Health, Community and Care Overview and Scrutiny Committee

Tuesday 20th November, 2012 at 10.15 am

Council Chamber - Shire Hall, Gloucester

Pre meeting for committee members at 9.30am
### Health, Community and Care Overview and Scrutiny Committee

**Tuesday 20th November, 2012 at 10.15 am**

**Council Chamber - Shire Hall, Gloucester**

#### AGENDA

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#### OVERVIEW ITEMS

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<td>Margaret Willcox</td>
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#### STANDING ITEM

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<td>10</td>
<td>Committee Report</td>
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Membership – Cllr Terry Hale, Cllr Ron Allen, Cllr Peter Braidwood, Cllr Stephen McMillan (Chairman), Cllr Christopher Pallet, Cllr Mike Skinner, Cllr Brian Thornton, Cllr Brian Oosthuysen and Cllr Gordon Shurmer

Co-Opted District Council Members - Cllr Jan Lugg (Gloucester City Council), Cllr Steve Lydon (Stroud District Council), Cllr Klara Sudbury (Cheltenham Borough Council), Cllr Sheila Jeffery (Cotswold District Council), Cllr Margaret Ogden (Tewkesbury Borough Council) and Cllr Marrilyn Smart OBE (Forest of Dean District Council)

(a) DECLARATIONS OF INTEREST – Members requiring advice or clarification about whether to make a declaration of interest are invited to contact the Monitoring Officer (Nigel Roberts 01452 425201/fax: 426790/e-mail: Nigel.Roberts@glocestershire.gov.uk) prior to the start of the meeting.

(b) INSPECTION OF PAPERS AND GENERAL QUERIES - If you wish to inspect Minutes or Reports relating to any item on this agenda or have any other general queries about the meeting, please contact:
Andrea Clarke, Democratic Services Unit
☎01452 425237/fax: 425850/e-mail: andrea.clarke@glocestershire.gov.uk

(c) GENERAL ARRANGEMENTS
1. Will Members please sign the attendance list.
2. Please note that substitution arrangements are in place for Scrutiny (see p64 of the Constitution).

EVACUATION PROCEDURE - in the event of the fire alarms sounding during the meeting please leave as directed in a calm and orderly manner and go to the assembly point. Please remain there and await further instructions.
HEALTH, COMMUNITY AND CARE OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health, Community and Care Overview and Scrutiny Committee held on Tuesday 18th September, 2012 at the Council Chamber - Stroud District Council.

PRESENT:

Cllr Steve Lydon  Cllr Mike Skinner
Cllr Klara Sudbury  Cllr Brian Thornton
Cllr Terry Hale  Cllr Sheila Jeffery
Cllr Ron Allen  Cllr Marrilyn Smart OBE
Cllr Stephen McMillan  Cllr Brian Oosthuysen
(Chairman)
Cllr Christopher Pallet

The following were also present:
Cllr Andrew Gravells Cabinet Member for Health and Wellbeing

Officers in attendance:
Barbara Marshall, Barbara Piranty – Gloucestershire Local Involvement Network (LINk)
Ruth Fitzjohn, Becky Parish, Jill Crook – NHS Gloucestershire
Rob Cunningham, Sue Field, Gill Vickers – Gloucestershire Care Services
Colin Merker – 2gether NHS Foundation Trust
Mark Branton – Gloucestershire County Council
Sally Pearson – Gloucestershire Hospitals NHS Foundation Trust
Mary Hutton – Clinical Commissioning Group

Apologies: Cllr Jan Lugg (Gloucester City Council), Trish Jay, Cllr Peter A Braidwood, Cllr Margaret Ogden (Tewkesbury Borough Council), Jan Stubbings, Trish Jay and Cllr Gordon Shurmer

40. MINUTES OF THE PREVIOUS MEETING
The minutes of the meeting of 10 July 2012 were agreed as a correct record and signed by the Chairman.

41. DECLARATIONS OF INTEREST
Cllr S Jeffery - Member of 2gether NHS Foundation Trust
Cllr R Allen - Winchcombe Day Care Foundation Member and GCC representative on Gloucestershire NHS Foundation Trust Council of Governors
Cllr M Skinner - Member of the 2gether NHS Foundation Trust

42. WINTER PLANNING BRIEFING
42.1 The committee received a briefing explaining the process involved in planning for winter. It was noted that this was a partnership approach, with NHS Gloucestershire (NHSG) undertaking the coordinating role. The plan supported the management of increased pressures on demand or impacts on capacity usually experienced over the winter period throughout the health and social care community.
Minutes subject to their acceptance as a correct record at the next meeting

42.2 Members were informed that key aspects of the plan included looking at whether there was sufficient capacity in the system; were the infection control measures robust; were the links to nursing homes in place? The committee also heard that part of this planning process involved a review of the previous winter plan in order to gain an understanding of what had worked well and what had not.

42.3 In response to a question it was explained that a particular issue coming out of last winter was that the escalation procedure, across all agencies, had not produced the necessary outcomes, and this was therefore being addressed within the planning for this winter.

42.4 The committee noted that the plan has to be formally submitted to the Strategic Health Authority (SHA), and needed to be in place by the beginning of November 2012. The committee asked to see the final approved plan for information.

ACTION: Mark Branton/Margaret Willcox?

42.5 It was stated that, alongside the traditional increase in demand in the winter period, there were also spikes in demand throughout the rest of the year and suggested that a flexible approach to demand management must be necessary throughout the year. This was acknowledged and members were informed that executive meetings took place fortnightly. The view was also put that what this was really about was business continuity across the year.

43. HEALTH AND WELL BEING STRATEGY (HWBS)

43.1 The Director of Public Health informed the committee that the HWBS was developed by the Shadow Health and Wellbeing Board (HWB). The priorities identified in the HWBS were informed by the data and information from the Joint Strategic Needs Analysis (JSNA). This plan is about to go out for consultation with stakeholders and the public (closes 12 December 2012). The aim of the consultation was to give stakeholders and the public the opportunity to let the Shadow HWB know whether they agreed with the priorities identified in the HWBS. Action plans to address the priorities will be developed following this consultation. It was noted that the HWBS also referenced the Children and Young People’s Plan (CYPP).

43.2 The committee was informed that although the priorities were focused over a three year period the wider plan took a long view over a twenty year period. This reflected the fact that some changes could take a long time to become effective.

43.3 Going forward it was hoped that there would be more of a partnership with citizens and communities with regard to health and wellbeing.

43.4 The committee welcomed the direction of travel of this strategy. Members asked whether members of staff had had the opportunity to engage with the development of the HWBS. It was explained that the intention was to engage with staff through staff meetings during the consultation period. It was acknowledged that staff engagement would be a key factor in the successful delivery of this strategy.

43.5 Members questioned whether the challenges around housing and future changes to the benefits system were part of this work. It was explained that the Shadow HWB included a district representative which linked into housing, and that the Shadow HWB was mindful of the economic climate and policy changes.

43.6 It was explained that much of this work was also about social networks, improving social inclusion through support from families and the community. The committee was reminded
that the outcomes from the Total Place project had shown that small actions could really help.

43.7 It was commented that the data in the Your Health, Your Care document, that accompanied the HWBS, demonstrated the stark reality of available resources (in particularly the chart on page 17 which demonstrated income against commitments) for the delivery of health and social in the county. Following the consultation it was suggested that it would be worth working up which services would be particularly affected and early notification of any modifications should be flagged up to the committee.

43.8 It was felt that there should be a high level of engagement with the VCS with regard to this strategy. Members were assured that engagement with the VCS was already built into the consultation exercise.

43.9 The Director Public Health informed the committee that she expected that following the consultation there would be a degree of modification to the strategy. She would ensure that information was brought back to this committee at the appropriate time.

44. **TRANSFER OF COMMUNITY SERVICES**

44.1 The committee was reminded that the engagement exercise on this matter would not finish until 3 October 2012. The report illustrated the events that had already taken place, and there remained much to do before 3 October 2012.

44.2 A detailed analysis of the responses to the specific questions asked as part of the engagement exercise would be undertaken. An analysis of the ‘free text’ would also be undertaken. It was noted that the council was assisting with this aspect.

44.3 The NHS Gloucestershire (NHSG) Board were due to meet on 15 October 2012 to make its decision on the way forward. It was explained that the Board would assess all the evidence including the views of the public as part of its decision making. The Chair of NHSG assured the committee that the Board would make its decision based on what is best for the people of Gloucestershire.

44.4 Members of the committee asked about the timeline for this work going forward post the Board decision. The committee was particularly concerned given the forthcoming structural changes to the NHS and how the implementation of this decision would be managed within this timeframe. Members also wished to be made aware of the outcome of the engagement exercise and it was agreed that the outcome report would be shared with the committee.

**ACTION:** Becky Parish

44.5 The committee was informed that following the decision there would be a plan in place to that managed this process. It was explained that elements of this work would be taken forward by the Clinical Commissioning Group (CCG).

44.6 Members felt that the development of the integrated workforce should also be a part of this issue. Members were assured that an integrated model of care was still an important factor, and would be the way forward whatever decision was taken on 15 October 2012.
45. **QTR1 ADULT CARE PERFORMANCE REPORT**

45.1 The committee was informed that the report reflected the council’s new operating model, and outlined what was achievable within available resources. Members were informed that where necessary actions were being taken in order to mitigate risk.

45.2 In response to a question it was acknowledged that ‘ordinary residence’ continued to be an issue for the council. This position was exacerbated by guidance from government which strengthened people’s right to take their agreed assessment of care with them when they moved.

45.3 A member asked a question relating to a sheltered housing provider in the Forest of Dean concerning whether the warden control service was being removed. It was explained that this service was not being removed, what was happening was that we were working with providers with regard to changing the delivery model. It was anticipated that we would be moving toward commissioning a more community based model of support. Members were also informed that many housing providers were reviewing their current use of alarms and looking at what was actually required to provide necessary support. It was noted that within this work it was recognised that many people valued their alarms. Members were also informed that the support that telecare and telehealth could provide had a key role to play within this context.

45.4 There was concern with regard to the predicted overspend in relation to external care budgets for older people and people with physical disabilities. Members questioned whether this could result in people feeling that they were being pressurised into changing their package of care; and whether this budget pressure could affect quality of care. In response it was explained that the personalisation agenda and in particular the use of the RAS (Resource Allocation System) to generate the indicative budget for the individual was changing the way in which care packages were put together. Some individuals could be in the position of being allocated a lower budget than previously, where it was recognised that this level of support needed to continue this would be undertaken. However it was important to help people see how the personalisation agenda could deliver the best options for them and enable them to tailor their care package to their individual circumstances within their indicative budget. It was explained that many clients were happy with this approach. It was also explained that if people’s needs couldn’t be met within the indicative budget then this could be challenged through the exceptions panel that was in place for this purpose.

45.5 It was noted that adult safeguarding referrals were reported to have increased from 6.83% at the end of year to 10.65% in June (against a target of 12%). It was explained that this was seen as a good thing as it brought the council into line with other local authorities in the south west and also showed that people understood these issues more. The committee was concerned as to whether there was the capacity to respond to this number of referrals. Members were informed that these referrals were treated as a priority and that this did have an impact on lower priority work. It was clear that the council needed to ensure that it was learning from these referrals and identifying if there were particular trends.

45.6 The statement made in relation to decisions made by NHS Gloucestershire was questioned. It was explained that as the joint commissioning work progressed historical decisions with regard to practice were being addressed and correctly assigned.
46. **NHS GLOUCESTERSHIRE CEO REPORT**

46.1 It was noted that the numbers of people receiving support through telehealth has increased, and that all GP practices were now referring patients. In response to a question it was explained that it was anticipated that this approach to healthcare would generate savings, but the committee was assured by NHSG that the main driver here was quality of care. Member’s attention was drawn to the recent patient survey which demonstrated that this system was being well received. Members were informed that there was still work to do in this area with regard to supporting people with dementia. It was also noted that data was not currently available to indicate whether this approach was supporting a reduction in the number of admissions to the acute hospitals.

46.2 In response to a question it was explained that the healthcare provision at Gloucester Prison was considered to be robust by the CQC. There had previously been concern about the quality of beds provided and this was why prisoners would now be treated on the prison wing(s). If necessary prisoners could be transferred to another location, e.g. hospital, although this happened infrequently.

46.3 With regard to IVF it was explained that there was also the option for people to apply through the interventions not normally funded process.

46.4 Members questioned how A & E performance was progressing following the intervention by Monitor. It was explained that performance against A & E targets were reported to be at 98% at the end of August 2012. It was also explained that the Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) was required to report to Monitor in October 2012. The significant factor would be whether the Trust could demonstrate that it could sustain this improved performance. The committee welcomed this improvement and hoped that the Trust was able to sustain this level of performance.

46.5 In response to a question it was explained that the rise in demand at A & E was a national trend and there was work being undertaken at the national level to try and understand the underlying reasons for this. Locally, NHSG was about to undertake a survey at the two A & Es in the county and would be asking people why they had chosen to attend A & E as opposed to the other available options. The committee asked to see the outcome of this survey.

**ACTION:** Becky Parish

47. **NHS GLOUCESTERSHIRE PERFORMANCE REPORT**

47.1 Members were pleased to note that the breast consultant locum was now in place.

47.2 There were concerns around ambulance response times in the rural areas, but it was agreed that these would be better directed to the Great Western Ambulance Joint Health Scrutiny meeting on 19 October 2012.

47.3 Concern was expressed with regard to the target relating to at least 90% of Trauma and Orthopaedic admitted through referral to treat (RTT) should be treated within 18 Weeks. It was noted that the GHNHSFT has had a persistent backlog of 200 to 300 patients. NHSG has been working with the Trust on this matter and mitigating actions to address this situation have been put in place. NHSG indicated that an update briefing could be prepared for members on this matter.

**ACTION:** Becky Parish
Minutes subject to their acceptance as a correct record at the next meeting

48. COMMITTEE REPORT
The committee agreed to delegate the report to the Chairman.

CHAIRMAN

Meeting concluded at 11:30
Health and Community Care Overview and Scrutiny Committee

November 2012

Reablement Update

1. **Introduction:**

   This report aims to provide:–

   1.1. Definition of Reablement
   1.2. Background information on the development of reablement
   1.3. Clarity on the service redesign implementation plan
   1.4. Achievements against the plan to date
   1.5. An outline of the work still to be undertaken

2. **Background.**

   2.1. As part of the community services integration agenda, between Gloucestershire Care Services and Gloucestershire County Council Adult Social Care, the community-based workers who deliver health & social care to adults in the community, including Social Workers, Physiotherapists, Occupational Therapists, District Nurses and support staff for each profession, are now integrated and largely co-located into multi-disciplinary teams organised within a Locality structure to ensure a local focus is maintained. These multi-disciplinary teams are also referred to as ‘integrated community teams’ (ICTs).

   2.2. Reablement aims to support an individual to manage their own lives in as independent a way as possible, usually following an illness, injury, or other sudden event which may have reduced their physical, emotional or psychological ability to manage their lives.

   2.3. In recent years, most Local Authorities (LAs) have commissioned an ‘enablement’ service. In this model, the individual is supported to gain greater confidence to manage more of their usual daily activities at home. The primary aim of this approach is to reduce or remove the need for ongoing services from other providers, including hospital care, domiciliary care or residential / nursing care.

   2.4. Additionally, many Health Services nationally have also commissioned an ‘Intermediate Care’ service, which included Physiotherapists and Occupational Therapists. This is based on a therapeutic or rehabilitative model of care which is a process of restoring the skills/functional ability of a person who has had an illness or injury so that they regain maximum self
sufficiency and function in a normal or as near normal manner as possible. The primary aim of Intermediate Care Teams is to avoid unnecessary admissions to hospitals and to facilitate timely discharge to the person’s usual residence.

2.5. There is considerable overlap in what these two types of service aim to offer to a service user / patient and increasingly LAs and Health providers are integrating these two types of service to create a clearer and more streamlined provision.

2.6. These services combined are referred to as ‘reablement’.

3. **Definition and evidence for reablement**

3.1 The national Care Services Efficiency Delivery Team (CSED) defined Reablement as: an approach or philosophy which aims to help people ‘do things for themselves’ rather than ‘having things done for them’.

3.2 Evidence from the report ‘Benefits of Homecare Reablement for people at different levels of need’, completed by Gerald Pilkington from CSED in 2009, demonstrated that where a homecare reablement service is mainstreamed and effectively implemented, it can reduce the demand for ongoing homecare packages for many people, reducing the pressures on social care budgets.

3.3 Within this report the following key benefits of reablement were identified:

- **without a phase of homecare reablement**, 5% no longer required a homecare package whilst 71% continued with an unchanged package

- **with a phase of homecare reablement**, 58% no longer required an ongoing homecare package and only 17% continued with an unchanged package.
  
  (Service evaluation from Leicestershire County Council)

3.4 Qualitative research on the impact of reablement on perceived quality of life showed that:

‘changes occurring over time in the whole cohort suggest a significant improvement in perceived quality of life after receiving reablement services’

‘statistically significant better perceived quality of life at the review stage ... compared to the comparison group’
3.5 To put reablement into further context, the table below shows how it links, often along a continuum, with other aspects of an individual’s care and wellness.

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<tr>
<th>Recovery</th>
<th>Rehabilitation</th>
<th>Reablement</th>
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<tr>
<td><strong>Description</strong></td>
<td><strong>Description</strong></td>
<td><strong>Description</strong></td>
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<tr>
<td>Healing</td>
<td>Targeted time limited therapeutic interventions to reduce impairments and restore optimal function</td>
<td>Short term programmes of care and support to facilitate independence in activities of daily living and lowest level of ongoing need</td>
</tr>
<tr>
<td>Symptom control</td>
<td>Personalised rehabilitation programmes</td>
<td>‘MDT’ focus with delegated activities and regular review</td>
</tr>
<tr>
<td>Regain strength and mental wellbeing</td>
<td>Goal setting, evaluation and review</td>
<td>Develop ongoing support to maintain independence and facilitate community participation</td>
</tr>
<tr>
<td><strong>Characteristics</strong></td>
<td><strong>Characteristics</strong></td>
<td><strong>Characteristics</strong></td>
</tr>
<tr>
<td>Clinical assessment</td>
<td>Reducing dependency and increasing participation</td>
<td>Plan for maintenance, self care and prevention</td>
</tr>
<tr>
<td>Care management plans</td>
<td>‘MDT’ focus self care and secondary prevention</td>
<td>Key worker / reablement staff</td>
</tr>
<tr>
<td>Essentials of care</td>
<td>Therapy led</td>
<td></td>
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<tr>
<td>Provide opportunity for ‘enhanced’ recovery</td>
<td>Doctor / Nurse led</td>
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4. **Gloucestershire’s provision**

4.1 Gloucestershire has had versions of community based ‘reablement’ services in place for a number of years. These were provided by the County Council’s countywide in house Community STEPs (Short Term Enablement...
Programme) team and by the joint health and social care funded Intermediate Care Teams delivered in the localities, in a similar way as is described above.

4.2 These services operated with different titles, had different referral criteria and different ways to access the services, causing high levels of confusion for referrers.

4.3 There was also a lack of consistency in type of provision, particularly in terms of access to therapists; in the Intermediate Care team, therapists were an integral part of the team, whereas the Community STEPs team had to refer on to a different Team or service to obtain therapy input – this led to considerable inconsistency in service provision for customers.

4.4 The decision was therefore taken, as part of the wider integration of health and adult social care agenda, that the STEPs service and Intermediate Care services would integrate, both with each other and then with the wider ICTs.

5. **Planned achievements**

5.1 As the project plan was created, a number of key achievements, or project successes, were identified. These included:

- To implement a customer-centric reablement pathway in line with the Integrated Model of Care (organisational restructure of multi-disciplinary teams) and the Use of Resources customer journey project.

- To ensure the community resources are available to facilitate efficient and effective movement along the reablement pathway

- Ensure reablement is the core business of the integrated health and social care multi-disciplinary community teams

- Agree reablement as the philosophy of the Teams; as a way of approaching the work, rather than a separate service

- To implement the integrated reablement pathway whilst at the same time remove old labels and language (e.g. Intermediate Care, Community STEPs etc) of previous services as a first step towards changing the culture of the workforce
o Work towards an ‘intake model’ for reablement where reablement, i.e. where reablement is the default service delivered for all those who are referred into the locality teams. This approach would enable many more people to benefit from reablement and requires maximising reablement capacity across the teams.

5.2. The expected benefits of both the reablement and the integration programmes were identified as:

a) Facilitate seamless care for patients on discharge from hospital and reduce delays
b) Prevent avoidable hospital admissions/readmissions
c) Further co-ordinate post discharge activity and strengthen community support
d) Improve access to reablement services
e) Promote uptake of community based prevention services
f) To support carers to continue caring for their loved one at home
g) To promote self care and self management

6. Service redesign Implementation:

6.1. In order to begin to implement the required changes to provision, a Reablement Steering Group (RSG) was created in early May 2012, under the auspices of the Integration Steering Group, to co-ordinate and oversee the reablement programme implementation. The membership includes the GCS/GCC strategic operational lead for reablement, staff representatives from various departments of both GCC and GCS and operational reablement ‘champions’ who are the key communication link between the programme and the locality teams. The RSG meets on a fortnightly basis which reflects the pace of the change programme being introduced. A list of RSG members can be seen at Appendix 1.

6.2. A series of small working subgroups focussing on aspects of the project, including IT & systems, Finance & Performance, Operational, Training & Development, HR, Risk & Governance, plus Processes & Documentation have been created to reflect the appropriate aspects of the programme and to ensure delivery of the service changes.

6.3. Each of the sub-groups is co-lead by a GCC staff member and a GCS staff member, to maximise and maintain the integrated working practice.

6.4. The key milestones of the programme and the progress against the proposed timescales are described below.
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<thead>
<tr>
<th>Action</th>
<th>Timescale</th>
<th>Progress</th>
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<tr>
<td><strong>Operational Implementation</strong></td>
<td></td>
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<tr>
<td>• Identify high level pathway</td>
<td>May 2012</td>
<td>Completed</td>
</tr>
<tr>
<td>• Identify and field test detailed new processes</td>
<td>October 2012.</td>
<td>On track</td>
</tr>
<tr>
<td>• System changes to support new pathway identified</td>
<td>October 2012</td>
<td>On track</td>
</tr>
<tr>
<td>• System changes to support new pathway implemented</td>
<td>November 2012</td>
<td>On track</td>
</tr>
<tr>
<td>• Roll out detailed pathway and processes across all localities</td>
<td>November 2012.</td>
<td>On track</td>
</tr>
<tr>
<td><strong>Workforce Development</strong></td>
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<tr>
<td>• Develop and deliver an introductory 1 day training session for all reablement workers</td>
<td>June – September 2-12</td>
<td>Completed</td>
</tr>
<tr>
<td>• Develop competency framework and training plan</td>
<td>September 2012</td>
<td>Completed</td>
</tr>
<tr>
<td>• Roll out competency framework and training programme</td>
<td>October/November 2012.</td>
<td>On track</td>
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<tr>
<td>• Competencies signed off</td>
<td>April 2012</td>
<td>On track</td>
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<tr>
<td><strong>Stakeholder Engagement</strong></td>
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<tr>
<td>• Involve key stakeholders in development of pathway</td>
<td>May 2012.</td>
<td>Completed</td>
</tr>
<tr>
<td>• Stakeholder evaluation of pathway and processes</td>
<td>February 2013</td>
<td>On track</td>
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7. **Key Achievements to date:**

As can be seen from the table above, considerable progress has been made against the project plan so far, although it is acknowledged that there is still work outstanding. The following are the highlights of the achievements -

7.1. **Integration of different reablement ‘services’**

Following the organisational restructuring in October 2011, the staff who previously worked in Community STEPs and Intermediate Care were integrated into the multi-disciplinary teams as Reablement support staff under
single line management. This has enabled the reablement support staff, which includes Reablement Workers (RWs) and Senior Reablement Workers (SRWs), to develop good working relationships with health and social care professionals which has improved the reablement pathway for service users. The majority of reablement workers are now located within the locality teams.

A number of training events and workshops have been held in order to ensure a shared understanding of the ethos of reablement across the teams.

- A specific training day for RWs and SRWs was delivered by an external consultant. The focus of this day was to facilitate a shared understanding of the emphasis within reablement to keeping people well and reducing dependency, rather than the ‘doing for’ approach which creates dependency. This day was positively evaluated and some of the comments from attendees are noted below:
  - “Good course, has made me think more openly about reablement”
  - “Clearer understanding of new role and why change is required”
  - “This course has given me a better understanding of my new role as a reablement worker”

- In addition, 7 workshops took place (one in each locality and one for the acute hospital social work teams) with a view to ensuring the teams had a shared understanding of the vision and aims of the reablement programme, were informed of progress to date and had the opportunity to comment and contribute to the planned next steps of the programme.

These events have helped to facilitate the start of the process of the change in culture and way of thinking that is required in order to ensure reablement is at the core of how the teams deliver support.

7.2. Reablement pathway

In order to ensure that operational staff fully understand the ‘journey’ of a service user/patient through their period of reablement, a reablement pathway, or flow chart, was designed and consulted upon within the RSG and subgroups. This was subsequently ratified at the RSG and also at the Integration Steering Group. The flowchart can be seen at Appendix 2.

The pathway/flow chart acts as a guide or process map, aiming to support staff in their day to day work, and has purposefully been kept simple to avoid confusion. It shows the flow/process from when a referral is received into the
locality teams through to the response, where contact is made with the service user/patients, assessment and intervention takes place, and on to final review and discharge. By its simplicity the pathway allows for an individual response to an individual’s need to ensure that it remains service user focused and person centred.

The response time will vary according to need, for example from a rapid response visit in less than 1 hour in an urgent situation, to a planned response to coincide with an individual’s discharge from hospital in 3 days time. The development of the rapid response business case is currently underway to gain additional support to roll out the rapid response element of reablement in the community teams to enable the urgent response within an hour timescale, or longer as appropriate.

The initial ‘MDT’ responder can be any member of the community team, (e.g. a reablement worker, a District Nurse, a Social Worker), according to the individual’s need and according to the skills required of the staff member to be able to support the individual initially.

Following the initial response to ensure the individual is safe and as comfortable as possible at home, a more detailed conversation with different professionals and the individual then aims to create a list of personal aims they wish to achieve as part of their recovery. This is referred to as a ‘goal plan’. These personal goals are then implemented and worked towards by the individual, with the support and assistance of reablement workers and other professionals.

Goal plans differ from ‘care plans’ in that the former is generally a multi-disciplinary and/or therapy led document, with the emphasis on self-care, self management and independence; a care plan is generally a uni-professional document e.g. a wound care plan created by a nurse. A care plan and a goal plan can of course run concurrently should that be necessary and appropriate for the individual.

Whilst the national guidance is that a period of reablement should last for a maximum of 6 weeks, the length of time that the teams spend with an individual locally could range from less than 48 hours to a little over 6 weeks. The average period of reablement nationally is approximately 3 weeks.

As goals are reached, the need for support from a reablement worker reduces. In practice, that usually means that the amount of time spent with an individual gradually reduces as they start to recover their own ability and confidence.
Once the individual reaches their optimum level of functional ability, the decision will be made with them as to what their ongoing support needs may be, if any should remain.

7.3. Customer Journey link and mapping

In September 2010, Gloucestershire County Council’s (GCC) Community & Adult Care Directorate (CACD) took part in the Use of Resources Southwest Regional Improvement Programme. This programme looked at developing a customer-focused pathway for Adult Social Care to enable choice and empowerment as well as providing support for service users.

This project followed on from the regional work and Putting People First (PPF) programme to introduce self directed support and personalisation, which is a move away from the traditionally prescriptive and reactive provision of care services, seeking to put the person at the centre of their own support and offering the customer greater choice and control.

The GCC Customer Journey project set out to find out from customers (previous and current service users), what their experience of adult social care had been, what was important to them and how they would prefer to be treated. Using this information, the project identified a number of key principles to be incorporated into the redesign of the customer journey pathway for people to follow when using Adult Social Care, from first contact through to no longer needing Adult Social Care services. These principles included:

- Ensure that the Customer’s view is considered through every step of the journey
- Create an Environment where staff are equipped and able to perform with the required skills and competencies
- Design for the norm not the exception and empower staff to deal with the exception
- Ensure that the Customer’s journey is supported by seamless and coordinated resources
- Maximise the opportunity to access early intervention and prevention opportunities

It has been important to ensure that these principles have also been kept at the heart of the development of the integrated reablement pathway. This has been achieved by working in partnership with the project manager for the Customer Journey project. Clarity has now been gained that the two pathways can be completely linked together.
7.4. Competency Framework

It was recognised that, in bringing together different groups of staff in order to deliver the reablement pathway, there was diversity in terms of the skills, knowledge and experience of the workers. A comprehensive competency framework was developed in consultation with Professional Team Leads and other members of staff in order to be able to ensure a consistent, baseline level of competency for all reablement workers and senior reablement workers, and to support staff develop in their roles. This framework has now been agreed and is in the process of being published with a view to rolling out at the end of October/beginning of November. A training programme has been developed and will be delivered in the localities to support the rollout of the competency framework.

7.5. Communications

As the programme of work is fairly fast moving, concerns were raised relating to keeping staff up to date with changes and progress made, quickly and effectively. A format for an email to all staff in the community teams, providing information on decisions and actions required was established, as a ‘Reablement Bulletin’. Since May, 15 subsequent bulletins have been issued. Feedback from operational staff indicates that the Bulletins have been very useful in supported staff in knowing the information is current, consistent, and issued centrally and they are therefore fully informed.

It was also recognised early on that a large cohort of the reablement support staff did not have an email account or access to email. There has therefore been a phased rolling programme to ensure all staff have a work email account, that this large group of community based staff are encouraged to come into the office for staff meetings and goal planning meetings and to access their emails in order to improve communication.

7.6. Staff Engagement

A large number of staff are engaged in the reablement programme via direct involvement in the reablement sub-groups described above. In addition, a series of 6 initial workshops have been held across the county with staff from the community teams, to share information on the reablement ethos, purpose, roles, challenges, progress, work streams and actions, and to give them an opportunity to ask questions, raise concerns and to contribute their ideas to the change programme. There has also been a specific workshop for the Acute Hospital Social Work Team which concentrated on the interface between the acute hospital and community based services and discharge planning.
7.7. Performance and Finance Framework

Finance

As part of the County Council’s ‘Meeting the Challenge’ programme, savings targets of £2m by March 2013 were set against the reablement programme with the assumption that successful delivery would reduce the level of ongoing support needs and therefore reduce external care costs.

The full £2m has been removed from locality budgets.

The target areas in terms of reducing the cost and maximising the financial benefit of reablement are:

1. Reducing non-contact time in the reablement teams to meet the target of 40%. Non-contact time for a worker is described as a proportion of ‘irrecoverable’ hours which includes annual leave, sickness and travelling time, which is usual in any worker’s diary. A smaller proportion of non-contact time is ‘downtime’, where the worker is available for work but does not have any specific work scheduled. In February 2012 this element of downtime constituted 22% of their time; by September this had reduced to 18%. Work continues to reduce this further, by ensuring the reablement workers are fully utilised (i.e. are more productive and doing more work each day) as a member of the integrated community teams and regularly reviewing and making small changes to the current scheduling system (Cold harbour), and its fitness for purpose for our new way of working, ensuring the workers do record all of their work activities onto the scheduling system including attendance at ICT goal planning sessions and joint visits with another member of the ICT.

NB: It should be noted that the reablement workers may well be spending longer periods of time with a service user working in a reablement ethos than in a traditional domiciliary care ethos, so changes in types and lengths of contact time are expected to vary as the service develops.

2. Increasing capacity within the reablement teams so that at least 50% of people who would benefit from reablement are offered that opportunity. As the Community STEPs team had previously been the County Council’s in-house domiciliary care agency prior to becoming a reablement service, in March 2012 there were 225 people receiving long term domiciliary care from the STEPs teams. This was having an impact on the capacity to pick up new reablement referrals. The locality teams reviewed these cases as a matter of priority with a view to putting in place appropriate solutions to meet the long term support needs of these service users, for instance providing them with a Personal Budget and/or providing them with a
commissioned domiciliary care service via an independent provider. There are now only 7 domiciliary care cases being provided by our reablement teams across the county.

3. Further investment is anticipated from commissioners to increase the number of reablement workers, to ensure the provision of a Rapid Response to reablement where required, and to introduce a “falls pick up” service as part of the reablement pathway.

Performance

GCC and PCT commissioners have agreed activity and performance trajectory targets for reablement. Table 1 shows the target trajectory for each key performance indicator (KPI) and the actual performance by month and year to date.

Table 1. Reablement Performance Framework

<table>
<thead>
<tr>
<th>Indicator</th>
<th>TARGET</th>
<th>2011/12</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>Dec-12</th>
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<th>Feb-13</th>
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<tr>
<td>Core dataset KPI</td>
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<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LPI AS 316 PIP</td>
<td>Number of new reablement services starts</td>
<td>Target</td>
<td>238</td>
<td>247</td>
<td>256</td>
<td>256</td>
<td>258</td>
<td>270</td>
<td>282</td>
<td>294</td>
<td>306</td>
<td>318</td>
<td>330</td>
<td>342</td>
<td>354</td>
</tr>
<tr>
<td></td>
<td>Actual</td>
<td>279</td>
<td>243</td>
<td>247</td>
<td>251</td>
<td>257</td>
<td>266</td>
<td>275</td>
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<td></td>
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<td>257</td>
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<tr>
<td>LPI AS 316a</td>
<td>Number of Reablement Contacts per month for Adult Occupational Therapy</td>
<td>Actual</td>
<td>240</td>
<td>243</td>
<td>216</td>
<td>206</td>
<td>200</td>
<td>181</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>128</td>
</tr>
<tr>
<td>LPI AS 317 PIP</td>
<td>% of reablement services that exceeded 6 weeks</td>
<td>Target</td>
<td>27.8%</td>
<td>30.9%</td>
<td>30.2%</td>
<td>29%</td>
<td>28%</td>
<td>27%</td>
<td>26%</td>
<td>25%</td>
<td>24%</td>
<td>23%</td>
<td>22%</td>
<td>21%</td>
<td>29.9</td>
</tr>
<tr>
<td></td>
<td>Actual</td>
<td>31.6</td>
<td>30.5</td>
<td>30.3</td>
<td>30.1</td>
<td>30</td>
<td>30.5</td>
<td>30.4</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LPI AS 318 PIP</td>
<td>% of people going into permanent services without reablement</td>
<td>Target</td>
<td>58.2%</td>
<td>56.3%</td>
<td>56.3%</td>
<td>56.0%</td>
<td>53.0%</td>
<td>50.0%</td>
<td>47.0%</td>
<td>43.0%</td>
<td>40.0%</td>
<td>38.0%</td>
<td>37.0%</td>
<td>35.0%</td>
<td>58.4</td>
</tr>
<tr>
<td></td>
<td>Actual</td>
<td>56.3</td>
<td>57.2</td>
<td>57.4</td>
<td>57.8</td>
<td>58.3</td>
<td>58.1</td>
<td>57.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>58.4</td>
</tr>
<tr>
<td>LPI AS 319</td>
<td>% of people ending reablement each month who go onto receive ongoing services</td>
<td>Target</td>
<td>48.0%</td>
<td>48.0%</td>
<td>48.0%</td>
<td>47.0%</td>
<td>46.0%</td>
<td>45.0%</td>
<td>44.0%</td>
<td>43.0%</td>
<td>42.0%</td>
<td>41.0%</td>
<td>40.0%</td>
<td></td>
<td>49.6</td>
</tr>
<tr>
<td></td>
<td>Actual</td>
<td>43.9</td>
<td>42.9</td>
<td>42.4</td>
<td>42.2</td>
<td>41.3</td>
<td>42.0</td>
<td>47.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>49.6</td>
</tr>
</tbody>
</table>

Key actions to improve performance against the amber and red rated trajectories include:
1. **Improving the number of new service starts:** (LPI AS 316)
   - The data does not appear to have captured all new service starts and may only be capturing one element of the service. E.g. ERIC report and Coldharbour report need to be reconsidered. This will therefore be investigated further.
   - The ongoing complex change process to deliver integrated community teams (including reablement) may be disrupting the functionality of the locality teams and affecting performance. This will be resolved as the reablement pathway is rolled out across all localities.

2. **Reducing the number of people going into permanent services without reablement:** (LPI AS 318)
   - It is expected that this will improve with the additional investment anticipated for reablement (for additional workers and Rapid Response element).
   - A process is to be put into place to ensure that reablement must be considered for all service users before application to panel for agreement to support long term/permanent care solutions.
   - Ensuring all stakeholders are aware of the reablement pathway to maximise referrals and prevent unnecessary admissions to hospital/residential care and/or long term support packages
   - It should be noted that it is recognised nationally that approximately 30% of adults/older people requiring health & social care support would not benefit from reablement. Therefore to achieve the target of 35% of people not going through reablement is particularly challenging.

3. **Reducing the number of people ending reablement who go on to receive ongoing services:** (LPI AS 319)
   - The September performance against this target is not in line with previous performance and may be an anomaly. This will be investigated further.

Regular monthly meetings with commissioners take place which ensures a joint understanding of the actions being taken in order to improve performance against the targets.

**Case Study**
To further express the successes to date, a short case example is as follows:

A service user in Cheltenham has been in receipt of a care package consisting of 2 carers, calling 2 times a day.
Following a planned review, the need for reablement was identified.
The Occupational Therapist and reablement workers visited and discussed
the current care they were receiving, and how that affected the quality of their
lives.
An agreed goal plan with the service user and her husband was created and
implemented.
By practicing new moving and handling techniques daily for 8 days, the care
package is now reduced to just 1 carer to visit 2 times per day.
This gave an immediate improvement by:

  o Reducing the cost of care by removing the need for a second
carer twice per day
  o Decreased the impact of possibly 4 different carers calling each
day to the service user
  o Increased the choice and control for the service user
  o Increased the confidence of the husband
  o Increased the independence of the service user

This story, and others very much like it, can be replicated across all Locality
teams.

8. **Work still to be undertaken:**

8.1. **Capacity Management**

Options for a capacity management/scheduling system that will meet the
service needs into the future are currently being explored. Visits and
discussions with those working on similar solutions have already been
undertaken.

8.2 **Finalise process and roll out**

The processes for recording activity that are required in order to make the
reablement pathway work have been identified and are being field tested in
the Cheltenham and Stroud localities. These are currently being evaluated
with a view to rolling out across all localities. Some significant system
changes to support the new processes (e.g. to ERIC and Coldharbour) have
been implemented and others are planned
8.3 Training programme delivery

The training programme to support the implementation of the newly created Reablement Worker Competency Framework has been developed. This includes a Foundation day which will be delivered centrally and a number of shorter, more clinical / practitioner focussed sessions which will be delivered in the localities by members of the multi-disciplinary teams.

8.4 Uniforms

Reablement Workers and Senior Reablement Workers currently wear a variety of uniforms across the county. In order to provide a more professional ‘corporate image’ for the reablement workers, and so that service users/patients are able to recognise them more easily, funding is being sought to enable the provision of new uniforms. Staff representatives will be involved in suggesting, consulting and agreeing the style and colour of any new uniforms.

9. Conclusion:

There has been significant work undertaken in order to implement the reablement pathway both from the project team and the multi-disciplinary teams in the localities.

There have been many achievements but as the project continues to progress there is also still work to do, as described above.

There is confidence that the reablement pathway will be rolled out across all localities from November this year and that performance against the trajectories set will continue to improve

10. Recommendations:

The HOSC are asked to –

1. Note achievements to date and
2. Support the ongoing work of the reablement programme.

Margy Fowler  
Locality Manager

Julie Goodenough  
Business Manager

Tewkesbury & Forest of Dean
**Appendix 1**

**Reablement Steering Group**

**Membership List**

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisational Role</th>
<th>Group Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Margy Fowler</td>
<td>Locality Manager</td>
<td>Project Lead &amp; Chair</td>
</tr>
<tr>
<td>Julie Goodenough</td>
<td>Business Manager</td>
<td>Project Manager &amp; Vice Chair</td>
</tr>
<tr>
<td>Deborah Greig</td>
<td>Head of Adult Social Care</td>
<td>Joint Lead – Process &amp; Documentation group</td>
</tr>
<tr>
<td>Des Gorman</td>
<td>External Consultant</td>
<td>Joint Lead – Process &amp; Documentation group</td>
</tr>
<tr>
<td>Angela Willis</td>
<td>Training Manager</td>
<td>Joint Lead – Workforce Development group</td>
</tr>
<tr>
<td>Sarah Warne</td>
<td>Clinical Quality Manager</td>
<td>Joint Lead – Workforce Development group</td>
</tr>
<tr>
<td>John James</td>
<td>Manager – Data &amp; Performance Team - GCC</td>
<td>Joint Lead – Performance &amp; Finance group</td>
</tr>
<tr>
<td>Chris Hemingway</td>
<td>Principle Accountant - GCC</td>
<td>Joint Lead – Performance &amp; Finance group</td>
</tr>
<tr>
<td>Michele Slater</td>
<td>Team Manager – Community Hospital (Forest)</td>
<td>Joint Lead – Operational Implementation Group</td>
</tr>
<tr>
<td>Tamsin Fedden</td>
<td>Community Manager - OT (Stroud)</td>
<td>Joint Lead – Operational Implementation Group</td>
</tr>
<tr>
<td>Ed Hewlett</td>
<td>Team Manager, Acute Hospital SW Team</td>
<td>Acute Hospital representative</td>
</tr>
</tbody>
</table>
Appendix 2

High Level Reablement Pathway

Referral Centre

Feedback to referral centre – confirm response

MDT Responders

Actual & Virtual Team

1st Contact
Generic Assessment
Make Safe

MDT assessment
MDT Assessment
Reablement Goal Plan

Goal plan implemented

Final Review

Review/ Evaluate/ Intervention

Outcomes Achieved
Discharged

Not all outcomes achieved

QSP

Purchase care package – fixed term

Support Plan in Place
Gloucestershire Health, Community and Care
Overview and Scrutiny Committee

20 November 2012

Transfer of NHS Gloucestershire’s Community Health Services

1. Background

1.1 Following a court challenge in 2011 to NHS Gloucestershire’s proposal to transfer community services to a community interest company, NHS Gloucestershire agreed to begin a new process to consider the most appropriate way of transferring NHS Gloucestershire’s community services in line with Department of Health policy.

1.2 This Report provides an update for HCCOSC on the outcome of the advertisement for expressions of interest, the outcome of the twelve week public and staff engagement, the outcome of the NHS Gloucestershire Board Extraordinary Board Meeting (15 October 212) and the statutory requirement for the Strategic Health Authority to carry out consultation with named stakeholders regarding the establishment of a new NHS Trust.

2. Expressions of Interest

2.1 As a first step, NHS Gloucestershire agreed to advertise for expressions of interest from providers and interested parties who might wish to provide our community services in Gloucestershire in the future. This advert was placed on 16 May 2012. No restrictions were placed on who might put themselves forward and providers and interested parties were given until 18 June 2012 to express an interest.

2.2 At the time of the closing date, some 63 replies had been received, with 25 organisations formally confirming their interest by providing responses to an initial questionnaire. These included a range of organisations such as NHS bodies, community interest companies, voluntary sector providers and private sector providers.
3. 12 week Engagement 11 July 2012 – 3 October 2012

3.1 As part of the agreed settlement to the court challenge NHS Gloucestershire also promised to take reasonable steps to ensure there was an appropriate level of staff and public engagement.

3.2 A period of engagement began on 11 July 2012 and lasted for 12 weeks. During this time local people were invited to have their say on the future management of NHS Gloucestershire’s community health services. There was a range of ways in which people could have their say. These are detailed below.

3.3 Engagement Booklet

An engagement booklet setting out the options and containing the Feedback Form was made available from a range of public places including pharmacies, GP surgeries, libraries and community hospitals. Additional copies of the engagement booklet were sent to individuals and groups on request. Individuals or groups could request the engagement booklet in other formats – the booklet was translated into Traditional Chinese following such a request.

3.4 Website/ staff intranet


3.5 Public ‘Drop-In’ events

In addition to the booklet, a number of public ‘drop in’ events were arranged across all districts in the county, at a range of times (morning, afternoon, evening), days of the week (including Saturdays) and venues (community facilities or the GUIDE & PALS Information Bus). The ‘drop-ins’ enabled local people to meet representatives from NHS Gloucestershire, ask questions and have their say. The public ‘drop-in’ events were open to all, including staff (full schedule in Outcome of Engagement Report).

3.6 Publicity

Information about how to access information, feedback materials and advance details of the public drop-in events, were advertised widely in the local media. Posters advertising the engagement were distributed across the county. An electronic link to the engagement booklet was sent by email to NHSG’s stakeholder database of over 600 individuals and groups at the
commencement of the 12 week engagement period. Information about the engagement was included in various publications such as the GP Newsletter. The NHS Gloucestershire website publicised the engagement through social media: Facebook and Twitter.

3.7 **NHS Gloucestershire Survey**

The methodology used by NHS Gloucestershire to collect and collate responses was a survey questionnaire. This survey was available in freepost print format in the engagement booklet and online on the NHS Gloucestershire website. Analysis of the survey responses was carried out by members of the NHS Gloucestershire Engagement team and the Gloucestershire County Council (GCC) Strategy and Challenge team. NHS Gloucestershire’s analysis focussed on the quantitative information, whilst the GCC analysis focussed on the qualitative analysis of the free text comments using a software tool called ‘Leximancer’. Leximancer is a text analytics software package to assist researchers in qualitative, text analytics. Leximancer is particularly suited for survey interpretation.

3.8 **Options for consideration**

The two Options for consideration were set out in the NSHG engagement booklet as follows:

**Option 1**

In May 2012, we were informed by the Department of Health that our Board will be allowed to consider the option of establishing a new NHS Trust, which would be independent of all other NHS bodies, to provide community services. Following an internal ballot carried out by Gloucestershire Care Services in June 2012, formation of an NHS Trust was the preferred option of the staff who responded. It may be possible that the new NHS Trust could be formed out of the existing Gloucestershire Care Services, with all existing staff and the premises owned by NHS Gloucestershire that are used to provide the community services, transferring to the new NHS Trust.

In considering this option, our Board would need to assure itself that the Trust was:

- able to provide safe, high quality NHS services and;
- financially viable (achievable with the money available).

If a contract was placed with a new NHS Trust, the Trust would be monitored and scrutinised like any other provider to ensure that standards were being met for the benefit of the service user and that it was achieving value for money. If, following appropriate public engagement and consideration, we were to seek the Department of Health’s agreement to establish an NHS
Trust, then it is likely that a formal procurement process would not be needed to transfer the services to it.

Option 2

Some of the other potential providers for the services are set out below. This is based on responses to the advertisement for expressions of interest. Each of these providers below would be considered through a formal procurement process. If such a process is required, then those organisations who expressed their initial interest would be invited to take part, although other bodies would be entitled to participate too. Procurement is a competitive tender process through which all types of providers have an equal opportunity to compete for the contract to provide services. Each provider must submit a tender in response to the stated requirements and the bids are assessed by a panel using a range of criteria, including quality of service, performance and finance. As explained earlier in this booklet, a number of organisations confirmed their interest in providing the community services currently provided by NHS Gloucestershire, but none have been asked to submit bids. This is because until we have taken a decision on how to proceed, it is not known whether procurement will be necessary.

Those expressing an interest include:

- other NHS Trusts
- NHS Foundation Trusts
- Community Interest Companies
- several Charities and;
- a number of Private Companies with existing healthcare businesses.

Some of those expressing an interest have indicated that they wish to provide only some of the services and others have suggested they might wish to provide all of the services, by way of joint ventures or partnerships.

3.9 Survey responses

Quantitative analysis

A total of 2564 responses to the survey were received; 1576 of which were submitted via the NHS Gloucestershire website.

The survey asked people to select their preferred option (as described above) and provided the opportunity for free text comments. The results are as follows:
My preferred option is:

- 3% Option 1
- 1% Option 2
- 96% No selection made

The demographic information supplied suggests that a good cross-section of the population responded to the survey. A full breakdown of the demographic information is given in Appendix 3 of the full report.

Gender

- 57% Male
- 37% Female
- 1% Rather not say
- 5% Not replied

Geographical (by Borough/District Council area)

- 33% Cheltenham
- 12% Cotswold
- 7% Gloucester
- 9% Forest of Dean
- 7% Stroud
- 6% Tewkesbury
- 11% Out of county
- 2% Not replied
Qualitative analysis
The qualitative analysis undertaken on behalf of NHS Gloucestershire by Gloucestershire County Council used ‘Leximancer’, a text analytics software package to assist researchers in qualitative, text analytics. Leximancer produces an ‘Insight Dashboard’ which identifies key issues, ranks lists of attributes for each category and selects supporting quotes. Leximancer also provides a “sentiment lens” into the data to allow for the association of positive and negative terms with concepts. It uses this lens to identify favourable and unfavourable comments in texts.

The qualitative analysis using Leximancer focussed on identifying concepts and themes, and the strength of feeling expressed by respondents, from across all the feedback received and from particular groups e.g. whether the comments came from professionals or non-professionals, whether they came from people with Gloucestershire post codes, and whether the comment came from someone with less than fair health and the strength of the sentiment.
Concepts and themes influencing preferences for either Option 1 or Option 2

The strongest comments about ‘services’ were from those preferring Option 1 and from people with a non-professional interest in the results, with a focus on concerns about ‘profits’ and other financial issues, ‘professional standards’, their high regard for the existing NHS and the importance of ‘local service provision’.

Those selecting Option 1 were concerned about the ‘costs’ and about ‘shareholder interests’ and ‘profits’.

People selecting Option 2 were hoping for improvements in the way the health system works, whilst those preferring Option 1 were concerned about the potential ‘costs’ and problems perceived to be associated with such a big change.

People preferring Option 2 seemed to be focussed on poor experience of the existing ‘structure’ and concerns about its ‘financial sustainability’.

Personal and professional

The concepts and themes emerging from the analysis of the comments varied between those who identified themselves as either having a personal interest or those having a professional interest in the subject.

Most of the professional comments received used the online survey, whilst many of the personal ones used the freepost print survey, very few ‘professional’ respondents said that they had disabilities and many more of the ‘personal’ respondents gave very explicit reasons for reaching their preferred choice (Option 1 or Option 2).

The differences were very clear.

Those with a ‘personal’ interest talked about ‘hospitals’ and ‘care’, but this was linked to concerns about ‘management’, ‘financial’ and ‘professional’ issues. Those with a ‘professional’ interest recommending Option 1 commented more on the ‘quality’ of services and those preferring Option 2 talked more about the ‘structural’ issues.

The responses indicated a feeling (particularly among those with a ‘personal’ interest) that a ‘privatised NHS’ would be less ‘professional’, and issues of professionalism were of particular concern to those with a ‘personal’ interest in the survey.
Out of county respondents

Out of county includes all those respondents with non GL postcodes. However, it should be noted that some areas within the county boundaries do have alternative postcodes e.g. WR, SN.

Comments from the small number of people giving a non GL postcode were very different to those from people with GL postcodes, and focussed on issues of the ‘care’ provided and ‘staffing’.

People with non-GL postcodes (and those recommending Option 2) were least likely to talk about ‘costs’ and about ‘shareholder interests’ and ‘profits’ and people with an out-of-county postcode were also more likely to have selected Option 2.

People with poor health
People with poor health were concerned about ‘hospitals’ and the ‘management’ of the local service. People with very poor health were more strongly concerned about the effects of change on service ‘quality’.

3.10 Other feedback received

In addition to the responses to the survey, NHS Gloucestershire received other forms of feedback. These are listed below.

Direct correspondence

A very small amount of correspondence was received by NHS Gloucestershire from individuals, groups or organisations (fewer than ten). All those who expressed a preference, not all chose to do so, selected Option 1.

In addition, several emails and telephone calls were received during the 12 week engagement period relating to the engagement process, clarification regarding the information provided in the engagement booklet and requests for copies of information booklets, or for information about public drop in events.

Gloucestershire Anticuts Campaign Keep the NHS: Public Petition in support of Option 1.

A petition was handed to the NHS Gloucestershire Board at its meeting on 27 September 2012 by representatives from the Gloucestershire Anticuts Campaign - Keep the NHS Public.

The petition is entitled:
Petition concerning the future of Gloucestershire Care Services comprising of 3000 people working in The Dilke and Lydney Hospitals in the Forest of Dean also hospitals in Stroud, Cirencester, Fairford, Bourton, Tewkesbury and the Vale at Berkeley and Dursley as well all the NHS health centres and including all the district nurses and all the health visitors in the county.

We the undersigned petition NHS Gloucestershire Primary Care Trusts to transfer Gloucestershire Care Services to a standalone NHS Trust (Option 1).

The number of (valid\(^1\)) signatures was 5,465.

Further signed petition sheets were delivered by representatives from the Gloucestershire Anticuts Campaign - Keep the NHS Public to NHS Gloucestershire’s offices on 2 October 2012. The number of valid signatures was 1,065.

The total number of signatures to the petition was 6,530.

Gloucestershire Anticuts Campaign Keep the NHS Public: Comment cards

During the 12 week engagement period, NHS Gloucestershire received 138 comment cards addressed to NHS Gloucestershire Chief Executive, Jan Stubbings, which stated: ‘I am a resident of Gloucestershire and, therefore, a stakeholder in NHS Gloucestershire. I want my community health services & local hospitals to be provided by a publicly-owned, NHS body because…’.

Some respondents chose to add further comments, which echoed those summarised above regarding a preference to Option 1. However, the majority of the comment cards were left blank.

4 Preparation of the Outcome of Engagement Report

4.1 The engagement period ended on Wednesday 3 October, 2012. All feedback received has been collated and analysed to inform the Outcome of Engagement Report for the information of the NHS Gloucestershire and NHS Swindon Board for consideration as part of its decision making process.


\(^1\) When the petition was handed to NHS Gloucestershire several signatures had already been crossed through. A review of these signatures showed that the signatories had given a postcode outside of Gloucestershire e.g. Dorset, Bristol.
4.3 **Outcome of Engagement Report Conclusion**

During the 12 week engagement period, NHS Gloucestershire has received a significant level of feedback regarding the Future management of its community health services.

The overwhelming majority of respondents, from all groups, expressed a preference for Option 1 – the establishment of a new NHS Trust.

5. **NHSG Board Decision**

5.1 The NHSG Board agreed at an Extraordinary Board Meeting on 15 October 2012 to seek the establishment of a new NHS Trust to provide current NHS Gloucestershire community health services from April 2013. NHS Gloucestershire and NHS Swindon Board Meeting.

5.2 Following the outcome of the Extraordinary Board Meeting on 15 October 2012, the NHS Gloucestershire Board is now seeking the establishment of the provider arm of the Primary Care Trust as a new NHS Trust. No service change would take place. This would enable NHSG, the Primary Care Trust, to become compliant with national policy on separating provision of services from organisations that commission them.

6. **Strategic Health Authority Proposed consultation**

6.1 NHS South of England has a statutory responsibility to carry out a single consultation on the establishment of a new NHS Trust and the transfer to it of provider responsibilities from the existing Primary Care Trust. This is governed by two Statutory Instruments:

- The Primary Care Trust (Consultation on Establishment, Dissolution and Transfer of staff) Regulations, 1999;
- The National Health Service Trusts (Consultation on Establishment and Dissolution) Regulations 2010.

6.2 This proposal is an organisational change, not a service change and the Regulations noted above state that such engagement / consultation should be led by the Strategic Health Authority and specifies with whom the consultation should take place, namely the Local Involvement Network (LINk).

6.3 The proposals also require a transfer of staff from the existing Primary Care Trust to the newly established NHS Trust, necessitating a wider range of consultees to be included:
• The Community Health Council (now abolished). The Gloucestershire Local Involvement Network will be included as the direct replacement for the Community Health Council.
• The Local Authorities in the area;
• Local NHS Trusts in the area (Gloucestershire Hospitals NHS Foundation Trust; 2Gether NHS Foundation Trust; NHS Gloucestershire and Great Western Ambulance NHS Trust);
• The Local Medical Committee; and
• Local Voluntary Sector as identified as having an interest.
• Although not listed in the Regulations, local Members of Parliament and the Overview and Scrutiny Committee of Gloucestershire County Council will be key stakeholders to engage with on this issue.

6.4 The proposal of the Strategic Health Authority is that a period of consultation is undertaken by the Strategic Health Authority, supported by local leaders, on the establishment of a new NHS Trust and the principle of the transfer of staff from the existing Primary Care Trust into the new NHS Trust. The consultation should take place with all of the stakeholders noted above and should take place over a 6 to 8 week period from the beginning of November 2012. The Regulations permit a combined consultation. A separate staff consultation would also need to be undertaken in parallel with this consultation, for the period defined under employment regulations and would be undertaken by the Primary Care Trust.

6.5 All of the listed stakeholders, with whom the Strategic Health Authority has to consult, will be invited to participate in a joint seminar on the issue. Members of the county’s NHS Reference Group, made up of HCCOSC and LINk Stewardship Board Members, together with the other listed stakeholders above will be invited to the joint seminar. Local NHS leaders will continue to make themselves available for individual meetings of any of the organisations listed, should they request a direct briefing.

6.6 The outcome of the consultation would be reported to the Board of NHS South of England from 1 February 2013 and if agreed, will be communicated to the Secretary of State to authorise the creation of the new NHS Trust and the transfer of staff from the Primary Care Trust from 1 April 2013.

6.7 The Primary Care Trust will be responsible for the drafting of relevant documentation to enable the new NHS Trust to be established.

6.8 Timetable

The following key milestones have been identified for the Strategic Health Authority consultation:
• November to December 2012: Consultation activity undertaken;
• January 2013: Report back to the South West Strategic Health Authority on consultation outcomes and refer matter to the Secretary of State.

7. **Activity to be undertaken locally by Primary Care Trust**

November to December 2012: Staff engagement on transfer of employment to the NHS Trust by Primary Care Trust;

November 2012: drafting of legal documentation to form an NHS Trust undertaken by the Primary Care Trust;

1 April 2013: Subject to meeting requirements, Establishment Order creates the NHS Trust.
Direct Payments Update

A Report for the Overview and Scrutiny Committee on the use of Direct Payments in Gloucestershire’s Learning Disability Services

Chris Haynes
Lead Commissioner-Learning Disability Services

What is a Direct Payment?

- A payment to a service user which allows them to make choices and decisions about how they spend their personal budget

- It should allow for maximum choice and for service users to use their funds to best meet their needs.

- The crucial litmus test for a Direct Payment is whether it allows the service user to meet their social care outcomes in a manner that gives them choice and control over their lives.

- Social Workers and Support Planners are expected to offer a Direct Payment to everyone who is eligible for a Personal Budget
Lisa was previously groomed via the internet, travelled to Leeds and was sexually assaulted. She now has a GPS locator, which has a geo boundary function which means that if she goes beyond certain ‘safe’ areas an alarm is sent to the providers Aspirations and they can track where she is on a computer!

The GPS device also has an SOS button, so if Lisa finds herself in a risky situation she can summon assistance without having to make a call!

Lisa had lost a lot of confidence after the assault and was very keen to have the GPS device to increase her security.

Due to the added protection this device provides, Lisa is now more independent and moving on to a home that has less staff.

In the future she will be able to become even more independent. The GPS device has increased Lisa’s confidence.

Annette really wanted to do her own shopping but frequently became confused using public transport and got lost, which was further complicated by Annette’s epilepsy.

Annette is now using a Personal Locator with an SOS button. Annette’s parents are immediately alerted when Annette’s device stops moving. The GPS gives Annette and her parents added security against possible falls. If she falls her parents are immediately alerted and can respond.
Tom who lives in the countryside just outside of Ross-on-Wye, used to need a member of staff to shadow him on a bus travelling into Ross where he would complete some shopping and then go on to visit his girlfriend for a few hours.

He occasionally gets confused in finding his way to his girlfriend’s house and won’t ring or ask for help. Because of this staff have had to shadow him and then support him when he gets lost which is very rare.

This requires 1:1 staff which has an effect on shared care for others in the house as a whole.

Now staff can monitor his movement accurately using a Skyguard MySOS and a computer to see his whereabouts in Ross and support him by phone / person if and only when he needs support!

This will increase his independence and reduce the risks Tom faces whilst enabling staff to be used in other areas in the home.

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**KEY CHARACTERISTICS OF DIRECT PAYMENTS**

- Money is paid directly to the Service User into a bank account set-up specifically for this purpose
- The Council makes payments every 4 weeks in advance
- The Service User is responsible for how the money is spent and must keep records to show this so the Council can check it is being used to meet the needs and outcomes defined in the Support Plan. This is checked at the 6 week review and then annually thereafter.
- Councils have a responsibility to ensure there are support services that will help to make it easier for people to take and manage Direct Payments – currently these are provided by Penderels Trust
STATISTICAL INFORMATION

The Care Minister has stated that Councils must have 70% of Service Users with Personal Budgets by April 2013

Having a Personal Budget means that a Service User has been through the “Self Directed Support” process i.e. the customer journey through assessment of need, resource allocation of a Personal Budget (£) and completion of a Support Plan which includes the offer of a Direct Payment

Gloucestershire County Council currently has 53% of Service Users with a Personal Budget

Of these people only 14% choose to take their Personal Budget as a Direct Payment

HOW DO WE KNOW IF OUR SERVICE USERS, CARERS and FAMILIES ARE SATISFIED WITH DIRECT PAYMENTS?

1. We listen to the voices and opinions of service users, families through the Partnership Board which comprises 50% service users, families and carers.
2. We seek to understand the reasons people may decline the offer of a Direct payment and to remove barriers.
3. We compare our levels of satisfaction against national benchmarks for service user satisfaction.
4. A recent summer survey of 35 Direct payment users; chosen at random; telephone survey of likes and dislikes and satisfaction levels.
What do our customers like about Direct Payments?
The top ten reasons......

1. The ability to control their own delivery of services
2. Receiving care when and how they would like it delivered to them
3. Greater freedom to make changes, more flexibility
4. Service Providers respond to them as the customer and not GCC
5. They get the best value for money from what is spent.
6. They are more aware of the ‘cost of care’.
7. Service users develop close personal relationships with their carers.
8. Service users deal with issues directly and don’t have to go through GCC all the time.
9. Families feel there is less stigma involved
10. It works!!

WHAT DO OUR CUSTOMERS SAY THEY THINK WE COULD DO BETTER?

• Administratively cumbersome
• No choice of Managed Account provider
• Services they require are expensive
• More support for when they run into difficulties
• Sometimes they are overwhelmed by the quantity of tasks to do from managing the finances to support planning.
WHAT CAN WE DO TO IMPROVE THE DIRECT PAYMENT SERVICE

- Listen to the customers
- Tackle the administrative complexity-make it easier for customers
- Increase the number and choice of organisations that will manage people’s accounts
- A Task Group has been formed and will be proposing a Timeline which will result in changes by April 2013.
- The changes in April 2013 will mean more agencies and a better variety of supports.
- The new procurement will address the following areas:
  1. Administration and Financial management
  2. Recruitment and Selection
  3. Support Services
- The result will be a Recognised Provider List

MANAGED ACCOUNTS

- If a Service User is unable to manage the day-to-day financial responsibilities associated with receiving a Direct Payment; or is able to manage but prefers to have someone else do this, they can nominate someone else to receive the money and deal with the day-to-day financial responsibilities of the Direct Payment on their behalf – this is called a managed account.
- Where a managed account is used the Service User must retain control over how the support is delivered.
- The person or organisation providing the “Managed Account” function is concerned only with supporting the Service User to manage the money, and cannot be delegated the responsibility of making decisions on how the Service Users needs are to be met and cannot be the employer of a Personal Assistant
- The person / organisation managing the account will ensure care and support is paid for, that the account does not go into arrears and will provide the Council with all information needed to monitor the Direct Payments for the Service User
TRAINING OF PAs

- Direct Payments require that there needs to be appropriate services for people to purchase when they have the funds.
- For many service users this means a Personal Assistant.
- Personal Assistants can deliver the same services as other people but without unnecessary on costs.
- GCC has developed a relationship with a social enterprise called Cool2Care.
- Cool2Care provides fully trained and CRB checked PAs to our local area.
- Penderells has now begun a service like this as well.
- Some of our PAs are looking at a social enterprise so they can support each other.
- We are working across children’s and adults services on this issue as we want children to be able to transition their PA into their adult service.
- On line training is also available to all PAs.

WHERE DO WE GO FROM HERE?

- Service Users are no longer being placed in other counties by Operations teams.

- Electronic monitoring pilot in place, evaluating the hours of care delivered by providers and comparing these against the funded hours and needs indicated by the Service User’s Support Plan.

- An Intensive Support Team is being set up by NHS Gloucestershire to deliver specialist community intensive support as advised by the Mansell Report, based on the model of the Birmingham Supported Living and Outreach Team (SLOT). The objective is to ensure people are sufficiently supported in the communities to avoid specialist placements or hospital admission and in the long-term to also create capable communities.
### Quality Assurance Reviews in Learning Disabilities

Quality Assurance Reviews assess the quality of service delivered to service users; these are now extended to all people with a personal assistant.

- It includes Quality 360 - which measures a service user's satisfaction with the service.
- Regular reviews by Care Services.
- Ensuring meaningful and enjoyable lives and achieving outcomes which matter to them.
- Personalised approach to delivering care and support.
- The PA supports people to be independent, make choices and be in control.
- People are treated with dignity and respect.
- Records, processes and procedures are of a high standard.
- People are safe and free from discrimination and harassment.
1 Department of Health Consultations

The following Department of Health consultations may be of interest to HCCOSC Members.

1.1 Views sought on strengthening NHS Constitution
http://www.dh.gov.uk/health/2012/11/constitution-consultation/

Proposals to strengthen the NHS Constitution have been set out for public consultation by the Department of Health in November 2012.

The main changes proposed cover:

- a new responsibility for staff to treat patients not only with the highest standards of care, but also with compassion, dignity and respect
- a new pledge making it explicit that patients can expect to sleep in single-sex wards
- a new pledge to patients that NHS staff must be open and honest with them if things go wrong or mistakes happen – this ‘duty of candour’ will become a condition in the NHS Standard Contract from April 2013.

The changes also make it clearer that:

- patients, their families and carers should be fully involved in all discussions and decisions about their care and treatment, including their end of life care
- patients who are abusive or violent to NHS staff could be refused treatment
- the NHS is equally concerned about physical and mental health.

The consultation follows work carried out by the NHS Future Forum on how the Constitution could be strengthened. The Government accepts the Forum’s recommendations in full and the new proposals reflect this.

The closing date for comments is 28 January 2013.

Responses to the consultation will feed into a revised version of the NHS Constitution, which will be published by April 2013.

1.2 National performers list for GPs, dentists and ophthalmic practitioners
http://www.dh.gov.uk/health/2012/10/consultation-national-performers/
A consultation proposing that in future there is one national list of general practice doctors, dentists and ophthalmic practitioners approved to provide NHS primary care services was launched in October 2012.

Medical, dental and ophthalmic practitioners may not perform NHS primary care services in England unless they are included on a performers list held by a primary care trust (PCT). The performers’ list system provides PCTs with powers to manage these performers and protect the public from any performers that fall below the required standards.

The consultation also considers recommendations made by two reviews that looked at the performers list system. It discusses the three different options that could be pursued and the option that has been chosen.

It seeks responses on proposed changes, including:

- the introduction of national lists
- changes to the ‘minimum service’ that performers on the list will need to perform
- changes to suspension powers, including, immediate suspension and additional powers at suspension hearings
- changes to the requirement to submit criminal records checks.

The closing date for responses is **14 December 2012**.

*The Health and Social Care Act 2012 requires changes to be made to the Performers Lists Regulations. The Health and Social Care Act 2012 abolishes PCTs and creates the NHS Commissioning Board (NHS CB) and clinical commissioning groups. From April 2013, the performers’ lists will become the responsibility of the NHS CB.*

1.3 **Ensuring fair and transparent pricing for NHS services**

A consultation to help ensure fair and transparent pricing for NHS services was opened in October 2012 by the Department of Health.

From April 2014, Monitor and the NHS Commissioning Board will take over responsibility for pricing NHS services from the Department. They will do this through the national tariff. These arrangements will place responsibility for pricing with the bodies best placed in the new system to undertake it.

This consultation seeks views on the Department of Health’s proposals for:

- which providers can formally object to Monitor’s way of calculating prices
- what level of objections from commissioners and/or providers would require Monitor to: reconsider how it calculates prices, or refer its way of calculating prices to the Competition Commission, who will then decide whether or not it is appropriate.

The closing date for responses is **21 December 2012**.
1.4 A full listing of all ‘live’ and ‘closed’ Department of Health consultations can be accessed via the Department of Health website: [http://www.dh.gov.uk/en/Consultations/Liveconsultations/index.htm](http://www.dh.gov.uk/en/Consultations/Liveconsultations/index.htm) This website also includes Government responses to closed consultations.

2. **Health and Wellbeing Strategy (Fit for the Future) and the Care Strategy (Your Health, Your Say)**

2.1 The Joint Health and Wellbeing Strategy (Fit for the Future) and the Care Strategy (Your Health, Your Say) are currently out for consultation and engagement until **12 December 2012**.

2.2 To support the engagement process short guides for each of the strategies have been produced which include Freepost feedback questionnaires. In addition to these booklets both strategies are available in full and provide more detailed information on health and social care. The 2011-2012 Director of Public Health Annual Report provides supplementary data and information on the priorities identified in the draft Joint Health and Wellbeing Strategy. *Your Health, Your Care - Our five year vision for Health and Social Care*, outlines how, given the financial and demographic challenge with our ageing population, the health and social care services are going to deliver care differently in the future.

2.3 All of these documents are available on the NHS Gloucestershire and Gloucestershire County Council websites. [http://www.gloucestershire.gov.uk/healthandwellbeing](http://www.gloucestershire.gov.uk/healthandwellbeing)

2.4 Engagement and consultation activity to date has included public drop-ins, invited stakeholder discussions and targeted focus groups. The Chair of the Shadow Health and Wellbeing Board has attended a meeting of LiNk Members to discuss the draft strategies, with a similar event organised by Gloucestershire Association for Voluntary and Community Action (GAVCA) planned for later in November 2012.

3. **Future management of NHS Gloucestershire Community Health Services**

3.1 The NHSG Board agreed at an Extraordinary Board Meeting on 15 October 2012 to seek the establishment of a new NHS Trust to provide current NHS Gloucestershire community health services from April 2013.

3.2 The decision followed twelve weeks of public engagement on options for the future. The decision by the Board Members to seek the establishment of a new NHS Trust, rather than pursue any of the other possible solutions, was based on feedback from the twelve week engagement exercise and factors such as the need for future improvements in service quality and efficiency and financial sustainability, which they were satisfied could be achieved through this option, within a relatively short timescale.

3.3 A further report providing more detail regarding the outcome of the engagement exercise, the NHSG Board decision and next steps is covered under a separate item on the November 2012 HCCOSC Agenda.
4. **Telephone Renumbering Update**

4.1 NHS Gloucestershire, Gloucestershire Care Services and Gloucestershire Hospitals NHS Foundation Trust have applied to the telecoms regulator Ofcom for telephone numbers in the 0300 range to replace the existing 084 number range. This will meet the national expectation that a caller to an NHS organisation will pay no more than if they were calling a local geographical number.

4.2 The change will address concerns raised by public representatives that callers on some call plans may be charged more than the cost of a local number by public sector organisations using the current 084 number range. NHS organisations will now meet the cost of incoming calls regardless of the telephone service from which the call is made.

4.3 A public communications programme will inform Gloucestershire residents of the new numbers on which to contact NHS services. This will include advertising in local media and communication with primary care, stakeholders and the public. A webpage explaining the changes and providing detailed information will be hosted on the NHS Gloucestershire website.

4.4 Revised entire have been submitted to the Phone Book and Yellow Pages.

5. **National Electronic Prescriptions Service (EPS)**

5.1 The national electronic prescriptions service (EPS) directions evaluation panel have approved 33 primary care trusts to be added to the EPS directions. Both NHS Gloucestershire and NHS Swindon are included in this list. This means that the Gloucestershire and Swindon cluster will now be able to implement the plans for release two of the Electronic Prescription Service (EPS R2), which allows the electronic transfer of prescriptions between prescribers and dispensers. Further information on the EPSA and the rollout can be found on the Connecting for Health website.


6. **End of Life Care in Gloucestershire and Swindon**

6.1 NHS Gloucestershire and NHS Swindon adopted the principles of care and goals as set out in the National End of Life Care Strategy (DoH 2008). This strategy was signed up to by all local statutory and voluntary care providers and included responsibilities to ensure individuals are asked about their preferred place of care. Many of the targets in the strategy are focused on ensuring services support people in their own home because national and local evidence would suggest this is what the majority of patients would choose. Therefore, much of the work involved in implementation of the strategy includes measures to ensure services are able to identify and care for patients in their own homes.

6.2 National End of Life Care profiles for Primary Care Trusts have recently been published [www.endoflifecareintelligence.org.uk/profiles.aspx](http://www.endoflifecareintelligence.org.uk/profiles.aspx). It is positive to note that the data shows that NHS Gloucestershire has significantly higher percentages of deaths in the person’s own home and in care homes compared to the national and south west average, with significantly lower percentages of death in hospital settings than the national average. In addition the percentage
of emergency admissions for end of life care is significantly lower than the national and south west average. It is important that work to support individuals to be involved in decisions about End of Life care is maintained and continues to be improved into the future to ensure Gloucestershire patients receive care in the setting of their choice wherever possible.

7. **NHS Gloucestershire Safeguarding Children Annual Report 2011-12**  
http://www.nhsglos.nhs.uk/?wpfb_dl=2435

7.1 All children deserve the opportunity to achieve their full potential. Safeguarding and promoting the welfare of children is the process of protecting children from abuse or neglect; preventing impairment of their health and development; and ensuring they are growing up in circumstances consistent with the provision of safe and effective care which is undertaken so as to enable children to have optimum life chances and enter adulthood successfully.

7.2 The purpose of the Safeguarding Children Annual Report is to fulfil the statutory requirement to report on safeguarding performance to the Trust Board annually, as set out in ‘Working Together to Safeguard Children’ HM Government 2010, as well as the requirements of the Care Quality Commission and Lord Lamming’s report ‘The Protection of children in England: A Progress Report’ 2009. It also seeks to reassure the NHSG Board that NHSG is working in partnership with other agencies to ensure that there are in place robust systems and processes to safeguard children and young people.

7.3 NHSG’s partners in this work are Gloucestershire County Council, NHS Gloucestershire Care Services, ²gether NHS Foundation Trust, Gloucestershire Hospitals NHS Foundation Trust, Great Western Ambulance Service and Gloucestershire Police Constabulary.

7.4 Specific initiatives that have taken place this year to improve child safeguarding include:

- Governance arrangements have been reviewed and the Safeguarding Children Strategic Group has been revised. Membership includes commissioners, providers and independent contractors. The group meets on a quarterly basis and is chaired by the Designated Doctor.

- Recommendations made following the Ofsted and Care Quality Commission inspection of safeguarding and Looked After Children in Gloucestershire in December 2010 are now complete.

- A Designated Nurse for Children in Care: The role of NHS Gloucestershire has been strengthened in respect of commissioned services using Safeguarding Children Board.

- Safeguarding Training which includes both adult and child protection, has been developed and is being delivered in two of the provider organisations.

- Independent contractors now have access to e-learning safeguarding training.
8. Medical Revalidation for General Practitioners

8.1 It is a national requirement for doctors to be licensed and registered to practice to ensure the delivery of best quality services and patient safety standards are met. The purpose of medical revalidation is to confirm that all doctors holding registration with a license to practise are up to date and fit to practise. The annual doctor appraisal will be the main system in which doctors will demonstrate that they are meeting the standards required for revalidation.

8.2 NHS Gloucestershire (NHS G) and NHS Swindon (NHS S) Cluster need to prepare for the introduction of this system and consider the options for GP appraisal systems, medical revalidation systems and toolkits. As part of the mandatory requirement a Responsible Officer (RO) has also been recruited. All doctors working for the Cluster on the medical performers lists will come under the RO remit. GPs will be required to be revalidated every five years. However latest guidance confirms that the first round of revalidation is based on a three year cycle (2012).

8.3 Alongside this work the National NHS Revalidation Support Team have led on pathfinder pilots, which included testing out strengthening medical appraisal, the role of the RO and information needed for revalidation. Findings from these pilots will assist with this project locally. Current guidance from the GMC states that we should schedule doctors for revalidation as follows:
- Year 1 (April 2013 – March 2014) 20% of the doctors on our Medical Performers’ list.
- Year 2 (April 2014 – March 2015) 40%.
- Year 3 (April 2015 – March 2016) the last 40%.

8.4 The national steer is that we should attempt both to offer up a sample of all doctors on our lists, and that we should also consider doctors in leadership positions for early revalidation. Doctors in leadership positions include, doctors working as Clinical Commissioning Groups leads or representatives, GP appraisers, GP trainers, other GP educators and LMC representatives.

8.5 The first wave of GPs is to be revalidated from April 2013. Prior to this a proposal of scheduling GPs to be revalidated has to be completed by September 2012 using the General Medical Council (GMC) Connect system.

8.6 A project has been set up to prepare for the commissioning and introduction of the new system building on the current robust cluster appraisal, accreditation, managing complaints, remediation and clinical governance systems which are a key component for revalidation. There are a total of 41 GP appraisers all of which receive on going appraiser training within the Cluster.

8.7 It is envisaged that following the GPs next appraisal revalidation will be scheduled in the next quarter. This will give GPs an opportunity to collect the necessary supporting information and review it at their appraisal. A self-assessment check list, covering the six General Medical Council requirements, measuring how ready each GP scheduled for the first year of revalidation, has
been sent out for completion. Returned forms are being collated for information to support recommendations for GPs to be revalidated.

8.8 Latest guidance aligns GP Appraisal and Medical Revalidation to sit under the NHS Commissioning Board. Both Gloucestershire and Swindon will amalgamate with Wiltshire and Bath and North East Somerset into a Local Area Team (LAT).

9. Future of Drug and Alcohol Treatment and Recovery Services

9.1 Following the recent competitive tendering process, as outlined in the May 2012 Chief Executive’s Report, Turning Point, a leading health and social care organisation with over 45 years’ experience, has been named as the preferred bidder for the community Drug and Alcohol Recovery Service for adults in Gloucestershire. In2Recovery (a partnership comprising 2gether NHS Foundation Trust, Independence Trust and Nelson Trust) has been confirmed as the preferred bidder for HM prison drug and alcohol services.

9.2 Two full competitive tendering exercises have now been completed in line with EU procurement requirements. Specifications for the new services were based on a full review of existing services and future need and included engagement with local stakeholders and service users. Engagement was undertaken with existing service users including focus group sessions, use of questionnaires and interviews. Specialist stakeholder events were attended by local representatives from the public sector, health and social care, housing providers and voluntary organisations.

9.3 The tender evaluation was carried out by a multi-agency panel including representatives from NHS Gloucestershire, Gloucestershire County Council and service users. The evaluation process gave all parties the assurance that the procurement was transparent and fair. Based on the results, a recommendation was made to the Board of NHS Gloucestershire on the preferred bidders.

9.4 The preferred bidders best demonstrated their ability to meet the service requirements, provide high quality care and deliver value for money. The top priority was to secure the very best services for Gloucestershire and this has been the guiding principle throughout this process.

9.5 Existing staff currently providing community drug and alcohol services will be given the opportunity to transfer to the new provider.

9.6 Subject to contract, we look forward to working with the providers to build on what has already been achieved, deliver excellent standards of care and treatment in to the future for the benefit of individuals, families and the wider community and ensure continuity of care in the coming months.

9.7 The new contracts are due to be signed in November 2012 and come into effect from 1 April 2013.

10. Joint Carers Commissioning Strategy

10.1 In October 2012, Clinical Commissioning Gloucestershire (CCG) Shadow Board (in principle) and Gloucestershire County Council Cabinet have
approved the Gloucestershire Joint Carers Support Commissioning Strategy. The Strategy, which has been influenced by carers and carer representatives, sets out the future approach to the Commissioning of Carers Support in the county.

10.2 The Strategy includes:
- Definition of a carer
- Policy and Legislation
- National research and evidence about caring
- Local Context
- Consultation with carers
- Provision of services
- Carers Assessments
- The Way Forward
- Proposed Service Remodelling
  - Carer advice and support service
  - Carers support planning
  - Carers breaks provision
  - Carers emotional support
- Remodelling of existing in house services (GCC)
- Future Funding Strategy

10.3 The next step is to develop detailed service specifications against which potential providers can bid to provide services. The formal procurement process, led by Gloucestershire County Council in partnership with NHSG/CCG is scheduled to begin spring 2013.

11. Gloucestershire’s Dementia Challenge Bid

11.1 In May 2012, NHS South of England launched a £10m Dementia Challenge. The £10m funding is being invested in the local NHS to support innovative solutions to improve the health and wellbeing of people living with dementia in the South of England.

11.2 This Challenge was for Clinical Commissioning Groups (CCGs) to work with local authorities, Health and Wellbeing Boards, NHS colleagues, voluntary, community and independent sectors, universities, industry, and people with lived experience, to identify and implement practical solutions to the problems faced by people living with dementia.

11.3 2gether NHS Foundation Trust (2gether) are part of the Gloucestershire Multi-Agency Dementia Project Management Board with representation from local health partners, local authority and independent and voluntary sector organisations. 2gether submitted two bids - one focusing on an ‘enhanced, more responsive and preventative community based care’ and the other to ‘make Gloucestershire a dementia friendly county’. Both bids were successful.

12. 2gether Service User Charter

12.1 Staff from 2gether were joined by service users, carers, businesses and representatives from local partner organisations to help launch Gloucestershire’s first NHS mental health service user charter on world mental health day (10 October).
12.2 The Charter was developed by 2gether’s service users, staff and representative organisations. It is a pledge to how everyone will work together; and a set of standards that can be expected when receiving local mental health services.

12.3 2gether staged an event in association with GUiDE & PALS and ASDA, Gloucester, to launch the Charter. Professionals were on hand to offer members of the public suggestions on how to improve emotional wellbeing and how to access appropriate, local mental health services.

14. **NHS Gloucestershire – Award for contribution to nature**

14.1 NHS Gloucestershire has been recognised for its contribution to nature at an exclusive business awards held at the House of Commons on 31 October 2012.

14.2 Gloucestershire Wildlife Trust acknowledged ten local businesses, leaders, landowners and organisations in their 2012 Nature Works business awards. NHS Gloucestershire’s Cirencester Hospital Green Gym Project won the award of ‘Nature Works Workers Award for the Business that Most Effectively Encourages Employee Volunteering to Support Nature’.

Jan Stubbings,  
Chief Executive, NHS Gloucestershire  
November 2012
Performance against Commissioning Report

1 Introduction

1.1 This report sets out NHS Gloucestershire (NHSG) 2012/13 Commissioned Service performance dependent upon the availability of the data. It is broken down into two sections covering performance relating to the key commissioning service targets and financial positions of NHSG.

1.2 Only those areas of performance assessed as being at significant risk of failure at year end, or other issues that engendered concerns throughout the year, for which the Board need to be made aware of, are included in the report. The full summary of performance is included in Appendix 1.

1.3 The format of the report has been altered from that presented in 2011/12. Rather than addressing each risk within an overarching narrative, areas of significant risk will now be presented in a template that identifies the nature of the risk, the mitigating actions being taken and the expected results of those actions if known. This will ensure that all significant risks and actions are clearly identified for the Board.

1.4 The supporting appendices provide a full analysis of the PCT’s performance against its Commissioning performance targets. The 2012/13 commissioning performance scorecard (appendix 1) provides an integrated report describing the performance of NHSG. The scorecard covers the 2012/13 Operating Framework targets, NHS Constitution commitments and key ‘local offer’ commitments.
2 Performance

2.1 A full overview of current performance of the Cluster against the national and key local targets is given in Appendix 1 that is ordered in the following overarching themes;

- Unscheduled Care
- Planned care
- Primary and Community Care
- Public Health
- Mental Health and Learning Disabilities
- Quality

All indicators are Red, Amber, Green (RAG) rated, based on the 2012/13 NHS Performance Framework thresholds. In addition to this Year To Date and Year End Forecast positions are given to aid quantifying the level of risk.

2.2 The overall level of performance is very good and a summary is given in the table below. This shows that of the total of 50 indicators reported on; 39 were rated Green (78%), 9 Amber (18%) and just 2 Red (4%).

<table>
<thead>
<tr>
<th>Breakdown of current year to date performance by RAG status of indicator</th>
<th>Green</th>
<th>Amber</th>
<th>Red</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Gloucestershire</td>
<td>39</td>
<td>9</td>
<td>2</td>
</tr>
</tbody>
</table>

| Percentage | 78% | 20% | 4% |

2.3 Areas where performance has been particularly good include:

- The 4 hour A&E target is being met by all providers within the cluster. There has been a significant improvement in 4 hour A&E performance at Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) where the target was achieved in May and June 2012 for the first time in 10 months.
- Both Cat A8 and A19 performance targets have been achieved throughout the year and within
Gloucestershire.

- Patients are able to receive treatment for Community Services in Gloucestershire within 8 weeks of referral. These are some of the best access times in the country.
- VTE risk assessment target has been consistently met within GHNHSFT.

2.4 The table below provides a fuller position statement for all the Red and significant Amber rated indicators. This table outlines current performance, identifies the issues leading to that performance and mitigating actions being taken to recover performance. The table may also include an update on other areas that may currently be performing well but have historically been the cause of concern, an example of this would be the 4 hour A&E target performance.
<table>
<thead>
<tr>
<th>Ref</th>
<th>PCT</th>
<th>Indicator</th>
<th>Status</th>
<th>Issue</th>
<th>Mitigating Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ19</td>
<td>NHS Glos</td>
<td>At least 90% of Trauma &amp; Orthopaedic admitted Referral to Treatment (RTT) pathways should be treated within 18 Weeks</td>
<td>RED YTD</td>
<td>Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) has had a persistent backlog of between 200-350 T&amp;O patients that have already waited more than 18 weeks. The bulk of this backlog needs to be cleared, and the average waiting time reduced, to enable the target to be achieved sustainably.</td>
<td>GHNHSFT have restated their commitment to achieve the target by the end of Q3 2012/13. Waiting list management by consultant has improved performance and those consultants not achieving the required standard will have their work plans altered to allow them to clear their backlog. The backlog of patients who have already waited over 18 weeks has reduced by over 60% since April 2012, which shows significant improvement in both waiting list and capacity management.</td>
</tr>
</tbody>
</table>

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) has had a persistent backlog of between 200-350 T&O patients that have already waited more than 18 weeks. The bulk of this backlog needs to be cleared, and the average waiting time reduced, to enable the target to be achieved sustainably.
<table>
<thead>
<tr>
<th>Ref</th>
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<th>Indicator</th>
<th>Status</th>
<th>Issue</th>
<th>Mitigating Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Patients suitable for transfer are to being offered alternative providers for their surgery.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>New Referrals into Orthopaedics have reduced by 10% at month 5, which will help with GHNHSFT capacity pressures.</td>
</tr>
<tr>
<td>PHQ22</td>
<td>NHS Glos</td>
<td>Not more than 1% of patients should have waited more than 6 weeks for one of the 15 key diagnostic tests</td>
<td>AMBER YTD</td>
<td>GHNHSFT have not had sufficient endoscopy capacity to meet demand and clear the waiting list backlog. The situation worsened following the departure of a locum and Clinical Fellow. The bowel cancer awareness campaign GHNHSFT have submitted a revised recovery action plan which states that they are committed to clearing the backlog by the end of November 2012. GHNHSFT have extended the contract of the two locums and increased weekend lists, this additional activity has been</td>
<td></td>
</tr>
<tr>
<td>Ref</td>
<td>PCT</td>
<td>Indicator</td>
<td>Status</td>
<td>Issue</td>
<td>Mitigating Action</td>
</tr>
<tr>
<td>-----</td>
<td>-----------</td>
<td>----------------------------------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>At least 93% of patients should be seen within 2 weeks of an urgent referral for suspected cancer</td>
<td>AMBER YTD 91.5% in August</td>
<td>Performance has been impacted by an increase of 11% in 2 week referrals in the first 4 months of 2012/13 compared to the same period the previous year.</td>
<td>Following a performance meeting with GHNHSFT on the 7 September 2012, GHNHSFT will discussing possible solutions to minimise patient choice breaches at the Clinical Programme Group.</td>
</tr>
</tbody>
</table>

Additionally many of the breaches are due to patients choosing to wait longer than 2 weeks. An audit by

The increased endoscopy capacity has reduced the number of lower GI breaches significantly.
<table>
<thead>
<tr>
<th>Ref</th>
<th>PCT</th>
<th>Indicator</th>
<th>Status</th>
<th>Issue</th>
<th>Mitigating Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>GHNHSFT of their 93 breaches in June found that 75 (81%) were due to patients being unable or unwilling to attend within 2 weeks. Lack of endoscopy capacity has also led to patients having to wait longer than 2 weeks.</td>
<td></td>
</tr>
<tr>
<td>PHQ25</td>
<td>NHS Glos</td>
<td>At least 93% of patients should be seen within 2 weeks of an urgent referral for breast symptoms where cancer is not initially suspected</td>
<td>AMBER YTD</td>
<td>Poor performance in April 2012, due to Breast Consultant unavailability, has impacted on YTD performance.</td>
<td>Staffing issues have now been resolved and the target has been achieved in every month since April 2012. It is predicted that the target will be achieved in Q2 and at year end.</td>
</tr>
<tr>
<td>Ref</td>
<td>PCT</td>
<td>Indicator</td>
<td>Status</td>
<td>Issue</td>
<td>Mitigating Action</td>
</tr>
<tr>
<td>-----</td>
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<td>--------</td>
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<td>-------------------</td>
</tr>
</tbody>
</table>
| PHQ03 | NHS Glos | At least 85% of patients receiving first definitive treatment for cancer should be seen within 62 days from an Urgent GP referral | AMBER YTD 82.9% in August, 83.4% YTD | Main theme for underperformance has been patients not having all diagnostic tests in time. Urology has been the specialty which has seen the majority of breaches. | GHNHSFT have submitted an action plan, primarily around addressing Urology breaches, which accounts for the majority of the breaches, with the following actions:  
- Increase theatre capacity (inc. evening & weekend sessions)  
- Review of clinical staffing rotas  
- Employment of a Consultant and Clinical Fellow  

Performance has steadily improved over the last three months and GHNHSFT expect the target to be attained from Q3. |
<table>
<thead>
<tr>
<th>Ref</th>
<th>PCT</th>
<th>Indicator</th>
<th>Status</th>
<th>Issue</th>
<th>Mitigating Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Primary and Community Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LO1</td>
<td>NHS Glos</td>
<td>The average wait to be seen by the Adult Physiotherapy Service should be within 2 weeks</td>
<td>AMBER YTD 2.2 in August</td>
<td>Gloucestershire Care Services (GCS) believe that the main problem is long waits in the Stroud &amp; Gloucester Localities.</td>
<td>GCS have submitted a recovery plan outlining a comprehensive set of milestones that aims to ensure that the target is achieved, and sustained, from September 2012. Progress is monitored weekly and the latest report shows that the average wait for both services is now within the 2 week target.</td>
</tr>
<tr>
<td>LO3</td>
<td>NHS Glos</td>
<td>The average wait to be seen by the Podiatry Service should be within 2 weeks</td>
<td>RED YTD 3.5 in August</td>
<td>Through a combination of an increase in referrals and staff shortages a backlog has built up that has led to increased average waits.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improving Access to Psychological Therapies (IAPT)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHQ13_5</td>
<td>NHS Glos</td>
<td>The proportion of people who have depression and/or anxiety disorders who receive</td>
<td>AMBER YTD 3.8% at Q2 against a plan of 4.5%</td>
<td>This target was achieved in 2011/12 however 2gether NHS Foundation performance in Q1 was significantly</td>
<td>A performance meeting was held with 2gether on the 25th September. Following this meeting an action Plan has been received by 2gNHSFT</td>
</tr>
<tr>
<td>Ref</td>
<td>PCT</td>
<td>Indicator</td>
<td>Status</td>
<td>Issue</td>
<td>Mitigating Action</td>
</tr>
<tr>
<td>---------</td>
<td>--------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------</td>
<td>----------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>PHQ13_6</td>
<td>NHS Glos</td>
<td>psychological therapies</td>
<td></td>
<td>below expected levels.</td>
<td>which includes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Working closely with Prison Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Increasing referrals into the service</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Streamlining initial assessments by making this part of their referral process</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>- Training of health visitors to support delivery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The proportion of people who complete therapy who are moving towards recovery</td>
<td>AMBER YTD</td>
<td>47.8% at Q2 against a plan of 51.9%</td>
<td>2gether are confident that the target will be achieved at year end and there has</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>already been a significant improvement in Q2 performance.</td>
</tr>
</tbody>
</table>

**Quality**

<p>| PHQ28   | NHS Glos | Number of C.Diff infections (Health)                                      | RED YTD     | Despite improved performance in recent months the                    | NHSG is working with Primary Care and all health care providers to ensure          |
|---------|----------|--------------------------------------------------------------------------|-------------|                                                                      |-----------------------------------------------------------------------------------|</p>
<table>
<thead>
<tr>
<th>Ref</th>
<th>PCT</th>
<th>Indicator</th>
<th>Status</th>
<th>Issue</th>
<th>Mitigating Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Community</td>
<td>of 11 in August, YTD 27 over Plan</td>
<td>July and August 2012 figure was above the agreed ceiling level. No specific themes can be identified to account for the increase; however similar levels of increases have been experienced in other health communities.</td>
<td>that anti-biotic prescribing are within guidelines and that RCAs (Root Cause Analysis) are carried out where clinical concerns exist. NHSG are part of a South West review group of community infections, to further understand the increases seen across the South West. Local infection control group countywide has been re-established to start discuss strains any identify any reoccurring themes</td>
</tr>
</tbody>
</table>
## Appendix 3

### NHS Gloucestershire 2012/13 Integrated Performance Scorecard

#### Principal Delivery Targets

|--------|----------------|---------|---------|-------------|---------|---------|--------------|---------|---------|-------------|---------|---------|---------|--------------|----------------|---------|--------------|

### Unscheduled Care

#### Accident & Emergency

|--------|----------------|---------|---------|-------------|---------|---------|--------------|---------|---------|-------------|---------|---------|---------|--------------|----------------|---------|--------------|

#### Ambulance

|--------|----------------|---------|---------|-------------|---------|---------|--------------|---------|---------|-------------|---------|---------|---------|--------------|----------------|---------|--------------|

### Planned Care

#### Acute Care Referral to Treatment

|--------|----------------|---------|---------|-------------|---------|---------|--------------|---------|---------|-------------|---------|---------|---------|--------------|----------------|---------|--------------|

#### Diagnostics

|--------|----------------|---------|---------|-------------|---------|---------|--------------|---------|---------|-------------|---------|---------|---------|--------------|----------------|---------|--------------|

#### Cancer Wait

|--------|----------------|---------|---------|-------------|---------|---------|--------------|---------|---------|-------------|---------|---------|---------|--------------|----------------|---------|--------------|

### Performance Measurement

- **Performance** is measured as a percentage of the target achieved.
- A **performance breach** occurs if the actual performance is below 90% of the target for that quarter or if there are more than three breaches within a year.

**Grades**:
- **A** for performance above 95%
- **B** for performance above 90%
- **C** for performance above 85%
- **D** for performance above 80%
- **E** for performance above 75%

- **Breaches** are calculated as the number of instances where performance fell below the threshold.
- **Performance** is calculated as the percentage of the target achieved.
### Primary and Community Care

#### Primary care

<table>
<thead>
<tr>
<th>PHQ31_04</th>
<th>Percentage of people eligible for the NHS Health Check programme who have been offered an NHS Health Check</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>18.0%</td>
</tr>
<tr>
<td>Actual</td>
<td>23.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PHQ31_05</th>
<th>Percentage of people eligible for the NHS Health Check programme that have received an NHS Health Check</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>6.1%</td>
</tr>
<tr>
<td>Actual</td>
<td>8.1%</td>
</tr>
</tbody>
</table>

#### Local 2 Week Offers

<table>
<thead>
<tr>
<th>LO1</th>
<th>Average wait to be seen by the Adult Physiotherapy Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target (weeks)</td>
<td>2</td>
</tr>
<tr>
<td>Max wait (weeks)</td>
<td>2.6</td>
</tr>
<tr>
<td>LO2</td>
<td>Average wait to be assessed for a wheelchair by the Specialist and Non-Specialist wheelchair Service</td>
</tr>
<tr>
<td>Target (weeks)</td>
<td>2</td>
</tr>
<tr>
<td>Max wait (weeks)</td>
<td>7.6</td>
</tr>
<tr>
<td>LO3</td>
<td>Average wait to be seen by the Podiatry Service</td>
</tr>
<tr>
<td>Target (weeks)</td>
<td>2.4</td>
</tr>
<tr>
<td>Max wait (weeks)</td>
<td>7</td>
</tr>
<tr>
<td>LO4</td>
<td>Average wait to be seen by the Children's Occupational Therapy Service</td>
</tr>
<tr>
<td>Target (weeks)</td>
<td>1.9</td>
</tr>
<tr>
<td>Max wait (weeks)</td>
<td>9</td>
</tr>
<tr>
<td>LO5</td>
<td>Average wait to be seen by the Children's Physiotherapy Service</td>
</tr>
<tr>
<td>Target (weeks)</td>
<td>2</td>
</tr>
<tr>
<td>Max wait (weeks)</td>
<td>6</td>
</tr>
<tr>
<td>LO6</td>
<td>Average wait to be seen by the Children's Speech and Language Therapy Service</td>
</tr>
<tr>
<td>Target (weeks)</td>
<td>1.9</td>
</tr>
<tr>
<td>Max wait (weeks)</td>
<td>9</td>
</tr>
</tbody>
</table>

#### Community Care Referral to Treatment

**Paeodiatrics**

<table>
<thead>
<tr>
<th>AMB 01</th>
<th>Percentage of patients referred to the Paediatric Speech and Language Therapy Service who are treated within 8 Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>95%</td>
</tr>
<tr>
<td>Actual</td>
<td>97.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AMB 02</th>
<th>Percentage of patients referred to the Paediatric Occupational Therapy Service who are treated within 8 Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>95%</td>
</tr>
<tr>
<td>Actual</td>
<td>97.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AMB 03</th>
<th>Percentage of patients referred to the Paediatric Physiotherapy Service who are treated within 8 Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>95%</td>
</tr>
<tr>
<td>Actual</td>
<td>99.0%</td>
</tr>
</tbody>
</table>

**Adult**

<table>
<thead>
<tr>
<th>AMB 04</th>
<th>Percentage of patients referred to the Adult Speech and Language Therapy Service who are treated within 8 Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>95%</td>
</tr>
<tr>
<td>Actual</td>
<td>96.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AMB 05</th>
<th>Percentage of patients referred to the Adult Physiotherapy Service who are treated within 8 Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>95%</td>
</tr>
<tr>
<td>Actual</td>
<td>99.0%</td>
</tr>
</tbody>
</table>

**Specialist Nurses**

<table>
<thead>
<tr>
<th>AMB 06</th>
<th>Percentage of patients referred to the Parkinson Nursing Service who are treated within 8 Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>95%</td>
</tr>
<tr>
<td>Actual</td>
<td>98.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AMB 07</th>
<th>Percentage of patients referred to the Diabetic Nursing Service who are treated within 8 Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>95%</td>
</tr>
<tr>
<td>Actual</td>
<td>99.0%</td>
</tr>
</tbody>
</table>
### NHS Gloucestershire 2012/13 Integrated Performance Scorecard

#### Target 2011-12 Outturn 2012-12 Outturn 2013-14 Outturn 2014-15 Outturn 2015-15 Outturn Year to date End forecast Measured

<table>
<thead>
<tr>
<th>Target</th>
<th>2011-12</th>
<th>2012-13</th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-15</th>
<th>Year to date</th>
<th>Year end forecast</th>
<th>Measured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clients to the NHS Stop Smoking Service who report that they are not smoking 4 week after setting a quit date</td>
<td>3,050</td>
<td>766</td>
<td>1,508</td>
<td>2,272</td>
<td>3,505</td>
<td>768</td>
<td>3,505</td>
<td>C</td>
</tr>
<tr>
<td>Actual</td>
<td>4,003</td>
<td>893</td>
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<td></td>
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<td>893</td>
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</tbody>
</table>

#### Mental Health and Learning Disabilities

<table>
<thead>
<tr>
<th>Target</th>
<th>2011-12</th>
<th>2012-13</th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-15</th>
<th>Year to date</th>
<th>Year end forecast</th>
<th>Measured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of those patients on a Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days</td>
<td>95%</td>
<td></td>
<td></td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>&gt;95%</td>
</tr>
<tr>
<td>Actual</td>
<td>100.0%</td>
<td></td>
<td>100.0%</td>
<td></td>
<td></td>
<td>100.0%</td>
<td>&gt;95%</td>
<td>C</td>
</tr>
<tr>
<td>Number of home treatment packages delivered by Crisis Team</td>
<td>939</td>
<td>255</td>
<td></td>
<td>483</td>
<td>711</td>
<td>939</td>
<td>255</td>
<td>939</td>
</tr>
<tr>
<td>Actual</td>
<td>3,848</td>
<td></td>
<td>461</td>
<td></td>
<td></td>
<td>401</td>
<td>&gt;939</td>
<td>C</td>
</tr>
<tr>
<td>The number of new cases of psychosis served by the Early Intervention Team</td>
<td>70</td>
<td>18</td>
<td></td>
<td>38</td>
<td>53</td>
<td>70</td>
<td>18</td>
<td>70</td>
</tr>
<tr>
<td>Actual</td>
<td>85</td>
<td></td>
<td>23</td>
<td></td>
<td></td>
<td>23</td>
<td>&gt;70</td>
<td>C</td>
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</table>

#### Quality Indicators

<table>
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<th>2013-14</th>
<th>2014-15</th>
<th>2015-15</th>
<th>Year to date</th>
<th>Year end forecast</th>
<th>Measured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eliminate mixed-sexed accommodation breaches at all providers sites</td>
<td>393</td>
<td>33</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>39</td>
<td>39</td>
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<tr>
<td>Achieve</td>
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<td>0</td>
<td>0</td>
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<td>0</td>
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</tr>
<tr>
<td>Percentage of all adult inpatients who have had a VTE risk assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>92.9%</td>
<td>92.9%</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>GHSNFT</td>
<td>92.9%</td>
<td>94.5%</td>
<td>94.0%</td>
<td>92.9%</td>
<td>93.9%</td>
<td>93.9%</td>
<td>93.9%</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>GCS</td>
<td>95.8%</td>
<td>98.1%</td>
<td>97.8%</td>
<td>94.9%</td>
<td>97.9%</td>
<td>97.9%</td>
<td>97.9%</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>Local offer to Gloucestershire Health Community to reduce waiting times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>92.9%</td>
<td>92.9%</td>
<td>&gt;90%</td>
</tr>
</tbody>
</table>

#### Methicillin Resistant Staphylococcus Aureus (MRSA)

<table>
<thead>
<tr>
<th>Target</th>
<th>2011-12</th>
<th>2012-13</th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-15</th>
<th>Year to date</th>
<th>Year end forecast</th>
<th>Measured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of MRSA infections (Health Community)</td>
<td>14</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td>GHSNFT</td>
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<td>1</td>
<td>1</td>
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<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>GCS</td>
<td>162</td>
<td>19</td>
<td>16</td>
<td>13</td>
<td>16</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Local offer to Gloucestershire Health Community to reduce waiting times</td>
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</table>

#### Clostridium Difficile (C.Diff)

<table>
<thead>
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<th>Target</th>
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<th>2012-13</th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-15</th>
<th>Year to date</th>
<th>Year end forecast</th>
<th>Measured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of total C Diff infections (Health Community)</td>
<td>182</td>
<td>19</td>
<td>16</td>
<td>13</td>
<td>16</td>
<td>11</td>
<td>11</td>
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<tr>
<td>Acute Hosp</td>
<td>162</td>
<td>19</td>
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<tr>
<td>Community</td>
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<td>6</td>
<td>4</td>
<td>5</td>
<td>10</td>
<td>13</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>GHSNFT</td>
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<td>19</td>
<td>16</td>
<td>13</td>
<td>16</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>GCS</td>
<td>182</td>
<td>19</td>
<td>16</td>
<td>13</td>
<td>16</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
</tbody>
</table>

### Key to abbreviations
- GHSNFT - Gloucestershire Hospitals NHSFT
- GCS - Gloucestershire Care Services
- GWAS - Great Western Ambulance Service