this. There was good news around reablement and lots of work was being done on contact time. There was concern re sickness levels from this group but they were now receiving HR support from GCC. SM asked for an overview on the quality impact of this service and that for this to be brought back to this Committee. SF agreed and suggested this was also taken to Board. The Committee **RECEIVED** the Terms of Reference and **AGREED** to receive a further update report.	**SF**
74/14	**Agenda Item 18: GSAB Annual Report** The Committee **NOTED** the GSAB Annual Report	
75/14	**Agenda Item 19: GSCB Annual Report** SM highlighted that there were some issues re Performance and Child Protection conferences and these needed to be tackled by the Safeguarding Board The Committee **NOTED** the GSCB Annual Report	
76/14	**Agenda Item 20: Healthwatch Gloucestershire Annual Report** IB noted that this report did not make any mention of the GCS or that they were part of the Your Care, Your Opinion forum and was disappointed in this. The Committee **NOTED** the Healthwatch Gloucestershire Annual Report	
77/14	**Agenda Item 21: Coroner's Inquest Process** JB advised the Committee that this Coroner's Inquest Guide would go on to the Intranet. The Committee **NOTED** the Coroner's Inquest Guide and Leaflet	
78/14	**Agenda Item 22: Learning Disabilities Steering Group – Terms of Reference** The Committee **NOTED** the Terms of Reference.	
79/14	**Agenda Item 23: Quality & Safety Governance Forum report** The Committee **NOTED** the Quality & Safety Governance Forum Report	

80/14	**Agenda Item 24: Infection Prevention and Control and Decontamination Committee Report** The Committee **NOTED** the Infection Prevention and Control and Decontamination Committee Report	
81/14	**Agenda Item 25: Any Other Business** The Director of Nursing & Quality (EF) wanted to advise the Committee of the publication of a serious case review on Tuesday (9 August). GCS public health nurses had been actively involved with this family. Media training is being held for the relevant people. It was noted that GCS have been commended for its contact with the family concerned. EF will represent GCS at the media briefing. EF advised that GCS were involved in three other serious case reviews currently. Two have been commissioned by the GSCB and the third by GSAB.	
82/14	**Date of Next Meeting** Thursday, 16 October 2014 at 1.30pm in the Leckhampton Room, Edward Jenner Court	

Chair's Signature **……...**

Date **……..…….**

Gloucestershire Care Services NHS
NHS Trust

HR & OD Report

Ref: 14/B038

This report is for Publication

Gloucestershire Care Services NHS Trust Board

HR & OD Report
25th November 2014

Objective:

This paper provides the Board with an update on:

The actions being taken under the Organisational Development Strategy:

- To improve the results of the staff survey and staff friends and family test regarding the Trust being recommended as a place to work.

The actions being taken under the Workforce Strategy to:

- To ensure early alert systems are in place regarding staffing levels
- To maximise nurse recruitment and retention across Community Hospitals and Integrated Community Teams
- To ensure the contingent workforce is fit for purpose
- To improve completion rates for mandatory training
- To improve the quality and completion rates of appraisals
- To reduce sickness absence across the organisation

The Board is asked to:

(1) acknowledge the actions being taken to mitigate risk and improve performance in these areas and (2) support the programme of work as detailed in this report.

Executive summary:

The Trust's Organisational Development and Workforce Strategies will address the "hotspots" that are identified in this report. Both strategies are supported by a detailed implementation plan and regular progress reports are provided to the HR & OD Committee. In addition, the workforce scorecard is being further developed to provide the Board and subcommittees with regular "snap shots" of progress. The revised scorecard will be in place from January 2015 onwards.

The table below provides a summary of each "hotspot" as identified in the workforce risk register and the actions that are being taken to address them:

Hotspot	Summary of Issues	Summary of Actions being taken	Key performance indicators
Low morale - staff survey and staff friends and family test	Poor staff survey and FFT results Low survey response rates	Top 3 priorities from OD Strategy: Listening into Action programme Leadership programmes Core values framework	Staff survey Staff Friends & Family Test Turnover rates Reasons for leaving
Early alert systems regarding staffing levels	High vacancy rates not escalated on a timely basis Disconnect between CIP savings and demand/ capacity modelling E-rostering system not being utilised effectively	Audit undertaken by Price Waterhouse Cooper – action plan in place to take forward issues identified which is monitored through the Audit & Assurance Committee Review of e-rostering system – detailed project plan in place which is monitored through the HR & OD Committee	Vacancy levels Turnover rates Reasons for leaving Sickness absence rates % of shifts not filled % of shifts filled by bank & agency
Nurse recruitment and retention	Additional recruitment to meet investment in Community Hospital Inpatient, High Intensity & Rapid Response Services	Centralised recruitment Dedicated post to lead on nurse recruitment & retention Targeted recruitment campaigns Preceptorship programme Return to practice programmes Nurse recruitment open days Exit interview analysis Detailed action plan in place monitored through HR & OD Committee	No of new starters Turnover rates Reasons for leaving Age profile of workforce
Contingent workforce strategy	Further understanding of contingent workforce demand and supply issues required Centralised bank function not being utilised effectively	Development of contingent workforce strategy and operational policies Review of centralised bank function – detailed project plan in place which is monitored through the HR & OD Committee Targeted recruitment campaign for bank staff	No of active bank staff No of unfilled shifts Bank spend Agency spend % of shifts filled by bank and agency
Mandatory Training completion rates	Completion rates below target rate of 100%	Review of content and frequency of mandatory training by lead specialists Monthly compliance reports issued to managers Detailed action plan in place to improve compliance monitored through HR & OD Committee	% of staff who are up to date with their mandatory training

Hotspot	**Summary of Issues**	**Summary of Actions being taken**	**Key performance indicators**
Appraisal completion rates	Completion rates below target of 100% Staff survey results indicates that further improvements can be made in the quality of appraisals	Appraisal policy and procedure being reviewed to embed core values framework Monthly compliance reports to managers Pay progression policy updated and linked to appraisal policy Workshops for appraisers Detailed action plan in place to improve compliance monitored through HR & OD Committee	% of staff with up to date appraisals. Quality of appraisals (monitored through staff survey)
Sickness absence rates	Current sickness absence rate above NHS average and benchmark group	Monthly reports to managers Healthy workforce plan Dedicated resource in HR to support managers Absence management workshops for managers Lighten up programme Review of occupational health service and employee assistance programme Review of Managing Stress policy and guidance Detailed action plan in place to improve rates monitored through HR & OD Committee	Rolling 12 month sickness absence rates Reasons for sickness absence No of staff who have met the sickness absence policy triggers

Tina Ricketts
Director of HR

Please complete the Equality Checklist

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.

1. Introduction

This paper provides the Board with an update on the actions being taken to address the following workforce "hot spots" as identified in the Trust's risk register:

- Low staff morale (risk register ID 407)
- Early alert systems re staffing levels (risk register ID 433)
- Nurse recruitment and retention (risk register ID 409)
- Contingent workforce strategy (risk register ID 414)
- Mandatory training completion rates (risk register ID 411)
- Appraisal completion rates & quality of appraisals (risk register ID 406)
- Sickness absence rates (risk register ID 404)

2. Staff morale (measured through the staff survey & friends and family test)

2.1 The issue:

The results of the 2013 national staff survey showed that the Trust scored 3.61 (score between 1 and 5 with the higher the score the better) against an average for Community Trusts of 3.59 for staff recommending the Trust as a place to work.

Since April 2014 the Trust has been required to undertake the staff friends and family test (FFT) on a quarterly basis. The results of quarter one and two are summarised in the tables below:

Table 1: How likely are you to recommend the Trust to friends and family if they needed care or treatment?

	Total Responses Qtr. 1	**Qtr1 %**	**Total Responses Qtr. 2**	**Qtr2 %**
Extremely likely	174	31	127	28
Likely	279	49	238	52
Neither likely or unlikely	93	16	75	15
Unlikely	13	2	9	2
Extremely unlikely	6	1	9	2
Don't know	8	1	10	1
Total	**573**	**100**	**468**	**100**

Table 2: How likely are you to recommend the Trust to friends and family as a place to work?

	Total Responses Qtr. 1	**Qtr. 1 %**	**Total Responses Qtr. 2**	**Qtr. 2 %**
Extremely likely	86	15	66	14
Likely	217	38	162	35
Neither likely or unlikely	136	24	135	29
Unlikely	76	13	62	13
Extremely unlikely	49	9	35	8
Don't know	4	1	8	1
Total	**568**	**100**	**468**	**100**

The national results for quarter one shows that on average 76% of staff would recommend their Trust as a place to receive care (extremely likely and likely) with 8% not recommending their Trust (unlikely and extremely unlikely). Gloucestershire Care Services quarter one results compares favourably with 80% recommending and 3% not recommending.

However the national quarter one results for recommending their Trust as a place to work shows an average of 62% recommending (extremely likely and likely) and 19% not recommending (unlikely and extremely unlikely). Gloucestershire Care Services compares less favourably with only 53% of our staff recommending the Trust as a place to work with 21% not recommending.

The overall response rate for quarter one was 17% and for quarter two was 14%. Quality Health has provided a comparison of our completion rates compared to other Trusts (who use Quality Health). They have confirmed that the top acute Trust achieved 29% and the lowest 13% and that looking at community and mental health Trusts the top is 20% with the lowest 4%.

Staff responding to the FFT survey are given the opportunity to provide additional comments by way of free text boxes. The full set of comments have been circulated to board members by e-mail. In order to further understand the comments received during quarter one and quarter two, a set of word clouds have been developed in appendix one which highlights both the positive and negative comments received for each question.

The first word cloud in appendix one summarises the positive comments received from staff about the Trust as a place to receive care or treatment. Top themes are good standards of care, professional staff and high quality services. The second word cloud summarises negative comments received from staff about the Trust as a place to receive care or treatment and the top themes can be seen as staffing levels and service user choice.

The third word cloud summarises the positive comments received from staff who would recommend the Trust as a place to work, the top themes being team, environment and rewarding work. The fourth word cloud summarises why staff would not recommend the Trust as a place to work. The top themes being poor communication, low morale, staffing levels/ workload, high levels of change, stress, lack of support from management and pay & conditions. Both the positive and negative themes are similar to the feedback received from the 2013 national NHS Staff Survey and Investors in People review.

2.2 What we are doing about it

The Trust has developed an Organisational Development (OD) Strategy and supporting implementation plan which is monitored through the HR & OD Committee. The top three priorities for 2014/5 are as follows:

2.2.1 Listening into Action Programme

In January 2014 the Trust launched the Listening into Action programme which is a tool widely used in the NHS to change the culture within an organisation. The three aims of the programme are to:

1. Invert the triangle – so that front line staff sit at the top of the organisation (rather than traditional models which show the board at the top) and are therefore empowered to make decisions
2. One organisation – to ensure staff identify with GCS as a new NHS Trust rather than any predecessor organisations
3. Taking responsibility - to change the culture in the Trust to enable all staff to "own" the challenges and problem rather than looking to their colleagues or manager for action/ resolution

The Trust has undertaken a range of activities under this programme which include:

- A pulse check to obtain a base line of how it feels to work for the organisation
- Five big conversation events (attended by over 300 staff) to understand what gets in the way of providing the best care possible
- The taking forward of 'quick wins' identified during the big conversation events
- Supporting thirteen teams across the organisation to make change
- A "pass it on event" to allow the thirteen teams to pass on what they have learnt from the change process

More information on the Listening into Action programme will be provided to the Board by way of a separate presentation.

2.2.2. Leadership Programmes

During 2014/15, the Trust has invested over £160k in leadership programmes for middle managers. This includes the Leading for Quality Care programme which is being delivered in conjunction with the Royal College of Nursing. This programme

includes five workshops, five action learning sets and requires all participants to undertake a work related change programme.

Since the Trust was formed in March 2013, 179 colleagues have participated in a leadership programme which are summarised in the table below.

Table 3: Number of colleagues undertaking leadership training since March 2013:

Programme	**No of Participants**
Leading for Quality Care (7 cohorts)	86
Leading an Empowered Organisation	69
NHS Leadership Academy programmes (Mary Seacole, Elizabeth Garrett Anderson & Nye Bevan)	24
Total to 31st October 2014	**179**

2.2.3 Core Values Framework

The Trust has developed a Core Values Framework (see appendix two) to ensure that all colleagues within the organisation are clear on the expected values and behaviours that are required of them. By embedding the framework within induction, recruitment, appraisal and training, it will support the Trust to achieve the culture as described within our Organisational Development Strategy.

The framework will be rolled out in two phases. Phase one will involve the embedding of the framework within our core policies and procedures and this will be completed by 31st January 2015. Phase two will involve the testing of the framework and updated policies and procedures across four services (1 x ICT team, 1 x Community Hospital, 1x Support Service and 1 x Countywide Service). Final revisions to the documentation will be made by 31st March 2015 with a view to launching the framework across the organisation on 1st April 2015. The launch of the framework will be supported by a detailed communications plan and will commence by issuing a booklet and covering letter to all staff.

2.2.4 Improving survey response rates

The Trust is working with Quality Health to improve the response rates for both the NHS Staff Survey and the Staff Friends & Family Test. This includes trialling different methodologies and also exploring the possibility of offering incentives.

3. Early Alert System re Staffing Levels

3.1 The issue:

There have been several incidents within the Trust whereby high vacancy rates within a particular team or ward have not been brought to the attention of the

Executive Team in a timely way. Furthermore, there appears to have been a disconnect between required cost improvement savings and demand/ capacity modelling to determine appropriate staffing levels. This combined with the lack of clarity around service specifications makes it challenging to ascertain appropriate staffing levels in each service whilst delivering the required cost improvement targets.

To understand the root cause of this issue the Trust commissioned Price Waterhouse Cooper to undertake an audit which resulted in seven medium rated risks being identified including:

- There appears to be limited sharing of information between central support service teams with budget holders regularly receiving duplicate requests for information from teams

- Budget holders do not always ensure that the HR team are provided with timely leaver information. Without this information the central support teams are unaware of staffing pressures. In addition late leavers forms may result in salary overpayments

- Budget holders should be encouraged to raise any concerns regarding staffing levels into Datix and to line managers on a daily basis if required. Line managers must keep a log of these concerns complete with actions taken and conclusions from escalation

In addition to the above audit, the Trust commissioned an independent review into its e-rostering system which identified a number of issues:

- There is no operational policy in place to support the e-rostering system

- Centralised monitoring of vacancy levels has only recently been implemented for Community Nursing and Community Hospital in-patient services and this is currently undertaken separately to the e-rostering system

- The functionality of the system seems adequate but is difficult to assess without defined operational requirements. The available functionality of the system is currently underused

- The ‘soft intelligence’ required for the system to be sensitive to a services needs has not been previously gathered or used

- Training has been seen as optional and ad hoc despite many attempts by the current trainer to engage with users

- There is resistance from some to use the system and therefore to revert back to paper based rotas — this is partly due to the problems in system accessibility

3.2 What we are doing about it:

An action plan has been developed in response to the findings of the audit and this will be monitored through the Audit & Assurance Committee and GCS leadership Forum.

Actions include:

- A review of the number and structure of budget holders across the organisation. This will ensure there are fewer signatories required for the establishment control process
- The use of ESSbase for finance and workforce reports to avoid duplication of requests
- As an immediate fix, the Trust has introduced a process that monitors vacancy levels on a weekly basis for Community Hospital Inpatient and Community Nursing Services. This includes the early alert of leavers to enable the timely processing of replacements and the completion of leavers forms. In the medium term, the Trust is reviewing its e-rostering system to ensure that its functionality allows the central monitoring of staffing levels across services on a daily basis. One of the functionalities being explored is the improvement of the direct feed to the electronic staff records system
- The development of workforce plans for each service as part of the annual operational planning cycle
- Training sessions and workshops for service leads/ budget holders to increase workforce planning capability and capacity
- An awareness campaign regarding the importance of logging and owning staffing issues on Datix and risks relating to staffing levels on local risk registers

To address the issues identified in the e-rostering review, three “try and test” sites have been selected. Managers at these sites are being supported by a project group to address current issues with the system and to ensure robust local workforce management practices are in place. In addition a short term working group has been set up to agree system rules and functionality and to develop the operational policy. Further roll-out of the system will be taken forward once it has been declared functional in the test sites.

4. Nurse Recruitment & Retention

4.1 The issue:

Since the Francis report and subsequent NICE guidelines for safer staffing levels all NHS Trusts have been required to increase the number of qualified nursing staff within their workforce. This along with the requirement for degree entrance for nurse

qualifications has resulted in a national shortage of nurses. The Trust has therefore found it challenging to recruit to the additional posts created as a result of the additional funding for Community Hospital Inpatient Services and the investment in the High Intensity and Rapid Response services.

As at the 31st October 2014 the Trust had the following vacancies across the Community Nursing and Community Hospital Inpatient Services.

Table 4: Current Qualified Nursing Vacancies as at 31st October 2014

	Community Nursing			Community Hospital (Inpatient)		
Band	Establishment (FTE)	Vacancies (FTE)	% Vacancy	Establishment (FTE)	Vacancies (FTE)	% Vacancy
6	57.59	11.31	19.6%	31.50	3.22	10.2%
5	151.15	23.22	15.4%	116.60	18.87	16.2%
Total	**208.74**	**33.53**	**16.0%**	**148.10**	**22.09**	**14.9%**

4.2 What we are doing about it

It has been recognised that to ensure sufficient nurses are recruited over the next twelve months the Trust needed to adopt a more innovative approach to its recruitment and retention.

From July 2014 the Trust centralised its nurse recruitment which is managed by a dedicated band 7 Nurse. Since this date the Trust has successfully offered roles to 43 qualified nurses over and above natural turnover.

In addition, the following actions have been undertaken:

- A recruitment and retention project group has been formed with representation from Community Nursing and Community Hospitals Inpatient Services. The role of this group is to review progress against recruitment trajectories and to generate further ideas regarding recruitment and retention initiatives
- Targeted adverts have been placed using both national and local media
- Nurse recruitment open day events were held in October 2014 at four Community Hospitals supported by a media campaign. These events showcased all nursing opportunities across the Trust and in total 87 potential applicants attended and to date five substantive Band 5 nurses, 1 bank nurse and 1 bank HCA have been offered roles with the Trust
- A preceptorship programme has been developed to support newly qualified nurses in both the Community Nursing and Community Hospital Inpatient services.

- The development of new rotational posts (between community nursing, inpatient units and minor injury units)
- The Trust recently launched a return to practice programme in conjunction with Health Education South West and the University of the West of England. The Trust has been successful in placing seven students on the programme which commenced in September and is currently recruiting to the January intake. Subject to satisfactory completion of competencies the Trust will offer all students a permanent role once they have completed the programme.
- The 'Work for us' section on the Trust's website has been further developed to highlight all vacancies and benefits of working for the Trust
- A thorough review has been undertaken of the Trust's pre-employment processes and the changes made will reduce the length of time taken from "offer" to "start date".

The Trust has set itself the following quality goals to maximise nurse recruitment and retention and these are supported by a detailed action plan which is monitored through the HR & OD Committee:

- Recruit to establishment levels
- Reduce turnover
- Reduce agency spend
- Improve time taken to recruit
- Reduce sickness absence levels

5. Contingent Workforce

5.1 The issue:

Whilst linked to the e-rostering review, the Trust has also commissioned a review into its contingent workforce and in particular the centralised bank function. This review has highlighted that the Trust needs further understanding of the demand and supply issues of its contingent workforce and also whether the current model of an internal centralised bureau will meet future needs.

The review has identified that limited work has been undertaken on the development of a framework, policies or procedures relating to the use of temporary staff and that further work is needed in this area. Other issues identified include:

- There continues to be a large demand for supplementary staff which is related to the current vacancy levels for qualified nurses
- There are currently 323 people on the bank (mainly nursing and support staff) with a further 164 staff holding substantive contracts but also holding bank contracts. However, only 120 bank shifts are currently being filled from this resource.

- There is an over reliance on the bank coordinator to undertake operational duties rather than developmental work
- The bank IT system holds limited information and the link to the electronic staff records system is not fully functional
- There is no regular organisational 'contract' monitoring of the bank service.
- Some managers bypass the current system and book their supplementary staff directly
- The relationship with temporary staffing agencies is unbalanced due to the requirement to cover shifts at short notice
- The e-rostering bank module is not being fully utilised the facility for bank staff to offer to pick up available shifts has not been brought into use.

5.2 What we are doing about it:

To address these issues a project team has been established (to support both the e-rostering and contingent work streams) and a detailed project plan has been developed. Key milestones include:

- The development and implementation of a contingent workforce strategy, operational policy and supporting procedures
- The testing of the e-rostering system at three sites to ascertain the required functionality and to inform the Trust as to whether the current system is fit for purpose
- Demand and supply modelling
- A dedicated web page and intranet pages for bank staff

6. Mandatory Training and Appraisal Completion Rates

6.1 The issue:

As at 31st October 2014 the performance of the Trust for mandatory training and appraisal completion rates against a target of 100% (for all staff including bank) is as follows:

Table 5: Mandatory training and appraisal completion rates as at 31st October 2014

APPRAISALS	MANDATORY TRAINING % of staff with completed and up to date Training					
% of qualifying staff with up to Date Appraisal	- Health, Safety & Welfare.	- Fire Safety.	- Equality & Diversity.	- Info Governance.	- Conflict Resolution.	Infection Control within Mandatory Training
81.54%	85.98%*	61.03%*	66.24%*	67.36%*	71.64%*	85.98%*

Please note the mandatory training figures in the table above are lower than previously reported as they now include staff who have undertaken the mandatory training but are overdue a refresher.

A survey of staff and managers identified "capacity" as being the main reason why mandatory training and appraisals were not being completed in a timely manner.

6.2 What we are doing about it

6.2.1 Mandatory Training

The Trust's mandatory training requirements are set by Skills for Health under the UK Core Skills Training Framework. This framework sets out the expected learning outcomes and standards for delivery of training for the following subjects:

Conflict Resolution
Equality, Diversity and Human Rights
Fire Safety
Health, Safety and Welfare
Infection, Prevention and Control
Information Governance
Moving and Handling
Resuscitation
Safeguarding Adults
Safeguarding Children

Currently the workforce dashboard does not report on completion rates for Moving and Handling, Resuscitation and Safeguarding (Adults and Children). Work is currently underway to include these in future monthly reports so as to be able to monitor performance.

The following table details the Trust's subject specialist for each area.

Table 6: Subject specialists for each Mandatory Training area

Subject	Lead Director	Subject Specialist
Conflict Resolution	Director of Finance	Security Manager
Equality, Diversity and Human Rights	Director of HR	Equality & Diversity Manager
Fire Safety Health, Safety and Welfare	Director of Finance	Head of Estates & Safety
Infection, Prevention and Control	Director of Nursing & Quality	Head of Infection Control
Information Governance	Director of Corporate Governance	Director of Corporate Governance
Moving and Handling	Director of Finance	Head of Estates & Safety
Resuscitation	Director of Nursing & Quality	Director of Nursing & Quality
Safeguarding Adults Safeguarding Children	Director of Nursing & Quality	Safeguarding Leads

Subject Specialists have been asked to consider whether any changes can be made to the content and frequency of the training for different staff groups and to confirm what actions they feel are required to obtain compliance. In addition, a detailed action plan has been developed which identifies further measures that are being undertaken to ensure compliance and this was shared with the HR & OD Committee in October 2014.

If we are able to reduce the current frequency of mandatory training it will provide further capacity for staff to undertake other essential training such as that identified under CQUIN 6.

6.2.2. Appraisal Completion Rates

Significant focus has been given to improving both the quality and completion of appraisals which has included the regular weekly reporting of compliance rates to the Executive Team. The completion rate as at 31st October 2014 was 81.54%.

A detailed action plan has been developed which identifies further measures that are being taken to improve the quality of appraisal and compliance rates and this was shared with the HR & OD Committee in October 2014. Further actions include:

- A review of the appraisal policy and procedure to embed the core values framework
- Further development of the pay progression policy linked to the appraisal process
- Workshops for appraisers
- The development of coaching cards

7. Sickness Absence

7.1 The issue:

As at the 31st October 2014 the sickness absence rate (rolling 12 month figure) for the Trust was 4.59%, compared to the national NHS average of 4.17%. Whilst it is difficult to identify an exact comparator Trust the national absence level for NHS Community Trust is 4.49%. Furthermore, the average cost of sickness absence to the Trust is £243k per month.

7.2 What we are doing about it

The HR Department has been working closely with line managers in supporting them to manage individual long term sickness cases and progress has been made in this area. However, a recent review has identified that short term sickness management needs to be a priority for the Trust and action is being taken to ensure that managers are able to support staff but take action where absence is identified in excess of the

Trusts agreed 'triggers'. HR Advisors are conducting sickness absence management workshops and feedback received to date has been extremely supportive of these sessions.

A detailed action plan has been developed which identifies a number of key actions that will be completed to ensure that sickness absence rates see a step change over the next 6-12 months and this was shared with the HR & OD Committee in October 2014. Further actions include:

- The development of a healthy workforce plan
- Further roll out of the Lighten up programme
- A review of the occupational health service and employee assistance programme
- A review of the Managing Stress Policy and guidance supported by workshops for managers

8. Monitoring & Next Steps

Both the Organisational Development Strategy and Workforce Strategy are supported by detailed implementation plans which will address the "hotspots" identified in this report. Furthermore, the forward agenda map for the HR & OD Committee ensures that progresses against these "hot spots" are reviewed on a regular basis.

This can be evidenced by the minutes of the Committee which are shared at each Board meeting. The minutes of the meeting held on 18th August 2014 are attached in appendix three for information.

Appendix 1 – Word Clouds which summarise the comments received from the Staff Friends and Family Test (quarter 1 and 2 combined)

Diagram 1 – Positive comments received about the Trust as a place to receive care or treatment

Diagram 2 – Negative comments received about the Trust as a place to receive care or treatment

Diagram 3 – Positive comments received about the Trust as a place to work

Diagram 4 – Negative comments received about the Trust as a place to work.

Appendix Two

Core Values Framework

The Core Values Framework is a behavioural competency framework which has been developed through consultation with staff side and colleagues. It describes the behaviours which will help us achieve our vision and support a positive culture across the organisation. It also complements the four pledges set out in the NHS Constitution about what the NHS expects from colleagues and what colleagues can expect from their employer.

Behaviours focus on **how** an individual carries out tasks, rather than on what they do. Behaviours can be described as the way a person behaves towards other people and the manner in which they act or control themselves. Behavioural competencies refer to personal attributes or characteristics that describe how a job or task is performed rather than the specific details of the job or task. For example, competencies like managing and responding to change, working with others or decision making are demonstrated through on-the-job behaviours, which can be applied in any number of job related situations.

Introducing behavioural competencies to colleagues is important in the ever changing working environment. Coping with change brings about many pressures and just one way these can be eased is by having clear common standards about how we go about things. There is also a growing need for all colleagues to become more customer focussed, flexible and able to carry out a range of different tasks.

The Core Values Framework:

- Introduces transparency in terms of the behavioural skills expected in each role
- Provides a tool for performance management
- Assists with succession planning and career development
- Gives recognition to people who meet / exceed the required levels of competency
- Emphasises that the softer 'people' skills are equally as important as technical knowledge and skills
- Supports our equality, inclusion and dignity at work policies
- Allows all colleagues to take personal responsibility for their actions and behaviours

Our Guiding Principles

Our Vision: To be the service people rely on, to understand them and organise their care around their lives

Our Core Values:
Caring
Open
Responsible
Effective

Core behaviours:
CARING – Respecting and valuing others
CARING – Acting in the best interests of Service Users
OPEN – Open in our communication
OPEN – Connecting with others and working across boundaries
RESPONSIBLE – Owning our actions
RESPONSIBLE – Professional in attitude
EFFECTIVE – Ensuring the best outcomes
EFFECTIVE – Realising your full potential

Our guiding principles are underpinned by the responsibilities which the organisation expects from all colleagues. These support the achievement of our vision, values and behaviours. We should all want to work in an organisation where:

Line managers have a duty to:

- Make sure that all direct reports have clear team and personal (development) objectives, which are linked to the strategic objectives of the Trust and that these are reviewed at least annually as part of the appraisal process
- Make sure that colleagues have the support they need to do a good job, unblock things that get in their way and provide them with opportunities to develop
- Listen to what colleagues have to say and encourage constructive feedback, challenge and debate whenever possible

And where colleagues:

- take responsibility for their ongoing learning and development and make sure they keep their skills and knowledge up to date
- look for opportunities to improve the way they work

Everyone should have a clear focus on reducing health inequalities and promoting diversity, inclusion and dignity at work.

How the Core Values Framework is constructed

There are 8 competency areas making up the framework. The competency areas give an overview of the types of behaviours associated with each competency. . The competencies in the framework are presented in the following format:

COMPENTENCY TITLE			
COMPETENCY DEFINITION: This defines in more detail what the competency is about and what it involves			
All colleagues	Supervisors / Team Leaders / Managers	Middle managers / Heads of Service	Deputy Directors / Directors
Behaviours that would indicate areas for improvement This gives examples of unhelpful and / or negative behaviours which are in need of further improvement			

COMPETENCY LEVEL: Competency levels are organised on a hierarchical scale and provide detail about what the behavioural competence looks like in roles with increasing levels of responsibility and complexity.

BEHAVIOURAL INDICATORS: These provide detail on specific behaviours for the competency at each level, providing examples of how the competency can be seen in practice.

CARING – RESPECTING AND VALUING OTHERS			
Having genuine interest in and concern for, the people around us. Builds and maintains a broad network, working collaboratively with internal and external partners. Acknowledges and respects the individual qualities and diverse needs of others. Is willing to challenge others' perceptions in order to achieve a positive outcome and is aware of the impact they have on others. Speaks up for service users and colleagues.			
All Colleagues	Supervisor / Team Leaders / Managers	Middle Managers / Heads of Service	Deputy Directors / Directors
• Works well with a diverse group of people • Takes opportunities to interact with others, in an inclusive way, demonstrates an acceptance of others who have different views or backgrounds • Clarifies others perceptions if unclear • Takes care to present self effectively • Listens to and considers colleagues' opinions • Values the contributions that each colleague makes • Introduces yourself explaining your role to service users, carers and families • Makes a difference to someone's day by kind actions such as a cheerful smile and friendly welcome • Answers questions politely and carefully	• Uses people or personal networks to the advantage of service users and/or the organisation • Challenges and facilitates others' thinking to achieve a positive outcome • Adapts behaviour/language to relate effectively with others • Works collaboratively with service users, individuals and teams, both within and outside the organisation • Recognises the need to bring together different skill sets to achieve a positive outcome	• Builds effective formal and informal networks inside and outside the organisation • Encourages a collaborative approach • Challenge and facilitates others' thinking in an effort to achieve the best outcomes for service users • Identifies and adopts most appropriate interpersonal style to suit different situations • Effectively uses the skills and knowledge of colleagues	• Establishes an effective network of formal and informal links with individuals and organisations • Creates the conditions for successful partnership working in the longer-term • Challenges the status quo in an effort to achieve the best outcomes for service users and encourages others to do the same • Creates an immediate, positive and credible impression on others; acts as an ambassador for the organisation

Behaviours that would indicate areas for improvement (not exhaustive)

- Processes service users without compassion or care
- Is rude or abrupt towards colleagues, service users, carers and families
- Fails to build effective relationships or develop networks
- Fails to consider the views of service users, their carers or families
- Fails to involve others and acknowledge their contributions
- Fails to share information or ideas; is obstructive when interacting with others
- Uses same style for all; does not adjust behaviour/language appropriately when dealing with others
- Fails to seek the input of others

CARING - ACTING IN THE BEST INTERESTS OF SERVICE USERS			
Continually seeks opportunities for service improvements by fostering a climate of creativity and innovation and applying this locally. Understands service user needs, taking a long-term perspective on problems and opportunities and sharing best practice. Values service users as partners in care making their feedback count.			
All Colleagues	Supervisor / Team Leaders / Managers	Middle Managers / Heads of Service	Deputy Directors / Directors
• Offers support to colleagues when they need help • Works across teams to deliver the highest quality of care • Stays focused on the goal of service improvement • Considers the practical issues related to implementing new and different solutions • Anticipates problems and thinks ahead • Ensures high quality standards are met • Treats all service users with dignity and respect • Shows pride in the important role you play in Gloucestershire	• Consults with colleagues to review and improve current services • Produces creative solutions that meet the demands of the situation • Gathers up-to-date information from a wide variety of sources • Develops and disseminates best practice; highlights if best practice is not being delivered	• Constantly seeks opportunities for service improvement • Thinks creatively; develops new ideas about issues that impact on service users, the organisation and local community • Understands and draws sound conclusions from data • Champions service development and ensures approaches are fully evaluated and outcome focussed • Participates in regular performance discussions ensuring any issues are resolved and services are continuously evaluated • Works to realise long-term organisational goals	• Invests in making a significant impact to service improvements • Champions, initiates, pilots and evaluates service improvements across the organisation • Uses benchmarking to compare performance with others • Ensures regular and constructive performance conversations with Commissioners • Acts as an advocate for sharing best practice and comparisons with external standards and benchmarks • Actively builds relationships with diverse communities and extracts key issues when considering improvements to services
Behaviours that would indicate areas for improvement • Fails to involve or draw on the experience of colleagues in reviewing and improving processes • Makes no or few recommendations for service improvements and does not appropriately highlight issues requiring resolution • Sticks to tried and tested approaches or safe options			

- Fails to work in line with, or promote, best practice
- Implements new approaches but does not clearly/fully evaluate them and adjust or discontinue accordingly
- Fails to seek external benchmark data; is out of touch with service user needs
- Fails to challenge, or raise awareness at the appropriate level, any issues regarding outdated or poor practice

OPEN – OPEN IN OUR COMMUNICATION			
Shares information appropriately so that everyone can work together towards a clear common goal. Conveys ideas and opinions clearly and confidently and translates complex issues in an effective and meaningful way to others, checking for understanding. Makes time to listen and talk to people to understand their priorities and needs and to keep them up to date with relevant information. Is honest at all times even when things go wrong.			
All Colleagues	Supervisor / Team Leaders / Managers	Middle Managers / Heads of Service	Deputy directors / directors
• Speaks and writes clearly • Promotes/encourages genuine two-way communication • Explains information in an uncomplicated way • Checks if message has been heard and understood when communicating with others • Communicates openly when mistakes are made and learns from them • Raises concerns about poor practice professionally and appropriately • Takes time to hear and consider what others say and need • Keep others up-to-date with relevant information • Supports internal communications by reading Team Brief and turning up to meetings on time • Provides unambiguous information about the Trust	• Makes accurate use of words to support a point of view • Uses appropriate language that is jargon free • Checks if message has been heard and understood when communicating with others • Conveys ideas and concepts that are understandable and relevant to all colleagues • Adapts the means of communication to ensure appropriateness, relevance and impact • Role models and encourages two way communication with team members	• Expresses opinions, information and key points of an argument clearly • Communicates consistent messages • Responds appropriately to feedback • Pays close attention to the priorities and needs of others • Makes others aware of information that may be useful to them • Role models a clear and considerate communication style to influence others	• Explain coherently and convincingly the benefits of a point of view • Responds to the needs of an audience when speaking by adapting communication to suit them • Creates a climate where respect for differences is the benchmark • Listens constructively and encourages others to share their views and priorities • Role models a clear and considerate communicative style throughout the organisation
Behaviours that would indicate areas for improvement • Language is verbose or full of jargon • Fails to capture and keep the audiences' attention • Withholds important information • Fails to report and or address difficult issues even though they may be challenging to overcome • Uses same communication style for all, without adapting this to suit the individual • Is difficult to understand, is unclear or mumbles			

- Conveys a lack of confidence in subject matter
- Fails to keep others informed
- Is unwilling to listen and prioritise the needs of others
- Communicates in a way which could be seen to be discriminatory or demeaning to others

OPEN - CONNECTING WITH OTHERS AND WORKING ACROSS BOUNDARIES			
Builds both internal and external relationships across the organisation and wider community to develop effective networks. Enables service users to only have to tell their story once. Gains agreement and commitment from diverse groups by understanding their needs and making effective use of political processes to influence and persuade others. Encourages an inclusive culture where differences are celebrated and embraced in order to improve practice.			
All Colleagues	Supervisor / Team Leaders / Managers	Middle Managers / Heads of Service	Deputy Directors / Directors
• Relates well to others e.g. colleagues, service users • Respects the views and opinions of others, even if they are different from their own • Works hard to meet the wider ranging needs of others and to reach a consensus • Influences others by showing enthusiasm • Shares experiences and best practice with colleagues • Challenges "us" and "them" attitudes	• Builds and maintains strong relationships inside and outside of organisation • Identifies the diverse needs of others to agree a shared way forward • Uses an understanding of how things work in organisation to get things done • Articulates features and benefits of ideas and gains agreement	• Builds strong relationships with key stakeholders within the organisation and wider community • Respects the views and opinions of others even if they are different from their own • Anticipates the needs of others and works proactively to achieve shared objectives • Appreciates, understands and manages self within the political environment the organisation operates in • Secures buy-in from a wide and diverse range of stakeholders through selling the features and benefits of initiatives • Routinely invites clinicians, service users and public to comment on issue in order to influence commissioning decisions	• Engages with key stakeholders to build strategic alliances • Ensures all colleagues understand the impact and benefits that effective stakeholder engagement has on service delivery • Respects the views and opinions of others even if they are different from their own • Uses an understanding of the diversity of others' needs to achieve a shared vision • Understands and proactively manages the complexities of the political environment; identifies and lobbies opinion makers • Forms a 'win-win' alliance with others; positions how a strategy can be mutually advantageous • Ensures colleagues, public and service users are engaged in service improvements

Behaviours that would indicate areas for improvement

- Ignores or helps to fuel the barriers that prevent effective engagement with others
- Blames others
- Works with others only when absolutely necessary; allows for relationships to deteriorate
- Fails to gain agreement or commitment of others
- Fails to persuade or influence others; is hesitant, lacks impact and loses credibility
- Lacks knowledge on key stakeholders within own sphere of influence
- Disinterested in needs of others; fails to take needs or views of others into consideration

RESPONSIBILE – OWNING OUR ACTIONS			
Holds self and others accountable for delivering a high quality service and is aware of own and others' strengths and limitations. Displays a willingness to learn and takes responsibility for own development and for standing up for what they believe in. Is confident in their ability to overcome obstacles and is willing to learn from their mistakes.			
All Colleagues	Supervisor / Team Leaders / Managers	Middle Managers / Heads of Service	Deputy Directors / Directors
• Works to high quality standards • Aware of own strengths and development areas • Is aware of own performance and seeks to continually improve it • Seeks support when task is outside of own capability • Stands up for what they believe in • Has a 'can do' approach when resolving problems or issues • Uses mistakes as an opportunity for learning and takes full responsibility for this • Provides balanced feedback and support to improve team performance • Introduces oneself to service users as to enable familiarity and encourage accountability • Signposts and/or follows up concerns to ensure better service user experience	• Sets and monitors high quality standards for self and others • Shares when appropriate own strengths and development areas • Seeks the support and guidance of more senior colleagues where appropriate • Stands by own decisions and takes responsibility for them • Proactively seeks solutions to solve problems and overcome obstacles	• Takes responsibility for implementing high quality services • Communicates an awareness of own strengths and development areas • Only refers upwards when deemed absolutely necessary • Stands up and maintains own ground when facing opposition, for the good of service users, organisation and public • Uses own experiences when facing and resolving obstacles	• Develops strategies and systems to enable provision of high quality services • Provides a realistic portrayal of personal capabilities and talents • Handles challenges and problems with minimal guidance • Takes a stand for the benefit of service users, organisation and the public • Takes a strategic perspective to overcome and resolve obstacles • Takes responsibility to ensure continuous and meaningful engagement with public and patients to shape services
Behaviours that would indicate areas for improvement • Is unconcerned about the level of quality of the service provided • Does not accept personal accountability • Displays little self-insight about strengths and development areas			

- Takes minimal interest in own development
- Works in a silo; does not seek guidance when it would be appropriate to do so
- Fails to actively seek out solutions; goes beyond limits of own authority or continually defers upwards
- Service users and public views tokenistic and seen as peripheral, rather than central to decision making
- Appears to be uncaring when mistakes are made and fails to identify how improvements can be made

RESPONSIBLE – PROFESSIONAL IN ATTITUDE			
Sets and develops the strategic vision of the organisation. Displays clear leadership by motivating and empowering others through coaching, mentoring and effectively managing performance. Makes prompt, clear decisions which may involve tough choices or taking calculated risks. Recognises potential changes in the way you work which could benefit everyone.			
All Colleagues	Supervisor / Team Leaders /Managers	Middle Managers / Heads of Service	Deputy Directors / Directors
• Works in line with the Trust's vision • Motivates colleagues to achieve goals • Encourages colleagues to develop themselves • Takes responsibility for managing their own performance • Makes appropriate decisions under pressure • Develops and sustains a credible reputation with colleagues for fairness, integrity, objectivity and accountability • Being aware of the contribution you make to your team and ensuring that you play your part • Uses appraisals as an opportunity to improve and plan your development • Acts as an ambassador for the Trust whether at work or not • Takes an active interest in the Trust's role in the local health and social care community	• Communicates a clear vision of the future • Motivates colleagues to achieve team goals, promote positive working relationships and integrated working • Creates equal access to development opportunities for colleagues • Sets clear objectives and performance targets for colleagues; provides constructive feedback to others • Uses own judgement confidently and decisively • Uses diversity within the team to best advantage • Develops and sustains a credible reputation with colleagues for fairness, integrity, objectivity and accountability	• Explores future possibilities that the organisation can aspire to achieve • Inspires enthusiasm and a positive attitude from colleagues about their work • Sets stretching and challenging performance targets • Makes prompt clear decisions which may involve tough choices or considered risks • Is seen to be actively engaged with diverse communities, service providers and partner agencies • Develops and sustains a credible reputation with diverse stakeholders for fairness, integrity, objectivity and accountability	• Imagines future possibilities and sets and develops organisational strategy in line with the organisational vision • Gets the best out of people; creates a climate where personal development is encouraged and supported • Recognises the achievements and efforts of others to develop their career; acts as a coach/mentor • Clarifies goals and objectives at an organisational and service level • Takes calculated risks in the interest of the organisation which will involve tough decisions • Creates a climate where individuals are empowered to make decisions and succeed

Behaviours that would indicate areas for improvement

- Fails to communicate a clear vision for the future/way ahead
- Rushes work without proper thought or consideration of outcomes
- Fails to manage workload or to seek help when required
- Fails to provide developmental or performance feedback
- Fails to identify or acknowledge other's achievements
- Delegates work in a haphazard way without regard for the individual
- Fails to generate any enthusiasm amongst others
- Little evidence of taking into account risks when making decisions
- Approach is based on 'what I can get away with?'
- Fails to actively engage with stakeholders and communities to draw up coherent plans
- Is deemed to have a 'poor' reputation for key leadership qualities by stakeholders and colleagues
- Acts in a way that could bring your colleagues or the Trust into disrepute

EFFECTIVE – ENSURING THE BEST OUTCOMES			
Maintains a strong commitment to achieving organisational objectives, setting, developing and delivering on strategies that meet the future needs of the local community. Takes account of a wide range of issues internal and external to the organisation and wider community and effectively identifies and manages resources and prioritises tasks. Keeps up to date with best practice ensuring competence in service delivery.			
All Colleagues	Supervisor / Team Leaders / Managers	Middle Managers / Heads of Service	Deputy directors / directors
• Displays a commitment to achieving organisational objectives • Works with an orientation to the future • Considers information from a wide range of sources • Identifies and organises resources needed to accomplish tasks • Makes sound judgements when prioritising tasks • Makes best use of the talent, skills and resources in your team • Disseminates accurate and up-to-date information in a timely manner	• Displays and maintains a commitment to achieving organisational objectives • Identifies priorities and actions for meeting future needs of the local community • Proactively seeks both internal and external information to the organisation • Identifies and allocates resources to meet team objectives • Prioritises own and other workload in the face of competing demands	• Demonstrates a commitment to the long-term success of the organisation • Translates strategies into reality, in association with stakeholders, to meet the future needs of the local community • Keeps abreast of key factors and issues internally and externally that can impact on the organisation and local communities • Allocates resources effectively with provision for contingencies • Establishes clear priorities for the service • Ensures equality and diversity issues are built into operational and project planning processes	• Develops through role modelling a climate where individuals are committed to the long-term success of the organisation • Formulates and embeds effective strategies in association with stakeholders, to meet the future objectives of the local community • Monitors changes within the wider health and social care economy and determines their impact on the organisation and local communities • Ensures availability of critical organisational resources taking into account resources across the wider community • Considers the impact of current organisational priorities on future possibilities and developments • Ensures equality and diversity issues are included in business planning processes

Behaviours that would indicate areas for improvement

- Disinterested in how own work impacts on the rest of the organisation
- Not engaging in discussions about change
- Strategies are short-term and do not fully address the needs of future objectives
- Fails to show consideration of urgency or importance of tasks; fails to prioritise effectively
- Considers information from limited sources; no consideration of wider picture
- Allows poor performance to remain unchallenged and unmanaged
- Cannot clearly articulate the results required from a commissioned piece of work

EFFECTIVE - REALISING YOUR FULL POTENTIAL			
Drives, innovative and transformational change initiatives that benefit the local community. Goes that extra mile to increase service user satisfaction. Works positively in ambiguous situations. Clearly communicates the need for change and engages others in the process and implementation of change.			
All Colleagues	Supervisor / Team Leaders / Managers	Middle Managers / Heads of Service	Deputy Directors / Directors
• Recognises opportunities for change • Works positively in uncertain situations • Approaches situations from alternative and diverse viewpoints • Enthusiastically supports change initiatives • Speaks positively about change and the benefits it can bring • Has the courage to take all relevant opportunities for life-long learning • Encourages free, creative thinking to problem-solve • Sets personal targets to improve service user care	• Improves work performance and systems by introducing new ideas • Adapts and responds positively to change • Communicates clear expectations of self and others in change process • Consults with colleagues to review and improve current processes • Communicates changes to services/working practices in a positive and engaging manner	• Constantly seeks new and more effective ways of doing things • Adapts rapidly to changing circumstances and conflicting information • Manages ambiguity positively during change and supports colleagues to do the same • Creates the conditions which enable individuals to embrace change • Understands the personal dynamics of change and allows colleagues reasonable time to adjust • Evaluates the wider implications of change and the impact it may have on people and processes • Role models positivity during times of change providing adequate emotional, as well as structural support for colleagues	• Devises effective change initiatives that benefit the organisation and local community • Cuts through ambiguity and complexity to achieve organisational goals • Acts as an agent for change and explains the benefits and the rationale behind key decisions • Inspires people to contribute to and lead change initiatives • Role models positivity during times of change • Ensures that all changes incorporate appropriate equality and diversity standards
Behaviours that would indicate areas for improvement • Fails to adapt to changes and continues to behave as if nothing has happened or undermines the change process • Is resistant to, or negative about changes • Is dismissive of the needs or experiences of service users			

- Becomes hesitant and ineffective when faced with uncertainty
- Considers how change will affect them but fails to recognise the impact it may have on people, systems and processes
- Is fixed in views, unwilling to adjust ideas in light of new information

How are we going to use the Core Values Framework?

We will embed the framework into all our key human resources (HR) practices including:

The Appraisal Process
The Core Values Framework will replace the existing Knowledge and Skills Framework. The appraisal process and guidance will be revised to include the Core Values Framework and the ongoing training programmes for managers (appraisers) and staff (appraisees) will be updated to include these changes.

Recruitment and Selection
It is vital that we recruit new staff to the organisation who are not only the best candidates for the job but who are able to demonstrate that they can work within our core values and behaviours.

Any new vacancies that are advertised will need to have an improved and revised person specification drawn up by the recruiting manager which incorporates, the core behaviours needed for the job role. Criteria from the Core Values framework will be incorporated into selection testing tools and techniques and managers will be able to obtain advice from the HR team on how these changes will be embedded. The content of future recruitment and selection training programmes will be reviewed and revised in due course.

Induction Training
The content of the corporate 'welcome' part of a new employee's induction has already been revised to include information on the Core Values Framework.

Later developments will see us looking at the policy and practice implications that the framework poses for such matters as **discipline, grievance and performance capability** issues.

Further information and advice can be obtained from the HR and workforce development team within the organisation.

GLOUCESTERSHIRE CARE SERVICES NHS TRUST
HUMAN RESOURCES / ORGANISATIONAL DEVELOPMENT COMMITTEE

Minutes of Meeting held on 18 August 2014

Present:	Chris Creswick – Chair (CC)	Non-Executive Director
	Tina Ricketts (TR)	Director of HR
	Duncan Jordan (DJ)	Chief Operating Officer, GCS
	Nicola Strother-Smith (NSS)	Non-Executive Director
In attendance:	Candace Plouffe (CP)	Director of Service Delivery
	Sarah Curtis (SC)	HR Business Partner
	Lindsay Ashworth (LA)	HR Business Partner
	Rod Brown (RB)	FT Programme Manager
	Liz Fenton (LF)	Director of Nursing and Quality
	Stuart Bird (SB)	Deputy Director of Finance
Secretariat:	Christine Thomas	

<table>
<tr><th>Ref</th><th>Item</th><th>Action</th></tr>
<tr><td>HR/OD 37</td><td><u>Agenda Item 1 - Apologies</u>

Apologies were received from Jason Brown, Faye Beddow, Sue Field and Mel Rogers. Liz Fenton attended the meeting in place of Mel Rogers and Rod Brown in place of Jason Brown.</td><td></td></tr>
<tr><td>HR/OD 38</td><td><u>Agenda item 2 – Minutes of the meeting held on 19 June 2014</u>

Subject to minor amendments the minutes of the 19 June 2014 were approved.</td><td></td></tr>
<tr><td>HR/OD 39</td><td><u>Agenda item 3 – Matters arising and Action Log</u>

The Committee REVIEWED the action log and the following amendments were noted:

<table>
<tr><th>Minute Reference</th><th>Action</th><th>Lead Exec</th><th>Status</th></tr>
<tr><td>HR/OD 2</td><td>The Chair asked for this item to be reopened as he did not feel it had been fully closed - The Workforce/Risk Register is discussed in at least three other committees. LF and JB to investigate the possibility of producing a single document for all sub committees.</td><td>Liz Fenton/Jason Brown</td><td>Open</td></tr>
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	HR/OD 22	Workforce plan needs to be aligned to the financial plan. This to be worked into the workforce plan and come back to the Committee in August.	Tina Ricketts	Closed	
	HR/OD 25	Criteria needs to be set around the effectiveness of staff engagement activities across the Trust. Draft criteria to be sent external to the Committee by the 18th July. This to come back to the Committee in August to review.	Tina Ricketts/Lindsay Ashworth/Laura Grainger	Closed	
	HR/OD 26.1	Board to be made aware that to comply with TDA standards all staff, regardless of circumstances, would need to be included in future appraisal completion rates.	Tina Ricketts/Jason Brown	Closed	
	HR/OD 26.3	Summary of actions to be taken to Board to give assurance that the Committee was aware of the workforce hotspots and was continuing to monitor these.	Tina Ricketts/Sarah Curtis	Closed	
	HR/OD 28	The workforce strategy needed to be amended into the approved format.	Tina Ricketts/Rod Brown	Closed	
	HR/OD 32	HR Policy Approval Process – the flowchart to be updated to show that not all policies go through JNCF.	Sarah Curtis	Closed	
	HR/OD 33	Update on Friends and Family test to be bought to the Committee in August.	Tina Ricketts	Closed	

HR/OD 40

<u>Agenda item 4 – Forward Agenda Plan</u>

The Chair (CC) raised concern that there may be too many items on the forward agenda map which may hinder the Committee in monitoring key HR & OD actions in line with the strategy implementation plans. He recommended that the Committee should look at only a few key items each month which could be discussed in detail.

It was agreed to defer the "Investors in People – next steps" agenda item to the December meeting.

The Committee NOTED the plan

HR/OD 41

<u>Agenda item 5 – OD Strategy Implementation Plan Update Report</u>

The Director of HR (TR) presented the OD Strategy Implementation Plan Update Report. There were four areas of change to note:

	• Undertake a staff skills audit and develop a training plan – this has been changed from a Green to Amber as it was not progressing as quickly as had been hoped. CC asked if a mandatory training matrix could be put together in a colour coded diagrammatic form to cover all staff in relation to both training needs and completion and be brought to the next Committee meeting. This would show any gaps identified. It would also be useful to see this tabulation split by function, occupation and level, providing a framework for audit. • Funding stream/resource needs to be identified for band 6 leadership training – there is no identified budget for this as yet and has moved from Green to Red. CP advised that the CCG had agreed to pay some backfill costs and this would include leadership training for community nursing so some of these costs could be covered. A proposal would need to be completed. The Leadership development of band 6 staff was felt to be very important. It was suggested that this was raised in the next report to Board. • Organisational change policy and process reviewed – this work had not yet been started due to workload capacity within HR. Currently amber • Equality impact assessment template reviewed – this had changed from Red to Amber, reflecting progress. LF felt that the evidence in item 13 would not be sufficient for NHS England and areas such as Board Development and Matron walk rounds should also be mentioned. RB advised that these did not need to be mentioned within the OD Strategy but should be mentioned in the Quality Strategy Implementation Plan, though it was noted that the OD plan did not refer to any other strategies **Subject to the above comments, the Committee NOTED the update.**	**TR**
HR/OD 42	**<u>Item agenda 6 – Core Values Framework</u>** The Foundation Trust Programme Manager (RB) presented the Committee with core value coaching cards that had been printed as an aid to rolling out the values and associated behaviours across the organisation. These cards were samples and TR explained that they had worked with a number of colleagues within the organisation to develop the behavioural framework. It was suggested that a booklet be developed that shows behaviours linked to competency. The Committee felt this was potentially a very useful tool. CP raised a concern as to how the organisation would monitor examples of poor behaviour. TR advised that the coaching cards would be tested in a couple of areas first from which a script would	

	be produced on how to deal with problem/inappropriate behaviours. It was felt that the role of the manager was important to this and there was a concern that this initiative would not be successful unless managers owned the implementation of the framework. TR suggested that the competency framework was issued first followed by the coaching cards. CC summed up that the Committee felt that the cards were a good idea and that following the discussions this work should be taken forward and an implementation plan bought back to this Committee. TR agreed to bring an update back to the Committee. **The Committee NOTED the report and requested a follow up report come back to the Committee.**	**TR**
HR/OD 43	**<u>Agenda item 7 – Listening into Action (LiA) Organisational Diagram – "Permission to Act"</u>** The Director of Human Resources (TR) presented the LiA-based Organisational Diagram. It was felt that the programme's aim of empowering staff was not yet filtering through to all levels within the organisation. The aim of the document was to put front line staff at the top of the organisational triangle diagram which had been reviewed by the LiA sponsor group. It was suggested that the "Service User" cog was moved to the top and then the frontline and support staff cogs would feed into this. It was important to show that Service Users inform all our work. **Subject to the above comments and amendments, the Committee NOTED the diagram and was happy for it to be sent out to colleagues across the organisation**	
HR/OD 44	**<u>Agenda item 8 – Review of Staff Engagement Activities</u>** LA, Human Resources Business Partner, presented the review of staff engagement activities. This had come to Committee previously and it had been requested that success criteria should be identified. This had been done and circulated outside the Committee. The review of the criteria against current staff engagement activities had highlighted quite a few green areas, but this was felt to not be truly reflective of the views of colleagues across the organisation. DJ suggested "N/A" should be recorded as blue rather than as red, which was felt to be a suitable approach. The Committee agreed that they were happy to use the criteria going forward as the basis for monitoring progress. CP asked if the goal of the programme of engagement activities was	

	to simplify staff engagement. LA advised that it was to streamline the current activity, but ensure a range of activities were in place to meet colleagues' needs. RB asked that the new Head of Communications be involved in this group and that relevant information is also sent to Joanna Scott (JS) for the next Comms and Engagement Steering Group meeting. **The Committee NOTED the report and agreed that it would go to the next Comms and Engagement Steering Group meeting.**	
HR/OD 45	**<u>Agenda item 9 – Workforce Strategy</u>** The Director of Human Resources (TR) presented the Workforce Strategy and advised that the JNCF had seen the presentation previously given to the Committee and were happy with the quality goals identified in the strategy. The Committee discussed the paper further and some amendments were noted: • The table on page 13 did not show the % next to the figures just at the top and this was not particularly clear. RB to amend. • DJ mentioned that he had a concern that the table reflected the workforce as it currently stood but did not pick up future workforce requirements. This was acknowledged and it was agreed that an annual refresh of the strategy was needed and that this would be flagged up to the Board in the covering page. RB advised the Committee that all strategies needed an annual review. The recently published NICE guidance did not apply to Community Hospitals. • There was no target figure put on reducing agency, it was agreed this would be added to the strategy Subject to these minor amendments this document to go to Board in September. **The Committee NOTED the report and subject to these amendments to go to the Board in September.**	**RB** **TR/RB** **RB**
HR/OD 46	**<u>Agenda item 10 – Workforce Plan Update</u>** The Director of Human Resources (TR) presented the Workforce Plan Update to the Committee. This is a top level workforce plan, as required by the TDA. Currently The Trust is 8.23 whole time equivalents over the stated workforce plan total due to the current spend on bank and agency. DJ confirmed that bank and agency usage is currently being reviewed.	

	The second part of the plan highlighted the need to review e-rostering. TR confirmed that PWC were currently doing an audit on early alert systems. CC recognised the TDA requirements but raised some concerns as he felt the aggregated totals and financial data did not make clear what the workforce position is and what it means in sufficient detail to identify problem areas. There is thus concern as to whether the Committee could provide the Board with assurance if required. TR confirmed that an updated workforce plan would be submitted to the Committee once the cost improvement plans had been updated. TR agreed to bring a report to the Committee on the review of e-rostering and bank. This was agreed by the Committee. **The Committee NOTED the report and the amends that were required to take it forward and provide the Board with assurance.**	**TR**
HR/OD 47	**Agenda item 11 – Training Plan** The Director of Human Resources (TR) presented the Training plan and advised the Committee that this was still currently Work in Progress. The aim of the plan was to show the Committee the priorities for training which were presented under 6 key priority areas. The Committee discussed the paper and noted the following: • Item number 1- target was now 100%. • LF commented on the paragraph on page 5 which stated that due to the Resuscitation Officer being on maternity leave that reduced training had been delivered. LF assured the Committee that maternity cover had been provided to ensure training remained available. • A distorting factor was that a lot of the staff were part-time and that affects training hours significantly. • The Chair felt that the current plan did not show clearly what needed to be achieved and that a clearer and simpler form of planning and monitoring would be helpful. **The Committee NOTED the paper and acknowledged that this was Work in Progress.**	
HR/OD 48	**Agenda item 12 – TDA Accountability Framework – areas for HR&OD Committee oversight**	

	LA, HR Business Partner, presented the TDA Accountability Framework. The question of how this is reviewed in the future was discussed and it was clear that there were some overlaps as to which Committee would be responsible for which areas, as many of these could be covered by more than one Committee. RB confirmed that he was developing a framework for the Trust so that each Committee was clear on its area of responsibility **The Committee NOTED the report.**	
HR/OD 49	**<u>Agenda item 13 – HR Policy Review Progress Report</u>** SC, HR Business Partner, presented the HR Policy Review Progress Report. The Committee were asked to note progress made to date and to ratify three policies. The policies were discussed and amends noted below: Notice Period Policy and Procedure: • The formal notice period does not apply for internal appointments • Rewording of section 5.4 • Section 10 was missing a word **Subject to the changes above the policy was APPROVED**. Flexible Retirement Policy and Procedure • Section 7.2 – 2008 section, wording is a bit vague around higher earnings • More detail in 6.1 re stepping down from job and protecting pension **Subject to the changes above the policy was APPROVED** Joint Negotiating and Consultative policy and procedure: • Under 6.4.2 it is not clear which Chair this refers to **Subject to the changes above the policy was APPROVED** **The Committee APPROVED the policies subject to the minor changes above.**	**SC**
HR/OD 50	**<u>Agenda item 14 – Workforce Risk Register</u>** The Director of Human Resources (TR) presented the Workforce Risk Register and made the Committee aware that this was still Work in Progress. The register captured current workforce hotspots	

	as identified from Committee papers. RB advised that any items highlighted as 12 or above would be incorporated into the Corporate Risk Register. **The Committee NOTED the Risk Register**	
	LF left the room	
HR/OD 51	**<u>Agenda item 15 – Workforce Scorecard</u>** The Director of Human Resources (TR) presented the Workforce Scorecard and advised the Committee that a more developed scorecard would be presented at the next Committee CC recognised the progress being made and suggested that this very detailed document would benefit from some consideration as to how to present the information in a more accessible form. **The Committee NOTED the Workforce Scorecard**	**TR**
HR/OD 52	**<u>Agenda item 16 – Friends and Family Test for Staff – Quarter 1 results</u>** SC, HR Business Partner, advised the Committee that the Staff Friends and Family Test results were currently on track for achieving CQUIN. It was felt it was too early to publish these results and that it would be better to do so when quarter 2 results were out. **The Committee NOTED the Friends and Family Test for Staff – Quarter 1 results**	
HR/OD 53	**<u>Agenda item 17 – Nurse Recruitment Update</u>** SC, HR Business Partner, presented a snapshot of the Nurse Recruitment Update. TR advised that there was a slight update on the table for Community Nursing figures: Band 6 – 10.38 vacancies with 1 in process Bank 5 – 27.72 vacancies with 19.8 in process The biggest delay to recruiting people into place was due to DBA checks. **The Committee NOTED the Nurse Recruitment Update**	
HR/OD 54	**<u>Agenda item 18 - Any Other Business</u>**	

	There were no other items for business	
HR/OD 55	**<u>Agenda item 19 - Matters for Board or Other Committees</u>** As captured on minutes and to be presented to Board	
HR/OD 36	**<u>Agenda item 20 – Date of Next Meeting</u>** The next meeting was confirmed as 22 October 2014, 11.30 – 13.30 in the Leckhampton Rood at Edward Jenner Court	

There being no further business the meeting closed at 17:40 p.m.

Chair's signature: ……

Date: ……

Gloucestershire Care Services NHS
NHS Trust

Charitable Funds Update

Ref: 14/B040

This report is for Publication

Gloucestershire Care Services NHS Trust Board

Charitable Funds Update
25 November 2014

Objective:

To understand the vision and objectives of the Trust's charity.

The Board is asked to:

To note the vision, objectives and implementation plan.

Executive summary:

The attached update paper provides an overview of the Trust charity's vision and objectives, as well as the actions to be realised over the next two years.

Jason Brown
Director of Corporate Governance and Public Affairs
25th November 2014

Please complete the Equality Checklist

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.

Charitable Funds Briefing

1.0 Overview

In August 2014, Gloucestershire Care Services NHS Trust's Charitable Funds Committee directed that Executive responsibility for managing the Trust's charity should be passed to the Director of Corporate Governance and Public Affairs.

Additionally, it was requested that a sound business plan be developed, to be supported by a clear vision and set of aims, and subsequently by a Charitable Funds Strategy.

This paper provides an overview of the work required in order to raise the profile of the Trust and to realise its objectives.

2.0 Charitable Funds Programme

2.1 Vision

"Helping local people at their time of need, crisis or illness"

2.2 Aims

- We will significantly raise the profile of the charity by committing to marketing, fundraising, merchandising, and making the outcomes of public donations increasingly visible.

- We will introduce a portfolio of fund options, so that donors can choose where their money will be allocated.

- We will facilitate the expansion and development of the charity through strong leadership, and the effective recruitment of administrative support.

- We will engage more closely with donors and their families, and broaden the ways in which they can actively support the charity.

- We will develop effective partnership working, in order to improve our relationships with key external partners and agencies.

- We will enable our volunteers to play an extended and more defined role in fundraising activities.

- We will ensure that our website is a recognised source of local fundraising and donor information.

- We will publish an events calendar highlighting all major fundraising campaigns, which will be supported where appropriate with an investment and marketing plan.

2.3 SWOT Analysis

Given the aims of the charity and notwithstanding the limited market analysis available, it is possible to identify a range of strengths, weaknesses, opportunities and threats relevant to managing an NHS charity. These are summaries below:

Strengths	**Weaknesses**
Trust commitment to charitable enterprises Charitable intentions align strongly with the Trust vision, values and strategic objectives, given that all are focused on supporting local people Good working relationship with League Of Friends Existing governance structure and reporting process in line with national requirements Clear Executive leadership with significant input and support from experienced Non-Executive Directors	Lack of day-to-day management of the charity by dedicated personnel Inadequate alignment of fundraising initiatives with business planning process Limited corporate vision for contribution of fundraising to strategic objectives Lack of fundraising expertise and market awareness in the Trust Limited unrestricted funds available to the Trust Limited coordination of use of multiple funds Lack of brand identity and local awareness of the charity Limited strategic vision and direction for the charity Dormant funds Lack of charity risk register to ensure major risks in respect of effectiveness, accountability, value for money etc. are identified – ensure links with the Trust's Corporate Risk Register Lack of Trust-wide arts programme Limited fundraising activities and plans to support the Trust's services

	Lack of partnerships with NHS and other charities Lack of charity membership in line with Charity Commission Guidelines Register of Trustees not established and made publicly available
Opportunities	**Threats**
Scope to increase major giving, corporate and charitable trust income Freedoms to innovate Potential reputation benefits through aligning fundraising and Trust marketing activities Potential to work in collaboration with LOF and commercial companies in Gloucestershire to raise funds Work with local parishes and the legal community to provide fund information and guidance to support future legacies and beneficiaries Provide appropriate guidance and training for staff about donor stewardship and charitable activities Register the Charity with the Fundraising Standards Board Produce bid applications for funds from grant making charities to support planned and future Trust initiatives Market the benefits of volunteering in collaboration with the HR Department Register the Charity with the National Council for Voluntary Organisations and Charities Aid Foundation Register the Charity with “Funding Central” the Government sponsored service for national, local or regional funding grants Register with the Lotteries Council	Crowded charitable fundraising marketplace Decline in charitable giving in line with national and regional economy Reduction in investment returns for linked charities and restrictions on spend Competition from local NHS providers charities Competition from academic institutions charities Potential competing charitable initiatives

2.4 Initial Implementation Plan

Please refer to appendix 1 where an overview of the initial implementation plan is outlined for consideration.

3.0 Charity Branding

The Trustees have agreed that the Charity will be referred to as *Giving to Gloucestershire* - appendix 2 shows the charity logos to support the funds.

4.0 Charity Funds

The Trust's charity *Giving to Gloucestershire* has developed six charitable funds. Donors and fundraisers can support one or any combination of these funds, or simply opt for the Charitable Funds Committee to allocate money wherever it will do the most good for local communities. Below is the official description of each fund.

Fund 1: Helping Hand Fund

Sometimes, a welcome delivery of comforting food or much needed clothing can make all the difference to vulnerable or elderly patients.

The Helping Hand Fund delivers bespoke food parcels to people following a spell in hospital or illness. Designed by clinical staff, these hampers are nutritionally balanced, healthy, and give vital help to people while they recover at home and can't get out and about for themselves.

Alternatively, our clothing parcels, which may include a cosy dressing gown and slippers, are primarily for frail, elderly patients who are about to go into hospital and don't have everything they need to make their stay as comfortable as possible.

Fund 2: Forever Active Fund

We know that elderly people who live at home can become socially isolated, but that sharing experiences and staying active can truly enhance their quality of life.

The Forever Active Fund is all about building a range of activities in local communities, so that people who may otherwise be lonely, can engage with others in a similar situation.

We aim to establish a network of painting, dancing and music classes across the county which will offer a welcoming environment, a creative outlet and an absorbing new hobby. It's also important that older people retain their independence and mobility, so we'll additionally be organising age-appropriate fitness classes, such as Tai Chi and Pilates.

Fund 3: Teddy Bear Fund

Fun toys, an exciting day trip or a specially arranged surprise can make a huge difference to children with serious illness, as well as to their families.

The Teddy Bear Fund is about turning these unexpected treats into a reality. We can provide toys and games for kids of all ages, and will help organise fantastic outings for children, such as a visit to the seaside, giving them a day to remember.

We can also arrange unique experiences inspired by a child's particular interests or wishes, which could involve a day at a favourite theme park or zoo.

Fund 4: Remembrance Garden Fund

Providing a quiet haven for patients, families and carers, means that we can offer a place of commemoration and reflection when people need it most.

The Remembrance Garden Fund is dedicated to developing outdoor spaces in a range of locations across the county, and decorating it with flora, fauna and furniture in order to create tranquil havens.

The Fund also enables families to purchase commemorative plaques or monuments so that they will have an enduring tribute to their loved ones, and a special place in which to share their special memories.

Fund 5: Jenner Fund

New technology and ground-breaking research are key elements in the delivery of exceptional healthcare. We are committed to ensuring that local clinical teams benefit from the finest of both.

The Jenner Fund aims to provide hard-working local professionals with medical equipment that would not normally be available to Gloucestershire Care Services NHS Trust. It's also about empowering clinicians to embrace the best in innovative ways of working in the community, so that local people are able to benefit.

Fund 6: Nightingale Fund

There's no such thing as too much education or knowledge, and that's why we want to provide professional support that goes above and beyond regular NHS training.

The Nightingale Fund aims to increase personal development opportunities for clinical colleagues, so as to enhance their skills and deliver the best possible quality care.

By providing this additional support, we can help an exceptional workforce make an even greater difference across Gloucestershire.

Appendix 1: Charity Implementation Plan

Reference	Action	Responsibility	Cost (where known)
1	Develop a Charitable Funds Strategy	Jason Brown	
2	Review the Committee Terms of Reference and Role of the Trustees	Jason Brown	
3	Produce Trustee Profiles	Mark Lambert / Claire Edwards	
4	Develop a Risk Register	Jason Brown	
5	Produce Charity Leadership Team Model to include (1) Charitable Funds Manager (2) Fundraising Manager (3) Administrator	Jason Brown	
6	Join the Fundraising Standards Board	Zoe Barnes	
7	Produce a Partnership Charter in collaboration with the League of Friends	Jason Brown	
8	Develop links with the Gloucestershire Business Community via the Gloucestershire Chamber of Commerce	Nicola Strother Smith / Jason Brown	
9	Explore the benefits of a Charity Patron	Nicola Strother Smith / Jason Brown	

10	Clarify and appoint the Solicitor Firm that will advise the Charity where appropriate	Jason Brown	
11	Clarify and appoint Charity Auditor	Jason Brown	
12	Trustees to sign the Fundraising Code of Practice	Zoe Barnes	
13	Trustee Indemnity Insurance	Zoe Barnes	
14	Compliance with the Charity Commission “The Essential Trustee”	Zoe Barnes	
15	Public Benefit Statement	Jason Brown	
16	Trustees’ Responsibilities Statement	Jason Brown	
17	Charity Advisors Register (1) Bank (2) Legal (3) Audit (4) Accounting (5) Tax (6) Investment	Zoe Barnes	
18	Charitable Funds Exclusions Register	Zoe Barnes	
19	Accounts prepared in line with the Statement of Recommended Practice (SORP)	Helen Leyshon	
20	Clarify Fund names and terms of reference	Jason Brown	
21	Produce a Fund Management Policy	Helen Leyshon	
22	Produce an Investment Policy	Helen Leyshon	

23	Fund Spending Plan – for each fund within the charity	Helen Leyshon	
24	Develop Charity Brand and Sub-Brands	Mark Lambert	
25	Produce Marketing Plan	Mark Lambert	
26	Design the website portal and produce an implementation plan to support its development	Mark Lambert	
27	Website technical support contract	Claire Edwards and IT Department	
28	Ensure a readers panel is convened to ensure that the website is fit for purpose and tested for clarity etc.	Mark Lambert	
29	Develop a Merchandise Plan	Zoe Barnes	
30	Produce a Charity Newsletter (ideally to be published on a quarterly basis)	Mark Lambert / Claire Edwards	
31	Create Twitter and Facebook accounts	Zoe Barnes / Claire Edwards	
32	Create a calendar of community based events to promote awareness of the charity	Zoe Barnes	
33	Produce a quarterly press release for the local media	Mark Lambert / Claire Edwards	

34	Produce a Fundraising Policy	Jason Brown	
35	Take out insurance cover for fundraising activities undertaken by the Charity	Helen Leyshon	
36	Develop a Fundraising Pack for the Public and also produce a Corporate Fundraising Pack	Zoe Barnes / Claire Edwards	
37	Produce a Fundraising Register to ensure all fundraising activity is captured accurately and monitored accordingly	Zoe Barnes	
38	Sponsorship Form to be produced	Zoe Barnes / Claire Edwards	
39	Events Calendar to be created and published on-line		
40	Explore the options of payroll giving with the Trust		
41	Produce a list of Grant-Making Charities in Gloucestershire (research via the Charity Commission website)	Zoe Barnes	
42	Donation Policy to be produced	Helen Leyshon	
43	Develop a Donation Form and Leaflet	Zoe Barnes / Claire Edwards	
44	Legacy Policy to be produced	Helen Leyshon	

45	Produce a Legacy Information Leaflet	Zoe Barnes / Claire Edwards	
46	Produce a Donation Register	Zoe Barnes	
47	Produce a Legacy Register	Zoe Barnes	
48	Standard Donation Receipt	Helen Leyshon	

Appendix 2: Logo sheet

GLOUCESTERSHIRE CARE SERVICES
NHS TRUST CHARITABLE FUNDS COMMITTEE

Minutes of the Meeting held on Wednesday 19 August 2014 from 11:00 to 12:30 in the Boardroom, Edward Jenner Court

Present:

Nicola Strother Smith (NSS)	Non-Executive Director (Chair)
Sue Mead (SM)	Non-Executive Director
Glyn Howells (GH)	Director of Finance
Jason Brown (JBr)	Director of Corporate Governance & Public Affairs

In Attendance:

Johanna Bogle (JB)	Financial Accountant
Helen Leyshon (HL)	Deputy Financial Accountant
Kim Stacey (KS)	Accounts Payable Officer
Jill Rowell (JR)	Minute taker

Item	Minute	Action
CFC 49/14	**Agenda Item 1: Welcome and Apologies** Apologies were received from Liz Fenton and Tina Ricketts.	
CFC 50/14	**Agenda Item 2: Declarations of Interest** There were no changes to the declarations of interest recorded.	
CFC 51/14	**Agenda Item 3: Minutes of the Previous Meeting** The Committee was advised that due to a technical malfunction the recording of the meeting on 21 May was impaired and the interim minute taker had struggled to produce a complete and comprehensive set of minutes. In light of this, a couple of amendments were recommended by the Committee and it was agreed JB review and reword Item 46/14 (Guidance on Charitable Funds Spend) around classification of a charity. **Resolution: The Committee APPROVED the minutes of 21 May 2014, subject to amendments.**	

CFC 52/14	**<u>Agenda Item 4: Matters Arising (Action Log)</u>** The Committee **REVIEWED** the action log and the following amendments were noted: CFC 18/13 – JBr will produce and circulate to the Committee wording for minuting on the statutory basis for GCS charging for administrating Charitable Funds. CFC 43/13 – JBr to produce an 'out of committee' brief on legacy gifts for circulation to members, prior to November's meeting. CFC 46/13 – Developing a Guidance on Charitable Funds spend is in hand and a presentation on the subject was recently given to the GCS leadership team by JB. Closed. **Resolution: The Committee NOTED the updates to the action log and the actions closed.**	**JBr** **JBr**
CFC 53/14	**Agenda Item 5: Donations Received** HL drew the Committee's attention to the Charitable Funds 2014/15 Quarter 2 update report (supporting agenda items 6 – 10) and gave an overview on the recommendations contained therein, requiring comment or action by the Committee. The Trust's facilitation of charitable funds and the administrative cost it incurred was discussed and the Committee was advised approximately 95% of it could be attributed to League of Friends' (LoF) activity. The list of individual funds in Table 1 of the report was reviewed and consideration given to merging those denoted in red to simplify the process and consolidate funds not being used. In regard to donations and grants received by the Trust, JBr recommended developing generic terms of reference and background material on key areas of the organisation, such as training, maintenance of grounds, innovation and technology, to inform and guide prospective donors on the choices available to them. Engagement with colleagues, Gloucestershire's service users and LoFs are key to the success of this venture and GH suggested funding could be found to appoint an individual to undertake this work. **The Committee NOTED the donations received and RECOMMENDED contacting and appraising the Charity Commissioner of the Trust's position with regard to inherited charitable funds and the direction of travel proposed for GCS at this meeting.**	**GH**

CFC 54/14	**Agenda Item 6: Update Brokenborough Plans** GH advised the issue with regard to the ownership of Brokenborough had moved on by PropCo appointing and handing responsibility to a new member of staff. A decision on whether PropCo wish to contest the case will be advised by their lawyer in three weeks' time. **The Committee NOTED the update.**	
CFC 55/14	**Agenda Item 7: Forward Plan** A revised forward agenda plan was tabled by JBr and reviewed by the Committee. The 2013/14 Annual Accounts, historically produced by Grant Thornton, are due and JB will write to the Audit Commission to request GCS be permitted to use a local company. **Resolution: The Committee APPROVED the Forward Plan subject to the following agenda updates for November's meeting:** • **include paper on Charitable Funds structure** • **include the Annual Statement, as this will require the Committee's attention before February 2015** • **produce and circulate before the meeting an 'out of committee' paper on the benefits of administrative resource, as discussed at item 5** **To accommodate the agenda items, the Committee RECOMMENDED November's meeting be extended by an hour.**	**JB** **JBr** **JR**
CFC 56/14	**Agenda Item 8: Legacy Gifts Update** Update on Legacy Gifts covered in the overview provided by HL at item 5.	
CFC 57/14	**Agenda Item 9: Current Funds Report** HL advised the charitable funds process was inherited from Shared Services, who had not provided the Trust with enough information on District General overdrawn funds' creditors and debtors to pursue money owed. The process for pursuing payment from the LoFs for goods bought on their behalf was not robust and in some cases, had not been billed at all by Shared Services. HL also noted the Trust has been unable to claim back VAT debtors.	

	GH considered it would be useful for the Committee to have sight of any proposed write-offs and HL agreed to prepare and circulate a list after the meeting for the Committee's attention. HL requested the Committee consider and approve the amalgamation of hospital department funds into one general fund, especially where not used in the last three years. **Resolution: The Committee discussed HL's proposal and RECOMMENDED JBr, JB and HL work together to:** • **Establish principles and agree criteria for merging funds** • **Consult with LoFs and interested parties to test reaction to proposal**	**HL** **JBr/JB/ HL**
CFC 58/14	**Agenda Item 10: Bids Approved Since Last Meeting** HL drew the Committee's attention to Table 4 of the Report and reported only two bids have been received in 2014-15, despite JB's presentation to senior managers on how charitable funds can be bid for and used by services. Data has been inputted to the Harlequin system and HL is arranging to meet with all GCS' Matrons to brief them on what can be achieved through bidding for charitable funds. The Chair expressed interest in taking part and supporting HL at these visits. **Resolution: The Committee NOTED the report.**	**HL/NSS**
CFC 59/14	**Agenda Item 11: Bids for Committee Approval** The Committee was asked to approve a bid for £625 for funding JB and HL's attendance at a Charitable Funds Conference. **Resolution: The Committee approved the bid**	
CFC 60/14	**Agenda Item 12: Q1 Activity Report** JB reported data for Quarter 1 has now been inputted to Harlequin and the Activity Report will be presented to November's meeting.	
CFC 60/14	**Agenda Item 13: 2013/14 Accounts and Annual Returns** The Annual Report will be presented to the next meeting and JB alerted the Committee that guidance on which company the Trust should use may take a while coming from the Audit Commission as they approach closure.	

	Resolution: With regard to the imminent decommission of the Audit Commission, the Committee RECOMMENDED JB inform them the Trust will use Grant Thornton to produce the Annual Report for 2013/14 and await response.	**JB**
CFC 61/14	**Agenda Item 14: Charitable Funds Branding and Marketing** JBr tabled papers showing examples of GCS branding logos for marketing Charitable Funds and images of a 'mocked up' web site. He proposed the portal would store information on, for example, trustees, appeals, brands, fund raising and corporate packs, legacy forms and minutes of Charitable Funds' meetings. The Chair will have a Twitter account to tweet messages and case studies about the fund and merchandising products produced, such as caps, tea towels, Christmas cards, etc. The Committee discussed the proposed branding and marketing of Charitable Funds and agreed that it was important to communicate and work with the LoFs from the outset. **Resolution: The Committee APPROVED Option 1 branding logo and RECOMMENDED:** • **NSS and the Trust Chair use quarterly meetings with LoFs to brief on the plans for Charitable Funds** • **Engagement with community and staff on the marketing proposal, to run concurrently with** • **Preparation of a business case by JBr, to include administrative support, possibly Band 5, for two days per week on an interim basis**	**NSS/IB** **JBr** **JBr**
CFC 62/14	**Agenda Item 15: Any Other Business** • Appreciation was extended to HL and KS, in particular, for the improvements to the Charitable Funds Report • HL will produce an appendix for the next report giving more detailed information on split of donations received • LoFs are concerned by the service they are receiving from Finance and HL is to undertake a series of meetings to build relationship with them	
CFC 63/14	**Agenda Item 16: Matters for Board and other Committees** There were no items recorded for Board or its Committees	

CFC 64/14	**Agenda Item 17: Date and Time of Next Meeting** **Tuesday 19th November 2014, Boardroom, EJC, 9.30am – 12.00 noon (note extended meeting).**	

Chair's Signature ……...

Date ……..…….

Gloucestershire Care Services NHS
NHS Trust

Finance Report

Ref: 14/B041

Gloucestershire Care Services NHS Trust Board

Finance Report
25 November 2014

Objective:

To advise the committee on the year to date actual and forecast full year out-turn position for the Trust at month 6 and also to provide updates regarding financial risks and priorities.

The Board is asked to:

- Note the current position and implications for the Trust.

Executive summary:

For Health budgets, the Trust has planned for a full year surplus of £1.5m. The current forecast is in line with plan though there is a risk that this may need to reduce when the month 7 position is finalised.

QIPP Schemes have been agreed at £3.9m and CQUINS at £2m.

CIP schemes are now forecast to deliver £2.5m in year and £3.4m recurrently which is significantly less than the £6.4m in the budget.

Work is ongoing to mitigate the shortfall in CIP and to ensure that the revised forecast of £0.5m is delivered. A financial bridge is included in the report summarising the main risk and opportunities within the forecast.

Gloucestershire County Council (GCC) expenditure figures for 2014/5 to the end of month 5 are now available and are included within this report.

Stuart Bird – Deputy Director of Finance
7 November 2014

Pease 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: • There will be impact analyses completed for the changes that come out of the decisions being considered in this paper rather than from the paper itself •

[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.

Board Meeting of Gloucestershire Care Services NHS Trust
To be held on: 25 November 2014
Location: Edward Jenner Court, Brockworth

Agenda item: 18 Finance Report

1. Purpose

To advise the Board of both the year to date and full year forecast out-turn positions for Gloucestershire Care Services NHS Trust at Month 6 and to highlight risks and plans to mitigate them.

2. Recommendations

The Board is asked to note the performance of the trust and to be aware of the risk and opportunities within the current full year forecast.

3. Background

The plans for the current financial year are challenging with £3.9m of QIPP income to be earned, £2.0m of CQUIN income to be earned and £6.4 of CIP savings required to deliver the budgeted surplus of £1.5m for the trust.

CIP schemes of are now forecast to deliver £2.5m in year and £3.4m recurrently which is significantly less than the £6.4m in the budget. There is a financial bridge at section 1 of this report showing how these shortfalls can potentially be mitigated but there remains significant risk of not delivering the planned surplus.

Trust staff are also involved in delivery of savings of more than £6.5m for external Care and £700k on the SLA spend for Gloucestershire County Council (GCC).

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 and will be invoiced before the end of November. This impact on income and cash flow of the delayed contract revisions has been managed closely and there has been no impact on services because of them.

The budget for Social Care Service Level Agreement (SLA) spend is set at £17.7M for 2014/5. As at month 6 the forecast was for an underspend on these budgets of approx. £660k. Latest forecast agreed at ASMT shows a reduced underspend of £60k with the other £600k being used to offset overspends in external care.

External care currently shows a forecast overspend of £2,277k

Capital of £6.4m is available for use in year including rolling forward the £1.5m from 2013/4 relating to finding an alternative site in Gloucester to consolidate our existing services into which will allow us to move from

expensive leasehold properties; and Cheltenham to allow us to relocate services from Cheltenham Royal Hospital where we have been served notice. A new site in Cheltenham has been identified and secured but the search in Gloucester is proving more difficult. As a result the planned spend of £6.4m is being reviewed and may be reduced by up to £2m as part of the month 7 reporting cycle.

4. Discussion of Issues

The main issues that the Trust faces from the financial perspective are:

1. Delivery of the £2.5m of committed CIP savings in year and working to find additional non recurrent savings to offset the gap between this and the planned £6.4m.
2. Delivery of £3.9m of QIPP income through tight monitoring of agreed schemes and overdelivery on selected additional work programmes to offset any shortfalls
3. Delivery of CQUIN schemes of £2.0m.
4. Complete the Contracting for GCC commissioned services
5. Recruiting required staff to reduce agency usage and related cost.
6. Delivery of the External Care recovery plan of >£6.5m
7. Zero base budget our hospital theatres and outpatients in line with contracted income. Begin to bill GHFT based in actual activity (including high cost consumables)
8. Non recurrent savings schemes
    a. Bringing stock onto balance sheet by 31/3/15
    b. Capitalisation of IT purchases (both new and retrospective impact)
9. Maintaining a solid cash position by collecting all contracted income and robust cash flow forecasting
10. Developing a detailed LTFM to support the Integrated Business Plan to underpin the Foundation Trust Application process.
11. Develop the 5 year Financial Management Strategy including:
    a. Cash Management
    b. Capital Spend
    c. Procurement
    d. Commercial Arrangements
    e. Performance Management Framework
    f. Efficiency / Productivity management

5. Key Findings and Actions

Financial Performance

Annual Plan

The Trust submitted a plan to the TDA for 2014/5 that shows income of £111.1m and a surplus of £1.5m (health figures alone).

As at Month 6 it is still believed that these numbers reflect the position that the Trust will achieve with delivery of the CIP as the biggest risk.

The Board has already discussed the risk that the forecast surplus will be reduced to £0.5m in the month 7 reporting cycle. These risks and opportunities are summarised below and a paper detailing this is to be considered in Part 2 of today's meeting.

High Level Bridge

£m

Item	Income	Cost	Surplus	Certainty (High / Medium /Low)
Plan	**111.1**	**109.6**	**1.5**	
CIP Underdelivery on mobile working and productivity		3.0	(3.0)	HIGH
Other CIP Underdelivery		0.9	(0.9)	HIGH
Additional agency premium		1.0	(1.0)	HIGH
Non Recurrent identified Savings		(0.3)	0.3	HIGH
Other potential non-recurrent savings		(1.0)	1.0	MEDIUM
Other potential non recurrent savings		(1.6)	1.6	LOW
QIPP underdelivery	(1.0)		(1.0)	MEDIUM
Funding for Overperformance	1.0		1.0	LOW
Release of Reserves		(2.0)	2.0	HIGH
Latest Forecast	**111.1**	**109.6**	**1.5**	

Budget Monitoring

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

Operational accountants are allocated by service and are responsible for supporting budget holders with the financial management and efficiency of their cost centres. The allocation of operational accountants with the organisation is currently being reviewed to ensure the most effective support and challenge for each function.

Performance in Achieving Cost Improvement Plans (CIP), QIPP and CQUIN

A sub-group of execs Chaired by the Chief Operating Officer now meets monthly to review CIPs, QIPP and CQUINs and progress being made.

Forecasts are being conformed on a project by project basis to get better operational grip and focus in this critical area.

These items are now reported separately through a report from the Chief Operating Officer which this month shows CIP delivering £2.5m in year (£3.4m recurrently) of the required £6.4m, it also lists areas being identified to mitigate this under-delivery. Some risks are highlighted on some CQUIN schemes but these are believed to be able to be mitigated away at present. On QIPP there is real likelihood that the Trust will not receive £1m of the available QIPP and the impact of this is captured in this report.

New Business

The CCG has requested that the Trust expand the level of the services in Integrated Community Teams (ICTs) and in the integrated discharge team (IDT), Single point of Clinical Access (SPCA) and Early Supported Discharge Team (ESD). Detailed plans are being drawn up within the Trust for the enhanced ICT service and once all recruitment trajectories have been finalised a variation to the contract will be drawn up. In year this is likely to be around £2.0m but will be £3.9m recurrently.

For the IDT and SPCA the situation is similar with an additional full year effect expected of approximately £1.3m of additional recurrent funding with circa £800k due in the current year.

As reported to performance and resources committee the GCS response to the tender process for Out of Hours GP services was unsuccessful. The trust is now planning the transition of the service to the successful bidder South West Ambulance Service (SWAST).

Capital Spend

The latest view of likely capital spend is the it will be significantly lower at £5.0m in year compared to a plan of £6.4m as two of the larger items are likely to be delayed, namely replacement of part of the IT infrastructure (Community of interest network – COIN) which is delayed as the procurement is taking longer than expected and the premises in Gloucester which are proving difficult to find. The Trust has made the TDA aware of the delays and will do a detailed review of the coming weeks to reduce the forecast spend in our TDA month 7 financial return. This reduction in capital spend will also protect the Trust's cash position which will start to come under pressure should the additional saving schemes not be cash releasing savings. Spend for the year to date is £1,082k.

GCC SLA

The figures reported are as at month 6.

Latest Forecast for External care budgets (including current year estimates for Recovery Plan) actions is:

- Older People (OP) External Care is overspending by £1.21m

- Physical Disabilities (PD) External Care is overspending by £0.85m

This is partially offset to an extent by;

- The services managed under SLA are underspending by £0.66m

The forecast outturn for all GCC service areas is an overspend of £2.21m.

These budget areas are dealt with in detail in appendix 1

6. Financial implications

The financial implications of the things discussed in this paper are summarised in the bridge on page 3 of this report and will be discussed in more detail in the Part 2 paper.

7. Implementation and Review of Progress

Income and expenditure position

The year to date financial performance and related forecast performance for the remainder of financial year 2014/15 are summarised in the table below.

High level overview of year to date and full year forecast

Statement of Comprehensive Income		Current Year to Date			Forecast Outturn	
Revenue	55,182	55,189	7	111,167	111,167	0
Gross Employee Benefits	(39,342)	(40,420)	(1,078)	(79,279)	(79,279)	0
Other Operating Costs	(15,404)	(14,419)	985	(30,388)	(30,388)	0
Operating Surplus / (Deficit)	436	349	(86)	1,500	1,501	0

The trust is currently showing a surplus of £349k for the first 6 months of the year. This represents a reasonable start to the year and is close to budget of £436k for the year to date.
The full year position is currently forecast at planned level of £1.5m but with the risks indicated above and requires an improvement on month on month position which will be difficult to achieve due to the phasing of CIP delivery.

The main variance to plan within the current forecast is that expected staff cost savings are being offset by non-pay reserve release.

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

None

9. Consultation and Communication including Public Involvement

None

10. Links to:

Objectives 5 and 6.

Prepared by: **Stuart Bird**
Presented by: **Glyn Howells**

Appendices

Appendix 1 Services managed by GCS on behalf of GCC

ATTACHMENT 1

GCC Services Managed through GCS
2014/15 full year forecast as at 30 September 2014

Service	Net Budget	Net Forecast Outturn	Post SAP Adjustments	Net Forecast Variance	Previous Month Forecast Variance
	£000	£000	£000	£000	£000
SLA- Not Devolved to Localities	420	460	-80	-40	713
Countywide Services	2,941	2,769	0	-172	-215
Gloucester Locality	3,234	3,220	0	-14	-136
Stroud Locality	2,493	2,335	0	-157	-271
Cheltenham Locality	2,503	2,320	0	-183	-322
Cotswold Locality	1,921	1,823	0	-98	-253
Forest Locality	2,059	2,240	0	181	91
Tewkesbury Locality	2,104	1,928	0	-176	-243
Agreed Adjustment			600	600	600
Total - SLA	**17,674**	**17,094**	**520**	**-60**	**-36**
External Care					
OP External Care					
Gloucester Locality (OP)	8,158	9,188	0	1,030	1,039
Stroud Locality (OP)	8,218	8,850	0	633	736
Cheltenham Locality (OP)	6,813	7,692	0	878	975
Cotswolds Locality (OP)	6,009	6,413	0	404	69
Forest Locality (OP)	6,177	6,226	0	49	90
Tewkesbury Locality (OP)	5,042	5,148	0	106	-47
Agreed Adjustment			-1,212	-1,212	-976
Total External Care OP	**40,416**	**43,517**	**-1,212**	**1,889**	**1,887**
PD External Care					
Gloucester Locality (PD)	2,769	3,527	0	758	800
Stroud Locality (PD)	2,195	2,181	0	-14	-23
Cheltenham Locality (PD)	2,839	3,116	0	277	246
Cotswolds Locality (PD)	1,657	1,139	0	-518	-546
Forest Locality (PD)	1,659	1,861	0	202	196
Tewkesbury Locality (PD)	1,277	1,046	0	-231	-284
Agreed Adjustment			-85	-85	0
Total External Care PD	**12,396**	**12,870**	**-85**	**389**	**389**
Total External Care	**52,812**	**56,386**	**-1,297**	**2,277**	**2,276**
Total	70,486	73,481	-777	2,218	2,240

Gloucestershire Care Services NHS
NHS Trust

Ref: 14/B042

This report is for Publication

Gloucestershire Care Service NHS Trust Board

Annual Security Report
25th November 2014

Objective:

To provide assurance that the Trust is complying with the NHS Standard Contract regarding security management.

The Board is asked to:

Note the report and actions being taken to assure compliance with the NHS Standard Contract.

Executive summary:

Under the NHS Standard Contract, Providers are required to submit an Organisational Crime Profile which informs the level of self-assessment required using the Security Review Tool. This self-assessment through RAG rating against 31 criteria enables the Trust to develop a work plan.

Glyn Howells
25th November 2014

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.

LOCAL SECURITY MANAGEMENT REPORT 2013/14

Introduction

This report provides assurance to the Board that Gloucestershire Care Services NHS Trust aspires to reach the highest possible standards of security management in accordance with the NHS Standard Contract.

The NHS Standard Contract

NHS Protect leads on work to identify and tackle crime across the health service. The aim is to protect NHS staff and resources from activities that would otherwise undermine their effectiveness and their ability to meet the needs of patients and professionals. This in turn helps ensure NHS resources are protected and a safer, more secure environment is provided in which to deliver and receive care. In accordance with the security standards and aligned to the provider contract in 2013 the Trust submitted an Organisation Crime Profile to NHS Protect and the Gloucestershire Clinical Commissioning Group (GCCG) which has resulted in a risk rating and category 1 allocation (Appendix 1) determining the security standards to be met.

Standards for Security Management

The security standards fall into four key sections:

Strategic Governance

Strategic governance arrangements are tested in order to ensure anti-crime measures are fully embedded at all levels across the organisation.

Inform and Involve

Inform and involve sets out the requirements in relation to raising awareness of crime risks against the trust assets and staff and working with staff, stakeholders and the public to highlight the risks and consequences of crime against the NHS.

Prevent and Deter

Details the requirements in relation to discouraging individuals who may be tempted to commit crimes against the Trust and opportunities to commit crime are minimised.

Hold to account

Hold to account sets out the requirements in relation to detecting and investigating crime, prosecuting those who have committed crime and seeking redress.

The Trust is required to submit an annual self-assessment to NHS Protect and the GCCG mapped against the Security Standards. The Submission for 2013/14 is attached at

appendix 2. The organisation's overall risk rating is currently amber. In the majority of cases this is due to the need for scheduled program of effective evaluation using sound data requiring further development in those specific areas.

To ensure continuing improvement in these amber categories over the next 12 months the security standards will be mapped against the Health, Safety and Security Strategy to ensure alignment. This will be reviewed by the Health and Safety committee by means of Quarterly reports and a security action plan (appendix 3).

Conclusion

It is concluded that Gloucestershire Care Services NHS Trust is committed to achieving the best possible security standards. This will be attained by aligning the security standards to the Health, Safety and Security Strategy and implementing the action plan prioritising high risk areas.

NHS Protect

Organisation Crime Profile

Please complete this sheet in as much detail as possible.
To 'Select from list', click on the relevant field, then click on the arrow button, which will reveal a drop down menu.

1a. Name of the organisation completing this organisation crime profile	**Gloucestershire Care Services NHS Trust**
1b. Organisation Code	**R1J**
2. National or Local organisation	**Local**
3. Organisation/Provider type	**Other**
If other, please state organisation type	**NHS Trust**

GENERAL

4. Type of service(s):

These categories have been defined using the CQC essential standards framework. Respondents will be required to identify which category or categories they fall into by identifying the services they provide.

Healthcare services: *(Please select YES or NO)*	Acute services	**NO**
	Hyperbaric chamber services	**NO**
	Hospice services	**NO**
	Long-term conditions services	**YES**
	Hospital services for people with mental health needs, and/or learning disabilities, and/or problems with substance misuse	**NO**
	Prison healthcare services	**NO**
	Rehabilitation services	**YES**
	Residential substance misuse treatment/rehabilitation services	**NO**
Community or integrated healthcare: *(Please select YES or NO)*	Community healthcare services	**YES**

	Doctor consultation services	YES
	Doctors treatment services	YES
	Dental services	YES
	Diagnostic and/or screening services	YES
	Community-based services for people with a learning disability	NO
	Mobile doctors services	YES
	Community-based services for people with mental health needs	NO
	Community-based services for people who misuse substances	YES
	Urgent care services	YES
Residential social care: *(Please select YES or NO)*	Care home services with nursing	NO
	Care home services without nursing	NO
	Specialist college services	NO
Community social care: *(Please select YES or NO)*	Domiciliary care services including those provided for children	YES
	Extra Care housing services	NO
	Shared Lives (formerly known as Adult Placement)	NO
	Supported living services	NO
Miscellaneous healthcare: *(Please select YES or NO)*	NHS ambulance services	NO
	Blood and transplant services	NO
	Remote clinical advice services	NO

5	**How many Clinical Commissioning Groups is this organisational crime profile being submitted to?** *(Please insert number)*	One
6	**What is the headcount employed (including contracted staff) by the organisation?** *(Please select from list)*	3,001-4,000
7.	**What is the percentage of total NHS funding as a proportion of the organisation's overall budget?** *(Please select from list)*	76 - 100%

8. How many NHS patient attendances did the organisation record in the last financial year? *(Please select from list)*	Over 500,000
9. How many NHS patient episodes did the organisation record in the last financial year? *(Please select from list)*	100,001 - 200,000

Name of person completing this assessment	Max Boyce
Job Title	Local Security Management Specialist
Contact address	Gloucestershire Care Services NHS Trust, Edward Jenner Court, 1010 Pioneer Ave, Gloucester Business Park, Brockworth, Gloucester GL3 4AW
Email address	max.boyce@nhs.net
Telephone number	0300 421 8272
Date completed	

By submitting this organisation crime profile, you agree to the following:

I am submitting this form with the authorisation of the Chief Executive. I declare that the information provided in this Organisation Crime Profile is complete and accurate to the best of my knowledge and belief. I understand that the Clinical Commissioning Group may share the information on this form with NHS Protect for the purposes of enabling it to carry out its functions in relation to tackling crime against the NHS.

Organisation rating:

(Will be determined when all questions have been answered)

VIOLENCE, COUNTER TERRORISM, CRIMINAL DAMAGE, THEFT	ECONOMIC CRIME
CATEGORY 1	CATEGORY 1

SRT Process Summary

Overall Score : **AMBER**

Status: Draft

1. Sections

1.1. **General**
1.2. **Strategic Governance**
1.3. **Inform and Involve**
1.4. **Prevent and Deter**
1.5. **Hold to Account**

General

Standard	Comments
Name of the organisation	GLOUCESTERSHIRE CARE SERVICES NHS TRUST
Annual budget of the organisation *	
Staff headcount including contracted employees *	3,000 to 10,000
Organisation code	R1J
Organisation/provider type *	Community Provider Trust
Co-ordinating Commissioner for this provider. *	NHS GLOUCESTERSHIRE CCG
Name of the member of the executive board or equivalent body responsible for overseeing and providing strategic management *	
Region *	South West
Date of completion of this review	
Name of the Local Security Management Specialist *	Max Boyce
Substantive role if not Local Security Management Specialist *	N/A
Name of the security management provider organisation (including in-house) *	N/A
Inform and Involve and Prevent and Deter days used (Maximum 3 digits)*	000
Hold to Account days used (Maximum 3 digits)*	000
Total days used for security management	0
Cost of security management staffing *	N/A
Cost of security equipment (including physical systems) *	N/A

Strategic Governance

No	Standard	Rating	Comments
1.1	A member of the executive board or equivalent body is responsible for overseeing and providing strategic management and support for all security management work within the organisation.	GREEN	
1.2	The organisation employs or contracts in a qualified person to undertake and/or oversee the delivery of the full range of security management work.	GREEN	
1.3	The organisation allocates resources and investment to security management in line with its identified risks.	GREEN	.
1.4	The organisation reports annually to its executive board, or equivalent body, on how it has met the standards set by NHS Protect in relation to security management, and its local priorities as identified in its work plan.	GREEN	
1.5	The organisation has a security management strategy aligned to NHS Protect's strategy. The strategy has been approved by the executive body or senior management team and is reviewed, evaluated and updated as required.	GREEN	

Inform and Involve

No	Standard	Rating	Comments

2.1	The organisation undertakes risk assessments in relation to: a) protecting NHS staff and patients b) security of premises c) protecting property and assets d) security preparedness and resilience. The organisation uses its identified risks to develop inclusive policies in respect of the above (a-d) and can demonstrate implementation of these policies. The policies are monitored, reviewed and communicated across the organisation.	GREEN	
2.2	The organisation develops and maintains effective relationships and partnerships with local and regional anti-crime groups and agencies to help protect NHS staff, premises, property and assets.	GREEN	
2.3	The organisation participates in all national and local publicity initiatives, as required by NHS Protect, to raise security awareness.	GREEN	
2.4	The organisation demonstrates effective communication between risk management, capital projects management, estates, security management and external agencies to discuss security weaknesses and to agree a response.	AMBER	Informal evaluation of outcomes only. No formal process exists. To be incorporated in the quarterly security reports to the H&S committee.
2.5	The organisation has an ongoing programme of work to raise awareness of security measures and security management in order to create a pro-security culture among all staff, across all sites. This programme of work will be reviewed, evaluated and updated as appropriate to ensure that it is effective.	AMBER	No formal process in place for 'meaningful evaluation of the success of the program and measures awareness levels'. To be incorporated in the security audit.
2.6	All staff know how to report a violent incident, theft, criminal damage or security breach. Their knowledge and understanding in this area is regularly checked and improvements in staff training are made where necessary.	GREEN	
2.7	All staff who have been a victim of a violent incident have access to support services should they require it.	AMBER	There is no process to evaluate third party support due to the wide ranging support offered and the confidential nature of the service.

Prevent and Deter

No	Standard	Rating	Comments
3.1	The organisation risk assesses job roles and/or undertakes training needs analyses for all employees, contractors and volunteers whose work brings them into contact with NHS patients and members of the public. As a result, the appropriate level of prevention of violence and aggression training is delivered to them in accordance with NHS Protect's guidance on conflict resolution training and/or the prevention and management of clinically related challenging behaviour. The training is monitored, reviewed and evaluated for effectiveness.	AMBER	Effectiveness of training is not currently evaluated via a formal system.
3.2	The organisation undertakes an assessment of the risks to its lone workers including the risk of reasonably foreseeable violence. Where appropriate, it takes steps to avoid or control the risks and these measures are regularly and soundly monitored, reviewed and evaluated for their effectiveness.	GREEN	
3.3	The organisation issues national and regional NHS Protect alerts to relevant staff and action is taken to raise awareness of security risks and incidents. The process is controlled, monitored reviewed and evaluated.	GREEN	

3.4	The organisation ensures that the provision of a secure environment is a key criterion for any new build projects, or the modification and alternation (e.g. refurbishment or refitting) of existing premises.	AMBER	Security is included in all projects. Cannot provide evidence of regular building design evaluation.
3.5	The organisation has arrangements in place to manage access and control the movement of people within its premises, buildings and any associated grounds.	GREEN	
3.6	The organisation has systems in place to protect its assets from the point of procurement to the point of decommissioning or disposal.	GREEN	
3.7	The organisation has clear policies and procedures in place for the security of medicines and controlled drugs (CDs).	GREEN	
3.8	The organisation operates a corporate asset register for assets worth £5,000 or more.	AMBER	New software system being purchased that will allow evaluation and audit of assets.
3.9	The organisation has in place departmental asset registers and records for assets worth less than ¿5,000.	AMBER	While asset registers exist evidence cannot be provided of regular, sound evaluation or audit of the registers.
3.10	Staff and patients have access to safe and secure facilities for their personal property.	AMBER	Secure facilities for staff is ongoing and being addressed at refurbishment or when new premises are taken on.
3.11	The organisation maintains comprehensive and systematic records of security breaches and incidents, acts of violence and incidents of theft or criminal damage affecting its property and assets and, where appropriate, these inform security management priorities and the development of security policies.	GREEN	
3.12	The organisation takes a risk based approach to identifying and protecting its critical assets and infrastructure. This is embedded in policy and can be evidenced.	GREEN	
3.13	In the event of an increased security threat level, the organisation is able to increase its security resources and responses.	GREEN	
3.14	The organisation has in place suitable lock down arrangements for each of its sites, or for other specific buildings/areas of priority.	GREEN	
3.15	Where applicable, the organisation has clear policies and procedures in place in relation to a potential child or infant abduction, and these are tested, monitored and reviewed.	GREEN	

Hold to Account

No	Standard	Rating	Comments
4.1	The organisation is committed to applying all appropriate sanctions against those responsible for acts of violence, security breaches, theft and criminal damage.	GREEN	
4.2	The organisation has arrangements in place to ensure that allegations of violence, theft and criminal damage are investigated in a timely and proportionate manner and these arrangements are monitored, reviewed and evaluated.	GREEN	
4.3	Where appropriate, the organisation publicises successful prosecutions of cases relating to a) denying unnecessary access to premises b) the consequences of assaulting NHS staff c) breaching the security of NHS premises and property d) acts of theft and criminal damage.	GREEN	

4.4	The organisation has a clear policy on the recovery of financial losses incurred due to theft of, or criminal damage to, its assets and can demonstrate its effectiveness.	RED	Dealt with on a case by case basis with recovery sought through the court process. Currently no policy but will be developed in 14/15.

		Security Management Action Plan for Gloucestershire Care Services NHS T rust - 2014/15					
SRT LEVEL		**Area**	**Task/Objective**	**Target Dates**	**Completed Date**	**Days/Time Allocated**	**Actual Days**
			STRATEGIC GOVERNANCE				
	1.1	A member of the executive board or equivalent is responsible for overseeing and providing strategic management and support for all security management work within the organisation.	LSMS reports to H&S committee (SMD chair) quarterly or directly if required.			4 days	
	1.2	The organisation employs or contracts in a qualified person to undertake and/or oversee the delivery of the full range of security management work.	Attend NHS Protect quarterly meeting and supporting events. Attend updates and CPD events as required			5 days 3 days	
	1.3	The organisation allocates resources and investment to security management in line with	Security risks reviewed and where necessary entered onto risk registers.			3 days	

		its identified risks.					
	1.4	The organisation reports annually to its executive board, or equivalent body, on how it has met the standards set by NHS Protect in relation to security management, and its local priorities as identified in its work plan.	Preparation and submission of annual security management report. Completion and submission of Security Management Self Review Tool and OCP.			2 days 4 days	
	1.5	The organisation has a security management strategy aligned to NHS Protect's strategy. The strategy has been approved by the executive body or senior	Review of Trust security management strategy to ensure alignment with Security standards and link to security audit tool			3 days	

		management team and is reviewed, evaluated and updated as required.					
INFORM & INVOLVE							
	2.1	The organisation undertakes risk assessments in relation to: a) protecting NHS staff and patients b) security of premises c) protecting property and assets d) security preparedness and resilience. The organisation uses its identified risks to develop inclusive policies in respect of the above (a-d) and can demonstrate implementation of these policies. The policies are monitored, reviewed and communicated across the organisation.	LSMS to conduct site security audits in accordance with the rolling program LSMS to attend The Emergency Preparedness and Resilience Group bi monthly LSMS to carry out annual reviews of security related policies and guidance and amend where appropriate			20 days 2 days 3 days	
	2.2	The organisation develops and maintains effective relationships	LSMS to liaise quarterly or as required with the Trust Local Counter Fraud Specialist.			2 days	

		and partnerships with local and regional anti-crime groups and agencies to help protect NHS staff, premises, property and assets.	LSMS to liaise as required with Public protection and crime reduction officers from Gloucestershire Constabulary as required.			3 days	
	2.3	The organisation participates in all national and local publicity initiatives, as required by NHS Protect, to raise security awareness.	LSMS to distribute Security Management materials and information. LSMS to facilitate security awareness and NHS Protect awareness presentations as required. LSMS to provide Trust Communications Team with information and articles for inclusion on team brief and newsletter.			1 day 1 day 1 day	
	2.4	The organisation demonstrates effective communication between risk management, capital projects management, estates, security management and external agencies to discuss security weaknesses and to agree a response.	LSMS, as part of estates and facilities to be involved in all new builds, refurbishments to ensure security requirements are incorporated. LSMS to incorporate evaluation into estates meetings			10 days	
	2.5	The organisation has an ongoing	LSMS to provide proactive and			12 days	

		programme of work to raise awareness of security measures and security management in order to create a pro-security culture among all staff, across all sites. This programme of work will be reviewed and updated as appropriate to ensure that it is effective.	reactive security briefings to staff groups. LSMS to liaise with Coms to provide county wide security updates via the Trust intranet LSMS to provide security briefings at corporate induction LSMS to include evaluation of awareness in the security audit.			2 days	
	2.6	All staff know how to report a violent incident, theft, criminal damage or security breach. Their knowledge and understanding in this area is regularly checked and improvements in staff training are made where necessary.	Staff briefings in consultation with the DATIX administrator LSMS to monitor through DATIX and provide feedback to service managers.			4 days	
	2.7	All staff who have been a victim of a violent incident have access to support services should they require it.	LSMS to respond to all reported incidents of violence and ensure staff are offered support by way of care First/Victim support.			12 days	

PREVENT & DETER							
	3.1	The organisation risk assesses job	LSMS to review course content			6 days	

		roles and/or undertakes training needs analyses for all employees, contractors and volunteers whose work brings them into contact with NHS patients and members of the public. As a result, the appropriate level of prevention of violence and aggression training is delivered to them in accordance with NHS Protects guidance on conflict resolution training and/or the prevention and management of clinically related challenging behaviour. The training is monitored, reviewed and evaluated for effectiveness.	with training department and provide training as and when required. LSMS to work with the training department to identify an effective evaluation tool for CRT effectiveness			1 day	
	3.2	The organisation undertakes an assessment of the risks to its lone workers including the risk of reasonably foreseeable violence. Where appropriate, it takes steps to avoid or control the risks and these measures are regularly and soundly monitored, reviewed and evaluated for their effectiveness.	LSMS to provide quarterly reports on LW incidents for review at the H&S committee LSMS to assist in assessing risk to LW as and when required			4 days	
	3.3	The organisation issues national and regional NHS Protect alerts to	LSMS to risk assess, manage, review, and disseminate NHS Protect Security Alerts and			2 days	

		relevant staff and action is taken to raise awareness of security risks and incidents. The process is controlled, monitored reviewed and evaluated.	additional security related notifications. Records are maintained of distribution and associated actions.				
	3.4	The organisation ensures that the provision of a secure environment is a key criterion for any new build projects, or the modification and alteration (e.g. refurbishment or refitting) of existing premises.	LSMS to advise management on provision of appropriate security requirements at sites subject to acquisition, refurbishment or change of use.			6 days	
	3.5	The organisation has arrangements in place to manage access and control the movement of people within its premises, buildings and any associated grounds.	LSMS to liaise with estates, site management and staff as required. Review of controls to be included in Crime Reduction Surveys and Lockdown process.			2 days	
	3.6	The organisation has systems in place to protect its assets from the point of procurement to the point of decommissioning or disposal.	LSMS to meet with finance bi annually to review asset management systems.			2 days	
PREVENT & DETER							
	3.7	The organisation has clear policies and procedures in place for the	LSMS to liaise with head of medicines management to ensure compliance with legislation.	As required		2 days	

		security of medicines and controlled drugs (CDs).					
	3.8	The organisation operates a corporate asset register for assets worth £5,000 or more.	LSMS to assist in auditing the effectiveness of the asset software	As required		2 days	
	3.9	The organisation has in place departmental asset registers and records for assets worth less than £5,000.	LSMS to assist with departmental and Business Unit audits.	As required To be confirmed		2 days	
	3.10	Staff and patients have access to safe and secure facilities for the storage of their personal property.	LSMS to ensure safe and secure facilities are considered in all refurbishments/new builds			1 day	
	3.11	The organisation maintains comprehensive and systematic records of security breaches and incidents, acts of violence and incidents of theft or criminal damage affecting its property and assets and, where appropriate, these inform security management	LSMS to review security and violence related incidents and where necessary update security policies and guidance as appropriate			4 days	

		priorities and the development of security policies.					
	3.12	The organisation takes a risk-based approach to identifying and protecting its critical assets and infrastructure. This is embedded in policy and can be evidenced.	Linked to 2.1 Additional advice to be provided as required.	As required		1 day	
	3.13	In the event of an increased security threat level, the organisation is able to increase its security resources and responses.	Linked to 2.1 Additional advice to be provided as required.	As required		1 day	
	3.14	The organisation has in place suitable lockdown arrangements for each of its sites, or for other specific buildings/areas of priority.	Linked to 2.1 Additional advice to be provided as required.	As required		1 day	
	3.15	Where applicable, the organisation has clear policies and procedures in place in relation to preventing a potential child or infant abduction, and these are regularly tested, monitored and reviewed.	**Not applicable**				
HOLD TO ACCOUNT							
	4.1	The organisation is committed to applying all appropriate sanctions	LSMS to attend court, case conferences and other sanction hearings as required.	As required		2 days	

		against those responsible for acts of violence, security breaches, theft and criminal damage.	Assist with police investigations where required. LSMS to prepare reports and evidence for use at court or other sanction hearings as required.	As required		1 day 1 day	
	4.2	The organisation has arrangements in place to ensure that allegations of violence, theft and criminal damage are investigated in a timely and proportionate manner and these arrangements are monitored, reviewed and evaluated.	Via DATIX LSMS to investigate as appropriate all incidents relating to security, staff safety and assets			45 days	
	4.3	Where appropriate, the organisation publicises successful prosecutions of cases relating to a) denying unnecessary access to premises b) the consequences of assaulting NHS staff c) breaching the security of NHS premises and property d) acts of theft and criminal damage.	Linked to 2.3			Not applicable	
	4.4	The organisation has a clear policy on the recovery of financial losses	LSMS to liaise with Finance to request development of policy			1 day	

		incurred due to theft of, or criminal damage to, its assets and can demonstrate its effectiveness.					

Signature of the local security management Specialist: **Date:**

Print Name: **Date:**

Signature of the Security Management Director:

Print Name:

Gloucestershire Care Services NHS
NHS Trust

Performance & Resources Chair's Report

Ref: 14/B043

This report is for Publication

Gloucestershire Care Services NHS Trust Board

Performance & Resources Chair's Report
25 November 2014

Objective:

To provide the Board with a summary of the key issues and actions arising from the meeting of the Performance & Resources Committee held on 21st October 2014

The Board is asked to:

The Board is asked to **NOTE** the report and the approved minutes for information and assurance.

Executive summary:
The report sets out the key points discussed at the meeting of 21st October 2014. The approved minutes of the meeting held on 2nd September 2014 are attached for information

Duncan Jordan
17 November 2014

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.

Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: 25th November 2014
Location: Malvern & Coopers Room, Edward Jenner Court, Brockworth, GL3 4AW

Agenda item 20: Performance & Resources Committee update

1. Introduction

This report provides a summary of the key issues and actions arising from the meeting of the Performance & Resources Committee held on 21st October 2014. The approved minutes of the meeting held on 2nd September 2014 are attached for information.

2. Chief Operating Officer's Report

The Committee received an update on the situation at Stroud Community Hospital. A temporary reduction in bed capacity became necessary due to a shortage in qualified staff. It noted that 30 beds were now in use and the remaining 8 will start to become available from the end of November.

The Chief Operating Officer (Duncan Jordan) with regards to community nursing reiterated the need for a service specification. This will be developed with the CCG and will need to include the interrelationship with the Rapid Response Service.

The Committee NOTED the report and updates given and welcomed the overarching report to this and future meetings.

3. Service Transformation – SystmOne

Director of Finance (Glyn Howells) presented the report to the Committee. The SystmOne project update included operational and project lessons learnt. The Committee was informed of the success to date of deployed SystmOne implementations. Implementations had been deployed on time and on budget. The Committee was reminded that a series of 6 phases between June 2013 and March 2015 were to be rolled out. The final two Phases 5 and 6 – Children's Community and Child Health - were currently on schedule and due to go live 1 December 2014.

The Committee was advised of improvements to services and capacity planning. A rise in activity level would potentially result in increased income, subject to the agreement of GCCG. A clear matrix of lessons learnt and project risks identified is to be made available going forward.

The Committee RECEIVED and NOTED the update Report incorporating the lessons learnt.

4. Quality & Performance Report

Target MSKCAT – The Director of Service Delivery (Candace Plouffe) provided the Committee with an update position which included the timeline for the performance recovery action plan.

The Committee advised that plans were already in place for the development of a Chlamydia testing performance action plan – teams will produce and circulate.

The Committee advised that plans were already in place for the development of a Podiatry service performance action plan – teams will produce and circulate. Teams are being encouraged to become more proactive in the information gathering.

As regards the Friends and Family Test, the Committee remarked on the low results for patient feedback forms. The Committee requested reassurances that feedback forms were being issued to appropriate patients based on observations a member made when visiting one of the community hospitals and MIUs. The Committee was advised that patients undergoing long term treatment resulting in multiple appointments would not be expected to complete a feedback form for each visit.

The Committee NOTED the report and positive steps being taken.

5. Quality Report on Falls

The Director of Service Transformation (Sue Field) briefly updated the Committee on the Falls element of the Quality Performance Report as a result of concerns raised at the Quality and Clinical Governance Committee. The Committee noted the significant amount of work currently in place across the Trust to ensure that fall numbers are reduced and the impact on patients and their families is minimised.

The Committee was advised that GCS currently had 64 active claims relating to falls. A breakdown report incorporating the number of claims and the monitor processes being adopted is to be prepared.

The Director of Nursing and Quality (Liz Fenton) has set up and is chairing a Falls Quality Group which will oversee further developments, embedding of pathways and innovative practice. The recently appointed Head of Community Hospitals will also support this work alongside the Community Hospital matrons.

The Committee NOTED the report and number of active claims.

6. Finance Performance Report

The Committee was advised of both the year to date and full year forecast out-turn positions for GCS at Month 5, and was also updated on the risks identified and plans in place to mitigate the risks.

The Committee was updated verbally on Month 6 Finance Performance returns which had been sent on to the TDA as normal on 20th of each month. The Director of Finance (Glyn Howells) explained that the Month 6 position was on plan and the forecast was indicating that GCS will remain on plan but that there are significant risks to this position, namely the need to find £2m of non recurrent savings to offset under-delivery of CIPs. GH confirmed that the TDA had been advised of the degree of risk in the forecast out-turn.

GH advised that there was the potential for GCS to incur costs relating to management of the Contractor's under-performance at Tewkesbury where there remained issues with both the completion of the new hospital and the demolition of the old hospital site for onward sale to GPs. Meetings were now taking place with the Managing Director of the Contractor and GH will update on progress at the November Board.

A sub-group was now meeting to review CIPs, QIPP and CQUINs, and the progress being made. Forecasts are based on a project by project basis to get better operational oversight and focus in this critical area.

The Trust's tender for the Out of Hours GP services contract was unsuccessful. The Trust is now planning the transition of the service to the successful bidder, South West Ambulance Service (SWAST). There are risks associated with retaining staff and therefore maintaining service levels during this period. These have been flagged to the GCCG.

The Committee NOTED the report and updates given.

7. External Care Update Report

Project Lead for External Care (Caroline Holmes) presented the External Care Update Report. The report provided the October update on the External Care Programme for 2014-15. The report noted the financial position which highlighted a forecast overspend against the original balanced budget of £2.6m in 2014/15 reflecting a number of cost pressures that had arisen since the start of the year. Since the last report further progress and understanding had been made in the following areas.

- A better understanding and detailed investigation of spend patterns – resulting in putting in place very tight controls to manage spend;

- As a consequence of this, further understanding about the quality of the assessment and support planning practice within teams and putting plans in place to address these concerns;
- Communicating across all teams the gravity of the situation and the changes that need to be made through 9 locality roadshows;
- Organisational and workforce development planning to address the cultural and behavioural issues identified earlier in the year;
- Emphasis across health and social care on the need to reduce placements into care homes to bring Gloucestershire in line with its comparator authorities; and
- Continuation of the new workstreams around placements and existing workstreams to reduce the overspend.

The Re-ablement Service was currently being reshaped, Robert Walker – previously Community Manager for Gloucester, will lead on the reshaping exercise. It was noted that new rotas came into effect on 15 October 2014, current feedback indicated a positive response to the changes proposed.

Committee advised that a successful bid by the Workforce groups had resulted in £200k Organisational Development training fund.

The financial implications and the need for further updates were noted.

The Committee NOTED the Trust's position and consistent monitoring to be continued.

8. CIPs, QIPP and CQUIN Scorecard Report

The Head of Transformation and Performance (Kate Calvert) presented the scorecard report. The Committee noted the position to 30 September 2014. The Committee was advised that there were risks within the three schemes, most notably for CIPs. At the time of the committee the RAG rating for each was as follows:

CQUIN – Green
QIPP – Amber
CIPs – Red

Action plans are in place to mitigate the risks with the intention to reach a favourable year end position.

Full payment for delivery of CQUIN 6 in Quarter 1 has been approved by the CCG. There is still a risk of missing the target due to vacancies and the need to achieve 95% mandatory training targets. Discussions are underway with the Director of Human Resources to identify the non-statutory mandatory training – these will then be re-prioritised so that this CQUIN can be delivered.

Kate Calvert advised that the 2014/15 QIPP Schedule had been difficult to finalise. The majority had only recently been agreed (3rd October) with GCCG. Outstanding was the final Schedule and revised financial phasing for the milestone activity. The Committee noted that AMBER milestones were still expected to be achieved by year end. KC asked the Committee to be aware of the risks linked with the KPIs for bed numbers in Community Hospitals. These were unlikely to receive allocated funding for the remainder of 2014/15

The 2014/15 QIPP Schedule does allow for over-delivery and the introduction of new schemes. Schemes currently being considered included:

- Diabetes service – further development
- Respiratory service – outpatient pathway
- Assessment beds
- Heart failure specialist services
- Complex wound care (business case with Commissioners).

The Committee NOTED the content of the plan and the associated risks within the programmes, an updated report is to be considered at the Performance and Resources Committee meeting in December.

9. Community Nursing – North Cotswold Focus

Interim Director of Nursing and Quality (Melanie Rogers) shared a presentation on community nursing that was developed jointly with GCCG. The Committee noted the joint commitment to the Local Medical Committees (LMC) by GCS and GCCG. There was a planned review period of 3 months. Greater emphasis was being placed on revised staffing rotas and quickly responding to issues raised.

Training Needs Analysis was being undertaken to ensure a suitably qualified pool of bank staff is available. A plan to ensure the same bank staff (where possible) are used to provide consistency for patients and GPs had been recently implemented.

Assurance was in place to provide professional leadership, supervision and support with the appointment of a Professional Head of Community Nursing. Dawn Allen started in the post on 20 October 2014. The Trust is committed to growing and supporting its workforce through appropriate mentorship and preceptorships.

The Committee NOTED the update and challenges ahead, requested updates at the next meeting.

10. Capital Schemes – approvals and progress review

The Deputy Director of Finance (Stuart Bird) presented the Capital Expenditure Update with current position and implications for the Trust.

The Trust had spent £1.1m of the planned £6.4m in 2014/15. Latest estimates indicated a total in year spend of £5.4m due to delays in procuring the replacement Community of Interest (COIN) network (which is being procured in collaboration with GHFT and 2GNHSFT) and delays in identifying a suitable property in Gloucester within which to locate some of the Gloucester City Services. There was a significant amount of work to be completed in the remainder of the year. The capex committee meet regularly to review spend and to direct resources in the most appropriate way.

The Committee APPROVED and NOTED the capital spend position of the report.

11. Business Development Tracker

The Deputy Director of Finance (Stuart Bird) updated the Committee on proposed changes to contracts and sales opportunities being explored with current and potential customers. A proposal had been submitted to GCCG around lower limb complex wound (leg ulcer) service, to be provided through the specialist nursing team. Potential gross annual value was approximately £1m.

Processes now implemented for moving to GHFT outpatient clinic activity based billing and charging for high cost consumables used in outpatient clinics. New temporary commercial manager in post and dealing with service change requests

The Committee NOTED the report.

12. Urgent Care Service Report and Action Plan

The Director of Transformation (Sue Field) presented the urgent care management and governance arrangements for the Committee's information and assurance.

The Committee was advised that the performance of urgent care services will be overseen by a newly formed Urgent Care Management Group. The Committee was asked to be aware of the potential risk associated with interdependencies with the GHFT and the Trust's community based services. The Committee noted the potential for de-stabilising the OOH service during the transition to the new provider, which could put GCS at risk during a period of vulnerability both in terms of increased demand, uncertainty for staff and ability to maintain a service within the current contract.

The Gloucestershire Health and Care community had been allocated funding to the value of £3.6m for Urgent Care resilience in 2014/15. Dependent on performance indicators being delivered, the GCS scheme

will receive £350k for the Integrated Discharge Team with an additional incentive of £50k.

The Committee NOTED the report.

13. IT Strategy Monitoring Review

The Committee agreed to receive regular exception reports.

The Committee DEFERRED this item to its December meeting.

14. Performance and Information Strategy

The Committee approved in principle. The P&I Strategy will be presented at Board for sign off. Update should incorporate the Governance structure and review the reporting line boundaries

The Committee APPROVED the strategy, forwarded to Trust Board for sign off.

15. Estates Strategy Implementation Plan

The Committee agreed to receive regular exception reports.

The Committee DEFERRED this item to its December meeting.

Prepared by: **Duncan Jordan, Chief Operating Officer**

Presented by: **Richard Cryer, Chair, Performance & Resources Committee**

Appendices

Appendix 1: Approved minutes of the Performance and Resources Committee on 2nd September 2014

GLOUCESTERSHIRE CARE SERVICES NHS TRUST
PERFORMANCE AND RESOURCES COMMITTEE

Minutes of the Meeting held on Wednesday, 2 September 2014 at 2.00pm in the Boardroom, Edward Jenner Court

Present:

Members:

Richard Cryer (RC)	Non-Executive Director (Committee Chair)
Rob Graves (RG)	Non-Executive Director
Chris Creswick (CC)	Non-Executive Director
Duncan Jordan (DJ)	Chief Operating Officer
Paul Jennings (PJ)	Chief Executive
Glyn Howells (GH)	Director of Finance
Ingrid Barker (IB)	Trust Chair

In Attendance:

Sue Meads (SM)	Non-Executive Director
Sue Field (SF)	Director of Service Transformation
Stuart Bird (SB)	Deputy Director of Finance
Candace Plouffe (CP)	Director of Service Delivery
Georgina Smith (GS)	Corporate Social Responsibility Manager
Lindsay Ashworth (LA)	HR Business Partner
Kathryn Calvert (KC)	Head of Programme Change & Information

Secretariat:

Christine Thomas (CT)	Interim Assistant Board Secretary
Bev Samuels (BV)	Executive Assistant

Apologies:

Tina Ricketts (TR)	Director of HR
Jason Brown (JB)	Director of Corporate Governance & Public Affairs
Bernie Wood (BW)	Head of IT, Developments and Operations
Matthew O'Reilly (MO)	Head of Performance & Information
Mark Parsons (MP)	Head of Estates, Safety, Security and Facilities

Item	Detail	Action
P&R 59/14	**Agenda Item 1: Welcome & Apologies** The Chair opened the meeting at 2.00pm. Apologies were noted from Tina Ricketts, Jason Brown, Bernie	

	Wood, Matthew O'Reilly and Mark Parsons. The Chair reviewed the agenda.	
P&R 60/14	**Agenda Item 2: Minutes of 2 July 2014 meeting** The Committee **RECEIVED** the unconfirmed minutes of the 2nd July. There were some amendments noted, these were: 40/14 – Reference to Capex minutes, these should be notes instead of minutes 42/14 – Delete the word yet, which appears twice Subject to the above amendments and some grammatical changes these minutes are approved by the Committee. **Resolution: The Committee RECEIVED and APPROVED the minutes of the 2nd July subject to the above amendments.**	**JB**
P&R 61/14	**Agenda Item 3: Matters Arising** The Committee reviewed the Action Log. There were four actions open: Action 49 – Recommendation that Capex notes are received by the Committee on a regular basis. This is now coming to the Committee and this item was closed. Action 53 – Update on SystmOne to come back to the Committee – on the agenda for Oct 14 Action 54 – Update on the purchase of a property in Cheltenham for the new Sexual Health clinic. GH updated the Committee. Action 55 – BW to share a high level diagrammatical paper with regards to IT Strategy. DJ tabled this diagram to the Committee on behalf of BW and asked for any comments to come back to him. This item was closed. **Resolution: The Committee APPROVED the updates and the closure of Action 49 and 55.**	
P&R 62/14	**Agenda Item 4: Review of Forward Agenda Plan** The forward agenda was reviewed and the following amendments were noted: Falls paper to be added to October Agenda. Urgent Care Action Plan to be added as a regular update. SF to add a patient flow section to give a broader report to the Committee. RC was happy for them to see this at the next meeting and take a	

	decision as to whether this should become a standing item. Community Nursing to be added as a standard item. SF was looking to produce a scorecard for CIP, QIPP and CQUIN and this would combine the three separate reports. External Care to become a standing item. RC asked that DJ produce a COO contextual report, which would give the Committee an overview of the important performance matters, this would give a focus to the meeting. This to be added as a standard item. GH advised that the high level LTFM assumptions and budget would need to be signed off in December to then go to Board. To be added to December agenda. **Resolution: The Committee NOTED the Forward Agenda Plan.**	**JB**
P&R 63/14	**Agenda Item 5: Finance Performance Report** SB presented the Finance Performance Report. SB highlighted the key issues: • Delivery of the £6.4m of CIP savings in year (with £2m of contingency to offset under delivery) • Delivery of £3.9m of QIPP schemes • Contract implementation for NHSE and GCC commissioned • Delivery of £1.7m GCCG CQUINS and agreement with commissioners and subsequent delivery of the remaining £0.3m of CQUINs • Recruiting required staff to reduce reliance upon agency staff with related premiums • Delivery of the External Care recovery plan of >£6.5m • Developing a detailed LTFM to support the Integrated Business Plan to underpin the Foundation Trust Application process • Develop the 5 year Financial Management Strategy including: o Cash Management o Capital Spend o Procurement o Commercial Arrangement o Performance Management Framework o Budget management o Efficiency / Productivity management The Committee discussed the above areas. There are continued pressures with External Care expenditure and	

	commitment reporting. Concerns raised by the Committee around the governance of External Care and the need for a senior GCC, GCCG and GCS Forum. PJ has written to both GCC and GCCG expressing these concerns. One of the issues in managing the External Care spend is that there is no requirement for someone to inform GCC that they are going into care if they are funding it themselves. The first the council knows is when the person has capital less than the limit (a capital drop) when GCC is expected to step in to fund the placement. The Service Level Agreement between GCC and GCS has not yet been finalised. The committee felt that it was important that GCS could identify where responsibility for each part of the process lies; with GCS, GCC or externally. GH has written to the GCC expressing these concerns. GH advised the Committee that the figures in this report were from month 3, and there had been further reviews since that time and the Trust is now more certain regarding the amount of CIP delivery. There is currently £0.5m to £1m net risk (CIP under-delivery being offset by contingency and other non-recurrent savings). Future finance reports will ensure that the degree of risk in the achievement of the outturn is clearly articulated **Resolution: The Committee NOTED the report and updates given.** CP joined the meeting	
P&R 64/14	**Agenda Item 6: Contract Performance Report** In MOR's absence GH presented the Contract Performance Report. GH updated the Committee that since the report had been written they had received 3 contract queries from the CCG with regards to dips in performance. These queries were issued when contractual performance had been missed for 2 consecutive months. The contract queries were around: • Out of Hours – This was due to closures at the Dilke when there was no GP availability to cover. This meant that patients had to travel to Gloucester. • Bone Health – This was due to the loss of one member of staff from an already small team. • MSKCAT – 1 person had missed the referral time period for urgent appointments The committee discussed the reasons behind these contractual issues and the actions being taken to rectify them. PJ raised a concern that though the Safety Thermometer was doing	

	better than before it was not achieving 95%. SF advised that GCS is targeted to reach 95%, but for the month of July had achieved 90.8%. There still appeared to be some issues with data and actions were being reviewed and strengthened where appropriate. MOR/SB will review and correct where necessary data that is submitted for The Trust. RC noted that in the Benchmarking section that GCS were below other Trusts and Peer groups in the overall summary of the May 2014 report, and asked why there were so many red areas particularly around finance. GH agreed that he would bring a paper back to the Committee regarding this. **Resolution: The Committee NOTED the report.**	**MOR/ SB** **GH**
P&R 65/14	**Agenda Item 7 Commissioning for Quality and Innovation (CQUIN) Report** SF presented the CQUIN report. SF had already updated the Committee on the Safety Thermometer and advised the Committee that there were action plans in place in order to achieve the 95% trajectory target by March 2015 and that these plans centred on pressure ulcers, quality of data improvements and provision of training and regular communications with community teams. CQUIN 6 were red rated and SF updated the Committee that there still remained some outstanding negotiations with the GCCG particularly around setting agreed targets for non-medical prescribing and cannulation competencies. GCS is planning to submit more detailed information in order to secure full payment for quarter 1 milestones for this particular CQUIN. However, it was highlighted to the Committee that staff capacity to undertake training and secure competency sign off was a risk as well as the capacity within some specialist teams to deliver this training. GH advised that there had been agreement with the GCCG about financing all CQUINs. However, NHSE CQUIN-negotiations £300k) were still on-going. **Resolution: The Committee NOTED the content of the plan and the risks around achieving some elements of the CQUIN programme** GS joined the meeting	
P&R 66/14	**Agenda Item 8: Quality, Innovation, productivity and Prevention (QIPP) Report.** SF gave a verbal update on QIPP. SF highlighted the risks around	

	QIPP. Meetings with the GCCG had not been taking place due to GCCG staff illness, which meant that formal targets and tracking had not been agreed. It was agreed that if they had not been able to set a date by 8th September then GCS would formally write to the GCCG. **Resolution: The Committee NOTED the update.**	**SF/GH**
P&R 67/14	**Agenda Item 9: Capital Schemes – approvals and progress review including Capex Meeting notes.** SB presented the Capital Expenditure Update. GH noted that they were waiting to exchange contracts for the sale of land at Tewkesbury which was being held up by getting Final Completion on the demolition of the old Tewkesbury Hospital. GH reassured the Committee that if they needed to adjust the CAPEX funded replacement programme, then this could be accommodated because of the relatively good condition and age of the trust's buildings, plant and machinery. **Resolution: The Committee APPROVED and NOTED the contents of the report.**	
P&R 68/14	**Agenda Item 10: Business Development Tracker** SB presented the Business Development Tracker. The GCS had been shortlisted and subsequently given a presentation for the Out of Hours contract. An undercharge has been identified with regards the use of outpatient rooms and facilities for GHFT. Finance are working to provide sufficient information to GHFT to allow the service to be stopped or funding to be received. **Resolution: The Committee NOTED the report**	**SB**
P&R 69/14	**Agenda Item 11: CIP update to include QIA update** The report was noted. The financial impacts were further discussed under part 2 of the agenda. **Resolution: The Committee NOTED the update.**	
P&R 69/14	**Agenda Item 12: Corporate Social Responsibility Report** GS presented the Corporate Social Responsibility Report. This was the first presentation of this report to the Committee and GS gave a brief overview of what they hoped to achieve and what she would be reporting back to the Committee on. For future meetings they would	

	be looking to present a scorecard to make progress clearer. The current work was focused on estates and new buildings. An update on this report would come back to the P&R Committee in December and then every 6 months thereafter. IB was keen to see more work completed around Corporate Citizenship; GS advised that discussions are ongoing. **Resolution: The Committee NOTED the report** GS left the meeting	**TR/GS**
P&R 70/14	**Agenda Item 13: Community Nursing** CP Presented an update on Community Nursing. This follows concerns raised by the North Cotwolds Local Commissioning Group to the GCCG in relation to staffing levels and community nursing. There is a recovery action plan in place, which is being overseen by the Director of Nursing & Quality (EF), Director of HR (TR) and Director of Service Delivery (CP). CP went through the list of daily and weekly actions to ensure the service operates effectively and that staffing levels are recovered as quickly as possible. The Trust is also looking at benchmarking but there is no national or local system in place. SM felt that it was important that lessons were learnt from this failing and avoid it in the future. DJ advised that PWC are undertaking reviews of our systems and processes and a piece on wider assurance. CP highlighted that they are working without a service specification and this adds to the problems as different areas receive different services. **Resolution: The Committee RECEIVED the presentation and asked for an update to come back to the Committee**	**CP**
P&R 71/14	**Any Other Business** **Agenda Item 14: External Care Programme** DJ presented the External Care Programme. The aim of this paper was to formally flag to the Committee the worsening financial position and the planned actions. It was noted that SF will present a report on adult social care and reablement to the Board on 16th September. It was agreed to	

	propose a seminar on adult social care for Board members. **Resolution: The Committee NOTED the current position and agreed for this to go to Board**	
P&R 72/14	**Date of Next Meeting** Tuesday 21 October from 14:00 – 16:00 in the Boardroom at Edward Jenner Court, Gloucester.	

Chair's signature……

Date……

Gloucestershire Care Services NHS
NHS Trust

Quality Impact Assessments

Ref: 14/B044

This report is for Publication

Gloucester Care Services NHS Trust Board

Quality Impact Assessments
25 November 2014

Objective:
The purpose of this report is to advise the Board on the status of the Quality and Equality Impact Assessments process that is currently being re-developed and introduced within Gloucestershire Care Services.

The Board is asked to:

a. **Note** that quality and equality impact assessments have in 2014/15 been combined into one assessment framework

b. **Note** that currently this new process (and templates) are still in development, however, are being trialled in a number of service areas, where service changes have been identified and/or made

c. **Note** that whilst the national quality focus is on Cost Improvement Plans, equality impact assessments are broader

d. **Receive** this report.

Executive summary:
In November 2013, the Board agreed the CIP Strategy: this included clear responsibility to include a Quality Impact Assessment and Equality Impact Assessment as part of the development of every CIP scheme, so as to provide assurance to the Trust Board that the proposal would make either a neutral or positive impact on the quality of care being provided. The Strategy also confirmed that in undertaking such assessments, the Trust would ensure that due consideration was given to the CIP's potential impact upon service user safety, clinical outcomes and patient experience. Moreover, that the Trust would include within these assessments, where appropriate, analysis of current processes, KPI benchmarking and historical evidence.

Over the past three months, GCS management has established a Quality and Equality Impact Assessment Framework that brings together what were previously two separate processes.

There are four key objectives that we are trying to achieve with this newly combined process.

1. To provide increased visible assurance to the GCS Board and Committees that management has considered the impact of service change decisions on quality, equality and human rights.

2. To provide a robust assessment framework that moves away from a computer-based tick-box process and towards a more open, collaborative approach, that can be embedded within the Transformation and Change Team's own business case and programme management processes, but can also be used with Business as Usual change activity.
3. Bring a stronger focus to understanding who will be affected by changes to services and functions (both service users and colleagues), evidenced by profiles of the affected populations. This is fundamental to understanding how they will be affected, and how GCS may then need to adapt what we're doing to enable people to use and benefit from our services/functions.
4. Ensure that our impact assessment process is flexible enough to allow a level of analysis which is proportionate to the scale and impact of the change.

An Assessment/Analytical tool has been developed and is currently being trialled. This quality and equality impact assessment tool will also be used as new CIP specific initiatives are introduced. In due course, it will be rolled out to existing activities and smaller development projects, and we will review it for its suitability for policies.

As higher risk projects are identified, a more detailed Quality Impact Assessment will be undertaken. Identifying how we determine what constitutes 'higher risk' is currently being considered.

Lucy Lea & Kate Calvert
11 November 2014

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;
c) foster good relations 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.

Meeting of Gloucestershire Care Services NHS Trust
GCS Board

To be held on: 25 November 2014
Location: Malvern & Coopers Room, Edward Jenner Court

Agenda Item 21 –Quality Impact Assessments

1. Purpose

The purpose of this report is to advise the Board on the status of the Quality and Equality Impact Assessments process that is currently being re-developed and introduced within Gloucestershire Care Services.

2. Recommendations

It is recommended that the Board:

a. **Note** that quality and equality impact assessments have been combined into one assessment framework

b. **Note** that currently this new process (and templates) are still in development, however, are being trialled in a number of service areas, where service changes have been identified and/or made

c. **Note** that whilst the national quality focus is on Cost Improvement Plans, equality impact assessments are broader

d. **Receive** this report.

3. Discussion

3.1 Background

National Guidance was issued by the National Quality Board in 2012 – How to Quality Impact Assess Provider Cost Improvement Plans

This guidance states that,

- CIPs should be categorised by potential impact on quality
- Quality impact assessments should be undertaken by a small team of staff with representation from clinical services, quality, workforce, finance and performance
- Quality impact should be assessed by means of a systematic exploration of quantitative and qualitative intelligence, and the orderly triangulation of pertinent information
- Quality impacts should confirm that the majority of CIPs are based on changes to current processes rather than “top-slicing” current budgets
- Quality impacts should confirm that registration is not being put at risk by means of bringing quality below essential common standards
- All quality impact assessments should include the following two stages as a minimum: (i) create a baseline of quality, patient safety and experience, activity, finance, workforce and performance metrics against which the CIP can be judged, and (ii) undertake measured surveillance and intervention by routine monitoring of performance against plan

In November 2013, the Board agreed the CIP Strategy: this included clear responsibility to include a Quality Impact Assessment and Equality Impact Assessment as part of the development of every CIP scheme, so as to provide assurance to the Trust Board that the proposal would make either a neutral or positive impact on the quality of care being provided. The Strategy also confirmed that in undertaking such assessments, the Trust would ensure that due consideration was given to the CIP's potential impact upon service user safety, clinical outcomes and patient experience. Moreover, that the Trust would include within these assessments, where appropriate, analysis of current processes, KPI benchmarking and historical evidence.

The TDA expect to see QIAs and EIAs for each CIP – this is in line with quality governance and board governance assurance standards

3.2 GCS' Quality & Equality Impact Assessment Framework

Over the past three months, management has established a Quality and Equality Impact Assessment Framework that brings together what were previously two separate processes.

3.2.1 Key Objectives

There are four key objectives that we are trying to achieve with this newly combined process.

1. To provide increased visible assurance to the GCS Board and Committees that management has considered the impact of service change decisions on quality, equality and human rights.
2. To provide a robust assessment framework that provides an open and collaborative approach that can be embedded within the Transformation and Change Team's own business case and programme management processes, but can also be used with Business as Usual change activity.
3. Bring a stronger focus to understanding who will be affected by changes to services and functions (both service users and colleagues), evidenced by profiles of the affected populations. This is fundamental to understanding how they will be affected, and how GCS may then need to adapt what we're doing to enable people to use and benefit from our services.
4. Ensure that our impact assessment process is flexible enough to allow a level of analysis which is proportionate to the scale and impact of the change.

3.3.2 Impact Assessment Tool

The tool is currently in development and has been trialled by Specialist Services for the Complex Wound Care Business Case that was presented to CCG in October. It is also being used by the Integrated Discharge Team to reflect the service changes implemented under this year's QIPP programme, and for the Out of Hours Service Transition Plan. This quality and equality impact assessment tool will also be used as new CIP specific initiatives are introduced. The SystmOne Child Health and Childrens Services, and Lower Limb and Complex Wound Care Impact Assessments are attached as Appendix One. Both were approved, subject to some recommended minor changes to the Lower Limb and Complex Wound Care Assessment.

In due course, it will be rolled out to existing activities and smaller development projects, and we will review it for its suitability for policies. Board and Committees will see:

- an initial indication of whether a Board/ Committee paper proposes changes, and therefore requires Quality & Equality Impact Analysis
- an appended Quality & Equality Impact Analysis if changes are proposed.

The tool has been designed as a single document for both quality & equality impact analysis. It provides mostly open questions, not tick boxes and is supported by guidance and example of evidence (draft documents attached as Appendix Two for your information). The tool will be an integral part of the business planning process.

It includes:

- a **profile** of service users and colleagues affected by proposed changes

- **analysis of likely impacts** on Safety, Effectiveness, and Experiences (both in relation to service users and colleagues)
- early identification of **practicalities** we need to consider in delivery, based on the profile of the affected population (e.g. transport, suitability of venues, appropriate materials etc.)
- **assurance** that decision-makers have considered the Public Sector Equality Duty in making decisions
- **risk assessment** to establish whether a greater level of scrutiny is required (e.g. if the work is higher profile, higher impact, has implications for financing, reputation, staffing etc.).

As higher risk projects are identified, a more detailed Quality Impact Assessment will be undertaken. Identifying how we determine what constitutes 'higher risk' is currently being finalised.

3.2.3 Governance

Governance arrangements will also be strengthened by Quality and Equality Assessments being discussed with the Clinical Senate, which reports through to the Quality and Clinical Governance Committee. This will occur prior to being signed off by the Medical Director and Director of Nursing.

4. Financial Implications

Nil

5. Legal Implications

Nil

6. Risk Implications

Nil

7. Equality and Quality Implications

This new process will strengthen the organisation's understanding and assessment of how service change within GCS can impact on health inequalities, diversity, and vulnerable populations. This should enable GCS to maintain the highest possible standards of quality for all our communities and colleagues.

7. Consultation and Communication including Public Involvement

None

Prepared by: **Lucy Lea & Kate Calvert**
Presented by: **Duncan Jordan**

Appendices

Appendix One: Quality and Equality Impact Assessments
Appendix Two: Quality & Equality Impact Assessment tool & Guidance

Quality & Equality Impact Analysis

1. Name of project:

2. What happens currently?

3. What will change?

4. Who will be affected by these changes?

Service users and their carers	
Our colleagues, including in partner agencies	
The wider community	

5. What do we know about the people likely to be affected by the changes?

4a. Tell us what you know about the service users

4b. Tell us what you know about colleagues

6. How will these changes affect people?

6a. How will service users and their carers be affected by the changes?

In general?	*(Describe in your own words)*

Specifically, in terms of…

Safety?	
Effectiveness?	
Their experiences?	

6b. How will colleagues be affected by the changes?

In general?	*(Describe in your own words)*

Specifically, in terms of…

Safety?	
Effectiveness?	
Their experiences?	

6c. How will the wider community be affected by the changes?

In general?	*(Describe in your own words)*

Specifically, in terms of…

Confidence in the Trust	
Employment and volunteering opportunities	
Physical environment	
Carbon footprint	
Healthy lives	

7. Is there anything to suggest that some people may need us to deliver the service/ function differently so that they can benefit from it?

8. Are there any implications for their Human Rights?

9. Are there any opportunities to bring people together, reduce isolation, and promote greater understanding, empathy and compassion?

10. 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:	
Job title:	

eQuality Impact Analysis

The starting point for any well-designed service is a good understanding of who will be affected by changes, use the service, and deliver it. You need to understand who they are, what their needs are, how we can make sure that the changes are safe and effective for them, and that they will have positive experiences. This analysis is critical to ensure we can deliver high quality services and functions that reach everyone who needs them. It also helps avoid unintended consequences.

1. What happens currently?

Child health and children's services use CarePlus as an administration and clinical system.

2. What will change?

Child health and children's services are moving on to SystmOne in Dec 2014 to use as the new administration and clinical recording system.

3. Who will be affected by these changes?

Service users and their carers	✓
Our colleagues, including in partner agencies	✓
The wider community	✓

4. What do we know about the people likely to be affected by the changes?

4a. Tell us what you know about the service users

Mothers/fathers/carers and children resident and registered with a Gloucestershire GP or accessing Gloucestershire Care Services CYP services. Also young people attending a Gloucestershire school.

4b. Tell us what you know about colleagues

Child Health Information Systems Team (CHIS)
Health Visitors
Nursery Nurses
School Nurses
School nurse assistants

School screeners
OTs
Physio's
Speech & Language therapists
Children's community nurses
Home Safety team
Therapy assistants
Specialist Nurses for Safeguarding/Children in Care
Admin and Clerical staff
Immunisations Team

5. How will these changes affect people?

5a. How will service users and their carers be affected by the changes?

In general?	Integrates with the rest of the SystmOne modules to effectively manage every aspect of child health from birth to age 19 in line with the healthy child programme. Links with local SystmOne GP practices and all the professionals involved in a child's healthcare can see relevant clinical information. Greater confidence that staff who visit families will have access to better information through visibility of the whole patient record to enable a quicker and more informed delivery of the necessary assessment. Reduction in errors through recording shared patient, medical/drug and treatment. Better management visibility of staff appointments ledgers and action plans.

Specifically, in terms of...

Safety?	Staff can record clear and unambiguous clinical information, at the correct time, in the correct format and section of the correct clinical record. Ensuring accurate information is held about the Carer and Child and as a result improve patient safety.
Effectiveness?	Clinicians able to make more informed clinical decisions at the point of care allowing time saved to be utilised to see more families effectively.
Their experiences?	Improve relationship and communication between the Clinician and Parent/Carer/ Young Person.

5b. How will colleagues be affected by the changes?

In general?	Minimum disruption as clinicians and administrators are already using an electronic clinical record however the benefits are that the system can be configured to each service requirement

Specifically, in terms of...

Safety?	Ability to provide up to date assessments due to access

	of up to date information, particularly with Disconnected Working.
Effectiveness?	Greater confidence in carrying out their roles due to the above
Their experiences?	Increase of staff morale and conviction.

5c. How will the wider community be affected by the changes?

In general?	Parents/Carers can have improved involvement in their care and would be encouraged to take an active part in the delivery of their care.

Specifically, in terms of…

Confidence in the Trust	Improve relationship and communication between Parent/Carer and the Trust/Clinician.
Employment and volunteering opportunities	N/A
Physical environment	Laptops, mobile working
Carbon footprint	Continue reduction of paper records
Healthy lives	Ability to improve work-life balance through greater opportunities for flexible working. Using IT resource with patients to promote healthy lifestyles through accessing relevant internet portals.

6. Are there any implications for their Human Rights?

N/A

7. Are there any opportunities to bring people together, reduce isolation, and promote greater understanding, empathy and compassion?

N/A

8. Assurances

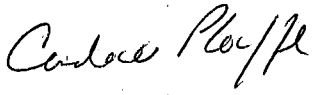
I, the project/ policy sponsor, am assured that the changes we are making take into account our responsibilities under s.149 of the Equality Act 2010 to have due regard to the need to:

(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:	 7/11/14
Name:	**Ann Ellis**
Job title:	**Child Health Systems Manager**

Signed:	 7/11/14
Name:	**Candace Plouffe**
Job title:	**Director of Service Delivery**

eQuality Impact Analysis

1. Name of project:

Lower Limb and Complex Wound Service

2. What happens currently?

Currently, patients in the community are managed through Practice Nurses, District Nurses, Leg clinics (Tewkesbury only), The Ellie Lindsay Leg Club (Cirencester only), Tissue Viability Nurses (supporting primary and community care nurses), and Acute Hospitals.

The above combination of providers represents a fragmented service, the consequences of which are:-

- No clearly defined referral process
- Delays in patients getting the appropriate treatment
- Mixed or inconsistent documentation
- Poor communication with GP practices
- Increased costs to the trust and to the general health economy
- Poorer patient outcomes and healing rates
- A failure to deliver a positive patient experience

Currently, although they are not specialists in Tissue Viability, Practice Nurses and District Nurses see the majority of patients. People who develop leg ulcers are managed in a variety of settings without any uniform pathways of leg ulcer management to guide clinical management irrespective of care setting.

3. What will change?

We propose introducing specialist-led satellite Lower Limb and Complex Wound clinics, delivering a uniformed approach to Lower Limb care.

Under the supervision of Tissue Viability Nurses in Gloucestershire Care Services who will supervise, manage and train an initial cohort of RGNs and HCAs to deliver this project. This cohort will, in turn, roll-out training and expertise to District Nurses working in the localities.

Under these proposals, clinics will run Monday to Friday and also some Saturday mornings: they will provide a high quality, cost effective, evidence-based specialist service.

There will also be integration with the voluntary sector to run a weekly Leg Café drop in service to promote well legs, after care and a hosiery test and treat program.

4. Who will be affected by these changes?

Service users and their carers	✓
Our colleagues, including in partner agencies	✓
The wider community	✓

5. What do we know about the people likely to be affected by the changes?

4a. Tell us what you know about the service users

There is a higher prevalence of leg ulcers amongst the over 65s (3.6%) than in the population as a whole (1%). As a result, the majority of people who will use this service (and be affected by the changes) will be older. Based on the demographics of Gloucestershire (taken from the 2014 Gloucestershire Profile[1]), the over 65s:

- Include more women than men, particularly when we look at the older age groups (as women are likely to live longer than men)[2],
- Are more likely to be living in the Cotswolds, Forest of Dean, Tewkesbury and Stroud, and less likely to be living in Cheltenham and Gloucester;
- Are far more likely to be have long-term limiting health problems;
- Will include people with dementia, increasing in prevalence in the older age groups;
- Will include a significant number of people with sensory impairments – sight loss[3], hearing loss[4] or both;
- Will include fewer people from BME groups than the population as a whole (1-2% of over 60s, compared with 4.6% of the whole population);
- Are more likely to be Christian than the county population as a whole (age and ethnicity have an impact on this);
- Are less likely to be (openly) Gay, Lesbian or Bisexual[5]

There is also evidence that social isolation is more prevalent amongst the

[1] http://www.maiden.gov.uk/InstantAtlas/Equalities/summary.pdf
[2] In Gloucestershire 53.5% of people aged 65-84 are female while males account for 46.5%. For people aged 85+ the difference is even more marked with females accounting for 67.3% of the total population
[3] According to a study by Access Economics in 2009, in the UK 1 in 5 people aged 75 and over are living with sight loss, and 1 in 2 people aged 90 and over are living with sight loss
[4] The vast majority of people with hearing loss are older and the prevalence increases with age (Davis, 1995): 71.1% of over 70 year-olds have some kind of hearing loss
[5] ONS (2013) Integrated Household Survey shows 2.7% of those aged 16-24 identifying themselves as Gay, Lesbian or Bisexual, compared with only 0.4% of those aged 65 and over

over-65s, especially those with long-term conditions, disabilities and leg-ulcers.

Leg ulcers also affect the under-65s, though in much smaller numbers. Amongst the under-65s, our experience shows us that the people most likely to benefit from this service are more likely to:

- Be overweight or obese;
- Smoke;
- Have lower socio-economic status/ low-paid jobs;
- Have underlying health conditions that affect the circulation, such as diabetes, COPD, CVD, oedema.

People who are homeless and people who inject drugs are also more susceptible to developing leg ulcers.

4b. Tell us what you know about colleagues who will be affected by these changes

Based on current workforce figures[6], we know that our current workforce is older, and mainly female, and has a higher proportion of 'White British' people than the county population as a whole.

We propose recruiting nurses with a specialist interest in leg ulcer and wound management and the national data shows us that the pool from which we will recruit includes substantially more women than men. We know that in the UK, women are more likely than men to have caring responsibilities, whether for children, older parents, or family members with disabilities.
The workforce will provide a countywide service potentially from 8:30am to 7:00pm arranged in shifts following an evaluation of the need.

6. How will these changes affect people?

6a. How will service users and their carers be affected by the changes?

In general?	• Instead of being seen in their own homes, service users will attend community-based clinics. • They will receive a higher quality of care, more effective management of their leg ulcers, and will have the opportunity to gain the skills and confidence to better manage their ulcers (and prevent recurrence) themselves • They will have the opportunity to join in the social and educational aspects provided by Leg Cafés.

[6] ESR 01-Sept-14

Specifically, in terms of…

Safety?	Providing a service to vulnerable people with the opportunity to have regular contact with a health professional to signpost for support as required.
Effectiveness?	A key driver for these changes is to improve the effectiveness of care of leg ulcers in the community. This will be achieved through a specialist team implementing best practice approaches. They will be conducting thorough assessments and training wider staff groups. It is anticipated that these changes will improve recovery rates, reduce admissions to acute settings, and improve quality of life. When we are designing the delivery of the service in detail, we will be mindful of people who may not be able to get to community-based clinics of their own accord, and make necessary arrangements, retaining an at-home service where this is necessary for individuals. Consideration will be given to ability to reach and access services, PROMs, recovery rates, length of stay, readmission likelihood, compliance with national guidelines/ best practice; effect on mortality and morbidity
Their experiences?	We anticipate service users' experiences being significantly improved. The improved care of their ulcers will help them regain confidence, independence and dignity. A clinic setting and the proposed Leg Cafés (with their social and educational functions) are designed to help tackle social isolation and build confidence. We recognise that the logistical and practical elements of the service – transport, venues, communication materials, timeliness, refreshments – will all be important in the service users' experience. These will be tackled at the point we design the delivery of the service, and in conjunction with service users and partner organisations. Key components to the delivery of a quality driven service will encompass compassion, dignity, privacy, autonomy; good transitions between/ within services; feeling involved in care, listened to;

	feeling care providers are accessible and responsive; feeling confident in care provided; care and information adapted to needs; willingness to recommend

6b. How will colleagues be affected by the changes?

In general?	Tissue viability nurses will feel more supported and able to share their expertise for the good of patients. The changes should reduce the pressures on practice nurses, GPs, and ensure district nurses have the opportunity to develop enhanced skills. There will be opportunities for practice nurses, District Nurses, HCAs and others to gain specialist knowledge and skills to enhance their practice and professional development.

Specifically, in terms of…

Safety?	Prior to the implementation of this new service staffing levels, risk of abuse or harassment, lone working; contact with dangerous service users/ others will be addressed as will working hours and skill levels;
Effectiveness?	We have recognised that currently there are gaps in the skills and competencies required to treat leg ulcers effectively. By establishing a specialist-led service, we are addressing this. The changes also provide existing staff with the opportunity to improve their skills and knowledge.
Their experiences?	This innovative service offers opportunities to improve staff morale, job satisfaction and stress levels. As a new provision of service there is clear guidance around working conditions and team commitments to fit with family, caring and other commitments

6c. How will the wider community be affected by the changes?

In general?	This is a community-based project which will reach out to some of the most vulnerable people in our county. One of our key objectives is to tackle social isolation, which should have a profound impact on the lives of these service users. This work has the potential to enable them to become more involved in their wider community.

Specifically, in terms of…

Confidence in the Trust	Reducing admissions – saving money for the NHS.
Employment and volunteering opportunities	The project involves the creation of new posts, providing more employment opportunities for people in Gloucestershire. We anticipate working with volunteers and the voluntary sector to deliver the leg clinics, which should improve opportunities for volunteering.
Physical environment	The project will use existing venues and buildings, making the best use of community venues.
Carbon footprint	The main impact will be transporting service users from their homes (where they are currently seen) to community venues. Clinics will be situated in each of the 6 districts in order to limit travel time. It is possible that we will reduce the numbers of trips if leg ulcers are managed more effectively, and service users are better able to care for themselves prevent recurrence. Longer recovery times and increased recurrence (as we have now) means District nurses making more trips to manage leg ulcers.
Healthy lives	The Leg Café component of this project offers the ideal opportunity for promoting healthy living, particularly given the number of lifestyle factors (weight gain, smoking, lack of exercise) that are associated with increased risk of leg ulcers.

7. Is there anything to suggest that some people may need us to deliver the service/ function differently so that they can benefit from it?

Based on our evidence of who will be affected by these changes, we will need to consider:

- Making sure that venues are physically accessible for people with mobility issues and for people in wheelchairs
- How people will get to the clinics, and transport needs they may have
- Venues that are welcoming and non-threatening, particularly for people who don't leave their homes very often
    - Potentially holding clinics in places where people already spend their time, e.g. Vaughan Centre for homeless people.
- Ensuring people can contact us – and we can contact them – in appropriate ways, providing alternatives for people who are hard-of-hearing, have sight-loss, dysphasia, or who don't use modern technology
- Materials we provide are appropriate and accessible (larger print, Easy-

Read, video)

- We can easily refer and signpost people onto services and organisations that can support them with wider needs (e.g. Gloucestershire Deaf Association can provide all kinds of equipment to help people hear on the telephone/ doorbells, to reduce social isolation; Expert Patient Programme)
- Privacy – we balance the benefits of group sessions with the need for privacy to discuss personal matters and deliver care
- Catering for particular dietary needs and preferences where relevant
- Fitting around caring commitments, and/or enabling carers to attend too
- Enabling flexible working as far as possible to cater for caring responsibilities and religious observances.

8. Are there any implications for their Human Rights?

The approach we are proposing is designed to protect and respect people's Human Rights. Based on the FREDA model (Fairness, Respect, Equality, Dignity, Autonomy), the proposed changes will introduce a fairer system, removing inconsistencies in service across the county, and ensuring a rigorous, evidence-based referral system. We know that many of the people who have leg ulcers – especially more complex cases – often experience numerous health and social inequalities – they tend to be older, in poorer health, in lower paid jobs (if under 65), more socially isolated. They include vulnerable groups such as people who are homeless and misuse intravenous drugs. This service will redress some of these inequalities by improving not just service users' health, but also their social interaction, confidence and social 'capital'.

The model we are proposing puts the clients in control of the care they receive and the setting in which they receive it. As such it will help restore their dignity, and promote independence and autonomy. The service will be delivered in a way to provide people with privacy where appropriate, balancing this with the opportunities for being in a group environment, learning and socialising.

We will have appropriate processes in place to ensure the highest standards of information governance to protect personal data and ensure service users' privacy.

9. Are there any opportunities to bring people together, reduce isolation, and promote greater understanding, empathy and compassion?

As discussed, a central role of the Leg Cafés will be to reduce social isolation and bring people together. This in itself will provide opportunities for people to

come into contact with others – including those who come from different walks of life – and understand more about them and their lives.

10. 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:	**Liz Fenton & Mike Roberts**
Name:	**Annie MacCallum**
Job title:	**Head of Specialist Services**

eQuality Impact Analysis

The starting point for any well designed service is a good understanding of who will be affected by changes, use the service, and deliver it. You need to understand who they are, what their needs are, and how we can make sure that the changes are safe and effective for them, and that they will have positive experiences of the experiences. This analysis is critical to ensure we can deliver high quality services and functions that reach everyone who needs them. It also helps avoid unintended consequences.

1. Name of project:

2. What happens currently?

3. What will change?

4. Who will be affected by these changes?

Service users and their carers	
Our colleagues, including in partner agencies	
The wider community	

5. What do we know about the people likely to be affected by the changes?

4a. Tell us what you know about the service users who will be affected

- How do they differ in profile to the population of the county as a whole? Refer to the Gloucestershire Profile, commissioners' needs assessments, JSNA.
- What age are they?
- Are they an even split of male/female?
- What's their ethnic profile – do they include people in 'non-White British' groups? Gypsies and Travellers? People who don't speak English?
- What disabilities might they have? Consider levels of dementia, learning disabilities, mental ill-health, sensory impairments, mobility/ physical disabilities. Are they more likely to have these than the population as a

whole? • Is there any evidence that they differ from the county average in terms of religion/ belief, sexual orientation, gender identity? • Are they any more or less likely to be pregnant or have recently given birth? • Do they include anyone in vulnerable groups, such as people living in rural isolation, people who are house-bound, people living in poverty, people who can't read or write, homeless people, sex workers, people who misuse substances, people in the military and veterans

4b. Tell us what you know about colleagues who will be affected by these changes

• How do they differ in profile to our workforce as a whole? Refer to the Gloucestershire Care Services Workforce Profile. • What age are they? Any older/ near 'retirement' age? Younger/ new starters? • Are they an even split of male/female? • What's their ethnic profile – do they include people in 'non-White British' groups? Gypsies and Travellers? People who don't speak English very well? • What disabilities might they have? Consider learning disabilities, mental ill-health, sensory impairments, mobility/ physical disabilities, long-term conditions. • Is there any evidence that they differ from the county average in terms of religion/ belief, sexual orientation, gender identity? • Do they include colleagues who are pregnant or on maternity leave? • Do they include anyone with caring responsibilities, especially for someone with disabilities, but including older parents or relations and children? • Do they include people with low literacy, i.e. people don't read or write? • Do they include people in the military and veterans?

6. How will these changes affect people?

6a. How will service users and their carers be affected by the changes?

In general?	*(Describe in your own words)*

Specifically, in terms of…

Safety?	*Consider:* increased/ decreased risk of harm – (falls, UTIs, VTE, pressure ulcers, infection, abuse or harassment); safeguarding issues
Effectiveness?	*Consider:* Ability to reach and access services, PROMs, recovery rates, length of stay, readmission likelihood, compliance with national guidelines/ best practice;

	effect on mortality and morbidity
Their experiences?	*Consider:* compassion, dignity, privacy, autonomy; good transitions between/ within services; feeling involved in care, listened to; feeling care providers are accessible and responsive; feeling confident in care provided; care and information adapted to needs; willingness to recommend

6b. How will colleagues be affected by the changes?

In general?	*(Describe in your own words)*

Specifically, in terms of…

Safety?	*Consider:* Staffing levels, risk of abuse or harassment, lone working; contact with dangerous service users/ others; working hours; skill levels;
Effectiveness?	*Consider:* skills and competencies required (any gaps?); efficient use of time, skills and resources; continuous improvement in skills and abilities; staff turnover and absenteeism
Their experiences?	*Consider:* staff morale and job satisfaction, stress levels; changes to working conditions (base, hours, team changes); fit with family, caring and other commitments; willingness to recommend Trust as a place to work;

6c. How will the wider community be affected by the changes?

In general?	*(Describe in your own words)*

Specifically, in terms of…

Confidence in the Trust	*Consider:* i.e. that the Trust is providing dependable services; is spending taxpayers' money in the best way possible
Employment and volunteering opportunities	
Physical environment	*Consider:* impact on public areas/public spaces/ green spaces; shared spaces/ social spaces; opportunities for people to network
Carbon footprint	*Consider:* increased/ decreased waste (packaging, products, travel) and use of energy (buildings, equipment travel)

Healthy lives	*Consider:* Enabling people to make healthy choices: physical activity/ active lifestyles, reducing smoking; adopting healthy eating; Making every contact with your clients count

7. What implications do their needs have for how we design and deliver this service?

Reflect on the profile of service users and colleagues who will be affected by the changes. Consider whether you will need to do things differently for some people to ensure the service/ function is safe, effective and a good experience for them. Consider:

- How you tell them about the changes
- Where the service is provided – physical accessibility, location
- When services are provided
- Communication - How people contact you; how you communicate with them (sensory impairments; learning disabilities; dementia; non-English speakers); appropriate formats and messages
- Sensitivity to cultural and religious behaviours and beliefs
- Flexibility to accommodate caring responsibilities, religious observances

See further detail in guidance

8. Are there any implications for their Human Rights?

Further guidance to be added

9. Are there any opportunities in designing and implementing these changes to bring people together, reduce isolation, and promote greater understanding, empathy and compassion?

Further guidance to be added

10. Risk rating – to determine whether you need to do more detailed analysis

Further guidance to be added

11. 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:	
Job title:	

Gloucestershire Care Services NHS
NHS Trust

Audit & Assurance Chair's Report

Ref: 14/B045

This report is for Publication

Gloucestershire Care Services NHS Trust Board

Audit & Assurance Chair's Report
25 November 2014

Objective:

To provide the Board with a summary of the key issues and actions arising from the meeting of the Audit and Assurance Committee held on 6th October 2014

The Board is asked to:

The Board is asked to **NOTE** the report and the approved minutes for information and assurance.

Executive summary:
The report sets out the key points discussed at the meeting of 6th October 2014. The approved minutes of the meeting held on 4th June 2014 are attached for information

Glyn Howells
17 November 2014

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 Trust Board

Title:	**Audit and Assurance Committee Report**		**Meeting Date: 25th November 2014**
Agenda Item:	**22**		
Purpose of Paper:	To provide the Board with a summary of the key issues and actions arising from the meeting of the Audit and Assurance Committee held on 6th October 2014		
Key Points:	The Committee approved the minutes of the meeting held on 4th June 2014. Other key points discussed at the meeting are outlined in the report.		
Options and decisions required	The Board is asked to **NOTE** the report and the approved minutes for information and assurance.		
Fit with strategic objectives	1. Achieve the best possible outcomes for our service users through high quality care		x
	2. Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work		x
	3. Provide innovative community services that deliver health and social care together		x
	4. Work as a valued partner in local communities and across health and social care		x
	5. Support individuals and teams to develop the skills, confidence and ambition to deliver our vision		x
	6. Manage public resources wisely to ensure local services remain sustainable and accessible		x
Next steps/future actions	The Committee has agreed a forward programme which will be reviewed on an on-going basis.		
Author name and title	**Glyn Howells** **Director of Finance**	**Director Name and Title**	**Robert Graves** **Non-Executive Director**

Meeting of Gloucestershire Care Services NHS Trust Board
To be held on: 25th November 2014
Location: Malvern & Coopers Room, Edward Jenner Court, Brockworth, GL3 4AW

Agenda item 22: Audit and Assurance Committee update

1. Introduction

This report provides a summary of the key issues and actions arising from the meeting of the Audit and Assurance Committee held on 6th October 2014. The approved minutes of the meeting held on 4th June 2014 are attached for information.

2. Review of overpayments

Two incidences of overpayments were reviewed and discussed. In one, management had given incorrect information that the staff member had acted on regarding returning to work after maternity leave. The committee APPROVED not reclaiming the overpayment as the staff member would not have taken the actions they did without the incorrect advice.

The second overpayment had been the subject of an internal audit report as it related to a Non Executive Director that has since left the Trust; the audit report was discussed at length and the action plans to ensure learning were validated. In this instance; there was additional work that had been performed on behalf of the Trust and some unclaimed expenses that when taken into account reduced the amount to less than £10.

The committee APPROVED the treatment.

3. Raising Concerns at Work Policy

Director of HR presented the policy to the Committee. The committee requested that a comprehensive communications plan be developed to support the issue of the updated policy to ensure all staff where made aware of the policy.

The Committee RECEIVED the Policy and agreed that this would come to the Committee with regular updates of the numbers of concerns being raised and the outcomes.

4. Internal Audit Update

Lynn Pamment of PwC presented a progress report on performance to date against the agreed annual audit plan and presented a draft of the Performance Audit Report. The Committee discussed the definition of a critical risk and Lynn Pamment confirmed that the definition of a critical risk was a risk that was deemed to be organisational wide as opposed to localised.

The Committee RECEIVED the Progress Report and NOTED the Internal Audit Performance Report was currently draft and that the final version was to come back to the Committee on completion.

5. External Audit Report and Letter

Duncan Laird of KPMG presented a brief update on external audit explaining that the bulk of the External Audit work was around the year end but that planning for the audit was well underway. Duncan also presented the Audit Letter for the 2013/4 accounts which formally closed off the 2013/4 reporting requirements.

The Committee RECEIVED the External Audit update and NOTED the receipt of the Audit Letter.

6. Counter fraud update

Sallie Cheung presented the update to the Committee focusing on the results of the Quality Assessment and the SRT Process Summary following the recent audit. NHS Protect used both the old and new SRT to complete their assessment and they upgraded the Trust on two lines from Amber to Green. They were particularly impressed with how problems with the service from SBS were identified and resolution pursued. The overall view was to keep up the good work.

One area of concern raised was ensuring that policies were updated; this is ongoing and taking time due to the volume of policies that need updating. The Director of Finance advised that one of the impacts of poor CIP delivery was that money that was in place to achieve ISO9001 was no longer available.

SC updated the Committee on the latest fraud cases.

The Committee NOTED the report and updates given.

7. Core Financial System Report

The Deputy Director of Finance updated the Committee on the issues that continue to exist with SBS and the lack of progress in resolving them. He explained that whilst there was minimal financial risk in the issues as the SBS contract includes the making good of the financial consequence of fraud,

there remained however both cashflow and reputational risks to the Trust from the issues identified.

The Committee NOTED the content of the report.

8. Better Payment Practice Report (BPPC)

The Committee RECEIVED the BPPC report; it was explained that the poor performance was partly due to a large payment overdue to Gloucestershire Hospitals NHSFT which contraed with a similar payment due to the Trust from GHNHSFT which was being held awaiting supporting evidence and partly through issues relating to SBS.

9. Review of Waivers; Special Payments and Write offs

The Committee RECEIVED the Waivers, Special Payment and Write offs report. The Financial Accountant advised that there were no new waivers; however, it was felt that this was probably incorrect. The Director of Finance stated that he would put out a communication to remind people of the correct procedures. The Chair asked if there was a role for internal audit, but Lynn Pamment (PwC) felt not if an internal review was being undertaken. The Chair asked that they review again once the internal review had been undertaken.

The Committee REVIEWED the Special payments and Write offs and APPROVED them with an action around one of them which was the payment of a fine on a pool car. The Committee also asked that all compensation payments that had not gone through the legal process, be bought back to the committee for review.

10. Any Other Business (AOB)

Under AOB the Chair advised the Committee that the Chair, Director of Finance and Director of Governance and Corporate Affairs had met out of committee to review a number of policies. This was done outside of committee due to the very large number of documents. The Chair listed them and asked that if any Committee member wished to see any of the policies they should contact the Director of Governance and Corporate Affairs.

The Committee NOTED the policies that had been reviewed.

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

Presented by: **Robert Graves, Chair, Audit and Assurance Committee**

Appendices

Appendix 1: Approved minutes of the Audit and Assurance Committee on 4th June 2014.

Gloucestershire Care Services NHS
NHS Trust

GLOUCESTERSHIRE CARE SERVICES NHS TRUST
AUDIT AND ASSURANCE COMMITTEE

Minutes of Meeting held on 4 June 2014
in the Boardroom, Edward Jenner Court

Present:	Robert Graves - Chair (RG)	Non-Executive Director
	Sue Mead (SM)	Non-Executive Director
	Chris Creswick (CC)	Non-Executive Director
	Richard Cryer (RC)	Non-Executive Director
	Glyn Howells (GH)	Director of Finance
In attendance:	Johanna Bogle (JB)	Financial Accountant
	Paul Dalton (PD)	Internal Audit, PWC
	Duncan Laird (DL)	External Audit, KPMG
	Jon Brown (JBr)	External Audit, KPMG
	Stuart Bird (SB)	Deputy Director of Finance
	Sallie Cheung (SC)	Local Counter Fraud Specialist
	Mal Jones (MJ)	Purchasing Consultant
Secretariat:	Christine Thomas (CT)	
Apologies:	Joanna Scott (JS)	Non-Executive Director
	Jason Brown (JaB)	Director of Corporate Governance & Public Affairs
	Lynn Pamment (LP)	Internal Audit, PWC

Ref	Minute	Action
A&A 41/14	**Agenda item 1. Apologies** The Chair welcomed colleagues to the Meeting and apologies were accepted from Joanna Scott, Jason Brown, and Lynn Pamment. The Chair noted that due to Stuart Bird needing to leave early Agenda Items 5, 6 & 14 would be bought forward.	
A&A 42/14	**Agenda item 5. Purchase Order Invoicing Report** SB introduced MJ to the Committee to present on Agenda Items 5 & 6. SB advised the Committee that the current Purchase Order system was not being used consistently by all operational staff and therefore exposed the Trust to risks on both spending practices and duplicate payments. It was recommended that a Head of Purchasing was needed to ensure more of a focus on this area. **Resolution: The Committee agreed and NOTED that more work was needed on ensuring that these risks were reduced, including by ensuring all front line staff understood the procedures. It was**	

	agreed that this area of work would become part of the financial strategy.	
A&A 43/14	**<u>Agenda item 6. Purchasing Policies</u>** The Committee **RECEIVED** the purchasing policies document and MJ updated the Committee on the purpose of the policy. The Committee were asked to approve the principles in the Purchasing Strategy and Purchasing Policy. The Chair asked if the Purchasing Policy needed to go into a formal policy and come back to the meeting. GH advised that it would become part of the Financial Management Strategy. It was agreed that the Trust must ensure it had a clear purchasing policy that explained to all staff what the procedures were and was not lost within another document. **Resolution: The Committee RECEIVED the report and agreed this was an important piece of work that needed to be developed further.** MJ left the meeting.	
A&A 44/14	**<u>Agenda item 14. Review and Approval of GCS Annual Report & Accounts</u>** The Committee **RECEIVED** the Annual Report & Accounts. GH presented the Annual Report & Accounts to the Committee and highlighted the changes made since the report had been seen last. Some minor amendments and typos were highlighted and GH requested formal approval of the report from the Committee. **Resolution: The Committee RECEIVED and APPROVED the report subject to the minor amendments noted being made.**	
A&A 45/14	**<u>Agenda item 2. Minutes of the previous meetings held on 14th May 2014</u>** The Committee **RECEIVED** the unconfirmed minutes of the meeting held on 14th May 2014. Some minor amendments and typos were highlighted. **Resolution: Subject to minor amendments the Committee APPROVED the minutes of 14th May 2014.**	
A&A 46/14	**<u>Agenda item 3. Action Log and Matters Arising</u>** The Committee **REVIEWED** the action log and the following amendments were noted.	

Minute Reference	Action Agreed	Lead Exec	Status
AA07/13	The Committee recommended a report on the invoice process to be	Director of Finance	Close

	prepared for June's meeting and Mal Jones to be invited to attend to provide statistical analysis.			
AA07/13	Core Financial Systems – The Committee recommended an update report is presented to the next meeting.	Director of Finance	Carried forward to Sept 14	
AA31/14	The meaning of deep-dive to be clarified. The Director of Corporate Governance will circulate to the Committee.	Director of Corporate Governance	Carried forward to Sept 14	
AA32/14	Response to the Annual Governance Statement – as the Trust can recover overpayments made it was agreed that this should be reduced from a high risk.	FT Programme Manager	Close	
AA33/14	Teleconference to be held to discuss the working of the Internal Audit Opinion.	Chair/Director of Corporate Governance/Director of Finance	Close	
AA34/14	The Standing Order report to be amended to show the correct number of Non-Executive Directors.	Director of Corporate Governance	Close	
AA38/14	SBS Annual Review - The Chair asked for the service with SBS to be kept under review and the Director of Finance advised that he would bring a summary paper to the Committee	Director of Finance	Close	

Resolution: The Committee NOTED the updates on the action log and closed actions.

A&A 47/14

Agenda item 4. Review of forward agenda 2014/15

The Forward Agenda Plan was reviewed by the Committee and the following changes agreed: **JaB**

(1) An additional meeting to be arranged for August to accommodate large number of ad-hoc reports.
(2) All standard items on the additional meeting to be taken off as not relevant.
(3) Core Financial Systems update report to be moved to September.
(4) Ad Hoc reports to move from September to additional meeting in August.

A&A 48/14

Agenda item 7. Internal Auditors update

PD gave a verbal update on the Internal Audit and the Chair agreed that PD could present agenda items 10 and 11 out of order.

A&A 49/14	**<u>Agenda item 10. Receive Internal Audit Annual Report 2013-14</u>** The Committee **RECEIVED** the Internal Audit Annual Report, which was presented by the Internal Auditor. The amended wording in the Opinion section was reviewed and one further amendment was suggested. It was agreed that the amended report would be circulated to members outside of the Committee Meeting. **Resolution: Subject to the one minor amendment the report was formally RECEIVED as part of the assurance process.** **[Post meeting notice: amended wording was received and agreed outside of the meeting by the Chair and Director of Finance].**	
A&A 50/14	**<u>Agenda item 11. Internal Audit review of clinical record keeping</u>** The Committee **RECEIVED** the Internal Audit review of clinical record keeping, which was presented by the Internal Auditor. PD advised that there was some progress on the five high risk actions and these had now become two medium and three low. SM advised that she would like this to come back to the Quality and Clinical Governance Committee to keep on top of it, as there was a danger of slippage, but that Audit and Assurance should also still review it. The Chair advised that he was satisfied for this to go to Quality and Clinical Governance Committee and that they would ask for ad hoc updates from the Quality and Clinical Governance Committee. The first update to be presented to the Board in the December meeting. The Committee discussed the issue of the definition of critical risk. It was raised that a critical risk to a local service may not be a critical risk to the Trust. It was agreed these concerns would be discussed with LP and added to the agenda for the August meeting. **Resolution: The Committee NOTED the content of the report and REQUESTED clarification from Internal Audit on critical risk definitions.**	**SM** **JaB / Internal Audit**
A&A 51/14	**<u>Agenda item 8. External Audit Update</u>** JBr gave a verbal update on External Audit and confirmed that they were happy to sign off the Accounts. The Chair agreed that JBr could present Agenda item 15 out of order.	
A&A 52/14	**<u>Agenda item 15. External Auditors Report on Annual Report & Accounts</u>** The Committee **RECEIVED** the External Auditors Report on Annual Report & Accounts. It was discussed that some other NHS organisations had not confirmed agreement of balances in accordance with NHS requirements, but the Auditors were satisfied that the GCS accounting was correct and that attempts had been made to gain agreement with the other parties. JB confirmed that she had confirmation from NHS	

	England regarding this and they had confirmed their balances were wrong, but they would not change their side of the accounts. This was to be removed from the table on Appendix C. DL confirmed that they were happy with the Internal Audits and concur with these results. They are satisfied that the Trust is meeting VFM requirements and will therefore sign off the Audits. **Resolution: The Committee RECEIVED the report and assurance from the External Auditors.**	
A&A 53/14	**<u>Agenda item 9. Counter Fraud update</u>** SC gave a verbal update on Counter Fraud and advised there was little to update the Committee on since the last meeting. SC advised that she had yet to sit down with GH and agree the Counter Fraud plan going forward, but that she saw this as changing little from the last year, with perhaps a greater emphasis on procurement. GH advised that any additional days needed for Counter Fraud in the coming year would be funded. SC added that she would be happy to offer their services to MJ and his team to help with any fraud issues. The Chair agreed that SC could present Agenda item 12 out of order.	
A&A 54/14	**<u>Agenda item 12. – Counter Fraud Annual Report</u>** The Committee **RECEIVED** the Counter Fraud Annual Report. SC advised that changes discussed last time had been made. CC asked when the Self Review tool would be completed and SC advised this needed to be completed by the end of June. The Chair agreed that this would be received at the September meeting. **Resolution: The Committee RECEIVED the report and NOTED the deadline for the Self Review tool to be received by the Committee.**	**SC**
A&A 55/14	**<u>Agenda item 13. Policy Management</u>** The Committee **RECEIVED** the Policy Management Document. GH presented the item in the absence of JaB. GH advised that this document promoted best practice going forward on policy management. The purpose of presenting this document is to give assurance that this is in place and seek approval that we can now go out and start using it. There was some concern that this document was fine for top line management but would not be easily accessible by other colleagues in the Trust. There was some concern that there would be conflicts between clinical policies and what was deemed best practice by professional bodies. It was **NOTED** that professional bodies' best practice would override the Trust's own policies. The policy does not	

	make this point and needs to be amended to show this to avoid confusion amongst colleagues. JaB to make this amendment and present a plan of how the policy management will be implemented to the August meeting. **Resolution: The Committee NOTED the Policy Management document and asked for this to come back to the Committee with the amendments in August.**	**JaB**
A&A 56/14	**<u>Agenda item 17. Better Payment Practice Code (BPPC) Performance</u>** JB presented an update to the Committee and confirmed that IPROC (SBS Procurement system) training had reached a lot of people, although not everyone, and a lot more work was needed on this. It was agreed that they must become much firmer on ensuring PO numbers were used and shown on invoices as this was causing delays to prompt payment. JB advised that the year to date figure is currently 90% of invoices paid within target by volume and 91% by value.	
A&A 57/14	**<u>Agenda item 18. Waivers</u>** JB presented the Waivers and asked if the Committee were happy to ratify the three current waivers. **Resolution: The Committee RATIFIED the waivers**	
A&A 58/14	**<u>Agenda item 19. Losses and Special Payments Register</u>** JB reported that there were no losses and special payments to report.	
A&A 59/14	**<u>Agenda item 20. Debt Management</u>** JB tabled a paper on debtors and asked the Committee to approve writing off of debts that were no longer viable to chase. The Committee discussed where these debts had come from and it was explained that most were small dental charges that were below economic benefit to be chased. The Committee **APPROVED** the writing off of these debts. **Resolution: The Committee RECEIVED the report and APPROVED the writing off of the debts.**	
A&A 60/14	**<u>Agenda item 21. Any Other Business</u>** There was no other business. The Chair closed the meeting.	
A&A 61/14	**Date of next meeting:** An additional meeting is to be arranged for August; the date, time and location of this to be advised in due course.	

Chair's signature ……..

Date ……..

Gloucestershire Care Services NHS
NHS Trust

SystmOne Paper

Ref: 14/B046

This report is for Publication

Gloucestershire Care Services Trust Board

SystmOne for Community Hospitals and MIIUs
25th November 2014

Objective:

This paper proposes implementing SystmOne into Community Hospitals and Minor Illness and Injury units to support the single system strategy.

The Board is asked to:

Approve the contents of the paper which is that GCS utilise the Southern Communities Programme offering of TPP SystmOne Community Hospital and MIIU modules and deploy the system within the timescales noted.

Executive summary:

GHNHSFT will be replacing both their PAS and MSS Patient First systems with a new Government funded Smartcare programme which will provide a universal system for all of their acute needs. This change will impact GCS as the organisation uses both of these systems for Community Hospitals and Minor Illness & Injury Units. GCS are not part of this programme as the Government funded solution for GCS is TPP SystmOne and organisations cannot benefit from 2 schemes at the same time. This paper proposes that GCS consider implementing the Community Hospital and MIIU SystmOne modules supplied by TPP under the Southern Communities Program to replace and enhance the existing PAS and MSS Patient First systems functionality in 2015/16.

Bernie Wood
November 2014

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: • Quality Impact Assessment was completed for the Community and Child Health services SystmOne deployment. This assessment will be updated following approval of this paper

[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 Trust Board

Title:	SystmOne for Community Hospitals and MIIUs	
Agenda Item:	**23**	
Purpose of Paper:	To seek board approval to deploy SystmOne into Community Hospitals and MIIUs	
Key Points:	• This paper proposes that GCS consider implementing the Community Hospital and MIIU SystmOne modules supplied by TPP under the Southern Communities Program to replace the existing use of PAS • Identifies benefits of moving Community Hospitals and MIIUs to SystmOne • Explores 4 Options • Provides a project deployment timeline • Finance: - Free software, support and hosting provided under the Southern Community Programme for 4 years from June 2013. - GCS existing staff will be used to support the deployment - Additional costs will include project implementation and capital costs of £75k, non-recurring costs of £708k plus recurring costs of £52k	
Options and decisions required	• That GCS select SystmOne as the system of choice for Community Hospitals and MIIUs utilising the Southern Communities Programme TPP SystmOne Community Hospital and MIIU module	
Fit with strategic objectives	1. Achieve the best possible outcomes for our service users through high quality care	x
	2. Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	x
	3. Provide innovative community services that deliver health and social care together	x
	4. Work as a valued partner in local communities and across health and social care	x
	5. Support individuals and teams to develop the skills, confidence and ambition to deliver our vision	x
	6. Manage public resources wisely to ensure local services remain sustainable and accessible	x
Next steps/future actions	Proceed with the TPP Initiation commitment documents	
Author name and title	Bernie Wood	**Director Name and Title** Glyn Howells

Glocuestershire Care Services NHS Trust Executive Board
To be held on: 25 November 2014
Location: Edward Jenner Court, 1010 Pioneer Avenue, Brockwoth, Gloucester, GL3 4AW

SystmOne for Community Hospitals and Minor Illness and Injury Units (MIIUs)

1. Purpose

Gloucestershire Care Services NHS Trust (GCS) manages 7 Community Hospitals and 7 Minor Illness and Injury Units (MIIUs) across Gloucestershire.

The IT system currently used by Community Hospital is primarily the acute services Patient Administration System (PAS) which supports the demographic and contact information only for inpatient management (including day care and day cases), outpatient management for therapies, theatre and case note tracking. Activity performed by Community Hospital staff is for both acute activity and GCS activity.

The IT system in place used by MIIUs is MSS Patient First which is a system also used by Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) Emergency Department (ED) department which links to their Patient Administration System (PAS). A one way link from GHNHSFT to GCS exists between the systems in that GCS can pull data down basic demographic information from PAS but GCS are unable to push data back up to PAS.

GHNHSFT will be replacing both their PAS and MSS Patient First systems with a new Government funded Smartcare programme which will provide a universal system for all of their acute needs. The system selected is called Trakcare. GCS are not part of this programme as the Government funded solution for GCS is TPP SystmOne and organisations cannot benefit from 2 schemes at the same time. However, GCS will continue to carry out GHNHSFT outpatient activity and as a consequence will also be users of the new Trakcare acute system.

Commitment to the continual use of both PAS and MSS Patient First has only been made to March 2016. Furthermore, MSS Patient First is not a clinical system but leans more towards capacity management and data flow for a large department. It does not support any Medicines Management which is a clinical risk, and has no record keeping audit. Patient information is collected via a form which is then later scanned into MSS Patient First which results in a delay in data being recorded.

This paper proposes that GCS consider implementing the Community Hospital and MIIU SystmOne modules supplied by TPP under the Southern Communities Program to replace and enhance the existing PAS and MSS Patient First systems functionality in 2015/16.

2. Recommendations

That GCS utilise the Southern Communities Programme offering of TPP SystmOne Community Hospital and MIIU modules and deploy the system within the timescales noted.

3. Background

There is clearly a desire and need across care settings to share information more widely, enable much closer and seamless integration of services and engage with patients and their care more proactively. This in turn will enable improvements in clinical delivery, outcomes and patient experience, whilst also beginning to reduce demand for unplanned acute services as patients are managed more effectively within the community and at home.

The systems being implemented must be part of a wider Trust strategy and be able to grow with GCS to reflect the changing needs and priorities of the community into the future. They must support both clinical and operational benefits, including transfer of care between care settings and dynamic scheduling of Community Hospital and MIIU resources and facilities to enable them to respond to changing clinical demands as effectively and efficiently as possible based on their skills and geographical location.

Most critically the systems must support the development of integrated care across health and social care settings to reduce the demand for acute and urgent care delivery, support chronic disease management, promote self-care and support successful partnerships with other health and social care partners.

GCS is investing significantly in the roll out of a patient centric clinical system across the services, and is able through the Southern Communities' procurement to procure and implement the systems Community Hospitals and MIIU modules with central funding support, which in turn will support a single clinical solution across the majority of GCS's services.

Service	**Clinical System**
Community	SystmOne
Child health	SystmOne
Community Hospitals	SystmOne*
Minor Injuries Units	SystmOne*
Out Of Hours	Adastra
Sexual Health	Millcare
Dental Services	SOELHealth
Smoking Cessation	Quit Manager

* Proposed

The product being implemented is SystmOne and is available in modules of which GCS can obtain 4 modules 'free' for 4 years from June 2013 with an option to extend at cost for a further 3 years. 2 of the modules; Community and Children's Health Services have been agreed for this deployment but

decisions on modules Community Hospitals and MIIUs have yet to be considered. This paper puts forward the options available when considering the implementation of the 2 other SystmOne modules.

GHNHSFT via their Smartcare Programme are also moving to a new electronic patient record solution and are currently in contract negotiations for an Intersystem's product called TrakCare. TrakCare and SystmOne are not interoperable but both are required to provide electronic messaging between the 2 systems either via standard HL7 messaging, the Medical Interoperability Gateway (MIG) or via more complex systems integration.

Ideally GCS would require services to have a single point of access to information and individual patient records that will support them in the delivery of safe and effective care. i.e. to hold patient and client information in a single system where possible that enables seamless working with Primary and Social Care. Gloucestershire County Council (GCC) are currently investigating SystmOne as a potential solution for their Adult Social Care staff which if selected will further enhance single access to systems. 36 GP practices already use SystmOne and the MIG is being investigated as the solution to connect SystmOne to the other 48 practices.

4. Discussion of Issues

An integrated set of clinical systems with integrated patient records will provide an opportunity to improve the efficiency of the patient care pathway and operational management processes which, in turn will speed up the delivery of efficient patient care and enable more effective management all of which support better patient care.

In order to achieve maximum benefit from implementing SystmOne GCS must adapt its culture to adopt the system. This will need executive leadership and staff must develop and change their practice to make the best use of the available technology. To realise the available benefits, GCS will need to take the opportunity to review, and potentially change fundamentally, its administrative and clinical processes within the Community Hospitals and MIIUs.

The case for change includes the following:

- A need to improve the capture and accessibility to all forms of patient clinical information e.g. assessments, risk scores, medication, consultations
- GCS requires a "paper-light" environment in which paper is produced, managed, transported and stored only at an absolute minimum level. This is not achievable with the current systems in place
- The current mixed paper and electronic systems of record-keeping create high levels of clinical risk through a lack of cohesion and no "one place to look" for a patient's history
- The storage and management of patient case notes are both costly and inefficient

- GCS incurs costs with the production and delivery of clinic letters that have not yet been moved into electronic delivery. Some letters are also kept separate from any current electronic patient record systems.
- The Trust requires as a minimum an integrated Community Hospital and MIIU system which is fully integrated and visible across health and social care community services
- The current range of disparate electronic and manual information systems inhibits the delivery of the safe and effective modern Community Hospital services that GCS aspires to deliver for its patients
- Whilst the disparate systems do meet data collection and processing needs they also create duplicate entry of information for staff and isolated sources of data along with multiple user interfaces for staff to learn and multiple technologies for GCS to support
- This creates further issues for reporting requirements as information is sourced from multiple systems and has to be combined to create the statutory reporting needed for Trust reporting

4.1 Operational Impact of Change

Specific areas of concern have been raised particularly in respect of moving to a different Community Hospital and MIIU system to the GHNHSFT Trakcare solution and any shift will require working groups to agree with our acute colleagues' solutions to these concerns.

The following list, although not exhaustive, addresses the main points of concern and possible mitigation which will need further exploration to introduce the change operationally into SystmOne.

GCS/GHNHSFT linked functionality	Usage	Potential Impact areas	Mitigation
Use of Dual Systems (Acute & GCS)	Community Hospital and MIIU staff support both GHNHSFT and GCS activity	Clinical, Admin staff and managers will be required to use 2 systems depending on the organisation activity	Generally most staff will only use one system e.g. staff working with inpatients will use SystmOne but staff working on GHNHSFT outpatients will use Trakcare Over time electronic data transfer will need to be implemented between both systems and/or a portal implemented to allow single access to data GHNHSFT and GCS will need to brief staff and prepare them for cultural change
Inpatient Management (including Day-care & Day cases)	Scheduling Waiting Lists Ward enquiries Tracking of waiting times Recording of outcome codes Discharge information Occupancy Whiteboards Contract & billing SUS data submissions	Reporting Bed management Clinical coding Single Case note tracking Theatre utilisation Wristband printing Current use of non PCT staff covering some admin processes Occupancy Contract & billing Discharge & Admissions	Clinical coding staff (GCS would prefer to continue to obtain clinical coding from GHNHSFT but this will need clarification and adjustment to existing contracts to incorporate the change) Potentially additional clerical staff to cover tasks currently undertaken by some GHNHSFT clerical staff, Staff working on day care and day cases will use 2 systems depending on organisations activity.
Outpatients for Consultant Led follow ups	Scheduling Pending lists Booked patient lists Attendance record Tracking of waiting times Recording of outcome codes Referral and discharge information Contract & billing, Utilisation rates SUS data submissions	Reporting Single Case note tracking Choose & Book Contract & billing, contract monitoring	GCS staff will use Trakcare as this is GHNHSFT activity

Outpatient Management for Therapies	Scheduling Pending lists Booked patient lists Attendance record Tracking of waiting times Recording of outcome codes Referral and discharge information Contract & billing, Utilisation rates SUS data submissions	Reporting Single Case note tracking Choose & Book Contract & billing, contract monitoring	Clinical coding staff (see above) Additional clerical staff to cover tasks currently undertaken by some GHT clerical staff GCS to develop its own Choose & Book requirement via central booking office proposal
Case notes Tracking Bar-coding	Case Notes shared Tracking of single case note folders Ability to bulk transfers via bar-coding.	Gaps in tracking of single Case note Clinical risk if patient notes are required but unavailable clinical coding - would need a clinical coder for GCS	All notes to be electronic Scanning of notes into S1 if required or S1 can hold acute case paper references
Theatres/Endoscopy	Scheduling Theatre Activity	Reporting Loss of links into Theatre modules Contracting & billing Utilisation Sexual Health	Theatre slots will continue to be booked via SharePoint SystmOne Community Hospital solution includes Theatre functionality appropriate to the care setting. If richer theatre functionality required will require theatres module at a cost Theatre utilisation for GCS activity will be booked on SystmOne Theatre utilisation for GHNHSFT activity will be booked on Trakcare Staff use 2 systems depending on activity – see use of dual systems above Sexual Health Terminations currently recorded on PAS will be required to move to MillCare
Pharmacy and E-prescribing	Services currently paper based	No impact as will continue with paper based systems	GHT Trakcare will implement an electronic system to be investigated when available compared to doing on SystmOne
Joint Clinics	There are a very small number of clinics that include both GCS and GHT activity	This could cause confusion for staff who enter the data onto systems on what data should be recorded and where	To be considered and resolved as a part of the 'To Be' process and change plan

White/Smart boards	Community Hospital currently use White/Smart boards to track their patients	Access to White/Smart boards would be a backward step for efficiencies	SystmOne provides a White/Smart board functionality that can be developed and improved on the current setup
Care Plans/Patient Notes	A lot of patient information is held on paper. Both GCS and GHT by implementing electronic systems will work towards a paper light environment	Paper notes will not be available except in a limited form	All patient information to be recorded electronically. This may require view access for staff into both SystmOne and the TrakCare
Patient Arrival Systems (Callaid)	Newly build Community Hospital provide a patient booking in system via touch screen technology	Backward step if patients have to revert to booking in via reception	2 Options: 1. Install the Self Arrival SystmOne software for all hospitals 2. Maintain existing Callaid system and implement Self Arrival SystmOne software in hospitals without this functionality
Migration of data	Demographic and content data is currently on PAS	Access to historic records are often required to understand as much as possible regarding the patients history	SystmOne will not migrate any data from legacy systems. Data take-on will be manual for future clinics only. This is similar to the recently implemented community SystmOne module. GCS will take a snapshot of the appropriate data and enter it into the GCS data warehouse to enable access of historic data

In addition to the above there are also local areas of concern that will need solutions to continue seamless support to patient care. An example of this would be the existing interfaces with Single Point of Clinical Access (SPCA) where staff currently obtains the Bed State by ringing around the wards. With SystmOne this will not be necessary as this information will be available directly from the system. However, considering another activity the referrals that are received from SPCA are currently received into the Community Hospital by electronic fax. This will require further investigated for a solution to receive an electronic referral directly into the SystmOne rather than fax. Another area that has been identified at this early stage is that Community Hospitals will also need to accommodate Wards that use winter pressure beds and SystmOne is flexible regarding opening and closing wards as and when required.

There will be many such queries and solutions raised when this project commences not only for Community Hospitals but MIIUs also and each area will be investigated to provide either a better solution, a workaround or the practice to continue until additional solutions are examined.

4.2 Reporting

In moving from the existing system to SystmOne, there will need to be a seamless transition to facilitate the following reporting requirements:

- Data is mandated to be flowed nationally to Secondary Uses Service (SUS). SystmOne design will need to meet the Community Data Set (CDS) technical specification, otherwise it will be rejected. This data is then available to commissioners from SUS and is intended to be used for commissioning and billing purposes.

- Data is also required to be available and accessible on a real-time basis to replicate existing availability and required reporting functionality.

- The Trust is required to submit a Situation Report (Sitrep) return to the Department of Health on a weekly basis for both Community Hospitals and MIIUs. Additionally for MIIU data GCS have to notify commissioners of any individual patient attendances that have duration in the MIIU department of over 6 hours within 48 hours of the attendance. The data is also reviewed on a daily basis, for internal monitoring and data quality validation.

- Clinical Coding (ICD10 and OPCS4 coding) has to be completed for all admitted patients (Inpatients and Day cases). This must be completed to allow HRG coding to be derived to be included within the SUS submission, and for Contract Monitoring and Non Contract Activity Invoicing.

- Development of real-time reporting.

GCS Performance and Information team are already developing the skills required to manipulate the data already collected on the existing instances of SystmOne. This is achieved through receipt of a daily full data extract from SystmOne into the GCS data warehouse.

4.3 High Level Anticipated Benefits

A number of themes support this project as follows:

- Integrated and joining up care across GCS, GPs and potentially Social Care services
- Automating administrative and clinical tasks and processes wherever possible to reduce delays and release clinical staff to deliver care
- Address issues associated with the use of paper e.g. inability to review full patient information due to the use of disparate systems

In support of these themes a number of benefits can be identified that GCS will achieve through implementing a new Community Hospital and MIIU system which can be categorised as:

1. Cash-releasing resulting in measurable realisable savings
2. Non-cash-releasing resulting in savings that may be difficult to release
3. Qualitative which will improve quality but may not result in directly attributable, quantifiable cash savings.

These can be identified as follows:

1: Improving the quality, safety and reputation of our services

Benefit	Benefit Type
Providing a single consistent view of the patient record that can be shared both across the Trust and into the wider community joining up primary and social care	Qualitative
Introduction of one consistent user interface that will be used throughout the community as a first access point for patient care and data retrieval will eliminate dual entry of patient registration across systems	Non-cash-releasing
Allowing patients to be admitted, discharged and transferred electronically within one system across the community and Social Care with all data collected in one database without double entry	Non-cash-releasing
Includes alerts rules for abnormal results/risk factors such as allergies/safety alerts etc.	Qualitative
Improving safety & security of data	Qualitative
Improving patient tracking - enable real-time bed management via white/smart boards. Ability to locate patients and track journeys in real time and provide audit trail in the event of infection outbreak	Qualitative
Enabling real-time clinical decision support and access to advice/ guidelines/ interactions/ contraindications	Qualitative
Facilitating timely discharge and a reduction of length of stay	Non-Cash Releasing (due to block contracts)

2: Developing the Trust's (and community partners') capacity to deliver the highest levels of performance

Benefit	Benefit Type
Enabling efficient scheduling of resources	Non-cash-releasing
Improving management of requests and results, and access to more timely information	Qualitative
Supporting provision of better care which will further shorten average length of stay so increase patient capacity	Non-cash-releasing
Flexibility to allow better working practices	Qualitative
Optimising production of clinical correspondence	Qualitative
Improving information for management	Qualitative
Enhancing the speed and accuracy of data collection for mandatory targets	Qualitative
Ensuring NHS reporting standards are met by collecting all data from one source and reducing reporting spend	Non-cash-releasing

3: Ensuring a sustainable financial future by protecting income, reducing costs and increasing profitability

Benefit	Benefit Type
Reducing administrative time	Non-cash-releasing
Reducing reliance on paper	Non-cash-releasing
Delivery of electronic case notes and the associated efficiencies around workforce and estate utilisation	Cash releasing
Enabling more efficient records management/electronic filing of results	Cash releasing
Improving data quality to support coding and costing (e.g. less duplication, more clinical involvement in data capture)	Non-cash-releasing
Reducing litigation risks through full availability of records and improved audit trails	Cash releasing
Providing a system that is securely hosted, consistently supported and updated for the needs of the Trust with much reduced annual support costs	Cash releasing
Replacing legacy and manual systems	Cash releasing

4: Build and develop effective partnerships with stakeholders to improve our long term sustainability

Benefit	Benefit Type
No longer reliant on ageing or unsupported systems and has one single integrated patient interface that offers the ability to share information across the Trust and beyond.	Qualitative
The new system will allow clinicians to use technology such as interactive whiteboards and mobile devices to improve care processes and communications and increase efficiency	Non-cash-releasing

Facilitating electronic communication with GP's and improve quality and timeliness of clinical correspondence and will result in anticipated cost reductions to the Trust	Cash releasing
Elimination of current inefficiencies such as dual data entry and the reliance on paper as a new system is introduced and manual processes are replaced	Cash releasing
Faster discharge enabled through co-ordination with transport services, community staff and social services	Qualitative

4.3 Options Appraisal

A number of options for a Community Hospital and MIIU system have been considered and these are as follows:

Option 1: Do Nothing. Maintain and exploit current disparate systems and manual processes as much as possible. Both PAS and MSS Patient First systems are being replaced by the GHNHSFT new universal system and so these systems will not be available to GCS as GCS is precluded from using the replacement Trakcare system under the procurement. Although MSS Patient First is a GCS owned system it was purchased due to its tentative links with PAS, this will no longer be available and MSS Patient First as a standalone system will not support the MIIUs in achieving integration with other services and will inhibit some clinical and patient benefits and the ability to be 'paper-light' and so **this option is not clinically or operationally viable.**

Option 2: Take on the GHNHSFT solution. The costs are likely to be considerable and it is unclear as to how integrated any such solution would be with other GCS and Social Care services, for both clinical and operational delivery. **Not viable as the risks of waiting for a product not yet developed and the unknown nature of the costs and links to other GCS services will mean missing the opportunity to obtain the 'free' Community Hospital solution offered by the Southern Community Programme. Additionally GCS cannot benefit from 2 centrally funded procurement initiatives.**

Option 3: Procure a stand-alone Community Hospital and MIIU solution that would be integrated with other GCS and Social Care systems. This would require OJEU procurement and it is not considered that a standalone solution of this nature would support the Trust requirement for a fully integrated single patient record across the Trust that would have access to and be visible by Primary and Social Care colleagues. **This is not considered a viable option to meet the objectives and vision of GCS and introduces disparity across the Trust systems.**

Option 4: Deploy the SystmOne Community Hospitals and MIIU solution procured and funded through the Southern Communities contract. Acute colleagues could, if required, initially use the TPP Clinical Record viewer to access the SystmOne record and in time SystmOne could be integrated with the acute hospital solution once procured and deployed; this is expected to be in within the next 18 months. This would also improve GCS links to Primary Care for safeguarding Adults and Children. SystmOne shares information with other services such as Health Visitors and GP

practices. **This is considered as the option that best meets the GCS's operational, clinical and strategic requirements and vision for the delivery of high quality integrated care.**

An evaluation of the options can be found in Appendix 1.

5 Timeline

There are a number of factors to consider in regard to starting this project:

- The 'free' funding provided under the Southern Program is only available until 23rd June 2017 and any delay is lost funding
- GHNHSFT will be replacing PAS sometime before March 2016
- 'Go Live' cannot happen during winter months when the Community Hospitals and MIIUs are at their busiest and it will be difficult for staff to be released for training etc.
- There is a requirement to maintain continuity with the trained fixed term project team already working on existing SystmOne rollouts

With the above in mind the attached proposed Deployment Plan (see Appendix 2) is presented for consideration.

6 Financial Implications

All costs presented here are for **both** the Community Hospital and MIIU deployments and assumes that all staff are trained in basic IT Keyboard skills.

6.1 Project Staff and Implementation Costs

Costs are based on normal working day salaries for training and scoping. If there is a requirement for staff to work unsociable hours with the Community Hospitals and MIIUs there will be additional overtime charges.

Table 1
Summary Cost Table

Funding Requirement	Capital	Non-Recurring	Recurring	Existing Budgets
Clinical Systems Project Staff		£365,485		
Floor Walking (Previously paid from Operational Budgets)		£77,968		
Server Desk Analysts (Restructure paper to follow)			£42,468	
Existing Clinical System Team				£159,449
Travel Expenses		£20,000		
Scanners (avg 3 per site to include CoHo and MIIU)		£20,000	£2,000 (based on £100 per device annual support)	
Tablet Devices for Beds (Assume 1 per single room	£75,200		£7520 (based on	

and 4 per ward) – 94 x £800 – *Requirement to be agreed*			estimated £80 per device)	
Backfill Funding		£124,840		
Software and Hosting			Free (until 2017)	
Assisted Deployment for first 'go live'		Free		
Contingency		£100,000		
Total Budget Required	**£75,200**	**£708,293**	**£51,988** (Revenue)	**£159,449** (Already funded)

Detailed Cost Tables

Clinical Systems Project Staff Financial year 2015/2016 (Non-Recurring)
Project staff resources are currently employed and funded until the end of March 2015 therefore there will be a requirement to extend the employment of some existing project staff for the duration of the Community Hospital and MIIU implementations.

In order to accommodate this, the following cost table is the estimated funding required to cover the deployment of both the Community Hospital and MIIU modules:

Table 2

Staff Requirement	Band	WTE	Cost (inc on-costs)
Senior Project Manager	7	1.00	£43,305
Business Analysts	5	2.00	£59,896
Clinical Safety Officer	8a	1.00	£53,490
Data Migration Inputters	2	2.00	£37,634
System Trainers	4	3.00	£74,316
Technical Deployment	5	1.00	£29,948
Information Analyst	6	1.00	£36,948
Information Analyst	5	1.00	£29,948
		Total Cost	**£365,485**

Floorwalkers (Non-Recurring Costs)
A lesson learnt from the ICT deployment was a requirement for local operational floor walkers to support 'go lives'. This function was paid for out of the Operational team budgets so this paper suggests that if extra floor walking is required that the service may benefit from funding this approach.

Table 3

Staff Requirement	Band	WTE	Cost (inc on-costs)
Floorwalkers (Based on 5 per Community Hospital and 3 per MIIU)	3	5	£77,968
		Total Cost	**£77,968**

Service Desk Analysts (Recurring Costs)

An additional Service Desk Analyst will also be required permanently for every additional 500 staff registered on SystmOne. The estimated number of Community Hospital and MIIU users is 1,100 staff so the following cost table is presented. Costs will be covered following savings that will occur due to the termination of the PAS contract:

Table 4

Staff Requirement	Band	WTE	Cost (inc on-costs)
Service Desk Analysts	3	2	£42,468
		Total Cost	**£42,468**

Clinical Systems Team (Existing Budget)

Further support for the project will be provided by the permanent Business as Usual Clinical Systems Team funded by GCS which is currently under review (a later paper to be presented which will included the additional recurring costs noted above for service desk staff). The existing recurring costs to support this are as follows and presented for information only:

Table 5

Staff Requirement	Band	WTE	Cost (inc on-costs)
Clinical System & Change Manager	8a	0.25	£13,372
Systems/Project Support Officer	5	0.25	£7,486
Change Support/Configuration	6	0.50	£18,060
Training Lead	6	0.75	£27,088
Technical Project Lead	8a	0.25	£13,373
UAT	5	1.00	£29,949
RBAC & Smartcards (via HR)	3	1.00	£21,234
Data Warehouse Manager	7	0.25	£10,827
Information Analyst	6	0.50	£18,060
		Total Cost	**£159,449**

Miscellaneous Costs

Other miscellaneous costs include staff travel and hardware peripherals to support ease of working particularly in Community Hospitals and MIIUs. These include Scanners and a number of tablet devices for each ward. In addition funding is being requested to cover any contingencies that may be required.

Table 6

Requirement	Capital	Non-Recurring	Recurring
Travel Expenses		£20,000	
Scanners (avg 3 per site to include CoHo and MIIU)		£20,000	£2,000 (based on £100 per device annual support)
Tablet Devices for Beds (Assume 1 per single room and 4	£75,200		£7520 (based on estimated £80 per device)

per ward) – 94 x £800 – *Requirement to be agreed*			
Contingency		£100,000	
Total Cost	**£75,200**	**£140,000**	**£9,520**

6.2 Clinical Staff Backfill Costs

A further lesson learnt from the ICT deployment was the lack of clinical and admin staff backfill during training. These deployments struggled to cover staff whilst they attended training. As there is no flexibility to drop activity in hospitals back fill costs will be required.

Following consultation with Community matrons a budget requirement was identified that would be used to backfill staff for Community Hospitals and MIIUs whilst in training. As the backfill staff will not be required for the whole year the calculation below has been based on 10 months for 6 WTEs. This budget will be managed by the Head of Community Hospitals.

Table 7

Staff Role	**Band**	**Mid-Point Salary**	**Monthly**	**WTE**	**No of Months**	**Total Cost**
Nurse	5	£29,948	£2,496	2	10	£49,920
HCA	2	£18,817	£1,598	2	10	£31,960
Admin	2	£18,817	£1,598	2	10	£31,960
Contingency@ 10%						£11,000
					Total Cost	**£124,840**

6.3 Hosting and Software Costs

Under the Southern Programme hosting and software costs are '**free'** for the first 4 years from June 2013. An extension of the existing contract can be obtained for a further 3 years in 2017. In addition support with the first 'go live' via the deployment company Accenture is also '**free'** under the existing contract.

The following SystmOne cost tables are supplied **for information only**:

Price Band	**Number of Active Registered User(s) in a calendar month**		**Monthly Charge (£)**
Lower limit of price band		Upper limit of price band	
Low User	1	600	£13,606.00 -
Standard User	Over 601	No limit	£35,746.30 -

Deployment Costs	One off cost £187,547

7 Implementation and Review of Progress

Implementation of the SystmOne Community Hospital and MIIU modules will be managed as an extension to the existing SystmOne project which reports to the SystmOne Project and Operational Board who meet fortnightly for executive sign off. The Prince2 methodology is used to monitor progress via operational work streams, highlight reports. 'As is' and 'to be' processes are signed off at executive and heads of service level. Due to the demise of PAS and MSS Patient First in the next 18 months it is suggested that this implementation starts December 2014 and works towards a March 2016 completion date (see Appendix 2 – Deployment Plan). This will ensure that GCS Community Hospital and MIIU systems are established before some of the staff have to embark on learning the new GHNHSFT system which they will need to use for acute activity (e.g. Outpatients and Theatre).

8 Legal Implications

All legal implications have been endorsed by HSCIC under the Southern Community Programme.

9 Risk Implications

The identified risks relate mainly to the replacement of PAS by GHNHSFT and are briefly as follows:

Community Hospitals

GCS currently use the GHNHSFT PAS system to record admitted patient, theatres and outpatient activity taking place in the Community Hospitals for both acute and GCS providers, irrespective of ownership. Due to GHNHSFT replacing PAS with their new TrakCare system some of the existing integrated functionality between both organisations will be lost. For example GCS currently obtain their Pathology results via PAS which will no longer be available so GCS are working with GHNHSFT to provide Pathology results via Sunquest ICE which will be chargeable to GCS to obtain Pathology results in the future.

GCS will need to work with GHNHSFT and SystmOne suppliers to ensure that moving from one system to another will not invoke a clinical risk to patients, that all existing working practices are identified and solutions found to mitigate risks and to safeguard against any changes that could affect patient safety.

Section 4.1 provides a table of some of the issues and impacts identified to date that will arise as a result of the system changes and the possible mitigation that will be required to support a move towards a single system for GCS and to replace the PAS functionality. There may be other issues or impacts that have not yet been identified but these will be picked up via the change management of the project. This information was collated as a result of a small group led by a Locality Manager (which includes GHNHSFT representation) that met previously to consider issues and impacts that are likely to result from the identified system changes. This group will be required to meet again when GHNHSFT have established their system deployment plan and the impact this will have on GCS.

MIIUs

MIIUs treat a variety of injuries and illnesses for adults and children and all data is recorded on MSS Patient First and linked via a one way link between this system and PAS which results in MIIUs searching for a patient in MSS Patient First and if the patient is not on the system the user then has to log on to PAS and register the patient and then go back into MSS Patient First to populate the MIIU information. The following risks are identified:

- **Registering Patients on PAS**: It has always been a risk that on occasion's staff will register patients immediately onto MSS Patient First not realising that this data will not subsequently populate PAS and subsequently the existing system has always been flawed.
- **Safeguarding**: MIIUs and acute ED services still maintain contact via the telephone to bleep holders to ensure safety of patients. PAS will continue to be available to MIIUs until the new acute system is in place and more robust electronic information is exchanged.
- **Onward Referrals**: All community and GP referrals will be improved in that the referrals will be a direct process with SystmOne to all services that use SystmOne. Adastra and PAS referrals will continue as now until these systems are replaced and more robust processes are available. Referral to the Community Hospitals in the existing PAS process has never been available to MIIUs but following the

implementation of the Community Hospital SystmOne module this will mitigate this issue.

9. Implications for Health Inequalities

Following approval of this paper the SystmOne Quality Impact Assessment will need to be updated.

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

None

11. Consultation and Communication including Public Involvement

None

12. Links to:

This project links to the SystmOne Project and Operational Board and to all data collection and reporting for GCS.

Prepared by: **Bernie Wood**
Presented by: **Glyn Howells**
Appendices

Appendix 1 – Evaluation of the Options
Appendix 2 – Proposed Deployment Plan

Appendix 1
SystmOne for Community Hospitals and MIIUs

Evaluation of the Options

To enable comparison of the options, 6 critical success factors were defined and assigned weightings and the options were scored against them. The factors are:

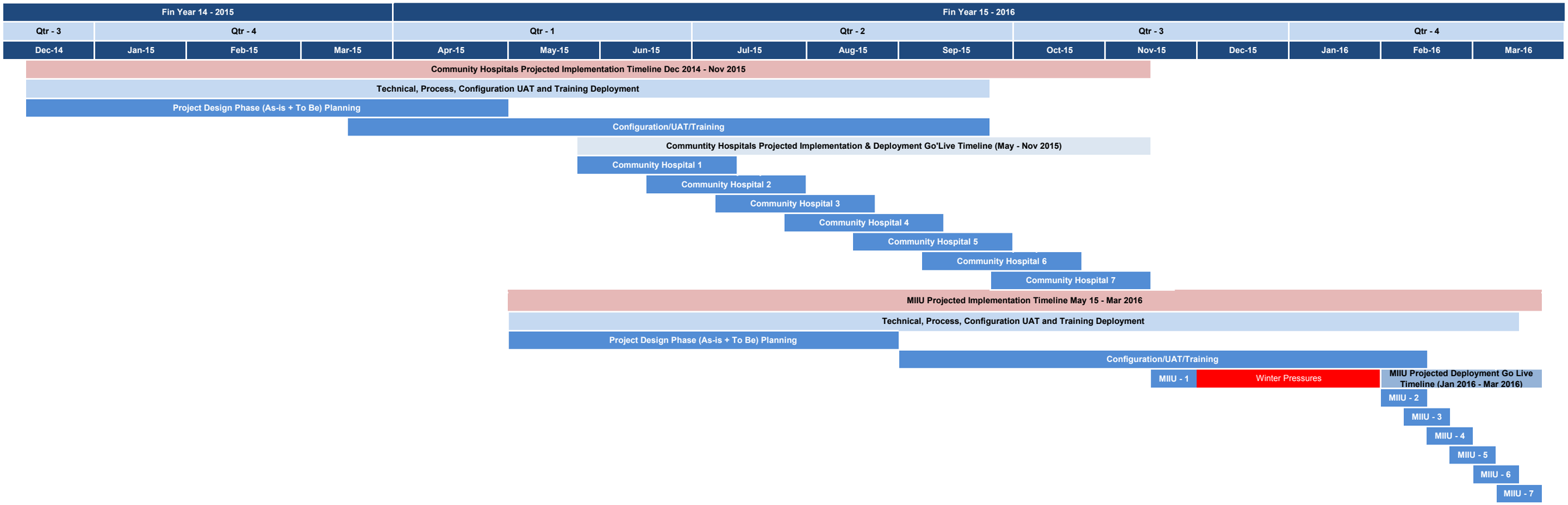
- **Business/strategic fit** - how well the option meets GCS requirements.
- **Integration** - ability to share system functions and data across community, primary and social care settings, and later acute settings.
- **Benefits optimisation** - optimising Return on Investment (ROI) and value for money (VFM).
- **Achievability** – degree of change required to implement successfully and realise benefits.
- **Affordability** - ability of GCS to fund the required investment.
- **Market capability** - existence of credible community solutions in the market place.

The following table sets out the scores, weighted scores and rankings of the options against these critical success factors. **Option 4 is the highest scoring option:**

	Weighting	Option 1 Do Nothing	Option 2 Adopt Acute solution	Option 3 Procure and deploy standalone solution	Option 4 Deploy SystmOne Community Hospital and MIIU Module
Business/Strategic Fit	5	0 Can't meet Trust requirements	3 Incompatible with single system GCS vision	1 Incompatible with Trust Strategy	5 Support GCS vision, and tailored development and configuration if required
Integration	5	0 Not integrated	2 Unclear	2 Unclear	4 Proven integration and visibility across GCS care settings (not acute)
Benefits Optimisation	5	0 Nil benefits	1 Unclear	1 Unclear	4 Meets GCS requirements
Achievability in required timescales	5	5 In place but being replaced	2 2 - 3 years away	2 12 - 18 months away	5 Deployment can commence upon GCS request and first go live in 3 months
Affordability	5	2 Existing costs in short term but nil benefits	1 Unclear	2 New funding required	3 Some of existing project resources required
Market Capability	4	1 No additional requirements	5 Anticipated a rich solution, but not integrated	3 Acceptable	5 integrated solution with existing GCS Systems
Raw Scores **(Rank)**		**8** **4**	**14** **2**	**11** **3**	**26** **1**
Weighted Scores **(Rank)**		**39** **4**	**65** **2**	**52** **3**	**125** **1**

Appendix 2
Proposed Deployment Plan

Copy of CoHo MIIU SystmOne High level


Fin Year 14 - 2015
Fin Year 15 - 2016
Qtr - 3
Qtr - 4
Qtr - 1
Qtr - 2
Qtr - 3
Qtr - 4
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Community Hospitals Projected Implementation Timeline Dec 2014 - Nov 2015
Technical, Process, Configuration UAT and Training Deployment
Project Design Phase (As-is + To Be) Planning
Configuration/UAT/Training
Communtity Hospitals Projected Implementation & Deployment Go'Live Timeline (May - Nov 2015)
Community Hospital 1
Community Hospital 2
Community Hospital 3
Community Hospital 4
Community Hospital 5
Community Hospital 6
Community Hospital 7
MIIU Projected Implementation Timeline May 15 - Mar 2016
Technical, Process, Configuration UAT and Training Deployment
Project Design Phase (As-is + To Be) Planning
Configuration/UAT/Training
MIIU - 1
Winter Pressures
MIIU Projected Deployment Go Live Timeline (Jan 2016 - Mar 2016)
MIIU - 2
MIIU - 3
MIIU - 4
MIIU - 5
MIIU - 6
MIIU - 7

Gloucestershire Care Services NHS
NHS Trust

Information and Performance Management Strategy

Ref: 14/B047

This report is for Publication

Gloucestershire Care Services NHS Trust Board

Information and Performance Management Strategy
25 November 2014

Objective:

To seek the Board's support for the Information and Performance Management Strategy in its current form

The Board is asked to:

Ratify the Information and Performance Management Strategy

Executive summary:

The Strategy has been formally approved by the Performance and Resources Committee

Once the Strategy has been approved, a detailed implementation plan will be developed, that will subsequently be monitored by the Performance and Resources Committee

Rod Brown,
Head of Corporate Planning

25 November 2014

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

INFORMATION & PERFORMANCE MANAGEMENT STRATEGY

2014-19

To enable the production of accurate, timely and credible information that actively facilitates continuous improvement in performance and therefore supports the delivery of the highest possible quality health and social care services across Gloucestershire

Version control	
Document reference:	TB09
Version:	0.13
Ratified by:	Trust Board
Date ratified:	
Originator/author:	Rod Brown, Head of Corporate Planning Matthew O'Reilly, Head of Performance and Information
Owner:	Matthew O'Reilly, Head of Performance and Information
Executive lead:	Glyn Howells, Director of Finance
Date issued:	
Review date:	

Contents

Appendices

Please note that this Information and Performance Management Strategy is applicable to both health and social care colleagues managed by Gloucestershire Care Services NHS Trust

0. Executive Summary

This Information and Performance Management Strategy acknowledges the very real value of information to Gloucestershire Care Services NHS Trust ("the Trust"), and thus recognises that robust information can:

- effectively enable clear understanding of the extent to which the Trust is fulfilling its vision, values, strategic objectives and key business priorities;

- highlight opportunities to improve performance and learning so as to ensure continuous quality improvement in care delivery.

As such, this Information and Performance Management Strategy seeks to:

- ensure that the Trust's information is of optimum accuracy, completeness and timeliness, and that information is used intelligently, thereby enabling the production of reliable and credible reports that practically support the delivery of high-quality care: this includes responsibility for achieving the highest standards of data quality, and for creating fully coordinated and triangulated activity, finance, quality, workforce and social care information so as to enable holistic analysis;

- facilitate the routine dissemination of information internally, and thus provide suitable opportunity for the monitoring of service performance: this includes a duty to maintain a formal schedule of reporting, particularly to the Trust Board, sub-Board Committees and all support forums;

- use a robust performance management framework to deliver the Trust's vision, values and strategic objectives, and to ensure appropriate learning and improvement across all Trust services: this will help ensure that the delivery of high-performing, high-quality services is rightfully regarded across all teams in the Trust as a required standard;

- share information as appropriate with all relevant external stakeholders, so as to build effective partnerships with both public and professional groups: this includes submitting all necessary national data returns, as well as sharing relevant information with professional partners in support of joint working, and increasingly making individuals' health and social care information accessible to service users, carers and families;

- ensure appropriate training and development for colleagues, so that they may best understand Trust information and thereby make well-informed decisions.

This Information and Performance Management Strategy therefore seeks to outline the Trust's aspirations and direction of travel in respect of information management, reporting and monitoring over the next 5 years. The accompanying implementation plan will detail the practical actions that will be taken in the period 2014-19 to fulfil these aspirations.

1. Introduction

"Information for patients and service users is an integral part of care. Like medicine, good information can heal, but poor information or poor handling of information can harm."

NHS Future Forum (2012)

Robust information is of fundamental importance to the future of the NHS. At its most basic level, information will enable Gloucestershire Care Services NHS Trust ("the Trust") to:

- understand the achievement of its key business priorities;
- highlight good performance so as to encourage learning across teams, and validate excellence both to the Trust's public and commissioners;
- identify areas where service delivery improvements can be made;
- monitor on-going work aimed at increasing performance and quality;
- ensure that the Trust is meeting all of its mandatory, statutory and contractual requirements;
- recognise trends in activity, workforce and/or finance and their corresponding impacts on care delivery;
- support the case for change, particularly where this can lead to quantifiable improvements in productivity and efficiency; and most importantly
- measure the relative success of health and social care interventions on the well-being of the local Gloucestershire population, so as to be assured that all viable actions are being taken to provide the highest possible quality services.

Given the above, it is essential that the Trust produces the most accurate, complete and timely information, and that this enables and underpins a performance management framework which is focused upon fulfilment of the Trust's vision, values and strategic objectives. Moreover, this framework must be fully embedded so as to empower individuals and teams across the organisation with a clear sense of purpose and understanding, and support them to deliver improved outcomes.

It is noted that this Strategy complements the Trust's Information Technology (IT) Strategy, given that the collation, reporting and dissemination of information both within and outside the organisation, is largely dependent upon the maintenance of a sound IT infrastructure: equally, this Strategy is aligned to the Financial Management Strategy which similarly describes escalation processes, albeit specifically for matters of fiscal concern.

2. Ambition and Objectives

2.1 The ambition of this Information and Performance Management Strategy is "*to enable the production of accurate, timely and credible information that actively facilitates continuous improvement in performance and therefore supports the delivery of the highest possible quality health and social care services across Gloucestershire*".

This aligns to the Trust's overarching vision which is "*To be the service people rely on to understand them and organise their care around their lives*", given that both intentions are ultimately focused upon service users, and more specifically, upon ensuring improvement in people's experiences and care.

2.2 This five year Information and Performance Management Strategy seeks to ensure that by 2019, the following objectives have been achieved, linked to the Trust's overarching strategic objectives:

Information and Performance Management Strategy Objectives	**Trust Strategic Objectives**
• Maximising the Trust's analytical capacity by converting raw data into intelligent information that enables decision-makers within the Trust and beyond, to evaluate the outcomes of local health and social care activities and interventions, and thereby ensure the highest quality services across Gloucestershire • Maintaining a robust performance management framework that promotes on-going learning and continuous improvement of service delivery	Achieve the best possible outcomes for our service users through high quality care
• Effectively triangulating all information, including that which stems from service user surveys, complaints, focus groups, audits or other feedback mechanisms, so as to be able to present a holistic assessment of Trust performance • Making pertinent information readily available to all local service users, carers and their families so that they may best understand their own care journey	Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work

• Utilising integrated financial, activity, performance, quality and workforce information from both the Trust and Gloucestershire County Council in order to effectively assist in the planning and assessment of local health and social care services	Provide innovative community services that deliver health and social care together
• Sharing and benchmarking Trust information where appropriate, so as to enable all relevant stakeholders to glean an accurate understanding of performance within the local, regional and national health and social care economy • Meeting all national reporting requirements so as to contribute effectively to information management practices across the health and social care community	Work as a valued partner in local communities and across health and social care
• Enabling clear understanding of the Trust's performance by staff / teams so as to create a shared single vision for improvement • Supporting operational staff to optimise the quality of information that is recorded and reported	Support individuals and teams to develop the skills, confidence and ambition to deliver our vision
• Ensuring that reports are clear, meaningful, timely and accessible, and facilitate understanding of the Trust's progress in delivering its key objectives • Supporting teams to replace manual data collection systems (including paper-based systems and those that use standalone databases) with the most appropriate networked electronic system in order to improve accessibility, efficiency, data quality and reduce waste • Replacing paper-based information dissemination wherever possible	Manage public resources wisely to ensure local services remain sustainable and accessible

3. National Context

3.1 In 2012, the Department of Health issued *The Power of Information: putting all of us in control of the health and care information we need*. This 10 year strategy provides a guide for how information can lead to more integrated, safer and improved services for the benefit of service users and professionals alike. At its heart, this document seeks to establish information as a health and care service in its own right, recognising the very real ability of information to lead to reductions in inequalities, and thereby benefit all populations.

More specifically, The *Power of Information* is focused upon:

- creating an information system that is built on innovative and integrated solutions and local decision-making, within a framework of national standards, wherein better quality information can move freely and safely around the system;

- using information to drive integrated care both within and between organisations, and across the health, care and support sector as a whole: this places clear responsibility upon all professionals and organisations whose policies influence healthcare delivery, to make determined effort to record and utilise information to best effect;

- enabling service users to provide their information once only, at first contact, with the onus then being on those organisations who are providing care services, to exchange this information safely and securely between themselves;

- ensuring that electronic care records progressively become the source for core information that will be used to improve care services, inform research, and measure quality;

- encouraging a culture of transparency, where access to high-quality, evidence-based information held by Government and health and care services regarding the quality of service user care, is openly and easily available;

- empowering service users to routinely access their own health and care records online.

3.2 Intrinsically, all national directives issued by the Department of Health and associated bodies / regulators, aim to promote ways in which NHS Trusts can improve their performance so as to deliver the highest standards of care.

Moreover, it is performance against which Trusts are measured and assessed: at time of writing, evaluation of the Trust by the NHS Trust Development Authority (TDA) focuses upon considerations of delivery, sustainability and quality, with the latter categorised by the five domains of Safe, Caring, Responsive, Effective and Well-Led.

4. Local Context

4.1 The Trust maintains a series of sub-Board Committees and lower-level forums through which information and performance is assured, and via which salient issues are escalated, ultimately to the Trust Board where issues are deemed to be business critical. At time of writing, the Trust is reviewing the robustness and integrity of this reporting framework, including an assessment of what information is provided to which forum: it is the intention that this Information and Performance Management Strategy, and the resultant implementation plan, will provide further impetus and guidance for this review.

4.2 As noted in the Trust's IT Strategy, as of 2013, the organisation has been rolling out a new Community and Child Health clinical system (SystmOne) which aims to be available in all required settings by the end of 2015. With specific reference to this Strategy, deployment of SystmOne will enable:

- a standardised approach to information management across the Trust, with streamlining of alternate information collection and reporting systems;
- clinicians and managers to have more timely and secure access to relevant, accurate clinical information;
- the ability to undertake reporting and data analysis in real-time;
- relevant information to be readily uploaded to the Trust's data warehouse so that it is then available for use by business intelligence tools (see section 6.1.4 below);
- the Trust's continued compliance with all prevailing statutory requirements and information returns;
- measured improvements in the quality of information that is collected, recorded and reported by the Trust.

It is also noted that a number of the Trust's key stakeholders (principally Gloucestershire County Council and local GPs) are also currently reviewing the primary electronic systems that they use for information management, and that within the lifecycle of this Strategy, decisions will be taken which will significantly impact upon the speed and ease with which access to relevant information will be facilitated across organisational boundaries.

4.3 The Trust's Performance and Information Team currently fulfils a range of mandated requirements from the Department of Health, the Health and Social Care and Information Centre, Public Health England, NHS England, the NHS Trust Development Authority (TDA) and the Health Protection Agency. These requirements include the following:

- completion of statutory returns for which information is routinely collated, validated and submitted to meet necessary deadlines;

- submission of nationally-mandated datasets within requisite timescales: these include, but are not limited to:

    - data flows to the Secondary Uses Services (SUS) in respect of admitted patient care, minor injuries units and outpatients;

    - safe staffing data that is submitted to the Department of Health;

    - data flows on behalf of the Trust's sexual health services including the Chlamydia Testing Activity Dataset that is submitted to the Health Protection Agency, the Genito-Urinary Medicine (GUM) Clinic Activity Dataset that is submitted to Public Health England etc;

    - data collected for the Safety Thermometer tool that is submitted to the Health and Social Care Information Centre;

    - the Community Information Data Set and the Children and Young People's Health Services Data Set that will be submitted to the Health and Social Care Information Centre when mandated.

4.4 Additionally, the Trust's Performance and Information Team produces internal management information, analysis and activity reporting. This includes monthly quality and performance reports, data quality reports, reports for commissioners, as well as other ad-hoc information reports requested by both internal and external stakeholders.

Similarly, colleagues within the Trust's finance, HR / workforce, clinical governance and transformation / change teams also produce internal management information and reports relevant to their respective areas of operation and influence.

4.5 At the time of writing, the Gloucestershire Clinical Commissioning Group has issued a draft Information Management and Technology (IM&T) Strategy. With reference to the remit of this Strategy, the commissioner's goals include:

- relevant information in respect of service users that is needed to support their treatment, will be available when and where it is required by any authorised member of the professional team caring for that person;

- service users and their carers will be empowered to take greater responsibility for their own health, including through access to information, availability of their own care records, and use of various technology-based support tools;

- commissioning decision-making will be informed and evidence-based, supported through the systematic management of knowledge, including the use of timely, high quality information and analytical tools.

The Trust's responses to these requirements are identified in section 6 below.

5. Quality Goals

5.1 In order to ensure that this Information and Performance Management Strategy maintains focus upon achieving quality outcomes, the following goals have been identified:

- to ensure that the Trust's information is of optimum accuracy, completeness and timeliness, and that information is used intelligently, thereby enabling the production of reliable and credible reports that practically support the delivery of high-quality care;
- to facilitate the routine dissemination of information internally, and thus provide suitable opportunity for the monitoring of service performance;
- to use a robust performance management framework to deliver the Trust's vision, values and strategic objectives, and to ensure appropriate learning and improvement across all Trust services;
- to share information as appropriate with all relevant external stakeholders, so as to build effective partnerships with both public and professional groups;
- to ensure appropriate training and development for colleagues, so that they may best understand Trust information and thereby make well-informed decisions.

6. Priorities and Actions

The following priorities have been identified, mapped against this Information and Performance Management Strategy's quality goals. Further detail regarding each of these priorities will be itemised within the Strategy's implementation plan, progress against which will be monitored on a regular basis by the Performance and Resources Committee.

6.1 To ensure that the Trust's information is of optimum accuracy, completeness and timeliness, and that information is used intelligently, thereby enabling the production of reliable and credible reports that practically support the delivery of high-quality care

6.1.1 The Trust will ensure that all information collection and management systems that are in regular use across the organisation, are able to capture and report the necessary level and detail of data required by the Trust, its stakeholders and regulators, and that this is achievable in real-time. Increasingly, this requirement is focused more upon electronic systems, given that the Trust has clear aspirations to reduce its on-going reliance upon paper and paper-based systems, so as to ensure greater reliability and consistency.

In respect of clinical systems, and as referenced in section 4.2 above, the Trust's priority over the lifecycle of this Strategy is upon the increased use of SystmOne which fulfils prevailing information management requirements. However, it is also recognised by the Trust's IT Strategy, that other clinical systems may continue to be used where specific services have unique data capture and reporting requirements: in such circumstances, the Performance and Information Team will be responsible for ensuring that these supplemental systems are fit-for-purpose from an information perspective, and for advising accordingly. Equally, where different clinical systems hold common sets of information (i.e. service user details), the Trust will maintain documented procedures for ensuring consistency and reconciling differences.

Similarly, the Trust will ensure that all of its corporate systems have the capability to record and report all relevant information, so as to effectively support robust information analysis and enable triangulated reporting (see section 6.1.4 below).

6.1.2 In order to enable exemplar information reporting, the Trust remains committed to ensuring the highest possible data quality. This requires the Trust to undertake the following actions:

- empower all relevant operational and administrative staff across the Trust to have specific personal responsibility to gather data that is accurate and complete, and that is input into the relevant system or systems in a timely manner;

- encourage an increased number of clinical staff to add their own data directly onto the relevant system and thereby achieve real time entry, rather than relying on clerks or administrative staff to input data on their behalf at a later date;

- provide the resources for staff to complete real-time data entry by, for example, giving increased access to mobile devices;

- ensure that the Performance and Information Team produces regular reports that highlight missing or erroneous data so as to support operational and administrative staff;

- undertake routine detailed reviews of operational processes to ensure that data quality is maximised;

- ensure that formal training is provided to all colleagues who require technical skills and knowledge as part of their job: this training must include principles of data quality maintenance and levels of responsibility, and must ensure that all staff understand the impact of poor data quality (see also section 6.5 below);

- ascribe and define accountability for data quality at both Board and team level, with Data Quality Leads receiving targeted support and dedicated training;

- maintain a clear and up-to-date Data Quality Policy which will be supported by other complementary guidance materials and documentation, all of which will be readily accessible to staff via the Trust intranet: in particular, this policy will seek to enforce consistent management processes in respect of information handling, irrespective of the source or owner of the information;

- regularly undertake a comprehensive review of data quality management processes against an agreed baseline in order to identify all possible opportunities for improvement;

- conduct routine system audits in order to validate that the Trust's electronic solutions effectively support good information practice, and that these systems are being used appropriately by staff;

- ensure that input data is validated to prevent incorrect or erroneous data being reported. For key validations, this requires a responsible owner and process to be defined: it also necessitates clinical staff to be involved in the validation of information that is derived from the recording of clinical activity. It may also require the Performance and Information Team to undertake batch tracing to validate key demographic data such as invalid or missing NHS Numbers or GP Practice codes.

6.1.3 The Trust will only develop scorecards and datasets based upon indicators and metrics that are meaningful to staff, and that are regularly reviewed and updated in line with the Trust's business needs. Furthermore, the Trust will ensure that where appropriate, its scorecards and datasets encompass both quantitative and qualitative measures, so as to represent a wider diversity of activity, outcomes and experiences, with particular focus upon quality, efficiency and effectiveness. As such, the Trust's scorecards should all serve to demonstrate:

- the Trust's ability to meet the needs of its service users, carers and families: this creates particular responsibility for producing scorecards that evidence service user outcomes rather than simply Trust activity, and that use SMART metrics (i.e. indicators that are Specific, Measureable, Attainable, Realistic and Timely);
- the Trust's ability to meet its contractual obligations as established with commissioners, and the mandatory standards set by regulators including the NHS Trust Development Authority and Monitor;
- the Trust's ability to meet its own internal standards, and in particular, those that are fundamental to achievement of the organisation's vision, values and strategic objectives;
- areas of current excellence by way of assurance, as well as areas for potential improvement so that appropriate investigative or remedial action can be taken proactively;
- where the Trust has already taken action to address or remedy issues identified by previous incidents, omissions or learning, and the outcomes of that action;
- the Trust's effective and efficient use of resources including finances, equipment, staff, estates etc;
- clear support for the Trust Board and its Committees (see section 6.2.3 below), as well as for the Trust's performance management framework (see section 6.3 below).

6.1.4 The Trust will ensure that where appropriate, its information reporting represents coordinated and triangulated activity, finance, quality, workforce and social care information, so as to enable more intelligent analysis and understanding of Trust performance, with full appreciation of all influencing factors. Such holistic reporting will enable the Trust to more readily identify correlations and trends in activity, recognise and respond more swiftly to emerging risks and pressures, and ensure more efficient and cost-effective service delivery for the Gloucestershire community.

To enable this, business intelligence tools will be utilised which will facilitate faster, more streamlined reporting. Moreover, the Trust will continue to refine and enhance this capability over time so as to include other data that will be of relevance to Trust understanding - this will include, for example, population data, cross-organisational pathway information etc.

6.1.5 So as to enable relative understanding of Trust activity, the Performance and Information Team will undertake benchmarking as appropriate. This will include local benchmarking, so that Trust services delivered by different teams can be assessed against each other so as to identify areas in which the Trust can develop greater consistency.

It will also include benchmarking against comparable community Trusts (at the time of writing, the Trust is acting as the lead for the national Aspirant Community Foundation Trust Network, and is also a member of the NHS Benchmarking Network) so as to compare information collection and reporting processes, as well as performance, against a number of criteria including quality, access, productivity, workforce and finance. This will allow the Trust to identify areas where improvements can be made, and strengthen the organisation's existing reputation for delivering high quality care.

6.1.6 The Trust will seek to ensure that real-time reporting supports a drive towards predictive modelling, enabling services to recognise previous trends and forecast future need and demand, rather than merely conducting retrospective analysis.

This initiative, which is being championed by the Gloucestershire Clinical Commissioning Group, plans for greater use of risk stratification tools so as to enable the identification of vulnerable and/or "at-risk" service users in advance of disease onset, in order to intervene earlier with appropriate care packages, thereby reducing their longer-term and more intensive reliance upon health and social care services.

6.1.7 All staff members have personal responsibility, relative to their areas of operation and influence, to ensure that appropriate information governance policies, guidelines and standards are observed whilst handling information.

With particular reference to this Information and Performance Management Strategy, this creates a need for the Trust to ensure necessary safeguards for the transfer and flow, and appropriate use, of the personal information of service users and staff, as well as all business confidential information. For further information, please refer to the Information Governance Strategy maintained by the Trust.

6.2 To facilitate the routine dissemination of information internally, and thus provide suitable opportunity for the monitoring of service performance

6.2.1 The Trust will adhere to a formalised schedule of data reporting and dissemination that will regulate the provision of required information to the Trust Board and all other committees and forums (see sections 6.2.3 and 6.2.4 below), but that also on a more routine basis, ensures that:

- all Trust professionals receive the information that they need, when they need it;
- clinicians are able to run real-time reports for purposes such as caseload management;
- real-time information is available to managers to readily enable performance management and decision-making.

6.2.2 This Trust will utilise web-based tools so that information reports can be shared with appropriate authorities across the Trust in a quick, easy and interactive way. To this end, it will be the responsibility of the Performance and Information Team, working alongside the IT and Clinical Systems Team, to ensure that these tools and all associated training are available to relevant Trust staff, and that the tools provide the requisite level of granularity in reporting.

6.2.3 There is a clear requirement for the Trust Board and its sub-Board Committees (see Appendix 2 below) to receive information reports that are relevant to their areas of operation. To this end, all forums will have responsibility to ensure that relevant authors/owners are given suitable notice when a specific information report is required: equally, authors/owners will have responsibility to ensure that the corresponding reports are delivered to time, and are clear, concise and focused upon the necessary issues.

6.2.4 Beneath the sub-Board Committees, the Trust will maintain an appropriate number of lower-level forums which will also receive relevant information and thereafter provide assurance and escalation upwards, in line with the concept of information transparency and reporting “from place of care to Chair” (see Appendix 3 below). These forums will therefore have specific responsibility for:

- validating information relevant to their particular speciality, discipline or area of influence;
- overseeing the implementation of action plans in respect of areas that have been reported as under-performing;
- appropriately informing more senior groups of concerns or risks.

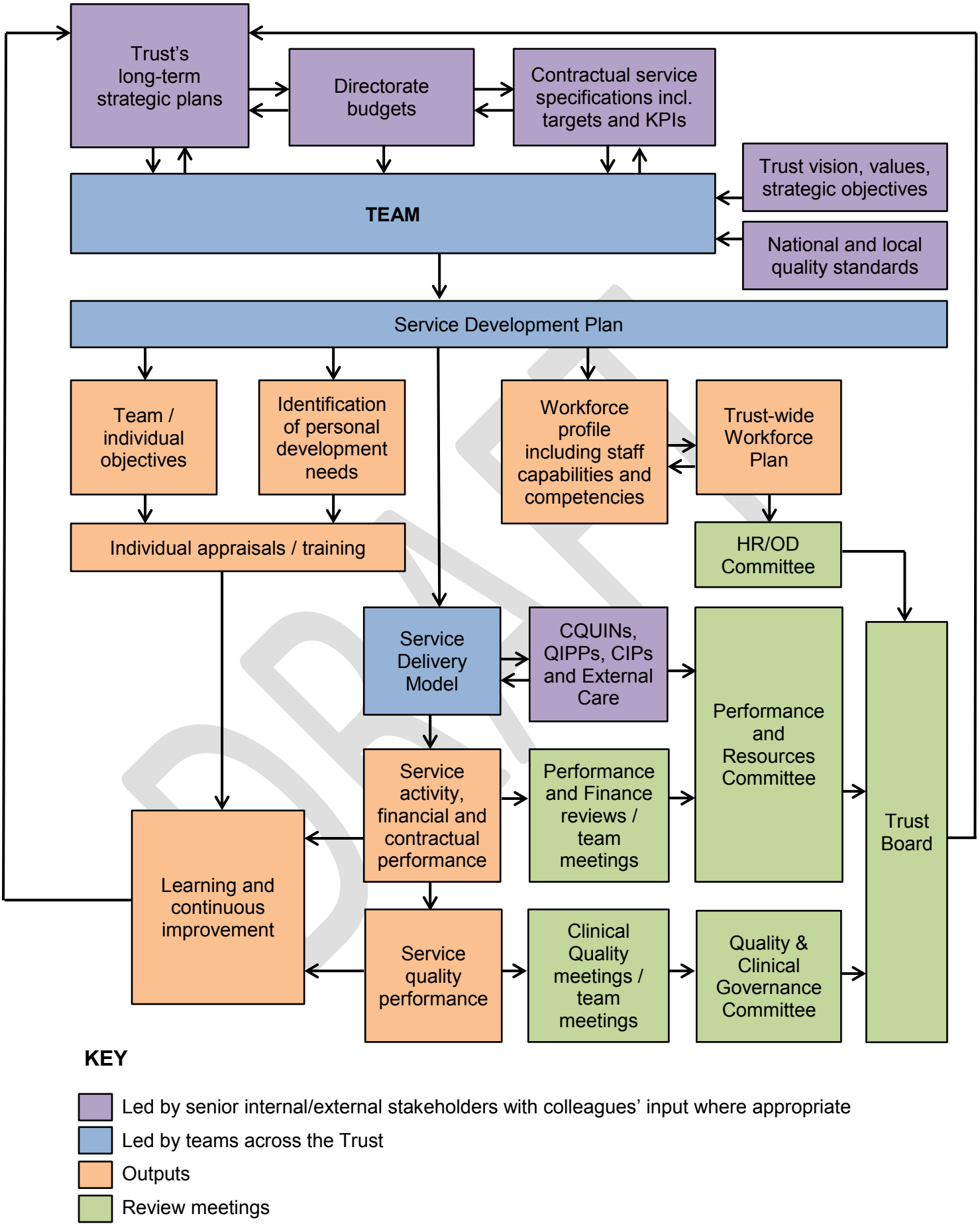
6.3 To use a robust performance management framework to deliver the Trust's vision, values and strategic objectives, and to ensure appropriate learning and improvement across all Trust services

The Trust will ensure the development and maintenance of a structured and comprehensive performance management framework as a way to ensure that:

- there is clear and consistent focus upon the Trust's achievement of its strategic, contractual and quality objectives, and more broadly upon the attainment of its overarching vision and values;
- the delivery of high-performing, high-quality services is rightfully regarded across all teams in the Trust as a required standard;
- there is accurate reporting of performance at team-level so that all Trust colleagues are empowered to act and drive forward continuous quality improvement in service delivery;
- both individual colleagues and teams are able to recognise their personal contributions, responsibilities and accountabilities for results, within a culture that does not automatically seek to apportion blame, but that instead encourages learning and improvement;
- teams can be clear about their performance priorities and can communicate their performance against these priorities comprehensively and responsively to the Trust Board, Executive team, staff, service users, the public and commissioners;
- there is clear opportunity to recognise and identify any weaknesses in performance or delivery which can then be addressed proactively;
- resources can be effectively allocated across the Trust to those areas that require additional attention and support, thereby ensuring best value for money and consistency of service offerings;
- the Trust is able to effectively promote the quality of its services and achievements in order to improve its credibility and reputation locally, regionally and nationally.

It is additionally noted that the performance management framework as articulated in this Information and Performance Management Strategy aligns to the Trust's operational framework as described in the Organisational Development Strategy and Workforce Strategy, as this seeks to empower teams to act with appropriate responsibility for their own performance and success. It also complements the Trust's assurance and escalation framework, and as such, these three schematics together serve to describe the range of the Trust's control processes and governance arrangements in respect of performance management.

In light of the above aspirations, the Trust's performance management framework can be summarised as per the illustration below:


Trust's long-term strategic plans
Directorate budgets
Contractual service specifications incl. targets and KPIs
Trust vision, values, strategic objectives
TEAM
National and local quality standards
Service Development Plan
Team / individual objectives
Identification of personal development needs
Workforce profile including staff capabilities and competencies
Trust-wide Workforce Plan
Individual appraisals / training
HR/OD Committee
Service Delivery Model
CQUINs, QIPPs, CIPs and External Care
Performance and Resources Committee
Trust Board
Service activity, financial and contractual performance
Performance and Finance reviews / team meetings
Learning and continuous improvement
Service quality performance
Clinical Quality meetings / team meetings
Quality & Clinical Governance Committee
KEY
Led by senior internal/external stakeholders with colleagues' input where appropriate
Led by teams across the Trust
Outputs
Review meetings

In order to ensure compliance with this framework, the Trust will ensure the following actions (please note that these actions are relevant to the remit of this Information and Performance Management Strategy only, and should therefore be considered alongside the complementary actions identified by the Organisational Development Strategy and Workforce Strategy which consider HR issues and thus, for example, describe how Service Development Plans will be used to identify workforce profiles including staff capabilities and competencies, as well as personal development needs etc).

6.3.1 The Trust will contribute to the development and maintenance of robust service specifications for its health and social care services, in partnership with the organisation's commissioners, and ensure that these provide clear detail about relevant metrics and key performance indicators by which the service, and primarily its outcomes, can be measured and assessed.

6.3.2 Budgets will be made available in advance of year start, so that teams will be able to develop service delivery models that can be realistically provided within financial constraints.

6.3.3 Annual Service Development Plans will be produced for every service provided by the Trust, including care, corporate and support functions: these will include coverage of how services will contribute towards efficiencies in line with Cost Improvement Programmes (CIPs), Commissioning for Quality and Innovation (CQUIN) targets and the Quality, Innovation, Productivity and Prevention (QIPP) agenda. This begets the need for the Trust to ensure that all CIP, CQUIN and QIPP targets are agreed in advance of year start, including negotiation with commissioners as appropriate.

6.3.4 Performance scorecards relevant to each individual team / service delivery model and highlighting both quality & performance and activity & finance, will be developed and populated on a routine basis each month, so as to facilitate effective evaluation of success and/or to identify gaps or weaknesses in service delivery.

6.3.5 The Trust will produce a high level dashboard report each month for the use of the Board: this will be informed by the lower-level performance scorecards as described in section 6.3.4 above.

6.3.6 Via the Trust's governance structure, and therefore at respective Committee meetings, learning will be captured in response to discussion about team quality and performance, and this learning will be used to support future quality improvement. Moreover, this learning will be effectively communicated across the Trust to all relevant colleagues so as to share best practice, and will additionally be fed back into the Trust's business planning processes, in order to inform subsequent organisational decisions and later iterations of teams' Service Development Plans.

6.3.7 Where a scorecard contains an indicator that is RAG rated as either amber or red, and thus there is failure to meet a target or ineffective arrangements to ensure the quality of services, the scorecard must be accompanied by an action plan that identifies the remedial actions that will be taken so that performance will be satisfactory within a stipulated timeframe. Moreover, the owner of the action plan must ensure that all risks associated with non-delivery or poor performance are captured within the appropriate risk register (please refer to the Trust's Risk Management Strategy and Risk Identification and Assessment Policy). However, please note that where an indicator is rated amber or red, and also risk rates as 12 or above on the Trust's risk matrix, only one action plan need be produced.

6.3.8 Additional to operational performance management, the Trust also has responsibility to ensure the review of its quality goals as described in its strategies, oversight for which is assigned as below:

- **HR/OD Committee**
  - Organisational Development Strategy
  - Workforce Strategy
- **Quality and Clinical Governance Committee**
  - Quality Strategy
  - Clinical and Professional Care Strategy
  - Audit and Effectiveness Strategy (shared)
- **Audit and Assurance Committee**
  - Financial Management Strategy
  - Risk Management Strategy
  - Information Governance Strategy
  - Business Continuity Strategy
  - Health, Safety and Security Strategy
  - Audit and Effectiveness Strategy (shared)
- **Performance and Resources Committee**
  - Estates Strategy
  - IT Strategy
  - Information and Performance Management Strategy
  - CIP Strategy
- **Communications and Public Affairs Committee**
  - Communications and Engagement Strategy
  - Membership Strategy
  - Public Consultation Strategy
- **Charitable Funds Committee**
  - Charitable Funds Strategy

Thus, these Committees will be responsible for receiving routine scorecards and associated reports so as to be assured of strategic performance, then communicate this assurance to the Trust Board.

6.4 To share information as appropriate with all relevant external stakeholders, so as to build effective partnerships with both public and professional groups

6.4.1 The Trust will ensure that all national reporting and requisite data submissions continue to be completed in line with prescribed timescales. This includes, but is not limited to, the submissions detailed in section 4.3 above.

As already referenced in section 6.1.2 above, all information and associated reporting will be fully validated by the relevant Trust owner prior to the information's submission. However, the Trust also has clear responsibility to validate information that is subsequently published about the organisation, irrespective of whether or not the Trust was the original source of that data. Thus, for example, the Trust must validate all information that appears on the NHS Choices website, so as to ensure that it represents the Trust accurately, and that therefore there is no unintentional but detrimental impact upon the Trust's reputation.

6.4.2 The Trust will remain committed to sharing relevant information with all professional partners in the local and national health and social care community so as to support joint working. This includes making appropriate information available for commissioners so as to inform contract monitoring, as well as partners in primary care, and acute and mental health care trusts, where this information exchange actively supports integrated working and shared service user pathways. This commitment also includes sharing information with third sector organisations and other health and social care providers as the Trust moves towards increasing its use of community-based assets.

In doing so, the Trust will seek to use appropriate and innovative channels of communication, so that information is received with optimum timeliness and in the most useful format. It is noted that during the lifecycle of this strategy, the implementation of SystmOne across the Trust, and the update of systems used by partner organisations, will significantly enhance this facility, and thereby enable improved information exchange and thus, service user care.

Fundamental to this principle of openness and transparency however, is the need to ensure that all such disclosures are handled according to information governance protocols, and are therefore fully in line with formally signed agreements which cover the secure sharing of service user data for clinical purposes.

Equally, the Trust will comply fully with all information disclosures required under the terms of the Data Protection Act 1998 and the Freedom of Information Act 2000 - for further detail, please refer to the Trust's Information Governance Strategy.

6.4.3 As noted in section 3.1 above, one key national drive, as articulated in *The Power of Information: putting all of us in control of the health and care information we need* (Department of Health, 2012) is to facilitate improved public access to information regarding the quality of service user care, and specifically to enable members of the public to routinely access their own health and care records online.

SystmOne has the ability to allow service users, carers and families to view patient records, and to this end, the Trust will continue to work towards implementation of this capability. This will be regulated by a robust and managed process for accessing information, secured by the use of user names and passwords that will be provided by the Trust to authorised individuals, and led by the IT and Clinical Systems Team.

Thus, the Trust will be fully committed and engaged in making relevant service user information far more accessible and available so as to ensure that:

- service users will be better involved and informed, and able to contribute to the planning and delivery of their own health and social care support services with greater accuracy and understanding - this aspiration is wholly in line with the Trust's Clinical and Professional Care Strategy;
- service users will themselves be able to share their details and records with other health and social care professionals involved in their care: this will significantly improve their experiences and continuity of care;
- there will be corresponding reductions in administrative support services, resulting in a more streamlined and cost-effective service.

6.4.4 Equally in line with the spirit of transparency and openness, the Trust will ensure that aggregated information about the performance of its services is also more readily available to the public so as to enable them to make informed decisions about their care. This will require the Trust to support national initiatives such as the MyNHS web portal that is hosted by NHS Choices, and also to submit data regularly to the Health and Social Care Information Centre in order to assist in the production of national dataset publications.

However, it also requires the Trust to ensure that non-patient specific information is available in a range of settings and locations so as to inform the public. This includes the need, for example, to maintain information boards in community hospitals in order to provide detailed, up-to-date information about a range of metrics including service user experience, infection control, waiting times etc.

6.5 To ensure appropriate training and development for colleagues, so that they may best understand Trust information and thereby make well-informed decisions

6.5.1 So as to ensure that the Trust is supported by an expert resource, the knowledge, capabilities and competencies of the Performance and Information Team will be routinely assessed. Thereafter, the Trust will seek to provide all necessary training in order to meet the team's identified individual and group needs, and thereby empower them with the full range of skills and abilities necessary to successfully deliver against their Service Development Plan. This is especially relevant as the Trust continues to adopt new technologies and systems such as business intelligence tools and the web-based reporting, as referenced in sections 6.1.4 and 6.2.2 above.

6.5.2 Routine staff training in the Trust's clinical and corporate systems, as well as in the use of devices and other new technologies, including at time of induction, will include coverage of colleagues' information management responsibilities, and in particular, those responsibilities relating to the need of staff to ensure the timely, accurate and complete recording of data. Equally, information governance training will need to make suitable references so as to clarify staff responsibilities, particularly with regard to the sharing of information with third parties.

In both instances, the respective training teams will need to work closely with the Performance and Information Team so as to ensure that training and messaging covers all necessary subjects, and is clear and comprehensive.

6.5.3 The Performance and Information Team will be responsible for working closely with Trust leads and service managers so as to ensure that the information that is captured by their respective teams is of optimum quality, and to ensure that the corresponding guidance can subsequently be cascaded to colleagues.

Additionally, where capacity allows, training and development will be provided by the Performance and Information Team directly to colleagues to enable them to understand the data output from systems, and how best to use and interpret information reports, so that ultimately, the quality of services can be improved.

6.5.4 As part of colleagues' personal development needs assessment as referenced in the performance management framework in section 6.3 above, review of their use of systems will be included so as to identify the required skills and corresponding abilities that staff have in order to perform their roles effectively. Thereafter, the Trust will endeavour to ensure that any training needs are met, so that staff can fulfil their information management responsibilities.

7. Quality Measures

Each of the quality goals as identified in section 5 above, will be supported by a series of performance measures as detailed below, to be reported to, and monitored by, the Performance and Resources Committee on a routine basis:

Quality Goal	Quality Measures
To ensure that the Trust's information is of optimum accuracy, completeness and timeliness, and that information is used intelligently, thereby enabling the production of reliable and credible reports that practically support the delivery of high-quality care	• Minimum 96% data quality of Trust returns to the Health and Social Care information Centre • Data Quality Leads assigned and active at both Board and team level • Measured increase in the availability of triangulated information reports • Evidence of participation in all relevant benchmarking networks
To facilitate the routine dissemination of information internally, and thus provide suitable opportunity for the monitoring of service performance	• 100% delivery of first draft performance scorecards to relevant teams by the fifth working day of each month • 100% delivery of final draft performance scorecards to relevant teams by the tenth working day of each month • 100% delivery of Board and sub-Board Committee information reports to time
To use a robust performance management framework to deliver the Trust's vision, values and strategic objectives, and to ensure appropriate learning and improvement across all Trust services	• Minimum annual update of service specifications including targets and KPIs • Annual production of local Service Development Plans • Evidence of action plans against all metrics RAG rated amber or red that appear in scorecards presented at Board or Board sub-Committees • Routine reporting at Board sub-Committees of performance against Trust strategies

To share information as appropriate with all relevant external stakeholders, so as to build effective partnerships with both public and professional groups	• 100% compliance with mandated data flows • Maintenance of a clear implementation plan to make individuals' information available to service users, carers and families via SystmOne • Routine updating of publically visible activity and performance information across community hospitals and other appropriate settings
To ensure appropriate training and development for colleagues, so that they may best understand Trust information and thereby make well-informed decisions	• Minimum annual assessment of the training needs of the Performance and Information Team • Suitable coverage of appropriate information management best practice within both clinical systems and information governance training programmes • Evidence of annual appraisal of individual staff's training needs in respect of information management

8. Accountabilities and Assurances

8.1 Trust Board

The Trust Board is responsible for the delivery of safe, effective health and social care, and for ensuring that all resources are used efficiently, including data. More specifically, the Board has clear responsibility for:

- being advised by evidence-based intelligence which will provide trend and comparative information on how the Trust is performing (a duty ascribed by *The Healthy NHS Board: Principles for Good Governance*, NHS National Leadership Council);
- receiving regular Quality and Performance Reports which detail the Trust's activity against all national and commissioned targets, and where appropriate, local quality metrics, for comment and/or direction;
- receiving regular Finance Reports for comment and/or direction;
- receiving assurance of the Trust's performance against all contracts and service level agreements.

8.2 Performance and Resources Committee

The Performance and Resources Committee has specific responsibility for:

- reviewing the Trust's service delivery performance and outcomes against its annual plan, and against all contracts and service level agreements, to ensure achievement of all nationally commissioned and locally set targets, and assure that any appropriate remedial action planning is in place;
- assuring the appropriate development of key performance indicators / performance tracking systems so as to provide all relevant stakeholders, including Trust colleagues, service users and Commissioners, with the requisite level of detail in respect of performance and service delivery;
- reviewing the Trust's current financial position, on-going financial performance and continued use of resources, including outsourced financial services, against its annual plan and budgets.

8.3 Other sub-Board Committees

As detailed in section 6.3.8 above, a number of the sub-Board Committees have direct responsibility for monitoring the Trust's performance against the quality goals and metrics articulated within the Trust's strategy documents. Additionally, each sub-Board Committee has responsibility for monitoring operational performance relevant to the areas and services that they regulate. In doing so, sub-Board Committees will be informed and supported by the lower-level forums shown in the schematics in Appendix 3 below.

8.4 Chief Executive

The Chief Executive is the Trust's Accountable Officer, and as such, has overall responsibility for ensuring that the organisation has access to all necessary resources including data, in order to deliver the highest quality care services. The Chief Executive also has responsibility for ensuring that the Trust's governance structures adequately support performance monitoring.

8.5 Director of Finance

The Director of Finance is the Trust's executive lead for performance and information, and thus is responsible for overseeing the delivery of comprehensive and robust information reporting both within and outside the organisation.

8.6 All Directors

All Directors within the Trust have responsibility to ensure that the teams within their directorate continue to perform to the required standards and are effectively supported to maximise their performance potential.

8.7 Head of Performance and Information

The Head of Performance and Information is responsible for the management of the Performance and Information Team, whose primary duties are detailed in sections 4.3 and 4.4 above.

8.8 All Trust colleagues

All colleagues across the Trust have responsibility for contributing towards the success of this Information and Performance Management Strategy. This includes responsibility for:

- being committed to delivering excellent service performance at all times, irrespective of their directorate or discipline;
- recording all information whether relevant to health and social care activity or support services, in as timely a manner as possible, using the appropriate system, and giving all due consideration to ensuring that the information is accurate and complete;
- undertaking local validation of recorded data and highlighting any concerns or discrepancies to managers;
- recording any actual or potential risks to service delivery within the appropriate risk register;
- taking or supporting remedial actions where appropriate to correct any weaknesses or failings in service performance.

9. Enabling and Supporting Strategies

9.1 This strategy complements the following documents maintained by the Trust:

- the Quality Strategy, which seeks to champion a whole-system approach so as to ensure that consideration of quality becomes fundamental to every decision and action taken by the Trust;
- the Clinical and Professional Care Strategy, which seeks to empower the Trust to remain a leading provider of community-based health and social care services that provide optimum quality, safety and effectiveness, and enable local people to experience a positive journey and outcome;
- the Risk Management Strategy, which serves to identify the framework and aspirations that will support the effective management of both strategic and operational (clinical and non-clinical) risks across the Trust;
- the Information Technology (IT) Strategy, which seeks to ensure that information technology is used as an aid to empower Trust colleagues to provide service users with the best possible care, and to provide steer for a reliable, effective IT infrastructure that employs a diverse range of technologies to improve communications both within the Trust and across the whole of the local health and social care system;
- the Information Governance Strategy that specifies the Trust's plans to achieve compliance with all requisite information governance standards, and thereby ensure that the information that is maintained by the organisation is complete, safe, secure, accurate, timely and reliable;
- the Financial Management Strategy which supports the Trust's long-term financial stability and sustainability, and that demonstrates robust strategies to achieve best use of public monies;
- the Workforce Strategy, which seeks to ensure that the Trust's projected staffing models are appropriate to deliver effective health and social care within Gloucestershire, are that all Trust colleagues are suitably involved, motivated, supported, resourced, trained and developed;
- the Communications and Engagement Strategy, which aims to ensure that the Trust's mission to provide high-quality health and social care across Gloucestershire is fully supported by an effective programme of communications and engagement activity with service users, carers, families and the wider Gloucestershire public, as well as with the organisation's own workforce and professional partners.

9.2 This Information and Performance Management Strategy is directly supported by the Information and Performance Management Implementation Plan, which will clarify the actions to be undertaken by the Trust within the period 2014-19 in order to fulfil the ambitions of this Strategy.

10. References

The Power of Information: putting all of us in control of the health and care information we need (Department of Health, 2012)

Liberating the NHS: An Information Revolution
(Department of Health, 2011)

NHS Future Forum

Healthy Lives Healthy People: Our strategy for public health in England
(Department of Health, 2010)

Putting Patients First (NHS England, 2013)

Innovation Health & Wealth (Department of Health 2011)

Outline Information Management and Technology Strategy
(Gloucestershire Clinical Commissioning Group, 2013)

The Data Protection Act (1998)

The Freedom of Information Act (2000)

The Healthy NHS Board: Principles for Good Governance
(NHS National Leadership Council)

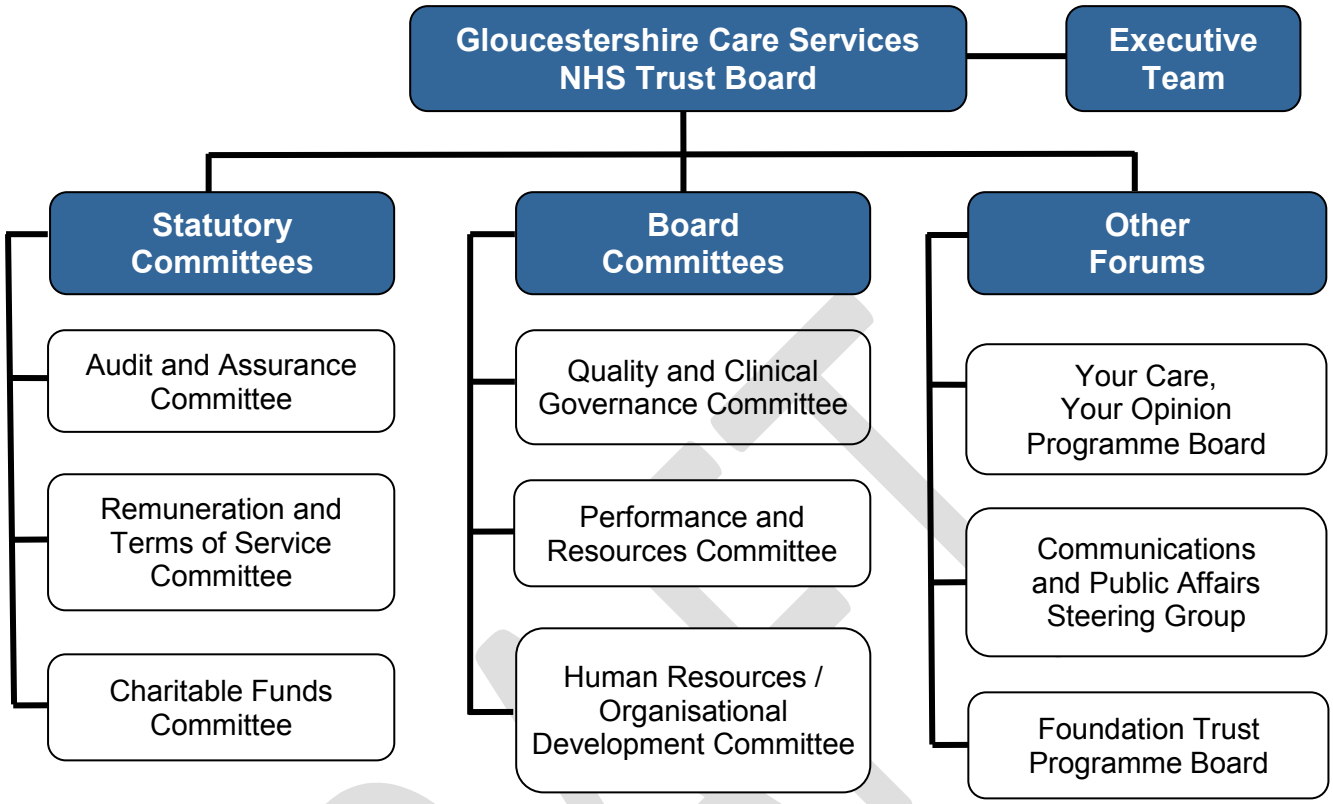
The NHS Benchmarking Network at www.nhsbenchmarking.nhs.uk/index.php

Appendix 1: Consultation

Drafts of this Information and Performance Management Strategy have been discussed at the following groups so as to ensure appropriate Trust-wide support, prior to escalation to the Trust Board in November 2014 for ratification:

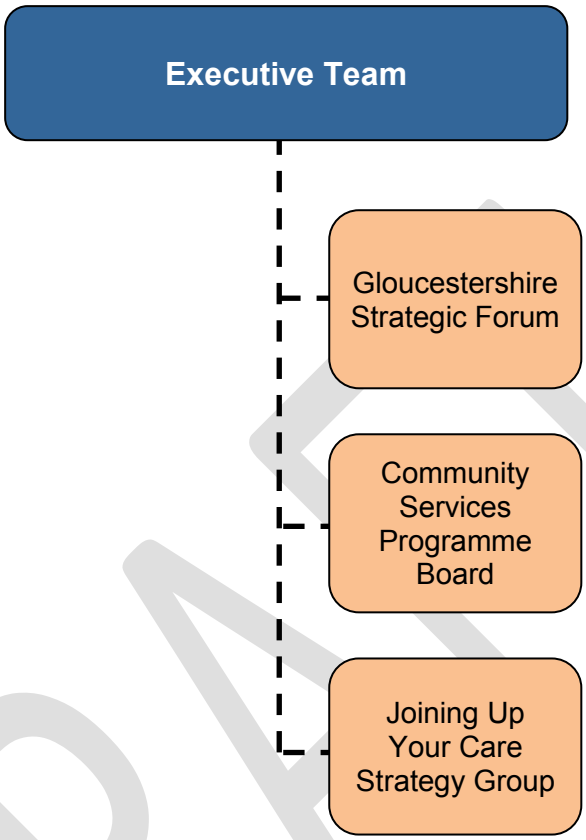
Consultation Group	Date of Meeting
Performance Framework workshop attended by: • the Director of Finance • the Director of HR • the Director of Corporate Governance and Public Affairs • the FT Programme Manager • the Head of Information and Performance • the Head of Programmes – Transformation and Change	29 September 2014
Performance and Resources Committee	21 October 2014
Trust Board	25 November 2014

Appendix 2: Board Committees



Appendix 3: Reporting to Board Committees

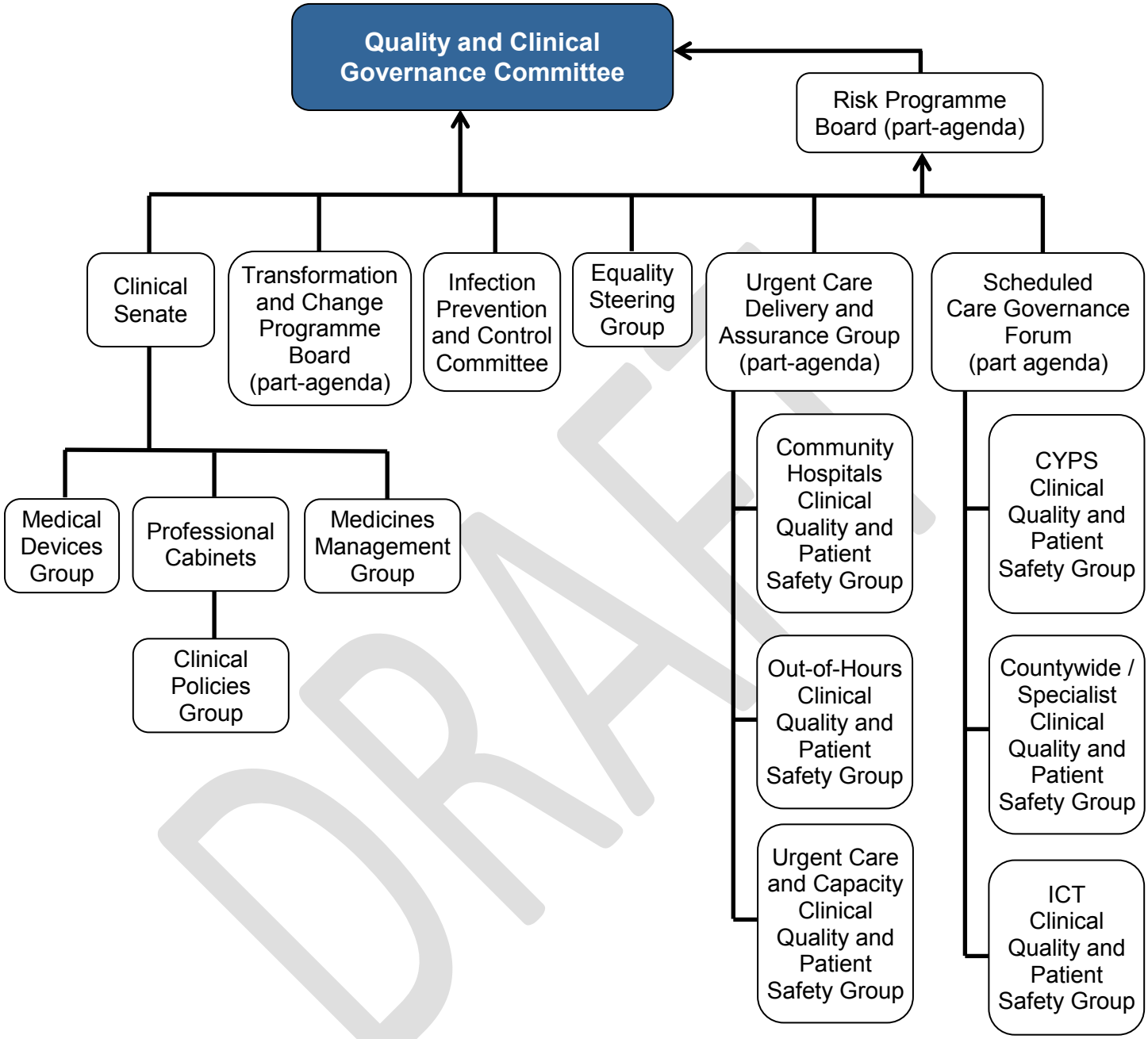
a) Executive Team



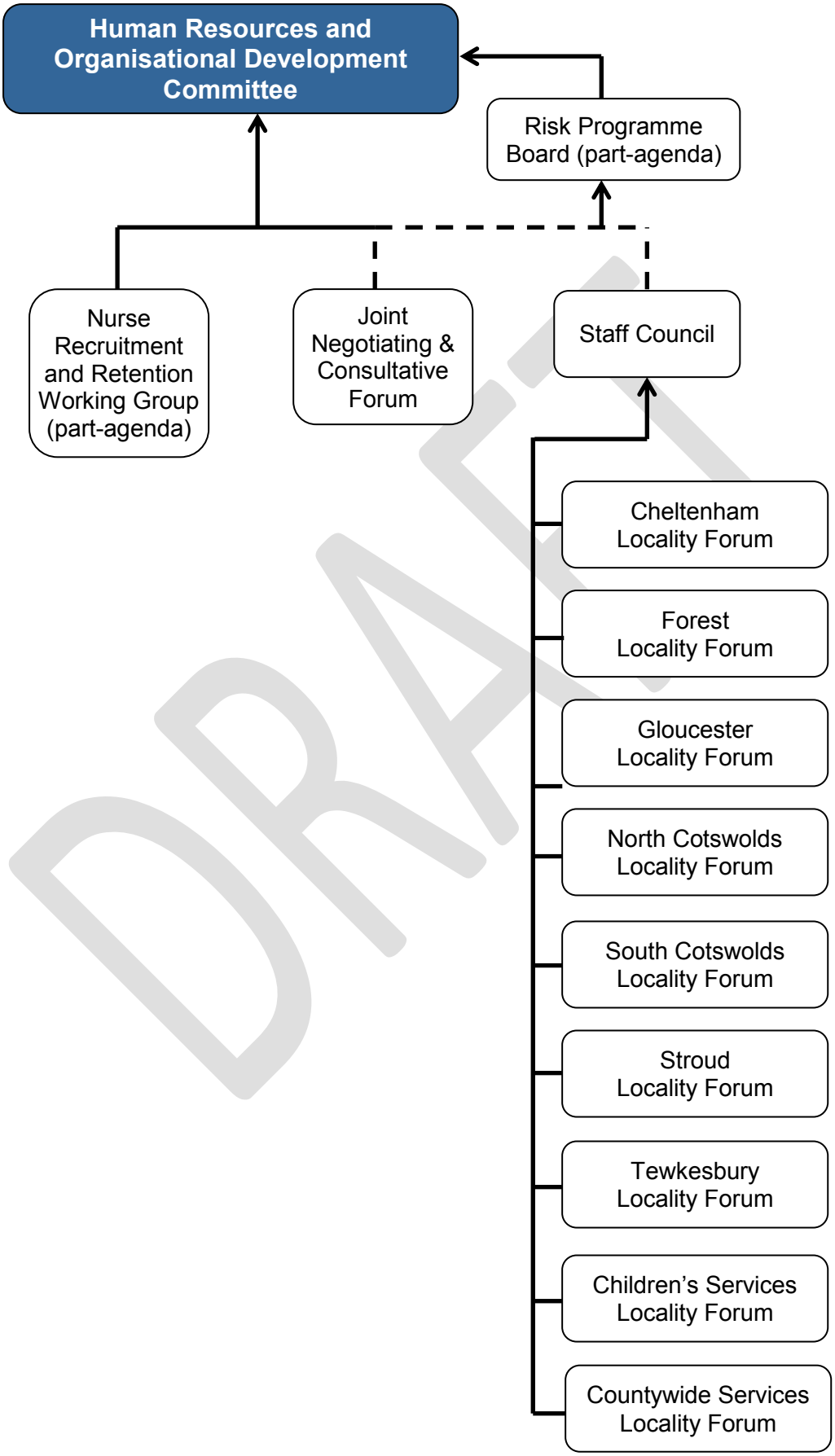
NB Dotted lines show groups that inform and support, rather than report

Boxes shaded in orange are externally hosted groups

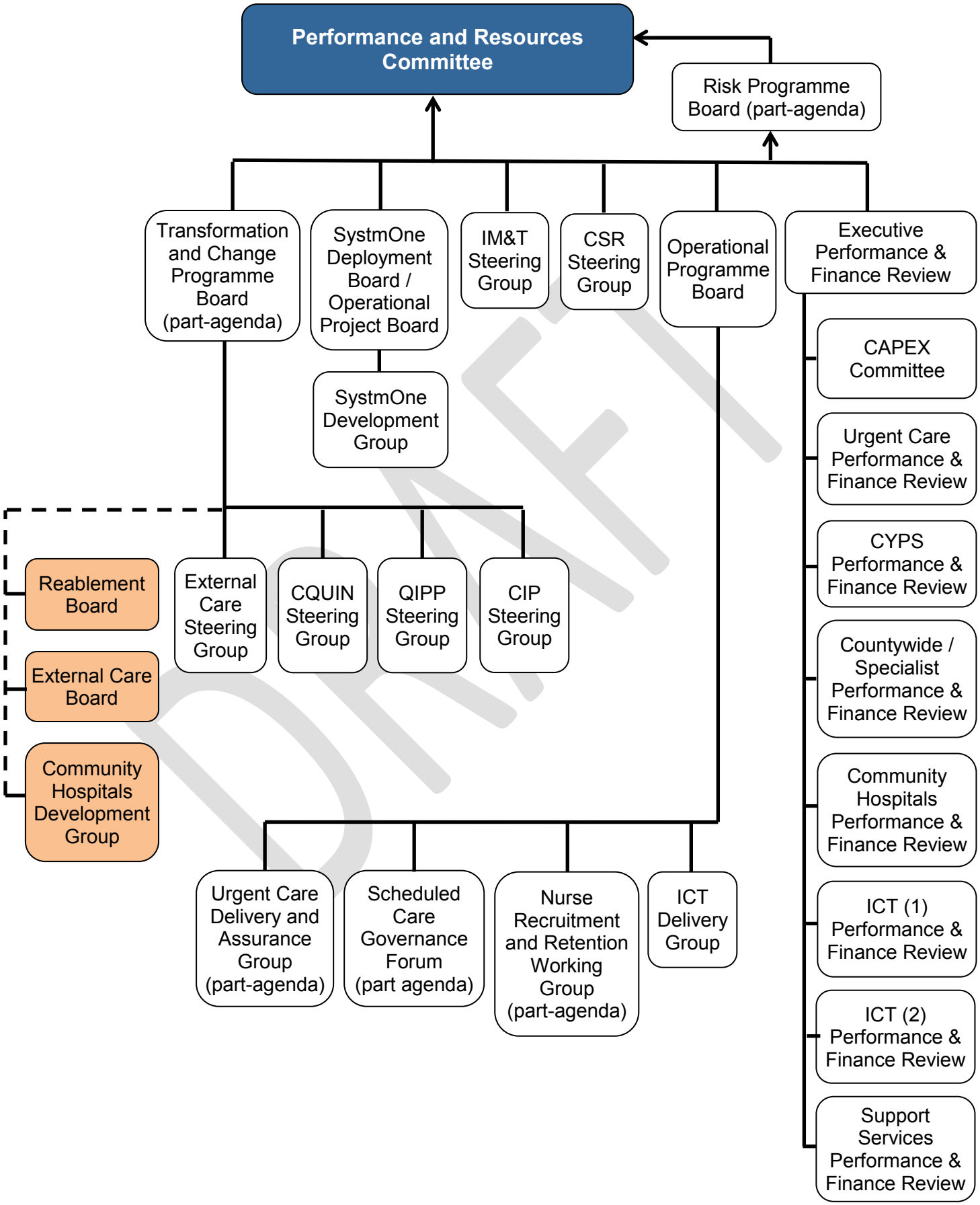
b) Quality and Clinical Governance Committee



b) Human Resources and Organisational Development Committee



c) Performance and Resources Committee



d) Audit and Assurance Committee