Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 20 September 2016

Agenda Item:	11 (Part 1)
Agenda Ref:	11/0916
Author:	Rod Brown, Head of Planning, Compliance and Partnerships
Presented By:	Rod Brown, Head of Planning, Compliance and Partnerships
Sponsor:	Glyn Howells, Director of Finance

Subject:	Board Assurance Framework

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

Executive Summary:

This iteration of the Board Assurance Framework (BAF) combines both strategic and high-level operational risks from the Corporate Risk Register into a single document, so as to provide the Board with broader insight / assurance into those areas deemed to threaten greatest risk to achievement of the Trust's vision and strategic objectives.

It is noted that following Board discussions regarding risk appetite, this BAF not only contains all operational risks rated 12+ but also all risks rated 8-10 where there may be direct impact upon service user safety.

Recommendations:

The Board is asked to:

Review the identified risks and validate that proposed actions are sufficient to mitigate those risks to an acceptable level.

Agree whether to remove strategic risk 001 given that the target has now been achieved in 2 successive periods.

Considerations:

Quality implications:

Implicit within the relevant risk descriptions

Human Resources implications:

Implicit within the relevant risk descriptions

Equalities implications:

Implicit within the relevant risk descriptions

Financial implications:

Implicit within the relevant risk descriptions

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

N/A

Does this paper link to any complaints, concerns or legal claims
No

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

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

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

Date:	12 September 2016

Where in the Trust has this been discussed before, e.g. Committee, Programme Board, Group?
This draft of the Board Assurance Framework was discussed at the Trust's September Risk Steering Group

Explanation of acronyms used:
BAF: Board Assurance Framework

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

Gloucestershire Care Services NHS
NHS Trust

Board Assurance Framework:

Strategic Risks

July 2016

Overview

This part of the Board Assurance Framework (BAF) serves to summarise the **strategic risks** that are faced by the Trust, linked to the organisation's five strategic objectives.

Contents

1. Definitions

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

1.1 Description of consequence

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

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

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

1.2 Description of likelihood

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

2. Strategic Risks

2.1 Summary of strategic risks

Trust strategic objectives	Strategic risks			
	Ref	Risk	RAG	Movement
Achieve the best possible outcomes for service users through high quality care	001	Inability to identify, address, or learn from trends that emerge as a result of complaints, concerns and incidents	8	⟺
	002	Inability to both embed and maintain consistent care pathways across all Trust services, and also ensure that staff observe these at all times	12	⟺
	003	Inability to observe robust record-keeping practices which may impact upon safety and care delivery	16	⟺
	004	Inability to maintain capacity, and match capacity to demand, which may impact upon service user and colleague safety, and the provision of continuous care	12	↓
Understand the needs and view of our service users, carers and families so that their opinions inform every aspect of our work	005	Variable engagement practices with service users, families and carers, which may result in the public voice not being used to inform the Trust	6	↓
Actively engage in partnerships with other health and social care providers in order to deliver seamless services	007	Lack of up-to-date service specifications for Integrated Community Teams limits the Trust's ability to effectively plan and deliver to plan	16	↑

Trust strategic objectives	Strategic risks			
	Ref	Risk	RAG	Movement
Value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision	008	Inability to recruit and retain the right staff with the right skills in the right place which may have a detrimental impact upon the quality of provided care	16	
	009	Inability to develop a culture that engages and motivates colleagues which may have a negative impact upon the Trust's reputation as an employer of choice	12	
	010	Inability to provide robust assurance that colleagues have the clinical skills to create a workforce with the necessary knowledge and expertise to deliver best care	16	
	011	Insufficient leadership capacity and capability within the Trust which could have a detrimental impact upon service transformation and service user care	12	
Manage public resources wisely to ensure local services remain sustainable and accessible	012	Failure to deliver the Trust's financial plan, including CIP, CQUIN and QIPP programmes	12	
	013	Inability to maintain robust internal control / governance systems which may lead to reputational loss and long-term sustainability	10	
	014	Inability to gain a "Good" or "Outstanding" rating following a CQC Chief Inspector of Hospitals' assessment	10	

2.2 Detail of strategic risks

Risk	**Inability to identify, address, or learn from trends that emerge as a result of complaints, concerns and incidents**					**Ref**	001		
Strategic objective	*Achieve the best possible outcomes for service users through high quality care*								
Description	The understanding and use of incident information management systems requires improvement across the Trust so that all colleagues know how to report issues which can then be reviewed and lessons learnt								
Date opened	30 March 2016					**Exec lead**	Susan Field		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	4	2	3	2	2				
- Consequence	4	4	4	4	4				
- Total	**16**	**8**	**12**	**8**	**8**				
Controls	• Datix software is used as the primary system for the collection, tracking and monitoring of incidents • Colleagues have expressed a need to update their understanding of incident management requirements and responsibilities • In August 2015, the Trust ratified an Incident Governance Policy which focuses on the benefits of achieving a learning culture and is supported by further guidance on the intranet • Incident reporting and trends is a standing agenda item in the Operational Governance Forum • An Incident Governance improvement plan is owned by the Professional and Clinical Effectiveness team					**Assurance**	• Incidents are identified in the Quality and Performance Report that is reviewed by the Quality and Performance Committee and the Board • Quarterly incident profiles are provided by the National Reporting and Learning System which provide an indication of the Trust's performance against comparable organisations • The Professional and Clinical Effectiveness team now provides a summary report of incidents, concerns and complaints to directorate governance forums • Both the Trust's Clinical Reference and Complaints Oversight Group (COG) scrutinise serious incidents		

Gaps in controls	• There is evidence of variance in understanding of incident reporting processes in some areas: this was confirmed by the CQC (September 2015) • Staff are not observing agreed incident governance processes	**Gaps in assurance**	• The Trust has now moved to within the middle 50% of comparative Trusts. This position needs to be sustained
Progress made in the previous period	• The Professional and Clinical Effectiveness (PaCE) team has continued to engage with clinical teams in order to promote a positive reporting and learning culture. This has included bespoke learning sessions and quality-focused briefings • Improved learning opportunities re: SIRIs continue to be overseen by the Trust's Clinical Reference Group • Undertake a "myth busting" approach to education and learning • The revised Datix form has been launched and early colleague feedback has been favourable • There are now weekly CORE communications and feedback mechanisms in place relating to Quality & Safety matters		
Actions in the next period	• Continue with the approved Sign Up To Safety work plans • Continue with "marketing" the importance of reporting incidents across the Trust • Progress with the publication of the Quick Reference Action Cards • Progress with the development of a Learning Assurance Framework in collaboration with GCCG colleagues • Finalise refresh of the Trust's Incident Governance Policy review		
Slippages on reported actions in the last reporting period	None		
Links to the Corporate Risk Register	ST5: Rising trend of reported falls at Community Hospitals		**9**
	NQ9: Staff's inability to observe the Trust's incident governance processes may result in non-compliance with the CQC's safety domain		**9**

Risk	**Inability to both embed and maintain consistent care pathways across all Trust services, and also ensure that staff observe these at all times**					**Ref**	002		
Strategic objective	*Achieve the best possible outcomes for service users through high quality care*								
Description	Services have not developed, or are not following, evidence-based care pathways, to support the right person and provide the right care at the right time. This can result in ineffective and inefficient care being provided to service users.								
Date opened	30 March 2016					**Exec lead**	Candace Plouffe		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	5	2	5	4	4				
- Consequence	3	3	3	3	3				
- Total	**15**	**6**	**15**	**12**	**12**				
Controls	• Some services are adopting a care pathway approach and this is being incorporated into the service specifications: an exemplar of good practice has been the Complex Wound service • NICE guidance provides information on best practice and is utilised to develop and refresh care pathways					**Assurance**	• Clinical protocols which incorporate care pathways facilitate an audit based approach to ensure compliance		
Gaps in controls	• Older service specifications tend to be input and activity based, and do not incorporate evidence-based care pathways					**Gaps in assurance**	• Not all interventions have nationally recognised evidence-based pathways, and as such, these will need to be locally developed and tested		
Progress made in the previous period	• Demand and capacity tool for ICTs localities which have implemented are providing data in relation to care bundles and capacity • Demand and Capacity tool in development for health visiting and school nursing as part of service redesign and incorporates care bundles based on National Healthy child programme schedule of reviews • Draft Operational service delivery plans reviewed • Ongoing Review of service specifications								
Actions in the next period	• Full implementation of demand and capacity tool for ICTs • Expand CYPS demand and capacity tool to Children's therapy services • Finalise care pathways for Continence service and Community IV therapy services • Finalise operational service delivery plans, incorporating 17/18 objectives • Complete outstanding service specification reviews								

Slippages on reported actions in the last reporting period	Finalisation of service specifications with the Commissioners, with both parties responsible for slippage due to capacity issues	
Links to the Corporate Risk Register	ST28: Inconsistent delivery of complex antibiotic therapy	**16**

Risk	**Inability to observe robust record-keeping practices which may impact upon safety and care delivery**					**Ref**	003		
Strategic objective	*Achieve the best possible outcomes for service users through high quality care*								
Description	The quality of record keeping is variable across services, and is potentially impacting on the quality of provided care as insufficient information is available for colleagues to act upon. This also creates a risk for the organisation when incidents occur, as care is not being documented to the standard expected as per the professional regulatory bodies and the Trust's record keeping policy								
Date opened	30 March 2016					**Exec lead**	Candace Plouffe / Susan Field		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	4	2	4	4	4				
- Consequence	4	4	4	4	4				
- Total	**16**	**8**	**16**	**16**	**16**				
Controls	• SystmOne allows for more robust record keeping audits, in which quality is the focus • All services carry out an annual record-keeping audit, and this process has been revised as the Trust has moved to an electronic records					**Assurance**	• Annual record keeping audits have been completed by professional heads of service, and subsequent action plans developed		
Gaps in controls	• Lack of standard operating procedures in SystmOne has resulted in information being recorded in various parts of the record, making it difficult to find easily, thereby impacting upon continuity of care • Training for clinical colleagues on how and what to record on electronic systems has yet to be provided – recognising this may require a different approach to paper based records					**Gaps in assurance**	• Need to review current record keeping and record management policy to ensure fits with new way of recording clinical information		
Progress made in the previous period	• Further Standard Operating Procedures have been developed on SystmOne, as well as redesign of modules to facilitate improved record keeping (i.e. tile approach) • There is a clear risk management workplan in place and meets monthly • Record keeping audits are being completed as per 16/17 audit schedule • Record-keeping "Task & Finish" group workplan progress being monitored by the Trust's Clinical Reference Group								

Actions in the next period	• Continue work via the Quality Improvement Group action plans, as well as identify training for clinical colleagues • Implement agreed work plan actions that include review of SystmOne templates, use of READ Codes, education, training, policy review and re-audit plans • Finalise re-audit plan • Present progress report to the August Quality and Performance Committee • Record keeping policy to be finalised and ratified	
Slippages on reported actions in the last reporting period	None	
Links to the Corporate Risk Register	SD35: Lack of compliance within ICTs with professional standards of clinical record-keeping	**16**
	NQ11: Record-keeping and records management processes are not compliant with clinical governance standards	**16**
	PCP01: Inconsistent record keeping means that allegations of negligence cannot always be refuted	**16**

Risk	**Inability to maintain capacity, and match capacity to demand, which may impact upon service user and colleague safety, and the provision of continuous care**					**Ref**	004		
Strategic objective	*Achieve the best possible outcomes for service users through high quality care*								
Description	Sustained and significant pressure for access to community services is reducing the ability to be proactive, as it is forcing the Trust to routinely react to the need to manage capacity. This not only distracts the organisation's senior operational staff from strategic planning, it also reduces the level of resource that is available elsewhere within the health and care system. Additionally, the demand to make additional community beds available to the acute sector may impact upon the quality of care being provided, and can place excessive strain upon colleagues, leading to higher turnover and lower morale								
Date opened	30 March 2016					**Exec lead**	Candace Plouffe		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	4	2	4	4	3				
- Consequence	4	4	4	4	4				
- Total	**16**	**8**	**16**	**16**	**12**				
Controls	• Alamac reporting enables a more measured and responsive approach to system-wide pressures, and is beginning to gather a body of information to support systemwide urgent care demand-capacity modelling • SystmOne is providing clearer evidence of Trust activity to underpin forward planning and a demand-capacity approach • Some services have demand-capacity models, and have used them to success in improving access times					**Assurance**	• Activity and performance against contracted service levels is reported on monthly through the Quality and Performance Report		
Gaps in controls	• The lack of service specifications which incorporate care pathways and demand-capacity models means that the Trust has very few cap-volume metrics agreed • There is insufficient clarity regarding step-up and step-down services to and from other providers • Without demand-capacity modelling, it is difficult to evidence when community services are "full" which impacts on the workforce and the quality of service delivered					**Gaps in assurance**	• There is not a consistent approach to proactive capacity planning across the whole of the health and social care economy: this should be one of the responsibilities of cross-organisational committees such as the Gloucestershire Strategic Forum and the Strategic Resilience Forum		

Progress made in the previous period	• Implementation of a number of pilots and initiatives including 2 x multi-agency discharge event, Home first pilot, pilot of GP priority admission beds in Community hospital. All to support the elements that should be included to an urgent care action plan as part of System reset to improve patient flow. • Further progress with Medworxx system • Progression by operational teams on demand-capacity frameworks for individual services, interlinked with defined care bundles	
Actions in the next period	• Complete roll-out of ICT demand and capacity tool • Complete roll-out of Health visiting and school nursing demand and capacity tool, expanding to include therapy services • Implementation of the Medworxx system • Determine additional capacity needed in Rapid Response with changes to front door avoidance service and care home pilot • Continue to develop demand and capacity tools in Countywide services • Define urgent care system pull model, incorporating demand and capacity tools to support patient flow and reduce number of acute sectors beds utilised	
Slippages on reported actions in the last reporting period	None	
Links to the Corporate Risk Register	SD5: Increasing demand for specialist services	**12**
	SD33: Increased demand for overnight community service - nursing and rapid response	**12**
	ST29: Bed occupancy levels consistently exceed CQC-advised thresholds and commissioned targets	**16**
	ST33: Rising demand for continuing healthcare assessments is placing unmanageable demand on district nursing	**12**

Risk	**Variable engagement practices with service users, families and carers, which may result in the public voice not being used to inform the Trust**						**Ref**	005
Strategic objective	*Understand the needs and view of our service users, carers and families so that their opinions inform every aspect of our work*							
Description	The Trust must ensure that it develops and maintains clear routes by which all service users, families and carers can provide feedback on their experiences so that this information may be actively used to improve service delivery and quality. This must include those service users who experience health inequalities or who traditionally find it hard to engage							
Date opened	30 March 2016					**Exec lead**	Susan Field	
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	3	1	3	3	2				
- Consequence	3	3	3	3	3				
- Total	**9**	**3**	**9**	**9**	**6**				
Controls	• Use of the Friends and Family Test (FFT) across all Trust settings • Direct feedback to teams from FFT comments • The updated Complaints Policy • The Service User Experience team which manages surveys including the FFT as well as complaints, Duty of Candour, concerns and compliments • The Community Partnerships Team which manages a range of engagement activities to include focus groups, community events and consultation opportunities • Information provided by external agencies such as Healthwatch, NHS Choices and Patient Opinion • On-going review of all feedback so as to ascertain themes • The Quality Equality Impact Assessments that are conducted against all service improvements / redesigns / Cost Improvement Plans • The Trust's Annual Quality Account • Being Open Champions					**Assurance**	• The Your Care, Your Opinion Programme Board • Relevant metrics within the Quality and Performance Report received at the Quality and Performance Committee and Board • 6-monthly Understanding You Report • Service user stories at Board • The Complaints Oversight Group • Regular partnership meetings with Healthwatch and Quality Review meetings with the CCG • Groups within the Trust which have a specific focus upon improving the experiences of those with dementia or a learning disability • The outputs of focus groups which are reported to relevant Trust forums for learning • The outputs of other ad-hoc engagement and consultation activities		

Gaps in controls	• Feedback to clinical teams and the public in respect of all forms of engagement needs to be strengthened • The Community Partnerships Team requires a more systematic approach so as to ensure effective engagement with all local populations including the most vulnerable • The Trust needs to actively engage with partners to truly evidence coproduction in service development	**Gaps in assurance**	• Service user feedback is not engrained in all service developments • Benchmarking data suggests that the Trust receives fewer complaints than other comparable Trusts
Progress made in the previous period	• The MIIU engagement was launched on 13 July, demonstrating clear working with the public and key stakeholders including Healthwatch Gloucestershire • Very successful Women's Health Day event targeting the BME community held at the Friendship Café • Patient stories heard at Board and Board Development • Finalising the planned Forest of Dean consultation exercise with the CCG • Countywide Equalities Group now established and convened – shared learning around the NHS Accessible Information Standard • New Complaints and Patient Experience leaflets continue to be circulated across the Trust • Quality / Equality Impact Assessment Policy developed for ratification • The Trust's Quality Account for 2015-16 published 30 June 2016 • The Understanding You Report presented at the June Quality and Performance Committee and July Trust Board • Community Partnerships Team continued to work with the end-of-life and continence projects to ensure that diversity is included within the workstream		
Actions in the next period	• Complete the MIIU engagement by 31 August • Merge the Engagement and Experience Strategy with the Communications and Marketing Strategy • Plan for compliance with the NHS Accessible Information Standard • Recruitment of a Community Partnerships Outreach Worker • Continue to review service of current external translation and interpretation provider		
Slippages on reported actions in the last reporting period	None		
Links to the Corporate Risk Register	None		

Risk	**Lack of up-to-date service specifications for Integrated Community Teams limits the Trust's ability to effectively plan and deliver to plan**					**Ref**	007		
Strategic objective	*Actively engage in partnerships with other health and social care providers in order to deliver seamless services*								
Description	Although the ICTs have been in existence for a number of years, the fundamental operational model has not been formally confirmed and agreed between partner organisations with a service specification. This, alongside further initiatives such as High Intensity/Enhanced Care service and case management, has resulted in a lack of agreed understanding between commissioners and the Trust of what is expected to be provided. The County Council has also introduced a change to the line management arrangements and responsibility for social work practice which has further impacted on the model. Overall, there is not a measure against which the Trust can effectively assess the success or otherwise of the ICTs. This results in an inability to set the service parameters and most significantly, the service cannot quantify when it is at capacity. With the development of the 30,000 people and place model, the Integrated Community Team will need to be redefined and service specifications refreshed								
Date opened	30 March 2016					**Exec lead**	Candace Plouffe		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	4	2	3	3	4				
- Consequence	4	4	4	4	4				
- Total	**16**	**8**	**12**	**12**	**16**				
Controls	• The Trust has created an ICT operational plan, based on previous business cases developed with the Commissioner and on draft and previous service specifications. • Individual action / recovery plans have been developed in respect of "hot spots" / areas of operational concern, such as reablement • Arrangements have been agreed with the Council to ensure that integrated care provision is provided by the ICTs, despite the change in line management and overall responsibilities for social work					**Assurance**	• Assurance and further direction is provided via the ICT Performance and Delivery Group which reports to the Joint Strategic Integration Panel. This in turn reports to the Contract Monitoring Board. • The refreshed governance structure has been agreed with Commissioners • Internal assurance is provided to the Operational Governance Group which reports to the Quality and Performance board subcommittee		

Gaps in controls	• The Trust does not have a final service specification for Integrated Community Teams within its core contract • The Trust does not have an agreed ICT service delivery model • Changes in operational management of Social Care services with competing organisational priorities between health and social care, may jeopardise the relationship between the Trust and Council, and thereby undermine delivery of integrated health and adult social care services. • The change to the social care management element has resulted in the need to review the overall management structure of the Integrated community teams	**Gaps in assurance**	• Although system wide key performance indicators are reported to the Commissioner, there is not a full set of metrics in which the individual elements of the Integrated Community Teams are reporting on
Progress made in the previous period	• Agreed reconfigured ICTs with GCCG, in order to increase clinical leadership and thereby facilitate the implementation of case management and support the people and place (30,000) model as part of the STP • Draft OT review completed, recommendations will require review of current appendices for this element of the ICT within the overarching specification • ICT KPIs and data monitored via the ICT Performance and Delivery Group, and has been shared with primary care as part of the cluster formation		
Actions in the next period	• Agreement with GCC commissioning for set management fee for social care elements of the ICTs • Request review of overarching service specification and appendices to ensure of the professional services/functions provided by the ICTs to ensure they in alignment with emerging people and place 30,000 model of care • Provide formal feedback from review of occupational therapy services • Agree programme of change framework to redesign reablement service		
Slippages on reported actions in the last reporting period	None		
Links to the Corporate Risk Register	ST31-ICT: Risk to service user safety, service effectiveness and Trust reputation as a result of competing developmental priorities in ICTs including the place-based model, frailty pathway and community matron model of care		**12**

Risk	**Inability to recruit and retain the right staff with the right skills in the right place which may have a detrimental impact upon the quality of provided care**					**Ref**	008		
Strategic objective	*Value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision*								
Description	The number of qualified nursing vacancies has remained static over the last 12 months. This has been compounded by the inability to attract new staff to the organisation and an increase in turnover rates in some areas. This is set in the national context that qualified nurses are included on the national shortage occupational list and the recent introduction of agency cap rates.								
Date opened	30 March 2016					**Exec lead**	Tina Ricketts		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	4	2	4	4	4				
- Consequence	4	4	4	4	4				
- Total	**16**	**8**	**16**	**16**	**16**				
Controls	• Weekly submissions of nurse staffing numbers within Community Hospitals so as to identify gaps and respond effectively • Monthly recruitment drives / fayres to attract new staff • Revised establishment control process • Any gaps in staffing are addressed by the use of bank/agency workers so as to maintain safe staffing levels at all times • Centralised bank and agency function • Roll out of e-rostering across the Trust • Safer recruitment practices in place • Development roles and training places for Community Nurses • Review of exit interviews, managed centrally in HR					**Assurance**	• Workforce data which is reported through the Workforce & OD Committee and thereafter to Board • Safer Staffing data which is included within the Quality and Performance Report which goes to Board • Top-level workforce plan submitted to Workforce & OD Committee • Agency working group chaired by the Director of Nursing • Recruitment & Retention Working Group		
Gaps in controls	• Lack of robust workforce information, particularly in terms of establishment & vacancies, which is essential in order to drive activity and response • Available staff banding does not help to retain talented staff – thus, for example, district nurses are unable to advance above Band 6 which results in them either having to specialise within other services, or leave the employ of the Trust • Low completion rate of exit interviews					**Gaps in assurance**	• Data is not available to review in real-time		

Progress made in the previous period	• Recruitment and retention report standing agenda item on Workforce and Organisational Development Committee • Detailed analysis of reasons for leaving included in report to Workforce and Organisational Development Committee • Development of capacity tool for Community Nursing • Development of complexity tool for Rapid Response Service • Attendance at university open days to promote the Trust as an employer of choice (particularly looking at 'border' universities who specialise in particular training e.g. physio)	
Actions in the next period	• Recruitment and selection processes to be further reviewed under a Listening into Action scheme • Contingent workforce plan in place with new initiatives including introduction of weekly payroll and peripatetic teams • Nurse Associate pilot submitted • Targeted recruitment campaigns in BANES and Swindon areas	
Slippages on reported actions in the last reporting period	None	
Links to the Corporate Risk Register	NQ12: No formal consultant microbiologist to support antimicrobial stewardship and provide clinical guidance	**16**
	HR3: High number of nurse vacancies across the Trust, particularly in community hospitals	**16**
	HR7: Insufficient workforce information may be masking further recruitment hotspots	**15**

Risk	**Inability to develop a culture that engages and motivates colleagues which may have a negative impact upon the Trust's reputation as an employer of choice**						**Ref**	009
Strategic objective	*Value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision*							
Description	Lack of a clear, consistent and positive working environment may negatively affect the Trust's ability to attract and retain staff. This may result in insufficient staff numbers and higher costs of employment due to increased bank/agency staff. More significantly, disaffected and demoralised staff can impact on the quality of provided care.							
Date opened	30 March 2016					**Exec lead**	Tina Ricketts	
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	4	1	3	3	3				
- Consequence	4	4	4	4	4				
- Total	**16**	**4**	**12**	**12**	**12**				
Controls	• Agreed Workforce and Organisational Development Strategy with corresponding implementation plans • Undertaking a third year of Listening into Action • Core Values Behaviour Framework • Annual staff survey • Quarterly Staff Friends and Family Tests • Workforce scorecards					**Assurance**	• Improvements in the Pulse Check for Listening Into Action between start and end of year two • Investors in People accreditation until March 2017 • Workforce and Organisational Development Committee • Workforce and Organisational Development Steering Group • Workforce Education & Development Group	
Gaps in controls	• The Trust's agreed Performance Management Framework is not widely understood or embedded across the organisation • High proportion of workforce risks relate to demand/ capacity issues • Inability to recruit to all qualified nursing vacancies having an impact on morale					**Gaps in assurance**	• Both the NHS Staff Survey and the Staff Friends and Family Test report below-target for staff recommending the Trust as a place to work. Hotspot identified at Edward Jenner Court.	

Progress made in the previous period	• Refresh of the Workforce & Organisational Development Strategy to identify strategic priorities for 2016/17 • Listening into Action "Enabling our People" scheme in place which focuses on supporting colleagues through change • Three LiA schemes (communications, leadership, behaviours) launched at EJC to address 3 priority areas identified in big conversations	
Actions in the next period	• Continue to work towards Listening into Action accreditation • Continue to focus on improving the Trust's rating as a flexible working employer in conjunction with Timewise • Listening into Action Board Development session planned for September 2016 • #takethelead event planned for 5 October 2016 • Refresh the combined Communications and Engagement Strategy	
Slippages on reported actions in the last reporting period	• LIA accreditation subject to further pulse check results	
Links to the Corporate Risk Register	HR13: Low staff morale within the Trust as a result of many changes and the mismatch between capacity and demand	**15**
	HR6: Low rates of Personal Development Reviews **RE-ENTRY**	**15**
	PCP23: Trust's WRES report shows significant discrepancies between the experiences of different staff groups **NEW**	**12**

Risk	**Inability to provide robust assurance that colleagues have the clinical skills to create a workforce with the necessary knowledge and expertise to deliver best care**						**Ref**	010	
Strategic objective	*Value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision*								
Description	The Board does not receive the necessary assurance that colleagues are suitably skilled. Moreover, the Trust needs to establish a clear link between Personal Development Plans and Service Development Plans in order to be able to evidence a competent and flexible workforce who are able to effectively provide care despite the changing profile of service users and their increasing acuity.								
Date opened	30 March 2016					**Exec lead**	Susan Field / Tina Ricketts		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	4	1	3	4	4				
- Consequence	4	4	4	4	4				
- Total	**16**	**4**	**12**	**16**	**16**				
Controls	• The Trust has a policy regulating the use of appraisals and Personal Development Plans • Clinical education programmes are in place and accessible via ESR • There is a defined pooled training budget • There are competency frameworks for statutory and mandatory training • The Trust is compliant with the Professional Bodies Registration requirements					**Assurance**	• Appraisals and mandatory training rates are included in the Quality and Performance Report which goes to the Trust Board: these are also reported at team and locality level on a monthly basis • Workforce Education & Development Group which reports to the Workforce & Organisational Development Committee		
Gaps in controls	• Completion rates for appraisals are below the required threshold • There are no commissioned audits looking at appraisals practice • Inconsistent provision of clinical supervision • Service Development Plans are not yet developed for all areas • Competency frameworks need to be developed across all roles and disciplines					**Gaps in assurance**	• Percentage of staff reporting access to relevant personal development • Percentage of staff compliant with statutory and mandatory training		

Progress made in the previous period	• Further development of the Oracle Learning Management system as to enable colleagues to access their own training records on line • Trust's statutory and mandatory training matrix continued to be promoted across the Trust • Intense statutory and mandatory training sessions arranged for July-October • Improved reporting now in place for safeguarding, resuscitation and relevant clinical mandatory training and appraisals • Access to e-learning simplified • Training booking system to be replaced to enable improved access • Appointed a management lead to progress apprenticeships across the Trust • Recruitment to apprenticeship roles commenced • Annual review of training and development undertaken and reported to Workforce and Organisational Development Committee • Refresh of the Trust's statutory and mandatory training policy completed • Refresh of the Trust's study leave policy completed • Workforce scorecard developed to include reporting of compliance on mandatory clinical training • Training data validation process with budget holders completed
Actions in the next period	• ESR self-service to be launched in September • Targeted approach to improving statutory and mandatory training compliance – action plans in place for each subject area • Training booking system to be replaced to enable improved access • Continue with Listening into Action "Enabling our People" schemes • Progress with training data validation process with Head of Services and budget holders • Focus on developing essential to role training matrices for each service (led by Professional Heads and Operational Leads)
Slippages on reported actions in the last reporting period	• Lack of capacity of services to release staff to complete the training

Links to the Corporate Risk Register	NQ3: The Trust is unable to evidence staff's safeguarding training	**16**
	NQ5: Insufficient staff competencies in MIiUs may result in incidents up to, and including, severe harm	**12**
	HR12: Low mandatory training compliance could have a detrimental impact on the Trust's reputation and its ability to meet CQC standards	**15**
	HR14: Low safeguarding and resuscitation training compliance could result in service users being at risk	**12**

Risk	**Insufficient leadership capacity and capability within the Trust which could have a detrimental impact upon service transformation and service user care**					**Ref**	011		
Strategic objective	*Value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision*								
Description	The Trust's cultural change programme requires all colleagues to be leaders so that service transformation and development can be driven from the front line. It is evident from staff survey results that leadership capability and capacity is varied across the Trust and this is having a detrimental impact on colleague engagement, service development and the Trust's ability to take forward service transformation at pace and scale.								
Date opened	30 March 2016					**Exec lead**	Tina Ricketts		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	4	2	3	3	3				
- Consequence	4	4	4	4	4				
- Total	**16**	**8**	**12**	**12**	**12**				
Controls	• NHS Leadership Competency Framework • Workforce and Organisational Development Strategy • Listening into Action programme year 3 • CORE values behaviour framework					**Assurance**	• Investors in People Accreditation to March 2017 • Workforce Education & Development Group which reports to the Workforce & Organisational Development Committee • Monthly leadership meetings		
Gaps in controls	• The Trust does not currently have a Talent Management Strategy or Leadership Development Plan • The assessment of individual's ability against the NHS Leadership Competency Framework is varied and it not intrinsically linked to personal development plans					**Gaps in assurance**	• Percentage of colleagues who have participated in leadership development activities		
Progress made in the previous period	• Edward Jenner leadership programme available to all staff • Leading an Empowered Organisation training available for band 6 and above • CORE Colleague Network attendee list updated • Bespoke leadership programmes in place for Integrated Community Teams and Community Hospital Managers								

Actions in the next period	• Leadership conference planned for 5 October 2016 • Listening into Action coaching for 30 colleagues in September 2016 • Trust Leadership Plan being developed which will be launched at the leadership conference in October 2016	
Slippages on reported actions in the last reporting period	Delay in the development of a Talent Management Strategy	
Links to the Corporate Risk Register	HR15: Lack of management capability and capacity could be the root cause of low staff moral and increased staff turnover	**16**
	HR16: Lack of leadership capability and capacity could be the root cause of lack of progress against service transformation and the Workforce and OD Strategy	**12**

Risk	**Failure to deliver the Trust's financial plan, including CIP, CQUIN and QIPP programmes**					**Ref**	012		
Strategic objective	*Manage public resources wisely to ensure local services remain sustainable and accessible*								
Description	The Trust has a challenging £4m Cost Improvement Programme for 2016-17. Additionally, the Trust is challenged to meet all QIPP and CQUIN targets which have another £6m of risk in them. The CQUIN schemes agreed are challenging but deliverable: however, there is £900k QIPP risk which is based on system-wide improvement in KPIs that are outside the Trust's control								
Date opened	30 March 2016					30 March 2016	30 March 2016		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	4	2	3	3	3				
- Consequence	4	4	4	4	4				
- Total	**16**	**8**	**12**	**12**	**12**				
Controls	• Robust project structure and governance framework in place to ensure continual monitoring and reporting with clear escalation • Accurate baseline reports and activity data to evidence progress • Financial targets agreed at the outset between operations and finance with more financial involvement throughout the process • Good historical delivery against QIPP and CQUIN and additional QIPP schemes close to agreement • A clear communications plan linking CIP delivery to LiA; highlighting that CIP is a collective responsibility and requires engagement from everyone • QEIAs will be completed and signed off for all CIP schemes before they are implemented • The Trust's main commissioner is supportive of the areas being targeted by the CIP plans					**Assurance**	• Progress against CIP targets is monitored at the CIP Steering Group which reports to the Finance Committee • Quality Equality Impact Assessments are discussed at Clinical Senate with recommendations made to the Executive Team for ratification • Quality Equality Impact Assessments are included with future Clinical Senate reports which are provided to the Quality and Performance Committee		
Gaps in controls	• Clear evidence-base / intelligence / operational modelling upon which to build CIP plans • Financial understanding and accountability by operational leads is improving • Financial projections are improving • Understanding of CIPs across the Trust is improving					**Gaps in assurance**	• The ability to deliver in-year and future CIP savings without reducing frontline services or generate additional income through increased productivity and efficiency		

Progress made in the previous period	• QIPP and CQUIN schemes are now fully agreed with main commissioner, good achievement in Quarter 1 and Quarter 2 • Detailed CIP programmes in place, with good achievement in Community hospital and ICTs • EQUIAs for CIP programme resulting in significant change being reviewed by Clinical Reference group • Continued identification of CIP opportunities that have been projected to deliver in Quarter 1 of 17/18	
Actions in the next period	• Continue to complete QEIAs for relevant CIP initiatives before implementing • Review of QIPP milestones and agree evidence required with Commissioners to minimise potential non-achievement • Continued management and monitoring of all CIP, CQUIN and QIPP plans • Accelerate development of plans for 2017-18 • Provider to Provider contract meeting with GHT	
Slippages on reported actions in the last reporting period	• Provider to provider contract meeting with GHT has not yet occurred for 16/17	
Links to the Corporate Risk Register	SD38: The Trust is not receiving funding for all out-of-county HIV care	**16**
	FIN1: Ability to deliver CIPs against pay costs	**12**
	FIN2: Ability to achieve Gloucestershire Hospitals NHS Foundation Trust service recharges and adhocs	**16**
	FIN3: Ability to control and reduce agency spend	**12**
	FIN5: Inability to identify required targets or cost savings across a five year period	**12**
	TC14: £900k admission avoidance QIPP scheme at risk of non-delivery	**16**
	TC15: Risk of not meeting reablement QIPP milestones	**12**
	TC16: Risk of not achieving QIPP milestones due to inability to accommodate complex leg wound services	**12**
	TC18: Risk of non-delivery £4 recurrent CIP savings	**12**

Risk	**Inability to maintain robust internal control / governance systems which may lead to reputational loss and long-term sustainability**					**Ref**	013		
Strategic objective	*Manage public resources wisely to ensure local services remain sustainable and accessible*								
Description	Non-compliance with requisite standards is a constant risk, to which the Trust must adopt a proactive approach so as to maintain its effective performance and organisational reputation as a provider of high quality services. Governance arrangements for Board and sub-committees that have been discussed and agreed with NHS Improvement need to be quickly embedded in the Trust, and these new arrangements mapped to strategies, relevant sub-committees and matters arising under the previous governance arrangements.								
Date opened	30 March 2016					**Exec lead**	Glyn Howells		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	2	1	2	2	2				
- Consequence	5	5	5	5	5				
- Total	**10**	**5**	**10**	**10**	**10**				
Controls	• Clinical and corporate governance arrangements enable controls to be effectively managed • Committee / reporting structures enable controls to be monitored and reviewed • The Trust's strategy framework provides oversight of activity and controls in all key operational and support areas • The Trust maintains its Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation of Powers by which its authority is managed and controlled • Line management structures provide clarity in terms of responsibilities and accountabilities • Internal and external audit provides additional scrutiny					**Assurance**	• The sub-Board Committee structure, and in particular, the Audit and Assurance Committee, the Quality and Performance Committee, the Finance Committee, and the Workforce and OD Committee, provide assurance on all corresponding controls to the Trust Board		
Gaps in controls	• Revised committee structures need to be embedded and run through reporting cycles to provide assurance • The Head of Financial Accounting position is vacant from the middle of June					**Gaps in assurance**	• Inconsistent hierarchies within governance arrangements • No consistent management of delegated authorities in committee sub-groups		

Progress made in the previous period	• Trust secretary started in role in July. • Head of Financial Accounting appointed in July (start date of August) • Work in improving reporting on key workforce data is gathering pace (eRostering, absence reporting) • Revised governance arrangements are being worked through cycles of reporting, including terms of reference review and submission to "parent" forum	
Actions in the next period	• Head of Financial Accounting starts in August • Develop reporting on data from e-rostering to get out to teams / management (to provide real time assurance on staffing levels) • Paper detailing committee structures to go to September Audit and Assurance Committee for review and approval • Paper proposing changes to assurance reporting to go to September Audit and Assurance committee for review before going to September Board	
Slippages on reported actions in the last reporting period	• Develop reporting on data from e-rostering to get out to teams / management (to provide real time assurance on staffing levels)	
Links to the Corporate Risk Register	SD42: Capacity to correct / amend countywide services data quality in SystmOne **NEW**	**12**
	PI3: Areas of reporting inconsistency and poor data quality across some services	**16**
	PCP2: Failure to comply with Information Governance standards, resulting in the Trust no longer being at level 2 compliance with the Information Governance Toolkit	**12**
	PCP4: Inability to comply with the NHS Accessible Information Standard	**12**
	PCP14: Low rates of Information Governance training across the Trust **NEW**	**12**

Risk	**Inability to gain a "Good" or "Outstanding" rating following a CQC Chief Inspector of Hospitals' assessment**					**Ref**	014		
Strategic objective	*Manage public resources wisely to ensure local services remain sustainable and accessible*								
Description	The CQC report published 22 September 2015 awarded the Trust a rating of "Requires Improvement". It is the Trust's clear ambition to secure a "Good" rating as a minimum in order to provide assurance of the organisation's high-quality services, care and regulatory compliance.								
Date opened	31 May 2016 (re-entry)					**Exec lead**	Susan Field		
Rating	**Initial**	**Target**	**March 2016**	**May 2016**	**July 2016**	**Sept 2016**	**Nov 2016**	**Jan 2017**	**March 2017**
- Likelihood	3	1		3	2				
- Consequence	5	5		5	5				
- Total	**15**	**5**		**15**	**10**				
Controls	• The development of a detailed Quality Improvement Plan in response to the CQC Chief Inspector of Hospitals' report, which details all the actions being taken by the Trust to address the identified gaps / inconsistencies over time.					**Assurance**	• The Quality Improvement Plan will continue to be monitored by the Quality and Performance Committee and the Trust Board • Actions to ensure compliance with CQC recommendations are also being monitored by the CQC Inspection Programme Board • CQC QIP Working Group • CQC QIP Oversight Group (TDA, CCG)		
Gaps in controls	• The Trust is currently unable to provide full evidence / assurance to the CQC of a number of actions, which have been organised under the twelve themes of (i) leadership, (ii) staffing, (iii) training, (iv) incidents, complaints and risks, (v) policies / protocols (including audit), (vi) medicines management, (vii) accessibility, (viii) records management (including document security), (ix) equipment and supplies (including cleaning), (x) information, (xi) estates (including security), and (xii) partnership working • Particular concerns noted about record-keeping and staff training rates					**Gaps in assurance**			

Progress made in the previous period	• CQC Quality Improvement Plan actions ongoing. Progress and risks discussed at every Quality and Performance Committee and July Trust Board • MIIU public engagement exercise has commenced • "Mock" CQC inspection took place June/July 2016	
Actions in the next period	• Review and archive completed actions of the CQC Quality Improvement Plan • Publish report of the CQC mock inspection to service leads • Maintain Peer Reviews to validate that actions reported as having been completed are recognised at frontline and ensure this is incorporated into developing Quality Assurance/Tracket tool being developed by the PaCE team and operational colleagues • Stand down the internal QIP group	
Slippages on reported actions in the last reporting period	None	
Links to the Corporate Risk Register	NQ13: Lack of temperature controlled storage for drugs and dressings at sites across the Trust	**16**
	ST8: Lack of a consistent staff model and system resilience in MIiUs	**12**

Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 20th September 2016

Agenda Item:	12
Agenda Ref:	12/0916
Author:	Susan Field, Director of Nursing
Presented By:	Sue Mead, Non-Executive Director
Sponsor:	Sue Mead, Non-Executive Director

Subject:	Quality and Performance Committee Report

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

Executive Summary:

The Trust Board are formally asked to receive assurance that on its behalf the Quality and Performance Committee **APPROVED** the following:

- The 28th June 2016 Committee minutes
- The Clinical Strategy 2016-19 and that it be formally ratified by the Trust Board
- That the Trust is on track with its CQC activities and that the Trust Board formally corresponds with the CQC inviting them to undertake a re-inspection
- The Trust's new Coroners Policy

The Quality and Performance Committee also **RECOMMENDED** that the following issues progress or be formally highlighted to the July Trust Board:

- That the Trust's performance with regards to harm free care remains below the target of 95% and that more specific work associated with pressure area care be progressed
- That bed occupancy rates remain high and that the Trust actively participates in a system wide bed review and a system wide "re-set" led by the GCCG and CEOs
- Safe staffing levels change were being introduced across the Community Hospitals and that future reporting for this will change

The Trust Board is also asked to receive assurance that the following items were **NOTED**:

- That the Trust had recently been an active contributor to a national CQC led review about Investigating Deaths – the outcomes are due to be reported December 2016
- The Trust's Safeguarding Annual Report (2015-16)
- The work and subsequent actions being progressed to mitigate the Trust's Clinical Record Keeping risks – currently rated 16

Recommendations:

The Board is asked to:

The Board is formally asked to:

- Receive the report and the approved minutes of the 28th June 2016 Quality and Performance Committee
- Correspond with the CQC by October 2016 inviting them to re-inspect the Trust

- Ratify the Trusts Clinical Strategy (2016-19)
- Ratify the Trusts Coroners Policy

Considerations:
Quality implications: This report draws on discussions and decisions at the Quality and Performance Committee that took place on 28th June 2016 and therefore has significant quality and patient safety assurance/implications throughout.
Human Resources implications: N/A
Equalities implications: N/A
Financial implications: N/A
Does this paper link to any risks in the corporate risk register: No
Does this paper link to any complaints, concerns or legal claims No

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

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

Reviewed by (Sponsor):	Sue Mead, Non-Executive Director

Date:	12th September 2016

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

Quality and Performance Committee – 31st August 2016

Explanation of acronyms used:

PaCE – Professional and Clinical Effectiveness
ICT – Integrated Community Teams
CORE – Caring, Open, Responsible, Effective
CQC – Care Quality Commission
GHFT – Gloucestershire Hospitals Foundation Trust
QIP – Quality Improvement Plan
GCCG – Gloucestershire Clinical Commissioning Group
QEIA – Quality Equality Impact Assessment

Contributors to this paper include:

Susan Field, Director of Nursing

Quality and Performance Committee August 2016 Report

1. Introduction

This report outlines agreed actions and assurances that emerged following the Trust's Quality and Performance Committee meeting which took place on 31st August 2016.

The minutes of the previous meeting of 28th June 2016 were approved and formally signed off by the Committee Chair and can be seen in Appendix 1.

The Committee Chair and the Director of Nursing would like to draw to the attention of Trust Board members the following issues:

2. Trust Clinical Strategy

This 3 year strategy can be seen in Appendix 2. The Quality and Performance Committee discussed the strategy and acknowledged:

- That it had been developed by the Heads of Profession and its development had been overseen by the Trusts Clinical Reference Group
- That the Strategy had been simplified, would potentially become more recognised with clinical colleagues and more meaningful
- That the outcome and impact of 3 year strategy needed to be clearly articulated, measured and monitored – this would be led by the Heads of Profession
- That the Strategy aligned to the Trusts CORE values and that there had been Trust-wide engagement during its development

3. Quality and Performance

The Committee reviewed the Trusts June Quality and Performance data and wished to highlight the following:

- Concerns that Harmfree Care remains below the trajectory of 95%. Action plans with the ICTs and community hospitals were now in place; that the required improvements needed to maintain some pace and momentum with operational and PaCE colleagues in order to effect change. The Committee also requested further work with regards to pressure ulcers and to try and understand if there was any correlation with reduced availability of packages of care.

- Although the Trust saw a slight decrease in its bed occupancy rate, this remains a concern and Committee members were keen that the Chief Operating Officer (COO) and colleagues progress with the wider systems activities with the Gloucestershire Clinical Commissioning Group (GCCG) and that this included the bed modelling review that was due to commence and a "system re-set" that the CEOs of both Gloucestershire Care Services (GCS) and Gloucestershire Hospitals Foundation Trust (GHFT) were progressing.

- Noted the risks associated with the changing model of service for the reablement service (and particularly the Trust having to hold a number of posts vacant), the sexual health and public health nursing.

- Appraisals being at their lowest rates, 66%, and there needed to be a better understanding as to whether this was impacting on the quality of care being provided to patients.

- Safe Staffing – the Committee welcomed the approach that revised staffing levels for each community hospital ward were being finalised and this would be in place by 1st October and; that the patient acuity audit was almost completed with the outcome of this being shared at the November Committee meeting.

  Post meeting note – the table on page 3 outlines the changes and future safe staffing levels across the 7 community hospitals and provides an indication that future reporting of safe staffing to the Committee and Trust Board will change from its current format. The wards that have already introduced these changes include:

  - Windrush Ward
  - Coln Ward

  } Cirencester Community Hospital

  - Cashes Green Ward – Stroud Community Hospital
  - Peakview – Tewkesbury Community Hospital
  - Lydney Community Hospital

It is anticipated that future reporting metrics will look different; will be based upon the revised staffing levels below and that this will commence October 2016.

Ward Name	Beds	Early Shift		Core shift	Late Shift		Night Shift	
		RN	HCA	RN	RN	HCA	RN	HCA
Windrush	21	2	4	1	2	3	2	2
Coln	20	2	4	1	2	3	2	2
Thames	8	1	2		1	1	1	1
Cashes Green	22	2	4	1	2	3	2	2
Jubilee	16	2	3		2	3	2	2
Peakview	20	2	4	1	2	3	2	2
Lydney	**20**	**2**	**4**	**1**	**2**	**3**	**2**	**2**
Dilke	27	3	4	1	3	4	2	2
Tewkesbury	20	2	4	1	2	3	2	2
North Cotswolds	22	2	4	1	2	3	2	2

4. CQC Quality Implementation Plan

The Committee discussed progress and received assurances that efforts continued to focus on mandatory training and MIIUs. The Committee wished to recommend to the Trust Board that the CQC be formally contacted and that a request be made for a re-inspection.

5. Policies

The Committee formally discussed two new policies that had been developed:

- The Coroners Policy – approved and recommended that it go to the Trust Board for formal ratification

- Quality Equality Impact Assessment Policy (QEIA) – advised that further work was required and that it be returned to the Committee no later than November 2016.

Report prepared by: Susan Field, Director of Nursing

Report presented by: Sue Mead, Chair, Quality and Performance Committee and Non-Executive Director

Appendix 1: Approved Minutes of Quality and Performance Committee Meeting 28th June 2016
Appendix 2: Clinical Strategy

CLINICAL STRATEGY 2016-2019

Understanding You

Contents

Executive Summary

The intention of this Clinical Strategy is for all Trust clinical colleagues to own and to have a meaningful approach developed by clinical leads, for clinicians to deliver. It supports the Trust's intention of being a clinically led and a clinically centred, safe organisation. It outlines the Trust's aspirations to provide high quality clinical, safe and innovative health care and focuses upon:

- Enabling the delivery of compassionate care which ensures that Service Users remain safe from avoidable harm: this includes actions to (i) increase the range of quality assurances, (ii) proactively manage infection prevention and control, (iii) ensure robust safeguarding, (iv) deliver better support for vulnerable people, (v) improve the quality of record-keeping and communications, (vi) ensure candour and openness, and (vii) embed safe medication practices.

- Adopting a person-centred approach to care (patient and capacity management), care that is effective and efficient: this includes (i) improving pathways, (ii) making best use of community hospitals, (iii) extending the use of technologies, (iv) ensuring appropriate community prescribing, (v) integrating care pathways and (vi) optimising access points for people, and (vii) promoting preventative and self-management approach that supports the health and well-being of both the people of Gloucestershire but also Trust Colleagues,

- Informing and involving patients, their carers and families so that they have the best possible experience: this includes (i) enhancing choice and quality of life, (ii) improving listening and responding to people, (iii) improving the capture and use of patient experiences, (iv) better involving families and carers, (v) providing access to real-time information, and (vi) developing interactive online services.

- Ensuring that the Trust has a culture which is clinically-led and focused which will strengthen developing Trust colleagues so that they remain competent and confident, which involves: (i) embedding quality and clinical governance standards, (ii) building and sustaining leadership skills, (iii) supporting professional and personal development and supervision, (iv) improving communications, and (v) rewarding high quality care and innovation.

- Ensuring an able, flexible workforce that can meet new challenges and that is supported by education, training and evidence: this includes (i) the availability and accessibility of training, (ii) being a Trust that ensures the availability of training and education, (iii) meets the requirements of professional regulatory bodies, (iv) maintaining safe case loads and staffing levels, and (v) committing to research.

- Achieving excellence in integrated pathways and developing partnerships with professional stakeholders: this includes (i) primary care and social care, (ii) forming critical alliances with other providers, (iii) increasing preventative and health and well-being services, and (iv) improving locality knowledge of current and projected need.

This strategy is supported by 12 clear Commitments (page 7) and an implementation plan that will guide the Trusts Clinical Reference Group of the actions to be taken forward during 2016-19.

1. Introduction

The strategy identifies and is aligned to a number of recently published national strategies and framework including:

- "Leading for Change – Adding Value" NHS England, May 2016
- "The Role of Allied Health Professionals in Public Health", Nov 2015
- Care Quality Commission (CQC) Strategy, 2016-21
- "Raising the Bar: Shape of Caring" Health Education England, May 2016

It is the intention that the strategy states the expectations placed on clinical colleagues as well as outlining what colleagues should expect from the Trust, and includes:

- Observing the Trusts core values *Caring*, *Open*, *Responsible* and *Effective.*
- Mirroring the principles of the 6 C's (i.e. Care, Compassion, Competence, Communication, Courage and Commitment).
- Seeking to outline the Trust's aspirations for the development of its community services over the next three years and endeavours to encourage a greater sense of innovation and creativity.
- Seeking to build directly upon the outstanding quality care provided to the people of Gloucestershire that effectively supports them from newborn to end of life.

2. Purpose

The purpose of this strategy is to:

- Articulate the over-arching philosophy of high quality safe care and best patient experiences that unites the Trust's clinical workforce within the Trust.
- Unite clinical and professional colleagues who are dispersed across the Trust both geographically and with regards to work environments.
- Provide a strong clinical identity across the Trust.

- Provide a framework for the Trust's Clinical Reference Group annual work plan with the purpose of maintaining clinical standards and developing clinical services.

3. Strategic Objectives and Commitments

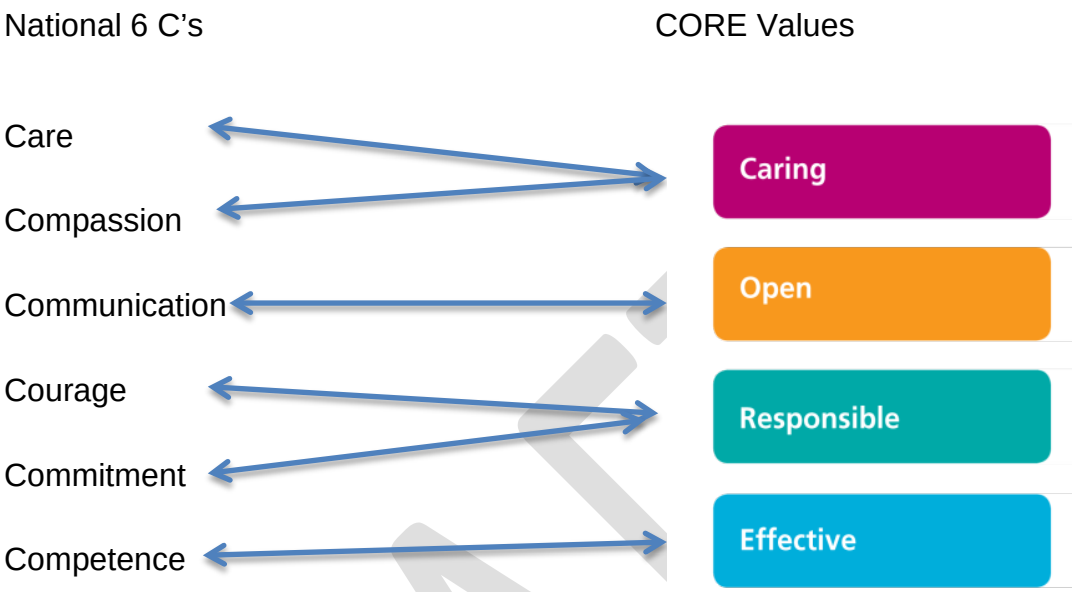
The ambition of this Strategy is *"to remain a leading provider of community-based services that offer optimum quality, safety and effectiveness, and to enable every person in Gloucestershire to experience a positive outcome"*. This aligns to the Trust's overarching vision, which is *"To be the service people rely on to understand them and organise their care around their lives"*.

This three year Clinical Strategy seeks to ensure that by **2019**, the following will be achieved and aligned to the Trust's overarching strategic objectives:

- Strategic Objective 1 – Achieve the best possible outcomes for our service users through high quality care
- Strategic Objective 2 – Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work
- Strategic Objective 3 – Actively engage in partnerships with other health and social care providers in order to deliver seamless services
- Strategic Objective 4 – Value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision
- Strategic Objective 5 – Manage public resources wisely to ensure local services remain sustainable and accessible

It also "fits" with the Trusts Core Values Framework.

…and within the National 6 C's Framework, where the Trust believes there remains a true "fit" with its CORE values



4. Education and Learning

Education and learning for clinical colleagues remains a strategic priority for the Trust as we believe this correlates well with raising of quality health care. By keeping this a priority there will be a strengthened focus of developing clinical colleagues with the right skills, knowledge, understanding and attitude. In order to deliver the Trust will:

- Continue its visible and proactive work with a range of education providers including University of West of England, Universities of Gloucestershire, Worcestershire, Plymouth and others.

- Work collaboratively with others in supporting the introduction of new roles such as the Clinical Apprenticeship and Nursing Associate roles. This partnership working will include Health Education England, University of Gloucestershire and other local NHS and Care Providers.

- Being an active member of Gloucestershire education and learning opportunities including the University Technical College developments, working with local colleges and utilising the clinical expertise within the Trust, when developing new pathways of care.

- Ensure that education and learning "fits" within the Trusts CORE values

The Strategy outlines 12 commitments which are as follows:

Clinical Strategy
Our 12 commitments

Caring	Deliver high quality and clinically focussed services aligned to national and local clinical pathways for the people of Gloucestershire	Support each other to recognise our individual leadership roles in delivering high quality care	Work with individuals, families and communities to equip them to make informed choices and manage their own health
Open	Work in partnership in a clinically focused and meaningful way with primary care	Celebrate and share our colleagues' clinical innovations, clinical effectiveness, audit and good practice	Work in partnership with key stakeholders for the benefit of patients, carers, families and clinical colleagues
Responsible	Support and develop a healthy and resilient workforce	Promote high quality, safe care so that there is a clinical passion for community health services and for constantly improving patient care	Deliver the right education and development to enhance the skills knowledge expertise and understanding of our colleagues
Effective	Embrace innovation, creativity and research	Recruit, develop and retain a high quality clinical workforce to meet current and future demand and to uphold the values of the Trust	Champion the use of technology to enhance our practice, reduce variation and increase consistency in our work

W E W I L L

Commitment 1 - We **will** deliver high quality and clinically focussed person centred care services aligned to national and local clinical pathways for the people of Gloucestershire.

This will mean:

- Having a co-ordinated consistent approach to the delivery of care
- Colleagues prompting more self-care, self-management health and well-being agenda's into everything they do
- Providing care that is evidence based and clinically effective
- Clinical colleagues being competent and confident to deliver care that is based around best practice
- Patients, carers and Trust colleagues having an excellent experience

The outcomes will be:

- Development, implementation and delivery of integrated care pathways
- Locally developed clinical policies and guidelines aligned to national NICE directives
- Clinicians having a clear understanding of clinical policies, procedures and guidelines, how to access them and the process for review and development of these documents is well understood
- Having an education and development plan which is aligned to this framework and to the Trusts Workforce and Organisational Development (OD) Strategy
- Seeing an increase in positive feedback from the staff Family & Friends Test (FFT)
- Clinical and public health nursing colleagues (health visiting and school nursing) responding to funding changes by delivering services and preventative agenda's differently
- Seeing an increase in research and clinical audit activity
- The Gloucestershire G-Care electronic clinical pathways tool is visible, well-recognised and utilised with clinical colleagues from the Trust contributing to its ongoing development

Commitment 2 - We **will** work in partnership in a clinically focused and meaningful way with primary care in order to make sustainability transformation plans a success

This will mean:

- Adopting a collaborative approach in service delivery
- Ensuring care is closer to home
- Using evidenced based pathway approaches wherever we can
- Respecting and valuing all differing contributions and diversity within the partner organisations

The outcomes will be:

- Increased care delivered in an appropriate setting away from secondary care
- Agree joint decision making between the Trust and primary care organisations (meeting minutes etc.) and clear joint objectives understood by all staff
- Delivering care against identified care needs specifically for the local population - (Understanding You)
- Proportionate service delivery based on the local population's needs
- Increased number of clinical links and clinics linked with GP surgeries

Commitment 3 - We **will** take responsibility to support and develop a healthy and resilient workforce

This will mean:

- Having an organisation that supports a healthy work and home life balance
- Having an organisation that recognises and promotes the importance of protecting colleagues' mental health and emotional wellbeing
- Having an organisation that supports its workforce to utilise their skills and competencies to meet the expectations of their job role.
- Having an organisation that recognises and supports colleagues to make career change decisions.
- Having available and timely occupational health services offering support and solutions to improve satisfaction in the workplace.
- Having human resource available and able to support the whole workforce.

The Outcomes will be:

- A sickness rate at least in line with national recommendations
- An increase of 5-10% in the positive responses for the well-being rating on the staff survey each successive year.
- A positive rating regarding job satisfaction - 70% of staff agree that they are satisfied with their jobs on the staff survey
- LiA Pulse check demonstrates a year on 5-10% positive increase in staff satisfaction with their jobs and working environment.
- Monthly training information to demonstrate that 100% staff have access to and completed their core mandatory skills training.
- 100% of staff have an annual personal development plan (PDP's) and a 6 monthly review of their personal objectives.
- Each member of staff has access to a named member of the human resource team.

Commitment 4 - We **will** promote high quality, safe care so there is a clinical commitment to community health services and for constantly improving patient care.

This will mean:

- All colleagues having an understanding of their roles, accountability and commitment to achieving Quality Care; 'Sign up to Safety'; 'Every Contact Counts' and other Trust actions
- Having talented and expert clinical staff who care about what they do and treat everyone with compassion
- All colleagues having a true understanding of how they are contributing to meeting the Trusts clinical, strategic objectives
- Colleagues feeling that they work in a genuinely positive learning environment knowing and experiencing when lessons are learnt, lasting improvements will be made
- Having a universal commitment to supporting patients to achieve their health and wellbeing goals
- Having a universal intention to safeguard vulnerable children and adults

The outcomes will be:

- All staff working within an agreed clinical framework that is visible and well understood
- A safety culture embedded across clinical teams with an understanding of roles, accountabilities , responsibilities and ownership of incident reporting and ongoing learning, evidenced by staff FFT surveys and a jointly owned Learning Associate Framework with GCCG
- No 'never events'
- Clinical effectiveness, innovation and change in all areas of clinical practice
- Year on year meeting the Trusts Quality priorities
- The role of the Clinical Reference Group is well understood and championed by clinical colleagues
- An annual evaluation of the Clinical Reference Group that demonstrates its effectiveness
- The Trust being awarded a 'Good' rating by the CQC and working towards an 'Outstanding' rating

Commitment 5 - We **will** embrace innovation, creativity and research.

This will mean:

- Having a positive risk talking culture embedded throughout the Trust
- Having a receptive and encouraging line management/leadership
- Having local ownership, responsibility and accountability of innovation as much as possible
- Valuing the Public Relations impact of raising the clinical profile of the Trust

The outcomes will be:

- Having a clinical programme of work that supports creative and innovative care
- An active research forum
- Evidence of published papers, articles, conference papers, posters by colleagues throughout the Trust
- A continual rolling programme of “Listening Into Action” schemes which will ensure new ways of working are co-produced as much as possible

Commitment 6 - We **will** celebrate and share our colleagues clinical innovations, clinical effectiveness, audit and good practice.

This will mean:

- Having a culture of sharing good clinical practice where new innovation transfers from one service to another
- Supporting our colleagues to publish their examples of good practice.
- Having services that are able to demonstrate their use of and share evidence based practice along all clinical care pathways
- Having a culture where colleagues have an awareness of the role of research in practice and know how to access the necessary support and development within the Trust.

The outcomes will be:

- An annual show case for staff to attend to demonstrate examples of clinical innovation, effectiveness, audit and good practice.
- 100% of services must work towards using appropriate clinical outcome measures for their service.
- 50% of services contribute to national, regional and local research based projects supported by a named and skilled research lead for the Trust.
- Services have 80% of their teams having attended or being represented at any in house audit training.
- 100% of services have an annual audit plan that reflects the quality of care and the re audit cycle.
- Two services or areas of clinical service delivery per annum will sign up to delivering regional and national innovation projects such as vanguard sites, new ways of working etc.
- The Trust Board will endorse a clinical research strategy for the organisation.

Commitment 7 - "We **will** work within an open culture in partnership with others for the benefit of patients, carers, families and clinical colleagues"

This will mean:

- Being a community organisation that is flexible and responsive and that our clinical teams have an approach that meets the needs of patient and partners
- More colleagues involving patients in service re-design, service developments and learning
- Colleagues having quality time to listen, respond and learn from feedback whether this is from patients or from other clinicians
- Seeing an increased and improved self-management pathways and health outcomes

The outcomes will be:

- The "LiA way" of doing things becomes everyone's business
- Seeing a reduction in unplanned re-admissions and attendances by patients
- Having appropriate levels of self-referrals as defined by individual service leads
- Improved feedback from primary care colleagues about partnership working
- Seeing an increase in the number of patients having self-management plans, evidenced by clinical audit
- Increased attendances at patient and public events
- Patient "pulse check" outcomes that demonstrates improvements
- Duty of Candour practices sustained across all services to ensure appropriate openness

Commitment 8 - We **will** support each other to recognise our individual leadership roles in delivering high quality care.

This will mean:

- Empowering individuals to view themselves as conduits for change
- Seeing visible leadership behaviours clearly demonstrated at all levels throughout the Trust
- Having a supportive learning culture which includes learning from mistakes and increased safe reporting
- Increased positive risk taking embraced and embedded within clinical teams across the Trust

The outcomes will be:

- Staff survey results which reflects an increase in colleagues embracing change
- Staff survey results which reflects strong evidence of leadership behaviours at all levels
- Having a 360 feedback loop for all Root Cause Analysis (RCA), Serious Incidents Requiring Investigation (SIRI) and other complaints and compliments as part of a Learning Assurance Framework
- Patient records clearly demonstrating a positive risk taking approach (annual record keeping audit, supervision records)

Commitment 9 – We **will** deliver the right education and development to enhance the skills knowledge expertise and understanding of our colleagues – a skilled workforce is an effective workforce

This will mean:

- Each clinical area/service contributing to writing their own training needs framework which will include succession planning
- The Trust seeing the importance of education and training for all its colleagues
- The Trust looking to the future to determine the education and training needs of its workforce
- The Trust supporting colleagues to meet the national and mandatory requirements of regulatory and professional bodies
- The education and training needs of each service being developed with consideration to future demographic, technological and innovative changes

The outcomes will be:

- An accurate and contemporaneous database for all colleagues who have attended mandatory and statutory training.
- 100% of line managers know how to undertake effective Personal Development Reviews (PDR).
- Individual PDR's will contain exactly what individuals require to meet their job role and the trust business.
- Each service and/or profession will agree what is essential for role to ensure that the right skills are in the right place at the right time.
- Essential to role needs will be reviewed annually to ensure that the skills and knowledge of the workforce reflect demographic and technological trends.
- 100% of staff recruited into the trust will have the appropriate qualifications, experience and professional registration for their job role.
- An annual in house training plan is developed with the Workforce and Education team, the heads of Services and Professions and shared with all clinical staff to support their specialist training needs.
- All access to external continuous professional development will be supported if this is essential to role and part of the staff members PDP.

Commitment 10 - "We **will** recruit, retain and develop a high quality clinical workforce to meet current and future demand and uphold the values of the Trust".

This will mean:

- Having a recruitment and retention plan in place and on target to ensure safe staffing levels and safe caseload management
- Having a clinical staffing levels that are resilient to meet increases and fluctuations in demand
- Clinical colleagues having an understanding of the demand and capacity model for their service
- Having a clear career pathways to support the development, education and learning for our clinical colleagues
- The Trust having an education and development plan that ensures high quality patient care and clinical leadership
- Having mutual nurture and support practices for colleagues that include recognising a climate of limited resources
- Having a recruitment and retention plan for those non-clinical colleagues who will support clinical colleagues

The outcomes will be:

- Being nationally and locally recognised as a "good" employer of choice
- That the Trusts CORE Values Framework is well recognised, understood and valued
- Increasing number of clinical colleagues leading on change management programmes
- An increase in the number of clinicians joining the Trust's flexible workforce i.e. bank service and supporting a reduction in the use of agency staff
- A reduction in the sickness and turnover rates of clinical colleagues
- A refreshed clinical supervision policy and embedded process for all colleagues

Commitment 11 – We **will** work with individuals, carers, families and communities to equip them to make informed choices and manage their own health.

This will mean:

- Facilitating motivational conversations with individuals, families and communities
- Valuing the contribution that they (individuals, families and communities) bring to a conversation
- Making every contact count
- Empowering individuals to use their own resources and those of their community
- Trust colleagues asking the important questions and listening to the answers

The outcomes will be:

- Individual care plans reflecting self-management goals and demonstrated by annual record keeping audits
- Patients view point clearly documented in records
- SystmOne reporting that demonstrates quality improvements
- SystmOne reporting which demonstrates where colleagues “sign post” ongoing care

Commitment 12 - We **will** champion the use of technology and informatics to enhance our practice, reduce variation and increase consistency in our work.

This will mean:

- All colleagues feeling confident in the use of SystmOne as the shared record for the patients story.
- Colleagues feeling confident in drawing on informatics to be able to accurately assess our services and therefore shape the changes required to deliver the optimum care to our communities.
- Colleagues having the ability to share best practice in SystmOne forums and increase consistency across the Trust.
- A skilled and knowledgeable IT and information team who are able to support colleagues with the latest technology and equipment to deliver high quality services.

The outcomes will be:-

- Monthly service activity reports that are accurate and appropriate to support service developments.
- A SystmOne user forum that meets regularly, is actively supported and attended by services that contribute to the live forum work plan, with actions that are minuted and outcomes are achieved.
- All services share knowledge about SystmOne template design to create consistency and accuracy to support service data.
- 100% of the redesign of service templates used by any service on SystmOne are completed in 8 weeks.
- An IT strategy that is developed with and shared around the needs of clinical services reflecting their vision for future service needs.
- 100% of staff have received training to use SystmOne and have access to refresher training when required.

5. National context

Over and above the national 5 year Forward View Policy and Strategy in order to best understand the environment in which this Clinical Strategy operates, a number of key National Strategies and policies have been reviewed. These include:

- ***Hard Truths: The Journey to Putting Patients First*** (Department of Health, 2013), which is the Government's response to the Mid Staffordshire Public Inquiry. This identifies recommendations for how the healthcare system must improve inspection, increase transparency, put a clear emphasis on compassion, standards and safety, increase accountability for failure, and build capability, these are:

    - Requiring healthcare organisations to be honest, open and truthful in all dealings with service users and the public, so that they are clear about the quality of care that is available.
    - Enforcing a professional duty of candour on individual staff through changes to professional guidance and codes.
    - Ensuring easier ways for service users to raise concerns or make complaints, with independent support available from local Healthwatch or alternative organisations.
    - Improving the ways in which organisations learn and respond as a result of concerns or complaints.
    - Enabling every person with a long-term condition to be offered a personalised care plan.
    - Improving the identification of problems within the healthcare system through fundamental standards of care, improved information sharing and a new inspection regime.
    - Introducing a new system of ratings for healthcare providers that have service user care and safety at their heart.
    - Increasing the responsibilities on Trust Boards to ensure that their organisations are working effectively to improve service user care.
    - Promoting successful leadership and addressing failures in leadership via recruitment, appraisal and exit procedures.
    - Ensuring that nurse training has an increased focus on the practical delivery of compassionate care, with recruitment focusing on values, attitudes, behaviours and motivation.

- **NICE Guidance** which informs Clinical Pathway developments e.g. Last Days of Life

- **The Role of Allied Health Professionals in Public Health** (Public Health England, 2015). This paper outlines a number of strategic goals which will support the Trusts Clinical Strategy. These include:

    - The current and future workforce being supported to acquire and maintain their skills, knowledge and attributes to promote health and well-being.

- AHPs being able to demonstrate their impact on population level outcomes.
- Raising the profile of AHPs and their contributions to public health agendas.
- Ensuring there are productive relationships that exist between AHP and Strategic Leaders and; being associated with public health at local, regional and national levels so that the role of AHPs are both recognised.

Public Health England

- Having effective leadership at every level which supports AHPs, to be an integral part of a public health focused workforce.
- AHPs feeling empowered to protect and improve their own health and well-being and that of their colleagues.

- **Care Quality Commission Strategy 2016-21**, which sets out an ambitious vision for a more targeted, responsive and collaborative approach to regulation so more people get high quality care. This strategy describes how the CQC will combine any learning from its previous comprehensive inspections with better use of intelligence from the public, providers and partners in order to focus inspections more tightly than ever to where people may be at risk of poor care.

  The strategy aims to support and encourage services to innovate and collaborate in order to drive improvement, while ensuring that people continue to receive good, safe care – which, in a time of tighter public finances, will be more crucial than ever. One of the key developments to CQC's approach will be the improved use of information from the public, providers, other regulators and oversight bodies in order to target resources more effectively to where risk to the quality of care provided is greatest, or to where quality is likely to have changed. In practice, this will mean more use of targeted unannounced inspections, based on information that is constantly updated – for example, if there is a sudden spike in people reporting poor care from a particular service. It would also mean longer intervals between inspections for services rated good or outstanding if they can continue to demonstrate that they are providing good care.

CareQuality Commission

- **The Shape of Caring Review (March 2015),** which looked at the role of education and training for registered nurses and care assistants remains "fit for purpose" and supports them to deliver high quality care over the next 10-15 years. Key themes that come out of this review included:

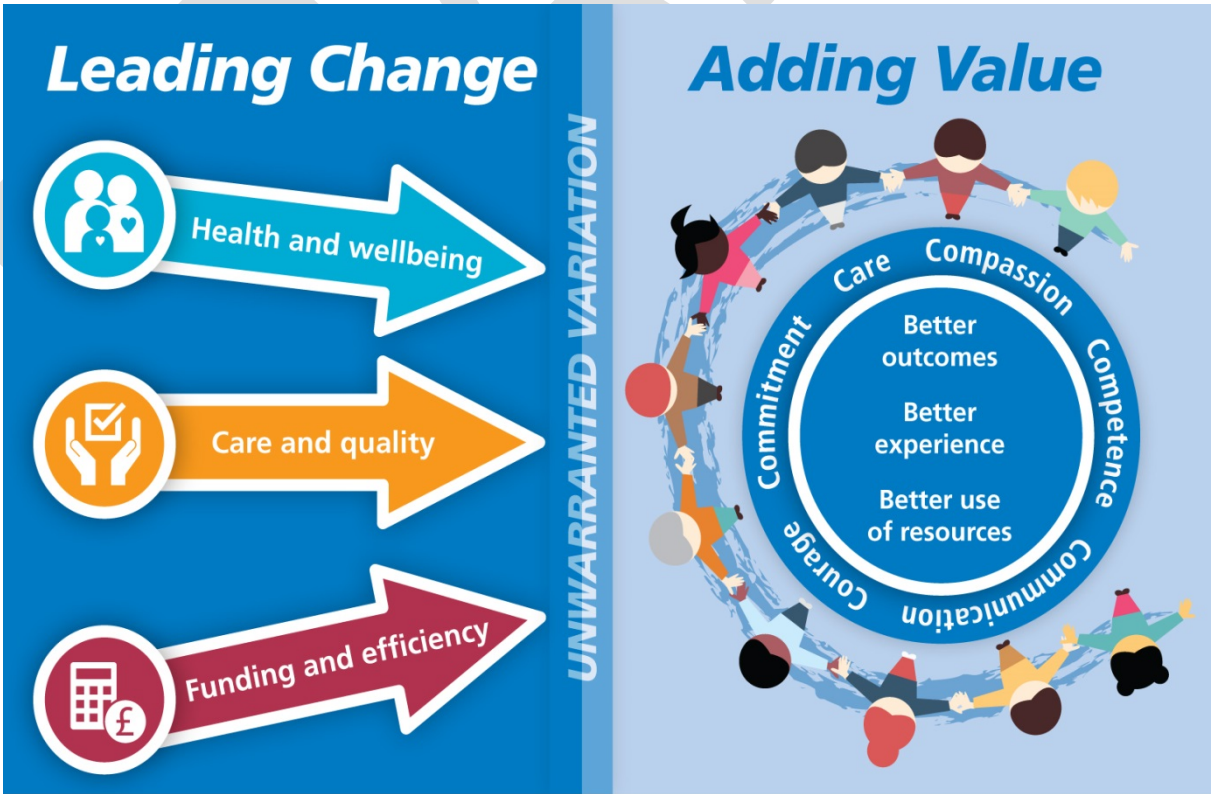
  - Enhancing co-production and the voice of the patient.
  - Valuing Care Assistants.
  - Widening access for care assistants who wish to enter nursing
  - Assuring high quality learning environments in under-graduate nursing education.
  - Assuring predictable and sustainable access to ongoing learning and development for registered nurses.

- Supporting and enabling research, innovation and evidence based practice.
- Funding and commissioning to support future education and learning

- **Making Every Contact Count (MECC),** is an approach to improving health and reducing health inequalities developed by the NHS and local government. Every contact with a patient should be seen as an opportunity to encourage healthier lifestyle choices. Through a Trust-wide "Listening into Action" scheme colleagues are being equipped through training to adopt the principles of MECC in their everyday practice.

- **Leading Change: Adding Value (May 2016)**
  This Nursing Strategy is a 5 year plan that aims to:

  - Take the lead on promoting health and well-being
  - Take the lead on improving care and quality
  - Take the lead on using resources effectively
  - Add value by improving outcomes focusing on unwarranted clinical variation
  - Add value by measuring the outcome and specifically the impact that nurses will have.



6. Local Context

The Trust employs more than 2,700 colleagues including nursing, medical and dental staff, allied healthcare professionals, as well as support service, administrative and clerical workers.

Services are delivered in a variety of settings including people's own homes, community clinics and community hospitals - we also work alongside GPs and other primary care colleagues, and provide some services in the acute hospitals in Gloucester and Cheltenham, social care settings, as well as in nursing and residential homes. Over the year 2015-16, the Trust recorded over 1.4million service user contacts across Gloucestershire.

The Trust has identified 6 Quality Priorities for 2016-17 and these are below:

	Priority	**Quality Domain**
One	To ensure that people with learning disabilities benefit from enhanced community services, have a positive experience of care, and are ably supported within a safe environment	Safe
Two	To deliver more care for people with continence probles in the community, increasing awareness of available services and promoting self-care where appropriate	Caring
Three	To better understand local people's extra or different needs, and ensure that all voices are heard and can directly influence service design	Responsive
Four	To use positive risk-taking in the Integrated Community Teams and Community Hospitals, enabling care to be solution-focused and service user-led	Effective
Five	To enourage colleagues to improve the quality of clinical record keeping practices so that our documentation achieves the highest level of quality	??
Six	To support colleagues to within the parameters of the National 6 Ambitions for end of life care, increasing our ability to work more closely with GP's, and ensuring that the wishes of people about their place of choice to die is met wherever possible	Well-Led

NB: Priority 4 – this will ultimately include promoting self-management and will include all services.

The Trust has also clearly indicated its ambition to achieve a "GOOD" CQC rating following the awarding it "Requires Improvement" September 2015. In addition to this the Trust

has ensured that this clinical strategy is aligned to the Sign up to Safety campaign which it is committed to, but is also mindful that this strategy is not communicated as yet another initiative.

Gloucestershire's Draft Sustainability & Transformation Plan outlines a number of key developments for supporting what needs to change with Gloucestershire's population. These are:

- **Enabling Active Communities** - building a new sense of personal responsibility and increased independence around health, supporting community capacity, and making it easier for voluntary and community agencies to work in partnership with us. Using this approach there will be a united radical Self Care and Prevention plan to close the Health and Wellbeing gap in Gloucestershire
- **One Place, One Budget, One System** - by taking a place based approach there will be the delivery of a best value for every Gloucestershire pound approach. One of the first priorities will be to redesign Gloucestershire's Urgent Care system and develop a 30,000 place based care model through this principle. This will ensure some closing of the Finance and Efficiency Gap, and move us towards delivery of a new care model for Gloucestershire
- **Clinical Programme Approach -** systematically redesigning pathways of care, building on our success with Cancer, Eye Health and Musculoskeletal redesign, challenging each organisation to remove barriers to pathway delivery. Year one will focus on delivery of new pathways for Respiratory and Dementia to help us close the Care and Quality Gap
- **Reducing Clinical Variation** - elevating key issues of clinical variation to the system level (including Primary Care) to have a new joined up conversation with the public around some of the harder priority decisions we need to make. Our first priority will be to deliver a 'Choosing Wisely for Gloucestershire' Medicines Optimisation and undertake a Diagnostics Review about this

6.1. The Health of Gloucestershire

- The projected 2016 resident population of Gloucestershire is 618,200
- The health of people in Gloucestershire is generally better than the UK average: similarly, life expectancy for both men and women locally is higher than the England norm.
- In Gloucestershire (like the rest of the country) variations in life expectancy by deprivation show how there are stark inequalities in life chances depending on where people live. Men living in the most deprived communities live on average 7.8 years less than those in the least deprived. For women the gap is 6.3 years less. Lifestyle factors such as poor diet, lack of exercise, smoking, alcohol consumption and drug taking all contribute to this. Obesity and smoking rates are both above the national average in the more deprived

wards of the county. In some of the most deprived communities nearly half of people smoke.

- 22.9% adults locally are obese which is broadly in line with the England average (23.0%).

- The number of alcohol-related hospital stays however are higher in Gloucestershire, both for under 18 year olds (44.1 per 100,000 compared to 40.1 nationally) and adults (654 per 100,000 compared to 645 nationally).

- The three main causes of death in Gloucestershire match the national profile i.e. cancer (27.9% all deaths), cardiovascular disease (26.8%) and respiratory disease (14.2%). These conditions are also more prevalent in the county's areas of higher deprivation.

- In addition to this the Trust has identified its quality priorities for 2016-17 and beyond, the embedding of these will be further provided for clinical colleagues to work towards

- Deprivation lower than average, but spread in pockets across the County

- 75 to 84 year olds set to increase by almost 20% by the end of 20/21. 85 and over group set to increase the fastest in the future.

- Children from poorer backgrounds are more at risk of poorer development and the evidence shows that differences by social background emerge early in life

In order to deliver any "health gaps" clinical colleagues need to stay true to the principles set out in the GCCGs commissioning plan 'Joining up Your Care' which broadly includes the following themes:

- **Healthy and Well** - Taking personal responsibility for their health and care, and reaping the personal benefits that this can bring. A consequence will be less dependence on health and social care services for support
- **Living** in healthy, active communities and benefitting from strong networks of community services and support
- **Ability** when needed, to access consistently high quality, safe care when needed in the right place, at the right time.

It is also clear that to meet the growing challenges Gloucestershire faces more of the same will "not do". There needs to be a level of acceleration about the pace of change and a need to be even more ambitious and innovative in how clinical services are organised and using money and other resources available even more effectively.

Clinical (and non-clinical colleagues) will need to embrace the 12 Commitments outlined in this clinical strategy in order to support:

- There being a far greater emphasis on personal responsibility, prevention and self-care, supported by additional investment in helping people to help themselves
- There being a greater emphasis on joined up community based care and support, provided in patients' own homes and in the right number of community centres, supported by specialist staff and teams when needed
- Bringing together specialist services and resources so that we become a Trust that is more of a 'Centre of Excellence', where possible reducing the need for bed based services across our system by using the facilities we have more efficiently and effectively in future.

7. Accountability Arrangements

All Clinical Colleagues
Colleagues across the organisation are all personally responsible for observing the Trust's CORE values in their interactions with patients, carers and families, and for adhering to prevailing professional standards and codes of good conduct.

Allied Health Professions (AHPs)
The Trusts AHP colleagues provide strong professional governance and clinical leadership for their relevant service working collaboratively with a matrix of operational management structures and are well supported by AHP Heads of Professions (OT, Physiotherapy, Speech and Language , Podiatry, Pharmacy).

The Trusts AHP colleagues develop best practice service modernisation and improvement plans to enhance patient experience and deliver value for money and have responsibility for identifying clinical priorities and setting and monitoring standards for clinical practice. The Heads of Profession in particular have a responsibility for ensuring teams have the right skills and support to deliver high quality service and provide professional strategic advice on interpreting and implementing 'Best Practice' and National policy.

AHP colleagues and their Heads of Profession ensure the dissemination, interpretation and implementation of evidence, best practice and clinical guidance and standards across their respective professional groups

Medical Director
The Medical Director is a key contributor to the Trust's strategic direction, with particular responsibility for ensuring that clinical issues are understood and incorporated appropriately into the Trust's forward plans. Additionally, the role serves as a champion for service user safety. In conjunction with the Director of Nursing and the Chief Operating Officer, the Medical Director also oversees arrangements to deliver safe, high quality services, effectively manage clinical risk, and address clinical governance issues as they arise.

Director of Nursing
As the Trust's lead for quality the Director of Nursing, whose remit includes Allied Health Professionals, is responsible for ensuring that the organisation provides the highest standards of care and is responsible for establishing the Trust's model for adult and children's nursing, safeguarding, clinical standards and CQC Compliance across the organisation.

The Director of Nursing is supported by both AHP and Nurse Heads of Professions.

Professional Forums
There are three Professional Forums that acts as sub groups to the Clinical Reference Group:

- Nursing Forum
- AHP Forum
- Medical and Dental Forum

Each Forum is responsible for sharing professional knowledge relevant to its respective professional registration and for providing clinical and professional perspectives on Trust-wide performance and quality, escalating any highlighted issues or concerns to the Clinical Reference Group. Each Forum also provides direct assurance to the Clinical Reference Group on matters relating to the appropriate professional and regulatory bodies.

Clinical Reference Group
The Clinical Reference Group provides a forum where the Trust's collective knowledge relating to clinical and care matters, is shared, evaluated and the implications for the Trust are considered. It also provides an opportunity for clinicians to champion innovation in practice, and offers leadership and expert advice to support strategic decision-making. The Clinical Reference Group provides direct assurance to the Quality and Performance Committee and makes any recommendations to the Trusts executive teams from any Quality Equality Impact Assessments (QEIAs).

Quality and Performance Committee
The Quality and Performance Committee is responsible for assuring the Trust Board that the Trust maintains effective processes for compliance with core standards, national practice and mandatory guidance in clinical care. The Committee is responsible for identifying gaps in compliance, and monitoring any action plans.

The Quality and Performance Committee is supported by the Trusts Clinical Reference group, the Workforce Education and Development Group professional forums and operational governance groups, all of which regularly submit reports for scrutiny and discussion

Chief Executive
The Chief Executive has overall responsibility for ensuring that the Trust meets its statutory and mandatory requirements in its delivery of clinical and high quality care.

Trust Board
The Trust Board has the clear remit to shape the future direction of the Trust, ensuring that at all times, the Trust's growth and development continues to support and enable the delivery of safe, high quality, effective health care and social care. The Trust Board has explicit responsibility for focusing upon quality, and will continue to receive reports, both anecdotal (i.e. patient stories) and demonstrable (i.e. quality of safety and performance reports), in order to evidence continued compliance with national and local quality care standards including the CQC.

8. Clinical Strategy, Measuring and Celebrating Success

The Clinical Reference Group will maintain oversight and scrutiny of implementing this strategy and will ensure that clinical colleagues celebrate success and continue to learn. The work plan has been developed with the intention of aligning to other Trust clinical and quality activities including Sign up to Safety and can be seen in Appendix 1.

"Soft" launch events in localities to promote this strategy and to develop and refine the associated work plan will be held in August 2016 - led and coordinated by the Clinical Reference Group. It is also intended that the 12 Commitments will be an integral part of the Clinical Action Cards/Apps developed as one of the LiA schemes.

9. Links to Other Strategies

The clinical strategy is clearly aligned to the Workforce and OD strategy published July 2016, the Quality Strategy and the Trusts CORE Values Framework in order to engage a competent workforce that is responsive and caring.

10. Consultation

This clinical strategy has been developed taking into account the following:

- A clinical review by members of the Clinical Reference Group (May 2016) of the Trusts Clinical and Professional Strategy 2014. Elements of this review highlighted that the strategy resonated with the Trusts Statement of Objectives but was not really understood or known to clinical colleagues
- Obtaining colleague feedback at the Trusts Celebrating Nursing event (Nov. 2015) and; celebrating Allied Health Professions event (April 2016)
- Interactive and written feedback from the CORE colleague network group (June 2016)
- Executive Team Feedback (July 2016)

11. Acknowledgments

We would like to formally thank the following who have contributed to the review and development of this strategy:

- Members of the Trusts Clinical Reference Group
- Clinical and Operational colleagues across the Trust who took the time to provide feedback and suggested changes
- Christine Thomas who has persevered with all the admin changes and who has added a level of creativity to the formatting of this Strategy

Appendix 1 – Clinical and Quality Activities

Gloucestershire Care Services NHS Trust

Minutes of the Quality and Performance Committee

28th June 2016, 13.30am – 16.30pm

Boardroom

Committee members present:	
Sue Mead	Chair (Non-Executive Director)
Susan Field	Director of Nursing
Candace Plouffe	Chief Operating Officer
Tina Ricketts	Director of HR
Ingrid Barker	Chair (Gloucestershire Care Services NHS Trust)
Nicola Strother Smith	Non-Executive Director
Dr Mike Roberts	Medical Director
Jan Marriott	Non-Executive Director
In attendance:	
Matthew O'Reilly	Head of Performance and Information
Hannah Williams	GCCG, Quality Manager
Rod Brown	Head of Corporate Planning (for agenda item 7, 15, 16 and 17)
Laura Bucknell	Head of Medicine Management (for agenda item 14)
Julie Goodenough	Head of Community Hospitals (for agenda item 12 and 22)
Claire Powell	Quality and Safety Manager (for agenda item 9)
Dawn Allen	Professional Head of Community Nursing (for agenda item 18)
Sian Thomas	Deputy Chief Operating Officer (as part of her induction to the Trust)
Carol Oram	Name Nurse for Safeguarding Children (for agenda item 13)
Christine Thomas	Minute Taker

Item	Minute	Action
1.	**Welcome and Apologies** The Chair opened the meeting and specifically welcomed Sian Thomas, Dawn Allen and Claire Powell to the meeting. Apologies were **Received** from: Glyn Howells, Director of Finance; Michael Richardson, Deputy Director of Nursing	
2.	**Confirmation that the meeting is quorate** The meeting was confirmed as quorate by the Chair	
3.	**Declarations of Interests** In accordance with the Trust Standing Orders, all Committee	

	members present were required to declare any conflicts of interest with items on the Meeting Agenda. No declarations of interest were made.	
4.	**Minutes of the meeting held on 26th April 2016** It was noted that Matthew Shewell's name was incorrectly spelt. Subject to this change the minutes of the meeting held on 26th April 2016 were **Received** and **Approved** as an accurate record and that the Chair would sign accordingly.	
5.	**Matters arising (action log)** The following matters were discussed and noted: 16/QP051 - There was concern that the Trusts Learning Disabilities activities not being delivered in a timely way was not on the Trusts risk register. It was agreed that the Executive team would formally assess the situation and any associated risk rating – 28/06/16 – report to go to Trust Board – **Closed** 16/QP062 - There was concern that patients were transferred without care plans in place and the Director of Service Delivery (DoSD) queried whether the Committee was assured that End of Life patients were not being inappropriately handed over from the acute hospital. It was agreed that this report would be sent to the Medical Director of Gloucestershire Hospital Foundation Trust (GHFT) and shared with the Gloucestershire Clinical Commissioning Group (GCCG), highlighting concerns about inappropriate patients being transferred and patients being transferred without care plans – 28/06/16 – To be taken to Countywide End of Life meeting to ensure all organisations linking up. 07/030316 - The Chair raised concerns that bed occupancy was now very close to 100% and that there had been a small decrease in achieving some quality metrics e.g. Safety Thermometer, within Community Hospitals. An QEIA to be completed for this risk. The Chair asked for these concerns to be formally raised at the Trust Board March meeting – 28/06/16 – this was being progressed with the GCCG and a further meeting had been organised to progress. 10/030316 - Concerns were raised about transfers happening within the Community Hospitals in the middle of the night. It was agreed that the COO would ask the Head of Capacity to look into this and that it is check that these were logged as incidents when they occurred. It was agreed that the outcome of this investigation would come to the June Committee meeting – 28/06/16 – risk to be highlighted on Chief Operating Officer Trust Board report - **Closed** 10/030316 - The DoN raised concerns about transfers happening within the Community Hospitals in the middle of the night. It was agreed that the Chief Operating Officer would ask the Head of Capacity to review this – 28/06/16 – **Closed**	

	15/260416 - The first full Quality Account draft would be ready w/c 2nd May 2016 and would be circulated to key colleagues for review. The HoPCP asked for the group to forward any comments on the report to him - **Closed** 07/260416 - The Quality Manager for Gloucestershire Clinical Commissioning Group (GCCG) agreed to highlight the concerns raised by the lack of the foot protection team service – 26/08/16 – HW agreed to let the Committee have a full update before the next Committee meeting in August. 10/260416 - The Deputy Director of Nursing (DDoN) to add a footnote to the pressure ulcer data to explain the changes - **Closed** 10/260416 - It was requested that the Head of Performance and Information (HoPI) add a footnote to the reablement figures slide to reflect that the reablement service had spent a lot of time in the Emergency Departments helping with patient flows - **Closed** 12/260416 - The HoMM to pursue benchmarking figures for other organisations - **Closed** 12/260416 - It was agreed that the Trust Board would be interested in the raised level of medical incidents and they would need to understand this. The Director of Nursing (DoN) would include this within the Committee's Trust Board report - **Closed** 12/260416 - The HoMM to bring an updated Medicines Management Report to the next meeting, with comparable benchmarking data - **Closed** 14/260416 - It was requested that a further update on Children Safeguarding be included within the Professional and Clinical Effectiveness (PaCE) Directorate report – **Closed**	
6.	**Forward agenda planner** The following changes were requested/agreed: • Benchmarking data was not yet available for the medicines management report – to be brought to the Committee in December 2016 • End of Life Developments and progress report to be brought forward to August 2016. The Forward Planner was **Discussed** and **Approved**	
7.	**Corporate Risk Register - Quality and Performance Risk** The Head of Planning, Compliance and Partnerships (HoPCP) presented the Trusts corporate risk register. There were 8 new risks. The Director of Nursing (DoN) noted that the risk register still	

	indicated Unscheduled and Scheduled Care directorate, but these no longer existed. The HoPCP advised that a full review of the risk register was due to take place and that these headings would be changed. There was concern about the new risk that SystmOne data quality was low and inconsistent. The Chief Operating Officer (COO) and Head of Performance and Information (HoPI) reassured the group that they believed the data received a considerable level of scrutiny before being published. The DoN suggested that this work align to the current record keeping work that was being undertaken. The Committee **Discussed** and **Approved** the Corporate Risk Register	
8.	**Operational Services Report** The Chief Operating Officer (COO) presented the Operational Services Report. The COO highlighted the concerns that 4 hour target in Emergency Departments were still being missed. A new avoidance team was now working in the Emergency Department to support and re-direct those patients who frequently attended Emergency Departments inappropriately to a more appropriate service. The COO provided reassurance that there had been an improvement in the recruitment of Band 6 District Nurses. Vacancies would be at 3.5wte in mid-August and 3.1wte in mid-September – a real achievement for the Trust. There had been a Joint CQC-OFSTED Special Education and Disabilities (SEND) Inspection (June 2016) and early indications were favourable, although some issues re transition of older children in to adult services had been highlighted as a potential concern. The Committee welcomed the Chief Operating Officer's report, which clearly outlined a number of activities and service developments that Trust Colleagues are involved with. The Committee considered it would be helpful, in light of some of the risks highlighted in both the strategic risk register and with some of the quality indicators within the Trust's April Quality & Performance Report that future Operational Service reports to include more of a quality and patient safety focus. For example: • Community Hospitals - high bed occupancy rates – is the Trust assured enough that this is not impacting significantly on patient safety care and colleague health and well-being? • Operational services response and subsequent action plans to the declining Safety Thermometer Harm Free Care metrics. • Developing quality metrics that are more clearly linked to any patient safety impact when capacity is limited within the Trust's Operational Services.	

	• Providing further assurances that any data quality concerns are being addressed and that this is involving colleagues directly involved in patient care. With regards to the high occupancy rate, the Director of Nursing suggested that there be another acuity audit undertaken and the Head of Performance and Information (HoPI) also advised that there had been a change of ratio from direct admissions to transfers and that this should be raised with the Commissioners. The Committee **Discussed** and **Approved** the Operational Services Report	
9.	**Professional and Clinical Effectiveness (PaCE) Directorate Report** The Quality and Safety Manager (QSM) presented the Professional and Clinical Effectiveness (PaCE) report on behalf of the Deputy Director of Nursing (DDoN). The PaCE Directorate were currently adopting the Listening into Action (LiA) approach to promote a culture of open reporting. A quality and safety tool kit was being developed and that this would take the form of an app for quick reference. The Pressure Ulcer Quality Improvement Group had been re-established; guidance for managing the assessment and treatment of pressure ulcers would be updated. It was noted that there were currently 4 SIRIs being investigated. A specialist nurse for Learning Disabilities had been appointed. The Chair shared that there had been a worrying decline in the reporting of Adult Safeguarding concerns, though it was noted that this was across all Gloucestershire organisations and due to factors previously reported (i.e. introduction of the advice line and change of Social Worker management arrangements). The Committee **Discussed** and **Approved** the Professional and Clinical Effectiveness Report	
10.	**Clinical Reference Group Report** The Director of Nursing (DoN) presented the first Clinical Reference Group report. The Clinical Reference Group were currently overseeing the updating of the Clinical Strategy and the Quality Equality Impact Assessments (QEIA), for which a policy was being developed between the DoN and Director of HR (DoHR). The Committee were pleased to see this work being undertaken, particularly the QEIA as concerns had been raised that decisions had previously been made	

	before the QEIA had been reviewed by the Clinical Reference Group. It was clarified that posts could be replaced on a like for like basis under the Mutually Agreed Resignation Scheme (MARS) However, best practice would be to complete an EQIA before any changes to establishment. The Head of Planning, Compliance and Partnerships (HoPCP) updated the group that a Coroners Management policy was currently being developed following a recent Coroner's inquest and would be discussed at the Committee's August 2016 meeting.	
11.	**Quality and Performance Report** The Committee once again noted that the high bed occupancy remained a risk at 99.4% and questioned the sustainability of this position in terms of other risk factors such as infection control, the morale of colleagues and longer term impact on patient care. There were also concerns raised about what appeared to be a declining picture with regards to Safety Thermometer activities – the 95% threshold has been missed indicating a decline in Harm Free Care and that this was being attributed mainly to ICTs. The Committee urged that this declining picture be better understood, addressed and reversed via: • Having a clearly defined action plan with agreed improvement trajectories. • Having a consistent approach to sampling opportunities across Integrated Community Teams (ICTs). • Maintaining a focus on reported Harm Free Care and Total Harms, across the ICTs. • Having an approach within community teams that maximized the impact on the overall percentage change within patient sample groups. • Refreshing with clinicians, their responsibilities associated with the validation of safety thermometer data so that robust information is submitted in a timely manner The Committee noted that overall performance across the Trust and with operational services remains good with some notable highlights, which include: • Chlamydia Screening • MSKCAT Other key discussion areas by Committee member included: **Objective 2** Jan Marriott queried about the Friends and Family Test, for which results remained low. The Chief Operating Officer (COO) acknowledged that though the Trust had tried multiple ways to improve the results this had been done with limited success. It was	

	noted that Children's services were trialling a new email and easy read approach. The Quality Manager (QM) for Gloucestershire Clinical Commissioning Group (GCCG) asked if information was available on what other providers were doing. It was not known that other providers were doing anything significantly different to Gloucestershire Care Services (GCS). Results that had been reported by Derbyshire Healthcare NHS Foundation Trust (DHCFT) were consistent with the Gloucestershire Care Services (GCS). It was recognised that not all Trusts shared their FFT results. **Objective 3** The Rapid Response teams continued to perform well and further work with the South West Ambulance Service NHS Foundation Trust (SWAST) remained ongoing. **Objective 4** The results of the last staff Friends and Family Test had been low. The number of colleagues (mainly based at Edward Jenner Court) who would recommend the Trust as a place to work was low. In response to this a series of "drop in" sessions were due to take place during July to assess why colleagues felt this way. The Committee **Approved** the Quality and Performance report The Named Nurse for Safeguarding Children joined the meeting	
12.	**Coroner's Outcome Report** The Head of Community Hospitals (HoCH) presented the Coroner's report on behalf of the Deputy Director of Nursing (DDoN). The report had been written following an inquest into the death of DS and at the Coroner's request. One of the outcomes from the inquest was an acknowledgement that if the correct clinical root cause analysis information had been presented early then this may avoid any colleagues having to attend a Coroner's court. The Coroner had requested a written report on the handover of patients within the Community Hospital wards to ensure this was safe and; that the Trusts procedures for investigating complaints be improved. (The Trust had not received any further comments from the Coroner office). The Director of Nursing (DoN) agreed that a Standard Operating Procedure (SOP) or policy was needed for managing coroner cases and that a meeting would be organised with the Medical Director (MD), Deputy Director of Nursing (DDoN), Head of Corporate Planning, Compliance and Complaints (HoCPCC) and DoN to discuss prior to anything being presented to the Quality and Performance Committee in August. The Chair raised concerns that the initial Root Cause Analysis (RCA) for this had been of poor quality, the HoCH reassured the Committee that procedures had been put in place and these were	**DoN**

	now improved. The Committee **Noted** the Coroner's Outcome report	
13.	**"Lucy" Serious Case Review outcomes** The Named Nurse for Safeguarding Children (NNfSC) presented the "Lucy" Serious Case Review and it was noted that this paper was not to be published until the 12th July. Gloucestershire Care Services (GCS) had had limited contact with "Lucy", and contact had predominately been through sexual health services and the school nurse. The NNfSC highlighted the key findings of the report: • "Lucy" had lived between her mother, father and maternal grandparents for most of her life due to her mother's mental ill health. • Prior to 2011, when she was 13, she was only known to health and education services. • Between 2011 and 2013 there was some involvement with the Children and Young People's Service at 2gether NHS Trust (Child and Adolescent Mental Health service) in Gloucestershire and one brief intervention by Children's Social Care. This was due to issues of behaviour and family breakdown including difficulties of relationships between Lucy and her separated parents and refusing to go to school and also an allegation of being hit by her grandfather. • The chronology in the serious case review demonstrates a picture of a young person at times displaying very disruptive behaviour, being sexually active, subjected to alcohol misuse, subsequently becoming pregnant and being in an abusive relationship with her boyfriend. • The first known physical assault by her boyfriend Daniel was on the 31st October 2013 which was also around the time "Lucy" found she was pregnant. • From that time until her death, agencies, including social care, were working with "Lucy" and her family. This was primarily because of concerns around "Lucy's" housing situation; "Lucy" and the professionals working with her considered her to be homeless, the fact that she was at times estranged from different family members and concerns about Sarah, the unborn baby. • The chronology in the case review outlines several incidences of abuse from her boyfriend, involvement by police, school nursing services, sexual health services, child and mental health services and social care.	

	• At the time of "Lucy's" death she had recently moved back to live with her mother, having left Daniel's home. It had been acknowledged in the report that it was sometimes seen that a degree of pushing around or bullying was considered as acceptable, and it was this that made it difficult to help someone in a relationship such as this. It had also been acknowledged that work not only needed to be done with victims but also perpetrators. Domestic abuse training was needed for all colleagues as this was often difficult to broach with younger victims but also those looking after their care. It was also acknowledged that it was difficult to challenge a relationship of a child who saw themselves as a grown-up transitioning to adulthood. It was acknowledged that most of the actions from this report had been completed as "Lucy's" death had occurred two years ago. The Committee felt that an assessment process was needed to aid colleagues. The Committee **Noted** the "Lucy" Serious Case Review The Named Nurse for Safeguarding Adults left the meeting It was agreed that item 14 would be moved to the end of the agenda to allow the Head of Medicines Management to join the meeting.	
16.	**Quality Account Final Draft** The Director of Nursing (DoN) advised that this report would be formally published on 30th June 2016 and would go to the July Trust Board meeting. The Committee **Noted** the Quality Account	
15.	**Understanding You Report** The Head of Planning, Compliance and Partnerships (HoPCP) presented the Understanding You report. This report covered patient experience and engagement for the period January – June 2016. The majority of the feedback from the Minor Injury and Illness Units (MIIUs) was positive, but there were some consistent concerns about colleague attitudes and waiting for transport. It was also noted that the translation costs have risen considerably, this service was due to go out to tender. The Committee highlighted that the use of percentages in the report as opposed to numbers did not provide a true reflection of the numbers involved; as a lot of the responses were low then the percentages looked higher. It was agreed that the number of responses should be shown as well as percentages in any future reports. It was agreed that the HoPCP and the Director of HR (DoHR) should look as to whether colleague attitude should be taken as an	**HoPCP/ DoHR**

	Listening into Action (LiA) approach. The HoPCP to ask the Trust Chair if she wanted this to go to the next Trust Board or not? The Committee **Noted** the Understanding You Report	**HoPCP**
17.	**Workforce Race Equality Standard Submission** The Head of Planning, Compliance and Partnerships (HoPCP) presented the Workforce Race Equality Standard Submission, which was a yearly submission the Trust was required to do. The number of Black and Minority Ethnic colleague responses was low within the Trust - only 12 colleagues responded to the survey. The HoPCP advised the Committee that the Trust would be required to submit an action plan following the submission of the data. The Trust would be holding an event to celebrate Black History week and looked to incorporate a stand on bullying and harassment experienced by Black and Minority Ethnic colleagues within the event. It was noted that the survey did not include white non-British colleagues. The HoPCP would work with the Director of HR (DoHR) and Ambassador for Cultural Change (AfCC) to formally consider these results. The Committee agreed to **Note** the Workforce Race Equality Standard Submission The Director of HR left the meeting	**HoPCP/ DoHR/ AfCC**
18.	**CQC Quality Improvement Plan and Presentation** The Director of Nursing (DoN) presented the CQC Quality Improvement Plan (QIP). The Compliance rate as of the end of June was 75%. The Trust was currently testing compliance against the QIP, the results of this would form the basis of the report that would be written to the Trust Board in July. The Professional Head of Community Nursing (PHoCN) presented the actions that had been taken to date to meet the QIP for Community Nursing. The Trust had reviewed 12 domains and taken a peer review approach to measure progress. This involved colleagues undertaking unannounced visits and working with colleagues of all levels and from this a clear plan has been developed to show the results and develop an action plan. One unexpected outcome of this result is that most colleagues had not seen or knew about the Trusts CORE Values, which opened the question as to how information is being disseminated. The DoN advised that the outcome of this week's external, independently led, CQC "mock" visit would form the basis of whether the Trust formally asked the CQC to visit. This report would be taken	

	to the Trust Board in July, but at present a visit from CQC was not expected until September or October 2016. The Committee **Noted** the CQC Quality Improvement Plan	
19.	**SEND Report** The Chief Operating Officer (COO) had previously presented the SEND report - this was just an update of that report. This report primarily involves allied health services and was presented to the Committee for noting. An update report would come from Children's services in December 2016. The Committee **Noted** the SEND report.	**COO**
20.	**Overnight Hospitals Transfers Report** The Chief Operating Officer (COO) presented the Overnight Hospitals Transfer Report, which was due to be presented to the Systems Resilience Group (SRG). The COO advised that they were currently struggling to obtain information from ARRIVA transport services, though it was acknowledged that the problems with delays may not all be because of transport, but due to the time it may take to register a service user onto SystmOne. Colleagues were now being encouraged to do incident reporting when services users arrived late or had spent a long time waiting to be picked up. It was agreed that an enhanced report would be brought to the next meeting. It was agreed that a late/delayed arrival should be defined as this could mean different things to different colleagues. There was also concern raised about patients arriving late and not being medically assessed until the next day, as there was no doctor on duty to do this. The Committed **Noted** the Overnight Hospital Transfer Report	**COO**
21.	**Annual Organisation Audit** The Medical Director (MD) presented the Annual Organisation Audit. This was the first time that this audit had been done and would need to be an annual return in future years. This had been reported to the May Trust Board verbally but in future years would need to be formally presented to the Board for approval. The Committee **Noted** the Annual Organisation Audit	
22.	**Safe Staffing** The Head of Community Hospitals (HoCH) presented the Safe Staffing paper. The new safer staffing model had been implemented in the Trusts larger hospitals where cover could be pulled from other areas of the hospital if required. It was found that levels of sickness	

	had gone down across all wards and the role of the co-ordinator had had a positive impact. However, there are concerns once the co-ordinator finishes a shift and colleagues don't feel as assured. It was acknowledged that the testing of the model had been during a challenging environment, particularly with high vacancy rates on some of the in-patient wards, escalation beds still open, high bed occupancy levels and SystmOne still taking time for colleagues to get used to, patient's acuity was also believed to be higher. The Safer Staffing model had been discussed at the May Clinical Reference Group and it was acknowledged that it was difficult to ensure Quality Care versus achieving the Trusts CIP requirements. It was believed that this should be presented to the Quality and Performance Committee to help with the decision making re next steps. It was felt by the Clinical Reference Group that this should be clinically led and not financially driven and taking into account recent reports about other Trusts such as Liverpool Community NHS Trust (Capsticks). It was felt that something different should be trialled from the current model, but it was acknowledged that as yet it was not sure what this was. It was acknowledged that there was not enough bank staff and this meant that agency staff often had to be brought in, even if off framework, to ensure adequate staffing levels on the wards. The Director of Nursing (DoN) asked if Health Care Assistants (HCAs) could work twilight shifts and the HoCH felt that this was something they wished to introduce. It was felt than a patient acuity audit should take place and that there was a need to strengthen flexibility and responsiveness. It was acknowledged that some hospitals were running the new model, not due to the pilot, but because they couldn't recruit staff. Committee members asked whether a relief team could be used to cover shifts across the hospitals and it was acknowledged that Derbyshire Healthcare NHS Foundation Trust have an emergency relief team. The Committee acknowledged that it was difficult balancing the needs of the Hospitals and the achieving the CIP savings. It was agreed that the DoN would summarise the discussions to go to the July Trust Board meeting for further discussions. The Committee **Noted** the Safer Staffing report and the further work and decisions required. The Head of Medicines Management joined the meeting	**DoN**
14.	**Medicines Management Report** The Head of Medicines Management (HoMM) presented the Medicines Management report. Some of the medication errors reported were due to duplicate medication administration, patient's lockers not being cleared, errors in insulin and blank administration records. The HoMM was currently looking to get medicines	

	management training and e-learning training in place; this would form part of the Clinicians Essential for Role criteria. The new Pharmacy technician was due to start in July 2016 and this role would work with inpatient colleagues and train them on safe prescribing working practices. The Committee had asked for benchmarking data, the HoMM advised that there were currently three other providers who were interested in doing some benchmarking. Lloyds pharmacy had changed their contract management structures so that all NHS Trusts are managed by one team. This was working really well. It was hoped that they would soon be working on stock management with the Trust. A recent Quality Equality Impact Assessment (QEIA) had highlighted risks to the Trust not having anti-microbial stewardship/microbiologist support for Clinicians. The HoMM raised that the Medicines Management Committee had a lack of Medical support and it was agreed that either the Medical Director of Deputy Medical Director would Chair this group in future. It was agreed that an update would come back to the Committee in December 2016. The Committee **Noted** the Medicines Management Report	
23.	**Subgroup Reports** The Committee **Noted** the Subgroup reports.	
20. 20.1 20.2	**Any Other Business** **July Trust Board Feedback** The Chair requested that the next Quality and Performance report for the Trust Board include the following items: • Patient Safety Analysis • Understanding you • Workforce Race Equality Submission • CQC Quality Implementation Plan update • Safe Staffing • Clinical Strategy Progress **CQC - Review of Deaths** The Director of Nursing (DoN) updated the group that the CQC would be visiting the Trust on 16th and 17th August to review its death review process. The national CQC led review was in response to the recent Southern Health report (Mazars).	

	There was no other business raised; the Chair thanked everyone for attending and formally closed the meeting.	
25.	**Date of the next meeting** The next meeting of the Committee to be held on 28 June 2016 in the Boardroom, EJC at 1:30pm.	

Signed …… Date ……

Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 20th September 2016

Agenda Item:	13
Agenda Ref:	13/0916
Author:	Susan Field, Director of Nursing; Matthew O'Reilly, Head of Performance and Information
Presented By:	Susan Field, Director of Nursing; Candace Plouffe, Chief Operating Officer
Sponsor:	N/A

Subject:	Trust Quality and Performance Report

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

Executive Summary:

This report aims to provide assurance to Board members that the Trust is delivering high quality, safe and effective care. The report relates to July 2016 information (NB June 2016 performance and quality data was formally discussed and reviewed by the Trust's Quality and Performance Committee on 28th June 2016).

Performance risks are highlighted and include:

- Harm free care – the Trust remains below its trajectory of 95%
- Although improved on June performance colleagues Personal Development Reviews (Appraisals) remain below plan
- Improved mandatory training reporting and compliance

Recommendations:

The Board is asked to:

- The Trust Board is formally asked to consider the Quality and Performance position as at July 2016

Considerations:

Quality implications:

Included throughout the attached report.

Human Resources implications:

Vacancy and sickness levels are impacting on the Trust on some service delivery and standards/targets, although it should be highlighted that sickness levels are seeing an improvement

Equalities implications:

No specific issues identified

Financial implications:

Inability to meet contractual obligations and commissioned quality metric will potentially have a detrimental impact on

the Trust from a financial perspective
Does this paper link to any risks in the corporate risk register: Yes, Strategic Risks: 003 (Inconsistent care pathways) 006 (Sustainability and Transformation Plan delivery) 008 (Inability to recruit staff) 010 (Clinical skills of the workforce) 012 (Failure to deliver community contract obligations, QIPP & CQUIN) 014 (Inability to achieve a "Good" or "Outstanding" CQC rating)
Does this paper link to any complaints, concerns or legal claims No

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

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

Reviewed by (Sponsor):	N/A

Date:	9th September 2016

Where in the Trust has this been discussed before, e.g. Committee, Programme Board, Group?
Executive Colleagues – Virtual review and comments (late August 2016) Quality and Performance Committee (June quality and performance) – 31st August 2016

Explanation of acronyms used:

Gloucestershire Care Services NHS Trust

Quality and Performance Report

Trust Board
20 September 2016

Understanding you

Contents

Report Overview

Gloucestershire Care Services NHS Trust continues with its commitment to provide high quality care ensuring that patients remain safe and well cared for. The Trust continues to make improvements in the care that is provided, and to respond to any performance or quality issues in a clinically effective, person-focused and safe manner.

This report has been developed to provide the Trust Board with assurance that quality and performance is scrutinised and monitored, and that improvement measures are being identified and implemented in a timely way. It also enables the Trust to demonstrate its commitment to encouraging a culture of continuous improvement and accountability to patients and communities, meeting its contractual obligations with the commissioners of its services and other key stakeholders.

The report aligns to the Trust's strategic objectives and provides a high level overview of how the Trust is meeting those commitments, which are illustrated via dashboards within this report.

This report relates to year to date performance up to end of **July 2016**.

Strategic Objective 1 - Achieve the best possible outcomes for our service users through high quality care

- It has been agreed with Commissioners at Contract Board meeting that metrics for services where the service model is being reviewed will not be subject to RAG rating. This includes Reablement, Integrated Sexual Health, Chlamydia and Smoking Cessation.

- Musculoskeletal Clinical Assessment and Treatment Service (MSKCAT) 8 weeks Referral to Treatment (RTT) target was achieved in July 2016.

- Patient slips, trips and falls within Community Hospital in-patient settings remains the highest reported incident by type. Of the total patient falls on a year to date basis to the end of July 2016, 217 (70%) resulted in no harm *(see page 21).*

- The Trust reported 1 Serious Incident Requiring Investigation (SIRI) for July *(see page 17). The Trust is reporting a rate of SIRIs (2.2 average per month) which is below the average of the Trusts within the Aspirant Community Foundation Trust group (2.4 average per month).*

- The Trust surveyed 1,048 patients episodes of care for the July Safety Thermometer census. Of these, 979 (93.4%) were harm free. This is below the 95% threshold for the fourth consecutive month (see page 18 for further details). *The national average for harm free care was 94.3% (July 2016).*

- 70 harms were reported via Safety Thermometer, of which 19 were new harms *(see pages 18-20). This means that The Trust reported 1.8% new harms compared to national average of 2.1% new harms (June 2016).*

- July 2016 shows the Trust reported 82.76% compliance rate with national targets on a year to date basis, and 65.52% compliance with local health targets. *(see page 11).*

Strategic Objective 2 - Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work

- There have been no single-sex environment breaches reported during July 2016.

- The Friends and Family Test question asks service users "How likely are you to recommend our services to your friends and family". During July, there were 2,087 responses (4.8%) from a total of 43,763 patients accessing GCS services. *This is the first time this year the response rate is above the 4.6% response rate recorded in March 2016. The average of Trusts within the Aspirant Community Foundation Trust group is 12.7% (based on 6 Trusts, with variance from 1.3% to 63.1%).*

  There have been discussions with other Trusts that had high response rates. This revealed a number of inconsistencies with reported data and application of definition by other Trusts and resulted in resubmissions of their data. This has reduced the group average from 28.6% to 12.7%, with one Trust showing as an outlier at 63.1%. If this Trust data was excluded the average would be 2.6%.

- Of those that responded, 95.3% said they were extremely likely or likely to recommend us. *This is slightly below the average of Trusts within the Aspirant Community Foundation Trust group (96.2%).*

- 14 NHS Choices comments were received in July, of which 79% (11) were positive.

- Complaints: 8 complaints were received in July 2016.

Strategic Objective 3 - Actively engage in partnerships with other health and social care providers in order to deliver seamless services

- Rapid Response service received 264 referrals in July. The number of referrals were slightly below the level expected at average of 59.6 referrals per week (target of 60 referrals per week in July) (see page 51).

- Reablement indicators continue to be behind target, with the exception of average length of reablement service (see pages 30-31).

- The Trust continues to perform well against national data quality targets. The 45 data indicators that measured from data submitted to the Secondary Uses Services (SUS) shows Trust performance to be 99.2% against a target of 96%, monitored by Health and Social Care Information Centre (HSCIC) (April 2016 to June 2016). The National average is 96.4%, South Central regional average 94.1%.

- Data quality reports are not yet available from HSCIC for the mandated Children and Young Peoples dataset that has been flowing since October 2015. HSCIC indicates first reports will be available after September 2016. The Trust will use these reports to benchmark data quality and identify any areas for improvement.

- Average length of stay in Community Hospitals increased to 25.6 days in July 2016 from 23.5 days in June 2016 (page 53). The average in 2016/17 to date is 24.4 days which is above that in 2015/16 of 20.9 days. The median (mid-point) in July was 20.0 days. *The NHS Benchmarking network average for 2014/15 was 26.7 days.*

- Bed Occupancy rates were 98.3% in July, a slight decrease from 98.4% in June. *The NHS Benchmarking network average for 2014/15 was 90.75%.* The Trust continues to monitor quality metrics that are aligned to bed occupancy e.g. falls and infection rates to identify if there is any impact and this bed occupancy risk remains on the Trust strategic risk register.

Strategic Objective 4 - Value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision

- The Staff Friends and Family Test is positive in terms of colleagues recommending the Trust as a place for treatments (83% Q1); however, there is significant opportunity to improve the Trust's recommendation as a place to work (see page 56)

- Sickness absence: remains above target (4.52%) rolling 12 months to July 2016, compared to target of 4%), also July 2016 rate of 4.25% is below target (see page 57).

- Appraisals: rate of reported completed appraisals (70.3%) continues to be below the highest point of 79.4% (February 2016), although a slight increase was observed compared to June (66.2%) but remains significantly behind trajectory of 95% (see page 57).

- Mandatory training: the report now shows the matrix of all aspects of mandatory training. Out of the 19 courses only 2 are ahead of the 85% trajectory (see page 58), but there continues to be improvement compared to compliance rates.

- Health and safety metrics are included within the report *(pages 59-60)*

Strategic Objective 5 - Manage public resources wisely to ensure local services remain sustainable and accessible

- A detailed Finance report was provided to the August Finance Committee and to Trust Board.

Strategic Objective 1:
Achieve the best possible outcomes for our service users through high quality care

Quality Strategy metrics - strategic objective 1

	2015/16 Outturn	Target	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	2016/17 YTD
Harm-free care in community hospitals and ICTs	**95.3%**	**More than 95%**	**95.1%**	**95.8%**	**95.4%**	**95.4%**	**95.3%**	**95.0%**	**96.2%**	**95.7%**	**93.6%**	**93.4%**	**93.1%**	**93.4%**	**93.4%**
Number of new harms (Safety Thermometer)	**154**	Less than 267 (14/15 total)	**14**	**10**	**10**	**14**	**18**	**21**	**6**	**13**	**18**	**28**	**18**	**19**	**83**
Reduction in incidents that result in severe harm	**8**	Less than 12	**0**	**1**	**0**	**0**	**4**	**1**	**1**	**0**	**2**	**0**	**1**	**1**	**4**
Not exceeding the agreed threshold of C. diff infections	**9**	Less than 18	**1**	**1**	**0**	**2**	**0**	**1**	**1**	**0**	**0**	**0**	**1**	**1**	**2**
Achieving agreed staffing levels in community hospitals	**101.3%**	80-120%	**99.2%**	**98.7%**	**99.7%**	**99.8%**	**99.4%**	**100.4%**	**98.7%**	**97.6%**	**98.7%**	**97.6%**	**96.0%**	**96.0%**	**97.1%**
Number of Never Events within the Trust	**1**	0	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Summary of health performance key indicators - July year to date

	July cumulative year-to-date (with comparators to June)							June cumulative year-to-date		
	Red		Amber		Green		Total	Red	Amber	Green
National	2 (6.90%)	↔	3 (10.34%)	↑	24 (82.76%)	↓	29	2 6.90%	2 6.90%	25 86.20%
Local	7 (24.14%)	↓	3 (10.34%)	↑	19 (65.52%)	↔	29	8 27.59%	2 6.90%	19 65.51%
Total	9 (15.52%)	↓	*6 (10.34%)	↔	43 (74.14%)	↓	58	10 17.24%	4 6.90%	44 75.86%

* The July YTD amber metrics have increased by two compared to June due to one indicator moving from red to amber and another indicator moving from green to amber, while 4 other indicators remained constant.

National indicators

Red	Safety Thermometer – percentage Harm Free	Page 12
	Time to initial assessment for patients arriving by Ambulance (MilU)	Page 12
Amber	National Childhood Measurement Programme (NCMP) – Percentage of children in Year 6 with height and weight recorded	Page 12
	Newborn Bloodspot screening coverage (2 targets)	Page 12

Local indicators

Red	Rapid Response – Number of referrals	Page 13
	Integrated Discharge Team – Number of avoided admissions (3 targets)	Page 13
	7 Day Service – Inpatients (2 targets)	Page 13
	Bed occupancy	Page 13

Local indicators

Amber	Speech and Language Therapy – referral to treatment	Page 14
	Occupational Therapy (Adult) – referral to treatment	Page 14
	Physiotherapy (Adult) - referral to treatment within 8 weeks	Page 14

Note: The total number of RAG rated indicators has reduced (see page 4) following agreement to remove RAG rating from Integrated Sexual Health, Reablement, Chlamydia and Smoking Cessation.

Performance exceptions - Year-to-date National targets

Indicator	YTD RAG	Performance	Actions	Projected date of remedy
Safety Thermometer – Percentage Harm free		Performance was 93.4% in July compared to 93.1% in June. Target is 95%.	This reduction in score is not due to clinical quality or safety factors as there is no correlation with incident reporting; it has been found that the accuracy of the data submissions has skewed the scores downwards due to reporting. Previously in the PaCE directorate a "second level" quality control was undertaken to correct the submissions. We are keen that this quality control remains in the ownership of operational teams and therefore support is focussed on: Training opportunities – reinforcement of the current standard operating procedure through team meetings and supporting the development of a myth busters for CORE newsletter/screensavers. Ensure understanding of national definitions for consistency of reporting practice. Increase accuracy of data at point of collection – such as increased prompts, reminder of definitions etc. Development of a system whereby managers can sign off their team with their current score available rather than just signing off raw data. Currently exploring whether a sliding scale tool can be developed whereby a team's score starts at 100% and score adjusts as data is inputted. In addition, retrospective quality control of data is being undertaken in order to improve the scores of previous months.	Chief Operating Officer to ensure actions are embedded to improve performance
Time to initial assessment for patient arriving at MIU by ambulance		Performance was 38 minutes in July compared with 43 minutes in June (95Th percentile). Target is 15 minutes.	There were 8 breaches of the triage target for patients arriving by ambulance in July. There were a total of 34 ambulance arrivals in July.	Remedial actions underway led by Head of ICT
National Childhood Measurement Programme (NCMP) – Percentage of children in Year 6 with height and weight recorded		Performance for the 2015/16 academic year is at 93.3% below target of 95%.	This is due to children who have moved into the area after the measurement exercise had been carried out in their school who then appear as not measured. Also children who have moved out of the area but not closed down in SystmOne.	Ongoing
Newborn bloodspot screening coverage by 17 days of age and by 21 days of movement into area		Coverage by 17 days - Performance was 94.4% in July, same as in June. Target is 95%. Coverage by 21 days of moving into area – Performance was 91.2% in July compared to 100% in June. Target is 95%.	GCS does not manage staff responsible for delivery of this.	GCCG has agreed to remove this target. GCS to complete contract variation.

Performance exceptions - Year-to-date Local

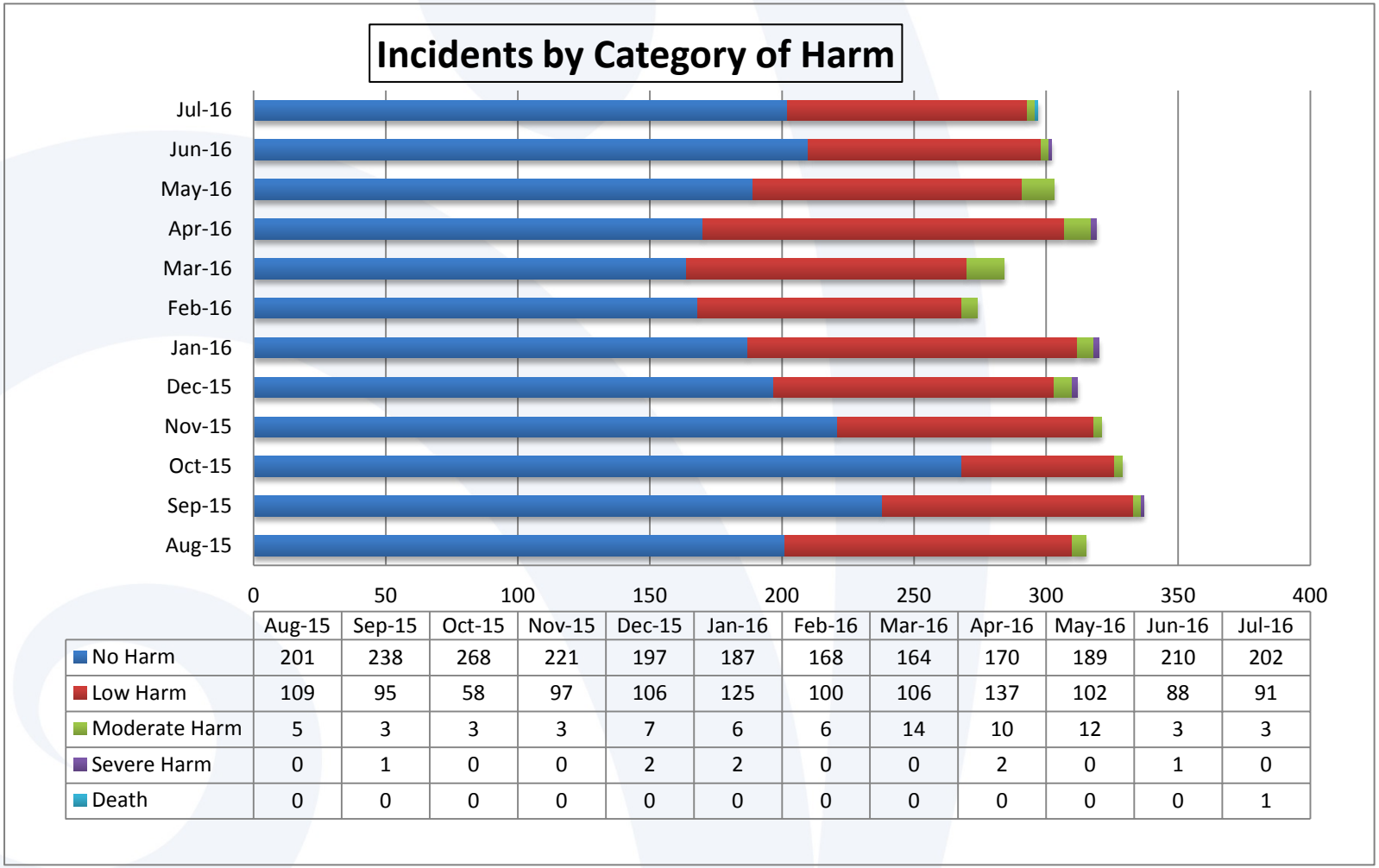
Gloucestershire Care Services NHS Trust

Indicator	YTD RAG	Performance	Actions	Project date of remedy
Rapid Response – Number of referrals		Number of referrals accepted was 264 in July with a target of 266 July referrals were 236 with a target of 257. July shows an improvement to amber RAG status but YTD remains Red.	RR practitioner (RRP) continued presence in SPCA to ensure the right RR clinical pathways are chosen at point of referral. Care Home project has linked RRPs assigned to 4 care homes around the county to improve their clinical knowledge on the deteriorating patient and facilitating a direct referral in to RR (as SPCA is not able to take care Home referrals). Increased referrals noted. RR attendance in GP Cluster meetings is raising the awareness of the service; will continue with case reviews of respiratory patients in Stroud and Berkeley Vale cluster planned for September. Trajectory of referrals appear to be upwards and commissioners have confirmed this is showing in the future trend data. A senior RR practitioner seconded into ED front door to work alongside the Admission Prevention Team for 3 months completes at the end of August; plan to replace this resource with other senior RRP, though not as a continuous resource, while the development of the APT progresses.	Ongoing
Integrated Discharge Team – Number of avoided admissions (3 targets)		Total number of admissions avoided in July was 189 with a target of 310. Year to date performance remains behind target.	Senior RRP and the Urgent Care Clinical Lead in ED/ACUA is supporting development of the IDT clinical skills to ensure IDT KPIs can be met on 5 discharges per day per site. IDT service redesign (split back and front door teams) in place and reviewing working practices and positive risk taking. RRPs are attending GP Cluster group meetings to raise awareness of the service.	Ongoing
Average number of discharges per day from Community Hospital (weekends and weekdays)		On weekends, the average number of discharges per day was 4.2 in July compared to 4.9 in June. Target is 10 discharges per day on a weekend. YTD performance remains behind target On weekdays, the average number of discharges was 9.4 in July compared to 9.5 in June. Target is 20 discharges per day. YTD performance remains behind target.	Number of discharges are currently behind target. The number of discharges have been impacted by an increased average length of stay within the Community Hospitals which has reduced the throughput. 2016/17 Contract Quality Schedule will include development of planned targets for Community Hospitals for average length of stay which will determine average number of discharged patients. Negotiations with GCCG are underway to define more realistic targets and a number of scenarios have been proposed by GCS based on bed occupancy, average length of stay, direct admission rate, all of which are expected to improve throughput.	Discharge action plan in place to improve performance. GCCG have confirmed the intention to reduce the targets
Bed occupancy		Performance in July was 98.3% compared to 98.4% in June	Beds are currently approximately 75% occupied with transferred patents from GHFT. Further analysis is required to process what the impact on system-wide length of stay has been especially as the facility for direct admission into community hospitals has reduced significantly (patients now admitted to GHFT and not locally). From the evidence, there has been no increase in clinical risk due to high occupancy but work is ongoing to manage bed pressures. The RAG rating above 95% reflects locally agreed target but performance exceeds CCG targets.	Occupancy has been consistent at this level due to demand and is expected to continue.

Performance exceptions - Year-to-date Local

Indicator	YTD RAG	Performance	Actions	Project date of remedy
Speech and Language Therapy – referral to treatment		Performance was 100% in July compared to 94.1% in June. Target is 95%. YTD performance is 91.9%	Service is showing significant improvement from previous months.	Ongoing
Adult Occupational Therapy - referral to treatment within 8 weeks		Performance was 92.8% in July compared to 89.9% in June. Target is 95%	Performance is impacted by the large number of vacancies. The service continues to monitor waiting lists and allocate according to clinical urgency.	Target unlikely to be achieved due to capacity. Data Quality work ongoing
Adult Physiotherapy Service - referral to treatment within 8 weeks		Performance in July was 92.5% compared to 92.7% in June. Target is 95%	Performance is impacted by the large number of vacancies. The service continues to monitor waiting lists and allocate according to clinical urgency.	Target unlikely to be achieved due to capacity. Data Quality work ongoing

Incidents by category of harm



	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
No Harm	201	238	268	221	197	187	168	164	170	189	210	202
Low Harm	109	95	58	97	106	125	100	106	137	102	88	91
Moderate Harm	5	3	3	3	7	6	6	14	10	12	3	3
Severe Harm	0	1	0	0	2	2	0	0	2	0	1	0
Death	0	0	0	0	0	0	0	0	0	0	0	1

Benchmarking		
Number of incidents (GCS)	**144.7 per 1,000 WTE staff**	**August 2015– July 2016**
Number of incidents (Aspirant Community Foundation Trust Group)	**176.3 per 1,000 WTE staff**	**Latest 6 months (February 2016 – July 2016)**

Duty of Candour (DoC)

Duty of Candour applied to 10 incidents from 1 April 2016 to 31 July 2016 but 1 incident from April was stepped down from a SIRI making a total of 9.

Patients and relatives have received a verbal apology and written apology as per DoC guidance.

Service user incidents by type (top 5 only)

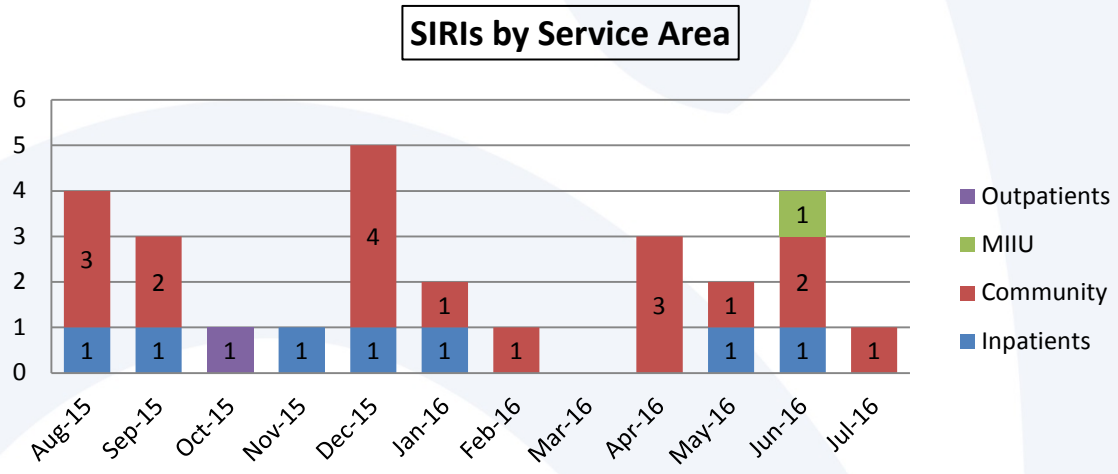
Category of harm /Type of incident - Patients (top 5 categories)	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	12-month total
Slip, Trip or Fall (Patient)	80	92	84	77	97	91	61	74	92	82	78	79	**987**
Pressure Ulcer	21	23	19	46	45	41	41	42	51	43	40	32	**444**
Medication or drug error	36	28	31	53	33	25	33	33	36	40	16	29	**393**
Treatment or procedure problem	13	12	23	12	8	11	8	7	13	13	11	7	**138**
Problem with patient records / information	7	22	8	5	5	2	8	7	1	5	4	0	**74**
Total (All)	**242**	**258**	**271**	**264**	**248**	**249**	**215**	**233**	**243**	**238**	**225**	**204**	**2,890**

Incident reporting:

The PaCE Directorate has worked collaboratively across the organisation to ensure that we collate and present a broad range of quantitative and qualitative data. As a result, an Executive decision was made to report all expected and unexpected child deaths on the Datix Incident Reporting System. Owing to this increased scrutiny, a recent unexpected child death has been declared as a SIRI. There have also been some positive developments regarding the Mortality Information Data Analysis System (MIDAS) of unexpected deaths in Community Hospitals. These are now following the RCA / SIRI process and following a recent CQC visit associated with their national Investigating Deaths process it is anticipated that the Trust will progress further with it's mortality and death reporting arrangements so that it becomes more triangulated with measures such as incidents and coroner inquests.

Serious Incidents Requiring Investigation And Never Events

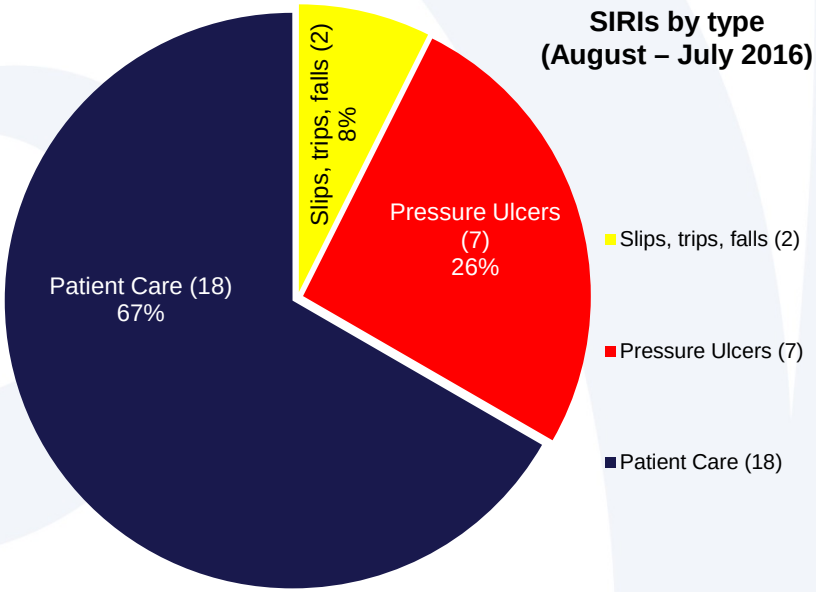
Gloucestershire Care Services NHS Trust



SIRIs

One SIRI was declared in July

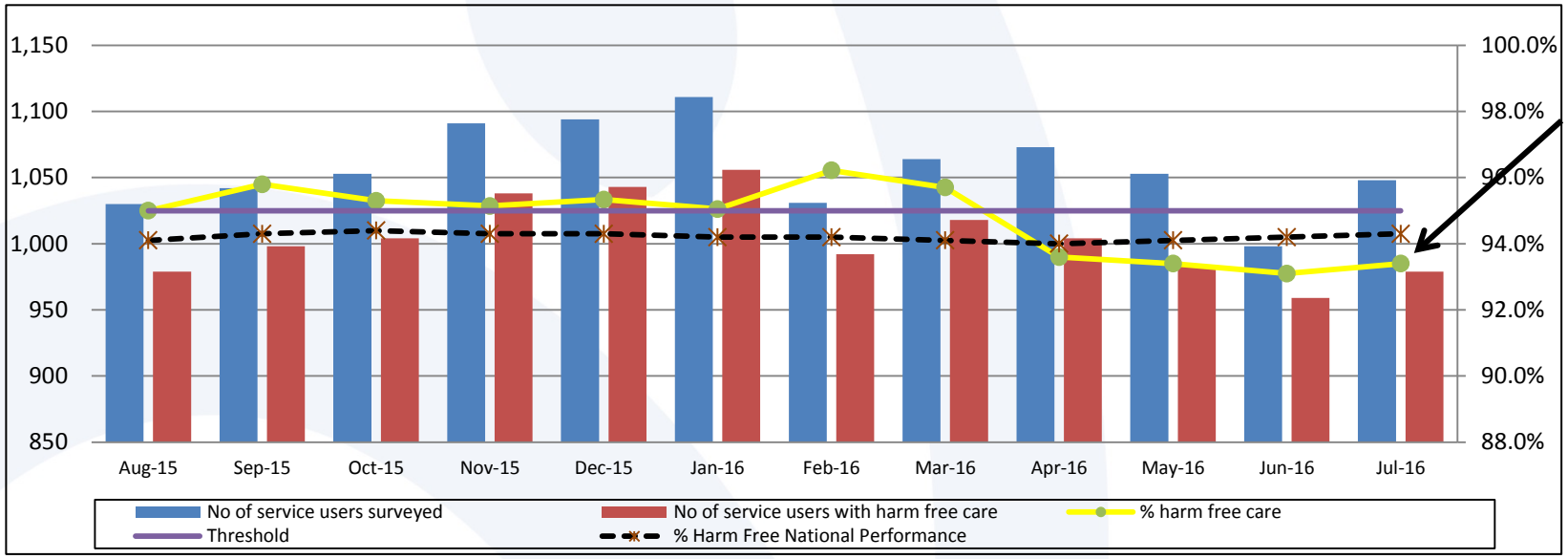
This involved a patient who was under the care of Gloucester Integrated Community Team (ICT) and the patient's GP. The patient displayed signs of sepsis leading up to her admission to GHFT. She died within a week of admission. A member of the PaCE team has made contact with the patients' family and a joint visit with the Investigating Officer has been arranged for the first week in September.



Benchmarking	
New SIRIs (GCS)	**2.2 average per month, August 2015– July 2016**
New SIRIs (Aspirant Community Foundation Trust Group)	**2.4 average per month, Latest 6 months (February 2016 – July 2016)**

Harm-free care / Safety Thermometer

Gloucestershire Care Services NHS Trust

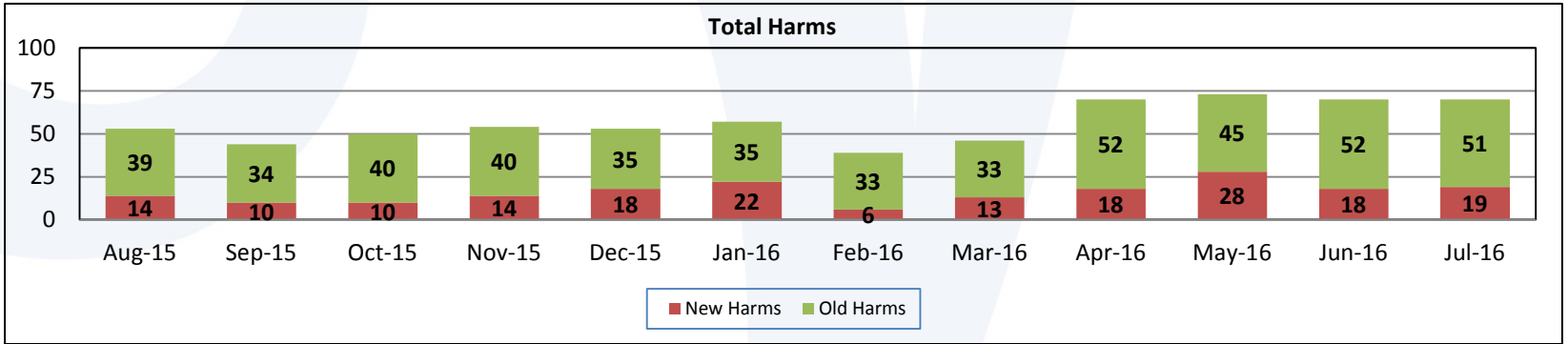


Harm-Free Care Performance below target from April 2016 to July 2016

The PaCE directorate is currently supporting operational teams to improve the quality of the data submitted because scores have dipped below the 95% harm free care threshold. We are confident that this reduction in score is not due to clinical quality or safety factors as there is no correlation with incident reporting; it has been found that the accuracy of the data submissions has skewed the scores downwards due to incorrect reporting. Previously in the PaCE directorate a "second level" quality control was undertaken to correct the submissions. We are keen that this quality control remains in the ownership of operational teams and therefore support is focussed on:

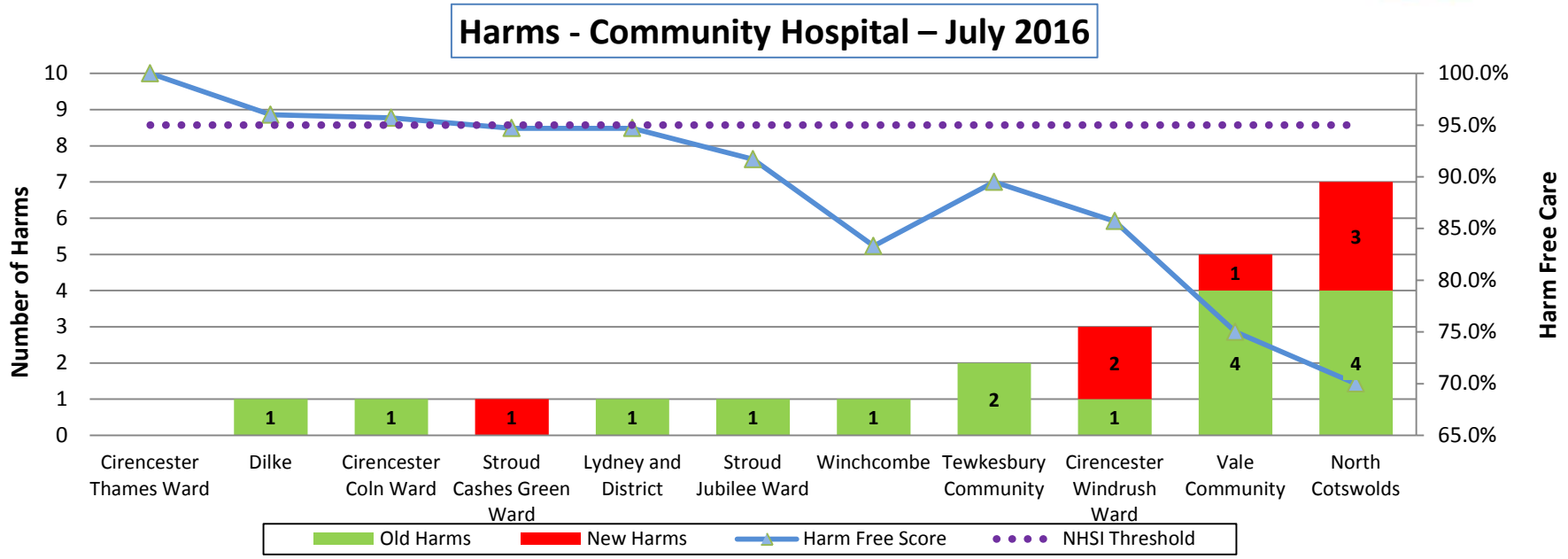
- Training opportunities – reinforcement of the current standard operating procedure through team meetings and supporting the development of a myth busters for CORE newsletter/screensavers
- Increase accuracy of data at point of collection – such as improving prompts, bubbles, reminder of definitions etc. liaising with the performance team
- Development of a system whereby managers can sign off their team with their current score available rather than just signing off raw data. We are currently exploring whether a sliding scale tool can be developed whereby a team's score starts at 100% and score slowly goes down as data is inputted

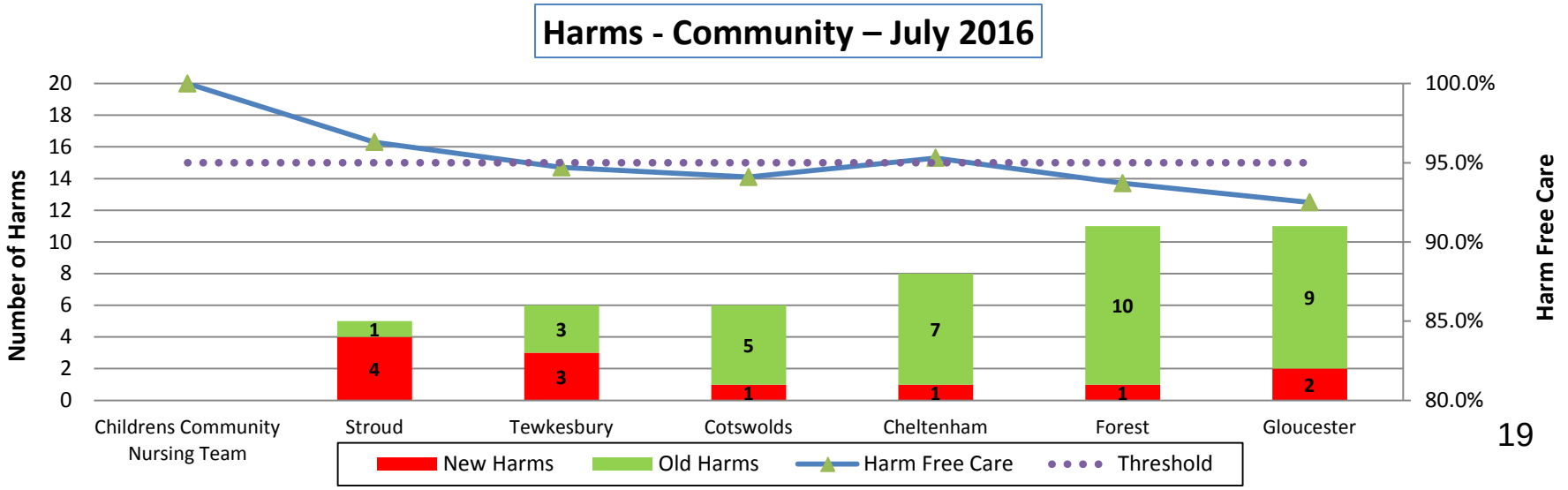
In addition retrospective quality control of data is being undertaken in order to improve the scores of previous months if they are due to inaccurate data submissions.



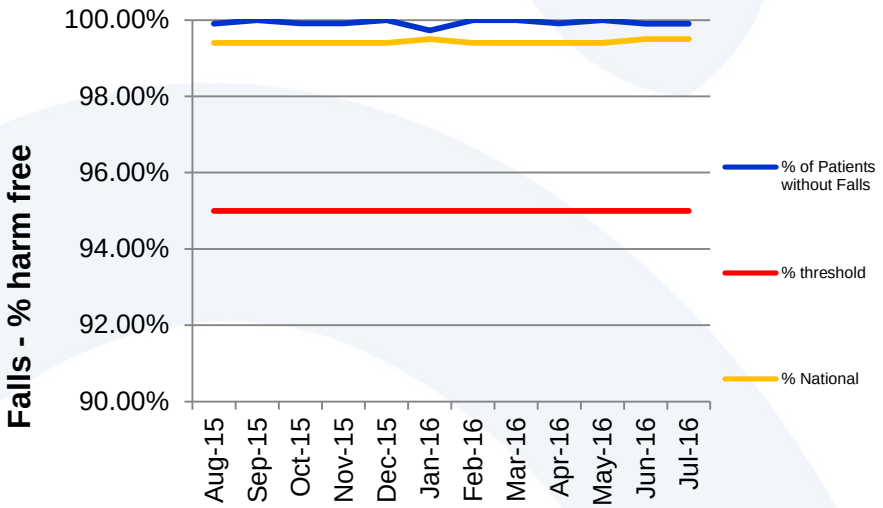
Harm-free care / Safety Thermometer

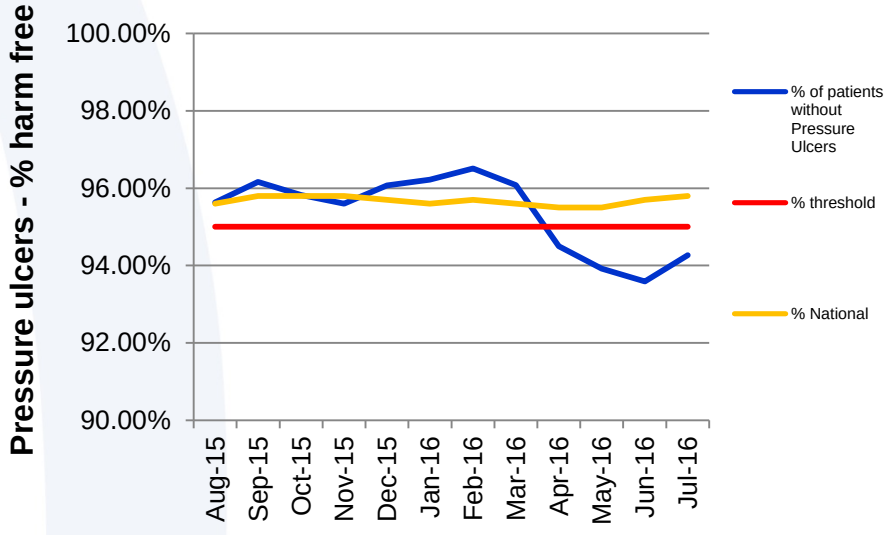
Gloucestershire Care Services NHS
NHS Trust

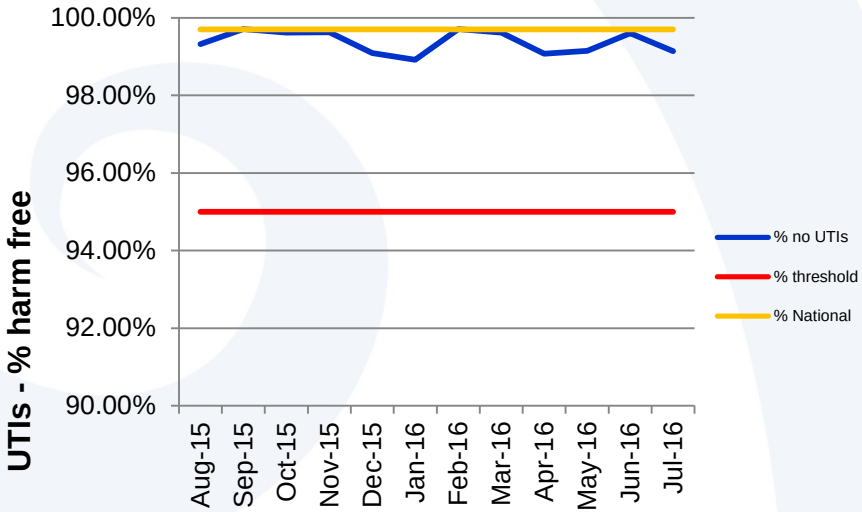


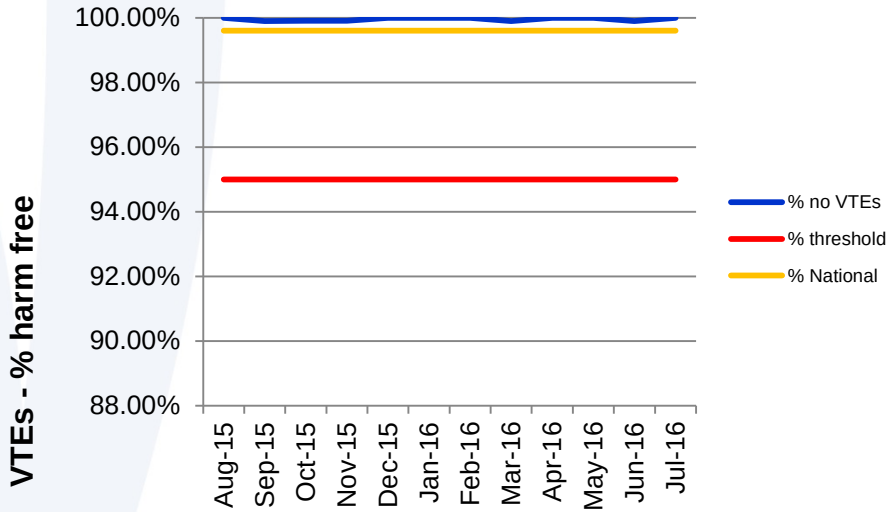


Harm-free care by type / Safety Thermometer







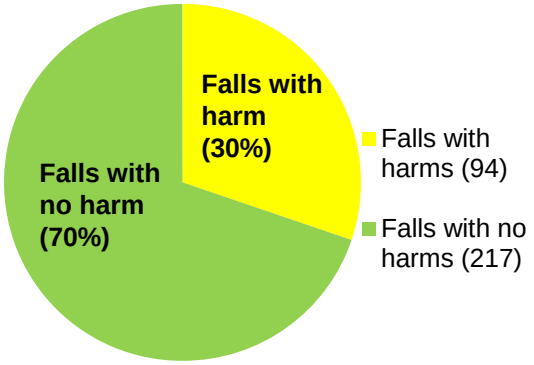


Falls in an inpatient setting

Gloucestershire Care Services NHS
NHS Trust

Hospital	Total Falls				Falls with harm			
	2016/17 Year to Date		2015/16 Total		2016/17 Year to Date		2015/16 Total	
	No of falls	Falls per 1,000 bed days	No of falls	Falls per 1,000 bed days	No of Falls with harm	Falls with harm per 1,000 bed days	No of Falls with harm	Falls with harm per 1,000 bed days
Cirencester	91	13.5	256	13.8	22	3.3	81	4.4
Stroud General	47	10.3	111	8.2	13	2.8	34	2.5
North Cotswolds	41	15.4	121	15.6	14	5.3	31	4.0
The Vale	40	16.4	109	15.2	14	5.8	33	4.6
Dilke	35	11.0	130	14.5	14	4.4	32	3.6
Lydney	30	12.0	65	8.3	9	3.6	19	2.4
Tewkesbury	27	11.1	100	14.0	8	3.3	26	3.7
TOTAL	**311**	**12.7**	**892**	**12.6**	**94**	**3.8**	**256**	**3.6**
FORECAST	**933**				**296**			

Result of falls (year-to-date)



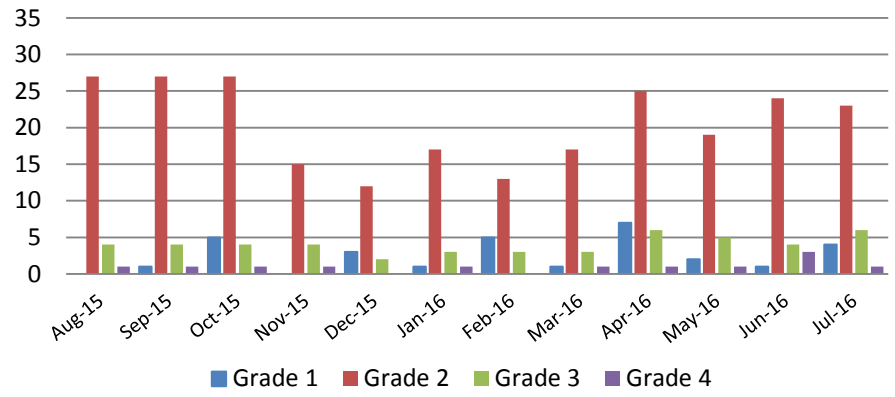
The severity of harm that patients in our Community Hospitals experience over the last few months has been in the categories of either "no harm" or "low harm."
Community Hospital falls data is now informing the Health &Safety Committee. However, at the moment this is only in relation to the severity of harm. Further breakdown of data could be presented to this forum in order to gain a greater understanding of trends.

Benchmarking	
Falls with harm per 1,000 inpatient occupied bed days (GCS)	**3.8 average per month (August 2015 – July 2016)**
Falls with harm per 1,000 inpatient occupied bed days (Aspirant Community Foundation Trust Group)	**2.7 average per month Latest 6 months (February 2016 – July 2016)**

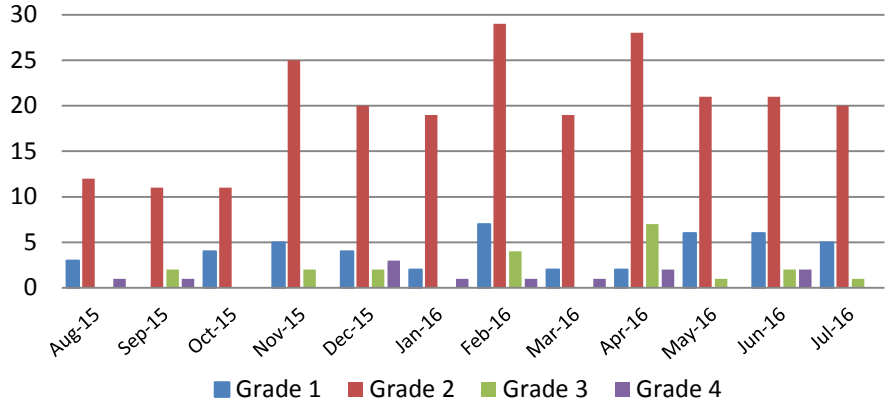
Pressure ulcers

Gloucestershire Care Services NHS
NHS Trust

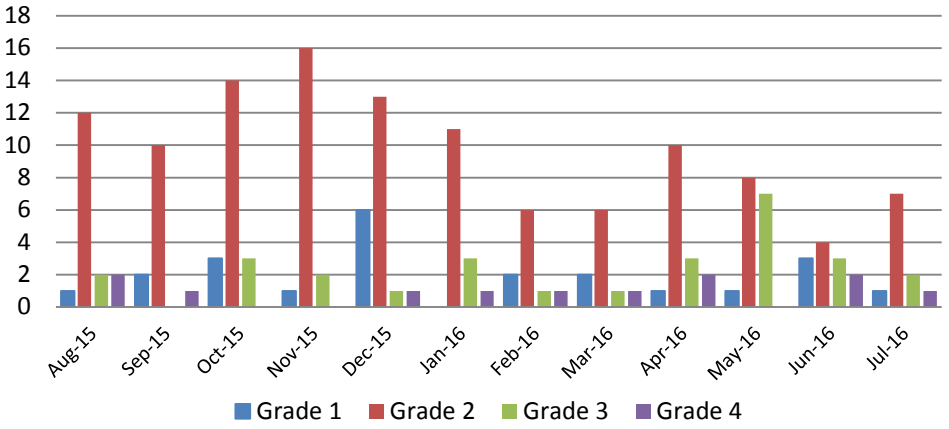
Inherited Pressure Ulcers - Community



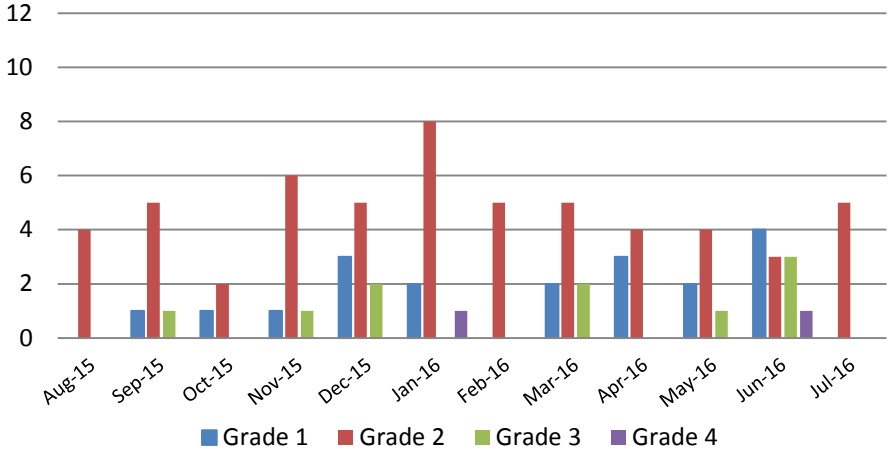
Acquired Pressure Ulcers - Community



Inherited Pressure Ulcers - Hospitals



Acquired Pressure Ulcers - Hospitals



There continues to be Grade 3 and 4 acquired pressure ulcers that are subject to the SIRI process. Recent requests for RCAs reveal that this is an ongoing risk. The majority of these have originated from the ICTs. The Deputy Chief Operating Officer; the Head of Community Nursing and the Head of the ICTs are working alongside the Professional and Clinical Effectiveness (PaCE) Directorate to work in innovative ways to address clinical assessment, decision making, therapeutic interventions and ongoing evaluation. In order to monitor SIRI action plans and to measure learning outcomes clinicians from the PaCE team are forming positive and visible alliances with the Community Nursing Service.

Infection control

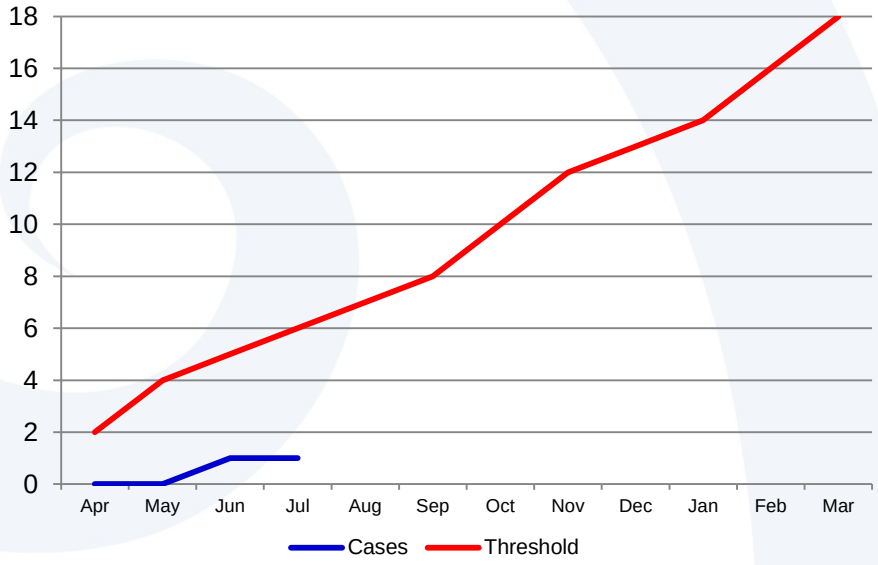
Gloucestershire Care Services NHS Trust

	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	2016/17 YTD
C diff Cases	1	1	0	2	0	1	1	0	0	0	1	1	2
Avoidable cases in GCS care	0	1	0	0	0	0	0	0	0	0	0	0	0
Unavoidable cases in GCS care	1	0	0	2	0	1	1	0	0	0	1	1	2
Norovirus Outbreaks	0	0	0	0	0	1	0	1	2	0	1	0	3

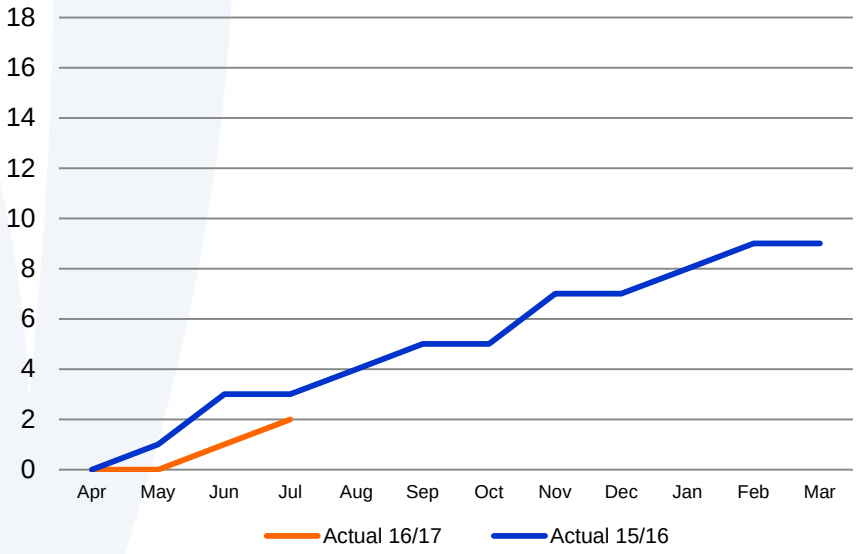
C. difficile: One Post 48 hour C. difficile was reported in July 2016. The patient was known to be C. difficile GENE positive and upon review/RCA there were no issues identified that contributed to the patients TOXIN positive diagnosis hence this is declared as an unavoidable case.

Outbreak July 2016: Cashes Green Ward, Stroud Hospital – Between July 15th and 21st five patients became unwell with symptoms of viral gastroenteritis. Samples provided to the labs identified no causative organism hence why this incident is not included in the figures above. The unit was reopened on the afternoon of Friday 22nd of July. 6 bed days were lost in total.

Incidence of C. diff 16/17 (compared to threshold)



Incidence of C. diff (comparing 15/16 actuals to 16/17 actuals)



July 2016 Hand hygiene observation audits including the 'Bare below the Elbows' initiative evidenced an average of 90% compliance.

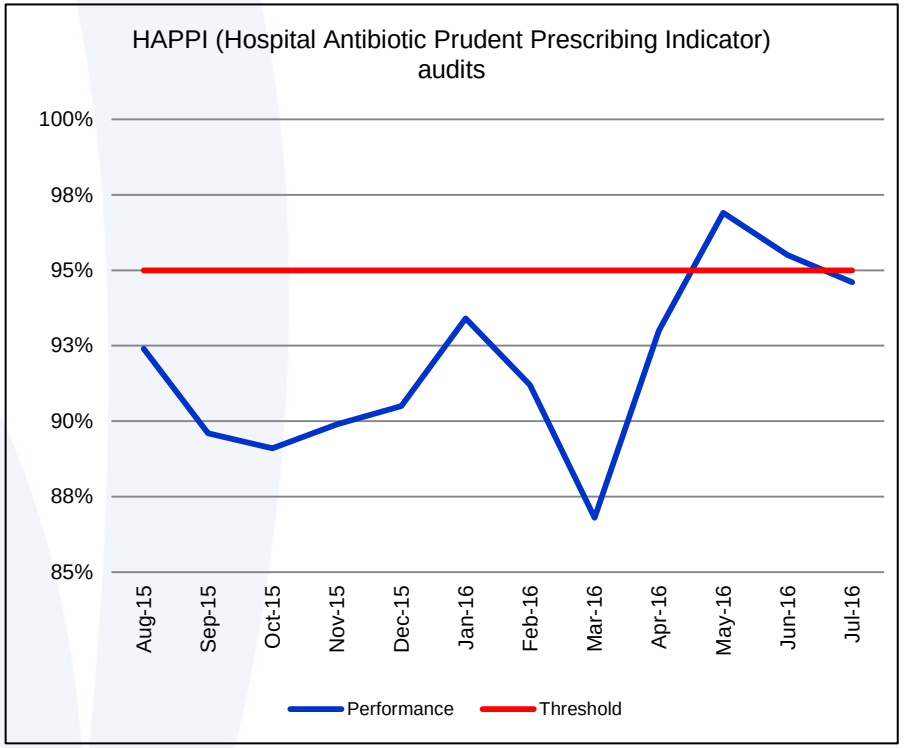
Medicines management

Gloucestershire Care Services NHS Trust

Medication incidents	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
2016-17	38	42	21	33									**134**
2015-16	16	33	38	29	40	29	36	54	34	31	35	34	**409**

Note: Medication incidents reported above include patient and staff incidents whereas those on page 16 refer to patient only incidents. Therefore the figures reported on this slide are higher than those on page 16.

Medication incidents by sub-category (2016/17)	Number
Medication administered in error/incorrectly	43
Omitted or delayed administration	30
Controlled drugs issue	18
Medication storage Issue	11
Medication missing	9
Medication prescribed incorrectly/in error	9
Medication supply problem	4
Illegible or unclear information	4
Discharge/transfer medication related issue	3
Medication not stopped/reviewed/followed up	2
IV therapy issue	1
Total	**134**



Hospital Antibiotic Prudent Prescribing Audits
The audits continue to be above target due to Community Hospital Matrons reinforcing best practice to prescribers

GCS continues to actively encourage reporting of incidents/near misses to support learning and ensure best practice

Safe staffing – July 2016

Gloucestershire Care Services NHS
NHS Trust

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	94.2%	96.3%	98.4%	90.0%	100.0%
	Windrush Ward	82.3%	97.7%	98.4%	100.0%	98.9%
	Thames Ward	101.6%	95.7%	100.0%	100.0%	97.2%
Dilke	The Ward	82.3%	92.7%	100.0%	104.8%	96.4%
Lydney and District	The Ward	82.8%	110.6%	100.0%	103.1%	96.0%
North Cotswolds	NCH Ward	91.9%	101.4%	100.0%	101.6%	98.7%
Stroud General	Cashes Green Ward	84.9%	106.0%	101.6%	127.4%	97.5%
	Jubilee Ward	99.2%	91.2%	100.0%	104.8%	100.0%
Tewkesbury Community	Abbey View Ward	97.3%	95.9%	100.0%	100.0%	98.4%
Vale Community	Peak View	80.6%	98.6%	100.0%	119.4%	99.8%
TOTAL		**88.3%**	**98.7%**	**99.8%**	**104.9%**	**98.3%**

Hospital	Ward	Bank Staff	Agency Staff
Cirencester	Coln Ward	18.8%	8.6%
	Windrush Ward	17.8%	14.8%
	Thames Ward	18.7%	4.2%
Dilke	The Ward	6.4%	4.5%
Lydney and District	The Ward	4.8%	7.4%
North Cotswolds	NCH Ward	9.3%	7.0%
Stroud General	Cashes Green Ward	17.5%	20.0%
	Jubilee Ward	15.8%	13.8%
Tewkesbury Community	Abbey View Ward	2.7%	0.4%
Vale Community	Peak View	13.6%	7.0%
TOTAL		**12.0%**	**8.9%**

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

Cashes Green – High HCA staffing rate due to a patient who required 1:1 supervision 24hrs a day, 7 days a week

It should be noted that the Trust is reviewing the National 1:8 staffing guidance and have embarked on testing an alternative staffing model. This work in essence reintroduces Clinical judgement and proactive management into staffing levels rather than purely a numbers based approach and commenced with Stroud, The Vale and Cirencester Hospitals in April 2016. A progress report was presented to the August meeting of the Quality and Performance Committee and was discussed further at the July Board Meeting. It is anticipated that future Safe Staffing and Quality reports will change to reflect the outcomes from the test sites and in light of recently published national guidance "Care Hours Per Patient Day" (May 2016) and the National Quality Board guidance 'Supporting NHS Providers to deliver the right staff, with the right skills, in the right place at the right time (July 2016). It s expected that future reports will look different to what is shared currently.

Safe staffing - June 2016

Gloucestershire Care Services NHS
NHS Trust

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	102.0%	96.7%	101.7%	108.6%	98.5%
	Windrush Ward	80.0%	99.5%	101.7%	101.7%	99.0%
	Thames Ward	101.7%	92.2%	100.0%	100.0%	96.3%
Dilke	The Ward	80.8%	96.7%	100.0%	101.7%	98.1%
Lydney and District	The Ward	81.7%	111.9%	100.0%	100.0%	94.4%
North Cotswolds	NCH Ward	92.8%	101.0%	100.0%	100.0%	98.5%
Stroud General	Cashes Green Ward	85.6%	98.1%	96.7%	103.3%	99.2%
	Jubilee Ward	100.0%	90.0%	100.0%	100.0%	100.0%
Tewkesbury Community	Abbey View Ward	96.1%	99.0%	100.0%	100.0%	99.7%
Vale Community	Peak View	80.6%	98.1%	100.0%	121.7%	99.7%
TOTAL		**88.8%**	**98.7%**	**100.0%**	**104.1%**	**98.4%**

Hospital	Ward	Bank Staff	Agency Staff
Cirencester	Coln Ward	15.6%	14.9%
	Windrush Ward	17.9%	7.6%
	Thames Ward	24.5%	1.5%
Dilke	The Ward	4.4%	2.2%
Lydney and District	The Ward	7.8%	12.4%
North Cotswolds	NCH Ward	10.0%	7.2%
Stroud General	Cashes Green Ward	14.2%	14.0%
	Jubilee Ward	17.2%	7.5%
Tewkesbury Community	Abbey View Ward	1.8%	1.4%
Vale Community	Peak View	13.8%	4.1%
TOTAL		**11.8%**	**7.7%**

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

Windrush – Ward trialling new staffing model with reduced RN hours.

Vale – Increase in HCA staffing due to several patients who needed 1-3 or 1-4 supervision

Gloucestershire Care Services NHS Trust

Quality Snapshot - Community Hospital Inpatient Care July 2016

Hospital site	Inpatient wards	FFT response rate	FFT number of responses	% of respondents 'extremely likely' or 'likely' to recommend service	Complaints	Number of cases of C.Diff	Safety thermometer harm free care	Number of patients who fell					Number of patients with acquired pressure ulcers		Safer staffing fill rate (aggregated)		Shortfall of 8 Hours or 25% of RN hours on the shift	Previous Month Sickness (FTE at start of month)		Appraisal %		Movement against Previous Month
								No Harm	Minor	Moderate	Major	Death	Grade 1& 2	Grade 3 & 4	RNC	HCA		RNC	HCA	RNC	HCA	
SGH	Cashes Green	7.7%	2	100.0%	1	0	94.7%	3	2	0	0	0	0	0	89.1%	110.8%	13	0.0% (11.6)	0.0% (16.5)	61.5%	84.2%	↓
SGH	Jubilee	No responses	0	No responses	0	1	91.7%	4	1	0	0	0	0	0	99.5%	94.3%	2	7.3% (9.1)	10.0% (15.3)	72.7%	52.4%	↓
NCH	North Cotswold	30.3%	10	100.0%	0	0	70.0%	12	4	0	0	0	0	0	94.0%	101.4%	13	4.5% (10.9)	3.9% (15.2)	42.9%	57.9%	↔
VLH	Peak View	17.6%	3	100.0%	0	0	75.0%	10	5	0	0	0	1	0	85.5%	103.2%	19	6.3% (13.4)	6.6% (13.8)	76.5%	73.7%	↓
DLK	Dilke	22.5%	9	88.9%	0	0	96.0%	3	3	0	0	0	0	0	85.8%	95.2%	0	1.5% (15.5)	1.5% (14.4)	70.0%	89.5%	↑
TWK	Abbey View	38.5%	10	100.0%	0	0	89.5%	3	1	0	0	0	1	0	98.0%	96.8%	8	2.8% (16.9)	8.6% (16.4)	75.0%	57.9%	↓
LYD	Lydney	52.4%	11	100.0%	0	0	94.7%	2	1	0	0	0	1	0	87.1%	109.0%	15	8.2% (11.2)	12.7% (18.9)	92.9%	92.0%	↔
CIR	Coln	40.0%	8	87.5%	1	0	95.7%	11	1	0	0	0	0	0	95.3%	94.6%	5	6.2% (13.4)	1.8% (12.6)	70.6%	100.0%	↑
CIR	Windrush	13.0%	3	100.0%	0	0	85.7%	3	3	0	0	0	2	0	86.3%	98.2%	3	0.3% (10.7)	16.1% (13.9)	15.4%	47.1%	↑
CIR	Thames	66.7%	6	100.0%	0	0	100.0%	4	0	0	0	0	0	0	101.1%	96.8%	0	17.2% (6.5)	9.8% (6.2)	62.5%	50.0%	↔

Quality Snapshot - Community Teams July 2016

Locality	Safety thermometer harm free care	Number of patients with acquired pressure ulcers				Previous Month Sickness (FTE at start of month)	Appraisal %	Complaints	Movement against Previous Month
		Grade 1	Grade 2	Grade 3	Grade 4				
Cheltenham	95.3%	0	1	0	0	4.9% (52.5)	68.9%	2	⟷
Cotswold	94.1%	0	3	0	0	5.6% 53.2)	74.7%	0	↑
Forest	93.7%	1	3	0	0	4.3% (47.4)	82.6%	1	⟷
Gloucester	92.5%	1	2	1	0	4.5% (53.8)	64.3%	0	↓
Stroud	96.0%	2	5	0	0	2.5% (67.0)	71.3%	0	↑
Tewkesbury	94.4%	1	6	0	0	4.6% (38.4)	79.6%	0	⟷

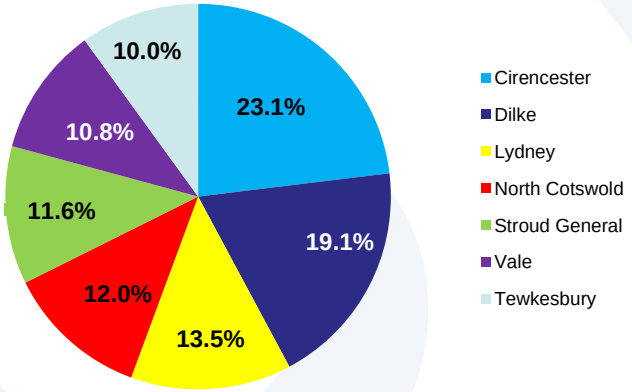
Mortality Reviews: Community Hospitals

Gloucestershire Care Services NHS Trust

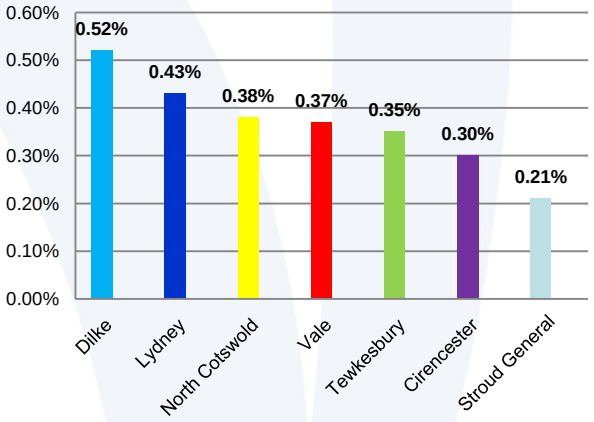
Number of Discharges from Community Hospital where discharge reason is as a result of death

Hospital Site	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Rolling 12 month total
Cirencester	6	3	4	2	5	6	4	6	7	5	7	3	58
Dilke	4	3	3	1	3	5	5	4	7	5	4	4	48
Lydney	4	3	2	2	3	6	2	3	1	3	2	3	34
North Cotswold	3	3	2	2	0	4	2	1	2	2	3	6	30
Stroud General	1	3	0	1	2	6	2	1	3	3	5	2	29
Vale	2	4	3	0	1	2	1	2	4	2	2	4	27
Tewkesbury	2	1	1	3	2	3	2	1	4	0	2	4	25
Total	**22**	**20**	**15**	**11**	**16**	**32**	**18**	**18**	**28**	**20**	**25**	**26**	**251**

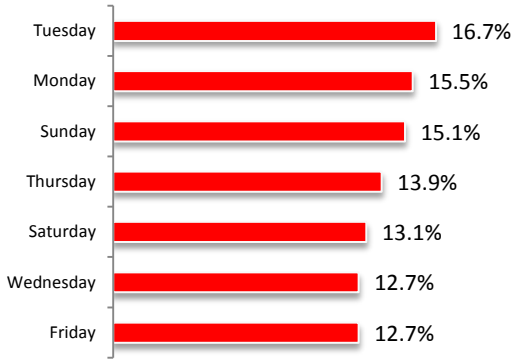
Number of deaths per Community Hospital (%) – *Rolling 12 month Total*



Number of Deaths as % of Occupied Bed Days per Hospital - *Rolling 12 month Total*



Number of Deaths (%) per Weekday -*Rolling 12 month Total*



- MIDAS is currently used to capture the record of care after death in the community hospital setting. A work programme is in place to enhance the system and further develop the use of MIDAS within the Trust.
- The Trust will also take into account any feedback that may emerge from the CQC Death Review work that took place in August 2016.

Reablement Service Key Indicators

Gloucestershire Care Services NHS Trust

Reablement service key actions to improve performance are detailed on the subsequent page

Target description	2015/16 Outturn	Target 2016/17	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	2016/17 YTD
% Contact Time	40.3%	TBC	36.7%	37.3%	41.4%	42.9%	45.8%	42.9%	43.3%	41.6%	41.5%	42.1%	42.4%	40.7%	41.7%
Number of Community Reablement Starts	3,636		302	289	291	336	283	304	260*	259*	284	308	286	279	1,157
Number of Current Cases open longer than 6 weeks	57	0	35	38	45	47	62	77	65	79	74	69	57	54	254
% of cases progressed within 6 weeks (from those closing this month)	82.8%	100%	84.9%	83.9%	84.4%	83.1%	87.0%	76.4%	83.0%	80.2%	79.2%	82.8%	84.5%	79.4%	81.5%
Average Length of Reablement Service (weeks)	3.2	6.0	2.9	3.0	2.9	3.0	2.7	3.6	3.4	3.7	3.5	3.3	3.2	3.6	3.4
Sickness rate in Reablement Workforce	6.5%	3%	7.7%	6.8%	6.8%	6.8%	6.0%	7.7%	10.7%	6.9%	4.3%	5.2%	4.4%	5.0%	4.7%

* Note: reduction in community reablement starts as a result of the impact of the reablement service spending significant time in the Emergency Departments helping with patient flows.

Reablement actions

Gloucestershire Care Services NHS Trust

The Reablement Delivery Group continues to oversee and deliver improvement are shown against key targets below:

Measure	Definition	Actions
Face to Face Contact Time	This targets relates to the amount of time the Reablement workers spend giving direct intervention with a service user	• Central point of referral from Community Hospitals (launched on 20th June) continues to meet targets and perform well without disruption to the established acute hospital referral process. • The beginning of the summer period combines with the high level of vacant posts to put stress on other performance metrics. Face to face contact time has accordingly slipped from the previous months 41.7% to 39.9%.
Sickness absence	This target relates to sickness absence of all staff within the reablement service	• The overall figure now stands at 1.056 average days lost per FTE – up from 0.956 in June. This remains above the Council-wide target of 0.608 per month.
Over 6 week length of stay	This target relates to the number of people receiving a reablement service who have been in the service for longer than 6 weeks	• Data continues to be produced and shared with ICTs and lead Commissioner weekly. • Currently figure of those still in reablement is 54 at the snapshot time. • The new Domiciliary Care tenders and contracts continue to impact on the service.

Integrated Community Teams Key Indicators

Gloucestershire Care Services NHS Trust

Integrated Community Teams key indicators

Target description	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	2016/17 YTD
% Service User referrals resolved at point of referral	71.7%	70.8%	68.0%	63.9%	64.5%	68.4%	64.6%	71.9%	38.4%	37.8%	37.9%	36.7%	37.7%
Number of Service User referrals resolved at point of referral	2,107	2,226	1,907	1,639	1,721	2,060	2,055	2,510	1,791	1,706	1,666	1,579	6,742
Service User Referrals from ICT to Specialist Services	30	20	23	68	49	37	36	27	49	27	41	39	156

The indicators above are reported to the ICT Performance & Delivery Group on a monthly basis as a part of a wider set of metrics and indicators. This Group is part of the revised Governance structure for ICTs and will be responsible for overseeing the specific delivery and development of the current ICT model including associated performance issues. It also aims to 'unblock' issues which adversely affect delivery.

The group continues to review operational issues and improvement action plans in more detail and make appropriate recommendations regarding required service change to the GCCG Contract Board; wider strategic issues / concerns will be escalated to the new Joint Integration Reference Panel Group.

The Joint Integration Reference Panel is designed to focus on wider strategic issues relating to integration and multi-agency working across the health, social care and third sector in Gloucestershire.

Safeguarding (1/2)

Gloucestershire Care Services NHS Trust

Total	2015-16 outturn	Aug -15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	2016/17 YTD
Adult safeguarding concerns raised by GCS	**160**	10	6	10	8	6	5	6	5	4	9	8	9	30
Total county adult safeguarding concerns	**3,279**	246	266	308	271	217	279	221	147	182	140	154	167	643
GCS adult section 42 enquiries	**51**	3	1	2	3	2	1	2	5	1	2	3	4	10
Total county section 42 enquiries	**1,007**	57	66	82	64	51	69	60	148	62	53	62	85	262
Number of new Children's Serious Case Reviews	**1**	0	0	0	0	1	0	0	0	0	0	0	0	0
Number of new Safeguarding Adult Reviews	**2**	0	0	0	0	1	0	0	0	1	0	1	2	4
Number of children subject to a Child Protection Plan	**580**	522 (Jul – Sept 2015)		595			580			**566** (April - June 2016)			**552** (July 2016)	

*Breakdown of adult safeguarding enquiries (2016/17)			
Client group		**Type of concern**	
Other vulnerable	17	Neglect	10
Physical Disability	5	Physical injury	9
Learning Disabilities	5	Financial	4
Dementia	2	Psychological	3
		Sexual	2
		Organisational	1

See page 34 for further details

Safeguarding (2/2)

Gloucestershire Care Services NHS
NHS Trust

Adult Safeguarding Concerns

As previously reported the number of adult safeguarding concerns (which had appeared as declining) from GCS and countywide will continue to be monitored to determine whether there are any other trends or causes to be explored. The current numbers appear to be commensurate with the support professionals are now receiving from the safeguarding helpline to ensure referrals are appropriate.

Children Safeguarding Concerns

Up to the period (July 2016) there have been no new children's serious case reviews. However it should be highlighted that in early August 2016 there have been two incidents that are highly likely to be Serious Case Reviews (SCRs); one of which has been declared as a SIRI.

Non-Executive Directors (NED) Quality Visit Report (2016/17)

Non-Executive Directors Quality Visit Schedule 2016 - 17					
Date	**NED**	**Service, Location**	**Key findings**	**Actions required**	**Director response**
6th April 2016	Richard Cryer	Specialist Heart Failure Nurse, Lydney	Feedback positive. Two patients suggested that the service scored 10/10 in terms of their experiences: they were always provided with good, caring, thoughtful and knowledgeable treatment. Patients particularly valued seeing the same person each time. There were no suggestions from the patients for any changes or improvements.	The Trust is in the process of submitting a business case to the GCCG to employ a further specialist nurse to operate within GHFT which clearly be beneficial to a number of patients.	Progressing with the GCCG
20th April 2016	Jan Marriott	SPCA, Edward Jenner Court, Gloucester	The service appears to work very well and effectively with other teams and clinicians both within and outside the Trust. Team members appear to be very committed to the value the service provides to patients and clinicians. SystmOne has proved helpful to the service. Communications within the team and with other teams and organisations appear positive. The fundamental ethos of community hospitals is that they provide local services for local people. SPCA appeared to respect this ethos and believed that it is both morally and clinically right. System pressures impact on the way SPCA works however, they have strong processes in place.	The service is clinically led, patient centred and excellent and as a result may be more expensive than some alternative services. Consider whether more of the functions could be delivered by non-clinical staff as many of the calls are relatively straightforward. The telephony system does separate out calls from different caller groups and it is clear that the calls from GPs need to be taken by a clinician in order to have the clinical conversation if necessary.	Feedback from GP colleagues is favourable because the service is clinically led. The team has considered “hot transfers” to the admin team but it is not feasible. This could be reviewed again. The GCCG also considering with GCS having a GP in SPCA – the impact of this will be evaluated jointly.

Non-Executive Directors (NED) Quality Visit Report (2016/17)

Non-Executive Directors Quality Visit Schedule 2016 - 17					
Date	**NED**	**Service, Location**	**Key findings**	**Actions required**	**Director response**
22nd April 2016	Rob Graves	Community Nursing Team, Cirencester	Overall it was an interesting and informative visit that reinforced the colleague commitment and professionalism of our staff. I would like to thank colleagues for their time and welcoming approach to my visit.	Areas that might merit follow up: How are patients made aware of the complaints procedure? Making sure there is appropriate awareness of Social Prescribing	The Trust has recently re-launched its complaints process including leaflets and posters. Operational managers will clearly know this has "reached" community Services. It is acknowledged social prescribing has been proven more successful where there has been a local area coordinator in place (Stroud and Dursley).
11th May 2016	Ingrid Barker	Podiatry Services, Rikenel, Gloucester	Both clinicians had a friendly and professional manner and gave good information to their patients about their condition and treatment options. It was interesting to see SystmOne being utilised so confidently.	The building is not ideal, being a 1960s block without its own parking, near the centre of Gloucester city centre. Although there are a small number of GCS leaflets in the waiting area they were difficult to find. The feedback and complaints leaflets had to be found for me by one of the podiatrists and there was no box in which to post feedback. The waiting area was generally quite messy and not very comfortable. Two of the hand gel holders were full but the one outside two of the clinic rooms which were in use was empty.	It is the intention that the Podiatry Service will re-locate to a new Gloucester site with other services. Action will be taken to address this Action will be taken to address this Action will be taken to address this

Non-Executive Directors (NED) Quality Visit Report (2016/17)

Non-Executive Directors Quality Visit Schedule 2016 - 17					
Date	**NED**	**Service, Location**	**Key findings**	**Actions required**	**Director response**
16th May 2016	Sue Mead	Lower Limb Service, Cirencester	The service is delivered in the ambulatory care part of the hospital. The environment is light, spacious and easily accessible, even though situated upstairs. The wheelchair users found it easy to navigate the route to the service. The service was being delivered in a pleasant environment with welcoming, friendly and professional staff. Good listening by the nurses to patient reports of progress and responsiveness to patients' questions. Treatment was applied with gentleness and sensitivity, checking with patients constantly as to how it was for them. As many patients are regular attenders it was clear relationships had built up, resulting in evident trust and confidence.	Hospital transport was said to be the biggest problem, and although it worked well for the patients attending that morning, there have been delays and failures to arrive or pick up at the appointed times. This has been reported back. FFT is very positive but there has been no effort as yet to get feedback from GPs. Suggest consideration is given to getting specific feedback from GPs and to patient leaflets having a little more prominence. Overall a great addition to our range of services.	Contractual/ relationships management between the GCCG, GCC, GHFT and Arriva are being re-instated Will progress as part of service evaluation plans
26th May 2016	Nicola Strother Smith	Fairford Hospital	Fairford Hospital is calm and quiet, with small numbers of patients attending. Many services are the activity of other providers; where the comments/ complaints relate to these providers, feedback is given to the relevant Trust. X-ray services are provided by Great Western Hospital NHS Trust and equipment is maintained by them; radiation protection supervision arrangements were unclear. There is no CQC Requiring Improvement notification report for GCS on site.	In discussion with physiotherapists, they identified that they had problems with funding for elastic stretch bands for patients. The old wards are set around a courtyard garden with a grassed area behind. This is in urgent need of maintenance as the grass was very high and the flower beds unattended. Staff were wearing old style name badges which needed to be reviewed. Need to understand more about how GCS and the local GP surgery work together in terms of activity and estate.	Need to clarify further the current situation. Gardening contracts are in place and overseen by the Head of Estates

Non-Executive Directors (NED) Quality Visit Report (2016/17)

Non-Executive Directors Quality Visit Schedule 2016 - 17					
Date	**NED**	**Service, Location**	**Key findings**	**Actions required**	**Director response**
28th June 2016	Ingrid Barker	Children's Speech and Language Therapy, Independent Living Centre, Cheltenham	Observed group speech therapy session with four pre-school children and their mothers who are working with therapists on exercises to improve their speech ahead of attending school in September. The session was fun for the children and it was very evident that the therapists, had a good rapport with the families, with clear communication and a caring and attentive attitude. One of the mothers in the waiting area spoke very highly of the service, saying that it had been easy to access with clear information about the nature of the course and good communications throughout. It was pleasing to see that the waiting area at the ILC has improved with better signage and more appropriate arrangement of chairs, toys and notice board information.	There is still a need to address the lack of a receptionist and volunteers might be found to undertake this.	Refurbishment work being considered re: improved patient friendly environment The volunteer co-ordinator is reviewing this again
13th July 2016	Jan Marriott	In patient ward , Lydney Hospital			Visit agreed
20th July 2016	Nicola Strother Smith	Children's Complex Care Service			Visit agreed
25th July 2016	Jan Marriott	Community Nursing (DN Team, Gloucester)			Visit agreed
24th August 2016	Richard Cryer	Ambulatory Care Unit, Cirencester			Visit agreed

Strategic Objective 2:
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work

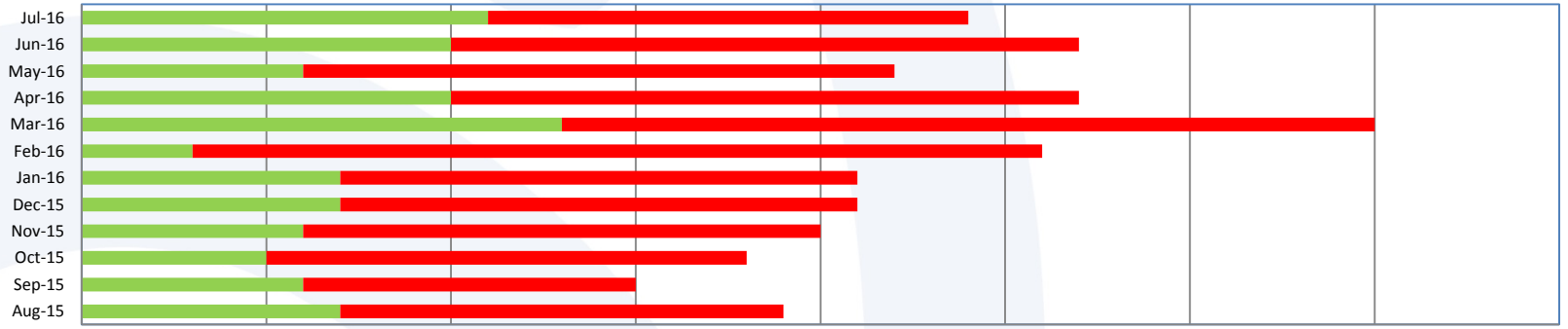
Gloucestershire Care Services NHS
NHS Trust

Quality Strategy metrics - strategic objective 2

	2015/16 Outturn	Target	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	2016/17 YTD
Percentage of service users recommending the Trust as a place of care	**95.2%**	**More than 90%**	**96.1%**	**93.5%**	**94.7%**	**94.6%**	**94.8%**	**95.2%**	**95.3%**	**95.3%**	**95.3%**	**95.3%**	**95.3%**	**95.3%**	**95.3%**
Measured increase in the number of service users who feel appropriately involved in their care and treatment	**95.0%**	Equal or more than 95%	**95.2%**	**93.4%**	**94.6%**	**94.0%**	**94.7%**	**94.2%**	**97.5%**	**97.0%**	**93.9%**	**94.3%**	**94.5%**	**94.8%**	**94.4%**
Increasing the number of service users who feel treated with dignity and respect	**98.3%**	Equal or more than 98%	**98.4%**	**97.9%**	**97.9%**	**98.5%**	**98.5%**	**98.3%**	**99.1%**	**97.0%**	**98.0%**	**97.9%**	**98.1%**	**98.1%**	**98.0%**
Increased response rates of service users completing the Friends and Family Test	**5.4%**	More than 4.6%	**5.4%**	**4.8%**	**5.7%**	**5.5%**	**5.0%**	**4.3%**	**4.2%**	**4.6%**	**4.2%**	**4.0%**	**4.2%**	**4.8%**	**4.4%**
Increase in the number of public focus / discussion groups per quarter	**23**	Two topics per quarter	**3 (Jul-Sept 2015)**		**13 (includes Healthwatch event, work with the VCS, Forest engagements etc.)**			**5**			**8 (Apr-Jun 2016)**			**TBC**	

Transitions from one service to another, for people on care pathways, are made smoothly

Below are the details of transfers into community hospitals wards between 23:00 and 05:59:



	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Direct Admission	7	6	5	6	7	7	3	13	10	6	10	11
Transfer	12	9	13	14	14	14	23	22	17	16	17	13

A patient transfer audit has yet to be fully completed, as the Investigating Officer is still awaiting information from partner organisations, in particular, Arriva transport regarding details of times transport has been booked.

Initial findings note the following 3 areas of further work:

1. Data entry - work has started with wards to ensure they record receiving patients in a timely way to improve data validity.
2. Responsibility for Booking Transport is not by one service and dependent on the location of the patient. It is not known if Arriva transport service responds differently, dependent on the location of the patient, or by the organisation making a request.
3. Incident Reporting – work is underway with the teams to remind them of the importance of Incident reporting.

Interim Recommendations

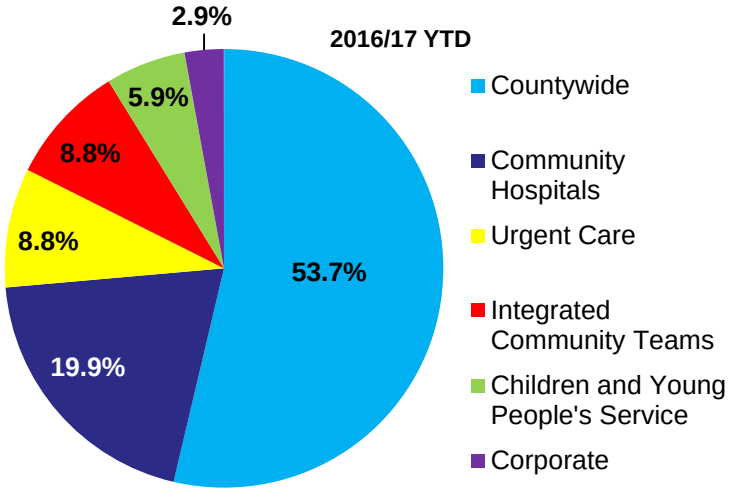
1. Identify way to support recording of patient on system on arrival and follow up with the detailed records after patient is on the ward.
2. Undertake a regular transport meeting with SWAST/Arriva as appropriate, in which late transfers can be collectively monitored and addressed.
3. Highlight the requirement for staff to complete Datix incident reports for all late transfers.

It should also be highlighted that the Trust's Head of Capacity has also been identified as the Trust's 'transport' lead. and will progress activities with Commissioners and any risks associated with patient care.

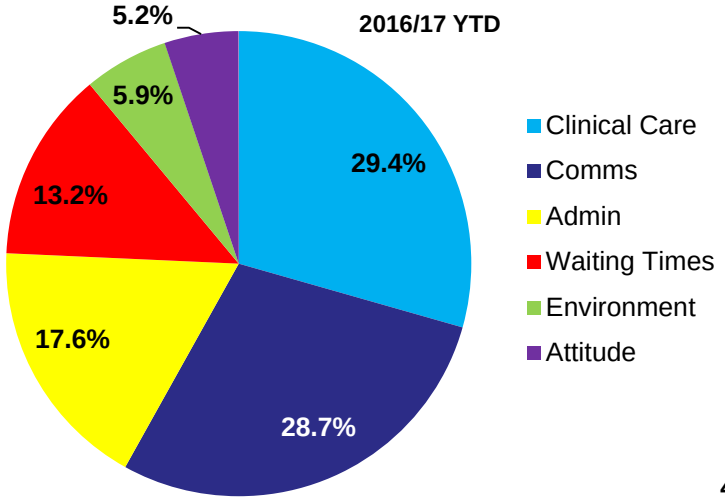
When people use NHS services, their safety should be prioritised and they should be free from mistakes, mistreatment and abuse

Below are details of reported concerns:

Concerns	Aug -15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May -16	Jun-16	Jul-16	2016/17 YTD
Countywide	9	8	10	12	11	17	6	15	15	17	16	25	73
Community Hospitals	4	3	7	5	6	2	9	2	9	3	11	4	27
Urgent Care	3	7	1	5	3	4	2	2	0	2	5	5	12
ICTs	2	6	7	1	1	0	3	5	1	3	2	6	12
CYP Services	1	1	1	0	1	1	2	5	2	1	2	3	8
Corporate	1	0	4	5	2	0	4	2	2	2	0	0	4
Total	20	25	30	28	24	24	26	31	29	28	36	43	136

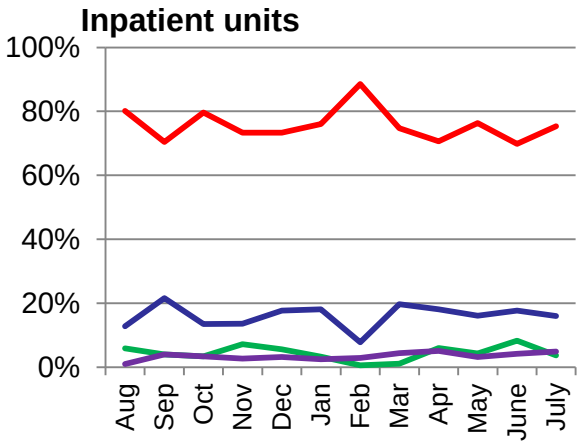


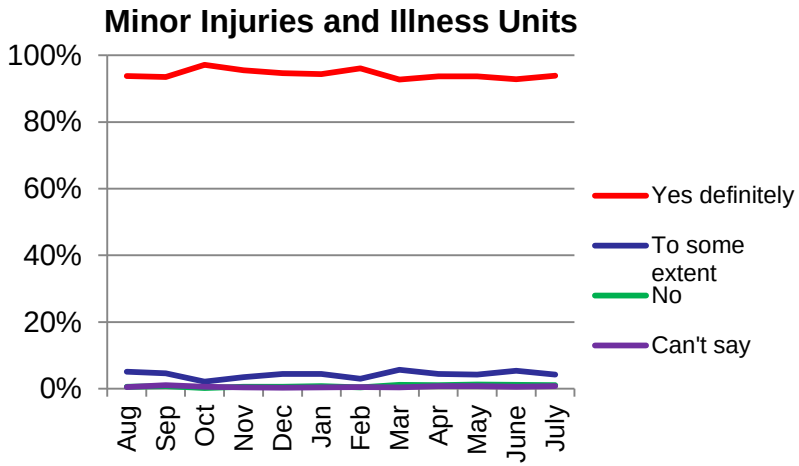
Concerns	Aug -15	Sep -15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May -16	Jun-16	Jul-16	2016/17 YTD
Clinical Care	10	9	6	4	7	7	6	6	10	7	8	15	40
Communications	3	8	11	9	5	10	8	11	6	9	17	7	39
Admin	3	3	4	10	4	5	7	7	9	9	0	6	24
Waiting Times	1	2	5	3	5	1	1	4	3	2	5	8	18
Environment	3	1	1	1	1	1	3	2	0	1	3	4	8
Attitude	0	2	3	1	2	0	1	1	1	0	3	3	7
Total	20	25	30	28	24	24	26	31	29	28	36	43	136



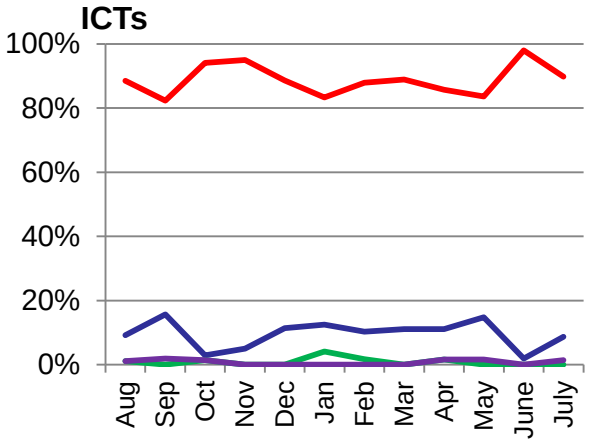
People are informed and supported to be as involved as they wish to be in decisions about their care

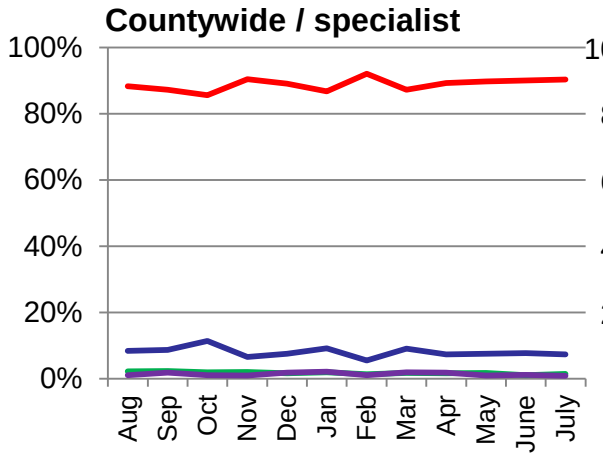
"Were you involved as much as you wanted to be in decisions about your care and treatment?"

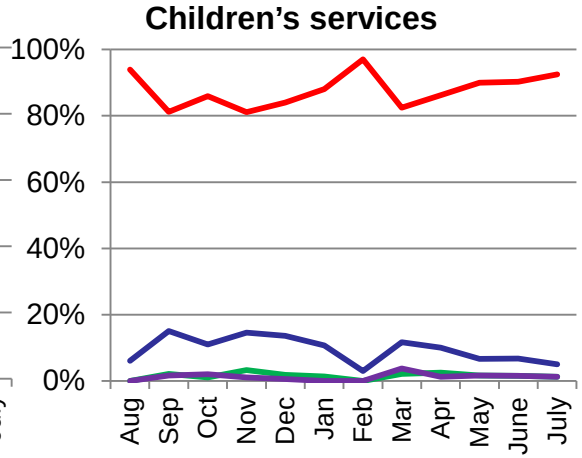




Please note that data for a number of services is based on a small sample so may not be wholly representative



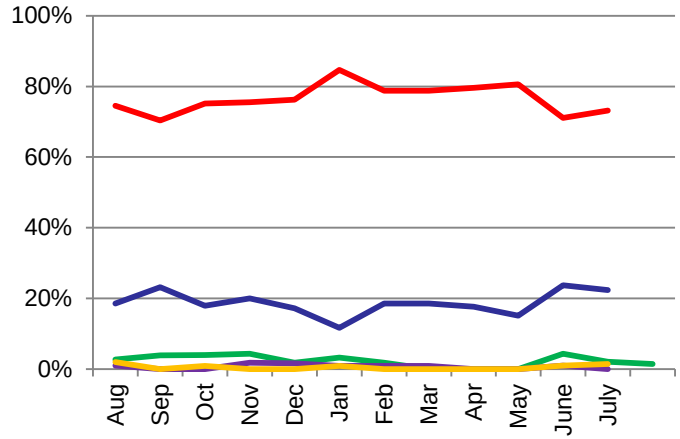




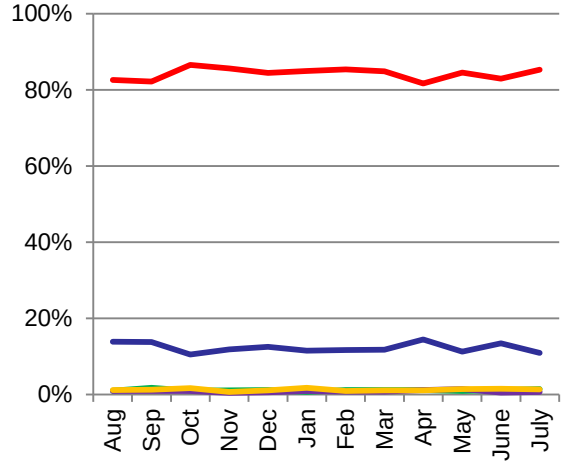
People report positive experiences of the NHS (1)

Friends and Family Test outcomes best indicate positive experiences of service users:

Inpatient units

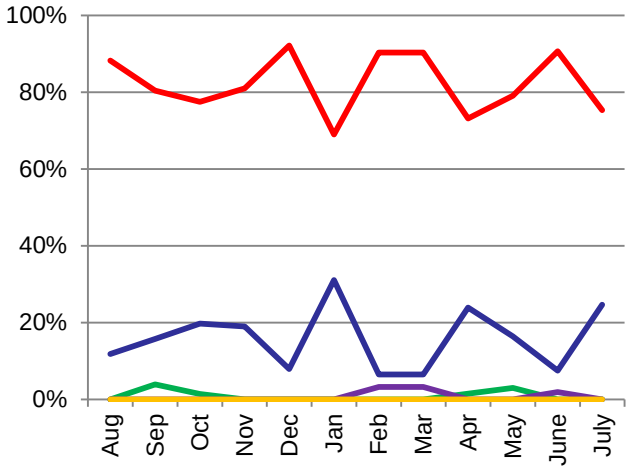


Minor Injuries and Illness Units

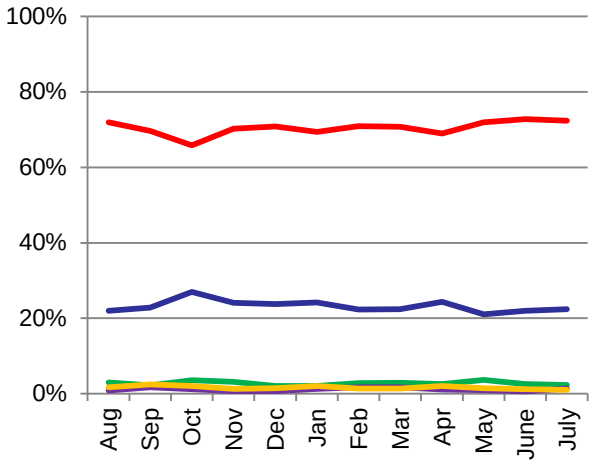


Please note that data for a number of services is based on a small sample so may not be wholly representative

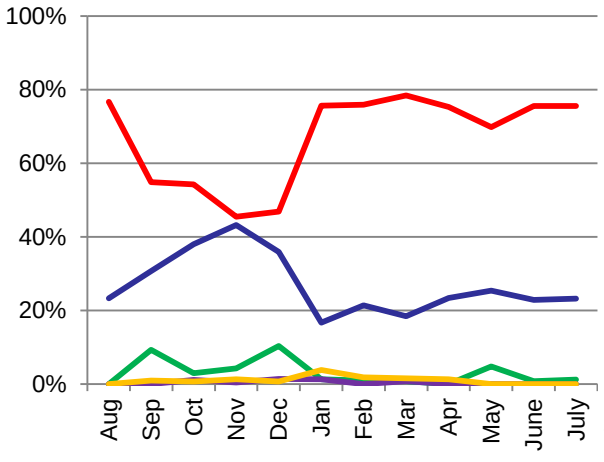
ICTs



Countywide / specialist



Children's services



People report positive experiences of the NHS (2)

Gloucestershire Care Services NHS Trust

We received 14 NHS Choices comments in July which were shared with the relevant teams:

Service	Themes	Positive	Negative
Tewkesbury Hospital	• I visited the physiotherapy department a number of times following a hip replacement and was delighted with the service I received. I can't thank you enough.	1	0
Tewkesbury MIIU	• I went in with a large burn, was seen very quickly and felt safe and looked after. • Wonderful minor injury nurses. They helped make a very traumatic experience that little bit easier with their professionalism, kindness and support. • Fantastic treatment for our baby son... the staff were very supportive, reassuring and acted immediately. We can't thank them enough for treating our son calmly, quickly & compassionately.	3	0
Cirencester MIIU	• Terrible service once again. Attended with a small child with breathing problems to be told he was fine and left waiting for over 40 minutes while staff were on a tea break, and on social media. Staff were rude and incompetent will not attend again. • Was seen straight away, treatment completed quickly, very good service.	1	1
Vale MIIU	• Came in on Saturday morning and seen immediately by professional and knowledgeable staff. • A wonderful local service, the staff were friendly and welcoming from reception to nurses.	2	0
Stroud MIIU	• Lovely staff, very friendly also very clean and professional. • My son's experience was made much more bearable by a really kind and gentle approach. • Rang to confirm they could see a child this evening. “Yes, we see patients till 10pm” was the reply. Half hour drive to Stroud only to be told “sorry we only see patients till 9.30pm”.	2	1
Stroud Hospital	• My husband never finds that practitioners take the time to understand his problems. However, at Stroud physiotherapy dept they did, and it made such a difference to the way this made him feel. • I attended day surgery on the Princess Elizabeth Ward. The staff were extremely friendly and provided exceptional care and eased my worries about being there.	2	0
Dental Access Centres	• Left in agony! Agonising dental pain on a Saturday morning. Received a call back from a triage nurse, who in a few minutes, mange to convey a complete lack of empathy, implied that I was using the service for convenience, and that if my pain was that bad I would have called sooner (I tried to manage the pain for a couple of days hoping it would get better not worse), and was so keen to end the call (it was nearly time for them to go home) I wished that I hadn't bothered!	0	1

Freedom of Information Requests

In July, the Trust received 20 Freedom of Information (FOI) requests re:

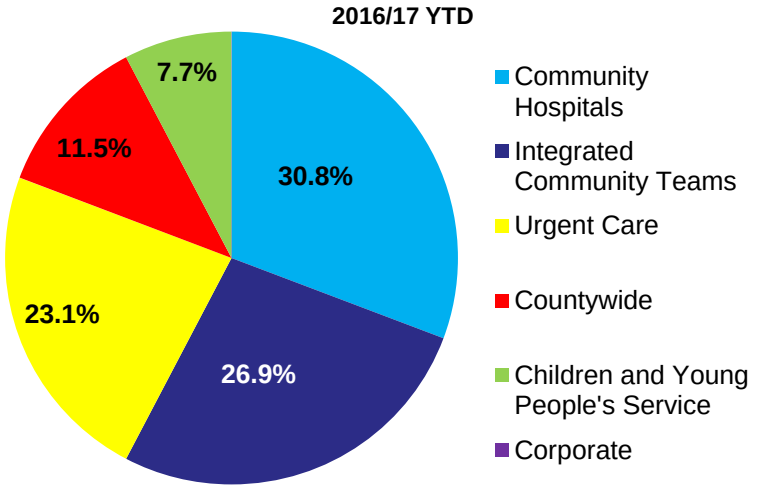
- use / pay of agency / bank staff including locum doctors, nurses etc (x4)
- doctors partaking in fellowship programmes (x3)
- workforce queries (substantive absences, recruitment and leavers, total spend) (x3)
- organisational structures for CAMHS / learning disability services (x2)
- the ICT Service Desk
- carbon monoxide poisonings seen in MIIUs / A&E
- energy efficiency
- register of payments from pharmaceutical companies
- blood pressure devices
- spend on continuing healthcare
- continence care
- telephony contracts

Of all FOI requests due to be answered in July, the following was achieved:

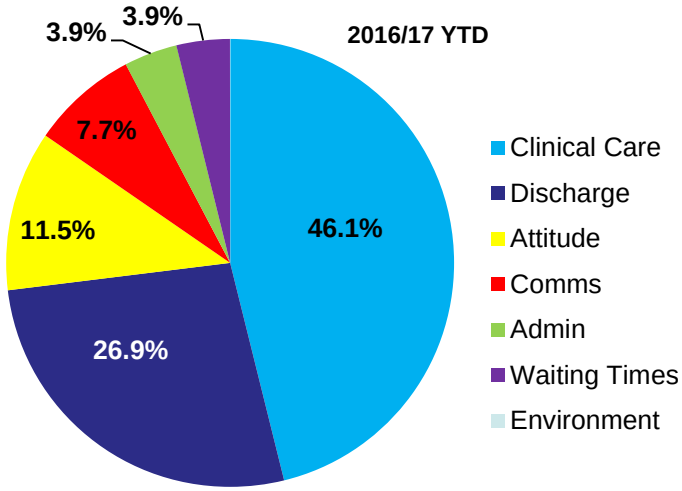
	Number due in month	Number replied in month	Total % in month	Year-to-date %
Target time within agreed timescale (20 working days)	**15**	**15**	**100%**	**100%**

People's complaints about services are handled respectfully and efficiently

Complaints	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	2016/17 YTD
Community Hospitals	1	2	5	3	2	5	3	0	2	2	2	2	8
ICTs	0	0	3	1	1	2	2	2	2	1	1	3	7
Urgent Care	3	9	0	0	1	1	2	0	3	2	1	0	6
Countywide	0	0	1	0	2	1	1	4	0	1	0	2	3
CYP Services	1	0	3	0	0	0	0	1	1	0	0	1	2
Corporate	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	5	11	12	4	6	9	8	7	8	6	4	8	26



Complaints	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	2016/17 YTD
Clinical Care	4	10	6	1	3	6	5	3	5	2	1	4	12
Discharge	1	0	1	1	1	2	1	0	1	2	2	2	7
Attitude	0	0	0	0	1	1	1	1	1	1	1	0	3
Communications	0	0	3	0	0	0	0	3	0	1	0	1	2
Admin	0	1	0	2	0	0	0	0	1	0	0	0	1
Waiting Times	0	0	1	0	1	0	1	0	0	0	0	1	1
Environment	0	0	1	0	0	0	0	0	0	0	0	0	0
Total	5	11	12	4	6	9	8	7	8	6	4	8	26



People's complaints about services are handled respectfully and efficiently (cont)

	2016/17			
Response Time	**Q1**	**Q2**	**Q3**	**Q4**
Target time within agreed timescale (25 working days)	92.3%	TBC		

There have been no complaints referred to the Parliamentary Health Service Ombudsman (PMSO) during July 2016.

Benchmarking	
Complaints per 1,000 WTE staff (GCS)	3.4 average per month, August 2015 – July 2016
Complaints per 1,000 WTE staff (Aspirant Community Foundation Trust Group)	5.7 average per month, Latest 6 months (February 2016 – July 2016)

Strategic Objective 3:
Actively engage in partnerships with other health and social care providers in order to deliver seamless services

Quality Strategy metrics - strategic objective 3

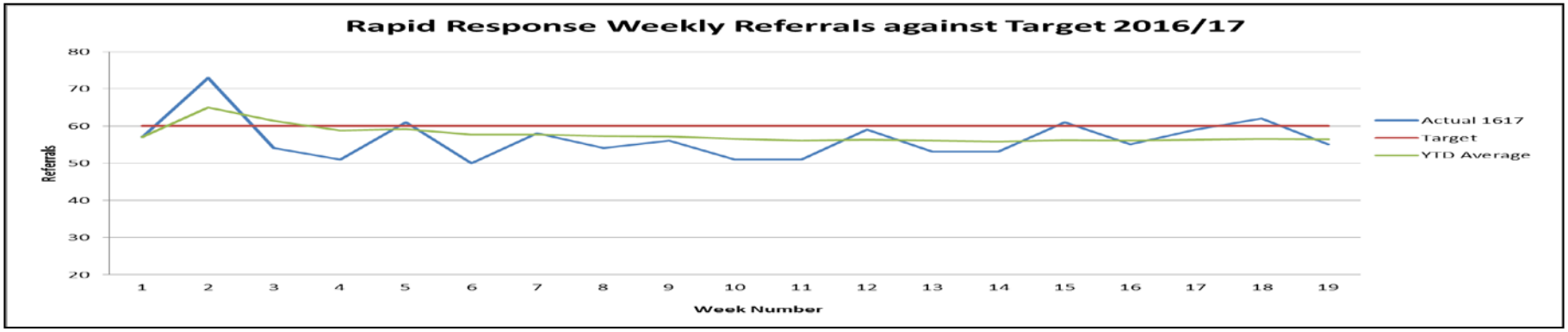
	2015/16 Outturn	Target	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	2016/17 YTD
% CQUIN milestones achieved against agreed plan	**96% - TBC**	n/a	**100% (Jul-Sept 2015)**		**100% - TBC**			**83.3% - TBC**			**TBC**				**TBC**
% QIPP milestones achieved against agreed plan	**81.6%**	n/a	**81.5%**		**80.0%**			**70.6%**			**TBC**				**TBC**
Number of referrals accepted by Rapid Response service	3,120	Target	265	256	265	257	263	263	246	263	257	266	257	266	1,046
	2,642	Actual	**239**	**264**	**244**	**214**	**223**	**213**	**224**	**276**	**257**	**232**	**236**	**264**	**989**
Number of avoided admissions as a result of ICT intervention	**97.0%**	80%+	**97.9%**	**97.0%**	**98.0%**	**98.0%**	**98.2%**	**95.8%**	**93.7%**	**97.9%**	**96.5%**	**89.7%**	**90.6%**	**96.0%**	**93.2%**
Number of service users discharged by the IDT from the acute Trust Emergency Department	**114 average per month**	280 per month	**96**	**119**	**119**	**121**	**108**	**118**	**104**	**125**	**88**	**126**	**114**	**112**	**110**
Number of service users discharged by the IDT from the acute Trust ACU (same day)	**34 average per month**	56 per month	**33**	**37**	**30**	**20**	**39**	**27**	**25**	**26**	**33**	**25**	**31**	**33**	**31**

Rapid Response - Key Indicators

Gloucestershire Care Services NHS Trust

Indicator	15/16 Outturn	Target	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	2016/17 YTD
Number of referrals accepted (plan)	3,120	Target	265	256	265	257	263	263	246	263	257	266	257	266	1,046
Number of referrals accepted	2,639	Actual	239	264	244	214	223	213	224	276	257	232	236	264	989
% of patients with assessment initiated within 1 hour	88.7%	95%	95.1%	95.8%	96.9%	96.1%	98.5%	95.1%	57.9%	45.5%	62.9%	52.0%	69.7%	54.3%	59.7%
% of patients referred from SPCA who have an agreed patient led care plan in place	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% of patients where SPCA reports that rapid response intervention avoids acute hospital admission	97.0%		97.9%	97.0%	98.0%	98.0%	98.2%	95.8%	93.7%	97.9%	96.5%	89.7%	90.6%	96.0%	93.2%
Number of referrals where SPCA reports that rapid response intervention avoids acute hospital admission	2,319		227	253	236	206	219	204	119*	140*	138	122	115	144	519

*direct referrer is only asked where referral is via SPCA and collected on SystmOne

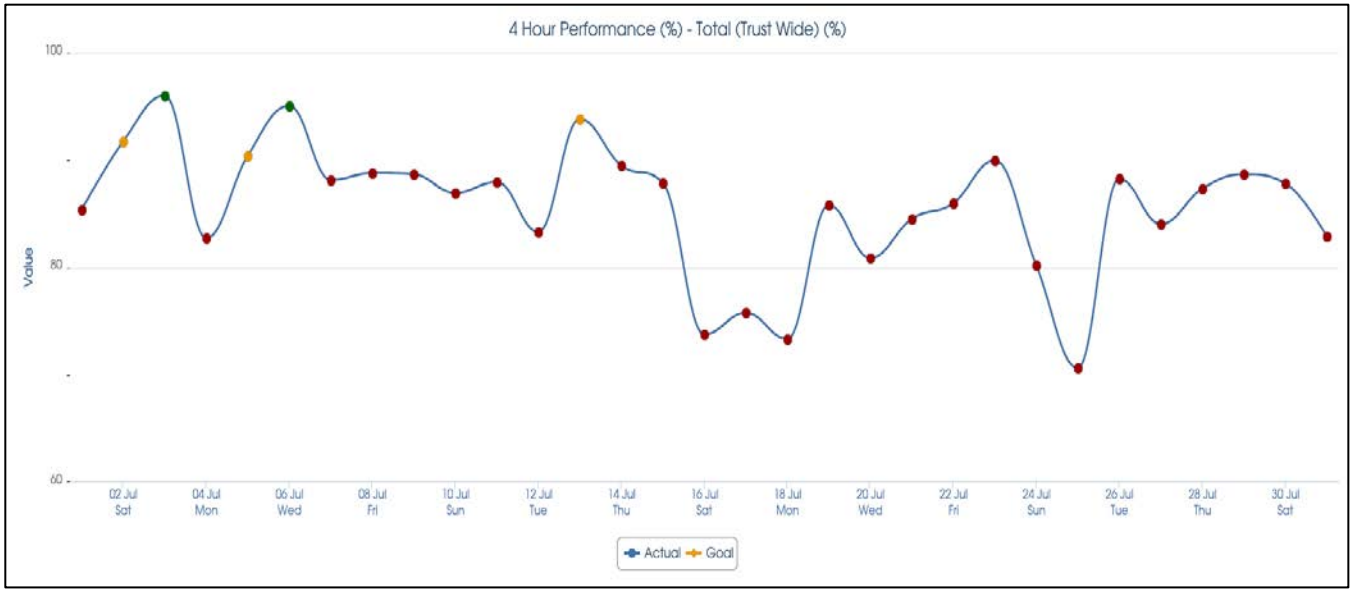


Rapid response referrals:
RR practitioner (RRP) continued presence in SPCA to ensure the right RR clinical pathways are chosen at point of referral. Care Home project has linked RRPs assigned to 4 care homes around the county to improve their clinical knowledge on the deteriorating patient and facilitating a direct referral in to RR (as SPCA is not able to take care Home referrals). Increased referrals noted.

RR attendance in GP Cluster meetings is raising the awareness of the service; will continue with case reviews of respiratory patients in Stroud and Berkeley Vale cluster planned for Sept. Trajectory of referrals appear to be upwards and commissioners have confirmed this is showing in the future trend data.

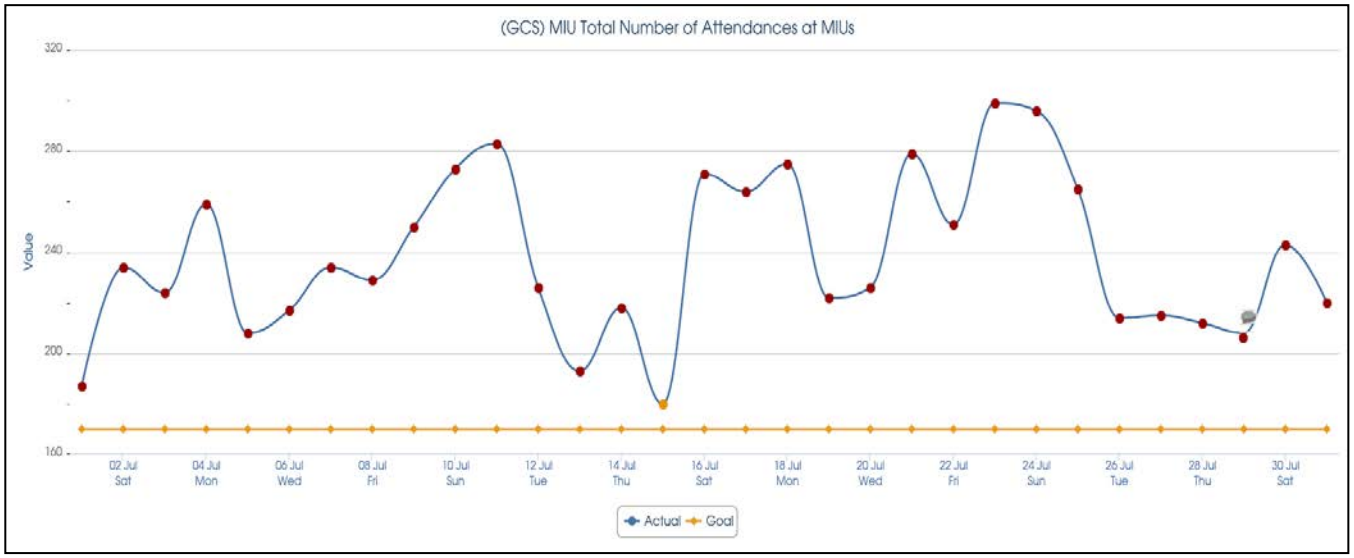
A senior RR practitioner seconded into ED front door to work alongside the Admission Prevention Team for 3 months completes at the end of August; plan to replace this resource with other senior RRP, though not as a continuous resource, while the development of the APT progresses.

Alamac - Gloucestershire Health Community reporting



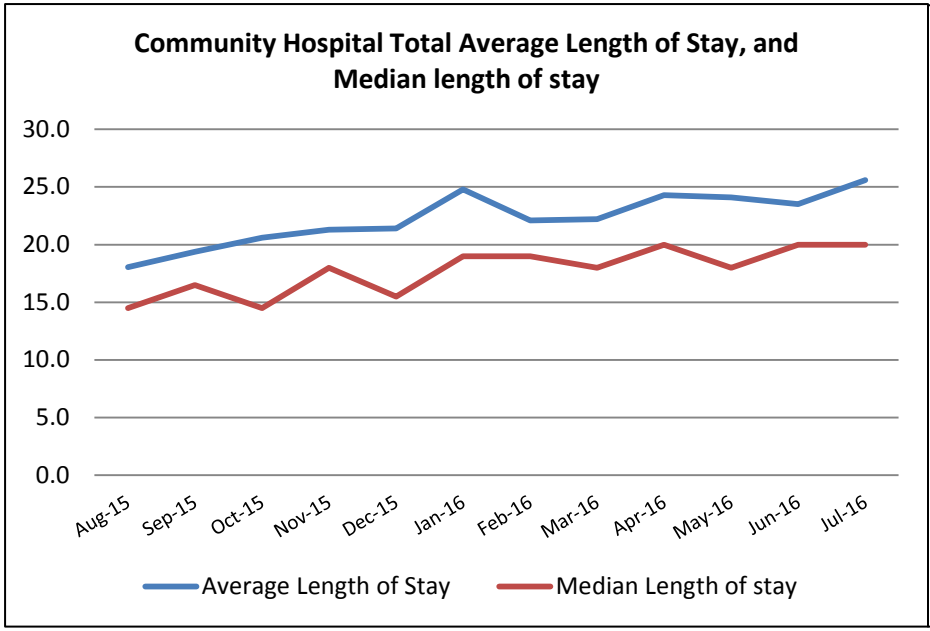
The Alamac System helps the Trust to deliver safer patient care and to improve its performance with regards to patient flow. It has now been adopted by a number of other NHS providers including GHFT and SWASTFT.
The charts provide a number of the headline measures reviewed.

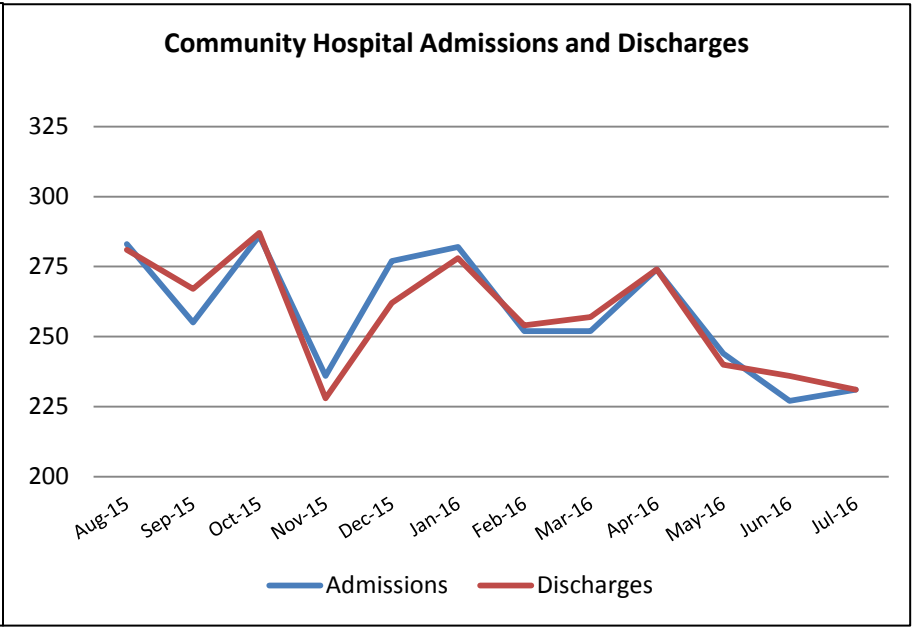
Countywide Emergency Department and Minor Illness and Injury unit performance compared to 4 hour target – performance was achieved twice during July



GCS Minor Illness and Injury unit attendances during July 2016.
This shows fluctuation in number of attendances, all above goal set.

Community Hospitals - Average Length of Stay





	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	12 Month Total
Average Length of Stay	18.0	19.4	20.6	21.3	21.4	24.8	22.1	22.2	24.3	24.1	23.5	25.6	22.3
Median Length of Stay	14.5	16.5	14.5	18.0	15.5	19.0	19.0	18.0	20.0	18.0	20.0	20.0	17.8
Admissions	283	255	286	236	277	282	252	252	274	244	227	231	3,099
Discharges	281	267	287	228	262	278	254	257	274	240	236	231	3,095

Bed occupancy remained high and direct admissions remain low (less than 30%). These factors affect the length of stay, evidence shows direct admissions have a shorter length of stay. Currently the pressure across the whole system in Gloucestershire remains high which drives the requirement to use all community hospital beds to support transfers from GHFT as soon as they become available.

Patient flow workshop was held in April including IDT, SPCA, Inpatient, ICT, referral centre and social work staff to improve networking and communication across the teams aiming to reduce the length of stay. Listening into Action teams are now formed to support work including improving data, improved communication and team working, acuity tool and discharge to assess. Work also continues with the Healthwatch report discharge recommendations.

The Reablement service has introduced a centralised referral process from July which appears to have improved the process of discharging patients from Community hospitals to home with reablement. Delayed discharges from community hospitals are currently mostly attributable to waiting for packages of care to become available.

Strategic Objective 4:
Value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision

Quality Strategy metrics - strategic objective 4

	2015/16 Outturn	Target	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	2016/17 YTD
Staff recommending the Trust as a place to work	**47%**	More than 60%	**51% (July-Sept 2015)**		**n/a**			**37%**			**50%**			**TBC**	**50%**
Percentage of annual staff appraisals	**77.3%**	More than 95%	**76.8%**	**76.1%**	**77.6%**	**78.6%**	**78.7%**	**77.7%**	**79.4%**	**76.3%**	**74.7%**	**70.7%**	**66.2%**	**70.3%**	**70.5%**
Completion of all mandatory training	**81.1%**	100%	**80.4%**	**79.4%**	**80.4%**	**82.2%**	**82.1%**	**80.8%**	**81.7%**	**81.8%**	**68.5%**	**72.9%**	**74.1%**	**80.3%**	**73.9%**

- Note: mandatory training performance reported on this summary is based on the 5 requirements as reported in 2015/16 to enable direct comparison.
- Reports have been developed to extend this to include Safeguarding, Moving and Handling, Infection Control, Resuscitation and PREVENT compliance. Performance against these measures is included on page 55 of this report.

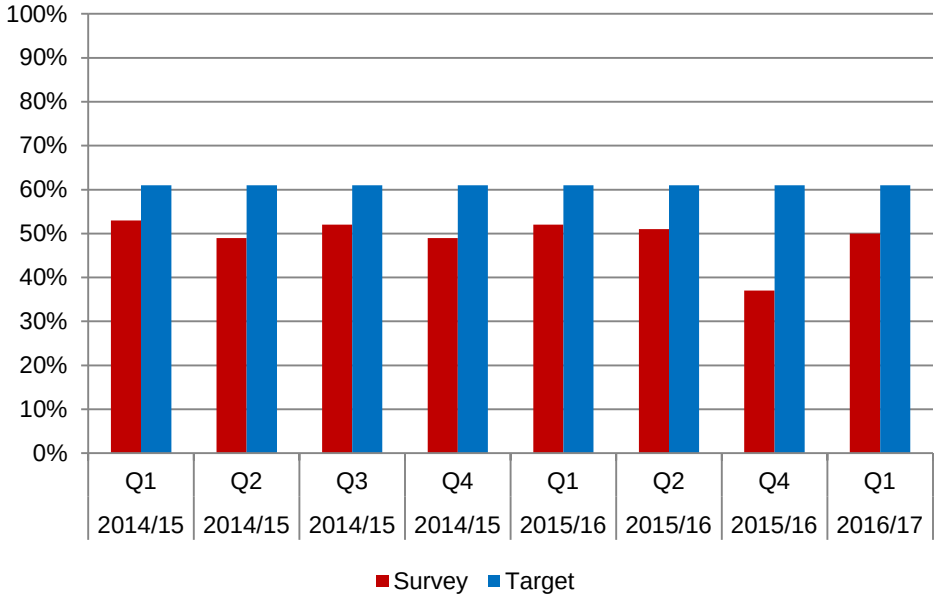
Gloucestershire Care Services NHS
NHS Trust

Staff Friends and Family Test

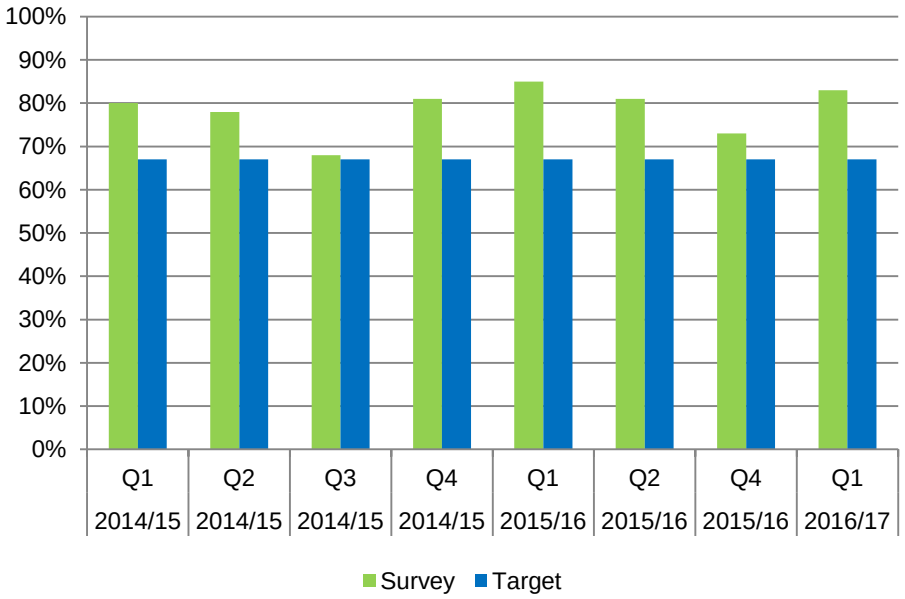
	2014-15				2015-16				2016-17
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Percentage of staff who would recommend the Trust as a place of work	53%	49%	52%	49%	52%	51%		*37%	50%
Percentage of staff who would recommend the Trust as a place to receive treatment	80%	78%	68%	81%	85%	81%		*73%	83%

**Note: only collected by staff based at Edward Jenner Court, Gloucester. Workshops are in place in July 2016 to explore and understand the reason for the low scores.*

Place of work



Place of treatment

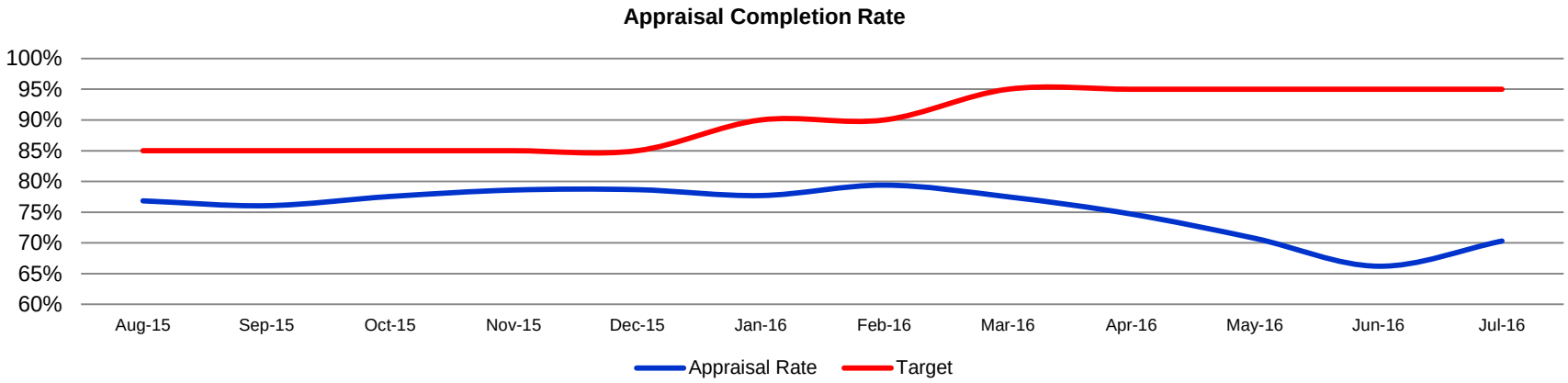


More detailed report provided to Workforce & OD Committee

Sickness absence /appraisals

	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Target
Sickness absence average % rolling rate - 12 months	4.84	4.88	4.85	4.85	4.74	4.71	4.68	4.67	4.69	4.62	4.53	4.52	**4.00**
Sickness absence % rate (1 month only)	5.04	4.93	5.09	4.21	3.91	4.73	4.56	4.37	4.53	3.85	3.76	4.25	**4.00**

	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Target	85%	85%	85%	85%	85%	90%	90%	95%	95%	95%	95%	95%
Appraisal Rate	76.8%	76.1%	77.6%	78.6%	78.7%	77.7%	79.4%	77.5%	74.7%	70.7%	66.2%	70.3%



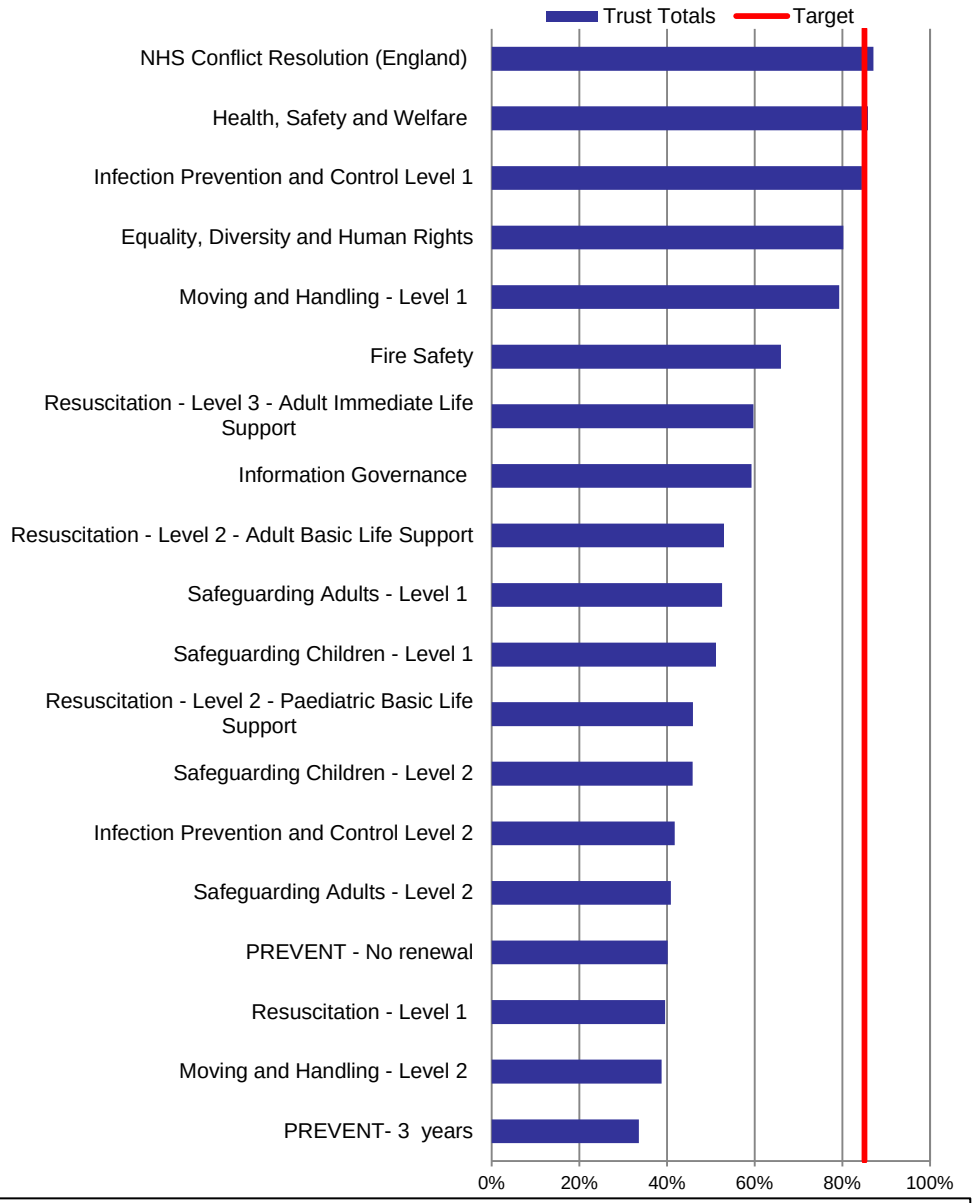
Appraisal completion rates showed an increase in July but remain well below target. Option exists for managers to reschedule appraisals between April to September if this will assist with planning and completion. The onus remains on managers to ensure appraisals are scheduled, completed and reported. If there is not significant improvement, operational managers will be asked to explain to the Workforce and OD Committee why they cannot achieve the required compliance.

Mandatory training

July 2016 performance

Gloucestershire Care Services NHS
NHS Trust

Mandatory Training Courses	Target	Trust Totals
NHS Conflict Resolution (England)	85%	87.1%
Health, Safety and Welfare	85%	85.8%
Infection Prevention and Control Level 1	85%	84.4%
Equality, Diversity and Human Rights	85%	80.3%
Moving and Handling - Level 1	85%	79.3%
Fire Safety	85%	66.0%
Resuscitation - Level 3 - Adult Immediate Life Support	85%	59.7%
Information Governance	85%	59.2%
Resuscitation - Level 2 - Adult Basic Life Support	85%	53.0%
Safeguarding Adults - Level 1	85%	52.6%
Safeguarding Children - Level 1	85%	51.2%
Resuscitation - Level 2 - Paediatric Basic Life Support	85%	45.9%
Safeguarding Children – Level 2	85%	45.8%
Infection Prevention and Control Level 2	85%	*41.7%
Safeguarding Adults – Level 2	85%	40.9%
PREVENT - No renewal	85%	*40.1%
Resuscitation - Level 1	85%	*39.5%
Moving and Handling - Level 2	85%	*38.7%
PREVENT- 3 years	85%	*33.5%



This matrix shows performance for the full range of mandatory training requirements based of the cohort of staff that are required to complete each element.

- Those marked * above are new requirements from April 2016.
- Managers have been provided with details of training and target to ensure staff receive these elements of training by October 2016. Training team are working with managers to facilitate training sessions locally (1 day / 2 day).

Health and safety - RIDDORs 2016-17

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

A RIDDOR incident is one that is reportable to the Health and Safety Executive (HSE) as a result of it causing:

- **death or serious injury** - this includes fractures of all but fingers and toes;
- **inability of the injured party to work** (i.e. the injured party is not available for work for more than 7 days);
- **inability of the injured party to work normally** (i.e. the injured party is not available to work normally, including on light duties, for more than 7 days.

	Aggression or violence towards staff	Manual handling	Occupational ill health confirmed or suspected	Slips, trips and falls	Falling object / struck against	Hot, poisonous or corrosive substances	2016-17 Total	2015-16 Total
Service user / visitor	-	-	-	-	-	-	**0**	**1**
Colleague	-	1	-	4	-	-	**5**	**15**
Bank / agency	-		-	-	-	-	**0**	**0**
Total	**0**	**1**	**0**	**4**	**0**	**0**	**5**	**16**

RIDDOR details
District Nurse from Gloucester ICT carrying out patient dressings at sheltered premises (manual handling)
District Nurse from Cheltenham ICT slipped in unlit area outside service user's residence (slips, trips and falls)
District Nurse slipped off the kerb when returning to car (slips, trips and falls)
District Nurse slipped off step on service user's premises when taking waste to the bin (slips, trips and falls)
Colleague slipped on newly mopped floor (despite clear signage in place)

Clinical Alert System (CAS) No overdue CAS alerts have been identified this year.

Health and safety - Incidents

2015-16

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Verbal Abuse	7	6	5	3	10	12	6	14	9	6	4	8	**90**
Needlestick	6	2	6	8	8	6	3	6	6	10	5	4	**70**
Buildings issues	7	3	5	7	6	3	6	7	4	6	9	6	**69**
Assault	5	6	1	7	4	8	9	3	4	8	5	1	**61**
Moving Handling	8	4	6	5	8	5	1	5	2	3	8	2	**57**
Slips/Trips/Falls	1	2	2	4	7	4	5	4	3	6	5	3	**46**
Stepping/Striking	-	1	-	1	-	1	3	-	2	-	1	1	**10**
Animals	-	1	2	-	1	-	-	-	-	2	-	-	**6**
TOTAL	**34**	**25**	**27**	**35**	**44**	**39**	**33**	**39**	**30**	**41**	**37**	**25**	**408**

2016-17

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Assault	3	13	6	8									**30**
Verbal Abuse	6	9	1	6									**22**
Buildings issues	3	3	3	1									**10**
Slips/Trips/Falls	1	1	2	2									**6**
Moving Handling	5	1	4	1									**11**
Stepping/Striking	5	-	2	2									**9**
Needlestick	-	1	1	1									**3**
Animals	7	7	8	10									**22**
TOTAL	**30**	**35**	**27**	**31**									**113**

Strategic Objective 5:
Manage public resources wisely to ensure local services remain sustainable and accessible

*Detailed Finance report will be provided separately.

Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 20th September 2016

Agenda Item:	14
Agenda Ref:	14/0916
Author:	Tina Ricketts, Director of HR
Presented By:	Nicola Strother Smith
Sponsors:	Nicola Strother Smith

Subject:	Workforce & OD Committee Update Report

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

Executive Summary:

As a standing agenda item, this report provides the Board with a summary of the key workforce risks and areas of underperformance. The report summarises the information considered by the Workforce & OD Committee in August 2016 to seek assurance regarding these matters and notifies the Board of items that were approved at the meeting.

The key items to note are:

- The continued improvement in mandatory training compliance
- The improvement in appraisal completion rates since the last reporting period (now at 75%)
- The continued improvement in the Trust's sickness absence rates (now at 4.5%)
- The work that is being undertaken to improve staff recommending the Trust as a place to work (internal engagement schemes, freedom to speak up guardian, listening into action schemes and embedding the core values initiatives
- The work that is being undertaken to reduce the Trust's agency spend (recruitment of relief team, incentives and weekly payroll for bank staff)

Recommendations:

The Board is asked to note the actions being taken to implement the Workforce and OD Strategy and to mitigate the key workforce and organisational development risks.

Considerations:

Quality implications:

The Workforce and Organisational Development strategy has been put in place to support the delivery of high quality care. The role of the Workforce & OD Committee is to oversee the effectiveness of the strategy and to ensure that actions are prioritised to mitigate risks to the quality of services provided.

Human Resources implications:

Human Resource accounts for 75-80% of the Trust's expenditure and therefore it is essential that we manage this resource wisely in line with our strategic objectives.

Equalities implications:

None identified

Financial implications: None identified
Does this paper link to any risks in the corporate risk register: Yes – this paper links to all workforce risks
Does this paper link to any complaints, concerns or legal claims No

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

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

Reviewed by (Sponsors):	Nicola Strother Smith

Date:	

Where in the Trust has this been discussed before, e.g. Committee, Programme Board, Group?
Workforce & OD Committee Workforce & OD Steering Group Workforce Education & Development Group

Explanation of acronyms used:

Contributors to this paper include:
Lindsay Ashworth, Head of HR Linda Gabaldoni, Head of OD Sonia Pearcey, Ambassador for Cultural Change

Workforce & Organisational Development - Board Report September 2016

1.0 Introduction

This report provides a summary of the key agenda items considered by the Workforce & OD Committee at its meeting on 24th August 2016. Attached in appendix 1 are the approved minutes of the meeting held on 13th June 2016.

The Committee is responsible for overseeing the development and implementation of the Trust's Workforce & Organisational Development (OD) Strategy, for seeking assurance that the Trust is aware of all key workforce & OD risks and that appropriate actions are being taken to mitigate these.

As a reminder to the Board the strategic workforce and organisational development priorities are:

- To ensure that a robust recruitment and retention plan is in place so that the Trust has the right staff with the right skills in the right place at the right time
- To develop and sustain a culture that engages and motivates colleagues
- To ensure that colleagues have the necessary knowledge, skills and expertise to deliver best care
- To ensure that the Trust has the necessary leadership capability and capacity to deliver on the sustainability and transformation agenda

The key workforce and organisational development operational risks are summarised in the following table by theme:

Table 1: Risks by Theme

Organisational Development	Workforce
Culture to support freedom to speak up/ speak up safely – the CQC report states that the threshold for reporting incidents within the Trust was too high and that improvements need to be made in how learning from incidents are shared across the organisation ***Leadership capability and capacity*** – insufficient leadership capability and capacity within the organisation may be impacting on the pace of service transformation and the achievement of appraisal and mandatory training compliance ***Staff satisfaction –*** the listening into action pulse check, staff friends and family test and NHS staff survey results all indicate that staff engagement and satisfaction requires improvement	***Workforce capacity to meet demand*** – the increase in demand on services coupled with vacancy rates within qualified nursing and Allied Health Professions may impact on the quality and level of service provided. This may also be having an impact on colleague morale and sickness absence as colleagues frequently report that they do not have enough resources to meet demand ***Workforce development*** – the lack of an overall workforce development plan linked to the Trust's Integrated Business Plan may impact on the pace of future service transformation and development

To monitor the effectiveness of the strategy, a number of key performance indicators are monitored by the Committee and the areas requiring improvement as at 31st August 2016 are as follows:

Table 2: Key workforce performance indicators as at 31st August 2016

Key Performance indicator	**Performance as at 31st March 2016**	**Performance as at 31st August 2016**	**Target by 31st March 2017**
Appraisal completion rate	77.5%	75%	95%
Staff FFT (recommending Trust as a place to work)	37%	50%	60%
Mandatory Training (includes all mandatory elements)	Comparable data not available	62%	95%
Sickness absence	4.7%	4.5%	4.0%
Turnover	15%	15%	12%

The full workforce scorecard is attached in appendix two.

2.0 Items the Committee NOTED that the Board should be aware of

2.1 Review of the Trust's Workforce and OD Strategy against national guidance

In July 2016 the National Quality Board issued guidance on safe sustainable and productive staffing (https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf). Whilst this document is centred on workforce (as opposed to the wider organisational development agenda) a gap analysis was been undertaken to ascertain whether the Trust's strategy aligns to this guidance.

This analysis identified that further work should be undertaken by the Trust in the following areas:

Identified Gap
1. Do workforce plans contain sufficient provision for planned absence? (e.g. training, mentor responsibilities etc.)
2. Does the organisation allocates significant time for team leaders, professional leads and lead sisters/charge nurses/ward managers to discharge their supervisory responsibilities?
3. Does the Trust's recruitment and retention plan contain a section on differing generational needs?
4. Is the productive series embedded across the organisation?
5. Is evidence available of the meaningful application of effective e-rostering policies?

6. Has the Trust undertaken an annual strategic staffing assessment?

The Committee noted that the strategy implementation plan would be updated to address these gaps. However, it was requested that where possible additional actions should be integrated with existing priorities.

2.2 Internal Engagement Strategy Progress Report

The Committee was presented with a progress report on the above strategy which included an update on a number of initiatives that were being taken forward by the Communications Team:

Saying thank you **-** this scheme aims to create an environment where all colleagues are encouraged to recognise each other. This may range from a simple thank you in person, sending a thank you message by email or on a printed "e-thank you card", a formal acknowledgement through the staff awards scheme or presenting the colleague with a badge representing one of the CORE values which could be displayed on lanyards.

Increasing the visibility of senior management and the executive team – this scheme will include roundtable discussions to provide colleagues with an opportunity to have an informal, valuable, lively conversation with a member of the executive team. The discussions will be rotated across the county, with each of the executive team taking it in turn to host a session.

Evolving the "Understanding You" road show events - Last year, the Understanding You road show events gave the executive team the chance to speak with – and listen to – colleagues across the Trust. The first events took place in early 2015 were well attended, but unfortunately the second wave later in 2015 had very low attendance. With this in mind, a new approach has been developed, which includes each of the executive team taking part in a short film in which they introduce themselves; describe what their role is and their priorities for the year. These films will be made widely available across the Trust at team meetings.

Line Manager tool kit - The toolkit will support managers to develop a range of communication and engagement activities to help improve engagement levels.

2.3 Workforce education and development report

The Committee was provided with an update on the progress that is being made in response to the Care Quality Commission's Quality Improvement Plan (CQC QIP) with regard to clinical supervision, mandatory and essential training. Assurance was received that all required actions were on track to be completed within the agreed timelines with the exception of mandatory training compliance.

The Committee was provided with a scorecard which detailed the current compliance rates against all of the mandatory training subjects and improvements had been seen in all areas since the last reporting period. The latest compliance figures are included in the workforce scorecard in appendix 2.

2.4 Freedom to Speak Up Report

The Ambassador for Cultural Change updated the committee on the national developments relating to the role of Freedom to Speak Up Guardian and provided assurance that the Trust had strong links with national networks.

Confirmation was received that colleagues had been approaching the Trust's Guardian as an additional route to raising concerns and/or seeking advice. At the time of reporting there had been 16 recorded contacts within the first 5 months with colleagues making contact via phone, email and face to face. The themes of the concerns raised to date include:

- Concerns about the threshold of incident reporting
- Inconsistent application of the Trust's sickness absence policy
- Concerns about staffing levels within community hospitals
- Concerns that a colleague had not declared their secondary employment
- Fairness of recruitment and selection processes
- Inappropriate behaviour of colleagues
- Inappropriate use of social media during work time
- Lack of support from manager

2.5 Listening into action progress report

The Ambassador for Cultural Change presented the Committee with a summary report highlighting the key achievements of the Listening into Action during the last reporting period. This included an update on the progress of the 14 wave three teams and schemes.

An update was provided on the Trust's progress in obtaining the Listening into Action kite mark for its commitment to the engagement and empowerment of colleagues. A self-assessment and review by the national team had highlighted that further work is required in the following areas:

- There had been a decline in the pulse check and leadership scorecard since 2015. (To address this the surveys are currently being undertaken again)
- More evidence was required of the outcomes of the LIA teams and schemes – the so what as measureable outcomes
- More evidence was required of operational teams involvement in implementing the LIA approach
- More evidence was required of patient conversations being held as part of LIA scheme development

A further review of the Trust's progress against the kite mark would be undertaken at the end of September 2016.

2.6 Embedding CORE Values Progress Report

The Head of Organisational Development presented the committee with a summary of the key achievements in the last reporting period:

- All colleagues have been issued with a Core Values Framework booklet resulting in the values being widely known and visible throughout the Trust
- The Personal Development Review (PDR) policy and form had been updated to include the core values framework
- The values had been incorporated into the 'Celebrating You Awards' this year with over 160 nominations received in the Core Values category.
- A session on the core values framework is now included within corporate induction
- The new weekly communication method for all colleagues is called 'The CORE'
- The Trust's job description template has been updated to include core values

The Committee was informed that embedding core values is one of our LiA enabling our people schemes and a dedicated team is in place to drive these activities forward. The team are currently working to further embed the values and behaviours into the recruitment processes from advert through to shortlisting and interviewing and are in the process of developing a toolkit for managers which includes one to one templates, coaching cards and workplace scenarios to prompt managers to engage their staff in core values discussions during team meetings.

2.7 Edward Jenner Court Staff Friends and Family Test Progress Report

In March 2016 the Trust undertook a staff friends and family test survey with all staff based at its headquarters in Edward Jenner Court. The results of this survey showed that the Trust scored above average for recommending the trust as a place to receive treatment but below average for recommending the Trust as a place to work.

To further understand these results and why colleagues feel the way they do, six big conversations were held in August 2016 under the Listening into Action (LiA) approach. From these big conversations three key themes were identified:

1. Leadership
2. Communication
3. Behaviours

To address the key themes, three LiA schemes have been set up which will run for a 20 week period. Good progress has already been made by the groups with a number of quick wins already identified.

2.8 Workforce Plan 2016/17 progress report

In April 2016 the Trust was required to submit a top level workforce plan to NHS Improvement to support its long term financial model. A "top down" plan was agreed through the Committee with the caveat that schemes still needed to be worked up under the Trust's cost improvement programme (CIPs), which may result in a change to the forecast reduction/increase within particular staff groups. The implications of

CIPs to the workforce plan are still being worked through by the CIP Steering Group and an update will be provided at the committee meeting in December 2016.

The Chief Operating Officer is leading the development of service development and operational plans for each service area within the Trust. This will include the requirement for each service lead to produce a three year workforce plan identifying planned and potential changes to the workforce profile including new roles and learning and development requirements. A guide to workforce planning has been issued to support this work with Health Education England attending the Workforce Steering Group to introduce the range of workforce planning tools that are available.

2.9 ***Contingent Workforce Plan***

The Head of HR provided the Committee with an overview of the Trust's contingent workforce plan which had been reviewed to support the achievement of the agency cap.

Data was shared which evidenced that Community Hospitals are the highest users of agency staffing reflecting the high level of band 5 vacancies across this service. Stroud (Cashes Green and Jubilee wards) and Cirencester (Windrush ward) remain the 3 wards with over 10% of all available hours filled by agency staff.

Three priority areas were being taken forward under this plan and these are:

- The recruitment of a relief team to reduce the reliance on agency staff
- The introduction of a weekly payroll for bank staff
- An options appraisal on the incentives that can be offered to attract more people to work on the Trust's bank

3 Items the Committee APPROVED that the Board should be aware of

3.1 Workforce Metrics

The Committee requested that a review be undertaken of the metrics that the Trust currently uses to monitor the effectiveness of the Trust's Workforce and Organisational Development Strategy. In addition, it was requested that the workforce dashboard and scorecard be reviewed to ensure that data is being triangulated so that current risks and hotspots can be easily identified.

In order to ascertain the most appropriate metrics to use, a review was undertaken of Monitor's Measurement Pick List which has been developed to support and inform Trusts of their approach to performance measurement. This full document can be reviewed here:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/365277/Strategy_development_toolkit_Measurement_pick_list_20102014.pdf

The Committee approved the following:

- A monthly workforce dashboard containing “hard” workforce metrics e.g. sickness absence rates, turnover, appraisals, mandatory training
- A quarterly workforce scorecard containing “soft” measurements e.g. staff friends and family test, pulse check, staff survey
- An annual detailed review of the Trust’s workforce e.g. age profile, participation rates, ethnicity etc.

4 Items the Committee REVIEWED and supports, but are presented for the Board to APPROVE

No items require Board approval.

Minutes of the Workforce and Organisational Development Committee

Boardroom, Edward Jenner Court

13 June 2016, 10am-12pm

Members:

Nicola Strother Smith (NSS)	Non-Executive Director	CHAIR
Tina Ricketts	Director of HR	
Candace Plouffe	Chief Operating Officer *(arrived 10:51am)*	
Richard Cryer (RC)	Non-Executive Director	
Joanna Scott (JS)	Non-Executive Director	
Susan Field	Director of Nursing	

In attendance:

Lindsay Ashworth	Head of HR *(10am-10:26am / 11:46am-12:25pm)*	
Linda Gabaldoni	Head of Organisational Development	
Sonia Pearcey	Ambassador for Cultural Change	
Mark Lambert	Head of Communications	
Michael Richardson	Deputy Director of Nursing	
Maria Wallen	Head of Professional Practice and Education	
Richard Hobbs	Volunteer Coordinator *(arrived 11:29am)*	
Harriet Smith	Senior Personal Assistant	Minute taker

Item	Minute	Action
16/HR036	**1. <u>Welcome and Apologies</u>** The Chair thanked everyone for attending the meeting. Apologies were received from: Stuart Bird, Deputy Director of Finance Rod Brown, Head of Corporate Planning Jan Marriott, Non-Executive Director	
16/HR037	**2. <u>Confirmation of Quoracy</u>** The Chair confirmed that the Committee was quorate.	
16/HR038	**3. <u>Declaration of Interests</u>** There were no conflicts of interest declared.	

Item	Minute	Action
16/HR039	**4. <u>Minutes of the Meeting held on 11 April 2016.</u>** The minutes of the meeting held on 11 April 2016 were **Received** and **Approved** as an accurate record subject to minor amendments.	
16/HR040	**5. <u>Action Log</u>** The Action Log was **Approved**. See action log for updates. • 15/HR053 – The Director of Nursing suggested that when the letters are sent next year for 100% attendance, these should be rolled out after the data has been validated. • 16/HR034.1 – The Head of HR has drafted a Plan and this has been shared with the Chief Operating Officer. The quality aspects will be shared with the Director of Nursing. It's an options appraisal on what the Trust can do to increase the colleagues on the bank register. The Head of HR will bring an overview of the plan to the next Committee meeting. • 16/HR030.1 – Still in progress. The Chair asked if this action could be closed at the next meeting.	Head of HR
16/HR041	**6. <u>Workforce and Organisational Development</u>** The DoHR presented this report to the Committee as a work in progress and asked for comments on both the format and the content of the document. The Chair asked if the Trust is working on strategies to a certain format across the Trust. The Director of Nursing stated that the Head of Corporate Planning (Rod Brown) will sense check strategies for compliance purposes. Once complete he is keen to get the strategies standardised but we need to ensure standardisation does not detract from the purpose of the strategy. RC stated section 1.1 internal context (4 bullet points) say the 'strategy aims to position us so we can recruit and retain the right staff and we do develop a culture and we are assured that colleagues have the right skills and leadership capability is enhanced'. This would be more positive. TR has noted this comment and will amend the context. The Head of HR left the meeting at 10:26am.	Director of HR

Item	Minute	Action
	The Director of Nursing stated that the strategy talks about individuals but there are achievements as a Trust which could be linked in. It would also be good to align this strategy with the emerging clinical strategy. The Director of Nursing also asked if the strategy can include information about our future workforce particularly around learners and students and use it as opportunity to attract students to apply for a position with the organisation.	Director of HR
	The Deputy Director of Nursing commented on section 1.1 internal context and stated this could be more visual as there are four big opportunities and there could be visual representation of the four points so could capture the information and make it stand out more.	Director of HR
	The Chair asked if all the strategies will be overseen by the Board. There has not been a review of all of the existing strategies at Board level to see the 'golden thread' running through the strategies. The Director of Nursing stated that this was done at the Board Development session in December 2015, 17 strategies were reduced to 13 strategies. The quality strategy was the overarching strategy that would be the 'golden thread'.	
	The Director of Nursing asked if the Workforce and OD strategy is strong enough on equality and diversity as this is a significant challenge for Gloucestershire. There needs to be acknowledgment of equality and diversity within the document.	
	RC asked if the strategy can focus on the organisation being younger in terms of demographics showing that the organisation is family friendly.	
	The Deputy Director of Nursing queried the meaning of 'Timewise status' on page 12 of the Workforce and OD Strategy. The Director of HR stated that it is regarding flexible working and Timewise accreditation looks at managers approaches to flexible working. The Director of HR will add more explanation regarding Timewise to the strategy.	Director of HR
	The Chair asked if re-energise should be included and the Director of HR stated that the Trust is focusing on Listening into Action instead.	
	The strategy is due to go to the Board on 19 July 2016, this	Director of HR

Item	Minute	Action
	will be circulated ahead of this date to the Committee for final comments. The Chair suggested to split the actions, where there is more than one person leading on an action. The Chair asked for the last column to be split into Lead and Support as opposed to two colleagues sharing the same action. The Chair gave the Director of HR written amendments/ comments. The Director of HR will amend according to comments and feedback raised by the Committee and re-circulate ahead of the Trust Board meeting on 19 July 2016.	Director of HR Director of HR
16/HR042	**7. <u>Communication and Internal Engagement Strategy</u>** The Chief Operating Officer arrived at 10:51am. The Head of Communications presented the key points of the Communication and Internal Engagement strategy to the Committee asking for approval of the contents and feedback. RC suggested the strategy be scaled down as it currently contained more detail than required and recommended fewer priorities to focus on. The stories about people (colleagues, friends, families) should be an overarching theme as this is what sticks in peoples mind. RC also queried why it is an internal engagement strategy and not just an engagement strategy. The Head of Communications explained external engagement was part of The Head of Corporate Planning's remit and the Communications team deal with internal engagement. JS suggested summarising and including last year's achievements in a separate document. JS commented that some of the priorities were business as usual tasks so removing these would reduce the priorities. For internal engagement, communication is the real priority and seems to be the "hardest nut to crack". There needs to be focus on how the Trust finds a way of communicating across the range of services and in particular within localities. There needs to be a timeline around internal engagement, a pilot phase and a then a launch.	

Item	Minute	Action
	JS also stated that she was not convinced around producing a paper version of the newsletter. The Head of Communications stated that a printed copy of the Team Brief would not be produced for every member of staff but they would be circulated to venues where colleagues congregate. This will be sampled and tested before it is launched across the Trust. The Head of OD stated that managers need to own the communications and make sure key messages are given and received within their team. JS congratulated The Head of Communications on the achievement of media exposure as it has been greatly improved. The Ambassador for Cultural Change concurred regarding the length of the document and commented it may deter colleagues from reading it. One of the CQC actions was to have communications more meaningful to colleagues so the internal communications does need to be a priority. The Ambassador for Cultural Changes also commented on how to measure of success. Pulse checks are being promoted with all teams. The Ambassador for Cultural Change has received an email from the manager of Optimise stating that there is a commitment about pulse checking teams locally. This needs to be linked to all other surveys. The Director of Nursing commented that section 4 should be more explicit. Being a Community Trust we provide quality community services and are responsive to the needs of our community. The Director of Nursing suggested an addition to the strategy to recognise the success of colleagues working with the media and that the filming has improved colleagues confidence. The Deputy Director of Nursing noted it was not for the Communications Team to oversee the introduction of management standards and suggested this be removed. The Director of Nursing requested that “Team meetings” be added under the section regarding ‘face to face’. RC commented that the Workforce and OD strategy is supported by the Communications and internal engagement strategy so could have a stronger link/synergy.	Head of Comms

Item	Minute	Action
	The Head of Communications will amend the draft strategy to incorporate the comments and feedback received by the Committee. The Chair asked if the communications and internal engagement strategy was to be presented to the Trust Board on 19 July 2016. The Director of HR confirmed it is scheduled to be presented at the Trust Board and therefore The Head of Communications will circulate a further draft ahead of the Trust Board by 24 June 2016. The Chair asked that the Committee feedback to the Head of Communications by 5 July 2016.	Head of Comms All
16/HR043	**8. <u>Strategy Metrics</u>** The Director of HR presented the strategy metrics to the Committee and stated that a review of the available metrics has been undertaken against Monitor's Measurement Pick list and this report proposes a revised monthly workforce dashboard containing 'hard' metrics, a quarterly scorecard containing 'soft' metrics and twice annual workforce reports. RC commented that the use of the staff survey and staff Friends and Family Test (FFT) appear to continue to focus on historical negativity and this may not reflect what is happening in all areas. The Director of HR replied that the pulse check can also be used as an internal measure. The Staff survey and the quarterly FFT are used nationally for benchmarking purposes. The Director of HR suggested that the Trust could look at local pulse checks as an internal benchmark which could add context. The Ambassador for Cultural Change shared information with the Committee regarding a member of staff reporting that they had put some negative comments within the staff FFT regarding culture and not being listened to at a higher level. The Ambassador for Cultural Change is meeting with this member of staff again next week (week commencing 20 June 2016). The Director of HR will bring a report to the next meeting with last quarters FFT results for Edward Jenner Court and what actions are being taken against these responses. If people do not feel listened to internally, this is a serious issue and needs to be addressed. The Director of HR will	Director of HR

Item	Minute	Action
	liaise with the Ambassador for Cultural Change to add comments from colleagues into the report for the next meeting. The Deputy Director of Nursing, commenting on the section within the report regarding 'Nurse staff to qualified nurse' ratio, asked for clarification around what this means. The Director of HR stated that it is under the operations on the pick list. It is the ratio of qualified to non qualified nurses. This is a particular measure that is used in Monitor's pick list. The Director of Nursing had a similar query regarding 'bed days' ratio and how this links. In April 2017, guidance for contact time for community hospitals will be released so the Director of Nursing is unsure how this will be measured in the wider community services. The Director of HR stated that this can be accessed through the Performance and Information team (Matthew O'Reilly) and benchmark against other metrics. The Deputy Director of Nursing asked if a 'question mark' can be held over 'nurse staff to qualified nurse' ratio and 'bed days' ratio for the time being. The Director of HR will review and get some more information around what these mean. The Director of Nursing also commented on 'Good communication between senior management and staff' under the workforce dimension. The Director of Nursing asked whether there is a definition of senior management. The Director of HR stated that when this has been tested with colleagues before, senior management has been classed as Executive Directors. The Director of Nursing also queried 'staff being given updated personal development plans' and stated that this goes against what the Trust promotes regarding personal development plans for colleagues. The Chief Operating Officer (COO) commented there needs to be information on why these measurements are being used and how they indicate colleagues feel more engaged. The Chief Operating Officer and The Director of HR will take the strategy metrics back through next Workforce and OD Steering group and bring back a new revised dashboard to the next committee.	Director of HR COO/Director of HR

Item	Minute	Action
16/HR054	**9. Workforce, Education and Development Report** The Head of Professional Practice and Education presented the WED report outlining the priorities that have been addressed by the Trust to ensure effective education, learning and development strategies are in place to support the achievement of the training outcomes identified as part of the Care Quality Commission Report (Ref 020). The Director of HR stated to the Committee that this report is the first following a comprehensive review of training and the figures are quite concerning, but do need validating. This is the first time that all elements of mandatory training are being recorded fully. Where the figures show low compliance, this is due to the requirement commencing April 2016 when new staff groups were introduced. As assurance for the Committee, The Head of Professional Practice and Education has produced a detailed action plan against each area in the report showing how the Trust can get to 85% compliance with priority groups being looked at first as training cannot be delivered to all at once. The next phase to July 2016 is a data quality audit with all line managers. Line managers have been issued with the compliance for all direct reports and they have identified underreporting on the ESR system. There should be an improvement every month going forward as this data is being verified. RC stated that the table in section 5.2 showing the headcount is useful as opposed to percentages. The Committee **Received** this report and **noted** the progress made against the CQC Improvement Plan. The Volunteer Coordinator arrived at 11:29am. The Chair took agenda item 11 next.	
16/HR055	**11. LiA (Listening into Action) Progress Report** The Ambassador for Cultural Change presented the LiA Progress Report to the Committee, discussed the key points within the LiA accreditation and gave an update as to the current position of the Trust with regards to achieving this. The Ambassador for Cultural Change confirmed that 30 colleagues have requested to be LiA coaches and are	

Item	Minute	Action
	attending a day's training on 21 September 2016. The Chief Executive will ask for input from the Executive Team who the 30 colleagues should be. RC queried 'non value added activity' within the report. RC asked who makes the judgment as to whether the activity is non value added. RC also stated when looking at the Finance Committee there is alignment between LiA and CIPs (Cost improvement plans) now. RC asked if the Trust is ensuring that people are not put off as they think LiA is all about cost saving. The Ambassador of Cultural Change stated that LiA is still about quality and not cost saving. Equality and Quality Impact Assessments (EQIAs) are completed for each scheme to ensure that quality is maintained. LiA is the framework used to empower colleagues. The Director of HR stated that the sponsor of the relevant scheme is the person making the decision on the non value added activities and they will escalate this to the Executive Team if there is a conflict identified between quality and finance.	
16/HR056	**12. <u>Colleague Health and Wellbeing Progress Report</u>** The Head of OD presented the health and wellbeing report for colleagues to the Committee and discussed the health and wellbeing strategic priorities, the high impact actions and the outcome measures for 2016/17. The Chair and RC have requested small amendments to the report. The Head of OD will amend the report accordingly. The Director of HR queried the target regarding "% saying they have felt unwell in the last 12 months as a result of work related stress". The Director of HR felts that the targets set were not challenging enough. The Committee **Approved** the health and wellbeing strategic priorities for 2016/17. The Committee **Approved** the high impact actions for 2016/17. The Committee **Approved** the outcome measures for 2016/17.	Head of OD
16/HR057	**13. <u>Workforce Risk Register</u>** The Director of HR presented the workforce risk register to the Committee containing risks rated 12 and above.	

Item	Minute	Action
	There were no new risks in this period. However, the risks around establishment and vacancy reporting, training compliance and staff morale are increasing. The Committee **Reviewed** the risk register to ensure that all key workforce risks have been identified and that ratings are correct. The Chair took agenda item 18 next.	
16/HR058	**18. <u>Volunteer Report</u>** The Volunteer Coordinator presented the key points of the Volunteer report to the Committee. The Volunteer Coordinator stated that he had omitted to include the extract from the CQC report that rated the Volunteers as outstanding. The Chair looked at the number of volunteers by site/service and noted there are a number of sites without volunteers (Fairford Hospital, Independent Living Centre and Quedgeley Clinic). The Chair asked whether there was scope to increase volunteers in these geographical areas. For example, help with the gardens at Fairford. Recruitment of volunteers at The ILC (Independent Living Centre) and Quedgeley Clinic has been tried before but this was unsuccessful partly due to these sites not having enough for the volunteers to do. The Chair suggested a review of what other tasks volunteers can do. The Volunteer Coordinator stated that it is easy getting volunteers to come in but getting them to stay can be difficult. The Volunteer Coordinator is due to visit ILC next week to review the roles available for volunteers. The Director of Nursing asked whether the age profile of volunteers is changing. The Volunteer Coordinator confirmed that the volunteers in the Community hospitals are mostly retired but conversation partners and Homeless Health Care volunteers are younger. The Director of Nursing asked whether the Trust does a survey similar to the FFT approach (with different questions) with volunteers. It would be good to get feedback from them	

Item	Minute	Action
	about working with colleagues and volunteering in the Trust. The results of this could then be used for marketing materials particular if could get feedback from different age profiles. The Head of Professional Practice and Education asked if there is a link with work experience and volunteering. The Volunteer Coordinator stated that some volunteers have come from local colleges. There are regular placements with Gloucestershire College and they supply volunteers to the Forest Hospitals. RC asked whether volunteers have sufficient recognition as they are not always visible. The Volunteer Coordinator confirmed that some areas have larger groups of volunteers and regular celebration events are held. JS asked if volunteers are they invited to AGMs (Annual General Meetings). The Volunteer Coordinator stated that they are made aware of these through Volunteer Supervisors and stated that they were invited to the last AGM but they did not attend. The Chair stated that when NEDs do their quality visits it would be nice to meet volunteers. The Head of HR returned to the meeting at 11:46am. The Chair took agenda item 10 next.	Director of HR
16/HR059	**10. <u>Flexible Working Progress Report</u>** The Head of HR presented the Flexible Working Progress Report and provided the Committee with an update on the progress made towards driving change through flexible working and becoming a 'Timewise Trust'. The Chief Operating Officer and the Head of HR met with Emma Stewart and Suzanne Hudson from Timewise. There is another meeting on 29 June 2016 to discuss the accreditation further. There will be communications on Timewise and a pulse check will be completed prior to holding a big conversation event. The big conversation will take place end of August/early September 2016. RC stated that there are certain positions/roles within the	

Item	Minute	Action
	Trust that cannot have flexible working. RC asked how is this dealt with and how is flexible working looked at with regards to the impact on your role. The Head of HR explained the principles of the scheme were to ensure balance across the diverse workforce and to ensure a fair and consistent approach to flexibility. JS asked if in principle, is flexibility open to all staff or does there have to be a reason for a flexible working request. The Head of HR stated that flexibility is open to all colleagues across the organisation. The Head of OD states that this will link with the health and wellbeing plan. The Director of Nursing asked whether flexible working excludes bank staff. The Head of HR stated that bank staff are already working flexibility so they are excluded. The Director of Nursing also asked for an equality and quality impact assessment to be undertaken as part of the baseline information. The Committee **Reviewed** the report and requested that a baseline of metrics be submitted to the next meeting. The Chair took agenda item 14 next.	Head of HR
15/HR060	**14. HR Policy Development** The Head of HR presented the HR Policy Development report and updated the Committee with an overview of the Trust's position regarding HR policy and development. The Committee **Noted** the progress of the HR Policy Development.	
15/HR061	**15. Workforce Report** The Head of HR presented the Workforce report and provided the Committee with end of year workforce information for 2015/16. The Director of HR asked the Head of HR to cross check hotspots identified against the risk register to make sure that the risk register has been updated and there is an action plan against each one. The Chair asked if the Trust's recruitment approach for	

Item	Minute	Action
	nursing vacancies was gender biased in any way. The Director of HR stated that the organisation uses NHS jobs and the design of the advert; job description and person specification are generic. The Chair asked if there is a gender bias at recruitment fairs and so attracts women more than men. The Director of HR stated that the RCN Network is used but will bear this in mind and take this query away to look into for the next recruitment fayres. The Head of HR stated that the Trust are looking at adverts to promote what we do well and what this Trust is doing differently. The Director of HR suggested that more diverse photos could be used at as they are predominantly female nurses currently. The Committee **Noted** the hotspots on the Workforce report. Agenda item 16 has been deferred to the Workforce and OD Committee meeting taking place in October 2016.	DoHR
15/HR062	**17. Worcestershire Investigation Progress Report** The Head of HR presented the Worcestershire Investigation report and provided the Committee with an update on the progress made against the actions recommended earlier this year following the review. The Chair asked if reviewing training for NEDs regarding the Doctors and Dentists Misconduct and Capability Policy is something that should be done. The Director of HR stated that a briefing could be arranged at a NED meeting or a board development session. The Committee **Reviewed** the report. The Chair took agenda item 19 next	Director of HR
15/HR063	**19. Workforce Plan Update** The Director of HR gave a verbal update to the Committee and stated that this is work in progress and the final report will be brought to the next Committee meeting. The Director of HR confirmed that this is a 'bottom up' workforce plan and with regards to the 'top down' plan the Director of HR is currently waiting (through the CIP	

Item	Minute	Action
	programme) to identify where posts will be removed from under CIP schemes and confirmation has not been received yet. With regards to the 'bottom up' plan, The Chief Operating Officer has sent out a service plan development template to all service leads which they are currently populating and through the Workforce and OD Steering group. A presentation from Health Education England was given around workplace planning tools and options to enable us to gather and analyse the information more effectively. One of the tools will be piloted in Children's services to see how it works. If it does work the Trust will be adopting through the other services. The Director of HR is now the STP lead for workforce planning. EQIA will be done for each post before any posts are moved from the structure. The Director of Nursing and the Director of HR are taking forward the new policy which is in progress at the moment. The Chair asked whether it's likely this will include another MAR Scheme. The Director of HR stated that this is not being considered at the moment.	
15/HR064	**20. Minutes from sub-committee** For information. **Noted**	
15/HR065	**21. Forward agenda plan** The next Workforce and OD Committee is scheduled for 24 August. The Chair requested that further dates be added to the forward agenda plan. • October - Colleague engagement update report • August – Strategy metrics update • October – SystmOne update • October – Timewise update	Director of HR
15/HR066	**22. Any other business** The Chair confirmed that it is the last meeting JS is attending as she is leaving the Trust.	

Item	Minute	Action
	The Chair thanked JS for her valued contribution and input to the Committee. The Chair closed the meeting at 12:25pm. The next Workforce and OD Committee is scheduled for 24 August 2016.	

Gloucestershire Care Services NHS Trust

Human Resources Performance Report - To the End August 2016

Training Data is from - 08/09/2016

Sickness is to the end - July 2016

Trust Mandatory Training All Staff

Directorates		Headcount	SICKNESS % rate - 12 month rolling average to end July 2016.	TURNOVER FTE % for 12 month period to the end of this month	STABILITY FTE % for 12 month period to the end of this month	APPRAISALS	% of staff with Up to Date Appraisal	MANDATORY TRAINING	Equality, Diversity and Human Rights - 3 Years	Fire Safety - 1 Year	Health, Safety and Welfare - 3 Years	Infection Prevention and Control - Level 1 - 3 Years	Infection Prevention and Control - Level 2 - 1 Year	Information Governance - 1 Year	Moving and Handling - Level 1 - 3 Years	Moving and Handling - Level 2 - 1 Year	NHS Conflict Resolution (England) - 3 Years	Resuscitation - Level 1 - 3 Years	Resuscitation - Level 2 - Adult Basic Life Support - 1 Year	Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year	Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year	Safeguarding Adults Level 1 - 3 Years	Safeguarding Adults - Level 2 - 3 Years	Safeguarding Children - Level 1 - 3 Years	Safeguarding Children - Level 2 - 3 Years	PREVENT - 3 Years
Training Targets: 85% to be achieved by Sept 2016; Sickness Target: 4.4% to be achieved by March 2017			**4.40%**	**11.00%**	**85.00%**		**95.00%**		**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**	**85.00%**
Paul Jennings	Chief Exec Office	15	0.00%	12.50%	100.00%		86.67%		73.33%	33.33%	40.00%	57.14%		26.67%	57.14%		40.00%	14.29%					28.57%		28.57%		11.11%
Paul Jennings Total		**15**	**0.00%**	**12.50%**	**100.00%**		**86.67%**		**73.33%**	**33.33%**	**40.00%**	**57.14%**		**26.67%**	**57.14%**		**40.00%**	**14.29%**					**28.57%**		**28.57%**		**11.11%**
Glyn Howells	Finance	25	1.56%	20.11%	88.35%		64.00%		90.91%	72.73%	90.91%	90.91%		68.18%	81.82%		95.45%	63.64%					77.27%		90.91%		36.36%
	IT & Clinical Systems	44	1.78%	27.03%	90.00%		93.18%		100.00%	97.67%	100.00%	100.00%		95.35%	95.24%		100.00%	73.81%					88.10%		90.48%		67.44%
	Performance & Information	13	4.91%	16.99%	77.22%		100.00%		100.00%	92.31%	100.00%	100.00%		100.00%	100.00%		92.31%	76.92%					92.31%		92.31%		84.62%
	Planning, Compliance & Partnership	6	0.30%	13.79%	136.36%		100.00%		100.00%	83.33%	100.00%	100.00%		100.00%	100.00%		100.00%	83.33%					100.00%		100.00%		100.00%
	Trust Secretariat	1	4.88%	50.00%	0.00%		100.00%		100.00%	100.00%	100.00%	100.00%		100.00%	100.00%		100.00%	0.00%					100.00%		100.00%		100.00%
Glyn Howells Total		**89**	**2.30%**	**24.09%**	**80.98%**		**86.52%**		**97.65%**	**89.41%**	**97.65%**	**97.62%**		**89.41%**	**92.86%**		**97.65%**	**71.43%**					**86.90%**		**91.67%**		**64.71%**
Sue Field	Professional & Clinical Effectiveness	31	3.01%	31.12%	87.83%		51.61%		72.73%	63.64%	81.82%	90.00%	41.18%	72.73%	94.44%	11.11%	90.91%	0.00%	15.38%			0.00%	40.00%	60.00%	40.00%	40.00%	50.00%
Sue Field Total		**31**	**3.01%**	**31.12%**	**87.83%**		**51.61%**		**72.73%**	**63.64%**	**81.82%**	**90.00%**	**41.18%**	**72.73%**	**94.44%**	**11.11%**	**90.91%**	**0.00%**	**15.38%**			**0.00%**	**40.00%**	**60.00%**	**40.00%**	**40.00%**	**50.00%**
Tina Ricketts	Central Nursing Bank	268	3.96%	23.53%	52.63%		40.67%		60.87%	47.41%	70.39%	67.12%	31.11%	38.30%	62.30%	26.67%	71.43%	16.44%	37.04%		100.00%	57.53%	32.76%	56.16%	33.74%	31.26%
	Communications	4	0.47%	0.00%	100.00%		100.00%		100.00%	75.00%	100.00%	100.00%		75.00%	100.00%		100.00%	75.00%					100.00%		100.00%		75.00%
	Human Resources	20	2.66%	25.29%	60.83%		105.00%		96.00%	88.00%	92.00%	88.00%		92.00%	92.00%		92.00%	60.00%					84.00%		80.00%		68.00%
	Learning & Development	14	4.91%	7.84%	148.78%		85.71%		93.33%	86.67%	93.33%	100.00%	60.00%	86.67%	100.00%	33.33%	86.67%	50.00%	55.56%		100.00%	50.00%	71.43%	50.00%	57.14%	46.15%
Tina Ricketts Total		**306**	**3.16%**	**17.73%**	**81.66%**		**47.71%**		**63.76%**	**50.66%**	**72.30%**	**74.04%**	**31.81%**	**42.50%**	**72.83%**	**26.76%**	**73.06%**	**29.81%**	**37.44%**		**100.00%**	**65.38%**	**33.41%**	**63.46%**	**34.14%**	**33.71%**
Candace Plouffe	Capacity	132	5.20%	15.73%	85.77%		74.24%		78.81%	65.56%	84.77%	90.00%	45.74%	59.60%	80.95%	47.12%	91.39%	45.00%	53.17%		37.50%	70.00%	50.39%	55.00%	50.39%	59.60%
	Community Hospitals	742	5.27%	15.58%	82.78%		71.70%		83.75%	66.71%	88.38%	94.34%	55.28%	61.96%	85.09%	51.51%	88.64%	35.85%	60.14%		61.95%	59.43%	50.88%	53.77%	50.00%	41.60%
	Countywide	516	4.01%	12.17%	94.01%		78.10%		85.41%	78.74%	86.49%	91.73%	51.80%	74.59%	82.06%	15.23%	90.99%	33.08%	60.10%		33.33%	63.91%	57.07%	65.41%	59.51%	56.07%
	CYPS	467	4.19%	10.90%	90.72%		85.01%		86.72%	76.46%	88.33%	93.65%	45.37%	66.80%	81.94%	38.98%	91.15%	60.32%		48.46%		58.73%	41.81%	71.43%	65.56%	65.45%
	Estates	175	4.80%	11.02%	84.81%		77.71%		92.09%	72.88%	84.18%	81.61%		66.67%	74.84%	0.00%	94.92%	18.97%				45.40%		47.13%		27.68%
	ICTs	574	4.77%	18.57%	79.99%		80.31%		85.69%	70.36%	90.12%	92.16%	57.78%	62.18%	83.64%	51.11%	92.16%	31.37%	73.20%			70.59%	53.89%	66.67%	49.90%	51.42%
	TO CLOSE	1	1.37%	0.00%	100.00%		0.00%		100.00%	100.00%	100.00%	100.00%		100.00%	100.00%		100.00%					100.00%		100.00%		
Candace Plouffe Total		**2607**	**4.67%**	**0.00%**	**85.92%**		**77.75%**		**85.32%**	**72.07%**	**87.89%**	**89.23%**	**52.56%**	**65.65%**	**81.40%**	**45.52%**	**90.90%**	**32.48%**	**64.38%**	**48.46%**	**60.25%**	**57.48%**	**50.96%**	**57.85%**	**55.21%**	**51.05%**
Mike Roberts	Medical	2	0.00%	0.00%	100.00%		100.00%		100.00%	100.00%	100.00%		50.00%	50.00%	100.00%	0.00%	100.00%		0.00%		0.00%		50.00%		50.00%	0.00%
Mike Roberts Total		**2**	**0.00%**	**0.00%**	**100.00%**		**100.00%**		**100.00%**	**100.00%**	**100.00%**		**50.00%**	**50.00%**	**100.00%**	**0.00%**	**100.00%**		**0.00%**		**0.00%**		**50.00%**		**50.00%**	**0.00%**
Trust Totals		**3050**	**4.52%**	**15.14%**	**85.74%**		**74.79%**		**82.12%**	**68.96%**	**85.45%**	**87.78%**	**49.01%**	**62.53%**	**81.63%**	**41.04%**	**88.08%**	**35.86%**	**57.53%**	**48.46%**	**59.38%**	**61.35%**	**48.07%**	**61.89%**	**51.54%**	**48.48%**
Comparative information as at 31 March 2016		3024	4.68%	15.16%	85.98%		77.45%		87.63%	78.60%	87.73%			64.68%			88.26%										
Comparative information as at 31 March 2015		2970	4.89%	14.70%	89.35%		70.91%		72.93%	60.03%	79.83%			61.58%			72.69%										
Comparative information as at 31 March 2014		2969	4.28%	11.71%	-		80.45%		50.20%	57.36%	88.37%			25.05%			65.90%										

* Bank Staff are shown under Human Resources for the benefit of reporting however Bank staff are spread across the Trust and responsibility for achieving performance targets rest with their Line Managers

Gloucestershire Care Services NHS Trust
Scorecard Trends for Top Level Figures
Includes Bank Staff

May 2016 - March 2017

Scorecard Details for Month Ending :	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	General Trend Line - 2016 / 17
Sickness		4.69%	4.62%	4.53%	4.52%								
Turnover		15.08%	14.70%	15.46%	15.14%								
Stability		85.81%	86.02%	85.69%	85.74%								
Appraisals		70.74%	66.15%	70.34%	74.79%								

Training Details for Month Ending :	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	General Trend Line - 2016 / 17
Equality, Diversity and Human Rights - 3 Years		65.98%	76.75%	80.25%	82.12%								
Fire Safety - 1 Year		66.25%	64.33%	66.00%	68.96%								
Health, Safety and Welfare - 3 Years		86.47%	85.74%	85.81%	85.45%								
Infection Prevention and Control - Level 1 - 3 Years		84.78%	84.03%	84.43%	87.78%								
Infection Prevention and Control - Level 2 - 1 Year		7.79%	8.54%	41.72%	49.01%								
Information Governance - 1 Year		59.36%	57.73%	59.24%	62.53%								
Moving and Handling - Level 1 - 3 Years		83.31%	81.07%	79.28%	81.63%								
Moving and Handling - Level 2 - 1 Year		27.20%	28.32%	38.73%	41.04%								
NHS Conflict Resolution (England) - 3 Years		86.47%	86.04%	87.10%	88.08%								
Resuscitation - Level 1 - 3 Years		2.14%	24.28%	39.52%	35.86%								
Resuscitation - Level 2 - Adult Basic Life Support - 1 Year		44.88%	43.90%	52.98%	57.53%								
Resuscitation - Level 2 - Paediatric Basic Life Support - 1 Year		52.21%	46.05%	45.90%	48.46%								
Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year		54.35%	61.75%	59.70%	59.38%								
Safeguarding Adults Level 1 - 3 Years		11.60%	44.37%	52.57%	61.35%								
Safeguarding Adults - Level 2 - 3 Years		32.00%	35.32%	40.88%	48.07%								
Safeguarding Children - Level 1 - 3 Years		11.60%	43.15%	51.16%	61.89%								
Safeguarding Children - Level 2 - 3 Years		39.45%	40.88%	45.83%	51.54%								
PREVENT - 3 Years		25.24%	27.70%	33.53%	48.48%								

January 2015 - March 2016

Scorecard Details for Month Ending :	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	General Trend Line - 2015
Sickness	4.85%	4.86%	4.82%	4.77%	4.85%	4.84%	4.88%	4.85%	4.85%	4.74%	4.71%	4.68%	
Turnover	15.22%	15.65%	15.06%	14.90%	15.06%	14.55%	14.80%	15.08%	15.60%	15.43%	15.53%	15.16%	
Appraisals	72.07%	78.16%	77.22%	77.73%	76.84%	76.05%	77.55%	78.64%	78.66%	77.70%	79.36%	77.45%	

Training Details for Month Ending :		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	General Trend Line - 2015
Training	Health, Safety & Welfare	87.68%	88.81%	90.04%	88.86%	88.64%	87.44%	87.80%	88.26%	88.20%	86.64%	87.20%	87.73%	
	Fire Safety	68.65%	71.30%	75.31%	71.54%	70.81%	70.71%	71.78%	75.50%	76.38%	77.18%	77.81%	78.60%	
	Equality & Diversity	80.90%	84.23%	86.20%	85.81%	86.80%	86.13%	86.01%	87.07%	87.11%	84.12%	85.79%	87.63%	

	Information Governance	65.86%	72.54%	75.99%	72.72%	62.57%	60.13%	63.06%	67.36%	65.94%	64.21%	65.15%	64.68%
	Conflict Resolution	79.81%	81.28%	83.24%	83.27%	84.85%	84.68%	85.58%	87.00%	86.94%	85.79%	86.94%	88.26%

Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 20th September 2016

Agenda Item:	15
Agenda Ref:	15/0916
Author:	Glyn Howells, Finance Director
Presented By:	Rob Graves, Non-Executive Director
Sponsor:	Rob Graves, Non-Executive Director

Subject:	Finance Committee Report

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

Executive Summary:

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

- The Month 3 Finance Report
- The performance and plans on CIP for 2016/17
- The performance to date on QIPP and CQUIN
- The performance to date of the Agency Usage Group
- The management of ICT Budgets
- The detailed review of Financial Corporate Risks

Recommendations:

The Board is asked to:

The Board is asked to receive the report and the approved minutes of the Finance Committee held on 15 June 2016.

Considerations:

Quality implications:
N/A

Human Resources implications:

N/A

Equalities implications:

N/A

Financial implications:

N/A

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

No

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

No

Understanding You

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

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

FINANCE COMMITTEE AUGUST 2016 REPORT

INTRODUCTION

This report provides an executive summary of the key issues and subsequent actions arising from the Finance Committee meeting held on 22ND August 2016. The minutes of the 15th June 2016 meeting were approved and can be seen in Appendix 1. It is the following issues that the Committee Chair and Director of Finance would like to draw to the Trust Board's attention:

FINANCE REPORT

The Committee received the Finance report for Month 3, the main points are summarised below:

- The Trust has a planned surplus for 16/17 of £1.793m.
- Conditions of Sustainability &Transformation funding include a cap on agency spend of £2.379m which will be monitored throughout the year. YTD spend at end of M3 is £584k which is £12k below the planned trajectory.
- Planned CIP for 2016/17 is £4m to be delivered through 3 executive led workstreams using Listening Into Action (LiA) principles and is progressing well with circa 50% delivered so far.
- Cash balance at 30/6/16 was £1,217k better than plan at £7,538k largely due to slower spend on capital projects than was planned.
- Mediation decision on year end balances between GCS and GHNHSFT (received 24/5/16) has now been implemented. Recharges and SLAs for 16/17 are now under discussion after initial exchanges of information in early July 2016

Main risks being managed to ensure delivery of the planned surplus are:

- Getting the ICT management structure revised following GCC removal of funding for joint positions (in agreement with the CCG)
- Delivering CIP including managing non-recurrent savings where recurrent savings are delivered later than planned)
- Managing the cost pressure arising from the outcome of the MIIU engagement
- Delivering QIPP and CQUIN milestones in line with plan and current forecast. Latest figures show under delivery in Q1 of approx. £200k across CIP and CQUIN milestones.

Given the importance of ensuring an effective recharge agreement with GHNHSFT going forward, the Director of Finance confirmed that the contract Board meetings between GCS and GHNHSFT need to be reintroduced and agreed to take this forward.

CIP REPORT

The Committee reviewed the performance against CIP for 2016/17 as at 31st July

- the year to date (YTD) financial position of the Trust's CIP 2016/17 as at 31 July
- progress with the LiA engagement process to improve the effectiveness of the CIP programme

The Committee noted the progress with the LiA approach to improve the effectiveness of the

CIP programme.

CQUIN REPORT

The Committee were asked to note the difficulty with the Positive Risk Training CQUIN as this is proving to be challenging to evidence.

QIPP REPORT

It was confirmed the Trust is currently working closely with the GCCG to reduce the potential penalties incurred by providing further evidence.

The Committee **noted** the report and the delivery of the estimated Q1 QIPP achievement
the forecasted QIPP Q2 achievement

BUDGET HOLDER REVIEW – ICT

The Head of ICTs delivered a presentation defining the service, budgets and funding.

It was agreed an update on the outcome of the current service redesign and on the challenges faced with the current funding shortfalls be provided to the October meeting.

CAPITAL REPORTING

For the 3 months to June the Trust had spent £595k compared to a year to a plan figure of £920k

The need to ensure capital funding could be rolled forward and would not be lost was highlighted.

The Committee **received** the report and noted the current position of the Trust

FINANCE RISKS

The Committee received all Corporate Risks that relate to Finance and discussed the mitigating actions.

Report prepared by: Glyn Howells – Finance Director
Report Presented by: Rob Graves, Chair, Finance Committee and Non- Executive Director

Appendix 1: Approved minutes of Finance Committee meeting: 15TH June 2016

Gloucestershire Care Services NHS Trust

Minutes of the Finance Committee Meeting

held on the **15 June 2016**
in the Boardroom, Edward Jenner Court, between 13:30– 17:00 hrs

Committee Members present:

Rob Graves	–	Non-Executive Director (Chair)
Glyn Howells	–	Director of Finance
Candace Plouffe	–	Chief Operating Officer
Susan Field	–	Director of Nursing
Richard Cryer	–	Non-Executive Director
Sue Mead	–	Non-Executive Director

In attendance:

Stuart Bird	–	Deputy Director of Finance
Johanna Bogle	–	Head of Operational Finance
Louise Moss	–	Deputy Trust Secretary
Steven Wainwright	–	Commercial Business Manager
Val Welsh	–	Sexual Health Operational Service Manager (item 11 Only)

Item	Minute	Action
16/FC138	**Agenda Welcome and Apologies** The Chair welcomed everyone to the Finance Committee meeting.	
16/FC139	**Confirmation that the meeting is quorate** The meeting was **confirmed** as quorate by the Deputy Trust Secretary.	
16/FC140	**Declarations of Interests** Members were asked to declare any updates from their original declaration of interests and to declare interests at the time of any concerned agenda item. No updates or interests were declared.	
16/FC141	**Minutes of the Finance Committee held on the 13th April 2016** The minutes of the meeting held on the 13th April 2016 2016 were **received** and **approved** as an accurate record with one minor amendment as below:	

Item	Minute	Action
	Business Development Tracker Notification received from NHS England (South Central) to terminate the Child Health Information Service Gloucestershire (CHIS) service with effect from March ***2017***	
16/FC142	**Matters Arising (Action Log)** All matters arising were noted as being; - On track for delivery within timeframe - On agenda for discussion at this meeting	
16/FC148	**The Chair then agreed to discuss agenda item 11 – Sexual Health Services Budget review - to accommodate the Sexual Health Service Manager's other commitments.** **Budget Holder review – Sexual Health** The Sexual Health Operational Service manager delivered a presentation on budgets and funding within the service. There are five services which are funded separately, Gloucestershire Clinical Commissioning Group, Gloucestershire County Council (GCC) and NHS England. The GCC commissioned services face a 27% budget cut over the next 4 years due to the national cuts to Public Health budgets and therefore the Sexual Health services provision for Gloucestershire is under review as a result of these cuts, The Sexual Assault Referral Centre (SARC) service has an income shortfall £100k which is currently being addressed with NHSE. The Integrated sexual health service has a potential income shortfall of £1m, however it is believed that the block income from the CCG currently part funds the Integrated Service now commissioned by Public Health. Further opportunities were identified: • IT system estimated to save on staffing costs as well as quality improvement • Current B7 0.8wte vacancy, reduced B7 provision by 3.2wte in 4 years • PAS re theatre use & patient pathway • Reviewing training charges • Formulate a pathway to invoice for out of county care • Streamlining of pharmacy requirements • Review reference costs for the service against national benchmarks	

Item	Minute	Action
	Rob Graves thanked the Sexual Health Operational Services Manager along with colleagues from the Finance team for the detailed review presented and highlighted that the Committee had found this both useful and enlightening and requested that she returns to the Committee in October to give an outcome on the current service redesign and an update on the challenges faced with the current funding shortfalls.	
16/FC143	**Finance Report – Month 1** The Deputy Director of Finance presented the report and highlighted the following key areas: - The trust has a planned surplus for 16/17 of £1.78m. - Conditions of S&T funding include a cap on agency spend of £2.379m which will be monitored throughout the year. - April 2016 (month 1) was on plan with a net deficit of £222k. - Planned CIP for 2016/17 is £4m to be delivered through 3 executive led workstreams using LIA principles - QIPP (target £3.9m) and CQUIN (£1.9m) milestones have been agreed and operational teams and now working on delivery. - Cash balance at 31/3/16 was on plan at £6.1m - Mediation on year end balances between GCS and GHNHSFT was received on 24/5/16 from NHSI and used to finalise position for 31/03/16 which resulted in a net debtor to GCS from GHNHST of £120k <u>Risks</u> - Managing agency spend within the cap - Getting service level agreements in place with GHFT – until agreements are in place there remains a difference in opinion on the value of services of circa. £1m. - Getting the ICT management structure revised following GCC removal of funding for joint positions (in agreement with the CCG which may provide some additional funding) - Delivering CIP including managing non-recurrent savings where in year savings are later than planned) - Delivering QIPP and CQUIN milestone in line with plans – as for the last two years we have £900k of QIPP dependent upon there being a change in urgent care admissions which has not been achieved in the last two years.	

Item	Minute	Action
	Following a detailed discussion the Committee **noted** the report and the financial position of the Trust.	
16/FC144	**CIP Report** The Chief Operating Officer presented the report and drew the Committee's attention to the following areas; - the year to date (YTD) financial position of the Trust's CIP 2016/17 as at 31 May - progress with the LiA engagement process to improve the effectiveness of the CIP programme <u>Progress</u> As highlighted in April's report it has now been agreed that the CIP programme will follow the LiA approach to create a discipline around delivery and ensure ownership and engagement across all teams. There were two Big Conversations held with budget holders in April which generated a number of ideas to take forward for further discussion and development. These were centred on: ensuring continuous quality improvement; improving consistency across services; reviewing workload management and creating a demand and capacity model; better use of GCS estates; more joint working across services; creating a flexible workforce (staff rotation in community hospitals) and reviewing procurement of consumables. Following the Big Conversations a new structure for delivery of the CIP programme was agreed and shared with budget holders at the May Core meeting. The work streams have now been reduced to three: 1. Productive and Miss Matched Services 2. Estates and Procurement 3. Support Services The Chair thanked the Chief Operating Officer for the detailed report and commented that in future reports it would be helpful for Committee members to see a red/amber/green approach to the table which demonstrates a breakdown of workstream initiatives and achievements to date. In response the Director of Finance agreed to amend the report for the next Finance Committee Following discussions the Committee **noted** the following: • delivery of the plan as at 31 May • the LiA process to ensure improved	**Director of Finance**

Item	Minute	Action
	engagement with all staff in the cost improvement programme. • the Community Hospitals Staffing Action Plan The Committee **approved**; • the amended CIP plan to include 3 work streams and 4 LiA groups	
16/FC145	**Focussed Report – Recharges to GHNHSFT** The Deputy Director of Finance presented the report highlighting the following areas; Current recharge values to GHNHSFT (subject to agreement). • GCS to GHNHSFT approximately £6.4m pa • GHNHSFT to GCS approximately £4.3m pa plus significant ad-hoc charges. GCS prepared revised costings in January 2016 based on up to date management accounts information and clinic volumes. There remains a risk that ad hoc charges (those raised outside SLA) will continue to be received and that even after dispute and/or escalation they will still be held to be valid charges. Agreeing ad hoc charges has always proved difficult due to lack of detail provided to support them and outstanding service specifications and costings that set out what's being paid for already within the base charge. There is an opportunity that GCS will be able to work with GHFT to get more up to date costings reflecting current activity levels and/or agree to change service specifications to enable things to be delivered more cost effectively. The potential opportunity is estimated at up to £1m though it can only be attained with open and up to date service costing along with proactive dialog between GCS and GHT about where savings can be gained Richard Cryer commented that it is critical we continue to work on our current relationship with GHNHSFT to ensure we are not in this same position next year. The Chief Operating Officer commented that she is confident that with the new Chief Executive Officer now being in post at GHNHSFT this will not be the situation.	

Item	Minute	Action
	The Director of Finance further noted that the process was ongoing to agree GHNHSFT recharges for 2016/17. It was confirmed that the mediation outcome on the position for 15/16 was currently being taken forward. The Committee **approved** the approach being taken by the finance team and **noted** the potential impact on the financial position of the trust.	
16/FC146	**CQUIN Report 2016/17** The Director of Nursing presented the report. The CQUIN schedule for this financial year covers the following seven topics: • Transition (Children to Adult services) • Positive Risk Taking • Frailty (Community based) • End of Life • Antimicrobial Resistance and Stewardship (National): Antibiotic prescriptions and consumption • NHS Staff health and wellbeing (National): staff initiatives, healthy food & staff vaccination rates • Dental – worth £74,716 in total The Director of Nursing confirmed that all had now been signed off and currently there are no risks in respect of delivery of any of the topics detailed in the CQUIN Schedule. The Committee **noted** the report.	
16/FC147	**QIPP Report 2016/17** The Chief Operating Officer presented the report highlighting the following areas: The QIPP schedule for this financial year covers the following topics: • ICT: Admission Avoidance • Continuation of Phase 1 • ICT: testing & roll out of Phase 2 • ICT: Reablement • Integrated Discharge Team • Signposting for Single Point of Clinical Access • MSK New Service Model • Complex Leg Wound Service	

Item	Minute	Action
	• Community IV Therapy provision • Occupational Therapy review • Rehabilitation Bi-monthly meetings are held to monitor achievement with the GCCG and reports are submitted with supporting evidence to GCCG. There are many milestones for June and these attribute to £620,000. There are risks around the ICT, Complex Leg Wound and Community IV provision schemes. The Trust continues a milestone tracker approach for its QIPP programme of work. The **Committee** noted the report.	
16/FC149	**Capital Schemes** The Deputy Director of Finance presented the report and drew the Committee's attention to the following areas: • As at month 1 the full year plan is still £5m of spend in year • For month 2 the trust had spent £647k • A number of projects have been proposed for 16/17 but no values are approved as yet. • The focus of the trust will be to ensure that all capital plans have a robust business case with clear clinical benefit. Capital schemes will also be managed tightly to minimise the risk that actual spend will be higher than the amount set out in the original business case. The Committee **discussed and note**d the current position of the Trust with respect to capital approvals and spend.	
16/FC150	**Business Development Tracker** The Deputy Director of Finance presented the report drawing the Committees attention to the following: • Following the binding mediation decision by NHS Improvement regarding cross-Trust charges as at 31 March 2016, work is now focusing on agreeing SLA's (both ways) and the associated pricing for services with the aim by both organisations to have these all agreed and in place by the end of	

Item	Minute	Action
	June 2016. • Tender activity for Healthy Lifestyle Service being re-commissioned by Gloucestershire County Council, and Child Health Information Service being re-commissioned by NHS England. • There are no contract variations currently being progressed with a material financial impact/value. **Confidential Item - Commercially Sensitive, CHIS Tender** **The Chair noted that a paper regarding the CHIS Tender had been submitted for the Finance Committee to consider and directed members to look at this item next.** The Chief Operating Officer informed the Committee that NHS England South Central served a twelve month notice to Gloucestershire Care Services NHS Trust in March 2016 for the provision of the Child Health Information System. The tender includes three components: • Child Health Information System • A child health records department (CHRD) • A personal child health record (PCHR) The procurement process was commenced on 10th May 2016 with a view to the new contract starting in early 2017. The three options currently being considered are: 1. No tender submitted 2. Tender as a sole provider 3. Tender as a part of a partnership **Following discussions the Committee;** a. **Noted** the work underway in understanding the Opportunities and Risks of this Tender b. **Noted** the Decision to not Tender as a Sole Provider **Confirmed** the Decision to pursue a Partnership Model	
16/FC151	**Corporate Risk Register** The Director of Finance presented the finance risk register noting the High risk items and the mitigating actions were discussed by the Committee.	

Item	Minute	Action
	The Committee **noted** the risks and took assurance from the mitigating actions.	
16/FC152	**Agency Spend and Reporting** The Chief Operating Officer presented the report as this group has now moved to her responsibility following recent changes in structures and highlighted the following areas: From the 1st April, NHS Improvement informed Gloucestershire Care Services that all NHS trusts and NHS foundation trusts have been subject to expenditure ceilings covering all agency and locum staff. These apply to 2016/17 expenditure. The ceilings have been calculated to drive a further significant reduction in agency expenditure in 2016/17. A monthly agency usage group continues to focus on understanding agency usage and ways in which to improve both substantive and bank workforce to reduce reliance on agencies. Due to the level of vacancies within some occupational groups, particularly Nursing there is a risk that continued agency usage is required to ensure the delivery of safe services. The Chair asked that this item is kept on the forward planner as a regular report to enable the Committee to keep this under close review. The Committee; a. Noted delivery of the Agency usage plan at 30 April 2016 b. Noted the progress in understanding overall Agency usage across all staffing groups within the organisation c. Noted the associated risks in delivering the Agency target set for 2016/17.	Deputy Trust Secretary
16/FC153	**Reference Costs Governance** The Deputy Director of Finance presented the report and highlighted the following areas: As part of an annual national requirement the Trust is required to complete a Reference Cost submission to the Department of Health towards the end of July. Reference costs are the average unit cost of providing defined services to NHS patients in England. In addition to satisfying the mandatory national requirement and provide indicative benchmark performance, the	

Item	Minute	Action
	Reference Cost findings will be used internally to highlight cost variations for the delivery of the same services across different teams and sites, and so inform service standardisation and cost improvement opportunities. Following discussion the Committee endorsed and **approved** the approach being followed and **authorised** the Director of Finance to submit the reference costs on behalf of the Trust..	
16/FC154	**Minutes from Steering Groups** - **CIP Steering Group** - **Quality Steering Group (CQUIN and QIPP)** The Minutes from the above Steering Groups were **received** and **noted.**	
16/FC155	**Forward Agenda Planner** The Forward Planner was discussed and approved with the following changes as listed below: - Sexual Health Services Budget review (update) in October Subject to the above changes, the Forward Agenda Planner was **approved**.	
16/FC156	**Any Other Business or any matter for another Committee.** No other business was reported for discussion.	
	Date and Time of Next Meeting The Chair **closed** the Finance Committee meeting at 16.40 hrs. It was **agreed** that the next meeting of the Finance Committee be held on the: 17th August 2016 13:30 hrs – 17.00 hrs Boardroom, Edward Jenner Court, Brockworth,GL3 4AW	

Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 20th September 2016

Agenda Item:	16
Agenda Ref:	16/0916
Author:	Stuart Bird , Deputy Director of Finance
Presented By:	Glyn Howells, Director of Finance
Sponsor:	Glyn Howells, Director of Finance

Subject:	Finance Report

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

Executive Summary:

Full year plan is for the trust to deliver a surplus before sustainability and transformation funding of £713k, S&T funding is currently advised as £1,080k so this would give a full year surplus of £1,793k.

At month 4 the year to date surplus and full year forecast surplus are both in line with plan.

Agency spend (full year cap £2.379m) is £727k at the end of month 4 which is £155k less than plan trajectory.

Noted risks at month 4 are :

- QIPP risk share of £900k which is dependent on system wide admission avoidance
- Agreeing GHT recharges in line with plan
- Offsetting any in year shortfall on CIP delivery with equivalent non-recurrent savings

Recommendations:

The Board is asked to: Note the report and actions being taken to manage the risks.

Considerations:

Quality implications:

None

Human Resources implications:

None

Equalities implications:

None

Financial implications:

The trust needs to deliver on its financial commitments and work to the agreed control total.

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

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

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

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

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

Date:	12th September 2016

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

Explanation of acronyms used:
None used.

Contributors to this paper include:
Stuart Bird, Deputy Director of Finance

Gloucestershire Care Services NHS
NHS Trust

Month 4 2016/17 Finance Report

V 2

Understanding you

Contents

Overview

- The total planned surplus for 16/17 is £1,793k. This will be delivered through a £609k operating surplus from ongoing operations, a donated asset adjustment of £104k and £1,080k of non-recurrent sustainability and transformation (S&T) funding.
- Conditions of the S&T funding include operating within a “capped” level of agency spend of £2,379k. Usage of agency staff is monitored closely as a measure of recruitment effectiveness, staffing quality and ability to satisfy the S&T funding criteria (YTD spend at the end of M4 is £727k which is £155k less than plan trajectory).
- YTD financial performance to July 16 (month 4) was on plan with a net surplus before S&T funding and donated asset adjustment of £148k. Full year forecast is currently in line with plan at £609k (pre S&T).
- Planned CIP for 16/17 is £4m to be delivered through 3 exec led workstreams using LIA principles which is reported on in detail in a separate report. In year CIP delivery is progressing well but full delivery is a key enabler of the planned surplus.
- QIPP (£3.9m) and CQUIN (£1.9m) are covered through separate reporting processes. The current income forecast is that these will both be delivered in full. Milestones have been agreed and operational teams and now working on delivery.
- Cash balance at 31/7/16 was £438k better than plan at £6.9m. Forecast balance at 31/3/17 is in line with plan at £6.2m
- Capital plan for the year totals £5m with main projects on Hatherley Road and IT infrastructure. Latest forecast is that the full amount will be spent in year.

Income and Expenditure

At month 4 the trust is in line with NHSI expectations with a YTD surplus before S&T funding and donated asset adjustment of £148k and a full year forecast surplus in line with plan at £609k.

If S&T funding is included the full year surplus becomes £1,788k which is £5k below the NHSI control total which will be corrected in future forecasts.

Full year agency spend in 15/16 was £3,717k, the ceiling for spend in 16/17 is set at £2,379k and year to date spend to M4 was £727k which is £155k lower than plan.

Significant risks are still as identified in the initial plan and as set out on page 6.

2016/17 Key Finance Data - Month 4

Statement of Comprehensive Income (£000)	Current Year to Date			Forecast Outturn		
	Plan	Actual	Variance	Plan	Forecast	Variance
Revenue	36,894	37,017	123	111,657	112,140	483
Gross Employee Benefits	(27,225)	(26,520)	705	(81,878)	(80,677)	1,201
Other Operating Costs	(8,734)	(9,561)	(827)	(26,806)	(28,490)	(1,684)
PDC Dividend	(788)	(788)	0	(2,364)	(2,364)	0
Trust surplus/deficit	**147**	**148**	**1**	**609**	**609**	**0**
Donated assets adjustment	36	33	(3)	104	99	(5)
Adjusted Operating surplus/(deficit)	**183**	**181**	**(2)**	**713**	**708**	**(5)**
S&T Funding	360	360	0	1,080	1,080	0
Adjusted Financial Performance	**543**	**541**	**(2)**	**1,793**	**1,788**	**(5)**

Capital Expenditure

Gloucestershire Care Services NHS Trust

(A) Identified at Plan:	Type	2016/17 Plan	By Quarter			
		£000s	Q1	Q2	Q3	Q4
Hatherley Road	Other	2,000	0	990	1,010	0
IT replacement	IT	500	120	120	120	140
IT WAN / LAN	IT	500	300	200	0	0
Building compliance	New Build	1,000	250	250	250	250
Building reconfiguration	Other	500	125	125	125	125
Systm1	IT	500	125	125	125	125
		5,000	920	1,810	1,630	640

- Trust full year capital plan is for a spend of £5m
- Year to date spend in 16/17 is less than £1m
- Forecast capital spend in 16/17 includes approx £1.5m of spend on redevelopment of the Hatherley Road site (still subject to business case) and around £1m of contribution to system wide IT infrastructure where there have been delays in finalising the implementation plan.

Risks

At this stage the risks being managed to ensure delivery of the planned surplus are:

- Managing agency spend within the cap of £2.379m to ensure the S&T funding will be available
- Getting service level agreements in place with GHFT – until agreements are in place there remains a difference in opinion on the value of services of circa. £1m.
- Getting the ICT management structure revised following GCC removal of funding for joint positions (in agreement with the CCG which may provide some additional funding)
- Delivering CIP including managing non-recurrent savings where in year savings are later than planned)
- Delivering QIPP and CQUIN milestone in line with plan and current forecast. Latest figures show under delivery in Q1 of approx £200k across CIP and CQUIN milestones.
- Earning the £900k of risk share QIPP that depends on system level admission avoidance schemes.
- Managing the cost pressure arising from the outcome of the MIIU engagement

Gloucestershire Care Services NHS
NHS Trust

Trust Board

Date: 20 September 2016

Agenda Item:	17
Agenda Ref:	17/0916
Author:	Gillian Steels Trust Secretary
Presented By:	Richard Cryer – Non Executive Director, Chair Audit & Assurance Committee
Sponsor:	Glyn Howells, Director of Finance

Subject:	Audit and Assurance Committee Update

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

Executive Summary:

Counter Fraud and Corruption Policy and Freedom to Speak Up Policy were approved.
Risk Management Strategy and Business Continuity Strategy approved subject to some minimal changes.

The Risk Register update was considered in detail to ensure timeframes for actions to mitigate risks were in place.

The Committee considered proposals relating to a review of the Governance Framework within the Trust to ensure the Framework maximises Board effectiveness.

The review includes the Governance Reporting Framework and the Core Corporate Governance documents and Report Frequency and Content with the core aim of supporting Board effectiveness at a time of significant challenge within the NHS: with pressure for on going improvement, financial constraint and the development of Sustainable Transformation Plans. It was agreed that consideration of reporting frequency should be discussed at a meeting of the Committee Chairs and Executive leads to agree key information to support effective operation of the Board

Recommendations:

The Board is asked to:

Note the update.

Considerations:

Quality implications:

Implicit within the relevant risk information.

Human Resources implications:

None

Equalities implications:

None

Financial implications:

None

Does this paper link to any risks in the corporate risk register: New risks on the Risk Register Relating to Information Governance Training and Register of Medical Equipment
Does this paper link to any complaints, concerns or legal claims No

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

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

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

Date:	12 September 2016

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

Explanation of acronyms used:
Detailed in report.

Contributors to this paper include:
Gillian Steels – Trust Secretary Glyn Howell Director of Finance

Audit and Assurance Committee September 2016 Report

1. Introduction

This report highlights key issues that were discussed at the Audit and Assurance Committee on 13th September.

2. Policies – the following updated policies were approved

Counter Fraud and Corruption Policy – had been updated to reflect personnel changes.

Freedom to Speak Up: Raising Concerns at Work (Whistleblowing Policy)

- significant re write to align to national best practice guidelines following the Francis Report Recommendations. The Freedom to Speak Up Guardian, Sonia Pearcey, attended the meeting. It was agreed going forward the Committee would receive an Annual Report on any concerns raised through the policy. The Workforce and Organisational Development Committee will receive regular reports at its meetings on formal and informal concerns raised and lessons learnt.

3. Strategies

The following strategies were approved:

- Risk Management Strategy - Committee approved subject to additional review to ensure resilience in the event of multiple risks crystallising simultaneously – it was also agreed this should be reflected on in the Board December Development Session when the Risk Register is reviewed.) (Attached Appendix 1)
- Business Continuity Strategy – subject to the Chair having a final review of the track changes version.

The Committee also reviewed the "Strategies on a page document" – and approved it as work in progress with further work to develop it for staff and patient use and would present at a Board Development Session.

4. Internal Control & Risk Management

Monitoring to gain assurance in relation to internal controls and risk management remains a key element of the work of the committee. Reports on Risk Management, Counter Fraud and Financial Controls were considered.

New Risks

(i) Information Governance Training Compliance was considered with reference to the update on Information Governance and the work required to meet the Information Governance Toolkit Compliance level required by March 2017. It was confirmed that an action plan was being actively worked on to meet requirements following the appointment of an experienced specialist. It was agreed he should provide an update to the next meeting of the Committee to demonstrate the Board's commitment to achieving the required level. Members also stressed the need for the compliance with the Information Governance Training to be looked at holistically with other Mandatory Training

and Appraisals. It was noted that time was now being allocated for these requirements to remove barriers from their completion.
The issues of ensuring Information Governance requirements to require consent to share information did not put in place a barrier to safeguarding children and vulnerable adults were discussed and it was agreed the Quality and Performance Committee would discuss this matter in more detail..

(ii) Medical Equipment – identification of equipment – it was confirmed that this risk related to the introduction of a new database for monitoring equipment to replace the current spreadsheet process.

5. Governance Framework

The Committee considered proposals relating to a review of the Governance Framework within the Trust to ensure the Framework maximises Board effectiveness.

The review includes the Governance Reporting Framework and the Core Corporate Governance documents:

- Code of Conduct and Professional Standards
- Scheme of Delegation of Power
- Standing Financial Instructions
- Scheme of Reservation
- Standing Orders of the Board of Directors (including the Committee Terms of Reference)

and Report Frequency and Content with the core aim of supporting Board effectiveness at a time of significant challenge within the NHS: with pressure for on going improvement, financial constraint and the development of Sustainable Transformation Plans.

The report outlined the processes and timetable for the review, with all work targeted to be completed by December 2016. It was agreed that consideration of reporting frequency should be discussed at a meeting of the Committee Chairs and Executive leads to agree key information to support effective operation of the Board.

6. Board Development– item for inclusion

The External Auditors highlighted STP (Sustainability and Transformation Plan) developments and it was proposed that consideration of STP developments in relation to balancing consideration of statutory requirements and system requirements should be considered by the Board at a Development session.

7. Minutes from previous meetings

The minutes from the Audit and Assurance Committee meetings held on 3rd and 31st May 2016 were approved as are attached as appendices 2 and 3

Report prepared by: Gillian Steels, Trust Secretary
Report Presented by: Richard Cryer, Chair, Audit and Assurance Committee and Non- Executive Director

Gloucestershire Care Services NHS
NHS Trust

RISK MANAGEMENT STRATEGY

2016-21

To create optimum opportunity for the successful delivery of exemplar healthcare services by ensuring a consistent framework for the identification, management and mitigation of all potential or actual risks

Risk Management Strategy 2016-21

Version control	
Document reference:	TB03
Version:	2.1
Ratified by:	Trust Board
Date ratified:	20 September 2016
Originator/author:	Rod Brown, Head of Planning, Compliance and Partnerships
Owner:	Rod Brown, Head of Planning, Compliance and Partnerships
Executive lead:	Glyn Howells, Director of Finance
Consultation	• Director of Finance • Information Governance and Risk Manager • Compliance Officer • Risk Steering Group • Audit and Assurance Committee (September 2016)
Date issued:	September 2016
Review date:	September 2018

Contents

0. Executive Summary

This Risk Management Strategy seeks to ensure that Gloucestershire Care Services NHS Trust ("the Trust") maintains clear oversight in its management of both strategic and operational risks. This is to safeguard against the occurrence of adverse incidents which may otherwise impact negatively upon the quality of Trust services, as well as upon the safety and experience of both service users and colleagues.

Risk management is rightfully recognised by the Trust and this Risk Management Strategy, as a key enabler to ensuring continuous improvement in the quality of delivered care.

In particular, this Risk Management Strategy seeks to ensure that:

- effective contribution is made to the Trust's culture, enabling risks to be openly and honestly acknowledged. Colleagues will therefore be actively encouraged to observe the Trust's CORE values and as such, to be open and responsible in their identification of risks, and effective in their contributions to risk management and mitigation. Moreover, the Trust recognises the need to be transparent in respect of risks within its routine engagements with service users, carers, families and the wider Gloucestershire public;

- there are clear and robust Trust procedures to identify, escalate, record, manage and/or mitigate all operational risks that may impact upon service delivery. This includes the need for colleagues to access and triangulate information from a range of sources in order to identify risks, and ensure that risk escalation and management is handled in a consistent manner. It also specifically requires action plans to be developed by appropriate leads to clarify and track all mitigations to reduce the Trust's more significant risks, and provide assurance up to the Trust Board;

- there is clear recognition and management of strategic risks so as to ensure the optimum sustainability, viability and quality of delivered care across Gloucestershire: these risks, which may threaten the achievement of the Trust's overarching strategic objectives, will be identified by the Trust's Executive and Non-Executive Directors, and monitored through the Board Assurance Framework;

- learning from risks is communicated and integrated so as to inform and strengthen future service delivery.

This Risk Management Strategy outlines the Trust's aspirations and direction of travel in respect of risk management over the next 5 years. The accompanying implementation plan will detail the practical actions that will be taken in the period 2016-21 to fulfil these aspirations.

1. Introduction

"Every person working in NHS-funded care has a duty to identify, and help to reduce, risks to the safety of patients, and to acquire the skills necessary to do so in relation to their own job, team and adjacent teams"

A Promise to Learn - a Commitment to Act
National Advisory Group on the Safety of Patients in England, 2013

1.1 This strategy details the intentions of the Trust to ensure the effective management of all emergent strategic and operational risks. This document therefore forms a core part of the Trust's internal control arrangements, and fulfils a specific legal requirement to provide assurance that risks in the organisation are being identified in a timely manner, and thereafter appropriately managed.

1.2 The Trust recognises that delivering healthcare services, and thus all associated activities including employment of the organisation's workforce, management of its premises and finances, provision of care services across Gloucestershire etc, all involve a degree of risk. The Trust is therefore seeking to build an integrated approach to the overall management of risks, including those originating from operational teams, estates, information technology and management systems, or other sources. This approach is detailed within the Trust's risk management documentation, which includes this strategy.

1.3 The Trust recognises that the key benefit of maintaining robust risk management processes is that the organisation will be able to minimise the effects of adverse incidents. Specifically, this means:

- the Trust will be better placed to fulfil its ambitions as articulated within its vision and strategic objectives, and thereby ensure its long-term sustainability;
- the Board and its subcommittees will have full understanding and assurance of all issues that may affect the Trust's operations;
- all relevant stakeholders including the Gloucestershire public and all professional partners, will have evidence that the Trust is aware of its environment, pressures and threats, and is taking all appropriate remedial actions in line with its legal and ethical responsibilities, so as to ensure continuous quality improvement;
- there will be a measurable reduction in detrimental impacts upon the quality of healthcare services provided across Gloucestershire, thereby improving service user safety and experience;
- decisions of the Trust will be taken with full consideration and awareness of the risk environment.

2. Definitions

2.1 "Risk" is defined as the likelihood that harm or damage may occur as a result of an action, inaction, activity, inactivity, failure or omission, and the relative consequence and severity of the outcome.

2.2 "Risk management" is defined as the proactive process by which the Trust identifies risks, assesses their relative importance, determines the appropriate risk control mechanisms, and ensures that agreed actions are taken. Risk management within the Trust will result in one of four possible responses:

- **Avoidance (or Termination):** some risks will only be manageable, or containable to an acceptable level, by termination of the associated activity;
- **Reduction (or Treatment):** although it may not be possible or practical to eliminate some risks completely, the impact of such may be reduced to an acceptable level by suitable management;
- **Transfer:** some risks may be transferable to a third party (for example, via insurance where appropriate), however this course of action would need to be undertaken with clear and transparent agreement;
- **Retention (or Acceptance):** the ability to mitigate some risks may be limited, or the cost of the necessary action may outweigh the potential benefit gained, and in such cases, the most appropriate response to the risk may be to tolerate or accept it.

2.3 "Strategic risks" are defined as those risks that, if realised, could fundamentally affect the way in which the Trust exists or operates, and/or which may have a detrimental effect on the organisation's achievement of its strategic objectives. The realisation of strategic risks may lead to material failure, loss or lost opportunity (for example, loss of significant sums of money), failure to meet Care Quality Commission (CQC) or other mandatory requirements, death or serious injury of a service user or Trust colleague, and/or failure to meet significant strategic targets.

2.4 "Operational risks" are defined as those risks that are associated with the day-to-day workings of the Trust that would increase the likelihood of a strategic risk being realised.

2.5 "Risk appetite" is defined as the level of risk that the Trust is prepared to accept, before action is deemed necessary to reduce it. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings. The Board will agree and maintain the risk appetite of the Trust, and review this in line with national and organisational change and the *Orange Book: Management of Risk - Principles and Concepts* (HM Treasury, 2013). For further details, please see section 5.2 below.

3. Ambition and Objectives

3.1 The ambition of this Risk Management Strategy is "*To create optimum opportunity for the successful delivery of exemplar healthcare services by ensuring a consistent framework for the identification, management and mitigation of all potential or actual risks*".

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 aspire to ensure delivery of the highest possible care quality to local service users.

3.2 This five year Risk Management Strategy seeks to ensure that by 2021, the following objectives will have been embedded, linked to the Trust's overarching strategic objectives:

Trust Strategic Objectives	**Risk Management Strategy Objectives**
Achieve the best possible outcomes for our service users through high quality care	• Reducing the occurrence of adverse events and incidents that could otherwise threaten or cause avoidable harm to service users and colleagues, and thus impact upon the quality of care services across Gloucestershire • Improving service user and colleague safety by increasing the Trust's ability to ensure clinical effectiveness • Enhancing service user and colleague experience by reducing or removing hazards or circumstances which are perceived as obstructive to care delivery
Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work	• Ensuring that all relevant feedback from service users, carers and families, including that from complaints and claims, is routinely captured and reflected within the Trust's risk management processes

Actively engage in partnerships with other health and social care providers in order to deliver seamless services	• Integrating risk management practices into joint organisational policies, planning and decision making, as well as day-to-day healthcare activity across Gloucestershire • Sharing best practice, risk actions and outcomes across the local healthcare economy in order to reduce exposure to risk, irrespective of setting
Value colleagues, and support them to develop the skills, confidence and ambition to deliver our vision	• Ensuring a culture that actively promotes risk awareness and personal and professional accountability • Ensuring that all appropriate reporting arrangements and individual responsibilities in respect of risk management, are clearly identified and understood • Empowering all Trust colleagues with the knowledge and skills to make effective contributions to risk management
Manage public resources wisely to ensure local services remain sustainable and accessible	• Supporting the achievement of the Trust's strategic objectives by ensuring that all risks which could otherwise threaten or prevent success, are proactively identified, mitigated or managed to an acceptable level • Complying with all relevant legislation, regulations and standards in relation to risk management

4. National Context

4.1 The *Well-Led Framework for Governance Reviews* (Monitor, now NHS Improvement, updated 2015) places a clear emphasis upon Trust Boards to be sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services. More specifically, there is explicit requirement for Trust Boards to ensure that:

- there is an effective and comprehensive process to identify, understand, monitor and address current and future risks;
- service developments and efficiency changes are developed and assessed with input from clinicians to understand their impact on the quality of care: also, that their impact on quality and financial sustainability is monitored effectively, and that financial pressures are managed so that they do not compromise the quality of care.

4.2 The *NHS Foundation Trust Code of Governance* (Monitor, now NHS Improvement, updated 2014) requires Trust Boards to:

- determine the nature and extent of the significant risks they are willing to take in achieving its strategic objectives;
- maintain sound risk management and internal control systems so as to safeguard assets, service user safety and care quality;
- maintain continuous oversight of the effectiveness of their risk management and internal control systems;
- report on risk management and internal controls, including financial, operational and compliance controls, within their Annual Report and Accounts.

4.3 Although responsibility for issuing guidance in respect of service user safety was transferred in 2012 from the National Patient Safety Agency (NPSA) to the NHS Commissioning Board Special Health Authority (subsequently, the NHS Commissioning Board and now NHS England), the NPSA documents still remain pertinent. Thus, the *Risk Assessment Programme Overview* (NPSA, 2006), *Healthcare Risk Assessment Made Easy* (NPSA, 2007) and *A Risk Matrix for Risk Managers* (NPSA, 2008) continue to provide the fundamental reference for risk management practice within the NHS.

4.4 The *Risk Management Standards 2013-14* (NHS Litigation Authority, 2013) incorporate a framework that enables Trusts to focus their risk management activities upon supporting the achievement of quality improvements in care delivery, organisational governance, and service user safety. Moreover, the standards seek to provide guidance in respect of the proactive identification of risks, the embedding of risk management into an organisation's culture, and the understanding of risk exposure.

4.5 At the time of writing this Strategy, NHS Improvement, in its capacity as the Trust's regulator, is consulting upon a Single Oversight Framework in order to identify where providers may benefit from improvement support. This Framework will latterly serve to replace the legacy Risk Assessment Framework (used by Monitor to regulate Foundation Trusts) and the Accountability Framework (used by the NHS Trust Development Authority to regulate Trusts).

Thus, it is currently proposed that the Framework will consider risk across five key domains, namely (i) quality of care, (ii) finance and use of resources, (iii) operational performance, (iv) strategic change, and (v) leadership and improvement capability.

Further details on the Framework will be available following the assessment of the consultation (anticipated autumn 2016).

4.6 There are also a number of key national documents, which although principally focused upon ensuring and assuring the quality of care services, also give consideration to the need for, and impact of, risk management processes. These documents include:

- *A Promise to Learn - a Commitment to Act* (National Advisory Group on the Safety of Patients in England, 2013), which focuses upon three categories of risk to service users, namely (i) risk of harm due to neglect or wilful misconduct, (ii) risk of harm due to failures in the system, and (iii) risk of harm from error. Whilst all three categories necessitate review and management as appropriate, the report advises that harm caused by neglect or wilful misconduct, warrants particular sanctions, as it would in settings other than the NHS. The report also recognises the inherent tensions between risks and resources, and advises vigilance against reductions in staffing, time or consumables, that may raise the risk of service user harm to unnecessary or unacceptable levels;

- *Hard Truths: The Journey to Putting Patients First* (Department of Health, 2013), which seeks to improve the identification of risks within the healthcare system by maintaining standards of care, improving information sharing, and observing a new risk-based inspection regime;

- *Review into the Quality and Safety of Care at 14 NHS Hospital Trusts in England* (Department of Health, 2013), which recommends that all NHS provider organisations must confidently and competently use data and other intelligence from a range of sources in their risk assessment practices. The report also highlights concerns as to a potential significant disconnect between what Trust Boards perceive to be their key operational risks, and what is actually happening in frontline services.

5. Local Context

5.1 The Trust maintains a number of formal processes and systems by which it seeks to manage both strategic and operational risk. These include:

- Trust policies, including the Risk Management Policy, the Incident Governance Policy, the Being Open and Duty of Candour Policy, the Complaints Policy and Procedure etc;
- local team / directorate risk registers which capture all operational risks;
- the Corporate Risk Register which captures all significant operational risks distilled from the local team / directorate risk registers;
- the Board Assurance Framework which details strategic risks and highlights links to all significant corresponding operational risks;
- the appointment of key individuals to oversee risk processes on behalf of the Trust, including the Head of Planning, Compliance and Partnerships, the Information Governance and Risk Manager and the Compliance Officer;
- the Risk Steering Group which serves to systematically evaluate all reported significant operational risks and all strategic risks so as to ensure a consistent approach to risk ratings;
- a number of key forums with specific responsibilities for relevant aspects of risk, which include the Trust Board and Board subcommittees (for further detail, refer to section 10 below);
- Risk Champions who serve as local advocates for risk across the Trust.

5.2 As noted in section 2.5 above, risk appetite is defined as the level of risk that the Trust is prepared to accept, before action is deemed necessary to reduce it.

Furthermore, an advisory paper produced by KPMG (*Understanding and Articulating Risk Appetite*, 2008) suggests that a well-defined risk appetite should embody the following characteristics:

- reflective of strategy, including organisational objectives, business plans and stakeholder expectations;
- reflective of all key aspects of the business;
- acknowledges a willingness and capacity to take on risk;
- is documented as a formal risk appetite statement (see the Trust's Risk Management Policy);

- considers the skills, resources and technology required to manage and monitor risk exposures in the context of risk appetite;
- is inclusive of a tolerance for loss or negative events that can be reasonably quantified;
- is periodically reviewed and reconsidered with reference to evolving industry and market conditions;
- has been approved by the Board.

To this end, the Board debated its risk appetite at a Board Development session in April 2016: this assessed and established the tolerance of the Board and its subcommittees to be notified of risks within the following seven domains:

- service user or colleague safety;
- clinical quality or operational effectiveness;
- service responsiveness;
- service innovation;
- compliance with regulatory, mandatory or professional standards;
- financial sustainability;
- reputation of the Trust.

It was agreed at that time, that the Board and its subcommittees should have sight, via the Corporate Risk Register and Board Assurance Framework, of all operational risks rated 12+ based on the NHS National Patient Safety Agency (NPSA) framework, in order to be suitably informed and assured of mitigating actions. The exception to this was any risk identified as posing risk to service user or staff safety for which risks rated 8+ were deemed appropriate for review and consideration, reflecting the Trust's lower tolerance for those potential or actual risks which could result in avoidable harm to service users, carers, families, colleagues or members of the public (for further detail, please refer to the illustration in section 7.3.2 below).

5.3 In 2015-16, the Trust's internal audit function undertook an assessment of the organisation's risk management function. This identified the need for six remedial actions, two of which were classified as medium risk, and four of which were deemed low risk.

The recommendations of this audit have been incorporated where appropriate within this Risk Management Strategy, the Risk Management Policy and all associated risk management practices and procedures.

6. Strategy Goals

6.1 In order to ensure that this Risk Management Strategy maintains optimum focus upon achieving quality outcomes, the following goals have been identified:

- to make effective contribution to the Trust's culture wherein risks are openly and honestly acknowledged;
- to observe robust procedures so that there is clear process to identify, escalate, record, manage and/or mitigate all operational risks that may impact upon service delivery;
- to enable clear recognition and management of strategic risks so as to ensure the optimum sustainability and quality of delivered care across Gloucestershire;
- to ensure that learning from risks is communicated and integrated so as to inform and strengthen future service delivery.

7. Priorities and Actions

The following priorities have been identified, mapped against the Strategy's 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 Audit and Assurance Committee.

7.1 To make effective contribution to the Trust's culture wherein risks are openly and honestly acknowledged

The Trust's CORE values are Caring, Open, Responsible and Effective. With regard to risk management, this requires the following actions.

7.1.1 Colleagues will be actively encouraged via routine communications and direct interactions with line managers, to be frank, honest and responsible, in their identification of risks, and in particular, if any omissions or errors have been made which resulted in a negative event. This approach is supported by *A Promise to Learn - a Commitment to Act* (Berwick, 2013), which states that "*transparency is essential…with regard to information. The most valuable of all information is information on risks and on things that have gone wrong. Everyone should be free to state openly their concerns about patient safety without reprisal, and there is no place for compromise agreements that prevent staff discussing safety concerns".*

In complying with this requirement, the Trust recognises the need for a balance between openness and confidentiality. Therefore, whilst colleagues will be required to be open about risks, they must nevertheless continue to appropriately safeguard personal information about service users, colleagues and matters of commercial sensitivity.

7.1.2 The Trust will maintain a robust process for whistleblowing, should colleagues feel unable to report any risk that they may identify through other means. To this end, the Trust's Raising Concerns at Work - Whistleblowing Policy, serves to support colleagues who may wish to register risks or concerns regarding the quality of care, the safety of service users or colleagues, professional misconduct or financial malpractice including fraud, bribery or corruption. Equally, the Trust's Ambassador for Cultural Change acts as the Trust's Freedom to Speak Up Guardian, offering colleagues an alternative route through which to raise concerns and/or risks.

7.1.3 The Trust will openly elicit the input of service users, carers, families and the wider public, in respect of any potential or actual risks that they may perceive, ostensibly to the quality of delivered care. Thus, opportunity to highlight risks will be clearly included within all forms of service user feedback, from surveys to focus groups. Moreover, all feedback that is captured will be rapidly escalated to the relevant Trust management, so as to ensure that the public's voice is heard.

7.1.4 The Trust will fulfil its responsibilities, in line with the duty of candour, to make relevant information available to the public. This will require, for example, the Trust to display information in community hospitals covering a range of issues, such as infection control rates, safety indicators and other service user experience feedback, from which service users may be able to extrapolate and interpret risks.

Additionally, and on request, the Trust will provide service users, as well as their carers and families where there is explicit consent, with a summary of their health needs and proposed treatments. This will include information about risks, and will detail all alternatives where appropriate. This commitment to openness seeks to ensure better involvement of service users and families, in decisions about their care. However, in sharing such information, the Trust will observe robust Information Governance practices, and so only share person-based information in a controlled manner that is wholly consistent with the interests of the service user.

7.1.5 Leadership is deemed essential to provide the necessary support for risk management, and to ensure that a proactive approach to risk is adopted Trust-wide. In encouraging such leadership, the Trust will recognise and embrace the behaviours identified as being fundamental to helping reduce risk. These behaviours include:

- seeking out and listening to colleagues;
- abandoning blame as a tool in the risk management processes;
- leading by example, through commitment, encouragement, compassion and a learning approach;
- maintaining clear, mature and open dialogue about risk;
- constantly and consistently asserting the primacy of safely meeting the needs of service users and carers.

Moreover, all Trust leaders will be required to routinely reinforce the message as per the quotation in section 1 above, that risk management is the shared responsibility of all Trust colleagues, irrespective of status or base of employment.

7.1.6 The Trust will ensure that throughout its training programmes, there is effective coverage of risk management processes. This commitment to increasing colleagues' awareness of their personal responsibilities for risk will be enhanced by an on-going programme of communications across the Trust, that will additionally seek to reinforce appreciation for the value and significance of risk management.

7.2 To observe robust procedures so that there is clear process to identify, escalate, record, manage and/or mitigate all operational risks that may impact upon service delivery

7.2.1 All Trust colleagues will have responsibility for identifying operational risks relevant to their service, team and/or working environment. These risks may be apparent as a result of colleagues' observations, or they may require the triangulation of information from a range of sources including:

- risk assessments conducted in respect of issues or concerns that have been highlighted through routine working practice;
- internal or external evaluations that include audits, peer reviews or other quality assurances;
- external guidance or alerts that are issued by the Department of Health, the Care Quality Commission, NHS Improvement etc;
- serious incidents, complaints or other related quality issues;
- public and stakeholder engagement, whether in relation to a specific consultation about a proposed service development, or as part of the Trust's regular internal or external engagement;
- routine benchmarking of the Trust's operational performance against that of its counterparts so as to ensure that risks are consistently identified, and managed to comparable levels.

7.2.2 A range of tools and resources will be maintained to support colleagues in the identification and escalation of risks, including:

- a comprehensive portfolio of fully documented risk management policies, protocols, procedures and guidance documents that will be readily available via the Trust intranet;
- an agreed risk register template that must be used by each service, team or directorate as appropriate;
- standardised risk assessment and incident reporting forms;
- an agreed Quality (Equality) Impact Assessment that will help identify the potential risks that may inadvertently result from Trust developments.

It is noted that at the time of writing this Strategy, risk registers are maintained on manual spreadsheets: however, it is the ambition of the Trust to migrate to an electronic system at the earliest opportunity.

7.2.3 The Trust will maintain a standardised process by which all operational risks will be effectively analysed, evaluated, managed and mitigated. This process will include the following:

- each identified risk will be assigned a lead and Executive owner;
- the risk impact (i.e. the score of the comparative likelihood and consequence of each risk) will be calculated for the following three circumstances:
  - no controls being in place (the inherent risk);
  - current controls being enacted in full (the residual risk);
  - the required target (the target risk).

  Scores will be assigned in a consistent and uniform manner, irrespective of the source or originator of the risk;
- each risk will require a corresponding proactive or remedial action to be ascribed. The selection of the most suitable action will include a measure of the potential impact of the risk weighed against the cost or effort necessary to enact it. Where substantive reductions in risk can be achieved with relatively low expenditure or activity, such actions will always be implemented, albeit with the approval of the risk lead. Further options for improvement may be deemed to be uneconomic or inappropriate, and therefore judgement must be exercised by the relevant risk lead or owner as to whether or not they are justifiable;
- once a risk has been rated and the corresponding actions determined, the risk will continue to be measured and monitored by the following process, which is based upon the severity implied by its rating. Thus:
  - risks that are attributed a residual 1-3 risk rating will be managed through local control measures, and will only be subject to aggregate review for trend analysis;
  - risks that are attributed a residual 4-12 risk rating will be subject to regular review at local level via the relevant forum, the exception being risks which impact upon safety which will require the development a formal action plan (see 7.2.4 below) and which will be escalated to the Corporate Risk Register when rated 8+;
  - risks that are attributed a residual 12+ risk rating will always require the development of a formal action plan with timescales, and will be used to inform the monthly Corporate Risk Register.

Full details of these processes will be captured in the Trust's Risk Management Policy. The Trust will also maintain a formal Escalation and Assurance Framework which will document the processes by which the Board will ultimately be assured that all operational risks are being appropriately highlighted and reported.

7.2.4 The Trust will ensure that a formally documented action plan is developed in order to support each operational risk with a residual risk rating of 8+ (where there is direct impact upon safety) or 12+ (for all risks other than those with direct impact on safety). This will require the risk lead to identify all controls and sources of assurance, together with any gaps that may be needed to strengthen these controls: additionally, to clarify and track all mitigations to reduce the risk, and provide assurance to appropriate Trust forums, including the Trust Board where requested, as well as all external bodies.

7.2.5 Responsibility to review the on-going management and mitigation of operational risks will be conducted within appropriate forums at both local and Trust-wide level, dependent upon the nature and severity of the risk, in order to maintain a clear governance process that ultimately provides assurance up to the Trust Board. In particular, each forum will be responsible for undertaking a process of "check and challenge" that will ensure rigorous review of all risks, and facilitate recommendations to adjust risk ratings accordingly. Most significant will be the Risk Steering Group which will receive monthly oversight of all operational risks that have either:

- a residual risk rating of 12+, or 8+ where there is direct impact upon safety;
- an inherent risk rating of 12+, irrespective of the residual risk, in order to be assured that identified controls are robust.

All such risks will be scrutinised in-depth by the Risk Steering Group, in order to identify trends across teams or directorates and thereby compound risks where appropriate: also to "normalise" risks so that risk scoring is consistent and proportionate across the Trust as a whole (thereafter, the Group will additionally be responsible for ensuring that any normalisation / rescoring is effectively communicated back to the responsible risk lead).

7.2.6 In respect of operational risks that are deemed most significant, colleagues should refer to business continuity arrangements to help identify potential mitigations, and to demonstrate an appropriate Emergency Preparedness Resilience and Response (EPPR).

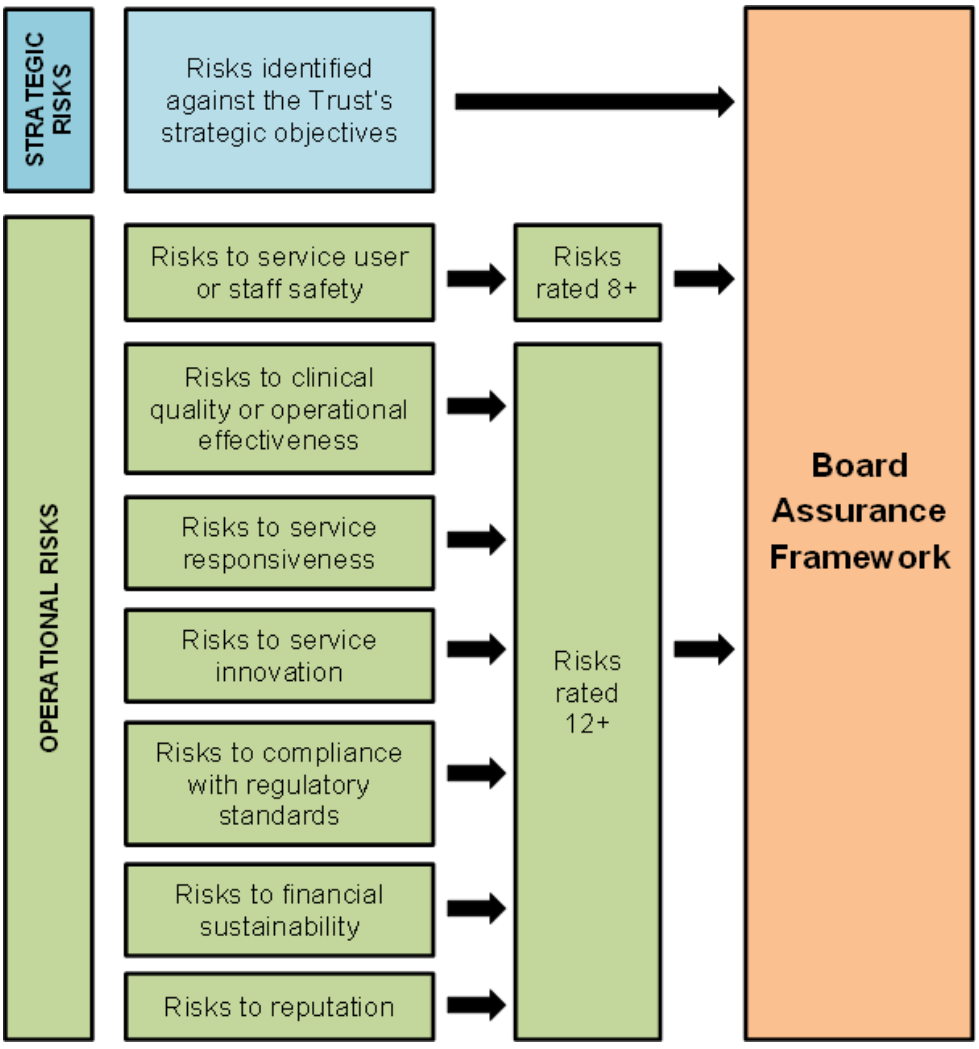
7.2.7 There will be a formal annual review of the effectiveness of the processes for managing operational risks across the organisation, and this will be documented in the Trust's Annual Governance Statement which forms part of the Annual Report and Accounts.

7.3 <u>To enable clear recognition and management of strategic risks so as to ensure the optimum sustainability and quality of delivered care across Gloucestershire</u>

The Trust will maintain robust processes to identify strategic risks to its business i.e. risks that may threaten or impede the achievement of the Trust's strategic objectives (see section 3.2 above).

7.3.1 Responsibility for the oversight and management of strategic risks will be allocated to the Trust's Executive and Non-Executive Directors. This includes responsibility for identifying all strategic risks on an annual basis, evaluating these risks on a bi-monthly basis, and routinely ensuring that adequate responses, actions and/or mitigations are in place and monitored.

7.3.2 The Trust will maintain an active Board Assurance Framework ("BAF") in order to document the identified strategic risks together with details relating to risk owners, severity, impact, mitigations etc. The BAF will also identify the most significant corresponding operational risks that require the input and direction of the Board. Thus, the format of the BAF is as summarised below:



As noted in section 7.3.1 above, the BAF will be evaluated by the Board every two months (i.e. at every Board meeting). This will include review, assessment and update of the BAF's content as appropriate.

This routine evaluation will also serve to provide assurance of the effectiveness of the controls and actions that have been implemented in order to manage or mitigate the identified strategic and high-level operational risks.

The BAF will also be annually evaluated by the Audit and Assurance Committee in order to ensure its consistent use to inform risk-based Board decision-making.

7.3.3 In order to support the BAF, the Trust's Executive and Non-Executive Directors will be required to refresh the Trust's SWOT and PESTELI analyses on an annual basis, and ensure that the outputs correlate to the strategic risks that are identified and captured within the Board Assurance Framework.

As such, the SWOT analysis (Strengths, Weaknesses, Opportunities and Threats) will serve to add maximum value to the Trust's strategic risk-based planning process, whilst the PESTELI analysis (Political, Economic, Sociological, Technological, Environmental, Legal and Industrial) will help structured planning in respect of all external factors that could be harmful to the Trust in its ambition to achieve its strategic objectives.

7.4 To ensure that learning from risks is communicated and integrated so as to inform and strengthen future service delivery

The Trust is committed to learning from its risk experiences, including learning from how risks occurred, how they were identified, mitigated or otherwise managed, and how they were finally resolved or accepted within the Trust's agreed tolerance levels. To this end, the Trust will ensure the following actions:

7.4.1 Within a risk's lifecycle, the risk lead and owner will formally assess the nature of the risk in order to ascertain whether it may be of significance or interest to colleagues outside the service in which it is being managed. Where the risk is deemed to be pertinent or applicable elsewhere, the risk lead will identify all transferable learning that can thereafter be escalated to relevant teams across the Trust so as to prevent or reduce the likelihood of the same or similar risk occurring. This informed guidance will include practical advice in respect of ways in which to better safeguard local activities or practice in order to ultimately improve care quality, as well as service user safety and experience.

By sharing such critical learning across teams and directorates, the Trust will seek to encourage closer working relationships within and across services, and will also strengthen its operational service delivery.

7.4.2 Via its routine communications processes, the Trust will seek to ensure that all changes to practice that result from risk learning, are effectively communicated to the Trust's professional partners and other stakeholders in order to evidence the organisation's integrity and commitment to continuous quality improvement. This action is also in line with the Trust's commitment to be an excellent partner within the wider community.

7.4.3 The Head of Planning, Compliance and Partnerships will be responsible for producing a formal analysis report in respect of service delivery risks for presentation to the Quality and Performance Committee on an annual basis, whilst a similar annual report in respect of non-service delivery risks will be developed and shared with the Audit and Assurance Committee. These reports will facilitate the identification of trends, and will enable proactive measures to be taken to reduce the potential of repeated risks occurring in future.

7.4.4 As referenced in section 7.2.7, the Head of Planning, Compliance and Partnerships will also be responsible for developing the Annual Governance Statement, which will provide the Board, NHS Improvement and Department of Health with suitable assurance that all internal control systems are performing with optimum efficiency.

8. Quality Measures

Each of the strategy goals as identified in section 6 above, will be supported by a series of performance measures as detailed below, to be reported to, and monitored by, the Audit and Assurance Committee on a regular basis.

Strategy Goal	Quality Measure
To make effective contribution to the Trust's culture wherein risks are openly and honestly acknowledged	• Increase in the total number of operational risks reported across the Trust • Increase in the number of operational risks identified as a result of engagement with local service users, carers and families
To observe robust procedures so that there is clear process to identify, escalate, record, manage and/or mitigate all operational risks that may impact upon service delivery	• Reduction in the overall severity of operational risks reported across the Trust • Clear evidence of action plans developed and reviewed by the appropriate forum, in respect of all operational risks rated 12+ • Formal annual review of operational risk management processes
To enable clear recognition and management of strategic risks so as to ensure the optimum sustainability and quality of delivered care across Gloucestershire	• Evidence that the Board has reviewed the content of the BAF every two months • Evidence that actions have been taken in response to strategic risks that have been identified within the BAF
To ensure that learning from risks is communicated and integrated so as to inform and strengthen future service delivery	• Evidence of the Annual Governance Statement • Evidence of trend analysis reports presented annually to the Quality and Performance Committee and the Audit and Assurance Committee • Evidence of actions and changes to practices that have been taken as a result of learning, in order to reduce the potential for risk

9. Accountabilities and Assurances

9.1 All Trust colleagues

Proactive management of risk is the responsibility of all Trust colleagues. Everyone who works for the Trust should therefore:

- be aware of local risks and the Trust's Risk Management Policy;
- record and notify managers of any risks identified;
- be aware of, and comply with, incident reporting policies and procedures;
- participate in risk assessment programmes relevant to their post;
- recommend risk management solutions;
- initiate action, where appropriate, to prevent or reduce the effects of risk.

9.2 Risk Champions

Risk Champions are nominated from across the Trust, and represent the range of services / functions provided by the organisation. They act as an advocate for risk within their respective teams, and therefore are a point of contact for risk queries locally; similarly, they are responsible for distributing relevant information regarding risk management locally, and for supporting Executives and risk owners in the routine gathering of risks as relevant to their team. Risk Champions are also required to attend quarterly meetings to discuss the Trust's risk management processes and identify opportunities for improvement: also to validate that Trust agreed practices are being enacted.

9.3 Locality Managers/Senior Managers

Locality Managers and other senior managers within the Trust are expected to take an active lead in ensuring that risk management and systems of internal control are of the highest standard and integral to the operation of the organisation, and that operational risks are appropriately identified and managed in their areas of responsibility.

9.4 Head of Planning, Compliance and Partnerships

The Head of Planning, Compliance and Partnerships is responsible for the management and oversight of the Board Assurance Framework and Corporate Risk Register. This role is supported by the Trust's Information Governance and Risk Manager and the Compliance Officer.

9.5 Executive Directors

Executive Directors will be responsible for ensuring that risks are managed in their own areas of responsibility. This includes duty for monitoring local systems of identification, recording and reviewing actions, escalating concerns where required, and tracking actions identified on the Board Assurance Framework.

9.6 Chief Executive

The Chief Executive is the Trust's Accountable Officer, and as such, will maintain overall responsibility for ensuring that the organisation delivers the highest quality services: this includes responsibility for the effective management of risks that may otherwise impact upon service quality. Moreover, whilst it is noted that in law, it is the Trust Board, as employer, that is responsible for compliance with risk management legislation, in practical terms, this responsibility is transferred to the Chief Executive.

9.7 Risk Steering Group

The Risk Steering Group serves to systematically evaluate all reported significant operational risks and all strategic risks so as to ensure a consistent approach to risk ratings. Additionally, the Group serves to enable a robust mechanism to provide feedback to local risk owners in respect of any risks which the Group deems incorrectly rated.

9.8 Board subcommittees

Each of the non-statutory Board subcommittees (namely the Quality and Performance Committee, the Finance Committee and the Workforce and Organisational Development Committee) will routinely receive and review extracts from the Corporate Risk Register that identify risks relevant to their area of operation, and as such, will be responsible for advising on mitigations and actions as appropriate.

9.9 Audit and Assurance Committee

The Audit and Assurance Committee will maintain responsibility for ensuring an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities, enabling achievement of the Trust's vision, values and strategic objectives. This includes responsibility for ensuring that a robust process for the identification of risk is in place.

9.10 Trust Board

The Trust Board will maintain overall responsibility for the management of risk across the organisation. Its specific duties include:

- routinely reviewing and re-evaluating the risk appetite for the organisation;
- ensuring an effective system of internal control including risk management across the Trust;
- receiving the Board Assurance Framework at each Board meeting, and advising on mitigations and actions as appropriate;
- receiving assurance reports from all Board subcommittees with regard to risks, internal control and assurance.

10. Enabling and Supporting Strategies

10.1 This Risk Management Strategy complements the following additional strategy documents maintained by the Trust:

- the Quality Strategy, which seeks to champion a whole-system approach so as to ensure that consideration of quality becomes fundamental to every decision and action taken by the Trust;
- the Clinical Strategy, which seeks to empower the Trust to remain a leading provider of community-based care services that provide optimum quality, safety and effectiveness, and enable every person in Gloucestershire to experience a positive journey and outcome;
- the Workforce and Organisational Development Strategy, which serves to identify how the Trust's working environment will be advanced in order to create a sustainable culture that supports the delivery of high-quality, person-centred care;
- the Health, Safety and Security Strategy, which serves to confirm the Trust's clear commitment to maintaining the physical and personal safety of all Trust colleagues, service users, carers, families as well as the wider Gloucestershire public who attend any of the Trust's facilities.

10.2 This Risk Management Strategy is directly supported by an implementation plan, which will clarify the actions to be undertaken in the period 2016-21 in order to fulfil the ambitions of this Strategy.

11. References

Orange Book: Management of Risk – Principles and Concepts (HM Treasury, 2013)

Well-Led Framework for Governance Reviews (Monitor, 2015)

NHS Foundation Trust Code of Governance (Monitor, 2014)

Risk Assessment Programme Overview (NPSA, 2006)

Healthcare Risk Assessment Made Easy (NPSA, 2007)

A Risk Matrix for Risk Managers (NPSA, 2008)

Risk Management Standards 2013-14 (NHS Litigation Authority, 2013)

Single Oversight Framework Consultation (NHS Improvement, 2016)

A Promise to Learn - a Commitment to Act (Berwick, 2013)

Hard Truths: The Journey to Putting Patients First (DoH, 2013)

Review into the Quality and Safety of Care at 14 NHS Hospital Trusts in England (DoH, 2013)

Understanding and Articulating Risk Appetite (KPMG, 2008)

Minutes of the Special Meeting Audit and Assurance Committee

Boardroom, Edward Jenner Court

Tuesday 31st May 2106

Committee Members present:

Richard Cryer - Non-Executive Director (Chair)
Robert Graves - Non-Executive Director
Jan Marriott - Non-Executive Director
Nicola Strother Smith - Non-Executive Director

In attendance:

Glyn Howells - Director of Finance
Stuart Bird - Deputy Director of Finance
Louise Moss - Deputy Trust Secretary
Rod Brown - Head of Compliance, Planning and Partnerships
Duncan Laird - External Audit, KPMG

Item	Minute	Action
	Agenda Welcome and Apologies The Chair welcomed members to the extra ordinary meeting of the Committee. Apologies were noted from; - Sue Mead	
	Confirmation that the meeting is quorate The meeting was **confirmed** as quorate by the Deputy Trust Secretary.	
	Declarations of Interests Members were asked to declare any updates from their original declaration of interests and to declare interests at the time of any concerned agenda item. No updates or interests were declared.	
	Annual Report and Accounts The Director of Finance summarised the Annual report and accounts noting two significant changes to the report since the Committee members met on 24th May 2016.	

Item	Minute	Action
	- Moving the amount of the charge (£6,854k) of the impairment amount arising from the revaluation of buildings from the I&E account to the revaluation reserve as requested by the external auditors; - Reflecting the outcome of mediation with Gloucestershire Hospitals NHS Foundation Trust. Duncan Laird confirmed that the auditors recommended the change to the presentation of where the revaluation impact was reflected and that they had confirmed the accounting treatment of the outcome of the mediation against the mediation letter from NHS Improvement. Nicola Strother Smith asked in respect of the remuneration report if the Trust has to make any declarations to the Secretary of State relating to payments of > £142.5 (Prime Minister's salary). In response Duncan Laird confirmed that this applies to Foundation Trusts and Clinical Commissioning Groups only and that NHS Trusts are excluded. On this basis the committee agreed that the Trust was not required to make any declarations regarding salary to the Secretary of State. Robert Graves noted that there are some minor amendments to be made in respect of consistency, style and presentation eg. NED should read Non-Executive Director. The Chair directed the Committee to view KPMG's draft ISA 260 Audit Memorandum document. Duncan Laird confirmed that the auditors will be submitting a final ISA 260 report stating the financial statements are unqualified and that the Trust had adequate arrangements to secure economy, efficiency and effectiveness in the use of resources. (clean) Duncan Laird further stated that as a result of the work undertaken two priority 2 recommendations have been made regarding the delays in the accounts and annual report production process and the lack of a process formal review of bank reconciliations. The audit has been completed in line with the agreed plan noting an improvement on last year. A small number of delays had occurred in receiving the supporting information, e.g. Remuneration information and GHNHSFT mediation outcome. This information has now been received and the final report will be amended to reflect this before sending onto the Department of Health.	

Item	Minute	Action
	There is one unadjusted difference which Duncan Laird brought to the attention of the Committee regarding Local Government Pension Scheme (LGPS) revaluation difference. Previously the Trust had an IAS19 net pension liability which was reflected in the financial statements. At 31 March 2016 this had turned into a net pension asset of £207k but this had not been recognised on the grounds of materiality. Duncan Laird informed the Committee that KPMG has responsibility for submission of the Annual Report and Accounts along with a number of related documents to the Department of Health once they are signed off by the appropriate GCS Directors. Following Committee approval the Deputy Chief Executive signed off the appropriate documentation required on behalf of Gloucestershire Care Services NHS Trust. The deadline for submission is 2nd June 2016. The Committee reviewed the draft annual report and accounts and subject to minor typographical amendments was content with both the content and style. The Committee, on behalf of the Board, formally **approved** the accounts for submission by the auditors to the Department of Health.	
	Any Other Business or any matter for another Committee. No other business was reported for discussion.	
	Date and Time of Next Meeting **13th September 2016, 10am – 12 pm** Boardroom Edward Jenner Court Brockworth GL3 4AW The Chair **closed** the Committee meeting at 11.05 hrs.	

Gloucestershire Care Services NHS
NHS Trust

`

Gloucestershire Care Services NHS Trust

Minutes of the Audit and Assurance Committee

Boardroom, EJC

Tuesday 3rd May 2016

Committee Members present:

Richard Cryer (RC)	Non-Executive Director (Chair)
Sue Mead (SM)	Non-Executive Director
Robert Graves (RG)	Non-Executive Director
In attendance:	
Glyn Howells (GH)	Director of Finance
Stuart Bird (SB)	Deputy Director of Finance
Rod Brown (RB)	Head of Planning, Compliance and Partnerships
Louise Moss (LM)	Deputy Trust Secretary
Lynn Pamment (LP)	Internal Audit (PwC)
Duncan Laird (DL)	External Audit (KPMG)
Lee Sheridan (LS)	Counter Fraud Specialist
Minute Taker:	
Pamela Farrow (PF)	Senior Personal Assistant

Item	Minute	Action
16/AA024	**Agenda Item 1 Welcome and Apologies** The Chair welcomed members. Apologies were **RECEIVED** from Jan Marriott, Non-Executive Director. The Chair then said that the Forward Planner would be reviewed at the end of the meeting in line with other committees' recent approach.	
16/AA025	**Agenda Item 2 Confirmation of Quoracy** The meeting was confirmed as quorate by the Deputy Trust Secretary.	
16/AA026	**Agenda Item 3 Declarations of Interest** There were no Declarations of Interest.	
16/AA027	**Agenda Item 4 Minutes of the Meeting held on 23rd March 2016**	

	The minutes were approved with the exception of Agenda Item 10 – GH confirmed that he would be signing waivers, special payments and write offs as they occur and they **would** continue be reported to the Committee.	
16/AA028	**Agenda Item 5 Matters Arising (Action Log)** 15/AA038 – Items 5 and 6 – GH reported that these would be reported at the next ordinary meeting of the Committee. 15/AA044 – Item 5 – GH reported that work was being undertaken to link all new compensation claims or incidents reported in Datix as well as linking all retrospective complaints/incidents and an update would be provided as part of the Legal Claims Report at the Committee on 8th December 2016. 15/AA066 – Item 10 – SB reported that as the focus has been recently upon the higher valued debts, this report would be provided at the next ordinary meeting. 15/AA070 – Item 14 – GH reported that as a result of a review of committees, it was ascertained that the new Chair of the Emergency Preparedness and Resilience Committee would be the newly appointed Chief Operating Officer. This item was then closed. 15/AA080 – Item 6 - LP reported in relation to SFIs, this work had been done and a letter would be forwarded to the Trust to confirm that there were no significant issues. It was agreed that the Committee would approve this item based on verbal confirmation by LP. 15/AA086 – Item 13 – RB reported that he had not received any feedback on the draft Risk Assessment and Management Policy and asked that any comments be forwarded to him. 15/AA089 – Item 15 – The two documents on Risk Appetite were discussed at the last Board Development meeting. GH reported that the documents would go forward to the next Risk Management Committee and be aligned to the new strategic risks.	**GH** **SB** **LP** **ALL**

16/AA030	**Agenda Item 6 Internal Audit Update** LP presented the following reports: Data Anonymisation and Pseudonymisation: The Trust achieved a 'Low Risk' overall with the aim of the report to ascertain that the Trust's policies provided the correct guidance for the anonymisation and pseudonymisation of data and how data is appropriately controlled. A number of areas of good practice had been identified. LP referred to the two areas of 'Low Risk' identified: the first relates to ensuring that the pseudonymised NHS numbers contain letters which avoids confusion with original NHS numbers; and the second relates to communication and awareness of the policy which could be improved. RG requested that these positive findings should be formally acknowledged to the relevant team. It was agreed that this acknowledgement of the work undertaken would be **NOTED** by the Committee and forwarded to Board. The Committee **RECEIVED** the Data Anonymisation and Pseudonymisation Report. SystmOne Project Benefits Realisation: Overall, the Trust is rated as 'Medium Risk', based on 2 medium risk and 2 low risk findings. The two medium risks are linked to the issues that although there are a number of important benefits identified and documented on the business case, most of the benefits are not currently being measured or tracked. The two low risks relate to limited evidence that risks to benefits realisation are identified, tracked and managed and that roles and responsibilities are not clear in this respect. RG queried progress towards ensuring the Trust has robust qualitative and quantitative evidence for SystmOne and GH reported that it is now part of the CIPs programme to look at a baseline prior to SystmOne implementation and then to track and monitor benefits through capacity and demand modelling approach. RG commented that any approach needed to be pragmatic and theoretically correct in order for the system to work as productively as possible. LP reported that the work undertaken provided an opportunity to learn from past issues and ensure benefits realisation and risks to benefits realisation are taken forward into the future. SB commented that a strong project management discipline will be needed so that outcomes identified at the beginning of a project are the same outcomes measured at the end. SM commented that clinical recording and links to SystmOne appear to be outside the scope of this report but this is an area that requires further assurance, particularly in relation to recording and sharing clinical information. SM also queried whether demand and activity information is linked and	

	GH responded that SystmOne tracks activity by individual and how much activity per episode of care. A complexity tool will assist in understanding how many 'units' are allocated in order to gauge true demand. The Chair commented that although this report is very useful, it raises a number of questions regarding SystmOne and queried whether the Committee could receive a level of assurance that SystmOne is achieving the appropriate impact and savings. It was agreed that GH would request a 'post implementation review' of SystmOne from Bernie Wood (Head of IT and Clinical Systems) that will show any 'gaps' in the system and inform future action. This review would initially be presented at the Finance Committee but it is likely to have implications for this Committee. Following comments by SM and RB regarding links to clinical recording and the need to recognise the difference between system functionality and records management, it was agreed that the review should also include the non-financial benefits of SystmOne. RG queried requested that user feedback could be included in the post implementation review document. GH responded that the post-project review to be undertaken by Bernie Wood would be predominantly a 'desk-top' exercise although work started by Podiatry and Physiotherapy areas into user feedback could be followed up. It was agreed that a Terms of Reference for the post-project review would be agreed outside the Committee. The Committee **RECEIVED** the SystmOne Project Benefits Realisation Report. LP reported that there had been some delays in starting the SystmOne Data Accuracy Audit during this last year and the remainder of the review has been moved forward to 2016-17. Annual Report: This final version of the Annual Report also includes achievement towards CIPs and is as planned with the exception of some days for SystmOne that have been taken forward into 2016-17. The Chair requested that the paragraph stating the overall numbers of reviews on page 3 should include the report rating as on page 5. The Committee **RECEIVED** the Annual Report subject to the amendment required.	**GH** **RC/GH**
16/AA031	**Agenda Item 7 External Audit Update** DL summarised work undertaken since March 2016: • Completed work to support Use of Resources judgement • Completed review of recharge arrangements between the Trust and GHFT • Received the draft annual accounts. Work is currently underway on: • finalising work on the financial statements, annual	

	accounts and consistency in relation to the annual reports • reporting findings to this Committee • submitting the audited Trust Statements to the Department of Health. DL highlighted a key announcement regarding the requirement for all NHS organisations to produce Sustainability and Transformation Plans as part of a shared planning approach to improvement. The Committee commended the work of colleagues to date on the Trust's plan. DL outlined work undertaken to review the basis of calculation of recharges by the Trust to GHFT and by GHFT to the Trust. A discussion took place regarding how the Trust could recover a positive working relationship with GHFT through a Board to Board discussion following the completion of the mediation processing that is currently ongoing. The Chair asked that it be noted that the Committee commend the professional way in which relevant Trust colleagues have managed the ongoing issue of recharges and their approach has been validated through the External Audit review. The Committee recognised however, that there needs to be a redoubling of efforts to get agreements in place to prevent future differences of opinion between the two Trusts. This issue will be discussed again at the next Committee when it is likely that the outcome of the mediation/arbitration process will be known. The Deputy Trust Secretary to add to the forward planner.	**LM**
16/AA032	**Agenda Item 8 Counter Fraud Update** LS directed the Committee to the Annual Report and asked for comments. LS confirmed that the date stated as March 2015 in the Summary of Risk (No. 3, page 5) is correct as it relates to the previous year and will be updated when the next Annual Report is submitted. LS does not anticipate any changes to the risks stated. GH queried whether there was a need for Internal Audit to review that the Trust's self-assessment of the risks have been correctly stated and linked this to the information governance process. It was agreed that LP and LS would discuss how a review of the processes have been undertaken as part of Internal Audit's review of wider review of self-assessment. LS reported that detailed in the Action Plan, there are 112 days' activity planned for 2016-17. LS provided a verbal update on ongoing cases and informed the Committee that the first of the awareness presentations to	**LP/LS**

	colleagues would be held week commencing 9th May 2016. Finally, LS reported that a new member of the team had been recruited who would be involved with investigations and the concept of producing an awareness video was being progressed. The Committee **RECEIVED** the Counter Fraud Update.	
16/AA033	**Agenda Item 9 Board and Monitor Statements** RB requested the Committee to note that NHS Improvement had discontinued their requirement for monthly submissions of the statements in February 2016 however it is likely that the requirement for monthly compliance returns will resume against a refreshed set of statements. Any submissions will require validation by Board. The Committee **NOTED** the update on Board and Monitor Statements.	
16/AA034	**Agenda Item 10 – Draft Financial Statements/Annual Report Review** GH reported that although this report will be presented at the extra-ordinary Committee on 31st May, the information contained within formed the basis of the information being reviewed by external auditors. GH reported that the highlighted sections require further updates or analysis, however a meeting for the Chair, RG, GH and SB to meet to finalise the report prior to it being received at the extra-ordinary Committee will be arranged within 2 weeks. SB reported that there is some outstanding payroll/pension analysis that is required. RC asked if the Trust needed to hold any provisions against any potential contractual issues at Tewkesbury Hospital. GH reported that the Trust is currently holding a retention against payments due to the Contractor which would be used to off-set any additional costs being incurred and so there was no need for any additional provisions at this time. Further information will be available prior to the next Committee. GH offered to take any of the Committee through the report or any queries they had outside of the meeting if they so desired. The Committee **RECEIVED** the Draft Financial Statements/Annual Report Review and **NOTED** that the Final Report would be presented to the Committee at the extra-ordinary meeting on 31st May.	**GH**
16/AA035	**Agenda Item 11 – Corporate Risks** RB reported that corporate risks have been divided for oversight	

	by the four main Trust Committees with Quality and Performance overseeing the majority of the risks. There are two risks for Audit and Assurance Committee oversight, one relating to the Information Governance Toolkit and the other regarding the Health and Safety function of the Trust. Progress to mitigating risks include the recruitment for a dedicated Information Governance and Risk Manager which is underway, as is a review of the existing Health and Safety Committee which will ensure the Committee is focused on the Trust's wider health and safety agenda and is effectively aligned with clinical governance. GH reported that realigning responsibility for statutory health and safety issues to a sub-committee of JNCF was being considered and then a refreshed Health and Safety Committee with the attendance of senior Trust colleagues will be able to also look at issues related to clinical incident and near miss reporting/lessons learned and continuous improvement. GH reported that these changes would be included in a revised overall governance structure with relevant Terms of Reference that would be presented to the Committee. In response to a query from SM, RB reported that the current approach to health and safety is limited by focusing too heavily on the review and approval of policies and procedures rather than looking to learn from real issues being experienced by our colleagues. GH added that health and safety requirements for Directors of the Trust will be presented at a future Board Development session. The Committee **APPROVED** the Corporate Risks update.	**RB**
16/AA036	**Agenda Item 12 Annual Governance Statement** RB reported that the draft statement had been submitted to NHS Improvement and auditors and will form part of the Annual Report and Accounts which is to be published by 2nd June 2016. The Chair asked members to view the Annual Sub-Committee Statements for the Audit and Assurance Committee. It was agreed that any input by Internal Audit relating to the delayed SystmOne data accuracy audit could be included in the statement for 2016-17. RB confirmed that the table on board attendance would be revised to reflect Ian Dreelan's designate status prior to his resignation. The Committee **APPROVED** the Annual Governance Statement.	**RB**

16/AA037	**Agenda Item 13 Annual Committee Evaluation and Review of Effectiveness** The Chair reported that Annual Committee Statement of the Audit and Assurance Committee will be part of the Annual Governance Statement and will include the Annual Committee Evaluation and Review of Effectiveness. GH reported that his input to the evaluation had been included so the evaluation would be revised and would include the free format comments from members. LP commented that sometimes feedback from attendees is included in other organisations and it was agreed that this could be considered for future evaluation approaches. The Committee **APPROVED** the Annual Committee Evaluation and Review of Effectiveness on the basis of the agreed revisions.	**GH/LM**
16/AA038	**Agenda Item 14 NHSLA Insurance Scheme (for information)** RB reported that as it was discovered that he did not have authority to access the costs of the three relevant schemes so GH would access the information and RB would bring the item to the next ordinary Committee. There are three schemes which are related to Clinical Negligence, Employer's Liability and Buildings Insurance. Post Committee Note: Costs provided following the Committee: Clinical Negligence Scheme for Trusts (CNST) - £365,505 Liability for Third Parties (LTPS) - £82,674 Property Expense Scheme (PES) - £9,848 Following a query from RC regarding Professional Indemnity Insurance, a discussion was undertaken regarding the costs and RB confirmed this information would be included in the Annual Report. The Committee **RECEIVED** the verbal update on the NHSLA Insurance Scheme.	**RB**
16/AA039	**Agenda Item 15 Quality Account GCS Draft** The production of this document is on track and is expected to be sent out to stakeholders during May for one month with results published at the end June 2016. The Committee **RECEIVED** the verbal update on the Quality Account.	

	Agenda Item 16 Any Other Business There was no other business.	
16/AA029	**Agenda Item 17 Forward Agenda Planner** GH confirmed that the SystmOne Report to be undertaken by Bernie Wood would be presented at the Finance Committee. The following items are to be deferred to the September Committee: • Risk Management Strategy • Business Continuity Strategy • Estates Strategy • Information Management and Technology Strategy It was agreed that quarterly meetings of the Committee would be reflected in the 2017-18 iteration of the Forward Agenda Planner. It was agreed that attendance at the extra-ordinary meeting of the Committee would include members, Trust attendees and External Audit only.	**GH/LM**
	Date and time of next meetings **31 May 10am – 12 pm (extra-ordinary meeting)** **13 September 11am – 1pm** **The Boardroom, Edward Jenner Court**	

TRUST PUBLIC BOARD - FORWARD PLANNER - 2016-2017

TRUST PUBLIC BOARD						
Month:	**19 July 2016**	**20 September 2016**	**22 November 2016**	**24 January 2017**	**23/03/2017 (Thursday -note change of date)**	**18/05/2017 (Thursday -note change of date)**
Venue:	**Roses Theatre TEWKESBURY**	**Stroud Subscription Rooms STROUD -**	**The Main Place - COLEFORD**	**Oxstalls Tennis Courts GLOUCESTER**	**Cirencester Town FC Cirencester**	**TBC**
Private Session:	09:30 - 10:45 hrs	09:30 - 10:45 hrs	09:30 - 10:45 hrs	09:30 - 10:45 hrs	09:30 - 10:45 hrs	09:30 - 10:45 hrs
Service User Story:	11:00 - 12:00 hrs	11:00 - 12:00 hrs	11:00 - 12:00 hrs	11:00 - 12:00 hrs	11:00 - 12:00 hrs	11:00 - 12:00 hrs
Public Trust Board	12:30 - 16:00 hrs	12:30 - 16:00 hrs	12:30 - 16:00 hrs	12:30 - 16:00 hrs	12:30 - 16:00 hrs	12:30 - 16:00 hrs
Standing Items						
	Service User Story - TBC	Service User Story - TBC	Service User Story - TBC	Service User Story - TBC	Service User Story - TBC	Service User Story - TBC
	Welcome and apologies	Welcome and apologies	Welcome and apologies	Welcome and apologies	Welcome and apologies	Welcome and apologies
	Confirmation that the meeting is quorate	Confirmation that the meeting is quorate	Confirmation that the meeting is quorate	Confirmation that the meeting is quorate	Confirmation that the meeting is quorate	Confirmation that the meeting is quorate
	Declaration of interests	Declaration of interests	Declaration of interests	Declaration of interests	Declaration of interests	Declaration of interests
	Minutes of the meeting held on the 18 May 2016	Minutes of the meeting held on the 19 July 2016	Minutes of the meeting held on the 20 September 2016	Minutes of the meeting held on the 22 November 2016	Minutes of the meeting held on the 24 January 2017	Minutes of the meeting held on the 23 March 2017
	Matters arising Action Log & completed Action Log	Matters arising Action Log & completed Action Log	Matters arising Action Log & completed Action Log	Matters arising Action Log & completed Action Log	Matters arising Action Log & completed Action Log	Matters arising Action Log & completed Action Log
	Forward agenda planner review (end of agenda)	Forward agenda planner review (end of agenda)	Forward agenda planner review (end of agenda)	Forward agenda planner review (end of agenda)	Forward agenda planner review (end of agenda)	Forward agenda planner review (end of agenda)
	Questions from the public	Questions from the public	Questions from the public	Questions from the public	Questions from the public	Questions from the public
	Chair's Report	Chair's Report	Chair's Report	Chair's Report	Chair's Report	Chair's Report
	Chief Executive's Report	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
Governance, Quality & Safety						
	Board Assurance Framework	Board Assurance Framework	Board Assurance Framework	Board Assurance Framework	Board Assurance Framework	Board Assurance Framework
	Quality and Performance Committee update	Quality and Performance Committee update	Quality and Performance Committee update	Quality and Performance Committee update	Quality and Performance Committee update	Quality and Performance Committee update
	Workforce and Organisational Development Committee update	Workforce and Organisational Development Committee update	Workforce and Organisational Development Committee update	Workforce and Organisational Development Committee update	Workforce and Organisational Development Committee update	Workforce and Organisational Development Committee update
	Quality and Performance Report (Month 2 data)	Quality and Performance Report (Month 4 data)	Quality and Performance Report (Month 6 data)	Quality and Performance Report (month 8 data)	Quality and Performance Report (Month 10 data)	Quality and Performance Report (Month 12 data)
	Finance Committee update	Finance Committee update	Finance Committee update	Finance Committee update	Finance Committee update	Finance Committee update
	Finance Report (month 2 data)	Finance Report (month 4 data)	Finance Report (Month 6 data)	Finance Report (Month 8 data)	Finance Report (month 10 data)	Finance Report (month 12 data)
	Learning Disability Report (see action log)					
Strategy						
	Communications Strategy *Approved by the Workforce & OD Committee - June 2016*	Financial Management Strategy *Approved at the Finance Committee - August 2016*		Quality Strategy		
	Workforce and Organisational Development Strategy - *Approved at the Workforce and Organisational Development Committee - June 2016*	Engagement and Experience Strategy *Approved at the Quality and Performance Committee - August 2016*	Health, Safety and Security Strategy *Approved at the Audit and Assurance Committee - September 2016*			
		Charitable Funds Strategy *Approved at the Charitable Funds Committee - July 2016*	Risk Management Strategy *Approved at the Audit and Assurance Committee - September 2016*			
		Clinical and Professional Care Strategy *Approved at the Quality and Performance Committee - August 2016*	Business Continuity Strategy *Approved at the Audit and Assurance Committee - Sept 2016*			
			Information Management and Technology Strategy *Approved at the Audit and Assurance Committee - Sept 2016*			
			Estates Strategy *Approved at the Audit and Assurance Committee Sept 16*			
Corporate						
	MIIUs	**MIIUs**	**MIIUs**			
	Understanding You report	STP	STP	Understanding You report		
	STP (GH)	Forest of Dean Consultation	Forest of Dean Consultation			
	Forest of Dean Consultation					
Assurance and Information						
	Audit and Assurance Committee update	Charitable Funds Committee update	Audit and Assurance Committee update	Charitable Funds Committee update	Audit and Assurance Committee update	Audit and Assurance Committee update
	Any other business	Audit and Assurance Committee update	Any other business	Audit and Assurance Committee update	Any other business	Any other business
	Review of Board and sub-committee performance	Any other business	Review of Board and sub-committee performance	Any other business	Review of Board and sub-committee performance	Review of Board and sub-committee performance
	Date of the next meeting	Review of Board and sub-committee performance	Date of the next meeting	Review of Board and sub-committee performance	Date of the next meeting	Date of the next meeting
		Date of the next meeting		Date of the next meeting		

AGM - October 11th 2016 Kingsholm Stadium, Gloucester

AGENDA ITEM 19

ANY OTHER BUSINESS