2GETHER NHS FOUNDATION TRUST

BOARD MEETING

THURSDAY 26 JANUARY 2017 AT 10.00AM

BUSINESS CONTINUITY ROOM, RIKENEL

AGENDA

10.00	1	**Apologies**	
	2	**Declaration of Members Interests**	
10.05	3	**Minutes of the Board meeting held on 24 November 2016**	**PAPER A**
	4	**Action Points and Matters Arising**	
10.10	5	**Questions from the Public**	
IMPROVING QUALITY			
10.15	6	**Patient Story Presentation**	**VERBAL**
10.40	7	**Performance Dashboard Report – November 2016**	**PAPER B**
10.50	8	**Progress Toward Smokefree Implementation**	**PAPER C**
		Improving Compliance with Statutory and Mandatory Training	**Additional Paper**
IMPROVING ENGAGEMENT			
11.00	9	**Chief Executive's Report**	**PAPER D**
IMPROVING SUSTAINABILITY			
11.10	10	**Summary Financial Report**	**PAPER E**
11.20	11	**Board Committee Summaries** • Delivery Committee – 23 November and 25 January (Verbal) • Governance Committee – 18 November and 16 December • MHLS Committee – 9 November and 11 January	 **PAPER F1** **PAPER F2** **PAPER F3**
INFORMATION SHARING (TO NOTE ONLY)			
11.35	12 13 14	**Chair's Report** **Council of Governor Minutes – November 2016** **Use of the Trust Seal – Quarter 3 2016/17**	**PAPER G** **PAPER H** **PAPER I**
11.40	15	**Any Other Business**	
11.45	16	**Date of Next Meeting** Thursday 30 March 2017 at Trust HQ, Rikenel, Gloucester	

QUESTIONS FROM THE PUBLIC

Written questions for the Board Meeting

People who live or work in the county or are affected by the work of the Trust may ask:

- the Chairperson of the Trust Board;
- the Chief Executive of the Trust;
- a Director of the Trust with responsibility; or
- a chairperson of any other Trust Board committee, whose remit covers the subject matter in question;

a question on any matter which is within the powers and duties of the Trust.

Notice of questions

A question under this procedural standing order may be asked in writing to the Chief Executive by 10 a.m. 4 clear working days before the date of the meeting.

Response

A written answer will be provided to a written question and will be given to the questioner and to members of the Trust Board before being read out at the meeting by the Chairperson or other Trust Board member to whom it was addressed.

Additional Questions or Oral Questions without Notice

A member of the public who has put a written question may, with the consent of the Chairperson, ask an additional oral question on the same subject. The Chairperson may also permit an oral question to be asked at a meeting of the Trust Board without notice having been given.

An answer to an oral question under this procedural standing order will take the form of either:

- a direct oral answer; or
- if the information required is not easily available a written answer will be sent to the questioner and circulated to all members of the Trust Board.

Unless the Chairperson decides otherwise there will not be discussion on any public question.

Written questions may be rejected and oral questions need not be answered when the Chairperson considers that they:

- are not on any matter that is within the powers and duties of the Trust;
- are defamatory, frivolous or offensive;
- are substantially the same as a question that has been put to a meeting of the Trust Board in the past six months; or
- would require the disclosure of confidential or exempt information.

For further information, please contact the Assistant Trust Secretary on 01452 894165

2GETHER NHS FOUNDATION TRUST

BOARD MEETING
THE KINDLE CENTRE, HEREFORD
24 NOVEMBER 2016

PRESENT

Ruth FitzJohn, Trust Chair
Maria Bond, Non-Executive Director
Marie Crofts, Director of Quality
Dr Chris Fear, Medical Director
Marcia Gallagher, Non-Executive Director
Andrew Lee, Director of Finance and Commerce
Jane Melton, Director of Engagement and Integration
Colin Merker, Director of Service Delivery/Deputy Chief Executive
Quinton Quayle, Non-Executive Director
Nikki Richardson, Non-Executive Director
Carol Sparks, Director of Organisational Development
Duncan Sutherland, Non-Executive Director
Jonathan Vickers, Non-Executive Director

IN ATTENDANCE

Hilary Bowen, Trust Governor
Anna Hilditch, Assistant Trust Secretary
Paul Maddox, O_2
Frances Martin, Director of Transformation
Andrew Smart, Head of Communications
Ian Stead, Herefordshire Healthwatch
Jennifer Thomson, Trust Governor
Svetlin Vrabtchev, Trust Governor

1. WELCOMES, APOLOGIES AND INTRODUCTIONS

1.1 Apologies were received from Shaun Clee and Charlotte Hitchings.

1.2 Ruth FitzJohn welcomed Maria Bond to her first Board meeting. Maria commenced in post as a Non-Executive Director on 1 November.

2. DECLARATIONS OF INTERESTS

2.1 There were no new declarations of interests.

3. MINUTES OF THE MEETING HELD ON 29 SEPTEMBER 2016

3.1 The minutes of the meeting held on 29 September were agreed as a correct record.

4. MATTERS ARISING AND ACTION POINTS

4.1 The Board reviewed the action points, noting that these were now complete or progressing to plan. There were no matters arising.

5. QUESTIONS FROM THE PUBLIC

5.1 Ian Stead, Herefordshire Healthwatch had asked the Trust for an update on progress with improving IAPT services and the implementation of Triangle of Care in Herefordshire. It was agreed that an update would be provided during the meeting as part of the relevant agenda items.

6. PATIENT STORY PRESENTATION

6.1 The Board welcomed Jamie-Lee to the meeting who gave the Board an account of her experience of Trust services in Herefordshire and of her time as a patient at Oak House.

6.2 Jamie-Lee had been a resident at Oak House for 2 years before recently moving into The Shires, a MIND nursing home. She said that she had found Oak House to be a safe and positive place to be and felt that the care that she received was very good. Jamie-Lee said that she had made some great friends during her time there and felt like Oak House was her home.

6.3 In terms of activities, Jamie-Lee said that she had attended weekly art therapy sessions and went grocery shopping with members of staff at Oak House. Jamie-Lee was still receiving support from 2gether's South Recovery Team following her move to The Shires.

6.4 The Board asked about the move from Oak House to The Shires and how Jamie-Lee had found this transition. Jamie-Lee said that colleagues from MIND had come to Oak House to meet her and to carry out an assessment and then she had carried out a few visits to The Shires to look at the unit and the gardens. She had gone there for a few hours a day at first but gradually started spending more time there and stayed overnight. Jamie-Lee said that she had felt supported during the transition and felt that she had a voice and could tell people if there was anything that she did not like.

6.5 In terms of improvements, Jamie-Lee said that she thought the car at Oak House could have been used more effectively, for example taking patients out for appointments and for activities.

6.6 Jamie-Lee said that she thought that there should have been more staff at Oak House and said that 4 members of staff had left within a short period of time, including the Unit Manager. She said that this was difficult as patients build up trust and rapport with staff members and it was therefore hard when someone new came in. Communication and reassurance to the patients at Oak House could have been improved.

6.7 Ruth FitzJohn asked Jamie-Lee about her plans for the future. Jamie-Lee said that she wanted to work at the Stonebow Unit and to get more involved in helping people with mental health and drug/alcohol addictions as she felt that she could use her own experiences to support others. The Board noted that Jamie-Lee was a volunteer at the Stonebow Unit currently.

6.8 The Board thanked Jamie-Lee and her support worker Jemima for coming and talking so openly to the Board. Ruth FitzJohn said that the Board was always so grateful to hear about personal experiences and that members of the Board would have the opportunity to reflect on the discussions that had taken place.

7. PERFORMANCE DASHBOARD

7.1 The Board received the performance dashboard report which set out the performance of the Trust for the period to the end of September 2016 against NHSI, Department of Health, Contractual and CQUIN key performance indicators. Of the 144 contractual measures, 96 were reported in September with 79 being compliant and 17 indicators non-compliant at the end of the reporting period. Where performance was not compliant, Service Directors were taking the lead to address issues with a particular focus continuing to be on IAPT services which accounted for 7 of the 17 non-compliant indicators (1.09, 1.10, 3.18, 3.19, 3.30, 5.08 and 5.09). Work was ongoing in accordance with agreed Service Delivery Improvement Plans to address the underlying issues affecting this performance.

7.2 The Director of Service Delivery tabled a written briefing setting out progress to date with improving IAPT services, as requested by Ian Stead. This briefing was welcomed.

7.3 Marcia Gallagher asked about the dip in performance of indicator 5.12 - Emergency referrals to CRHT seen within 4 hours of referral (8am-6pm). There was one case not seen and this has been confirmed as a recording error which has since been rectified.

7.4 The Board noted the dashboard report and the assurance that this provided.

8. QUALITY REPORT – QUARTER 2

8.1 The Director of Quality reported that this was the second review of the Quality Report priorities for 2016/17 and this quarterly report was in the format of the annual Quality Report.

8.2 The report showed the progress being made towards achieving targets, objectives and initiatives identified in the Annual Quality Report. The Board noted that the report had been scrutinised in detail by the Governance Committee.

8.3 Overall, there were 2 confirmed targets which would not be met by year end:
- 1.3 – Joint CPA reviews for young people transitioning to adult services
- 3.2 – Reduction in the number of detained patients who are AWOL

8.4 There was currently limited assurance that target 3.1 – Reduction in the numbers of reported deaths by suspected suicide, and target 3.3 – 5% reduction in the number of prone restraints on adult wards/PICU would be met. However, the Board noted that a number of developments were in place to improve compliance against these important targets and that the targets would continue to receive considerable focus through operational management systems, wider work streams such as the Patient Safety Improvement Programme, and sub-committees such as the Positive & Safe Sub-Committee. The data provided within the report related to Quarter 2 and would, therefore, be subject to change throughout the year.

8.5 The Board noted that there had been sustained improvements across all User Experience targets, 48hr follow up and Personalised Discharge Care Planning which demonstrated that measures put in place to improve performance in these areas by Service Directors had been effective. These would continue to receive focus throughout the year.

8.6 The Medical Director referred to target 3.1 and the reduction in the numbers of reported deaths by suspected suicide. He said that there had been an increase in suicides and this was in line with national trends. The Governance Committee would be receiving a detailed report on suicides and suspected suicides and the links to the National Suicide Inquiry at its January 2017 meeting. It was noted that as well as an overall increase, there had specifically been an increase in incidents of suspected suicide by people who were not in contact with 2gether services which it was felt should be a key area for the Trust to focus on in terms of improving access.

8.7 Nikki Richardson offered the Board assurance that the Governance Committee had spent time reviewing this report and had drilled down into the detail of all targets.

8.8 The Board noted the progress made to date and supported the recommendation that the Quarter 2 Quality Report update be shared with partner organisations, commissioners and governors.

9. SERVICE EXPERIENCE REPORT – QUARTER 2

9.1 The Director of Engagement and Integration presented the Service Experience Report for Quarter 2 2016/17. The Board noted that the report had been scrutinised by the Governance Committee in November 2016.

9.2 The Board noted that there was significant assurance that the organisation had listened to, heard and understood patient and carer experience of [2]gether's services. This is offered from a triangulation of feedback including complaints, concerns, comments and compliments. Survey information had also been used to understand service experience.

9.3 The report offered full assurance that complaints had been acknowledged within the required timescale, with 100% of the 28 complaints received in Q2 being acknowledged within 3 days. The report also offered significant assurance that all complainants receive regular updates on any potential delays to the provision of a response. However, there was limited assurance that all complainants receive a letter detailing the outcome of the complaint investigation within the initially agreed timescale, with 41% of complaints during the quarter being closed within the timescale agreed with the complainant. The Board noted that this figure had significantly decreased from the previous quarter (78%); however, the Director of E&I advised that the contributory factors to these delays had been identified and the Service Experience Department were working with Service Directors to create systems to ensure investigations were completed within the agreed timescales. The Board asked that the Director of E&I ensure that all efforts were made to improve this performance for the next quarter report.

9.4 The report offered significant assurance that the majority of service users value the service being offered by the Trust, and would recommend it to others. The Board noted that during quarter 2, 90% of people completing the Friends and Family Test said they would recommend 2gether''s services. The Trust continues to maintain a high percentage of people who would recommend our services.

9.5 The Board noted however, that there was limited assurance that people are participating in the local survey of quality in sufficient numbers. Further work is underway to raise the profile of the local survey amongst staff and also to find other ways of presenting, distributing and collecting the required information. The establishment of a Task and Finish working group to review how people are involved in planning their care and treatment would also raise the profile of this source of feedback amongst staff.

9.6 Between 1 July and 30 September 2016, we received 28 complaints, 48 concerns were expressed through PALS and 389 people told us they were pleased with our service by giving us a compliment. The Board noted that there was still limited assurance that services were consistently reporting details of compliments they have received and the Service Experience Department were working with services to raise the profile of compliment reporting throughout the trust. A dedicated email address has now been set up in order to ease the process for staff to report compliments that they have received and compliments are being shared and regularly updated with colleagues via the Trust Intranet system to encourage reporting.

9.7 The Trust continues to seek feedback about service experience from multiple sources on a continuous basis. During quarter 2 there had been a concern raised regarding the informal submission of documents by our staff to legal proceedings. A Trust policy is being developed to guide staff and this will be cascaded throughout the organisation once ratified.

Other themes which have been identified following triangulation of all types of service experience information, includes learning regarding:

- We must communicate clearly with carers and families. We should write down what we talk about with them.
- Some people are unhappy that we did not do the things we said we would do. We should keep our promises or explain why we can't.

9.8 The Director of Finance and Commerce made reference to the easy read summary, noting that where the number of concerns had gone down since last quarter, this was accompanied by a downward Red arrow and he queried whether this was correct. The Board agreed that this could be seen as confusing; however, the rationale for this rating was understood.

9.9 Quinton Quayle said that he found the Service Experience Report extremely helpful and it was excellent by way of demonstrating how seriously 2gether regards the handling and responding to complaints. He noted that the majority of complaints received by the Trust related to softer issues such as communication and staff attitude. The Director of OD advised that the Trust was aware of these concerns and that a lot of work was going on behind the scenes to address these issues.

9.10 Following a request from Ian Stead, the Director of E&I provided the Board with an update on progress with the implementation of Triangle of Care in Herefordshire. The process had started last year within inpatient services and the Trust had been awarded a Gold star by the Carers Trust for the first year of its work. However, implementing the Triangle of Care standards was an evolving process that was ongoing. The Director of E&I noted that the engagement of clinical staff was very important and the huge involvement from partners equality critical to the success of this practice development project across the Trust. The Director of E&I agreed to provide a written briefing including trajectories for Ian Stead, which would also be shared with Board colleagues for information.

ACTION: Jane Melton to provide a written briefing outlining progress with the implementation of Triangle of Care, to be shared with Herefordshire Healthwatch and Board members

10. NATIONAL PATIENT SURVEY RESULTS

10.1 The Director of E&I presented the results of the National Patient Survey results. Overall the results were very good; with 2gether receiving the best results from those Trusts surveyed. The survey had been sent out to a random sample of 270 community mental health service users. The Board noted that work to analyze the results would now be carried out and an action plan developed to focus on any areas still requiring improvement. The Director of E&I advised that there was still more work to do but thanked Trust colleagues for their considerable efforts.

10.2 The Deputy Chief Executive informed the Board that this was an excellent performance by the Trust and people should feel very proud. It was noted that the RCN Magazine had picked up on the results and had carried out an interview with the Trust. A number of other positive achievements and awards had been received by 2gether and its staff recently, and these included:

- In the CQC annual report our PICU had been highlighted as good practice within the report
- A training placement at Oak House being awarded "Best" placement from students from the University of Worcester

- Trust Nurse Mentors have received awards at a Mentors ceremony at Worcester University.
- Herefordshire CAMHS were judged as exemplary at a recent CQC inspection
- 2Gether was the highest ranking Mental Health Trust in the Severn School of Psychiatry for trainee satisfaction for the second consecutive year as per the GMC National Trainees Survey 2016
- The Trust's Crisis Team was awarded the place of Mental Health Team of the Year at the Gloucestershire health and social care awards. One of our senior social workers, Steve Keech, who unfortunately died earlier this year, was also recognised at the awards for his significant input into Social Care practice and was awarded the place of Social Care Professional of the Year.

The Board congratulated all those people, teams and services who had been recognised for their work and dedication.

11. NON EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS

11.1 An audit of the process in place to resolve complaints is undertaken by Non-Executive Directors (NEDs) on a quarterly basis.

11.2 Nikki Richardson advised that last year, the Trust Board requested a revision of the audit process with the aim of maximising the rigor of process and learning from undertaking the audit. A meeting took place with the NED members of the Governance Committee and the Director of E&I in October to review the current template for carrying out the complaints audits and to discuss the findings from the audits carried out for quarters 3 and 4 of 2015/16. This audit piloted the use of a revised audit process and template, a copy of which was presented to the Board.

11.3 The Board noted the levels of assurance received in relation to the results of the audit, noting that this had been discussed with the Service Experience Clinical Manager and work was underway to implement the recommendations, as follows:

- Significant assurance regarding the timeliness of the complaint responses
- Significant assurance regarding the quality of the documentation
- Significant assurance regarding the quality of the investigation and whether it addressed the issues raised by the complainant
- Limited assurance regarding the accessibility and style of the final response letter
- Limited assurance regarding the learning and actions identified during the complaint process

11.4 It was agreed that the Non-Executive Director audit added real value in terms of sharing their emotional response to the complaints process and correspondence. An audit that considers this element would ensure that both quantitative and qualitative information would be captured.

11.5 The Board thanked Nikki for leading on this piece of work, and the proposed changes to the audit process and template were fully supported. A few minor comments were suggested to the revised audit template and it was agreed that Nikki Richardson and the Director of E&I would meet to discuss these and confirm the final template.

ACTION: Nikki Richardson and Jane Melton to review the suggested amendments to the audit template and confirm the final version.

11.6 The Board agreed to the development of a quarterly programme of NED audit of complaints, to recommence from Quarter 3 and 4 2016/17. A schedule would be pulled together and shared with all NEDs.

ACTION: Quarterly programme of NED audit of complaints to recommence from Quarter 3 and 4 2016/17 and a schedule would be pulled together and shared with all NEDs.

12. CHIEF EXECUTIVE'S REPORT

12.1 The Deputy Chief Executive presented this report to the Board which provided an update on key national communications via the NHS England NHS News and a summary of key progress against organisational major projects.

12.2 The Board noted the extensive engagement activities that had taken place during the past month, and the importance of these activities in order to inform strategic thinking, raise awareness of mental health, build relationships and influence the strategic thinking of others. The Deputy Chief Executive advised that this report offered the Board significant assurance that the Executive Team was undertaking wide engagement; however, it only offered limited assurance on the effectiveness of that engagement.

12.3 The Board was asked to note that the Executive Team was trialing Easy Read summaries of Board papers, with some examples having been tabled at the meeting. It was agreed that this was an excellent and welcome development. More work was needed to develop the process for getting these summaries produced and made available in advance of meetings.

12.4 The Board noted the Chief Executive's report

13. SUMMARY FINANCIAL REPORT

13.1 The Board received the month 7 position which was a deficit of £57k in line with the planned position. The budgets have been revised to include the £650k Sustainability and Transformation Fund monies that have been allocated to the Trust. Two quarters of this fund have been included at the month 7 position. The Trust was allocated £650k from the Sustainability and Transformation Fund (STF) by NHS Improvement. The Trust also had its 2016/17 control total of a surplus of £4k adjusted upward by £650k to a revised 2016/17 revenue control total of £654k surplus. The month 7 forecast outturn is a £654k surplus, excluding impairments, as per the revised revenue control total and Trust budgets. The Trust is anticipating it will meet its targets and receive the full allocation from the STF.

13.2 The Trust has a confirmed Financial Sustainability Risk Rating of 4 at Q1. NHS Improvement has introduced a new Oversight Framework from the 1st October. Under this framework the Trust has been informed that our shadow segment is a 1 - the highest score, 4 being the lowest.

13.3 The Trust has a revised forecast agency spend taking into account the impact of the considerable number of actions taken of £4.251m at month 7, which is above the £3.404m control total, but £1.25m below the spend in 2015/16. This equates to achievement of 60% of NHS I's required reduction in agency spend in 2016/17. The Trust also projects it will meet the run rate to fully deliver the target reduction in 2017/18. The Director of Finance and Commerce advised that some of the actions in place were likely to have a slower

impact than originally planned, hence the change in year-end forecast spend from £3.9m last month to £4.251m at month 7.

14. BOARD ASSURANCE MAP

14.1 The Board received an updated Assurance Map which had been scrutinised beforehand by both the Executive Committee and the Audit Committee. The Assurance Map is similar to the previously presented Board Assurance Framework in that it is a dynamic document, comprising strategic risks to the achievement of the Trust's strategy, with risks being added and removed as they are identified or mitigated, contains only those risks in the corporate risk register scoring 12 or more, identifies the 'Top 5' risks, indicates overall assurance levels and identifies Committee 'ownership' of risks, along with lead Executive Director. However, the Assurance Map differs from the BAF, in a number of respects including:

- Risks are grouped by category.
- Risk trend is shown.
- Controls are set out in accordance with the '3 lines of defence' model which represents good practice in terms of risk management.
- Assurances obtained through each of these lines of defence are indicated by RAG-rated bullets. However, detailed assurances and controls are not listed as these will be available through the risk register reports provided to the Board and to each of the Board's Committees on a quarterly basis.
- The Assurance Map approach makes clear to the Audit Committee and the Board those risks which have not been subject to independent verification. The Audit Committee in particular is thus able to draw on this information when considering the content of the Internal Audit plan.
- The format also enables the Audit Committee and the Board better to judge the adequacy of controls and assurances by comparing the target and current risk scores.

14.2 The Board was asked to note that the wording of the safety/clinical risk (AM8 – CYPS Tier 4 services) had been amended to reflect the fact that the element of risk which the Trust can control is the provision of adequate safeguards in the event of an under 18 admission to an adult inpatient ward, rather than the provision of Tier 4 services. Given this revised wording, the current risk score had been reduced, reflecting the comprehensive safeguarding measures which the Trust puts in place whenever an under 18 admission takes place. The threshold for inclusion on the Assurance Map was a risk score of 12 or more and consequently, this risk would normally come off the Assurance Map at the next iteration. However, the Board was asked to note that this was one of the Top 5 risks, and it was therefore for the Board to agree to its removal from the Assurance Map, and to decide whether it should remain as a Top 5 risk. The Board noted that the risk would remain on the Corporate Risk Register and would thus be subject to quarterly review by the Governance Committee. The Board agreed to the removal of this risk from the Assurance Map and from the "Top 5" risks.

14.3 A suggestion was made in relation to the "Risk Trend" column within the assurance map, and it was agreed that it would make more sense to have an upward arrow representing a negative impact and a downward arrow being positive. This would be revised accordingly.

ACTION: "Risk Trend" column within the assurance map to be amended to have an upward arrow representing a negative impact and a downward arrow being positive

14.4 Maria Bond said that she would find it helpful to see how the risk score had been calculated for each of the risks and asked that this be considered for future iterations of the assurance map.

ACTION: Future iterations of the assurance map to include how the risk score had been calculated for each of the risks

15. RISK MANAGEMENT FRAMEWORK

15.1 The purpose of this report was to obtain Board endorsement of the Trust's Risk Management Framework document (formerly entitled Risk Management Strategy). The Risk Management Framework had been reviewed and updated to reflect some significant changes, which included:

- Risk Appetite / 3 Lines of Defence model
- Directorates - Oversight Committees / Meetings – Terms of Reference
- Levels of Assurance
- Risk Co-ordinator role / Datix risk module

15.2 The publication of this document is an important initial step to meet the objective of embedding a robust risk management framework. However, work continues throughout the Trust to ensure that this fully achieved. A key driver for these changes emanated from the annual internal review by PricewaterhouseCoopers (PwC). The Board noted that a draft version of the framework was provided to PwC as evidence of compliance with their recommendations.

15.3 Maria Bond made reference to the RAG rating of risks and asked whether timescales or tracking information could be considered. If an extreme risk had been identified, having this additional information would help the Board keep track of the risk and to re-assess whether the actions that had been put in place to mitigate it were effective, or whether additional actions needed to be put in place. This also emphasised the need for the risk register to include a pre and post risk mitigation score. The Director of Quality agreed to see whether this could be incorporated.

ACTION: Marie Crofts to discuss the potential inclusion of timescales and tracking information of risks with the Risk Manager

15.4 Subject to the suggested addition, the Board approved the revised Risk Management Framework.

16. BOARD COMMITTEE REPORT – AUDIT COMMITTEE

16.1 Marcia Gallagher presented the summary report from the Audit Committee meeting held on 2 November 2016 and the Board noted the key points raised during the meeting and the assurance received by the Committee.

17. BOARD COMMITTEE REPORTS – DELIVERY COMMITTEE

17.1 The Board received the summary reports from the Delivery Committee meetings held on 27 September and 24 October and noted the key points raised during these meetings and the assurance received by the Committee.

17.2 Quinton Quayle provided a verbal report from the Delivery Committee meeting held on 23 November. A full written report would be presented at the next Board meeting.

18. BOARD COMMITTEE REPORTS – GOVERNANCE COMMITTEE

18.1 Nikki Richardson presented the summary report from the Governance Committee meetings that had taken place on 16 September and 21 October 2016, and the Board noted the key points raised during these meetings and the assurance received by the Committee.

18.2 Nikki Richardson presented a verbal report from the Governance Committee meeting on 18 November. A full written report would be presented at the next Board meeting.

19. BOARD COMMITTEE REPORT – MH LEGISLATION SCRUTINY COMMITTEE

19.1 Quinton Quayle provided a verbal report from the Mental Health Legislation Scrutiny Committee meeting held on 9 November. A full written report would be presented at the next Board meeting.

19.2 The Board was asked to note the positive results from a recent audit of capacity and consent which had seen an increase in compliance from 48% at the time of the last audit to 80% in November which was excellent.

20. BOARD COMMITTEE REPORT - CHARITABLE FUNDS COMMITTEE

20.1 The Board received the summary report from the Charitable Funds Committee meeting held on 2 November 2016.

20.2 The Committee had reviewed its Terms of Reference and agreed a number of changes making clear that the Committee's reporting relationship was to the Board in its role as the charity's Board of Trustees. The Board, acting as the Board of Trustees received and approved the revised TOR.

21. INFORMATION SHARING REPORTS

21.1 The Board received and noted the following reports for information:

- Chair's Report
- Council of Governors Minutes – September 2016
- Use of the Trust Seal

21.2 Ruth FitzJohn informed the Board that the Council of Governors, at their meeting on 10 November had approved the appointment of Nikki Richardson as Deputy Chair following Charlotte Hitchings' departure. However, it was for the Board to appoint a Senior Independent Director and the Board was therefore asked to support the appointment of Nikki Richardson as SID. This was fully supported by the Board.

22. ANY OTHER BUSINESS

22.1 The Board presented Carol Sparks with a bouquet of flowers and expressed their thanks and good wishes to her as she stepped down from the role of Director of OD. It was noted that Carol would continue to work for the Trust until the end of March 2017 and would be leading on the programme for reducing the use of agency staffing. Neil Savage, the new Director of OD would be commencing in post on 28 November.

23. DATE OF THE NEXT MEETING

23.1 The next Board meeting would take place on Thursday 26 January 2017 at Trust HQ, Rikenel, Gloucester.

Signed: …….. **Date: ……**

Ruth FitzJohn, Chair

BOARD MEETING
ACTION POINTS

Date of Mtg	Item ref	Action	Lead	Date due	Status/Progress
24 Nov 2016	9.10	Jane Melton to provide a written briefing outlining progress with the implementation of Triangle of Care, to be shared with Herefordshire Healthwatch and Board members	Jane Melton	Jan	**Complete**
	11.5	Nikki Richardson and Jane Melton to review the suggested amendments to the audit of complaints template and confirm the final version.	Jane Melton / Nikki Richardson	Dec	**Complete**
	11.6	Quarterly programme of NED audit of complaints to recommence from Quarter 3 and 4 2016/17 and a schedule would be pulled together and shared with all NEDs.	Trust Secretariat	Jan	**Complete**
	14.3	"Risk Trend" column within the assurance map to be amended to have an upward arrow representing a negative impact and a downward arrow being positive	John McIlveen	Jan	**Complete**
	14.4	Future iterations of the assurance map to include how the risk score had been calculated for each of the risks	John McIlveen	Jan	**Complete**
	15.3	Marie Crofts to discuss the potential inclusion of timescales and tracking information of risks with the Risk Manager	Marie Crofts	Jan	**Complete**

Agenda item 7 **Enclosure Paper B**

Report to:	[2]gether NHS Foundation Trust Board – 26 January 2017
Author:	Chris Woon, Head of Information Management and Clinical Systems/Colin Merker Director of Service Delivery
Presented by:	Colin Merker Director of Service Delivery
SUBJECT:	**Performance Dashboard Report for the period to the end of November 2016**

This Report is provided for:			
Decision	Endorsement	**Assurance**	**To Note**

EXECUTIVE SUMMARY

Overview

This month's report sets out the performance of the Trust for the period to the end of November 2016 against our NHSI, Department of Health, Herefordshire and Gloucestershire CCG Contractual and CQUIN key performance indicators.

Of the 147 performance indicators, 87 are reportable in November with 71 being compliant and 16 non-compliant at the end of the reporting period.

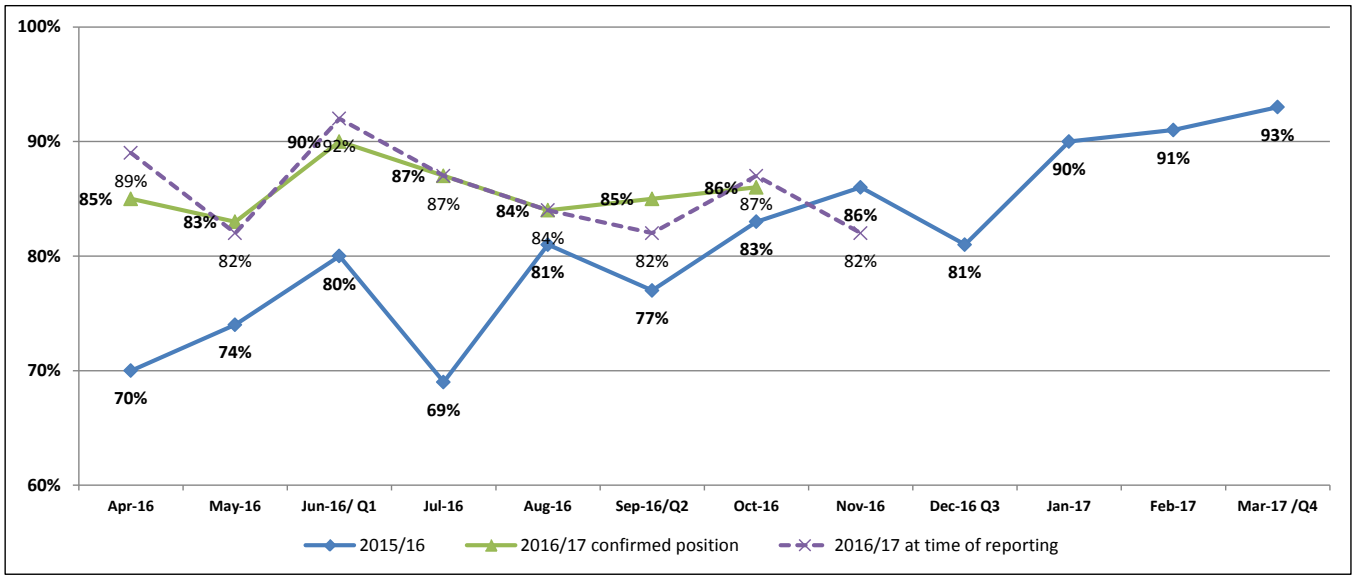
Where performance is not compliant, Service Directors are taking the lead to address issues with a particular focus continuing to be on IAPT services which account for 8 of the 16 non-compliant indicators (1.09, 1.10, 3.18, 3.19, 3.30, 5.08, 5.09 and 5.11). Work is ongoing in accordance with our agreed Service Delivery Improvement Plans to address the underlying issues affecting this performance.

A red flag '  ' continues to be placed next to indicators where further analysis and work is required or ongoing to fully scope potential data quality or performance issues.

The following table summarises our performance position as at the end of November 2016 for each of the KPIs within each of the reporting categories.

Indicators Reported in Month and Levels of Compliance							
Indicator Type	Total Measures	Reported in Month	Compliant	Non Compliant	% non-compliance	Not Yet Required	NYA / UR
NHSi Requirements	13	13	9	4	31	0	0
Never Events	17	17	17	0	0	0	0
Department of Health	10	8	7	1	13	2	0
Gloucestershire CCG Contract	56	16	13	3	19	40	0
Social Care	15	13	9	4	31	2	0
Herefordshire CCG Contract	25	20	16	4	20	5	0
CQUINS	11	0	0	0	0	11	0
Overall	147	87	71	16	18	60	0

The following graph shows our percentage compliance by month and the previous year's compliance for comparison. The line "2016/17 confirmed position" has been added to show the confirmed position of our performance. This is reported a month in arrears to enable late data entry/late data validation to be taken into account.



Summary Exception Reporting

The following 16 key performance thresholds were not met for November 2016:

NHS Improvement Requirements

- 1.02 – Number of C Diff cases
- 1.07 – New psychosis (EI) cases as per contract
- 1.09 – IAPT: Waiting times - Referral to Treatment within 6 weeks
- 1.10 – IAPT: Waiting times - Referral to Treatment within 18 weeks

Department of Health Requirements

- 2.21 – Number of under 18s admitted to adult inpatient wards

Gloucestershire CCG Contract Measures

- 3.18 – IAPT Recovery rate : Access to psychological therapies should be improved
- 3.19 – IAPT Access rate : Access to psychological therapies should be improved
- 3.30 – MHICT (IAPT/Nursing Integrated service): 14 days from referral to screening assessment.

Social Care –Gloucestershire CCG Contract Measures

- 4.02 – Percentage of people receiving long-term services reviewed in last year.
- 4.03 – Ensure that reviews of new packages take place within 12 weeks
- 4.06 – Percentage of service users asked if they have a carer
- 4.07 – Percentage with a carer that have been offered a carer's assessment

Herefordshire CCG Contract Measures

- 5.08 – IAPT Recovery rate – those who have completed treatment and have "caseness"
- 5.09 – IAPT maintain 15% of patients entering the service against prevalence
- 5.11 – IAPT High intensity – Number of discharged patients that received step 3 treatment
- 5.15 – Reduce numbers of people readmitted to inpatient care within 30 days

RECOMMENDATIONS

The Board are asked to:

- Note the Performance Dashboard Report for November 2016.
- Accept the report as a significant level of assurance that our contract and regulator performance measures are being met or that appropriate action plans are in place to address areas requiring improvement.
- Be assured that there is ongoing work to review all of the indicators not meeting the required performance threshold. This includes a review of the measurement and data quality processes as well as clinical delivery and clinical practice issues.

Corporate Considerations	
Quality implications:	The information provided in this report is an indicator into the quality of care patients and service users receive. Where services are not meeting performance thresholds this may also indicate an impact on the quality of the service / care we provide.
Resource implications:	The Information Team provides the support to operational services to ensure the robust review of performance data and co-ordination of the Dashboard
Equalities implications:	Equality information is included as part of performance reporting
Risk implications:	There is an assessment of risk on areas where performance is not at the required level.

WHICH TRUST STRATEGIC OBJECTIVE(S) DOES THIS PAPER PROGRESS OR CHALLENGE?	
Continuously Improving Quality	P
Increasing Engagement	P
Ensuring Sustainability	P

WHICH TRUST VALUES DOES THIS PAPER PROGRESS OR CHALLENGE?			
Seeing from a service user perspective			P
Excelling and improving	P	Inclusive open and honest	P
Responsive	P	Can do	P
Valuing and respectful	P	Efficient	P

Reviewed by:		
Colin Merker	Date	November 2016

Where in the Trust has this been discussed before?		
Not applicable.	Date	

What consultation has there been?		
Not applicable.	Date	

Explanation of acronyms used:	
	AOT Assertive Outreach Team AKI Acute kidney injury ASCOF Adult Social Care Outcomes Framework CAMHS Child and Adolescent Mental health Services C-Diff Clostridium difficile CIRG Clinical Information Reference Group CPA Care Programme Approach CPDG Contract Performance and Development Group CQUIN Commissioning for Quality and Innovation CRHT Crisis Home Treatment CSM Community Services Manager CYPS Children and Young People's Services ED Emergency Department EI Early Intervention EWS Early warning score HoNoS Health of the Nation Outcome Scale IAPT Improving Access to Psychological Therapies IST Intensive Support Team (National IAPT Team) KPI Key Performance Indicator LD Learning Disabilities MHICT Mental Health Intermediate Care Team MHL Mental Health Liaison MRSA Methicillin-resistant Staphylococcus aureus MUST Malnutrition Universal Screening Tool NHSI NHS Improvement NICE National Institute for Health and Care Excellence SI Serious Incident SUS Secondary Uses Service VTE Venous thromboembolism YOS Youth Offender's Service

1. CONTEXT

This report sets out the performance Dashboard for the Trust for the period to the end of November 2016, month eight of the 2016/17 contract period.

1.1 The following sections of the report include:

- An aggregated overview of all indicators in each section with exception reports for non-compliant indicators supported by the relevant Scorecard containing detailed information on all performance measures. These appear in the following sequence.

    - NHSI Requirements
    - Never Events
    - Department of Health requirements
    - NHS Gloucestershire Contract – Schedule 4 Specific Performance Measures
    - Social Care Indicators
    - NHS Herefordshire Contract – Schedule 4 Specific Performance Measures
    - NHS Gloucestershire CQUINS
    - Low Secure CQUINS
    - NHS Herefordshire CQUINS

2. AGGREGATED OVERVIEW OF ALL INDICATORS WITH EXCEPTION REPORTS ON NON-COMPLIANT INDICATORS

2.1 The following tables outline the performance in each of the performance categories within the Dashboard as at the end of November 2016. Where indicators have not been met during the reporting period, an explanation is provided relating to the non-achievement of the Performance Threshold and the action being taken to rectify the position.

2.2 Where stated, 'Cumulative Compliance' refers to compliance recorded from the start of this contractual year April 2016 to the current reporting month, as a whole.

2.3 Indicator IDs has been colour coded in the tables to indicate whether a performance measure is a national or local requirement. Blue indicates the performance measure is national, while lilac means the measure is local.

	=	**Target not met**
	=	**Target met**
NYA	=	**Not Yet Available from Systems**
NYR	=	**Not Yet Required by Contract**
UR	=	**Under Review**
N/A	=	**Not Applicable**
Baseline	=	**2016/17 data reporting to inform 2017/18**

DASHBOARD CATEGORY - NHSI REQUIREMENTS

NHS Improvement Requirements				
	In month Compliance			Cumulative Compliance
	Sep	Oct	Nov	
Total Measures	13	13	13	13
🔴	4	4	4	4
🟢	9	9	9	9
NYA	0	0	0	0
NYR	0	0	0	0
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month

(Reference number relates to the number of the indicator within the scorecard):

1.02: Number of C Diff cases

There was one case in November on Priory Ward in Gloucestershire. The review meeting to determine if the case was avoidable or unavoidable has not yet been held.

For transparency, and following NHS Improvement guidelines we are reporting this case as avoidable until it can be confirmed and agreed with commissioners that it is unavoidable.

1.07: New psychosis (EI) cases as per contract

Year to date Gloucestershire have reported 40 new cases against an expected threshold of 48 new cases and Herefordshire 17 new cases against an expected threshold of 16 new cases. In total the Trust is 7 cases below the 64 new cases required by the end of November.

In Gloucestershire there are fewer new cases reported this financial year compared to 2015/16 where we reported 47 new cases by the end of November 2015. In April 2016, the methodology for this KPI was amended, due to new national guidance and work is being carried out operationally with the information department to assess the impact of this change. Referral trends across the two financial years will also be analysed.

Work continues to understand what an accurate threshold looks like for both the Gloucestershire and Herefordshire counties. The Committee will be updated once work in this area has been completed.

This indicator has been red flagged as it requires further analysis to fully understand the issues and identify the actions required.

1.09: IAPT: Waiting times - Referral to Treatment within 6 weeks
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

1.10: IAPT: Waiting times - Referral to Treatment within 18 weeks
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

Cumulative Performance Thresholds Not being Met

1.02: Number of C Diff cases
As well as the November case in Gloucestershire, there have also been 3 incidents in Herefordshire which were previously reported for August, September and October. These 3 incidents have been confirmed as avoidable and issues relating to cleanliness, which were non-contributory, were identified as part of the investigation have been addressed.

1.07: New psychosis (EI) cases as per contract
As above

1.09: IAPT: Waiting times - Referral to Treatment within 6 weeks
As above

1.10: IAPT: Waiting times - Referral to Treatment within 18 weeks
As above

Changes to Previously Reported Figures
None

Early Warnings / Notes
None

NHS Improvement Requirements

ID	Performance Measure (PM)		2015/16 Outturn	September-2016	October-2016	November-2016	(Apr to Nov) Cumulative Compliance
1							
1.01	Number of MRSA Bacteraemias	PM	0	0	0	0	0
		Gloucestershire	0	0	0	0	0
		Herefordshire	0	0	0	0	0
		Combined Actual	0	0	0	0	0
1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	0
		Gloucestershire	0	0	0	1	1
		Herefordshire	0	1	1	0	3
		Combined Actual	0	1	1	1	4
1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%
		Gloucestershire	95%	95%	99%	98%	98%
		Herefordshire	96%	100%	100%	100%	98%
		Combined Actual	96%	97%	99%	99%	98%
1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%
		Gloucestershire	99%	99%	99%	97%	99%
		Herefordshire	98%	99%	98%	97%	99%
		Combined Actual	99%	99%	99%	97%	99%
1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%
		Gloucestershire	1.0%	2.5%	2.8%	1.1%	1.8%
		Herefordshire	1.2%	0.0%	0.0%	0.0%	1.4%
		Combined Actual	1.0%	1.9%	2.1%	0.8%	1.7%
1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%
		Gloucestershire	99%	100%	98%	100%	99%
		Herefordshire	100%	100%	100%	100%	100%
		Combined Actual	99%	100%	99%	100%	99%
1.07	New psychosis (EI) cases as per contract	PM	72	36	42	48	48
		Gloucestershire	76	32	36	40	40
		PM	24	12	14	16	16
		Herefordshire	41	14	16	17	17
		PM	92	48	56	64	64
		Combined Actual	117	46	52	57	57
1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%
		Gloucestershire	66%	80%	100%	100%	75%
		Herefordshire	61%	100%	100%	0%	71%
		Combined Actual	64%	83%	100%	80%	74%

NHS Improvement Requirements

ID	Performance Measure		2015/16 Outturn	September-2016	October-2016	November-2016	(Apr to Nov) Cumulative Compliance
1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%
		Gloucestershire	87%	32%	30%	33%	33%
		Herefordshire	95%	39%	58%	52%	53%
		Combined Actual	89%	33%	35%	37%	37%
1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%
		Gloucestershire	99%	82%	78%	81%	85%
		Herefordshire	99%	83%	87%	86%	88%
		Combined Actual	99%	83%	80%	82%	86%
1.11	**MENTAL HEALTH SERVICES DATA SET PART 1 DATA COMPLETENESS: OVERALL**	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.6%	99.9%	99.9%	99.9%	99.9%
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%
		Combined Actual	99.6%	99.9%	99.9%	99.9%	99.9%
1.11a	Mental Health Services Data Set Part 1 Data completeness: DOB	PM	97%	97%	97%	97%	97%
		Gloucestershire	100.0%	100.0%	100.0%	100.0%	100.0%
		Herefordshire	100.0%	100.0%	100.0%	100.0%	100.0%
		Combined Actual	100.0%	100.0%	100.0%	100.0%	100.0%
1.11b	Mental Health Services Data Set Part 1 Data completeness: Gender	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	99.9%	99.9%	99.9%	99.9%
		Herefordshire	100.0%	99.9%	99.9%	99.9%	99.9%
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%
1.11c	Mental Health Services Data Set Part 1 Data completeness: NHS Number	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.9%	99.9%	99.9%	99.9%	99.9%
		Herefordshire	99.9%	99.9%	99.9%	99.9%	99.9%
		Combined Actual	99.9%	99.9%	99.9%	99.9%	99.9%
1.11d	Mental Health Services Data Set Part 1 Data completeness: Organisation code of commissioner	PM	97%	97%	97%	97%	97%
		Gloucestershire	98.8%	100.0%	100.0%	100.0%	100.0%
		Herefordshire	99.9%	100.0%	100.0%	100.0%	100.0%
		Combined Actual	99.1%	100.0%	100.0%	100.0%	100.0%
1.11e	Mental Health Services Data Set Part 1 Data completeness: Postcode	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.5%	99.8%	99.8%	99.9%	99.8%
		Herefordshire	99.6%	99.8%	99.8%	99.8%	99.8%
		Combined Actual	99.5%	99.8%	99.8%	99.8%	99.8%
1.11f	Mental Health Services Data Set Part 1 Data completeness: GP Practice	PM	97%	97%	97%	97%	97%
		Gloucestershire	99.1%	99.4%	99.4%	99.4%	99.4%
		Herefordshire	99.5%	99.7%	99.7%	99.7%	99.7%
		Combined Actual	99.2%	99.5%	99.5%	99.5%	99.5%

NHS Improvement Requirements

ID	Performance Measure		2015/16 Outturn	September-2016	October-2016	November-2016	(Apr to Nov) Cumulative Compliance
1.12	**MENTAL HEALTH SERVICES DATA SET PART 2 DATA COMPLETENESS : OVERALL**	PM	50%	50%	50%	50%	50%
		Gloucestershire	97.9%	97.5%	97.4%	97.3%	97.5%
		Herefordshire	95.3%	93.3%	93.9%	93.9%	94.0%
		Combined Actual	97.4%	96.7%	96.8%	96.7%	97.0%
1.12a	Mental Health Services Data Set Part 2 Data completeness: CPA Employment status last 12 months	PM	50%	50%	50%	50%	50%
		Gloucestershire	97.2%	96.4%	96.4%	96.1%	96.4%
		Herefordshire	93.7%	90.4%	91.4%	91.4%	91.8%
		Combined Actual	96.4%	95.3%	95.5%	95.3%	95.6%
1.12b	Mental Health Services Data Set Part 2 Data completeness: CPA Accommodation Status in last 12 months	PM	50%	50%	50%	50%	50%
		Gloucestershire	97.1%	96.6%	96.6%	96.6%	96.7%
		Herefordshire	93.8%	91.2%	91.8%	91.8%	92.0%
		Combined Actual	96.5%	95.7%	95.7%	95.7%	95.9%
1.12c	Mental Health Services Data Set Part 2 Data completeness: CPA HoNOS assessment in last 12 months	PM	50%	50%	50%	50%	50%
		Gloucestershire	99.6%	99.4%	99.3%	99.3%	99.5%
		Herefordshire	98.5%	98.2%	98.5%	98.5%	98.3%
		Combined Actual	99.4%	99.2%	99.2%	99.2%	99.3%
1.13	Learning Disability Services: 6 indicators: identification of people with a LD, provision of information, support to family carers, training for staff, representation of people with LD; audit of practice and publication of findings	PM	6	6	6	6	6
		Gloucestershire	6	6	6	6	6
		Herefordshire	6	6	6	6	6
		Combined Actual	6	6	6	6	6

DASHBOARD CATEGORY – DEPARTMENT OF HEALTH PERFORMANCE

DoH Performance				
	In month Compliance			Cumulative Compliance
	Sep	Oct	Nov	
Total Measures	27	27	27	27
	2	1	1	2
	23	24	24	24
NYA	0	0	0	0
NYR	1	1	1	0
UR	0	0	0	0
N/A	1	1	1	1

Performance Thresholds not being achieved in Month

2.21: No children under 18 admitted to adult inpatient wards
There were 3 admissions of under 18s to adult wards in November, 2 in Gloucestershire and 1 in Herefordshire.

In Gloucestershire, one patient was admitted via the 136 suite and the patient was discharged to an age appropriate placement the next day.

A second patient was admitted to Dean Ward under Section 2 as there was a risk of serious self-harm. At the time of reporting the patient currently remains on Dean Ward as they are nearing their 18th birthday.

The patient in Herefordshire was admitted informally after being transferred from 136 due to expressing harm to self and others. The patient was placed on 1-1 nursing observation on Mortimer Ward and following review by the CAMHS consultant the next day was discharged home to the family.

Cumulative Performance Thresholds Not being Met

2.21: No children under 18 admitted to adult inpatient wards
Year to date there have been 11 admissions, 6 admissions in Gloucestershire and 5 in Herefordshire.

2.26: Interim report for all SIs received within 5 working days of identification
There have been 3 late submissions year to date, 2 in May for Gloucestershire and 1 in September for Herefordshire.

Changes to Previously Reported Figures

None

Early Warnings

There has been an under 18 admission to Mortimer Ward in December

DOH Never Events

ID	Performance Measure		2015/16 Outturn	September-2016	October-2016	November-2016	(Apr to Nov) Cumulative Compliance
2							
2.01	Wrongly prepared high risk injectable medications	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.02	Maladministration of potassium containing solutions	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.03	Wrong route administration of oral/enteral treatment	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.04	Intravenous administration of epidural medication	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.05	Maladministration of insulin	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.06	Overdose of midazolam during conscious sedation	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.07	Opioid overdose in opioid naive patient	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.08	Inappropriate administration of daily oral methotrexate	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.09	Suicide using non collapsible rails	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.10	Falls from unrestricted windows	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.11	Entrapment in bedrails	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.12	Misplaced naso - or oro-gastric tubes	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.13	Wrong gas administered	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.14	Failure to monitor and respond to oxygen saturation - conscious sedation	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.15	Air embolism	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.16	Severe scalding from water for washing/bathing	PM	0	0	0	0	0
		Actual	0	0	0	0	0
2.17	Mis-identification of patients	PM	0	0	0	0	0
		Actual	0	0	0	0	0

DOH Requirements

ID	Performance Measure		2015/16 Outturn	September-2016	October-2016	November-2016	(Apr to Nov) Cumulative Compliance
2.18	Mixed Sex Accommodation - Sleeping Accommodation Breaches	PM	0	0	0	0	0
		Gloucestershire	0	0	0	0	0
		Herefordshire	0	0	0	0	0
		Combined	0	0	0	0	0
2.19	Mixed Sex Accommodation - Bathrooms	Gloucestershire	Yes	Yes	Yes	Yes	Yes
		Herefordshire	Yes	Yes	Yes	Yes	Yes
		Combined	Yes	Yes	Yes	Yes	Yes
2.20	Mixed Sex Accommodation - Women Only Day areas	Gloucestershire	Yes	Yes	Yes	Yes	Yes
		Herefordshire	Yes	Yes	Yes	Yes	Yes
		Combined	Yes	Yes	Yes	Yes	Yes
2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0
		Gloucestershire	11	1	0	2	6
		Herefordshire	4	0	0	1	5
		Combined	15	1	0	3	11
2.22	Failure to publish Declaration of Compliance or Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	Gloucestershire	Yes	Yes	Yes	Yes	Yes
		Herefordshire	Yes	Yes	Yes	Yes	Yes
		Combined	Yes	Yes	Yes	Yes	Yes
2.23	Publishing a Declaration of Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	Gloucestershire	Yes	Yes	Yes	Yes	Yes
		Herefordshire	Yes	Yes	Yes	Yes	Yes

DOH Requirements

ID	Performance Measure		2015/16 Outturn	September-2016	October-2016	November-2016	(Apr to Nov) Cumulative Compliance
2.24	Serious Incident Reporting (SI)	Glos	32	2	7	0	25
		Hereford	11	1	0	1	6
2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%
		Gloucestershire	100%	100%	100%	N/A	100%
		Herefordshire	100%	100%	N/A	100%	100%
2.26	Interim report for all SIs received within 5 working days of identification (unless extension granted by CCG)	PM		100%	100%	100%	100%
		Gloucestershire		100%	100%	N/A	89%
		Herefordshire		0%	N/A	100%	83%
2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM		100%	100%	100%	100%
		Gloucestershire		NYR	NYR	NYR	100%
		Herefordshire		NYR	NYR	NYR	100%
2.28	SI Report Level 3 - Independent investigations - 6 months from investigation commissioned date	PM		100%	100%	100%	100%
		Gloucestershire		N/A	N/A	N/A	N/A
		Herefordshire		N/A	N/A	N/A	N/A
2.29	SI Final Reports outstanding but not due	Gloucestershire	3	2	7	0	12
		Herefordshire	0	1	0	1	3

DASHBOARD CATEGORY – GLOUCESTERSHIRE CCG CONTRACTUAL REQUIREMENTS

Gloucestershire Contract				
	In month Compliance			Cumulative Compliance
	Sep	Oct	Nov	
Total Measures	56	56	56	56
	5	3	3	4
	22	13	13	23
NYA	1	0	0	1
NYR	26	39	39	26
UR	0	0	0	0
N/A	2	1	1	2

Performance Thresholds not being achieved in Month

 **3.18: IAPT Recovery rate: Access to psychological therapies should be improved**
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

 **3.19: IAPT Access rate: Access to psychological therapies should be improved**
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

 **3.30: Adult Mental Health Intermediate Care Teams (IAPT/Nursing Integrated Service): Wait times from referral to screening assessment within 14 days of receiving referral**

Expected compliance: The new MHICT Service Specification is currently under review, which includes a review of clinical capacity. Once this is complete and a contract variation is finalised this indicator will change to report on Nursing activity only. This indicator is unlikely to be compliant until that piece of work is complete

This indicator has been red flagged as it requires further analysis to fully understand the issues and identify the actions required.

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Cumulative Performance Thresholds Not being Met

3.18: IAPT Recovery rate: Access to psychological therapies should be improved
As above

3.19: IAPT Access rate: Access to psychological therapies should be improved
As above

3.27: CYPS Level 2 & 3: Referral to treatment within 8 weeks
For Quarter 2 performance is 2% below the expected performance threshold of 80%. The attendance rate in Quarter 2 was low across the school holiday period and the total number of non-compliant cases high as an increased number of long waiters were seen during the month of September. The service receives frequent requests for delays in appointments until young people return to school.

Expected compliance: Low performance in September for the reasons detailed above have meant lower than expected compliance for quarter 2. As the indicator is compliant for October and November it is anticipated that it will be compliant when reported for Quarter 3.

3.30: Adults Mental Health Intermediate Care Teams (New Integrated Service): Wait times from referral to screening assessment within 14 days of receiving referral
As above

Changes to Previously Reported Figure

None

Early Warnings

None

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	September-2016	October-2016	November-2016	(Apr to Nov) Cumulative Compliance
	B. NATIONAL QUALITY REQUIREMENT						
3.01	Zero tolerance MRSA	PM	0	0	0	0	0
		Unavoidable	0	0	0	0	0
3.02	Minimise rates of Clostridium difficile	PM	0	0	0	0	0
		Unavoidable	0	0	0	0	0
3.03	Duty of candour	PM	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant	Compliant	Compliant
3.04	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS,	PM	99%	99%	99%	99%	99%
		Actual	100%	99%	99%	99%	99%
3.05	Completion of Mental Health Services Data Set ethnicity coding for all detained and informal Service Users	PM	90%	90%	90%	90%	90%
		Actual	97%	100%	100%	97%	100%
3.06	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	PM	90%	90%	90%	90%	90%
		Actual	85%	98%	99%	99%	99%
	C. Local Quality Requirements						
	Domain 1: Preventing People dying prematurely						
3.07	Increased focus on suicide prevention and reduction in the number of reported suicides in the community and inpatient units	PM	Report				Annual
		Actual	Complete				NYR
3.08	To reduce the numbers of detained patients absconding from inpatient units where leave has not been granted	PM	N/A	<36			<72
		Actual	55	36			57
3.09	Compliance with NICE Technology appraisals within 90 days of their publication and ability to demonstrate compliance through completion of implementation plans and costing templates.	PM					PM
		Actual					NYR
3.10	Minimum of 5% increase in uptake of flu vaccination (15/16 55.3%)	PM					Annual
		Actual					NYR

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	September-2016	October-2016	November-2016	(Apr to Nov) Cumulative Compliance
	Domain 2: Enhancing the quality of life of people with long-term conditions						
3.11	2G bed occupancy for Gloucestershire CCG patients	PM	N/A	>91%	>91%	>91%	>91%
		Actual	92%	91%	92%	93%	92%
3.12	Care Programme Approach: 95% of CPAs should have a record of the mental health worker who is responsible for their care	PM	95%	95%	95%	95%	95%
		Actual	100%	100%	100%	100%	100%
3.13	CPA Review - 95% of those on CPA to be reviewed within 1 month (Review within 13 months)	PM	95%	95%	95%	95%	95%
		Actual	99%	100%	100%	99%	99%
3.14	Assessment of risk: % of those 2g service users on CPA to have a documented risk assessment	PM	85%	95%			95%
		Actual	99%	99%			99%
3.15	Assessment of risk: All 2g service users (excluding those on CPA) to have a documented risk assessment	PM		85%			85%
		Actual		95%			94%
3.16	Dementia should be diagnosed as early in the illness as possible: People within the memory assessment service with a working diagnosis of dementia to have a care plan within 4 weeks of diagnosis	PM	85%	85%	85%	85%	85%
		Actual	89%	88%	93%	96%	95%
3.17	AKI (previous CQUIN 1516) 95% of pts to have EWS score within 12 hours	PM		95%			95%
				100%			100%
	Domain 3: Helping people to recover from episodes of ill-health or following injury						
3.18	IAPT recovery rate: Access to psychological therapies for adults should be improved	PM	50%	50%	50%	50%	50%
		Actual	35%	41%	46%	44%	47%
3.19	IAPT access rate: Access to psychological therapies for adults should be improved	PM		7.50%	8.75%	10.00%	10.00%
		Actual		3.72%	4.24%	5.08%	5.08%
3.20	IAPT reliable improvement rate: Access to psychological therapies for adults should be improved	PM	N/A	50%	50%	50%	50%
		Actual	55%	76%	75%	69%	74%
3.21	Care Programme Approach (CPA): The percentage of people with learning disabilities in inpatient care on CPA who were followed up within 7 days of discharge	PM	95%	95%	95%	95%	95%
		Actual	100%	N/A	N/A	N/A	N/A
3.22	To send :Inpatient and day case discharge summaries electronically, within 24 hours to GP	PM		Report			Report
		Actual		NYA			NYA

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	September-2016	October-2016	November-2016	(Apr to Nov) Cumulative Compliance
	Domain 4: Ensuring that people have a positive experience of care						
3.23	To demonstrate improvements in staff experience following any national and local surveys	PM	Annual				Annual
		Actual	Compliant				NYR
	CYPS						
3.24	Number of children that received support within 24 hours of referral, for crisis home treatment (CYPS)	PM	95%	95%			95%
		Actual	97%	N/A			N/A
3.25	Children and young people who enter a treatment programme to have a care coordinator - (Level 3 Services) (CYPS)	PM	98%	98%	98%	98%	98%
		Actual	99%	99%	99%	99%	99%
3.26	95% accepted referrals receiving initial appointment within 4 weeks (excludes YOS, substance misuse, inpatient and crisis/home treatment and complex engagement) (CYPS)	PM	95%	95%			95%
		Actual	98%	98%			99%
3.27	Level 2 and 3 – Referral to treatment within 8 weeks , excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	80%	80%			80%
		Actual	65%	78%			78%
3.28	Level 2 and 3 – Referral to treatment within 10 weeks (excludes LD, YOS, inpatient and crisis/home treatment) (CYPS)	PM	95%	90%			90%
		Actual	78%	93%			93%
3.29	Adults of working age - 100% of MDT assessments to have been completed within 4 weeks (or in the case of a comprehensive assessment commenced within 4 weeks)	PM	85%	85%	85%	85%	85%
		Actual	94%	95%	95%	97%	95%
3.30	Adults Mental Health Intermediate Care Teams (New Integrated service) Wait times from referral to screening assessment within 14 days of receiving referral	PM	85%	85%	85%	85%	85%
		Actual	70%	62%	65%	67%	64%

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	September-2016 / Quarter 2	October-2016	November-2016	(Apr to Nov) Cumulative Compliance
	Vocational Service (Individual Placement and Support)						
3.31	100% of Service Users in vocational services will be supported to formulate their vocational goals through individual plans (IPS)	PM	98%	98%			98%
		Actual	100%	100%			100%
3.32	The number of people finding paid employment or self-employment (measured as a percentage against accepted referrals into the (IPS) Excluding those in employment at time of referral - Annual	PM	50%				50%
		Actual	45%				NYR
3.33	The number of people retaining employment at 3/6/9/12+ months (measured as a percentage of individuals placed into employment retaining employment) (IPS)	PM	50%	50%			50%
		Actual	65%	67%			67%
3.34	The number of people supported to retain employment at 3/6/9/12+ months	PM	50%	50%			50%
		Actual	73%	82%			82%
3.35	Fidelity to the IPS model	PM	Annual				90%
		Actual	NYA				NYR
	General Quality Requirements						
3.36	GP practices will have an individual annual (MH) ICT service meeting to review delivery and identify priorities for future.	PM	Annual				Annual
		Actual	NYA				NYR
3.37	Care plan audit to show : All dependent Children and YP <18 living with adults know to Recovery, MAHRS, Eating Disorder and Assertive Outreach Services. Recorded evidence in care plans of impact of the mental health disorder on those under 18s plus steps put in place to support.(Think family)	PM		Report			Report
		Actual		Compliant			Compliant
	New KPIs for 2016/17						
3.38	Transition- Joint discharge/CPA review meeting to be held within 4 weeks of acceptance into adult MH services during which a working diagnosis to be agreed, adult MH care coordinator allocated and care cluster and risk levels agreed as well as CYPS discharge date. The meeting will be recorded on RIO.	PM					100%
		Actual					NYA
3.39	Number and % of crisis assessments undertaken by the MHARS team on CYP age 16-25 within agreed timescales of 4 hours	PM					90%
		Actual					NYR
3.40	MHARS wait time to assessment (4 hours)	PM					TBC
		Actual					NYR

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	September-2016	October-2016	November-2016	(Apr to Nov) Cumulative Compliance
	New KPIs for 2016/17 LD						
3.41	To define LD clearly and the route into specialist LD service	PM					Annual
		Actual					NYR
3.42	LD: To implement Pathways for work within specialist service with easy read supporting information	PM					Annual
		Actual					NYR
3.43	The CLDT will ask when an annual health check is due and will notify GP where one is needed, and offer support regarding reasonable adjustments.	PM					80%
		Actual					NYR
3.44	LD: All clients referred will have a risk assessment completed when core assessment is completed	PM					80%
		Actual					NYR
3.45	LD:All clients referred for difficulties they are expressing through their behaviour will have an assessment and formulation completed within 56 days of case being opened by the relevant clinician	PM					80%
		Actual					NYR
3.46	LD: All clients referred for difficulties they are expressing through their behaviour will have single support plan, containing (as appropriate) changes within the person, changes external to the person (systems), and reactive interventions completed within 56 days of case being opened by the relevant clinician	PM					80%
		Actual					NYR
3.47	LD: All new patients have a risk assessment completed within 48 hours of admission	PM					80%
		Actual					NYR
3.48	LD: All new patients have a psychological assessment and formulation of behaviours and emotions completed within 28 days of admission.	PM					80%
		Actual					NYR
3.49	LD: All new patients have a single support plan to support their behavioural and emotional presentation completed within 28 days of admission. This will contain, as appropriate, goals targeting changes within the person, changes external to the person, and reactive interventions.	PM					80%
		Actual					NYR

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 outturn	September-2016	October-2016	November-2016	(Apr to Nov) Cumulative Compliance
3.50	LD: All new patients receive a health check within 48 hours of admission.	PM					95%
		Actual					NYR
3.51	LD: All new patients have a Health Action Plan completed within 3 days of admission	PM					95%
		Actual					NYR
3.52	LD: All new patients requiring a health screening are supported to access screenings where appropriate.	PM					95%
		Actual					NYR
3.53	LD: All clients referred for challenging behaviour will have a risk assessment completed within five days of case being allocated to clinician	PM					80%
		Actual					NYR
3.54	LD: All clients have a functional assessment / formulation of behaviours completed within 28 days on completion of assessment	PM					80%
		Actual					NYR
3.55	LD: All clients referred for challenging behaviours will have a single plan describing how their behaviour will be supported positively. It will contain primary, secondary and reactive interventions. Goals for the person and the wider system will be clear. The plan will be completed within 30 days of case being opened by the clinician.	PM					80%
		Actual					NYR
3.56	LD: All clients being admitted for challenging behaviour to Learning Disability Assessment and Treatment services will have a blue light meeting where feasible. This will be notified to Commissioners for Commissioners or their designee to Chair	PM					80%
		Actual					NYR

Schedule 4 Specific Measures that are reported Nationally

Performance Thresholds not being achieved in Month

NHS Improvement

1.02: Number of C Diff cases
There was one case in November on Priory Ward in Gloucestershire. The review meeting to determine if the case was avoidable or unavoidable has not yet been held.

For transparency, and following NHS Improvement guidelines we are reporting this case as avoidable until it can be confirmed and agreed with commissioners that it is unavoidable.

1.09 IAPT Waiting times: Referral to Treatment within 6 weeks (based on discharges)
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

1.10 IAPT Waiting times: Referral to Treatment within 18 weeks (based on discharges)
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

Department of Health Requirements

2.21: No children under 18 admitted to adult inpatient wards
In Gloucestershire there were 2 admissions of under 18s to adult wards in November.

One patient was admitted via the 136 suite and the patient was discharged to an age appropriate placement the next day.

A second patient was admitted to Dean Ward under Section 2 as there was a risk of serious self-harm. At the time of reporting the patient currently remains on Dean Ward as they are nearing their 18th birthday.

Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures - National Indicators

ID	Performance Measure		2015/16 outturn	September-2016 / Quarter 2	October-2016	November-2016	(Apr to Nov) Cumulative Compliance
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	0	0	0	0
		Actual	0	0	0	0	0
NHSI 1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	0
		Actual	0	0	0	1	1
NHSI 1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%
		Actual	95%	95%	99%	98%	98%
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	1.0%	2.5%	2.8%	1.1%	1.8%
NHSI 1.06	Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams	PM	95%	95%	95%	95%	95%
		Actual	99%	100%	98%	100%	99%
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%
		Actual	66%	80%	100%	100%	75%
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%
		Actual	87%	32%	30%	33%	33%
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%
		Actual	99%	82%	78%	81%	85%
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	0	0	0	0
		Actual	0	0	0	0	0
DoH 2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0
		Actual	11	1	0	2	6
DoH 2.25	All SIs reported within 2 working days of identification	PM	100%	100%	100%	100%	100%
		Actual	100%	100%	100%	N/A	100%
DoH 2.26	Interim report for all SIs received within 5 working days of identification (unless extension granted by CCG)	PM		100%	100%	100%	100%
		Actual		100%	100%	N/A	89%
DoH 2.27	SI Report Levels 1 & 2 to CCG within 60 working days	PM		100%	100%	100%	100%
		Actual		NYR	NYR	NYR	100%

DASHBOARD CATEGORY – GLOUCESTERSHIRE SOCIAL CARE

Gloucestershire Social Care				
	In month Compliance			Cumulative Compliance
	Sep	Oct	Nov	
Total Measures	15	15	15	15
🔴	2	2	4	4
🟢	10	10	9	9
NYA	0	1	0	0
NYR	1	0	0	0
UR	0	0	0	0
N/A	2	2	2	2

Performance Thresholds not being achieved in Month

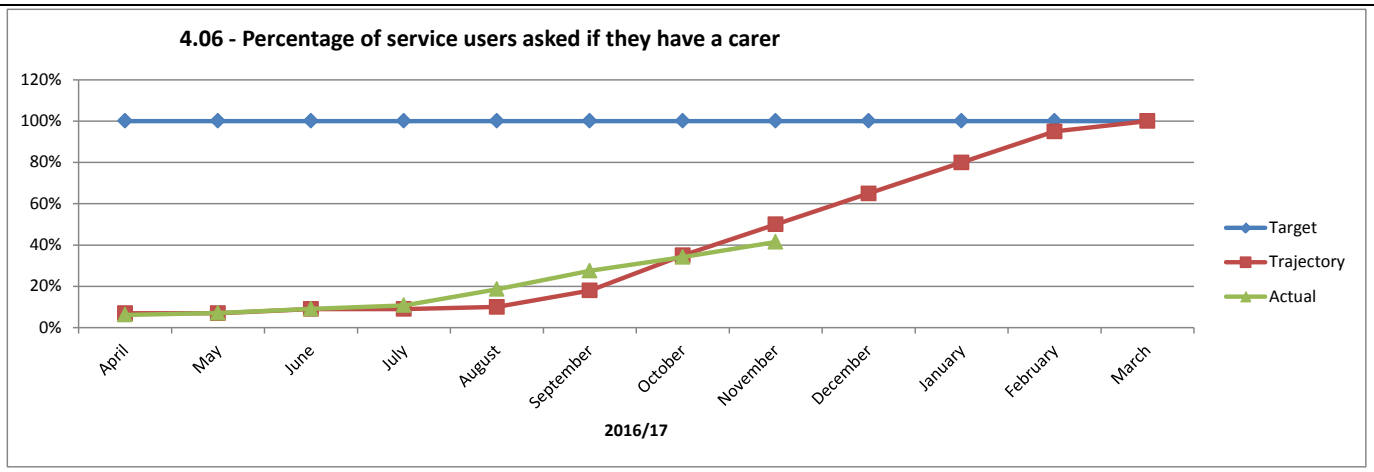
4.02 – Percentage of people receiving long-term services reviewed in last year
There are 14 cases currently recorded as not having been reviewed in the last year. CSMs are working with staff to ensure that RiO is updated in a timely manner.

4.03 – Ensure that reviews of new packages take place within 12 weeks
At the time of reporting there were 8 cases recorded as not having been reviewed within 12 weeks. It has been confirmed that these clients have received a review and that RiO will be updated. This is the first month that we have been able to report on this indicator and services are working on processes to ensure that going forward RiO is updated in a timely manner.

🚩 **4.06 – Percentage of service users asked if they have a carer**
The new data collection form went "live" in RiO in June 2016 and work is on-going to inform staff about the new way to record carer information. CSMs are focussing on these KPIs with their Team Managers over the next 4-8 weeks to resolve exceptions and a flow chart has been devised to assist staff.

This indicator has been red flagged as it requires further analysis to fully understand the issues and identify the actions required.

Expected compliance: The trajectory below shows we are slightly below our planned trajectory and the agenda will be highlighted again with staff in an attempt to improve compliance.

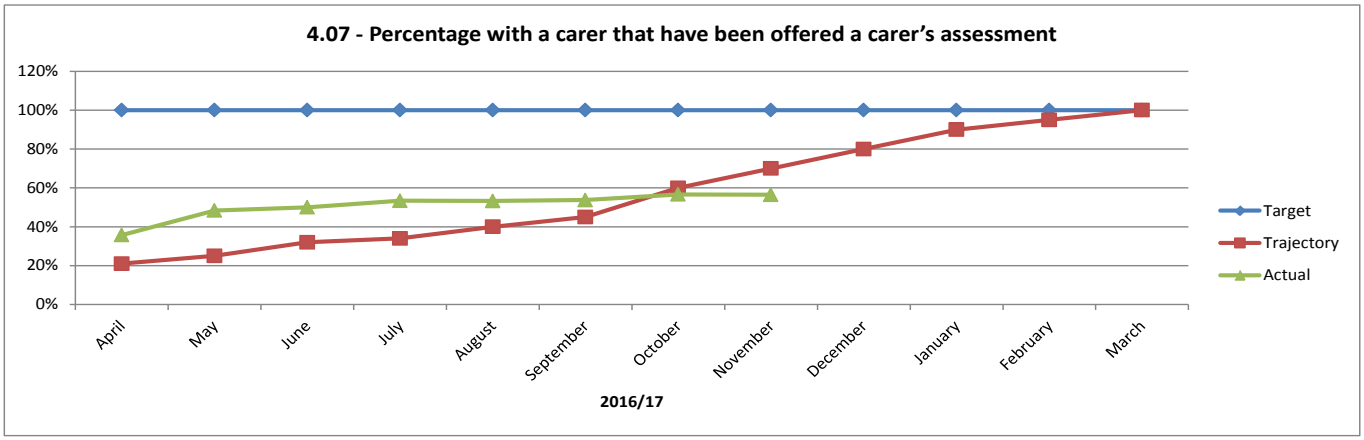


4.07– Percentage with a carer that have been offered a carer's assessment

The new data collection form went "live" in RiO in June 2016 and work is needed to ensure all staff are aware that it is available and that information is collected at the right time in the pathway. CSMs are focussing on these KPIs with their Team Managers over the next 4-8 weeks to resolve exceptions and a flow chart has been devised to assist staff.

This indicator has been red flagged as it requires further analysis to fully understand the issues and identify the actions required.

Expected compliance: The trajectory below shows we are behind with our planned improvement trajectory. A further push with staff has been planned in an attempt to improve compliance.



Cumulative Performance Thresholds Not being Met

4.02 – Percentage of people receiving long-term services reviewed in last year
As above

4.03 – Ensure that reviews of new packages take place within 12 weeks
As above

4.06 – Percentage of service users asked if they have a carer
As above

4.07– Percentage with a carer that have been offered a carer's assessment
As above

Changes to Previously Reported Figures
None

Early Warnings/Notes
None

Gloucestershire Social Care

ID	Performance Measure		2015/16 outturn	September-2016	October-2016	November-2016	(Apr to Nov) Cumulative Compliance
4.01	The percentage of people who have a Cluster recorded on their record	PM	TBC	90%	90%	90%	90%
		Actual	96%	96%	96%	95%	96%
4.02	Percentage of people getting long term services, in a residential or community care reviewed/re-assessed in last year	PM	95%	95%	95%	95%	95%
		Actual	96%	94%	95%	94%	94%
4.03	Ensure that reviews of new packages take place within 12 weeks of commencement	PM	95%		95%	95%	95%
		Actual	96%		NYA	13%	13%
4.04	Current placements aged 18-64 to residential and nursing care homes per 100,000 population	PM	TBC	13	13	13	13
		Actual	13.01	12.90	12.90	12.90	12.80
4.05	Current placements aged 65+ to residential and nursing care homes per 100,000 population	PM	TBC	22	22	22	22
		Actual	21.21	16.34	16.34	16.34	16.63
4.06	% of WA & OP service users on caseload asked if they have a carer	PM		100%	100%	100%	100%
				28%	34%	41%	41%
4.07	% of WA & OP service users on the caseload who have a carer, who have been offered a carer's assessment	PM		100%	100%	100%	100%
		Actual		54%	57%	56%	56%
4.08a	% of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC
		Actual	NYA	43%	53%	42%	42%
4.08b	Number of WA & OP service users/carers on caseload who accepted a carers assessment	PM	TBC	TBC	TBC	TBC	TBC
		Actual	NYA	59	81	93	93
4.09	% of eligible service users with Personal budgets	PM	80%	80%	100%	80%	80%
		Actual	97%	100%	100%	100%	100%

Gloucestershire Social Care

ID	Performance Measure		2015/16 outturn	September-2016	October-2016	November-2016	(Apr to Nov) Cumulative Compliance
4.10	% of eligible service users with Personal Budget receiving Direct Payments (ASCOF 1C pt2)	PM	15%	15%	15%	15%	15%
		Actual	19%	20%	18%	18%	19%
4.11	Adults subject to CPA in contact with secondary mental health services in settled accommodation (ASCOF 1H)	PM	80%	80%	80%	80%	80%
		Actual	86%	87%	88%	87%	87%
4.12	Adults not subject to CPA in contact with secondary mental health service in settled accommodation	PM	TBC	90%	90%	90%	90%
		Actual	91%	96%	96%	96%	96%
4.13	Adults subject to CPA receiving secondary mental health service in employment (ASCOF 1F)	PM	13%	13%	13%	13%	13%
		Actual	14%	15%	15%	16%	16%
4.14	Adults not subject to CPA receiving secondary mental health service in employment	PM	TBC	20%	20%	20%	20%
		Actual	23%	24%	25%	24%	24%

DASHBOARD CATEGORY – HEREFORDSHIRE CCG CONTRACTUAL REQUIREMENTS

Herefordshire Contract				
	In month Compliance			Cumulative
	Sep	Oct	Nov	Compliance
Total Measures	25	25	25	25
	2	3	4	2
	18	17	16	18
NYA	0	0	0	0
NYR	0	0	0	0
UR	0	0	0	0
N/A	5	5	5	5

Performance Thresholds not being achieved in Month

5.08: IAPT Recovery rate – those who have completed treatment and have "caseness"

This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

5.09: IAPT achieve 15% of patients entering the service against prevalence

This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

5.11: IAPT High intensity – Number of discharge patients that received step 3 treatment

Fewer clients have received step 3 treatment due to staffing issues in Herefordshire. Further information is available in the IAPT Service Improvement Plan progress report.

5.15: Reduce numbers of people readmitted to inpatient care within 30 days

During November there were 4 patients readmitted within 30 days of their previous discharge date. All cases have been assessed by our clinical team and the review has confirmed that the patients were appropriately admitted due to escalating factors that could not be safely managed within the community.

Cumulative Performance Thresholds Not being

 **5.08: IAPT Recovery rate – those who have completed treatment and have "caseness"**
As above

 **5.09: IAPT achieve 15% of patients entering the service against prevalence**
As above

Changes to Previously Reported Figures

5.16: Number on the caseload who have been seen within the previous 90 days
This was reported as compliant at 99% for October, however due to subsequent updating of records, October is now reported as non-compliant at 97%.

Early Warnings / Notes

None

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 Outturn	September-2016 / Quarter 2	October-2016	November-2016	(Apr to Nov) Cumulative Compliance
5.01	Duty of candour	Plan	Report	Report	Report	Report	Report
		Actual	Compliant	Compliant	Compliant	Compliant	Compliant
5.02	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS	Plan	99%	99%	99%	99%	99%
		Actual	100%	99%	99%	99%	99%
5.03	Completion of Mental Health Services Data Set ethnicity coding for all detained and informal Service Users	Plan	90%	90%	90%	90%	90%
		Actual	100%	100%	100%	96%	99%
5.04	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users	Plan	90%	90%	90%	90%	90%
		Actual	96%	100%	100%	96%	99%
5.05	Zero tolerance MRSA	Plan	0	0	0	0	0
		Unavoidable	0	0	0	0	0
5.06	Minimise rates of Clostridium difficile	Plan	0	0	0	0	0
		Unavoidable	0	0	0	0	0
5.07	VTE risk assessment: all inpatient service users to undergo risk assessment for VTE	Plan	95%	95%	95%	95%	95%
		Actual	99%	100%	97%	97%	99%
5.08	IAPT Recovery Rate - The number of people who are "moving to recovery" (those who have completed IAPT treatment and have "caseness" at the final session did not)	Plan	50%	50%	50%	50%	50%
		Actual	33%	48%	46%	29%	42%
5.09	IAPT Roll-out (Access Rate) - IAPT maintain 15% of patient entering the service against prevalence	Plan	2,178	1089	1271	1452	1452
		Actual	2,005	714	794	879	879
5.10	IAPT waiting times and completed treatments - Number of ended referrals in the reporting period that received a course of treatment against the number of ended referrals that received a single treatment appt	Plan	N/A	TBC	TBC	TBC	TBC
		Actual		52%	46%	42%	47%
5.11	IAPT High Intensity - Number of discharged patients that received step 3 treatment	Plan	350	29	29	30	234
		Actual	356	57	34	23	267

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

ID	Performance Measure		2015/16 Outturn	September-2016 / Quarter 2	October-2016	November-2016	(Apr to Nov) Cumulative Compliance
5.12	Emergency referrals to Crisis Resolution Home Treatment Team seen within 4 hours of referral (8am-6pm)	Plan	98%	95%	95%	95%	95%
		Actual	99%	100%	100%	100%	100%
5.13a	Dementia Service - number of new patients aged 65 years and over receiving an assessment	Plan		45	45	45	360
		Actual		53	47	47	372
5.13b	Dementia Service - total number of new patients receiving an assessment	Plan					
		Actual		63	48	52	401
5.14	Waiting times - Specialist Memory Service: All patients are offered a first appointment within 4 weeks of referral	Plan	100%	95%	95%	95%	95%
		Actual	97%	100%	100%	100%	100%
5.15	Reduce those people readmitted to inpatient care within 30 days following discharge.	Plan	<8%	<8%	<8%	<8%	<8%
		Actual	6%	7%	0%	20%	5%
5.16	Number of service users on the caseload who have been seen (face to face) within the previous 90 days (Recovery Service). Excludes service users with a medic as Lead HCP.	Plan	100%	98%	98%	98%	98%
		Actual		99%	97%	99%	99%
5.17	Patients are to be discharged from local rehab within 2 years of admission (Oak House). Based on patients on ward at end of month.	Plan	80%	80%	80%	80%	80%
		Actual	86%	100%	100%	100%	100%
5.18	CYPS IAPTOutcomes - Consistent with the data specification for CYP-IAPT CAMHS V2 (Dec 2012).(Caseload at month end for CYPS IAPT trained staff with a CYPS IAPT outcome recorded).	Plan		40%	60%	60%	60%
		Actual		92%	92%	91%	91%
5.19	All admitted patients aged 65 years of age and over must have a completed MUST assessment	Plan		95%	95%	95%	95%
		Actual		100%	100%	100%	98%
5.20	Any attendances at ED with mental health needs should have rapid access to mental health assessment within 2 hours of the MHL team being notified.	Plan		50%	80%	80%	50%
		Actual		72%	82%	83%	79%
5.21	Attendances at ED for self-harm receive a mental health assessment	Plan		55%	85%	85%	85%
		Actual		100%	100%	90%	97%

Herefordshire Carers Information

ID	Performance Measure		2015/16 Outturn	August-2016	September-2016 / Quarter 2	October-2016	(Apr to Oct) Cumulative Compliance
5.22	Working Age and Older People service users on the caseload asked if they have a carer	Plan					
		Actual		15%	17%	16%	14%
5.23	Working Age and Older People service users on the caseload who have a carer who have been offered a carer's assessment	Plan					
		Actual		35%	32%	34%	37%
5.24	Working Age and Older People service users/carers who have accepted a carers assessment	Plan					
		Actual		61%	56%	60%	60%

Schedule 4 Specific Measures that are reported Nationally

Performance Thresholds not being achieved in Month

NHS Improvement

1.08: New psychosis (EI) cases treated within 2 weeks of referral
There was one new case reported in Herefordshire during November. The client had an appointment booked within 12 days of their referral but cancelled this appointment. The first appointment attended was 19 days after referral.

1.09: IAPT Waiting times: Referral to Treatment within 6 weeks (based on discharges)
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

1.10: IAPT Waiting times: Referral to Treatment within 18 weeks (based on discharges)
This service is subject to an agreed Service Development Improvement Plan which is under specific monthly review by the Delivery Committee.

Department of Health Requirements

2.21: No children under 18 admitted to adult inpatient wards
There was 1 admission of an under 18 to an adult ward in November in Herefordshire

One patient in Herefordshire was admitted informally after being transferred to the 136 suite due to expressing harm to self and others. The patient was placed on 1-1 nursing observation on Mortimer Ward. The patient was reviewed by the CAMHS consultant and team the following day and a package put in palce so that they could be discharged home to their family.

Herefordshire CCG Contract - Schedule 4 Specific Performance Measures - National Indicators

ID	Performance Measure		2015/16 outturn	September-2016 / Quarter 2	October-2016	November-2016	(Apr to Nov) Cumulative Compliance
NHSI 1.01	Number of MRSA Bacteraemias avoidable	PM	0	0	0	0	0
		Actual	0	0	0	0	0
NHSI 1.02	Number of C Diff cases (day of admission plus 2 days = 72hrs) - avoidable	PM	0	0	0	0	0
		Actual	0	1	1	0	3
NHSI 1.03	Care Programme Approach follow up contact within 7 days of discharge	PM	95%	95%	95%	95%	95%
		Actual	96%	100%	100%	100%	98%
NHSI 1.04	Care Programme Approach - formal review within12 months	PM	95%	95%	95%	95%	95%
		Actual	98%	99%	98%	97%	99%
NHSI 1.05	Delayed Discharges (Including Non Health)	PM	7.5%	7.5%	7.5%	7.5%	7.5%
		Actual	1.2%	0.0%	0.0%	0.0%	1.4%
NHSI 1.08	New psychosis (EI) cases treated within 2 weeks of referral	PM	50%	50%	50%	50%	50%
		Actual	61%	100%	100%	0%	71%
NHSI 1.09	IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges)	PM	75%	75%	75%	75%	75%
		Actual	95%	39%	58%	52%	53%
NHSI 1.10	IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges)	PM	95%	95%	95%	95%	95%
		Actual	99%	83%	87%	86%	88%
DoH 2.18	Mixed Sex Accommodation Breach	PM	0	0	0	0	0
		Actual	0	0	0	0	0
DoH 2.21	No children under 18 admitted to adult in-patient wards	PM	0	0	0	0	0
		Actual	4	0	0	1	5

DASHBOARD CATEGORY – GLOUCESTERSHIRE CQUINS

Gloucestershire CQUINS				
	In month Compliance			Cumulative Compliance
	Sep	Oct	Nov	
Total Measures	2	2	2	2
🔴	0	0	0	0
🟢	2	0	0	2
NYA	0	0	0	0
NYR	0	2	2	0
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
Both CQUIN measures reported as compliant for Quarter 2 have now been awarded

Early Warnings
None

Gloucestershire CQUINS

ID	Performance Measure		2015/16 Outturn	Quarter 2		(Apr to Nov) Cumulative Compliance
	Local CQUINs					
	CQUIN 1					
7.01	Transition from Young People's Service to Adult Mental Health Services	PM	Qtr 4	Report		Qtr 2
		Actual	Compliant	Awarded		Awarded
	CQUIN 2					
7.02	Perinatal Mental Health	PM	Qtr 4	Report		Qtr 2
		Actual	Compliant	Awarded		Awarded

DASHBOARD CATEGORY – LOW SECURE CQUINS

Low Secure CQUINS				
	In month Compliance			Cumulative Compliance
	Sep	Oct	Nov	
Total Measures	1	1	1	1
	0	0	0	0
	1	0	0	1
NYA	0	0	0	0
NYR	0	1	1	0
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
This CQUIN measure reported as compliant for Quarter 2 has now been awarded

Changes to Previously Reported Figures
None

Early Warnings
None

Low Secure CQUINS

ID	Performance Measure		2015/16 Outturn	Quarter 2		(Apr to Nov) Cumulative Compliance
	Local CQUINs					
	CQUIN 1					
8.01	Reducing the length of stay in specialised MH services	PM		Report		Qtr 2
		Actual		Awarded		Awarded

DASHBOARD CATEGORY – HEREFORDSHIRE CQUINS

Herefordshire CQUINS				
	In month Compliance			Cumulative Compliance
	Sep	Oct	Nov	
Total Measures	8	8	8	8
	0	0	0	0
	3	0	0	7
NYA	5	0	0	1
NYR	0	8	8	0
UR	0	0	0	0
N/A	0	0	0	0

Performance Thresholds not being achieved in Month
None

Cumulative Performance Thresholds Not being Met
None

Changes to Previously Reported Figures
The following CQUIN measures reported as compliant for Quarter 2 have now been awarded:

9.02a: Cardio Metabolic Assessment for patients with psychoses
9.03: Personalised relapse prevention plans for adults accessing services
9.04: Personalised relapse prevention plans for children and young people accessing services.

Early Warnings
None

Herefordshire CQUINS

ID	Performance Measure		2015/16 Outturn	Quarter 2		(Apr to Nov) Cumulative Compliance
	National CQUINs					
	CQUIN 1					
9.01a	(b) Introduction of Health and Wellbeing Initiatives	PM		Report		Qtr 1
		Actual		NYA		Awarded
9.01b	Healthy food for NHS Staff, Visitors and Patients	PM		Report		Qtr 1
		Actual		NYA		Awarded
9.01c	Improving the uptake of Flu vaccinations for Front Line Clinical Staff	PM		Report		Qtr 1
		Actual		NYA		Awarded
9.02a	Improving physical healthcare: Cardio Metabolic Assessment for patients with psychoses	PM	Qtr 4	Report		Qtr 2
		Actual	Compliant	Awarded		Awarded
9.02b	Improving physical healthcare: Communication with GPs	PM	Qtr 2	Report		Report
		Actual	Awarded	NYA		NYA
	Local CQUINs					
	CQUIN 2					
9.03	Personalised relapse prevention plans for adults accessing and using 2G Mental Health Services	PM		Report		Qtr 2
		Actual		Awarded		Awarded
	CQUIN 3					
9.04	Personalised relapse prevention plans for children and young people accessing and using MH services			Report		Qtr 2
				Awarded		Awarded
	CQUIN 4					
9.05	Appropriate care and management for frequent attenders to WVT A&E dept			Report		Qtr 2
				NYA		Compliant

Agenda item 8 **Enclosure Paper C**

Report to:	2gether Board Meeting – 26 January 2017
Author:	Alison Curson, Deputy Director of Nursing & Louise Forrester, Lead Nurse
Presented by:	Marie Crofts, Director of Quality
SUBJECT:	**NICE (2013) PH 48 Smoking Cessation in Secondary care: acute, maternity and mental health services update.**

Can this report be discussed at a public Board meeting?	***Yes***
If not, explain why	

This Report is provided for:

Decision Endorsement **Assurance** **To Note**

EXECUTIVE SUMMARY

The National Institute for Clinical Excellence - NICE (2013) PH 48 – published guidance in November 2013 for smoking cessation in secondary care: acute, maternity and mental health services. At that time there was no nationally mandated date for completion of this guidance; however the Trust implemented a planned approach to take this recommendation forward to successful implementation. NHS England now recommends that all mental health inpatient units and facilities be smoke free by 2018.

The purpose of this paper is to update the Trust Board on the progress of the implementation of the smoke free guidance that is proposed to be introduced in April 2017 across 2gether Trust sites.

The Trust remains on plan to implement a smoke free environment from April 2017 and we continue to gain intelligence from other Trusts who have already implemented this guidance. A number of work streams continue to deliver outputs and key risks and issues have been identified and mitigated against. Further discussion regarding potential costs for treatments will be discussed at the Executive Committee.

Corporate Considerations	
Quality implications:	Implementation of NICE guidance is a quality and contractual requirement of NHS Organisations.
Resource implications:	Potential resource implications are detailed in paper.
Equalities implications:	The implementation of this guidance will be subject to an equality impact assessment – related work is fully inclusive of all demographic groups.
Risk implications:	A range of risk issues are associated with this guidance that will require scoping as part of the project approach.

WHICH TRUST STRATEGIC OBJECTIVE(S) DOES THIS PAPER PROGRESS OR CHALLENGE?	
Continuously Improving Quality	P
Increasing Engagement	
Ensuring Sustainability	

WHICH TRUST VALUE(S) DOES THIS PAPER PROGRESS OR CHALLENGE?			
Seeing from a service user perspective			P
Excelling and improving	P	Inclusive open and honest	P
Responsive	P	Can do	P
Valuing and respectful	P	Efficient	

Reviewed by:		
Marie Crofts, Director of Quality	Date	18/01/17

Where in the Trust has this been discussed before?		
Trust Exec Board	Date	10/10/16
Trust Exec Board		21/11/16
Smoking Cessation Project Board		06/12/16

What consultation has there been?		
Ongoing engagement with staff and service users)	Date	

Abbreviations	
CQUIN	Commissioning for Quality & Innovation
DoH	Department of Health
HR	Human Resources
JNCC	Joint Negotiating and Consultative Committee
NICE	National Institute for Clinical Excellence
NRT	Nicotine Replacement Therapies

1. Introduction

1.1. The Trust has previously agreed the implementation of NICE (2013) PH48 Smoking Cessation in Secondary care: acute, maternity and mental health services update which was initially due to commence in October 2016. This date was then postponed until April 2017 due to the complexities of implementation. Other Mental Health Trusts who have achieved smoke free status all advocate a carefully planned lead up to becoming smoke free. This report provides an overview of the smoke free plan to date including current challenges, risks and timeline.

2. Context

2.1. The current Trust systems and practices do not comprehensively promote and support smoking cessation, harm reduction or temporary abstinence. The NICE guidance requires a comprehensive structure to be in place to support smoking cessation.

2.2. The Trust currently operates a permissive approach to service users smoking at Trust inpatient facilities by allowing smoking within the grounds of Trust buildings in specially designated areas. NICE guidance mandates that this is prohibited and that temporary abstinence for all inpatients is facilitated. The NICE (2013) PH 48 guidance states that:

- It is widely accepted that stopping smoking at any time has considerable health benefits for people who smoke, and for those around them. For people using secondary care services, there are additional advantages including shorter hospital stays, lower drug doses, fewer complications, higher survival rates, better wound healing, decreased infections, and fewer re-admissions after surgery.

- Secondary care providers have a duty of care to protect the health of, and promote healthy behaviour among, people who use, or work in, their services. This duty of care includes providing them with effective support to stop smoking or to abstain from smoking while using or working in secondary care services.

2.3. The guidance aims to support smoking cessation, temporary abstinence from smoking and smoke free policies in all secondary care settings.

2.4. Smoke free mental health services in England: Implementation document for providers of mental health services (2016) and recent government guidance to support implementation has been developed providing information and lessons learnt from those Mental Health Trusts who have fully implemented NICE PH48.

"As with all projects of this scale and importance, a well-defined and tested project management approach is crucial. Realistic timescales, identification of key milestones, communication, monitoring and evaluation are all crucial to ensure that, "Smoke free policy implementation is a process not an event".

3. Background Information

3.1. The Trust implemented project management to oversee and manage the implementation of Smoke free within ^{2}gether Trust providing an organisational structure which includes staff and experts by experience.

3.2. It was initially anticipated that the Smoke free implementation date would be October 2016; however in May 2016 the Trust Board agreed that the implementation date would be postponed until Spring 2017 due to recent guidance that indicated that 12-18 months is required for practice and cultural change.

3.3. There was some slippage in time scales owing to a number of factors which primarily reduced capacity with the project office and with the clinical leadership. The Director of Quality has enabled the work streams on this project to continue effectively and the Deputy Director of Nursing is overseeing this work.

3.4. This paper details the specific work of the Smoke free project work streams and identified risks to the project to ensure the Board are fully aware of progress and risks to date.

3.5. A paper outlining the costs associated with this project was presented at the Executive Board on 10/10/16 and on 21/11/16 and the costs were highlighted. (namely Nicotine Replacement Therapy (NRT) and training costs). The Director of Finance has contacted the commissioners to request they consider supporting funding this large scale programme of work which will significantly impact positively on the health of our service users. Gloucestershire County Council has stated they would pick up costs related to staff and outpatients using NRT – however they would not consider funding the costs related to our inpatient service users.

4. Work Streams

There are 5 work streams within the project:

	Work Stream	Lead
1.	Communication	Kate Nelmes
2.	Staff Engagement	Alison James
3.	Support Systems	Louise Forrester
4.	Training	Louise Forrester
5.	Treatments	Jenny Romer

4.1. Communication

4.1.1. The purpose of this work stream is to contribute to the creation of a smoke free environment within the Trust by delivering the following deliverables:

- Create and implement a communications strategy
- Create a suite of literature that informs and promotes the introduction

- Create a set of signage that informs and promotes the introduction

4.1.2. A short film has been created which features senior clinicians and a service user detailing the importance of quitting smoking and the help available – this can be viewed here.

4.1.3. An identified smoke free logo has been developed for use in all communications.

4.1.4. The Communications Team has developed a page on the Trust's intranet for the smoke free project, containing a 'count-down clock' and advice for staff who wish to quit smoking.

4.2. Staff Engagement

4.2.1. The purpose of this work stream is to contribute to the creation of a smoke free environment within the Trust by delivering the following deliverables:

- An implemented strategy and plan to integrate staff into a smoke free culture
- An implemented strategy and plan to support staff to quit or abstain from smoking
- A system for monitoring and reporting the level of staff that smoke during working hours
- An agreement that manages the expectations of staff in enforcing a smoke free environment
- Instructions, guidelines and support for staff to maintain the smoke free environment
- Training for staff in challenging non-compliance
- An agreement that informs the management of staff for non-compliance

4.2.2. There has been a staff survey undertaken asking staff their opinion on smoke free implementation. Opinions and feedback varies often between staff who feel that this is a good idea and that staff and patients will benefit from this, and staff who feel that introducing a smoke free environment for patients should not be implemented.

4.2.3. There have also been some staff forums which have generated interest amongst staff groups. Staff have raised concerns relating to:

- Implementation of the smoke free policy for staff and what support is available for staff who would like to quit
- How to clinically manage patients who smoke and who present a challenge e.g. will incidences of violence and aggression increase

4.2.4. To alleviate staff concerns in these areas, the Trust has since trained a number of Level 2 Quit Advisors who can help support and/or signpost staff who wish to undertake a quit attempt. The Trust's 'Working Well' Team are also available to provide help and support. In addition information from other

Trusts is being used and disseminated to staff to demonstrate positive clinical practice in relation to violence and aggression incidents.

4.2.5. Training and increased knowledge of nicotine addiction and withdrawal will assist staff in understanding and managing challenging situations. All instances of any smoking-related instance will be reported on 'Datix' (incident reporting system) and these will be reviewed and monitored.

4.2.6. A 'soft start' approach to the implementation has already been adopted. Once staff have received training, all patients will be offered NRT on admission and given support to quit and/or abstain from smoking. This will reduce the anxieties around the countdown to the Trust becoming smoke free, and ensure staff and patients are prepared in advance. In addition, feedback from other Trusts that are currently smoke free have helped in guiding us in the implementation of this project to enable us to learn lessons from their implementation process.

4.2.7. The membership of the project team has been revised and this has included a staff side representative. Front line clinicians are also represented on the project team.

4.3. Support Systems

4.3.1. The purpose of this work stream is to contribute to the creation of a smoke free environment within the Trust by delivering the following deliverables:

- Revise policies to establish and support a smoke free environment
- Introduce systems that support those affected by the introduction of a smoke free environment. (Produce guidelines on what will be expected to ensure compliance)
- Secure the resources (financial and non-financial) to ensure project delivery
- Identify a system of outcome measurements to monitor the effects of establishing the smoke free environment
- Provide changes to the buildings and grounds to support a smoke free environment
- Review of current record keeping and introduce new recording methods to support the delivery of care in a smoke free environment
- Provide assurance that service user smoking management is fully embedded in assessments
- Review personal care plans to ensure they include a stop smoking element
- Review clinical guidelines to ensure stopped or reduced smoking is reflected in medicines management
- Ensure that exhale equipment available to level 2 quit advisors

4.3.2. The Smoke Free Policy (2011) is already an existing policy, but following discussion and consultation it was agreed to update and revise the existing policy to ensure the most up to date legislation and guidance. The existing policy already details guidance for staff who smoke however there may be a

culture shift for staff in terms of taking breaks. This policy and any implications for staff will be reviewed by JNCC in January 2017. The Quality team and HR have worked closely together to update this policy.

4.3.3. Support to service users and staff will be addressed via training and also staff engagement forums.

4.3.4. The project has identified significant resource implications associated with the NRT and training (this will be detailed later within this report)

4.3.5. The recording of physical health on RiO has been redesigned following a piece of work with clinicians and the RiO Team. This allows the capturing of 'smoking' data which is also a requirement of the 2017/18 national CQUIN.

4.4. Training

4.4.1. The purpose of this work stream is to contribute to the creation of a smoke free environment within the Trust by delivering the following deliverables:

- A training strategy and plan that equips all staff to manage and support the creation and delivery of a smoke free environment
- The timely delivery of awareness training to all staff to 'Level 1'
- Identified staff trained to 'Level 2' quit advisors
- Training to medical staff
- Quit champions at each inpatient site to promote and support smoking cessation
- Ensure 'Level 2' training sessions regularly delivered

4.4.2. The recommendation is that all inpatient clinical staff with patient contact from in-patients have training at Level 1 smoking cessation. This training takes 1 hour and provides staff with brief interventions and signposting for those who wish to quit. All registered nurses within the inpatient units need to undertake an additional 1 hour training relating to the use of NRT which will give them the knowledge to assess and administer NRT within 30 minutes of admission.

4.4.3. **Level 2 Training** - All in patient clinical areas have been requested to release 2 staff per unit/ward to undergo the Level 2 training. The Level 2 advisors role is to offer additional support to those who do want to quit smoking. The Level 2 advisors provide the ongoing behavioural support and ensure the continuing provision of NRT. 'ICE Creates' (who have taken over the contract for smoke free services within Gloucestershire from 'Gloucestershire Stop Smoking Service') provide the Level 2 training in conjunction with the Trust (only within Gloucestershire). To date, Herefordshire has no Level 2 Quit Advisors, but discussions with Public Health within Hereford will hopefully resolve this.

4.5. Treatments

4.5.1. The purpose of this work stream is to contribute to the creation of a smoke free environment within the Trust by delivering the following deliverables:

- A service that makes readily available medicines to support individuals to quit smoking or temporarily abstain
- An estimate of the additional cost to the Trust of the delivery of that service
- Guidelines for the management of related medicines
- Decision algorithms to assist in the selection of appropriate medicines
- A list of local stockists/providers of related over the counter medicines
- A researched assessment of the potential for the Trust to sell related over the counter medicines

4.5.2. NRT will be the method to secure temporary abstinence or support to quit smoking altogether. Patients who are admitted to the inpatient units will be ***assessed and offered NRT products within 30 minutes of admission***.

4.5.3. Ongoing support and management of their requirements in relation to nicotine withdrawal will be monitored. NRT products have already been placed on wards within Gloucestershire and staff are being encouraged to discuss with service users the benefits of using these products.

4.5.4. The use of NRT for those wishing to quit or those opting for temporary abstinence could be significant and will be the main cost of implementation of a smoke free environment within our inpatient units. Based on a survey undertaken within our inpatient sites (on those who currently smoke) the cost of NRT could be up to £172K. This is worst case scenario as this does not take into consideration any services users who will be vaping. When drawing on the experience of other mental health Trusts they have informed us that costs have been much lower.

4.5.5. The Executive team will consider the cost implications further following feedback from Public Health and other Trusts.

5. Vaporisers and Vaping (e-cigarettes)

5.1. In July 2016, Public Health England released guidance on the use of e-cigarettes in public places and workplaces with advice to inform evidence based policy making. The guidance and information regarding vaping is fast evolving and the overall evidence to date demonstrate that e-cigarettes have rapidly become the most popular ‘stop smoking’ aid in England. The latest evidence published by Public Health England (PHE) in 2015 found that, based on the international peer-reviewed evidence, vaping is around 95% safer for users than smoking.

5.2. Vaping provides a generally lower blood nicotine level and takes longer to reach a desired level, requiring frequent interim top-ups. This difference should be taken into account, particularly when developing policies for workplaces.

5.3. Recent guidance demonstrates that the success rate of smoking cessation with the use of vapes is increased rather than conventional nicotine replacement therapies. Currently patients can vape outside but not within

buildings. There have been issues with vapes causing the fire alarms to be set off. Advice from the fire officer would be not to allow vaping within any buildings at this time but review of this would be part of the ongoing smoke free agenda. There appears to be no standardisation across mental health hospitals who are already smoke free about the use of vapes with some Trusts advocating their use and even providing e-cigarettes on admission, to other Trusts that condone their use.

5.4. The issue of charging the vaporiser has produced an alert from the DoH to Estates and Facilities in 2014 which offers guidance around the charging of the vaporiser to minimise any fire risk.

5.5. Currently there is only one Vape available on prescription and feedback is that this is of a poorer quality than current Vapes so users are not keen to use this. Therefore at this time, the Trust will not be recommending this on prescription, although it is envisaged that this will change in the near future.

5.6. Further information needs to be gained regarding the different types of vapes that are available and the risks that they could potentially pose if ingested etc.

6. Risks Identified with the Implementation of the Project

6.1. The three main risks within the implementation process are detailed below:

6.2. **Training** - especially for in-patient staff, is crucial to the success of the implementation of the project. A trainer to deliver the training has now been identified and training dates have been advertised (within Gloucestershire). However release of staff from clinical duties to attend training remains a risk and the Deputy Director of Nursing is now directly managing the overall implementation of the programme and closely monitoring delivery of the training plan. Mental Health Trusts who have been successful with smoke free implementation, have stressed the importance of training and in some cases the implementation has failed due to the lack of training.

6.3. **Culture** – smoking within the mental health community is much greater than within the general population. Mental Health Trusts who have successfully implemented smoking cessation all report that this is challenging to the long-standing culture. Therefore the Trust has acknowledged this and is putting in place ways of supporting our staff and service users who smoke. We realise that this is the start of the Trust's smoke free journey, and will continue to work with staff and service users to help them to quit smoking. The Chief Nursing Officers (CNO) office has approached the Trust to take part in a national programme to support us with our smoke free journey which we are now pursuing with NHSE.

6.4. **Costs** – as identified earlier in this report there is potentially significant cost implications with the supple of NRT. The Executive team will model this further based on up to date information from other Trusts and further data from within our own inpatient units.

7. Next Steps

7.1. Work Stream – Communication

7.1.1. Further communication will be provided to staff and service users in the form of a page on the Trust's Internet, updates to the Trust's intranet, posters, leaflets and signage.

7.2. Work Stream – Staff Engagement

7.2.1. The Project Lead and Deputy Director of Nursing will continue to attend team and community meetings etc to raise the profile of the smoke free project.

7.3. Work Stream – Support Systems

7.3.1. The current Smoke Free Policy has been revised, and together with operational guidelines, will be presented at the JNCC Committee on 31 January 2017.

7.3.2. Smokers status needs to be recorded on every admission and within community – without this then accurate success of quit cannot be established/monitored. (The aim is for this to link with the 2017/18 CQUIN.)

7.4. Work Stream – Training

7.4.1. 24 Level 2 Quit Advisors are now trained (apart from staff in Herefordshire, where there are no Level 2 advisors trained). Discussions with Public Health Hereford will continue to support this training.

7.4.2. Monthly drop-in support sessions for Quit Advisors are being scheduled.

7.4.3. Training sessions will continue to be advertised across Gloucestershire for Inpatient staff.

7.4.4. Owing to capacity issues, training sessions have not been advertised to Herefordshire staff, although options are being investigated to rectify this.

7.5. Work Stream – Treatments

7.5.1. A Standard Operating Procedure for the management and prescribing of medicines, including an algorithm, is in development and will need to be agreed by the Drugs & Therapeutic Committee.

7.5.2. Work needs to be carried out & the Trust to decide the way forward regarding vaping.

7.5.3. NRT products will continue to be available on inpatient wards.

8. Recommendations

8.1. The Trust Board supports the ongoing implementation of the smoke free guidance

Agenda item **Enclosure No** **Additional Paper**

Report to: 2gether Board Meeting - 26th January 2017
Authors: Ruth Thomas, Head of Training, Sue Heafield, Assistant HR Director & Neil Savage, Director of Organisational Development
Presented by: Neil Savage, Director of Organisational Development

SUBJECT: **Improving Compliance with Staff Statutory and Mandatory Training**

Can this report be discussed at a public Board meeting?	Yes
If not, explain why	

This Report is provided for:
Decision Endorsement **Assurance** **Information**

EXECUTIVE SUMMARY

Under the Monitor Code of Governance, the Board as a whole is responsible for ensuring the quality and safety of health care services, education and training delivered by the Trust.

This report provides an update on progress towards delivering improved compliance for staff statutory and mandatory training.

Training compliance was 80% in December 2016. Reported compliance tallies with the draft results from the 2016 Staff Survey, which suggested that 80% of staff had received training, learning or development in the previous 12 months. Additionally, 86% of staff felt that this had helped them to do their jobs more effectively.

As a key part of our delivery strategy, we have focused on implementing the Learn2gether system to deliver, record and report on compliance.

Additional work has been identified to improve compliance going forwards. This includes: -

- the further development of Learn2gether functionality and use
- a review with external benchmarking on our future approach to compliance targets
- the option to develop a new governance mechanism for overseeing, challenging and confirming the inclusion of training as either statutory or mandatory, its content, delivery methodology, duration, frequency and its on-going review.

RECOMMENDATIONS

It is recommended that the Board:

- Notes the progress being made towards improving compliance with statutory and mandatory training
- Notes the further work identified in section 7 of this report

Corporate Considerations	
Quality implications:	The Trust aims to provide high quality statutory and mandatory training for all staff, clinical and non-clinical, to ensure that we provide safe, effective and compliant services and that we comply with related statutory responsibilities.
Resource implications:	The resources required for delivering statutory and mandatory training are already identified and budgeted for.
Equalities implications:	Statutory and mandatory training includes equal opportunities training as a requirement for all staff to ensure that the Trust delivers the requirements of national legislation and good practice.
Risk implications:	Failure to provide high quality statutory and mandatory training and related compliance with the targets set by the Trust may result in legal non-compliance (e.g. Health and Safety, Fire, Manual Handling), regulatory non-compliance (e.g. Care Quality Commission, General Medical Council, Nursing and Midwifery Council, Health Professions Council), damage to the reputation to the Trust as an exemplar employer and avoidable difficulty in recruiting and retaining staff who feel valued. Staff who do not undertake their statutory and mandatory training may be at greater risk of being involved in accidents or incidents at work, and may place service users, carers and others at greater risk of receiving a service that is not of an acceptable standard. Of particular importance is the Care Quality Commission's Regulation 18 on Staffing. Under this staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities. Failure to breach this requirement can lead to regulatory action.

WHICH TRUST KEY STRATEGIC OBJECTIVES DOES THIS PAPER PROGRESS OR CHALLENGE?	
Continuously Improving Quality	P
Increasing Engagement	P
Ensuring Sustainability	P

WHICH TRUST VALUES DOES THIS PAPER PROGRESS OR CHALLENGE?			
Seeing from a service user perspective			
Excelling and improving	P	Inclusive open and honest	
Responsive	P	Can do	P
Valuing and respectful	P	Efficient	P

Reviewed by: Executive Committee		
N/A	Date	N/A

Where in the Trust has this been discussed before?		
Organisational Development Directorate	Date	December 2016 / January 2017

What consultation has there been?		
N/A	Date	N/A

Explanation of acronyms used:	N/A

1. CONTEXT

1.1 In order to achieve the Trust's vision, objectives, regulatory and statutory requirements, the knowledge, skills and shape of our workforce needs to evolve and adapt against a context of challenging and sometimes seemingly conflicting requirements e.g. the need to make cost savings in an increasingly constrained financial environment whilst improving the quality of service alongside patient and staff experience.

1.2 Integral to our success is the provision of high quality training for all staff groups across every level of the organisation. A core component of this is the successful delivery of statutory and mandatory training.

1.3 Statutory and mandatory training compliance is measured against profiles for each staff group and these are defined in the Trust's Training Matrix. The matrix describes compulsory training for staff in relation to their staff group, the work they do and where they work. The training profiles are developed in line with statutory Trust policies and are determined through consultation with Heads of Profession, other lead clinicians and Subject Matter Experts. Compliance against the Trust's key performance indicator for statutory and mandatory training is monitored through reports which are available to managers, senior managers and Service Directors through the Learn2gether training system. All staff are expected to take personal responsibility for their training and line managers are responsible for ensuring that all staff within their teams achieve 100% statutory and mandatory training compliance. This is a target agreed by the Board a number of years ago.

2. STATUTORY AND MANDATORY COMPLIANCE

2.1 Compliance varies across teams and services. 9% of teams achieved 100% in December 2016. The average compliance across all areas is 85% which is broadly comparable to other medium and high performing NHS trusts. It is important to note that this figure is made up of staff who are at work and available to undertake training. The monthly compliance figures exclude staff who are away from work such as those on maternity leave, long term sick leave, career breaks and external secondments. New starters are also excluded for a period of three months as are those who are not able to undertake more specific aspects of their jobs because illness or injury.

3. STATUTORY AND MANDATORY TRAINING COMPLIANCE JANUARY 2015 TO DECEMBER 2016

3.1 The table below shows that training compliance has remained steady throughout the above period. The fall in compliance between May and December 2016 was expected with the introduction of the new training system, the detail of which is summarised in a later section. It is anticipated that compliance will continue to improve as the new system beds in and managers and staff continue to check the data that was transferred from the previous system.

Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Training validation exercise		85%	85%	86%	*Introduction of new Learn2gether training administration system*						80%
Jan-15	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**
84%	82%	82%	82%		83%		83%		85%		86%

3.2 The above data reveals that the highest compliance over the period was in December 2015 and May 2016 when it stood at 86%. Further monitoring will demonstrate whether the newly implemented system will have an additional positive impact on compliance as managers now have access to up-to-date information which they can act on in a timely way.

4. BACKGROUND TO LEARN2GETHER

4.1 In June 2016, Learn2gether, a new training software package based on the Moodle platform, was introduced. This system provides both e-learning, recording and reporting functionality for statutory and mandatory training. The new system is operational but is still being embedded and has further longer term functionality opportunities.

4.2 The new system allows for changes to be made to training profiles at an individual level which previously the Electronic Staff Record was unable to do and this should help further improve the quality of the data presented. It also provides managers with more up to date information than the previous system. Managers can access real-time reports at any time rather than waiting for the information to be collated and posted on the Trusts Share Point site monthly.

4.3 Very positively, initial manager and staff feedback suggests that they are now finding e-learning easier to access, there are fewer technical problems and that the recording of completed training is much more reliable. Managers are generally finding the system helps them to better monitor and manage their staff compliance rates.

4.4 In terms of additional functionality and effectiveness, further work will be progressed during Q4 to transfer appraisal compliance via the Learn2gether system.

5. EMBEDDING AND DEVELOPING LEARN2GETHER

5.1 In order to ensure optimal roll out, functionality and future development, Ruth Thomas, Head of Training, has been working with other senior managers on a delivery plan presented to the Delivery Committee in Spring 2016. Progress against the plan is

highlighted in the report's next section. This has included work on developing and delivering a programme of focussed assurance, reconciling data and confirming staff structures and related profiles.

5.2 There was an initial suggestion at Delivery Committee that there should be a manual process of reconciliation but it was agreed that this would have been disproportionally time consuming. So, as an alternative, in November 2016, it was agreed that Service Directors would identify one team and carry out a manual audit/reconciliation of a sample of courses. Some external support was also commissioned. This process is currently under way.

5.3 A number of "clinic" sessions for managers and staff have already taken place. Through this and other fora, any identified changes or inconsistencies are being altered on the system as soon as they are identified. The first day of formal clinic sessions was on 12th January, with a range of further dates now available into Spring.

5.4 There is also an on-going reconciliation of training required against the training identified in policies so that Learn2gether fully identifies the correct profile for each individual and provides assurance that training requirements are accurately captured. Subject Matter Experts have been asked to confirm the training requirements for each of their subjects and the Training Matrix is being revised and will be republished shortly.

5.5 Reconciliation of the system is to be completed by 31st March 2017.

5.6 Due to a wide combination of factors -- these include more accurate training profiles, improved data quality and an increase in the take up of training places -- the reported compliance (Trust Overall) has increased from 66% in August 2016 (the first reported data from the new training system) to 80% in December and, so far, in January 2017 to 82%.

5.7 Going forward, a process is being established whereby a system proforma will be emailed to all managers at the end of each month to identify if their staff are:

- On longer term sickness absence and need to be excluded
- A new recruit and therefore, and thus have a lead in time to complete training
- Identified by Working Well as medically excluded

5.8 Monthly meetings to review progress are in place and are being managed by Ruth Thomas, Jan Furniaux and Sarah Batten.

6. PROGRESS AGAINST THE LEARN2GETHER DELIVERY PLAN

6.1 A summary is presented below of progress with the implementation plan taken to the Delivery Committee in Spring 2016 with delivery RAG rating.

Action	Action Owner (s)	Date	Narrative	RAG
Agree Programme for focussed assurance	Sarah Batten & Ruth Thomas	7th Nov 2016	Meeting with Ruth Thomas. Services wide plan developed.	
Identify Individual Lead	Ruth Thomas & Jan Furniaux	7th Nov	Tim Coupland engaged. First date due for 12/01/16	
Seek approval and funding	Ruth Thomas & Colin Merker	By 23rd Nov	Agreed	
Engagement of Policy Holders/subject leads	Ruth Thomas	By 30th Nov	Commenced and on-going. Survey of users being drafted to obtain further feedback.	
Meet with Director of OD & HR	Ruth Thomas, Jan Furniaux, Sarah Batten	Nov 16th	Programme discussed, reviewed and agreed	
Monthly Programme meetings	Ruth Thomas, Jan Furniaux, Sarah Batten	7th Nov	5/12, 13/01, 6/2, 6/3	
System reconciliation to be complete.	Ruth Thomas & Tim Coupland	March 31st 2017	Exception report to Trust Delivery monthly any challenges to timeline	
Additional Identifiers	Ruth Thomas and Collingwood Admin	March 31st	Establish a system/proforma for use to maintain assurance	
Report to Trust Delivery Committee	Ruth Thomas, Jan Furniaux & Sarah Batten	April 2017		

6.2 It should be noted that the Delivery Committee will receive a progress report in April 2017.

7. FURTHER WORK TO ENSURE IMPROVED COMPLIANCE

7.1 A number of actions are being progressed which will further improve compliance, including:

- Continuing to support and progress the accuracy of training data compliance
- Additional training on how to use the new system. Managers and staff continue to make use of the facility that the Training administration team have of remotely accessing staff PC's to help them log on to the Learn2gether system
- All managers and staff continuing to check training records reporting any discrepancies to the Training administration team promptly so that they can be rectified
- Complete training capture on Learn2gether. Currently, not all training sessions are booked via the main Training Centre and some of these do not yet appear on the Learn2gether system. This is because training is booked directly with the trainer. We are developing a process whereby all training will now be recorded onto the new system. This will mean that bookings will appear on staff records, that reminder e-mails will be sent and that the process of tracking registers will be easier. This is expected to be completed by the end of Q2 in 2017

7.2 Additionally, the Board should note that work is currently underway with the Staff Bank Manager to ensure the training system accurately reflects training requirements for all bank staff. This process is more difficult than for substantive staff as bank staff can work in a number of different locations or move regularly.

7.3 Finally, two other key elements of future work have been identified to develop and improve compliance going forwards. These are: -

- a review of the Trust's approach to its compliance target and exclusions. This will include an external benchmarking exercise and will aim to achieve challenging but deliverable compliance targets. This will also agree the future approach to performance managing both team and individual compliance
- the option to develop a new multi-disciplinary governance mechanism for overseeing, challenging and confirming the inclusion of training as either statutory or mandatory. This will include oversight on content, delivery methodology, duration, frequency and on-going review

7.4 These latter points will be progressed initially through the Executive Committee.

Agenda item 9 **Enclosure Paper D**

Report to: 2gether NHS Foundation Trust Board - 26th January 2017
Author: Shaun Clee – Chief Executive
Presented by: Shaun Clee – Chief Executive

SUBJECT: **Chief Executive's Report**

Can this report be discussed at a public Board meeting?	***Yes***
If not, explain why	

This Report is provided for:
Decision Endorsement Assurance **To Note**

EXECUTIVE SUMMARY

This paper provides the Board with:
1. An update on key national communications via the NHS England NHS News
2. A summary of key progress against organisational major projects

RECOMMENDATIONS

The Board is asked to note the contents of this report

Corporate Considerations	
Quality implications:	
Resource implications:	
Equalities implications:	
Risk implications:	

WHICH TRUST STRATEGIC OBJECTIVE(S) DOES THIS PAPER PROGRESS OR CHALLENGE?	
Continuously Improving Quality	P
Increasing Engagement	P
Ensuring Sustainability	P

WHICH TRUST VALUE(S) DOES THIS PAPER PROGRESS OR CHALLENGE?			
Seeing from a service user perspective			
Excelling and improving	P	Inclusive open and honest	P
Responsive		Can do	C
Valuing and respectful	P	Efficient	C

Reviewed by:		
Executive Team	Date	

Where in the Trust has this been discussed before?		
CEO	Date	*13.01.17*

What consultation has there been?		
N/A	Date	

Explanation of acronyms used:	

1. CONTEXT

1.1 National Context

1.1.1 Children and Young People's Mental Health Research Campaign

As part of Children's Mental Health Week the National Institute for Health Research (NIHR) has launched a Children and Young People's Mental Health Research Campaign to highlight that children and young people have the right to take part in research. Mental health research offers children and young people the opportunity to access cutting-edge treatments and to have a say in how new treatments are developed.

1.1.2 One year on from Future in Mind - Vision to Implementation,

In March 2016 it will have been a year since the publication of Future in Mind, setting the direction of travel for children and young people's mental health. The focus of this event will be how to move forward from the vision of a joined up system to implementation. It is aimed at all partners helping to improve children and young people's mental health, whether within the NHS, a local authority, education or the third sector.

1.1.3 NHS commits to major transformation of mental health care with help for a million more people

The Mental Health Taskforce has published its Five Year Forward View with recommendations for changing and developing mental health care across the NHS. It calls for £1 billion investment to help over a million more people to access the services they need.

1.1.4 New training to support mental health professionals to tackle stigma and discrimination within services

A new training pack has been launched to help reduce the stigma and discrimination sometimes experienced by people when using mental health services. Insight from research, focus groups and individual interviews, demonstrated that a high number of people using mental health services felt they experienced stigma and discrimination. This helped Time To Change to work with mental health professionals and service users to identify examples of good practice as well as the barriers which can sometimes stand in the way of positive interactions. The resulting training pack focuses on the positive changes which can improve both team culture and working practices.

1.1.5 Inspiring leaders in learning disability services

Health Education England has launched a new campaign, to encourage leadership in learning disability services across health and social care. Strong leadership is vital for the delivery of change needed to achieve the aims of the Transforming Care Programme. Be inspired by Daniel Marsden's story and take a look at the leadership training courses available to you. You can also join the conversation on Twitter using #inspiringleadersinLD and say thank you to great leaders who've influenced your practice

1.2 Delivering our Three Strategic Priorities

1.2.1 Continuously Improving Quality

1.2.2 Building Engagement

Board Engagement Report – November 2016

Internal Board Engagement

01.11.16 The Director of Finance and Commerce chaired an Internal Appeal against Dismissal Hearing
02.11.16 The Director of Finance and Commerce attended Audit Committee
03.11.16 The Director of Organisational Development chaired the Workforce & Organisational Development Sub Committee
07.11.16 The Director of Service Delivery attended the Executive Business Meeting
07.11.16 The Director of Service Delivery attended the Senior Leadership Forum Meeting
07.11.16 The Director of Organisational Development attended the Senior Leadership Forum
08.11.16 The Director of Organisational Development attended the Trust-wide Quality Improvement Project Board
09.11.16 The Medical Director attended a Patient Safety Visit at Jenny Lind Ward, Stonebow Unit, Hereford
09.11.16 The Medical Director attended a Patient Safety Visit at the ECT Suite, Stonebow Unit, Hereford
09.11.16 The Medical Director attended the CYPS Consultant meeting
10.11.16 The Director of Organisational Development attended the Council of Governors
14.11.16 The Director of Engagement and Integration joined the 'meet and greet' new colleagues team at Corporate Induction
14.11.16 The Director of Service Delivery attended the Executive Development Meeting

15.11.16 The Director of Organisational Development chaired the Occupational Health & Safety Sub Committee
16.11.16 The Director of Service Delivery attended the JNCC Meeting
16.11.16 The Director of Organisational Development attended JNCC
16.11.16 The Director of Engagement and Integration conducted a Board Visit at Children and Young Persons Services at Park House in Stroud
18.11.16 The Director of Engagement and Integration attended the Governance Committee
21.11.16 The Director of Service Delivery attended the Executive Business Meeting
22.11.16 The Director of Finance and Commerce held a mentoring session with Pawel Abramik of NHS Leadership Academy
23.11.16 The Director of Service Delivery attended the Delivery Committee Meeting
23.11.16 The Director of Engagement and Integration conducted a Patient Safety Visit with the Cheltenham Crisis Team
23.11.16 The Director of Engagement and Integration conducted a Patient Safety Visit at the ECT Suite at Wotton Lawn Hospital
24.11.16 The Director of Finance and Commerce attended Board
24.11.16 The Director of Engagement and Integration attended the Board Meeting
24.11.16 The Director of Organisational Development attended Trust Board Meeting
24.11.16 The Director of Service Delivery attended the Board Meeting
28.11.16 The Director of Service Delivery attended the Executive Development Meeting
28.11.16 The Director of Engagement and Integration joined the 'meet and greet' new colleagues team at Corporate Induction
29.11.16 The Director of Finance and Commerce was a Panel Member at the Head of Contracts and Commissioner Relationships interview day

Board Stakeholder Engagement

01.11.16 The Medical Director attended a meeting with GPs.
01.11.16 The Director of Service Delivery attended the NMOC Board
01.11.16 The Director of Service Delivery attended the Countywide IM&T meeting
02.11.16 The Chief Executive attended the Countywide IM&T Meeting
02.11.16 The Director of Service Delivery attended the Charitable Funds Committee
02.11.16 The Director of Service Delivery attended the New Surgery Development Meeting
02.11.16 The Director of Finance and Commerce attended a Quarterly Internal Audit Meeting with PwC
03.11.16 The Medical Director attended a meeting with Dorset NHSFT
03.11.16 The Director of Finance and Commerce attended a Board Visit to Hereford East Recovery Team, with Carine Robinson
03.11.16 The Director of Service Delivery attended the AMHP cover meeting
03.11.16 The Director of Service Delivery met with the Head of Learning Disabilities from Berkshire NHS FT
04.11.16 The Director of Service Delivery attended the Primary Care Mental Health Services - TN&S Meeting
08.11.16 The Director of Service Delivery attended the A & E Delivery Board
08.11.16 The Director of Service Delivery attended the CYPS/CAMHS Management Changes Meeting in Hereford
08.11.16 The Director of Service Delivery attended the Joined up Working Opportunities Meeting in Hereford
08.11.16 The Director of Finance and Commerce attended a Resources Steering Group Meeting at Glos CCG
08.11.16 The Director of Service Delivery attended the Gloucestershire Health and Social Care Awards Evening

08.11.16 The Director of Engagement and Integration met with Bishop Rachel Trewick, Ruth FitzJohn and stakeholders for Gloucestershire Children and Young Peoples Services
09.11.16 The Director of Organisational Development supported the interview process to recruit the new CEO of Worcestershire Acute Hospitals NHS Trust
09.11.16 The Director of Service Delivery attended the MH Legislation Scrutiny Committee Meeting
09.11.16 The Director of Service Delivery attended the Crisis Service Development Meeting
09.11.16 The Director of Service Delivery met with representatives from Wye Valley Trust
10.11.16 The Director of Service Delivery attended the STP Programme Development Group Meeting (JUYC)
10.11.16 The Director of Service Delivery attended the Council of Governors Meeting
10.11.16 The Director of Engagement and Integration attended the 2gether Time to Change Facilitator Meeting
11.11.16 The Medical Director held a meeting with relatives following a serious incident
11.11.16 The Director of Service Delivery attended the Primary Care MH Services Tewkesbury, Naunton & Staunton Meeting
11.11.16 The Director of Service Delivery attended the EDT Meeting
14.11.16 The Director of Service Delivery attended the Gloucestershire Whole System Resilience & Escalation Meeting
14.11.16 The Director of Service Delivery attended the E Roster - Senior Team meeting with Allocate
15.11.16 The Director of Engagement and Integration attended the Gloucestershire Health Care Overview and Scrutiny Committee Meeting
15.11.16 The Director of Engagement and Integration met with colleagues from Crossroads at the Belle Vue Centre in Cinderford
15.11.16 The Director of Service Delivery attended the S&BV Cluster 4 Meeting
16.11.16 The Director of Service Delivery attended the Swindon Mind & 2gether - Strategic Partnership Meeting
16.11.16 The Director of Engagement and Integration chaired a partnership meeting with colleagues from 2gether and Swindon Mind
16.11.16 The Director of Finance and Commerce attended a Strategic Partnership Meeting with Swindon Mind
17.11.16 The Director of Finance and Commerce attended a Contract Monitoring Meeting with Herefordshire CCG
17.11.16 The Director of Organisational Development attended the Takeover Challenge Magic Wand Event organised by Action for Children in partnership with 2gether CYPS
17.11.16 The Director of Engagement and Integration attended a Joint Strategic Needs Assessment Working Group meeting organised by colleagues from Herefordshire Public Health
17.11.16 The Director of Service Delivery attended the STP Delivery Board Meeting
17.11.16 The Director of Service Delivery attended the S&BV Pilot Board Meeting
17.11.16 The Director of Service Delivery attended the Clinical Programme Board Meeting
18.11.16 The Director of Service Delivery attended the Engaging with 4x localities in Herefordshire Meeting
18.11.16 The Director of Service Delivery attended the Configuring Services Meeting in Hereford
18.11.16 The Director of Service Delivery attended the Psychiatric Liaison Meeting in Hereford
18.11.16 The Director of Engagement and Integration met with the CEO from Carers Gloucestershire
18.11.16 The Director of Engagement and Integration met with the CEO and Chair of Healthwatch Gloucestershire

21.11.16 The Director of Service Delivery attended the Primary Care MH Services Tewkesbury, Naunton & Staunton Meeting
21.11.16 The Director of Service Delivery attended the Urgent Care Programme Board Meeting
21.11.16 The Director of Service Delivery attended the Acute Patient Pathway - Medical Support Arrangements Meeting
21.11.16 The Director of Service Delivery attended the AO & REHAB Pathway - Medical Support Arrangements Meeting
22.11.16 The Director of Service Delivery attended the Senior Management Team Meeting
22.11.16 The Director of Service Delivery attended the LDR Infrastructure Delivery Group Meeting
22.11.16 The Director of Service Delivery attended the Perinatal Stocktake Meeting
22.11.16 The Director of Organisational Development attended the first meeting of the Herefordshire & Worcestershire STP HR Directors Working Group
22.11.16 The Director of Engagement and Integration Chaired the Tackling Mental Health Stigma Group meeting at Sanger House
22.11.16 The Director of Finance and Commerce attended a Herefordshire Workstream Meeting with Herefordshire CCG
22.11.16 The Director of Finance and Commerce attended a Takeover Challenge Event with Quinton Quayle
23.11.16 The Medical Director held a meeting with relatives following a serious incident
23.11.16 The Director of Finance and Commerce attended a 2017-19 Contract Finance Offer Meeting with Herefordshire CCG
23.11.16 The Director of Service Delivery attended the Pilot Board for Glos City Meeting
25.11.16 The Director of Service Delivery attended the CYPS Pathway/Data Meeting with GRH – Update Meeting
25.11.16 The Medical Director held a meeting with relatives following a serious incident
25.11.16 The Director of Finance and Commerce attended a Countywide Finance and Information Away Day at The Chase Hotel
28.11.16 The Director of Service Delivery attended the 2g/Hereford Contract Meeting 17/19 in Hereford
28.11.16 The Director of Engagement and Integration attended a Link Director Workshop held at Gloucestershire Royal Hospital's Education Centre
28.11.16 The Director of Finance and Commerce attended a Hereford Contract Meeting with Herefordshire CGG
29.11.16 The Director of Service Delivery attended the Gloucestershire LDR Feedback Meeting
29.11.16 The Director of Service Delivery attended the Herefordshire AO Follow Up Meeting
30.11.16 The Medical Director attended the annual contract meeting with HESW
30.11.16 The Director of Service Delivery attended the Gloucester City MH Pilots Meeting
30.11.16 The Director of Service Delivery attended the 2gether GCCG Negotiation Meeting
30.11.16 The Director of Finance and Commerce attended SLR/PLICS Project Board
30.11.16 The Director of Finance and Commerce attended a Contract Negotiation Meeting with Gloucestershire CCG

Board National Engagement

02.11.16 The Chief Executive chaired the Patient Safety Collaborative
02.11.16 The Director of Organisational Development met with Mike Robinson, CEO of British Safety Council
04.11.16 The Chief Executive attended the NHSi making change happen seminar

10.11.16 The Chief Executive attended the launch of the Chaffinch Trust at Buckingham Palace

Board Engagement Report – December 2016

Internal Board Engagement

01.12.16 The Director of Finance and Commerce attended an Introduction Meeting with Neil Savage, newly appointed Director of Organisational Development
02.12.16 The Director of Service Delivery attended the Senior Operational Management/Leadership away day
05.12.16 The Director of Service Delivery attended the Executive Business Meeting
05.12.16 The Director of Service Delivery attended the Senior Leadership Forum
08.12.16 The Director of Organisational Development attended the Trust-wide Quality Improvement Project Board
09.12.16 The Director of Engagement and Integration met with the Director of Organisational Development as part of his induction
12.12.16 The Director of Service Delivery attended the Executive Development Meeting
12.12.16 The Director of Organisational Development attended Corporate Induction to meet new Trust employees
15.12.16 The Director of Organisational Development attended the Transformation (CIP) Project Board
16.12.16 The Director of Engagement and Integration attended the Governance Committee
19.12.16 The Director of Service Delivery attended the Executive Business Meeting
21.12.16 The Director of Organisational Development attended the Development Committee
21.12.16 The Director of Finance and Commerce attended Development Committee
22.12.16 The Director of Finance and Commerce attended Board
22.12.16 The Director of Service Delivery attended the Board Meeting
22.12.16 The Director of Organisational Development attended Trust Board Meeting
22.12.16 The Director of Engagement and Integration attended the Board Meeting
29.12.16 The Chief Executive visited colleagues at Charlton Lane
29.12.16 The Chief Executive visited colleagues at Wotton Lawn

Board Stakeholder Engagement

01.12.16 The Director of Service Delivery attended the STP - CEO Meeting
01.12.16 The Director of Organisational Development attended the Alexandra Wellbeing House Open Day with Swindon Mind
01.12.16 The Director of Organisational Development attended / co-facilitated the Herefordshire & Worcestershire STP Workforce and OD Strategy Workshop
01.12.16 The Director of Engagement and Integration attended a meeting with professional colleagues from the University of the West of England at the Fritchie Centre, Charlton Lane, Cheltenham
01.12.16 The Director of Engagement and Integration attended the open day of the Alexandra House with Swindon Mind
01.12.16 The Director of Engagement and Integration attended a meeting with the Police and Crime Commissioner at the Police Headquarters at Waterwells, Gloucester
01.12.16 The Director of Finance and Commerce attended a Contract Performance and Information Meeting with Herefordshire CCG
02.12.16 The Medical Director held a meeting with relatives following a serious incident
02.12.16 The Director of Finance and Commerce attended a Contract Negotiation Meeting with Herefordshire CCG

06.12.16 The Chief Executive chaired the inaugural meeting of the Improvement Academy Steering Group
06.12.16 The Chief Executive attended the Gloucestershire Strategic Forum
06.12.16 The Director of Service Delivery attended the Mental Health Matters Helpline Presentation
06.12.16 The Director of Finance and Commerce attended a SLR Business Rules and Assumptions Meeting
06.12.16 The Director of Service Delivery participated in the Gloucestershire Clients Meeting (teleconference)
06.12.16 The Director of Organisational Development attended the inaugural meeting of the Improvement Academy Steering Group
07.12.16 The Director of Engagement and Integration attended a Local Clinical Research Network Partnership Group meeting at Kingsholm
07.12.16 The Director of Engagement and Integration met with the Engagement Lead for Gloucestershire Care Services
07.12.16 The Director of Engagement and Integration provided keynote presentation at Research 4 Gloucestershire Seminar at the University of Gloucestershire
08.12.16 The Director of Service Delivery attended the Senior Management Meeting
08.12.16 The Director of Service Delivery attended the Treasure Seekers PA - Police HQ, Waterwells
08.12.16 The Director of Organisational Development attended the Herefordshire and Worcestershire STP Workforce and OD Working Group
09.12.16 The Director of Engagement and Integration attended the Bishops Breakfast and co-facilitated a conversation about Children and Young People's Mental Health
13.12.16 The Chief Executive attended the Worcestershire STP Programme Board
13.12.16 The Chief Executive attended the Gloucestershire Contract Negotiation meeting
13.12.16 The Director of Service Delivery attended the A & E Delivery Board Meeting
13.12.16 The Director of Service Delivery attended the Joining Up Your Information Project Board Meeting
13.12.16 The Director of Finance and Commerce attended a Resources Steering Group Meeting at Glos CCG
13.12.16 The Director of Finance and Commerce attended a Contract Meeting with Gloucestershire CCG
13.12.16 The Director of Service Delivery attended the 2gether 17/18 Contract Meeting
13.12.16 The Director of Engagement and Integration co-facilitated an event for Herefordshire Councillors at Stonebow in Hereford
14.12.16 The Director of Organisational Development attended the Gloucestershire STP HR and OD workstream meeting
14.12.16 The Director of Engagement and Integration attended a Forest of Dean Community Services Steering Group meeting at Edward Jenner Court
14.12.16 The Director of Service Delivery attended CYPS Evergreen on a Board visit
15.12.16 The Director of Service Delivery attended the STP Delivery Board Meeting
15.12.16 The Director of Service Delivery attended the 2gether CMB Meeting in Hereford
15.12.16 The Director of Engagement and Integration chaired the multiagency Research and Development Consortium Meeting at Gloucestershire Care Services Headquarters, Edward Jenner Court
16.12.16 The Director of Service Delivery attended the Medicines Optimisation CCG/2G NHSFT Meeting
16.12.16 The Director of Service Delivery attended the Networking Project Finance Meeting between GHC and Updata
19.12.16 The Director of Service Delivery attended the 2gether Contract meeting
20.12.16 The Chief Executive attended the Gloucestershire STP Advisory Group meeting
20.12.16 The Chief Executive attended the Pilot Board for Gloucester City
20.12.16 The Chief Executive attended the Herefordshire contract meeting
20.12.16 The Director of Service Delivery attended the Action for Children meeting

20.12.16 The Director of Service Delivery attended the Pilot Board for Gloucester City Meeting
20.12.16 The Director of Service Delivery attended the Hereford Contract Meeting
20.12.16 The Director of Engagement and Integration met with the Matron of Wotton Lawn Hospital
20.12.16 The Director of Engagement and Integration met with Professor Wilcock to discuss the Fritchie Centre developments
20.12.16 The Director of Finance and Commerce attended a Contract Meeting with Herefordshire CCG
20.12.16 The Director of Engagement and Integration met with a member of the Pied Piper Appeal
21.12.16 The Director of Organisational Development attended the Herefordshire and Worcestershire STP Workforce and OD Working Group
29.12.16 The Director of Finance and Commerce attended a Patient Safety Visit, with Sally Ashton to Oak House, Hereford and met with Greg Luetchford

Board National Engagement

01.12.16 The Director of Engagement and Integration was a guest speaker to the Allied Health Professionals Faculty at the University of the West of England in Bristol
07.12.16 to 09.12.16 The Director of Finance and Commerce attended the HFMA Annual Conference in London
08.12.16 The Chief Executive attended the NHS Confederation Board or Trustees meeting
09.12.16 The Chief Executive chaired the SW MH CEO's forum
08.12.16 The Director of Engagement and Integration attended the College of Occupational Therapists Fellowship Committee Meeting
23.12.16 The Director of Engagement and Integration met with the National Lead for Veterans Mental Health for NHS England
15.12.16 The Chief Executive attended the half yearly meeting of the Patient Safety Collaborative

Major Project Update – January 2017

Smoking Cessation quality

The Trust's objective is to achieve, by 03 April 2017, full implementation of the National Institute for Clinical Excellence - NICE (2013) PH 48 - Smoking Cessation in secondary care: acute, maternity, and mental health services. NHS England now recommends that all mental health inpatient units and facilities be smoke free by 2018. The Trust has a duty of care to provide staff and service users with support to stop or abstain from smoking while using or working in our services.

Staff and service user engagement continues. The Trust has trained a number of 'Level 2 Quit Advisors' who can help support and/or signpost staff who wish to undertake a quit attempt and the Trust's 'Working Well' Team are also available to provide help and support to staff. Training in Level 1 (1 hour brief awareness) for all clinical staff together with an additional 1 hour training course in NRT (Nicotine Replacement Therapies) have been scheduled between January and March.

A 'soft start' approach to the implementation has already been adopted. Once staff have received training, all patients will be offered NRT on admission and given support to quit and/or abstain from smoking.

Communication is well underway with a section on the Trust's intranet for the smoke free project, containing a 'count-down clock' and advice for staff who wish to quit smoking. The Project Lead and Deputy Director of Nursing continue to attend team and community meetings etc to raise the profile of the smoke free project.

Temporary Staffing Demand **sustainability/quality**

The Executive Team continues to monitor, on a weekly basis, the use of agency (agency spend and shifts covered), and the effectiveness of the improvement actions. In addition, the project board meets monthly, and the matrons meet fortnightly to pursue improvements and actions.

The key aim is to be within 25% of the 2016/17 agency spend ceiling set by the NHSI (the ceiling set was 38% less than the 2015/16 actual spend). In preparation for e-rostering and to reduce shift cover for the Christmas and New Year fortnight, rosters were produced 6-8 weeks in advance, initiatives were put in place to encourage bank staff to work over that period, and on-framework agencies were pre-booked to mitigate urgent demand. As a consequence, the demand for agency and shift cover was significantly lower than the same period last year.

E-rostering will be implemented between January and April, and in addition, 'direct engagement' of locums commences in January. These actions will result in further savings and reduction in agency demand within the Trust. During the next quarter, use of partnership working to achieve improved agency rates, and weekly pay for staff bank will be pursued.

Gloucester City Hub **sustainability/quality**

The project has now reached the stage where tenders have been invited from a list of selected contractors. This stage will be completed by mid-February and, following a period of time to analyse the tenders, a contractor should be appointed in early March.

The overall project programme and the budget have been reviewed in the light of emerging information. Following a detailed survey which identified the poor condition of the mechanical and electrical equipment in the building, the budget has been increased to include its replacement. It was also decided that the most efficient and cost effective way of completing the construction works is with a single contractor and not phased work by different contractors. Hence, the works are now programmed for completion in Autumn 2017.

The consultation process for the design continues with service users to finalise the detail within the building and with staff to agree the location of all the different services office accommodation.

Improving Care Through Technology **sustainability**

Activity in Herefordshire has now transitioned out of project and into Business As Usual activities and are being managed by Countywide IT Services' operational teams. The Trust "L and P drives" that had been on various pieces of server infrastructure have been moved to our current storage and back-up platform.

In Gloucestershire, the project team has been deploying laptops to colleagues in group sessions at Lexham Lodge since the beginning of December, in a similar fashion to the approach taken in Herefordshire. These sessions will continue until the end of January, after which time up to date computers will have been deployed to the majority of Gloucestershire based colleagues. 171 laptops were deployed during December, and at least another 144 laptops will be deployed during January.

Agenda Item 10 Enclosure No Paper E

Report to: 2gether NHS Foundation Trust Board 26th January 2017
Author: Stephen Andrews, Deputy Director of Finance
Presented by: Andrew Lee, Director of Finance and Commerce

SUBJECT: **Summary Finance report for period ending 31st December 2016**

Can this report be discussed at a public Board meeting?	Yes
If not, explain why	

This Report is provided for:
Decision Endorsement **Assurance** **Information**

EXECUTIVE SUMMARY

- The month 9 position is a surplus of £293k in line with the planned position. The budgets have been revised to include the £650k Sustainability and Transformation Fund monies that have been allocated to the Trust. Three quarters of this fund have been included at the month 9 position.
- The Trust was allocated £650k from the Sustainability and Transformation Fund (STF) by NHS Improvement. The Trust also had its 2016/17 control total of a surplus of £4k adjusted upward by £650k to a revised 2016/17 revenue control total of £654k surplus.
- Despite a number of cost pressures arising in recent weeks the Trust anticipates it will still meet its financial control total. The Trust has recently introduced tight controls on discretionary spend for the remainder of the financial year. The month 9 forecast outturn is a £654k surplus, excluding impairments, as per the revised revenue control total and Trust budgets. The Trust is anticipating it will meet its targets and receive the full allocation from the STF.
- NHS Improvement has introduced a new Oversight Framework from the 1st October. Under this framework the Trust has been informed that our segment is a 2, with 1 being the highest score, 4 being the lowest.
- The Trust has a revised forecast agency spend taking into account the impact of the considerable number of actions taken of £4.812m at month 9, which is above the £3.404m control in 2015/16. This equates to achievement of 33% of NHS I's required reduction in agency spend in 2016/17. The Trust has seen a recent increase in agency spend due to the need to recruit additional staff to meet IAPT targets and in order to cover medical staffing vacancies.
- The Trust has nearly completed budget setting for next year following submission of the Operational Plan in December, and has updated its financial projections for the next five years in this report.
- The Trust has signed two year contracts with its three main commissioners for 2017 to 2019.

RECOMMENDATIONS

It is recommended that the Board:

- note the month 9 position
- note the reasons for variances from budget and risks to delivery of the financial plans

Corporate Considerations	
Quality implications:	None identified
Resource implications:	Identified in the report
Equalities implications:	None
Risk implications:	Identified in the report

WHICH TRUST KEY STRATEGIC OBJECTIVES DOES THIS PAPER PROGRESS OR CHALLENGE?	
Continuously Improving Quality	
Increasing Engagement	
Ensuring Sustainability	P

WHICH TRUST VALUES DOES THIS PAPER PROGRESS OR CHALLENGE?			
Seeing from a service user perspective			
Excelling and improving	x	Inclusive open and honest	
Responsive		Can do	
Valuing and respectful		Efficient	x

Reviewed by: Andrew Lee, Director of Finance and Commerce		
	Date	16th January 2017

Where in the Trust has this been discussed before?		
	Date	

What consultation has there been?		
	Date	

Explanation of acronyms used:	See footnotes

1. CONTEXT

The Board has a responsibility to monitor and manage the performance of the Trust. This report presents the financial position and forecasts for consideration by the Board.

2. EXECUTIVE SUMMARY

The following table details headline financial performance indicators for the Trust in a traffic light format driven by the parameters detailed below. Red indicates that significant variance from plan, amber that performance is close to plan and green that performance is in line with plan or better.

Indicator	**Measure**		
Year End I&E	Single Oversight Framework Segment	2.00	Confirmed by NHS I at quarter 2
Income	FOT vs FT Plan	102.6%	
Operating Expenditure	FOT vs FT Plan	102.0%	
Cash	Number of creditor days	23	Balance of £13.9m (including investments) which equates to 23 creditor days.
PSPP	%age of invoices paid within 30 days	97.0%	86% paid in 10 days
Capital Income	Monthly vs FT Plan	99.4%	
Capital Expenditure	Monthly vs FT Plan	94.5%	£8,513k expenditure.

The parameters for the traffic light dashboard are detailed below:

INDICATOR	RED 	AMBER 	GREEN 
NHS Improvement FOT segment score	>3	2.5 - 3	<2.5
INCOME FOT vs FT Plan	<99%	99% - 100%	>100%
Expenditure FOT vs FT Plan	>100%	99% - 100%	<99%
CASH	<15 days	15-40	>40 days
Public Sector Payment Policy - YTD	<80%	80% - 95%	>95%
Capital Income - Monthly vs FT Plan	<90%	90% - 100%	>100%
Capital Expenditure - Monthly vs FT Pla	>115% or <85%	110% - 115% or 85% to 90%	>90% to <110%

- The financial position of the Trust at month 9 is a surplus of £293k which is in line with the plan.
- Income is £1,739k over recovered against budget and operational expenditure is £1,185k over spent, and non-operational items are £554k over spent.

The table below highlights the performance against expenditure budgets for all localities and directorates for the year to date, plus the total income position.

Trust Summary	Annual Budget £000	Budget to Date £000	Actuals to Date £000	Variance to Date £000	Year End Forecast £000	Year End Variance £000
Cheltenham & N Cots Locality	(4,862)	(3,646)	(3,661)	(15)	(4,891)	(29)
Stroud & S Cots Locality	(3,990)	(2,988)	(3,232)	(245)	(4,361)	(371)
Gloucester & Forest Locality	(4,220)	(3,167)	(3,151)	16	(4,198)	22
Social Care Management	(3,806)	(2,855)	(3,668)	(814)	(4,914)	(1,107)
Entry Level	(5,892)	(4,293)	(4,299)	(5)	(5,853)	39
Countywide	(29,585)	(22,156)	(22,556)	(400)	(30,352)	(767)
Children & Young People's Service	(6,216)	(4,650)	(4,153)	497	(5,771)	445
Herefordshire Services	(12,434)	(9,324)	(9,792)	(469)	(13,091)	(657)
Medical	(14,881)	(11,161)	(11,854)	(693)	(15,780)	(899)
Board	(1,658)	(1,244)	(1,241)	2	(1,753)	(95)
Internal Customer Services	(1,792)	(1,348)	(1,283)	65	(1,795)	(3)
Finance & Commerce	(6,627)	(4,911)	(4,827)	84	(6,404)	223
HR & Organisational Development	(3,134)	(2,352)	(2,465)	(113)	(3,266)	(132)
Quality & Performance	(2,721)	(2,023)	(2,080)	(57)	(2,808)	(87)
Engagement & Integration	(1,343)	(1,007)	(1,002)	5	(1,398)	(55)
Operations Directorate	(1,197)	(865)	(894)	(29)	(1,221)	(24)
Other (incl. provisional / savings / dep'n / PDC)	(4,231)	(3,429)	(2,966)	463	(3,499)	732
Income	109,242	81,710	83,418	1,707	112,008	2,766
TOTAL	**654**	**291**	**293**	**2**	**654**	**0**

The key points are summarised below;

In month

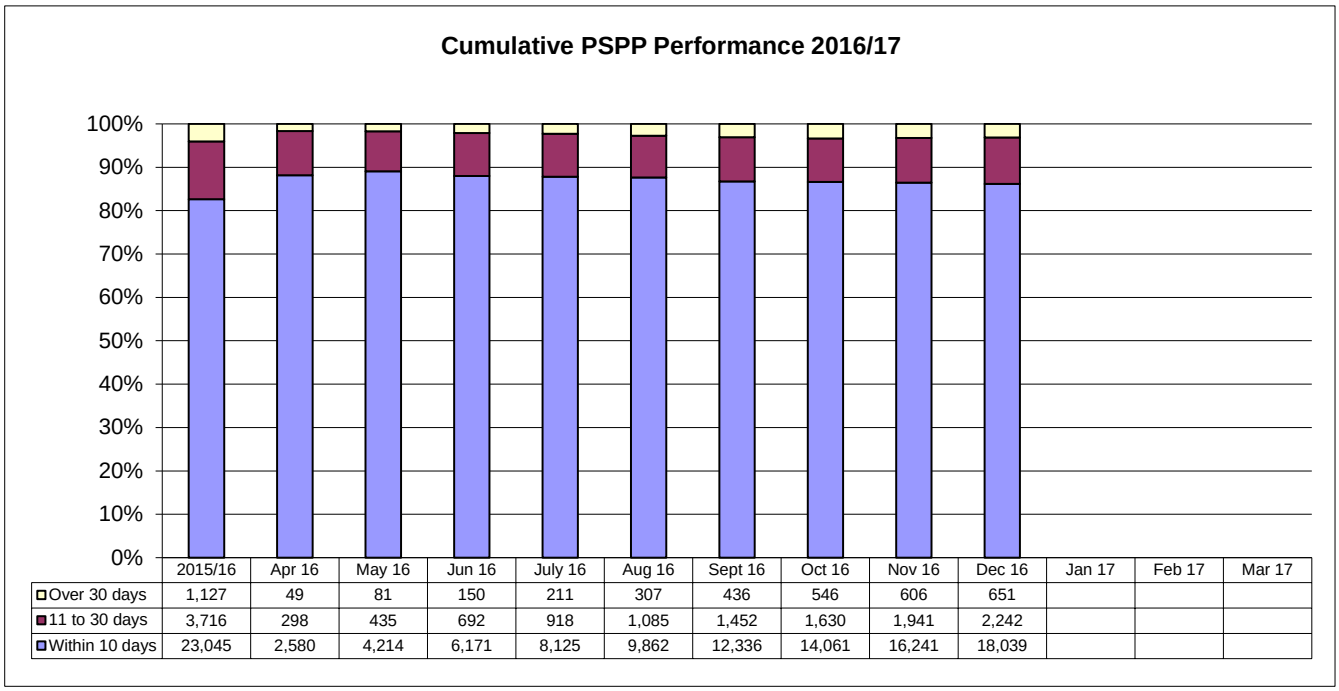
- Stroud locality was over spent due to higher than budgeted Supporting People costs. This is matched by additional income.
- Social Care Management was over spent due to over performance against the funded level for Community Care, which is offset by additional income. Expenditure is being
- Herefordshire was over spent due to agency costs to cover specialling costs on Mortimer and Cantilupe wards, and significant vacancies across the wards.
- CYPs was under spent due to a number of vacancies across many services.
- Medical budgets over spent due to agency usage in Countywide, Children and Young People, Herefordshire, Occupational Health, Localities and Learning Disabilities to cover vacancies, sickness and maternity leave.
- Countywide was over spent due to complex care costs from new high cost placements and additional inpatient costs covering vacancies and clinical need.
- Human Resources was over spent due to nursing and medical agency costs in Occupational Health and unbudgeted employment tribunal costs.
- Other was under spent due to development funds not being utilised.
- Income is over recovered due to additional funds from Supporting People, Community Care and development income.

Forecast Outturn

- Stroud locality is forecast to be over spent due to higher than budgeted Supporting People costs. This is matched by additional income.
- Social Care Management is forecast to be over spent due to over performance against the funded level for Community Care, which is offset by additional income.
- Countywide is forecast to be over spent due to complex care costs from new high cost placements and additional inpatient costs covering vacancies and clinical need.
- Herefordshire is forecast to be over spent due to agency costs to cover specialling and vacancies across all wards.
- Medical costs are forecast to be over spent due to agency usage across many areas.
- Human Resources is forecasting an over spend due to agency costs within Occupational Health.
- Income will over recover due to additional funds for Supporting People, Community Care, Improving Patient Safety and development income.

A mid-year review of the financial position was undertaken and reflected in the report. All aspects of financial performance were reviewed from budgets to agency spend and savings and capital. The review concluded that the Trust remains on track to deliver its financial control total of a £654k surplus in 2016/17. As part of the review the financial plans and assumptions for 2017/18 were updated to reflect the latest assumptions on income, expenditure, capital, savings and reserves in light of the work on the Sustainability and Transformation Plans process, and the proposed control totals for 2017-19. The figures in this report formed the basis of the financial projections in the Operational Plan submitted to NHS Improvement on the 23rd December, and underpin the budget setting exercise that is well advanced.

The cumulative Public Sector Payment Policy (PSPP) performance up to month 9 is 86% of invoices paid in 10 days and 97% paid in 30 days. The cumulative performance to date is depicted in the chart below and compared with last year's position. It highlights that the Trust has a strong balance sheet and has the cash available to consistently pay its invoices promptly and meet the Public Sector Payment Policy target of 95% of invoices paid within 30 days.



	2015/16	Apr 16	May 16	Jun 16	July 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
Over 30 days	1,127	49	81	150	211	307	436	546	606	651			
11 to 30 days	3,716	298	435	692	918	1,085	1,452	1,630	1,941	2,242			
Within 10 days	23,045	2,580	4,214	6,171	8,125	9,862	12,336	14,061	16,241	18,039			

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Delivery Committee

DATE OF COMMITTEE MEETING: 23 November 2016

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PERFORMANCE DASHBOARD

At the end of October, of the 147 performance indicators, 86 were reportable with 75 being compliant and 11 non-compliant at the end of the reporting period. The following key performance thresholds were not met for October 2016:

NHS Improvement Requirements

- 1.02 – Number of C. Diff cases - There was one case in October on Jenny Lind Ward in Herefordshire. After the first review indications were that the patient was a C. Diff carrier and therefore this incident was potentially unavoidable, however, results of further diagnostic tests were still required before this case could be confirmed as either avoidable or unavoidable. This case would be reported as avoidable until it could be confirmed and agreed with commissioners that it was unavoidable.
- 1.07 – New psychosis (EI) cases as per contract - Gloucestershire reported 37 new cases so far this year against an expected threshold of 42 and Herefordshire reported 16 new cases against an expected threshold of 14. The Trust was 3 cases below the 62 new cases required. The Committee noted that this had previously been looked at 'in month' which meant figures varied. This was now being looked at 'over the month' and work continued to agree an accurate threshold for both counties.
- 1.09 – IAPT: Waiting times - Referral to Treatment within 6 weeks
- 1.10 – IAPT: Waiting times - Referral to Treatment within 18 weeks

Gloucestershire CCG Contract Measures

- 3.18 – IAPT Recovery rate: Access to psychological therapies should be improved
- 3.19 – IAPT Access rate : Access to psychological therapies should be improved

Herefordshire CCG Contract Measures

- 5.08 – IAPT Recovery rate – those who have completed treatment and have "caseness"
- 5.09 – IAPT maintain 15% of patients entering the service against prevalence - The Committee noted that the IAPT service was subject to an agreed Service Development Improvement Plan which was under specific monthly review by the Delivery Committee.
- 3.30 – MHICT (IAPT/Nursing Integrated service): 14 days from referral to screening assessment - The new MHICT Service Specification was under review. Once this was complete and a contract variation was finalised this indicator would change to report on nursing activity only. This indicator was unlikely to be compliant until that piece of work was completed.

Social Care – Gloucestershire CCG Contract Measures

- 4.06 – Percentage of service users asked if they have a carer

- 4.07 – Percentage with a carer that have been offered a carer's assessment - The new data collection form relating to the above indicators went "live" in RiO in June 2016 and work was on-going to inform staff about the new way to record carer information. These indicators were slightly below the planned improvement trajectory and would be highlighted again with staff in an attempt to improve compliance. A focussed report to include plan and trajectory was scheduled to be brought to the Delivery Committee in January.
- 4.03: Ensure reviews of new packages take place within 12 weeks of commencement - An early warning regarding this indicator was reported. Work had been carried out involving the Social Care Team, Clinical Systems Team and Information department to enable this information to be captured on RiO. This work was nearly complete and it was anticipated that performance would be reported from the January meeting.

The Committee noted the Performance Dashboard Report for October 2016 and were significantly assured that the Trust's contract and regulator performance measures were being met or that appropriate action plans were in place to address areas requiring improvement.

CQUIN IMPLEMENTATION
Quarter 1 reports had been submitted for 2016/17 and were all deemed fully compliant. The Q2 reports had been submitted on time and at the time of writing the results from all three commissioning bodies were awaited.

LOCALITY REVIEW – GLOUCESTERSHIRE SOUTH
The presentation included an overview of the team structure, current service delivery statistics and performance against HR and finance targets. The Committee noted the high level of compliance, with 97% of staff having completed Statutory and Mandatory training.

Current developments in the South Locality included the Stroud & Berkeley Vale Pilot which involved health and social care organisations across the locality working together to provide joined up care. The Triangle of Care approach was being adopted within the Locality with the Social Inclusion Team supporting the initiative. The Accommodation Service was currently undertaking focussed work with hard to house service users.

The Locality had been proactive in engaging with young people and encouraging them to think about careers in healthcare. Three young people had undertaken work experience, resulting in one person undertaking their student nurse training and another going into medicine. The Committee was pleased to note one student had won an award for work experience placement of the year at the 'Grow Gloucestershire awards'.

IAPT SERVICE IMPROVEMENT PLAN
This report updated the Committee on all aspects of the IAPT recovery plans. The Committee noted that the implementation of the service development improvement plans was overseen by the Trust's IAPT Project Delivery Team which included clinical, operational, project management, finance, and HR staff representation. The report identified any risks relating to the delivery of the agreed recovery plan. The Committee noted the following key issues:

- Waiting list backlog clearance had been achieved in line with plans; with waiting lists in both counties now within the national standard of 95% of patients treated within the 18 week wait time threshold.
- Access rates were under the levels set out in the improvement plan trajectory; this was mainly due to staff capacity in both localities being below the level set out in the staffing capacity plan. Work to increase staffing levels in both counties was ongoing and it was anticipated that with the number of permanent staff appointments made levels were scheduled to come on line in the coming months.
- Recovery rates were improving on previous months and were now above the national average of 40% in both localities. It was anticipated that with recent changes made to the

care pathway the improvement in recovery rates would continue. The 50% target was expected to be reached by year end.

- The 18 week national waiting time threshold was now being achieved. However the combined step 2 and step 3 overall position was slightly under performing against the trajectories in the plan for achieving the national standard of 75% of patients treated within 6 weeks.

It was noted that improvement was not happening as quickly as had been hoped and the IAPT Delivery Team were planning a review of all of the improvement plan objectives and milestones; with a view to resetting the planned trajectories for access and waiting time thresholds. Going forward the full IAPT Service Improvement Report would be brought to the Committee bi-monthly and the dashboard would be brought monthly. A draft IAPT Service Improvement interim report, including a mock-up of what the monthly dashboard report would look like would also be included.

SERVICE PLANNING QUARTERLY REVIEW

The Committee reviewed progress against the Trust's Service Plan and noted the intended actions. The report included narrative around those "red" rated objectives.

The Committee discussed the usefulness of receiving this report as Service Planning was now embedded in services and reviewed at Locality Delivery Committees. It was agreed; however, that the report would continue to be received at the Committee quarterly, with a clear executive summary included highlighting what the findings of the report were and including key risks and mitigation.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to note the content of this report.

SUMMARY PREPARED BY: Maria Bond **ROLE: Committee Chair**

DATE: 25 November 2016

2gether Making life better

2gether NHS Foundation Trust

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Governance Committee

DATE OF COMMITTEE MEETING: 16 December 2016

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

ESTABLISHMENT OF A QUALITY AND CLINICAL RISK SUB COMMITTEE

Following a consultation it had been agreed that a Quality and Clinical Risk Sub-committee (QCR) would be established. This would further strengthen the clinical governance structure for the Trust and provide opportunity for locality governance leads to have a more in depth debate about issues or concerns. In addition it would allow for scrutiny and challenge with all exceptions reported to the Governance Committee. From January, meetings of the QCR Sub-Committee would take place monthly at 9.30am -11am on the dates already advised. The Governance Committee meetings would be held bi-monthly from February to follow the QCR meetings. These new arrangements would be reviewed in 6 months' time to determine whether they were adding value and to ensure that robust quality and clinical risk mechanisms were in place.

PATIENT SAFETY

There had been one Serious Incident reported during November in Herefordshire. Although the numbers of serious incidents were reducing, the numbers of suspected suicides were rising and there was a trend of more fatalities from incidents. The National Inquiry had shown a peak in Suicides of people not referred to Crisis Teams and that this demonstrated the importance of people being able to access Crisis Care.

The SI Action Plan 2015/16 contained 6 outstanding amber actions which required some additional assurance before full closure (9 previously when last reported in October 2016). The high number of actions on the 2016/17 action plan not closed was noted and it was agreed that all non-closed and overdue actions from the 2016/17 Serious Incident Action Plan would be reported to the QCR meeting in January.

The Committee noted that the late provision of preliminary SI investigation reports from the Localities was causing delays in the process. Locality Governance Leads were asked to remind staff in the localities of the importance of providing timely preliminary investigation reports and it was agreed that the QCR Sub-Committee would monitor progress.

The Committee was significantly assured that the Trust had robust processes in place to report and learn from serious incidents.

SAFE STAFFING LEVELS

The Committee received the safe staffing levels report for November, noting that there was a significant level of assurance that this continued to be monitored and safe staffing levels were being maintained. There was discussion about the use of agency staff, noting that 2gether was not currently compliant with its control total. However, the Committee received detailed quarterly reports on the agency position and the actions in place to reduce agency expenditure. The position would continue to be monitored closely as this was not just a financial issue but also one of quality.

STAFF INCIDENTS REPORTS

Fire
The Committee noted that there was Significant Assurance on the potential for staff to respond appropriately in the event of a fire. Some staff had not undertaken their refresher training on time; however the Committee was assured that all staff had received some fire training. The new Learn2gether system provided automated reminders and compliance had now increased to 80%. The improved compliance was congratulated. Assurance on system, equipment and building maintenance and the management of fire had increased from Significant to Full Assurance.

Health and Safety
There were 51 Health and Safety incidents recorded and there were 25 closed incidents reviewed in this report. These incidents related to staff, visitors, contractors etc. Gloucestershire Countywide Services reported the greatest proportion of incidents across all types of Health and Safety incidents; however this reflected the nature of the services provided.

There was Limited assurance around the accuracy of the 'grade of harm' or level of seriousness of incidents as assessed by handlers. Consistency of data and trend analysis needed to be undertaken before significant assurance could be provided.

The Committee noted a significant reduction in the overall number of incidents reported across all areas in quarter 2, when compared with previous quarters; therefore there was Limited assurance that all incidents had been reported on Datix. The Committee noted that there was no specific Health and Safety category provided on Datix and conversations were taking place with other Trusts to share learning around the reporting of incidents.

COST IMPROVEMENT PLANS AND QUALITY IMPACT ASSESSMENTS
All CIPS had been reviewed on 12th December and the Committee was provided with significant assurance that the governance of the Cost Improvement Programme (CIP) savings and Quality Impact Assessment (QIA) process was effective.

JUNIOR DOCTOR CONTRACT UPDATE
It was reported that the local implementation of the New Contract for Doctors in Training was progressing well. Job plans were being completed and Junior Doctors were being advised. An issue of pressure on the Junior Doctors on-call rota system from midnight to 5am was noted and a piece of work was to be undertaken to address the appropriateness of out of hours contact.

OTHER ITEMS
The Governance Committee at its December meeting also received and noted the National Patient Survey Results, the Q2 Aggregated Learning Report, a Datix Update and an update on progress with the CQC Action Plan.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to note the content of this report.

SUMMARY PREPARED BY: Nikki Richardson **ROLE: Chair**

DATE: 22 December 2016

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Governance Committee

DATE OF COMMITTEE MEETING: 18 November 2016

KEY POINTS TO DRAW TO THE COMMITTEE'S ATTENTION

Patient Safety

There had been 7 Serious Incidents reported during October which is an increase from last month. All were in Gloucestershire.

There was discussion about the impact of the Coroners' Bill on internal timescales. As coroner processes are now quicker; the first relatives might hear of the findings from our internal review process could be from the coroners' office. A review was to be undertaken of the Trust's processes to address this.

Safe Staffing Levels

The Committee received the safe staffing levels report for October, noting that there was a significant level of assurance that this continued to be monitored and safe staffing levels were being maintained.

There was discussion about the use of agency staff, noting that 2gether was not currently compliant with its control total. However, the Committee received detailed quarterly reports on the agency position and the actions in place to reduce agency expenditure. The position would continue to be monitored closely as this was not just a financial issue but also one of quality.

Supervision

The Committee had requested a report on supervision compliance for Nursing and Occupational Therapy staff. Limited assurance was received regarding compliance but the Committee was assured that there were plans in place over the next 3 months to address this. A further review would be carried out by the Committee in January.

Safeguarding

Although the Trust's Safeguarding Lead provided significant assurance in relation to safeguarding activity within 2gether, limited assurance was provided regarding compliance with safeguarding training, which is affected by non-recording of the training and also its provision by the Local Authority. Issues had also been identified in relation to documentation on RiO.

Medical Education

The Committee received an excellent annual report on Medical Education. The Committee was particularly pleased to see an increase in the involvement of service users and carers in Medical Education activity.

Quarterly Review of NHSLA Claims

The Committee noted that at the end of quarter 2, 2gether had 11 open claims – 1 was a reopened claim under the Clinical Negligence Scheme for Trusts (CNST) and 2 within the Risk Pooling Scheme.

It was noted that the total value of CNST claims had increased significantly since the last quarter (from £3.6m to £10.675m) due to the impact of a recently reopened case. This has also impacted on our NHSLA Scheme contribution which has increased (40%) for next year. This will be offset in part by a decrease in LTPS (Liabilities to Third Parties Scheme) contribution but there will be a net increase of £33,365 for 2017/18. The Trust is rated as Amber by the NHSLA, which places the Trust in the middle 60% of the Mental health group.

Assessment and Care Management Audit Report

This continues to receive considerable scrutiny from the Governance Committee as there has been on-going concern regarding compliance rates. Unfortunately, only a 1% increase in compliance was seen since the last audit (now at 51%) which provided limited assurance. A Task and Finish Group has been set up to look at the issues that have been identified and to seek a way forward to improve compliance.

Clinical Audit Programme

The Committee received significant assurance around the process in place to action and monitor the audit programme; however, of the 11 audits carried out between August and November, 9 were RAG rated Red, many of which had been rated as Red previously and therefore have shown little or no improvements in compliance. This offered the Committee limited assurance and the Committee has therefore asked that the Task and Finish Group approach that is being adopted for the care management audit is considered for these non-compliant audits.

The Committee also considered the draft audit plan for 2017/18; which if the number of non-compliant audits that would have to be carried over if progress isn't made are included, at present totals 112. The Committee raised concern at the size of the programme and asked that this be reviewed.

Other Items

The Governance Committee at its November meeting also received and noted the Quarter 2 Quality Report, the Service Experience Report and the revised Risk Management Framework – all of which would be presented to the Board.

ACTIONS REQUIRED BY THE COMMITTEE

The Board is asked to note the content of this report.

SUMMARY PREPARED BY: Nikki Richardson **ROLE: Chair**

DATE: 22 November 2016

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Mental Health Legislation Scrutiny Committee

DATE OF COMMITTEE MEETING: 11th January 2017

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

The Chair reported that an Operational Group composed of key staff dealing with MHLS issues had now been set up and would hold its first meeting before the end of the month. It would meet bi-monthly thereafter between the MHLSC meetings and it was hoped that the Group would resolve outstanding points on the Action Log. The Group would look at what CQC inspectors were focussing on and how the Trust could prepare better for inspections. The Committee decided that it was not necessary at this stage to establish formal terms of reference for the Operational Group, though it would look again at this if necessary.

MENTAL HEALTH LEGISLATION TRAINING

At the November meeting the Committee requested a further update on training figures. Overall compliance was increasing, but there was still more work to do. There was also some variation between and within each area. The Committee noted that CYPS had achieved 97% compliance, though there were lower levels of compliance for bank staff.

REVIEW OF MHA COMMISSIONER (CQC) VISITS

The Committee received assurance on the processes, responses and actions to address observations made by CQC inspectors conducting annual inpatient monitoring visits. The Committee noted that there had been 5 visits by the CQC to the Trust inpatient units for the reporting period October to December 2016. Of the twelve action statements submitted to the CQC, 6 had been closed with all actions completed, 6 remained open with actions that were being managed centrally; Process for photographing patients for AWOL purposes (CoP Section 27.22) and the recording of advance decisions and statements) and 5 reports had been added recently and would be actioned over the coming months.

The Committee noted that the CCTV Policy had been revised to include the use of CCTV for capturing patient images for use during AWOL events. The Trust was awaiting confirmation from the CQC that they were happy with this approach.

SECLUSION POLICY

Sally Simmonds updated the Committee on the work being carried out on the Trust's Seclusion Policy. Two special area policies, De-escalation and Extra Care Area (ECA), had been reviewed by the Consultant Nurse and it was found that the Trust's ECA Policy did not meet CQC requirements. The Policies had now been updated in line with DoH and CQC guidelines. The Committee noted that there were no seclusion or de-escalation areas anywhere else in the Trust although seclusion may happen in individual rooms if necessary.

HUMAN RIGHTS REPORT

Colin Merker provided the Committee with a framework to demonstrate assurance around the monitoring of patients human rights, including how this was measured. The Committee suggested that the areas within the framework should be linked to particular parts of the act.

RISK REGISTER AND DASHBOARD REPORT

Alan Bourne-Jones provided the Committee with details of those higher scoring risks (risk score 12 and above) that were on the Corporate Risk Register. The Committee noted that there were no key risks for which it had oversight responsibility. However, it did have responsibility for the following higher scoring risk identified at the previous meeting; this had been given a provisional limited assurance level:

- AMHP Service provided by EDT (Emergency Duty Team) - If the AMHP Service provided by EDT is not appropriately staffed because of availability then cover may not be provided in evenings, overnight and weekends; thereby adversely affecting patients.

HEALTH-BASED PLACE OF SAFETY

Establishment of a Health-Based Place of Safety in Herefordshire
Colin Merker reported that there was currently no Health-Based Place of Safety in Herefordshire. However, £250,000 of funding had been secured to enable the Trust to make improvements to accommodation. Work was likely to be completed by September.

Use of the Health-Based Place of Safety Gloucestershire
Les Trewin reported that there was an established Health-Based Place of Safety at Wotton Lawn. This facility consisted of 2 rooms staffed by the crisis teams and there was a multi-agency S136 Policy in place. In 2016 there were 441 detentions; peaking at 70 in one month. There had been an increase in assessments and discussions were taking place with the Police around the number of detentions.

The Committee noted that around a third of the people taken to the S136 Suite were discharged without action. The Crisis Team was working closely with the Police and it was hoped that fewer people would be brought to the suite in future.

ITEMS FROM MHA FORUM 14 DECEMBER

Quinton Quayle reported that the Forum had discussed the issue of future allowance payments for MHA Managers and Les Trewin had confirmed to the forum that the Executives had agreed an increase to £50 per session from January 2017. However, MHA Managers agreed to defer this increase until the next financial year.

ACTIONS REQUIRED BY THE COMMITTEE

The Board is asked to note the contents of this report.

SUMMARY PREPARED BY: Quinton Quayle **ROLE: Committee Chair**

DATE: 11 January 2017

BOARD COMMITTEE SUMMARY SHEET

NAME OF COMMITTEE: Mental Health Legislation Scrutiny Committee

DATE OF COMMITTEE MEETING: 9th November 2016

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

REVIEW OF MENTAL HEALTH LEGISLATION TRAINING

Following the CQC inspection in October 2015, a series of actions were agreed to address the concern that staff had a lack of knowledge around the new MHA Code of Practice and the MCA (2005), including the Code of Practice. A number of recommendations were agreed, including the publication of a mandatory read MCA/MHA Legislation Briefing document and the development of a new e-learning course which would be made mandatory for clinical staff. A further update, including a breakdown of compliance with training would be received at the next meeting.

REVIEW OF MHA COMMISSIONER (CQC) VISITS

There had been no visits by the CQC to inpatient units for the reporting period August to October 2016 and no further reports had been issued.

Progress on actions from previous reports was provided along with a summary of completed and outstanding actions from CQC Monitoring Visit Reports (January 2016 to October 2016). The Committee noted that of the twelve action statements submitted to the CQC:

- 4 had been closed with all actions completed.
- 4 remained open with all actions scheduled to be completed in line with original targets.
- 2 remained open with an action that was being managed centrally.
- 2 remained open with some actions having passed their completion dates and/or an update not having been provided.

It was agreed that the monthly operational meeting would receive updates on the actions and take decisions on what needed to be done.

REPORTS OF ISSUES ARISING AT MHA REVIEWS

Eight MHA Hearing Issue forms had been received between 6 July and 31 October 2016. Issues included attendance of care coordinators, service users and advocates and availability of the Nursing Report. All issues raised required an investigation and corresponding action to address shortfalls or improvements needed. These actions were captured in the MHA Managers' issue form and monitored by the Assistant Director of Service Continuity. A summary of the 17 actions from hearing issues that arose between 1 January 2016 to 31 October 2016 was received and it was noted that:

- 13 had been closed with all actions completed within the original target date set
- 3 had been closed with all actions completed outside of the original target date set.
- 1 remained open with all actions expected to be completed within the original target date.

KEY PERFORMANCE INDICATORS

Significant assurance of compliance with the MHA and Code of Practice was provided. A number of trends were highlighted; however, none appeared to be of significant concern. The trends for holding in a Health-Based Place of Safety were very different in both counties and it was reported that there was currently no Health-Based Place of Safety in Herefordshire. Provision of this was being investigated and if established figures were likely to increase. The use of S136 and the establishment of a Health Based Place of Safety in Herefordshire would be monitored.

MHS POLICIES – MHLSC MONITORING

SCT Concerns of the Family

The Committee noted that in November 2016, of the 35% of cases where a carer or relative had raised a concern 100% of these concerns had been followed up. The Committee noted that the outcome of this review had been shared with the Director of Engagement and Integration and would be added to the work currently underway in relation to Triangle of Care, which provided evidence of ongoing support and engagement with carers. The Committee agreed that this review and the Triangle of Care offered a significant level of assurance of compliance with the Policy.

INTERNAL AUDIT REPORT

Section 17 Leave Arrangements

The audit was carried out on a random sample of 40 patients from Gloucestershire and Herefordshire detained under S2, S3 or S37 of the MHA for whom S17 leave had been authorised. Compliance across nine audit criteria was measured; seven were the same as for the previous audit, one was not directly comparable and two criteria were not applicable. Average compliance was 73%; a reduction on last year's aggregate of 76%. Compliance for one criterion had improved but had worsened for three and remained static for one. Compliance was better in Gloucestershire than Herefordshire which was the opposite of last year. A review of the S17 Leave Arrangements Policy was due to be carried out and an update would be provided at the next meeting of the MHLSC.

Follow up Audit of T2/T3 Compliance

A pilot audit was carried out at Wotton Lawn Hospital (WLH) in March 2016 with the aim of identifying and quantifying any compliance issues and testing the methodology. This identified two main areas of concern:

- treatment authorisations were not always attached to the drug chart;
- drugs prescribed were not always compliant with the T2/T3 authorisation forms.

Following actions to address these issues, a re-audit was carried out in July 2016 this found an improvement in compliance from 60% to 69%. All treatment certificates were uploaded to RiO and were present in 64% of paper notes; an improvement from 56%. 23% were attached directly to the prescription chart, a further 64% were present in the drug chart folder but not directly attached. All of the files had the most recent T2/T3 form present, an improvement on the previous audit when two were out of date. 91% of certifications were fully compliant and covered all psychotropic drugs prescribed, a significant improvement from the 60% compliant in the previous audit. There were only two non-compliance issues in total, compared to 14 in the previous audit.

Capacity to Consent to Admission

A previous audit of the recording of Capacity to Consent to admission had found that

compliance was poor and further work had been carried out. The definition of the gatekeeper had been clarified as the person offering admission to Hospital. With that definition in mind the previous findings had been reconsidered and showed improvement. This was good progress and a positive direction of travel; it was agreed that this report provided significant assurance.

SECLUSION ASSURANCE REPORT

A Trust Seclusion Policy was to be developed but this had now been superseded by a National Policy. A full report would be brought to the next meeting to consolidate the work on the Seclusion Policy.

ADVOCACY ASSURANCE REPORT

From January 2016 to date, there had been 7 reported issues regarding Advocacy provision at MHA Managers hearings that had given rise to some concerns. These issues had been reported to the MHA Administration Team and jointly investigated by the Head of Health Records and the Assistant Director of Service Continuity. A series of meetings to more fully understand the issues had taken place and the Committee noted the process for which these were more formally lodged and investigated. One issue remained unresolved but action was taking place to address this. The Committee was substantially assured around the systems and processes in place.

COMPLIANCE WITH SECTION S27.22 OF THE MHA (POLICY FOR RECORDING OF PHOTOGRAPHS)

Meetings had taken place to discuss the best approach for recording photographs of patients; legal advice had been sought and the Trust had been advised that CCTV could be used if certain conditions were met. The quality and capability of CCTV provision across the Trust had been examined and upgrades to the system were being considered; a capital sum would be required and the issue had been referred to Executives Committee. An update would be provided at the next meeting of this Committee.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to note the content of this summary report.

Agenda item 12 **Enclosure Paper G**

Report to: Trust Board - 26 January 2017
Author: Ruth FitzJohn, Trust Chair
Presented by: Ruth FitzJohn, Trust Chair

SUBJECT: **CHAIR'S REPORT**

Can this report be discussed at a public Board meeting?	**Yes**
If not, explain why	

This Report is provided for:			
Decision	Endorsement	**Assurance**	**Information**

1. PURPOSE, ASSURANCE AND RECOMENDATION

This report sets out the key activities of the Trust Chair and Non-Executive Directors for the period 17 November 2016 – 16 January 2017.

The report offers full assurance that regular, targeted and purposeful engagement is being undertaken by the Chair and Non-Executive Directors aiming to support the strategic goals of the Trust.

This report is for information only and the Board is invited to note the report.

2. CHAIR'S KEY ACTIVITIES

- Chairing two Board meetings one in Herefordshire and one in Gloucestershire
- Chairing a Nomination and Remuneration Committee of the Council of Governors
- Chairing an Appointments and Terms of Service Committee of the Board
- Chairing a Development Committee of the Board
- Attending a Safeguarding event of the Health and Well Being Board at Shire Hall
- Attending the Gloucestershire Health, Oversight and Scrutiny Committee meeting at Shire Hall

- Attending pre and post meetings and chairing the judging panel for the Recognition Outstanding Service and Commitment Awards
- Visiting the Children and Young Peoples Service and Learning Disability teams in Evergreen House based at Charlton Lane, Cheltenham
- Meeting with the newly recruited Director of Organisational Development as part of their induction
- Meeting with the former Director of Organisational Development
- Meeting with the Chief Executive and Director of Organisational Development
- Meeting with the Lead Governor
- Meeting with a Herefordshire Councillor in Hereford
- Meeting with the newly appointed Chair from Gloucestershire Hospitals NHS Foundation Trust
- Meeting with a former Non-Executive Director of the Trust
- Meeting with the newly appointed Chair from AWP NHS Trust
- Teleconferencing with a candidate for the role of chair of Leeds and York Partnership NHS Foundation Trust
- Meeting with the Public Health Registrar
- Hosting a visit of Herefordshire Councillors to Stonebow Unit in Herefordshire
- Attending the Bishop's Breakfast at Gloucester Cathedral, leading a county wide session on young people's mental health together with the Director of Engagement and Integration
- Meeting with the Chair of South Warwickshire NHS Foundation Trust in Warwick
- Attending a meeting of the Gloucestershire GP Education Trust in Cheltenham
- Attending a meeting with Chief Executive of OPENhouse in Stroud
- Attending an interview at BBC Radio Gloucestershire
- Attending the Gloucestershire Chartered Institute of Personnel and Development Human Resources Directors' Forum in Cheltenham
- Participating in a NHS Improvements stakeholder research telephone call
- attending a meeting of south west NHS chairs and the Chief Executive of NHS Providers
- Meeting with the Head of Patient Experience and Involvement from Ashford and St Peters Hospital NHS Foundation Trust

- Writing individually to every New Year's Honours recipient from Herefordshire and Gloucestershire and every recipient nationally of an award related to mental health, learning disability and inequalities

- Meeting with a Trust Governor at their request

- Participating in the recruitment of a Non-Executive Director for the Trust through various meetings, calls and emails

- Meeting with and preparing objectives for a newly appointed Non-Executive Director

- Additional regular background activities include:
    - attending and planning for smaller ad hoc or informal meetings
    - dealing with letters and e-mails
    - reading many background papers and other documents.

3. NON-EXECUTIVE DIRECTORS' ACTIVITIES

Jonathan Vickers

Since his last report Jonathan Vickers has;

- Prepared for and attended two board meetings
- Prepared for and chaired two development committee meetings
- Prepared for and attended an ATOS meeting
- Attended a board visit at Park House
- Held discussions with the Director of Finance on development committee matters
- Prepared for and attended a board strategy session
- Attended a training day on psychosis awareness
- Attended an informal board gathering

Nikki Richardson

Since her last report Nikki has;

- Attended a MHA Managers hearing
- Visit to Alexandra Wellbeing House
- Prepared for and attended a Governance Committee
- Meeting regarding NED complaints audit process
- Attended a Gloucester CCG STP meeting
- Prepared for and attended a Board meeting
- Meeting regarding NED recruitment process
- Prepared for and attended an Appointments and Terms of Service Committee
- Prepared for and attended a MHLS Committee
- Participated in group assessments for Head of Communications recruitment
- Attended the HFMA Annual Chairs Conference
- Attended a Service Experience Committee
- Meeting with Trust Secretary Office
- Attended a CYPS Takeover Challenge event
- Prepared for and attended a Delivery Committee
- Meeting with the Chair

Marcia Gallagher

Due to annual leave commitments, a verbal report will be presented at the Board meeting.

Duncan Sutherland
A verbal report will be presented at the Board meeting.

Quinton Quayle
Since his last report, Quinton Quayle has:

- Prepared for and attended three Mental Health Act Manager Review Meetings
- Prepared for and attended a board meeting
- Prepared for and attended a meeting of the Delivery Committee
- Met a group of young service users in Gloucester at an event entitled "Mapping our Journey"
- Prepared for and attended a Mental Health Act Managers Forum
- Prepared for and attended two meetings of the Governors
- Prepared for and attended an Appointments and Terms of Service Committee meeting
- Prepared for and chaired the Mental Health Legislation Scrutiny Committee

Maria Bond
Since the last meeting, Maria Bond has:

- Attended a Training session for Mental Health Act Manager Role
- Had one week annual leave
- Prepared for and attended a board meeting
- Prepared for and attended an Appointments and Terms of Service Committee
- Prepared for and attended a personal objective setting meeting with the Chair
- Prepared for and attended a Council of Governors meeting
- Prepared for a board strategy meeting (subsequently postponed)

4. OTHER MATTERS TO REPORT

There are no specific matters to be drawn to the attention of the Board at the time of writing.

[2]GETHER NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING
THURSDAY 10 NOVEMBER 2016
BUSINESS CONTINUITY ROOM, RIKENEL, GLOUCESTER

PRESENT:

Ruth FitzJohn *(Chair)*	Hazel Braund	Alan Thomas
Vic Godding	Jo Smith	Dawn Lewis
Rob Blagden	Paul Toleman	Mervyn Dawe
Cherry Newton	Jenny Bartlett	Hilary Bowen
Tristan Lench	Ann Elias	Katie Clark
Richard Butt-Evans	Said Hansdot	Svetlin Vrabtchev
Pat Ayres		

IN ATTENDANCE: Colin Merker, Deputy Chief Executive
Maria Bond, Non-Executive Director
Marcia Gallagher, Non-Executive Director
Alan Gillespie, Member of the Public
Andrew Lee, Director of Finance & Commerce
John McIlveen, Trust Secretary
Quinton Quayle, Non-Executive Director
Nikki Richardson, Non-Executive Director
Andrew Smart, Head of Communications (Item 12)
Carol Sparks, Director of Organisational Development
Jonathan Vickers, Non-Executive Director
Charlotte Hitchings, Non-Executive Director
Bren McInerney, Member of the Public

1. WELCOMES AND APOLOGIES

1.1 Apologies for the meeting had been received from Roger Wilson, Paul Grimer, Jennifer Thomson, Elaine Davies and Amjad Uppal. Shaun Clee had also sent his apologies, and Colin Merker would deputise for Shaun at the meeting.

1.2 Governors were asked to welcome Hazel Braund, Appointed Governor from Herefordshire CCG, who had taken over that role from Simon Hairsnape.

2. DECLARATION OF INTERESTS

2.1 Hilary Bowen asked the Council to note that she was a Governor of the Barnwood Trust. This had previously been recorded as Barnwood “House” Trust and would be corrected.

2.2 Al Thomas informed the Council that he had been appointed as Vice Chair of Healthwatch Gloucestershire.

3. COUNCIL OF GOVERNOR MINUTES

3.1 The minutes of the Council meeting held on 13 September were agreed as a correct record, subject to a change in the attendance list as Kate Nelmes had not attended the meeting.

4. MATTERS ARISING, ACTION POINTS AND EVALUATION FORM

4.1 The Council reviewed the actions arising from the previous meeting and noted that the majority of actions had been completed, or were progressing to plan. The inclusion of more detail against "completed" actions was helpful by way of tracking progress and adding additional assurance of completion.

4.2 With regard to action 10.11, Alan Thomas said that he could not find the new Performance Information section on the Governor Portal. John McIlveen agreed to check and update the portal if necessary and notify Governors accordingly. The Council agreed that action 10.11 would therefore remain open.

5. REVIEW OF LAST MEETING'S EVALUATION FORM

5.1 Ruth FitzJohn noted that following the last meeting, a number of issues had been raised through the meeting evaluation forms. The Trust had provided a written response to this feedback given the range and number of responses received. Governors were asked to return evaluation forms from future meetings to the Assistant Trust Secretary either at the end of the meeting, or at most within 3 days, so as to give Executive Directors sufficient time to respond, where necessary, to any issues raised.

ACTION: Governors to return evaluation forms to the Assistant Trust Secretary within three days of each Council meeting

5.2 The Council noted that the evaluation forms seemed to be working well, and Governors had generated some constructive feedback and learning points which the Trust would take on board. These included achieving the right balance between written reports in advance and verbal reports at the meeting, the timings allocated to agenda items, the balance between conciseness and detail in written reports, the need to be aware of body language at meetings, and the need to avoid acronyms. Comments in the evaluation forms about improved engagement and partnership between the Board and the Council were welcomed.

5.3 Some feedback would have benefitted from more detail, and the Council agreed to review the evaluation form in 2017 to provide more space for explanatory comment. This review would take place as part of a wider review of the Board/Governor development programme.

ACTION: Evaluation form to be reviewed as part of a wider review of the Board/Governor development programme to provide more space for explanatory comment

6. CHIEF EXECUTIVE'S REPORT

6.1 Colin Merker gave the Chief Executive's report to the Council of Governors, which is intended to draw Governors' attention to key areas for awareness, information or for exploring further if of sufficient interest. The Council was assured that the content of this verbal report would be captured fully in the minutes in order to provide Governors with a written record.

National Initiative Funding

6.2 The Trust has recently been working with CCG colleagues in both Herefordshire and Gloucestershire in relation to a number of bids for National Initiative monies around “Perinatal Mental Health Services” and “Place of Safety Services”.

6.3 The Perinatal Mental Health Services funding was recurrent funding, which would be available on a year on year basis, to fund the ongoing service delivery. The Place of Safety funding was capital funding which would be available as a one-off to fund a defined capital development, and would not cover any ongoing running costs associated with either the service that would operate from the capital development and/or the cost of the capital development itself.

6.4 In Gloucestershire the Trust has been awarded funding for the development of a Perinatal Mental Health Service. This service will enable the Trust to significantly improve services that will undoubtedly benefit many mums and young children within Gloucestershire. Unfortunately the Trust’s bid for a similar service in Herefordshire and Worcestershire was unsuccessful.

6.5 2gether has however been successful in Herefordshire in being awarded capital funding to support the development of a Health Based Place of Safety, as part of our Stonebow inpatient services unit. The capital development will take until September/October 2017 to complete and during this time we will continue to work with CCG colleagues and in particular Police colleagues to progress the proposals around the operational/clinical services development, which will need to be put in place for the Health Based Place of Safety to become fully operational.

6.6 This is a significant service development for Herefordshire which will offer great benefits to people bought into our care under Section 136 of the Mental Health Act and will help us address an issue that has been of concern to Herefordshire Health and Police partners for some time. Gloucestershire already has a purpose-built Health-Based Place of Safety on the Wotton Lawn Hospital campus, known as the Maxwell Centre.

6.7 2gether has also been successful in Gloucestershire in being awarded capital funding to support the development of a Children and Young Persons Community-Based Place of Safety. This development will provide the facilities for us to develop an alternative to Wotton Lawn for children and young people who require some form of supported care, pending their possible transfer to an age-appropriate inpatient service and/or a return home with an appropriate community package of care. This innovative service development will span input from across all of Gloucestershire's children's services, the Voluntary Sector and our own services.

Wye Valley Trust

6.8 Colin Merker informed the Council that Wye Valley Trust (WVT) in Herefordshire was formally brought out of special measures by CQC last week. This is good news for the health care system overall, as all partners been working together to support WVT colleagues in the work they have been progressing to support the necessary improvements in the Acute Services they provide. This news has been a great boost for WVT staff for whom the placement in special measures

had a significant impact upon morale. As WVT move out of special measures, 2gether is aware that there will be changes in their senior leadership team and we will need to work closely with the incoming team so that the progress we have been making towards delivering integrated community mental health and physical health care services, alongside GP services, maintains the pace and programme we have established, and on which we have briefed members previously.

Sustainability and Transformation Plans – Herefordshire & Worcestershire and Gloucestershire

6.9 Both Gloucestershire and Herefordshire will be starting to share their individual Sustainability Transformation Plans (STP) that we have been working on over the last year in the coming weeks ahead.

6.10 As the various Partner and Stakeholder briefing material becomes available for each area over the next couple weeks, the Trust will ensure that Governors are kept sighted on this information as far as possible.

2017/18 and 2018/19 contract offers

6.11 On the 4th November 2016, The Trust received its two-year contract offers from both of our commissioners, Herefordshire and Gloucestershire CCG's. These contract offers have to be fully developed, agreed and signed off by the end of December 2016 and whilst the outline offers are in line with what 2gether had anticipated, they need to be informed by the agreed STP development plans for 2017/18, which are still being finalised/agreed at the current time. A further briefing on this issue will be available for Governors in January.

ACTION: Further STP briefing to be provided to Governors in January 2017

IAPT Recovery Plan

6.12 At the end of October 2017 the Trust achieved the first significant milestone in its IAPT recovery plans, whereby we now have nobody in Herefordshire or Gloucestershire waiting over 18 weeks for access to services. We will keep Governors briefed as our action plan progresses.

HSE Investigation Outcome

6.13 Governors will recall the tragic events of July 2014 and the death of a colleague, Sharon Wall, at our Montpelier inpatient services unit. The Trust has now heard from the HSE in relation to the conclusions from their investigation that has been ongoing for the last two years.

6.14 Their conclusions are that there is no further regulatory action that they need to progress in relation to the Trust. The Trust's thoughts remain with Sharon's family and friends for whom these events continue to have a profound impact.

6.15 As we have shared this outcome with our services and the staff directly involved in the incident, we know it has helped them find some closure and move on from the events. 2gether has implemented a range of improvements following our review of the incident, which hopefully will avoid similar future events

reoccurring. The learning and improvements we have made will be shared at a Regional/National level to help improve safety across services nationwide.

Gloucestershire Health and Social Care Awards

6.16 On Tuesday evening (8th November 2016), the Trust's Crisis Team was awarded the place of Mental Health Team of the Year at the Gloucestershire health and social care awards. Governors may also remember one of our senior social workers, Steve Keech, who unfortunately died earlier this year. Steve was also recognised at the awards for his significant input into Social Care practice. He was awarded the place of Social Care Professional of the Year. Steve's partner and members of his family were there to receive his award.

Other Items for Discussion

6.17 Hilary Bowen asked what arrangements were in place to support unaccompanied refugee children. Colin Merker replied that our services were open to all regardless of their point of origin. The Trust could call on specialist support and translation services if required.

6.18 Alan Thomas said that he believed that Governors were required to have a role in signing off the operational plan submission, and he asked about the process for involving Governors ahead of the submission date on 23 December, given that there was no Council meeting scheduled before then. Colin Merker referred to guidance from NHS England which confirmed that it was for the Board to sign off the plan before submission, but that Boards should have regard to the views of Governors in preparing the Trust's forward plans. The timescale for submission was considerably shorter than on previous occasions, but it was agreed that it was important for the Trust to involve Governors. Colin therefore suggested that a small working group be convened which could review the draft plan and provide feedback in to the Board before final submission on 23 December. The Council of Governors welcomed this suggestion, and Alan Thomas, Dawn Lewis, Rob Blagden and Mervyn Dawe agreed to take part in the working group.

ACTION: Governor working group to be convened (Alan Thomas, Dawn Lewis, Rob Blagden and Mervyn Dawe) to review the draft operational plan and provide feedback to the Board before the December submission

7. LEAD GOVERNOR REPORT

7.1 Rob Blagden presented the Lead Governor report and informed the Council that he had taken part in the Board Committee observation trial, having attended several meetings of the Delivery Committee. Rob informed the Council that he had witnessed a robust assurance and challenge process by the Committee, and outlined some of the specific topics which the Committee had considered. These included benchmarking arrangements, workforce indicators, and assurance reports about IT systems.

7.2 Rob said that his access to the Committee had been supported by the Trust, and that the observation process had been particularly valuable as it presented the only opportunity for Governors to see Non-Executive Directors in action. Rob noted that the observation trial would be reviewed in January, and urged other

Governors to take advantage of the opportunity to observe Board Committees should the process continue.

8. APPOINTMENT OF DEPUTY CHAIR AND SID

Nikki Richardson left the meeting at this point

8.1 The Council received a report concerning the appointment of a Deputy Chair and a Senior Independent Director. The appointments were required as Charlotte Hitchings, who currently held both roles, would be leaving the Trust at the end of the month to take up the role of Chair of Avon and Wiltshire Partnership NHS Trust. The report noted that the Deputy Chair appointment was a matter for Governors, while the appointment of a SID was a matter for the Board. Both roles must be drawn from the existing group of Non-Executive Directors. The report recommended that Nikki Richardson be appointed to both roles with effect from 1 December, and that she receive additional combined remuneration of £2500 per year for undertaking these roles.

8.2 Rob Blagden commented that while he was happy to endorse the recommendations in the report, Governors had not been involved in the process to select the candidate for Deputy Chair due to the timing of Charlotte's departure, and Rob suggested that the process might be reviewed for the future, perhaps to involve the Nomination and Remuneration Committee. Ruth FitzJohn said that had the Trust had longer to plan, a more extensive process would have been undertaken.

8.3 Mervyn Dawe asked how the additional remuneration for these roles had come about. Ruth FitzJohn explained that historically each role had attracted a separate additional payment. However, a previous Council had agreed to combine these two payments into one, given that the same person would be undertaking both roles.

8.4 The Council noted the recommendation to appoint Nikki Richardson to both roles until further notice, but felt that aligning the appointment with Nikki's term of office as a NED would be more appropriate. The Council therefore agreed to appoint Nikki Richardson as Deputy Chair with effect from 1 December 2016, until the end of her first term of office on 31 January 2018. The Council noted that Ruth FitzJohn would be recommending to the Board that Nikki also be appointed as the Senior Independent Director for the same term. The Council agreed that these roles should attract a combined additional remuneration of £2500 per year.

8.5 The Council thanked Charlotte Hitchings for her service and support, and wished her well in her new role.

Nikki Richardson re-joined the meeting at this point

9. PROPOSAL FOR APPOINTMENT OF A NON-EXECUTIVE DIRECTOR

9.1 The Council received a report from Carol Sparks regarding the appointment process for a new Non-Executive Director, which was required to bring the Board up to its full complement following Charlotte Hitchings' resignation.

9.2 The Council noted that the Trust uses an agency - Gatenby Sanderson - to undertake executive searches and to screen potential candidates. The Trust pays for this service only once a successful appointment is made. Following the last NED recruitment exercise, a number of highly eligible candidates have come forward to enquire about additional NED vacancies, meaning that the Trust would not need to utilise Gatenby Sanderson's network of contacts in order to produce a field of candidates, but could instead use its local contacts and hold a local recruitment process which would achieve a cost saving. The Council was assured that such a process would be robust and transparent, and would include local press advertising as well as national online advertising. There would be no dilution in the standards required of candidates. The Council noted that were the local recruitment to prove unsuccessful, a full recruitment process would be undertaken as usual through Gatenby Sanderson.

9.3 Paul Toleman asked how potential candidates could apply for the position if they did not see the advertisement. Carol Sparks agreed that if Governors knew of any prospective candidates, those candidates should contact Carol who would ensure that they were fed into the recruitment process. In response to a question from Mervyn Dawe, Carol Sparks confirmed that there were no contractual barriers to the Trust's suggested course of action, and that Gatenby Sanderson had agreed to screen at cost any candidates identified through the Trust's local recruitment.

9.4 The Council agreed to implement a local recruitment process to facilitate the appointment of a Non-Executive Director, and should this prove to be unsuccessful, to utilise the full resources of Gatenby Sanderson as the Trust's Executive Search agency.

10. BOARD/GOVERNOR DEVELOPMENT PROGRAMME REPORT

10.1 The Council received a close down report setting out the outputs from the joint Board and Governor Development Programme which had begun in 2015. The Council noted the developments arising from the programme, which had been delivered through working groups comprising Board members and Governors. These developments included a revised induction process, a Team Charter, a Council of Governor meeting evaluation form, a signposting document to assist Governors in directing queries about Trust services to the right person, a role description for Governors, and a revised Holding to Account process. The development programme had been a standing agenda item for Council meetings throughout 2016.

10.2 The Council agreed that the joint development work had produced some excellent outcomes.

10.3 The Council agreed that it would be helpful to review those outcomes, and that the best way to do so would be through a further development day, including both Board members and Governors, in a month when there was no Council meeting.

10.4 The Council therefore agreed to review the outcomes of the Board/Governor development programme by means of a development day for Board and

Governors which would be held in June 2017. The Trust Secretary would confirm the date and venue as soon as possible.

ACTION: Board/Governor development day to be arranged for June 2017 to review the outcomes of the Board/Governor development programme

11. HOLDING TO ACCOUNT – FINANCIAL ASSURANCE

11.1 Marcia Gallagher and Andrew Lee gave the Council a presentation focussing on the work of the Audit Committee in holding the Executive Directors to account for service and financial delivery performance, and in particular in terms of financial assurance. The Audit Committee's purpose is to provide the Board with a means of independent and objective review of financial and corporate governance, assurance processes and risk management. The Committee scrutinises the actions of management in delivering the Trust's objectives, strategy and regulatory/contractual obligations. The Committee receives assurance on compliance and performance in all areas, and because the Audit Committee comprises only NEDs who are members of other Board Committees, information can be triangulated to ensure consistency with other reports, and thus provide more robust assurance.

11.2 The Committee focuses on the clear identification of risk, mitigating actions and assurance, and looks for more detail if the assurance offered isn't clear. In her role as Audit Committee Chair Marcia signs the Trust's annual accounts to say that they are a fair and positive record. As Audit Committee Chair, Marcia also monitors the recommendations from Internal Audit reviews, to determine whether actions arising from those recommendations are completed in a timely way. At the last Audit Committee meeting there were only two Internal Audit recommendations outstanding, and Marcia had since received assurance over the telephone that these were being actioned.

11.3 Marcia outlined how she uses her 40 years' NHS finance experience, and the knowledge gained as a qualified accountant, to be assured about the Trust's financial performance and sustainability. In order to receive assurance on the financial position, Marcia meets Andrew Lee on a monthly basis to review the finance reports as part of her 'confirm and challenge' process. Marcia has ad hoc telephone conversations with Andrew to clarify any issues or queries which might arise between these scheduled meetings.

11.4 The key areas which she focusses on to receive that assurance include:

- reviewing the cash flow forecast in Board reports, and discussing queries with Andrew Lee in his role as the Director of Finance
- reviewing how promptly the Trust pays its bills. A slow-down in payments could signify forthcoming cash problems
- reviewing outstanding bills at the end of the financial year to determine how these might affect the Trust in the future
- reviewing how efficiently the Trust chases up monies owed to it
- monitoring the rate at which the Trust spends money throughout the year, in order to be assured that it will meet its control total target set by the regulator

11.5 As the Audit Committee Chair Marcia also needs to be assured that the Trust's savings plans are robust and deliverable, as these savings not only enable to

the Trust to meet its financial control totals but also to invest in safe and more effective services for patients. While the monetary impact of these savings plans is important, great emphasis is placed on the quality impact of any savings proposal. Quality Impact Assessments (QIAs) are conducted for each savings plan, in line with national good practice, and in her role as a member of the Board Marcia focusses on the assurances provided in the finance report that set out when QIAs have been, or are expected to be undertaken for each savings scheme, and the impact on quality of each savings plan.

11.6 Marcia and other members of the Board had received a mid-year finance review which had been undertaken by the Finance Team, in line with good practice. Andrew Lee outlined for Governors some of the key points contained in the mid-year review, which showed that the Trust expects to deliver its 2016/17 Financial Control Total, and the Trust's plans for 2017/18 anticipated a recurring balance position. Governors noted the expected financial outturn position for the years up to and including 2020/21.

11.7 A number of actions had been taken as a result of the mid-year review exercise. These included the re-introduction of financial performance reviews in all areas of the Trust, the review of planned maintenance, removal of all budget underspends on a monthly basis, and a review of the capital programme. Marcia and the other NEDs on the Board had thoroughly examined the content of the review and Marcia was assured that there was no 'bias for optimism' in the assumptions it contained.

11.8 Marcia concluded by noting some of the financial assurances available to Governors:

- In previous years the Trust has received an unqualified audit opinion from the External Auditors, which is a good result.
- Internal and External Audit plans are in place
- A Counter Fraud plan is in place
- The Trust currently has the highest possible rating from NHS Improvement. This will remain the case when the assessment rating methodology changes later this year.
- The Trust's CQC inspection produced an overall rating of 'Good.
- The Trust received a good outcome from its external Well Led Review of Governance.

11.9 Hilary Bowen asked about the Trust's performance in paying its bills. Andrew Lee replied that the Trust paid at least 90% of its bills within 30 days, which was the required standard, and paid 80% of its bills within 10 days.

11.10 Mervyn Dawe said that he felt reassured by Marcia and Andrew's presentation, and asked whether the Trust was required to maintain a reserve to ensure that it could meet its financial obligations for a period of time. Andrew Lee replied that Trusts were required to maintain a facility to meet one month's obligations. Trusts could either maintain this facility with a bank, (which would incur a cost), or as at 2gether, could keep money in the bank.

11.11 Rob Blagden asked whether Marcia was confident that she is aware of all risks to the Trust, and that these risks are being managed appropriately. Marcia replied that it was not possible to mitigate all risks, as some of these were

outside the Trust's control. Marcia confirmed that in terms of financial risk she is as assured as she can be at the moment, but once contracts are signed with commissioners, more assurance will be available.

11.12 Rob also asked how Sustainability and Transformation Plans would affect the Trust's finances. Andrew Lee replied that STPs would allow for a fixed amount of growth in terms of income, which had not been the case previously as the Trust was on block contract arrangements with its commissioners. Achievement of CQUIN (Commissioning for Quality and Innovation) payments would also provide additional funding for the Trust, but would depend on performance targets being achieved.

11.13 Jenny Bartlett asked how NEDs could be assured that cost savings plans were robust. Marcia replied that all savings plans were rated red, amber or green according to the timing of the savings delivery. NEDs would look for delivery of savings at the rate agreed. Marcia informed the Council that she had recently asked for a change in the way savings information was presented so that NEDs could be clearer about the year to date position regarding savings. Marcia also confirmed that if a savings plan goes off target, the Trust would look for alternative savings to compensate.

11.14 Alan Thomas informed the Council that he felt assured by what he had heard, and that it reflected his experience as a Governor observing the Audit Committee, where NEDs were persistent in their questioning in order to receive good assurance.

11.15 The Council thanked Marcia Gallagher and Andrew Lee for their presentations which had been very helpful and informative.

12. MEMBERSHIP REPORT

12.1 Andrew Smart provided an update for the Council of Governors about membership activity, the membership development plan and Governor Engagement Events.

12.2 In terms of membership statistics, the Council noted that there continued to be a steady increase in the number of members, including in respect of under-represented groups.

12.3 Plans were being made for Governor engagement events, including an event at Gloucester College's Cheltenham Campus in February 2017, and a possible event at Stroud College soon after.

12.4 Hilary Bowen asked whether efforts to increase membership might also increase pressure on the Trust's services. Ruth FitzJohn replied that if people needed the Trust's services, we were happy for them to come to us, but membership was not directly linked to service use. The Trust was seeking to recruit more members in order to support the work of the Trust and raise the profile of mental health.

12.5 Mervyn Dawe asked if Governors could be issued with a recruitment pack which could be handed out at Governor events to prospective members for

them to fill in on the spot. Andrew Smart agreed to provide Governors with membership materials.

ACTION: Andrew Smart to supply Governors with a membership recruitment pack to aid with new member recruitment

13. KEY ISSUES FOR DISCUSSION FROM THE GOVERNOR PRE-MEETING

13.1 Rob Blagden said that a number of the key discussion points from the pre-meeting had already been raised and responded to elsewhere in the meeting.

13.2 A request was made that thought be given as to how Governors might support the Trust when information appeared in the media whether information about key media issues could be shared with Governors as appropriate. Colin Merker agreed to consider this issue and report back to the Council.

ACTION: Colin Merker to consider how Governors could be kept briefed on key media issues.

14. GOVERNOR ACTIVITY

14.1 Governors updated the Council about activities they had undertaken in their role as a Governor.

15. ANY OTHER BUSINESS

15.1 Mervyn Dawe brought to Governors' attention a recent report in The Guardian regarding a shortage of mental health nurses, and asked what plans the Trust had to recruit nursing staff. Ruth FitzJohn replied that this was not primarily an issue for Council, but asked Carol Sparks to prepare a briefing note for Governors about the current state of vacancies and the process for recruitment.

ACTION: Carol Sparks to produce a briefing note for Governors regarding current nursing staff vacancies and recruitment process.

15.2 Mervyn Dawe asked about the cost to the Trust of Out Of County placements. Ruth FitzJohn replied that this was not an issue for Governors, but asked Colin Merker to provide a short note to Governors explaining the situation regarding Out Of County Placements and any costs to the Trust. Ruth FitzJohn informed the Council that the choice of placement was a matter for commissioners, not the Trust.

ACTION: Colin Merker to produce a briefing note for Governors regrading Out Of County Placements and any associated costs to the Trust

15.3 Cherry Newton asked whether the Trust has a plan to reduce suicide. John McIlveen agreed to post the Trust's Suicide Prevention Strategy onto the Governor portal.

ACTION: Suicide Prevention strategy to be posted on the Governor portal

15.4 A Governor recommended Radio 4's All in the Mind as a good source of information about mental health issues.

16. DATE OF NEXT MEETINGS

Council of Governor Meetings

Business Continuity Room, Trust HQ, Rikenel		
Date	**Governor Pre-meeting**	**Council Meeting**
2017		
Tuesday 17 January	9.00 – 10.00am	10.30 – 12.30pm
Thursday 9 March	1.30 – 2.30pm	3.00 – 5.00pm
Tuesday 9 May	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 13 July	9.00 – 10.00am	10.30 - 12.30pm
Tuesday 12 September	4.00 – 5.00pm	5.30 – 7.30pm
Thursday 9 November	1.30 – 2.30pm	3.00 – 5.00pm

Board Meetings

2017		
Thursday 26 January	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 30 March	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 25 May	10.00 – 1.00pm	Hereford
Thursday 27 July	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 28 September	10.00 – 1.00pm	Business Continuity Room, Rikenel
Thursday 30 November	10.00 – 1.00pm	Hereford

Council of Governors – Action Points

Item	Action	Lead	Progress
13 September 2016			
10.11	Governor Portal to be updated with a new section for the Performance Dashboard	Anna Hilditch	**Complete** Governor Portal and Handbook has been fully updated to include the performance dashboard reports. A network error was reported to the web developers in October but this has now been rectified and all documents have been uploaded.
12.2	Information about the Governor observation at Board Committees and upcoming engagement events to be shared with all Governors	Anna Hilditch	A review of the Board Committee observation trial will be taking place at the January 2017 Council meeting. Following this a new schedule of meetings will be issued and all Governors will be given the opportunity to participate in the process of observation
10 November 2016			
5.1	Governors to return evaluation forms to the Assistant Trust Secretary within three days of each Council meeting	Governors	Noted
5.3	Evaluation form to be reviewed as part of a wider review of the Board/Governor development programme to provide more space for explanatory comment	Trust Secretariat	Will be reviewed at joint Board/Governor Development session proposed for June 2017
6.11	Further STP briefing to be provided to Governors in January 2017	Trust Secretariat	**Complete** On agenda for January meeting
6.18	Governor working group to be convened (Alan Thomas, Dawn Lewis, Rob Blagden and Mervyn Dawe) to review the draft operational plan and provide feedback to the Board	Trust Secretariat / Andrew Lee	**Complete** Working Group to take place on 12 December to enable feedback to be given to the Board in time for the 23 December submission
10.4	Board/Governor development day to be arranged for June 2017 to review the outcomes of the Board/Governor development programme	Trust Secretariat	**Complete** Provisional date of Thursday 29th June at 2.00 – 5.00pm proposed for this development session
12.6	Andrew Smart to supply Governors with membership recruitment packs	Kate Nelmes	**Complete** Packs produced and offered to Governors. Proposal to distribute these at the January Council meeting unless requested to send in advance
13.2	Colin Merker to consider how Governors could be kept briefed on key media issues.	Colin Merker	Verbal update at the January meeting
15.1	Carol Sparks to produce a briefing note for Governors regarding current nursing staff vacancies and recruitment process.	Carol Sparks	**Complete** Sent out with hard copy of papers for January Council meeting

15.2	Colin Merker to produce a briefing note for Governors regrading Out Of County Placements and any associated costs to the Trust	Colin Merker	Carried forward to March 2017 meeting
15.3	Suicide Prevention strategy to be posted on the Governor portal	Anna Hilditch	**Complete** Gloucestershire Suicide Prevention Strategy and the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness have both been uploaded onto the portal under "Key Documents and Publications"

Agenda item **14** **Enclosure** **Paper I**

Report to: Trust Board, 26 January 2017
Author: John McIlveen, Trust Secretary
Presented by: John McIlveen, Trust Secretary

SUBJECT: **USE OF THE TRUST SEAL**

Can this report be discussed at a public Board meeting?	**Yes**
If not, explain why	

This Report is provided for:
Decision Endorsement Assurance **Information**

PURPOSE

To present the Board with a report on the use of the Trust Seal for the period October to December 2016 (Q3 2016/17).

SUMMARY OF KEY POINTS

Section 10.3 of the Trust's Standing Orders requires that use of the Trust Seal is reported to the Board on a quarterly basis.

"10.3 Register of Sealing - The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document. Use of the seal will be reported to the Board quarterly."

During the quarter, the Seal was not used.

RECOMMENDATIONS

The Board is asked to note the use of the Trust seal for the period October to December 2016